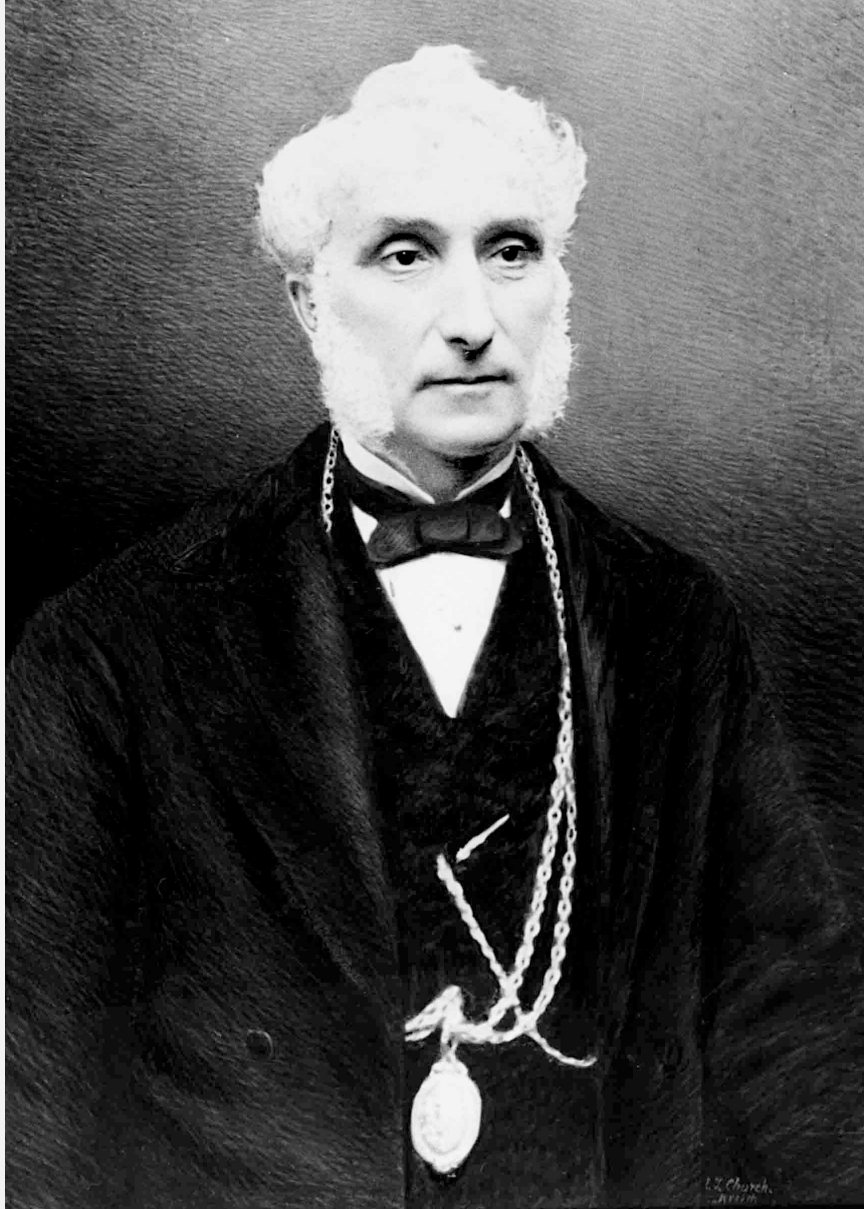


Records
of the
Medical Societies of Belfast.

1822–1884

Volume 2



Samuel Browne

Records
of the
Belfast Medical Society,
Belfast Clinical and Pathological Society,
Ulster Medical Protective Association,
and the
Ulster Medical Society.

1822–1884

Volume 2

Compiled by

J I Logan

BELFAST
27 February 2020

Samuel Browne, R.N., whose photograph is shown above, seems to have been a remarkably able man. He was an organiser and a leader and was concerned with the well-being of the societies he was president of, and with the well-being of the profession. He presented many cases to the societies and his descriptions of his major cases are significantly better than most other reports.

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2020
WHITLA MEDICAL BUILDING
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J. I. Logan

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*In Memory of All Those
Whose Suffering Is Described in These Records
Especially the Children.*

BELFAST CLINICAL AND PATHOLOGICAL SOCIETY

SIXTH SESSION

1858–1859.

CONTINUED FROM VOLUME 1

NINTH MEETING.

1st January, 1859.

The PRESIDENT said he would be glad to hear the observations of members on Dr. Murney's cases of injuries of the head.

Dr. M'GEE said the cases reported by Dr. Murney offered several points of interest. The first case he considered singular, for the lateness at which coma set in—49 hours after the fall. He pointed out, as a possible cause of extravasation and consequent coma, the occurrence of laceration of the middle meningeal artery by its own pulsations against the margin of the fissured bone; and he related a case of gun-shot wound in which a similar occurrence took place, and extensive hæmorrhage, followed by friction of the femoral artery against spiculæ of the comminuted femur, six days after the injury.¹

The second case he considered interesting, from the cessation and resumption of the respiration and pulsations, and he ventured a supposition that the heart might have been in a state of fatty degeneration—such condition, according to Dr. Stokes, being a cause of apnœa.

In the third case he considered there had been fracture of the base and rupture of the membranes, and he formed this opinion in consequence of the serous hæmorrhage from the ear.

Professor GORDON said, in the case of the boy, he did not agree with the opinion expressed by Dr. Murney as to the time at which the effusion of blood took place. He thinks that it occurred shortly after the accident, and gradually accumulating, had not attained sufficient magnitude to produce fatal compression until a short time antecedent to death. He looked upon this case as having a very important practical bearing on the treatment of severe injuries of the head. It points very distinctly to the injurious consequences that might result from the early exhibition of stimuli; for, if the amount of injury the intra-

cranial mass be such as likely to lead to the extinction of life, the early exhibition of stimuli will not prevent a fatal result, but in cases in which recovery from the collapse supervenes they will rouse prematurely vascular action, and determine to hæmorrhage. It is, therefore, our duty to prolong the collapse rather than to shorten it. A turpentine enema at such a time will do good. As to the use of the stomach pump, he could not comprehend the principle which would justify its use. The introduction and pressure of the tube in the œsophagus would unquestionably induce spasm of the glottis, and, as a consequence, venous congestion in the right side of the heart, in the veins of the neck and head, and determine to hæmorrhage. He, therefore, regarded the use of the stomach pump as decidedly injurious, entailing much more serious consequences than any that might result from the contents of the stomach. In forming a diagnosis and prognosis in severe injuries of the head, the vital symptoms are generally vague and unsatisfactory as to the real nature and extent of the intra-cranial lesions. The physical conformation of the cranium, and forces acting on it, have been too much overlooked. Thus, when a man falls from a height and alights on the upper part of the head, the vertex is depressed and approximated to the base, whilst the lower borders of the parietal bones are thrown outwards, frequently detaching the squamous from the petrous portion of the temporal bone. When a person falls in this manner, and *from no great elevation*, from the force and conformation of the skull we may naturally expect fracture of the temporal bone, and its consequences—effusion of blood between the dura mater and anterior inferior angle of the parietal bones from rupture of the middle meningeal artery; also hæmorrhage from the ear, frequently from laceration of the lateral sinus, and also welling of a clear fluid from the ear, mixed or un-mixed with blood, from the sac of the arachnoid being opened. Effusion of blood from the ear has been regarded as indicative of a fracture of the base of the skull, but to give to it its true signification, it is only a strong presumptive evidence of a fracture of that part of the base of the cranium corresponding to the juncture of the squamous and petrous portions of the temporal bone. This is true as regards the generality of such cases, but rare instances have occurred in which there was in some cases hæmorrhage, in others welling of clear fluid, without fracture. Let us carry our reasoning a little further; let us suppose that the height of the fall has been considerable, and the man weighty. The violence will, therefore, be greater, and we must expect more extensive injuries; fractures of the vertex, disjunction of the sutures, fracture of the basilar process, and fractures radiating from the condyles, taking different directions, according to the relative strength of the several parts of the cranium. Dr. Gordon, therefore,

¹ [When this report was published in the *Dublin Hospital Gazette*, the Editor added:—"We are cognizant of a case in which a similar occurrence took place. A gentleman was riding about four miles from town, when his horse fell, but not seeming to be much hurt, he remounted and rode home. When near home, he observed the horse to be gradually becoming weaker, and at last to stagger under him. He had barely time to leap off, push the animal from him, when it dropped dead. *Post-mortem* examination showed that at the time of the first fall the animal had fractured a rib, and that the aorta, pulsating against the point of fracture, had gradually torn itself, and that a sudden burst of hæmorrhage had proved fatal."]

infers that if Dr. Murney had taken these various circumstances into consideration, he might have anticipated the extensive injuries met with in one of his cases. The man falls from a considerable height upon a *flagged flooring*, alighting upon the upper part of the right parietal bone. The vertex thus first reaches the flags, the whole weight of the body impinges upon the condyles, and comminutes the base. From the very nature of the forces brought into operation, so are we to expect fractures. Hence valuable information may be gained as to the diagnosis and prognosis from the physical conformation of the cranium, and from the forces acting on that structure. In blows and falls upon the head, the most frequent seat of separation of the dura mater from the skull is unquestionably at the anterior inferior angle of the parietal bone, and the reason of this is, that the connexions of the dura mater, especially the tentorium, does not permit this membrane to follow the sides of the cranium, when thrown outwards by force acting on the vertex. As regards the treatment of injuries of the brain, Dr. Gordon expressed himself as opposed to exhibition of mercury pushed to salivation. He says that injuries of the brain depress vital energies and the reparative process, and determine to unhealthy action in the part of the brain injured. A person who is under the influence of mercury is not in a fit state to undergo a surgical operation, as unhealthy inflammation is almost certain to attack the wound. He, therefore, recommended the head and shoulders to be well elevated, cold applied to the head, and a mild but continuous action to be kept up in the bowels, by the exhibition of the neutral salts, so that the patient may have at least three or four motions daily, at distant intervals. He does not object to the exhibition of mercury as a purgative, for he looks upon it as a most valuable remedy for the removal of mucous secretions and other unhealthy matters from the intestinal canal.

Dr. Ross wished to ask Dr. Murney if in his first case, he had observed layers in the clot effused from the lacerated meningeal artery, as such a constitution of the clot would show that the effusion had not taken place suddenly.

The PRESIDENT said that while he fully concurred in several of the remarks of Professor Gordon, he must dissent from one or two of his propositions. In the first place, as to the non-exhibition of stimuli in bad injuries, under any circumstances, he could not agree, as he had seen several cases of concussion in which life seemed hanging in the balance, and when both alcoholic and diffusible stimuli had been given with the happiest results. In fact, he felt certain that such cases would have succumbed had stimuli been withheld. He also could not subscribe to the Professor's doctrines regarding mercury in the cases under consideration; he had seen many cases of very severe injury of the head, where the grave symptoms

were at once relieved when the patient came under the influence of that most valuable drug, and one of the cases reported by Dr. Murney fully illustrated this. In conclusion, he felt it his duty to express the pleasure he had experienced in listening to Dr. Murney's lucid and able paper, and the interesting discussion which it had elicited; both were exceedingly valuable in a practical point of view.

Dr. MURNEY said—Observations have been made on the cases I have brought before the Society, by Dr. M'Gee, Professor Gordon, Dr. Ross, and the President. As the last-named gentleman has addressed himself to the remarks of those who immediately preceded him, I do not consider I am called upon to do more than express my concurrence generally with the opinions he has just stated. If I mistake not, Dr. Ross asks, "Was the clot, formed in the first of my cases, carefully observed, to note if it had all been poured out at the same period, or if there were any lamellæ of fibrine to indicate a series of extravasations," as appearances of this character had fully warranted the opinion of a number of hæmorrhages in a case which had been examined by him. In reply, I beg to say, not anticipating a clot of the magnitude I described, I examined it with the utmost care, and am perfectly satisfied all the blood was poured out in a very few hours.

Professor Gordon has stated—

1st. He considers the tentorium cerebelli officiates as a "beam" to hold the lateral portions of the dura mater in their places, and in case of violence from above, that portion of the membrane in which the arteria meningeal media is placed, will be stretched or torn according to the amount of force.

2nd. He considers too little attention is devoted to the mechanism of the head, and seems to think if I had studied that subject more carefully, I would not express surprise at the direction of the fracture in one case.

3rd. He most emphatically disapproves of my having administered stimulants in one case, as he believes such are always inadmissible in injuries of head.

4th. He objects to my having used the stomach pump in one case.

5th. He disapproves of the use of any mercurial preparation, with the object of producing the constitutional effects of that drug.

1st. The arteria meningeal media is placed on a plane anterior, and the tentorium is posterior to the petrous bone. To no part of the base of the skull is the dura mater more intimately adherent than the upper and anterior surface of the petrous portion of the temporal bone; for a strain applied to the tentorium to influence in any degree that part in which the trunk of the meningeal vessel lies, would require the membrane to be separated from the bony surface to which it is so intimately attached, and as I cannot

think of any force which would produce this result, I consider the first statement is not correct.

2nd. I believe no surgeon can form a proper estimate of injuries of the head unless he has studied the mechanism of the skull. If Dr. Gordon will again refer to my cases and observations he will find to my fourth case the following—"I would have been slow to expect a fracture taking the direction I point out. I have not seen any example of it before, and, judging from the strength of the parts involved, I am sure it must be very rare." I confidently repeat this expression of opinion, and am satisfied fracture in this direction must be very infrequent.

3rd. I think no surgeon can be more strenuously opposed to the indiscriminate administration of stimulants than I am. I consider it my duty, however, to protest against the sweeping rule as laid down by the Professor. I believe stimulants are not only admissible, but absolutely necessary in those most serious cases of head injury in which the collapse is extreme, and the very life of the individual is hovering in the balance. In milder cases, experience teaches us excitants are absolutely prejudicial.

4th. Reference to the case in which the stomach-pump was used, will, I consider, readily explain my reason for applying it. The man was intoxicated when he received the injury, and I believed it was most desirable to remove, if possible, any whiskey or other drink. Nothing was found in the stomach. Most probably as the patient had not partaken of dinner, absorption from the digestive cavity occurred with considerable rapidity. Upon this subject I have not heard any argument to change my view, and indeed cannot understand how, if stimulants are at all times inadmissible, there can be such serious objection to the use of the stomach pump in cases such as mine.

5th. I do not this moment recollect any exception to the rule that some of the preparations of mercury should be used in *all* cases of injury of the head—in the milder forms, as purgative, alterative, or both—in the more serious, with the design of producing the full constitutional effects. We all know that, with the exception of some head cases, general bleeding is now rarely practised by surgeons, and in no class of cases are we more imperatively called upon to pursue antiphlogistic treatment and regimen than in those under consideration. Now, mercury is an admirable antiphlogistic, and, therefore, do I use it. In addition, I believe it is impossible to say, in any given instance, we have an unmixed case of concussion or compression, and as mercurial preparations are pre-eminently useful in promoting the action of the absorbents, and thereby facilitating the removal of deposited blood, lymph, we have a second and most cogent argument for its administration.

Dr. M'Gee asks, at what period I calculated the fatal hæmorrhage in the head had commenced in the

first case. I think I have given an explanation most in accordance with the circumstances. I made careful inquiry to know if the patient had made any exertion—as getting up from bed, urination, defecation—prior to the stupor which preceded death, but I was unable to obtain satisfactory information. I believe a clot was formed in the lacerated artery at the time of the accident. From some cause this was dislodged within five hours of his death, and bleeding, of course, ensued. I cannot answer Dr. M'Gee's second query, as to the condition of the muscular fibres of the heart in my second case, as I was not permitted an opportunity of examining the thoracic, or abdominal contents.

{Rough minute book: Dr. M'Gee made a speech moving that all legally qualified physicians and surgeons be members.

Dr. Maconchy was elected unanimously.}

Council Ordinary Meeting January 5th 1859.

President, Dr. Murney, Dr. Heeney, Dr. Wales, Dr. Cuming.

Form of notice of election ordered to be printed.

Circular prepared.

TENTH MEETING.

8th January, 1859.

Mr. Johnston exhibited some fine specimens of *tubular lymph casts* of trunks of the bronchial tubes with their ramifications, which had been expectorated by a patient under his care, suffering under a combination of pneumonia and bronchitis. He read the case as follows:—

Ellen Harrison, aged 15 years, slender figure, pale, anæmic appearance, and nervous temperament, became unwell on Sunday, December 12th, being seized with rigor, sickness of stomach, loss of appetite, and stitch in right side. On Monday, 13th, she was feverish, and had a teasing cough. Tuesday and Wednesday, in addition to the symptoms mentioned, her expectoration was rust-coloured. I visited her on Wednesday evening, fourth day of her illness, and on examination found the usual physical signs of pneumonia of the right lung, passing into the second stage; the greater portion of posterior surface of the organ was engaged. The physical signs were *dulness*, where crepitus was passing in to bronchial respiration, *rusty sputa*, and *difficult breathing*. There was a considerable amount of bronchitis of left lung and anterior portion of right. This might in part explain the great difficulty of breathing present, which was out of proportion to the extent of the pneumonia. In all its characters the case bore a very urgent aspect. I ordered powders, with one grain of calomel, two grains of grey powder, and three grains of Dover's, every

second hour. On Friday, 17th, thirty-six hours after the first exhibition of the mercury, there was evidence of its action on the system, and at the same time an immediate improvement in the symptoms. On this day and Saturday, coincident with the action of the mercury, there occurred what I regarded as a feature of interest in the case, viz., the expectoration of lymph membranous casts of the bronchial tubes, and their ramifications, similar in character, I presume, to those occasionally thrown off from the trachea in cases of croup; I have not known, however, of such membranous excretions being of usual occurrence in cases of pneumonia. You have here one or two specimens. Upon examination you will find these hollow; indeed, shortly after being thrown off we were able to inflate them, so as to represent a bronchial tube of the second or third order, with its minute divisions. I need not follow up the details of the case.

She continued to improve from this date, and when I saw her on Thursday, she was sitting up, her chief complaint being in regard to her mouth. We must attribute the rapid and favourable progress of this case to the salutary action of the mercury, one scruple of calomel and less than one drachm of grey powder was the entire amount given. She was neither blistered nor bled. I mention these facts, as I consider it is instructive as well as satisfactory to point to the unaided and salutary action of such a small amount of mercury.

Are we to regard these cylinders of membrane as identical with the false membranes thrown off from inflamed serous membranes; and as, therefore, affording us an example of adhesive inflammation in a mucous membrane? We know that such an event of inflammation does take place in early life, but I believe it is rare after puberty, so far at least as regards the pulmonary mucous membrane. I was led to consider the casts as emanating from the pneumonic part of the lung, from the fact of the bronchitis not being intense, and from the improvement in the lung affected by pneumonia being coincident with the expectoration of the casts.

Watson, in his last editions, points out two points of distinction between such membranous excretions and those false membranes that are formed on serous membranes, viz., that such an example as I here present is more of an *albuminous* nature, brittle, and less fibrous; and secondly, that it is not *plastic*; that is, that it never becomes organized, never connects itself with the surface from which it proceeds, but, as in this case, becomes detached, and if the patient progress favourably, is thrown off. The last point that crossed my mind in reference to this case is, whether, with the occurrence of such membranous excretions in a case of pneumonia, we have any more need to fear the supervention of phthisis, than in ordinary cases of pulmonic inflammation.

Professor FERGUSON said he wished to ask Mr. Johnston the physical signs of pneumonia present in this case, and their extent.

Mr. JOHNSTON said the physical signs were dulness, where crepitus was passing into bronchial respiration, rusty sputa, and difficult breathing.

Professor FERGUSON next enquired whether Mr. Johnston considered the casts the product of pneumonia or bronchitis.

Mr. JOHNSTON said he believed they were thrown off from the tubes penetrating that portion of the lung affected by pneumonia.

Professor FERGUSON said that, at the present time, the pathological indications of such formations deserved special attention. He adverted to the probability of the tube casts being the result of a diphtheritic state of the bronchial lining, rather than of pneumonia; and also to a case brought under the notice of this Society, in which similar formations were expectorated by a person in health (a cast of which he exhibited.) He further said, that he was not aware of such casts accompanying pneumonia, though not uncommon in bronchial and catarrhal affections.

Professor REID said that such casts had occurred in pneumonia as well as in bronchitis, and according to Stokes, they had been thrown off more frequently by the aged than by the young. In the case before the meeting he considered it difficult to say from what part the casts came—whether from the pneumonic or bronchitic part of the lungs.

Dr. PATTERSON said the substance of the casts under notice very much resembled that of exudations from the fauces in a case of diphtheria under his care.

Dr. ROSS said the casts, in his opinion, indicated inflammation of an active character. He expressed surprise at Dr. Reid's statement as to the more common appearance of such formations in the old than in the young.

Professor REID said that statistics bore out his statement.

Professor FERGUSON remarked the disproportion between the dyspnoea and the extent of pneumonia in Mr. Johnston's case. He asked if the former was not relieved by the expectoration of the bronchial casts, and he said he did not think the exudations the result of pneumonia.

Dr. HEENEY said he considered the relief to the dyspnoea in this case due to the expectoration of the casts, and its previous existence chiefly to their presence in the bronchial tubes.

The PRESIDENT said he believed such formations may result from asthenic as well as acute action. In cases of diphtherite he had seen patches of exudation, but no tube casts like those under notice of the Society.

Mr. JOHNSTON said he was quite alive to the importance of considering the prevailing type of dis-

ease, in coming to conclusions as to the nature of his case. He had recently had exudations on the pharynx in cases of typhus and hydrocephalus. In the case before the Society he was led to consider the casts as emanating from the pneumonic part of lung, from the fact of the bronchitis not being intense, and from the improvement in the lung affected by pneumonia being coincident with the expectoration of the casts.

Professor FERGUSON wished Mr. Johnston to explain how crepitus could be heard in the pneumonic lung, if the trunks leading to the smaller tubes and air cells had been obstructed by casts, such as these exhibited.

Mr. JOHNSTON observed that a similar difficulty would stand in the way of the Professor explaining the presence of bronchial rales in the bronchitic part, supposing that to be site of the exudations.

Dr. M'GEE said that Professor Ferguson's objection could not weigh, as the tube casts were tubular, and therefore pervious to air.

Professor FERGUSON said that the object of his remarks was to ventilate the subject thoroughly, and he had succeeded.

Case of Abscesses in the Brain, by Dr. Harkin.

Robert Elliot, aged 35, unmarried, of temperate habits, and recently returned from America, called on me upon the morning of Thursday, 23rd December last, complaining of intense headache, debility, and pain of the back. He had never been subject to headache or any cerebral affection in his youth, but about fifteen years since had a severe attack of hæmoptysis, and more recently suffered from three prolonged attacks of "fever and ague." Since his return from the United States, in October last, his friends state that he had become irritable in temper, lost his accustomed cheerfulness, and avoided all society. It was not, however, until the 14th December that he exhibited any symptoms of illness, when, after taking saline medicine to relieve some uneasiness in the stomach and bowels, he was seized with a rigor which continued for three-quarters of an hour, followed by a hot fit and by vomiting.

On the 15th and 16th he complained of violent pain in the back, extending along the greater part of the spinal column; about the 17th it extended to the loins, the groin, and the lower part of the abdomen; at this time his urine was found to be loaded with lithic acid deposits, and the chamber utensil stained as if with red paint. He continued in this state till the 20th, becoming very restless at night, when he first discovered weakness and loss of power in his right arm; on the 21st it became completely paralyzed. He remained in this condition, still taking food, and his bowels acting, after mild purgatives, till 23rd, when, becoming alarmed at his state, he called on me. I advised him immediately to return home and lie

down, and saw him soon after in his bed, when he presented the following symptoms:—His principal complaint was of intense pain of a dull throbbing kind, which extended all over the head from the forehead to the occiput, constantly present, but aggravated at intervals, and at night becoming unendurable. He was very giddy when he attempted to stand, and his pulse was about 100 in the erect position, lower when in bed, very small and compressible. The forehead and temples hot; the eyes natural; the pupils obeyed the stimulus of light, but slowly, especially the left. His tongue dry and brown; sense of hearing unimpaired; speech occasionally indistinct; had also transient fits of incoherence. The right arm was completely paralyzed, and a little colder than the other; the fourth and fifth finger bent; no other sign of contraction; no lesion of sensation in the arm. The application of leeches to the temples, cold lotion to the forehead, occiput to be shaved, and a blister to the back of the head and neck were then ordered. He had also ten grains of calomel administered, to be followed by two grains every alternate hour, and warm applications to the feet. The leeches were applied, and procured an interval of ease for about three hours; he, however, peremptorily refused to permit the application of the blister. He passed the night of the 23rd in a very excited state, having dressed and undressed himself three times. His sufferings were intense and his screams very loud. Finding on the 24th that he still persisted in refusing to have the blister applied, and that his friends had lost all moral control over him, I recommended his removal to the General Hospital, whither he was taken same evening. From the first moment I had seen the man, it was quite evident disorganization of the brain had set in; that the inflammatory period had gone by, and with it the time for active treatment and hopeful interference, and that in the presence of abscess or softening of the brain, medicine had no effectual remedy.

Dr. W. MacCORMAC, in continuation of Mr. Harkin's case, said the man was admitted to the General Hospital, on the 24th December last. He complained of headache and motor paralysis of right arm. Pulse normal, vision and hearing perfect. On the 25th he was worse, the pain in the head occurred in violent paroxysms, and mercurial fœtor set in. On the 26th the pain was still worse. No sickness. Suspicions of the pain being of a neuralgic character were entertained at this time. On the 27th the pulse was slow and irregular. The pupils, one natural, the other dilated. The right leg became paralyzed. He complained of ringing noise in the left ear, and remained sensible till the 2nd of January, when he died.

The *post-mortem* examination was made by Dr. Murney, on Sunday last. On removing the dura mater, he found pus on it. He exhibited the brain, and demonstrated its condition to the Society as follows:

—An abscess in the anterior part of the right hemisphere; another in the same part of the left; one in the left lobe of the cerebellum; together with several smaller abscesses in the upper part of both cerebral hemispheres, but none whatever in the base of the brain. He adverted to Rokitansky's observation on the rarity of circumscribed abscess of the brain, and said the present case afforded well-marked illustrations of such.

Dr. M'GEE said the impairment of hearing on one side, and the loss of motive power on the other, were points of interest in the case.

Dr. ROSS said the large abscess in the left cerebral hemisphere might have been primary—the other abscesses resulting from it by absorption. He said the supervention of loss of power on the right side bore out that view somewhat.

Mr. HARKIN said he believed rigors had only occurred once.

Dr. MOORE exhibited a left testis greatly enlarged by medullary disease (of which it was a good specimen), which he had removed ten days previously from a man aged 42. The disease commenced about 12 months since, and originated in a hurt. The symptoms were those of hydrocele, and a practitioner, supposing it to be such, had tapped the part, but only blood flowed. After this the tumour became painful and rapidly increased. The spermatic cord was, however, free. The wound healed by the first intention, and the man was able to leave hospital in a week.

The President said his experience of such cases made him fear the disease would return.

Council Ordinary Meeting January 12th 1859.

President, Drs. Dill, Bryce, & Cumming.

Circular prepared.

ELEVENTH MEETING.

15th January, 1859

The PRESIDENT exhibited the recent parts after amputation, and made the following observations.—

Case of Resection of the Knee-joint.

The subject of the following brief remarks is a man aged 27 years, named Samuel Goudy, a painter by trade, and a native of Belfast. He is of phlegmatic temperament, and of the strumous diathesis. Some seven years since he first came under my notice, with the usual symptoms of inflammation of the right knee-joint, as seen in a person of scrofulous habit. From time to time these inflammatory attacks were subdued, recurring, however, from very slight exciting causes, the joint remaining stiff and swollen, but without pain, in the intervals. This state of things continued up till the period of his last admission into

hospital, in July, 1858. He then complained of pain on any attempt at motion, and on pressure over the patella and condyles of femur, especially the inner. The parts were infiltrated and considerably swollen, giving the knee all the appearance of a joint suffering from pulpy degeneration; and the severe pain on motion pointed out the probability that erosion or ulceration of the cartilages had taken place. His general health was deranged, the vital functions much depressed, and his total aspect demonstrated bodily suffering and imperfect nutrition. The treatment adopted was with the view of improving the health, and it did improve for some time, when confinement and hospital air began to tell against the system, and it was determined, in consultation, to remove the diseased part; and I wished to give the patient the chance of a good limb, by performing excision of the knee-joint. This operation of resection I performed, accordingly, on the 25th of August. The patient having been brought fully under the influence of chloroform, I made an incision four inches on either side of the joint, *well back*, and united these by a cross-section through the soft parts and the *ligamentum patella*, so as to open the joint. The flap thus formed was turned up, the ligaments were divided, and the ends of the bones exposed, and freed from the soft parts, and were sawn off. An inch and half of the femur, and about three-fourths of an inch of tibia, were removed, and the face of the patella was likewise removed, by means of a metacarpal saw. Upon attempting to bring the cut bones into opposition, it was found requisite, in consequence of the contraction the joint had assumed, to saw off another thin slice from the femur. The limb was then put up on a modification of Mr. Butcher's splint. Some hours afterwards these bleeding vessels were tied, five points of suture introduced into the flap and opposing parts, and the wound was dressed with strips of wet lint. The shock after the operation was trifling, the reaction not at all great, and everything promised well. The wound was dressed first on the fifth day, and every second day afterwards. In a week the cross section had healed, and the wounds looked well, a healthy suppuration having been established.

Up till November everything seemed prosperous, save that I experienced considerable difficulty in retaining the parts in situ, more especially as the patient was impatient of restraint, and his skin became abraded by the necessary bandages. For some ten days I had to allow the limb to be removed from the apparatus, and after the re-adjustment suppuration set in very copiously, the patient's health suffering from the drain. Every means likely to improve matters were resorted to, but beyond the constitutional improvement, no advance was made towards cure. Under these circumstances, I most unwillingly resorted to amputation, which I performed on the 8th

instant, by the rectangular flaps, as recommended by Mr. Teale, of Leeds, and sawed the femur through, a little above the middle part, having been obliged to go so high, in consequence of the sinuses of the soft parts above the knee. I put the flaps together with a few points of suture, and a very few narrow strips of adhesive plaster, and did not disturb the stump till the eighth day. I then removed the points of suture and strips, and the ligatures, save that on the femoral artery, and found adhesion had taken place, without any tendency to suppuration; and the case bids fair to progress to a satisfactory termination, as regards the patient's life.

In conclusion, I beg to offer one or two observations—first, as to the state of parts at the time of the resection. The soft parts had largely degenerated, and the bones showed erosion and ulceration at several points of their cartilages, the patella alone being free from disease. The end of the femur, when cut through, presented a softened state of its cancellated structure, and on the whole did not look well, though not actually diseased beyond repair. Second, as to the steps of the operation, I feel satisfied that I should have divided the hamstrings by subcutaneous section, and I ought also to have removed the patella. Were I to operate again in a similar case, I think I would proceed differently from that I followed in this instance, or that which has been usually recommended. Dr. Murney, who has kindly made a dissection of the amputated parts, will be able to give a report of what he observed, and also to express his views on the whole case, and also the statistics of resection of the knee-joint.

Dr. MURNEY remarked—This patient was under my care for about a fortnight or three weeks in July of last year. At the 1st August he was transferred to Mr. Browne. When first examined there was evidence of ulceration of the cartilages of the knee, of a chronic character. On consultation it was agreed, in the absence of any acute symptoms, that mercurial strapping, perfect rest, and a course of one of the preparations of mercury gently introduced into the system, should be tried. As in this my colleagues expressed the opinion I entertained myself, I gave the patient the only chance of saving his limb (without operation), by endeavouring to procure ankylosis. In a few days the constitutional effects of mercury were manifested; and after continuing its use as long as was considered necessary, without any beneficial result, it was omitted, and every effort made to improve his general health, preparatory to the operation which has just been described. Altogether he was under the influence of mercury about a fortnight; after that time the management devolved on my successor.

At the examination of the limb, I found fatty degeneration of all the muscular textures in the neighbourhood of the knee. A great number of sinuses

passed in various directions, but some of the principal ran to large exfoliating surfaces on the tibia and femur. The hamstring tendons, which were divided a short time since, were connected by organized lymph, and were being united in the usual fashion.

The patella was connected to the anterior surface of the lower end of the femur by bone. A considerable part of the upper end of the tibia was removed by ulceration. Similar action existed on the femur. On the former bone the fore part, on the latter the posterior portion, was affected. A good deal of new bony tissue was deposited on the femur, so as to spread out or expand that bone to a breadth fully as great as before the removal of the condyles. The opposing ends were coated, except the carious portions, with a velvet-like membrane, of a highly vascular character. The two bones did not form a right line, for fully one-third of the femur was in front of the tibia, so that a glance at the specimen suggested the idea of incomplete luxation of the leg backwards.

This case verifies an anatomical objection which frequently occurred to me when considering the operation of excision of the knee—viz., on making the customary incisions, the ligamentum patellæ is cut, and the action of the vasti-rectus and crureus muscles is unopposed, so that the patella must be drawn upwards, and rest, as in this case, upon the femur only. In this situation it does not in any way strengthen the knee. Now, I consider the transverse incision should be made *above* the patella, cutting through the attachments of the muscles already named, that bone thrown down, its posterior surface cut away, if necessary; and when the operation would be terminated it could be replaced, when it would lie in front of both bones, would become united to both, and of course strengthen materially the parts to be ankylosed.

Some observations have been made as to the results of this operation, contrasted with amputation of the thigh. I find in Mr. Butcher's paper, "On Excision of the Knee-joint," published in the *Dublin Quarterly Journal*, for February, 1855, that since 1850, "31 operations are recorded. Out of this number, 5 have died;" and of these latter, one was carried off by epidemic dysentery; another died of pyæmia, sixteen days after operation; and a third was killed by diarrhœa on the twenty-fourth day. Again, in a second table by the same writer, in February, 1857, we have the statistics of 50 additional cases:—16 cures with useful limbs; 15 recovering; 1 relieved; 1 in a precarious state; 9 died; and 7 required amputation; total, 81 cases, followed by death in 14 instances; and if we add to this list 7 amputations, we have non-success in 21, out of 81 persons subjected to excision.

Dr. MOORE exhibited a diseased knee, the opening of which, exposed ulceration of the cartilages, degen-

eration of the synovial membrane, and a curdy deposition in the joint. He said—

“The subject of this amputation is a man, aged 40, who, four years since, became affected with pain in the knee, which yielded to leeching and ordinary treatment. Three months ago he was admitted to hospital. His knee was swelled and painful, and his system participated in the derangement. Alterative and anodyne medicines, together with rest, speedily improved him. He became able to sustain pressure on the joint, and ultimately to walk, when, of his own accord, he went home to the country. In the course of a month he returned, with the joint in a much worse condition, and all blistered over, by the direction of some country adviser. Examination satisfied me as to the propriety of amputation, which, at the end of three weeks’ preparatory treatment, I performed by antero-posterior *semicircular* incisions, and subsequent *circular* muscular cuts down to the bone. While being put under chloroform, I bandaged the limb upwards from the toes, and the femoral artery being well commanded by thumb pressure, I completed the operation with hæmorrhage not exceeding 3 drachms, which was chiefly venous. The flaps came well together, and were retained by six or eight stitches, and the wound is healing by adhesion.”

Dr. MOORE said his case was not suitable for resection, but anyhow, he was opposed to that operation; and Mr. Browne’s case, he said, did not tend to alter his opinions with regard to it.

Dr. MOORE next exhibited a foot which he had removed by *Syme’s operation*, the patient having since done well. He said—

“The subject of this amputation is a woman, aged 28. She was admitted to hospital with *talipes varus*, the foot much swelled, and a large gangrenous ulcer between the great and adjoining toe, extending upwards on the dorsum of the foot. The whole lower limb up to the groin was swelled nearly twice the size of the other, representing, in fact, in most of its characters, the disease known as *Elephantiasis*. The cellular tissue, however, was the part chiefly engaged. There was no pitting on pressure. Rest and suitable treatment reduced the painful swelling of the foot. The history of this case is this—About 15 years ago the patient received a prick of a thorn on the inner side of the foot, which, producing great pain, caused her to walk on the outer part of her foot. The wound from the thorn not healing, and the pain remaining, obliged her, for relief, to continue to walk on the outer side of her foot, until ultimately *talipes varus* was induced, for which, at her own request, amputation was performed.”

Dr. MOORE next introduced a young man, 22 years of age, with an extensive tumour extending from the

posterior part of the neck to the front of the thyroid cartilage, and from behind the ear close to the clavicle, tilting the ear upon it. It is half as large as his head, with a flat irregular circular ulcer on the front. The general colour of the tumour is of a bluish red. He states that about two years ago, a small tumour formed at the angle of the jaw, which was leeches, rubbed with ointments, leeches again, and poulticed, and so on, till it reached about the size of his fist, when, feeling soft in front, it was opened, and a small quantity of thin watery fluid, with a few curdy flakes, escaped. Since then the tumour has increased rapidly. Dr. Moore looked upon it as a malignant growth, and one that would go on increasing, and involving as it does the important part of the neck, he considered it to be beyond surgical art.

The PRESIDENT remarked that the case of knee disease, presented by Dr. Moore, fully justified its removal. He could not agree with him, however, that it was unsuitable for resection; had it been his, he would have given the patient the chance of saving the limb, which, if preserved, is always better than a wooden pin: Moreover, he could not agree that resection of the knee-joint was to be cast aside because some cases had failed—as fail some must—for the statistics of the operation, as already published, give very great encouragement indeed to surgeons to perform the operation in suitable cases. For his own part, his personal experience, like that of Dr. Moore, was not great regarding this operation, but he felt satisfied that the published statistics were correct, and such as to induce him not to abandon it.

He also said he did not consider the second case related by Dr. Moore one of “*Elephantiasis*” as he had described it. He looked upon the affection before them as one of thickening and infiltration of the subcutaneous tissues, without hypertrophy of the skin at all; therefore, not one of elephantiasis. He had seen the disease in a vast number of instances, both in the West Indies and all over the East. In reply to a query from Professor Ferguson as to the advantage of metallic sutures, he said he approved highly of them, and recommended annealed iron wire, No. 32.

The members generally concurred with Dr. Moore in his view of the nature of the tumour in the neck, and in the hopelessness of surgical interference in the case.

Case of Labour, complicated with accidental Hæmorrhage. By Dr. DILL.

On the 13th ult., at 5 o’clock, a.m., I was sent for to attend in her confinement Mrs. C., aged 37. She was the mother of six children. She had one or two miscarriages, and she believed herself to be about a fortnight from the full period of pregnancy. Before I saw her she had one or two faintish fits; however, on reaching her, she had improved, and labour had com-

menced. She was pale, pulse was under 80, and feeble, and the skin was considerably under the natural temperature. She was under the impression that the membranes had given way, and that the waters were discharged, but an examination satisfied me that this was not the case. The os uteri had dilated to the extent of half-a-crown, and the presentation was natural. The pains were feeble, and the progress of labour slow; however, in about eight hours she was delivered of a dead male child. The placenta was expelled in a few minutes afterwards, and with it a great mass of very dark coagulated blood. The uterus contracted perfectly; the bandage was applied, when a few additional clots came away, dark as before. The stomach, which was very irritable from the first, continued so, with retching and vomiting. Opiates were administered with but very temporary relief.

I found, next morning, that she had some rest through the night, but the sickness continued, and there was considerable pain in the epigastric region. No pain or uneasiness whatever over the uterus; pulse under 80 and feeble; skin dry and very cool, tongue pale, dry, and glossy. A sinapism was applied to the epigastrium. The bowels were opened by means of an aperient and an enema, and the opiate was repeated at bedtime. On the 15th, I found Mrs. C. a little improved; she had had some sleep; the sickness was not so distressing; the pain at the stomach was nearly gone, but had shifted towards the right side. I could not ascertain that she had passed any urine since her confinement, and the renal secretions appeared to be suspended. She had been taking a mixture of mindererus and sweet nitre, and she was now ordered, in addition, half-a-dozen pills, each containing half a grain of opium and three grains of blue pill. She took one of these every three hours, until she had taken the fourth. She had, besides, a blister applied to the side. On the 16th, the pain in side was somewhat relieved, but the sickness continued. She passed some urine, but the quantity was so small, and being mixed with other discharges, it could not be examined. From the first there was occasional giddiness, with indistinctness of vision. In the evening I was sent for in a hurry, when I found her sitting up in bed, the mind wandering, and she was totally blind. The pupils were fixed and dilated, and she appeared as one in amaurosis. Her head was placed upon the pillow, and in a short time she became tranquil, and her sight and mental faculties were restored. The pain had now shifted from the side to the back and loins, to which parts a sinapism was applied, and a mixture containing Rochelle salts and a little sweet nitre, was ordered. An involuntary jerking motion of the muscles had been observed for some time, which was becoming worse.

On the 17th I found the pain in the stomach and side quite gone, but some uneasiness in the back and

sickness continued. On the 18th a very small quantity of urine was secured, and being tested with heat and nitric acid, it was found to be highly albuminous, and continued so under repeated examinations up till the 20th, just eight days after her confinement, when she sank rapidly, and to some unexpectedly, though not to myself.

Although we were not allowed a *post-mortem* examination, which no doubt, would have added greatly to the interest in this case, yet I think we should look upon it as one possessing some features of practical instruction.

1st, The complications of labour with accidental hæmorrhage, at first recognised by the fainting fits, and afterwards corroborated by the large quantity of dark coagulated blood which was discharged with and after the placenta; and 2nd, the giddiness in the head and indistinctness in vision, which were observed from the first, and appeared to be increased when in the erect position, struck me as being naturally chargeable to the loss of blood and weakness, although at a later period these aggravated symptoms, as exhibited in the total blindness and mental wanderings, plainly indicated something worse. 3rd, The suspension of the renal secretion was at first accounted for by the fact that no drink, and indeed nothing, had been retained upon the stomach, and of course did not get into the circulation, and hence no secretion by the kidneys. 4th, As the symptoms became more developed, as seen in the jerking motions of the extremities, the total blindness, state of the mind (though but for a brief period), the albuminous urine, too plainly showed that at least the kidneys were the organs primarily affected, and that we had to deal with as pure a case as is on record of blood-poisoning, and at the same time one of a most intense character—or uræmia, which is the result of albuminuria. 5th, The jerking motion reminded me very vividly of the effects produced when strychnia is introduced into the system. And 6th, that disease of the kidneys should have existed, with such an amount of albumin in the urine, is rare in the puerperal state, unless accompanied by œdema, anasarca, and convulsions, which did not at all exist here, and without one or more of which the case was considerably masked at first; and that the latter symptom did not take place can only be accounted for by the poison expending itself in the eccentric, in place of, as is more usual, the concentric form.

Some unimportant observations on this case brought the proceedings to a close.

Council Ordinary Meeting January 19th 1859.

President in chair. Drs. Murney, Bryce, Wales, & Cum-
ing.

Circular was prepared.

TWELFTH MEETING.
January 22nd, 1859.

Dr. MOORE introduced a lad about 18 years of age, having a large venous cutaneous nævus, about nine inches by seven, on the outer part of the thigh, and scarcely elevated above the surface. About four years ago he was admitted into hospital with an ulcer about the size of a halfpenny on the lower part of the nævus, which healed. He was again admitted about three weeks ago, with another ulcer higher up in the nævus, from which there was a great amount of bloody discharge. The ulcer was large enough to contain half a walnut. It was cleaned out repeatedly, touched with solid caustic, and is now healed. From the toes up to the middle of the thigh the whole limb is surrounded (when in the erect position) with a perfect plexus of enormously distended veins, some of them an inch in diameter, and would be supposed to contain, in their distended state, close upon three pints of blood. If the patient suddenly raise himself from bed and stand up, *Syncope* is induced. Dr. Moore remarked, the wound having healed, there is nothing to be done but judiciously to apply a laced stocking for support.

Queries were put by members to ascertain the duration of the nævus, whether it, and the varicose condition of the limb had come on and progressed simultaneously? and whether or not any tumour or other obstruction to the venous reflux could be discovered above the nævus to explain the cause? In answer to these it was stated that the nævus was congenital, and had but slightly increased; that the enlarged veins were the result of gradual and progressive development; and that the most careful examination had failed to discover any mechanical or other cause for the varicose condition of the limb below the nævus.

Professor GORDON next read the following case:—

“Jane O’Hara, aged 40, admitted into the General Hospital on November 12th, 1846. She says that about eight years ago, a small tumour, not larger than a pea, formed in the left mamma. This tumour remained almost of the same size for three years, when the skin covering it became discoloured, and on its being punctured, fluid resembling jelly escaped. After that the wound healed, but the fluid re-accumulating, a second puncture was made, and a discharge of a like description came away. Since that time the tumour has been frequently opened, always followed by the escape of a fluid of the same clear, gelatinous character. About eight months before her admission into hospital I saw her for the first time. The left mamma was considerably enlarged, but not painful, and there were several cicatrices on its surface.

“On admission into hospital the size of the mamma is somewhat smaller than when I first saw her, the

tumour in the interval having been opened. It is very moveable on the surface of the pectoral muscle; the nipple is perfectly healthy, not in the least degree retracted, but immediately below it there is a fistulous opening leading into the interior of the tumour, and giving exit to a sanious discharge. External to this, the skin is, for a small extent, ulcerated, but otherwise not unhealthy. The remainder of the surface of the mamma is slightly uneven, firm to the feel, but not hard, and presenting depressions and cicatrices, the results of former incisions.

“On the 16th I removed the tumour and mammary gland. On making a transverse incision in the tumour, through the fistulous opening, the appearance presented by the section was that of a ripe peach, but external to this it resembled amber-coloured jelly, traversed by widely separated, but extremely delicate bands of fibro-cellular tissue.

“On the day succeeding the operation, the patient was attacked by unhealthy inflammation in the wound, followed by sloughing of the cellular tissue. Three weeks after this the wound was nearly healed, with great improvement in her complexion and general health. A short time after this she left the hospital, and went to America to join her husband, who had emigrated a few months previously. In 1856, O’Hara called on me. On exposing the front of the chest, there was a large cancerous ulceration 8 inches by 6 over the lower part of sternum and upper part of epigastrium; the edges were hard, everted, and prominent, and immediately around it the skin was firm and discoloured. The cicatrix of the operation was healthy.”

Dr. WALES introduced a boy with an anchylosed condition of the shoulder-joint, and relaxation of the sterno-clavicular ligament, permitting free luxation of the sternal end of the clavicle. Motion in this case (which was curtailed and somewhat painful), produced singular frictional phenomena, the source of which was a matter of some doubt, and gave rise to considerable discussion, some considering the grating due to a supposed partial motion in the shoulder-joint, others to the condition of the sterno-clavicular ligament, and most to the friction of the muscles and bony surfaces about the part. The disease commenced seven years since with pains of a rheumatic or neuralgic character in the shoulder and arm, particularly the latter, and gradually motion became impaired. The boy is of a scrofulous habit.

Some unimportant discussion followed this case, with which the proceedings terminated.

Council Ordinary Meeting January 26th 1859.
President in chair. Drs. Wales, Bryce, & Cuming.
Circular was prepared.

THIRTEENTH MEETING.

29th January, 1859.

Vascular tumour of lip.

Dr. CUMING stated that he had examined a portion of a lip which had been removed by Dr. Babington, of Londonderry.

The diseased structure was entirely composed of an immense number of small dilated blood-vessels, interlacing in areolar tissue. There was no evidence of any malignant growth. The following notes of the case had been furnished by Dr. Babington:—

“The patient stated that some two years since she was sucking a thimble, which adhered so tightly to her upper lip that it had to be filed off; that soon after she experienced an unusual pulsation in the lip, and that it gradually increased in size. When first under treatment the pulsation occupied the whole labium. Injections of per-chloride of iron were tried, and it was hoped successfully, as the swelling became solid and all pulsation ceased. She again came under treatment, the pulsation was at this time limited to the right side of the lip, the other side was cured. “Injections were again tried as before, but without benefit, and as the lip was increasing rather rapidly, it was deemed advisable to remove the whole diseased mass.

“The wound healed by first intention, and the patient suffers no inconvenience.”

Arsenical poisoning by wall-paper.

Dr. WALES read a paper on this subject. He said—

Mr. President, the first notice on the circular of to-day is a “Case of Arsenical Poisoning by Room-Paper.” That case, Sir, I have the honour to bring under the notice of this Society, and I would substitute for the startling announcement the less alarming, though perhaps not less true title, “Supposed Deleterious Effects of Green Flock Paper.” Is bright green flock paper on the walls of our sitting-rooms prejudicial to us? This is a question, Sir, that people are beginning to ask. It has been answered in the affirmative and in the negative by high authorities on the one side, and official authority on the other.

Conceiving it to be the object of our high calling to endeavour to prevent as well as to remove disease, I deem it a question demanding our careful consideration. It is, however, one which nothing short of experimental evidence can decide; consequently, it is our duty cautiously to examine the cases adduced as examples of arsenical poisoning, before receiving them as such; but being satisfied, it is equally our duty to make known our opinions, that the community may benefit by them. I will now, Sir, read my case—

“BELFAST, January 26th, 1859.

“DEAR SIR,—At your request, I have pleasure in stating the particulars of my health, since August, 1856, when

I first occupied my present sitting-room, and for a while experienced no change in my naturally robust health.

“For the first time that I remember, however, I was, the following winter, affected with a sore throat, which I attributed to the dampness of the house, with north-east aspect; but as the warm weather returned, I gradually got better, and was comparatively well in the summer.

“As the winter again approached I was, as before, affected, but to a far greater degree; I had pain in evacuating the bowels, and extreme soreness of the anus; the latter was allayed by your application of nitrate of silver.

“Having at this time occasion to visit the north of England for a few days, I there heard that similar effects were attributed to the poisonous colouring matter in bright green wall-papers, and as my parlour was papered with a rich green flock, immediately, on my return, I removed to the drawing-room, which is covered with a simple gray and gold pattern, and, very strange to say, I was for the rest of the winter perfectly well.

“In the summer of 1858, I was induced, for convenience, to again occupy my parlour, and in a few weeks my throat became sore, and the sides of my tongue most painful from small vertical openings or cracks, as if cut with a knife, which led me to suppose they arose from the teeth, which were accordingly filed, but with little effect; and the tip of the tongue was so sore that to touch my gums was painful. The parts thus affected were treated, as before, with nitrate of silver with little benefit. I removed to my upper room, and in a week or two I was quite well; but wishful to fully satisfy myself, I again returned to the parlour for a few days, but feeling my tongue beginning to be affected as before, I had the green flock paper at once removed, since which I have occupied this sitting-room only, without the slightest return of any one of the previous symptoms; and I now enclose a piece of the green paper, for your analysis, that if found poisonous, others may benefit by my experience.—Dear Sir, very truly yours,

“V. Z.”

“Dr. Wales.”

The first point, Sir, in this case is—Does the paper contain arsenic? I enclosed a portion of it for examination to my coadjutor, Dr. Cuming, and I have examined another portion of it myself, and found it to contain arsenic.

I will now mention other cases in which injurious effects are recorded as resulting from a similar cause.

In the *Medical Times and Gazette*, of May, 1857, Dr. Hinds, of Birmingham, writes, showing the danger to which people are exposed by arsenical paper-hangings. In his case, the symptoms of chronic poisoning

by arsenic were produced, viz., prostration, headache, tightness across forehead, a low febrile state of the system, inflammation of the eyes, and soreness of the mouth and throat. In the same journal, in January, 1858, Dr. Halley writes, saying, "In Autumn, 1856, my study was papered by an emerald-green flock. I worked in it every evening five or six hours, the room being lighted by a single burner. Within a few days I began to suffer from headache, dryness of throat and tongue, and internal irritation. In three weeks I was prostrated, almost losing the use of my left side. Somewhat recovered, I returned to my study, and, after a few days, the symptoms returned and obliged me to desist, until at last I found that whenever I worked for any length of time in this room I invariably suffered from the same sort of symptoms, which did not come on if I remained in other rooms not so papered."

Dr. Halley's attention was directed to the cause of his illness by reading Dr. Hinds' letter, and, on examining the paper, he found *arsenite of copper* in it in the proportion of nearly one drachm to the square foot. He also obtained crystals of arsenious acid on paper saturated in ammonio-nitrate of silver, after exposure in the air of the room for ten hours.

Dr. Alfred Taylor, Mr. Kesteven, and Mr. Gay have detailed similar cases equally convincing, which will also be found in the *Medical Times and Gazette*, but which I need not here enter on, as the history of one is nearly the history of all. Suffice to say, that the fact of such cases occurring in the persons of medical men whose attention has been called to the subject, leads to the inference that many similar cases of disease exist, the result of slow arsenical poisoning, which are ascribed to other causes, and which, were the real cause known, might swell the list of examples of the injurious effects of arsenical green paper to an alarming degree.

So much, Sir, in the affirmative response to the query introducing these remarks. The negative rests chiefly on the testimony of Mr. Fletcher, a paper manufacturer, who says that his workmen enjoy perfect health, though for years they have constantly handled arsenic; and on a Report of the Board of Trade founded on the experiments and observations of their chemist, which sets forth the innocuous characters of bright green flock paper, as regards atmospheric contamination, and which, when published, allayed the apprehension excited by Dr. Hind's letter, and produced the impression that his, Dr. Taylor's, and Dr. Halley's observations might be erroneous. Recently, Dr. Taylor has given reports of cases, and indisputable experimental evidence in support of his former statements and opinions; and I think those who have read what has been written on the subject, will be strongly disposed to answer the query I have put in the affirmative.

Presuming, then, on the injurious influence exercised by wallpapers containing arsenic, it becomes interesting, Sir, to enquire how the poison is conveyed from the walls into the system—in what state, and by what channels.

Dr. Halley says, that at ordinary, or even higher temperature, *with common air*, the amount given off is inappreciably small. That the products of the combustion of gas passed through an aspirator filled with arsenical paper, gave distinct evidence of the imbibition of arsenic in the passage of the air through to the paper—crystals of arsenious acid being obtained from it; and that no arsenic was found in the gas supplied for the experiment. In other words, the *arsenic in the wall-paper is vapourized*, but mere temperature alone is not the chief agent in separating it from the copper with which it exists in combination, but that such vapourization is due to the action of the products of combustion of carburetted hydrogen on the arsenite of copper, by which the former element is separated and vapourized.

Under these circumstances, the pulmonary mucous lining would be the channel by which the poison would be conveyed into the system, and it happens to be a ready and effective one in this very case.

The poison, however, acts on the body, beyond all doubt, in another way—whether only locally, or locally and generally, I cannot say. The dust of the paper (*i.e.*, arsenite of copper with the fabric of the paper), carried from its rough surface by currents of air, or by brushing, will eddy through the room's atmosphere, and will come in contact with, and adhere to the exposed mucous surfaces of the body, and will also be inhaled. May not, therefore, the affections of the eyes, mouth, tongue, throat, &c., be due only to direct irritating contact of the poison, rather than to preceding systemic contamination by it; and may not these differences in the condition of the poison also explain that while in all cases reported we have affections of the mucous surfaces, in some and in the one I have brought forward, we have no constitutional symptoms.

Mr. President, I will conclude these observations by saying, that in this country, where liberty is so extensively enjoyed, that all kinds of poisoning, save malicious, is permitted, the thing being done on a scale of respectable magnitude, diffusion of the knowledge of the danger of papering our rooms with green flock is the mode best calculated to remedy the evil. In Prussia there is a special prohibition to the use of arsenic in the manufacture of papers and paints, arising no doubt from the knowledge of the injury likely to result to the public health therefrom.

Council Ordinary Meeting February 2nd 1859.
Dr. Dill in the chair. Present Drs. Cuming & Wales.

Circular was prepared.

FOURTEENTH MEETING.

5th February, 1859.

The President in the Chair.

{Rough minute book: Dr. Murney, Patterson, Moore, M'Minn, M'Cleery, Dill, Gordon, Halliday, Wales, Ferguson, Pirrie, Reid, Heeney, Ross, Arnold, Johnston, Warwick, Rea, Murney.}

Amputation of Leg.

The PRESIDENT exhibited a leg which he had amputated that morning; it was a case of secondary amputation. The patient I.J., aged 48, came into hospital in September last, suffering from disease of the astragalus of left foot. This disease had existed from the preceding July. On the 25th of October, Mr. Browne removed the foot, commencing the operation as that of "Pirogoff," but finding the os calcis carious, he completed it by "Syme's." On sawing through the end of the tibia, the structure was found to be rather softened. The wound healed rapidly, though extensive suppuration occurred in the sheaths of the extensor tendons, a result, Mr. Browne remarked, which occasionally follows Syme's operation at the ankle-joint.

After the parts had quite healed up and were regaining their natural appearance, the tibia took on disease which necessitated the removal of the limb below the knee. This was done by the double flap, three vessels were ligatured, and the wound was united by metallic sutures. The pathological specimen exhibited a beautiful illustration of the excellent elastic pad which the soft parts of the heel form in cases where Mr. Syme's operation has been adopted; and, as the President remarked, it has yet to be proved that, while Pirogoff's operation gives an additional inch, or a little more, to the length of the limb, it will also afford an equally good point of support, and be as useful as the limb after Syme's operation.

Case of frequent serous discharge from Uterus.

Dr. BRYCE read the following case:—The patient whose case I am to bring before you, is the mother of eight children; the youngest was a year old at the first of September last, and still on the breast. At this period she had a severe attack of hæmorrhage. I may mention that for the previous ten months, she had smart attacks of menorrhagia, occurring at intervals varying from one to three weeks, from the effects of which her health had suffered considerably, and she had become nervous and hysterical. She had a second attack about the middle, and a third about the end, of September.

During the last attack there was discharged a gelatinous-looking mass, very much resembling frog's spawn, but firmer, which was studded with vesicles filled with a light straw-coloured fluid. After the discharge of this mass, there was no return of hæmor-

rhage for four weeks, and the patient was rapidly recovering strength, and I believed that this substance, by distending the uterus, had been the cause of the hæmorrhage. However, it again returned, but now mixed with a serous fluid. After two or three attacks of this kind, the blood disappeared, and there were discharges about once a week, for five or six weeks, of a clear watery fluid, in quantities varying from one to two pints. On one occasion she succeeded in collecting a pint of this fluid. There was sometimes a slight discharge of fluid blood, and at others a clot was expelled before the water. The uterus could not be felt externally, and to the touch internally and when viewed through the speculum, it appeared quite healthy, only there was seen a softish substance plugging up the os, which required to be pushed aside before a sound or other instrument could be introduced.

I at first considered this a case of hydatids, but am now inclined to believe that this fluid was secreted by a false membrane lining the cavity of the uterus, and discharging its contents occasionally. About four weeks ago, I ordered her the carbonate of iron, (by double decomposition); since this period she has greatly improved in health and appearance. There has been no return of the watery discharge for three weeks, but there was, on two occasions, a slight sanguineous discharge which continued for a day. I had tried the injection of the sulphate of alum, but without any apparent good effect.

Scirrhus of the Pylorus.

Professor REID exhibited some morbid parts removed from the body of a patient who died recently in the Union Hospital. The woman, aged 56, was in hospital about three weeks, and gave the following history of her illness:—She stated that, about August last, she began to vomit her food about an hour after taking it, but that the interval gradually became shorter, until now that she rejects it almost immediately. The matters vomited are very sour; she suffers much from thirst; the urine is scanty and the bowels constipated. Her eyes are much sunk, the malar eminences flushed, the skin of the body sallow, and she is greatly emaciated. The abdomen was flat, and a distinct hard tumor was at once detected in the right hypochondrium. Three days after her admission she passed a large quantity of urine, which had been previously scanty. The sp. g. was 1,018, and contained no albumen.

With the presence of such symptoms, there was of course no difficulty in concluding that she was the subject of scirrhus pylorus; but on some subsequent examinations, it was not so easy to confirm this opinion, because the tumor was not to be felt in the right hypochondrium, but had shifted into the locality of the cardiac orifice, and on other occasions was to be

found below the umbilicus. Combining this last locality with where it was first found, I had no doubt of the pyloric orifice being affected; but the vomiting immediately after taking food, and the hardness felt in the region of the cardiac orifice, led me to believe in the possibility of the cardiac end being also involved. The mobility of the tumor, when the pyloric end is involved in cancer, should never be forgotten, as cases have occurred where non-attention to this has led to the disease being undetected. An instance of this fell within my observation about two years ago, in which an eminent physician in another town had for many months been in attendance on a lady suffering under the usual symptoms of scirrhus pylorus, but had failed to detect the disease in consequence of not searching for the tumor sufficiently low down, where there was no difficulty in detecting it below, and to the right of the umbilicus. Some days she would reject everything; again she would take and retain large quantities for a period of 48 hours; and again the quantity rejected appeared far in excess of what she had taken into the stomach. Latterly the matters vomited had all the characteristics of what has been described as “coffee grounds.” In this, as in several previous cases, I found a combination of sweetmilk, whiskey, and lime water, to be retained when taken in small quantities at stated intervals, when all other kinds of nutriment had been rejected. There was present in this woman what I had observed in a few other similar cases, viz., that when commencing to examine the abdomen, its parietes would be found flat and retracted to the spine, but soon after the withdrawal of the hand, the stomach would be observed to swell up, raise the parietes, and contract like a worm from end to end. She required aperient medicine and enemata till the 26th ult., when diarrhoea set in, and continued till death, on 3rd instant, the evacuations resembling coffee grounds, and being very foetid. On *post-mortem* examination, it was found that the stomach had contracted no adhesions to any neighbouring organ, and, as is generally the case when the pyloric orifice alone is diseased and greatly contracted, the cavity of the viscus was greatly enlarged, capable of containing several quarts, which at once explained how the tumor was to be felt in different localities. The pylorus was surrounded by a hard ring of scirrhus, and so contracted that it only allowed a No. 10 catheter to pass into the duodenum. There was no scirrhus deposit in the liver or mesentery. The small intestine was natural to within about one foot of the cæcum, when it was found invaginated; the upper portion being inverted into the lower. The uterus was found very small, it and the rectum healthy. The spleen unusually small, and free from any morbid deposit. The kidneys large and healthy in structure. The supra renal capsule enlarged considerably; there was, however, no discoloration of the skin

during life, as has been observed by Dr. Addison in connection with disease of these organs.

Case of Chlorosis—Anæmic Murmur at Apex of Heart.

Professor REID then stated that a chlorotic girl was, three weeks ago, admitted into the Union Hospital, in whose case there were some points of interest, and who gave the following account of her health:—About two years ago, the catamenia had been too profuse, which medical treatment, however, soon restrained, without her strength or usual ruddy complexion being at all diminished. About twelve months since she complained of pain in the epigastrium, suffered from vomiting, and found her strength, appetite, colour, and catamenia gradually diminishing, the latter still appearing at the regular periods. About eight months ago, she began to suffer from palpitation and breathlessness on going up stairs, or on making any exertion, with throbbing in the back of the head, noise in the ears, and often pain in the right side of the head. She was certain that, from the attack of menorrhagia two years previously, there had been no debilitating discharge of any kind; neither epistaxis, hæmorrhoids, hæmatemesis, nor leucorrhœa.

She sought hospital treatment on account of palpitation and debility. On admission, her eyes, naturally large, were very bright; the conjunctiva, the lips, the gums, and tongue bloodless. The skin of the face and body was pale yellow, and free from œdema about the ankles, although the stethoscope leaves a slight depression on the chest. There was no evidence of organic disease of either the lungs, the liver, or spleen, and she had never had intermittent fever; and as she had always been well fed, and clothed, and kindly treated in a gentleman's family, I had no difficulty in making my diagnosis that she suffered under chlorosis, fairly attributable to the affection of the digestive organs, which appeared one year previously. When the hand was laid over the heart, its action was found irritable; percussion did not detect any enlargement. The stethoscope revealed the existence of a distinct systolic murmur in the second left intercostal space, and extending towards the left shoulder, in the locality of the pulmonary artery. A murmur very much fainter was heard over the sternum, rather lower down, or in the position of the aorta. The second sound of the heart was quite distinct. Over the body of the ventricle, no murmur was heard, but finding the apex of the heart, and placing the stethoscope over it, a distinct murmur was also heard at the period of the heart's systole. There was also heard a continuous murmur in the jugular veins, most distinct in the right; but I could detect none over the site of the longitudinal sinus or the torcular herophili, where in similar cases a murmur has been heard. This girl was positive that she had never suffered from rheumatism in any form, nor had any symptom that would

indicate the presence of a previously inflammatory state of the heart; and as she is remarkably intelligent, and gave a most connected account of her illness, I have every confidence in her statement. My reason for bringing this case before the Society, is the presence of murmur at the apex of the heart, in a chlorotic female; and I have been compelled to go more fully than I wished into the history of her health, and the symptoms present on her admission, because the existence of such a murmur, independent of organic disease, is still a disputed point, and the bare possibility of its occurrence has been only recently, and indeed but very partially admitted—as may be learned from the following extracts on the literature of the question:—Dr. Hope “considers that an inorganic murmur is confined to the aortic orifice.” Dr. Latham appears to hold the same opinion. Dr. Davis states, “that functional murmur is exclusively situated at the base of the heart.” Dr. Bellingham writes, “that the systolic bellows murmur in organic affections of the heart, has its seat at the aortic orifice, and is not audible at the apex of the organ.” Dr. Hughes states a similar opinion. Dr. Markham “believes that mitral systolic murmurs invariably indicate a defective condition of the mitral valves and are never inorganic—he is not prepared to admit or deny, that spasmodic contractions of the papillary muscles, the tendons of which are inserted into the mitral valves, may occur, and so prevent the closure of the mitral valves for a certain period.” Dr. Walshe states “that hæmic murmurs are invariably basic in seat, systolic in time, only in exceptional cases audible below nipple, and never perceptible as far as left apex.” He admits “that a dynamic murmur,” that is, a murmur dependent on some “abnormal state of the heart’s action, as in chorea, and probably in other nervous disorders, is heard at left apex, owing to a disordered action of the muscular apparatus of the valve.” He has “never seen a murmur at left apex of purely blood origin, and has never heard, in a purely chlorotic woman, a murmur having all the characters of a mitral regurgitant one.” Dr. Stokes advises us “to be cautious in rejecting the opinion,” that inorganic murmurs may not be seated in the mitral orifice, “as he believes that he observed cases of inorganic murmurs, which, so far as physical signs went, were closely similar to those of ordinary regurgitant disease.” Dr. Stokes has recorded two most instructive cases, in which organic disease of the mitral orifice was associated with chlorosis. In one there was marked lividity of the lips, until the chlorosis was cured, the systolic murmur at apex remaining, the lady dying suddenly some years afterwards. The other had previously suffered from an attack of pericarditis, and *post-mortem* examination proved the existence of organic disease of the mitral orifice. Dr. Barclay “is quite certain that an anæmic murmur is occasionally heard of greater intensity

towards the left apex.” It would thus appear that Drs. Stokes and Barclay are the only authors who admit that a blood murmur may exist at the apex of the heart, independent of organic disease. It is strange that, notwithstanding many sudden deaths in chlorosis, we have no record of any *post-mortem* examination in a case in which a murmur at the apex had been heard in chlorosis, except where there existed during life evidence of organic disease.

Dr. REID remarked, that as there was neither cough, nor hæmoptysis, nor lividity of the lips, nor any symptom that would indicate regurgitation through the mitral orifice, he was disposed to believe that the murmur at the apex was caused by the friction of the spanæmic blood against the *columnæ carneæ* of the ventricle, the sound being conveyed to the surface by the apex of the heart when in contact with the side; and that from this case we should draw the practical lesson, that we are not hastily to decide, that when a murmur is heard at the apex, therefore organic disease of the mitral orifice must be present, always bearing in remembrance that Dr. Stokes has proved that such disorganization may co-exist with well-marked chlorosis, and remain and cause death after the chlorotic murmurs had been removed. This patient derived marked benefit from the administration of iron, the colour of the lips and tongue improving greatly; the murmur much less distinct at the second intercostal space, and not constantly heard at the apex.

Council Ordinary Meeting February 9 1859.

The President in the chair. Present Drs. Dill, Murney, Cuming, & Wales.

The circular was prepared.

FIFTEENTH MEETING.

12th February, 1859.

The President in the Chair.

Porriigo existing only on the Chest.

Mr. H. M. JOHNSTON having, at the last meeting of the society, introduced a child, aged 2 years and 4 months, on whose chest a solitary spot of disease existed of six weeks’ standing, which he believed to be porriigo; and some diversity of opinion having arisen as to its nature, in consequence of no trace of eruption having appeared on the scalp, it was ordered that the crust should be examined microscopically. Accordingly,

Dr. CUMING stated, that, having examined the crust, he had been able to identify the parasite, so that the disease was undoubtedly porriigo.¹

¹ On the inaccuracy of this test, see paper by Jabez Hogg, Esq., read before the Medical Society of London, page 110.—ED. D.H.G.

Dr. WALES exhibited the *achorion schænleinii*, the vegetable parasite of the crust in question, under the microscope.

Case of Placenta Prævia.

Dr. HEENEY read the following case:—On the 8th of November last, I was hastily summoned by a junior member of the profession to render assistance in a case of excessive hæmorrhage from the womb, occurring in a parturient woman in the ninth month of her pregnancy. On arriving at the bed-side, I found the patient in a state of extreme debility, and it was with great difficulty that any pulsation at the wrist could be found; her extremities were cold, and her face quite pallid, although her head was placed low. The patient was too weak to give me any information at the time, but I was informed that she had previously several attacks of flooding.

I afterwards learned from the patient herself, the following details: She is about 35 years of age; the mother of six children; and there was nothing unusual in the present pregnancy beyond a constant pain in the back, which, however, disappeared on the occasion of the first hæmorrhagic discharge, which took place on Monday, exactly sixteen days before her delivery. She found occasion to empty the bladder, and, whilst doing so, she remarked upon the unusual quantity of fluid which was passing from her, and was surprised and horrified to find that the chamber utensil was literally overflowing with blood. She lay down, and the hæmorrhage ceased till the second day afterwards, when it again returned without pain or warning of any sort, and there issued, according to her own estimation, about three or four pints. She now felt very weak and alarmed, and sent for an accoucheur, who, upon visiting, found the hæmorrhage had ceased, and ordered the continuous use of a mixture, with a view to bring on labour pains. He then left her and did not return. She drank the entire of the mixture, but without the desired effect.

On the Sunday following she had another attack, then on Tuesday, and finally, on Wednesday, two other attacks—the first at two o'clock, p.m. This left her in a very alarming state, when another accoucheur was summoned. He found it necessary to administer stimulants, and some local applications to the genital organs, and, I believe, not suspecting unavoidable hæmorrhage, resolved on waiting the efforts of nature for the expulsion of the fœtus. He left the patient to repose, as the hæmorrhage had ceased, but was summoned in two hours afterwards, as it had returned with force, and he was so alarmed at the quantity lost, and the great prostration, and almost moribund condition of the patient, that he demanded assistance, when I was sent for. Before I arrived the hæmorrhage had ceased. I then proceeded to a careful examination. I found the os uteri pretty high up,

but dilated to nearly the extent of half-a-crown, and somewhat dilatable; the anterior half of the circular opening of the womb was covered with a fleshy or fibrous substance, which I readily concluded to be the margin of the placenta, and whose presence in this situation was the cause of the previous hæmorrhage. I then endeavoured to find out the part of the child presenting, but was unable to do so, as I could touch nothing within but the membranes filled with the waters. The hand, however, I afterwards discovered to be the presenting part, but the water behind, and the placenta attached principally to the cervix anteriorly, prevented me from then ascertaining that point.

I found myself now in a critical position. To wait for the efforts of the womb, and another attack of bleeding, would be to consign the woman to certain death, and to turn, in her present depressed and anæmic condition, would be attended with considerable risk, and, if unsuccessful, with perhaps no small amount of obloquy. However, a sense of duty compelled me to adopt the latter alternative, which was readily agreed to by my colleague; but, as I have said before, that he was a young practitioner, I thought it prudent to seek the opinion and consent of an experienced accoucheur. As the bleeding had again ceased, there was time to send for one, and I thought it right, in the meantime, to give as much stimulus as she could take, which was little, owing to the difficulty of swallowing.

Dr. Wales was the gentleman sent for, who, after hearing the case as far as I could explain, and after due examination and deliberation, concurred with me that immediate delivery was the most proper course. On introducing my hand within the os, and behind the margin of the placenta, I experienced no resisting *contractile* efforts, but it was with some difficulty that I got the hand introduced. I then ruptured the membranes, and sought the foot of the child. I could not conveniently grasp more than one, and brought it down, and there was no difficulty till the breech came low enough to pass the os, the passage of which occupied a considerable time, as there was a steady *passive*, though not *active* resistance. However, by steady perseverance and repeated tractile, though not violent, efforts, the delivery was accomplished. The placenta immediately followed, and I never saw a delivery where there was less loss after the expulsion of the fœtus, which was stillborn. She had no labour pains from first to last, but I thought I perceived some slight bearing efforts on her part during the latter part of the delivery. The woman is now perfectly well, but it was several weeks before she could leave her bed from debility alone. She had no subsequent inflammatory symptoms, but the pulse ranged high for a considerable time after delivery; it however gradually improved under the use of hæmatics and nutritious diet.

I am happy to think, that cases of placenta prævia do not often occur, as, although I have practised pretty extensively for many years, I never met one before. I adduce this instance to illustrate the danger of leaving cases to nature where the loss and weakness have been so alarming—a course advised by some authors, and as confirmatory of the views of those who deprecate delays. Such cases are extremely perplexing even to the experienced practitioner. My opinion, however, corresponds with the teachings of those who recommend delivery as soon as the *dilatable* state of the os uteri will permit, and not to be deterred from interfering even where the loss and debility have proceeded to an extreme degree, (whether from neglect or ignorance of the consequences, as in the present instance,) as immediate delivery affords the best, if not the only, chance of rescuing the unhappy patient from the jaws of death.

Bigg's Orthoæpede.

Dr. WALES next exhibited an instrument, invented by Mr. Bigg, for use in equino-varus. He said he had been using it for some time, and with modifications had found it to answer the purpose for which it was intended. The mechanical merit of the instrument consisted in the simplicity and ingenuity of the arrangement by which three distinct movements of the foot-piece could be produced by acting on one centre; these movements were eversion, rotation, and elevation of the anterior portion of the foot, and consequent depression of the heel, such motions as were requisite for the restoration of the foot affected with equino-varus to the normal position. In slight cases, the use of this instrument would suffice for a cure, without surgical interference; but when the latter was necessary, it became still more useful. The instrument being adjusted to the deformed position of the limb, and section of the tendons being performed, it maintains the foot immovable, until the new bond of union safely admits of elongation, which can be so gradually and steadily accomplished that all risk of loss of power from imperfect or weak union is avoided.

To keep the stem of the instrument, however, firmly in the middle of the lateral aspect of the leg required extension of the short thigh stem to the hip joint, and its pivot attachment there to a pelvic band. This addition renders the instrument very effective. He further said, that though the instrument answered exceedingly well for very young children, he preferred, where a child is *about walking*, dispensing with it altogether, and operating at two distinct periods. His plan was to convert *equino-varus* into *equinus*, by section of resisting structures and *immediate* extension on a common straight splint. Eversion being complete, he next divided the tendo-achillis, and by simple mechanical means, brought up the foot *gradu-*

ally to a right angle with the leg, which position, with proper and common appliances to the foot, will be maintained by the weight of the child's body in its attempts to walk or support itself.

Fractures of the Acromial End of the Clavicle.

Professor GORDON read the following case:—As the following case and specimens of fracture of the clavicle, near the acromial end, have an important bearing on the present knowledge of such accidents, I have, therefore, been induced to bring this matter before the Society, more especially as the conclusions at which I have arrived are different from those of Dr. R. W. Smith, whose work on fractures and dislocations embraces, with some trifling exceptions, almost all that is known on the subject.

A carpenter, aged 30, whilst assisting in carrying a heavy piece of timber, on the 19th January, 1859, fell at least from a height of 20 feet, in his descent striking the side of the wall, and alighting on the posterior and outer part of right shoulder and axilla. About an hour after the accident I saw him. He was in a shed adjoining the place where he had fallen; he was sitting on a form, leaning slightly forwards and to the right side. His sole complaint was of severe pain in the right hypochondrium and upper and back part of axilla. On passing my hand beneath his clothes, and desiring him to take a deep inspiration, I was unable to make out any fracture of the ribs; but as the attitude in which he sat and the way in which he had fallen, led me to suspect fracture of the clavicle, I next proceeded to examine that bone. On carrying my finger along its upper surface, when I arrived within $\frac{3}{4}$ of an inch of its acromial end, the continuity seemed to be lost, and pressure here caused him to wince; but the pain was very trifling indeed when compared with that experienced when the trapezius was pressed forwards against the seat of fracture. He was directed to be taken home and to go to bed for a further examination.

On visiting him shortly afterwards, I found him sitting up, being unable to lie down from the severe pain in the right hypochondrium and back part of axilla; but as the most careful examination of these regions did not reveal either crepitus or inequality of the external surface of the ribs at the seat of pain, I regarded it as proceeding from muscular contusion. I now requested him to raise the arm, which he did slightly, at the same time flexing and extending the fore-arm upon the arm with tolerable freedom, and without complaint of pain. On exposing the shoulder, it was found to be more depressed, and the spinal border of the scapula more prominent than that of the opposite side. When measured from the acromion to the sternal end of the clavicle, there was shortening to the extent of half-an-inch. On carrying my finger along the anterior border of the clavicles, on

arriving near the acromion, the anterior concavity was much deepened; the outer, or acromial fragment formed almost a right angle with the sternal portion, which seemed to be displaced backwards. On the upper surface both fragments were on the same level. Pressing the trapezius forwards opposite the fracture caused very acute jaggings pain. No crepitus was detected by slightly raising or depressing the shoulder. However, as he suffered very acute pain in the right hypochondriac and axillary region on the slightest motion of his body, and as the signs of fracture of the clavicle were quite conclusive, no further attempts were made to elicit crepitus. A large pad was placed in the axilla, and a figure of 8 bandage applied, which removed almost completely the inclination forwards of the acromial fragment of the clavicle.

Dr. Smith, to whom we are indebted for pointing out this displacement forwards of the outer fragment, says—"From an examination of these preparations, we learn that the outer end of the clavicle may be broken either between the coraco-clavicular ligaments, or between the trapezoid ligaments and the acromion; and that fracture in the former situation is of comparatively rare occurrence, and attended with scarcely any displacement of either fragment of the bone; but that in the latter, contrary to what is usually stated, there is generally a considerable amount of displacement. The specimen of fractured clavicle which I now exhibit, and which I shall call No. 1, resembles so accurately that of No. 3, page 22 of Dr. Smith's work, that if we had a like horizontal section in it, it might almost be said that the drawing was a faithful representation of it.

But was this a fracture external to the trapezoid ligament? Unquestionably not. The trapezoid ligament was attached, in any dissection made by me nearer to the acromial end than $\frac{3}{4}$ of an inch. From half-a-dozen of examinations recently made, half-an-inch would represent the average distance between the trapezoid ligament and the acromio-clavicular articulation. In this specimen the fracture is a little more than one inch from the acromial end, and yet the acromial fragment forms almost a right angle with the sternal. This specimen, which I shall call No. 2, I dissected to-day (Feb. 12th, 1859). The acromial, or outer fragment, is on a plane, about a line above the sternal portion; it is so much displaced forwards as to form an angle of about 43° with it. The fracture is oblique from before backwards, and from above downwards and outwards; it commences four lines internal to the acromio-clavicular articulation, and running obliquely backwards and inwards, terminates opposite the posterior and outer border of the root of the coracoid process; and yet the most careful examination shows that, although from its obliquity the line of fracture is nearer to the acromio-clavicular articulation on its under surface than above, there is

none of it external to or between the trapezoid ligament and the acromio-clavicular articulation. The conclusions to be drawn from the case related, and from the two specimens exhibited, are—That in many instances of fracture between the coraco-clavicular ligaments, the outer or acromial fragment is so displaced as to form a right angle with the inner or sternal portion, the upper surfaces at the same time maintaining the same horizontal level, or, as in No. 2 specimen, with the acromial fragment, on a plane somewhat above the sternal fragment. When the clavicle is broken between the attachments of the coraco-clavicular ligaments, the scapula rotating on an axis nearly corresponding to its anterior border, falls forwards and inwards. The acromial fragment is thus brought into relation with the anterior border of the sternal portion, and, if the accident has been overlooked, unites at right angles with it. That the attachments of coraco-clavicular ligaments do not oppose any obstacle to the outer fragment being applied to the anterior surface of the inner, and, when we have fracture between these ligaments without displacement, it must be referred to some other cause rather than to the resistance offered by these ligaments.

That the chief agents in causing displacement are the same as those in the ordinary fracture in the middle third of the clavicle, excepting the subclavius muscle. That the outer end of the inner or sternal fragment seems to be displaced backwards, but this is more apparent than real from the shoulder falling forwards and inwards. From the inclination forwards and inwards of the shoulder, the outer end of the sternal fragment comes into more close proximity to the trapezius. Hence, when we press on that muscle opposite the fracture, it becomes applied against the broken end of the sternal fragment, causing a jaggings pain, much more acute than when pressure is made over any other part of the fracture. That, from the shape of the clavicle, fracture is most likely to occur at the centre of, or a little external to, the centre of the posterior concavity, than between the trapezoid ligament and acromio-clavicular articulation. That, from the attachments of the coraco-clavicular ligaments and the two specimens exhibited, I am of opinion that many of the cases of fracture of the clavicle described by Dr. R. W. Smith as external to the coraco-clavicular ligaments, are really between them, and that his observations apply more correctly to the fractures between, than to those external to, the coraco-clavicular ligaments.

Council Ordinary Meeting February 16 1859.

The President in the chair. Present Dr. Dill, Dr. Murney, Dr. Heeney, & Dr. Wales.

The circular was prepared.

SIXTEENTH MEETING.

19th February, 1859.

{Rough minute book: President, Dr. Ferguson, Patterson, Wales, Heeney, Moore, Harkin, Mulholland, Reid, Rea, Warwick, Murney, Bryce, Murray, Patrick (Carrickfergus), M'Minn, Dill, M. M'Gee, Johnston, Dunlop.}

Fatty Tumour of Back of Neck.

Dr. MOORE exhibited a cast of a fatty tumour of the back of the neck, extending from the occipital protuberance to the first dorsal vertebra, and measuring in its transverse diameter about 6 inches.

About twelve years ago Dr. Moore had been consulted by the gentleman who was the subject of this growth, who was then in his 72nd year, with regard to its removal. Dr. Moore at that time advised, considering his age, non-interference, remarking that it would be a tumour to him all his life. His death was caused by a railway accident, necessitating the removal of both legs below the knee four days after the receipt of the injury. Dr. Moore believed that he would have recovered from the effects of the amputation but for an injury of the spine, which he received at the same time, causing paraplegia.

Chopart's Operation.

The PRESIDENT exhibited a foot, which he had amputated that morning, by Chopart's operation, for disease of the internal cuneiform and cuboid bones. The only remarkable feature in the case was the small evidence there was, at first, of such extensive disease as was exhibited by the tarsal bones, and the rapidity with which they had become disorganised; the internal cuneiform especially was almost completely transformed into tubercular softening. The soft parts in the dorsum of foot had also taken pulpy degeneration. Three vessels had been ligatured, and the edges of the flaps had been brought together by metallic sutures. The patient was a young countryman, aged 24 years.

Uterine Tumour.

Dr. MURNEY placed before the Society a specimen of a uterus, which he considered was an example of the fibrous tumour of that organ; it was taken from a subject in the anatomical rooms of Queen's College. He said—Unfortunately, I am not able to give any history of this case. On inquiry, I have been able to learn only the two facts, that the woman was 40 years of age, and has been an inmate of the idiotic ward in the Union Workhouse for some time past. She was very much emaciated. There was complete absence of mammary development; no fatty deposit at the region of the mons veneris, and there were extremely few hairs about the pubis; altogether, a superficial exam-

ination would have led to the inference it was the body of a girl about 18 years of age, who had never menstruated.

The brain was normal in every respect; the viscera of the abdomen were also healthy, with the exception of the uterus, which was somewhat spherical in shape, nodulated, about the size of a cricket ball and half. The tissue of the organ was not of uniform density; some portions of it were of a natural firmness, others much harder. The "os" was transverse and the margins cicatrized, having evidently been ulcerated at some period. In two instances the nodosities were connected to the tumour by very narrow peduncles. The whole weight of it was 8 oz. 6 drachms, the average weight of healthy specimens being, for the virgin 6 to 10 drachms, and from 1½ to 3 ounces in females who have borne children.

Having cut into the specimen in the presence of the Society, Dr. Murney called attention to the fibrous deposit which had taken place in the two customary situations—viz., on the surface of the uterus, beneath the peritonæum, and in the interior, close to the lining mucous membrane. From the appearance of parts of the section, and the manner the knife cut through it, he was inclined to think portions of the new deposit were undergoing malignant change. Parts of the suspected structure were taken for microscopic examination by some of the members.

Fracture of Neck of Femur.

Dr. MURNEY then showed an example of intra-capsular fracture of the neck of the femur, also met in the anatomical rooms of Queen's College during the past week. The specimen consisted of the articulating part of the bone, connected by a quantity of fibrous structure to the upper end of the shaft between the trochanters. Every portion of the neck had been removed by absorption. The capsular ligament was very greatly thickened, and the muscles around the joint, particularly the glutæi medius and minimus, had undergone fatty degeneration from non-use. The presence of intra-capsular fracture had been recognised when the body, that of a female, was received for dissection, as there was eversion of the foot, shortening of the limb to the extent of one half inch, and upon rotation the trochanter rolled upon its own axis.

Dr. MURNEY remarked—On looking at this specimen, I find the portion of the head which remains exactly corresponds to the superior epiphysis of the thigh. It may be recollected that in the case in which the President performed amputation at the hip joint, and about which case some difference of opinion existed as to the pathological changes, one portion exhibited was precisely similar to this one; also, in a case forwarded to the Society by Dr. Babington, of Londonderry, the same extent of bone occupied the

acetabulum. These instances, and others I have seen, lead me to conclude that at all periods of life the epiphysary, and perhaps the apophysary parts of long bones, receive their nutrition independent of the supply given to the shafts. We know, of course, that, during the development of the bones, the progress of each centre is in a great measure independent of those parts to which it is as yet imperfectly connected, but about the age of 25 years, ossification is completed. This person, a woman, was 65 or 70; Dr. Babington's patient was, I think, 40 or 50; and Mr. Browne's case was 26 or 27 years of age. In two at least of these we might have expected the circumstances which caused removal of the neck of the thigh would also have carried off the head, had both those parts been nourished from the same source; but as I believe they derive their supply of blood from different vessels, we can readily explain why certain parts are so frequently to be found cut off from the remainder of the bone at precisely the same situation.

Dr. Dill introduced the discussion of the Placenta Prævia by asking for adjournment and recommending that it should *take precedence* of all others.

Council Ordinary Meeting February 23rd 1859.

Present, the Secretary.

The circular prepared.

SEVENTEENTH MEETING.

26th February, 1859.

Deformity of Hand, with Operation.

Dr. GORDON presented a boy, 8 years of age, on whom he had operated eight months ago, for a deformity of the hand from a burn. The boy was two years of age when the accident occurred, and being weak and delicate, his mother said, "I did not pay sufficient attention to him, thinking he would not live long." Shortly after the commencement of last session, Dr. Halliday brought him before the Society.

After that this cast was taken, on his admission into hospital. The hand is flexed at an acute angle with the forearm, and the proximal, or upper end of the carpus, and its dorsal surface, projects downwards, so that when he falls forwards the upper and back part of the carpus comes in contact with the ground. The palmar aspects of the ulnar site of the hand, and a considerable portion of the little finger, are united to the anterior surface of the lower fourth of the forearm. On the radial side, the ball of the thumb is approximated to the forearm, but the cicatrix does not extend so high by an inch as on the ulnar side. The hand is thus not only greatly flexed, but also very much adducted and slightly rotated, the

palm looking upwards and towards the radial border. The thumb is so much bent backwards that its phalanges form an acute with its metacarpal bone, the dorsal surfaces looking towards each other. The band of skin which has thus bent the thumb backwards proceeds from the root of the nail, burying, as it were, the whole thumb except its apex. The fore and middle fingers are free, but the ring finger is held very much flexed, whilst the little finger is greatly adducted, and held against the ulnar surface of the forearm.

The boy was put under the influence of chloroform, and a V incision, its apex upwards, was made through the band uniting the ulnar side of the hand to the forearm. The angular flap was next dissected downwards, until the hand formed an obtuse angle with the forearm. A similar V incision was made on the radial side. After that the two sides of each of the V incisions were approximated transversely by sutures, the water dressing applied, and extension maintained by a splint passing along and beyond the back of the forearm and hand. When these incisions had cicatrized, and when the hand had been brought on a line with the forearm, a V incision was also made in the cicatrix, which held back the thumb. The state of the parts at present are—The hand is on the same line as the forearm, with the exception of a very slight inclination towards flexion. The thumb is inclined backwards, but not to the same degree as before operation, its extremity, as high as the second joint, being free. The ring finger is considerably flexed by a contracted band. The little finger is so flexed, deformed, and incapable of motion, that it would not be possible to make it of any use to him.

{Rough minute book: Professor Gordon also exhibited a specimen of extra-capsular fracture of femur.¹

Professor Gordon exhibited an amputated limb from scrofulous disease of knee joint.}

Cases of Placenta Prævia, by Dr. DILL.

It will be admitted by all who practise obstetric medicine and surgery, that there is no one complication in midwifery attended with more danger to the patient, and difficulty to the practitioner, than those cases wherein the placenta presents, and unavoidable hæmorrhage occurs. Under circumstances of such extreme peril to the patient, the accoucheur may be said, indeed, to be actually combating death. With such facts before us, and acknowledging the serious responsibility that presses upon us, we are imperatively required to be not only intimately acquainted with the symptoms, but to analyse thoroughly and impartially, and examine carefully, the different methods of treatment which have been from time to time recommended by the various authorities, so as

¹ [See page 780 for details of case.]

to come to a safe and satisfactory finding regarding the management of placenta prævia. It is not necessary for us here to pause and inquire how it comes to pass that the placenta is occasionally to be found planted over the os uteri, and at times in its immediate vicinity. It is only required of us, at the present time, practically to know that such cases do exist, and that we may be suddenly and unexpectedly called upon to deal with placental and partial placental presentations. Placental presentations are to be diagnosed, first, by the sudden attacks of discharge of blood from the uterus, usually commencing with the sixth month of pregnancy, and recurring occasionally until the full period of gestation arrives, or until the approach of labour. Second, by a vaginal examination, when a firm, fibrous, and fleshy sensation is communicated to the finger by the part presenting. Third, by the body conveying such a sensation being attached to the inner side of the os uteri; and fourth, by a loose membranous-like substance hanging down through the os, when the placental presentation is partial. The different modes of managing cases of placenta prævia, may be briefly stated in the following order:

The first plan proposed may be said to be the use of the “tampon,” or the plug. This practice is only indicated when the os is not dilated sufficiently, or dilatable. Under these circumstances, I have used the “tampon” with advantage. The only objection to it is, that hæmorrhage may go on inwardly.

The second is the puncturing of the membranes, which has been practised from a very early period, and I would merely allude to one very formidable objection, viz., that should turning be the practice required at any future period, it is found to be much more difficult, if not dangerous, in consequence of the evacuation of the waters, and the contraction of the uterus.

The third is the partial separation of the placenta. With this proposal, which originated with Dr. Robert Barnes, I shall not occupy your time, as it does not recommend itself to my mind in any case; I shall only say, that in most cases of partial presentation, we have at a certain stage a partial separation of the placenta without any good results following.

The fourth is the complete separation and extraction of the placenta before the child; and the fifth is what I would consider the grand and the chief operation in placenta prævia—viz., the turning of the child.

The fourth and fifth plans of treatment appear to me to be the modes of managing cases of placenta prævia, with which we have principally to do, and which have occupied the minds of the profession as rival or antagonistic operations since 1844, when Dr. Simpson revived the plan as proposed by Mr. Wood and Dr. Radford, viz.:—the separation and extraction of the placenta before the child. We have now to take up and carefully inquire into the merits and demerits

of that proposal which has been made, of artificially separating and bringing away the placenta before the child. And this practice having had the advocacy of Wood, Radford, and latterly of Simpson—men of such high standing—we are bound, before condemning it, to give it our best attention. Dr. S. appears to think that this operation should supersede the operation of turning; but the theory and arguments which have been advanced in its favour, and which he makes the basis of his practice, are not (as I shall show) to be relied upon. The recommendation is founded upon the hypothesis, that the flooding comes from the cells in the placenta—not from the uterine vessels—and if this can be sustained by facts and arguments, then, indeed, should the placenta, the source of the discharge or hæmorrhage, be the body first removed. No satisfactory proof can, however, to my mind be given, that the great quantity of blood which flows in these cases, proceeds altogether from the placenta. Is it at all likely that this large quantity of blood should come from such a small portion of detached placenta as is usually at first separated? Besides, if the extremities of the blood-vessels on the surface of the placenta be open at all, they must of necessity be very minute. Some anatomists and physiologists assert that they have not open mouths, and Dr. H. Madge, who instituted a series of experiments, established the fact that the vessels on the surface of the placenta are shut sacs. The experiment was this: he injected the umbilical vein with a quantity of coloured fluid, and in place of escaping at the surface of the placenta, the fluid returned by the arteries. On the other hand there are strong and valid reasons for believing that the mouths of the vessels on the inner and stripped surface of the uterus, are the principal sources of hæmorrhage in placenta prævia. The size of these vessels in the mouths of the sinuses which will expand at the mouth and neck of the uterus with each pain, at which time an increased quantity of blood is discharged, furnish satisfactory arguments in favour of the opinion that the flooding comes directly from the uterus. Moreover, Dr. Simpson himself states, that there is a greater development of the uterine blood-vessels in the neighbourhood of the placental attachments, and also a larger determination of vital fluid to this quarter. And hence, we must most naturally infer, that when the placenta is separated, the flow of blood from this part of the uterus becomes excessive.

As often as I have examined the portion of separated placenta, so often have I observed that the surface and cells were coated and filled with coagulated blood. The fact is also on record, that although the placenta has been separated and expelled, the flooding has continued. We may also adduce post-partum hæmorrhage, as a very strong argument in favour of the opinion that it is from the uterine vessels the discharge comes. No doubt hæmorrhage has occa-

sionally ceased by extracting the placenta before the child; but this is to be ascribed to, and accounted for, by the fact that the head of the child is pressed down, and shuts up the mouths of the uterine vessels. But admitting that this may occur, and although the placenta may become spontaneously detached and lodged in the vagina, from which of necessity it must first be removed, yet this does not satisfactorily prove the propriety of artificially separating and extracting the placenta in all cases before the child is delivered. Nay, more, I believe I have advanced arguments strong and sufficiently numerous to deter the practitioner from such a mode of procedure. We now have arrived at that point at which we shall consider the most important operation in placenta prævia, viz., turning, which operation, if performed judiciously, and at the proper time, gives us the best chance for preserving the lives of both mother and child, as I shall endeavour to show, in the favourable results which flow from this practice, in the relation of a few cases which lately came under my own observation:—

Case 1.—Mrs. C., aged 30, April 21st, 1858, Keegan-street.—Mr. J. called me to see this patient, who was far advanced in pregnancy, and had been attacked with profuse uterine hæmorrhage once or twice during the eighth month, and now again towards the close of the ninth. The placenta was felt adhering at the neck of the uterus; the os was about the size of a crown piece, and dilatable. The woman was weak, but there were symptoms of a living child. She was put under the influence of chloroform. I introduced the left hand, the os easily yielded, passed onward, punctured the membrane, got a hold of one foot, turned, and delivered her, in the usual way, of a living child. The placenta very soon followed; the hæmorrhage ceased; the woman did well; the child died within a week.

Case 2.—In June, 1858, I was called, by Drs. S. and J., to a woman residing in Fourth-street, who had been attacked with profuse hæmorrhage at the close of the ninth month of pregnancy. She had been ill for nearly two days when I saw her. The edge of the placenta was protruding through the mouth of the womb. The waters had been discharged some hours. The woman was weak, and life in the fœtus could not be detected. It was agreed that turning was the proper course. Dr. J. introduced his hand, got hold of a foot, turned, after some difficulty, and brought away a dead child. Marshall Hall's plan of treatment was vigorously instituted, but without effect. The mother did well till the tenth day, when she died, but as I did not see her after being delivered, I cannot state the particulars.

Case 3.—Mrs. M. was brought into the Lying-in-Hospital in a very weak and exhausted state from hæmorrhage, about the full period of gestation. The placenta presented. Dr. Pirrie, whose patient she was,

finding the os but slightly dilated and rigid, thought it better to introduce the “tampon.” It remained in for four hours, during which time the pains had increased. The “tampon” was removed. The os was found to be farther dilated. She was placed under chloroform. Dr. Pirrie introduced the hand, turned, and delivered; the child was dead; the woman made a good recovery.

Case 4.—On the 10th of September, 1858, Mrs. F., aged 33, took ill of flooding at 5 o'clock, a.m. I was with her at 6 o'clock. She had completed the sixth month of pregnancy. She had lost a good deal of blood, and the discharge was continuing. The placenta presented; os, size of half-a-crown and rigid. I introduced the “tampon,” applied cold, and admitted cool fresh air into the room. Mrs. F. was a delicate woman, and she had become rather weak. I was soon afforded the assistance of Dr. P., when we agreed to administer chloroform, and deliver. I introduced the right hand into the vagina; found the os more yielding, so much so as to enable me to introduce two fingers; found it to be a cross birth; hooked one of my fingers into the groin of the fœtus, and soon brought it away; being premature, the fœtus was of course dead, but the mother made an excellent recovery.

Case 5.—On the 12th of July, 1858, at two o'clock, a.m., I was sent for by Mr. Moore, resident pupil in the Belfast General Hospital, to see Mrs. L., whom he had brought into the house the night before. She had now reached the full period of pregnancy, and during the last three months she had been attacked frequently with profuse hæmorrhage. I found her very weak; pulse nearly gone. On examination discovered a complete placental presentation. The hæmorrhage continued. The child was found to be alive; but both mother and child were in extreme danger. She was placed under chloroform. I introduced my left hand, separated the posterior edge of the placenta from the uterus; passed onward; punctured the membranes, got a hold of the child's foot, turned, and brought away a living child. Although the mother had a severe attack of puerperal fever, both she and the baby did well. I was present when a member of this Society, in a case of placenta prævia, turned. His patient did well; but as I was only in the room, and did not make an examination, I am not in a position to say more.

I would conclude by stating that I know of no case in which the use of chloroform is more indicated, and in which the good results arising from it are so apparent, than when turning is practised.

Lastly, Dr. Simpson's statistics show that where turning is practised, there is a mortality of one in three and a-half, and consequently argues against it; whereas, I have brought under the notice of this Society six cases in which turning was the practice, and in some of them under very unpromising circumstances, with only one death, and which, I believe, was not to

be ascribed to the operation. I may add, that in this case, at her own request, chloroform was not administered.

{Rough minute book: Dr. Ross asked how would Dr. Dill act when the child was not viable.

Dr. M'Gee had seen three cases of placenta prævia and had once seen the placenta removed naturally before birth of the child. He always turned and the child had always been stillborn and the mothers had been saved.

Dr. Ferguson asked had Simpson more than 6 cases or what was the actual amount of his cases.

Mr. Johnston attended 1 case in which he got jaundice. He mentioned 1 case in which in the 7th month there was an enormous hæmorrhage. One day the membranes burst and pains commenced then enormous hæmorrhage cut in he turned and delivered. Both child and mother survived. Craniotomy had before been performed once twice child had been delivered by forceps.

Dr. Pirrie held that in partial presentations turning should not be adopted.

Dr. Heeney held that the hæmorrhage would be likely to be increased by the dilatation.

Dr. Patterson met partial placenta prævia often always with hæmorrhage and never had to turn.

Dr. Murray met one case in which he turned readily.

Mr. McCormac said it has been shown that the termination of the placenta vessels is by tufts dipping into veins.

The printed transactions to be sent to the editor of the "Dublin Hospital Gazette".}

Council Ordinary Meeting March 2nd 1859.

Present, the Secretary.

The circular prepared.

EIGHTEENTH MEETING.

March 5th, 1859.

{Rough minute book: President in the chair, Drs. Moore, Halliday, Murney, Patterson, M'Gee, Mulholland, Seaton Reid, Gordon, Arnold, Drennan, M'Cleery, Bryce, Rea, Ross, Dunlop, Johnston, Murray, Harkin, M'Minn.

Dr. Hodges proposed by Dr. Reid seconded by Dr. Mulholland.

The Treasurer Dr. Halliday had statement of a/cs. £24-5-3 in hand.

Dr. Gordon moved and Dr. Patterson seconded, That the words viz "Licentiate Apothecaries" ...

Dr. Gordon then gave notice that he would bring forward the subject at the annual meeting.

Mr. Browne introduced a woman in whom malignant disease had returned 3 years after operation unmarried 45 years of age.}

Foreign body in Bladder.

The PRESIDENT exhibited a piece of bone, two inches and one-eighth in length, thickly incrustated with phosphates, so as to make it one inch and a-half in circumference, which he had removed from the bladder of a male patient in the hospital that morning. The operation performed was that recommended by Mr. Allarton, and which had been recently adopted successfully by himself, in the case of stone which he had brought under the notice of the Society at the early part of this session.¹ The history of the case, he said, might be stated in a few words. The patient, a man of 50 years of age, looking now, however, much older, some few months since, while labouring under an extraordinary state of morbid feeling, had introduced into the urethra a pin of turned bone, a part of a crochets-needle handle, which, finally, had either slipped, or had been pushed into the bladder. From that time, of course, a good deal of suffering commenced, and continued to increase up to the period of his admission to the hospital, near the end of January last. During all the time he was under treatment he never divulged what he had done, save to the first surgeon whom he had consulted, and who told him that the foreign body could only be removed by some operative proceeding. Even after he was admitted into hospital, and when sounded for a calculus, which was suspected, he did not once mention the peculiar circumstances of his case; and it was only on Monday last that he hinted at the true nature of the exciting cause of his symptoms. On Wednesday Mr. Browne introduced a sound, and then believed he felt a foreign substance; but on Thursday, having injected the bladder with six ounces of tepid water, the body was easily detected lying in the left side of the base and near the neck of that viscus. An operation was then of course the only remedy for the poor man's most painful sufferings; and consequently, on Saturday, at ten o'clock, the patient was brought into the operating theatre, placed upon the table, and subjected to the influence of chloroform.

When he was fully under the effect of the anæsthetic, the bladder had six ounces of warm water injected into it, and the sound having been introduced, the foreign body was appreciable to the touch of the surgeons present. The sound having been withdrawn, and a No. 11 grooved staff having been substituted, the patient was secured in the usual position for lithotomy. Mr. Browne then introduced the index finger of the left hand into the rectum, so that its tip rested against and fixed the staff at the prostate. A

¹ [Page 730.]

straight sharp-pointed knife was then thrust into the centre of perinæum, half an inch anterior to the anus, and carried horizontally on till it struck the groove of the staff, immediately in front of the prostate gland. The membranous portion of the urethra having been divided, the knife was withdrawn, and the external wound was extended anteriorly towards the scrotum for an inch and a-half; the staff, it should be remarked, was held perpendicularly, and hooked up under the pubis. A long ball-pointed director was next passed along the staff; the staff was withdrawn, and the left index finger, well greased, was carried along and above the director with a slow rotatory dilating movement, till it entered the bladder, and the tip of it rested against the foreign substance, which lay obliquely across, and a little to the left side of the neck of the bladder, one point being firmly fixed in behind the prostate, and the other held in a fold of the mucous membrane of the anterior part, and it was only after repeated attempts that the points of the bone could be freed from the structure of the bladder in which they were imbedded, every application of the instruments proving fruitless, till Mr. Browne having pushed the upper point backwards with his finger, was enabled to seize the other with the forceps, and to extract the body exhibited. The bladder was then well washed out with warm water, the patient was removed to bed, and an opiate was exhibited. Some twenty-five minutes elapsed after the section of the bladder before the bone could be extracted.

The PRESIDENT concluded by observing, that from the long-continued irritation and injury of the bladder by the pointed body grasped by, or rather imbedded in, its structure, and from the great difficulty experienced in the extraction of the foreign substance, he considered the patient in imminent peril; however, what had been done was imperative, and as little injury was inflicted as, in the circumstances of the case, was possible.

{Rough minute book: Dr. Halliday had attended him for a month without learning whether he had passed a bone.

Dr. Murney had him in hospital but he had not learned whether he had passed ...}

Recent Parts in Case of Dysentery.

Dr. DRENNAN exhibited the transverse colon and rectum of a sailor, aged 32, who had died four days after admission to hospital, in an advanced stage of dysentery. The disease had commenced as diarrhœa, four months previously, after exposure in the Chinese seas to great vicissitudes of weather and temperature, and had been aggravated, he thought, on the voyage home, by unsuitable diet.

For the last month there had been copious discharges of blood, tenesmus, and general abdominal uneasiness on pressure. On admission he was in a

state of great prostration. Opium was freely given, and on the second day an enema, containing 1 scruple nit. arg. in 4 oz. of water, was administered, with an O'Beirne's tube, and repeated on the following day. Slight relief followed the first—no marked symptoms at either injection. He continued to sink, and for some hours before death, there was very frequent action of the bowels and hiccough.

The *post-mortem* examination (twelve hours after death) disclosed disease amounting almost to disorganisation of the greater part of large intestine. The descending colon gave way under the hand. The mucous membrane was extensively destroyed, and in several places the muscular coat also. About three inches above the anus a rounded aperture of more than half-an-inch in diameter, and with thinned edges, had given rise to an extravasation of fecal matter into the abdominal cavity. Some soft lymph coated the peritoneum around this opening. The stomach and small intestines seemed blanched; the liver not abnormal; the spleen contracted.

The practical conclusion drawn from the case was the necessity of great caution in administering enemata where such a state of the intestines as the foregoing might possibly exist. Whether or not the enema-pipe had in this instance caused the perforation, the state of the intestinal coat rendered such an accident, under the most careful management, far from improbable.

Case of Severe Injury.

Dr. W. MACCORMAC said—The following case is that of a man who was first knocked down and then run over by a heavy four-wheeled machine. When first seen, about twenty minutes subsequent to the occurrence of the accident, he presented the symptoms of extreme collapse, the pulse and breathing barely perceptible. He died a few minutes afterwards. On a *post-mortem* examination, the eighth, ninth, and tenth ribs of the left side were fractured, as also the left ulna. On being opened, the abdominal cavity seemed completely filled with blood. The superior surface of the liver presented two fissures, which had not quite divided the capsule. On the inferior surface in the portal region the substance of the organ was most extensively broken up and lacerated, while the portal vein was ruptured. The liver seems to have suffered in this instance from a species of *contre coup*, as the external injuries were all on the left side. As the cause of death—the object in view—was rendered quite apparent, no further examination was instituted.

The recent parts were exhibited.

Removal of Prepuce.

Dr. MOORE exhibited a prepuce which he had removed. The patient, he said, had injured the penis by the introduction of a rusty nail: inflammation had en-

sued, followed by ulceration, and the glans penis had protruded through an opening thus formed in the side of the prepuce. The larger part of the prepuce, accordingly, resembled a small supplemental penis at the side of the organ. Considering the inconvenience and unsightliness of such an appendage, he had deemed it advisable to remove it.

Artificial Arm.

Dr. MURNEY showed a highly ingenious artificial arm, made by Mr. Bigg, of London.

Council Ordinary Meeting March 9th 1859.

Present, the President, Dr. Cuming & the Secretary.
Circular prepared.

NINETEENTH MEETING.

12th March, 1859.

The Case of Foreign Body in the Bladder.

The PRESIDENT stated that the man on whom he had operated for the removal of the handle of a crochet-needle from the bladder, and whose case was before the Society at last meeting, had since died. He regretted his inability to procure an examination of the parts, but, from inspection of the foreign body, it was evident (about one-twelfth of an inch of each extremity being free from deposit) that the impaction must have been due to partial penetration of the walls of the bladder.

L'Estrange's Sound.

The PRESIDENT also exhibited L'Estrange's instrument for detecting and measuring calculi in the bladder.

Dr. ROSS eulogised this instrument, pointing to the advantage of the employment of the sense of hearing as well as feeling in discovering the presence, and, in a degree, the character, of vesical calculi.

Recent Parts in Case of Supposed Fatty Heart.

Professor REID exhibited to the Society some morbid parts, which were removed from the body of a patient who died recently in the Union Hospital. He said, the only portion of his previous history that I can give is, that his age was 62; that he walked into the car that conveyed him to the hospital, and also to his bed, from the chair upon which he had been carried from the bath-room; and then stated, that for the last two months "he had suffered from weakness only," and had slight dropsy of his feet and legs. He was very cold and pale, and on getting into bed, appeared quite exhausted and dying. Dry heat was immediately applied, and he was seen at once by the Resident Surgeon, who very properly gave him some whiskey in hot milk, and prescribed a cordial stimulating mix-

ture, with a sinapism over the chest. Soon afterwards he ceased to speak, although still conscious, and lay in a lethargic state all night, passing a considerable amount of urine in his bed; the bowels remaining quiet.

At my visit in the morning of the 1st inst., he was still cold and pale, opened his mouth when directed to do so, but did not speak. There was slight puffing of the cheeks during breathings, and occasional tremors or writhing movements about the shoulders and arms, such as are often seen to precede a fit of convulsions, or to follow an attack of apoplexy. He could move both arms and legs, which were rather emaciated, free from fat, and with little anasarca. The pupils were of equal size, and not dilated. The lower part of the abdomen was full, and dull on percussion, and on the catheter being passed, about three pints of urine were withdrawn, which was healthy in smell and appearance, free from albumen, and of sp. g. 1,013.

The respirations were regular, about 14 each minute, and the pulse in the radial artery 30 or 40. The veins on the temples, chest, arms, and legs were distended. No impulse was to be seen or felt in the region of the heart, and on applying the stethoscope over its base, a distinct cooing or musical murmur was heard, in place of the first sound; followed, after a short interval, by an indistinct second sound; this murmur was also heard in the sub-clavians and carotids, and very distinctly at the region of the apex. It was considered to be systolic, because it was heard immediately after the longest period of repose; although the pulse, at the wrist, was synchronous with the second sound. The radial and brachial arteries felt so full and firm, that I believed their coats to be atheromatous.

Interpreting the symptoms I have just enumerated, as indicative of fatty degeneration of the heart, I gave him at once four ounces of whiskey in hot punch, which was swallowed without much difficulty, but made no change in the frequency of the heart's action. The stimulating plan of treatment was continued during the next twenty-four hours, when, at my visits, I found his pulse to be 38, and of the same degree of fullness. The respirations increased to 18, and regular. He was now unable to swallow, and moaned often, which, with his lungs full of sonorous and mucous rales, rendered it quite impossible for me to ascertain the existence of either the musical murmur, or any sound of the heart; and, although the intercostal spaces were depressed, no impulse was either to be seen or felt. The tracheal rales increased during the evening, and he died at 2, a.m., on the 3rd instant.

Feeling much interest respecting the pathological state that existed in this case, I requested Dr. Murney to dissect for me the parts that had been removed by

Surgeon Rea, which he did with his usual courtesy and kindness. Mr. Rea, when removing the parts, found some fluid in both pleuræ; the lungs distended, and some old-standing adhesions in the left, and that no effusion existed in the pericardium. But that I was wrong in believing him to be the subject of fatty degeneration of the heart, is shown by the following statement of the morbid appearances:—The brain was found free from all indications of inflammation, effusion, or congestion, and was healthy in every part, except one or two specks of atheromatous deposit in the basilar artery. The heart was firm, of natural colour, retaining its natural shape and bulk, and having no disposition to collapse by its own weight. The valves of the aorta and pulmonary artery showed their sufficiency on the application of the hydrostatic test. The aorta, for several inches from its origin, was rough, owing to fatty degeneration, which, in some patches, had become atheromatous. On dividing the aortic orifice, we found a small ridge of soft vegetation on the ventricular surface of one of the valves—all the rest being healthy. A small fourth valve, in all respects complete, was observed at the pulmonic orifice. The walls of the left ventricle, as may be seen, are hypertrophied, being nearly an inch in thickness, and the cavity, if not contracted, is assuredly not dilated. Dr. Murney has examined it carefully with the microscope, and has found no indications of fat. The mitral valves were found healthy in structure, and the orifice natural. The brachial and radial arteries were free from any atheromatous deposit. The right kidney was found large and congested, but perfectly healthy in structure, while the left was found small, and in a state of fatty degeneration. There was no disease of the liver, spleen, or prostate gland.

Dr. Reid then said—Now, Mr. President, there are two points of interest in this case. 1st, Was it possible, under the circumstances I have stated, to have avoided this error in diagnosis? and, 2nd, How can the symptoms be explained?

To the first I reply, that the amount of information I obtained from what is called “the previous history of the patient,” was simply, “that he had suffered from weakness alone for two months;” and next, that the pulse continuing under 40 during the two days he was in hospital; the fulness of the radial artery; the first sound of the heart replaced by a murmur; the absence of all impulse to either sight or touch (not to be explained by pericardial effusion); the cold and pallid state of the body; the lethargic state, without paralysis, constituted a group of symptoms that might be considered almost pathognomonic of fatty degeneration of the heart.

To the second query I reply, that, to explain the feeble sound and absence of impulse in this patient, we have to remember that various writers on cardiac pathology have observed such to occur where the

ventricle was hypertrophied and contracted; but, should we agree with Cruveilhier and Budd that contraction cannot take place, we are absolutely certain that in this instance there was no dilatation. The cooing murmur that was present during the systole is sufficiently explained by the vegetation on the ventricular surface of one of the valves, and, perhaps, more satisfactorily by the roughened state of the first four inches of the aorta. The murmur being so distinctly heard at the apex, although the mitral orifice was healthy, must, I conceive, have been owing to the firmness of the substance of the heart rendering it a better conductor of sound. Dr. Bellingham states that this cooing, or musical murmur, is almost pathognomonic of regurgitant lesions of either the aortic or mitral valves.

This case, however, proves this opinion to be incorrect, because after a small opening was made into both ventricles, the water test proved that no regurgitation could take place at either the aortic or pulmonary orifice, and the mitral valve is to be seen perfectly healthy. The frequency of the murmur, and of the second sound of the heart when heard through the stethoscope, tallied so accurately with the number of pulsations at the wrist, that it is evident there could not, in this case, have been any of those practical and more frequent contractions of the ventricle that have been observed occasionally by others when the pulse was unusually slow. But of all the symptoms, it is perhaps most difficult, and, at the same time most interesting, to attempt an explanation of the relation that existed between the feeble action of the heart and slow pulse, and the lethargic or cerebral symptoms—or to decide in which of these organs was the first link of the morbid chain. We all know, that disease of the brain will undoubtedly diminish the frequency of the heart's action; and whilst Dr. Bellingham states “that the heart's sounds being slow, are more frequently due to disease of the nervous centre than of the heart;” yet he adds, “that fatty degeneration of the heart appears to be the only diseased state ever accompanied by diminution in the frequency of the heart's action.” Now, Dr. Murney, whose experience in examining this organ is unquestionable, is positive, after a most cautious and minute dissection of it, that it presented no evidence of any form or amount of disease, except one or two very small atheromatous deposits in the basilar artery. I believe, therefore, that the first link was furnished by the heart and aorta, and that the lethargic symptoms were due to the blood being sent into the brain in insufficient quantity and force; and that the inaction of the bladder was dependent on the depressed state of the brain; as the state of the prostate and urethra show that there was no impediment to the passage of the urine; while the natural thickness of the coats of the bladder, the smell of the urine, and its freedom

from mucus, prove that the bladder had not been habitually distended.

I should, perhaps, mention the absence in this patient of two symptoms, which are often associated with fatty heart; namely, the *arcus senilis* of Cauton, and the *respiratory distress* of Stokes—when these are present, they are valuable aids in diagnosis, but they may be absent, although fatty degeneration exists.

Professor GORDON, in allusion to the fourth pulmonary valve in the heart exhibited, said he never had seen such before, though he had seen a variety in the aortic valves. He also remarked that a pulse synchronous with the heart's second sound did not argue weakness of that organ.

Dr. MURNEY said he never had seen a variety in the number of the aortic valves, but he had before seen a fourth pulmonary valve. In relation to the symptoms in this case, he considered a distended radial artery and a firm pulse rather incompatible with the supposition of a fatty heart. He further said that the hypertrophied condition of the left ventricle was undoubtedly due to the obstruction offered to the circulation by the deposition on the semilunar valves and aorta.

Dr. ROSS was impressed with the idea, that this was a case of death from ureal poisoning, which supposition, independent of the symptoms detailed, he considered strengthened by the state and diminished size of the left kidney.

Dr. HEENEY asked if the spinal cord had been examined. He thought any inference as to the cause of death imperfect without an inspection of the whole nervous centres.

Professor REID stated, in reply to observations, that a distended state of the radial artery had repeatedly been observed in cases of fatty degeneration. The idea of its being a case of uræmic poisoning had not been overlooked by him; but, that when he found one kidney perfectly healthy, and shown by the catheter on two occasions to be capable of secreting 3 pints of urine daily, which was free from albumen, and of a sp. gr. of 1013, he could not satisfy his own mind, that there was any evidence, that a sufficient amount of urea was not eliminated from the system. He said the spinal cord had not been examined; and he further stated, that as the "Respiratory distress of Stokes" was a symptom that was not to be seen frequently, he would be happy to afford any member of the Society an opportunity of seeing it in a patient in the Union Hospital, in whom it was very well marked.

Case of Pemphigus Gangrenosus.

Dr. ROSS read the following case—

Catherine Kelly, aged four years, residing in a very contaminated atmosphere, was seen by me on the 20th of January, 1859. It was stated she had been about a week ill. Constitutionally there were febrile

symptoms, and locally, over the upper parts of the thighs, the lower portion of the abdomen, and the internal and external surfaces of the labia, and around the anus, there were several well-marked gangrenous ulcers and vesicles of pemphigus gangrenosus. Dysuria, and pain and tenderness of the affected parts were also present. As to the treatment, the chlorate of potash was given internally, and the nitric acid lotion was applied externally, with well-marked and immediate good effects.

On the 17th of February, 1859, the child was quite well, presenting no appearance of the attack she had passed through, with the exception of the cicatrices of the gangrenous ulcers.

Case of Anthrax in the Breast.

DR. MOORE exhibited a coloured cast of anthrax in the breast. The subject was a spare attenuated woman, aged 50. The case was unmistakably carbuncle, involving a portion of the mammary gland, and the line of demarcation was about to be formed. There was no interference beyond the application of a poultice, and the carbuncle sloughed out. He had never seen a similar case before, and from its rarity he considered it worth bringing before the Society.

Council Ordinary Meeting March 16th 1859.

Present, the Secretary.

Circular prepared.

TWENTIETH MEETING.

19th March, 1859.

{Rough minute book: President, Present, Drs. Halliday, Mulholland, Wales, Heene, Gordon, Ross, Reid, Ferguson, Patterson, Drennan, Dunlop, Warwick, Dill, Rea, M. M'Gee, Murray, Harkin, W. M'Cormac, Arnold, Johnston, Moore, Bryce.

Send back-reports to Maconchy.}

Professor FERGUSON laid before the Society two small bodies, resembling leaves in size and shape, which had passed from the bowels of a young woman, after a dose of castor oil. The patient had long suffered pain in the left hypochondrium, which had ceased since these substances had been passed.

Case of Polypus Uteri.

Mr. HARKIN read the following case:—

Margaret Devlin, aged 50 years, married, and mother of three children; her husband dead for 13 years; of spare anæmic habit, and melancholic temperament. Had enjoyed uninterrupted good health till within six years previous to my visit. At the commencement of that period, however, the menstrual

discharge ceased, and her health became much impaired.

For about four years, a copious and constant discharge of thin sanguineous looking fluid took place from the vagina, accompanied, at intervals, by what the patient described as “pure blood.” Cold and astringent injections were then used, which had the effect of putting an end to the discharge; but its disappearance was followed by severe attacks of pain in the hypogastric region, and general constitutional irritation, from which she very slowly recovered. After this time, she consulted several practitioners, who treated her for various diseases of the uterus, with little relief.

I was called to see her at eleven o'clock, p.m., on the 10th February, 1842,—the messenger stating that “the woman’s bowels had all come out.” I found her lying upon her back, her legs widely extended, and a large firm globular tumour, as large as a good sized turnip, protruding from the vagina. The tumour very much resembled an inverted uterus, and great difficulty was experienced in introducing the finger to make the necessary examination—the os externum being completely plugged by the tumour. The woman’s pulse was very feeble, her extremities cold, and the bedding was quite saturated with blood; I immediately administered a stimulant, which had the effect of rousing her from a state of syncope, and sent a messenger for Dr. Burden, who kindly favoured me with his advice.

After as careful an examination as was possible, and after obtaining from the patient the history of the case, we concluded that we had a pediculated polypus to deal with, attached to the os uteri; and determined upon its removal by means of the ligature and double canula. However, on grasping the tumour firmly for the purpose of passing the tube and ligature around it, the mass separated, the connecting fibres having given way, and without hæmorrhage or any other unfavourable symptom, the woman recovered.

The tumour weighed 1 lb. 9¼ oz.; its smaller circumference measured 11½ inches, its greater 15 inches. Upon cutting into its substance it appeared to be composed of fibro-cartilage, deposited in layers of a circular form, and white pearly colour.

The great point of interest in this case, irrespective of its unusual dimensions, was the difficulty which we met in making an exact diagnosis, and this applies to many uterine tumours; but the globular shape, the density and the weight of the tumour, and the absence of any trace of the fallopian tubes, and the history of the case which completely shut out any idea of its being an inverted uterus, decided our opinion. The converse, however, might occur, and it would be a sad misfortune, and one not at all unlikely to happen, to mistake an inverted uterus for a polypus, and not discover our error until it was too late to rectify it.

On Extra Capsular Fracture of Neck of Femur.

Professor GORDON read the the following paper:—

William Mitchell, aged 58, but apparently older, a pensioner, admitted into the Belfast General Hospital, February 12, 1859. He states that his habits are temperate, and also for some time past he has been subject to a chronic cough and shortness of breathing. On the evening previous to admission when passing along a dark lane, he was tripped by a rope, fell against the curbstone, and broke his thigh. On admission into hospital, the long splint was applied. On visiting him on the following day, there was no deformity, no shortening of the limb, nor complaint of pain in the thigh or hip.

15th—As the difficulty of breathing had increased, obliging him at intervals to assume the sitting posture, he removed the perineal band to be enabled to sit up. To permit him, therefore, to do so with greater facility and comfort, the long splint was taken off, and the limb placed on the double-inclined plane. This did not cause him pain, at least he made no complaint, nor was the fracture apparently disturbed.

16th—His expression is maniacal; he is talking incoherently. During the night he made several attempts to rise out of bed. The upper fragment of femur can be felt distinctly, about three inches below the trochanter major, causing the thigh at this part to be much bowed outwards. Measurement along the convexity does not show any shortening of the limb, but that of the concavity, or inner side of thigh, is shorter by two inches at least. Pulse 88, soft; skin moist; bowels open; tongue slightly furred; respiration 40. The limb was extended, and a pad and splint applied to the outer side of thigh, which was still kept on the double-inclined plane, and a broad piece of linen, with straps attached, was laid along the outer side of opposite thigh; some of the straps were carried behind, and others in front of the thigh, and being tied, prevented the outward displacement.

20th—Is becoming insensible; the forehead is covered with an abundant perspiration; pulse 108.

He died on the night of the 21st, or on the 9th day after the accident; and on the following day the femur was removed from the thigh; much blood was effused amongst the various tissues of the limb, even down to the knee. At first sight, the accident seemed to be a fracture of the upper third of the shaft of the femur, running obliquely upwards to the anterior part of the root of its neck; the capsular ligament attached to its end, preventing displacement upwards; but on removing this ligament, and the other soft parts adherent to the bone, it was found to be an extra-capsular fracture of the cervix femoris.

I exhibited at a former meeting of this Society this fracture, when the periosteum was on the cervix; then the line of fracture on the fore and upper part of the neck was so indistinct as to be incapable of detec-

tion, either by the sight or touch, and it was only by moving the fragments that the whole of its course could be traced. Now, however, when the parts have been boiled, we are able to perceive the full extent and true nature of the injury. The more carefully I studied the case, the more and more interesting it became, as affording us an example of extra-capsular fracture, which may have an influence in settling disputed points, by corroborating the views entertained by some, whilst at the same time it modifies, or is opposed to the statements or conjectures of others.

The fracture may be said to consist of four main fragments, in each of which may be included several minor ones.

The first consists of the head and neck. The second consists of the trochanter major; the posterior intertrochanteric line; part of the posterior surface of the lesser trochanter; and a triangular portion of the upper end of the shaft, which may be easily determined by a point on its external surface $3\frac{1}{4}$ inches below the base of the trochanters; and from the point thus indicated by drawing two other lines, one passing upwards and inwards, and ending where the base of trochanter joins the neck, the other, upwards and backwards to the lesser trochanter. We have thus a portion of the anterior external, and posterior surfaces of the shaft attached to the trochanter major, and posterior intertrochanteric line. The third portion consists of the lesser trochanter, and a small elongated triangular piece, running obliquely downwards and backwards to the *linea aspera*. The fourth portion consists of the remainder of the shaft.

Let us now trace the line of fracture. On looking downwards at the centre of the upper border of the trochanter, where the neck of the femur joins it, impaction commences. The fracture from this point runs obliquely downwards and backwards, internal to the *digital fossa*; after that it corresponds exactly to the junction of the neck with the posterior intertrochanteric line, and on reaching the upper and back part of the root of the lesser trochanter, it bifurcates, the posterior division running along the middle branch of the *linea aspera*, whilst the other branch runs above the lesser trochanter, separating it from the neck, and having gone forwards so as to be on a vertical plane anterior to the lesser trochanter, it again divides into a descending and ascending branch. The former running in front of the lesser trochanter, and passing obliquely downwards and backwards joins the branch behind it, or that which is in the middle branch of the *linea aspera*. Thus we have the lesser trochanter, with a triangular piece of bone attached to it, completely isolated. At the place where the fracture passes above the lesser trochanter, separating it from the neck, there were several comminuted pieces of bone. The fracture after that takes a course upwards and outwards along the inner bor-

der of the anterior intertrochanteric line as high as the base of trochanter. There the impaction ceases, the remainder of the fracture along the upper and anterior part of the root of the neck did not suffer the slightest displacement. Anteriorly, where the intertrochanteric line joins the trochanter, the fracture of the upper end of the shaft commences, whence it runs obliquely downwards and backwards, and joins that proceeding from the lesser trochanter, $3\frac{1}{4}$ inches below the base of the greater trochanter.

Besides these complete separations, we find partial fractures or fissures, which have, as I shall presently attempt to show, an important bearing on the mode by which fracture of the trochanter is produced. In the upper and external surface of the trochanter major there is a letter H like fissure, the upper limbs of which ascend over the upper border of the trochanter, and join the main fracture opposite to the commencement of the impaction, whilst the lower limbs pass half way down the trochanter. The extent of space within these vertical limbs is nearly one-third of the transverse breadth of the trochanter. There is also another fissure in the upper part of the posterior intertrochanteric ridge, which ends in posterior and superior angle of the greater trochanter.

Previously to the patient becoming delirious, I was fully satisfied with the statement made by our intelligent house pupil, Mr. Moore, that there was merely a fracture in the upper third of the femur; there was not the slightest appreciable deformity, nor did the patient make any complaint; and even when, in his delirium, he had disarranged the relation of the fractured surfaces, and even when I found the point of the lower end of the upper fragment displaced outwards $3\frac{1}{4}$ inches below the base of trochanter, the thought of the fracture being extra-capsular never occurred to me.

As the conclusions at which I have arrived from the study of this specimen of extra-capsular fracture are in several respects not in accordance with those of others, I shall first consider the question of shortening of the limb. Dr. Smith says, "From the opinion, therefore, of Rodet, that there may be no shortening of the limb in certain cases of fracture external to the capsule, I must altogether dissent...for in all such injuries there is impaction, and if so, there must inevitably be shortening of the limb, even though there be no loss of obliquity in the neck of the femur, no separation or displacement of the fractured trochanter, no laceration of the fibrous structure." (Smith on *Dislocations and Fractures*, pp. 18, 19). Now, the question at issue is this,—Is Dr. Smith right in maintaining that there is, in every instance of fracture of the neck of the femur, external to the capsule, a primary and immediate shortening, and Rodet wrong in supposing that when the trochanter and the fibrous tissue surrounding it is uninjured there is no shorten-

ing? I am fully sensible of the difficulty of giving a positive value to the precise signification of the term shortening. If by the words “primary and immediate shortening,” Dr. Smith means a shortening that can only be detected by the most accurate measurement,—a measurement that will detect shortening to the extent of a line, or a line and a half at the utmost,—then I should say that this specimen will corroborate his statements.

If, on the other hand, he means to imply a primary and immediate shortening, unequivocally capable of being detected in the living subject, and leaving no doubt on the mind of the surgeon that there is shortening, then I say that this specimen will not warrant such a positive statement. On the fore and upper part of the neck there is not the slightest displacement, and even behind and below at the base of the lesser trochanter, where the impaction is best marked, it is not more than a line and a half at the utmost. Now, is it possible that such a slight degree of impaction could cause a primary and immediate shortening capable of detection in the living? I think not. I am, therefore, bound to adopt the following inference, that this is an undoubted example of extra-capsular fracture, in which there was scarcely any eversion of the limb, and no shortening capable of being detected by the most accurate measurement. But, in addition to this, it presents us with an example of an extra-capsular impacted fracture, in which shortening might be referred to two different conditions of the same fracture.

The first, is that to which I have already referred, viz., the impaction of the neck of the femur. The second, is the oblique fracture through the shaft, which was produced in the following manner. When the lower part of the neck was driven into the shaft by the shock, it became wedged between the posterior part of the base of the lesser trochanter and the inner surface of the shaft, and instead of detaching the posterior part of base of the lesser trochanter and inferior part of posterior intertrochanteric line, it caused a very oblique and complete fracture of the shaft itself. Although anteriorly and internally the upper part of the shaft is detached from the base of the neck, almost as high as the anterior and internal part of the base of the greater trochanter, and after that running outwards and downwards for $3\frac{1}{2}$ inches, until it meets with that proceeding downwards from the lesser trochanter, still there was no displacement in the vertical direction, as the attachments of the capsular ligament in front, and the insertion of the gluteus maximus behind prevented it.

Another interesting question in connexion with this fracture is the *modus operandi* of the force causing it. With the first part of Dr. Smith’s explanation, I entirely agree, but the latter I cannot adopt. He says, (*Ibid*, p. 17) “What occurs appears, in fact, to be this—

the neck of the femur is, in the first instance, broken by the fall upon the hip, and then driven into the cancellated tissue, between the trochanters, by the weight of the body, and the prolonged action of the shock; but as soon as the neck of the bone is broken, the femur is rotated outwards, and even before the action of the first impulse has ceased. Thus the posterior intertrochanteric ridge being thrown forwards, is forcibly driven against the back of the neck of the femur; two forces, therefore, combine to produce the fracture through the intertrochanteric space, one of which consists in the impaction of the cervix into the shaft, whilst the other is found in the collision which takes place between the broken neck of the bone and the posterior intertrochanteric ridge.”

In this, and several other specimens in Queen’s College Museum, I do not find that the posterior intertrochanteric ridge lies in contact with the posterior surface of the neck, and, therefore, cannot admit that it is driven forcibly against the back of the neck, and produces the fracture through the trochanter; for if this were the case, would we not find the back of the neck lying against the ridge, and probably a depressed fracture in it? The fracture through the trochanter occurs antecedent to the impaction, and, therefore, antecedent to the inclination forwards of the posterior intertrochanteric ridge; and what seems to me to have occurred, and I think is capable of demonstration in the recent subject, was as follows:—the patient, on being tripped, fell upon the posterior and outer surface of the greater trochanter, which was, therefore, thrown inwards and forwards; the impulse, therefore, instead of being received equally on all parts of the base of the neck, fell, in the first instance, on its posterior part at its junction with the greater trochanter and posterior intertrochanteric ridge, which giving way, impaction occurred, and after that the remainder of the fracture.

The extent of the comminution and impaction will vary according to the fragility of the bone, and the amount of violence applied. The impaction of the neck will have unquestionably an influence in determining displacement of the trochanteric fragment; but, from the effects of blows on the trochanters, as witnessed on the dead body, the sequence of events seems to be as follows—direct lateral violence produces primary and immediate comminution of the trochanter, fracture of the base of the neck, impaction, additional fractures, and then displacement. Violence applied from behind forwards, produces primarily fracture and displacement inwards and forwards of the trochanter, impaction posteriorly, fracture of the base of the neck generally, and then displacement and fracture from the impaction. When the trochanter strikes the ground, it will be for the instant fixed, perhaps at this time, the extremity being in projectile force, acts obliquely, as a lever, in

breaking up the base of the neck. I think this specimen points to the impaction acting powerfully at two points, viz.—at the upper part of the neck corresponding to the prominent ridge which bounds superiorly the digital fossa.

It is at this part and a little in front of it, that the starting point of the fracture of the trochanter originates. The second point is, where the neck joins the lesser trochanter. There the compact tissue of the neck in expanding to form the lesser trochanter, is less thick than higher up, and when it gives way and enters the cancellated structure, it drives backwards the base of the posterior trochanter and the intertrochanteric ridge.

The impaction thus occurring simultaneously above and below, causes further detachment of the posterior part of the trochanter, even before the broken edge of the intertrochanteric ridge could possibly have come in contact with the posterior surface of the neck. Now, in this instance, the wedge-like action of the base of the neck at these two points, acting as it were differently, and instead of mutually contributing to detach the trochanter, have caused two different fractures. That above is the usual fissure or fracture of the trochanter; that below, instead of acting in a posterior direction on the lesser trochanter and posterior intertrochanteric ridge, has splintered the upper part of the shaft of the femur.

Council Ordinary Meeting March 23rd 1859.

Present, the President & Secretary.

Circular prepared.

TWENTY-FIRST MEETING.

26th March, 1859.

{Rough minute book: Present, the President, Drs. John Moore, Thomas Reade, Ross, Heenev, Seaton Reid, Warwick, Dunlop, Johnston, Ferguson, Hugh Rea, Mulholland, Patterson, Drennan, Moore, Halliday, Bryce, Murney, M'Gee (William), M'Cleery, Wales. Dr. Murray was balloted for and elected a member of the Society.

The President introduced a patient with recurrent scirrhus of lip. Dr. Thomas Reade opposed operation, also the President. Bryce and Ross favoured the operation as the glands of the neck were unaffected and as operations on cancer of lip promise more success than in most other sites.

Dr. Johnston introduced a case of tumour in parotid space. Browne Bryce and President considered strumous. Dr. J. wished to know the opinions of the Society as to its malignancy.}

Case of Injury of Head.

E. M., aged 20 years, was admitted into hospital on the evening of the 17th instant, from a severe injury of the head which he had just sustained. He stated that about an hour before admission, he had been spoking the fly-wheel of a steam-engine he was starting, while using considerable exertion, the wheel suddenly turned rapidly round, by which he was precipitated with great force into the wheel-pit, five feet deep, alighting on his head upon an irregularly paved surface. He at once recovered himself, and would have proceeded again to his work, had he not perceived that his face and neck were covered with blood. He was quite collected, not at all stunned, and walked a considerable distance to the hospital, to have his head dressed.

On examination, it was found that a portion of the skull at the anterior inferior angle of the left parietal bone was depressed beneath a lacerated wound of the integument, and that this piece of bone was about 1½ inches by 1¼ inches in extent. On further examination, this portion was seen to be actually stove in, and depressed fully half an inch. At the posterior inferior part of the same parietal, another fracture, to the extent of about half an inch, was found also to be deeply depressed.

Dr. MOORE, in my absence, saw the case, and very properly elevated and removed the depressed portions of the fractured bone; during this operation, and previous to the patient's arrival at the hospital, there was considerable hemorrhage from the torn branches of the meningeal artery. A dossil of lint was placed upon the bleeding vessel, and a light water dressing applied to the wounds. When I saw the patient at 9 o'clock, p.m., two hours after the receipt of the injury, he was perfectly conscious, and complained merely of the smarting of the cuts in his head. Pulse was then 86.

Early next morning I found he had rested tolerably well, and his bowels had been freely opened by the purgative and the enema, which had been exhibited; pulse 112. He told me he was "rightly," and felt little or no pain. On that day, about one o'clock, after he had exhibited some restlessness, he suddenly was seized with a convulsive attack, followed by unconsciousness, which lasted for about twenty minutes. When I saw him immediately after, he had recovered, and seemed calm and collected—pulse, 120; and he only exhibited some involuntary tremor of the limbs, and slight twitching of the muscles of the face. I had the dressings and dossil of lint removed, and directed cold applications to be constantly kept to the head. In the evening, I found him still quite intelligent, pulse, 126; he had, during the interval from my former visit, thrown off some bilious matter; and, I should remark, that he had had occasional vomiting from the period of his admission.

On the morning of the 19th, Saturday, I was informed that he had passed a fair night, and had vomited only once. He seemed unchanged, save that there was almost constant tremor of the voluntary muscles; he was perfectly conscious and capable of explaining his sensations; he complained of headache, but referred that to the wounds. On visiting him at five, p.m., I found that while he had not had any return of the convulsions of Friday, the muscular tremor had increased; and that, although he was evidently conscious, he could not speak or open his mouth to exhibit his tongue according to his desire, and yet, when requested to take some drink, he directly sat up and swallowed some milk and water. The following day, Sunday, he was dull and could barely articulate “no.” He also swallowed with difficulty, pulse, 126; breathing occasionally much hurried, but usually under 30 in the minute; pupils contracted; had strabismus of left eye; still he was evidently conscious when spoken to. That night he became violently delirious, and required restraint. Monday, the 21st, I found him restless, and incessantly straining his eyes in the attempt to look upwards, and to the left side. He had also an increase of that twinkling of the eyelids, that I have often seen in the last stage of fever, when fatal. From an early period, there was the muscular tremors and twitchings to which I have referred, but there never was sign of paralysis in any of his limbs; and the bladder and bowels acted naturally up till a short time before his dissolution. During the night, he gradually sank, and died without any return of the convulsions, at three, a.m., of the 22nd.

Post-mortem.—On removing the scalp, the site and extent of the injuries of the skull came into view. On the anterior inferior angle of the left parietal bone, an aperture to the extent of fully half-a-crown, and with comminuted edges, was exposed, within this the space was filled by a firm clot of blood. On the posterior inferior part of the left parietal an opening large enough to admit the end of the little finger was observed,—it was from this several small comminuted portions of bone had been removed. When the calvarium was removed, it was found that all around the edge of the large anterior fracture, the *dura mater* was separated to the extent of 1½ inches, fully, and was *bulged inwards* for more than half an inch, by a firm clot. On the inside of the posterior injury, the internal table was driven in to the extent of nearly a square inch, the *dura mater* also separated from the bone, but was not torn. When the brain was removed, the *dura mater* in the occipital fossæ, and in the right temporal fossa, was found to be detached and very easily separable.

The brain itself presented on the surface of the left hemisphere a considerable depression, corresponding to the part where the *dura mater* was detached, and bulged in by the clot of blood. The

arachnoid was very slightly opaque, and there was a small quantity of sub-arachnoid fluid. The cerebral mass, divested of the arachnoid, seemed paler than natural, and felt firm. On slicing the hemispheres the structure was found to be acutely congested—the vascular puncta being exceedingly numerous, the blood oozing from them in minute drops for some time after the division of these capillaries. The lateral ventricles were natural in appearance. The outer side of the posterior lobe of the cerebrum, at a point corresponding to the posterior fracture, had a portion, about the size of a small walnut, broken up, softened and infiltrated with blood, and, on the cerebellum, immediately adjoining this part, there was a bruised point, of the size of a field-bean. These were the lesions observed. There was not fracture of the base of skull.

Remarks.—The case briefly stated is one of those instances occasionally met with where the brain sustains a most severe and usually fatal injury, without any urgent symptoms being manifested at the outset; and is in striking contrast with others when an apparently trifling injury is attended by the most urgent immediate effects, and finally by fatal results—sometimes recovery. Here we had most extensive injuries, yet, as we have seen, the subjective signs were not manifested for some time, and then, indeed, very slowly. From the first, there had not been any symptoms of concussion, and, throughout the progress of the case, though there was considerable pressure on the brain, first by the depressed bone, and next by the effused clot, there was not any evidence of compression. The absence also of paralysis, was another striking feature in the case.

The *post-mortem* examination shews that the cause of death was the acute congestion of the entire brain, and the softening and effusion that occurred in the posterior part of the left hemisphere.

The remarkable vascular condition of the brain, (I refer to the multitude of bleeding points revealed by every slice that was made) I have only seen in cases of death resulting from yellow fever, and where head symptoms had prevailed, and when death took place very early in the disease.

{Rough minute book: Mr. Johnston exhibited a mass of uterine hydatids and read the history of the case.}

Council Ordinary Meeting March 30th 1859.

Present, Drs. Cuming & Wales.

Circular prepared.

TWENTY-SECOND MEETING.

2nd April, 1859.

{Rough minute book: President in the chair. Present, Dr. Ferguson, Arnold, William M'Gee, Heeney, Seaton

Reid, Johnston, Mulholland, Ross, Dunlop, Halliday, H. Rea, Wales, M'Cleery, T. Reade, M'Minn, Moore.

The President showed a flexor tendon which had been taken from a boy by machinery.}

Extirpation of Eye.

The PRESIDENT exhibited an eye, which he had removed that morning in consequence of long-continued irritative inflammation, and gave the following history of the case:—

J. S., aged 49, a mechanic, upwards of twenty years ago received an injury in his right eye, by a chip of iron having been projected against it with great force. A small portion of the metal was removed, immediately after, from the margin of the cornea, and gradually the eye recovered, so far as to be able to distinguish print, and to see small objects by the assistance of a glass. This state continued for some months, but at the end of a year and a half after the accident, vision was completely lost in that eye. During the subsequent ten years the injured eye gave no trouble: but since that time, it has been attacked, at intervals, with severe inflammation, during which attacks the patient suffered great agony, and, for the last four months, the distress has been so great as to incapacitate him for any employment. Under these circumstances, it was deemed advisable to remove the diseased globe. This was done while the patient was under the influence of chloroform; the conjunctiva was incised with a knife, and the curved scissors were then carried rapidly around the eye-ball, the muscles, optic nerve, and other attachments being divided close to it. There was not much hemorrhage, a little cold water and the infusion of matico sufficing to allay the bleeding; the part was dressed with a light compress of wetted lint and a bandage.

On laying open the eye-ball, it was found that all of the normal internal structure, with the exception of the choroid, had disappeared, and was replaced by a sepia-coloured fluid. The choroid was thickened, and adhered firmly to the sclerotica by layers of superimposed lymph, and the inner surface of the sclerotica, when these were peeled off, exhibited a beautiful rose tint. On washing the eye in a little water, a small piece of metal as large as a mustard seed was discovered: this was, doubtless, the cause of all the mischief that had ensued to the eye, and of all the patient's lengthened sufferings.

Diseased Mamma.

The PRESIDENT also brought under the notice of the Society a diseased breast, which he had excised a few hours before. The patient, a woman aged 82 years, *though looking much younger*, had always enjoyed excellent health till about three years since, when she had inflammation, and, as she described, likely sup-

uration of the left mammary gland. This abscess soon closed, and, for some eighteen months, it gave her no annoyance. About a year since, she felt a small tumour in the centre of the same breast. This gradually increased in size, till the entire gland became engaged, but without giving any pain. Two months ago a couple of vesicles appeared, one on either side of the nipple. These had been opened by a needle, and soon after a fungoid growth sprung forth, since which time the patient has felt a severe burning, shooting pain in the part. She was admitted into hospital on the 29th March, when the tumour was found to be about the size of the largest orange, of a deep puce colour, with many enlarged veins radiating over its surface. The site of the nipple was occupied by a pink fungoid growth, the size and shape of a large mushroom. This was covered by a smooth polished membrane, and was free from any sanious discharge. The tumour was quite moveable over the subjacent parts, though the integument adhered to the greater part of its circumference. The patient's health being good, the axillary and cervical glands being quite free from any disease; and, as her sufferings were daily increasing, it was resolved to remove the entire morbid mass. As it was feared that there would be profuse hemorrhage, it was deemed advisable not to add also the depressing effects of chloroform. Mr. Browne, therefore, determined to try the effects of local anæsthesia, and chose cold, with the view both of allaying the pain of cutting, and of avoiding the risk of profuse bleeding. Pounded ice, inclosed in a thin cloth, was therefore applied for about twenty-five minutes, when the integuments were found to be becoming white, and were insensible to the prick of a pin. A couple of sweeps and a few light touches of the bistoury sufficed, in five or six seconds, to remove the diseased structure. During the use of the knife the patient did not complain of any pain, and blood did not flow, but merely trickled forth for a brief period; the venous blood oozing out, thickened and very dark coloured. Cold and then tepid water was applied to the part, and, on the return of the circulation, three vessels were ligatured; the edges of the wound were brought together by three points of metallic suture, strips of dry lint and a compress, with bandage. In an hour after, smart hæmorrhage took place, which required the application of firm pressure and exposure for two hours.

This case, he considered, illustrated the benefit to be derived from cold as a local anæsthetic, where applicable, and where chloroform could not properly or safely be used.

A section of the tumour showed it to consist of a series of cysts in the glandular structure, surrounded by a capsule, as it were, of encephaloid deposit. These cysts at first seemed to be filled with colloid matter, but, on closer inspection, they were observed to con-

tain a straw-coloured fluid within the usual lining membrane.

{Rough minute book: Professor Ferguson lauded the application of cold.}

Uterine Hydatids.

Mr. JOHNSTON read the following particulars of a case attended by Dr. Hunter, Townsend Street:—

Sarah Molyneux, aged 21; married one year; four months advanced in pregnancy, as supposed; having menstruated last in November, 1858. Enjoyed good health till menstruation ceased; from that period has suffered much from sickness, without any positive ailment. On Wednesday, 16th inst., hurt herself pushing or lifting a large stone. Same evening was attacked with pains in the back and flooding, both continuing all night.

Dr. H. saw her on Thursday morning, and, finding the flooding slight, directed her to keep her bed, and gave her 30 drops every fourth hour of a mixture composed of three drachms of aromatic sulphuric acid and two drachms of laudanum. On Sunday morning, both hæmorrhage and pains had been absent for a considerable time, and neither returning till Thursday 24th, at eleven o'clock, p.m., the patient, in the meantime, expressing herself as very strong and well. Dr. H. saw her about half-past six o'clock on Friday morning. She had flooding and pains all night. On examining, found it difficult to make out more than the situation of the os uteri. The upper part of the vagina was filled with clots, very little escaping outwardly. The loss of blood evidently being by the accumulation of clots, which were expelled at intervals. Shortly after making an examination, a gush of fluid and clotted blood took place, and, judging from the hæmorrhage that it would be useless to arrest the threatened miscarriage, he plugged the vagina, applied cold, and gave ergot and borax. The pains becoming severe, he removed the plug for the purpose of examining, and found the os uteri sufficiently dilated to admit the point of the finger. On introducing the point of the finger, he felt a substance presenting—too firm for a clot and too rough for the membranes. On carefully examining, he came to the conclusion it was a case of placenta prævia, and sent for assistance. The patient getting low, he gave a stimulant, and the pains continuing, the plugging was forced out suddenly, and a large mass of hydatids appeared at the os externum, which was soon succeeded by another mass. The hæmorrhage ceased, and the patient afterwards progressed favourably.

Professor REID presented the following

Cases of Aneurism; With Remarks.

Having four cases of thoracic aneurism at present in the Union Hospital, in each of which there is some peculiarity in the symptoms, a few observations upon

them may be acceptable to the members of the Society.

I shall commence with one in which the presence of aneurism is rather a matter of inference than of proof. When thoracic aneurism has made its way into a locality where it can be seen and examined, its diagnosis is generally easy, and it loses somewhat of its interest. It is otherwise, however, when it is concealed from sight and touch, and when the symptoms it produces may, as in the present case, be caused by other kinds of tumor within the thorax.

This man, on admission, stated his age to be 37, but he looks at least fifteen years older. He has always been employed lifting and carrying heavy goods to his carts on the quay, and for several years past has been subject to cough, and pains about both shoulders, the latter of which often caused him to knock and press his shoulders against bags or posts in the shed, to obtain relief. These pains were felt at all times of the day, and he thinks they immediately disappeared on his putting on flannels; but has observed them to return "with a dart," if he left off the flannels for half an hour. He has never been intoxicated three times in his life, although generally taking stimulants daily, and has never had acute rheumatism. During the last eighteen months his cough and dyspnoea have increased, and the expectoration has been repeatedly mixed with blood.

About five months ago he entered an hospital in another town, and remained in it till a few weeks before entering the Union Hospital. During his entire stay there, he says that attempts were made, every few days, to pass a sponge saturated with a solution of caustic, through a tube, into his larynx, and that he believes this did him harm. He has often suffered from pain in his left ear on going to bed, which was immediately relieved by turning on his right side. There has never been any numbness felt in either arm, nor œdema of any part. He felt some difficulty in swallowing, for the first time, about ten days before admission, which required him to take his food in a softer state than usual. His bowels have been regular, and he has no difficulty in passing urine, which is of specific gravity 1,015, and free from albumen. He says he is much annoyed with flatulence in his stomach.

On admission to our hospital, he complained chiefly of the troublesome cough and dyspnoea, and pointed to the lower part of the trachea as the seat of all his ailments. His face was swollen, his cheeks (especially the left) flushed, his eyelids puffy, the conjunctivæ injected, and both pupils considerably, but equally dilated. There was some fulness at the base of the neck, and over the first bone of the sternum, and both jugulars were swollen. His voice was hoarse, and at times whispering. He had a loud, ringing, stridulous cough, the sound of which indicated that the cause of the stridor was situated low down in the trachea, or

behind upper part of sternum, and that it was an instance of Stokes, "stridor from below." His expectoration was composed of a viscid mucopurulent fluid, considerable in amount, and containing much florid blood. The right side of the chest was almost quite immoveable during respiration. When a finger was passed in behind the upper bone of the sternum, a rather hard and very indistinctly expanding tumor was to be felt, but no tumor or pulsation was to be felt or seen at any intercostal space at either side of the sternum.

When the hands were placed between the scapulæ, and over the sternum, no impulse was to be felt; but when I applied Dr. Green's test, of placing the chest in profile, a slightly heaving impulse was to be seen. The upper part of the right side of the chest, next the sternum, was duller on percussion than the same locality on the left. The stethoscope revealed, over the upper part, and to the right of the sternum, a distinct double sound and slight impulse, but no murmur. This double sound diminished in intensity as we approached the heart, the double sounds of which were feebler than those heard above; and no murmur was to be heard at either the aortic or mitral orifices, or in the subclavian or carotid arteries. A double sound is also heard from the occiput to the sixth dorsal vertebra, and between the spine and margin of right scapula, but no murmur. His pulse is 80, regular, and equal in both radials. At the apex of the right lung the natural respiratory murmur was replaced by a loud bronchial breathing or stridor, which was most distinct during expiration; and a similar condition existed behind. Lower down at the base a feeble respiratory murmur was heard, presenting thus a marked contrast to the puerile respiration heard over the entire of the left lung. His respirations are regular, about 24 each minute.

With such a group of symptoms, it is evident that the diagnosis lay between aneurism or the presence of some other tumor behind the sternum. The cough, the stridor, the double sound, the immobility of the side, the dysphagia and impulse, have all been produced by tumors that were not aneurismal, and therefore could not be relied on as diagnostic of an aneurism in this case, especially when he stated that one of his sisters had died of some form of cancer, although he was free from any external tumor.

There were, however, two circumstances connected with this man's history, which, associated with the symptoms I have just enumerated, warranted me, I believe, in deciding that he suffered from an aneurismal tumor. These were—first, that he always experienced relief from the pain in his left ear by turning on his right side; and the second is, that he now finds the cough, dyspnœa, and stridor so much relieved by lying on the right side, that he almost constantly assumes that position.

These two facts, I think, indicate that the tumor is moveable, to some extent, by its own weight, which could not likely occur were the tumor one of those that occasionally form in the mediastinum.

With respect to the portion of the aorta that is involved—whilst fully alive to the difficulty of deciding such a point, yet I believe, that the pains having been felt in both the shoulders, the stridor and other tracheal symptoms, the double sounds to be heard over the upper portion and to the right of the sternum, the immobility and change of the respiratory sounds, with dulness at apex of right side, all tend to indicate that it is the ascending portion, and chiefly the arch, that are implicated; but both pupils remaining of equal size, with no pulsation at any intercostal space, would, I think, justify the conclusion that the tumor, on either side of the medial line, cannot as yet be very large. This man has been in hospital for ten weeks, and his treatment has consisted in confinement to bed, a nutritious diet, with opiates, and regulation of the bowels. Under this plan almost all his symptoms have been relieved. The cough and stridor are greatly less, the blood has entirely disappeared from the sputa, and he has no difficulty whatever in swallowing; indeed he says he would be quite well, "were it not for the cough and the wind in his stomach." His appetite, he says, is good, but he is steadily emaciating since his admission, without there being any severe pain or waste of any kind to account for it. We might, therefore, infer that the tumor is pressing on the thoracic duct, and thus depriving him of nutriment.

SECOND CASE.

In the second patient, there is no doubt respecting the existence of an aneurism, but still there are some points of interest connected with his symptoms. His age is about 70. He has been several times a patient in the Union Hospital, in consequence of a troublesome cough and dyspnœa, with severe pains about his chest and shoulders, which were sometimes felt on the right side, and at other times on the left; but his intelligence is so much inferior to that of the last patient, that no great reliance can be placed on the accuracy of any history he would give. His employment was that of a turner of wood, and he admits that he lived rather freely.

On his last admission to the hospital, his voice had become so hoarse, and his cough had acquired that peculiar ringing and stridulous sound, that I suspected an aneurismal or other tumor to be the cause of all his sufferings and symptoms. I consequently made repeated examinations with reference to the presence of an aneurism, but failed in finding any symptoms of it, till about two months ago, when I detected a double sound over the upper part of the sternum, without any murmur. In a few weeks afterwards a

pulsation could be felt and seen between the second and third left intercostal spaces, where a double sound was now also to be heard, but without murmur. This double sound became feebler as we approached the heart, and markedly so at one spot. The sounds of the heart were feebler than those heard above, and there was no murmur at either the aortic or mitral orifices, or in the carotids. Soon afterwards a soft puffy tumor appeared above the left clavicle, and the jugular vein on that side was seen distended.

For some months past he has less power in his lower limbs than usual. At present his pulse is about 80, and regular, but feebler in the left radial artery than in the right; it is quite distinct in both carotids. His respirations are quiet and regular, his cough ringing and stridulous, its sound indicating that the cause of the stridor is below. Pressure behind the sternal notch does not reach any pulsating tumor. There is marked dulness at the upper part of the left side, where the double sounds are rendered more distinct by placing the patient erect; and pulsation is to be seen and felt between the third and fourth intercostal spaces, and as far outwards as a line perpendicular to the nipple. Pulsation is also to be felt, on deep and backward pressure, between the sterno-mastoid and trapezius muscles; and there is a distinct double sound between the edge of the left scapula and spine, but none along the spine itself. He has never had numbness or œdema of either of his arms, nor any difficulty in swallowing, nor expectoration of blood; nor is he now much troubled with cough. He says he can lie on either side, but I always find him lying on his left.

Both the pupils are contracted, but the left is permanently more so than the right; and this difference in size is still more marked when both are brought under the influence of belladonna. This contracted state of one pupil in aneurism was first recorded by Dr. Walshe, but a similar state had been described, in the *Medical Gazette* for 1838, to have been produced by a hard, but not aneurismal, tumor in the neck.

The merit of fixing the attention of physicians upon its frequent association with aneurism is due to Dr. Gairdner, of Edinburgh, and it is now invariably looked for in cases of that disease. Dr. Gairdner's first case, and an attempted explanation of its cause, led to a controversy in the *Edinburgh Medical Journal* for 1856, respecting the *modus operandi* of belladonna in producing dilatation of the pupil, to which, as the pupil is contracted in three of my patients, and that I had applied belladonna round all their eyes, I shall allude very briefly.

It is known that the iris is composed of circular and radiating fibres, the former of which contract, whilst the latter dilate, the pupil. It is stated that the circular fibres are supplied with nervous power from the third and also the fifth cerebral nerves, whilst the

radiating fibres receive filaments from the sympathetic, which joins the ophthalmic branch of the fifth, after it has passed through the Casserian ganglion; and that these filaments from the sympathetic derive a motor power from anterior roots of the spinal nerves in the lower cervical and upper dorsal region; and that division of the sympathetic in the neck, or of the anterior roots of the spinal nerves, causes the pupil to contract, by resigning it to the exclusive influence of the circular fibres supplied by the third. Now, it is known, that when the third nerve is destroyed, incomplete dilatation of the pupil takes place, and that a complete dilatation follows the application of belladonna to the eyebrows. It has, therefore, been asked, does belladonna cause dilatation of the pupil by paralysing the ciliary branches of the third pair, which supply the circular fibres, or does it act by exciting the motor filaments which join the fifth from the sympathetic and anterior roots of the spinal nerves, and thus stimulate the radiating fibres to contract, and thereby dilate the pupil?

It occurred to me, that as there was no evidence of disease of the brain in any of my patients with contracted pupils, that if I brought all their eyes under the influence of belladonna, the result might support one or other of the views in the foregoing question; for I thought that if belladonna acted solely by paralysing the third nerve, which supplied the circular fibres with motor power, its application to the eyebrows should be followed by an equal dilatation of all six pupils, as the radiating fibres in what we may call the aneurismal eyes would then have nothing to oppose their contraction. Equal dilatation, however, did not follow the application of the belladonna, for in each of the patients the contracted pupil, although dilating very considerably, was still markedly smaller than the other; nor have I been able to dilate it to the same extent as the sound eye by several days' application of the belladonna.

Now, it has been observed, that when disease or injury had paralysed the third nerve, complete dilatation of the pupil did not take place, but that it would do so if belladonna was subsequently applied; which would certainly imply that it had the power, by its action on the radiating fibres, to cause the latter to contract.

Dr. Benjamin Bell, of the Edinburgh Eye Infirmary, who advocates the stimulating theory of the action of belladonna, considers that in aneurismal cases the pupil is not fully dilated by it, because the circular fibres of the iris are then in unimpaired power, whilst the radiating fibres have their power of contraction impaired by the pressure of the aneurismal tumor, and that therefore the relative power of the circular fibres is increased. In one of the patients, whose freedom from suffering enabled me to observe the effects of belladonna more accurately and continuously, I

found that when it was applied equally to both eyelids, the sound eye was completely dilated, and the aneurismal one markedly less so; but when I applied the belladonna for several days around the latter, it dilated to a much greater extent than it had done at the period of the sound eye's full dilatation. Now, if the belladonna acted by paralysing the branches of the third, which supply the circular fibres, as there was no disease of the brain present to prevent its action, ought not the dilatation to have been as great, on the first day, in the one eye as in the other, and is it not therefore rational to suppose that the increased dilatation was due to the persevering stimulation by it of the partially paralysed radiating fibres? I therefore consider that the results that followed the application of the belladonna, in my cases, tend to support the accuracy of the opinion advanced by Dr. Bell. It is interesting to find, that in the case of aneurism in which the disease appears, for so far, to have chiefly implicated the arch of the aorta, the pupils are both rather dilated, and equally so; whilst in the three other cases, in which there is evidence of tumors on the side of the spine, the pupil is affected on the side where the tumor is; so that a contracted pupil, if it had been previously of natural size, might, in an obscure case, become an important sign of the presence of a tumor on the same side. And again, when both pupils are greatly contracted, as is the case in one of my patients, the application of belladonna would indicate the one that was so from the paralysing presence of a tumor.

As one pupil is occasionally smaller than the other, owing to previous inflammation in the iris, or some other cause, it will be necessary to bear this in mind, when looking for it as a symptom often present in aneurism.

In this man the aneurism appears to be enlarging very rapidly in the direction of the left thoracic cavity; but in consequence of its not coming in contact with any of the bones or nerves, it is really giving him little, if any, annoyance. Whilst in the former patient I considered that it was the ascending portion, and chiefly the arch of the aorta, that was involved, I think that the symptoms in this patient would indicate that it was the arch and descending portion of the thoracic aorta that is implicated.

My next two cases differ from those I have just noticed, in having, I believe, a different vessel in the thorax affected with aneurism; and in both of them there is much interest connected with some of their symptoms. One is a male, and the other a female.

THIRD CASE.

The male patient stated, on admission, that his age was 60, and that for the last six or seven years he has had pain in his right shoulder, and also in the neck of that side for about two years. No pain was felt on the

left side at any time. He suffered from dyspnoea since the pain in the neck appeared, but had no cough till within the last six months. During the last four days, only, has he had any difficulty in swallowing, and he thinks the food is stopped about the base of the neck.

He was able to lie on either side till twelve months ago; since then he was easiest on right, till within the last few days, when he requires to sit up; for if he lay down, he would perspire profusely from pain. He has never had œdema of any part, or any expectoration of blood, or any numbness or want of power in either arm. His urine has a specific gravity of 1,025, and is free from albumen. The sternal end of the right clavicle is dislocated by a pulsating tumor behind it, which is felt not to extend across the trachea, or into the sternal notch; but an apparent prolongation of it can be felt distinctly, deep in the neck, between the sterno-mastoid and trapezius muscles. No pulsation is to be felt or seen in any of the intercostal spaces, and that in the radial artery on the right side is feebler than in the left; it is distinct in both carotids. The right jugular vein is distended, but no puffiness about neck. His feet, knees, and hands are slightly livid, but free from œdema. His face is sallow, and lips pale. The right pupil is smaller than the left. A distinct double sound is to be heard at the top of the sternum and to the right of it, as also in the neck, and at the supra-spinous fossa. The heart's sounds are feeble, but distinct, with considerable pulsation in the epigastric region. No murmur is to be heard at either mitral or aortic orifice, or in the carotid arteries, or over any of the localities where the double sound is to be heard in the tumor. The respiratory murmur is less distinct at the right apex. His cough is troublesome, and the expectoration difficult; it is muco-purulent, and free from blood. The respirations are irregular in frequency, ranging from 40 to 50 at different periods of the same minute. His pulse is also irregular in frequency, ranging from 70 to 110, when counted at different portions of the same minute.

Next to deciding the site of the aneurism, the state of the respiration and pulse are the two symptoms to which, in this and the next case, I attach the chief interest, and to which I shall now allude.

For about the sixth of a minute there is perfect quietness and regularity in this man's breathing; then the respirations gradually increase in frequency and loudness, till they became so loud, especially during expiration, as to be heard several yards off, and so laboured, that every muscle appears to be acting to dilate the chest. Then the respirations become gradually less loud and less frequent, till they return to the state of quietness and regularity I have mentioned, when he will say, "Now I am quite well." After a few seconds of repose, the same process is commenced again; and this is continued, with more or less intensity, whether asleep or awake.

This man called this state “palpitation,” and said that it had annoyed him much for the last three months; but it is evidently an instance of what is called “the respiratory distress of Stokes.” The number of respirations would vary from 40 to 58 during a period of distress, and on other occasions from 32 to 37, when six or eight calm respirations will take place. This symptom is the cause of his greatest suffering, as he has now little, if any, pain or cough.

I have stated that his pulse was also irregular, which it is, if felt during a minute; but I found, on closer examination, that both in this man, and in the female whose case I have next to notice, there was a curious regularity to be observed in its irregularity. For example:—counting it during an entire minute, it would be about 90; but when it was counted from about what I may call the mid-way up of a paroxysm of respiratory distress to mid-way down of the same state, it would be found to number about 12, or at the rate of 70 in a minute; then it would rapidly increase to 17 or 20 in the next sixth of a minute; so that, if counted from that time till the “respiratory distress” was again mid-way up, it would be found beating at the rate of 120 or 130 in the minute; and this state of the pulse was found present from day to day.

The symptom of respiratory distress was first observed by Dr. Cheyne, in 1816, in a gentleman who suffered under fatty degeneration of the heart; and Dr. Stokes, who first directed the attention of the profession to it, states, “that he has never seen it except in examples of fatty heart.” I am not in a position to say that fatty degeneration does not exist in this man’s heart, but that he is the subject of aneurism there can be no doubt; and that it is the arteria innominata is involved, I am disposed to believe from the following reasons:

1st. There has been pain for years, confined exclusively to the right shoulder and neck. The sternal end of the right clavicle is dislocated by a pulsating tumor immediately behind it, which tumor is also to be felt higher up in the neck, at the edge of the trapezius muscle. The pupil of the right eye is smaller than that of the left. The right radial artery has a feebler pulsation than the left; and the double sounds are heard most distinctly at the right of the top of the sternum, and in the site of the tumor. Again, there has been no stridor or ringing cough; no pulsation in the centre of the sternal notch, or in any of the intercostal spaces. With respect to the peculiarity of the pulse I have mentioned, I have not been able to find, in any work on cardiac pathology, that the pulse had been observed to become invariably slow during the period that the respiratory distress was most severe, and again invariably quick when the distress was least, and, I might say, absent; and as this continued day after day, and was observed also in the female patient, I think it cannot be looked upon as a mere

accidental occurrence. It may, perhaps, be found by myself and others so frequently as to prove that there may be (to use an Irishism) a *regularly irregular* pulse as an associate of the respiratory distress.

This patient has now been in hospital for three weeks, and a marked amelioration of his sufferings has taken place. Within the first week he was able to lie down on his right side, with his head resting on his hand, and his elbow on the pillow. Now he is able to lie on his back, and occasionally, for a short time, on his left side. He has no difficulty in swallowing, and has little cough, and no stridor. The respiratory distress has almost entirely disappeared, his respirations being yesterday about 26 in the minute, and now, to a casual observer, partaking more of the character of sighing respiration than of the distress I have described, and which had been seen by several members of the Society during the past fortnight. The pulse has also become all but perfectly regular, and beats about 90 in the minute. This group of symptoms would, therefore, appear to be one that is not continuous in intensity, whatever may be its cause. Since its great diminution, I have observed that the thorax is now more shaken by the impulse of the aneurism, and the clavicle moved forward each time, and I fancy I observe it larger at the sternal notch; the relief to the distress may, therefore, be owing to the backward pressure of the aneurism being less.

FOURTH CASE.

My fourth and last case is that of a female, aged 59, who stated, on admission, that for five years past she had severe pain in her right shoulder and arm, which was always most severe at night. This pain continued till about three weeks ago, when it ceased entirely. She had also had numbness of right arm. She never had any pain or numbness in left arm.

About two years ago, she had an attack of epistaxis from the right nostril, and about that time vomited a considerable quantity of blood. For years she had been subject to a “winter cough,” which is, however, quite free from any stridor or ringing sound, and she is quite certain she never coughed up any blood. She has been a hard-working industrious woman, and ascribes the commencement of her illness to a severe fall. Her face is puffy, and there is also some anasarca of the lower limbs, and ascites, but no fulness about the base of the neck. The right pupil is contracted, being markedly smaller than the left, and this difference continues when both are brought under the influence of Belladonna. Both jugular veins are swollen, but there are no enlarged veins on the chest. There is no displacement of the clavicle, nor any pulsation to be felt behind the sternal notch, although she describes the tumor as being there, which she says she can push aside with her finger, and thus relieve a difficulty in swallowing that is occasionally,

but not always, present. An unusual pulsation is to be felt and seen about the inner third of the clavicle, and the carotid artery there feels dilated, as also an artery crossing towards the trapezius. An indistinctly pulsating tumor is felt deep at the back of the neck, between the sterno-mastoid and trapezius muscles. No pulsation is to be felt or seen at any of the intercostal spaces. Pulsation is distinct in both carotids, rather stronger in the right, and the pulse in the right radial artery is feebler than in the left. A distinct double sound is to be heard over the upper part and to the right of the sternum, and louder than at the left of it, or over the region of the heart. It is also heard over the supposed tumor in the neck, and between the scapula on both sides of the spine, but loudest on the right. The heart's sounds are distinct, especially the second, and its impulse is also to be felt. There is no murmur at either the aortic or mitral orifices, or in the subclavians or carotids, or at any of the localities where the double sound is heard. Since her admission, she has at times been able to lie on her back; but, generally, she is obliged to rest on her knees, with her face on the pillow, inclining a little to the left side. This position appears to increase the dropsy of the eyelids, face, and chest; the right mamma is greatly more swollen than the left, and to-day there is a large anasarca over the trachea and sternal end of right clavicle, and the ascites and anasarca of the lower limbs are increasing. The urine is acid, of sp. g. 1,020, and albuminous. I have already stated in my review of the symptoms of the last patient, that the "respiratory distress of Stokes" was present in this female also for the last two months; and that it was associated with precisely the same regular irregularity of the pulse. Resting the head with the face to the pillow, and lower than the trunk, is a position, described by Dr. Stokes, to have been assumed intentionally by some of his patients, who had fatty degeneration of the heart. Six days ago, this woman coughed up three or four sputa composed of blood and pus; and, during the next night, she states she vomited fully a pint of blood. Although the existence of a pulsating tumor could not be so certainly felt as in the last patient, yet the other symptoms present, and the history of her ailment, tallied so exactly with his, agreeing with him also in the absence of certain symptoms, that I am disposed to believe that the arteria innominata is also implicated here, with perhaps a portion of the aorta.

She is in every respect becoming so rapidly worse, that I believe her dissolution to be not far off. When noticing a contracted state of the pupil being present in three of my cases, I already mentioned that the tumor and contraction were on the same side. With respect to treatment—these two last patients have earnestly asked for stimulants, and have reported that they were greatly relieved by them; whilst the two in

whom the aorta appeared to be solely involved have shown no such craving for them.

{Rough minute book: (Dr. Maconchy, Mr. Murray (Lurgan), Dr. Hodges.)

Dublin Hospital Gazette.}

Council Ordinary Meeting April 6th 1859.

Present, the President.

Circular prepared.

TWENTY-THIRD MEETING.

9th April, 1859.

{Rough minute book: President in the chair. Present, Dr. Ferguson, Dill, Patterson, Wales, Rodd, Heeney, Seaton Reid, Murney, M'Cleery, O'Hare, Cuming, W. M'Gee, M'Minn, Murray, Moore, Mulholland, Warwick, Johnston, T. Reade.}

Cases of Aneurism Continued.

Professor REID exhibited the heart, large vessels, and kidneys of the female patient whose aneurismal symptoms had been described at the last meeting of the Society. For several days before death, she was so exhausted as to be compelled to assume the recumbent posture; and that in consequence, the dropsy of the face and eyelids, as also that of the greatly enlarged right mamma, had diminished very much; with, as might be expected, a corresponding increase in the size of the arms and legs. Her pulse had become more regular, and the right pupil had assumed the size of its fellow. Her death was quiet, and apparently from exhaustion.

He said:—Dr. Murney, with his characteristic courtesy, had made a *post mortem* examination which revealed, as will be seen from his report, fatty degeneration of an hypertrophied and dilated heart, Breschet's cylindrical aneurism of the aorta and innominata, effusion into both pleura and contracted and fatty kidneys, &c.

Dr. Murney found the body was emaciated; upper and lower limbs anasarca; and, on dissecting back the skin from the anterior regions of the neck, the external and anterior jugular and other superficial veins were found greatly distended. In the thorax a few unimportant pleuritic adhesions, and a considerable amount of effusion, were observed on both sides. The pneumogastric and phrenic nerves of both sides were traced to the lower part of the chest—the former from the middle, the latter from the lower, parts of the neck. No peculiarity was observed, nor did those trunks appear to have been subjected in any degree to pressure. The thyroid body was at least twice its normal size, and very firm. The subclavian, internal jugu-

lar, innominate and caval veins were greatly distended with fluid blood, without any clots. The ascending and transverse portions of the arch of the aorta were considerably dilated, but the descending portion and thoracic aorta were of normal calibre. The left carotid and subclavian arteries were also natural. The innominate, right carotid, and subclavian were a good deal enlarged, and the two latter were markedly different from the vessels of left side. The increase was, therefore, principally in the aorta and innominate, which latter was at least twice the usual calibre, and a minor degree of increase existed in the branches of this vessel.

Only two patches of atheromatous deposit could be felt externally, one at the upper part of the transverse portion of the arch, the other at the termination of the innominate; but when the vessels were laid open, a most copious deposit was found; it was as yet soft, and in no part, save those named above, had undergone calcareous degeneration; it varied from the size of a pin head to even larger than a split bean, in greatest quantity in the dilated vessels, but it also extended into those which did not exceed their natural dimensions. The right coronary artery showed the same diseased action in its coats. The heart was considerably enlarged and very greatly distended with blood, it completely filled the pericardium, and was from three to four times the natural size; large clots and fluid blood were found in each of the cavities: in the right auricle the coagulum was of the amber colour so frequently met with. Both ventricles having been opened, the hydrostatic test showed the perfect competency of the aortic and pulmonic semilunar valves. The wall of the left ventricle was 7-10ths of an inch in thickness; the cavity was very considerably dilated. The heart, with aorta, and other arteries referred to, weighed $20\frac{1}{2}$ oz. Deducting $2\frac{1}{2}$ ozs. for the vessels, will leave 18 oz. as the weight of the central organ of circulation. The firmness and colour of the muscular structure of the heart would not have indicated the existence of fatty degeneration, but microscopic examination showed the presence of a considerable amount of such disease. The liver, which seemed of normal size, was not removed. Both kidneys were small and firm, the right weighed 3 oz., the left $3\frac{3}{4}$ oz., both were highly congested, and had apparently undergone some degree of fatty degeneration; time, however, did not permit of a microscopic examination of their structure, but from the casual observation made, there seemed to be sufficient healthy material for the due formation of the renal secretion. A small abscess existed at the lower portion of the left kidney, situated between the fibrous coat and the secreting structure of the gland, but not communicating with its interior.

Dr. Reid being anxious to let the members of the Society see the morbid parts as nearly as possible in

the state in which they were found, the vessels had not been at first opened, and, therefore, as already stated, only two patches of atheromatous disease could be felt externally, one at the upper part of the transverse portion of the arch, the other at the termination of the innominate; but when the vessels were laid open in the presence of the members of the Society, a most copious deposit was found; it was as yet soft, and in no part, save those named above, had undergone calcareous degeneration; it varied from the size of a pin head to even larger than a split bean, in greatest quantity in the dilated vessels, but it also extended into those which did not exceed their natural dimensions. The right coronary artery showed the same diseased action in its coats.

He then said, I have no doubt Mr. President, that those members of the Society who were acquainted with the literature of aneurism, and who have followed my description of the symptoms present in these several cases, will have observed that in forming my diagnosis I have been chiefly guided by the information derived from the researches of the late Dr. Greene, and also from the labours of Dr. Stokes; and from an able memoir by the late Dr. Holland, of Cork, in which he has carefully compared the symptoms present in Dr. Greene's cases of aneurism of the arch of the aorta, with those reported by various writers to have been observed in 24 cases of aneurism of the arteria innominata. From this comparison, Dr. Holland deduced the following rule:—"That the symptoms and signs of innominate aneurism have a tendency to occur on the right side of the body; whilst those of the transverse portion of the arch, as shown by Dr. Greene's cases, appear on the left."

Having read the abstract he gave of the 24 cases, I considered he was justified in proposing the rule I have just quoted as being applicable at least to aneurism of the arteria innominata; and it was on this rule that I based the opinion that in the woman who has since died, "the arteria innominata and perhaps the aorta was involved." In her case the diagnosis was far more difficult than in any of the others, owing to the absence of unequivocal tumor and pulsation; yet the *post-mortem* examination shows how much we may rely on Dr. Holland's rule, when meeting with a similar group of symptoms.

I shall briefly review those symptoms, as now interpreted by the *post-mortem* examination.

1. There was pain felt exclusively in the right shoulder and arm for several years. Now, pain I believe is one of the earliest, most constant, and, perhaps, most frequent symptom of aneurism. But what is its cause? I believe the majority of us associate with its presence the idea of pressure by a tumor on the nerves, or other tissues in its vicinity. But in this woman, although pain was felt during five long years, yet the *post-mortem* examination showed, that in her

there was no circumscribed tumor to produce pressure, and that the enlargement of the aorta and innominate, were only to such an extent as we can readily imagine must be the case when all aneurisms are commencing; at which stage pain is almost invariably present, although tumor to any extent cannot as yet exist.

It therefore seems to me that the cause of the pain is owing to the enlarging vessels stretching the filaments of the nerves that surround it, and this view I conceive receives support from the state of the aneurismal parts in this case, in which the disease has taken the form of an equal dilatation of the vessels for several inches, to which the name of cylindrical or fusiform aneurism has been given, and in which a sack or tumor does not exist, to produce pointed pressure on the surrounding parts.

2. Next, there was some fulness and pulsation at sternal end of the right clavicle; whilst nothing similar was to be seen or felt on the left side.

3. There were the double sounds heard in the same locality, and behind; no doubt conveyed to the latter locality by the vertebræ. During life, I thought these were produced behind by what I considered was a pulsating tumor at edge of the trapezius muscle; but no such tumor was found after death, and I cannot satisfactorily account for my mistake, unless it was owing to the transversalis humeri artery arising, as it did, much nearer the axillary artery, and being, therefore, obliged to cross the locality where I felt this pulsation. It was the three foregoing circumstances that caused me to form the diagnosis I have stated.

4. With respect to some of the other symptoms that were present, I would remark, that we learn from the *post-mortem* examination that a large tumor is not necessarily present when the pupil on the same side is contracted, and that the current of motor power from the spinal nerves to the radiating fibres may be interfered with by a moderate dilatation of the aorta and innominate.

5. The microscopic examination of the heart supports the opinion of Dr. Stokes, that a connection exists between the symptoms of "respiratory distress" and a fatty heart. Had it not been for the microscope, this degeneration of the muscular fibres of the heart could not have been discovered in this case, as we had no other proof of its existence. The craving for stimulants in my two patients who had the respiratory distress, and who felt relief from their use, might be an indication of this enfeebled power of the heart, and of the propriety and safety of their use in similar cases.

6. I did not detect the effusion into the pleuræ during life; and cannot, therefore, say how long it was in existence; but having examined the right lung about a week previously, to ascertain if the aneuris-

mal symptoms might not be caused by cancer of the lung,

I think if the effusion had then been in existence, it would not have escaped my notice, as I examined the base of the lung on that side. I am therefore disposed to believe, that this effusion took place within the last few days; this, however, can be but a matter of opinion, because I was so much on the alert for aneurismal symptoms, that the others might have escaped my notice.

7. Unless we admit, that the right vena innominate was compressed by the dilated artery, nothing was found to explain the extraordinary œdematous state of the right mamma—extraordinary because she generally rested on the left elbow. That such was the cause is rendered probable by the fact, that the enlargement of the breast almost entirely disappeared, as soon as the patient was forced by debility to assume the recumbent position, and thus take off the pressure of the artery on the anterior wall of the chest.

8. I have next to notice the state of the kidneys, which, as may be observed, were much smaller than natural; but as their secreting structure was not much impaired, and as the urine on several occasions was of high specific gravity, I am disposed to believe that the albumen, in this case, was due to impeded circulation, rather than to a disorganized condition of these organs.

9. It only remains for me to allude to the statement of the patient, that she felt, and was able to push aside with her finger, a tumor at the sternal notch; I am disposed to hazard as an explanation of this, that the arteria innominate did occasionally approach too near the trachea, and that she was then enabled, by pressing her finger in behind the sternum, to push it a little aside.

Postscript.—The first of the foregoing cases died on the 22nd May, after two or three days' suffering from increased stridor, dyspnoea, and much increase of lividity. *Post-mortem* examination refused.

The second patient died suddenly on the 30th June, without any suffering; a small quantity of blood being found on his pillow. On *post-mortem* examination the left lung was found adhering to the aneurism, with a rent in it and in the pleura, through which a large amount of blood had been effused into the cavity of the latter. The parts were removed for a more minute examination by Dr. Murney, who kindly furnished the following report:

Heart normal, 9 ounces in weight; the walls of usual thickness, except those of the left ventricle, which were slightly hypertrophied. The aortic and pulmonic valves were healthy and competent. The ascending aorta was of greater calibre than usual; patches of atheromatous and calcareous deposit were found along it, at the origins of the three great vessels

and also on the descending aorta, which were the only parts submitted to me. None of these patches were large. An irregular-shaped opening, which would readily have admitted the extremities of three fingers, was found leading from the convexity of the aorta to the left side of the left subclavian trunk, opposite the ligamentous remains of the ductus arteriosus. It opened into an aneurismal sac, about the size of a cocoa-nut, which rested across the spine, almost symmetrically, being somewhat more prominent to the left side; in appearance it was not unlike a small double hydrocele.

In its general expansion forwards and laterally, the areolar tissue had been spread out into an innumerable series of layers of fascia. On its anterior surface, rather to the left side, a jagged irregular opening communicated with the interior of the aneurism. To this part the left pleura had been adherent, and on the giving way of the tumor, the membrane had also burst, permitting the hæmorrhage which preceded death. Behind there was no such protection, as the vertebræ, &c., were in direct contact with the stratified layers of coagula. Pressure had caused the removal of nearly the entire thickness of the bodies of the second, third, fourth, fifth, and upper part of sixth dorsal vertebræ; the heads of the ribs corresponding to these bones, on both sides, were also partially eroded; that of the fifth, on left side, was entirely destroyed.

The trachea, œsophagus, and other parts which must have been more or less displaced or compressed, had been removed when the *post-mortem* was held; I cannot therefore speak of the effects produced by the aneurism on those structures.

The *third* case died on the 4th May, after several days' severe suffering. Very great œdema appeared in region of right mamma (as in the fourth case), followed by œdema of right arm, and base of right side of neck. Considerable puffiness also appeared over sternum, with much lividity everywhere during last 48 hours. The symptoms connected with the respiration and the pulse rendered a *post-mortem* examination most desirable, and every influence was brought to bear to obtain one, but without success.

Case of Chlorosis.

Professor REID then added—It may be in the recollection of the Society, that at our meeting of the 5th February, I made a communication to them respecting the symptoms that were present in a girl, who was suffering from chlorosis,¹ in the Union Hospital. I then mentioned, that the reason for my bringing her case before the Society was, that a murmur was heard at the apex of her heart, in addition to the basic murmurs usually present in chlorosis. As soon as I had

observed this unusual murmur, I asked several members of the Society to examine her, in order that the accuracy of my observation might be confirmed or not. You alone, Mr. President, had done so, when I made my communication to the Society, and you were satisfied that a murmur was present at both base and apex.

Professor Ferguson visited her a few days afterwards, and also had no doubt that both murmurs were present; although treatment had even then been beneficial to her. At the period of his visit she was suffering from an inflammatory attack of her left lung, chiefly affecting the apex; and, I feared she might, like many other chlorotic girls, be passing into phthisis. I am happy to say that the attack passed off without any injurious results, and her lungs appear now to be perfectly healthy. Her general health has since then been rapidly improving. All the uncomfortable head and chest symptoms have disappeared; her colour and strength are vastly improved; and her general stamina so much increased, that the catamenia have reappeared.

When Dr. Ferguson was in the hospital last week, seeing some aneurismal patients, I asked him to examine her again, when he agreed with me that the murmurs had disappeared from both localities. It will be recollected, that I had heard a murmur at the apex of the heart, in the patient whose hypertrophied heart I exhibited here two weeks ago; and which, during life, I had thought was the subject of fatty degeneration; and that the mitral orifice and valves were found healthy in that heart. That case, and the one whose history I now complete, tend to confirm the opinion of Dr. Stokes, that a systolic murmur at the apex is not necessarily a proof of organic disease of the mitral orifice or valves, in opposition to the opinions of those authors whose views I formerly quoted in connection with this case of chlorosis.

Council Special Meeting April 13th 1859.

Present, the President in the chair Drs. Moore, Patterson, Bryce, Heeney, Halliday & Wales.

Carpenter's a/c 18/9 for repairing glass case was ordered to be paid.

Moved by Dr. Murney seconded by Dr. Patterson "That a circular requiring payment of annual subscription be issued by the Treasurer, and that those whose subscription remain unpaid after Saturday will be ineligible to vote at the ensuing election of officers."

A meeting of Council was ordered for Saturday after the weekly meeting notice of which was to be inserted in the circular.

A proof of voting papers was ordered to be submitted to Council at next meeting.

The weekly circular was prepared.

¹ [Page 766.]

TWENTY-FOURTH MEETING.

16th April, 1859.

{Rough minute book: President, Drs. Gordon, Ferguson, Patterson, M'Minn. Mulholland, Drennan, R. Stewart, O'Hare, Arnold, Ross, Halliday, Murney, Wales, & Cuming, Moore, Martin.}

Scirrhus of Mamma.

Dr. O'HARE read the following case, and exhibited specimen.—The subject of this disease was a lady, aged 50 years, unmarried; had ceased menstruating for the last seven years; had always enjoyed pretty good health up till seven months ago, when she complained of shooting pains through her left breast and shoulder. About this time I was called in to treat her for a very prolonged attack of gastric fever, which seemed to resist all the treatment I could devise. However, she got well, and at that time she noticed a small hardened tumour in the left mammary gland, in the seat of the darting pain, which never subsided, At this time it was not larger than a small split pea, and very hard. This was in Nov., one month after the gastric fever had subsided.

I lost sight of her up till six weeks ago, when I was asked to visit and treat her for an attack of bronchitis, and, upon examining her chest with the stethoscope, I detected a tumour the size of a hen's egg, which I at once believed to be cancerous, and advised its removal. To this she readily agreed, not, however, until I would first acquaint her friend, who is a surgeon of standing in the West of Ireland, He at once gave it as his opinion that the tumour should be removed, and seemed to be quite prepared for something of the kind, inasmuch as four sisters out of six of the family had cancer. The four, he said, had been unmarried; the other two had been married, and had large families, and always enjoyed excellent health, free from all appearance of cancerous degeneration, apparently, though beyond 50 years of age. He operated on two of the four alluded to, both of whom died within the three succeeding years of the operations. The third went up to Dublin, and was there operated upon by Mr. Cusack, of Steeven's Hospital, about two years ago, and still enjoys good health, without any apparent return of the disease. The fourth and last sister I operated upon on Tuesday last, who is now recovering rapidly. The wound is almost entirely healed, and on the whole, the operation appears to be successful.

The only feature in this case, Mr. President, in my mind, worthy of note, is the tendency in certain members of the same family to cancerous degeneration, and still more, in the unmarried portion of that family. It would appear to me that married life in the female is a prophylactic, to a certain extent, to cancerous degeneration.

The appearance of the tumour under the microscope warrants the operation, if operations in this disease be warrantable. Under a power of 450 degrees, the granular cells are very well marked, containing nuclei and nucleoli. A few caudate cells appeared, but not well marked. Upon the application of acetic acid, the cells still appeared more distinct.

Cancerous Growth.

The PRESIDENT exhibited a scirrhus tumour which he had removed from a female, aged 60 years, that morning. This growth was unconnected with the mammary gland, though in its immediate neighbourhood, being situated two inches behind the breast, and exactly below the axilla. He stated that he had seen three cases of cancerous growths occurring in the like situation, which very soon invaded the mamma. In two, the parts had been entirely removed by the knife, but the disease returned, and proved fatal within three years. One had advanced so far as to forbid any operation. In the case before the Society, he hoped the very early removal of the growth would be followed by permanent benefit.

Local anæsthesia had been produced by congelation. The patient did not suffer pain; but, in some time after, there was, as in the former case he related where cold had been applied, very smart hæmorrhage.

In the discussion which followed, some members attributed the bleeding to the active reaction after the congelation, others considered it was accidental, and that by a coincidence both of the growths had been freely supplied with blood-vessels.

The President promised to investigate the question farther, upon suitable opportunities offering.

Cystic Tumour Developed in Nævus.

Dr. GORDON read as follows:—

Mrs. P., aged 39, the wife of a respectable farmer, came to me on the 23rd of March, 1859, fully determined to have a wen removed, which, for the last six months, had caused her great pain and mental anxiety. On examination, I found on the left side of head, posteriorly, a tumour of the size of a turkey's egg. Its surface at several points, was of a livid red colour, and prominent, elsewhere it was unequally lobulated, firm to the touch, quite moveable on the parts beneath, and not very painful on being handled. Supposing it to be an ordinary cystic tumour, in which suppuration had taken place, and which would soon ulcerate, I felt no hesitation in assenting to its removal. Having procured the assistance of Mr. Moore, one of the resident pupils of the General Hospital, I proceeded to its removal—the patient lying on a sofa, with the head resting on one of its ends. As the scalp on the most prominent part of the swelling was very much thinned and discoloured, I determined to leave an ellipti-

cal portion of it attached to the tumour, of about 2½ inches in length and one in breadth.

The first cut, which was made rapidly, went through the skin, and about a line into the tumour. Hæmorrhage most profuse, in fact alarmingly profuse, and to a degree which I had never before witnessed, followed, not only from the vessels of the divided integument, but also from the tumour itself, preventing them being seen and tied. A sponge was pressed into the wound, and pressure made on it and around the tumour. I now requested Dr. Murney's assistance, who arrived in a very few minutes. In the meantime, the patient became faint, the hæmorrhage having ceased, partly from the weakness, and partly from the pressure around the tumour. A second incision was made as rapidly as the first, but the stimulus of the knife aroused the patient and the hæmorrhage. With my fingers the tumour was almost instantly raised from its bed, and the remaining connections separated by a few strokes of the knife. Three arteries were secured by ligatures, and yet the hæmorrhage was profuse from numerous small vessels. A compress of lint was placed in the wound, and the scalp brought partially over it, and then a second compress and a tolerably firm bandage restricted any farther loss of blood. Nine hours afterwards, the compresses and a small piece of the tumour which became detached during its evulsion, were removed. The edges of the wound were approximated, and the water dressings and bandage applied. During the day, the patient was weak, and the stomach irritable; but, on the next morning, she had recovered sufficiently to be able to go home, a distance of 12 miles.

The history given by the patient herself was as follows—She first observed the tumour when nine years of age, and, after gradually increasing in size for several years, it was punctured; suppuration supervened and continued for two years. In 1848 she married. Then it was about the size of a large pea; after that it gradually increased, until two years ago it was as large as a hen's egg. During the last six months it was the seat of constant and severe pain, which rendered her existence miserable.

On examination, the tumour was found to be invested by a thin fibro-cellular capsule, oval in shape, and made up of lobes or cysts. On making an incision into it, the knife, as it were, grated through it; and, on passing my finger along the cut surfaces, they felt rough, and this roughness was due to a large quantity of calcareous matter embedded in numerous small cysts. My first impression was that the tumour was sebaceous, which had undergone calcareous and malignant degeneration. But on examining it more carefully, with the object of determining the source of the hæmorrhage referable to itself, I found it bore an exact resemblance to those cases of cystic tumours developed in nævi, and which have been described by

Mr. Lawrence, in the 22nd volume of the *Medical Times*.

There are two cysts, sufficiently large to admit the point of the finger, which contained blood alone; these communicated with several others, and with a large vessel divided in the first incision. There are several other cysts, one of them of the size of a large filbert, in which there was a slightly yellow serous fluid and a quantity of fibrine; a third set, of which the main bulk of the tumour consists, are entirely filled with cholesterine, granular or molecular matter, free, or irregularly aggregated, resembling corpuscles, and a paste-like or nodulated calcareous matter.

I shall now relate one of the cases of Mr. Lawrence, with a few of his observations, which will show the close similarity of his cases and that now under consideration. There is, however, this difference, that in none of Mr. Lawrence's cases was calcareous matter present; but I regard this as denoting merely a more advanced condition of the same disease. "In the autumn of 1848, I removed from the chest of a child two years of age, a small tumour, partly solid and partly vascular. It had ceased to enlarge at the circumference, but the vessels, tortuous and with thinned walls, were becoming more prominent, and assuming the form of cysts. Upon examination after extirpation, it was found to be composed of veins, which, after pursuing a short course, became much dilated, and eventually formed cysts. In many situations the continuity with the vessel was completely cut off. The more recent cysts contained nearly pure blood; others contained a yellowish fluid, composed of fibrine, albumen, and altered blood-discs, mixed with a large proportion of water. The older cysts contained a limpid fluid, composed of water, albumen, granular matter, and cholesterine. In all the cases of cystic tumour now brought under your notice, the disease was either congenital, or of so long duration, that the patient could not remember its commencement. In this respect they resemble nævi. The smooth internal surface of the cysts in the three first cases, was more like that of veins than any other structure, while their firm texture, irregular dilatations, and partial constructions presented just such an appearance as might have been expected in veins which had undergone dilatation, and then lost their connection with the corresponding trunks. The venous origin thus assigned to these cysts is not an explanation of mine; *non meus his sermo*. I merely set before you the conclusions deduced by Mr. Coote, whose industry and accuracy you are well acquainted with, from a careful examination of the parts removed in the cases now related."—*Medical Times*, Vol. 22, p. 561.

Scirrhus of the Pylorus.

Dr. MURNEY exhibited specimen of scirrhus of the pylorus, which he had met with in the dissecting room.

Worms in General, and Tænia in Particular.

Dr. ROSS exhibited specimen of tænia, and read as follows.—While some are inclined to overrate the constitutional injury and disturbance produced by worms in the alimentary canal, others, I have no doubt, under-rate the effects they cause. If the ova of worms are ingested, in proportion as the system is below par, there will be a tendency to their growth and reproduction. A favourable nidus, and the introduction of the parasites into the body, are the general conditions of their existence in man. The most practical and useful view to take of the entozoa, is to consider them a complication of a deranged state of the constitution and of the alimentary canal, and that while we hold it to be of primary importance to improve the general health, we have a secondary affection, as in many other cases, requiring special treatment. For the expulsion of the whole tapeworm, I place most confidence in the oil of the male fern. The efficacy of oil and turpentine, however, is un-questionable, as the following case will show—

A girl aged 7, was “fat and lusty” until March 8th, 1859. For the two weeks succeeding this date, her general symptoms were feverishness, thirst, headache, severe umbilical pain, diarrhœa, and cough. Her food was porridge, potatoes, and bread, and her residence was in a wretchedly bad sanitary state. She got a tea-spoonful of spirits of turpentine in the morning, and in the evening a table-spoonful of castor oil, (by which the bowels were freely acted on,) a few days before the 22nd of March, on the morning of which the specimen of tænia, which I now show you, was expelled.

The only diagnostic symptom of tapeworm, is the appearance of it, or its segments, in the evacuations; and as the segments are shed every three or four months, by keeping a constant look out we may come to an unerring decision. I have only further to say, that unless the head be expelled, we cannot be sure that the animal will not be reproduced.

Labour, with Unusual Complication.

Dr. MADDEN, Portglenone, forwarded the following communication, which was read by Dr. Cuming:—

On the 31st December, 1858, I was summoned to attend Mrs. S. in her third confinement. On reaching the house, the noise made by the patient led me to believe that the child was on the point of being born. On examination, however, I found it otherwise. The os uteri was dilated to about the size of a shilling, and placed right over the symphysis pubis. A large tumour, in the form of a crescent, extending from side to side, occupied the posterior part of the pelvis. The tumour was so large and firm as completely to prevent the descent of the child's head into the pelvis. At first I thought it might be the rectum filled with fæces, and compressed into this peculiar shape. On,

however, emptying the rectum and bladder, I found it consisted of a misplaced or a partially retroverted state of the uterus. It was evidently formed by a fold of the uterus that had descended into the pelvis. The pains continued very severe and frequent for four hours after my arrival, without effecting the least change in the state of matters.

During this time, I made two unsuccessful attempts at reduction. Fearing that the uterus might suffer injury from the long continued pressure betwixt the child's head and the sacrum of the mother, I had her placed on her back, with her head low, and the pelvis raised. I then introduced my hand, placed my fingers along the tumour, and, having used considerable force during the absence of the pains, ultimately succeeded in reducing the part to its proper position. The os uteri was then easily brought to the centre of the pelvis, dilatation took place rapidly, and the child was expelled in about twenty minutes after the parts were righted. Mother and child did well. It might be supposed that this woman had a very large pelvis, from a fold of the uterus having thus descended before the child's head, but so far from this being the case, the forceps were used in her two previous confinements.

Council Special Meeting 16th April 1859.

Present, the President, Drs. Patterson, Dill, Murney, Cuming, Halliday, Moore, Wales.

Arrangements made for the issuing of ballot papers.

Council Ordinary Meeting April 20th 1859.

Present, the President, Drs. Dill, Heeney, Wales.

Moved by Dr. Murney seconded by Dr. Dill and resolved That a special meeting for the purpose of examining ballot papers and preparing weekly circular be held on Thursday 28th April at 2 o'clock and that the ordinary Council meeting on Wednesday be not held.

Circular prepared.

TWENTY-FIFTH MEETING.

23rd April, 1859.

{Rough minute book: President in the chair, Drs. Ferguson, McClelland, Wales, Bryce, Heeney, S. Reid, Dunlop, Halliday, Drennan, Murney, Moore, Johnston, Wales [sic], Harkin, Stewart, Reade, M'Minn, Ross.}

Rheumatic Arthritis.

Dr. DRENNAN presented a man, aged 60, a carpenter by trade, who had been admitted into hospital with chronic bronchitis, and complaining, likewise, of pain in left arm and shoulder. This pain, he asserts, was first felt between two and three months ago, and has persisted since in variable degree. The shoulder joint

has undergone a marked change in form, which the patient himself, however, had not noticed. The acromion is higher than on the opposite side; the roundness of the shoulder is lost; and the axis of the limb altered. The head of the humerus is above and within its normal situation, and crepitus is perceived on moving it. The elbow cannot be brought into apposition with the side, nor the arm raised beyond a horizontal line, whilst its under movements are performed with facility. The other joints seem unaffected.

Dr. DRENNAN considered this an example of Rheumatic Arthritis, as described by Mr. Adams. Its progress to luxation seems to have been remarkably rapid. The man is of intemperate habits, and, notwithstanding his denial, a fall may perhaps have led to, or aggravated, the arthritic affection.

{Rough minute book: Dr. Murney said that there was bony deposit the whole shoulder being mobile.

Dr. Moore thought there was distraction and ossific deposit.

Dr. Halliday introduced a woman who had been the subject of exfoliation of the parietal bone.

The President exhibited a *lusus naturæ* sent by Dr. Charles of Cookstown.}

Cases of Uterine Phlebitis.

Dr. BRYCE read the following paper:—

I have proposed to bring under your notice six cases, which I will designate as uterine phlebitis, as they resemble that complaint more than any other occurring in the puerperal state. In order to be as brief as possible, I will detail the symptoms occurring in the first case, and then notice any peculiarities occurring in the other five.

Mrs. O. was confined on the 27th April, 1858, I did not see her again until the 30th; found the abdomen greatly enlarged, especially over the epigastric region; the uterus was tender to the touch and greatly enlarged, as large as the gravid uterus at the sixth month. In none of the other cases was the uterus so large as in this, owing, I suppose, to the length of time that elapsed before there was any treatment. The pulse ranged from 120 to 140, the attacks were not preceded by shivering, nor were there any febrile symptoms of any consequence. There was no peritonæal tenderness.

There was little or no pain, except on pressure: in fact, no urgent symptom to attract the attention of the attendants. This patient's labours were always difficult, requiring the use of the forceps. She sank rapidly, and died on the 1st of May, the fifth day after her confinement.

The second case was also delivered by the forceps, in this and the previous labour, although on twelve previous labours she received no assistance. She made a tedious recovery.

The third case differed from the first two in having

considerable head affection. She became quite delirious (so that she could with difficulty be restrained), accompanied with hysterical screaming. This might be owing to her having drunk whiskey to intoxication shortly after her delivery, and to being greatly disturbed the night after her confinement. She died on the sixth day.

Case fourth. This patient was considered out of danger on the fifth day, but was seized with excessive hæmorrhage about 2 p.m. on that day, and gradually sank, and died on the sixth day. In this case the labour was tedious, in consequence of an unnaturally enlarged and pendulous abdomen.

In the fifth case the labour was easy. On the next day after her confinement, and a few hours after the other symptoms set in, she became incoherent, or rather she could not find the proper word to express what she meant, and her articulation was indistinct. These symptoms went completely off, but returned again two or three times in the twenty-four hours. When the general swelling had been somewhat reduced, the transverse colon could be traced through its whole length, distended to the utmost degree, and tympanitic. There was no tympanitis over any other part of the abdomen, in this, or in any of the other cases; but when pressed on, it gave the same feeling as a bladder half filled with fluid, although, of course, distended with air. On the fourth day all symptoms of danger had disappeared, and the pulse had fallen to 90, but on the evening of the same day she became suddenly worse, and died on the sixth day.

Case sixth presented no peculiarity, only that the symptoms presented themselves sooner than in the other cases, coming on in six hours after delivery, whereas, the others were from ten to fifteen. The labour in this case was difficult, and the child dead.

I gave 10 grains of calomel with 2 of opium, followed in three hours by $\frac{3}{4}$ of an ounce of oil of turpentine and some castor oil. This reduced the swelling considerably. This was followed by calomel and opium, in small and frequently-repeated doses, until the mouth was affected. At the same time leeches were applied over the uterus, followed by a blister; the leeching was repeated eight or ten times, and the blister applied twice. This patient recovered after twenty days' treatment.

Cases of Diphtheria.

Dr. HALLIDAY read the following—My attention has, within the last few weeks, been directed to a peculiar form of disease, differing widely in its character from anything which I have heretofore witnessed; and, as no reasonable doubt can now be entertained, that the disease which has been termed "Diphtheria," is epidemic in parts of England, and partly so in this country, I thought it might be well to give to the Society a short account of two or three cases which have fallen

under my own observation.

The first was that of a boy, aged 4 years and 4 months, of delicate constitution, but in ordinary good health, who took ill on Saturday evening, 29th January, with symptoms of influenza, of which other members in the family had been complaining. His mother gave him a purgative powder, and he appeared to be quite better on the following Sunday, and part of Monday; on this night he became restless and feverish, asking frequently for drink. Up to this time, and even on to Friday, there was no evidence of throat affection; but on this day, his mother enquiring as to the seat of illness, he pointed to his head and throat, and she remarked a stiffness in his neck when turning.

He rested very badly on Friday night, and on Saturday morning, at eleven o'clock, she remarked, for the first time, that his breathing was somewhat croupy. He was able to swallow without difficulty. Shortly after this, I visited him for the first time, and, on examination, found the tonsils slightly inflamed, and a whitish yellow slough occupying the back part of fauces; pulse, 120; tongue slightly furred; skin hot; countenance thoughtfully anxious. The solid nitrate was freely applied, which appeared to afford relief. The bowels having been freely acted on, I prescribed a diaph. mixt. Visited again same evening. The breathing, which had been much relieved, was again becoming difficult. Ordered a turpentine stupe and a mixt. containing chlorate of potass. On Sunday morning, the symptoms were much as they had been on Saturday at same hour; he had passed a restless night, and had difficult breathing, with occasional spasm. The caustic in solution was again applied, with slight relief. Ordered a blister round the throat, and a calomel purgative, but without any marked benefit; the symptoms went on increasing. Saw him again at 3 p.m., and at 10 o'clock, and, as there was no improvement, decided, on consultation with Surgeon Browne, on performing laryngotomy, as affording a last chance, but shortly after the operation, he sank calmly, as if from exhaustion, dying on the eighth day.

I have been particular in describing this case, as the two following were very much like to it.

The second, was that of a little girl, aged 3 years and 8 months, who enjoyed good health up to 18th March, when she was observed to be feverish and restless, with slight cough. Saw her in my own house, on Monday, the 21st. There was then slight redness of throat, and also a swelling in submaxillary region, on both sides.

At first, I thought it might be scarlatina. I prescribed a couple of aperient powders, and she left. On Tuesday night, dyspnoea set in, and, on Wednesday, I visited her at her own home. She was still feverish, with rapid pulse, and, on examination, I found a yellowish slough situated on the left tonsil. In this case, I

prescribed calomel in small doses, applied caustic, and blistered. I also gave the chlorate of potass, and supported the strength with chicken broth. On Sunday, the 26th, she was much better, the croupy breathing had left completely, but on Monday morning, she was much worse. She had coughed severely during the night, and the other tonsil was now affected, having passed an exceedingly, restless night. She died on Tuesday, the 29th, tenth day of illness. Surgeon Browne saw this case also with me, and we agreed that an operation would not be likely to afford any relief.

My third case was that of a female child, aged 1 year and 9 months, who took ill on Sunday, the 10th April, with slight cough and feverishness. On Monday, the 11th, she was much worse, and her mother observed a slight swelling on left side of neck, under the jaw; all this time she made no complaint of throat, and swallowed well, but on this night, her mother became alarmed at what she called a "choking in her sleep."

I saw her on Tuesday, the 12th, at Dispensary, the throat was apparently ulcerated, and the tonsils slightly inflamed. I gave nothing in this case save the tinct. ferri mur. 5 drops every fourth hour, and kept hot stupes constantly round the throat. On Thursday she was somewhat better, but became worse on this night, and died on Friday morning, at 9 o'clock, apparently of croup, on the sixth day. The mode of death in these cases, and the course of the disease, correspond with the description given by Bretonneau, and is similar to what has taken place in England, viz., that it is first pharyngeal, extending afterwards to the air passages, and very few are stated to have been saved by tracheotomy. In none of these cases could I obtain a post mortem examination, which I regret. Dr. Corriگان has given a description of a case in the *Dublin Hospital Gazette*, for February, in which the post mortem appearance was described, and dwells upon the peculiar form of the swelling in neck, as likely, perhaps, to form a distinguishing mark. I may add, that the throat, in my cases, presented more the appearance of ulceration, coupled with slough, than that of being covered with the pasty exudation described by writers on this disease; and my little patients had all been previously well nourished, and living in healthy localities.

{Rough minute book: Dr. Harkin had seen a child with cough, sore throat, no croup, great salivation, small ulcers on the lips and tip of tongue. Died of croup refractory all remedies. His aunts went to see it, a child in each house took ill with croup, both ulcers on tongue and lips.

Dr. Heeney saw 4 or 5 cases of ill-defined nature in all which disease commenced as sore throat. Tonsils swollen in some but whitish exudate in back of throat sometimes extending to tonsils. All recovered. Marked with caustics in the first instance then tonics

and nutritious diet. Solid caustics disagreed producing ulceration. 15 grains to ounce, ulceration not present.

Dr. Ferguson asked had any affection of the nasal fossæ been present. In his case two had died and of croup. Would recommend hot moisture.

Dr. Reade said that he had seen 3 members of a family who all had grume into the nasal fossæ and not into the trachea.}

Council Special Meeting Thursday April 28th 1859.

In accordance with circular calling a special meeting of Council to examine ballot papers and prepare circular, the Council met this day at 2 o'clock.

Present, the President, Drs. Dill, Halliday, Heeney, Cuming & Wales.

It was proposed by Dr. Dill seconded by Dr. Heeney and resolved that the examination of all the voting lists then in the possession of the Council be proceeded with.

The following is the result of the counting.

For President. 1st Professor Reid had 22 votes, Dr. Thomas Reade 7 votes, Dr. Murney 6, Professor Ferguson 3, Dr. Pirrie 1 vote, Dr. McMechan 1.

For Town Vice-President. 1st Dr. Murney had 10 votes, which with 6 for President make 16, 2nd Dr. Thomas Reade 8 votes which with 7 makes 15, 3rd Professor Gordon 11, Dr. Drennan 9, Dr. Dill had 9 votes, Patterson 8, Heeney 7, Bryce 7, Pirrie 6+1 as President 7, Professor Reid 6, Professor Ferguson 4+3 as President 7, Dr. C. Purdon 4 votes, Wales 4, Ross 3, Mr. Johnston 3, Dr. W. MacCormac 3, M'Gee 2, Andrews 1 vote, Stewart 1, Mulholland 1, Cuming 1, Mawhinney 1, Aiken 1.

For Country Vice-Presidents. 1st Dr. Babington Derry 12, 2nd Ferris Larne 6, McMechan Whitehouse 4+1 as President 5, [Maionely?] Downpatrick 4, Mr. Madden Portglenone 4, M'Laughlin Lurgan 4 votes, M'Caldrin 4, Graves Cookstown 4, Dunlop Holywood 4, Bruncker 3, Patten Tandragee 3, Clugston Ballyclare 2, Mahood Enniskillen 2, Gassen Coleraine 2, Jamison Newtownards 2, Dickson Ballynahinch 2, Smith Dublin 1 vote, Diamond Rasharkin 1, Forsyth Culmore 1, Stewart Asylum 1, Knox 1, Nixon Antrim 1, Kelso Lisburn 1, Taggart 1, Frame Comber 1, Scott 1.

For members of Council. 1st Dr. Drennan had 12 votes +9 for V.P. 21 votes, 2nd Patterson 10+8 18, 3rd Dill 9+9 18, 4th Dr. Pirrie had 11 votes +6 as V.P. 17 votes, 5th Mr. Johnston 14+3 17, 6th Dr. Bryce 7+7 14, 6th Heeney 7+7 14, Ross 9+3 12, Professor Gordon 8, Dr. Murney 8, Professor Ferguson 4+4 8, Dr. C. Purdon 4+4 8, Mr. M'Cleery 7, Harkin 7, Browne 7, Dr. M'Gee 4+2 6, Wales 2+4 6, Corry 6, McCormack 3+2 5, Moore 5, Stewart 3+2 5, Dunlop 1+4 5, Cuming 4+1 5, McCaldin 1+4 5, Mulholland 3+1 4, Halliday 4, McMinn 3, Professor Hodges 3, Dr. Wheeler 3, Murray 3, Professor Andrews 2+1 per V.P. 3, Dr. Carson 1+2 3, Pro-

fessor Reid 2, Carlisle 2, Dr. Ferris 2, Stronge 2, Aiken 1+1 2, Mr. Smyth 1 vote, Rea 1, Lamont 1, Warwick 1.

The circular being prepared the proceedings terminated.

TWENTY-SIXTH MEETING.

30th April, 1859.

{Rough minute book: President, Drs. Patterson, Wales, Heeney, Murney, Gordon, Moore, Halliday, Stewart, Arnold, Seaton Reid, Johnston, Dill, Ross, Warwick, M'Minn, Mulholland, M. M'Gee, W. M'Gee, Bryce.

Dr. Murney reported that he had made a partial examination of the *lusus naturæ* of Dr. Charles. A cast ordered to be taken and Dr. Murney to furnish a report for the transactions.

Dr. Murney exhibited a small uterus with an enlarged ovary consisting of granular fat with lesions in the centre.}

Fracture of Clavicle Between the Coraco-clavicular Ligaments.

Dr. GORDON read the following paper:—

This specimen of an old and ununited fracture of the clavicle between the coraco-clavicular ligaments, was taken from the body of a man who died during the past week of traumatic delirium, supervening on an extensive lacerated wound of the scalp. The deformity, from projection backwards of the trapezius muscle by the outer end of the inner or sternal fragment, was well marked. The fracture is oblique from behind forwards, being, posteriorly, 10 lines distant from the acromio-clavicular articulation; but it is, anteriorly, 16 lines. There is no osseous union, and the ligamentous bands which, unite the fragments are thick and strong. The articular surface of the outer fragment is applied against the anterior border of the inner fragment; the end of the latter is free, and projects considerably beyond the former, and instead of looking directly upwards, it has undergone a slight degree of rotation, so that its upper surface looks upwards and forwards. The tubercle on its under surface, which lies above the angle of the coracoid process, is surmounted by an osseous process, about half-an-inch in length, to the extreme end of which the conoid ligament is attached. Between this process and the insertion of the trapezoid ligament, there is a space of half-an-inch unoccupied by any of the attachments of the conoid or trapezoid ligaments, but the seat of a considerable amount of ossific deposition, nature having formed a glenoid cavity, with prominent margins on the anterior border of inner fragment, to receive the rounded head of the inner extremity of the outer or acromial fragment. This example, the third which I have met within less than six months, fully corroborates the remarks which I

previously made during the present session regarding this form of fracture; and, I am now more surprised, that the true nature of an accident, seemingly so common, should have been hitherto completely overlooked by surgeons.

Osteo-cancer of Shoulder.

Dr. MOORE exhibited a cast of a gigantic example of osteo-cancer of shoulder. The cast had been taken after the death of the patient, and coloured by Dr. Moore, so as to represent accurately the appearance presented during life. The patient was about 20 years of age. The new feature of the case was the enormous size to which the tumour attained, and its extremely rapid progress, the disease having appeared about four months before the death of the patient.

When seen by Dr. Moore, the disease had invaded the textures connected with the shoulder joint to such an extent as to preclude all operative interference. He remained at home under the care of his ordinary medical attendant. The disease having all the appearances of a malignant growth, advanced rapidly, engaging the entire shoulder, neck, superior part of breast and arm, as far as junction of lower and middle thirds of humerus, and attained the magnitude of an ordinary small-sized bees'-cap. It ulcerated at three points, discharging sanious fluid, with occasionally clots of blood. By this discharge the tumour was reduced in size, and frequent hæmorrhages occurring, the patient succumbed. On cutting down on the shoulder joint, the whole osseous textures therein engaged had almost disappeared, leaving only a mere friable shell.

{Rough minute book: Dr. Murney made some observations as to the rapidity of the growth.

Dr. M'Gee asked had the tortuous state of the veins brought Dr. M. to the conclusion that malignant disease existed.

Dr. Gordon said that the enlargement of the veins was characteristic pattern with pain and tumour in this situation.}

Dr. MOORE also exhibited a cast of foot after removal, in the case of elephantiasis which he had brought before the Society at a previous meeting.

Cases of Tracheotomy.

Dr. MURNEY read the following—

I propose to bring under your notice, the history and results of some cases which required tracheotomy. The reports are taken from my hospital book, but I have curtailed them as far as adherence to the peculiarities and features of interest would warrant.

On the 6th February, 1854, a girl, 2 years old, was admitted into the General Hospital. Some time previously, when thirsty, she attempted to take a drink from the spout of a kettle which contained boiling

water. A quantity of steam, was, of course, inhaled, scalding the mouth, upper portions of pharynx and larynx. She was brought to a practitioner in the neighbourhood, who smeared the parts with oil, and directed her to be taken to hospital if the symptoms became more urgent. Some time, therefore, elapsed, before her admission into this institution. When seen by the resident pupil, her respiration was hurried and laboured; expression of countenance anxious; the uvula large and tense, and the fauces congested. A concentrated solution of nitrate of silver was applied with decided relief, and a mustard synapism placed over the anterior region of the neck. For an hour the respiration became easier, and the symptoms abated. At a quarter before nine o'clock, I saw her, when I was informed the symptoms were becoming more alarming. Strong ammonia was applied externally, so as to vesicate, and the pharynx "swabbed" with solution of nitrate of silver. At ten o'clock, the temporary advantage resulting from the last treatment having subsided, no prospect remained for the preservation of life, save by the performance of tracheotomy, which was done in the usual mode, eight hours after the inhalation of steam.

The trachea was opened close above the thyroid body, and a part of a full-sized flexible catheter introduced and tied in the wound; not more than half an ounce of blood was lost during the operation. Immediately, after some four or five deep inspirations, the child fell into a placid and refreshing sleep. I need not follow the daily reports, but may mention, until the 9th, she progressed favourably; she had now, however, accelerated pulse, although stated to have slept well. On the 14th, she had general bronchitis, which could not be in any way controlled. She died on the 26th February, twenty days after the performance of the operation. The treatment consisted in placing the little patient's bed close to a fire, so that the atmosphere around her was but slightly influenced by external cold; the administration of small doses of calomel, combined with compound hippo powder, in the early stages; and, during the progress of the bronchitis, carbonate of ammonia, in decoction of senega. Stimulation was also used to the surface of the chest, but without any benefit.

The second case occurred on the 2nd January, 1858. It was that of a little girl, aged two years, who also inhaled steam from a kettle, had similar symptoms, and was brought to hospital 6 hours after the unfortunate occurrence. I saw her shortly after admission; external stimulation and caustic solution were here also applied, but with only temporary benefit. At 7½ p.m., viz.—7½ hours after the accident, I opened the trachea at the same part as in the last case. During the operation I tied two arterial twigs, and from the highly congested condition of the veins, there was pretty smart venous hæmorrhage, which

ceased after a few deep inspirations.

On the introduction of the gum-elastic tube into the opening, some blood escaped by its side into the trachea, which produced suffocating cough. To remove this I found it necessary to apply my lips to the wound, and suck out the blood. As in the former case the patient fell asleep immediately after the operation.

Bronchitis set in at once, and the patient died on January 7th, five days after operation. I need not particularize the treatment, as in many respects it was the same as that detailed more at length for the first case.

On the 6th November, 1858, at noon, a fine little boy, aged three years, was admitted into hospital labouring under all the symptoms of œdema of the glottis, caused, as in the other cases, by the inhalation of steam from the pipe of a kettle; the occurrence took place at 9 a.m. Again was I induced to try the application of solution of nitrate of silver; and, as the surface was cold and somewhat dusky in hue, partly from incomplete clothing on a cold day, and partly from obstructed respiration, I placed him in a bath at 110 deg. F. for eight or nine minutes; relief of a decided but only temporary character followed. Again the solution of caustic was used, but with the usual result. At half past one, p.m., namely, four hours and a half after the inhalation of steam, on consultation, tracheotomy was deemed necessary and immediately performed. During its progress nothing untoward occurred; two small vessels spouted, but were immediately secured. He continued to improve till the 10th, when he suffered from bronchitis. Till the 13th this gradually became worse,—on which day and the 14th the severity of the symptoms caused me to fear he would not survive. Steadily, however, the cough diminished, and on the 20th he was convalescent. On the night of Monday, the 22nd November, we had, I believe, the first intense frost experienced this winter. Unfortunately, on the evening of that day the fire in the ward (which was close by the patient's bed, and about which I had been most particular and precise in my directions,) was neglected, and died out about six o'clock. The temperature of the room was gradually sinking, and I suppose about nine was little above that of the lobby or stair. Shortly after the child became restless and fretful, had teasing, irritating, then difficult and croupy cough. I saw him shortly after midnight, and certainly feared all our attention and care were about to prove unavailing; but in a little time he began to exhibit the good effects of a fine fire warming the cold air, and I considered he was also greatly benefitted by a turpentine stupe, which I directed to be applied all round his chest. In the morning he was greatly improved, and in a couple of days he was again convalescent. Considerable caution was exercised in confining the patient, when almost recovered, at first

to his bed, after a time in allowing him to play about the ward, and later on, on mild days in permitting him to expose himself to the colder currents of the lobbies and stairs. He was discharged quite well on the 3rd December. The wound in the trachea had completely cicatrized on the 22nd November, so that, had the difficulty of respiration become greater, another opening of the windpipe would have been necessary, which would have been more troublesome in the performance, and assuredly would have been undertaken with a much more unfavourable prognosis than the original operation.

On the 12th November, 1858, a man, aged 31 years, unmarried, was admitted into one of the medical wards, labouring under an attack of laryngitis, which commenced six weeks previously. He had placed himself successively under the care of two practitioners, from whose treatment he derived some temporary benefit; but, the recurrence of his symptoms, in a more severe form, induced his last attendant to recommend him to hospital. When first visited, he had pain on pressure over the region of the larynx, especially between the *alæ* of the thyroid cartilage; hurried and difficult respiration, each inspiratory effort being accompanied by a crowing sound, which could be heard at some distance from the ward he occupied, even when the door was closed. Four years ago, he had a sore on the penis, after connection, which in a little time healed up. Never had any eruption or other constitutional result of syphilis. The sore was never shown to a medical man, but was treated under the advice of some acquaintance, so that the existence of venereal taint, although probable, could not be ascertained with certainty. On Monday, the 15th, the pain about the larynx, and difficulty of respiration, had increased so much, I recommended tracheotomy, but a number of his friends induced him to leave the hospital. On the 16th, about eleven p.m., I was sent for by my friend, Dr. Heeney, to perform the operation. I found the man in a miserable apartment, surrounded by a number of his friends—several of the male portion more or less intoxicated. He was much worse than when I had last seen him. His lips were blue, the surface dark, and it was apparent, the quantity of air passing to the lungs was now very small, and momentarily diminishing. My friend and I agreed we could not venture to remove him to hospital before operation, nay, I even feared to leave the house to get a tracheal tube, as I had not one with me, so imminent was the state of asphyxia. Before proceeding farther, I would explain the reasons for choosing another and a more difficult operation than that which was performed in the cases of œdema of the glottis. The connection between syphilis and the present affection being very obscure, it was impossible to form any estimate of the extent of the disease in the larynx, and therefore I would not perform laryngotomy for

the same reasons I avoided that part of the trachea above the thyroid body. I therefore determined to open the windpipe at the more difficult, *but, apart from the operation*, the safer locality, immediately below the azygos lobe of the gland. For this purpose, assisted by Dr. Heeney, I made my incision in the usual region, when having, of course, cut some turgid veins, from which a good deal of blood poured, I naturally waited a few seconds to sponge the surface, when I observed respiration had ceased. Nothing then remained but to open the trachea at all hazards, which was immediately done.

In previous operations, the plunge of the knife had been invariably followed by a gush of air into the tube. Now no such pleasant sound was heard. The man was virtually dead, and remained so for at least thirty or thirty-five seconds, during which time I thrice applied my lips to the wound, and sucked from the trachea large mouthfuls of blood, when at first, slowly and imperfectly, then more deeply, the respiration returned; subsequently I introduced a tube and had him removed to hospital, where, having passed through a smart attack of bronchitis, he recovered. There has been complete occlusion of the larynx for more than five months; and I do not anticipate he will ever be able to permit the closure of the artificial opening.

From a consideration of the anatomy of the parts occupying the median line of the neck, I consider there are two situations at which the trachea may be opened—viz., one above, the other below the median lobe of the thyroid body. The former is much the more simple operation, and, I believe, is applicable to the great majority of cases; in fact, at this moment, I do not recollect any instance in which, as I would style it, the low operation should be performed, except a case such as that just detailed, or where a foreign body has passed through the larynx into the trachea, and is, perhaps, situated at the lower part of that tube. The isthmus of the thyroid rests anterior to the third ring of the trachea, consequently, the upper two rings may be reached with some facility, and, when we consider, usually there are no vessels or parts of importance very near to this region, that its depth from the surface is not very considerable in the child, and there are not usually so many turgid veins as exist where the inferior operation is to be executed, there cannot be a doubt as to which locality should be chosen, unless when special contra-indication existed. A little point in the progress of the operation, I think, is not sufficiently insisted upon by surgical writers. It is—in the dissection of this part of the neck we find four layers of fascia, three of which will be cut through in ordinary fashion, and do not require any special notice. The fourth layer is that which lies between the sterno-thyroid muscle and the trachea. It is of considerable thickness and strength. Now,

more than once I have observed, unless care be taken, this membrane was cut, and the trachea not opened until the knife was used a second time. Its position should therefore be borne in recollection, and when cut, I would suggest, the opening should be free, as from the tossing of the patient the orifices in the membrane and the windpipe may not correspond, resulting in impeded respiration to the patient, and some trouble to the operator in the introduction of the tube.

I cannot find any statistics to place before you the results of a number of operations on the windpipe, but I believe I am warranted in saying, at the age of five, seven, or ten, the deaths are not much more numerous than occur with adults, but that during the first two or three years the mortality is very high, and the question naturally arises, Can this be attributed to any source susceptible of removal or mitigation? Now, it is well known, one of the most frequent causes of death after operation for strangulated hernia is having permitted too long a period to elapse before resorting to the knife, and I am fully persuaded the performance of tracheotomy at an earlier period than has hitherto been customary would give the patient a better chance of life; for it seems that by delaying until a condition of venous congestion is produced, and allowed to exist with increasing intensity for a time, we have a lowered tone of vitality induced in the lungs, and perhaps in other organs, but especially the lungs, about to be subjected to various causes which would set up inflammation—certainly a state the most unfavourable. As a probable cause of the greater mortality among young subjects, I would suggest that, as the capillary circulation is so remarkably active, the condition of lowered vitality will be more rapidly induced than in those of more advanced years, and, of course, there is, in addition, that tendency to succumb to any serious disease so invariably exhibited in children.

{Rough minute book: Dr. M'Gee said that the change of position in placing the patient in the horizontal position as orthopnoea had existed generally before operation has been recorded.

Dr. Murney agreed with Dr. M'Gee with regard to the cause of the asphyxia being the position in which the head was placed.

Dr. Moore said that his father had operated in a case in which the patient was given over after the operation.

Dr. Gordon said that there should be a bit of wire keeping the wound open and that no tube should be used. He said that when infiltration has taken place nitrate of silver should not be applied. It was useful in chronic cases but not in cases when inflammation has not checked its acme.

M'Minn and Bryce auditors.}

Examination of Specimen of "Lusus Naturæ"

Forwarded to the Pathological Society
Some Time Since.

The manubrium of the sternum is natural in all respects. The mucro is developed in the usual fashion by centres of ossification placed laterally; the right portion is larger and more fully ossified than the left; the cartilages of the ribs are connected in the normal manner to the sides of the sternum. A wide interval exists between the lateral parts of the body of this bone through which the heart is protruded, and rests in front of the thorax perfectly destitute of covering. Behind it, and separating this organ from the lungs, &c., &c., is a serous membrane, which, in a more developed condition, I consider, would have formed the serous layer of the pericardium. The heart is natural in shape except at the apex, from which a conical-shaped process, which might be styled an auricular process, passes towards the left side for about one-half inch in length, and is connected by a muscular bundle to the anterior part of the cartilage of the sixth rib. The only peculiarities observable in the dissection of the heart are, the walls of the right ventricle are very much thicker than those of the left, and from the latter cavity a *cul de sac* runs for about three lines in the interior of the “conical-shaped process,” already referred to.

Council Ordinary Meeting 4th May 1859.
Present, the President, Drs. Bryce and Wales.

The circular was prepared and the following report approved.

“At the close of the sixth session, the Council have again to report on the position and progress of the Society.

We have on our list fifty country members, three of whom are honorary, and forty-four town members, in all ninety-four, showing in comparison with last year, a decrease of four in the former and an increase in two in the latter. In connection with the notice of our strength, it may be well to attract attention to a falling off in the number of country members in the last two years, The decline amounts to no less than one third of our former number—a fact which merits attention with a view to the consideration of issues calculated to promote and sustain the interest and co-operation of our country brethren.

It is gratifying to have to record no local deflexion.

The Society has had twenty-seven meetings during the bygone session, the average attendance of members being above twenty. The students have not so generally availed themselves of the privileges given them of attending our proceedings as might have been expected, their average attendance being only eleven.

We have to record the enrollment of ten new members since our last report.

Our museum has been further enriched by the addi-

tion of sixteen casts, three of which are plaster, and thirteen coloured wax. The latter deserve special notice and commendations as faithful and beautiful facsimiles of the original morbid specimens here exhibited. With the view to make these valued works of art as serviceable to members as possible the Council would suggest to their successors their management in the approaching recess, and the publication of a comprehensive catalogue.

The past session has been unusually rich in material. The morbid specimens with few exceptions have been of the highest logical interest. The papers and cases brought forward have been very numerous, and for the most part far removed from the common order. Many of them teem with suggestive hints of great practical value. Most of them serve as illustrations of principles or opinions in surgery, pathology and therapeutics while some, the offspring of original observation, who have gone out of the beaten track in search of hidden truths have actually made known and established previously unsuspected facts. The discussion on the various subjects brought under notice have [been] exceedingly important. While they have evinced an utter freedom from personality, they have fearlessly and firmly declared individual conviction, thereby correcting error, promoting progress, and improving facts.

That our proceedings have not declined in value and importance, that on the contrary they have become more instructive and attractive, may be fairly assumed by the fact that during the present session we have had a higher average attendance with our total number at 94, than when we enrolled 123 members.

In devising means for the recovery and extension of our country connexion, we have to refer to a powerful agency already in operation, namely the weekly transactions. At an early period of this session, the Council with the view of development of our resources, to stimulate the zeal and [?] of our members, and to enlist greater general interest and support, determined on printing a weekly record of the Society's proceedings. The increased expense rendered this measure somewhat experimental in character. It has however been already largely supported having received above 50 subscribers and we have reason to believe that notwithstanding the absence of any report of the discussions, it has given considerable satisfaction, and has in some degree fulfilled the expectations of its promoters. The Council however are fully sensible of the defects of the present weekly report, and they would recommend to the consideration of the Society the printing the discussions and remarks in detail next session. To accomplish this a special reporter would be required, but the Council hazarding in some degree the value and extent of our resources, believe that the increased expense would

Belfast Clinical and Pathological Society
Sixth Session: 1858–1859
President Samuel Browne

be ultimately met by additions to our ranks and to the list of subscribers to the Transactions; and [?] these compensated by the influence which a full and carefully arranged record of our proceedings must exercise in promoting the advancement of our science, the interests and permanency of our Society, and our own individual improvement.

In conclusion while we have given prominence to our shortcomings with the view of amendment, we cannot but congratulate the Society on its unmistakable progress. While it has stirred up in the minds of our local and surrounding brethren an earnest, increased, and increasing thirst for the acquirement and extension of medical knowledge, it has afforded ample room and opportunities for its gratification.

The past session has been in every sense pleasing, rendered so by the able, zealous guidance of our esteemed President, and by the general good feeling and cordial sympathy in purpose which has uniformly animated all the members."

ANNUAL MEETING.
7th May, 1859.

{Rough minute book: The President in the chair, Drs. Patterson, Dill, Halliday, M'Minn, Wales, Ross, Seaton Reid, Mulholland, M'Cleery, Dunlop, Ferguson, Murney, Bryce, Stewart, Murray, Mr. Whitaker, Dr. W. Aickin, Cuming.

Dr. Wales read report of Council.

Moved by Dr. Wales seconded by Dr. Ferguson that the report be adopted.

Dr. Bryce read report of auditors and moved adoption. Dr. Patterson seconded.

Dr. Murney gave notice of motion that after 1st November the subscription be 12/6 and 7/6 and that the transactions be furnished.

Dr. Ferguson gave notice of motion that he would bring before the Society the question of whether the transactions be continued in this present form and what form.}

THE Council and Auditors' Reports having been read, the Office-Bearers for the ensuing Session were announced as follow:—

PRESIDENT.—Dr. J. Seaton Reid.

VICE-PRESIDENTS.—Dr. Murney, Dr. Thomas Reade, Dr. Gordon, Dr. Babington, and Mr. Ferris.

MEMBERS OF COUNCIL.—Dr. Drennan, Dr. Dill, Dr. Patterson, Dr. Pirrie, Mr. Johnston, and Dr. Heaney.

{Rough minute book: Dr. Dill gave notice that the Council's attention be given as soon as possible to the financial position of the Society and call a special meeting of the Society and that in future an additional

County Vice-President [be appointed].}

After which the retiring President delivered his closing address, the business being brought to a close by a vote of thanks to the Ex-President, Honorary Secretaries, and Treasurer, separately, and by the installation of the President-Elect.

Paper.¹ It now becomes my duty, gentlemen, to bring the sixth session of the Belfast Pathological Society to a close. Before, however, I resign the chair in which your kindness placed me for the bygone year, I crave your indulgence while I make a few observations which, I trust, you will consider appropriate to the occasion. In the first place, then, I may say that I have just grounds for offering you my congratulations on the success of the session that has terminated. On a review of the papers brought forward, and the discussions to which they gave rise, I feel I may affirm that, for accuracy of research, truthfulness of detail, and practical and scientific deduction, they bear satisfactory comparison with those introduced before any pathological society of the Kingdom, and I can, moreover, most unaffectedly state that I have received much valuable instruction and information on several subjects, besides having had my attention directed to points of practise that I had not hitherto sufficiently weighed and investigated. In these respects, I am sure, I do not stand alone. Nay, more, I can, without the smallest disparagement of any, believe that every one of us has been materially benefited by the free interchange of sentiment which has taken place, and that the most experienced, as well as the youngest member, has gathered mental riches, as, in friendly discussion, we have expressed our own views or criticised the opinions of others. It is, gentlemen, in such interchange of thought, sometimes agreeing, and occasionally coming into—not hostile—collision, that the advantages of a society like this mainly consist, and, properly directed, duly estimated, these advantages are unquestionably great. If carefully cultivated, our society opens up a large and productive field into which each of us may cast some good seed, and from which all must reap fruitful information. The power of carrying out the culture is within ourselves; it requires but our united will, energy, and perseverance; with these, the result is beyond a doubt, the reward rich and absolutely certain. Our society, gentlemen, is but in its infancy, and, therefore admits of many of those improvements which maturer years will naturally bestow.

There is one requisite improvement to which, I trust, I may be permitted to refer, and that is with regard to the discussions elicited by the papers read here, but especially to their being published in the weekly report of our transactions. During the three last sessions, many valuable papers have been produced, important in themselves, and highly creditable to their

¹ [Belfast Newsletter, 1859, May 12, p3.]

authors. These have regularly appeared in the abstract issued to our country members, but reports of the discussions that have taken place have either been neglected, or have not been recorded and issued; I fear, indeed, that they are entirely lost to the society. Now, you will all admit that this is a great misfortune, and renders our transactions, in many respects, very meagre, and less interesting, for it will not be denied that, in the discussion, much of the practical value of the question introduced was frequently to be found. Hence, I think that some steps should be adopted by which full reports of our discussions shall be taken; and as this work could not be efficiently performed by our secretaries—indeed, it would be unreasonable to require the duty of them—it would be necessary that a reporter should be engaged for the purpose, and then that his reports should be placed in the hands of the Council to prepare them for publication. I need not enter more into details, as it will be the duty of the Council to make the necessary arrangements, if it be deemed right to carry out the suggestions I now make; at all events, I think that some steps will be considered requisite, for every one of us must have felt the desideratum to which I have referred. This question was forced upon me early in the session, and I refer to it only now, as I did not see how we could remedy the evil sooner. It is true that the published abstract usually furnished the papers, as read, and thus laid before the members such excellent matter; but these reports fell far short of giving an idea of the many valuable and practical questions to which these papers gave rise. Now, occupying, as I did, the chair at every one of our sessional meetings, I gave strict heed to the subject, and had frequently to regret the absence of arrangements by which much important information would have been preserved to the society, and would have made our sessional volume of transactions more valuable than it can now be. It is then, to supply a defect that admittedly exists that I have ventured to make the preceding remarks, and to offer the suggestions which, in conjunction with the report of the Council, I beg again respectfully to press upon your notice.

I have referred to the professional advantages which this association confers upon its members, and in which the community at large are, more or less, participators; for whatever lends to the advancement of medical science must, of necessity, advantage mankind; but, beyond this, there is here a kindly fellowship which brings us to know, and I trust to esteem, each other; and I hold that the more frequently we are thrown together and mix on friendly terms of equality, the more we shall feel, as brethren should, interested in each other's welfare, and ready to unite for the promotion of whatever is for our general weal. The longer I live, and the greater my experience of the world, the firmer becomes my conviction that it exhibits suicidal folly when the members of our profession remain disunited,

and without a common centre of co-operation. Hence, I feel it a bounden duty to promote, by every means in my power, our medical and pathological societies; and now, from this chair, before I leave it for the last time, I would affectionately entreat my brethren to be kindly disposed one to the other, remembering that we are all engaged in the same great cause—the promotion of the health, and, consequently the happiness, of mankind. This recollection should go far to allay all our differences, and to draw us together by the gentle bonds which ought to unite in fellowship and amity those who labour together in an arduous and philanthropic undertaking. This respect towards each other, moreover, is necessary to command the respect of the world; for in no way could we more effectually mar our usefulness than by losing that esteem, and by no means are we so likely to lose it as by internal bickerings and disunion, or by individual underrating of, and keeping aloof from, one another. This, like the Medical Society, is, in some measure, for us a bond of union; but neither of these societies, in my opinion, is made to perform the professional social good of which each is capable, and, although they are centres round which our brethren of Ulster should rally, I feel they are not so esteemed, and are not sufficiently made the media of promoting the interests of our common profession. With whom the blame rests I will not venture to affirm; but I fear that we of the town are somewhat careless of what does not seem to affect ourselves immediately, and that our country brethren are rather apathetic. Yet both parties may rest assured that whatever affects the interests of the one must, more or less, bear upon the other, and that union and hearty co-operation, in all cases, would give us double strength. Holding such views, then I feel that it is my duty to urge the extension of our society so that, as far as possible, it may be made to embrace the wide extent of Ulster; and that it shall be not only, as at present, the medium of our scientific communication, but also, the focus, under certain limitations, of our professional action in all that affects the brethren. I am not aware whether this latter object was contemplated by the estimable founder of our society (Doctor Malcolm); but every one who remembers his zeal, his esprit de corps, his untiring energy, in all that concerned our interests, will readily believe that, nothing could have rejoiced him more than to see the association he had called into existence spreading its influence far and wide, and giving union and stability to our body.

This union and stability are highly desirable, as I for one believe that, till we are more united, we must fall far short of duly fulfilling our mission. It cannot be denied that our influence is not at all commensurate with the opportunities we have for promoting our common interests, and that we are not held in the esteem we should be by a community which owes so much to our profession. This want of position or respect is not any fault of the public; the blame must rest with ourselves. I

often hear and read melancholy complaints of the small value the public is inclined to put upon our services; but, while I admit the truth of the complaints, and know the readiness with which every community ignores our usefulness, I also feel that the evil originates with ourselves, and that the unbecoming jealousies and the personal strife which disgrace our body lay the foundation for nearly all the social disabilities we endure. Nearly all of us may be personally honoured and esteemed, and, within certain limits, can exercise considerable power; but, as a body, we fall very far short of commanding an influence at all commensurate with what belongs to us individually—the individual power, in fact, loses considerably in the aggregate, and this is naturally the result of disunion. And, gentlemen, until very recently, our co-members of the public service have even suffered from the very causes which operate against us in private life. Our want of influence extended to, and affected their interests, both in the army and navy; at length, however, these invaluable officers sought, and, by union, obtained, redress, and, in the struggle, they were warmly and generously sustained by the entire profession, which, however disunited and at variance regarding their own social interests, worked harmoniously to obtain for their ill-requited brethren of the two services at least an instalment of the rights which had long been denied to them, and these benefits are now likely to be largely increased in the prospect of war. We cannot but deplore the horrors of war; we cannot but earnestly hope that they may be averted from us; yet, if it becomes necessary that England shall be engaged in the defence of her honour, or of the right, we must also rejoice that our brethren, who will be called on to exercise their humane duty amid the crash of battle or in the face of the dire pestilence, will have the consolation of feeling that their services will be more valued than they have ever hitherto been, and that, in the day of honourable reward, they will not be forgotten.

Perhaps at no period have the union and stability to which I have referred been more required than in these days. After many years of barren legislation, a measure of medical reform has, at last, been passed into a law; that Act I shall not venture to criticise, because it would scarcely be fair to find fault with or praise a measure not yet fully in operation; but this much I may say, that we can only regard it as an instalment of what was urgently required, and what our interests yet demand. Still, such as it is, we must accept it, and it becomes our duty to render its protective provisions as effective as possible, and to use all the influence we possess towards the carrying out of those clauses which affect unqualified practitioners. These steps can only be taken, however, when the list of registered medical practitioners shall have been published. But, in the meantime, our union and steady watchfulness are necessary to guard against the several kinds of quackery which, under the

guise of medical science, are mere specious pretences. These should have our determined opposition; they should not find any favour at our hands. For I hold that, if we do not, on all fitting occasions, oppose and expose them, we are tacitly assisting in the deception—we are permitting the world to believe that our minds are unsettled on the question. Thus do we sanction judgment to go by default; but, above all, in a cowardly manner we permit the profession we are bound to defend to be trampled on. And why? Is it not because we are too disunited, too timid, too time-serving, and fearful of creating enemies? No one should unnecessarily provoke enmity; but, when a great principle is at stake, I hold that no man who values his privileges should shrink from maintaining them, in opposition to everyone whom he considers in the wrong, and he must never yield a principle for expediency sake, or conciliate any man by admitting an error to assume the place of truth. When I was called to this chair, at the commencement of the session. I felt myself necessitated to express my opinion on some of the medical heresies of the day. This I did, fully and fearlessly, and I do not now regret the course I then pursued, nay, I now reiterate every word I uttered against them.

Some of my brethren, I believe, considered that my attack upon certain quackeries was calculated to serve rather than damage those systems; whether they still adhere to that notion I know not, but I am satisfied that, when the gage had been thrown down, I was not only right, but was called on, from my position as president of this society, to take it up. Nay, more, I feel that, had I not done so, I would have merited your contempt, and, certainly, I must have despised myself. Just look across the Channel, and see the pusillanimous and time-serving course pursued by some members of a medical association there, and ask yourselves whether those who, under the guise of pseudo-liberalism, contended for the admission of homeoquacks to the privileges of that society did not display an utter disregard for the honour and interests of the professions? How they could have acted so I am at a loss to conceive, unless I believe that they had a decided leaning to the system, without the courage to confess their real sentiments. The majority, however, have nobly vindicated the character of the association, and have taught a lesson to homœoquacks and their sympathisers which these gentlemen will not readily forget.

The Council has suggested—and I quite agree with their views—that some means should be adopted by which country practitioners may be induced to become members. Indeed, I believe that the report of the transactions may be made so ample and interesting as to create a desire on the part of nearly every medical man in Ulster to join with us, and I hope that, before the opening of next session, the Council will have matured a plan by which every inducement will be held out to our country brethren, and that we shall have a great

increase of our enrolled members.

The remarks of the Council relative to the museum are worthy of the most attentive consideration. We have now amassed a valuable collection of pathological specimens and illustrations; but, until they shall have been properly arranged, described, and tabulated in a catalogue, they must remain nearly useless. Indeed, to the majority of our members, they are as a sealed book; hence the earliest duty of our new Council, I respectfully submit, will be the careful examination of the collection and the arrangement of it, so as to make it available; and, as I shall still, *ex-officio*, be a member of Council, I shall have great pleasure in devoting a portion of my time during the Summer to this essentially necessary undertaking. To the general body of the members I would earnestly recommend the storing up of clinical facts and observations during the recess, and the pursuit of pathological research whenever opportunity offers, so that we shall have ample stock of matter wherewith to begin the ensuing session. I throw out this hint as I know that men are too apt to disregard that which they cannot turn to immediate use, and overlook many useful and interesting matters, but of which they do not happen to stand in need, or for which they are not then in search.

And now, gentlemen, it only remains for me to thank you, in the first place, for the honour which you conferred when you called on me to preside over your deliberations. This, like every other professional distinction which you and the Medical Society have bestowed, I owe entirely to the kindness of my brethren, not to any merit of my own. That friendly esteem I hope I shall still continue to possess. In the next place, I have to tender you my very grateful acknowledgements for the unwearied interest which has attended the progress of the past session, and for the anxiety all have manifested to render the papers and discussions of practical value. The President's duty is easily performed, where the members vie with each other in courtesy, and in the maintenance of the order of discussion. Such I have felt to be my position at every one of our meetings; and I shall ever look back upon my presidency of the Belfast Clinical and Pathological Society with feelings of satisfaction and gratitude. (Applause.)

{Rough minute book: The new President was then installed, and returned thanks.

Dr. Ferguson moved that the thanks of the Society be given to the retiring President. Seconded by Dr. Cuming and carried by acclamation.

Dr. Patterson moved that the thanks be given to the Secretaries and that they be requested to continue their services. Seconded by Dr. Bryce.

Dr. Murney moved that the thanks of the Society be given to Dr. Halliday and that he be requested to continue. Mr. Browne seconded.

Dr. Bryce moved the publication of the President's

address. Dr. Ross seconded.}

Belfast Clinical and Pathological Society
Seventh Session: 1859–1860
President James Seaton Reid

BELFAST CLINICAL AND PATHOLOGICAL SOCIETY

SEVENTH SESSION

1859–1860.

OFFICE-BEARERS
FOR THE SESSION 1859–00.

PRESIDENT.
PROFESSOR J. SEATON REID, M.D.

VICE-PRESIDENTS.

RESIDENT,	NON-RESIDENT,
DR. MURNEY.	DR. BABINGTON,
DR. THOS. READE.	Londonderry.
DR. GORDON.	SURGEON FERRIS,
	Larne.

SURGEON BROWNE, R.N., *Ex-President*.

TREASURER.
DR. HALLIDAY.

HON. SECRETARIES.

DR. CUMING, DR. WALES.

COUNCIL.

DR. DRENNAN.	DR. DILL.
DR. PATTERSON.	DR. PIRRIE.
DR. HEENEY.	SURGEON JOHNSTON.

BELFAST
CLINICAL AND PATHOLOGICAL SOCIETY.

SEVENTH SESSION—1859–60.

Council Special Meeting May 19th 1859.
Present, the President, Professor Reid, Mr. Browne, Dr. Dill, Dr. Murney, Dr. Wales.

The recommendations of Ex-President and Council considered with the view of extension of the reports of the Society at a reduced expense.

The meeting adjourned until 26th May 1859.

Council Special Meeting 26th May 1859.
Present, the President, Drs. Drennan, Patterson, Dill, Johnston, Heeney & Wales.

With the view to increase the revenue of the Society so as to meet the increased expenses of publication &c. It was moved by Dr. Murney seconded by Dr. Patterson and unanimously resolved that as a recommendation of Council That the subscription of town members be increased to 12/6 and that of country members to 7/6 and that for such increase all members receive the transactions as published.

It was also moved by Dr. Murney seconded by Dr. Patterson that in future there be no reprints of the transactions at the end of the session.

A committee consisting of Mr. Browne, Dr. Murney, Dr. Drennan, Dr. Moore, Dr. Cuming and Mr. Johnston was appointed to arrange to catalogue the museum.

Signed
J. Seaton Reid.
June 9th 1859.

Council Special Meeting June 9th 1859.
Present, Professor Reid, President, in the chair, Drs. Murney, Johnston & Wales.

Mayne's a/c ordered to be paid.

Council Special Meeting September 8th 1859.
Mayne's estimate considered.
Adjourned until 10th inst. at 3 p.m.
Present, Professor Reid, Dr. Murney, Dr. Heeney, Dr. Patterson, Dr. Cuming, Mr. Johnston, & Dr. Wales.

Council Special Meeting September 10th 1859.
Present, Dr. Murney, in the chair, Dr. Halliday, Dr. Patterson, Mr. Browne & Dr. Wales.

Revenue of Society considered, as also expenses of past year with the view to the reduction of outlay.

Mr. Browne moved and Dr. Patterson seconded the confirmation of the motion recommending an increase of annual subscription passed at the Council meeting of 26th May last.

It was also moved by Mr. Browne and seconded by Dr. Patterson that a special general meeting of the Society be called for the 24 inst. at 3 p.m. for the consideration of the Council recommendation viz: the increase of 2/6 to the annual subscription of town and country members, in consideration of their getting the transactions as published weekly or fortnightly and with the view to meet necessary expenses.

Society Special General Meeting to consider the question of subscription. September 24th 1859. Present, the President, Drs. Blakely, Hume, M'Gee, Arnold, Browne, Murney, Dill, Rea, Clugston, Patterson, Heeney, Mulholland, Cuming, & Wales.

In accordance with the Council recommendation it was on the motion of Mr. Browne seconded by Dr. Hume resolved "That *all* members shall contribute, with their annual subscription, the sum hitherto paid for the ordinary weekly abstract (2s 6d), by which the Council will be enabled to issue, during the session, improved reports of the Society's proceedings, in a permanent form, which will then be forwarded to every member."

Council Council Meeting October 22 1859. Present, Professor Reid (President), Drs. Halliday, Pirrie, Heeney, Cuming & Wales.

Arrangements made for the opening of the session on Saturday next.

Advertisements in the local and leading provincial periodical papers ordered setting forth opening of the Society &c.

Circular arranged.

FIRST MEETING
Saturday, October 29th, 1859
at the General Hospital.

The President, Professor J. SEATON REID, M.D., was in the chair.

The following members were present:—Professor Ferguson, Drs. M'Minn, Wales, Dill, Heeney, Mulholland, Ross, Patterson, Halliday, Murray, Reade, Lynch, Moore, Drennan, O'Hare, Dunlop, M'Cormac, Pirrie, M'Mechan, M'Crea; Surgeons Browne, Ross, Arnold, M'Cleeny, &c.

Dr. Cuming, one of the secretaries, read the minutes of the previous meeting, which were confirmed.

Dr. DILL then, according to previous notice, moved that an additional country Vice-president be appointed, so that the number in town and country be equalised. Dr. Heeney seconded the motion.

Professor FERGUSON moved, as an amendment, that the question be deferred till the annual meeting,

and being seconded by Surgeon BROWNE, the amendment passed unanimously.

{Rough minute book: Motherell, Castlederg, was proposed by Dr. Reid.

Moved by Dr. Murney, seconded by Mr. Johnston "That Mayne's proposal for printing be accepted."}

The President delivered the Opening Address as follows:—¹

GENTLEMEN,—*Since the establishment of the Clinical and Pathological Society of Belfast, it has been the custom for the President to deliver an inaugural address at the commencement of each session. It, therefore, now devolves upon me to place before you a few observations of an introductory character.*

I have, in the first place, however, to return my most sincere and grateful acknowledgements to the members of this Society, for the very high honour which they have spontaneously conferred upon me by electing me their President.

This Society was established for the high and noble purpose of advancing medical and surgical science in their practical departments, in the hope of rendering them more efficient for the removal or relief of disease. To preside over the deliberations of gentlemen engaged in so important and vital an object requires such varied accomplishments that I would have been disposed to recoil from the office, had I not been certain of the assistance and support of those who had acted so efficiently as my predecessors, and did I not rely on a continuance of that courtesy towards each other which has hitherto characterised the members of this Society, even when challenging the correctness of each other's views.

The subject matter of an address like the present necessarily varies with the person who holds the office of President. The special branch of practice to which he is devoted, the direction of his reading, and the nature of the questions that at the time agitate the public mind, naturally exercise an influence over the subject he may select for the consideration of his hearers. My professional career having been that of a physician, I have naturally selected for my theme, a subject connected with practical medicine. I have just stated that this Society originated in a desire to contribute to the advancement of medical science; but it is, doubtless, known to you all, that whilst we have claimed for medicine a place amongst the progressive sciences, the validity of our claim has been denied, and it has been asserted, that no progress has been made by it for centuries past. For example, when the late Sir William Hamilton, of the Edinburgh University, reviewed, a few years ago, "Dr. Thompson's Life of Dr. Cullen," he did

¹ [Kindly supplied by Professor R S J Clarke, Honorary Archivist, Royal Victoria Hospital, Belfast. The original was printed in *The Belfast News-Letter* for Tuesday, November 1, 1859.]

not hesitate, after calumniating the members of our profession, to ask, in the most disparaging manner—“Has the practice of medicine made a single step since the days of Hippocrates?”¹

Believing that he and others have acted most unjustly, in denying that our knowledge has increased, I shall, in the following remarks, endeavour to show that, even within the last half-century, a large amount of progress has been made, and that no little amount of benefit has been conferred on mankind by the results.

You are aware that medical science may be defined to be an aggregate of the knowledge we derive from the study of anatomy, physiology, pathology, chemistry, materia medica, and the practice of medicine and surgery. But, it is evident, that were I to go into details respecting the contributions made by each of these, I would far exceed the limits of an address like the present. I must, therefore, endeavour to find some department in which the contributions made by each would appear to be concentrated, and, by a brief and impartial examination of it, endeavour to vindicate our profession against the charges which have been so inconsiderately brought against it.

Now, I believe that you will agree with me in stating that, as the chief object of medical science is the removal of disease, each case presents to the physician two grand problems to be solved. First, to discover its nature; and, secondly, to devise its cure; so that all the benefits resulting from a study of the various branches I have named must be found centred in diagnosis and therapeutics, and are ultimately valuable to us in proportion as they facilitate the recognition and treatment of diseases. That various maladies attack the human body must be admitted by the most superficial and illiterate observer. The records of medicine, in their most imperfect state, recognise this as a fact, and it is employed as the basis of every treatise on medical practice. Diagnosis, or the power of distinguishing these diseases from one another, lies at the very foundation of our art; and just in proportion to the perfection and accuracy of our diagnosis, and our power of discrimination, will be the certainty of our therapeutics, and the attainment of the grand object for which our profession was instituted. Now, if it can be shown that medical science has made progress in the acquisition of knowledge in these two departments, even within so limited a period as the last half century, I conceive it will go far to vindicate our profession against the disparaging charge that has been brought against it.

In attempting the fulfilment of such a task, it is desirable to follow some method or arrangement, and I am not aware that I can suggest a better one than to take as a basis the usual anatomical divisions of the organs of the body, and endeavour to ascertain what improvements have been made in the diagnosis and

treatment of their respective diseases. By this plan, the diseases of the nervous system; next those of the respiratory and circulating systems; then those of the digestive and eliminative organs, will successively be examined.

I shall commence with an examination of the nervous system, rather out of deference to the important place which it holds in the animal economy, than because it is the department in which the greatest progress has been made. That this has not resulted from any want of zeal on the part of our profession, but from the existence of circumstances beyond their control, may be shown by a brief mention of some obstacles that, so far, appear insurmountable. Chief among these may be mentioned the enclosure of both brain and spinal cord in cases of bone, which remove them beyond the reach of any direct examination of their condition, and thus compel the physician to rely almost exclusively upon derangement of their functions as indications of the presence of disease. But our experience of thoracic disease has taught us how little dependence can be placed on derangement of function alone, and what innumerable mistakes we should commit had auscultation not enabled us to test the correctness of its indications. I need but mention, as examples, that the greatest dyspnoea, the most agonising pain, and the most hurried breathing, may be dependent on either functional or organic disease. Again, if distrusting functional derangements, we are disposed to rely upon the statements of the patient, we know that, in many instances, only a very small amount of disease shall have taken place on the surface of the brain, till the mind becomes so confused that no reliance can be placed on the descriptions of the unhappy sufferers. A third obstacle exists in the peculiar structure of the nervous tissue itself. You are aware that this is composed of two materials, called respectively the grey and the white, and that anatomists and physiologists, in their most recent investigations, have endowed each of these with peculiar powers. But they find these structures so intimately blended together that they have difficulty in deciding the boundaries of each; so that, when the pathologist, after a careful observation of symptoms during life, attempts to explain them by organic changes found after death, he is much embarrassed by this structural intermixture. Although an attempt has been made to overcome the first of these obstacles, by the application of auscultation to the brain, yet it has hitherto been barren in results, and I fear that we must look upon them all as belonging to a class that human skill will never be able to remove.

It was necessary to mention the existence of such impediments, in order to protect our profession against a charge of being deficient in zeal; and to account for the want of that precision and accuracy in the diagnosis of diseases of the nervous system which has been acquired regarding diseases in other departments. Still,

¹ Discussions on Philosophy and Literature. By Sir William Hamilton, Bart. 1852. p.253.

the investigations and observations carried on during the last half-century have not been entirely without fruit; and we are enabled to point to several discoveries of the greatest scientific importance, which have rendered our diagnosis more accurate, and extended our knowledge in various directions.

In the first place, we have acquired the power of distinguishing from one another several diseases of the brain that were formerly confounded together. By an application of the law which connects symptoms with lesions, and which led to a closer study and record of the former; and by a subsequent comparison of them with the records of dissections, it was found that diseases very dissimilar in their nature and seat, although similar in their more prominent features, had hitherto been confounded under the same name. For example, there can now be little doubt that, under the name of phrenitis and brain fever, several diseases were described and treated that were in their nature totally distinct, while there were also united under the name of inflammation of the brain, several others, which are now well known to be distinct, both in their seat and in their results.

When inflammation is confined, as is occasionally the case, either to the substance of the brain or to the membranes covering it, we are enabled not unfrequently to tell which is involved; and, when the membranes are the seat of it, to decide whether it be those covering the base or the surface that are diseased—a precision in diagnosis which was assuredly unknown to our immediate predecessors. In the diagnosis of these inflammatory affections we have learned the great reliance that may be placed on our opinion, when either persistent vomiting or sighing respiration, or both, may be present. Whilst our forefathers in medicine would have ascribed the first of these to deranged stomach or biliousness, we have been taught the fearful significance that it gives, in either old or young, to apparently trivial cerebral symptoms; and, if sighing respiration be a less obtrusive symptom, experience has taught us all how to interpret its association with cerebral indications, although these may appear to be of little importance. So indicative of serious brain disease are these two symptoms, that their absence justifies us in holding out hopes of a favourable result to our treatment of others in the same region, which their presence would debar us from entertaining. One of these diagnostic symptoms we have seen manifested by a derangement of the digestive functions, the other through the respiratory system; but there is a third, of equal significance, indicated by the organs of circulation, though of rather less value, because it requires the disease to have reached its last, if not hopeless, stage, before it is fully developed. I allude to the varying frequency of the pulse, first mentioned by Dr. Whytt. Repeated observations have confirmed the accuracy of his remark, that in inflammatory affections of the brain, the pulse is

first frequent, then becomes unusually slow, and again resumes still greater frequency towards the termination of life.

Now, it is not without interest to remark, as a corroborative proof of the difficulties connected with an investigation of the diseases of the brain, that the three chief symptoms which modern research has proved to be the most indicative of inflammation of that organ are learned through a derangement of the digestive, the respiratory, and the circulating systems, rather than from a direct interrogation of the brain itself. I may here state a fact that might be of use on some occasion to some of the junior members of our Society, as I have not observed the point noticed by any authors. Before death takes place from inflammation of the brain in children, there appears occasionally a dusky rash over some parts of the body, which has led the attendant to suppose the child was dying from undeveloped scarlatina. I have known this opinion to have been held with such pertinacity, that whilst the symptoms had been persistent vomiting, constipation, screaming, coma, squinting, convulsions, and hemiplegia, extended over ten or twelve days, yet, in opposition to the opinions of two others, death was asserted to have been caused by suppressed scarlatina, and no other certificate would be given. The more correct diagnosis of these inflammatory affections of the brain has caused the term hydrocephalus to be used much less frequently; as it is now known that the coma, the dilated pupil, and squinting, which were formerly believed to indicate effusion of water in the brain, may be the accompaniments of a mere inflammatory opacity or thickening—effusion of fluid being rather the exception than the rule.

Again, paralysis was formerly described and treated of as a distinct disease, and in almost every instance subjected to the same treatment; whereas now it has been proved to be only a symptom, common to various structural lesions of the nervous centres, such as rupture, inflammation, softening, pressure, &c.; each of which requires a variation in our remedies. And with regard to that form of paralysis that appears occasionally in the insane, it was in consequence of the accurate observations of physicians who practised little more than thirty years ago, that we have been taught to predict an invariably fatal result from the association of the slightest amount of unsteadiness or slowness of articulation with the very mildest form even of mental aberration; repeated observations having proved it to be a law, that the slightest delay in the formation of successive syllables or words by the insane is the certain forerunner of that general paralysis in them which invariably terminates life within two or three years. No remedial measure has hitherto been found to ward off the issue, though lowering treatment has been followed by most injurious results. Now, it is extraordinary that not a trace of a description of this peculiar kind of

paralysis, is to be found in the writings of any physician prior to the year 1822; though it possessed such peculiar characteristics as to be confined almost exclusively to males, to be most frequently associated with that form of insanity in which the patient is always hopeful, the world prospering with him in every respect, his power of motion and his health, in his own opinion, always improving, though he can scarce move or speak. Such patients, also, almost invariably become fat, the very opposite result of the presence of other forms of insanity; yet, with such peculiarities, its natural history was only discovered about the date I have just mentioned.

Within the last few years a peculiar inflammatory affection has been discovered, attacking the base of the brain and superior part of the spinal cord, to which the name of cerebro-spinal meningitis has been given. This, although an acute inflammation, appears to prevail at times as an epidemic, and did so some years ago in the Belfast Workhouse. It most frequently attacks boys, or young men recently subjected to the vicissitudes of a military life.

The foregoing statements have indicated the progress of medical science, by showing that we have acquired much greater facility in the interpretation of symptoms; so that we are enabled, not only to distinguish more accurately diseases of the brain from each other, but also to assert with greater confidence the existence of particular diseases from the presence of certain symptoms, though these latter may not appear to be directly connected with the brain.

I have now to adduce proofs of progress of a somewhat opposite character, by showing that certain symptoms, which at the commencement of the present century were looked upon as infallible evidences of serious, if not fatal, disease of the brain, are now to be interpreted in a very different way. We are indebted for this discovery to our celebrated English physiologist and physician, the late Dr. Marshall Hall. At the period I have mentioned, all diseases were ascribed to inflammation, and it was to the discovery and treatment of it that every physician directed his attention. Pain was known to be one of the most certain indications of its presence in inflammation of the bowels and other localities; and when it was complained of in the head, it was at once held to be indicative of inflammation of the brain, which required the most active blood-letting for its removal. Dr. Hall's great powers of observation soon told him that pain was by no means a certain indication of inflammation of the brain; and that it was almost invariably present when that organ was deficient in blood, rather than overcharged. All who have read his invaluable essay on bloodletting, will recollect his instancing case after case, in which severe pain in the head was but temporarily mitigated by bleeding; but at once relieved by nourishment—brandy and ammonia. To the same illustrious physician are we indebted

for another discovery of a similar nature, as he was the first to point out that a group of symptoms in children, such as insensibility, squinting, and convulsions, which had hitherto been looked upon as certain indications of hydrocephalus, or inflammation of the brain, and requiring the most decided lowering treatment, were in reality the result of exhaustion; and were most certainly removed by brandy nourishment and ammonia. Dr. Watson, of London, has truly remarked that one of the most trustworthy diagnostic symptoms of this peculiar condition of the brain in infants, consists in depression of the anterior fontanelle, the reverse of what occurs when the brain is inflamed. When we recollect the saving of life that has resulted from the discovery of the two foregoing facts, we must admit, that apart from his discovery of the "reflex function," Dr. Hall was entitled to be enrolled amongst the most successful benefactors of his race. Few discoveries of modern times are of greater importance than that which has taught us that exhaustion and irritation may originate a group of symptoms in both brain and intestinal diseases having a great resemblance to inflammation, but which would be aggravated and perpetuated by a lowering treatment, and almost immediately relieved by the reverse. Intimately connected with the brain, are to be found the spinal cord, and certain cerebral nerves; each liable to serious diseases, which, if not so destructive to life as those we have been alluding to, are still of such importance as to cause us to inquire what progress has been made in their diagnosis and treatment.

In connexion with the discoveries in this portion of the nervous system, we may well be proud that Great Britain and Ireland have furnished such experimental physiologists and practical physicians as Sir Charles Bell, Dr. Marshall Hall, and Dr. Bentley Todd. Sir Charles Bell's discovery, in 1811, that the anterior and posterior roots of the spinal nerves performed different functions, enabled an explanation to be given why disease in one part of the cord caused a loss of power, and in another a loss of sensation; and, although the recent investigations of Brown Sequard have shown that he had not succeeded in unravelling all the mysteries connected with sensation and motion, still the accuracy of his original discovery remains almost intact. By Sir Charles's discoveries, also, respecting certain cerebral nerves, we are enabled to explain why, in disease or injury of the seventh pair of nerves, certain superficial muscles of the face are paralysed, and others escape uninjured; and, again, when the anterior root of the fifth is involved, how it happens that the temporal and masseter muscles have lost power, whilst others do not suffer. Two kinds of facial paralysis are met with; one is of trivial importance, almost invariably amenable to treatment, and needs cause little anxiety to the patient; the other is of most serious import, generally dependent on disease of the brain, and too often uninfluenced by treatment. Now, you well know that we are indebted to

the discoveries of Sir Charles Bell and Dr. Bentley Todd for our capability of distinguishing between them; in the one case warranting words of comfort and assurance to the patient; in the other, demanding those of a less hopeful character. Sir Charles's investigations have explained that when the eyelids are incapable of being closed in facial paralysis the disease soon yields to proper treatment, and a permanent recovery results. Indeed, there are few of us who have not found the value of this knowledge, and the relief from anxiety it enabled us to administer to our patients, whose cheeks had become suddenly paralysed. Whilst, on the other hand, by the investigations of Dr. Bentley Todd, we have been taught that the power of closing the eyelids, in a case of facial paralysis, is an absolute proof that the affection is of a more serious character, and depending on disease of the brain itself.

Again, the discovery by Marshall Hall of the propriety of "reflex action," and which has immortalised his name in the science of physiology, has furnished us with unerring means of ascertaining whether the cause of the paralysis of the limbs of our patient is due to disease of the brain, or seated lower down in the cord, thus indicating not only the locality to which our remedies should be applied, but furnishing us with the means of deciding on the propriety of using that most powerful remedy, strychnine, which is beneficial when the spinal marrow is the cause of the paralysis, but hurtful when the brain is diseased. Although this knowledge had been acquired within the last quarter of a century, yet some recent investigations of Professor Van Der Kolk have extended our knowledge of the reflex function, by demonstrating that the posterior roots of the spinal nerves divide in the spinal cord into two parts, one of which passes directly up to the brain, and is the channel of sensation; whilst the other penetrates through the white masses of the cord into the grey substance, and becomes the channel through which the phenomena of the reflex action are excited. I might add to the foregoing other examples of improvement in our diagnosis of other diseases of the nervous system, but I have limited myself to a notice of the most important conquests that have been achieved; conquests which have been acknowledged by the most enlightened practitioners in every country, and by them admitted to have contributed to the preservation of human life.

Such, gentlemen, is the reply that an examination of even one portion of the diseases of the human body enables us to present to the detractors from our professional renown. And when we recollect that some of the most important of those discoveries were made by Sir Charles Bell in Edinburgh; that they had procured for him so world-wide a reputation, that no disease of the nervous system could be mentioned without his discoveries being noticed; that he was the co-professor of Sir William Hamilton in the University of Edinburgh; and that Scotchmen are generally not insensible to the

claims of their countrymen, we are at a loss to account for the utterance by Sir William of such a calumny on our profession as "that medicine in the hands by which it is vulgarly dispensed is a curse to humanity rather than a blessing,"¹ or for his addressing to us the question, "Has the practice of medicine made a single step since the days of Hippocrates?" When language like this is published by a writer of such unquestionable attainments in philosophy, and attempted to be justified by quoting a statement of the blacksmith Priesnitz, of water cure celebrity, surely we must accuse him of having shown a most unpardonable ignorance respecting the history and progress of medical science, or conclude that his mind had become warped by a most unjustifiable prejudice against it. But, I must remember that Sir William is no more, and that—

De mortuis nil nisi bonum.

The plan which I had laid down for my inquiry into the progress of medical science, requires me next to ascertain what improvements have taken place in the recognition and treatment of diseases in the organs of respiration and circulation. I am certain that you will agree with me in stating that it is here that the practice of medicine has achieved its greatest triumphs, and that we are enabled to enumerate discoveries in diagnosis and therapeutics that half-a-century ago would not have been deemed possible by the most enthusiastic member of our profession. It is almost superfluous to state that these have resulted from the application of auscultation and percussion in the investigations of all diseases of the lungs and heart. Auscultation in medicine, you are all aware, is the art of listening to the different sounds produced in the living body; and, as a method of diagnosis, it has for its object to determine the condition of an organ in which the natural sounds are altered. Its application to the study of diseases of the respiratory and circulating organs proved it capable of rendering the diagnosis of nearly every disease of the lungs, of the pleura, and of the heart more certain, and more minutely accurate, than perhaps even those diagnoses established by means of the sound, the probe, or the finger. For the discovery of this valuable and useful art we are wholly indebted to the immortal Laennec, and at a date so recent as 1816. Not only did he lay the foundation of our knowledge respecting it, but, by his indefatigable industry and ardent zeal, he brought it very nearly to that degree of perfection which it has now attained, and which renders it one of the most efficient means ever devised by the skill of man for the elucidation of pulmonary and cardiac affections. The stethoscope enables the physician of the present day, as it were, to see through the body of the patient, and to announce, in the great majority of instances, what alterations of structure exist at the point which is subjected to his examination. No intelligent

¹ Discussions on Philosophy, &c. p. 252.

practitioner can now refuse to acknowledge that the discovery of auscultation, by this eminent Parisian, forms one of the most memorable eras in the history of medicine; nor will its practical utility be denied by any one who has qualified himself to estimate its value. Whilst we have claimed for our countrymen, Sir Charles Bell, Dr. Marshall Hall, and Dr. Todd, some of the most valuable discoveries in connexion with the nervous system, we must, in candour, acknowledge that the entire merit of the discovery of auscultation is due to the illustrious Frenchman, although, as an art, it has been greatly extended and more accurately applied by Drs. Stokes, Williams, Walshe, Corrigan, and Hope. It has rarely happened, however, that there has been an instance of a discovery of equal importance in which so little was left by the discoverer to be performed by others; and we, who have benefited so much by his genius, cannot but rejoice that, as an exception to the general rule, the gratification was enjoyed by Laennec of witnessing the acknowledgment of the value of his discovery, and its adoption by the most intelligent of his countrymen and contemporaries.

Exactly a century ago an Austrian physician had announced the discovery of a new means of detecting the diseases of the lungs and the heart, to which he gave the name of percussion. This discovery attracted little attention, and had fallen into oblivion till about the year 1808, when Auenbrugger's treatise was translated into the French language by Corvisart. The value of percussion was soon tested, more extensive applications of it proposed, and, under the distinguished Piorry, of Paris, it has been brought to a high degree of perfection as a means of diagnosis. He, however, appears to place too exclusive reliance on this method, and professes to obtain results with his pleximeter which others of equal ability and honesty are quite unable to confirm. Still it must, in candour, be admitted that many who have accompanied him in his visits to his hospital patients have been astonished at the accuracy of his diagnosis. The most ignorant vender of whiskey or beer knows how to estimate the gradual falling of the liquor in a cask, by the different sounds elicited on striking it above and below the level of the liquid. In like manner, every part of the human body, when struck, emits a certain sound, and always the same sound under the same circumstances, and, therefore, when found altered by disease, it becomes a valuable symptom. Ordinary percussion is chiefly used to ascertain the degrees of intensity of sound, or, in other words, the degrees of sonorousness or clearness, and their opposites—dulness or flatness. It, however, reveals only one symptom, and but one element of diagnosis; although that symptom is often of paramount importance, yet it rarely, if ever, is of itself sufficient for determining the nature of the disease. If, for example, percussion discovers dulness at the base of a lung, other means must be employed to discover its cause. In such a case, it

merely indicates that a comparatively dense body occupies the place which in health is occupied by a substance of lesser density. If we wish to know more, auscultation and the general symptoms must determine what the nature of that body is, and how it affects the general system. When auscultation and percussion are thus combined, they become invaluable in diagnosis; in fact, they are essential to the successful practice of medicine, nor can either be relied on to the exclusion of the other. Their mutual dependence is so well known to you all that I need not mention many examples. But, having given one illustration of the insufficiency of percussion without the aid of auscultation, I may, in justice to Auenbrugger, give one where percussion is as necessary in aid of auscultation. Certain circumstances cause the stethoscope to be applied over the right lung, but no sound whatever of respiration can be heard. Is the lung solidified, or is the pleura full of fluid? Auscultation cannot furnish a reply, because no respiratory sounds are heard, either healthy or morbid. The aid of percussion is sought to clear up the difficulty, and it finds perfect, or even unusual, clearness of sound; therefore, neither solidification nor effusion can exist. There must be some cause preventing the air passing into or out of the lung, and a reference to the patient's history may furnish good grounds for believing that a foreign body blocks up a bronchial tube, thus rendering the passage of the air through the lung impossible, and, consequently, stopping all sounds. This body may be a "wisdom tooth," as in the late Dr. Houston's patient, or a half-sovereign, as in the case of the celebrated engineer, the late Mr. Brunel. The idea of combining auscultation and percussion originated with Laennec, proving that he desired progress in medical science rather than fame for himself, by an exclusive advocacy of auscultation.

Percussion, I have said, had been proposed as a means of distinguishing diseases of the chest fully a century ago, but it attracted little notice, and had fallen into oblivion till Corvisart recalled attention to it in Paris in 1808, and it was little practised in England till 1824. Whilst, therefore, it cannot, like auscultation, be claimed as a discovery of the last half-century, still to the physicians of this period is due the merit of its application, and a more accurate and extensive appreciation of its value.

I make no apology for this allusion to the discovery and history of auscultation and percussion; because, in common with every practical physician, I witness daily the incalculable benefits they confer on mankind, and feel that medical science can most truthfully point to both, as discoveries of recent date, which exercise an unquestionable influence in the relief of human suffering and the preservation of life; in this way accomplishing the noble purpose for which our profession has been organised. And if any sceptic wishes to be convinced of the great progress that the practice of medicine has made since the introduction of these methods

of investigation, it is only necessary to contrast the facility of discriminating the most frequent pulmonary affections at the present time with the difficulty which confessedly existed prior to the employment of those methods. If we turn to the works of Cullen, in praise of whom Sir William Hamilton could find no language sufficiently eulogistic, or to the more recent writings of Good or Thomas, we will find that these authors acknowledge the inability of the practitioner to distinguish, by means of symptoms, pneumonia, pleuritis, or bronchitis from each other. At the present time, by associating auscultation and percussion with other symptoms, it rarely happens that the discrimination cannot at once be made. And that this improvement is mainly due to these newly-discovered aids in diagnosis is shown by the fact that, to distinguish the affections referred to by symptoms alone, is still as difficult as it was to the physicians I have named. If any one ascribes our success to a more accurate interpretation of mere symptoms, it is sufficient to refer to the mistakes in diagnosis daily made by practitioners who rely exclusively on symptoms; mistakes which might be easily avoided by their practising auscultation and percussion. Bronchitis, pneumonia, and pleuritis, are not unfrequently latent, so far as distinctive symptoms are concerned, and consequently overlooked; or they may be completely masked by the symptoms of other associated affections, and thus escape detection. Of this we have daily examples in fevers and in head affections of both children and adults. But the application of auscultation and percussion at once enables the modern practitioner, if properly qualified, to arrive at a correct conclusion as to their existence.

Chronic pleurisy was habitually mistaken for other affections by the physicians of former times, and still is mistaken by those who do not practice auscultation and percussion; and yet nothing is now more simple than to determine the existence of this affection by these new methods of investigation. In illustration of how much we are indebted to these methods for improvement in the accuracy of our diagnosis, let us examine for a moment the value of the definition given of acute pleurisy, by the late Dr. Good, in these words:—"Acute pain in the chest, increased during inspiration; difficulty of lying on one side, hard pulse, short distressing cough." Is there a physician who would now accept this as a definition of the disease, or from the presence of these symptoms state that it existed? You all know that he would not, and for the simple reason, that the use of his stethoscope and percussion have taught him that the disease may exist without any of these symptoms, and, what is of more importance, that if they were present, they may indicate the existence of pericarditis rather than pleuritis. How different is the accuracy of our diagnosis of acute pleurisy, as revealed by auscultation and percussion. This will be best shown by a rapid sketch of what they indicate as taking place in

such a case. A patient complains of his left side. The symptoms I have quoted from Dr. Good may or may not be present. His physician immediately applies his stethoscope, and through it hears the sound, as of two rough surfaces rubbing over each other; percussion at first finds no dulness. In a few days the rubbing sound ceases to be heard, and it might be supposed that the disease had disappeared, were it not that percussion now detects dulness, owing to effusion of fluid, where clearness previously existed. Day after day this is found increasing in extent. The sounds of the heart now cease to be heard through the stethoscope in the region of the nipple, but are heard underneath, or to the right of the sternum, and can be traced daily passing gradually across till they are heard on the margin of the right arm-pit. In a few days more, the patient has been brought under the influence of medicine, and the fluid which had dislocated the heart begins to be removed; then, day after day can the heart's progress back to its natural position be traced by auscultation, till in a short time, by means of auscultation and percussion combined, we can assert that all fluid has been removed, and the lung has been enabled to resume its natural functions. There are few present whose experience could not verify the description I have given, and all are aware that the information thus obtained may be implicitly relied on, even should the patient's mind be so utterly prostrated as not to be able to answer a single question. It is known to you all that, for any such accuracy in diagnosis, or history of a case of acute pleurisy, we would search in vain the works of either Cullen, Thomas, or Good; yet this accuracy of knowledge is now possessed by every well-educated physician, though he should only have just completed his education.

It is unnecessary to make similar special remarks regarding the accuracy of our diagnosis of pneumonia, bronchitis, and other diseases of the lungs. Indeed, the value of auscultation and percussion might be illustrated by almost innumerable instances, but I shall only notice a few general examples of their utility. By them we are enabled to distinguish at once between organic and functional disorders of the respiratory organs; to detect serious lesions, while their functions seem almost unimpaired; to determine the precise situation of the lesion, its stage, and extent; to indicate the proper place to which our remedies ought to be applied, as well as to prevent error in their selection, by establishing that essential preliminary to all successful treatment—a correct diagnosis.

Acknowledging, to the fullest extent, the discoveries that have resulted from the application of auscultation and percussion to the investigation of the diseases of the lungs, we are constrained to admit that they have been surpassed in novelty and extent, if not in accuracy, by those that have resulted from the use of these new methods in recognising and distinguishing dis-

eases of the heart and large blood-vessels. These diseases were imperfectly understood until within a comparatively recent period—almost within the last quarter of a century. Formerly, they were thought to be very rare, and, because not recognised till their advanced stages, were considered to be almost uniformly fatal—a popular impression which has still such hold on the public mind as to require extreme caution in announcing their existence, They often escaped detection altogether, in consequence of the attention of the practitioner being directed to other prominent morbid affections, such as congestion, and hæmorrhage from the lungs, cerebral apoplexy, and different forms of dropsy, of which they were in reality the primary cause; but which, from an ignorance of auscultation, there was no means of detecting. For, if it has been successfully shown that general symptoms are insufficient to enable us to detect diseases of the lungs, we may, with tenfold accuracy, assert their incompetency with respect to diseases of the circulating organs, as every practical physician is aware that, where they would seem to point unerringly to the presence of organic disease, it may not be present; and, even when it is present, no general symptom might indicate its existence.

Formerly, as I have said, the diseases in question were considered to be rare, and almost uniformly fatal; now they are known to be very frequent; but, if treated in their early stages, they are found, though dangerous, to be by no means uniformly fatal, nor entirely beyond the control of medicine. The facility with which the stethoscope enables us to detect these diseases, and to announce their presence, has caused non-professional persons to imagine that diseases of the heart were surely becoming more frequent. Recently they have been ascertained to be so associated with, and dependent upon, certain diseased conditions of the fluids of the body, that the early application of therapeutic measures to the latter has repeatedly been successful in preventing them.

Great as we have found the revolution produced by the application of auscultation and percussion to diseases of the lungs, it is undoubtedly greater and more important in connexion with diseases of the circulating organs; for these methods have revealed to us diseases, the very existence of which was previously unknown, and enabled us to detect them in their very earliest stages, and before a single feeling on the part of the patient or a single constitutional symptom had given warning of their presence. And if there be here to-day any member of this Society who is disposed to disparage the value of auscultation, I would ask him could any of our forefathers in medicine have detected in a single instance the existence of acute inflammation in either the lining or the covering membrane of the heart? We know well they could not; and that, even with reference to the most frequent cause of inflammation in both these localities, the only extent to which

observation of symptoms through thousands of years had increased their knowledge was, that disease of the heart followed so often on acute rheumatism that they appeared to stand towards each other in the relation of cause and effect. But to tell at what period the heart became diseased, with what morbid process it commenced; in what texture of the organ it had originated, or how its presence was to be detected, was to them impossible.

How entirely has the application of auscultation removed this professional ignorance and incompetency! If we see a patient at the commencement of an attack of acute rheumatism, before the heart becomes involved, we can, by the aid of auscultation, tell almost the very hour in which inflammation will commence. We can tell, in the overwhelming majority of instances, whether it is seated in the interior or the exterior covering of the organ. If in the interior coating, we can tell whether it is the orifice through which the blood enters, or that through which it leaves the heart, that is involved. We can tell whether the disease only obstructs the passage of the blood from the heart, or whether it has so disorganised the valves as to render them incapable of preventing the regurgitation of the vital fluid.

For this precision in our diagnosis, we are chiefly indebted to the labours and observations of Bouillaud, in France, and in England, to those of Williams, Hope, and Latham.

Again, if the exterior covering be attacked, the same sound of two roughened surfaces passing over each other which auscultation detected in acute pleurisy, is found to exist here also. This friction sound may, as in pleurisy, disappear in a few days, and the same erroneous conclusion might be formed as to the cessation of the disease, did not percussion inform us that the natural dull sound over the heart had become extended over a larger space, indicating an accumulation of fluid round the heart. In a few days the patient has been brought under the influence of medicine; the removal of the fluid commences; and when it has so far disappeared as to allow the roughened surfaces to approach each other, we have a return of the rubbing sounds for a short period, and then, by the conjoined application of percussion and auscultation, we learn that all morbid indications have ceased, and that all immediate risk to life is over.

Now, this knowledge has been acquired within the last quarter of a century, and it is with feelings of no little gratification that we can point to it as the result of the genius and industry of our illustrious countryman, Dr. Stokes.

But the value of auscultation is not confined to acute cases alone. Many of you, like myself, have been asked to visit a patient who thought “he had caught cold.” Every portion of the lungs is explored with the stethoscope, without finding any disease. At last a faint murmur is heard over one of the large arteries; it is

traced to its origin in the heart, and reveals the existence there of deadly disease, of old standing, the patient being all the while ignorant of its existence, and unconscious of any illness in which it originated. If asked of what value is the discovery of this incurable disease, which is causing no inconvenience? I reply that, apart from the scientific interest connected with its detection, it may be of vital importance to the patient. With a knowledge of its existence no intelligent physician would apply those debilitating remedies which, under other circumstances, might be applied with propriety. Nor could he forget, in the treatment of such a patient, that

Hærit lateri lethalis arundo.

The examples I have given have shown the value of auscultation in the detection of diseases of the heart; but it is of no less importance in a group of cases in which certain symptoms and sensations in a patient lead him to believe that he is the subject of disease, when in reality he is not. These symptoms often imitate very closely those of real disease, and occasion much mental distress and anxious apprehension to the subject of them, lest he may be labouring under an incurable affection. I am certain that there are few members of this Society who have not had opportunities of removing such mental disquietude by the application of the stethoscope, which enabled them to assure their patients that there was no evidence of organic lesion.

Time will not permit me to furnish illustrations of the great improvements that have taken place in our power of detecting those diseases of the substance of the heart and of the large blood-vessels, which are developed in the enlargement, the softening, or the conversion into fat of the former, and in the dilatation into aneurisms of the latter. In the discovery of these, our countrymen, Dr. Stokes, Dr. Corrigan, Dr. Greene, and Dr. Bellingham, have all borne a most distinguished part, having extended our means of diagnosis, and contributed rules for their treatment, that in practical utility could not be surpassed. I am certain that you will not have forgotten how unhesitatingly the indebtedness of our profession and of mankind to Laennec, as the discoverer of auscultation, has been admitted, and also the great perfection to which he had brought its application in investigating diseases of the lungs; but truth compels us to acknowledge that he was not by any means so successful in his application of it to the diagnosis of diseases of the circulating organs; inasmuch as many of the diagnostic symptoms and rules which he inculcated have been found by his successors to be quite incorrect. This, you are aware, was owing to the inaccuracy of the knowledge of his day respecting the motions and sounds of the heart, and not to a want of accuracy of observation on his part. In fact, the order in which the contraction of the various parts of the heart took place, and the cause of the sounds that were heard, were not ascertained till many years afterwards; and in

their elucidation Professor Carlisle of Queen's College, Belfast, took a most active part.

The high state of perfection that has been reached in the diagnosis of diseases of the heart and large blood-vessels has resulted from the researches and discoveries of Laennec, Corvisart, Collin, Louis, and Bouillaud, in France; of Hope, Williams, and Latham, in England; of Stokes, Corrigan, Green, and Bellingham, in Ireland. Nor do I consider that I am detracting from the merits of British stethoscopists, if I assign a pre-eminent position amongst them to our countryman Dr. Stokes. He has shown himself to be a master in the diagnosis of disease of both the heart and of the lungs—in the former discovering almost all that we know of pericarditis and fatty degeneration; in the latter, the differential diagnosis of intra-thoracic tumours. Indeed, by his discoveries and published works on the diseases of the respiratory and circulating organs, he has earned for himself a position in the history of auscultation, only second to that of the immortal Laennec.

Whilst referring to what we owe to distinguished men in our own and other countries, in this department of medical science, we may observe, that we are not aware of any contributions Scotland has furnished to it by any of her physicians, or the professors in her universities or colleges. Dr. Hope, who wrote so ably on diseases of the heart, was, indeed, born in Scotland, but he pursued his investigations into cardiac diseases in England; so that we think it will be found, that all the really valuable additions which have been made, out of France, to the diagnosis of the diseases of the lungs and heart, have resulted from the researches of either Englishmen or Irishmen, in which investigations, Ireland's sons have borne no inglorious part.

We must not, however, forget how much our therapeutic knowledge has been advanced by the zealous and judicious manner in which Dr. Bennett, of Edinburgh, has introduced cod-liver oil as a remedial agent in the treatment of thoracic and other diseases.

I have now terminated my inquiry into the progress that has been made in our knowledge of diseases of the lungs and of the heart; and I believe that I am justified in stating that if medical science could indicate no other discoveries than those I have mentioned, they are abundantly sufficient to prove that the slander that has been published against us was unfounded and unjust. More numerous proofs of advancement could have been given, had I not been compelled to limit myself to an enumeration of some of the most prominent, the value and accuracy of which have been admitted by the most intelligent and trustworthy physicians in every country. I must add that the largest exercise of charity cannot reconcile us to the opinion that a discovery like auscultation and the stethoscope, which was the theme of conversation amongst all classes in the community, and which had its aid invoked by the highest and wealthiest in the land, as well as by the poorest of the

poor, could have been so utterly unknown to the reviewer I have named, as to warrant his asking the disparaging question—“Has the practice of medicine made a single step since the days of Hippocrates?”¹

I have next to inquire into the improvements that have been effected in the diagnosis of the diseases of the digestive and eliminative organs. Many asserted discoveries in this department have not yet received the assent of the majority of physicians; and as in my examination of the nervous, respiratory, and circulating systems, I only noticed such discoveries as had met with general acceptance, a similar course here will render my notice a very brief one. Notwithstanding the increase to our knowledge of the physiology of digestion that resulted from the observations and examinations made by Dr. Beaumont, through the valvular opening in the stomach of the Canadian, St. Martin, we are still compelled to admit that little, if any, improvement has taken place in acquiring a more accurate diagnosis in the diseases of the stomach. Some progress has, however, been made in distinguishing the inflammatory diseases of the intestines. The researches of the late Dr. Abercrombie have shown that inflammatory pain, when associated with a loose state of the bowels, may be, in the majority of instances, accepted with considerable confidence as indicative of the mucous coat of the intestines being involved; that pain, if accompanied by a constipated state of the bowels, may be interpreted as symptomatic of inflammation of the muscular coat; and again, that when the inflammation is limited to the peritoneal coat there will be pain, soon followed by dullness on percussion, and that the bowels may be either loose or constipated. Previous to those investigations of Dr. Abercrombie, all the inflammations of the bowels were included under a common name, and the peritoneum supposed to be frequently involved, when the mucous membrane alone was affected, it being now well ascertained that the serous and the mucous tunics of this organ are rarely involved in the same acute inflammation, except when occurring in the puerperal state.

With respect to chronic inflammation of the peritoneum, an interesting application of the law of tubercular development was found to apply. Louis had observed, during his researches into tubercular disease of the lungs, that if, after the age of fifteen years, tubercles, or grey semi-transparent granulations, were found in any organ, they existed at the same time, in a more advanced stage in the lungs. And, as chronic peritonitis, occurring subsequently to the age of puberty, is always tubercular, an application of the law just stated indicates that that disease is always associated with tubercles in the lungs, although their numbers or development may not have intimated their presence. The well known accuracy of Louis's observations requires us

to admit this as a fact, and it should never be forgotten in the treatment of chronic peritonitis, for it at once prohibits the use of mercury, which has been found of such unquestionable value in the treatment of the acute disease. The only eliminative organ in the abdomen, in which the diagnosis of its diseases has made undoubted progress, is the kidney. About a quarter of a century ago, Dr. Bright discovered that this organ was very frequently the subject of disease, which gave origin to a number of other secondary diseases that, previous to his investigations, had never been supposed to be in any way connected with the kidney. This state of the kidney he considered capable of being ascertained by a diminished specific gravity of the urine, but especially by the presence of albumen in it.

A considerable amount of discussion and investigation, continued even to the present day, followed his announcement of this hitherto unknown disease. Some have differed with him respecting its nature, others as to the pathognomonic value of the diagnostic symptoms he had announced. All, however, are unanimous in acknowledging the kidney to be liable to a disorganisation previously unknown, and that its detection depends on an examination of the urine. In honour of the discoverer, it has received the name of “Bright's Disease,” which will perpetuate the name of this distinguished physician, like that of Mr. Pott, through all future ages of our profession, and mark him as one of the most accurate observers of symptoms during the lives of his patients, and a successful tracer of them to their cause after death.

It is not without some interest to remark, in passing, that notwithstanding Dr. Bright's unlimited zeal in examining patients when alive, and their bodies after death, yet he possessed so little moral courage, that when ill himself, he would permit no minute investigation to be made into the nature of his disease; so that, although he had the advice of some of the most eminent physicians of the metropolis, yet from compelling them to rely upon mere symptoms in the formation of their opinion, he died without his disease being detected, although the examination of his body after death proved that the application of the stethoscope would have revealed it in a few seconds.

But, to return to the diagnosis of Bright's disease of the kidney. If some recent statements be verified, there would at last appear a means of reconciling the conflicting opinions and statements I have alluded to, and of establishing some most valuable symptoms for diagnosis. The researches of Dr. George Johnston and Dr. Wilkes, some years ago, conjoined with the recent investigations of Mr. Dickenson into the particulars of a large number of cases treated at St. George's Hospital, appear to have proved that there are two forms of diseased kidney to be met with under the name of Bright's disease, and that each of these possesses peculiar diagnostic symptoms, amongst which Mr. Dickenson now

¹ Op. Cit. p.252.

wishes us to include the age of the patient. First, there is an enlarged kidney with a smooth surface, in which it is the secreting surface of the tubes that is deranged. The diagnostic symptoms of this form are stated to be scanty urine, with a specific gravity above 1,015, much albumen and coarse granular tube casts; considerable dropsy; the average age of fatal cases being 28 years. In the other kind, the kidney is contracted, granulated or lobulated on the surface, and the disease seated in the tissues between the tubes. The diagnostic symptoms of this form are stated to be a rather abundant secretion of urine, with a specific gravity below 1,015; little albumen; some transparent tube casts, loaded with fat or oil; little dropsical effusion, and the average age of fatal cases 50, the patients being often gouty. My own experience leads me to believe that this new classification and indication of the symptoms peculiar to each may be relied on in practice, if we take care to separate those cases in which the urine contains albumen, in consequence of impeded circulation through the heart.

Here, again, we have another example of the discovery of a new disease and its diagnostic symptoms, resulting from the observations and researches of physicians within a comparatively recent period. Nor must we forget that Dr. Christison, colleague of Sir William Hamilton in the Edinburgh University, took a very distinguished part in indicating the secondary diseases that most frequently appeared during the progress of Bright's disease; whilst Dr. George Johnston, and, more recently, Dr. Basham, have most successfully applied the microscope in detecting the various kinds of casts and transudations that are found present in the urine during the course of this disease. Indeed, the latter asserts that greater dependence can be placed on the revelations of the microscope than on those other diagnostic marks hitherto relied on.

The recent researches of Dr. Addison, of London, have directed the attention of physicians to a diseased state of the supra-renal capsules, and to a frequent association with it of a peculiar discolouration of the skin, and a state of great constitutional languor and debility. As yet, however, it has not been proved that these exist in the relation of cause and effect; nor has much practical utility resulted from the discovery.

I have now passed in review the more important discoveries that have been made during the last fifty years, in connection with the diseases of the three great anatomical divisions of the human body. In all of them we have found evidence of additions to the knowledge of the practice of medicine, that could not have been anticipated at the commencement of this century. There are few amongst us who have not read the terms of derision in which all the leading journalists received the announcement of what auscultation and percussion proposed to effect; and we now know that they vie with each other in proclaiming their success. Notwithstanding the physical obstacles opposed to a minute invest-

igation of another department, we have found discoveries effected of the very highest importance, and conjoined with a more accurate interpretation of symptoms in their diagnostic, therapeutic, and prognostic relationships; all contributing to the preservation of life. And, lastly, we have had revealed the existence of a most fatal form of disease in one of the eliminative organs, and its diagnostic symptoms established on a most certain and accurate basis. With such indisputable evidence of progress in the practice of medicine, are we not justified in appealing to every impartial mind, whether a satisfactory reply has not been furnished to the defamatory remarks which a high name has circulated against us.

Had time permitted, I might have alluded to the glorious termination to the investigations of the physicians of the last century in the discovery of vaccination by the immortal Jenner, in 1796, which is estimated to save at least 500,000 lives each year, and which, if unacknowledged by the reviewer I have named, had elicited from the savage chief of the Indian tribes, the following most striking language:—"We shall not fail to teach our children to speak the name of Jenner, and to thank the Great Spirit for bestowing upon him so much wisdom and so much benevolence." I might have alluded to the labours of Howard, the philanthropist, a member of our profession, who has effected such an annual saving in human life by his reformation in the management of jails and lunatic asylums. I might have instanced the saving of life that has resulted from the practice of medicine in its obstetrical department, so that the mortality from child-bearing has been reduced from one in fifty to one in two hundred; and that, from a better management of children's diseases, and attention to hygenics, 100,000 lives are now annually saved, when compared with the mortality that prevailed among children less than two centuries ago. And, finally, I might mention the prolongation of human life generally in these countries, resulting from a more successful treatment of diseases, and from the adoption of various sanatory arrangements, first suggested, by our profession; so that, whilst it is known that one in every twenty-one of the inhabitants of England and Wales died annually about a century and a-half ago, now the bills of mortality only indicate one in every forty-five.

I had originally intended to have entered more minutely into these subjects, and to have reserved a portion for a closing address. I feel compelled, however, to condense both addresses into one, and to indicate only the more prominent discoveries in our science. I trust that enough has been said to establish for medicine a valid claim to an unquestioned position amongst the progressive sciences. I have only to regret that the enumeration of the proofs of its advancement, and the defence of its practitioners from the slanders that have been published against them, had not devolved upon one more competent to the task.

Belfast Clinical and Pathological Society
Seventh Session: 1859–1860
President James Seaton Reid

Gentlemen, the value of a society like this to ourselves, as well as to the public, the spirit that should influence our proceedings, the necessity for each member exerting himself to promote its success, have all been so well placed before you by others, that it would be a work of supererogation did I dwell on them again. Aware that my position as President renders it undesirable that I should be a frequent contributor to your proceedings, I have to hope, that the Session we now enter upon shall be productive of such varied and valuable communications from you all, as to prove that your zeal, industry, and anxiety for the prosperity of this society have in no degree diminished.

I enter on my duties, pleading for an extension of your forbearance, in consideration of my many shortcomings, and with unfeigned anxiety, lest anything should occur that would in any way check the hitherto prosperous career of this society.

Need I add, how desirable it is that all possible courtesy should be extended by you towards each other during debate, so that when the session closes we shall separate with those feelings of mutual esteem and respect which it is desirable should exist among the members of a profession that has been organised in harmony with the commands of the Great Physician to His disciples, when He said—“Into whatsoever city ye enter, heal the sick that are therein.”

Having such an authority for the practice of a profession which exercised the sympathies of even Divinity itself, I shall close in the not inappropriate language of an eloquent historian of medicine, who says—“Who of us shall forget its ever-living charities; its moving scenes of joy and sadness; its many sunny aspects; its benignant, ennobling, liberalising influences; which few beyond our own circle can properly appreciate, and none so well understand as ourselves.”

{Rough minute book: Moved by Mr. Browne seconded by Dr. Moore “That the address would be published.”}

It was moved by Dr. FERGUSON, seconded by Dr. MOORE, and resolved, “That the Address of the President be published as part of the Transactions.”

The PRESIDENT then presented to the members a handsomely-framed engraving¹ of the late Dr. Malcolm, Founder of the Society. He was sure his departed friend required no eulogium here, as he lived in the memory of them all; but he hoped that his example would excite them to emulate that zeal which was so characteristic of him.

{Rough minute book: Moved by Ferguson seconded by Browne “That the thanks be given for Dr. Malcolm’s portrait.”}

¹ [The image of Malcolm currently in the possession of the Ulster Medical Society seems to be a photocopy. The whereabouts of the original is unknown.]

Council Council Meeting November [2nd] 1859.

Present, the President, Surgeon Browne, Drs. Dill, Cuming, & Wales.

The President read a letter from Dr. Browne of Derry in which the writer stated “that he had been elected a member of the Society two years since, and had received some of the weekly reports, but that through the misadventure of a friend to whom he gave his subscription it had never been forwarded. He therefore enclosed two years subscription.” It was arranged that if Dr. Browne’s name could be found in the minutes as having been proposed and seconded that he should not again be submitted to proposal and ballot but that his subscription for two years be received and that he shall receive the transactions for the past year.

Enlarging the size of the type and paper of the transactions was considered and it was resolved to make no change.

The circular was prepared as follows. To be discussed the medical journal or journals in which it will be advisable to publish the transaction of the Society.

The ballot to be taken for John Motherwell M.D. (Edin.) L.R.C.S. (Edin.) Castledearg, C^o. Tyrone.

To be proposed Samuel Hunter M.D. Edin. L.R.C.S.I. Belfast.

Morbid exhibits. Recent parts in elephantiasis, case of enlarged nymphæ of clitoris. Case of aggravated hysteria.

SECOND MEETING.

November 5th, 1859.

The President in the Chair.

{Rough minute book: President, Dr. M’Gee, Patterson, Ross, Corry, Wales, Heeney, Halliday, Mulholland, Browne, Dill, M’Cleery, Arnold, M’Minn, Warwick, W. Aickin, Murney, Murray, Ferguson, Rea.

Dr. Motherell elected.

Dr. Hunter seconded by Dr. Ferguson, proposed by Dr. Reid.

Moved by Dr. Ferguson seconded by Mr. Browne that Dr. Hunter be admitted as country member.

Dr. Connor by Dr. Halliday seconded by Dr. Mulholland.

Dr. Buckingham by Dr. Halliday seconded by Dr. Corry.

Moved by Mr. Browne seconded by Dr. Patterson “That transactions be published in the Dublin Gazette.”

Moved by Dr. Halliday seconded by Dr. M’Gee “That the transactions be continued to be published in the Dublin Hospital Gazette.” Passed.}

Mr. BROWNE introduced a patient on whose foot he had recently performed an operation. This man, S. G., aged twenty-two, some four years ago, first suffered from strumous disease. He then had a tumour over

the carpal end of the radius, which, after some time, suppurated. Three years after, ten months since, he felt pain over the metatarsal bone of the great toe of right foot. This part became enlarged, and finally suppurated. On examination, the metatarsal bone and first phalanx of the great toe were found to be in a necrosed state, necessitating their removal. Seven weeks since the parts were amputated, and the wound healed up kindly. He now walks well, and with a very slight halt in his gait.

While under treatment, a portion of the radius was found to be necrosed; this was removed, since which the open sore, of several years' standing, has completely cicatrised, and the man's health, formerly very bad, has been quite restored.

Case of Elephantiasis.

By Dr. Babington, Surgeon, Londonderry Infirmary.

(Read by Dr. Cuming.)

H. S., the subject of accompanying drawings, was admitted into County Londonderry Infirmary, 15th August, 1855, presenting the appearances accurately delineated, and sketched soon after his admission.

He did not complain of any particular disease, but wished to have something done to his leg, the weight of which caused him much annoyance.

He was a man of weak intellect, and could give but an imperfect account of the commencement and progress of his case. The following particulars are all which could be obtained:—Aged thirty-six years. Disease commenced in the skin of his back, over the lower part of the spine, when fourteen years of age, and gradually increased to its present size, as represented in the drawing. His leg began to enlarge about ten years since, and the tumours, scattered over the chest and trunk, appeared at intermediate periods—those on the face and neck since the leg began to enlarge. The leg measured twenty-seven inches in the centre of the swelling, which was quite loose, without any deep attachment, and rolled about from side to side over his foot, the skin of which was natural in appearance. An ulcerated opening existed in the lower part of the tumour, from which an ill-digested sanious discharge flowed in small quantities. He complained of no pain either internally or externally; his urine presented no morbid indication; there was no evidence of any internal organic disease, with the exception of the left side of the chest, in which no respiration could be detected. He complained of weakness, and suffered from occasional attacks of diarrhoea. He remained in hospital till December 8th. He was again admitted on 10th April, 1856; and remained till 30th October. His appearance had undergone no change, the leg measured thirty inches. He spent the year 1857 wandering over the country as a mendicant, and again returned to the hospital on 10th May, 1858, and remained to 12th August. At this time he was suffer-

ing from severe and protracted diarrhoea. The leg now measured thirty-four inches; the other appearances had undergone no change. He was much weaker than formerly. He was admitted again, for the fourth and last time, in a state of extreme debility and prostration, on the 4th January, 1859. The leg measured thirty-five inches, and he was labouring under very severe diarrhoea, which baffled all treatment, and continued till 19th June, when he died exhausted. On the day of his death the leg measured twenty-seven inches.

The result of the *post-mortem* examination was anything but satisfactory. The drawings before the Society accurately represent the external appearance of the body, except that the integuments were of a darker colour. There was a total absence of fat and cellular tissue, and the greatly-thinned integuments were everywhere adherent to the muscles underneath, which were wasted and of a pale greenish colour. The tumour could be easily dissected off and had no subcutaneous attachments. The brain was softer than in health, but presented no other morbid appearance. The heart was softened in its muscular structure. Right lung healthy. Left atrophied, adherent to the spine, carnified, and about the size of a turkey's egg. Liver, kidneys, and spleen healthy. The peritoneum and mesentery presented no morbid appearance, but the internal surface of the intestines was thickly studded over with small tumours resembling those on the skin. A slice of the leg and one of the cutaneous tumours were microscopically examined by Mr. M. Collis, of Dublin, and pronounced to belong to a class of tumours denominated "dermoid," non-malignant, "and having a great tendency to multiplication in the same subject." A slice was also sent to Dr. Cuming, but was decomposed before it could be examined.

I had hoped to have exhibited the leg for the inspection of the Society, but notwithstanding the greatest care, it became rotten and offensive, and the only portion that remained at all capable of examination was forwarded to Dr. Wales on the 28th inst., to be laid on the table.

{Rough minute book: Mr. Browne dissented from the term elephantiasis.

Dr. M'Gee said that it was not elephantiasis from its multiplication.

Dr. Ferguson said that he considered it disease of the skin.

Ordered to write to Dr. Babington regarding copies of drawings. Moved by Mr. Browne seconded by Dr. M'Minn.

Dr. Corry requests to take photographs.}

Case of Hypertrophy of Clitoris and Nymphæ.

By Surgeon Browne, R.N.

The plaster casts upon the table illustrate the appearance of the morbid parts before removal, and the

condition after. The first shews the size and position of the flap-like appendage, as it lay in front of, and concealing the vulva; the second shews the growth raised up, and displays the right nymphæ greatly enlarged; the left not so much so; while the third exhibits the appearance of the parts after the removal of the growth, and healing had taken place.

As will be seen, the hypertrophied structure measured 5½ inches in length, 3 in breadth, and was 7 inches in circumference at its largest point. The patient from whom these casts were taken, and this structure removed, had been for some years a prostitute, though she is now only in her 19th year. She states, that at the age of 13, she first had connexion, and suffered injury: from that time, however, she continued for some three or four years to earn her bread by prostitution; she then became diseased; after being cured, she went to the country for one or two years. About three years since, she observed the commencement of the growth which has since enlarged so much, and for several months she has not been able to pursue her unhappy calling, in consequence of the position the diseased structure occupied.

When she came into the hospital, I was not aware of the nature of the case; but desiring to ascertain her disease, I instituted an examination, and found the condition of things presented by No. 1 cast. Shortly after her admission, I determined to remove the impediment of which she complained. Having brought her fully under the influence of chloroform, I introduced a female catheter into the bladder, so as to mark the position of the orifice of the urethra, that I might avoid injury to that passage; I then made an incision on each side of the neck of the tumour, uniting them above, just within the *labiæ majores*, and then completely dissected off the hypertrophied mass, including the clitoris and nymphæ. There was very little hæmorrhage,—two small vessels only requiring ligation.

The upper part of the elevated structure, above the vestibule, for about one inch, was united by two sutures—the parts healed up satisfactorily, and left the improved face on affairs that are exhibited by cast No. 3.

After the external parts had healed, I examined, with the speculum, and discovered several growths on the walls of the vagina,—some attached by small pedicles, and two by broad bases, the largest being immediately below the orifice of the urethra. These I removed by means of the strong curved scissors. Some of these growths were of hard firm structure, covered by the fine polished mucous membrane; and others were of the soft friable character often presented by condylomata.

On examining the structure removed, it was found to consist of mucous membrane thickened, the mucous follicles being greatly enlarged, and the sub-

mucous cellular tissue filled with the so-called lactaceous deposit, similar to what is observed in cases of lipoma.

Amputation of Foot

Dr. MOORE exhibited a portion of foot, removed by Chopart's operation, on account of ulceration and swelling of a malignant character, at metatarsal joint of great toe, involving the next two toes and adjacent textures. There was considerable redness and tumefaction of the part, accompanied by pain. Dr. Moore was inclined, at first sight, to regard it as a specific ulceration, and it had been so looked upon and treated by the medical gentleman who consulted him in the case. The disease was progressing rapidly, and, fearing that it might extend to the ankle joint, Dr. Moore deemed its removal advisable, knowing as he did that several members of the young man's family (cousins) had suffered, and still are suffering, from malignant disease affecting different parts. One, a young gentleman on his return from abroad, consulted Sir Benjamin Brodie and other eminent members of the profession in London, for disease of the antrum, which had rapidly increased. He came to Dr. Moore with regard to operation for its removal; but from the extent to which the disease had engaged the bones of the face, and the ethmoid, and from its pressure on the eyeball, Dr. M. considered that there was not the slightest room for operative interference. From that time the destruction of the bones of the face, forehead, and lower jaw had progressed with great rapidity, laying open the cavity of the mouth, the orbit, and attacking the root of the tongue, rendering deglutition almost impossible. Another cousin suffered from malignant disease of breast, which was removed, but ultimately attacked her again with a fatal result. Another had a tumour of the neck of a large size, which was of a fibrous character, containing cysts of cheesy matter, which was removed by operation. Dr. Moore has since seen another member of the family with ulceration of the dorsum of foot, on which he looks with suspicion.

Council Council Meeting November [16?] 1859.

Present, Surgeon Browne, Dr. Drennan, Dr. Halliday, Surgeon Johnston, & Dr. Wales.

The circular was prepared as follows. For ballot for membership Barnwell White M.D. Edin. F. & L.R.C.S.I. Londonderry.

Surgeon Johnston will introduce a case of popliteal aneurism.

Surgeon Browne R.N. will exhibit a melanotic tumour, and will give details of the case and operation.

Dr. C. D. Purdon will read a case of aggravated hysteria.

THIRD MEETING.

November 12th, 1859.

Surgeon Browne, ex-President, in the chair.

{Rough minute book: Mr. Browne in the chair, Drs. Ferguson, M'Gee, Corry, Dunlop, O'Hare, Halliday, Arnold, Wales, Dill, Mulholland, M'Laughlin, Murney, Johnston, Thomson, M'Cleery, Smith, Bryce, Heeney, M'Minn, Ross.

Dr. Cuming proposed, Dr. M'Laughlin seconded, Barnwell White.

Drs. Hunter, Connor, Buckingham were elected.

Dr. Purdon's paper was postponed.}

Turning in Labour When the Pelvis is Contracted.

Dr. DILL read the following paper:—The question of turning in the case of a narrow pelvis, or in one very slightly contracted or deformed, must be considered by the obstetric practitioner as one of some importance. It is my intention to advance a few statements and illustrations, which will prove the impropriety of having recourse to this operation. At the same time, I may here state, that I shall not by any means assert that we may not have exceptional cases. My position is, that, as a general rule, turning, under such circumstances, is bad practice. It is Professor Simpson who to a certain extent revived, and now advocates, the affirmative side of the question; and, although his name and his authority stand high, yet, I believe, the weight of argument and evidence is against him.

The following are, very briefly, a few of my reasons for not turning, where the vertex presents, in a slightly contracted pelvis. And, first, have we not all very frequently observed cases of lingering labour, where the impaction of the head in the pelvis was such as to force us, for a time, to entertain the opinion that nothing but artificial means could dislodge it, but which has been expelled after all, by the natural efforts of the mother, thereby proving that while there is in many cases a contracted pelvis, or a want of relative proportion between the head of the child and the pelvis of the mother, nature unaided will overcome the difficulty, by our merely exercising a due amount of patience. Second. In my opinion the vertex is a more favourable part to present to the brim and outlet of the pelvis than that portion of the head which reaches the brim first when extracted by the lower extremities. In the first instance, you have a part presenting of a cone-shape, and by means of the sutures, the bones so overlapping, accommodating, and adapting themselves to the pelvis as to enable the head to pass through, though it maybe with difficulty; while, in the second instance, you have to deal with a firm, angular, unyielding body. I would, therefore, be disposed to ask, if the head, with a vertex presentation, will not pass through a slightly-contracted pelvis by the natural efforts, or even assisted by the forceps,

will the delivery not be more difficult, when the head is being extracted, after turning? Third. It will, I believe, be conceded that there is, at all times, considerable danger to both the life of mother and child in turning; and how often, even when turned, is it necessary to call in the aid of either the forceps or perforator to complete the delivery? But, even though these instruments be not required, have we not to contend with the long delay of the head all this time pressing upon the funis? Besides, is not the force which we are frequently obliged to apply to the neck in extracting the head, calculated not alone to endanger the life of the child, but seriously injure the soft parts of the mother? I was called upon to assist Surgeon S., in the case of Mrs. A. It proved to be very tedious labour, from a slightly-contracted pelvis in the conjugate diameter. The head had somewhat descended, but, from the long delay, it was thought right first to try the forceps, and, not succeeding, craniotomy was performed, and the child easily extracted by the hook. She became pregnant a second and a third time with similar results. I was sent for to attend the same woman in a fourth confinement, but on this occasion the breech presented, at which I was pleased, as it, without the risk of turning, afforded a favourable opportunity of testing Simpson's mode of dealing with such cases. The breech, trunk, and shoulders were expelled with some little assistance, but, with all my efforts, the head could not be brought away until it was perforated, reduced in size, and extracted by means of the hook; thus proving that by turning, in such cases, the practice becomes complicated, by adding a second, and it may be a third operation to the first.

{Rough minute book: Dr. M'Gee, Dr. Halliday, Dr. Heeney said that when the head was impacted we should not turn, but when the head is above the pelvis if the head can pass he would turn and by no means perforate.

Dr. Dill said that when the head could be brought away by turning it could be brought away by the long or short forceps.}

Surgeon BROWNE introduced a patient from whom the eye had been extracted in consequence of melanosis, and said that he would lay before the Society an account of the case at a subsequent meeting.

Dr. BRYCE introduced a patient, aged thirty-eight, affected with what were believed to be fibro-cartilaginous tumours of the fore-head of ten years' standing.

*Case of Horny Growth Removed
From Lower Lip.*

Surgeon BROWNE exhibited a horny growth which had been removed from the lip of a man 60 years of age in

the Cookstown workhouse by Dr. D. Hamilton, and which had been sent to the Pathological Society by Dr. Thomas Hamilton, late of Belfast. This, when recent, was an inch and a-half in length, being fully an inch in circumference at the point of attachment to the lip. The man had been a great smoker, but it seems that he had always held the pipe in the opposite side of his mouth. The part from which the growth had been excised healed up, and no return took place. Mr. Browne remarked that the Society had had three different kinds of necrosed structure before it, wherein dame nature's supply of material was more abundant than either ornamental or useful.

FOURTH MEETING.

November 18th [sic], 1859.

The President in the Chair.

{Rough minute book: President, in the chair, Dr. Halliday, Ferguson, S. Reid, M'Gee, Rea, Thomson, C. D. Purdon, Mulholland, Murney, M'Cleery, Browne, Patterson, Dill, M'Minn, Warwick, Heeney, Bryce, Johnston, Gordon, Wales, Murray, Moore, Arnold, Ross, M'Cormac, Pirrie.}

Case of Aneurism of Aorta.

The PRESIDENT gave an account of three of the cases of aneurism, the histories of which he had brought before the Society towards the close of last session,¹ and exhibited the heart and aneurismal tumour of the second of those cases.²

Case of Staphyloraphy.

Surgeon BROWNE introduced a young woman, aged 28 years, on whom he had operated for the case of cleft palate, on the 11th of last October. The part had united perfectly, the sutures having been removed on the fourth day of the operation.

He referred to a case he had published in the *Dublin Quarterly Journal of Medical Science*, 25th vol.³ and stated, that since that report, he had operated in four additional cases of cleft palate. In three of his cases, the operation had been completely successful; in one, partially so; and in another, failure followed two operations to which the patient had submitted.

He expressed his intention of giving his views on the subject of staphyloraphy, at some length, in an early number of the *Dublin Quarterly Journal*.

Artificial Anus.

Dr. MOORE introduced a patient who had consulted him with regard to the propriety of closing an arti-

ficial anus in his lumbar region. He was a soldier at the siege of Lucknow, and when in the act of holding his musket to his shoulder, received a gunshot wound in his left arm, close to the elbow-joint; the ball passed through the arm from without inwards, then entered the abdomen immediately below the lowest rib, and made its exit above the ilium, close to the spine. He was confined in hospital in India for three months, and afterwards transferred to one of the depot hospitals in England, being in hospital eight months in all. There is a slight discharge from the wound of matter, occasionally flatus, and several times during the twenty-four hours feculent matter passes through the orifice. Dr. Moore did not deem it advisable under the circumstances, to interfere.

Removal of Metatarsal Bone.

Dr. MOORE exhibited the diseased metatarsal bone of the great toe, which he had removed from a lad 15 years of age. There was considerable swelling, and three fistulous openings existed which communicated with the bone. The great toe and the rest of the foot were in a healthy condition. Dr. M. was anxious to try, by the removal of this bone, whether the symmetry of the foot could be preserved, and whether the great toe could obtain any support after the removal of its natural one.

Exostosis of Finger.

Dr. MOORE exhibited a little finger which was a marked example of exostosis of the little finger; the finger weighing upwards of three ounces. The lad's occupation was that of a weaver, and the disease interfered with his prosecution of it. It was removed at the joint, and the head of the metacarpal bone, which was quite healthy, was snapped off merely to preserve the symmetry of the hand.

In answer to a question from Dr. Heeney, Dr. Moore stated that the little finger of the other hand was slightly affected with the same disease. He had observed in such cases that some of the other fingers, and sometimes toes, were similarly altered in structure.

{Rough minute book: Dr. Gordon considered that it was a cartilaginous tumour and that exostosis was a misnomer.}

Case of Aggravated Hysteria.

Dr. C. D. PURDON read the following case—

A. B., aged 14, born in one of the Southern states of North America, of a nervous temperament, was attacked with intermittent neuralgia of the face, which continued for three weeks. After an interval of several days, gastric fever came on, and continued for six weeks. During the attack, the heart was feeble, and the pulsations amounted to 50 in the minute; and this slow state of the pulse continued for several weeks.

¹ [See page 786.]

² [Account omitted as it is identical to that given in the Post-script on page 793 which was taken from the Transactions.]

³ [*Dublin Quarterly Journal of Medical Science*, 1852, v13, p214. The case had been presented to the Belfast Medical Society on 1 September 1851 (see page 111 et seq).]

During the convalescence, she complained of a slight pain in the lumbar region, which lasted for a short time, and was at first attributed to exhaustion. This uneasy sensation remained for some days, and then became more severe at a certain period of the day, and after continuing some time, subsided—recurring again daily at the same hour. She complained now of intolerance of light. After ten days or so, on the subsiding of the lumbar pain, she was seized with a severe pain in the head, and great intolerance of sound; and now, each day, at the same hour, she was attacked with a very severe pain in the loins for about three-quarters of an hour; and on its subsiding, the head-ache came on, and lasted for an hour, when the paroxysm ceased. This attack came on day after day, increasing in violence and inducing great agony; and when at its height, she would throw herself about the bed in extreme pain, uttering frantic screams for four hours; on the attack subsiding, sleep would come on, and would last for a considerable time. As the disease progressed, delirium, and a state approaching to catalepsy, frequently came on, and lasted for some hours, also frontal neuralgia. The spine, at this time, became very tender, particularly at the lower lumbar vertebræ, the mammæ developed, and the uterus tender on pressure; and it appeared that the catamenia would soon appear, which, however, did not take place. The disease continued increasing in violence, the patient became more exhausted each day, and every remedy that could be thought of was used in vain, as well as moral control. She was now unable to use any exertion, and on account of the extreme agony she suffered in her back, she could not be raised, for when forced to sit up, an attack of hysteria was produced, and often followed by a cataleptic seizure.

It now occurred to me to try the effect of ice, which was used successfully by Sir H. Marsh in a case of hysteric vomiting; so, half-an-hour before the paroxysm came on, I applied it to the lumbar region, and kept up the application for four hours with the best result, as there was no attack that day. This treatment was followed for several days, during which time the threatened attacks became less and less, and after the withdrawal there was no recurrence of the paroxysm. Salt water was now poured over the back every day, and a wet bandage applied round the loins, with the best effect.

The intolerance of light and sound were greatly abated. After waiting for some weeks, she was raised in the bed, but the pain was so great that she became quite cataleptic for some time; after using strong sedative linaments to the spine for some time, it was again attempted to raise her, at the same time supporting the back, and still there was no improvement. I then made a gutta percha cast of the back, and padded it with cotton wadding, and applied it to the

back as she lay on the bed, and then raised her up a little without much inconvenience or suffering. Each day she was raised more and more, till she was able to sit upright. The catamenia now appeared very scantily, with a still further improval of the symptoms; and, although now and then she had frequent attacks of hysteria, in different forms, she still improved, and was soon able to be wheeled out in a Bath chair. After using the gutta percha cast for six months, she was able to take it off, and in a short time she could sit up in a chair without any other support than the back of it; and, after persevering for more than two years, I had the pleasure of seeing my efforts crowned with success, and the sufferer restored to health.

{Rough minute book: Dr. Purdon said that the ovary was the starting point.

Dr. Heeney asked was the globus hystericus present.

Professor Gordon thought we should take a broader view of the case and look upon the affection as part of a marked change in the system.

Dr. Pirrie knows that the case is hysteria of the mucous membranes of the intestinal case having been admitted as paralysis, then having a tumour of the frontal brain.}

Council Council Meeting November 23rd 1859.

Present, the President, Surgeon Browne, Drs. Dill, Heeney, & Wales.

For election William Greenfield M.D. (QUI).

Surgeon Browne will exhibit a melanotic tumour which had occupied the orbit, and will give details of the case and operation.

Dr. Heeney will read notes of a protracted case of prurigo resisting ordinary treatment.

FIFTH MEETING.

November 26th, 1859.

The President in the Chair.

{Rough minute book: Dr. Wales, Mr. Browne, Dr. Ferguson, Mulholland, Halliday, Patterson, Murney, Dunlop, H. Thompson (Ballylesson), Rea, M'Gee, Connor, Bryce, Johnston.

Dr. Greenfield of Holywood was elected.}

The PRESIDENT exhibited uterus and uterine appendages removed from a patient who had died in the Union Hospital. A large cyst existed, supposed to be connected with the round ligament of the uterus.

The specimen was referred to Dr. Murney for examination and report.

Surgeon BROWNE introduced a patient from whom he had removed three toes for serpiginous ulcer.

Dr. HEENEY introduced a young man, a millworker, in whom the left lung presented the physical signs of phthisis and extensive pleuritic effusion. He believed that succussion could be produced in the patient.

The patient was examined by several members, and a discussion ensued, in which there was evidenced difference of opinion with regard to the existence of the phenomenon in question.

{Rough minute book: Dr. Murney said that he would bring the association before the Society at next meeting.

Dr. Ferguson said that it might be water and flatus in the stomach. He thought that there was phthisis with effusion.

Dr. M'Gee said that there is no pneumothorax.}

Case of Melanosis of the Eye.

Surgeon BROWNE, R.N., read the following:—In *The Dublin Quarterly Journal of Medical Science*, for 1857, will be found a paper which I published on melanosis attacking the eye, and which was read before the Belfast Medical Society.¹ In that paper, I stated, in reference to the disease under consideration, that there cannot be a question that melanosis is closely allied, in some respects, to tubercular and cancerous deposits or growths, bearing some resemblance to both; like tubercle, it has not any true organization within itself, while the cancerous growths have; but, like all of these affections, the deposit of which it consists, once commenced, goes on to invade and destroy the organization with which it is in contact, finally leaving an inorganic or foreign mass in place of the vital structure which it caused to disappear. The origin and cause of melanosis we do not know; there is no appreciable sign by which such a development can be prognosticated, nor do we really know what is the first step in a disease which always leads to a fatal deterioration of the frame; hence, in this, as in all the so-called malignant affections, we cannot adopt any means to prevent their origin and consequent growth. Whether the system be in the first instance affected in all or in any of these malignant diseases, is very uncertain; but it must be admitted that a very short time elapses until it participates in the morbid action; and then the disease, no matter under what name, is no longer a local malady and removable. The question then arises, is there any time in the existence of these malignant affections that they can be said to be certainly removable? My belief is, that many of them may be so removed, when in the very early or the *inactive* stage, and are situated in parts that admit of operation. I believe that some of these growths may be removed with certainty before the taint has been reabsorbed into the system, and hence we have permanent recoveries after the excision of undoubted

cancerous or analogous growths. Now, I consider that melanosis of the eye illustrates this position. Very early removal of the eye has frequently preserved the system from contamination, and consequently has saved life, while late extirpation has always been followed by an outbreak of the disease in several other localities. Hence, I feel satisfied that whenever we find an eye deprived of sight, and presenting the signs of melanosis, we should extirpate at once; and the same remarks apply to cancerous and medullary disease of the eye. Melanosis usually begins within the eye, seemingly in the choroid; it is said also to attack the conjunctiva. I have never seen the disease, in the first instance, in that tissue; but wherever situated it soon invades the surrounding structures. Like the other forms of malignant disease, it is often associated with another form of destructive growth; and the case I am now to submit to the Society illustrates this fact, as will be seen presently.

On the last day of meeting, I introduced to your notice a respectable female whose eye I had recently extirpated in consequence of the organ being affected with melanosis; and the members had an opportunity of observing that the person seemed to be in robust health, as she stated herself to be. Her history may be briefly related. She is 66 years of age, is unmarried, had enjoyed good health till within the last two years. About fifteen years since, after exposure to cold and wet, she had severe inflammation of the right eye, which resulted in destruction of sight, but without deformity of the organ. Some time after, a small black speck become visible on the upper and outer side of the sclerotica: this gradually spread until the entire globe became involved in the disease. She never suffered any pain in the part until two years since. When I first saw her in July last, the globe was greatly enlarged and protruding—the camera was clear in its surface, but surrounded with a nodulated black mass, and behind it there was the same dark-coloured appearance. The eye was also quite immovable; while on its outer side, within the margin of the orbit, and in the situation of the lachrymal gland, there was a small hard mass, which could be slightly moved.

I advised immediate extirpation of the diseased structure, as the only chance for prolonging life. At this time, I should remark, the patient's health was very much impaired; she seemed weak and emaciated, she had lost her appetite, and her nights were nearly all sleepless, and she suffered constant severe pain; her colour was very dusky, and characteristic of a person labouring under malignant disease.

The first week in August I extirpated the eye—the patient being under the influence of chloroform,—the hæmorrhage was not very great, and was easily suppressed; the entire contents of the orbit were removed, with the exception of some perfectly healthy adipose structure. The optic nerve was divided close

¹ [See page 184.]

to the optic foramen. With the exception of some slight sickness at stomach,—the effect of the chloroform,—the patient recovered without an unpleasant symptom, and she returned home at the end of three weeks, greatly improved in health and in capital spirits, so that she could at last sleep, and eat, and drink, and enjoy life as formerly. More than three months have now elapsed since the operation, during which time the patient has not had a single uneasy sensation, and her health continues to be excellent; but time alone can shew whether the disease has been not only locally removed, but also completely banished. Of course the chances are rather against her, and in favour of a return of the disease, as there cannot be a question but that the taint of the disease was in the system before its local extirpation. An earlier operation would have given her a much better chance of complete immunity. This has been fully exemplified by the case to which I referred at the opening of this paper. That young lady now enjoys most perfect health, though more than two years have elapsed since I removed her eye. In her case, moreover, the system was still free from any apparent taint at the time of the operation. At all events, in the case immediately before us, the complete extirpation of the eye was the only chance to prolong the poor patient's existence.

The diseased mass removed is now before the Society, and presents the usual appearance exhibited by melanosis of the eye of some standing—namely, a complete destruction of the normal parts, and the substitution of this peculiar deposit. In its present state, after being in spirits for three months, it looks like a mass of fresh consolidated peat; the sclerótica and cornea alone remain, the former surrounded by the melanotic matter externally, and its inside completely filled with the same. When the parts were freshly removed, nothing of the original tissues, save those I have named, remained; the deposit seems to have filled up the inside of the globe of the eye, and then to have burst through the sclerótica on the upper and outer side, a line or two from the margin of the cornea. The growth seems to have been circumscribed or restrained, in a measure, by the suspensory ligament of the eye—the fibrous membrane, which Mr. O'Ferrall has described as the *tunica vaginalis oculi*—and which surrounded the growth like a capsule. This may be still observed, giving a smoothness to the surface of the growth. On the outer side of the removed mass, the hard substance to which I have already alluded was found loosely attached. This was not the lachrymal gland, but a scirrhous deposit, and which, under the microscope, exhibited the usually-observed cancer cells, thus illustrating what has often been remarked by pathologists, the coexistence of what has been considered distinct varieties of the carcinomata.

On examining the cut optic nerve, its structure was found to be quite healthy, and it had been divided beyond or outside of the capsule-like tissue, which surrounded and enclosed the melanotic mass.

I have already referred to the adipose condition of the orbit; this was perfectly healthy, and unaltered. The lachrymal gland, which was removed, was free from any change, though it was somewhat flattened by the pressure to which it had been subjected by the diseased growth.

Council Council Meeting November 30th.
Present, Drs. Browne, Read, Halliday, and Wales.
The circular prepared.

SIXTH MEETING.
December 3rd, 1859.
The President in the Chair.

{Rough minute book: Dr. M'Gee, Mulholland, Stewart, Patterson, Ferguson, Gordon, Warwick, M'Minn, Dill, Wales.}

Notes on Scarlatina.

Dr. M'GEE read the following:—

Scarlatina, from its prevalence and severity of late, having become of more than usual interest to us all, to bring the question fully before the Society, I have availed myself of its occurrence in a family which I attend, and where it was ushered in, accompanied, and followed by an epidemic, if not a contagious, visitation of a throat affection, closely resembling cynanche tonsillaris, attacking nearly all those of the family who had in former years had scarlatina.

The family in question, residing in a large, airy mansion, in a rural district, where scarlatina of a malignant type had appeared about three weeks before, consisted of fourteen, exclusive of servants, viz., the parents, governess, and eleven children. The five youngest children alone had never had scarlatina. Of the six elder children, five of whom had, in former years, passed through the disease, the youngest, a boy, Master F_, now aged 12, had had the disease (if at all) in so mild a form that a subsequent attack was prognosed.

This boy was attacked on the 14th Nov. by sore throat and difficulty of swallowing, accompanied by high fever, hot but moist skin; tongue thickly loaded with brown fur; no fiery edges on tip; no prominent papillæ. Both tonsils, the uvula and soft palate, were swollen and of a dusky red, and the lining membrane of the posterior nares seemed to partake of the inflammatory action. Notwithstanding the local application of nitrate of silver, and the use of antiphlogistic treatment, the left tonsil and left side of the soft

palate suppurated and burst on the fifth day, when the fever subsided, leaving a cool, but harsh, dry skin. The uvula now became rigid and more swollen, as if infiltrated, and its point covered by a diphtheritic patch, stood prominently forward. On the tenth day his pulse had fallen to 68, and his pupils, usually large, were still more dilated. He had no rash nor desquamation, and his tongue, on becoming clean, shewed no trace of scarlatina. On the 12th day he was convalescent, and recovered without further unpleasant symptoms.

On the 19th Nov., five days from Master F_ being attacked, one of the younger children sickened—the tongue and throat indicating scarlatina, and a well-marked rash appeared on the third day. Between the 19th and 22nd, the remaining four of the younger children were attacked by scarlatina. Of the five cases, three might be termed scarlatina simplex, and two scarlatina anginosa. In all, the characteristic strawberry tongue was present. The tongue covered over its roots and centre by a thick, brown fur. On this coating becoming detached (about the fourth or fifth day), had the raw-beef appearance, with a glazed centre, as if seared by a hot iron. All, during the progress of the disease, had the uvula swollen, rigid, and protruded, or pointed forward, as in the case of Master F_, and in two there were a few small patches of diphtheria on the tonsils. They were all convalescent on the tenth day. During convalescence, three shewed some slight puffiness of the face. In two, the desquamation was furfuraceous, and in three flaky.

I need not at present occupy the time of the Society with a detail of the local and general treatment. I may state, however, that so long as there was morbidly pungent heat, I used frequent tepid sponging, and gave nauseating doses of ant. tart., without any evidence of sinking. To the tonsils, uvula, and soft palate, nitrate of silver, in both its solid and fluid state, was applied freely during the first three days of the attack.

During the progress of the younger children toward convalescence, three of the elder children, with the governess, and Mrs. F_, were attacked by sore throat, with much pyrexia and constitutional disturbances; pulse very quick; skin hot, but moist: tongue furred deeply; dark brown at the root and centre; loss of appetite; little thirst. In every one of these cases diphtheritic patches were observable on the tonsils and uvula—very trifling, indeed, in three of the cases, and well marked in two. Mild purgatives when required, stimulants to the throat externally, and nitrate of silver internally, were the remedial measures adopted in four of these last cases, and I tried a capsicum gargle, but it did not answer. I am happy to be able to say that the four here referred to are convalescent, the tongue having presented nothing of the raw, seared look present in the cases of scarlatina.

I have now to describe the remaining case, that of Miss F_, aged 21. She was seized with symptoms closely resembling those of Master F_, my first patient, but in a more intensified form, with some pain on pressing over the thyroid cartilage and sides of the trachea; no hoarseness, and little pain in speaking; deglutition difficult, and very painful; the left tonsil and left side of the soft palate more especially affected. The uvula on the second day became rigid, and as if infiltrated. Treatment similar to that adopted in Master F_'s case was used, with the inhalation of the vapour of hot water and vinegar, with external stimulants. On the sixth day, the left tonsil had suppurated and burst; but, although the fever abated, and the pulse fell to 86, she had little relief from pain. Swallowing still difficult and painful; both tonsils tumid; uvula yet more rigid, and turned upward and forward, shewing its posterior surface, with its rounded tip, as if adherent to the soft palate anteriorly. The uvula, both tonsils, the arches of the soft palate, were covered by a diphtheritic exudation, of which some patches were observable on the pharynx. As is observable in some cases of cynanche tonsillarum, there was difficulty and pain felt in opening the mouth. The parts affected were mopped over with a solution of chloride of calcium, of a strength varying from two to four parts of water to one of the ordinary solution. This I have found to be a valuable application in foul or sloughing throat, or mouth affections; but it requires to be applied by means of a mop made of linen, as it almost immediately destroys sponge. Under this treatment Miss F_ is convalescing, though slowly. The diphtheritic exudation is gradually clearing off, and no fresh patches have shewn themselves, excepting some very trifling ones on the gums over the front teeth in both upper and lower jaws.¹ As I do not remember to have seen any case recorded in which the peculiar affection of the uvula is described, I request my medical brethren will give me the result of their experience thereon.

Some questions of interest present themselves in regard to these two sets of cases. Were the cases of scarlatina and those of throat affection the same disease? Where should we seek, if we search at all, for the source? Is it probable that the poison was conveyed to his home by the father, nine days before the outbreak in his own family, having been in contact with a mild case of scarlatina at a distance of eighty or ninety miles from home? Should we refer the source of the contagion to the immediate neighbourhood where scarlatina was rife, or to some atmospheric

¹ Dec. 31.—Miss F_ has had a return of the inflammation and swelling in the left soft palate, which rapidly spread across to the right side. Tongue deeply furred, of a dark brown colour; much difficulty of swallowing. The swelling and pain continued unrelieved, until recourse was had to free scarification of the soft palate, when she convalesced rapidly, and is now quite well—Note by Dr. M'Gee.

condition? I should not omit to state, that the servants escaped an attack, though not more favourably situated, and though two of them were in close and constant communication with the sick.

In reply to Professor Gordon, Dr. M'GEE referred to the difference in the appearance of the tongue in the two sets of cases. In all the scarlatina cases the strawberry tongue was present, succeeded by a clean, seared or glazed centre, varying in intensity in the patients. In the other cases, the tongue was covered by a thick coating of brown fur. As to the exudation being aphtha, Dr. M'G. observed that neither had the patches the appearance of aphtha, nor were his patients of the class or of the bodily condition in which such a disease could be expected to occur. As to the manner in which the poison of contagious disease had been conveyed, though he had but submitted the question for the consideration of the meeting, he detailed some curious instances.

To Dr. Ferguson, he replied that he viewed the rigid condition of the uvula as analogous to œdema, as it affects the epiglottis. He could not agree with Professor F. in classing all the cases under the head of scarlatina, even while admitting that scarlatina may appear, as he had seen it, twice in the same subject, and that the primary attack modifies or diminishes the severity of a second attack. He observed that, while the scarlatina rash is sometimes absent, yet it is usually in the very severe or malignant cases that the rash is absent. Now, in the two sets of cases there was a marked distinction:—in the tongue, as already described; in the skin, which was hot, but moist; in the throat affections, hot and dry, with a sense of itching in the scarlatina; and there was consequent desquamation in the latter cases, none in the former.

Surgeon JOHNSTON, who had entered the room after the reading of Dr. M'Gee's paper, detailed some complications attendant on cases of scarlatina in his practice, and he referred especially to diphtheritic exudation, and a very interesting discussion arose as to sthenic and asthenic cases, and as to the particular tissues affected in scarlatina.

Malignant Disease of Antrum.

Dr. MOORE introduced a patient, a man aged 57, with disease of antrum. About nine months ago he perceived a swelling in the cheek, and afterwards experienced pain in his gum, with loosening of a tooth. He consulted Surgeon Thomson, of Ballylesson, who diagnosed disease of the antrum, and advised him to come to Hospital for operation; but for weeks after this advice he did not present himself. On admission, it was found that the roof of the mouth had lost its resistance; there was swelling of the alveolar process, with slight discharge therefrom, and prominence of the upper maxilla. In this condition he was shown to the Society, but on Dr. Moore explaining to him the

nature of his case, and the operation which would be required, namely, to remove the whole of the superior maxilla, with the floor of the orbit, and the great risk of hemorrhage, he would not consent to the operation; nor did Dr. Moore, considering his time of life, urge or wish him to undergo it, but if the patient himself would urge it he would have no objection to undertake the task.¹

Council Council Meeting December 7th.

Present, Drs. Moore & Wales.

The circular prepared.

SEVENTH MEETING.

December 10th, 1859.

Dr. Murney, V.P., in the chair.

Removal of Tumour.

The SECRETARY exhibited a portion of a tumour forwarded by Dr. BABINGTON, V.P., Londonderry, and read the following communication from that gentleman:—

“I have forwarded for exhibition at meeting of Pathological Society, half of a tumour which I removed this morning at the Infirmary here. The patient was a healthy man, aged 42. The tumour was situated on the right scapula. Had been removed twice before; first time in this infirmary, eight years since; second time, five years since, by a practitioner in his own neighbourhood. The tumour again began to grow about a year since, and has attained its present size. On removal it weighed 1¼ lb. It had no deep attachments; was contained in a capsule; and was nourished by ten arteries. You will observe a patch of ulceration on the portion sent, from which he had frequent attacks of hæmorrhage.”

Case of Hare-Lip.

Surgeon BROWNE said—The little patient which I have the pleasure of exhibiting to the Pathological Society, is one I operated on for simple hare-lip on the 15th of October last, and in whose case I used a new sort of suture. Before I enter upon any description of the operation, I beg to call the attention of the Society to the splint and metallic suture I now hold in my hand. This is the splint that has been lately introduced to the notice of the profession of this country by Dr. Battey of America, and used by him for the cure of vesico-vaginal fistulas; and who, when here, in the month of October, kindly explained to me his operation for the lesion in question. I have not had any opportunity of using his splint and metallic sutures in a case of vesico-vaginal fistula, but at the time of his describing his method of approximating the fistulous

¹ Since then the disease has increased rapidly, the patient having left the Hospital.

edges, it struck me that the appliance could be adapted to a case of harelip. A very short time before this, I had operated upon a fine little fellow, three years old, the son of a gentleman in town, for hare-lip, using the ordinary needles and twisted sutures. The operation was quite successful; but I had so much difficulty in removing the needles, at the end of three days, and as one of them, which I had to leave in for another day, caused deep ulceration of the part, I determined to adopt a different method the first opportunity; and having seen Dr. Battey's splint and sutures, I fixed upon his appliance.

The child before the Society presented soon after. It was then six weeks old, a remarkably fine infant, but with a single hare-lip, the upper part of the fissure exhibiting the shape of the letter V, in consequence of a central part which stood out beneath the septum of the nose. Having the splint prepared, with three sutures attached, I brought the child under the influence of chloroform, rapidly pared the edges of the fissure, and then, with a long three-edged glover's needle, I carried the metallic sutures completely through the right and left sides of the lip, embracing both skin and mucous membrane, about the 16th of an inch from the raw edge. I then drew the sutures home to the splint, saw that the wounds were in close apposition, and fastened each point by taking a turn or two of the wire around and beneath the little shot in which the opposite end was made fast. At the end of three days I removed the splint and sutures very easily by dividing the latter as they lay across the former, then by gently raising the splint upon its edge, the sutures were drawn out without causing any disturbance or pain.

The part I found to have united, save at the top—the site of the V-shaped portion—where the splint had got in beneath its point. However, I applied three slips of court plaster, and did not disturb the parts for two more days. On the fifth day after the operation, and while endeavouring to fix the little V part in its place, the child screamed and struggled violently, and the consequence was, the newly united parts were torn asunder. Though not very well pleased, I was not much disconcerted by the *contre-temps*. I prepared a new splint, pared the edges afresh, and once more brought the parts into apposition. The sutures, as before, were removed at the end of three days, and, after carefully dressing the lip for some ten days, with ordinary adhesive plaster, complete and firm union was established.

So far as I can judge, this splint and these sutures will be found very useful in the surgical treatment of hare-lip. They bring the parts into, and retain them in, close apposition; they cannot strangulate any part of the lip; they are very easily removed; and they cause exceedingly little irritation, and might be left in for many days without causing ulceration.

The splint is a thin piece of lead, half an inch in breadth, and as long as may be required. It is perforated by small holes, at intervals of a third of an inch; these are in two rows, a fourth of an inch apart, and a small slit is carried from each hole of *one* row through the edge of the splint. The sutures are No. 32 wire, iron or silver, and each is passed through a small perforated shot, these shots forming the points of attachment for both portions of the suture. The only thing to be observed in the application of this apparatus is the accurate passing of each suture through the entire thickness of the lip, and that they are introduced at an exact distance from the cut margin.

Council Council Meeting December 14th.

Present, Professor Reid, Dr. Heeney, Dr. Halliday, Dr. Wales.

Circular prepared.

A/c of 19/- for postage and stationary ordered to be paid.

EIGHTH MEETING.

December 17th, 1859.

The President in the Chair.

{Rough minute book: Present, Drs. Halliday, Johnston, Stewart, Ferguson, Warwick, Johnston, Thomson, [John?] Moore, Gordon, Patterson, Rea, Heeney, Wales, Connor, Browne, Mulholland, Bryce, Dill, Murney, Moore, M'Cormac.}

Inversion of the Bladder.

Surgeon JOHNSTON read the following—

On the evening of Sunday, August 8th, I was requested to visit Mrs. M_, aged 20 years, and was informed that she was threatened with a miscarriage. On visiting her I found my patient apparently suffering very intensely from "pains," attended with such tenesmic efforts, as to induce her to remain almost constantly on the night-chair. I was told that there had been considerable hæmorrhage with discharge of "waters" the previous day. She had been nine months married, and calculated that she was rather more than four months pregnant. For weeks past she had suffered from irritability of the bladder, but enjoyed very fair health until Friday, the 6th, when, after over-exerting herself in lifting a box, she felt great uneasiness in her back, attended with frequent and urgent desire to pass water. These symptoms became more urgent on Saturday, and were accompanied with severe attacks of vomiting. She was unable to retain the contents of the bladder; the tenesmus was most distressing; and she had no relief except when on the night-chair. It was thus I found her on my first visit; and after considerable persuasion I succeeded in get-

ting her to retire to bed. On my attempting to make a vaginal examination, she became very impatient, and complained very much of the intense pain I gave her, far exceeding that commonly given in a vaginal examination. This did not escape my notice. On examining I found a soft fluctuating tumour, in size about that of a pear, pyriform in shape, extending as far down as the os externum of the vagina, and feeling very like a bag of membranes. My finger passed from the base of the tumour along its narrow neck-like portion, into a small narrow cavity, which I considered was the dilated os uteri, being also under the impression that the narrow neck-like portion of the tumour was the cord attached to the ovum. I followed up this cord into a cavity, which I presumed to be that of the uterus. My patient now insisted on being allowed again to remain on the night-chair, and complained of her inability to bear any further examination. Being under the impression that the uterus would expel its contents, and there being no hæmorrhage, I gave some general directions and returned home.

I visited her on Monday morning, and found her in the same state of suffering; and having slept none during the night, her pulse was now excited, and the attacks of vomiting frequent. She was unwilling that I should make any examination. I therefore administered an anodyne, and returned in the evening with my friend Dr. Bryce, to whom I communicated my impression that my patient was going to miscarry. He examined the tumour; but in making his examination, discovered that he could pass his finger up behind it, into the vaginal canal, where he felt the “os uteri” still undilated. He felt puzzled to explain matters, and at first suggested the idea that there was a malformation. On further consideration he concluded that the tumour was a vaginal vesicocele—a prolapsed bladder—and not a bag of membranes.

Dr. Bryce’s discovery of the vaginal canal, and of the os uteri still undilated, was certainly new light to me. I again made an examination of the tumour; in doing so, I found that it yielded to gentle pressure, continuing which, it retired upwards, through the cavity which I had supposed to be the os, into the cavity which I had supposed to be the uterus, but from which flowed a small quantity of urine. The true nature of the case was for the first time manifest, viz., that it was one of inversion of the bladder, that the os through which I passed the tumour was the “meatus urinarius,” dilated to such a capacity as to admit two of my fingers. I suggested this explanation to Dr. Bryce, and, in order to satisfy ourselves on this point, we made an ocular inspection of the state of the meatus urinarius, which confirmed the diagnosis. Immediate and decided relief followed the reposition of the inverted bladder; the vomiting ceased; the pulse fell; our patient’s expression changed; the pain in the back ceased; the urgent symptoms of irritation of the

bladder were almost quite relieved; and she soon fell asleep. We visited her some time afterwards, and found that there had been no return of the inversion. I drew off a quantity of bloody urine with the catheter. We enjoined her to employ no voluntary efforts in micturating, for a time; administered an anodyne; and ordered an oil draught the following morning.

The next day I found her comparatively easy. During the next month, however, she suffered from incontinence of urine, even when sleeping; and complained very much of a scalding sensation in the urethra. The urine was bloody, and there was a considerable deposit of mucus. These symptoms were treated, and gradually disappeared. I saw her last on the 3rd of December. She was then quite free from any vesical uneasiness; was able to retain her urine as usual; felt in perfect health; and was soon expecting her confinement.

Believing that medical science may be advanced by a publication of our mistakes, as well as of our successes, in practice, I have given a fair and candid account of this peculiar, and I believe I may add uncommon, case.

Prior to my meeting with it, I had never heard of such an accident. I was, therefore, quite unprepared for it, and did not recognise it. It is well that it should be recorded, in order that it may enable others to exercise caution in dealing with tumours of an obscure character, and attended with perplexing and anomalous symptoms. We should ever be prepared to meet with cases presenting symptoms and features for which we may have no precedent. It may appear strange that I was so slow in recognising the true nature of the case, and that in the first instance I made a very decided, and what might have been a very serious, error in diagnosis (as owing to the view I first took of this case I contemplated puncturing the membranes). I had been led to believe that Mrs. M_ was about to miscarry. My mind was preoccupied with that idea; and after I examined, I felt so satisfied that the tumour was the ovum entering and protruding from the os, that I did not see any necessity to push my external examination, and my patient was certainly very unwilling that I should do so. To Dr. Bryce belongs the credit of throwing that light on the case which led to the recognition of its true nature. I have been unable to discern any similar case on record, viz.—inversion of the bladder occurring during pregnancy.

Dr. Meig, in his work on “Diseases of Women,” details the history of a case of inversion of the bladder at the orifice of the urethra, in the person of a little girl three years of age. In her case, it was mistaken for a vascular tumour, and was about being ligatured, when its true nature was fortunately discovered. Dr. Murphy had a similar case in Dublin, an account of which I have been unable to find. Jones and Sieveking,

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in their "Pathological Anatomy," mention the possibility of introversion of the bladder, and even, in females, of its projecting from the meatus urinarius externally. We find, therefore, that inversion of the bladder is an accident with which we should be prepared to meet in females—that we may meet it in children, or in pregnant females. In the former we should be careful to distinguish it from a vascular tumour, and avoid ligaturing it; in the latter from a bag of membranes, and avoid puncturing it, as in either case fatal results would be almost certain to follow. I would only suggest whether we might not mistake inversion of bladder for polypus?

{Rough minute book: Dr. Patterson saw with Dr. Simpson a case of prolapsus of the bladder.

Dr. Bryce said that he corroborated Mr. Johnston's remarks.

Dr. Gordon said that there must be malformation of the urethra and some deficiency of the neck of the bladder.}

Surgeon JOHNSTON also introduced a patient, the subject of extraordinary contraction of the thoracic parietes, the result of empyema.

Council Council Meeting January 4th 1860.
Present, President, Drs. Browne & Wales.
Circular prepared.

NINTH MEETING.

January 7th, 1860.

The President in the Chair.

Dr. HEENEY introduced a patient over the greater part of whose chest a loud blowing sound could be heard, the cause of which was the subject of considerable difference of opinion among the members present.

Pericarditis and Hypertrophy of Heart.

Dr. PIRRIE exhibited a greatly-enlarged heart, weighing 34½ oz. There were vegetations on the mitral and aortic valves. The pericardium was covered with highly-organized lymph. The patient had had an attack of rheumatism two years since, which had left him subject to palpitation, in consequence of the increasing hypertrophy. A recent attack of rheumatism caused his admission to Hospital, during the progress of which pericarditis had supervened.

Council Council Meeting January 11th 1860.
Present, the President, Drs. Dill, Murney, & Wales.
Circular prepared.

TENTH MEETING.

January 14th, 1860.

The President in the Chair.

{Rough minute book: Murney, Dr. Dill, Browne, Dunlop, Warwick, Heeney, Patterson, M'Cleery, Mulholland, M'Minn, Wales, Johnston, Stewart, Connor, Cuming.

Dr. Heeney introduced the question of the existence of gonorrhœal rheumatism, expressing his belief that there was no pathological connexion between gonorrhœa and rheumatism, and stating that he had not in an experience of several hundred cases of gonorrhœa met with rheumatism on more than two or three occasions.

Dr. Brown concurred with Dr. Heeney believing rheumatic attacks occurring during gonorrhœa to be merely coincidences.

Surgeons Warwick and Johnston differed with Dr. Heeney stating that they had both observed cases of gonorrhœa in which rheumatism had occurred in successive attacks of gonorrhœa in the same person.}

Some Cases of Excision of the Eye.

Mr. BROWNE read the following:—

In the Transactions of the Pathological Society for last session will be found the record of a case in which I excised the globe of the eye,¹ to relieve the patient from the constant pain which he suffered, and to save the other eye from the destructive effects of irritative or sympathetic inflammation with which it was threatened, and which is a most intractable form of disease, and very frequently destructive of vision.

I have now to bring before the Society two other cases in which I excised an eye, and for similar reasons, and under similar circumstances, to the one already related.

The first is that of A. M'G., aged 54 years, from Islandmagee. About eleven years ago, a chip of metal was driven forcibly into his right eye; the immediate consequence was intense inflammation of the organ, with great swelling; when this subsided, he was without any vision in the eye. From that time, he suffered at intervals excruciating pain in the part, and which, during the time, incapacitated him for any work; latterly, the left eye began to be affected with cloudiness of vision, and he was advised to have the injured eye removed.

In August last I excised the globe; he recovered without a single backset, and returned home at the end of a fortnight. Since then he has been quite free from his former severe suffering; he is in perfect health, and the left eye has quite recovered its impaired vision.

¹ [See page 785.]

As in the former case, a minute particle of metal was found imbedded in the choroid, near the bottom of the eye; and the lens, vitreous humours, and retina, had completely disappeared.

The second case is that of B. M'G., aged 46 years, of Belfast. Some seven years since, this man was struck upon the eye by a chip of metal, which stuck in the margin of the right cornea, but did not penetrate. Severe inflammation followed—this I was enabled to subdue by active treatment. For some time the sight did not seem to have suffered; but, at the end of several months, vision began gradually to be lost, without any severe pain. About that time, he received another blow in the eye from a chip of metal—this rekindled active inflammation, and vision became permanently extinguished. I was not certain whether this latter chip of metal had penetrated the chambers of the eye; but as he suffered very severe paroxysms of neuralgic pain in the globe and eyebrow occasionally, it was considered probable that a foreign body lay in the interior of the organ. About a year ago, the left eye became sympathetically affected, vision becoming cloudy and indistinct; this, with the frequent attacks of pain in the right eye, prevented him from following his trade, that of a “fitter,” and he finally consented to have the injured organ excised. This operation I performed early in September last, and with very good results, as the patient has been free from pain ever since, and the clouded state of vision in left eye is gradually clearing off.

I carefully examined the excised eye, but could not find any foreign body, properly so called; but the structure of the part was entirely changed. The choroid was thickened and strongly adherent to the sclerotic, while it surrounded and was firmly attached to bone-like lamina of considerable density, which represented the hyaloid membrane. There was not any vestige of the retina left, and the lens was shrunk to the size of a mustard seed. This, the nucleus, apparently, of the lens, was attached loosely to the hollow bony plate which had replaced the anterior part of the hyaloid membrane. The iris and ciliary body were thickened—the former adherent to the cornea. The long ciliary nerves were seen penetrating the sclerotic and passing along the surface of the choroid to their destination. On separating the choroid from around the optic nerve, the mouth of the central artery of the retina was visible, and the remains of its direct branch which runs in the vitreous humour to the back of the lens, could be seen entering a foramen in the posterior bony plate which represented the hyaloid membrane.

This conversion of some of the inner structures of the eye into bony or calcareous matter I have frequently seen. I had a beautiful specimen of a crystalline lens I extracted, which had been converted into a solid, polished bony ring, the centre consisting of a

very fine cribriform plate. But I have never before seen the vitreous humour, or rather the hyaloid membrane, thus changed into bone-like structure. The cases I have now submitted to the Society beautifully illustrate the several results which may follow inflammation in the same organ in separate individuals. In one, scarcely a vestige of normal structure remains; in another, a part of these structures are converted into a new organization; and in a third, an inorganic material has not only replaced the original structure, but has invaded the surrounding parts also; and beyond that, even the system has become contaminated from this source.

With respect to the operations of extirpation and excision of the eye, I need scarcely trouble the Society with any remarks, beyond stating that the one is very simple as compared with the other, as may be imagined, as in the one case the entire contents of the orbit are, or should be, cut out, while in the other, the globe is merely removed.

Council Council Meeting January 18th 1860.

Present, the President, Drs. Halliday, Johnston, Dill, Browne, & Wales.

Circular prepared.

ELEVENTH MEETING.

January 21st, 1860.

The President in the Chair.

{Rough minute book: Drs. Dill, Mulholland, Halliday, Bryce, Patterson, M'Minn, M'Gee, Heeney, Cuming, T. Reade, Warwick, Rea, Johnston, Wales, Moore, Murney.}

Retained Placenta.

Dr. HALLIDAY read the following case:—

On Saturday, the 16th inst., I was called upon, at 12 o'clock, noon, to visit Mrs. S., aged 38, a dispensary patient, who, I was informed, had been delivered prematurely of her twelfth child, at 6 A.M.; and the placenta not having been thrown off, the parties became uneasy. I found her in bed, free from pain, but evidently under the influence of drink; there was little or no loss. On making an examination, and exerting gentle traction on the cord, it broke off; the midwife having previously tried to remove it by pulling. I was barely permitted to pass my finger inside the vagina, up to the os uteri, which was considerably closed, but through which I could feel the edge of the placenta. Upon endeavouring to pass my hand a little further, so as to lay hold upon it (having previously firmly pressed over the fundus), she became exceedingly impatient, and would permit no farther interference. I endeavoured to reason with her, but all in vain. I then

prescribed ergot, and left. On calling again I found she had not taken the medicine, but said she would not mind anything, as she was well enough, and would be all right. For two or three days she remained free from pains, and had little or no discharge, when she got up and attended to her household duties. On the fifth day after delivery she began to have occasional loss, with pains, which increased up to Tuesday week, the eleventh day, when the mass was expelled, accompanied with violent hæmorrhage, occurring to such an extent as to endanger life. She recovered, however, although slowly; and months elapsed ere she regained her usual looks or health.

I should have stated, that during all the time there was little or no pain on pressure; the pulse was but slightly quickened; and the child, though it lived for a short time, could not be quite seven months.

{Rough minute book: Dr. M'Gee spoke with reference to the dispensary question. Dr. Halliday should have given in his patient to protect himself from possible consequences.

Dr. Dill thought that Dr. Halliday should have given chloroform and not have left the patient.

Dr. Murney exhibited morbid parts removed from a man who died in consequence of a fall down a staircase of a steam vessel.}

Penetration of Brain by a Nail.

Surgeon JOHNSTON read the following case:—

A lad aged 15 was, with other boys, amusing himself and them by firing off a pistol, to ram down the colfing of which they used an ordinary cut nail of about four inches in length, as a ramrod. The nail was slightly bent. Accidentally the pistol went off in the hands of one of them, while the nail acting as the ramrod had not been removed. In consequence of the discharge the nail passed through the hand of one of the lads, and entered the brow of the patient, above the internal angular process of the frontal bone, passing horizontally into the brain. He was seen by Surgeon Johnston and Dr. Bryce, who, on examination, found a hard body embedded underneath. The nail was then withdrawn by Mr. Johnston and the boy sent to Hospital.

Dr. MOORE stated, that when the boy was admitted to Hospital there was slight ptosis, with swelling of eyes. He ordered him to be put under a mercurial treatment combined with antimony. This course was pursued, due attention being paid to the state of his bowels, till ptyalism was produced, cold lotions being applied to the scalp, the hair having been shaved off. Under this treatment his pulse, which had risen to 120, gradually became slower. In a few days the exudation from the wound was of a clear amber-like colour, in considerable quantity, and which became gradually less as the wound cicatrized. Dr. Moore

remarked that he had seen many injuries of the brain from the wounds of which the same class of fluid exuded when the substance of the brain had been penetrated. Dr. Moore did not wish to bring him down from his ward, as his pulse rose on the slightest exertion or excitement, but hoped, on that day week, that he might be able to do so.

Dr. HALLIDAY introduced a boy the subject of very frequent micturition, each evacuation of the bladder being followed by a discharge of blood.

Council Council Meeting January 25th 1860.

Present, the President, Drs. Cuming, Halliday, Browne, & Wales.

Circular prepared.

TWELFTH MEETING.

January 28th, 1860.

The President in the Chair.

{Rough minute book: Present, Dr. M'Gee, Moore, Wales, Ferguson, Patterson, M'Cormac, Rea, O'Brien, Johnston, Moore, Cuming.}

Dr. WALES introduced a patient with an intractable eczema.

{Rough minute book: Dr. M'Gee uses chloride of lime alternating with stupes of bran water and using occasionally ... [?] applications [?].

Dr. Ferguson would treat him as antiphlogistically as if he had pneumonia.}

Injury of the Brain.

Dr. MOORE introduced the boy whose brain had been penetrated by a nail, and whose case had been described by Surgeon Johnston and himself at previous meeting. The lad was doing very well.

Tumour of Cranium.

Dr. MOORE introduced a patient with extensive atheromatous deposit, forming a continuous tumour of the forehead and side of the head, who had come to the Hospital expecting its removal by operation. From the nature of the tumour, and its extent, he did not think operative interference advisable, but merely introduced the patient as an example of an interesting affection.

Scirrhus of the Pylorus.

The PRESIDENT exhibited the liver, kidneys, heart, and stomach of a woman who had died in the Union Workhouse of scirrhus of the pylorus. He said—I exhibit to-day some morbid parts removed from the body of a married female aged 56, who died a few days ago in the Union hospital.

She complained on admission chiefly of cough, and some dyspnoea, and that she had suffered occasionally from vomiting. The chest symptoms were soon relieved by the ordinary treatment, when vomiting became a more prominent symptom, and led to an examination of the region of the stomach, where a knotty tumour was found rather to the left of the medial line of the epigastrium, and could be traced to be connected with a larger, but much smoother tumour in the right hypochondrium. There was, however, so distinct a sulcus to be felt between the two, that I considered there was evidence of scirrhus pylorus, as well as of enlarged liver. The vomiting was immediately checked by bismuth, lime water in milk, and a diet of bread and milk—a course of treatment which I have often found markedly beneficial in similar cases, only requiring small quantities to be administered at a time. The vomited matters had never been discoloured, or of “coffee-grounds” character, consisted chiefly of food, and an acid, glairy fluid.

The vomiting did not return for fourteen days, when it became for the first time of “coffee-grounds” character, and continued so until her death, accompanied by tarry evacuations from the bowels. These, no doubt, led to a fatal termination sooner than I anticipated, for she was neither so emaciated, nor had her abdomen the retracted appearance which almost invariably precedes death in such cases. This latter might, perhaps, be partly owing to the fact that she had never given birth to a child, and, consequently, the abdominal walls had not lost their natural tension, whilst the absence of extreme emaciation, was, no doubt, owing to the fact revealed by the post-mortem examination, that the pyloric orifice was patent enough to permit the digestive process to be generally completed. Like many childless women, she had a considerable beard upon the chin.

The post-mortem examination revealed a moderately dilated stomach, with a dark patch on the mucous membrane of the greater curvature, and a similar, but smaller, discolouration near the pyloric orifice; from these the blood had probably been effused, but there was no ulceration in either. The pyloric orifice was surrounded by a hard, but not very thick, ring of scirrhus matter, with nodulated parts on both the mucous and peritonæal surfaces. It admitted readily the passage of the little finger through it; and there was no ulceration. A firm adhesion existed between the pyloric end and the liver; and the sulcus observed during life was still quite evident.

The liver was greatly enlarged, and was studded with a large number of whitish-coloured tumours; some distinct, and having a well marked central depression, whilst in other parts they appeared to run into each other. Where some of these tumours were in contact with the peritoneum of the abdominal parieties, an elevated deposit had taken place on the

latter, but without any direct vascular continuity. Similar tumours also existed in the omentum, which was attached to the uterus by a firm adhesion.

A section of the liver found some of the tumours distinct, but the majority coalesced, and left little of the natural structure of the liver to be seen. A few of the tumours had a vascular ring about one-eighth of an inch from their circumference. Their density was not so great as the deposit at the pyloric orifice; but near the latter there was one that was so soft as to bear a great resemblance to broken down reddish cerebral matter.

The microscopic examination by Dr. CUMING confirmed the opinion that the deposit in the liver was that of encephaloid cancer. The spleen was free from disease.

Enlargement of Testicle.

Dr. MOORE introduced a patient who had been admitted to hospital with a chronic enlargement of testicle to the size of an ordinary clenched fist. He did not look upon it as a malignant disease, but as that class of enlargements of the testes which is remediable by the introduction into the bladder, twice or so weekly, of a full-sized metallic bougie. This course was persevered in for two or three months, and now the testis was reduced to almost its natural size, and the patient stated that its wonted action was renewed.

Fluid from Ranula.

Dr. MOORE exhibited a quantity of glairy amber-coloured fluid, about 3 ounces, which he had removed from the mouth of a middle-aged man in the hospital on the previous day. The patient presented himself with a tumour near the ramus of the jaw, as large as a turkey's egg, which fluctuated; but opening the mouth, the tongue was seen to be pressed aside by a well-formed ranula.

A portion of the tumour was lifted up by the forceps, and about an inch in length of the covering below the tongue was snipped away with scissors. The glairy fluid exhibited flowed out with slight pressure upon the tumour. The sac was then thoroughly emptied, and its lining membrane was swabbed with a strong solution of caustic. Dr. Moore found by the introduction of his finger that no concretion was present. The operation has been followed by complete recovery.

Council Council Meeting February [undated]

President in the chair, Present, Mr. Browne, Dr. Halliday, Dr. Wales, Dr. Dill, Dr. Cuming, Mr. Johnston.

The Treasurer was directed to issue circular relative to defaulting subscribers and form was approved of.

Circular was prepared.

Council Council Meeting February [undated]
Papers wanting Dr. Murney account of post-mortem
of uterine tumour, amputated limbs, fractured skull.

Dr. Heeney Prurigo
Dr. Moore's amputation
Dr. Murney's arm

THIRTEENTH MEETING.

February 4th, 1860.

The President in the Chair.

Case of Hysteria.

Surgeon JOHNSTON introduced a girl affected with what he supposed to be hysteria. She was in a debilitated state, and had menstruated scantily, though regularly. The most marked characters of the case were the frequent recurrence of incomplete *syncope*, without loss of consciousness, apparent *respiratory distress*, and a slight *cataleptic* tendency, as exhibited in the momentary preservation of any altered position of the extremities. Considering debility to be the chief cause of the malady, he had prescribed suitable sanatory measures, together with *chalybeate* and other *hæmatic* remedies, but so far without any apparent effect.

Concurrent opinions as to cause, nature, and treatment of this case were expressed.

Puerperal Observations.

Dr. W. AICKIN exhibited a *placental cord* 4 feet 3 inches long, which had encircled the child's neck five times. The case did not present any remarkable features; the only point worthy of note being the fact that *ergot* had failed to excite uterine action, while *opium* had succeeded. In the course of his remarks, Dr. A. condemned the side as a lying position in advanced labour, and recommended the back, which led to the following observations on the merits of different parturient postures.

Dr. PATTERSON—"The back is the best position during labour."

Surgeon JOHNSTON—"Nothing is gained by separating the knees during the expulsion of the child."

Dr. WALES—"The practice of abducting the knees during expulsion of the child endangers the perineum by advancing and tightening it anteriorly"

Dr. HALLIDAY, in reference to the cord encircling the neck: "It is elongated in proportion to its requirements in this respect."

The PRESIDENT—"Observed the *funis* so much shortened by entwining the neck as to retard labour."

Surgeon BROWNE—"No advantage generally in any particular position in labour, save convenience; uterine action being sufficient to effect expulsion of the child without other muscular aid, as evidenced under the administration of chloroform."

Dr. M'GEE—"Will not agree with Surgeon Browne in ignoring the powerful aid afforded by the respiratory and abdominal muscles."

Dr. DILL—"Most women seek fixed points for muscular action during the throes of labour. If this has a purpose, auxiliary muscular action has its advantages. The left side is the most convenient; and in the obese, separation of the knees during expulsion of the child diminishes resistance. The occasional success of opium in exciting the uterus to action is due entirely to its first or stimulating effects."

Exhibition of Recent Parts.

The PRESIDENT exhibited some morbid parts removed from the body of a female, aged 25, who died of phthisis.

A large amount of tubercular deposit existed in both lungs; and the disease appeared in a more advanced stage in the right than in the left, which had also been indicated by auscultation during life. The liver was very pale, greatly enlarged, and much thickened at its base; its surface was smooth, pitted, and broke down easily on pressure, and was deeply indented by the pressure of the ribs. When a slice of it was placed in the centre of a bright fire, it shrivelled up like a piece of leather, without emitting any sparks or flame; nor was any mark left on paper when a piece of it was laid on it on the heated bar of the grate. As it did not therefore furnish the indications usually relied on as indicative of a deposit of fat, a piece of it was boiled in a weak solution of nitric acid, when it became white—in so far tallying with Dr. Budd and Dr. Beale of what takes place with one test when the deposit is chiefly of an albuminous nature.

Dr. Cuming then examined a portion with the microscope, and found a considerable amount of oil globules; but as some oil might be present when the deposit was chiefly albuminous, Professor Hodges, M.D. kindly undertook to ascertain the percentage of fat, and found it to be nearly 9½, the healthy proportion being about 4, which has been found by Dr. Beale to be reduced to near one, or even so low as one-half per cent., when the enlargement of the liver was due to an albuminous deposit. This chemical analysis proving that the enlargement of the liver was owing to a deposit of fat and not of albumen, the fire and the paper tests were applied again at the end of ten days, when it was found that owing to the evaporation of fluid, and consequent drying of the liver, it now both stained paper and emitted sparks and flame in the fire, thus indicating that before a liver can be pronounced not to be enlarged by fat, care must be taken that it is sufficiently dried when applying the rough and ready tests that were relied on till the introduction of the microscope, &c.

Great dulness, on percussion, existed at the base of the chest, but the enlargement of the liver was so

evident on percussion and to touch, that no difficulty existed in accounting for the dulness. There was neither jaundice nor ascites, and not more œdema of the limbs than is usually present in phthisis. This patient denied that she had ever expectorated blood, nor was any observed during her two visits to hospital.

FOURTEENTH MEETING.

February 11th, 1860.

The President in the Chair.

Congenital Malformation of the Pupils.

Mr. BROWNE introduced a little girl, aged 10 years, in whom there exists a peculiar malformation of the iris in each eye. In the right, the pupil is transverse, and has a double aperture; in the left, the pupil is single, but is also transverse, the slit extending to the ciliary attachment on the outer side, while on the inner side, the iris presents the appearance as if the transverse slit had become united for about half a line in breadth. Both pupils, upon being dilated with atropia, became nearly circular; both apertures, in the right, dilating so as to leave a merely thread-like division of the iris between them. Vision in the left eye is good, but in the right, is very imperfect, in consequence of the anterior chamber having become greatly enlarged from hydrophthalmia. The cornea, and about a line in breadth of the upper portion of the sclerotic, being very much thinned, Mr. Browne expressed it as his opinion, that nothing could be done to remedy these changes of structure in the right eye; but that tonic treatment, rest, and care, might prevent the left eye from becoming dropsical also.

*Impaction of a Pin in the Throat
for Four Months.*

The SECRETARY read the following case from Surgeon M'DONNELL, of Randalstown:—

Catherine M'Gee, aged 61, a country servant, had been in town in September last; on her way home, she put a pin in her mouth, and forgot about it. On getting to her master's, she ate some bread, in swallowing which, she found something prick her at the lower part of her breast. She endeavoured to bring it up by retching, and succeeded so far as to get it to the upper part of the œsophagus. She now found it impossible to swallow anything, either food or drink, and she remained in this state for eight days, when she applied to me. I examined her throat carefully, but could find nothing; however, I passed a probang into the stomach, and this enabled her to swallow, but she complained of pain in doing so. I heard no more about her till the 1st of January, when she came to me, saying she was sure the foreign body still remained, and pointed to a swelling over the thyroid cartilage. On examining this swelling, I thought I could find fluctu-

ation, and made an incision in the median line,—a little unhealthy pus came away, but I could detect no foreign body. I desired her to poultice for a few days, and return again. She did so on the 3rd inst., but I was unsuccessful this time also. She became much alarmed, and requested me to do anything that I considered safe to relieve her. I was cautious in cutting in so intricate a situation. I made my first incision in a V shape, extending the lateral cut along the corner of the thyroid body, and raised the angular flap, and after a long and careful search, I found the head of a pin protruding through the hyo-thyroid ligament, about half-an-inch from the surface. The greatest difficulty I experienced was from the cough produced on touching the deep parts. I would infer from the way it came out, and its appearance—the head and great length of the pin, being oxydized carbon, and the point clear—that it passed across the trachea and pierced the œsophagus; but how it got into this position, and how she tolerated it so long in so important a part, is what I cannot account for; and also the head of the pin appearing first, seems to me strange. I may add, the old woman got immediate relief, and she is now quite well.

Disease of the Heart.

The PRESIDENT exhibited the heart, kidneys, and liver of a female, aged 57, who had died of dropsy.

When first seen, she was found lying flat in her bed, with intense circumscribed lividity of her cheeks and nose, general anasarca and ascites, with lividity of forearms and legs, and pulsation in both jugular veins. She suffered much from cough and dyspnœa, and large crepitation was heard over both lungs. The rales in her chest prevented any correct conclusions being formed as to the state of the heart. When the lung symptoms had been considerably relieved by treatment, a systolic murmur was heard below the nipple, which could be traced with increasing distinctness towards the cuniform cartilage, but not in the direction of the side:—at the right side of the upper portion of the sternum, three sounds were audible, having a striking resemblance to the cantering sound heard often in pericarditis. She continued to assume a perfectly prone position to the last, and died sooner than was expected.

Post-mortem examination found a hypertrophied and dilated right ventricle and auricle, which had permitted regurgitation, and consequent pulsation in the jugular veins. The left ventricle had been laid open, without testing the sufficiency of the aortic valves—a deposit had taken place between the folds of membrane forming these valves, and there was a small vegetation on the aortic surface of two of them; a similar deposit, but to less extent, was found also in the pulmonary valves, but no vegetation. No murmur had been heard at the base of the heart during any of

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these examinations. The kidneys were enlarged and deeply congested, but their structures healthy. On the surface of the left, there was found a cyst containing more than an ounce of fluid. The urine was not albuminous. The liver was enlarged and thickened at its base, where it had several fissures of near an inch in depth. Dr. Murney stated, that he had only met with these in females, and that he ascribed them to the habit of wearing stays—but as these fissures were vertical, it is difficult to account for their production by pressure of this kind.

Observations on Mushrooms.

Professor DICKIE, M.D., made some observations on mushrooms. He said that many varieties of these fungi, which were considered unsafe as food in this country, were used on the continent. Pickled mushrooms and black bread constituted a meal in some parts of Russia. To the *Amanita Muscaria* he called particular attention. After describing its beautiful appearance, he said it was met with in Autumn throughout Europe, and flourished in Colin Glen, in our own neighbourhood. The Kamtschatkans, and other inhabitants of the north-eastern parts of Asia, used it in a *dried* condition, as a means of producing intoxication; and he adverted to the long-known fact of its inebriating principle being eliminated by the kidneys almost unimpaired. In illustration of this peculiarity, he said it was common for an individual, his edible stock being exhausted, to prolong his debauch for several days by the more disgusting debauch of drinking his own urine; and also, that the urine of one who had feasted on the *Aminata* was esteemed by his more degraded companions for its inebriating qualities, who in turn, and through several successive persons, could reproduce the original effects. He next called attention to the physiology of the action on the body of this class of fungi as a field for investigation almost untrodden. So far as known, the poisonous mushrooms might be considered narcotic, the first effect being stimulation, and the second, sleep. In conclusion, he expressed himself willing to aid in a more extended inquiry into their actions on the system. He also said that the mushroom fungus could be developed by exposing ergot of rye in a warm and moist situation.

FIFTEENTH MEETING.

February 18th, 1860.

The President in the Chair.

Dr. MURNEY exhibited several specimens of the shortening of the neck of the femur from injury *without* fracture, which were interesting from the liability to error in diagnosis. His remarks will be given in detail in Appendix.¹

¹ [Not available.]

SIXTEENTH MEETING.

February 25th, 1860.

The President in the Chair.

Cases brought forward at this meeting by Professor Gordon, Dr. Moore, and Dr. W. Aickin, on chimney-sweeper's cancer, medullary disease of testis, destructive ulceration of fore-arm, and carcinoma in sub-maxillary region, have not yet been furnished to the Secretaries, but will be given in Appendix.¹

SEVENTEENTH MEETING.

March 3rd, 1860.

The President in the Chair.

Dr. WALES introduced a child suffering under chronic hydro-cephalus. The head was greatly enlarged and increasing, and yet the little patient was improving in general health. Dr. W. observed, that the child's mother was lying under well-developed small-pox when he delivered her, and he considered the absence of the disease in the child an interesting fact.

Dr. HARKIN exhibited a girl having a small encysted tumour above clavicle, which, from pulsation derived from the carotid, simulated aneurism.

*Case of Compound Comminuted
Fracture of Tibia and Fibula.*

Surgeon BROWNE stated that the specimen before the Society was taken from the leg of a patient at present in hospital, and which had been amputated after an attempt to save the limb had been persevered in for nearly four weeks. He stated, also, that the specimen which he exhibited was a beautiful illustration of the lesion sustained by the bones of a limb from direct violence—the result, in fact, of a heavy body having passed over the leg while it was extended, on its outer side, on the ground. It would be observed, that about an inch below its centre the tibia is fractured obliquely, with a small detached portion; opposite this point there is an oblique fracture of the fibula also. About three inches lower down the tibia is again fractured transversely, the posterior part of the bone being comminuted; the part of the bone between the oblique and transverse fractures is detached and displaced outwards above, its upper point pressing against the oblique fracture of the fibula. It was, he might remark, at these points—at either end of the separated portion of the tibia—that the injury had become compound, as a wound extended through the soft parts to the bone. Then a little above the inner malleolus there is a split into the structure of the bone, perpendicularly for an inch and a half, extending towards, but not into, the ankle joint. The fibula is likewise again broken a little above the outer malleolus. It would be further observed, that the detached

portions of the tibia and fibula are stripped of their periostum, and are becoming necrosed.

The immediate cause of amputation, was the amount of suppuration which had taken place, and which was daily increasing—and it would be seen from the specimen before the meeting, that there was no other resource to give the patient a chance for life. Indeed, it is now clear, that from the first there could not have been any reasonable prospect of saving the limb, and it is to be regretted, that primary amputation had not been resorted to. However, in these days of conservative surgery, and as he had not the consent of his colleagues, he did not urge what all along he believed to have been the safest step for the patient.

The question of primary amputation is one of vast importance, and is one, also, frequently of very difficult solution; still, in cases like the one under consideration, the difficulty is, in some measure, removed—as every hospital surgeon must be aware, that in injuries arising from very heavy bodies passing over a limb, there is often, very generally, a much greater amount of lesion, both to the bones and soft parts, than what is indicated by the eye; and that, in these cases, the attempt to save the limb is not only a hopeless proceeding, but exposes the patient to greatly increased risk. In corroboration of these remarks, his hospital experience had afforded him many examples, and he had, on more than one occasion, to regret some attempts at preserving limbs, which after circumstances had proved to have been wrong in the first instance.

The patient now under notice is doing pretty well, and he hoped would eventually recover.

Dr. ROSS read the following paper

On Typhoid Fever.

Of late years it has been much insisted upon, by many able clinical observers, that typhus and typhoid are different forms of fever, and my own experience leads me to believe that the distinction is well founded and has important practical bearing. The few following remarks will apply to the *Ætiology*, *Pathology*, *Semiology*, and the *Therapeutics* of typhoid fever.

Ætiology.—It has been a matter of much controversy whether typhoid fever is infectious or not infectious, which I believe it to be not at all so much so as typhus—Cases have occurred to me in which it appeared to be undoubtedly propagated in this way. I consider the alvine evacuations more than any of the other excretions, a fertile source of its communication from person to person, and that it is prudent to act on this opinion, and to pour some solution of chloride of lime into the bed-pan before using it, and to have the defecations removed from the patient's bed-room at once, and so disposed of as to have as few individuals as possible exposed to their poisonous

influence. Defective action of the excreting organs seems to have some influence in the causation of typhoid fever, and in this way I account for its being occasionally a sequel of long-continued delicate health. To neglect of the laws of hygiene, as unhealthy residence and bad sewerage, its origin is most of all attributable. This has been well exemplified in the Windsor Epidemic.

Pathology.—In this disease there is a peculiar fever poison in the blood, and, as in other constitutional affections, so in this, nature tends to throw off the poison by elimination. To Peyer's glands the *materies morbi* is remarkably directed, causing their enlargement, congestion, and too often their ulceration. Thus I view the morbid changes of these bodies, which are so pathognomonic of typhoid fever, as an invariable complication, and not, as some would have us believe, the *fons et origo* of the mischief. Allowing for the difference between an acute and a chronic disease, we may see some analogy between the destruction of Peyer's glands by the fever poison, and the injury to the kidney by the gouty poison. In each case the organ does nature's work, excretes a poison from the system, but in doing so may suffer more or less disorganization.

Semiology.—No symptom is so diagnostic of typhoid fever as diarrhœa, coming on during its course without any assignable cause, or after a mild aperient, and obstinately resisting treatment; with the looseness, gurgling over the ilea cœcal valve, and tympanites, are generally combined. Gastro-enteric derangement, foul tongue, and fœtid breath, generally precede the diarrhœa. Chest affections are frequent complications, particularly latent bronchitis, indeed I don't recollect meeting with a case in which the pulmonary mucus membrane was not engaged in a greater or lesser degree. In the early stage only a few rales may be heard, but these often extend, pass through the dry and moist characters, and implicate both lungs. The cerebral functions are often disturbed, and I have been often struck with the alternation between the delirium, bronchitis, and diarrhœa. A rose-coloured rash over the chest and abdomen is another most important sign of typhoid fever. The constitutional affection is indicated by the febrile symptoms, as quick pulse, hot skin, loaded urine, general depression of the vital powers, and pains over the body and limbs.

The difference in the countenance of one in typhus and one in typhoid fever is marked. In the former, from an early period, the face is confused, oppressed, and congested. In the latter, there is an absence, at least in the early stages, of these signs, and the patient is more intelligent when addressed.

It is now well established that typhoid fever is chiefly confined to the ages from 15 to 30—not so typhus.

The duration of typhoid fever is much longer than that of typhus. While in the latter a crisis generally comes on about the 14th or 15th day, typhoid is not unfrequently of several weeks' duration, exhausting the patient, and also his physician and relatives.

Treatment.—The important rule of supporting the system until nature effects a crisis is as necessary in this form of fever as in the other varieties.

The entire affection indicates a bland and farinaceous diet; but there are few cases in which, as the disease advances, wine or brandy and animal broths, with arrow-root, do not become necessary. Much discretion, however, is required in the use both of food and stimulants.

Whilst using these general means, we must keep a strict look out for the complications. If there be head affection, the hair must be cut off, and cold lotion or affusion used at intervals. Leeches and henbane will be useful if there be sleeplessness.

If there be much chest affection, we must be sparing in the use of full opiates, and we will find sinapisms and blisters, hippo, camphor, and ammonia most useful aids, if employed with discrimination.

But of all the complications, the diarrhoea requires the most careful management, preventing it, as much as possible, by regulation of diet, and by abstaining from purging. When it does become troublesome, the opiate enema, chalk mixture and catechu, lead and opium, and counter-irritation of abdomen, are the remedies which I have used with the most benefit.

Attention to the bladder, the prevention of bed-sores, general cleanliness, and pure air, are, I need scarcely say, indispensable to the safety of the patient.

EIGHTEENTH MEETING.

March 10, 1860.

The President in the Chair.

Case of Elephantiasis of Penis.

Dr. CORRY introduced a young man, aged 22, by occupation a labourer, affected with elephantiasis of the penis. The history of his case was rather peculiar. He stated that about six years ago he had one day fallen asleep in a field, exposed to the glare of a scorching sun, from which he was awakened by an acute pain in his genital organs; this continued for several days, and prevented him following his usual avocations. From that date his penis has gradually increased in size, and he has had a periodical return of the pain about four times each year. On examination, the penis was found greatly hypertrophied, presenting a fine specimen of the true Elephantiasis Arabum; it measured seven inches in length, and in circumference, five inches at root, seven inches at body, and six inches at glans. The organ had a hard, horny appearance, being intersected by several deep fissures, and studded over

with a number of small tubercles; the prepuce was much thickened, and had completely lost its distinctive character. The disease, which had evidently commenced in the penis, was gradually extending, the scrotum and inner parts of the thighs having become implicated.

This case created considerable interest among the members on account of its extreme rarity in this country.

Dr. PURDON said the disease was endemic in Kilkenny.

Dr. C. D. PURDON read the following observations on

The Use of the Hypo-Phosphates.

The hypo-phosphates were first brought under the notice of the profession by Dr. Francis Churchill, of New York, who then stated that he had found the use of them to be very successful in phthisis, but the results in this country not being so very favourable, the preparations had fallen into disuse; but having tried these remedies frequently in gastric afflictions of children with great benefit, I again bring them under your notice as most useful remedies in these diseases. The first case in which I used these remedies, was one of chronic remittent fever, which had persisted for one year and a-half in spite of all remedies, and the little patient was rapidly sinking, and from the state in which she was in, there appeared no release from suffering but death. I may mention the symptoms, viz.—loss of hair; dark coloured rays under the eyes; point of nose red; aphthæ at either commissure of the mouth, as well as in the mouth; gums spongy; tongue covered with a creamy exudation, which frequently exfoliated; abdomen tympanitic, with enlarged inguinal glands; constant diarrhoea, with clayish-coloured stools frequently, at other times rather dark coloured and mucous, always offensive; frequent prolapsus of the rectum, which was dry and glazed and aphthous; vulva covered with aphthæ; limbs wasted, and body covered with small boils; skin dry and rough. As a last resource, I tried the hypo-phosphates, and after persevering in their use, the child rapidly improved, and is now a fine healthy one.

The next case in which I used them was a child that had been under treatment for several months for remittent fever, and was wasting away as children usually do in that affection, no remedy having any permanent effect; and on having recourse to them, the child gradually improved, and the hectic fever, as well as the other symptoms, abated, and the child became quite convalescent.

I have used these remedies in cases where there was gastric irritation with good results, and from the great improvement that I have witnessed from their use, I can confidently recommend them as a most valuable remedy in gastric and mesenteric affections.

As to the manner in which I use it—I always, in gastric fever, try to improve the character of the bilious secretion; and, should the disease continue after the natural-coloured stools are obtained, then I have recourse to it. In the case of gastric irritation, I give them at once, in syrup, three times a day on an empty stomach.

“Respiratory Distress” No Longer a Pathognomonic Symptom of Fatty Degeneration of the Heart.

The PRESIDENT made the following communication:—

A remarkably well-formed man sought Hospital relief in consequence of his suffering from cough and dyspnoea, and latterly from anasarca. During the night after admission, he had a severe paroxysm of dyspnoea, which caused him to rush into the lobby for air, and made the night-nurse raise the Resident Surgeon to see him. At my visit next morning, I was struck with the peculiarity of his breathing, and his position in bed, and elicited from him the following history:—

He stated that he was by trade a cooper, and that his age was 56, although he looked at least ten years older. During the last two years he had been subject to cough and dyspnoea, and was compelled to lie almost constantly on his left side; but he had never expectorated any blood. For six months past he had suffered much from pain in his shoulder, neck, and head, on the right side, but never on the left, nor had he at any time an attack of acute rheumatism. His legs had been œdematous during the last half year. Some months ago he had a “catch in his breathing” similar to that of last night, which compelled him to run into the street for air; and he pointed out the seat of his suffering to be between the Pomum Adami and upper edge of the sternum; and was certain he had never had any dysphagia.

Increased pulsation *was seen* in the carotid and subclavian arteries, and was more manifest at the right sterno-clavicular articulation than on the left. A feeble, undulating pulsation was also seen between the third and fourth intercostal spaces on the right side near the sternum, but none on the left.

Strong pulsation *was felt* at the right side of the sternal notch, and in behind the insertions of the sterno-cleido mastoid muscle, unaccompanied with thrill; and both subclavian arteries expanded much, just where they escaped from under the clavicle.

A single murmur *was heard* in the carotid and subclavian arteries, which became double under the top of the sternum and sternal end of right clavicle, and continued so as low down as a line on a level with the left nipple. A single murmur could be heard about two inches lower, and to the left, in the region of the apex of the heart.

The impulse of the heart is entered in my case-book as “fair,” so that it was neither unusually feeble, nor in excess; nor was any heaving expansion of the

chest to be seen or felt when it was examined in profile.

Both pupils were natural.

On watching the peculiarity of his breathing, it was found to be an example of the “Respiratory Distress of Stokes”¹ on that day, unaccompanied with moaning, and much less intense than it became subsequently, but still presenting its peculiar ascending and descending scale.

When a paroxysm of the distress had terminated, and that the breathing had become quiet or had ceased for a time; he would then be attacked with a fit of coughing, which afforded no relief, as he was unable to obtain any expectoration. During the fit of coughing both external jugulars, and a large vein crossing just above the sternal notch, were distended to a size not less than that of the fore-finger, without any pulsation being observed in them. The pulse, if counted during a minute, would be described as irregular; but presented that *regularity in its irregularity*, which several members of this Society had an opportunity of witnessing last year, in two of the aneurismal patients whose histories I brought before you, and in whom the symptom of Respiratory Distress was also present.² This patient was therefore the third, during the last twelve months, in whom I had observed, that during the paroxysm of “distress,” *the pulse became invariably slow when the distress was greatest, and as invariably quick when it was subsiding, or whilst the patient had ceased to breathe.* I am therefore disposed to believe, that this is not “a mere coincidence,” but that it and the distress stand towards each other in the relation of cause and effect; and as I find no mention of this peculiarity in the pulse by any writer on cardiac pathology, I believe I may claim to be the first who has noticed its association with the Respiratory Distress. Neither it nor the distress, is to be found equally marked or intense on every day, for, as in other cases of suffering, the patient has his “good days” and his “bad days,” his hours of comparative ease as well as of severe suffer-

¹ It may not be out of place if I quote a description of a paroxysm of the Respiratory Distress. I shall presume that one has just terminated:—“After a period of apparently perfect cessation of breathing, the faintest possible inspiration takes place, succeeded by one a little stronger and longer; the respirations then gradually increase in strength and depth, till the respiratory act is carried to the highest pitch it seems capable of; when the head is thrown back, the shoulders raised, and every muscle of inspiration thrown into the most violent action, accompanied often by a loud moan from the patient. When the respirations have reached this maximum, they pursue a descending scale, and commence to regularly diminish in strength and fulness, until they apparently cease;” when, as some members present saw in one of my patients last year, the sufferer may say—“Now, I am quite well;” or the respiration may cease for so long as to impress a looker on, as it did my nurse in this case—“Sir, his breath stopped for so long that we thought he was dead.”

² Transactions of the Belfast Clinical and Pathological Society, p.97, 1858–59.

ing. Innumerable opportunities, however, were afforded me of pointing out the peculiarities of both to my Clinical Class and some medical friends; and I had also, the gratification of being able to show them in full intensity to Surgeon-Major Pilleau, M.D., and to Staff-Assistant Surgeon O'Brien, M.D., when I had the pleasure of a visit from them at the Hospital. The pulse at the wrist varied in strength and fulness, but in the brachial arteries it presented the well-marked character of the "jerking pulse," and occasionally also in the radial artery.

During the ten weeks this patient was under observation, I never found him lying on his right side but once; his usual position was leaning on his left elbow, with his head about a foot off the pillow; occasionally resting it on his hand, which was, no doubt, the cause of a varying œdematous state of his left arm and forearm. He had most ease sitting up with his feet hanging over the side of the bed, and although at the very side of the fire, and that he had abundance of clothes, he was always complaining of cold. His sufferings were generally increased in the evening, and he insisted at night on being allowed to sit before the fire with his bedclothes wrapped round him. This necessarily led to considerable dropsical swelling in his legs, which, indeed, vesicated and burst, and were with difficulty healed. At no period of his illness was there any ascites, or œdema of the face—nor was the urine albuminous.

In the two other patients with Respiratory Distress there was a constant craving for stimulants, but such was not the case with him; for although he was aware that several hours of severe suffering would be relieved in a few minutes by a couple of ounces of whiskey, he had generally to be solicited to take it.

With respect to the diagnosis in this case. The double murmur at the base of the heart, and the single murmur at the apex, warranted the conclusion that both the aortic and mitral valves were incompetent to close their respective orifices. In support of this view we had also the "visible pulsation" of Dr. Corrigan in the carotid sub-clavian and brachial arteries; but not to be seen so distinctly in the radial. We had, however, in addition, some of the symptoms that I had observed in the female who suffered from the fusiform aneurismal dilatation of the aorta and innominata (but without any imperfection of the aortic valves) the diseased structures of which I exhibited here last session.¹ I therefore concluded, that a similar lesion existed in this patient, for he had also suffered from pain in his shoulder, neck, and head, confined exclusively to the right side; accompanied by a pulsation to be felt and seen at the right of the sternal notch, and in behind the insertion of the sterno cleido mastoid muscle.

¹ [See page 790.]

In the female referred to, and also in the third aneurismal case, in which there was every reason to believe that the aorta and innominata were also dilated (though a post mortem examination was refused), there appeared some time before death, œdema of the right mamma, and upper part of the right side of the chest.

This did not take place in this patient, which was probably owing to the incompetency of the aortic valves, preventing the possibility of *continuous* pressure by the dilated arteries on the right vena innominata.

But the chief diagnostic interest in this case is connected with the symptom of Respiratory Distress, to which Dr. Stokes was the first to assign a diagnostic interpretation; making its presence pathognomonic of fatty degeneration of the heart, as he states¹ "that he had never seen it except in examples of that disease." I had only been able to obtain a post mortem examination in one of the other patients, in whom this symptom was present; and as fatty degeneration of the muscular fibre of the heart existed in her, I continued to look upon it as a symptom that might be relied on as indicative of the presence of that particular morbid state. I therefore added to the diagnosis of fusiform aneurism of the innominata and aorta, with incompetency of the aortic and mitral valves, the further lesion of fatty degeneration of the heart.

I am unable to offer anything but a speculative explanation of the undulatory pulsation that could be seen, but barely felt, between the third and fourth intercostal spaces on the right. If we admit that the regurgitation through the mitral orifice would so impede the circulation through the lungs, as to prevent the right side of the heart having free action; then a distended state of the right auricle might be the cause of a feeble pulsation in this locality. This is the second occasion in which I have observed this symptom. The first was in a patient of Dr. M'Gee's, with enormous hypertrophy of the heart. It is a symptom of some interest, as its locality would suggest the idea of a sacculated aneurism, though it is deficient in the expansile force of an arterial pulsation.

Having the good fortune to obtain a post mortem examination, I again availed myself of Dr. Murney's well known microscopic and anatomical knowledge, to obtain for the Society an accurate examination of the state of the morbid parts that had been removed, which was granted with his characteristic readiness to oblige, and he reports as follows:—

"The heart, when divested of extraneous matter weighed 27 oz. There were several 'lymph spots,' apparently between the serous membrane and the muscular structure; one, of several inches in extent,

¹ Stokes on Diseases of the Heart, &c, p.324.

on the right ventricle. The hydrostatic test showed the pulmonic valves to be perfectly competent, but the aortic semi-lunars were quite incompetent—on each of its three divisions a hard calcareous-like deposit was found. On the back of two of these, little wart-like growths projected from the surface. There are a few soft wart-like vegetations on the mitral valves. The left ventricle is considerably dilated; its walls very much thickened, measuring at its middle $1\frac{1}{8}$ inch; the muscular structure firm, and without any trace of fatty degeneration, when carefully examined by the microscope. The right cavities and valves are normal, and without any dilatation of the venæ cavæ. The lining membrane of the aorta was thickly studded for several inches with atheromatous deposit. The aorta and innominata were dilated, and, in order to note the extent, they were compared with a healthy specimen. When both were slit open and spread out, it was found that the aorta in the healthy specimen measured, transversely, $2\frac{1}{2}$ inches immediately above the semilunar valves, and the innominata, before its bifurcation, $1\frac{1}{8}$ inch; whilst in the diseased specimen they measured at the same parts respectively 4 inches and $1\frac{3}{8}$ inches. There was calcareous and atheromatous deposit in both coronary arteries, which were also dilated."

I need not say how disappointed I was to find that Dr. Murney's microscopic examination of the structure of the heart had proved it to be free from fat, and that the symptoms of Respiratory Distress must henceforth cease to be looked upon as pathognomonic of fatty degeneration of that organ.

Before communicating this result to the members of this Society I felt bound, in justice to Dr. Stokes, as well as for the interests of science, to have Dr. Murney's opinion either confirmed or disproved; and I, therefore, wrote to my friend Dr. S. Gordon, of Dublin, requesting him to have the slices from base to apex of both ventricles, which I forwarded, thoroughly examined with the microscope, which he was kind enough to do, and says, in reply—"The result of my enquiries as to the condition of the heart-fibre which you sent me for microscopical examination, is that it is quite healthy. One gentleman writes to me, 'it is quite healthy, even up to the fat under the "white spot" there is no degeneration; under the said spot, there is some common yellow fat. As in all negative cases, this result has only been arrived at, after a careful examination of several parts of the specimens. The glass used was Smith and Beck's one-fifth.'"

A similar opinion as to the absence of fat was given by several others, who examined it for Dr. Gordon.

No practical physician likes to part with a symptom that has been held to be pathognomonic, and, therefore, further observation must determine, whether Respiratory Distress may be found associ-

ated with any other lesions of the heart than fatty degeneration, and those present in this patient. I would be disposed to think that it would not, because a little reflection will suggest to any one how similar the state of the circulation must be in the minute capillary vessels of the brain, upon which the integrity of the nervous system depends, produced by fatty degeneration of the heart, and by regurgitation from the arteries into the aorta, then into the ventricle, and again into the auricle; and how difficult it would be to find a lesion that would produce a similar effect on the brain, which I believe to be the cause of this Respiratory Distress. And should further observations prove this limitation, it is evident, that, as the stethoscopic and other symptoms would generally ascertain the existence of regurgitation, when it was proved absent, Respiratory Distress would still remain a most valuable diagnostic symptom of the presence of fatty degeneration, though this case removes it from the higher position of being pathognomonic.

I shall not, however, enter on any speculations on this point, feeling that I have only been justified in occupying so much of your time, in consequence of the points of diagnostic interest that were connected with this case, and that the exhibition of morbid structures here, are chiefly of value in confirming or rendering more accurate our means of diagnosis.

I have now only to mention the state in which the post mortem examination found some other structures. There was no effusion into the pericardium or peritoneum, but there was a considerable amount into both pleuræ; the left lung was quite healthy, but there were very firm adhesions of the base of the right lung to the diaphragm; and bands of several inches in length between the sides of the chest and the surface of the lower lobes. The liver was healthy. On the spleen there was a depressed spot, with calcareous deposit in it. The left kidney was very small and lobulated, but its structure healthy; whilst the right was very large, and had a considerable amount of fatty deposit in its cortical structure.

NINETEENTH MEETING.

March 17th, 1860.

The President in the Chair.

Necrosis of Femur.

Surgeon BROWNE exhibited a portion of the left femur, which he had amputated on the preceding Monday for necrosis. The history of the patient, a lad of 15 years, was, that about six years since he had injured the limb in leaping, that suppuration immediately above the inner condyle had taken place, and that some portions of bone had been cast off. For the last four years, up till six weeks ago, the limb had been pretty well. Within the past two months he had begun

to feel pain above the knee, and to walk with a halt; there was some swelling and tenderness of the soft parts. Two weeks since he applied for admission to the General Hospital, and could still bear his weight on the leg, and walk. On admission it was found that a strumous abscess had formed on the outer side of the thigh, a few inches above the knee; this was opened, and discharged some unhealthy grumous matter. About a week after, in attempting to get into bed, he heard a crack, felt something give way, and immediately observed deformity of the part. At first it was imagined that the epiphyses had separated from the shaft of femur; but further examination showed a spontaneous fracture had taken place four inches above the knee. Extensive suppuration followed, with marked symptoms of hectic, and, on consultation, amputation was decided on. This operation was performed, under the influence of chloroform, by the long anterior flap, made from without inwards, and a short posterior flap made by transfixing the limb. The bone was sawed above the middle third, and was found healthy. On cleaning and examining the amputated bone, traces of the old inflammation and exfoliation were visible, and a rugged portion through a necrosed shaft some five inches above the condyles. This point was very much thinned and discoloured, without the smallest sign of any attempt to repair.

The point of interest is, that the patient could have used such a limb up to within a fortnight of its having given way under slight exertion.

Since the operation the little fellow has progressed most satisfactorily, the hectic has entirely ceased, and there is every prospect of his being quite well in the course of a month.

Dr. GRAVES, of Cookstown, read the following

Case of Gastric Parasites.

Some months since a patient came under my notice in the Cookstown dispensary. A young woman about 24, in phthisis, in the second, and verging on the third stage. In the physical signs there was nothing unusual, nor in the symptoms, save that she complained of frequent severe deep gnawing pain at the epigastrium, very irregular and intermittent, but generally worse when the stomach was empty. I saw her one evening suffering severely and prescribed a draught with morphia and hyd. acid. On the following morning her mother brought me the specimens contained in this bottle and told me the girl had slept well and comfortably during the night, that while dressing she was suddenly seized with pain and vomiting, and that these parasites were ejected on the floor. Instant relief followed. This is the only history of the case I can give. But let it be remembered, from this date the gastric symptoms entirely ceased. She lingered for some weeks, and was carried off as we had foreseen, by pulmonary consumption.

I must confess these worms puzzled me not a little. I have never seen any similar, nor can I in the limited references at my command, find any description of them. When brought to me, some two or three hours after their ejection, they were exceedingly active, of a deep straw colour (the spirit has darkened them), and rather elastic to the touch—reminding me much of a grub I have seen in turnip fields. One I sent to my friend Dr. Hay in Dublin, who submitted it for observation to Professor Bache. I much regret having mislaid the Professor's most courteous letter. He pronounces them to be the "meal worm," and suggests that the girl might have eaten some unsound meal in which the ova might have been conveyed to the stomach. It is not unusual for farm servants to help themselves to the *raw material* while preparing "porridge," but on this point I could obtain no information. I find a curious case in the last vol. of Rankin's *Hosp. Prac. Assist.* recorded by Mr. David Dickman, extracted from *the Lancet*, October 1st, 1859, in which a girl of 12 vomited seven or eight garden slugs, the smallest two inches long, and all alive. Some others—supposed from the patient's sensations who "felt something crawling up her throat," and "frequently introduced her fingers to seize what she felt,"—were killed by repeated doses of ammonia and camphor.

After stating that the girl had an unusual craving for fresh vegetables during her illness, the author goes on to say [I quote from Rankin]:—

"The three slugs that came up first were not preserved; but the five others have been kept alive and fed on vegetables, which they preferred being cooked, having at first refused to eat them raw. They are now fed on raw vegetables."

I regret I did not know this before, otherwise you might have had those curious specimens of "our fellow-lodgers" alive and active before you, with a small stock of oatmeal as their entire subsistence.

Dr. CORRY read the following

Case of Epileptic Puerperal Convulsions.

Feb. 25th, 1860.—At 8 A.M., was called to see Mrs. G., aged 21, who was suffering from severe epileptic convulsions. On enquiry I ascertained she was eight and a-half months pregnant of her first child, and had, for several weeks past, been affected with giddiness, headache, digestive derangement, and anasarca of face, upper and lower extremities. The primary attack occurred at 9 A.M. the previous day; but as her friends attributed it to a fright she had received, little alarm was at first created, however, during the day, the paroxysms increased in frequency and violence, though she was conscious during the intervals. About 9 P.M. the symptoms became greatly aggravated, and from that period she had remained in a state of insensibility. On my arrival I found her skin hot, face flushed, eyes injected, breathing laboured, pulse, 140 firm; on

examination, the os uteri was discovered low in the pelvis, but firmly contracted. Ordered two drops of croton oil, and six leeches to the temples, head to be shaved and ice applied, also a blister to nape of neck, and an enema of castor oil and turpentine.

12, noon.—Paroxysms more frequent and severe, face greatly swollen, livid, and distorted, bloody froth exuding from the mouth during each attack, breathing stertorous, pulse 155, very firm, involuntary discharge of urine and fæces, os uteri dilated about the size of a shilling, bled from the right arm to the extent of thirty ounces.

1.30, p.m.—Skin cooler, pulse softer, but still very rapid, paroxysms greatly diminished in intensity. On examination, found os uteri fully dilated, and child's head low in pelvis; introduced the short forceps, and in a few minutes delivered the patient of a stillborn male. Shortly afterwards, during a fit of convulsions, the placenta was expelled, the uterus contracted well, and there was no tendency to hæmorrhage.

4, p.m.—Symptoms much improved, though patient still continues unconscious, has had only two attacks since delivery, countenance pale, pulse 120, soft, introduced a male elastic catheter, and obtained about one ounce of urine, free from blood or mucus, for chemical examination.

9, p.m.—Has had only one attack since last visit, remains in a comatose state, bowels have acted freely, and blister has risen well.

26th, 9, a.m.—Has had only one fit during the night, slept well, and is now conscious; but does not incline to speak much, skin cool, pulse 115.

9, p.m.—No change since last visit.

27th, 12, noon.—Continues to improve, pulse 112, no abdominal tenderness.

28th.—Still improving, skin cool, pulse soft, 110, no evacuation from bowels since 26th instant, ordered six drachms castor oil.

Since the last date she has progressed favourably, and is now convalescent.

Remarks.—As with some members of the medical profession there has of late been a feeling adverse to blood-letting in the treatment of puerperal convulsions, I have been induced to bring forward the foregoing case, as I believe it was one in which the free use of the lancet was required. I had previously availed myself of the various remedies recommended by the most recent writers on the subject, but without success, and it was not until after thirty ounces of blood was abstracted that relief was afforded. It may be suggested that this was not a case of albuminuria, however, such was not the fact, as upon subsequent examination of the urine, I found albumen present in large quantities. There are several strong reasons in favour of venesection in puerperal convulsions, accompanied by vascular plethora; it acts as a powerful sedative, and tends to preserve the brain from

injury during the convulsion, assists in dilating the os uteri, and greatly diminishes the tendency to abdominal inflammation.

Dr. CORRY, in reply to the observations of several members of the Society, was strongly of opinion that the line of treatment followed in the foregoing case, was in accordance with the views of the most recent writers on obstetrics. He was by no means an advocate for the indiscriminate use of the lancet; but in this instance, the free abstraction of blood was followed by such favourable results, that he considered it his duty to report the case to the Society.

Dr. MOORE introduced a person from whose foot he had found it necessary to remove the metatarsal bone of the great toe. No retraction of the toe had taken place, and the perfect use of the foot was preserved.

TWENTIETH MEETING.

March 24th, 1860.

The President in the Chair.

Dr. CORRY introduced a young woman who had suffered from

Laceration of the Cornea.

He gave the following details of the case:—

“May 1st, 1858.—I was sent for to see Agnes Smyth, aged 20, who had received severe injury to one of her eyes from the shuttle of a steam-loom, which had penetrated the sclerotic, producing a lacerated wound extending across the cornea, and dividing that texture. From the formidable nature of the accident there appeared little chance of preserving vision; however, I as soon as possible brought her under the influence of mercury, at the same time applying anodyne lotions to the injured organ, and producing dilatation of the pupil by belladonna. This course was pursued for three weeks, by which time the wound had completely healed, leaving a white line or cicatrix which has now partially become absorbed; and there is little deformity.”

Dr. W. MAC CORMAC read the following

Observations on the Syphilitic Poison.

In laying the following observations on syphilis before the Society, I cannot claim its attention on the score of saying anything new, or perhaps, anything which is not known to most of its members; but the subject is interesting in itself, and from the fact of the large proportion of the human race it affects, our best skill and attention will be demanded in furthering the better knowledge of its nature. Mr. Solly of London propounds a doctrine, which, if carried out to its fullest extent, would prevent the administration of a dose of medicine for the treatment of syphilis. I think his tenets are hardly consistent with true philan-

thropy, nor would I rank Phillippe Ricord among the least of the many benefactors which medicine has conferred on our kind. He it was who, in conjunction with Cullerier, first developed the rational treatment of the disease. It was Cullerier who rescued the unfortunate sufferers from the dungeons of the Bicêtre, where they were confined, often enduring the utmost hardship, till released by death from their tortures.

Having attentively followed the clinique of Ricord for nearly a year, I have become more or less imbued with his doctrines. He acknowledges two forms of the so-called primary disease, viz., the soft and the hard chancre. The first, known by its peculiar worm-eaten appearance, its tendency to be multiple, its extreme contagiousness, and usually the presence of a suppurating bubo in the groin, from the pus of which the chancre may be reproduced by inoculation, and lastly, by the absence of all constitutional affection. The second variety, known by its peculiar hardness, the multiple induration of the glands in the groin, subsequently those of the neck and elsewhere, without suppuration, by its being single usually, and non-inoculable, and lastly, by the inevitable occurrence of secondary symptoms in a space of a month or six weeks, sore throat, roseola, falling out of the hair, &c. In the first case, local treatment alone is required; in the second, constitutional measures are imperative. That these well-marked distinctions exist, I have ascertained, scores of times, in the wards of Midi, and have been able to trace their progress for myself. In my own mind, I am convinced of their truth. The soft chancre exists in far greater proportion than the hard. M. Puche in 10,000 cases, collected in from 1840 to 1852, found the ratio 4 to 1. The soft chancre may attack the same subject several times, while, except in the rarest instances, the victim of a hard chancre is not again liable to the disease. The soft chancre reproduces the soft chancre, whether on the same or another individual, and whether these individuals have suffered from syphilis or not, except in certain exceptional cases which I shall afterwards endeavour to explain, while the hard chancre only once affects the same individual, and is not transmissible to a person who has had constitutional syphilis. Thus it is that the doctrine of syphilisation falls to the ground. It is but the reproduction *ad infinitum* of the soft chancre in the same individual. Lindmann, who inoculated himself upwards of 2,200 times, did not attain the desired saturation; and some of the more celebrated expounders of the doctrine, Hebra and Sigmund, of Vienna, will not assert that the most thoroughly syphilised persons possess an entire immunity. The contrary has been established, in fact, by Ricord, who has more than once exposed the fallacy of this pretended protection with the point of his lancet. Before the time of Hunter, and since it, down to

our own time, the different forms of the malady were ascribed, not to any modification of the virus, but to such causes as a different constitution, temperament, &c.—in fact, the unity of the virus was universally admitted. Several modern writers have sought to explain the different manifestations of the syphilitic poison by adopting a plurality of causes. Carmichael was among the first who mooted this idea. He proposed to recognize four distinct forms of virus, each the antecedent of a peculiar variety of the disease. This theory, however, could not stand the test of a more extended experience. It has yielded in later times to the doctrine formularised by Ricord and his followers, viz., that there are but two distinct primary manifestations of syphilitic poison,—one the hard or infecting chancre, the other the soft or non-infecting chancre. Bassereau further believes that each of these varieties transmits itself as a pathological species, and cannot engender the other. Bassereau attempts to establish his position by historical evidence. Up to the end of the 15th century, gonorrhœa, chancre, buboes, were described by writers on these subjects, as diseases merely requiring local medication, and in no instance were any sequelæ to these diseases mentioned. The end of the 15th century, however, is stated by contemporary writers to have been marked by the appearance of a new disease, the symptoms of which were similar to those now described under the titles secondary and tertiary syphilis, and for the treatment of which constitutional measures were necessary. When Bassereau asserts that the one form of sore is not convertible into the other, he is mistaken, as, under peculiar conditions, as I shall afterwards strive to explain, a hard chancre may be transmitted to another individual under the form of a soft non-infecting sore, while authentic instances are also recorded when the soft chancre will produce the hard infecting sore with all its sequelæ in the economy. Bassereau and Clerc, as well as Diday and Rollet, of Lyons, from their personal experience, state that the hard chancre transmits itself in its own form. Ricord cites fifty-nine examples in which the origin of the disease was traced, and in each case, without a single exception, the relation was found to hold good. In all these cases, however, the subject to whom the chancre was transmitted by contagion, was free from all syphilitic antecedents. In the case of persons who have previously had syphilis, the question becomes changed. Let us now inquire if the hard chancre always owes its origin to a chancre of a similar nature, or can give rise to any other form of primitive sore. It has been established by the syphilisators, though the result had been an undesired one, that the ordinary soft chancre in a person free from constitutional syphilis, can only recognise for origin chancre of the same nature. There is, however, another variety of soft chancre, undistinguishable, save by its origin,

from the usual kind. It is the chancre produced in a person who has had syphilis, by the contagion of a hard or infecting sore. This, in virtue of the unity of the syphilitic virus, does not indurate, it presents the usual characters of a soft chancre; and, according to M. Clerc, who has given it the title of chancroid, should perpetuate itself in that form, totally irrespective of its origin. But the question now arises, whether this so-called chancroid, if transmitted to a third person, free from all syphilitic antecedents, would retain the non-infecting character, or take on the infectious nature of its origin. This is a point which cannot be very readily cleared up, from the number of elements concerned in its solution. There is a less complex problem, however, which has been satisfactorily answered, viz.: can a person having had constitutional syphilis, the subject of a new chancre, which must, of necessity, be a soft one, transmit to another individual hitherto free from syphilis, a hard chancre, followed by the symptoms of secondary syphilis? Cullerier has furnished us with an example in the affirmative. Robert of Marseilles, one of the most ardent champions of the unity of the virus, has given us several conclusive examples to the same effect. But it is by no means a necessary consequence, and Ricord arrives at the following conclusion on the matter, viz.:—that the chancre with soft base occurring in syphilitic subjects, may transmit itself either as a hard chancre, or as a soft chancre, and that it is probable that the form under which this chancre reproduces itself, depends on the nature of its origin, that is to say, whether it was derived in the first instance from a hard or a soft sore.

It is these points of connection which lead one to believe that the two forms of primary sore are not manifestations of two different forms of virus, however different they may be as to their primary aspect, and as to the after progress of the disease. That they are sufficiently distinct as pathological conditions is admitted, I believe, by most persons. And it is surely a matter of vital importance, as to whether we have to deal with a local disease, merely requiring topical medication, or a constitutional malady, which some of the greatest authorities consider can never be entirely eradicated from the system. Nevertheless, in spite of well-marked distinctions, I think the weight of evidence goes to establish that the two varieties of chancre are manifestations of one and the same virus; that in some instances they are convertible, although in the great majority of cases they follow distinct courses. There is another circumstance also, which, I consider, establishes a close relation between the two chancres—one which fortunately cannot be put to the test of experience in this country—namely, that as yet no example of soft chancre has ever been found on the face or scalp. It would seem as if any syphilitic sore, whatever be its origin, were, of necessity, of the

infecting kind when situated in that region. M. Puche gives 28, and M. Ricord 26 examples, in which chancres situated on the cephalic region, whether externally, or on the tongue, lips, nostrils, always evinced an infectious nature, and were of the indurated variety. In the course of last year, M. Founder published a pamphlet on the subject of cephalic chancre, in which he records 120 cases collected at the hospitals of Midi and St. Lazare, in which he states, that in only two or three instances were the sores in this region unfol-
lowed by the usual sequelæ of the hard infecting chancre, and that in these two or three instances there was a considerable amount of doubt as to the true nature of the affection. This is a very important fact in the history of syphilis, and is an additional circumstance in favour of the unity of the syphilitic virus. Moreover, if the two forms of chancre were proved to belong to two distinct pathological species, it would establish nothing contrary to the unity of the true syphilitic poison. It would merely prove that in addition to the syphilitic poison, there was another affection commencing in a similar manner, with a sore, secreting virulent pus, but unlike syphilis, exercising no after effect on the economy.

I do not consider myself justified to judge on this matter, but I have ventured to lay the subject before the notice of the Society, in order that the individual experience of the members might be brought to bear *pro* and *con* on the subject.

TWENTY-FIRST MEETING.

March 31st, 1860.

The President in the Chair.

Dr. HARKIN introduced a child six days old, in whom the cerebrum was very imperfectly developed. The cranial bones were fully formed, the scalp loose, and the pupils contracted to the finest points. The child in other respects seemed healthy.

Case of Neuroma.

Surgeon BROWNE exhibited a neuroma which he had dissected out of a stump of the arm a few days previously.

The man from whose arm the growth was taken had, in Nov. last, his hand crushed by machinery, necessitating amputation of the forearm; this was done by Dr. Murney; disease of the bones, however, ensued, and the arm was again amputated about the middle. The case had been brought under the notice of the Society¹ early in the Session, by Dr. Murney. When the stump had healed up, acute irritation and periosteal inflammation set up, leading to the fear that it would be necessary to remove the limb at the shoul-

¹ [Occasion not identified.]

der joint. After some active treatment, however, the inflammation was subdued, and the part healed up entirely, save at one point, where a ligature was firmly held, and touching which gave intense suffering. At length, after repeated efforts, the ligature came away, the wound healed up, and the man was discharged for change of air, as his general health had declined considerably. He remained out of hospital for four or five weeks, but did not improve, as he latterly suffered constant irritation of the stump, and neuralgia of almost the entire system. On readmission, it was found that a neuroma had formed, and from which all his suffering proceeded. This growth was firmly attached to the inner portion of the cicatrix, in connexion with the bone.

“This,” Mr. BROWNE then said, “I dissected carefully out, dividing all the nerves I could discern in connexion with it, and divided the nerves some inch and half above the neuroma; in this dissection the brachial artery and a smaller vessel were divided and ligatured. My friend and colleague, Dr. Murney, examined the removed structure, and found the growth contained the extremities of the median, ulnar, and internal cutaneous nerves. The ulnar exhibited principally the congested and inflamed condition usually observed in this painful affection. Of course there is not any certainty that the disease will not return. At present, however, while there is pain and inflammation in the part, the general neuralgia has almost subsided. The patient I shall now treat by the exhibition of the preparations of iron, quina, and valerian, with a view of improving the health, and acting specially on the nervous system. Of course change of air will be advised.”

Dr. CORRY presented the Society with a drawing copied from one which accompanied the history of a case of Molluscum, furnished by Dr. Babington, of Derry, on the 5th Nov. last. The thanks of the meeting were conveyed to Dr. Corry for his contribution to the Museum.

TWENTY-SECOND MEETING.

April 7th, 1860.

The President in the Chair.

Dr. PIRRIE exhibited a foetus, with extra-cranial development of cerebrum.

Case of Senile Gangrene.

Surgeon BROWNE exhibited the morbid parts in, and read a case of, Senile Gangrene.

The patient, J. M'C, aged 67, a native of Whitehouse, was admitted into the Belfast General Hospital on the 12th of March, labouring under an attack of *gangrene senilis* of the leg and foot. The history of the

patient may be briefly stated. He had been an agricultural labourer all his life; had worked very hard; had been frequently exposed to great hardship and vicissitudes of weather; he had always lived temperately, and had reared a family of several children. Up till six weeks before admission to hospital, he had enjoyed excellent health, and had followed his calling every day. At the time specified, he began to have an uneasy burning sensation about the toes and heel of the left foot, with a pain and stiffness in walking. For three weeks he continued to work in the fields, the pain, however, increasing. About that period, he first saw discoloration of the toes, and he observed a coldness and numbness in the part. He was then compelled to take to his bed, the discoloration and coldness gradually creeping up the leg.

On the day of his admission to hospital, he presented the following signs and symptoms. From the left knee to the toes the part was quite cold and insensible; the upper part a deep olive colour, and flaccid to the touch; the lower portion and the foot quite black, and harder than natural. Above the knee there was an irregular line of demarcation, the part being dusky red and exceedingly painful; along the thigh, and upon the abdomen, the superficial veins were of a deep chocolate colour, and highly congested; the skin was covered with a free perspiration, and was all over of a dusky hue; the tongue was thickly coated with sordes; he had great thirst and oppression in breathing, and was very restless; the pulse was very irregular, weak, and about 110 beats in the minute. On examining the heart with the stethoscope, it was found to be weak and laboured in its action, an intermission, or rather a flutter, taking place about every four or five beats; no *bruit* could be detected; sugar in quantity was found in the urine. The femoral and external iliac arteries of the left limb were quite obliterated; the vessels of right limb pulsated throughout. This state of matters continued increasing, the thigh became greatly swollen and discolored, and the superficial veins all over the body became congested, and a most offensive odour escaped from the gangrened limb. For a few days before his death, the pulsation ceased in both radial arteries, and in the brachial artery of the right side; but on the 5th of April, the day before he died, pulsation, warmth, and colour were restored to both arms.

The post-mortem examination showed the heart to be hypertrophied in its left ventricle, with some fatty degeneration. The mitral valve was quite healthy, but the aortic semi-lunars were incompetent. The ascending aorta was considerably dilated, and covered with patches of atheroma, while the entire of that vessel, as well as the iliac arteries, were greatly inflamed. In the left common iliac there was a firmly-organised fibrinous clot; the vessels also arising from the arch of the aorta partook of the arteritis which

prevailed in the main trunk. The iliac veins and ascending *vena cava* were also inflamed, while in the latter, for several inches there was a fibrinous deposit or clot, firmly adherent to the lining membrane of the vein.

Surgeon BROWNE directed attention to the similarity of the case before the Society to one he had related in the November number of the *Dublin Journal of Medical Science*, and to be found among the *Transactions of the Belfast Medical Society*, for 1859,¹ and which he had given in full detail. Both cases illustrate the pathology of senile gangrene, as demonstrated by the Baron Dupuytren, namely, inflammation of the arterial system in some of its parts, and also of the veins; this inflammation, no matter how provoked, causing occlusion of the vessels, and consequent gangrene in the parts which they should supply with blood.

Dr. DRENNAN exhibited the larynx and lungs of a man whose symptoms previous to death were aphonia, cough, and great debility. The condition of the parts did not explain the cause of the aphonia, and though the lungs exhibited numerous isolated diseased spots, their condition was deemed insufficient to account for death.

447 Notice of the Twenty-Third Meeting in the Seventh Session.

Office-Bearers

President—Professor Reid.

Ex-President—Surgeon Browne, R.N.

Vice-Presidents

Dr. Murney.	Professor Gordon.
Dr. Reade.	Dr. Babington, Derry.
Surgeon Ferris, Larne.	

Council

Dr. Drennan,	Dr. Pirrie.
Dr. Dill.	Surgeon Johnston.
Dr. Patterson.	Dr. Heeney.

Treasurer—Dr. Halliday.

Secretaries.

Dr. Wales.	Dr. Cuming.
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The Twenty-Third Meeting of the Society this Session will take place in the Museum of the General Hospital, on Saturday, April 14, at Three o'clock.

BUSINESS.

The President will exhibit "Recent Parts illustrative of Morbid Appearances in Typhoid Fever."

Professor Gordon will exhibit—"Specimen of Scrofulous Disease of Shaft of Femur;" and make observations on—"Amputation at and in the neighbourhood of the Hip-Joint."

¹ [See page 225.]

Surgeon Johnston will read "Case of Empyema, with Post Mortem."

Dr. William Aickin will read "Notes of rapidly fatal Case of Diphtheria."

The Subscription—increased so as to enable the Council to forward the Transactions, as published, to every Member—being 12s 6d. to Town, and 7s. 6d. to Country Members, will be received by the Treasurer, at this Meeting.

Members desiring to forward Cases and Observations to be brought under notice of the Society, or to propose Candidates for Membership, will please communicate with the Secretaries, at least Three clear days before the day of Meeting.

Members of the Society have the privilege of forwarding Morbid Specimens, for examination by the Chemical and Microscopical Committee, and of receiving reports on their nature.

The Museum of the Society is open to all Members, between Two and Three o'clock on each day of Meeting.

JAMES CUMING, M.D.,
GEORGE F. WALES, M.B.,
Hon. Secs,

General Hospital, April 12, 1860.

TWENTY-THIRD MEETING.

April 14th, 1860.

The President in the Chair.

Dr. MOORE introduced a coloured woman, the greater part of whose right upper maxilla he had removed some time since. The absence of much apparent deformity, and the partial reproduction of the lost parts, were the points of interest in the case. He also exhibited a cast of the parts removed, which contrasted surprisingly with the slight deformity now discoverable.

Typhoid Fever.

The PRESIDENT made the following communication:—

I exhibit to-day two morbid specimens, of much interest in connection with the pathological changes occurring during "*typhoid fever*." It is only occasionally that such cases occur under circumstances that render them instructive and available for the elucidation of disputed points in the etiology or symptomatology of that disease. I shall, however, at present only allude to such of these points as my cases appear capable of illustrating.

I may premise my observations on the patients to whom these specimens belonged, by stating, that in this town and neighbourhood there has prevailed, for some time past, and in greater frequency than our usual "maculated typhus," a fever bearing the charac-

teristics of the species to which the name of “typhoid” has been given.

Since the publication, in 1829, of Louis’ treatise on the typhoid fever of France, much discussion has taken place in this country as to whether typhoid fever existed also here as a separate species, capable of being recognised and distinguished from our own “*maculated typhus*.” Unfortunately, the discussions on the affirmative and negative sides of this question were, until very recently, couched in general terms by both parties, without any attempt at investigating the subject by the method adopted by Louis. Whilst, therefore, we are not unmindful of Dr. Stewart and other physicians, who had ascertained and asserted that typhoid and maculated typhus were different species, we must accord to Dr. Jenner, of London, the merit of having been the first who adopted fully the method of Louis in his investigations, and of having succeeded in convincing many, that both species may be found prevailing at the same time in this country, and with varying frequency in the same hospital;—that infection from one kind will not produce the other, and that they are capable of being recognised and distinguished at the bedside of the sick.

In my report of the epidemic fever that prevailed in this neighbourhood in the years 1847 and 1848, which appeared in the *Dublin Quarterly Journal of Medicine* in 1849, I had advanced similar views respecting there being a plurality of fever poisons in that epidemic. Two years afterwards, I had evidence to satisfy me that typhoid fever existed also here as a distinct species, with all the characteristics described by Louis; that it might be found in the same hospital with cases of maculated typhus, and I am now certain that I had previously classified many cases of it as “*synochus*.”

In opposition to those who assert, that the different fevers which they acknowledge they meet with are merely the result of the influence of age, peculiarity of constitution, season of the year, or epidemic constitution of the year, the holders of the doctrine of a plurality of fever poisons adduce, as one of their arguments, that infection from one kind will not produce fever of another kind, and that it is possible to be able to trace in innumerable instances, that the cases of one species have been infected by persons suffering under the same kind of fever.

Now this is one point upon which I believe that the histories of my patients may be said to be instructive.

For some months past typhoid fever has prevailed in a village in this neighbourhood, and, through the kindness of a medical friend, I have been able to ascertain that both patients were, from periods varying from one to five days, in the house of his patients there who were ill with typhoid fever; whilst from another medical friend, who visited them when they took ill on their return to town, and whose official

position keeps him cognisant of the diseases prevailing where they resided, I have ascertained that there were no other cases of fever in their house, or in the neighbourhood of their residence.

Having thus traced them to have been within the sphere of typhoid infection, I next proceed to state the histories of their illness, and I shall commence with that of the girl who died first, premising that they were both aged about 18. This girl could give no history of her illness, being unable to speak when first seen, and, therefore, the account of it had to be obtained from her sister and others, who, however, agreed in all important particulars.

She visited the infected house on the 26th February, slept there at night, and returned to town the next day; continuing to work till mid-day of the 29th. Between these dates, it has been ascertained that she had frequent rigors, with intense headache, and alternate pallor and flushing of face. Diarrhoea also existed, as the floor of her room was in many parts covered with intestinal discharges. Her sister (whose intelligence was perfect) stated that the bowels had been very loose from the commencement, and that she had a rigor on the 27th. The existence of vomiting could not be ascertained. From the 1st of March her sister could not understand what she said, and in this state she was seen by her town attendant at his first visit, on the 4th, who directed her removal to hospital, which she did not reach till the evening of the 5th. She was then very cold and trembling, with a feeble pulse; her right eye much injected, the right pupil contracted, the other dilated, and still unable to speak. The appropriate treatment for the relief of the head symptoms was adopted, and she was reported, at my visit in the morning, to have improved in appearance during the night. I could not, however, count her pulse with accuracy, owing to the great subsultus, nor could she speak or protrude her tongue, although she appeared to understand what was said to her. The pupils were then both dilated, and the eyes injected. The bowels had become quiet. No improvement took place during the day, and she died before midnight of the 6th.

On post-mortem examination, the membranes of the brain appeared to be minutely injected with blood, entirely free from opacity in any part, and without any serous effusion. The substance of the brain, on being sliced, presented numerous dotted points, but there was no effusion into the ventricles. The lungs were both healthy.

No evidence of disease was found in the small intestine, until within a foot of the cæcum, when the mucous membrane became intensely injected. Peyer’s patches were now found swollen, red, and elevated above the surface, and this became more manifest as the cæcum was approached; six of them were found, (as may be seen in the specimen,) in a state of ulcera-

tion. There were no ulcers in the cæcum or colon, but about four inches from the commencement of the latter a brightly-injected patch of some inches was found. The mesenteric glands were enlarged to the size of filberts, and of a bright red colour.

This preparation, having been kept in spirits for some weeks, has become shrunken and much paler, and the non-ulcerated patches less raised than they were at first. Even the ulcerated patches have contracted fully one-half, so that the specimen has now less the appearance of acute disease than it had on removal.

Such was the state of the morbid parts on the ninth day, after she had spent a portion of a day and night in a house in which typhoid fever prevailed; and on the *eighth day* after she had experienced the initiatory rigor and other symptoms of her own illness.

And here I have to mention one of those disturbing elements that so often interferes with the accuracy of our conclusions in the investigation of disease. Had there been no possibility of her receiving infection, except during her visit on the 26th, we could have said, that the period of incubation in typhoid fever might be only 24 hours; but, it unfortunately happened, that the sister, whose history I have next to notice, had spent a portion of the day of the 19th February in the infected house, and as we admit that the infection of maculated typhus may be carried by the clothing of a healthy person going from an infected to a healthy house, if we extend the same law to typhoid fever, we must admit the possibility of her having imbibed the infection off her sister's clothing during the night of the 19th, which she spent with her in town, this sister having returned to the country the next morning. This would extend the period of incubation to eight days. I am not, however, disposed to adopt this latter view.

In addition to our being able to trace this case to have originated in infection from a typhoid patient, there are several other interesting circumstances connected with it.

1. Her death, within eight days after the initiatory rigor had taken place, and the existence already of ulceration in the ilium. Louis records only three cases of death so early as this, and it is somewhat remarkable, that the cerebral symptoms, such as the intense headache, the state of the pupils, the indistinct articulation, and latterly the taciturnity, and also the state in which the post mortem examination found the brain and the ilium, were, with a few trivial variations, precisely similar in his cases to what were present during life, and now exhibited as found after death in this case.

2. I believe that I am justified in ascribing the early death in this case to a destruction of nervous power from the circulation of the fever poison through the brain. We know that in small-pox, scarlatina, and

maculated typhus, cases occur occasionally, in which the nervous system is destroyed at once by the poisons of these diseases, and that the patient dies before their usual symptoms have had time to develop themselves.

3. The case is also instructive, as showing how early in the illness ulceration may take place, and that the disease is always farther advanced in the vicinity of the cæcum than in the direction of the duodenum. It also shows that the mesenteric glands are involved from the commencement of the fever, and not, as has been said by some, from irritation produced by extensive ulceration in the intestines.

I have next to notice the history of the second girl.

She, as I have already stated, visited the infected house on the 19th Feb., coming into town in the evening, and returned to attend the sick the next day, remaining with them till the 25th. Her intelligence, when seen, was unimpaired, and she stated that she was in perfect health on the 29th, that she had rigor and headache on the 1st March, and, although unwell, struggled on at her work till midday on the 3rd, when she was obliged to give up, and, as there was no one to look after her or her sister, they were sent into hospital on the 5th.

On the morning of the 6th her pulse was 114, her tongue red at the tip, furred, and moist in the centre; her bowels had been loose from the commencement, but the evacuations were free from blood. Her abdomen was full, and there was pain in the region of ilium. She had slight vertigo, but the headache had ceased; there was no noise in her ears, and the eyes were bright. A few red papulæ were found on the back of the chest, removeable by pressure. There was no cough, but there was present a symptom which I have observed to be of serious import, namely, a jerking or rather sobbing kind of inspiration.

I shall not occupy your time with a detail of the symptoms as they were daily entered in the case book, but shall only mention the gradually increasing intensity of them all till her death on the 25th of March, the 25th day after she had suffered from rigor and headache; and, it will be observed, that the day of the month answers also for the day of her disease, as her illness began with rigor on the 1st. On the day after her admission the pulse had risen to 132, and was found only once again so low as 120, having on two occasions reached 140. On the 6th of March the tongue was dry at the tip, and this state soon became general over it. On the 12th it was protruded with difficulty, and the voice became tremulous on the 18th, with indistinct articulation on the 20th. On the 19th there was tremor and subsultus; and on the 21st these involved almost every muscle of the body. Only once did she complain of headache; and her eye remained clear and bright till within a few days of her death. From about the 20th she was much disposed to

sleep, and there was occasional quiet delirium. The bowels acted two, four, six, or sometimes eight times daily, through all her illness; the abdomen was tympanitic, and remained full, whilst it was never free from tenderness on pressure over all the lower part of it. The evacuations from the bowels were generally very fluid and yellow, and never contained any blood. There appeared some cough on the 21st, with frothy expectoration, occasionally streaked with blood; it did not, however, increase in intensity. There was never any epistaxis.

On post-mortem examination, the lungs were found quite healthy.

Over several feet of the ilium, the elliptical or Peyer's patches were found red, raised, and ulcerated, as also a few of the solitary glands. These patches are evidently larger, and the disease in a more advanced stage, in the immediate vicinity of the cæcum. Two ulcers were found in the cæcum, and two on the commencement of the ascending colon. The mesenteric glands were found enlarged and much injected with blood, but not so swollen as in the other case. It is not without interest to observe how closely the morbid appearances found in this patient tally with several of Louis' cases who died about the twenty-fifth day of their illness. The brain was not examined. The immersion in spirits of the morbid parts since the 26th, has rendered them paler and contracted, and thus diminished the appearance of active and acute disease which they presented on their removal. I was constrained to do this, by feeling that I could not present their cases so instructively before you, until I had ascertained the nature of the disease from which they appeared to have imbibed infection; and for the trouble taken by my medical friends in obtaining information for me on this point, I feel very grateful.

Surgeon JOHNSTON read the following

CASE OF EMPYEMA.

During the summer of 1856, the subject of these remarks went to Newcastle for a holiday; when there he caught cold, and was seen and treated by Dr. Rea, who was also there at that time. He returned to Belfast in the beginning of September, when he first came under my notice. At this time, he looked very ill, had fever of the hectic type, suffered from dyspnoea and cough. On examination, I found evidence of disease in the upper portion of the left lung. There was crepitation, the expiratory murmur was unusually loud, and there was slight comparative dulness. The heart was in its normal position, and there was a *bruit* heard over its apex. Connecting the local and constitutional signs and symptoms, I was led to fear that his disease was of a tubercular character. Dr. Seaton Reid also saw him, and after repeated examinations, was of opinion that there were evidences of diseased action in the upper portion of left lung. He remained in town

during the winter of 1856, and until the summer of 1857. During this period, he continued in delicate health, suffered from exhausting night perspirations, had an attack of diarrhoea, and was quite unable to continue his duties as a clergyman. About July he went to the country, and whilst there he was laid up with what his friends considered an attack of fever, but which attack was ushered in with a severe shiver, and acute pain in his left side. Finding that he only partially recovered, and that his health continued to decline, he went to Dublin in October, 1857, and placed himself under Dr. Stokes's care. Dr. S. now discovered that he had extensive pleuritic effusion into the left side, the heart being completely displaced to the right. Dr. S. prescribed a prolonged course of iodine taken internally, and applied externally. He also administered the infusion of digitalis for a few days, but with great caution and constant watching.

Dr. Stokes took a great interest in his case: and here I cannot help gratefully acknowledging his uniform kindness and generosity to him,—I believe, only in keeping with his usual benevolence. Finding that the effusion continued, and that its amount was uninfluenced by the remedies administered, that the side was distended, and that the fluid was rather increasing than diminishing, he entertained the idea of tapping the chest. With this view Dr. S. called in Mr. Adams; on consulting, however, and hearing somewhat more of his previous history, and of his illness here in 1856, they determined not to interfere. He passed the winter of 1857 and spring of 1858 in Rostrevor. Writing from Rostrevor in December 1857, he thus describes his own feelings, position, and appearance, "It has pleased God to lay me aside as a useless vessel, a broken trumpet, a bruised reed. I have long felt as one carrying his coffin under his arm, unseen by any but himself."

He returned to Belfast in the summer of 1858, and I now for the first time had an opportunity of examining him since he left Belfast in 1857, and of course since the effusion had taken place in the left pleural cavity.

He presented an emaciated anæmic appearance. His pulse was seldom above 84. He had no hectic. The digestive functions were but slightly impaired. He slept comfortably, lying diagonally on the diseased side. He had a dry cough, and except when hurried, complained very little of any respiratory distress. I should say that the ratio of the respiration to the pulse was but slightly, if at all disturbed. His voice was weak; he complained very little of any local pain. The left side was visibly enlarged, and its movements restricted as compared with the right. The intercostal spaces were dilated and bulging.

The mediastinum was displaced; the left hypochondriac region was filled up; there was complete dulness all over the left side, absence of the respira-

tory murmur, except at the vertebral column behind, where respiration of a bronchial, blowing character could be heard. Vocal vibration was abolished. The heart was felt beating to the right of the sternum, beyond the cartilage of the fifth rib. And here I must advert to a symptom, in the observation of which Dr. Stokes took a considerable interest, viz., a distinct pulsating movement conveyed to the empyema from the heart, and manifest in the left cardiac region, so as at first to lead you to believe that there was two centres of pulsation.

This curious phenomenon may exist in various degrees, and is adverted to by Dr. Stokes p. 607 in his work on Diseases of the Heart. Walsh also, in his treatise on chest diseases, has described a pulsating variety of empyema, and narrated cases in illustration. The right lung was healthy, the respiration loud and puerile. From this period up till his death he continued under my observation. In the spring of the year 1859 he had a sharp attack of bronchitis in the right lung, which confined him for some weeks to the house, and caused him considerable uneasiness. If I except this illness, I might say that, up to within ten days of his death, he was able, with care, to follow to a very great extent his ordinary pursuits. He visited his friends, and enjoyed their cordial hospitality—administered to the poor and the sick. He presided at public meetings, and frequently preached and conducted the religious exercises of his charge. All this will appear the more wonderful if we contemplate “the coffin he was carrying about under his arm.”

Ten days prior to his death he presided at an evening meeting in one of the churches in town. The following day he felt ill, and was seen by Dr. Rea, who, with Dr. S. Reid and myself, attended him until his death. He had a shiver, and complained of acute pain in his right side, near the base of lung, where, on examination, we found evidence of localised pleuritis. There was also considerable diffused bronchitis. His pulse quickened; his breathing became somewhat distressed; he complained of a feeling of distension and uneasiness in the left side. He lost his appetite; stomach refused to retain food; he gradually sank, and without much pain or distress, died on the evening of Tuesday, March 14th, aged 36 years. His death was rather from asthenia than dyspnoea.

Dr. Murney kindly conducted the post mortem 30 hours after death, in presence of Dr. S. Reid, Surgeon Rea, and myself. The left hypochondriac region was completely filled up by a prominent fluctuating tumour. On opening the abdominal cavity, we found the left pleura covered by the left leaf of the diaphragm, projecting into and completely filling up the left hypochondriac region, even extending into left iliac, displacing the left lobe of the liver downwards, and to the right, and pushing the stomach completely into the umbilical region. The liver was not larger than

usual. It presented a mottled or speckled appearance. There were no evidences of any tubercular deposits in the abdominal cavity. On opening the left pleural cavity, we found it completely filled with pus, which, on careful measurement with a graduated measure, was found to amount to above the almost incredible quantity of two gallons. A small elongated, flattened mass, about four inches in length, and two in breadth, was found at the upper and back part of the cavity. This was all that remained of the lung, its surface covered with a false membrane fully one-sixth of an inch in thickness, and completely tied down by firm bands of adhesions. On making a section, we discovered purulent deposits in its substance.

The small bronchial tubes were very manifest, and on careful examination of the compressed mass, we found traces of an old-standing cavity, viz., a defined space, lined with a thin membrane, with the extremities of small bronchial tubes opening on its surface, but no evidence of its having been a tubercular cavity, nor could tubercle be discovered elsewhere in the compressed lung. The right lung was considerably encroached on by the fluid contents of left pleura, as well as by the heart. It was rather hypertrophied, somewhat emphysematous, but perfectly free from any tubercular deposit. The pleural covering of the base was coated with recent lymph, and there was about 10 or 12 ounces of serous effusion into the right pleural cavity. The heart was small and flabby; its apex was opposite the right rib one inch beyond its junction with its cartilage.

The retrospect of this case suggests two or three points of interest. First, the amount of purulent effusion found, is, I believe, almost unparalleled. Dr. Watson mentions a case in which Sir P. Crampton drew off the “almost incredible” quantity of fourteen pints—here we had over seventeen. No doubt the fluid had increased during the patient’s final illness, but even making some allowance for such increase, does it not strike one with surprise, that for the last two years and a-half he was capable of such physical and mental efforts. Not more than two months since, I was myself present at a large public meeting at which he presided, and made a very happy and pleasing speech in honour of a much esteemed friend, who had been acting for some time as his assistant. We have certainly here manifest proof of great strength and composure of mind, as well as of the adapting and sustaining power of nature. But another point of interest suggests itself—was the effused fluid from the first of a purulent character; or was it sero-albuminous?—the sac afterwards taking on a pyogenic character, and the watery constituents of the primary effusion undergoing absorption. I am rather inclined to think, that the chronic supervened on the acute attack—and that the products of the diseased action changed. The absence of any well-marked hectic, for a period of

above two years, is worthy of notice, and was calculated to mislead one in regard to the nature of the contents of pleural sac. He had no night perspirations of any moment after the spring of 1857, and his pulse was seldom or ever above 84. But the most important inquiry in connection with this case is, how far it would have been suitable for the operation of paracentesis, and whether such operation would have proved effectual, in restoring or prolonging the life of our patient?

In Ireland we are much behind our French and English brethren in adopting this operation. "A procedure," says Walsh, "which, no matter how divided opinion may be respecting its general feasibility, has assuredly been sufficiently often either completely successful, or productive of marked improvement, to justify its being numbered among the valuable gifts of surgery."

Dr. Watson lays it down as a rule, that whenever (no matter how we ascertain the fact) the effused liquid consists of pus, it should be let out. And Laennec advocates the performance of the operation in tuberculous patients, because even in them it may be the means of somewhat prolonging life. Out of sixteen cases of empyema, in which paracentesis was performed, Dr. T. Davis reports twelve recoveries.

The necessity of operating in the case I have detailed was for a time a subject of serious consideration with Dr. Stokes; and now, in reviewing the case, with the light thrown upon it by the postmortem, I am inclined to conclude that, failing the remedies administered to promote the absorption of the fluid, it would, (when the adhesions were recent,) have been a fair case for the operation. No doubt, we are now in possession of knowledge which at that time it was impossible to arrive at, and in regard to which the weight of evidence leads one to arrive at a different conclusion from that to which the results of the post-mortem conduct. I refer, of course, to the prior existence of tubercular disease of the left lung.

Whether it is possible that the pressure of the fluid may have expelled any tubercular matter from the cavity, the remains of which we have shown you, may admit of some doubt; but I believe that the weight of evidence is in favour of the view, that the attack at the apex of his left lung, for which I attended him eight months prior to the effusion, was of an asthenic inflammatory character, terminating in abscess, but not tubercular.

The absence of all trace of tubercle, either in the healthy lung, or in the abdominal cavity, and of any cretaceous particles in the remnant of the left lung, lead one to conclude that we had not a tubercular patient to deal with. And if we add to this the power which his constitution showed in bearing up so long and so well under such an amount of disease, we will feel more impressed with the opinion that, at an early

period, paracentesis might have possibly been attended with success. No doubt any interference of late would have been very injudicious, the lung being so firmly compressed and bound down by such thick adhesions, as to forbid any hope of its expansion—a very material condition to a successful issue.

In support of the view I have here taken, I cannot help adverting to the case of M'Donnell, the news-boy, whom I presented to the notice of the Society some time ago. In this case, nature performed the operation under very unpromising circumstances, and yet, notwithstanding that he has been constantly exposed during the past inclement winter, his health continues to improve, the discharge from the fistulous openings has almost ceased, and I believe that there is now every prospect of a permanent recovery. On the other hand, however, weighty reasons may be adduced for not interfering in the case now reported:—The absence of hectic, or any urgent symptoms of respiratory oppression, and the fear that the entrance of air might have caused putrefactive decomposition, with accompanying constitutional disturbance, under which our patient might have succumbed at a much earlier date.

Council Special Meeting Monday 16th April.

Present, the President, Drs. Dill, Halliday, Wales, Cuming, Patterson, Browne.

List of members was prepared.

Moved by Mr. Browne seconded by Dr. Patterson "That casts to be taken of the morbid parts presented by the President at last meeting."

Accounts were passed of advancements in medical registration.

Council Wednesday [undated].

President, Dr. Cuming.

Circular was prepared.

Passed 10/6 to J. McCann for materials for casts.

TWENTY-FOURTH MEETING.

April 21st, 1860.

The President in the Chair.

Aneurism of Aorta, Opposite the Cæliac Axis.

The PRESIDENT said:—

I exhibit to-day some morbid structures, removed from the body of a patient who died from the bursting of an aneurism.

His age was 40. He stated that his employment had required him for years past to lift heavy weights; but that he had never felt any sudden pain, or received any injury till about one year and a half ago, when, on stooping to roll a barrel, he felt a severe pain across "the small of his back."

Having a considerate employer, he was changed by him to a less laborious kind of work, which enabled him to continue constantly on duty till one month ago.

Since he first felt pain, he has always had difficulty in stooping, and required help to put on his shoes in the morning. The pain was always increased in the evening, and during the early part of the night, till he became warm in bed. It was renewed by cold, and became less severe when he was engaged at work. It was so much relieved by the hot weather during two months of last summer, that he thought he had got rid of it entirely.

The pain was of a constant boring kind across the spine, and in both haunch bones, "as if his loins were in a vice," but this feeling did not extend to the front of the abdomen.

He had never had any shooting pains or cramps in the abdomen or legs. He is unable to flex the right leg up towards the trunk as perfectly as the left, and when he stands it is advanced forward in much the same position as in a person with hip-joint disease. There is no œdema of the limbs, but when he stands up the veins in both legs become suddenly and unusually prominent.

He has never had any difficulty in swallowing, or any hiccup or vomiting. His bowels only require medicine occasionally; they act without pain, and the evacuations have never contained blood. He has no difficulty in passing urine, which has never been bloody; its specific gravity is 1,635, neither saccharine nor albuminous. He has never had any pain in the testicles.

He lies best on his right side, less easily on his back, and worst on his left side.

His countenance is pale and sallow, and he has been emaciating rapidly during the last four or five weeks.

He has never had any cough or dyspnoea, or expectorated blood.

About two weeks ago, he observed "a beating pain" in his back, and some numbness in right loin, extending about four inches forward.

A pulsating, slightly elevated tumour is to be felt and seen between the 11th, 10th, and perhaps 9th intercostal spaces, on the right side, about one or two inches from the vertebræ, but none on the left. Pulsation is also seen extending forwards round the right loin, just below the margin of the ribs. The slightest pressure over this locality gives acute pain, but there is no pain on left of the spine.

A slight pulsation is to be seen and felt in the mesial line between the ensiform cartilage and to within an inch or two of the umbilicus.

A double sound, almost identical with that of the heart, is heard quite distinctly over the tumour and the spine, and to the left of the latter; but there is no

murmur. This sound only continued for about four days after he was first seen by me.

A single murmur is heard about half an inch below the ensiform cartilage, and over a triangular space, bounded by the margins of the ribs and a line crossing about an inch above the umbilicus. This murmur is best heard on light pressure with the stethoscope, and disappears entirely as we approach the region of the heart. It is but doubtfully heard when he stands erect, and is not equally distinct on every day.

No murmur is heard in the aorta, at, or below the umbilicus.

The right pupil is markedly smaller than the left, but capable of being dilated by belladonna to the same size as the left; again resuming its contracted state as soon as the effects of the belladonna passed off.

There is a distinctly increased pulsation in the right side of the neck, and in behind the sterno-clavicular articulation, which is very marked when compared with the left side.

A double sound is heard continuously from the top of the sternum, and its margin on both sides, till the heart is reached. No murmur is heard at any portion of the chest or cardiac region, till the stethoscope again reaches the epigastrium. No heaving pulsation is to be seen or felt over the front of the chest or cardiac region in any position.

Such is a statement of the positive and negative symptoms, presented by this patient when I first saw him.

The only change in them for several days, was his feeling more pain in the left hip, and some pain for the first time in his left shoulder, and in attempting to raise the arm of that side; A "smarting pain" was also felt in the right loin, where the sensation of numbness existed; this continued till the morning of the day on which he died. At two o'clock in the morning of that day, he awoke with a "tickling in his throat," coughed once or twice, and brought up two mouthfuls of blood, he was certain he coughed it up, and did not vomit it. Shortly afterwards, he experienced a very severe pain below the right nipple, which compelled him to turn on his left side, being quite unable to lie on his back.

At my visit in the morning, I found he had passed urine; he had no cramps in his legs, or hiccup, or vomiting; he had felt very faintish when up to get his bed made.

The pulsation was less in the right side of the neck, he had no noise in his ears, and there was no change in the tumour in the back. His pulse was 114, with little strength, and his skin was hot and dry. At 7, P. M., the pain in the right side of his chest became so severe that he could lie no longer on the left side, and he was gently turned over on the right; he immediately coughed up two or three ounces of frothy blood,

became pale, with profuse perspiration all over the body, and gradually cold. The breathing never became hurried; and some rale that appeared after he had brought up the blood, soon ceased. He became gradually weaker, and died quietly, and without any convulsion, at half-past nine, within three weeks after he had first observed the “beating pain,” and in about six after he had been obliged to give up working.

I had no difficulty in arriving at the conclusion, when I first saw this patient, that he was the subject of aneurism; and I considered that the locality of it was the very lowest portion of the thoracic aorta.

I was led to this conclusion respecting its seat by the distinct pulsation that was felt and seen between the two, if not three, lowest intercostal spaces on the right side, but more especially by the fact that he asserted that there was but one kind of pain, and an entire absence of the shooting or lancinating pain first noticed by Dr. Beatty, of Dublin, to be one of the most certain diagnostic symptoms of abdominal aneurism, when conjoined with the constant gnawing pain so very frequently present in all internal aneurisms. Nor was there any vomiting, or peculiar pain when the bowels acted, or indeed any symptom of disordered function of any organ below the diaphragm. In support of the opinion that there was no disease in the upper portion of the aorta, we had neither cough, nor dyspnoea, nor stridor, nor pain in or between the shoulders, nor diminished expansion of one lung, nor heaving pulsation of the upper portion of the chest; in fact there was not a single chest symptom except the pain and pulsation at its very base; and although Stokes, Bellingham, Walsh, and Sibson all mention that aneurism of the descending portion of the thoracic aorta almost invariably makes its way between the intercostal spaces on the left of the spine, still, from the absence of the symptoms discovered by Dr. Beatty to be peculiar to abdominal aneurism, as well as of those of the upper portions of the aorta, I felt justified in assigning to the aneurism the locality I have named.

Having been fortunate in obtaining a post mortem examination, the following is the state in which the various organs implicated were found.

On laying open the chest, nothing unnatural was found in the left side except a band several inches in length between the costal and pulmonary pleuræ. A considerable amount of serum flowed out from the right pleura; and at its back part were found several pounds of firm clots of blood, which had compressed and indented the upper portion of the right lung. The lower lobe of this lung was found adhering at one part to the aneurismal sac, and through the walls of the latter lower down a rent had taken place into the pleural cavity, through which the blood had escaped. The heart was healthy in structure and size—no disease of any kind was found at either of the orifices, or

in the structures of the valves. The arch of the aorta was not dilated; there were a few soft atheromatous patches in it. The innominate artery, when slit open and spread out, measured transversely $1\frac{1}{2}$ inch, and the right carotid appeared also a little dilated. This dilatation of the innominate and carotid would explain satisfactorily the increased pulsation that existed during life in the right side of the neck. With the exception of some atheromatous deposits, the calibre and coats of the aorta appeared normal until within an inch and half of the origin of the cœliac axis, where it became dilated to near double its natural size, and continued so for about an inch below it. From the back, or vertebral surface of this dilatation, two sacs, or perhaps a bilocular aneurism, were given off; that on the left side of the vertebræ was about half the size of a cricket ball, whilst that on the right was the size of a large cocoa nut, and had dissected its way between the diaphragm and the pleura, extending into the cavity of the chest fully six inches, and perpendicularly to almost the same extent, firmly attached to the sides of the bodies of the four last dorsal and two upper lumbar vertebræ, and in close contact with the ribs for several inches.

Over the anterior portion of this large sac, the upper or great splanchnic nerve can be seen stretched. The bodies of two or three of the vertebræ can be felt to be eroded. The origin of the right psoas magnus muscle was stretched by the lower portion of the aneurismal sac, which was no doubt the cause of the imperfect flexion of the thigh upon the trunk.

In addition to the rent into the cavity of the pleura, another had taken place into the lower lobe of the right lung, and had dissected the pleura from the lung for several inches in extent. To this rent we are no doubt justified in ascribing the occurrence of the hæmoptysis on the two occasions shortly before his death. This would appear to be a very rare symptom in aneurism of the aorta *opposite the cœliac axis*, as in 131 cases tabulated by Dr. Sibson, in his “Medical Anatomy,” hæmoptysis did not occur once.

I apprehend that the locality in which this aneurism extended is a very unusual one. I find no record in any of the books I have access to, of an aneurism separating the pleura from the diaphragm; and whilst the original opening was in that portion of the abdominal aorta that is behind the origin of the cœliac axis, still the aneurismal sac extended in a direction and produced symptoms that were exclusively thoracic in their seat, and unassociated with a single symptom that is considered to be characteristic of aneurism of the abdominal aorta.

There is just one other point of interest in connection with this case, to which I feel called on to refer. I allude to the undoubtedly contracted state of the right pupil. A contracted state of one pupil has been found to be of frequent occurrence in thoracic aneur-

ism, since the attention of the profession was directed towards it by Dr. W. T. Gairdner of Edinburgh, in 1856. So far as I am aware, the patients in whom it was observed had all suffered from aneurism or dilatation about the arch of the aorta, or a non-aneurismal tumour in the neck, in which cases it was considered to have been produced by pressure on the sympathetic, or on the anterior roots of the spinal nerves in the lower cervical or upper dorsal region, which are supposed to confer a motor power on the filaments of the sympathetic which join the 5th pair that supplies the dilating fibres of the iris.

It is clear, from the slight amount of dilatation of the innominate and healthy state of the aorta in this patient, that there was no possibility of any pressure being made at the cervical region in him; and we are therefore forced to inquire if the contracted state of the right pupil might not have been owing to the unavoidable pressure that must have been made on that portion of the sympathetic that forms the great splanchnic nerve, by its being stretched to such an extent over this large aneurism on the right of the vertebræ.

It is not without interest to notice how this man was able to continue in an occupation that required frequent changes in the position of the trunk of the body till within five or six weeks of his death, and that his disease, up till within a few weeks of its termination, had originated (so far as he had observed) but a single symptom, or at most two, namely, pain and an inability to stoop to put on his shoes.

Malformation of Sternum.

The PRESIDENT next introduced Herr Johann Heinrich Woytiz, a young man, who is the subject of a remarkable congenital depression of the lower third of the sternum and adjoining cartilages. By measurement, it was found that the sternum, at its greatest depression, approached to within about an inch and a-half of the vertebral column. Whether depending on this condition of the chest, or otherwise, the subject of this formation exhibited extreme mobility of the shoulder articulation. He was thus enabled to rotate and advance his *humeri* to such a degree as readily to bring their external condyles together. The Society deemed this malformation of sufficient anatomical interest, in relation to the existing healthy condition of the thoracic viscera, to authorize a cast of the thorax, which was accordingly secured, and has been added to the Pathological museum.

448 Notice of the Twenty-Fifth Meeting in the Seventh Session.

Office-Bearers

President—Professor Reid.

Ex-President—Surgeon Browne, R.N.

Vice-Presidents

Dr. Murney.

Professor Gordon.

Dr. Reade.

Dr. Babington, Derry.

Surgeon Ferris, Larne.

Council

Dr. Drennan,

Dr. Pirrie.

Dr. Dill.

Surgeon Johnston.

Dr. Patterson.

Dr. Heeney.

Treasurer—Dr. Halliday.

Secretaries.

Dr. Wales.

Dr. Cuming.

The Twenty-Fifth Meeting of the Society this Session will take place in the Museum of the General Hospital, on Saturday, April 28, at Three o'clock.

BUSINESS.

Appointment of Auditors of Accounts.

Professor Gordon will exhibit—"Specimen of Scrofulous Disease of Shaft of Femur;" and make observations on—"Amputation at and in the neighbourhood of the Hip-Joint."

The Subscription—increased so as to enable the Council to forward the Transactions, as published, to every Member—being 12s 6d. to Town, and 7s. 6d. to Country Members, will be received by the Treasurer, at this Meeting.

Members desiring to forward Cases and Observations to be brought under notice of the Society, or to propose Candidates for Membership, will please communicate with the Secretaries, at least Three clear days before the day of Meeting.

Members of the Society have the privilege of forwarding Morbid Specimens, for examination by the Chemical and Microscopical Committee, and of receiving reports on their nature.

The Museum of the Society is open to all Members, between Two and Three o'clock on each day of Meeting.

JAMES CUMING, M.D.,
GEORGE F. WALES, M.B.,

Hon. Secs,

General Hospital, April 26, 1860.

441 To the Secretary

General Hospital
27th April 1860

Sir

Would you be so kind as to obtain for me certificates of attendance on the meetings of your society during the past and present sessions.

I am
your obedient servant
W. James Wilson
sen. sch. 2.C.B.
Resident Pupil, B.G.H.

Belfast Clinical and Pathological Society

Seventh Session: 1859–1860

President James Seaton Reid

TWENTY-FIFTH MEETING.

April 28th, 1860.

The President in the Chair.

Articular Injury.

Dr. MOORE introduced a person who had sustained an injury some time since, by which the ankle joint was laid open. By suitable treatment, Dr. M. was enabled to bring about the recovery of his patient, with the function of the articulation unimpaired. He considered the case a good example of conservative surgery in a most serious class of injuries.

Artificial Anus.

Surgeon JOHNSTON introduced an aged woman who had escaped the consequence of strangulated hernia by the spontaneous formation of an artificial anus in the left inguinal region. She experienced little inconvenience beyond that produced by a prolapsus of the gut at the artificial opening; to prevent which, she was obliged to resort to mechanical support.

Ballot paper from Council minute book.

List of members:

List of Members of the
Belfast Clinical and Pathological Society
Session 1859-60
With Register of their Attendance at the first
Twenty-three Meetings.

Law 23.—“Ballot Papers, initialed by one of the Secretaries, shall be issued to the Members on or before the Third Tuesday in April. Each Member shall send forward to the Secretaries his Ballot Paper, properly filled with the names he shall select, on or before the Fourth Tuesday in April. If a Candidate for any office be unsuccessful, the votes recorded in his favour shall be available for the next lower office.”

LAW 24.—“That no Member be hereafter eligible for the office of President, unless he has previously filled the office of Vice-President.”

Aickin, W., M.D.	6
Andrews, Professor, M.D.	
Anderson, J. C., Surgeon, (Kilkeel)	
Arnold, Wilberforce, L.K.Q.C.P.I.	5
* Babington, T. H., M.B., (Londonderry).	
Blakely, S., Surgeon, (Aughnacloy).	
* Browne, Samuel, Surgeon, R.N., Ex-P.	16
Brown, W., M.D., (Derry).	
Brunker, E. J., M.D. (Dundalk).	
Bryce, R., M.D.	13
Buckingham, J., Surgeon.	
Carson, J. C. L., M.D., (Coleraine).	
Cavin, W., M.D., (Coleraine).	
Clugston, W. A., M.D., (Ballyclare).	
Conner, _ Surgeon, (Newry).	3
Corry, T. C. S., M.D.	5
Crothers, R., M.D. (Moy).	
Cuming, James, M.D., Hon. Sec.	17

Diamond, C., Surgeon, (Rasharkin).	
Dickie, Professor, M.D.,	1
Dickson, J., M.D., (Ballynahinch).	
Dill, R. F., M.D., Mem. Council.	15
Drennan, J. S., M.D., Mem. Council.	3
Dundee, J., M.D., (Carnmoney).	
Dunlop, A., M.D., (Holywood).	4
* Ferguson, Professor, M.B.	14
* Ferris, C., Surgeon, (Larne), V. Pres.	1
Forsyth, J., M.D., (Culmore).	
Frame, J., L.F.P.S., (Comber).	
* Gordon, Professor, M.D., V. Pres.	4
Graham, J., M.D., (Templepatrick).	
* Graves, H., M.B., (Cookstown).	1
Greenfield, _ M.D., (Holywood).	
Halliday, J. H., M.D., Treasurer.	11
Hanna, H., Surgeon.	3
Harkin, A., M.D.	5
Hawthorne, J., Surgeon, (Banbridge).	
Heeney, F., M.D., Mem. Council.	19
Hodges, Professor, M.D.	
Hume, G. A., M.D., (Crumlin).	1
Hunter, S., M.D.	
Jamieson, D., M.D., (Newtownards).	
Jeffres, _ Surgeon, (Clough).	
Johnston, H. M., Surgeon, Mem. Council.	17
Johnston, Aug., Surgeon, (Lancashire).	
Kelso, J. J., M.D., (Lisburn).	
Kennedy, _ (Comber).	
* Knox, A., M.D., (Strangford).	
M'Bride, H., Surgeon, (Gilford).	
M'Caldin, J. J., M.D., (Coleraine).	
M'Cleery, J. C., Surgeon.	10
M'Clelland, R., M.B., (Banbridge).	
M'Cormac, W., M.D.	7
M'Gee, W., M.D.	17
* M'Keag, D., M.D., (Coleraine).	
* M'Laughlin, W. R., M.D., (Lurgan).	2
* M'Mechan, J., M.D., (Whitehouse).	1
M'Minn, F., M.D.	11
Macaw, J., M.D., (Bushmills).	
Madden F., Surgeon, (Portglenone)	
Mahood, G., M.D., (Enniskillen)	
Mawhinney, J., Surgeon.	
* Moore, James, M.D.	14
Moore, W., Surgeon, (Dungiven).	
Moreland, H., M.D.	
Motherell, J., M.D. (Castlederg).	
Mulholland. C., M.D.	20
* Murney, H., M.D., Vice-Pres.	16
Murray, D., M.D.	4
Musgrave, S., Surgeon, (Lisburn).	
Neligan, J. M., M.D., (Dublin), Hon. Mem.	
Nixon, G., M.D., Antrim.	
O'Hare, Owen, M.D.	3
Patrick, W., Surgeon, (Carrickfergus).	
Patterson, J., M.D., Mem. Council.	19
Patton, A., M.D. (Tandragee).	
* Pirrie, J. M., M.B., Mem. Council;	9
Purdon, C. D., M.B.,	2

Rea, H. P., Surgeon.	16
* Reade, Thomas, M.B., Vice-Pres.	5
* Reid, Professor, M.D., President.	21
Ross, R., M.D.	12
Rutherford, W., Surgeon, (Anahilt).	
Scott, W., M.D., (Aughnacloy).	1
Sharpe, R., M.D., (Coleraine).	
Smith, R. W., M.D., (Dublin), Hon. Mem.	
Smith, J. W. T., M.D.	2
Smyth, J., Surgeon.	2
* Stewart, R., M.D.	9
Stokes, W., M.D., (Dublin), Hon. Mem.	
Taggart, J., M.D., (Antrim).	
Taylor, W., M.D., (Articlam, Coleraine).	
Thompson, H., Surgeon, (Ballylesson).	7
Thompson, T., M.D.	8
Wales, G. F., M.B., Hon. Sec.	22
Warwick, W., Surgeon.	13
Weir, M., Surgeon, (Dromore)	
Wheeler, T. K., M.D.	
White, Barnwell, M.D., (Derry).	

Those marked (*) thus, are, or have been, Vice-Presidents.

448 Notice of the Annual Meeting in the Seventh Session.

Office-Bearers

President—Professor Reid.

Ex-President—Surgeon Browne, R.N.

Vice-Presidents

Dr. Murney. Professor Gordon.
 Dr. Reade. Dr. Babington, Derry.
 Surgeon Ferris, Larne.

Council

Dr. Drennan, Dr. Pirrie.
 Dr. Dill. Surgeon Johnston.
 Dr. Patterson. Dr. Heeney.

Treasurer—Dr. Halliday.

Secretaries.

Dr. Wales. Dr. Cumming.

The Annual Meeting of the Society this Session will take place in the Museum of the General Hospital, on Saturday, May 5, at Three o'clock.

BUSINESS.

Report of Council.
 Report of Auditors.
 Announcement of new Office Bearers.
 Election of Secretaries,
 Closing Address of retiring President.
 Installation of President-Elect

The Subscription—increased so as to enable the Council to forward the Transactions, as published, to every Member—being 12s 6d. to Town, and 7s. 6d. to Country Members, will be received by the Treasurer, at this Meeting.

Members desiring to forward Cases and Observations to be brought under notice of the Society, or to

propose Candidates for Membership, will please communicate with the Secretaries, at least Three clear days before the day of Meeting.

Members of the Society have the privilege of forwarding Morbid Specimens, for examination by the Chemical and Microscopical Committee, and of receiving reports on their nature.

The Museum of the Society is open to all Members, between Two and Three o'clock on each day of Meeting.

JAMES CUMING, M.D.,
 GEORGE F. WALES, M.B.,
 Hon. Secs,

General Hospital, May 3, 1860.

Council Report of Council.

[This report is identical to that recorded in the transactions of the annual meeting which is reproduced below.]

TWENTY-SIXTH, OR ANNUAL MEETING.

May 5th, 1860.

The President in the Chair.

The business of this, the final meeting of the session, was entirely engrossed by the details of the Society's management and progress, comprising reports from the Council and Auditors, and the appointment of the Executive for the ensuing year.

REPORT OF COUNCIL.

"In bringing forward the report on the Session which is now closing, the Council has much satisfaction in congratulating the members of the Clinical and Pathological Society on its position and prospects.

The Society now includes within its ranks 100 members, of whom 45 are town members, 52 are country members, and 3 are honorary members, showing an increase of 6 upon the number of members in last Session, and of 4 upon Session 1857-58.

This augmentation of the Society's numbers, in itself highly satisfactory, becomes especially gratifying when viewed in connexion with the fact, that the annual payment for the Abstract of the Society's proceedings, which in former years was paid only by a limited number of members, has, during the present Session, been made compulsory on all.

This change, recommended by the Council, was adopted at a special meeting of the Society, held on the 24th of September, 1859, and the Council refer with pleasure to the fact, that an addition to the amount of subscription has been accompanied by an increase of the number of members as a significant evidence of the existing appreciation of the utility of the Society, and as an auspicious omen of its permanence and progress in the future.

Belfast Clinical and Pathological Society

Seventh Session: 1859–1860

President James Seaton Reid

During the Session 26 ordinary meetings have been held, at which a large number of communications of value and interest have been brought forward.

The Museum has been increased by specimens, casts, models, and drawings, and considerable progress has been made towards the completion of a catalogue of this valuable collection.

In conclusion, the Council has great satisfaction in being able to bear testimony to the undiminished interest which the members have exhibited in the progress and welfare of the Society, and to the unbroken harmony which has continued to characterize the meetings, as well as to the able and dignified manner in which the presidential duties have been discharged by Dr. Seaton Reid.”

Drs. Cuming and Wales, the Honorary Secretaries, having resigned, and their successors appointed, the proceedings were brought to a close by the thanks of the Society being conveyed severally to the retiring President, the retiring Secretaries, and the Treasurer.

Belfast Clinical and Pathological Society

Eighth Session: 1860–1861

President Alexander Gordon

BELFAST CLINICAL AND PATHOLOGICAL SOCIETY.

EIGHTH SESSION—1860-61.

437

May 7 1860

Dear Sir

Will you and Dr. McCormack be kind enough to call a meeting of the Council of the Belfast Clinical and Pathological Society at the hour of 7 P.M. Tuesday 8th May "to receive a report of Dr. Murney's reply respecting the office of President of the Society and to adopt such measures as the Council may in consequence deem necessary."

Very truly yours
J. Seaton Reid
ex-President

455 *Draft agenda dated May 7th 1860 for a meeting of Council and draft minutes of that meeting which was held on May 9th 1860.*

Session 1860 & 61

May 7th 1860

by letter N^o. —

The ex-President requested a meeting of Council to be called to receive a report of Dr. Murney's reply respecting the office of President of the Society to adopt such measures as the Council may in consequence deem necessary.

The following were summoned as members of Council the list not being completed. S. Reid, Drs. Patterson, Pirrie, Bryce, Babington, Dunlop, Graves, Johnston, Browne, Dill, Drennan, Corry, MaCormac and Aickin.

The meeting was held on May 9th 3 p.m. Present Drs. S. Reid, Browne, Drennan, Dill, Corry, MacCormac, Aickin.

Resolution 1. Proposed by Surgeon Browne, seconded by Dr. Pirrie. That in consequence of the non-acceptance of office of President by Drs. Murney and Reade to which they were successively elected the Secretaries are directed to issue new ballot papers for the election of a President for the current year. The names of the eligible candidates to be appended to the circular.

Resolution 2. Proposed by Dr. Drennan, seconded by Surgeon Browne. In compliance with the above Resolution, the following note be appended to the ballot papers.

N.B. Members are to observe that all ballot papers must be received by the Honorary Secretaries at the Hospital on or before Tuesday the 22nd inst. at 6 p.m.

Resolution 3. Proposed by Dr. Dill, seconded by Dr. Corry. That a second box with admissions valve be procured for the reception of the ballot papers. The

box to be in charge of the President and the box to remain at the General Hospital in care of the Secretaries. The box to be opened at the meeting of Council appointed for the counting of the ballot papers, the valve having been introduced previously at the hour specified by the Council as the latest for receiving them.

Mr. W. James Wilson, Sen. Sch. 2.C.B. Resident Pupil in Hospital was granted a certificate of attendance at the Society meetings during the past session.

There were 100 ballot papers printed and circulated on the 10th. initialled W.A.

Next Council meeting to be held Wednesday 23rd May at 3 P.M.

Council Meeting of Council May 12th 1860.

Summoned by order of the Ex-President.

Moved by Mr. Browne and seconded by Dr. Pirrie "That in consequence of the non-acceptance of the office of President by Drs. Reade and Murney fresh ballot papers be now issued to all the members for the purpose of electing a President for the ensuing year."

Moved by Mr. Browne seconded by Dr. Dill "That in order to guard against error in the reception of ballot papers, none be acknowledged that are not received by the Honorary Secretaries at the General Hospital on or before Tuesday the 22nd inst. at 6 P.M."

Moved by Dr. Drennan, seconded by Mr. Browne "That the preceding resolution be placed as an N.B. on the ballot paper, and also the names of the Vice-Presidents eligible for election—Drs. Ferguson, Gordon, Mr. M'Gee, Murney, Pirrie, T. Reade, Stewart."

Moved by Dr. S. Reid, seconded by Dr. Dill "That a ballot box be purchased for the reception of balloting papers" also "That a meeting of Council be summoned at 3 P.M. on Wednesday 23rd to examine the ballot papers."

438 *Handwritten note [see also 439]*

In consequence of the non-acceptance of the office of President by Drs. Reade and Murney, to which they were successively elected, we have been directed by the Council to issue new Ballot Papers for the election of a President for the current year.

439 *Printed ballot paper [see also 438]*

Sir

In consequence of the non-acceptance of the office of President by Drs. Reade and Murney, to which they were successively elected, we have been directed by the Council to issue new Ballot Papers for the election of a President for the current year.

The following is the list of those eligible for election:—

Professor Ferguson.
 Professor Gordon.
 Dr. W. Magee.
 Dr. Murney.
 Dr. Pirrie.
 Dr. Thomas Reade.
 Dr. Stewart.

President, _____

N.B.—Members are to observe that all Ballot Papers must be received by the Honorary Secretaries, at the Hospital, on or before Tuesday, the 22nd instant, at Six, p.m.

Signed;
 W. MAC CORMAC, M.A., M.D.,
 W. AICKIN, M.D.,
 Honorary Secretaries

General Hospital, Belfast
 May 9th, 1860

440 To the Secretaries

Dundalk
 11th May

Gentlemen

As it quite out of my power to attend the meetings of the Belfast Pathological Society it is not my intention to continue to be a Member. I need therefore not fill up the voting paper just received.

Your Obedient Servant
 E. J. Brunker
 M.D.

442 To the President &c.

Newtown Butler
 May 21, 1860

Sir

I beg again to bring under your notice my application for certificates of two seasons attendance on the Clinical and Pathological Society and hope to hear from you a favourable reply.

It has I understand been customary to grant them to students, and as I am looking for a public appointment such certificates would of course be of infinite service to me.

Please excuse this trouble.

I am Sir
 Yours respectfully
 John Thomas Moore
 M.R.C.S.Eng.

Council Meeting of Council May 23rd 1860 3 P.M.
 Counting of ballot papers.

443 Tally of votes for President, dated May 23 1860

No 1	Dr. Gordon	26
No 2	Dr. Murney	12
No 3	Dr. Pirrie	7
No 4	Dr. Ferguson	8
No 5	Dr. Stewart	<u>1</u>
		54

[Signed diagonally across the paper] J. Seaton Reid
 Ex-President

456 Draft minutes of Council meeting on May 23rd and part of meeting on May 26th.

May 23rd. 3.P.M.

Gordon	26
Murney	12
Pirrie	7
Ferguson	8
Stewart	<u>1</u>
	54

Council summoned. S. Reid, Patterson, Pirrie, Bryce, Johnston, Browne, Dill, Drennan, Corry, Maccormac, Aickins.

Proposed by Dr. Patterson and seconded by Dr. Johnston that a Special Meeting of the former Council be summoned to make out a correct list of Vice-Presidents and Council for the current year.

The 54 ballot papers were destroyed by the President.

Members present. S. Reid, Johnston, Patterson, Maccormac, Bryce, Corry, Aickins.

Letter from Dr. Brunker, Dundalk, withdrawing his name as a member, and from Surgeon John Thos. Moore, Newtown Butler, applying for certificates for attendance at the Society's meetings for two sessions.

Surgeon Johnston received an order for two pounds sterling being the amount paid to _ German for a cast of his chest, and also for showing himself at the last meeting of the Society.

Double Council summoned for Saturday 26th. May 3 o'clock.

Dunlop. Johnston, Bryce, Pirrie, S. Reid, Patterson, Cuming, Murney, Drennan, Dill, Corry, Wales, Heeney, Maccormac, Gordan, T. Reade, Browne, Halliday.
 = Present.

Belfast Clinical and Pathological Society

Eighth Session: 1860–1861

President Alexander Gordon

444 Undated list of members of Council. With the exception of Dr. Murney as President, the names correspond with those who made up the Council in 1860–61.

The names written in a lighter ink are those who, in Item 445, gained the highest number of votes in the relevant section (President one name; Vice Presidents three names; Council six names).

[Names darker ink.]	|	[Names lighter ink.]
	President	
Murney	|	Thomas Reade
	Vice Presidents	
Patterson	|	Murney
Pirrie	|	Patterson
Bryce	|	Pirrie
	Country	
Babington	|	
Dunlop	|	
Graves	|	
	Council	
Johnston	|	Bryce
Browne	|	Johnston
Dill	|	Dill
Drennan	|	Drennan
Corry	|	Browne
Mulholland	|	Corry
	Secretaries	
Dr. MacCormac	|	
Dr. W. Aiken	|	
	Treasurer	
Dr. Halliday	|	

445 Undated spreadsheet with entire list of members, and records of votes cast for the various positions (President, Vice Presidents, Council, &c.) and the results.

COMPILER'S NOTE

In Item 445, Dr. Thomas Reade topped the list for President; Drs. Murney, Patterson and Pirrie for Vice Presidents (Resident); Drs. Babington, Dunlop and Graves for Vice President (Non-resident); and Drs. Bryce, Johnston, Dill, Drennan, Browne, and Corry for Council.

Item 445 must be the original record of voting and the list in lighter ink in Item 444 represents the results of that vote.

The list in darker ink in Item 444, must have been written after Dr. Reade refused to serve as President with the result that Dr. Murney's name was moved up to replace his.

Dr. Murney also refused to serve (Dr. J. Seaton Reid's letter, Item 437), and this led to the Council meetings (Items 455 and 456), the circular regarding a second vote for President (Items 438 and 439), and the election of Dr. Gordon as President for 1860 to 1861 (Item 443).

450 Report on a Pathological Specimen¹

Clinical and Pathological Society

General Hospital Belfast

May 26th 1860

R. B. McClelland Esq. M.D.

Dear Sir

The slice of Tumour you sent us for microscopic examination appears to be osseous and cartilaginous but there is no appearance of cells of a malignant growth.

The cartilage cells are of the simplest formation almost like fat cells.

The bone cells are not so well developed but you can find out traces by examining several sections.

We are Sir,

Your obedient servants

William Aickin M.D.

William MacCormack M.A. M.D.

Honorary Secretaries

P.S. Would you please let us know the size and general appearance of the tumour.

You might please mark out a detailed case if you think it of any peculiar interest and forward it to us.

Council Meeting of Council August 30th 1860, 3 P.M.

Present, Drs. Dill, Patterson, S. Reid, W. Aickin.

Moved by Dr. S. Reid, seconded by Dr. Patterson "That the Treasurer be authorized to pay the following accounts remaining due from the session 1859–60.

William McNeill, Corn Market, for ballot box. 15/-
Alexander Mayne, High Street, for printing and binding transactions.

Dr. Aickin, Secretary of Council, for stamps for circulars. 5/-"

OFFICERS FOR 1860–61.

PRESIDENT.—Professor Gordon, M.D.

EX-PRESIDENT.—Professor Reid, M.D.

VICE-PRESIDENTS.—(Town)—Dr. Patterson, Dr. Pirrie, Dr. Bryce. (Country)—Dr. Babington, Londonderry; Dr. Dunlop, Holywood; Dr. Graves, Cookstown.

COUNCIL—Surgeon Johnston, Surgeon Browne, R.N, Dr. Dill, Dr. Drennan, Dr. Corry, Dr. Mulholland.

TREASURER.—Dr. Halliday.

HON. SECRETARIES.—(General) Dr. W. Mac Cormac, (Council) Dr. W. Aickin.

¹ [Perhaps the earliest extant Belfast pathological report.]

LAWS OF

THE BELFAST CLINICAL & PATHOLOGICAL SOCIETY.

I. NAME AND OBJECTS.—The Society shall be called “The Belfast Clinical and Pathological Society,” whose objects shall be the cultivation of Practical Pathology, Diagnosis and Therapeutics, by means of the accumulation and analysis of appropriate Cases and Pathological Reports, and public discussion thereon; the establishment of a Pathological Museum; and the keeping of records, to indicate the progress of discovery in Medical Science.

II. MEMBERS.—The Society shall consist of Ordinary Resident and Non-Resident, and Honorary Members—number unlimited.

III. QUALIFICATION.—The Candidates for Membership shall be regularly qualified Physicians or Surgeons.

IV. ANNUAL SUBSCRIPTIONS.—The Annual Subscription shall be *Twelve Shillings and Sixpence* to Residents, and *Seven Shillings and Sixpence* to Non-Resident Members, payable on the first day of Session, or, if a new Member, on the day of his election.

V. ELECTION.—The Candidate for Membership shall be proposed by two members at one meeting, and balloted for at the next; *one black bean in five* to exclude, and prior to ballot, the legality of his qualification shall be duly certified, and his subscription paid.

VI. HONORARY MEMBERS.—Honorary Members shall be elected only at the stated annual meeting; the names of candidates to be entered on the *Minutes* at least one month previously, and proposed by four members. When elected, they shall be free to all the privileges of membership, except share in the property, without subscription; and in the ballot for honorary members, *one black bean* shall exclude.

VII. OFFICERS.—The officers of the Society shall consist of a *President*, to be elected annually by a majority of votes, not re-eligible for three successive years after expiration of office, but entitled, as *Ex-President*, to be placed on the *Vice-President* list for one year after expiration of office, *six Vice-Presidents* (three of whom shall be chosen from the Non-Resident Members), exclusive of the *Ex-President*, two *General Secretaries* and a *Treasurer*, all to be elected annually by a majority of votes, and after expiration of office, eligible for re-election.

VIII. THE COUNCIL.—ITS FORMATION AND DUTIES.—The Council shall consist of the Office-Bearers, and six other members, who shall be also elected annually by a majority of votes.

The duties of the Council shall be to make all the necessary preparations for the ordinary weekly meetings, to examine the contributions of members, and select for reading such as may be eligible; to report, by the aid of sub-committees, upon any morbid specimen which may be forwarded by members, or examination of which may be specially requested by a

vote of the Society; to conduct the financial and ordinary business of the Society; to make bye-laws and other regulations not provided for in the stated laws of the Society; to report at the annual meeting upon all the proceedings of the session, and draw up the annual transactions.

IX. DUTIES OF THE GENERAL SECRETARIES.—The General Secretaries shall keep a record of minutes, enter the cases and notices received, or remarks furnished, in their respective books, and summon and attend all meetings of the Council and Society.

X. DUTIES OF THE TREASURER.—The Treasurer shall keep an account of all receipts and disbursements, and furnish his financial statement twice during the session, also at the close, and whenever required by a vote of the Society.

XI. CASE PAPERS.—Each member can be supplied with forms of “Case Papers,” having the annexed heading to guide him in drawing up the contributions which he may furnish. “The reporter is requested to note particularly the following points, in the reading of his case, viz.:—If from any author, the particular volume and page; if original, the place and date; in any case, his age, history, management, impressions regarding same at different periods, the termination, and P. M. examination if any.”

XI. MEMBERS’ CONTRIBUTIONS.—The contributions shall be of the following description:—

1. Cases showing unusual sequence or co-existence of diseases.
2. Do. showing any practical lesson, point, or caution, useful in practice.
3. Do. exhibiting any rare form, complication, exception to the laws of Diagnosis, Pathology, or Therapeutics; or unusual interpretation.
4. Summaries of *Medical Statistics* to prove frequency of type, average of age and mortality, and effects of remedies in any disease, or other point susceptible of proof by statistics.
5. Reports on *novel modes of practice* in any disease.
6. Morbid Specimens of Pathological or general interest, with or without case, or for Microscopic or Chemical examination.
7. Replies to *Medical Queries* proposed by members.
8. Brief *Clinical facts* of practical interest.

All contributions to be original, or original translations from authentic foreign records, not generally accessible to members.

XIII. THE SESSION.—The Session shall commence on the last Saturday in October, and terminate the first in May; and the ordinary meetings shall be held every Saturday, at three o’clock, afternoon; and the *annual meeting* the first Saturday in May.

XIV. BUSINESS OF THE ANNUAL MEETING.—The business of the annual meeting shall embrace the following subjects, viz.:—1. The Report of the Council. 2. The Report of the Auditors. 3. The announcement of the

Belfast Clinical and Pathological Society

Eighth Session: 1860–1861

President Alexander Gordon

New Office-bearers. 4. The Election of the New Council. 5. The Closing Address of the retiring President. 6. Installation of the President-elect.

XV. BUSINESS OF THE ORDINARY WEEKLY MEETINGS.—The ordinary sittings shall be limited to *one hour*; but, at the discretion of the President, may be extended to *one hour and a-half*: five Members to form a quorum. On the first Saturday of November, January, and March, any business may be introduced without notice having been previously given. The following shall be the order of proceeding:—

1. The chair to be taken by the President: if he be absent, by one of the Vice-Presidents present, if possible in rotation.
2. The Minutes of the previous meeting read and signed.
3. Announcements from the Council.
4. The proposal of Candidates and Election of New Members.
5. The following in such order as the Council may direct:—
 - a. The Exhibition of Morbid Specimens.
 - b. The result of Microscopical and Chemical Examination.
 - c. The Reading of Cases.
 - d. Brief notices of Clinical Facts and Summaries of Medical Statistics.
 - e. The Exhibition of New Instruments and Medicines.
 - f. Papers on New Modes of Treatment.
 - g. Debates on doubtful points in Medical Practice.

XVI. VISITORS.—Medical Students shall be admitted as visitors by official orders of Members only. Any Medical practitioner, not being a member, may be admitted as a visitor *once only* during a session, on being introduced by a member.

Surgeons and Assistant-Surgeons of the Garrison, also of the Militia and Navy on active service, may be admitted to any meeting on Members' orders.

XVII. RESERVE FUND.—*One-fourth* of the subscription money shall be set aside as a reserve fund, and deposited in bank in the names of the President and Treasurer for the time being, to the credit of the Society, and shall not be drawn thence except by a vote of the Society at the annual meeting.

XVIII. BOOKS OF THE SOCIETY.—The books of the Society shall consist of the following:—General Minute Book; Council's do.; General Proposal Book; Treasurer's Account Book; Treasurer's Receipt Book General Case Book; General Note Book for Record of Discoveries, Inventions, and interesting Medical Notes; Pathological Museum Record; Microscopical Reports; Document Book.

XIX. PROPERTY OF THE SOCIETY.—The property of the Society shall not be disposed of except by the unanimous vote of a special meeting. Due notice of

intention to take such a vote shall be given in a special circular to all members, one month previously.

XX. DEFAULTERS.—No fines whatsoever shall be imposed on members; but in case of Subscriptions more than two months due, and after two successive notices from the Treasurer, the names of the defaulters shall be struck off the Roll of Members, and they shall be ineligible for re-election during the remainder of the current session. The *last day* allowed for payment of subscriptions for *old* members shall be NEW YEAR'S DAY each Session.

XXI. EXPULSION or MEMBERS.—Members may be expelled for unprofessional conduct, by a vote of the Society, provided that such vote be carried by three-fourths of a meeting of at least twelve resident members, and that due notice of the intention to take such a vote, with grounds of the charge, be given to each member eight clear days before meeting.

XXII. PRIVILEGES.—It shall be a privilege exclusively granted to Members, to receive reports upon any morbid specimens which they may furnish for examination.

Members shall be also entitled to receive the "Transactions," being a Record of the Proceedings of each meeting during the session.

XXIII. ELECTION OF THE OFFICE-BEARERS AND COUNCIL.—Ballot papers, initialled by one of the Secretaries, together with a list of members and their attendance during the session, shall be issued to the Members on or before the third Tuesday in April. Each Member shall send forward to the Secretary his ballot paper properly filled with the names he shall select, on or before the fourth Tuesday in April. If a candidate for any office be unsuccessful, the votes recorded in his favour shall be available for the next lower office.

Council 1st meeting of Council, Wednesday October 24th 1860, 3 P.M.

Present, Professor Reid, Dr. Mulholland, Dr. William MacCormac, Dr. Aickin.

Resolved that a circular be issued calling the first meeting of this session for Saturday next to hear the President's address and transact such other business as may be brought forward.

Circular cut out and stuck into Council minute book.

The first meeting of the Society this session will take place in the Museum of the General Hospital, on Saturday, October 27, at three o'clock.

Business

Considerations arising out of minutes.

The address of the President.

The subscription—increased so as to enable the Council to forward the transactions, as published, to

every member—being 12s 6d. to town, and 7s 6d. to country members, will be received by the Treasurer, at or after the first meeting.

Members desiring to forward cases and observation to be brought under the notice of the Society, or to propose candidates for membership, will please communicate with the Secretary of the Council for the time being, Dr. Aickin, at least three clear days before the meeting.

Members of the Society have the privilege of forwarding morbid specimens, for examination by the Chemical and Microscopical Committee, and of receiving reports on their nature.

The museum of the Society is open to all members, between two and three o'clock on each day of meeting.

W. Mac Cormac, M.A., M.D.,
W. Aickin, M.D.
Honorary Secretaries.

General Hospital, October 25, 1860.

{Rough minute book:

FIRST MEETING OF PATHOLOGICAL SOCIETY
27th October 1860.

The President in the chair. Present Drs. Halliday, Dill, M'Mechan, Corry, Reid, Buckingham, Cuming, Murney, Murray, Patterson, Aickin, MacCormac, Stewart, Ferguson, M'Gee, Mulholland.

The minutes of last ordinary meeting were read and confirmed.

The President then read his opening address.

Proposed by Dr. MacCormac and seconded by Dr. Patterson that Drs. H. Burdon A.M., M.D. M.R.C.S.E., [and] D. Moore M.D. be candidates for election at next meeting.

Moved by Dr. Stewart and seconded by Dr. W. M'Gee and resolved that the thanks of the Society be given to the President for his address, and that he be requested to print it.¹

Clipping in the Council minute book from the Belfast Newsletter of November 1, 1860, page 2.

The session 1860–61 was inaugurated by Professor Gordon, the president of the society, on Saturday last, in the Museum at the General Hospital, at three o'clock. The Professor delivered an able and learned address to a large and attentive meeting, concluding with a hope that many more would unite themselves members with a society so important to the cultivation of medical science, and to the better harmonising of certain discrepancies which frequently arise in medical practice. A vote of thanks was presented to

¹ [Has not been found.]

Professor Gordon for his address, after which the meeting separated. The next meeting will take place on Saturday next, when the usual business of the session will be proceeded with.

Council 2nd Meeting of Council 31st October 1860, 3 P.M

Present, Dr. Mulholland, Dr. Mac Cormac, Dr. Aickin.

Moved by 2 and seconded by 3, That the circular be altered according to the form subjoined.¹

Subscriptions—12s. 6d. to Town, and 7s. 6d. to Country Members, will be received by the Treasurer, who requests that they will be forwarded immediately, in order that the Transactions, as published monthly, may be sent to every Member from the commencement of the Session.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary of Council not later than Wednesday morning in each week.

The Museum of the Society is accessible at all times to Members, or to Students accompanied by a Member.

Morbid specimens, for Chemical or Microscopic examination, should be forwarded to either of the Secretaries.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretaries, with their qualifications and Subscription.

Signed by order,

W. Mac Cormac, M.A., M.D.,
W. Aickin, M.A., M.D.,
Hon. Secs.

General Hospital, Oct. 31, 1860.

Business of meeting on Saturday November 3rd.

Members for election. Dr. David Moore and Dr. Henry Burden.

Cases to be read. Dr. Moore will read notes of case of gangrene of mamma. Also case of operation for foreign body in trachea. Dr. Aickin will read notes of a case of ovarian dropsy.

{Rough minute book:
SECOND MEETING
November 3rd 1860.

Dr. Patterson in the chair. Present, Drs. Halliday, McLaughlin, Mulholland, W. MacCormac, Dill, Thompson, Johnston, Moore, Stewart, Bryce, Warwick, Ferguson, Wales, Reid, Pirrie.

The minutes of last meeting were read and confirmed.

Dr. H. Burden and Dr. D. Moore having been balloted for were duly elected members of the Society.

Dr. Moore read a case of foreign body in trachea.

Dr. Mulholland stated he had [such?] the case on the evening of the [O C A???] when he passed a [?] into the œsophagus.

¹ [Printed on a piece of paper stuck into Council minute book.]

Belfast Clinical and Pathological Society

Eighth Session: 1860–1861

President Alexander Gordon

Surgeon Johnston asked the Chairman if it would not be advisable to open the trachea previous to upturning the patient in order that access of air might be afforded in case the foreign body would lodge in the larynx.

Professor Ferguson considered that in the first instance there was physical evidence of the existence of the foreign body, but that subsequently there were no physical signs of its presence and that the stone was passed previous to operation.}

Council 3rd Meeting of Council, November 7th 3 P.M. 1860.

Present, Drs. Mulholland & Aickin.

The third meeting of the session will be held in the Museum of the General Hospital, on Saturday, November 10th, at three o'clock.

Cases to be read. Dr. Aickin will read notes of a case of ovarian dropsy. Dr. James Moore will read case of gangrene of breast; also exhibit foreign body removed from œsophagus.

{Rough minute book:
THIRD MEETING
November 10th 1860.

The President in the chair, Drs. Ferguson, Reade, Dill, Halliday, Johnston, Murray, Moore, Wales, Thompson, Patterson, Stewart, Aickin, Mac Cormac, Assistant Surgeon M. Brennan.

Dr. Patterson gave notice that on this day week he would bring forward for the decision of the Society what journal the transactions would be published in, and that notice of the same be inserted in the circular.

Dr. Murray was called on to read his case of gangrene of breast.

After several remarks by Drs. Dill, Patterson, Johnston, the President called on Dr. W. Aickin to read his case of ovarian dropsy.}

Council 4th Meeting of Council, November 14th 1860 at 3 P.M.

None held, there being a subject for Saturday's meeting sent to the Secretary.

The fourth meeting of the Society will be held in the Museum of the General Hospital, on Saturday, November 17th, at three o'clock.

Business. Communication respecting the illness of a late member of this Society, by Dr. Patterson and Dr. S. Reid; also, Post Mortem, by Dr. Murney.

{Rough minute book:
FOURTH MEETING.
November 17th, 1860

The President in the chair, Drs. Pirrie, T. Reade, Warwick, Ross, Bryce, S. Reid, Rea, Ferguson, Wheeler, Murney, McMechan, Patterson, McCleery, Johnston, Dunlop, Dundee, Mulholland, Dill, Stewart, Aickin, MacCormac, Thompson, Cuming, Assistant Surgeon O'Brien.

That notice be inserted on the next circular, what journal the transactions should be published in and also as to the propriety of appointing a publication committee.

Dr. Ross introduced a woman labouring under a nodulated tumour of the breast which he considered cancerous.

Dr. T. Reade did not consider that an operation would not be justifiable as he considered it was doubtful as to whether it was of a cancerous nature.

The President considered it was a case of genuine scirrhus, and that the patient would only last a couple of years, and that an operation would be of questionable advantage.}

Pulmonary Phthisis—Case of Dr. M'Minn, M.D.

Professor Reid said—The proceedings of our Society, Mr. President, become unusually interesting, when they refer, as on the present occasion, to the illness and death of a member, who a few months previously had attended our meetings; and who, when dying, gave an unequivocal proof of his zeal for the advancement of medical science, by directing a *post-mortem* examination of his body to be made, and the result communicated to the society.

The preliminary history of the case was detailed by Dr. Patterson, who said—When I first became acquainted with the late Dr. M'Minn, in the year 1835, he was then in the 35th year of his age, a remarkably fine-looking, handsome man, six feet high, about fourteen stone weight. Some years previously he had completed his studies for a Presbyterian minister, but never took out license. After this he made a trip to Canada, and travelled over the greater parts of British America. During his residence there he had a severe attack of cholera; and from this time, during the remainder of his life, he was liable to periodical attacks of bilious diarrhœa, and boils occurring on all parts of his body. He was subject all his life to great mental depression, which increased greatly during the last few years.

In 1837 he married, and went over to Edinburgh to complete his education for the medical profession. Two sisters and a brother died, in successive years, from consumption. In 1838 he graduated, and took a diploma in surgery in Edinburgh. On his return he had

frequent attacks of diarrhœa, which he regarded as salutary, and also almost constant cough and expectoration, which, he said, arose from the stomach, and that when either was checked by medicine, he was invariably worse. He also suffered from hæmorrhoids, which frequently bled—he also regarded this as beneficial. About eight years ago, when his cough was unusually troublesome, he was persuaded to give Locock's wafers a trial. On doing so, his cough and expectoration was checked; also the diarrhœa and bleeding from the hæmorrhoids—a high feverish state set in. This was the first time I professionally saw him. I ordered leeches to the anus, which was the first thing gave him relief. After some time, the cough and expectoration retarded, and he was gradually restored to his usual state. This was, I think, the last time he would take any remedy for his cough—though he consulted many medical friends their prescriptions were not taken. All this time he resided in the country, but in November, 1847, he disposed of his farm, and came to reside in Belfast. During the winter, his cough, on the whole, was better, though his spirits were greatly depressed, and he regretted giving up his farm, which had been a source of occupation. In the latter end of 1858 he lost his wife, after a protracted and severe illness. After this time he never recovered his spirits. His cough and diarrhœa became very severe, and he was urged, or rather “driven out,” as he said, to try Harrogate. He remained there six weeks, using the waters. Although he said the diarrhœa was very severe while there, he gained flesh, and the cough also improved, which continued up to Christmas, when the diarrhœa and cough again increased violently. Early in February I visited him, at the request of his sister. I found him in bed in a most desponding state. The cough was severe, with copious mucous expectoration; there were no perspirations; he never had an attack of hæmoptysis; he was suffering from one of his usual attacks of diarrhœa; the evacuations were highly offensive, as they always were when he was labouring under such attacks. He was recommended change of air, either Queenstown or some other milder climate than Belfast. For some time he positively refused, but on the 1st of March he left home, and on the following day stopped at the Hydropathic establishment at Blarney, where he remained for nearly four months, under active hydropathic treatment. On his arrival there, he was able to walk into Cork and back on the same day, which he did on several occasions during the first month. For the first three or four weeks he wrote that he was gaining flesh; that his appetite was remarkably good. From the end of the first month he wrote in the most melancholy strain—his strength, he said, giving way, and losing flesh. Still he continued the hydropathic treatment, though he complained the baths were not agreeing with him. When he returned, in the latter

end of June, it was quite evident that he had lost flesh, and was much weaker than when he left home—he was low and nervous.

Early in August he went over to Edinburgh, Dr. Simpson paid him the greatest attention, and had many medical friends to examine him, and a variety of prescriptions were given him, none of which were taken more than once or twice, except the infusion of Virginian prune, which he thought was useful, but, after using it a week or so, it checked the expectoration and diarrhœa, he then gave it up. On his return to Belfast, his depression of spirits was so great, that his friends persuaded him to go to Ballynahinch Spa, where he drank the waters, and took a great deal of outdoor exercise, both on foot and car; his spirits became more cheerful, the character of the excretions from the bowels, he wrote, were much improved, and, on the whole, he considered himself better than he had been for some time. When he had been there for some weeks a sudden change took place—the pulse, which had hitherto been quite regular, suddenly became quick and weak; urine scanty; œdema of feet and legs; diarrhœa increased; and, for the first time, he wrote asking me to send him some astringent for the bowels. I sent him chalk mixture and catechu, a few doses of which checked the diarrhœa, and it did not annoy him again during his lifetime. I advised him to give up the use of the Spa waters; on doing so, the urine returned to its usual quantity. I may here remark, it was frequently tested and was always normal; the œdema in feet and legs greatly subsided, but the prostration increased. He bore the journey home well in a carriage; it was quite evident his decease was near at hand. From the time he arrived home he gradually became weaker; he suffered from dyspnœa at intervals, which was relieved by chlorodyne. He sank on the evening of the 30th October, having been perfectly composed and tranquil up to the moment of his death.

The only pain he ever complained of was in the rectum, after having a motion; for the last six weeks, he said, he was liable to it.

Dr. Reid detailed the particulars of his physical examination of the chest, and confirmed Dr. Pater-son's account in his review of the history and general symptoms. He said the disease was senile phthisis, brought to a premature termination by failure of the heart's action from atrophy of its muscular tissue.

The following is an account of the *post-mortem* and microscopic examinations, by Dr. Murney, and also the results of an analysis of a portion of the calcareous deposit in the right lung, by Dr. Cuming:—

“*Post-mortem* examination on the body of Dr. M'Minn, at a quarter-past ten o'clock, A.M., on Thursday, the 1st November, thirty-eight hours after death, in the presence of Drs. Patterson, H. Ferguson, Moore, Reid, Cuming, and Mr. Aickin:—

“Some slight rigidity of the limbs, as the rigor mortis had not passed off completely. On cutting through the soft parts to open the chest, the greater pectoral muscles were found atrophied; in fact, but a mere trace of the muscular structure remained. In the bag of the pericardium about two or two and a half ounces of clear serum was found.

“*The Heart.*—On the surface were three ‘lymph spots.’ The organ was rather larger than natural; its structure soft and flabby. I had not the means of weighing it, but consider it was about ten ounces; had its tissue been dense and normal, I would have calculated the weight at twelve or thirteen ounces. The thickness of the walls, and capacity of the cavities were natural; the mitral valves healthy; The aortic semilunars presented on the outer or arterial aspect of each at its base a hard calcareous-like nodule; there was no deposit or growth on the ventricular surface. A piece of the wall of the left ventricle was removed for examination, and submitted by Dr. Cuming to the microscope. He states he observed absence of the striæ in the muscular structure, but noticed no very large globules, but a large number of granules and oil matters. Subsequently the specimen was given to me. I also was unable to find the transverse striations; but on the addition of acetic acid, I think I witnessed a greater number of oil globules than were seen by my friend; at the same time, the number was very inconsiderable. I conclude, therefore—and in this statement I am joined by Dr. Cuming—although not a well marked example of fatty heart, the softened texture and microscopic appearances indicate the early stage of that degeneration. A few small patches of atheromatous deposit were found at the commencement of the aorta.

“*The Pleura and Lungs.*—Several old adhesions of the right pleura were found, more especially at the upper part; similar connections existed on the left side, but much stronger; in fact, in breaking them down to remove the lung, the apex was torn in two places. The lobes of the right lung presented to the touch the nodulated sensation customary to phthisis; on being cut into, tubercle was scattered in all parts, even to the base—of different degrees of consistence, the soft or semifluid, cheesy-like, and the hard chalky concretions. The latter were only found in the apex; no cavities were found here. In the left lung similar diseased conditions were found, but much more extensive; the masses of tubercle were, in many places, larger; and some vomicae were opened in the apex, from the size of a pea to that of a small walnut. I may add, the tissue of the upper lobes, on both sides, readily broke down under manipulation.

“The liver was of normal size and consistence. It presented on the upper surface of the right lobe three broad sulci, as if indentations produced by the ribs. They could not, however, have been produced by this

cause, as they passed vertically. Section presented the appearance of some fat; the lobules were in the condition of the first stage of venous congestion; under the microscope, a considerable amount of fat was observable; otherwise the tissue was natural. A small piece of the pyloric end of the stomach and upper part of the duodenum was laid open, and was found perfectly healthy.

“The physicians who had visited Dr. M’Minn declared it was unnecessary to prosecute the examination farther. I did not, therefore, remove the other abdominal viscera, nor was the head opened.”

Dr. Cuming stated that the cretaceous mass which he had examined consisted mainly of phosphate of lime, with some phosphate of magnesia and carbonate of lime. There was about eleven per cent. of organic matter in it. He said that he had been surprised to observe a statement in the work of Messrs. Sieveking and Jones, on Pathological Anatomy, to which his attention had been drawn by Professor Reid, that these concretions consisted of sulphate of soda and chloride of sodium. Such was certainly not the fact; and he was at a loss to conceive how salts of such marked solubility could possibly exist as concretions in the lungs.

Dr. Reid then resumed his remarks:—

The *post-mortem* examination having discovered cavities at the apex of the left lung, and the microscope atrophy of the muscular substance of the heart, confirms the opinion I had given, as to the nature and localities of his disease. The examination revealed another fact, viz., that disease was rapidly disorganizing the entire substance of both lungs. In addition to calcareous deposit (of course, of old standing) at the apex of the right, tubercular deposit had recently invaded the middle and lower portions of both lungs; and though the liver was found of natural size, yet a considerable amount of fat was deposited in it; a change which, when unaccompanied by enlargement, we have no means of detecting during life.

The different conditions in which the deposit was found at the apices and bases of the lungs, warrant, I think, the conclusion, that two deposits of tubercle had taken place, and at considerable intervals of time; the first at the apex, and the second lower down; that at the right apex was changed into calcareous matter, the qualitative and quantitative composition of which has been so fully ascertained by Dr. Cuming; whilst that on the left, if also changed into earthy matter, had been expectorated, and originated the cavities that have been mentioned. It is, therefore, not improbable that our friend was saved from dying of phthisis in early life (like some other members of his family) by the tubercular matter becoming changed into calcareous.

The opinion that there were two deposits is also supported by the firm adhesions that existed at the

tops of both lungs; that on the left being so firm, that the substance of the lung was torn in separating it; indicating clearly that a cause of irritation had long ago existed there, and had produced a localised plastic pleuritis.

The second deposit had taken place in the middle and lower portions of both lungs, and was evidently of a more recent date, as no portion of it had yet taken on the process of softening.

The case is instructive to us all, by showing how necessary it is to have healthy lungs as a standard for comparison when practising percussion. In this case, the existence of very great dulness below the left clavicle, masked whatever was produced by the calcareous deposit below the right one; and as tubercular deposit existed at the back base of both lungs, the percussion sound was the same in each, and the existence of deposit there was, in consequence, not detected.

So convinced was our friend that his disease was seated in the digestive organs, that he had been studying Dr. Johnson's work on Indigestion, and had found a case recorded, in which the same severe pain had existed in the rectum, whilst the only cause found after death for it was an aneurism in some portion of the arch of the aorta. I could detect no pulsating tumor along the abdominal aorta; and it entirely escaped my memory to have the lower portion of the intestines and the cavity of the abdomen examined carefully after death, in the hope of discovering its cause. I am under the impression that this peculiar pain in the rectum had been noticed by the late Dr. Marshall Hall, in some of his writings; but I have not been able to find the passage in either of his volumes on "Observations on Medicine," though I have a distinct recollection of his mentioning it as an ailment that could be relieved by some kind of manipulation about the sphincter ani muscles.

I cannot close this communication without expressing a feeling of deep respect for the mental constitution of our late friend; for whilst we can all be eloquent on the propriety and advantages of *post-mortem* examination, it requires a high caste of intellectual endowment to direct examinations to be made of our own bodies, with the sole object of advancing science and benefiting mankind.

Council 5th Meeting of Council, November 21st 1860, 3 P.M.

Present, Drs. Dill, W. MacCormac, Aickin.

[Preparation of Circular.]

Questions for discussion.

1. In what periodical the transactions of the Society for the current session were to be published.
2. The propriety of appointing a Publications Committee.

Cases to be read.

1. Dr. Murney will read notes of case of disease of foot.
2. Dr. Browne and Dr. Murney will introduce patient and give history of case of recovery from fractures of arm and forearm.

Patients to be exhibited.

1. Man with congenital absence of anterior wall of bladder.
2. Mr. Hanna will bring forward a child with a large ulcer on back.

Resolved that the first 12 pages of the transactions be issued with this notice.

Letters were received from Dr. Patterson Tandragee, and Dr. E. J. Bruncker, Dundalk, withdrawing their names as members.

To be proposed for membership. H. Purdon, Jun., M.R.C.S., Edin.

FIFTH MEETING.

November 24th, 1860.

Dr. Patterson, V.P., in the chair.

{Rough minute book: Present, Drs. Stewart, Cuming, T. Reade, Ferguson, J. Moore, Thompson, S. Reid, Rea, Murray, Johnston, Warwick, Mulholland, Dill, W. Aickin, W. MacCormac, Pirrie, Wales, Drennan, Halliday, Bryce, Mac Laughlin.

A majority having been declared in favour of publishing the transactions in the Dublin Hospital Gazette, it was resolved that for the current session the transactions be published in that journal.

A discussion then arose as to the propriety of establishing a publication committee. It was voted that the communications should be published as hitherto.}

Dr. Halliday presented a patient with a fluctuating tumor around the first finger. He stated there was no pain, and considered it non-malignant.

{Rough minute book: Dr. S. Reid stated that before he would pronounce his opinion, he would examine the nature of the ...

Dr. Murney expressed a similar opinion.}

Dr. Murney exhibited a case of *epispadias* in which the anterior wall of the bladder was absent. The testicles were contained in folds similar to the labia majora, ascending and descending according to the variations of the temperature. The urethra was imperforate. The penis was capable of erection.

Dr. Dill exhibited a child with spina bifida. At first the lesion appeared like a simple ulcer, and the character of the disease was not manifest.

Council 6th Meeting of Council, November 28th 1860, 3 P.M.

Present, Drs. Murney, Patterson, Mac Cormac, Mr. Browne & Dr. Aickin.

[Preparation of Circular.]

To be balloted for membership. H. Purdon, Jun., M.R.C.S. Edin.

Cases to be read.

- (1.) Mr. Browne and Dr. Murney will introduce patient and give history of case of recovery from fractures of arm and forearm.
- (2.) Dr. Murney will read notes of case of disease of foot.
- (3.) Dr. Murney will give report of operation for strangulated hernia and post-mortem.

For exhibition.

- (1.) Dr. Moore will exhibit cancerous disease of superior maxilla removed post-mortem.
- (2.) Dr. Mac Cormac will present photograph of the congenital absence of anterior wall of bladder exhibited at last meeting.

SIXTH MEETING.

December 1st, 1860

Dr. Patterson, V.P., in the chair.

{Rough minute book: Present, Dr. Wales, Moore, Thompson, D. Moore, Rea, Murray, Dill, W. Aickin, W. MacCormac, Browne, Johnston, Warwick, Murney.}

Dr. Browne introduced a patient who had recovered from a fracture of the ulna and radius together with a fracture of the humerus. The arm was at first completely distorted, and doubts were entertained as to the possibility of saving the limb. It was, however, put up in a gutta percha splint, and now, at the end of six weeks, complete recovery had ensued.

Amputation of Foot.

Doctor Murney showed a portion of foot, which he had amputated by Chopart's operation.

The patient, a young gentleman, has, for the last twelve months, labored under brown fibroglutinous degeneration of the synovial membranes of the small articulations of the tarsus and metatarsus. The operation had been deferred, at the request of the sufferer, until the loss of appetite and sleep, with other symptoms of irritation, indicated immediate removal. After the lapse of three weeks, the stump is almost completely united. He has not had a single bad symptom. From the day of operation his appetite was restored. He now rests without the use of anodynes, and is beginning to get fat.

Case of Femoral Hernia.

Dr. Murney also shewed a specimen which he had removed from the body of a patient on whom he had

operated for strangulated hernia, and who died thirty-six hours subsequently. The following report was given:—

A woman, aged 50, labored under reducible hernia for twelve months. On the 20th November, when crossing the street, the tumor became irreducible. She was admitted into hospital on the 21st; and thirty hours after the increase of the protrusion, having constant vomiting of the contents of the duodenum, and other symptoms of strangulation, chloroform was administered, and the taxis being tried without success, the usual operation was performed. Cutting down to and opening the sac was effected with great facility. It contained omentum only, somewhat, but not greatly congested. A stricture at the usual situation was relieved, and the protruded parts returned. In doing so my nail twice caught upon a firm band of lymph, situated anterior and external to the ring. This was cut, the parts dressed, and the patient taken to bed. At the time, the prognosis was more favorable than in a similar case of femoral rupture, on which I operated a week before; yet the more unpromising case recovered, and she, with brighter prospects for a few hours only, seemed to be relieved by the operation, and sank with symptoms of strangulation on the morning of the 23rd, sixty-six hours from the commencement, and thirty-six from the time of operation. For eighteen hours after section of the stricture, pain at the umbilicus and vomiting became much less frequent, but then returned, and continued almost constantly until death. The friends would not permit a proper examination *post mortem*, so I merely examined the parts adjacent to the wound, ten hours after the termination of life. The opening through which the hernia had passed was quite free. A piece of small intestine projected into it, but was not subject to the least compression. On enlarging the wound, fresh lymph was poured out freely on the visceral and parietal layers of peritoneum of the inguinal region. For about one foot in length, the vessels of the small intestine were congested, apparently the extension of irritation from the region of the femoral ring. Nearly every portion of the small and large intestines was examined through the wound, but, with the exception of the parts referred to, nothing was noticed. Close in front of the femoral vein, near the band of fibrine which was divided during the operation, lay a little pouch of serous membrane, about 1¼ inch in depth, sufficiently wide at the bottom to hold a shilling, with an orifice only large enough to admit a No. 4 catheter, puckered and appearing to have been as dilated as its cavity, but contraction of the lymph had caused it to assume its present appearance; it bearing a good resemblance to a purse or bag provided with a "string-case" drawn tightly.

Now, although the abdominal cavity was not freely laid open, so as to permit an examination of the dif-

ferent viscera, I have no doubt all the parts in any degree implicated in causing the strangulation were exposed. The feeling of the constriction before its division, and the appearance of the protrusion, shewed distinctly it was not what would be designated a tight stricture; no doubt quite sufficient to cause the symptoms, which, however, yielded upon its relief. I therefore think we cannot attribute the condition of the patient for the last eighteen hours *directly* to injury done by the stricture to bowel or omentum but ascribe it to the formation of this bag of peritoneum, which, I believe, did not exist until after the hernia became irreducible, was, in fact, created by the lymph poured out during the inflammation, and as this underwent organization, the orifice become more and more contracted. Why a condition of parts, such as I have described, not involving any vital organ, and certainly not interfering *directly* with the peristaltic movements of the intestine, should produce fatal results, I am unable to say; but we have all had ample experience that such terminations are not unfrequent.

Dr. Browne remembered having operated on a case where the peritoneum formed a band tying down the bowel, outside the position of the internal ring.

Society agenda from Council minute book.

The seventh meeting of the Session will be held in the Museum of the General Hospital, on Saturday, December 8th, at three o'clock.

Cases to be read.

Dr. Browne will read notes of case of disease of eye.

To be exhibited.

1. Dr. Moore will exhibit cancerous disease of superior maxilla, removed post mortem.
2. Surgeon Johnston will exhibit child with ossification of muscles.
3. Surgeon Warwick will exhibit case of cyanosis.

SEVENTH MEETING.

December 8th, 1860

The President in the chair.

{Rough minute book: Present, Drs. Ferguson, Patterson, Dill, Halliday, Rea, S. Reid, Dr. Moore, Mr. Purdon, Drs. D. Moore, Drennan, Dunlop, W. MacCormac, Browne, Stewart, Warwick, [?], Johnston, Bryce.}

Cases of Excision of Eye.

Dr. Browne read the following:—During last session, I brought under the notice of the Society three cases in which I had found it necessary to remove the globe of the eye. Two of these were removed by excision, in consequence of the irritative inflammation induced

and kept up in the uninjured eye, by a foreign body which had been in the opposite eye for some time. The other was extirpated for melanosis of the organ. In this case the disease has returned.

I have now to bring before the Society the brief notes of two additional cases of excision of diseased eyes.

The first is that of a young lady from the country, aged eight years, who was first brought to me in September, 1859, in consequence of her parents having observed something unnatural in the appearance of the left eye, and loss of sight in it. Upon dilating the pupil and examining the organ, the bottom of the eye presented a dull white appearance, and the ophthalmoscope revealed a prominence on the right side of the centre of the retina, with enlarged vessels passing on it. The retina seemed totally insensible to light, though the pupil, before the use of the atropia, contracted under its stimulus, evidently through sympathy with the healthy eye. At that time I advised the parents to bring the little girl to me at the end of three months, and, as she was not suffering any pain, and was in excellent health, I prescribed nothing for her. She did not return till July, 1860, when I found the aspect of the eye considerably altered; the growth seemed to have advanced toward the front; the vessels radiating on the growth were visible to the unaided sight; the conjunctiva was injected, and there was constant lacrymation; besides which objective symptoms, she had constant severe pain in the eye, brow, and head, and her general health had become affected.

Under these circumstances, though I could not pronounce the disease malignant, I thought it right to advise extirpation of the diseased organ. The operation was accordingly performed on the 8th of July. She made a rapid recovery, and remained quite well till the end of September, when her health began to fail, and constant severe pain in the head to be felt. Although the orbit has not yet exhibited any disease, I fear very much that the optic nerve within the skull is diseased, and that the case will prove to be one of fungus hæmatodes.

The diseased eye was examined after extirpation by Professor Gordon, who looked upon the case as non-malignant, as he could not discover any cancer cells, only exuded lymph and granular deposit at the bottom of the eye.

The next case is that of J. B. Dunlop, aged thirty-five, who applied to me early in August last. He stated that in the month of May, or early in June, he had observed his right eye to become bloodshot and painful every evening, with some dimness of sight; for this he was treated by a careful and experienced practitioner in the country. The disease, however, increased, the cornea gave way, the globe became greatly enlarged and exceedingly painful.

When he applied to me, the eye presented a very suspicious appearance, being very much enlarged, projecting from the orbit, and of a dusky red color, the blood-vessels being large and tortuous. There was constant pain in the part, and a considerable amount of sympathetic irritation in the left eye. The only remedy was excision, and that operation I performed early in September. He made an excellent recovery, and has remained quite well ever since.

The diseased eye was exhibited, and shewed a lobulated appearance within the sclerotic, the entire structure being filled up with organized lymph, presenting much the appearance of the vitreous humor, as figured by M. Bannon in his paper on the structure of that body. The case was regarded as non-malignant.

{Rough minute book: Resolved proposed by Dr. Ferguson and seconded by Dr. Moore That a notice inviting medical students to attend the Society meetings be posted in the hall of the Hospital and also of the College.}

Cyanosis.

Dr. Warwick exhibited a case of cyanosis in a child eighteen months of age. He said—According to her mother's report, this child enjoyed good health for about two months after her birth. I saw her for the first time about six months ago, when I found her laboring under a succession of violent paroxysms and remissions, accompanied with venous congestion, great difficulty of breathing, coldness of body increasing towards the extremities, as well as lividity of face, hands, and feet.

There is distinct pulsation of the jugular veins at all times, which are very much dilated during the attack, especially the left, which is much larger, caused by regurgitation of blood from the venous side of heart. I think I have been able to detect a distinct murmur, not only over the apex, but also over the base of the heart. She has become greatly emaciated and very peevish, sleeps badly, and takes very little food. She has a great desire for cold liquids, such as water and milk, which she consumes in large quantities, while the father of the child has told me that hot tea will produce a fit.

Dr. Browne asked if the symptoms might not be ascribed to mere anæmia.

Professor Ferguson found, on auscultation, a very intense murmur, which he found difficult to localise. He did not consider anæmia as a sufficient cause for the child's present condition.

Dr. Drennan stated his opinion; that to be a case of open foramen ovale it was by no means necessary that the child should manifest lividity immediately after birth.

The President considered the case one of imperfect septum.

Dr. Johnson read notes of, and exhibited a case in which there were extensive osseous deposits in a number of the muscles.

Society agenda from Council minute book.

The eighth meeting of the Session will be held in the Museum of the General Hospital, on Saturday, December 15th, at three o'clock.

Cases to be read.

Dr. Pirrie will read case of intussusception, and exhibit the recent parts.

To be exhibited.

Dr. Moore will exhibit cancerous disease of superior maxilla, removed post mortem.

EIGHTH MEETING.

December 15th, 1860

Dr. Patterson, V.P., in the chair.

Dr. W. MacCormac introduced a patient with aneurism, probably of the ascending aorta. It formed a swelling of the magnitude of half an orange, in front, and to the left side of the sternum. The patient enjoyed capital health, and positively asserted that, until two months previously, there had been no appearance of the swelling.

Surgeon Johnston introduced a child with a vascular tumor situate in the cheek, and alveolus of the left side. When the child cried oozing from the gums in the vicinity took place.

Case of intussusception.

Dr. Pirrie reported the details of a case of intussusception in a healthy infant four months old.

Dr. Pirrie had arrived at a correct diagnosis of the case during life chiefly from the suddenness and severity of the abdominal symptoms, and the long-continued efforts at straining without the evacuation of anything but a little bloody serum.

The *post-mortem* examination showed that the cæcum had entered and passed along the ascending colon, and through the sigmoid flexure, till it had almost reached the top of the rectum, where two ulcers had formed on the sheath of the volvulus, opening into the peritoneal cavity.

Models in wax of this interesting specimen, shewing the relative position of the parts of the intestine involved, are preserved in the Museum of the Society.

Society agenda from Council minute book.

The ninth meeting of the Session will be held in the Museum of the General Hospital, on Saturday, December 22nd, at three o'clock.

To be exhibited.

Dr. Moore will exhibit cancerous disease of superior maxilla, removed post mortem.

Also, foreign body removed from œsophagus.

NINTH MEETING.

December 22nd, 1860

Surgeon Browne in the chair.

{Rough minute book: Present, Drs. Moore, D. Moore, Mulholland, Johnston, Murney, Murray, W. MacCormac & W. Aickin.}

On a report from Dr. Murney on the case of tumor of cheek, exhibited by Surgeon Johnston at last meeting, a discussion arose in which Dr. Murney, the chairman, Dr. Johnston, and Dr. Moore took part.

{Rough minute book: Resolved that the Society do adjourn till 1st Saturday in January.}

Society agenda from Council minute book.

The tenth meeting of the Session will be held in the Museum of the General Hospital, on Saturday, January 5th, at three o'clock.

To be exhibited.

Dr. Moore will exhibit cancerous disease of superior maxilla, removed post mortem.

Also, foreign body removed from œsophagus.

Dr. Drennan will introduce a child suffering from deep ulceration of the parts around the nose after small pox.

TENTH MEETING.

January 5th, 1861

Dr. Patterson, V.P., in the chair.

{Rough minute book: Present, Drs. Moore, Dill, Ferguson, Rea, Wales, Thompson, W. Aickin, Drennan, Mulholland, W. MacCormac, Johnston.}

Dr. Drennan introduced a child with extensive gangrene in the region of the mouth and nose, and with the same lesion manifesting itself in different parts of the body.

{Rough minute book: Dr. Thomas Reade has found application of citric acid to be beneficial in such cases.}

Dr. Moore exhibited an example of cancer of superior maxilla. The disease commenced in the base of the tongue, attended with difficult deglutition. It rapidly extended, until it involved the larger portion of the superior maxilla, and ran its fatal course in about three months.

A large pebble was exhibited by Dr. Moore, which had been swallowed by a patient in the Lunatic Asylum. It was lodged in the œsophagus, and was there felt by Dr. Purdon, who was, however, unable to seize it. The patient drank a large quantity of water, both before and after he had swallowed the stone, and by this means emesis was induced, and thus the stone was forcibly ejected.

{Rough minute book:

ELEVENTH MEETING

January 12th, 1861.

Dr. Bryce V.P. in the chair, Drs. Warwick, Murney, S. Reid, Murray, O'Brien, Johnston, W. Aickin, Moore, Dill, D. Moore, W. MacCormac.

Moved and seconded and unanimously resolved at the meeting of the Clinical and Pathological Society of the 12 January 1861

That the members of the Society regret the repeated absence, and the apparent want of interest manifested by the President in the business and welfare of the Society, the more so as they were not led to anticipate such an event from aspirations contained in his president's opening address.

Moved by Dr. Dill and seconded by Dr. Reid that a copy of the forgoing resolution be forwarded to the President.

Moved by Dr. Murney and seconded by Dr. Moore

That the Secretaries be instructed to call a special general meeting of the Council on Wednesday 16th inst, and that the circular bear the following

I am directed to call your attention to rules 7, 8, 9 in which you will find it is a portion of your duty to aid the other officers in preparing for the business of the Society.}

Council 11th (Special) Meeting of Council, January 16th 1861, 3 P.M.

Present, Drs. S. Reid, Dill, Mulholland, Mac Cormac, Aickin. Dr. S. Reid in the chair.

The Secretary reports that a copy of the resolution of the Society was forwarded on last Saturday to Dr. Gordon.

Letters were received in reply, and directed to be laid before a special general meeting to be summoned on Saturday 19th January 3 P.M.

The notice to contain

Business. To consider letters received from the President and adopt such measures as may be necessary in consequence of their content.

To be exhibited. (1) Professor Reid will exhibit morbid parts and give history of case. (2) Dr. Corry will introduce a patient with an enormous inguinal hernia.

Belfast Clinical and Pathological Society

Eighth Session: 1860–1861

President Alexander Gordon

{Rough minute book:
TWELFTH (SPECIAL GENERAL) MEETING
19 January 1861

Dr. Patterson, Dr. Magee, T. Reade, J. Moore, J. Cuming, S. Reid, Mr. Purdon, Browne, Drs. Murray, Warwick, Drennan, Corry, W. Aickin, W. MacCormac, Pirrie, D. Moore.

Moved by Dr. S. Reid and seconded by Dr. Dill that the minutes of last meeting be confirmed.

Moved as an amendment by Dr. McGee and seconded by Dr. T. Reade that the minutes of last meeting be not confirmed.

A show of hands having been taken the majority declared for the amendment.

Moved by Mr. Browne and seconded Dr. Stewart that the President be furnished with a copy of the foregoing resolution and that his letters be returned as unopened.}

Dr. Corry introduced a man subject for many years to an immense scrotal hernia. The tumor varied somewhat in bulk, but was about the size of the man's head. It was irreducible, and Dr. Corry had constructed a large bag by which adequate support was afforded.

Dr. Moore exhibited four fingers removed from a boy's hand, in consequence of injury received from a circular saw.

He also exhibited a hand which he had amputated just above the wrist, in a man of sixty years of age. The injury had been sustained by the hand passing diagonally between two cog-wheels belonging to a threshing-machine.

Complete laceration had taken place in consequence, necessitating removal of the entire member. The operation was performed four hours after the accident, without chloroform, at the wish of the patient. Compression was maintained so perfectly throughout, that no blood was lost during the operation, and, on the third day after, union by the first intention had taken place.

Council 12th Meeting of Council, January 23rd, 3 P.M. Present, Dr. Patterson in chair, Drs. Corry, Browne, Drennan, Mac Cormac, Aickin.

Notice to contain. For exhibition

- (1.) Professor Reid will exhibit morbid parts and give history of case.
- (2.) Dr. Moore will exhibit cancer of mamma removed by operation.
- (3.) Also a patient affected with a peculiar form of skin disease.

THIRTEENTH MEETING.

January 26th, 1861

The President in the chair.

{Rough minute book: Murney, Wales, Professor Ferguson, Drs. Magee, Patterson, Halliday, M'Cleery, S. Reid, Purdon, Rea, Cuming, Mulholland, W. MacCormac, Stewart, Dill, Moore, Aickin, Browne, D. Moore, Murray, Bryce, Johnston.}

Disease of the Pancreas.

Professor Reid stated—I exhibit to-day some morbid parts removed from the body of a patient who died early last summer.

His age was forty-four; and he stated at my first interview with him that he had been subject to frequent attacks of vomiting during the previous three years; that the matters ejected were very acid, and often contained "sooty-looking" matter, or what we would have described as "coffee grounds."

The case possessed two points of diagnostic interest. First, with reference to a tumor that was felt in the region of the pyloric orifice of the stomach; and secondly, with respect to the frequency of vomiting.

At first a very hard, knotty tumor was felt in the region of the pylorus, and could be traced extending in a semicircle to near the margin of the right ilium. After a few days had elapsed, this tumor became much less distinct, and might have escaped detection on a cursory examination. In this way it would be on some occasions quite perceptible, whilst again it would be much less so. It was always, however, felt to be of the semi-circular form I have described. There was no enlargement of the veins of the abdomen, or of the limbs, nor did the latter ever become œdematous.

He stated that at first vomiting generally occurred about three quarters of an hour after taking food. In a few days, however, the period and frequency of its occurrence changed; and during a period of five weeks it took place regularly on every second day, and at varying intervals after taking food. These changes were so well marked as to attract his own attention. During the succeeding two weeks, the vomiting did not occur oftener than every fifth day. This was followed by a remission of remarkable duration, for no vomiting took place for a period of three weeks, which excited in him much hope of recovery, as he had not enjoyed so long a respite at any time during the previous three years. After this it appeared at very regular intervals, and which became shorter as his life drew to a close.

The colour of the matters vomited varied much, being sometimes yellow, then changing to green, and during the last few days chiefly of a "coffee-ground character."

The evacuations from the bowels presented nothing peculiar in their appearance, and although minutely examined, no fatty matter was ever observed in them. The emaciation of the body increased steadily, notwithstanding the long intervals between his attacks of vomiting. He suffered much from mental depression, and seldom spoke to any one.

On post mortem examination no fluid was found in the peritoneal cavity, although the vena cava was encircled by the tumour. The stomach was found much dilated; its mucous membrane free from any ulceration, though stained from ecchymosis in several parts. The posterior portion of the pyloric orifice was found intimately adhering to a tumor, but the anterior was not, and the forefinger could be passed freely through it, the elasticity of this portion being quite unimpaired.

A hard knotty tumor was found crossing the spine, involving the pancreas, surrounding the vena cava, adhering, as already stated, to the back of the pylorus, implicating the omentum, and with it forming the semi-circular hard tumour that was so often felt to the right of the mesian line during life.

Dr. Moore exhibited a *cancerous tumor of mamma* which he had excised. He also introduced a patient labouring under general *ichthyosis*.

Dr. Pirrie exhibited a *diseased uterus*. The cervix and body were very much elongated, and the fundus was occupied by a large fibrous growth. For upwards of three months this patient had been in hospital. She had been admitted for rheumatic pains of a trifling description. About a fortnight subsequently she complained of intense pain in the right knee, and soon afterwards the thigh and lower limb of that side swelled very considerably. This condition gradually became worse and worse, until the entire member was double the size of the other limb. No local tenderness was discovered along the course of the veins, but the general aspect indicated phlebitis. The woman was about fifty years of age, and had had children, but no uterine symptoms were complained of. On one or two occasions she suffered from temporary retention of urine.

On examination after death, the uterus was found, as described above, lying over the right common iliac vein. The vessels on that side were, with surrounding cellular tissue, matted together as the result of long standing inflammation, and a tuberculous matter was found in considerable quantity in the neighbourhood. The right femoral vein was found to be plugged up with a mass of lymph. The iliac veins, and all the veins of the left side, were free. The veins on the affected side were not traced further, owing to the great obesity of the subject, nearly two inches of fat being found in the sub-cutaneous cellular tissue.

Professor Ferguson asked if the presence of such a tumor of the uterus could be accounted an adequate cause for such an extensive lesion of the veins.

Dr. Murney, who performed the *post-mortem*, believed that, as the site of venous obstruction was the femoral, the uterine tumor which lay over the iliac vein could not be considered the primary cause.

Dr. Pirrie thought it probable that the uterine tumor was the starting point of the disease.

{Rough minute book: Dr. Bryce asked if any other veins were diseased.

Dr. Murney stated that from the great obesity it was difficult or impossible to detect in life any affection of veins, and no veins were seen after death but those specially sought for.}

The President thought it probable that the venous system of the entire limb was diseased, although the lesion only extended upwards as far as the profunda femoris.

Society agenda from Council minute book.

The thirteenth meeting of the Session will be held in the Museum of the General Hospital, on Saturday, February 2nd, at three o'clock.

Business.

Dr. Drennan will exhibit heart and lungs of asthmatic patient.

FOURTEENTH MEETING.

February 2nd, 1861

The President in the chair.

{Rough minute book: Drs. Ferguson, M'Gee, Patterson, S. Reid, Warwick, Rea, Drennan, Aickin, MacCormac, Burden, D. Moore, Pirrie, Cumming, Bryce, Mulholland, Dill, Browne.}

Dr. Drennan exhibited the heart and lungs of a woman aged between thirty-five and forty, who had for twenty years suffered from bronchitis and dyspnoea; her cough had latterly subsided, but her asthmatic symptoms had become much aggravated, and were accompanied, on her admission to hospital, eleven days before death, by anasarca swelling of feet and legs. The chest was of rounded form and limited motion, with a clear sound and feeble respiratory murmur throughout; a loud bruit was heard with the first sound at the apex of the heart, and the jugular veins were tortuous, distended, and pulsating.

The *post-mortem* examination revealed strong and extensive pleuritic adhesions on both sides, and distended lungs, presenting, round their edges especially, numerous projecting sacculi, from which the air could be with difficulty expressed. The right heart was much dilated, and slightly hypertrophied; both

mitral and tricuspid orifices were abnormally patulous. Dr. Drennan considered the case as a typical one, both as to symptoms and morbid anatomy.

Dr. S. Reid referred to the difference of opinion entertained by Drs. Stokes and Walsh, with reference to friction sounds as diagnosing the particular form of disease.

The President considered that the intensity of friction sounds depended very much on the state of the rubbing surfaces, whether they were moist or dry.

Dr. Ferguson said that the dry crepitus described by Laennec was not to be confounded with the rough sounds produced by effused lymph.

Anasarca.

Dr. Dill exhibited the brain and kidneys of a patient who died in hospital last night, at eleven o'clock, in convulsions. He was sent for about two o'clock to see a patient just admitted, suffering from acute anasarca, with convulsions. On his arrival he found the breathing stertorous, with great labour and distress, and congestion of face. Pulse was quick and flagging. The pupils were dilated and fixed, especially the left. The convulsions were often repeated until the time of death, which took place during one. The patient was a man of twenty-nine years of age. He was large, stout, and fat, and of generally healthy appearance. There was not much appearance of anasarca during life, but some was apparent after death.

Dr. Johnston said that the patient came, on Thursday last, to the dispensary, complaining of a cold; had puffy eyes and cheeks; never before had fits; told him to encourage the action of the skin; and gave him a purgative powder; saw him at his home on Friday morning; he was then heavy, restless, and somewhat stupid, not inclining to rise. He had three convulsions before being sent to hospital. He was conscious after the first two but not after the third. The habits of the patient had been intemperate.

Dr. Murney had made a *post-mortem* examination. The brain surface was covered with blood. The veins and structure were very much congested. The substance and ventricles contained no effused blood. The brain seemed very healthy. The kidneys were both much larger than normal, especially the right, which was very much congested. They each weighed about six ounces, being two ounces more than normal. The structure of the left kidney was completely altered, being paler than in health. No urine could be procured during life, but after death two ounces was procured from the bladder, which appeared more like thin porridge.

It was found to be completely albuminous.

Dr. Pirrie said that of course the congestion of the brain was secondary, depending on the previous state of the kidneys, very similar to cases of puerperal convulsions.

Dr. Ferguson observed that this form of disease was like another form of apoplexy, that the two diseases are too often amalgamated, and that a very large proportion of deaths, apoplectic so called, are examples of this, the true form of Bright's disease.

Dr. Drennan detailed the case of a sailor who died with similar symptoms. The form, however, was rather coma; the case appeared to result from disease of kidneys, but, after death, there was no appearance of unhealthy structure in either brain or kidneys; there was, besides, no albumen discoverable in the urine.

Dr. Pirrie referred to the case of a servant of this hospital who has had several attacks of convulsions with coma, one of which attacks lasted five days. He is the subject of albuminuria.

Society agenda from Council minute book.

The fourteenth meeting of the Session will be held in the Museum of the General Hospital, on Saturday, February 9th, at three o'clock.

Business.

The President and Dr. Browne will each exhibit examples of extensive tearing of skin off the hand by mill accident.

FIFTEENTH MEETING.

February 9th, 1861

The President in the chair.

{Rough minute book: Ferguson, Patterson, Thompson, D. Moore, Cuming, Mulholland, Purdon, Browne, Dill, Bryce, Aickin.}

Amputation of Hand.

Dr. Browne exhibited a hand removed by operation after a mill accident. The skin had been torn down off it like a glove, and the hand itself greatly mutilated. He remarked that in all such accidents it seems necessary to remove the injured parts at a point higher than the apparent injury, as the stretching of the soft parts render them liable to extensive sloughing.

The President exhibited one very similar, but not so much mutilated. Had two former cases of more extensive tearing, from the elbow down, followed by tedious inflammatory action, rendering the limbs almost useless. The cases referred to were not healed after eight months, so that experience would show the necessity of operation immediately, or within a few days after accident.

An interesting discussion ensued between Dr. Ferguson and Drs. Browne and Gordon with reference, (1) to allowing the integument to be replaced over the

denuded bone and soft parts, in such cases as might be given a chance of healing without operation; (2) the comparative merits of reapplying the raised integument, or application, such, as cotton wool, lint, and unctuous dressings; (3) the comparative vitality of integument torn up or down off the arm, and compared with vitality in the scalp; (4) the nature of the anatomical formation of that covering which replaces lost integument.

SIXTEENTH MEETING.
February 16th, 1861
The President in the chair.

{Rough minute book: Drs. Halliday, Patterson, Graves, Dill, Reid, Rea, D. Moore, Browne, MacCormac, Ferguson, Johnston, T. Thompson, Dr. Moore, Dr. Pirrie, Drs. Scott & O'Brien.}

RHEUMATISM.

Dr. Graves brought under the notice of the Society the therapeutic action of the tincture of *actea racemosa* in cases of acute rheumatism. He had tried it in several cases successfully, and had failed in only one case, when he had recourse to the opiate treatment. The disease generally yielded in about four days, and in no instance was the treatment prolonged beyond seven days. In none of the cases was there any cardiac affection. The dose was thirty drops thrice daily. It seemed to cause the subsidence of pain and uneasiness. It likewise produced a certain amount of diaphoresis and diuresis. He brought the remedy before the notice of the society, not as a specific, but as having succeeded with him in several cases. Dr. Simpson of Edinburgh had used it with great benefit in hypochondriasis and debility after parturition.

Dr. Browne asked if it had been employed in chronic as well as acute rheumatism.

Dr. Johnston inquired if it was equally applicable in cases where complication ensued.

Dr. Ferguson entertained great doubts as to the efficacy of specifics generally, and thought that this would probably run the course of such remedies. At the same time, he could not doubt the evidence of the facts laid before the society by Dr. Graves.

{Rough minute book: Dr. S. Reid read the following notes of a case of acute rheumatism ...

Dr. Bryce thought Dr. Reid's case was a most interesting one and one that should excite discussion.

Dr. Johnston noticed the fact of the Edinburgh School not employing mercurials in the cardiac complications of rheumatism.

Dr. Browne thought that the mercurials were greatly abandoned in the treatment of serous inflammation generally.

Dr. Graves thought that while avoiding one extreme we should not fall into the other and that the anti-mercurial feeling should not be pushed too far.

The President treated a case in which KI produced livid discoloration of lips.

Dr. Ferguson thought that the treating of acute rheumatism could not be generalised so. That in some cases mercurials were applicable and in other cases they were not. Some cases required the most active antiphlogistics, others required stimulation and support. Opium he thought protected considerably against the complications.

Dr. Reid stated that Dr. Richardson produced endocarditis at will by injection of lactic acid into the peritoneal cavity, and that thus one had a hint as to the nature of the treatment in acute rheumatism. He found KI beneficial in many cases of cardiac affection where mercury had pushed to the full extent.

Dr. Ferguson said that lemon picric was considered most important in the treatment of acute rheumatism by a large section of the profession. He thought pericarditis more frequent than endo- and he thought the mere presence of a murmur was by no means conclusive in the course of an acute rheumatism of the occurrence of endocarditis. In the latter case he thought it was necessary for some physical obstruction and then he was not sanguine as to the effects of treatment. In such cases he thought that a bruit which came today and went off in a few days was not likely to be produced by a physical cause.

Dr. Browne whether if Dr. Ferguson thought medicines did not limit cardiac lesions—e.g. mercury followed by iodide of potassium just as in lymph on the front surface of the iris.

Dr. Ferguson had great doubts of the removal of lymph from the endocardial lining by any medicines.

Dr. Reid states Dr. Richardson on examination no murmur at first, then found an [?] murmur 4 days after injection of lactic acid. On autopsy found the valves swollen and a deposit of gelatin within pericardial serous membrane. On puncturing the membrane an exudation come out. In such cases medicines might produce absorption.}

Society agenda from Council minute book.

The sixteenth meeting of the Session will be held in the Museum of the General Hospital, on Saturday, February 23rd, at three o'clock.

Business.

The President will exhibit and describe a new form of splints for fracture of the radius.

Belfast Clinical and Pathological Society

Eighth Session: 1860–1861

President Alexander Gordon

{Rough minute book:
SEVENTEENTH MEETING.
February 23rd, 1861

The President in the chair. Drs. Ferguson, T. Reade, Cuming, Johnston, D. Moore, Browne, Patterson, Warwick, Dill, Pirrie, O'Brien, W. MacCormac, J. Moore, Murney, Bryce, Thomas Thompson.

The President then exhibited and described a new form of splint for fractures of lower end of radius.

Dr. Browne thought there could be no second opinion of the value of the proposed radial splint. He had himself treated several cases successfully. He thought however that other means would produce the same effect but not with the same ease and satisfaction. He referred to the liability of unstable fractures of lower end of radius for luxation—fall on the palm.

Dr. Johnston referred to the practice of treating the radius which had been practiced in Dublin. He thought Dr. Gordon's paper a most valuable one.

Dr. Browne exhibited a cancerous tumor removed from mamma. The disease was medullary and he thought it likely that it would not be of any benefit to the patient.}

Society agenda from Council minute book.

The seventeenth meeting of the Session will be held in the Museum of the General Hospital, on Saturday, March 2nd, at three o'clock.

Business.

Dr. Bryce will exhibit casts of triplets, and give history.

{Rough minute book:
EIGHTEENTH MEETING
March 2nd, 1861

Chair taken by Dr. Patterson, Warwick, D. Moore, Johnston, Aickin, Dill, J. Moore.

Dr. Dill exhibited a uterus containing an enormous tumour, supposes it to be fibro-cystic.

He also exhibited a brain and piece of left lung of a patient admitted into hospital a short time since. The brain showed numerous abscesses.}

Society agenda from Council minute book.

The eighteenth meeting of the Session will be held in the Museum of the General Hospital, on Saturday, March 9th, at three o'clock.

Business.

Dr. Bryce will exhibit casts of triplets, and give history of case.

Dr. Dill will exhibit tumor of uterus, and give history of the case. Also a wax model of brain with several abscesses, and give history of the case.

{Rough minute book:
NINETEENTH MEETING
March 9th, 1861

The President in the chair. Drs. Ferguson, Murney, D. Moore, Rea, Dunlop, Mulholland, Dill, W. Mac Cormac, J. Moore, Patterson, S. Reid, Johnston, Cuming.

Dr. Dill exhibited uterus with tumour removed from a patient æt 40, unmarried. Case of hæmorrhage when admitted to hospital. On examination there found to be a large abdominal tumour. The patient when placed in Dr. Dill's hands seemed to be suffering from weakness principally. She was in fact anæmic.

When this tumour was examined it was found to be fibrocystic involving the anterior part of the uterus. The fundus and posterior wall were almost healthy and the ovaries also. The neck and os were ulcerated and from this proceeded the drain on the system which caused the fatal termination, not so much the tumour itself.

Dr. Ferguson asked if the patient had laboured under any affection of the veins or swelling of the lower limbs.

Dr. Dill stated there was none which he ascribed to the fact that the tumour was free in the cavity of the abdomen and not in the pelvis.

Dr. Murney thought the ulcerated action of the os was due to epithelial cancerous action, from the appearance of the one and the fetid nature of the discharge.

Dr. Dill stated in reply to Dr. Moore that the discharge was sometimes ordinary, at other times [?] clotted and even fœtid.

Surgeon Johnston has a dispensary [patient] with aggravated menorrhagia coming off in clots of blood. It is the second case he has seen. The neck and os healthy. Over the vesical region can feel a globular tumour which appears to him to be a uniform enlargement of body of uterus. He found gallic acid to give great relief in staying the discharge.

The President has seen one or 2 cases in which a similar [?] had taken place from the increase of the cavity, probably from the contraction of the neck and os.

Dr. Dill then exhibited a wax cast of abscess of brain occurring in a patient admitted from disease of chest. He recovered from this and was permitted to rise. He

then had a rigor and severe headache. He was blistered and treated with mercurials without any good effect. He then had convulsions and the symptoms continued to aggravate until death.

On opening calvarium sinuses much gorged and on cutting into hemispheres several abscesses were found.

In answer to Dr. Ferguson Dr. Dill said the case lasted 14 days after the 1st rigor.

Dr. Ferguson asked if the paralysis of arm and eyelid left-side were of the ordinary kind and not the spasmodic, or the abscesses were the result of the acute inflammation or a secondary result from deposition of pus in brain substance.

Dr. Reid asked if the lesions of brain might not be result of the disease of lungs.

Dr. Murney who performed the P.M. found the left lung adherent to left nipple for some extent and lung was almost carnified.

Dr. D. Moore stated that for 2 days subsequent to rigor he was perfectly well, and when he was called to him he was in the warm stage of a fit of ague not the cold. The patient had been admitted for pleuritic affection of left side.

Dr. Dill was asked by Dr. J. Moore if the restlessness was of any peculiar form as Dr. M. had seen several cases of rolling motion.

Dr. Ferguson asked if any means could have been employed in such cases. Would bloodletting be of use.

Dr. Cuming thought it possible that the abscesses might be of old standing and ...}

Society agenda from Council minute book.

The nineteenth meeting of the Session will be held in the Museum of the General Hospital, on Saturday, March 16th, at three o'clock.

Business.

Dr. Bryce will exhibit casts of triplets, and give history.

Dr. Moore will exhibit encysted tumor removed from eyelid.

{Rough minute book:
TWENTIETH MEETING
March 16th, 1861

Dr. Patterson V.P. in the chair, present Drs. D. Moore, McLaughlin, Magee, Halliday, S. Reid, Dill, W. MacCormac, Aickin, Johnston, Warwick.

A man æt 42 admitted January 12 under Dr. Drennan's care. On 1st February came under Dr. Dill's care.

On admission he had been given Iod. Pot. with sarzal then Liq. Donovan's and then again Iod Pot and Brand Sol with Antim Tart and baths 65° low diet.

Had this attack of skin disease for 15 weeks which was now quite general. At first it was considered a

case of eczema afterwards psoriasis. 6 weeks treatment cure.

Dr. Magee would not have used low diet. Would have prescribed a [sturaling?] wash [of?] lyttæ, borax, glycerin, rose water.

Dr. Johnston thought it probably a case of eczema more than psoriasis and that you might thus ...

Dr. Halliday considered the addition of the Tart. Ant. to the medicine very judicious and baths with bran and about 3oz Carb Pot formed a very excellent application.

Dr. Bryce brought forward case of triplets. Two were small and each of them $\frac{1}{4}$ the size of the 3rd. They were about 5 or 6 months. A very large quantity of water came away with the 1st. With the 2nd none. With the 3rd a very large quantity of water came away.

Dr. Aickin remembered a case where there was a very large quantity of water, a large child. He thought the large quantity in Dr. Bryce's case had exerted a pressure on the umbilical by one fœtus in distinction to the others.

Surgeon Johnston mentioned a case under his treatment which had been operated on for cancer 7 weeks since in which the cicatrix had not healed and the disease was rapidly returning with enlarged glands in axilla.}

Society agenda from Council minute book.

The twentieth meeting of the Session will be held in the Museum of the General Hospital, on Saturday, March 23rd, at three o'clock.

Business.

Dr. Moore will exhibit encysted tumor removed from eyelid.

Dr. Browne will notice successful cases of Wurtzer's operation for reducible hernia.

Dr. W. MacCormac will exhibit a patient affected with an unusual form of skin disease.

Dr. S. Reade will read notes of a case of Addison's disease.

{Rough minute book:
TWENTY-FIRST MEETING
March 23rd, 1861

Professor Reid in the chair, present Drs. Bryce, J. Moore, D. Moore, Murney, Magee, Cuming, Ferguson, Halliday, Dill, Murray, W. MacCormac, Browne, Mulholland, Patterson.

Dr. W. MacCormac ...

Dr. Halliday said he had a similar case under treatment.

Dr. Browne had seen the case and given sol. Donovan and glycerine with T. Iodine.

A lengthened discussion took place on the application of T. Iodide and the question of its production of pain.

Dr. J. Moore then exhibited a tumour which he had removed from the upper eyelid.

A tumour which was the size of a Spanish chestnut conjunctal in a lady of 28. Cut down on it and found the cyst very thin, the envelope of a turkey's egg. When the dissection was nearly completed a small cut was made into the tumour with escape of a portion of contents. It was necessary to open the sac completely, pass in the finger and finish the dissection with it. The contents were of the consistency of cream changed and filled with hairs and on fully extracting the sac the lining membranes there were hairs growing. The wound healed by the 1st intent.

Dr. Bryce had a case in which there was a mass of hair discharged from an abscess on the scalp.

Dr. Murney thought it would be interesting to know if the hairs contained a central canal.

Dr. Dill inquired if injection and evacuation of sac ever effected a cure in cases of cystic tumour.

Dr. Moore thought in this case such treatment would be of no avail.

Dr. Murney stated with regard to Dr. D. brain that there was no abscess in cerebellum on P.M. and the abscess in hemispheres was in upper part of hemispheres.

There was no evidence of phlebitis Dr. M. said in answer to Professor Reid.

Dr. Moore exhibited a thumb removed after mutilation in a straw cutter. The palm is somewhat mutilated. Dr. Moore however found tetanus. The thumb was very much lacerated.

Dr. Browne brought forward Wurtzer's cases.¹

Dr. Murney gave an explanation of the way in which the mechanical appliance acted. In Dr. Murney's case there was complete adhesion of the invaginated skin which would he thought be desirable to strengthen the abdominal parietes. Now no external sign of the operation remains.

Dr. Moore's case he kept the plug in for six days. The invaginated portion of skin remains plugged up and appears to be no probability of the descent of the gut.

Dr. Dill asked if there was hernia on P.M. in any of these cases.}

¹ [Wurtzer invented an instrument for the treatment of hernia which invaginated a portion of skin and fascia and held it there until inflammation united the invaginated portions. Ref. Greenville Dowell, *Treatise on Hernia*, 1876, Philadelphia, p38.]

Society agenda from Council minute book.

The twenty-first meeting of the Session will be held in the Museum of the General Hospital, on Saturday, March 30th, at three o'clock.

Business.

Dr. S. Reade will read notes of a case of Addison's disease.

{Rough minute book:
TWENTY-SECOND MEETING
March 30th, 1861

The President in the chair, present, Dr. D. Moore, Dr. W. MacCormac, Ferguson, Browne, Patterson, Dill, Mulholland, S. Reid, J. Moore, Rea, Warwick, Johnston.

Professor Ferguson brought before the Society for discussion the question of the present asthenic character of disease.

In some cases of pneumonia with solidification lately he had given up reflecting measures such as tartar emetic and administrated wine.

Dr. Browne agreed with Professor Ferguson and thought that surgical as well as medical cases exhibited a similar tendency.

With regard to the hospital gangrene which recently took place in the house the President thought it arose from local causes, although he thought it worthy of note that there had been previously puerperal fever in the house.

Surgeon Johnston mentioned possibly as a coincidence the fatal occurrence of convulsions with whooping cough arising without any premonitory symptoms such as vomiting. Treatment seemed to have no effect.

Dr. Moore exhibited a girl with a large polypoid growth in the ear.

Dr. Browne mentioned that it was not always safe to remove these polypi for when the origin of the growth is from the internal ear the sequel of meningitis may arise.

Active hæmorrhage frequently takes place, and the restoration of hearing is not general.}

Society agenda from Council minute book.

The twenty-second meeting of the Session will be held in the Museum of the General Hospital, on Saturday, April 6th, at three o'clock.

Business.

Professor Reid will read notes of a case of Addison's disease, with morbid representations.

{Rough minute book:
TWENTY-THIRD MEETING
April 6th, 1861

Dr. Patterson V.P. in the chair, Drs. Reid, Ferguson, Mulholland, Murney, Thompson, D. Moore, W. Mac-Cormac, Rea, Johnston, Dill, J. Moore, Browne, Murray, Warwick, Bryce.

Professor Reid then read notes of a case of Addison's disease.

Surgeon Johnston described a case which he had had some years since in which the symptoms, coloration of skin, intense debility, from which the patient sank, lead him now to consider that it was a case of Addison's disease.

Professor Ferguson asked the connection between the suprarenal lesions and the color of skin. Brown-Séquard thinks that the suprarenal capsules have an influence on the elimination of pigment.

Dr. Drennan referred to Dr. Laycock's theory on coloration of skin and to the frequent instances in which this peculiar color exists with no suprarenal lesion.}

Society agenda from Council minute book.

The twenty-third meeting of the Session will be held in the Museum of the General Hospital, on Saturday, April 13th, at three o'clock.

Business.

Professor Reid will read notes of intra-thoracic tumor, with history of patient.

Dr. Moore will describe an affection of the testicle.

Dr. Browne will exhibit limb removed for extensive necrosis of bone.

Professor Gordon will exhibit limb removed for compound fracture.

{Rough minute book:
TWENTY-FOURTH MEETING
April 13th, 1861

Dr. Patterson in chair, Drs. Browne, C. Ferguson, T. Reade, S. Reid, Mulholland, Dill, D. Moore, Aickin, Johnston, Warwick.

Professor Reid read notes of a case of intra-thoracic tumour. Exhibited morbid parts.

Dr. Ferguson thinks that the absence of external tumour renders it very difficult of diagnosis.

Dr. Murney apology for Dr. Scott who had to leave town on business.

Dr. Warwick exhibited contents of tumour removed from forehead of girl 23 or 24 years of age. Sebaceous

secretion, about size of large hen egg. Did not remove sheath.

Dr. [T.?] Reid considered it an ordinary wen.

Dr. Moore exhibited polypus of ear, in girl æt. 12.}

Council 24th Meeting of Council, April 17th 1861.

Present, Dr. Patterson in chair Drs. Drennan, Dill, Mulholland, Aickin.

Resolution. Proposed by Dr. Patterson, seconded by Dr. Mulholland and passed "That rule 23rd be left out for the election of the office-bearers."

Ballot papers to be issued as soon as possible with the list of attendances of members of the different meetings.

{Rough minute book:
TWENTY-FIFTH MEETING
April 20th, 1861

President in chair. Professor Ferguson, Reid, Drs. Dill, D. Moore, S. Browne, Patterson, Cuming, Aickin, Bryce, Halliday, Johnston.

Dr. Browne exhibited parts residuum of surfaces of knee joint.

Also exhibited leg removed for extensive necrosis.

Also exhibited leg amputated for extensive gangrenous sloughing from accident.

Dr. Bryce asked

President. 5th cases operated in this hospital.

Operated on case of pulpy degeneration as well for 9 [cases?] but turned out ...

This scrofulous is a proper case to operate on especially when confined to articular surfaces, the constitutional symptoms are not so serious in the latter.

Remarked with respect to 3rd case ...

President exhibited leg removed from old man, 77 years, [?] [?] amputated [?] after accident. Today is 10th day after operation, doing well.

Professor Reid exhibited morbid parts and read notes of case of disease of kidneys and bladder.

Professor Ferguson mentioned had seen a case of catalepsy.

President remarked a case where friction bands after accident in a mill. Reoperated and disease in edges.

Belfast Clinical and Pathological Society

Eighth Session: 1860–1861

President Alexander Gordon

Dr. Dill exhibited instrument Hulls utero-abdominal support.}

Ballot paper from Council minute book.

Left-hand leaf—voting form.

Right-hand leaf—list of members:

List of Members
of the
Belfast Clinical and Pathological Society
Session 1860-61
with
Register of their Attendance at the first Twenty-four
Meetings.

LAW 24.—“That no Member be hereafter eligible for the office of President, unless he has previously filled the office of Vice-President.”

Aickin, W., M.D., Hon. Sec.	16	Jamieson, D., M.D., (Newtownards).	
Andrews, Professor, M.D.		Jeffres, _ Surgeon, (Clough).	
Anderson, J. C., Surgeon, (Kilkeel)		Johnston, H. M., Surgeon, Mem. Council.	22
Arnold, Wilberforce, Surgeon, L.K.Q.C.P.I.		Johnston, Aug., Surgeon, (Lancashire).	
* Babington, T. H., M.B., V.P., (Londonderry).		Kelso, J. J., M.D., (Lisburn).	
Blakely, S., Surgeon, (Aughnacloy).		Kennedy, _ (Comber).	
Browne, Samuel, Surgeon, R.N., L.K.Q.C.P.I. Mem. Council.	14	Knox, A., M.D., (Strangford).	
Brown, W., M.D., (Derry).		M'Bride, H., Surgeon, (Gilford).	
* Bryce, R., M.D., V.P.	13	M'Caldin, J. J., M.D., (Coleraine).	
Buckingham, J., Surgeon.		M'Cleery, J. C., Surgeon.	2
Burden, H., M.D.	1	M'Cllelland, R., M.B., (Banbridge).	
Carson, J. C. L., M.D., (Coleraine).		M'Cormac, W., M.D., Hon. Sec.	21
Cavin, W., M.D., (Coleraine).		* M'Gee, W., M.D.	8
Clugston, W. A., M.D., (Ballyclare).		M'Keag, D., M.D., (Coleraine).	
Conner, _ Surgeon, (Newry).		* M'Laughlin, W. R., M.D., (Lurgan).	4
Corry, T. C. S., M.D., Mem. Council.	2	* M'Mechan, J., M.D., (Whitehouse).	2
Cuming, James, M.D.,	12	Macaw, J., M.D., (Bushmills).	
Diamond, C., Surgeon, (Rasharkin).		Mahood, G., M.D., (Enniskillen)	
Dickie, Professor, M.D.,		Mawhinney, J., Surgeon.	
Dickson, J., M.D., (Ballynahinch).		* Moore, James, M.D.	17
Dill, R. F., M.D., Mem. Council.	22	Moore, W., Surgeon, (Dungiven).	
Drennan, J. S., M.D., Mem. Council.	4	Moreland, H., M.D.	
Dundee, J., M.D., (Carnmoney).	1	Mulholland, C., M.D.	15
* Dunlop, A., M.D., V.P., (Holywood).	4	* Murney, H., M.D.	14
* Ferguson, Professor, M.B.	19	Murray, D., M.D.	12
* Ferris, C., Surgeon, (Larne).		Musgrave, S., Surgeon, (Lisburn).	
Forsyth, J., M.D., (Culmore).		Moore, D., M.D.	20
Frame, J., L.F.P.S., (Comber).		Neligan, J. M., M.D., (Dublin), Hon. Mem.	
Gordon, Professor, M.D., Pres.	12	O'Hare, Owen, M.D.	
Graham, J., M.D., (Templepatrick).		Patrick, W., Surgeon, (Carrickfergus).	
* Graves, H., M.B., V.P., (Cookstown).	1	Patterson, J., M.D., Vice-Pres.	23
Greenfield, _ M.D., (Holywood).		* Pirrie, J. M., M.B., Vice-Pres.	7
Halliday, J. H., M.D., Treasurer.	10	Purdon, C. D., M.B.,	
Hanna, H., Surgeon.		Purdon, H., M.D., Jun.	6
Harkin, A., M.D.		Rea, H. P., Surgeon.	12
Hawthorne, J., Surgeon, (Banbridge).		* Reade, Thomas, M.B.	9
Heeney, F., M.D.		Reid, Professor, M.D., Ex-Pres.	19
Hodges, Professor, M.D.		Ross, R., M.D.	1
Hume, G. A., M.D., (Crumlin).		Rutherford, W., Surgeon, (Anahilt).	
Hunter, S., M.D.		Scott, W., M.D., (Aughnacloy).	1
		Sharpe, R., M.D., (Coleraine).	
		Smith, R. W., M.D., (Dublin), Hon. Mem.	
		Smith, J. W. T., M.D.	
		Smyth, J., Surgeon.	
		* Stewart, R., M.D.	9
		Stokes, W., M.D., (Dublin), Hon. Mem.	
		Taggart, J., M.D., (Antrim).	
		Taylor, W., M.D., (Articlam, Coleraine).	
		Thompson, H., Surgeon, (Ballylesson).	10
		Thompson, T., M.D.	2
		Wales, G. F., M.B.	7
		Warwick, W., Surgeon.	15
		Weir, M., Surgeon, (Dromore)	
		Wheeler, T. K., M.D.	1
		White, Barnwell, M.D., (Derry).	

Those marked (*) thus, are, or have been, Vice-Presidents.

The Annual Meeting will take place at Three o'clock, on
Saturday, May 4th.

Council 25th Meeting of Council [probably on 24th April 1861]

Dr. Patterson, Mulholland, Aickin.

The President and Secretary to attend on Friday evening to make up number and lock up the ballot box.

Society agenda from Council minute book.

The twenty-fifth meeting of the Session will be held in the Museum of the General Hospital, on Saturday, April 27th, at three o'clock.

Business.

Dr. Moore will describe an affection of the testicle.

Dr. Browne will exhibit necrosed femur, and describe the case, requiring amputation.

Professor Ferguson will read notes of a case of intestinal calculus, and exhibit specimen.

{Rough minute book:
TWENTY-SIXTH MEETING
April 27th, 1861

President in chair, Patterson, Cuming, D. Moore, Bryce, Professor Reid, Murray, Rea, Mulholland, Dill, Patterson, Warwick, Aickin, J. Moore, Professor Ferguson.

Professor Reid moved and Dr. Dill seconded "That the time of receiving the ballot papers be extended to 6 P.M. on Friday 3rd May and that a circular be issued to that effect."

The President read notes of case of necrosis of femur for Dr. Browne and exhibited limb removed.

Dr. Dill exhibited and described post-mortem appearances of brain on woman who died in hospital, disease apoplexy. There is a large coagulum in the left ventricle. The origin of the hemorrhage is from the corpus striatum.

Professor Ferguson thought it was rare to see such extensive hemorrhage in a patient living 15 hours.

Professor Ferguson exhibited biliary concretions and read notes of case.

Dr. Cuming had examined the specimen chemically. Considered it of the same composition as ordinary biliary gall stone.

President. Calculus passes the duct but very slowly. Death may occur in the process.

Dr. J. Moore described and showed drawing of disease of testicle.

Professor acute meningitis.}

Special Council Meeting to be called before the annual meeting at 1½ P.M. Saturday May 4th for counting of papers &c.

Notice of the Annual General Meeting in the Eighth Session.

CLINICAL AND PATHOLOGICAL SOCIETY.

General Hospital,
May 3rd, 1861.

Sir

We beg to inform you that the Annual Meeting of the Society will be held in the Museum of the General Hospital, on To-morrow, May 4th, at Three o'clock, to receive—

1. Report of Council.
2. Report of Auditors.
3. Announcement of New Office-bearers.
4. Closing Address of President.
5. President Elect.

N.B.—The Treasurer, Dr. Halliday, requests all Members who have not yet paid their Subscriptions to forward them immediately.

We are Sir,
Your obedient Servants,
William Mac Cormac, A.M., M.D.,
William Aickin, M.D.,
Honorary Secretaries.

Council May 4th 1861, 1½ P.M., Special Council Meeting for counting of ballot papers &c.

Present, the President in the chair, Drs. Patterson, Professor Reid, Pirrie, Bryce, Dill, Corry, Halliday, Aickin.

The ballot box contained 31 papers which was the number received up to the hour of _ the previous evening at which time the Secretary of Council secured the box and delivered the key to the President.

One of the ballot papers was from Dr. Babington, Londonderry, who declined to vote as he did not intend continuing a member of the Society. The counting of the remaining 30 was proceeded with and results as follows.

Officers for the session 1861 & 2.

Ex-President,	Professor Gordon.
President,	H. Murney Esq., M.D., J.P.
Vice-Presidents, Town	Dr. Patterson.
	Pirrie,
	Browne,
Country	Graves, Dublin ¹
	Browne, Derry,
	Dunlop, Holywood.

¹ [Probably Cookstown is meant.]

Belfast Clinical and Pathological Society

Eighth Session: 1860–1861

President Alexander Gordon

Council,

Surgeon H. Johnston,

Dr. Dill,

Corry,

Drennan,

Mulholland,

Bryce.

Treasurer,

Halliday,

Secretaries,

William MacCormac,

William Aickin.

{Rough minute book:

ANNUAL GENERAL MEETING

May 4th, 1861

President in chair, Dill, Patterson, J. Moore, Johnston, Professor Ferguson, Cuming, D. Moore, Pirrie, Murray, Warwick, Bryce, Stewart, Mulholland, Aickin.

After the minutes of the last meeting were signed the minutes of the last annual meeting were also read and signed.

Report of Council ...

Report of Auditors ...

Announcement of Office Bearers ...

Secretaries and Treasurer ...

President regretted his inability to attend regularly.

Professor Ferguson was moved to chair.

Dr. Stewart moved a vote of thanks to the retiring President requesting him to still take the same interest in the [Society]. Seconded by Dr. Patterson passed unanimously.

Professor Gordon returned thanks.}

Belfast Clinical and Pathological Society

Ninth Session: 1861–1862

President Henry Murney

BELFAST CLINICAL
AND PATHOLOGICAL SOCIETY

NINTH SESSION
1861–1862

President HENRY MURNEY, M.D., Surgeon to Belfast
General Hospital; formerly Demonstrator of Anatomy
Queen's College, &c., &c.

FIRST MEETING
October 26th, 1861.

Case of Cataract.

Dr. BROWNE introduced a young girl, aged 14, from
the country, labouring under cataract in both eyes.

He observed, that the case before the Society pre-
sented the usual appearance of congenital cataract,
though the patient, up till two years ago, had enjoyed
good sight; since that time the powers of vision had
gradually declined, until now she could merely distin-
guish the outline of large objects, even when the
pupils were fully dilated.

No cause whatever could be assigned for the
occurrence of the disease, as there had not been any
injury or previous affection of the eyes. In his opinion
it was the result of slow inflammation, and the con-
sequent arrest of nutrition, just as, he believed,
occurred in congenital cataract, either in utero or
very soon after birth. Certainly it was very rare, he
said, to see cataract occurring, as this had done, in a
perfectly healthy young person, and where there had
not been injury.

The operation he designed was that for breaking
up and absorption—improperly called the operation
for solution. He observed, that the needle—a very fine
one—should be introduced through the cornea, and
the capsule of the lens should be only slightly torn in
the first operation, lest inflammation should be set
up.

In the future operation or operations the needle
could be more freely used with comparative safety.
Some weeks should intervene between the opera-
tions; indeed the needle should be only used afresh
when absorption or the disintegration and disappear-
ance of the cataract seemed at a stand still.

SECOND MEETING
November 2nd, 1861.

Dr. BROWNE exhibited a patient labouring under *trau-
matic cataract*. The capsule had been wounded by a
blow from a hackle-pin; and spontaneous cure was
now going on by absorption.

THIRD MEETING
November 9th, 1861

Case of Enchondroma of Hand.

Dr. BROWNE presented the model of a hand, taken in
plaster, and also the morbid specimen which he had
recently amputated for enchondroma.

The patient was a woman, aged 64 years, from the
country, near Belfast. She stated, that some 16 years
since she had observed a small swelling close to the
head of the metacarpal bone of great finger. This, she
says, was entirely dispersed by treatment. Within the
last two years, however, it had returned, and the
swelling extended rapidly from that point to the rest
of the hand, involving the metacarpal bones and the
phalanges, with the exception of the distal phalanges
of the thumb and little finger. The principal enlarge-
ment was on the back of the hand, where the tumour
presented a somewhat unequal, glistening surface,
the veins at some parts being tortuous, full, and
enlarged. This tumour was elastic; and, at one or two
places, there was a sensation of fluid beneath the
touch. She came into hospital on the 4th; and on the
10th. of September the hand was amputated three
inches above the wrist joint, by the double flap of the
integument and circular of the muscular structure.
The stump, an excellent one, healed up kindly. Six
weeks after the operation he saw the patient in excel-
lent health. Indeed her health had not suffered much
before, as she had not had very much pain—only neu-
ralgic uneasiness arising from pressure upon the
nerves.

On making a section of the tumour, and dissecting
back the integuments, there was a very thin shell of
soft bony structure, then cartilaginous structure con-
taining gelatinous matter in cells. This portion very
closely resembled boiled sago mixed with red wine.
The entire normal structures of the entire hand had
been destroyed. The metacarpal bones of the thumb
and little finger were flattened, and changing into
cartilage, the osseous structure having nearly disap-
peared.

Though the age of the patient, the rapidity of the
growth, and resemblance of some parts of the mass to
colloid cancer, might raise a doubt as to the true
nature of the growth, he still thought the case one of
enchondroma, rapidly degenerating—doubtless a rare
affection, and not one of malignant disease.

FIFTH MEETING
November 23rd, 1861.

Fracture of Clavicle.

Professor GORDON exhibited a patient who had sus-
tained a fracture of the clavicle at the junction of the
outer with the two inner thirds. The outer fragment

had undergone the usual displacement, inwards and downwards. He has maintained, for some time past, that in fracture of the clavicle the shoulder is elevated, instead of being depressed. In the treatment of this accident he does not push the shoulder upwards and backwards, as usually recommended, but depresses it. He places a very large pad over the lower part of the side of the thorax; along the arm and forearm an angular splint, well padded above, where it rests against the biceps muscle, and extending from the anterior border of the axilla to the hand. The lower part of arm and inner surface of elbow is then firmly bandaged to the large pad. The elbow joint being thus fixed, and rendered incapable of flexion by the splint, he next elevates the forearm at the wrist, by a sling, which passed round the neck; and by so doing the shoulder is depressed and pushed outwards. In the present case this apparatus has succeeded admirably in maintaining accurate apposition of the fragments. It is simple in construction, easily applied, and not liable to become disarranged.

Professor GORDON introduced a patient whom he was treating for *comminuted fracture of the clavicle*.

The PRESIDENT then read his opening address which had been deferred until this date owing to his unavoidable absence.

On the Statistics of the Mortality of Fractures of the Skull; Effects of Operation, &c., &c.

I HAVE frequently noticed there is a tendency to class all fractures of the skull together, and to look upon the patient's prospect as little short of hopeless. Serious as the mortality is, I did not think an examination of statistics would show so many sufferers rescued from death.

I would here observe that, as a rule, I look with great caution on statistical tables, knowing how frequently cases are classed together because of some trifling point of resemblance, although they may differ in most important particulars; and also, that it is much more likely a man would publish a successful than a fatal case, not that any desire to mislead or give a false idea of the mortality of a disease might exist; but when, from the serious character of the affection, it was expected the tendency would be to death, a sense of satisfaction, perhaps a lurking one of pride, that, contrary to all anticipations, recovery ensued, might tempt him to place on record that which probably he would not have done if the prognosis had been verified. Grave objections, no doubt; but, on the other hand, I may say, for some time past, our Medical Journals have contained records of all the most serious cases, with operations performed, in the London and principal Provincial Hospitals in England, we are thus likely to obtain an account of all unsuccessful as well as successful cases, and will be enabled to

approximate the mortality of many injuries not yet precisely defined. I would add my belief that, from the fatal character of fractures of the skull, surgeons hesitate less about the publication of the cases than in many other affections requiring interference. These reasons I consider are sufficient to warrant a greater degree of confidence than is usually reposed in statistical tables, and I make use of them as giving by figures an approach to the mortality, effects of operation, &c., &c., and some other particulars in this class of affection.

I have records of several cases of fractures of the head which have come under my notice, I shall take the liberty of referring to a few of them where I find they illustrate portions of the subject. My information is not so accurate on some points as I could wish: for instance, in fracture of the base, the reporter frequently mentions that fact without specifying the part of the skull involved; and in injury of the superior region of the head, the calvaria is named without specifying the bone or bones injured.

I have taken a period of 10 years, from 1851 to 1860, inclusive, and have tabulated the cases of fractures of the skull to the number of 253, which appear in the following Journals:—*Times and Gazette; Lancet; Dublin Medical Press; Dublin Hospital Gazette; Edinburgh Monthly Journal; Dublin Quarterly; Guy's Hospital Reports; and the Trans. Belfast Clin. & Path. Soc.* I have also examined *Braithwaite's Retrospect*, and the *British and Foreign Medico Chirurgical Review*. I had not access to other Journals. Twenty five cases were treated by practitioners not attached to public institutions; all the others were contributed by the attendants on the large metropolitan and provincial institutions, or by medical officers in the public service.

Of course I shall follow the usual division of the subject, viz.:—Fractures involving the calvaria or lateral parts of the head, and fractures of the base; and first of the former:—In addition to cases I have treated myself, I have the particulars of 187. In 84 of these the fracture was situated in one of the parietal bones; in 57 the frontal; in 9 the occipital; and in 37, two bones of the calvaria or lateral regions of the head were implicated, or the precise part of the skull-cap was not specified.

The mortality in these several localities was as follows:—most serious of the last mentioned—out of 37 cases, 22 died; then in fractures of the occiput—of 9 cases, 5 died; next we have injury to the frontal bone—of 57, 25 died, and one remained under treatment. Fractures of the parietal bones were most numerous and least fatal, as of 84 cases, 34 died, and one remained under treatment. As a summary we have 86 deaths; 99 recoveries; and two undisposed of, in a total of 187 cases, being 46 per cent. of deaths. A question has occasionally arisen, which are the most fatal fractures of the superior region of the head? The

above shows that injuries to the posterior region are most, and to the superior least dangerous; and that fractures of the frontal occupy the middle place in danger as in frequency.

Of the 187 cases the bone was depressed in 149. Should the bone be elevated in every such case? should elevation be performed on the occurrence of reaction, whether symptoms of compression are present or not? or would the prospect be more satisfactory by delaying till well marked signs of pressure are exhibited? does the age of the patient modify in any way our opinion?

On reference to some of the older writers, as Pott and O'Halloran, we find that every case of fracture, with depression, was considered fit for the trepan. In the introductory observations to his work on injuries of the head, published in 1793, the latter writer lets us know, in his quaint style, how frequently he was called on to perform this operation, he writes:—"I have had no less than four fractured skulls to trepan on a May morning, and frequently one or two. In the course of above thirty-five years practice, I may safely affirm, because truly, that on an average, one month with another, from three to four cases have fallen to my share, of either fractures, concussions of the brain, or extravasations."¹ Again he says, "Every fracture with depression necessarily demands the operation; and though some particular cases may be adduced, when nature has somehow or other brought about the business of healing, yet it is by no means to be trusted to; and the surgeon is inexcusable who fails to attempt, at least to propose and press it. Simple fractures of the cranium, with depression, when relieved on the spot, or in the space of two or three days, almost always terminate happily. In the course of more than 200 accidents of this simple kind, I cannot recollect a failure in a single instance."

"Fractures without depression do not demand operation."² Pott considers all depressed fractures require operation; and nearly all undepressed, also require the interference of the surgeon. He says, "perforation is absolutely necessary in seven cases out of ten, of simple undepressed fractures of the skull. Let us for a moment inquire why it is so. The reasons for trepanning in these cases are, first, the immediate relief of present symptoms arising from pressure of extravasated fluid; or second, the discharge of matter formed between the skull and dura mater, in consequence of inflammation; or third, the prevention of such mischief as experience has shown, may, most probably, be expected from such kind of violence offered to the last mentioned membrane. These are the only reasons that can be given for perforating the skull in the case of an undepressed fracture; and very

good and very justifiable reasons they are, but not drawn from the fracture."¹

In another place he says, "I have no doubt that although by establishing it as a general rule, to perforate in all cases, some few would now and then be subject to the operation, who might have done very well without it; yet, by the same practice, many a valuable life would be preserved, which must inevitably be lost without it, there being no degree of comparison between the good to be derived from it when used early as a preventative, and what may be expected if it be deferred till an inflammation of the dura mater, and a symptomatic fever make it necessary."²

I find elevation of depressed bone was practised in 124 of the cases I have tabulated, of these 60 died; 62 recovered; and 2 remained under treatment; as nearly as possible the deaths were 50 per cent.

In 25 cases of fracture with depression, no operation was performed. On analysis of the symptoms of those who recovered—one had profound insensibility; another was insensible and convulsed; another had partial paralysis; the remainder were partially insensible, or had threatened inflammation in the head. Of those who died the symptoms recorded are:—insensibility in one; paralysis in another; epileptic fits in a third; (I use the expressions of the reporters,) 7 died; 18 recovered: being a mortality of 28 per cent.

Some interesting Cases of Fracture of the Calvaria with Depression, have come under my observation in hospital:—

A lad 16 years of age, while engaged at work in one of the ship yards, received a blow on the side of the head from a heavy piece of timber which had fallen a height of 10 or 12 feet; when brought to hospital we were informed he had vomited a large quantity of blood; he laboured under collapse first, then concussion; on careful examination of the head (there was no scalp wound,) a fissure extended from the left parietal protuberance forwards for about one and a half inch, bifurcated, producing the shape of the letter Y; the piece of bone between the limbs of the letter, and also, one margin of the fissure, in its posterior part, were depressed, I would say rather more than the thickness of a half-crown. The symptoms of concussion yielded after a time, and were followed by cerebral irritation, and inflammation of a not very intense form. When convalescent I felt dissatisfied with his stolid stupid manner, but learned from his friends he was of a sulky disposition, and that his mind and character were as before the accident. The treatment adopted was cold applied to the head, mercury in small doses, until the constitutional effect was produced, and when necessary, purgatives.

¹ Introduction, p. 5.

² Introduction, p. 31.

¹ Vol. I., p. 104.

² Page 111.

In this case, from the vomiting of blood, I feared more serious mischief than the fissure of a small portion of bone. The possibilities of fractured base, or of injury to the liver, or some important abdominal organ, suggested themselves; but when hours passed by and full reaction was established without its recurrence, my attention was fully turned to the concussion; as it subsided from the depression of bone, I looked for the appearance of symptoms of compression—had such manifested themselves, I would have cut down and raised the bone.

A few days after the admission of the last, a boy, aged 13 years, came under treatment. Two evenings previously, while seeking for a ball, he had fallen from a man's shoulders and alighted on his head; he is reported to have been insensible for a short time, and on recovery to have vomited repeatedly, and complained of pain in the part injured, with general headache and sickness of stomach. On admission the head was shaved, no wound or abrasion was visible, but a fissure of the skull, as in the other case, was felt, extending from the left parietal protuberance forwards almost to the anterior border of the bone; the upper margin of this was depressed to about the same extent as in the other case.

I placed him on low diet, gave him some alterative doses of mercury, and kept him in hospital for a time.

Here we have one of those most infrequent cases—a grave injury followed by most trifling constitutional disturbance; in fact, from the time he came under my care he was well—all headache, &c., &c., had passed off. My treatment was merely precautionary.

Again, about a week later, a fine boy, about eight years old, was brought to hospital—a log of timber had fallen on him, fracturing the right forearm very severely, and causing a wound which commenced at the right frontal protuberance and stretched upwards and backwards about four and a-half inches in length; the scalp was separated to a considerable extent, and a fracture, parallel to the wound, occupied fully three inches of the frontal and a small portion of the parietal bones; there was depression to fully the thickness of the skull. In the unavoidable absence of my colleague on duty, I saw him about an hour after admission. Bodily warmth was then restored, his pulse and respiration were slow; pupils dilated, uninfluenced by light; he lay quietly, head resting on the right (the injured) side; when turned on the left side he gave a fretful cry and endeavoured to replace it; by sharp speaking or pinching he could be partially aroused—give a monosyllabic answer, and then sink back into insensibility. The house surgeon informed me, half an hour before my visit he could be roused with much greater facility, when he gave his name, residence, &c., &c. That I might have an opportunity of noting the increase of the coma, I deferred operative interference for an hour, when I returned and examined

him, and was satisfied the insensibility was greater than before.

I then had him removed to the theatre for the purpose of operation; immediately before commencing, I again essayed to arouse him, when suddenly he opened his eyes and answered quite collectedly, although slowly and rather stupidly. Under these circumstances I did not deem it necessary to raise the depressed bone.

The boy passed to the care of my colleague; he laboured under concussion for a time, and gradually recovered. He was discharged in seven weeks.

This was to me a most interesting case; had the profound insensibility, which was twice so marked, continued, my treatment would have been elevation of the bone with Hey's saw, if possible, if not, by the trephine first, then the saw. The occurrence of insensibility, followed by a state from which he could be aroused, I believe, was due to cerebral congestion, for, after severe injury the circulation is embarrassed and imperfectly performed; and, I have several times noticed, although not so well marked as in this case, the insensibility sometimes more, sometimes less profound, without any apparent cause.

Ten months ago, a boy, 16 years of age, fell a height of 12 feet in the hold of a ship on Queen's Island, he alighted on the posterior part of his vertex. I was in the hospital on his admission, and was informed that he was insensible for a period of about 10 minutes after the accident, but from the time he was placed in the ferry boat until his arrival here, he was perfectly collected. There was a wound one and a-half inch long, situated over the upper part of the occipital bone; almost at the summit of that bone a V shaped fracture was seen, the point directed upwards; the limbs were each about one inch long; the bone was depressed fully the thickness of two half-crowns; he merely laboured under collapse, and was quite astonished when I ordered him to bed. The wound healed up, and he was discharged in a month.

I saw him six months afterwards, he had not experienced the slightest bad effects from the fracture.

This is another example of a most serious injury without the appearance of a single bad effect—in fact, so well did he feel, I had considerable difficulty in keeping him in hospital for a reasonable time.

Is the danger to the patient increased by cutting down to make an examination merely of the site of fracture—by, in fact, rendering the fracture which was simple, compound? Most surgeons are opposed to this treatment, Sir Astley Cooper, in his forcible language, says, "the man who would do so should be cut for the simples." Mr. Guthrie and others do not consider the patient's danger is in any way increased by it.

I believe the principal advantage to be attained by it is, that we can ascertain more accurately the extent

to which the cranium may be fissured, and the amount of depression of the outer table; also, if death of a piece of bone is about to take place we are made cognizant of the fact at an early period by its altered appearance. Although I would not practice it heedlessly, or without due consideration, I should have no hesitation in cutting down, provided I was uncertain as to the extent or amount of the depression of bone.

Of fractures without depression we have reports of 38 cases, of which number 25 were subjected to operation and 13 were not; of the former 13 died, 12 recovered; of the latter 5 died, 8 recovered. Among those subjected to operation, we have 3 cases of paralysis; 5 more or less convulsed or with epileptiform fits; 4 insensible; 3 of compression; 3 of encephalic inflammation; and, what I consider strange, 5 are marked as labouring under very slight symptoms or none at all. Those not submitted to operation suffered from slight concussion, collapse, effects of shock, &c., &c. One, a recovery, had epileptic fits.

In December, 1858, I brought before the notice of the Belfast Clinical and Pathological Society, some cases of fracture of the skull. One was a patient with fissure of the frontal bone. In giving a brief account of his case, I stated, he laboured under paralysis which gradually became general. Under treatment this slowly passed off, and he was discharged from hospital quite restored.

Twelve months after, this man came under the care of one of my colleagues, he had fallen into a vat of boiling ley in a bleaching establishment. He told me he had enjoyed excellent health since his dismissal; he had not suffered from headache, loss of power, or any effect of his injury. In a few days after his second admission he was attacked with tetanus, and died. I made an examination of the head and removed the portion of the calvaria which had been fractured, and which was completely united. The dura mater was most intimately adherent to the bone in the vicinity of the fractured part. The brain, &c., &c., were perfectly normal.

A man, aged 22, had the upper part of his occipital bone fractured by a heavy piece of iron falling on him, from a height of 12 or 14 feet. When admitted he laboured under the ordinary symptoms of collapse; then well marked concussion. The fissure of the bone could be readily detected at the bottom of an extensive wound. There was no depression. In a month he was discharged from hospital perfectly well. The case was an average one, without the appearance of a single peculiar or anomalous symptom.

Thirty-four cases with depressed bone, although not labouring under symptoms of compression, were operated on; of these, 22 recovered, 12 died. As many of the contributors do not mention the symptoms (if any) which existed before operation, I have no doubt, this series should be much greater. I have, however,

merely tabulated those in which the writer distinctly records the absence of compression.

I must confess my inability to understand the indication for the use of the trephine or saw, where the report states the patient was "sensible" or had no symptoms of compression. And, although I find this practice has been followed by some surgeons, I would not pursue it, therefore, cannot commend it. I consider, at all times, even in the hands of the most skilful, the use of the trephine must expose the patient to considerable risk of encephalic inflammation, and, that we are not justified in operating as a mere precautionary measure, but only in those cases, in which, from symptoms of compression, we have reason to believe there is pressure on the brain which may be relieved by interference.

There may be an exception to this rule, as occurs frequently in military practice, a bullet producing what might be styled an indented or stellate fracture; or in civil practice, a blow from the sharp angle of a brick or slate, driving in the outer table and breaking the inner to a greater extent. Here we might expect pressure on the brain or more extensive laceration of the membranes than the slightly depressed condition of the outer table would indicate; in such a case the appearance of less urgent symptoms, as convulsive twitchings, epileptiform seizures, would be a sufficient warrant for the use of the trephine.

I may here appropriately refer to the question of the frangibility of the tables of the skull. For many years my anatomical experience made me look with considerable doubt on the generally received opinion, that the inner table is so much more easily fractured than the outer. I often observed, if great violence be applied to a skull-cap, the tables would be fractured to about the same extent. In 1858, in a most valuable series of lectures, delivered in the College of Surgeons, England, Mr. Prescott Hewett, not only noticed this, but carried his observations further, he found where violence is applied from within outwards, the outer table is usually injured more extensively than the inner—if from without inwards, the reverse; where great force is used, both will be broken to about the same extent. On reading his remarks I tried these experiments repeatedly, and believe his statements are correct. If, then, an individual has fallen from a great height, alighting on his head, or has received a fracture in some other way, from great violence, I would anticipate the tables of his skull would be broken to the same, or nearly the same extent, but, if a less force were applied to a small surface, I would dread splintering of the inner table.

Another question of interest is that of injury to the brain. We all know the prospect is much brighter where bone is merely depressed without lacerating the dura mater; and injury to that membrane is less fatal than where some of the cerebral texture is torn,

and possibly protruding from the wound. Some of the most experienced surgical writers look upon this latter form of injury as almost necessarily fatal—the mortality is very large—and yet many recover. I have made a distinction between protrusion of the brain and hernia cerebri, as it is at times called, on the one hand, and simple wound or laceration on the other. Where wound of brain has terminated in hernia, I have placed the case under the former head.

Of cases styled protrusion or hernia, there were 35 reported—17 died, 18 recovered. Of wound or laceration, 27 cases—18 died, 9 recovered; total, 62 cases, with 35 deaths. Of these, 9 had more or less of paralysis or convulsive twitchings; 7 symptoms of inflammation of varying degrees of intensity; 9 compression, the majority well marked, although some were not very profound. Then we have concussion, collapse, and shock; several described as not labouring under any symptoms; and some, in which the reporter mentions many of the leading features, but does not state this particular.

On looking at the mortality as it occurred at the different periods of life, we find up to the age of 10 years, inclusive, there were 24 cases with 9 deaths; between 10 and 20, 49 fractures, with 16 of a mortality; from 30 to 40, 86 cases, 48 fatal; and from 40 to 60, 24 with 10 deaths; two had not terminated when their reports appeared.

I do not consider it necessary to give an analysis of the plans of treatment pursued. In a considerable proportion indeed, the writers seem to have considered the indications so obvious, as not to have recorded it at length.

I would merely observe, venesection was practised in 24 cases only. A marked contrast to the custom of the older writers, and also to the injunctions of many within a very recent period. Tartrate of antimony also seemed to be at a discount, for I find it was used in three instances only. The preparations of mercury were most generally employed, in some, merely as purgatives, in a considerable number until the constitutional effect was produced.

I would briefly sum up my views of fractures of the calvaria. The most dangerous are those of the occipital; the frontal next in order; the parietal least so.

The mortality in fissure of the calvaria and depressed fracture is nearly equal, considering all the cases. But take all the cases, whether depressed or not, in which operation was performed, the death rate was 50 per cent. All the cases where no operation was performed, the per-centage was about 34; or if we contrast those cases in which there was depression but no operation, the mortality was 28 per cent.; with those also depressed and operated on without any symptoms, the deaths were 36 per cent. These facts must, I consider, point to the conclusion, that operative measures should only be used as a *dernier ressort*.

The cases of fracture without depression subject to operation, showed a mortality of 52 per cent. Similar cases not operated on, presented 33 per cent. of deaths. In cases of injury to the brain, the mortality was about 43 per cent. Operation is fully warranted when the injury is of the indented class already referred to.

In simple fracture, where there exists a doubt as to the extent of the depression, I consider the surgeon adds extremely little, if anything, to the risk of his patient by cutting down. Fractures are borne with greatest immunity in the first and second decennial periods. The danger to life is greatly increased in the third and fourth, and again diminished in the fifth and sixth periods. I have given a brief report of six cases of fracture of the calvaria with recovery in each. In two of these the occipital—in two the parietal—and in one the frontal were broken—and in one case the frontal and parietal were both involved.

I have examined the reports of 66 cases of fracture of the base of the skull. Of this number, 46 died, 20 were restored; about 69 per cent., an enormous death rate.

When we consider the great injury inflicted on parts so nigh to the most essential portions of the nervous system, generally themselves sufferers from laceration or extravasation, and the uncertainty which surrounds the recognition of these fractures during life, we need not feel surprise at the short list of authenticated recoveries.

In those injuries hitherto considered we had, generally, *tangible* and frequently *visual* evidence of their existence. In the present class, during life, in many cases we are dependent for our prognosis on symptoms which bear no proportion to the amount of fracture sustained.

As an illustration, I would mention the following:—Within half an hour of the admission of the boy with compound fracture of the frontal and parietal bones, whose case I have related just now, a man, aged 60, was also admitted to hospital. While engaged white-washing a house, on a ladder about 20 feet high, a sudden gust of wind precipitated him to the ground. When I saw him about half an hour after admission, the surface was cool, not cold; he was *perfectly* collected; described how he had been engaged before his fall; said he was insensible until shortly before his admission; complained of pain across the temples. I noticed he was somewhat (a little) deaf; I asked was this the result of his injury, he stated he had been deaf for many years—he had bled from the right ear; but when I visited him within an hour of the accident the hemorrhage had ceased, and there was a little dried encrusted blood in the meatus externus.

Immediately after leaving the bed, the house surgeon, in conversation, suggested the existence of fracture of the base. My reply was, it may be present,

but if we have not an opportunity of examination we are not warranted in placing the case on record as one of this injury.

This, with the other patient, passed to the care of my colleague on his return to town. Frequently, when in the ward, I spoke to the man; his mind was quite clear; he many times complained of being deprived of his snuff box. The only circumstance which attracted my attention was, he always lay on his back, and complained of pain in his head if the nurse turned him on his side. Until three days before his death, when he had symptoms of encephalic inflammation, his mind was perfectly clear. Death occurred ten days after admission.

I was not present at the *post-mortem*, but was informed the brain showed evidence of inflammation, and a fracture passed through the right petrous bone, without involving the tympanum.

Now, I consider the absence of all head symptoms fully warranted the opinion I expressed. The small quantity of blood which flowed from the ear was of no value as a diagnostic, and the trifling complaints of the patient might readily be caused by contusion.

I consider these two cases are worthy of being placed on record. First, a sailor, 20 years of age, was admitted on 16th. June, 1859. While intoxicated he had fallen into the hold of his vessel, a height of 12 or 14 feet, alighting on his head, and receiving a fracture on the left side of his forehead from the sharp angle of a brick. The fissured condition of the bone was visible at the bottom of an extensive scalp wound, it stretched down to the supra orbital foramen, and was of a “+” shape. The amount of insensibility was only partial, as he could tell his name and age. His breathing was natural; pulse 60; skin cool; on being let alone he turned off to sleep immediately. There were two small contused wounds on the left side of the face, one beneath the outer, the other beneath the inner canthus; for some hours continuous bleeding poured from these wounds, followed, for 24 hours, by *copious weeping of serum*. There was considerable extravasation of blood behind the left ocular conjunctiva, and the eye-lids were very much ecchymosed. From this I diagnosed that the fracture, which was traced to the supra orbital foramen, extensively involved the roof of the orbit. I also considered the serum was arachnoidian which had passed behind the ball, and made its way out by these wounds. On the 18th, he had well marked symptoms of inflammation of the encephalon; on the 21st, he had paralysis of the right side; he died on the 25th.—nine days from the injury. Insensibility was almost complete after the first day.

I made a *post-mortem* 12½ hours after death. A large collection of pus occupied the cavity of the arachnoid anterior to the left hemisphere; the arachnoid, especially in the neighbourhood of the superior longitudinal sinus, was thickened and opaque; general

vascularity of the pia mater. On removing the brain, two clots, each about the size of a shilling, were found, one on the roof of the left orbit, the other in the middle fossa of the left side; the brain substance was normal in consistence, but highly vascular in all parts, both cortical and medullary. The fracture in the calvaria was more extensive on the inner than the outer table, without depression, extending from below the left frontal eminence to the margin of the orbit at the supra orbital foramen, in length, say one and three-quarters inch; a similar fissure extended across the top of this, at right angles, producing a T shape. In the base the fracture stretched backwards, from the supra orbital foramen through the roof of the orbit, completely breaking away a piece of bone, nearly circular in shape, of the size of a shilling, rather internal to the centre of the orbital roof; this could be readily removed by the forceps; the continuation of the fracture extended from the left towards the right side, through the olivary process and body of the sphenoid bone, into the right side of the basilar portion of the occipital, terminating half-inch anterior to the foramen magnum. None of the other cavities were examined.

The extravasation beneath the conjunctiva enabled me to express the opinion that the fracture extensively involved the roof of the orbit. The weeping of serum also pointed to fracture of the base. I had never witnessed it from this situation, nor do I recollect having seen it recorded—I think it must be infrequent.

The second case was somewhat similar:—On 11th May, last year, a man, 19 years of age, fell from a scaffold 20 feet high, alighting on his head. On admission he had bleeding from the left ear and nose; he had also extravasation of blood beneath the left ocular conjunctiva; he had symptoms of collapse first; then concussion; during the day he several times vomited blood. As the effects of the concussion passed off in the evening and early part of the night, he was not only able to answer questions, but manifested curiosity as to where he was; how the accident occurred, &c., &c. This continued till within an hour of his death, which took place 13½ hours after the accident. On examination, two fractures extended from the left frontal eminence downwards; one in front of the external angular process, the other behind it; the brain was considerably congested, but was not lacerated or injured in any part; a small extravasated spot was on the most prominent portion of the middle lobe of the left side; another over the superior vermiform process of the cerebellum; and a third on the upper surface of the tentorium, near the right perpendicular semi-circular canal; the brain substance was healthy.

There were two fractures in the roof of the orbit—one at its fore, the other at its back part; both were connected with the fissure which stretched down the forehead; two also ran in the middle fossa and termi-

nated at the foramen ovale. Here the bleeding from the ear and nose, with the vomiting of blood, pointed to the existence of fracture of the base; the extravasation behind the conjunctiva, to injury of the orbital roof.

In the former case, the fracture stretched into each of the three fossæ, in this the anterior and middle were involved.

Two other instances of extensive fracture of the base came under my notice. One, an elderly man, was knocked down in the street by a blow from the shaft of a car, he lived five days. On *post-mortem* at least one ounce of blood lay between the dura mater and the skull-cap; there were three clots on the surface of the brain, and there was laceration of the grey matter on that portion of the middle lobe which occupies the middle fossa; the calvaria was most extensively broken, and the anterior and middle fossæ fractured. The other, also an elderly man, had fallen down the cabin stairs of a steam boat, a height of about 12 feet; he lived 24 hours. On *post-mortem* the condition of the brain and membranes was much the same as just described; there was no fracture of the calvaria; in the base the middle fossa was extensively broken, and the lesser wing of the sphenoid chipped off. I do not give the details—as neither of these cases presented features of much interest, but place them on record for future statistical inquirers.

From the accounts of the *post-mortem* examinations, the following were the situations of the fractures:—Of the middle fossa alone there were 11 cases; of the anterior 10; of the posterior 2; of the anterior and middle 4; of the posterior and middle 9; one of these had separation of the coronal suture. There were 5 cases of fracture running into each of the three fossæ; three of these had, in addition, separation of the coronal suture. There were 5 cases in which the precise locality is not described. On analysis of the fatal cases, we may fairly exclude the following, when considering the per-centage of mortality.

First, a case of fracture of middle and posterior fossæ, with fracture of some of the lumbar vertebræ; second, fracture of the anterior fossa, and of the seventh cervical vertebra; third, fracture of middle and posterior fossæ, with fracture of several ribs and other injuries.

In such instances the serious injuries mentioned would of themselves suffice to cause fatal issue.

Again we have unusual, and I may say, necessarily fatal cases, such as a piece of nail-rod penetrating the roof of the orbit, lacerating the brain, and causing copious hemorrhage by rupture of the anterior cerebral artery.

The extremity of a walking-cane passing through the nostril, perforating the ethmoid and sphenoid bones, and impacted in the lower part of the brain.

Brass ferrule of an umbrella perforating the roof of the orbit and impacted in the brain—and a piece of tobacco pipe lodged in the same locality. The last three were only discovered on *post-mortem*. In all, 7 to be deducted from the number of 46 deaths, which would leave 39. Add to these the 5 cases I have now recorded. This would leave the mortality as already stated. I have brought forward some of, to me, the most interesting matters connected with 193 fractures of the calvaria, and 71 fractures of the base of the skull. In all, 264 cases. Many of the matters I have only touched upon would, I know, supply ample material for valuable papers.

SIXTH MEETING
November 30th, 1861.

{Rough notes at back of Council Minute book: President in chair, Gordon, S. Reid, Cuming, Mulholland, Dill, Patterson, Browne, Ferguson, Bryce, Halliday, D. Murray, Aickin, D. Moore, Johnston.}

Compound Comminuted Fracture of the Tibia and Fibula of the Right Leg.

Dr. BROWNE read the following case:—

George Mayers, aged 18 years, a strong healthy young man, was admitted to the General Hospital on the 18th. of October; three hours before, the wheel of a baker's heavy cart had passed over the right leg, about four inches above the ankle. Both bones were broken. At the posterior part of the leg a wound existed about an inch in length; but the bones did not protrude from this, though the bruised tissues did. The limb was put, upon the outside, in a padded splint, and flexed at the knee, and the wound covered by water dressing. Erysipelatous inflammation, with considerable serous infiltration, soon set in, and extended to the knee; and in a week after admission the integuments on the front part, over which the cart-wheel had passed, as well as the posterior wound, had sloughed, exposing the broken ends of the tibia, denuded of periosteum for about three-fourths of an inch. Various contrivances were adopted to keep, or rather to bring, the fractured ends in apposition; but this could not be accomplished. At this time the constitutional disturbance became great, and the suppuration copious; still it was determined to give him a chance of saving the limb. Stimulants and tonics were freely exhibited; and, for some days, considerable improvement took place. However, the sores soon after assumed a very sloughy, in fact phagedenic appearance, the constitutional irritation increased, and there was great infiltration of the entire limb up to the groin, with pain along the course of the saphena and femoral veins, upon pressure. At that time the fractured parts of tibia were exposed for an inch above and below, and a large slough had taken place

in the back part of the limb, behind the seat of fracture. Under these circumstances, though the issue seemed very doubtful, it was evident that amputation must be resorted to, to save life, if possible. The operation was accordingly performed by me, on the 14th. instant, by the double flap of the integuments and circular incision through the soft parts, the bones being cut through three inches below the tubercle of the tibia. Three vessels were tied, and the stump was put up four hours after, with straps of wet lint. Besides the great serous infiltration of the limb, to which reference has been made, the veins were found to be greatly inflamed and blocked up by a clot. He had had, moreover, on two occasions, severe rigors—one a week, and another three days, before the operation.

The opium and quinine, with six ounces of wine, beef tea, &c., which he had been taking, were ordered to be continued. On the 18th. the wound was opened for the first time. The stump did not show the smallest sign of any healing by the first intention; but, otherwise, did not look unhealthy. The infiltration of the limb had greatly subsided; and the pain, on pressure along the veins, was not so great as before. Opiated mercurial ointment was directed to be rubbed along the course of the inflamed veins, and the stimulants, opium, &c., to be continued. On the sixth day after the operation, he had a sharp rigor, which caused some apprehension. On the eighth, pretty free suppuration of the stump had taken place, and there had not been any return of the rigor. On the tenth, the last ligature came way, and the patient seemed improving. On the twelfth day after the operation, however, he had, in the course of nine hours, three severe rigors, followed by profuse sweating. On the thirteenth day, an increased discharge of pus occurred; and there was not any recurrence of the alarming symptoms which caused the dread of pyemia; and he was discharged, four weeks after the operation, with a good stump, and with completely restored health, which had been so much shaken by the results of his unfortunate accident. On the whole the case is interesting, as showing that young persons will survive operations frequently, even when performed under the most unpromising conditions.

The bones of the parts at the seat of fracture were found to have been greatly comminuted, stripped of periosteum, and, in fact, in such a state as to have afforded no chance of repair.

Case of Disease of Hand, requiring Amputation.

Dr. BROWNE showed the morbid parts, and gave the following statement of the case:—

Peter M'Caffrey, aged 54, previously of excellent health, and of temperate habits, was admitted into the hospital—first, in September, 1857, having had the middle finger of his left hand crushed between rollers, so much so that amputation of the part was per-

formed by Dr. Browne, through the first phalanx. In five weeks he was then discharged, with the part quite healed up; and he remained well till the month of August of the present year, when he sustained a kick from a horse on the old cicatrix, which broke up the remaining portion of the first phalanx, and drove the splinters into the palm of the hand. He was admitted into hospital, when Dr. Murney removed the fractured portions of the bone, and took away the former stump at the metacarpo-phalangeal articulation; the parts healed up, and he went out quite well at the end of a month. On the 12th of October he returned with the cicatrix completely opened, and presenting a most unhealthy phagedenic character, with disease of the metacarpal bone. Extensive sloughs, burrowing beneath the palmar fascia, took place, with great enlargement of the wound; in fact the gangrenous state progressed, despite all treatment, till hemorrhage took place which could not be controlled, and rapidly reduced the strength of the patient; this, combined with the excessive pain of the part, was quickly wearing the patient out, so that it seemed amputation was the only resource left, and for which the patient was most solicitous. Dr. Browne, therefore, amputated, a little above the wrist, on the 16th. of November. The stump healed up quickly, and the patient regained his health and strength—the only retarding circumstance to his rapid convalescence having been suppuration of the glands in the axilla.

Compound Comminuted Fracture; Amputation.

Dr. BROWNE exhibited a limb which he had to amputate the preceding week, in consequence of being completely smashed by a railway waggon which had passed over it. The operation was performed through the lower third of femur, by the double flap of integument, and circular incision of muscles—care being taken to make the anterior flap long. The stump promises to be an excellent one.

{Rough notes at back of Council Minute book: Professor Gordon exhibited patient in Hospital recovered from fracture of radius to which he had applied his own splints. Also showed a patient who had sustained fracture of neck of humerus with dislocation. Case with union. No reduction could be made with chloroform.

Dr. Browne using Gordon's splints with greatest benefit.

Professor Gordon: It almost impossible to reduce the dislocation with chloroform even at time of injury.

President remarked on difficulty of reducing.}

Professor GORDON introduced a patient who had sustained an *impacted fracture of the surgical neck of the humerus*, together with fracture of the radius of the same limb.

At the same meeting Professor GORDON showed an arm which he had found necessary to amputate for compound fracture at the elbow joint.

Epulis.

Professor GORDON exhibited a specimen of fibrous epulis, and gave the following details:—

Ann Dyer, admitted into hospital November 9, 1861, aged 18, complexion florid, and her general health very good. About five years ago a small tumour appeared in the gum, opposite the second incisor tooth of the right side. At first this tumour grew very slowly, being at the end of three years scarcely half its present size. On admission into hospital the right side of lower jaw presents a firm oblong tumour, extending from the first incisor to the second molar tooth; it is almost an inch in length, and fully three-fourths of an inch in depth, rising upwards almost to the level of the upper margin of the crown of the canine tooth; it is not painful on pressure; in colour a little whiter than the gum; firm, and slightly elastic; its surface perceptibly irregular from numerous small protuberances.

Around its margin it overlaps closely the neighbouring gum and teeth; the first molar tooth is directed more inwards than that of the opposite; but this seems due rather to crowding of the teeth than to displacement by the tumour, as none of them are in the slightest degree loose. There is increased vascularity beneath the mucous membrane, at its reflection upon the lip, immediately below the tumour.

On attempting to remove the tumour with the scalpel osseous substance was encountered. The scalpel was, therefore, laid aside, and the cutting forceps applied, one blade above and the other below the tumour. The mass was thus easily and perfectly detached; and were I called upon to perform again a similar operation I would use the cutting forceps. The fang of the canine tooth was denuded almost to its point, and an osseous spicula, about one-eighth of an inch in diameter, divided. This spicula projected fully one-fourth of an inch into the tumour.

Although the alveolus between the canine and second incisor tooth seemed sound, yet, from the recognised tendency of such tumours to repullulate, the incisor and canine teeth were extracted, the intervening alveolus removed, and the surface touched, lightly, with *potassa fusa*. On examination of the tumour, after removal, we find it firm, slightly elastic, colour white; its surface perceptibly uneven, with a fibrous section, presenting a groove corresponding to the fang of the canine tooth; and that its point of attachment was much less than would have been supposed from the external examination. When cut into, a small cavity was exposed, filled with sebaceous-like matter, which, when examined by the microscope, is found to consist of plates of cholesterine, oil globules,

granular matter, and a few epithelial scales. The tumour itself seems, on section, to be decidedly fibrous, yet the microscope shows it to belong rather to the fibroid than fibrous tumours. The several cavities containing sebaceous-like matter are, I think, the follicles of the gum distended by a secretion which has undergone degeneration. If we give to this fact its due weight I think it will lead us to infer that the tumour involves, and has its origin, simultaneously in the gum, periosteum, and alveolus.

SEVENTH MEETING

December 7th, 1861.

{Rough notes at back of Council Minute book:

President in chair, Mulholland, Gordon, Browne, Pirrie, Cuming, Professor Ferguson, Arnold, Professor Reid, Johnston, Thompson Senr., D. Moore, M'Gee.

President reported the results of the labours of the Amalgamated Councils with reference to a union of the two Societies. Question was referred on meeting of 26 October.}

Disease of Femur.

Dr. BROWNE exhibited a patient labouring under disease of the left femur, and made the following statements regarding the case:—

The lad, now eight years of age, had, till four months since, excellent health, and is descended from healthy parents, not related by blood. At the time referred to he had a fall upon the hip, but which neither caused fracture nor luxation; indeed he continued to walk for a week after the fall without suffering pain, and without lameness. He then began to keep his bed, and suffered, for several weeks, great pain, with much swelling around the hip, and of the thigh also. The medical practitioner who saw the case in the country, supposed that suppuration was about to take place.

By degrees the pain subsided, and the swelling diminished; but then, for the first time, some five weeks' since, great shortening of the limb was observed to have ensued. When the boy was brought to the hospital, on the 4th. instant, he (Dr. Browne) diagnosed spontaneous luxation at hip joint, with disease of the shaft of the femur. He said he was led to believe, from the history of the case, that acute hip-joint disease had resulted from the fall; that dislocation ensued, after some weeks of destructive inflammation; and that the disease of the shaft of femur had occurred about the same time.

The present condition of the patient, he said, is obvious. The femur is displaced upwards; the head and neck partially absorbed, are resting on, and nearly fixed to the dorsum of the ilium; the shortening amounting to fully three inches; the shaft of femur

and soft parts are greatly enlarged, and the integuments have large veins ramifying extensively through them. The patient's health is good; and there is not the smallest pain on pressure, or on attempting motion of the hip.

Still, even with these negative signs, he could only arrive at the conclusion that cerebriiform disease of the femur is present, and that it would eventually prove fatal. The progress of the morbid growth had not lately been rapid; but the members of the society were well aware that in many of these cases the disease, for some time, seemed almost stationary, when all at once it advanced with great speed; and finally, having burst through the integuments, it soon destroyed the life of the patient, either by the constitutional irritation set up, or, in some instances, by the exhaustive drain of repeated hemorrhages. He concluded by stating he would keep the patient in hospital for some time, would watch the progress of the disease narrowly, and would report the issue to the Society.

Extroversion of Bladder, &c.

Dr. BROWNE introduced a lad of 14 years of age, who had congenital absence of the anterior walls of the lower part of abdomen and bladder; the back part of the bladder projected forward, and exhibited the mucous surface to the extent of about an inch and half square, with the ureters opening at the lower portion. Beneath this the rudiment of a penis appeared, the corpora cavernosa separated above, with a small opening in the sulcus, between the bladder and back of penis, seemingly the mouth of the common seminal ducts.

The testicles were fully developed and enclosed in the scrotum, which approached to the normal condition beneath, but separated above, passing to each ascending ramus of the pubis, the two portions being united by a thin integument and membranous band. The pubes were separated at the symphysis, the interval being filled by strong ligamentous structure. There was no trace of a urethra, except what has been referred to as the openings of the ejaculatory ducts.

Excision of the Tonsils.

Dr. BROWNE introduced a young female, 18 years of age, from whom he had excised greatly enlarged tonsils, and exhibited the hypertrophied parts.

This young girl was of small growth, and not at all developed according to her age. She had suffered, for several years, from repeated attacks of inflammatory sore throat; and latterly the enlargement of the tonsils had become so great as to interfere materially with deglutition, speech, and breathing; and her general health had suffered also. The catamenia had never been properly established, and the mammæ were undeveloped.

Dr. Browne regarded the operation of removal as established in such cases; and his experience of many cases was, that within one year after the excision of the hypertrophied tonsils, in young females, the system became fully developed, and the health quite re-established.

He considered the operation quite safe, provided the surgeon took care not to cut too deep, or outwards; but having drawn the tonsils towards the mesial line, he carried the knife—probe-pointed—with its edge directed forwards, and its flat pressing against the arches of palate, completely through the enlarged mass. Very little hemorrhage had occurred in his practice, and he had never witnessed any unpleasant results.

With regard to the notion entertained by some authors that removal of the tonsils would interfere with the sexual reproductive powers, he said, in the first place, the tonsils never were, and *could not* be excised; it was only the *morbid growth* or *hypertrophied portion* that was removed; and in the second place, he contended that the removal of these morbid growths, instead of interfering with sexual development, actually had the very opposite effect. He concluded by saying that he strongly recommended the operation in all suitable cases—such, in fact, as the one he had introduced to the notice of the society.

EIGHTH MEETING

December 14th, 1861

{Rough notes at back of Council Minute book:

President in chair, Patterson, Mulholland, Browne, D. Moore, Professors Gordon & Reid, Smyth, Cuming, M'Gee, Dill, Johnston, Aickin.

Dr. Browne introduced case of amputation &c.

Dr. Mulholland introduced a boy ill with enlargement of ...

President small arteries

M'Gee spurious elephantiasis wants, infiltrate

Dr. Gordon extra-capsular impacted fracture, with fracture of radius of same side, question of impaction.

Dr. Gordon compound fracture of elbow joint, amputation, boy in flax mill, carried round drum, different fractures, nerve in pulp.}

NINTH MEETING

December 21st, 1861

{Council Minute book: Dr. Murney, President, in the chair, Drs. Drennan, Patterson, Moore, Ferguson,

[Th?] Reid, Gordon, Bryce, Smith, D. Moore, Dr. Dill, Dr. Johnston, McMechan, Murney.}

Dr. James CUMING read a case of:

*Case of Tetanic Spasm, chiefly affecting the
Extremities.*

On the evening of the 7th. December, I was asked by a benevolent gentleman to see a youth, of between 16 and 17 years of age, who, he said, was dying. On reaching the house, I found the patient—a thin, nervous-looking lad—suffering from very violent pain in the region of the heart and in the limbs. On applying my hand over the precordial region, I felt the heart acting with a violent heaving impulse, shaking the patient with every pulsation, indeed I do not remember having ever felt a more forcible impulse. There was, however, no irregularity, and the pulse did not give any indication of the disturbance at the centre of the circulation, being 84, full, and not remarkably strong. The breathing was hurried. On examining the extremities, I found that the muscles of the forearm were rigid, the wrists slightly flexed, and the thumb drawn into the palm of the hand. The fingers, without being clenched, were so strongly flexed, that a moderate force was not sufficient to open them. The feet were turned inwards and the soles arched. There was no swelling of the joints, nor any tenderness on pressure.

The patient told me that paroxysms occurred about every 10 minutes, and I remained in the house so as to have an opportunity of seeing one. When it occurred, the trunk and limbs became quite rigid and extended, the abdominal muscles were strongly contracted, and the patient screamed loudly.

Observing that the affection presented a distinctly tetanic character, I looked carefully for the affection of the facial muscles, which is so generally present in that disease, but I could detect no trace of it. The countenance was certainly for a moment convulsed with pain, but there was no corrugation of the brow, no risus sardonicus.

I inquired minutely and carefully as to the existence of any difficulty in mastication or deglutition, or of any painful spasm of the jaw, but the patient assured me that he had not suffered anything of the kind, and his relatives were confident that there had been no change whatever in his features or expression. He stated, however, that his tongue had been stiff, and the tip turned up, and that there had been some pains and rigidity in the sides of the neck.

The history of the case was as follows:—He was apprentice to a carpenter, and about a fortnight before, while working out of doors, had been one day exposed to much cold and rain. The day after, he had taken the cramps through his body and limbs. For eight days he had suffered from them, at first about every hour, but subsequently much less frequently,

and three days before my visit, feeling much better, he had returned to his work. But the spasms recurred so violently, that he was obliged to return home, and from that day had become progressively worse. During the entire time, the pain about the ensiform cartilage was the most severe symptom under which he laboured; and his father, with whom he slept, said that he had been kept awake by the beating of his son's heart. The bowels had been pretty regular, and he had been besides two or three times smartly purged with salts and senna; no worms had been passed, and he had always had some appetite.

I ordered small doses of laudanum and tinct. hyoscyami, to be given during the night. In the morning I was agreeably surprised to find that he had slept a good deal, and that the spasms were much less frequent. During the intervals the heart's action was tranquil and quiet, and, even during a paroxysm, the impulse had a much less violent character than on the preceding night. There was no sign of organic disease. From that period the spasms diminished in frequency and in severity, the excited condition of the heart only occurring when the spasmodic attacks supervened, and soon subsiding after their cessation; and on the 13th I allowed him to rise, as no paroxysm had occurred for 24 hours.

The chief points of interest in this case are, I think, the absence of any affection of the muscles of mastication and deglutition, and the symmetrical affection of all the muscles supplied by the spinal nerves, and of that one of the so-called cerebral nerves, which presents, perhaps, the closest analogy to a spinal nerve, the hypoglossal. It is also a question of some interest to remark how closely the symptoms resembled those of a case of poisoning by strychnia, especially when we consider that in all probability the exciting cause of the disease must be looked for in the repression of some excretory matter giving rise to an impure condition of the blood.

{Council minute book: Dr. Reid did not look on case as one of idiopathic tetanus as trismus was wanting, rather as hysterical affection.

Dr. Gordon as neuralgic affection.

Dr. Murney did not consider trismus as necessary to be present, but thought combination of opium and hyoscyamine useful.

Dr. Reid considered it was the rapid disappearance of the disease that negated the idea of tetanus, and did not consider the combination of substances as so opposite in their action as opium and hyoscyamine.

Dr. Ferguson thought that tetanus was slow in progress, said symptoms more marked, that excessive action on heart arose from nervous irritation.

Dr. Murney for Dr. Browne brought forward a case of excision of knee joint.

Dr. Moore looked on case at first as the most favorable to excision.

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Dr. Gordon do. and felt disinclined to perform the operation in any case.

Dr. Murney looks on amputation as more favorable to persons in [?] close of life.}

TENTH MEETING
January 4th, 1862

{Rough minute book: Dr. Murney President in the chair. Professors Gordon, Ferguson, Drs. Cuming, Patterson, Brian Smith, Browne.}

Popliteal Aneurism.

Professor GORDON introduced a patient who had been successfully treated for popliteal aneurism by compression. There only remained a small tumour in the ham of the size of a pigeon's egg.

Fracture of Femur; Amputation.

Professor GORDON also exhibited the amputated limb, after mill injury, which had caused separation of the lower epiphysis of the femur, and extensive separation of the periosteum.

{Rough minute book: The President remarked that in young subjects generally the periosteum was more easily denuded.

He then exhibited a portion of frontal bone removed from a boy who had sustained an injury of the head, and read a history of the case.

Dr. Browne then described a case of injury of head and neck.

The President described the post-mortem made of the brain.

Profession Ferguson remarked that he had never seen a case of such extensive effusion not followed by sudden death. He thought it remarkable there was no evidence of an extension of the hæmorrhage at a period shortly anterior to death.}

Bright's Disease of the Kidney; Fever.

Professor FERGUSON brought before the society some particulars of a case which, at first, presented the aspect of simple fever. The case, however, did not follow the usual course of the disease. There was constant cough, great epigastric tenderness, and subsequently bloody stools. About 36 hours before death the patient became rapidly worse, and sank without any apparently sufficient cause. At the *post-mortem* examination, all the mucous membranes were found congested, and in both kidneys the usual appearances of *morbus Brightii* were presented. The congestion of the bronchial mucous membrane accounted for the incessant cough. No history which could elucidate the case could be obtained.

{Rough minute book: Dr. D. Moore remarked that it was unusual to find the kidneys both so equally advanced in morbid ...}

ELEVENTH MEETING
January 11th, 1862

{Rough minute book: The President in the chair, Drs. Patterson, Ferguson, Cuming, S. Reid, B. Smith, Murray, Mulholland, Browne, MacCormac, J. Moore, D. Moore.}

Epithelial Cancer.

Dr. BROWNE exhibited two specimens of epithelial cancer which he had removed from the scrotum. He considered them excellent examples of the disease.

Rectal Tumour.

Dr. BROWNE showed a remarkable tumour, removed from the rectum of a boy. It had been attached by a long fibrous pedicle which gave way under slight traction. Its appearance and size was that of a small strawberry. On section, and examination under the microscope, it indicated a striking glandular structure, containing numerous secreting cells, similar to the follicles of Liberkuhn of the large intestine, and lined with columnar epithelium of a very perfect kind.

Compound Fracture of Ulna; Secondary Amputation.

Dr. BROWNE exhibited a forearm which it had been necessary to amputate after severe mill injury. There was extensive laceration of the soft parts, and fracture with denudation of the ulna. In the first instance, after consultation, it was deemed advisable to attempt to save the limb, while it was requisite to remove the lower half of the ulna, the wrist joint being necessarily laid open. The case did not progress favourably, and secondary amputation was had recourse to with a good result. Dr. Browne considered that even had the limb been saved, its usefulness would have been seriously impaired owing to the loss of so large a portion of the ulna, and the destruction of the soft parts.

{Rough minute book: Dr. Moore considered it would have been more advisable to amputate in the first instance as when so large a portion of bone was lost, a useful limb would not remain.

The President observed that if the wrist joint had been intact the chances of recovery would have been greater, and then it would have been necessary to speculate what amount of use would have remained to the limb.}

Caries of the Metacarpal Bones; Amputation.

Dr. BROWNE exhibited the fourth and fifth fingers, with portions of the corresponding metacarpal bones

which he had removed from a patient admitted to hospital for what was at first a simple phlegmon. This had been treated in the usual way, and the patient left the hospital almost well. In a few days he returned, unhealthy action having set in; and, on examination, the metacarpal bone of the third finger was found distinctly carious. It was surmised, but could not be clearly ascertained, that the fifth metacarpal was also diseased. Under the circumstances it was decided to amputate the diseased portions of the hand, and to be guided in the steps of the operation by the condition in which the fifth metacarpal might be found.

Council Council Meeting January 15, 1861.
Present, Dr. Murney President, Drs. Browne & Mac Cormac.

That a special meeting of the Society be summoned for Saturday to elect a Secretary in place of Dr. W. Aickin resigned.

Dr. Browne undertook to exhibit a case of recurring malignant disease after extirpation.

TWELFTH MEETING
January 18th, 1862

{Rough minute book: With reference to a letter received from Dr. Jacob Junior it was moved by Dr. Browne and seconded by Dr. Patterson and resolved "That Dr. Jacob be informed that arrangements have been made for the publication of the transactions of the present year, but that he be thanked for his attention and informed that his proposal will be considered at the ~~close~~ commencement of the present session."}

Melanotic Tumour of Orbit.

Dr. BROWNE introduced a woman of 30 years of age, labouring under melanotic tumour of the orbit. In this case excision of the eye-ball, for melanosis, had been performed by him two and a half years ago. At that time the tissues external to the eye-ball were not affected. For 18 months after, the patient enjoyed good health, when a small tumour began to be observable at the inner canthus, growing slowly at first, but latterly with rapidity, extending down the cheek, and probably into the nasal cavity, as there is at present a sanious discharge from the nose. It is now of a year's duration, in length two and a half inches from the margin of the orbit to its extremity, and rotund in shape. Sensations of acute pain are occasionally experienced in the part, followed by a discharge of blood from the nares which relieves the pain for the time. None of her relatives suffer from any form of cancer, nor can any history of it be traced in her family. Dr. Browne stated that, under all circumstances, melanotic and cerebriiform tumours of the eye-ball are most liable to recur. In six cases of this form of

disease in which he had extirpated the eye-ball, there was only one in which the affection did not return. Operative interference with this case would be useless now, the disease having implicated the wall of the antrum, and extended into the nasal cavity.

{Rough minute book: The President had seen melanosis only in those of dark aspect, with much pigment.

No doubt minute structure of melanosis is identical with other forms of carcinoma with addition of pigment. Hard forms of melanosis proceed with same rapidity as schirrhous, soft forms of melanosis with same speed as cerebriiform.

Thought it soft form of cancer now. Interesting to observe loss of sensation over parts supplied by infra-orbital nerve.}

Congenital Cataract.

Dr. BROWNE introduced a case of double congenital cataract in a boy of thirteen years of age.

Both eyes had undergone the "needle operation," and were progressing satisfactorily. Dr. Browne remarked, with respect to the period of life in which the operation should in such cases be performed, Mr. Saunders considered that it should be done early; whilst others held that there was a risk of too active absorption after needle operations in infancy. Dr. Browne agreed with Mr. Saunders, as when an early operation was had recourse to, the children were enabled to be educated at a proper age, and the eyes had not acquired the habit of rolling about in search of light, which is extremely difficult to counteract when the muscles have once acquired it.

Since the operation the boy stated that all surfaces, whether prominent or not, appeared flat to him, and he evidently imagined all objects to be much nearer him than they really were, arising, no doubt, from the want of a proper idea of perspective.

*Cataract.*¹

Dr. BROWNE also introduced a case of double cataract in a girl of fourteen years of age, in whom one eye had been operated on. The needle operation had been performed on the right eye on the 29th. October. Smart inflammation ensued, persistent, requiring the repeated application of leeches. A small bit of the capsule of the lens still remained unabsorbed. Dr. Browne remarked that, when the lens is in a semi-fluid condition, there is much risk of inflammation if the needle be too freely used. In this case, although its use had been slight, yet smart inflammation had set in. This girl did not suffer from any inaccurate appreciation of distances, like the boy previously introduced, as her sight had been pretty good until two years ago.

¹ [See page 889.]

{Rough minute book: President considered there could be no objection to operation in childhood—and would expect from activity of capillary circulation that a slighter touch of needle would suffice.

Dr. Browne thought children less susceptible of inflammation than adults. }

THIRTEENTH MEETING¹

January 25th, 1862

Strangulated Incarcerated Femoral Hernia.

Dr. BROWNE read notes of a case of strangulated incarcerated hernia in a female of 40 years of age, in whom death had occurred from peritonitis, two days after the operation for the relief of the constriction.

The patient had laboured under incarcerated femoral hernia for the past two years, for which she had never worn a truss.

On the 14th. of the present month she first complained of pain in the site of the tumour. On the 15th. vomiting set in, and on the 16th. she was admitted to hospital.

On admission she experienced general and diffuse pain over the whole surface of the abdomen—most marked in the vicinity of the tumour. Her face was pale, shrunken and anxious. Pulse 130, and scarcely perceptible.

On consultation with Dr. Murney it was considered advisable to operate, although sub-acute peritonitis had evidently set in.

Chloroform having been administered, the tumour, 3½ inches in length by 2½ in breadth, and in depth two inches, was cut down upon, the sac opened, and found full of apparently healthy omentum, on raising which, a knuckle of the ilium, three inches in length, of a very dark chocolate colour, but still retaining its glossy appearance, was found.

The stricture having been divided, the intestine was gently drawn downwards, when the part above the site of constriction being found healthy in appearance, the gut was carefully returned—due care being taken that no part of it was constricted by omentum.

After the operation the vomiting ceased, but the pain and tenderness of the abdomen still continued, and the pulse, which had risen under the influence of the chloroform administered, became almost as rapid and feeble as before. It was evident that the operation had afforded little or no relief to the shock inflicted by the strangulation of the bowel.

Next day, on finding considerable fulness of the great intestine, an enema of oil and turpentine was exhibited without effect.

The patient gradually sank, and died on 18th, 51 hours after the operation.

On *post-mortem* examination, the great omentum was found much congested in its upper and middle portions; its lower border being inflamed, in a soft and ragged condition, and coffee coloured in appearance. It was adherent by lymph to the inner aspect of the opening through which the protrusion had occurred.

The small intestine, generally, was congested, and for the distance of several feet, on either side of the constricted portion, presented marks of inflammation, with spots of lymph exudation, of the size of a shilling, or larger, scattered over its surface. The part which had been engaged in the protrusion was highly inflamed, of a dark chocolate colour (which scarcely seemed, however, so dark as at the time of the operation), its surface being studded with lymph exudation.

Parietal peritonitis existed over the lower three-fourths of the abdominal cavity, which contained a pint and a-half of effused serous fluid. The ascending and transverse colon were full of feces.

Dr. Browne remarked, that although the presence of peritoneal inflammation, in cases of strangulated hernia, renders the prognosis very unfavourable, still it should not deter the operator, as the inflammation frequently begins to subside on the relief of the stricture. He had lately operated for the relief of a strangulated femoral hernia, of four days, duration, where subacute peritonitis also existed, and where, on opening the sac, upwards of 40 ounces of highly coagulable serum flowed away; yet, on the relief of the constriction, the unfavourable symptoms gradually abated, and the patient did well.¹

{Rough minute book: President showed that omentum united to wound would prevent recurrence of prolapse. Hernia largest one he had ever seen.

Dr. Ferguson, operation successful as by P.M., asked Dr. Browne, cause of death no doubt peritonitis, whether peritonitis existed formerly to operation is not [clear].

Dr. Browne stated that peritonitis existed before operation and continued unrelieved.

Dr. President that signs of inflammation had been unfavourable. At operation appearance of gut looked better.

Dr. Ferguson asked how far peritoneal inflammation could go.

Dr. Murney stated that no estimate could be formed from length of time of constipation, amount of pain, as one person had more promise of recovery than another.

Dr. Brown would operate in all cases unless in articulo mortis. Gut sphacelated, patient may have

¹ [Text is recorded in the Transactions as belonging to the twelfth meeting but examination of the rough minute book suggests the text is from the thirteenth.]

¹ [See *Dublin Quarterly Journal of Medical Science*, 1852, v13, p218, for a similar (if not identical) case described by Dr. Browne.]

artificial anus, so that no amount of severity of symptoms should preclude operation. Two cases in Hospital since Dr. Browne was attached that recovered against all hope.

Ferguson: Dupuytren came 5 or 6 mornings to bedside of patient in hernia who refused operation. On last morning, gave consent. Dupuytren said “I can do nothing for you, you will be dead in 12 hours”—no doubt from peritoneal inflammation.

President asked if there was any evidence linking of pulse—no.

Dr. Browne said that Dupuytren saw that man was in articulo mortis and hence would not operate.

Dr. Johnston: Patient admitted to Richmond, morning, no urgent symptoms. Bath and taxis, no success. In evening another bath, patient got into collapse. Perforation, great hemorrhage had taken place into bowels. Had knife been used, and less taxis, good effect.

President asked from what point hemorrhage came—from both above and below strangulation, the whole ileum.

Dr. Browne as to loosening of sac or not? Drs. Luke and Gray advocated non-opening of sac in many cases. The patient would be far worse than at first if sac not opened. In present case you could not tell where obstruction existed or whether knuckle of intestine was strangulated by omentum or not. Stricture often exists in neck of sac itself.

President always opened sac and that benefit of opening more than counterbalanced additional danger. Little added to risk by it. If strangulation tight and existed for considerable time the gut may be gangrenous, and if returned sac unopened, effusion into cavity to abdomen. If opened a false anus may be formed.

In a recent hernia, small and only gut, would not feel inclined open sac.

Dr. Ferguson—acute rheumatism, in 12 hours had 6 gr opium. Next 24 hours had 18 gr as extract. No narcotism. All local rheumatic affections removed save pericarditis one. So much opium in 24 hours, with no narcotism—it purges bowels, produces thirst and slight feverishness. Think opium most useful agent known in pericarditis.}

{Rough minute book:¹
FOURTEENTH MEETING
February 1st, 1862

Present, President in the chair, Drs. Ferguson, Seaton Reid, Browne, Patterson, Johnston, Murray.}

¹ [From here on the records of the meetings are found only in the Rough Minute Book. Most cases were not recorded in detail but the discussions were. The scribbled notes are not so easy to read and contain a number of gaps and guesses.]

{Rough minute book:
FIFTEENTH MEETING
February 8th, 1862

President in chair, Drs. J. C. Ferguson, Patterson, Cuming, Bryce Smith, Halliday, W. MacCormac, Mulholland, Dill.

After minutes read. President stated: 35 town and 7 county members had answered in the affirmative—2 town [?] since. 37 + 7. forms sent out no replies yet.

Only one negative answer.¹

18th man admitted with haggard emaciated aspect, no well defined complaint but referring gut malaise and abdominal pain. 5 weeks ago [amount?] diarrhoea but never altogether unequal to his work. For last 2 or 3 days bowels confined.

On 19th occasional diarrhoea followed by occasional costiveness. Ordered ʒij ol R. and ʒi ol turpentine [and] ʒi [?].

20th Next day better. No local pain or uneasiness. Asked for and ate a better diet. Only sign was foul tongue with dark streak down centre. Had grX pill [Rhubarb?] co, night and morning. Open diet.

21st Pills had no effect. Ordered ʒi oil with success and marked relief.

On night 22nd began to complain of pain in abdomen. On 23rd countenance altered and more miserable. When suspicion of abdominal affection were confirmed—peritonitis—turpentine stupe, gr iij grey pulv and gr iij Dover, every _ for 23 and 24. On 25th aspect altered for worse of extreme anxiety, but it was not the pinched expression of extreme peritonitis. Still very considerable pain and uneasiness. 24th abdominal parietes retracted, but tenderness comparatively slight unless over region of bladder. Also dysuria.

25 Much pain in abdomen, refused food. That night restless and sleepless. At 8 a.m. on 26 he suddenly became weak and delirious, refused no special pt. as seat of affliction. At 11 a.m. died quietly.

That peritonitis arose from extension from mucous surface of inflammation and ulceration.

P.M.: Mesenteric gland in direct connection with the ulcer. All glands of the mesentery that were enlarged were in direct connection with ulcer, and were effect not cause as some maintained of ulcer.

1 When did inflammation set in

2 Of what was it effect

3 When did perforation occur

Man had subacute inflammation for some time previously. How long lying dormant cannot tell but when gut arises from extension of institution from mucous surface prior to perforation. That perforation was of late date of sometime during Saturday night.

¹ [It is very likely that these were the results of a ballot on a possible merger with the Belfast Medical Society.]

A case similar occurred in Dr. Ferguson's house and died in 24 hours after with all signs of perforation. 4 or 5 months ago had severe colic, burning piles and loss of appetite. Purgation full by anodyne. For several visits same treatment. Man recovered so far as to attend to his business. 3 weeks after called at his house. Tongue dry, brown. Loss appetite, nausea and appearance of man in typhoid fever. There was much difficulty of diagnosis—1st typhoid fever, 2nd malignant disease. Had blue pill and opium. Turpentine stupes. From that time until admission time had not seen him.

Existence of only one ulcer would militate against typhoid fever. That perforation may have existed at time his admission to hospital. Thinks that peritoneal inflammation may have extended from mucous coat, but thinks that when much suffering from ulceration has occurred, symptoms of effusion are not so urgent.

Dr. Ferguson: Amount of peritonitis not necessary to find cause of in perforation—inflammation set up often to [?] Effusion. The formidable symptoms set in suddenly on Saturday night.

President: That chronic peritonitis has existed for some time, and that perforation occurs when formidable symptoms set in.

Dr. Ferguson: Doubts if such care were given by purgatives but happened, had peritoneal inflammation existed then. When peritonitis set in purgatives lost their effect.

Dr. Pirrie mentioned case ...

Ferguson: That if signs of inflammation and increasing and final death. He thought ...

Halliday: ...

Dr. Cuming: That there was something more than mere ulceration of intestine.

[?] for idiopathic ulcer of intestines. In Crimean cases there were no ulcers.

Are we entitled to date the perforation from ... life has been prolonged for upwards of some days after a perforation so he would not date perforation, but probably on Saturday morning.}

{Rough minute book:
SIXTEENTH MEETING
February 15th, 1862

Present, President chair, Drs. Moore, Ferguson, Dill, McMechan, W. McCormac, Bryce Smith, Pirrie, Gordon, William Magee, Cumings, Browne, D. Moore, Bryce, Halliday, Mulholland, Johnston.

Dr. Ferguson read notes of a case of acute rheumatism with cardiac, pleural and peritoneal complications.

Dr. Pirrie: Dr. Ferguson ascribed good effects to opium. 1st alkaline treatment adopted and after carb potass. materies morbi and that of acid nature and Dr. Pirrie ascribed gradual effects of alkalis to counteract

of this—opium as adjuvant, calomel, that when peri or endo cardial affections, the joint symptoms may [mean?] do disorganisation and calomel necessary. If no heart affection no calomel necessary.

Dr. Cuming: As to diarrhoea, is opium cause of it. Opium in poisoning has sometimes shown signs of action as irritant. Might not diarrhoea have occurred without opium, and as an elimination of poison, and would seem to act as natural indicator of disease.

Magee: In active disease large amounts of opium may be [laxative?]. Agreed with Dr. Pirrie, same as to materies morbi of acid character and benefit of alkalis, if so, how. Lemon juice useful.

Pirrie: Lemon juice other acid has small affinity for alkali and easily decomposed and [Potass?] produced good effect.

Browne: Case of 12 gr opium for 3 days.

Prostration, diarrhoea, vomiting in opium [?] it acts as a purgative

Dr. Pirrie: when serous tissues are affected would combine Cal[omel?] with opium.

S. Reid: Citric acid acts as sedative on heart and large [dose] will lower heart's action from 100 to 70 or 60 in 24 or 48 hours. Acts as antiphlogistic.

Dr. Ferguson reply: As to Dr. Murney's relapses, 70 exposed, only alkaline [?] [?] 2 oz. fluid magnesia until rheumatism had entirely disappeared. 20 no benefit from alkalis. When extension of inflammatory rheumatism from joints in patient to pericardium, pleura and peritoneum, he yielded in his views [generally?] entertained but he wished he had not and had seen pericardial effusions yield to opiate treatments solely. As to diarrhoea, Dr. Ferguson had never used opium in large doses for rheumatism but it was followed by gastro intestinal irritation, and as to diarrhoea (as Dr. Cuming stated which might have proved useful) forming as [?] he had given purges freely.

Pirrie: As to peritonitis, Dr. Pirrie had never seen it in acute rheumatism before. Would ask Society if they had.

President: Do. Had seen case and agreed with Dr. Pirrie as to only case.

Ferguson had never seen *meningeal* inflammation and instanced case where all membranes save meninges.

Dr. Gordon exhibited a case where 3 inches of bone end of fibula for scrofulous caries, epiphysis was found diseased but with finger was scooped out, and this is part of case.

Dr. Gordon read notes of a case of symptomatic pelvic abscess. Disease began 1st in hip, through acetabulum, and up to abdomen.

Dr. Magee: Gordon had said that he had no proper examination. Why did he not give chloroform.

Dr. Pirrie could not adhere to Dr. Gordon's explanation. Agreed with Dr. Read as to came about in form ...

Murney: united tendons of psoas and iliac pass in front of joint which often arrangement might no inflammation be carried up tendon into general body of psoas and iliac muscles. That so much existed as that a perfect examination could not be had for long time.

Johnston: Walked a mile with assistance to dispensary. No pain in knee or hip, but tender over iliac fossa. Had suspicion of peritonitis. The leg not then flexed as it after became. Considered that no opening through acetabulum but that it was made by finger.

Dr. Ferguson: Thought disease began in hip as Dr. Gordon stated. Unusual for dislocation to occur in 3 weeks.

Dr. Browne same as Dr. Gordon, ...

Johnston 7 weeks elapsed since the diagnosis of pelvic abscess.

P.O. Treasurer 3/6 received for Transactions.}

{Rough minute book:
SEVENTEENTH MEETING
February 22nd, 1862

Present, President chair, Drs. Drennan, Browne, Ferguson, Patterson, McMechan, W. MacCormac, Cuming, Halliday, Moore, Dundee, Dill, Murray, Mulholland, T. Thompson, Bryce Smith.

Minutes read.

Dr. Dundee's case ...

Dr. McMechan read notes of the latter part of the case.

Dr. Halliday: 6 hours after accident no thickness of speech. No hemorrhage from nose, mouth or ear. No swelling of temporal fossa. No brain matter on end of stick. It might have passed into temporal fossa.

Dr. Browne, in temporal fossa although review refines as crowbar, breach of [?] and [?] still temporal fossa. Thinks man will lose the sight of 2nd eye, that irritative inflammation will act in 2nd eye. In temporal fossa not from direction [but] damage to nerves and no paralysis, inflammation in temporal fossa.

President agreed with Dr. Dundee that injury to temporal fossa would not induce a pulse of 58 or lower for weeks. A nail 4 inches long was drawn from supra-orbital ridge with brain matter on end. No constitutional symptoms.

Ferguson: No spiculæ of bone came away?—none. That if it entered brain, spiculæ of bone would be carried in and would induce serious consequences— injury to nerves at that part of brain—and yet no paralysis appeared.

President: That it penetrated into middle fossa of base of brain, into [?] of grey matter, what would become of spiculæ of bone if [?] went into temporal fossa.

Johnston: Asked as to medico-legal matter.

Browne: Weight of medical would go to [?] that when ...

Dr. Ferguson: A physical impossibility for sharp lathe in ...

Dr. Dill: Not temporal fossa. More uneasiness and that a person will not suffer much from excision.}

[There is sketched a rectangle in the book. May be a doodle or may be a representation of the foreign object which penetrated the brain.]

{Rough minute book:
EIGHTEENTH MEETING
March 1st, 1862

President chair, Drs. Thomas Reade, Patterson, Dundee, Dill, Drennan, Cuming, W. MacCormac, Johnston, Browne, Moore, Gordon.

Minutes read.

President read report from Council meeting of Medical and Pathological Societies.

Dr. Drennan read notes of a case of aneurism of thoracic aorta, and exhibited morbid pathology.

Dr. Murney explained parts—at first true and after false aneurism—Bellingham's mixed aneurism.

Dr. Drennan asked Society cause of diastolic bruit—regurgitation of blood from aneurism into aorta. The pulsation of carotids interesting. Nodules on aortic valve. Could some be called an imperfection in this case, though carotid pulsation varies with aortic regurgitation through valve.

And mobility of radial with small and feeble imperfect pulse. The pulse was distinct from the half-filled pulse of aortic regurgitation.

State of pupils—had an opiate.

Emphysema of lungs, had no cough and fits dyspnoea were attributed to aneurism.

Effusion into right pleural cavity must have occurred immediately before death as day before chest examined and clear.

Dr. Moore's case of pancreas ...

Dr. Gordon had seen [?] of gallbladder ... and obstruction of common duct by gall-stone, diseased pancreas, &c.}

{Rough minute book:
NINETEENTH MEETING
March 8th, 1862

President chair, Drs. Gordon, Ferguson, ...

Dr. Gordon: in abducting arm felt a tear, thought it due to ligament giving way. On removing soft parts

found fracture glenoid cavity extending down anterior border.

... fits to a form of accident he thinks connected when [?] such an accident may happen. If circumstances were in force it is well to know such may be [?]

Bones generally were atrophied, shafts of long bones [?]

Dr. Moore: if muscles rigid.

Dr. Pirrie—patient complaining for 15 months, off work for 5. A few weeks before, admission complained of laryngeal stridor and laryngeal cough and dyspnoea.

Dr. Smith had considered it aneurism.

A small aneurismal tumor back part of aorta where transverse part ends, lying over oesophagus and touching trachea. [?]. Never difficulty of swallowing or inspiration. Difficult cough from below with expiration.

President as to relative frequency of open into trachea or oesophagus.

Ferguson—on tube fixed and resisting and when soft and yielding and would give every accts so for want of dysphagia Pain

Dr. Gordon—Pain if pressure on intercostal nerves. Simulation of laryngeal affection. Mentioned a case in point.

Dr. Moore—Paroxysms

Dr. Gordon—Anything that determines to increased pressure would give rise to paroxysms. Mental symptoms, change of position etc.

Ferguson—Diagnosis, [?] enlarged and very high, one sign. Benist no necessary altered [?] aneurismal tumor, a tumour of that size and locality might be detected by pulsation lone.

Dr. Johnston—If atheroma ...

Dr. Gordon—Aneurisms due to partial atrophy of middle coat in many cases and no atheroma.

Dr. Moore—Fatty tumour ...

Dr. Moore—Hand ...

Sloughing wound, sufficient for stump, hysterical, no chloroform.

President: as to hysteria, and no chloroform, is it desirable to omit it. Would give chloroform as stimulant same as in collapse, as stimulant to rouse from collapse or hysteria.

Dr. Pirrie: Hysterical woman, chloroform not necessary.

Ferguson: On touching by M. if mesmerism would produce insensibility as this hysteria.

Johnston: Odd that the knife would not rouse from hysteria.

Dr. Johnston—Peritonitis. Whether from pressure or [?] or ulcerated margins.

Dr. Dill—Kidneys of dropsical patient, woman 60, who died of influenza.}

{Rough minute book:
TWENTIETH MEETING
March 15th, 1862

President in the chair, Drs. Drennan, Patterson, Thomas Reade, Gordon, Bryce Smith, S. Reid, Dundee, Dill, W. MacCormac, D. Moore, Cumming, Browne.

President read notes of case of femoral aneurism treated by compression and exhibited patient.

Gordon: Signorini compressor, 3 sloughs of vessel tied, wound would slough. Signorini's compressor more easily applied. Patient's thanks. Until complete stop of all pulsation for some hours at a time. A progress to case occurred.

Dr. Browne: Not necessary in most cases to completely arrest flow, merely minimal current.

Gordon would bandage for a fortnight if the patient muscular before compressor applied.

Dr. Browne exhibited patient ... Said ligature put on high up, none below. Wound of vessel. 6th day, 2^{oz} hemorrhage, thigh enlarging. Wound opened. Pus large in amount 30oz. Bleeding point where anastomotica magna was given off. Ligature applied, [sacs?] to common and both vessel and anastomotica magna. 12 to 18 ounces of pus daily came away or 3 or 4 weeks. Leg was kept completely bandaged. Ligature came away, 13 day 1st ligature came away, 18th day of wound, (2nd do.)

Dr. Dill's case ...

Dr. Drennan: No pain [?] save for 12 hours. Sharp in character. Some days previous admission vomiting oily, bilious matter.

Tumor middle and left hypochondrium. Suspicion of accumulated faeces. Purgatives tumor less. After going off duty, saw her again. [Later?]. Tumor on right side which had not previously existed. No pain except vomiting and diarrhoea ceased. No prominent symptoms at that time. Tumour had a sharp pulsation but not of the expansion characteristic of aneurisms. No bruit. No suspicion of aneurism. Had appearance almost of malignancy. No vomiting of blood. No symptoms of stomach affections.

Dr. Browne sent in a small tumour, liver—no oily matter in stools.

Dr. Cumming: Difficulty of diagnosis, liver not easily diagnosed in this case. Spleen, dulness well marked. For right lobe of liver did not to him present nodular form. So much affected of left side, little of right. Of long standing. Broke down. Jaundice not prominent with all that disease of liver.

Dr. Gordon—Hydatid disease of omentum. Medullary disease of liver ascending as high as 4th rib. Organ generally enlarged. Right hypochondrium the liver no enlargement, left mass irregular, different degree of consistency. Beneath left mass tympanitic sound on percussion, in front of stomach distended with wind, however, not spleen, for stomach would have been displaced to the right by it.

What are circumstances thus determining the rising of liver or sinking as in this case.

Conjunction diarrhoea.}

{Rough minute book:
TWENTY-FIRST MEETING
March 22nd, 1862

President chair, Drs. S. Reid, Dill, Ferguson, Bryce, Smyth, Mulholland, Patterson, Drennan, W. MacCormac, Cuming, D. Moore.

Dr. Reid read notes of cases of [heart disease] and exhibited recent parts. ...

1st no murmur. 2 apex and systolic. 3rd at base and systolic too.

Dr. Ferguson considered valves aortic sound. Would not look upon small action of vessels [?]. Regurgitant. Did not understand *triple* motion of blood waves.

Dr. Reid: Imperfect tricuspid orifice and wave came up *in vein* after systole.

Dr. Drennan: Marked visible pulsation in large vessels of neck and extremities with small pulse. Bruit depends on dilatation of vessel and not on imperfect aortic valve.

Ferguson: *Visible* pulse not except with aortic incompetency. For dilatation will if it comes close enough to valves so separating them so that they admit of regurgitation.

Dr. Drennan did not agree.

Cuming: If rigid unyielding tubes, on physical principles, not visible pulsation. If vessels so dilated as to lose contractility there would not be a visible pulse.

Dr. Ferguson proposed a discussion on pulsation of vessels without aortic regurgitation.

President—13 January, a man 56yr admitted under Dr. [Ph?] in America under treatment. An instrument was passed with force but no urine.

Dr. Browne: All [?] passed same distance. No success to point anterior to bulb urethra. Passed copious pus in urine. No perineal section [?] and no passage. Sound passed and cut upon—unsuccessful as point behind stricture could not be found. Died with stricture unrelieved.

Urinary fever—Syme always opening [?] no orifice to be found. But no opening, structure seems to be ...

Dr. Johnston: Case Richmond of Dr. Adams, failed in same way. The distal opening was not to be found. Dr. Johnston made P.M. and parts just same as in the present case. $\frac{1}{8}$ inch of stricture not cut.

Dr. Ferguson: A chance of life from state of bladder and kidneys had operation been successful.

President: Large amount of pus in urine was from collection of a bladder and inability to pass it. Local in bladder with thickened coats. Symes operation from 2nd case usually not fatal.

Dr. Browne: Operation only chance; agree with Dr. Ferguson.

Johnston: Differed—saw no reason why he should not live for years.

W. MacCormac: Nélaton drew a diagram showing impossibility of passing an instrument through canal, and [why?] instrument would not pass.

President: Size of stream a measure of size stricture, immediately given anterior to bulb. Expulsion of urine is mainly affected as the stricture passed the urine is expelled with violence.

Dr. Brown's case ...

President: One ligature put on, 2 better. Distance of single ligature 2 inches from main vessel objectionable. When ligature placed on distal side of vessels hemorrhage did not come at once.

[?] of sutures difficulty of seeing vessels at all for venous hemorrhage.

W. MacCormac: No hemorrhage at admission. Not desirable to operate unless hemorrhage resumes. Erichsen. [?] [?] [?] [?] in pain. Hemorrhage easily controlled, no interference, good result.

President: Wounds [?] if punctured wound in axis vessel. May heal without trouble. Was vein wounded. [?] circulation does not spout, wells up.

Dr. Moore: Ligature on lower point of vessel.

President: [?] [?] blood, and pressure brought would check arterial bleeding too as well as venous.}

{Rough minute book:
TWENTY-SECOND MEETING
March 29th, 1862

President chair, Drs. Drennan, Patterson, Gordon, Thompson, Ferguson, S. Reid, Stewart, Dundee, W. MacCormac, Dill, H. Cooke, D. Moore, Johnston.

Minutes read and signed.

Dr. Dill—"Bright's". Notes of case read and kidneys exhibited. Specimens of Bright's disease.

Dr. Reid: Any peculiarity of inspiration, not guttural from back of throat.

Drennan: Heart complications common in Bright's disease. Any enlargement of heart would tend to cause effusions and dropsy, and effusion [neck] into

head. Coma may depend on that effusion found heart as well as from uræmia.

Johnston: Cases where only œdema a slight present, and yet head affections from *uræmia* present. One case 48 [?] died.

Ferguson: Case of John Porter, aggravated Bright's disease, comatose for several days and nights and yet recovered, and was alive for months or a year. Shortly before same case end fatally albumin will disappear. Specific gravity never seen to vary. Of *modus operandi* of poison much yet to learn.

President: Also [?] of albuminuria when well ascertained and have been present for a tumor, and disappearing for years say. Desquamative nephritis has spoiled parts of kidney which no longer separate urine from blood, other parts carry on function. When albumin appears it is owing to fresh attack of same part.

Dr. Dill: Interesting that so much urine was passed as there was, with such atrophy as kidney, and no swelling of body of limbs.

Dr. Dill: Reilly—liver ...

Jaundice depending on inflammatory closure of hepatic duct.

Dr. Drennan: Woman 3 months ill. No marked symptoms save a change of color, some constipation. 1 month before admission some swelling and tenderness in hypochondrium. Bowels costive on admission and white. Urine very dark and showed the lime yellow.

Cupped and leeches, calomel, mist alba. A few days later stools became remarkably dark. Seemed better. Afterwards blue pill and [tara?] and [?], gums touched. Stools alternated white and dark occasionally. At end of month 28th day, came in on 12th January, had stinging pains in liver. Itchiness of skin did not occur till *after* jaundice. Graves mentions cases in which itching preceded jaundice.

Dr. Ferguson: Perfect obstruction probably did not occur till after dark stools ceased. Was it inflammation of lining membrane of ducts.

Gordon: Affords a case of jaundice from contraction of Glisson's capsule or before from pancreas. Can we form a differential diagnosis—an enlargement and softening of liver or biliary system but here contraction.

Dr. Reid ...

Dr. Drennan: Yellow appearance of objects ...

Dr. Ferguson: Has man sees yellow tinges of objects.

Dr. [Reid?] known patients say but rarely that white objects looked yellow.

Dr. Drennan said Dr. Graves had noticed it.

Dr. Dill: Gall bladder empty. Occasional tinge of stools might be due to small quantity passing obstruction to intestine until it was emptied.}

Council Council Meeting April 2nd

Present, Drs. Moore & W. Mac Cormac.

The Saturday business was arranged.

{Rough minute book:

TWENTY-THIRD MEETING

April 5th, 1862

Dr. Patterson chair, Drs. Reid, McMechan, W. Mac-Cormac, Dill, Moore & Moore.

Dr. Moore—Selston—Strumous affection of ankle joint, tibia and fibula. Excitable pulse, hectic feverish, [?] and much disabled. Good foot [?]. Circulation settled. No movements of joint [?] which would aggravate. Erosion of cartilage and bare bone. Movement would irritate and aggravate malady.

Paralysis of side of face. [?] cicatrix of neck. 2 long flaps and circular muscles. Wound healed almost by 1st. intention. 2 arteries only [?] out of 3. A similar case but much more hopeful, good air. Joint much in rotten condition. Boy died. Woman not [?] hectic and induration. A similar case in Antrim. [?] not favourable.

Dr. Moore—Amputation after surgery—dislocation.

Foot ankle swelled, pulse 160. 2 long flaps [?] head of tibia. Anterior flap long and come behind line of bone. Circular muscles. Healed almost by 1st. intention. Fibula end higher up [?] 1ⁿ. Did not level front of bone as [Jennet?] recommended if plenty of flap not required. Patient doing well, will [mobilise soon?].

Dr. Moore—Fatty tumor. Said carrying weight on back gave rise to it. Some uneasiness and annoyance as it had rapidly increased latterly. Report—firmly attached at lower and upper points, cellular tissue. Venous hæmorrhages in most fatty tumors. At first [point?] one artery and *pain* on cutting. 3 or 4 ozs. blood lost. Wound after filled with blood as large as inguinal tumor, sponged and healing by granulation. (Other case 7½ lbs. weight and only two arteries. Wound healed almost 1st intention.

Dr. Moore—Cyst from eyelid, male. Cyst thin, in outer and upper part of upper eyelid. Tumor removed perfect. Skin healed 1st intention except at lower part of incision. Sac granulated, in five days, discharged.

Cyst, lower eyelid. Thin quantity of fluid. If fluid discharged it would be filled again, and cicatrix under it hard to remove from skin. Subsequently transverse incision, carefully dissected and almost got out except just at the end of pea-shaped mass. Sac opened into by chance rendering removal difficult. Such a tumour removed from [?] eye caused it to fall down, as though it had communicated. Rest, antiphlogistics, inflamma-

tion subsided. In 8 days presented himself, wound healed, almost no scar. Thinks it arose from malar bone, confirmed by Mr. Walsh of Edinburgh.

Series of tumors removed from a lady. Gleetomatous of scalp. A curved or straight knife through tumor, allow wound to bleed, open another and came back to 1st. Skin has ulcerated and tumors may be *drawn* out. Pearly in appearance. 4 latter not here. Has removed as many as 16 from a gentleman.

Tend to run in families.

“Tumor from anus external”

Dr. Moore: Much itchininess or pain?

A very firm tumor. Snipped off with scissors, cold water applied.}

{Rough minute book:
TWENTY-FOURTH MEETING
April 12th, 1862

President chair, Drs. Stewart, J. C. Ferguson, Patterson, Moore, Browne, S. Reid, Dill, McMechan, Bryce, Smith, D. Moore.

Minutes read and signed.

Dr. S. Reid read notes of a case of aneurism of thoracic aorta (arch) opening into pleural sac and peritoneum.

Dr. Reid remarked that two effusions of blood had occurred.

President: True aneurism. Full coats. Rupture of middle coat and internal. After rupture of remaining coat and a dissecting aneurism of coats of œsophagus formed.

Dr. Browne read a paper on congenital cataract. Milky cataract and giving [exit?] to aqueous humor. 2 or 2¼ to read—see 4 to 4½ glasses.

Dr. Reid proposed Dr. J. C. Ferguson 2nd and passed unanimously That the issue of the annual balloting papers for the election of officers of this Society be deferred for one week later than the usual period.}

{Rough minute book:
TWENTY-FIFTH MEETING
April 19th, 1862¹

President chairman, Drs. Dill, J. C. Ferguson, Cuming, Bryce Smith, Johnston, D. Moore.

Dr. D. Moore for Dr. Pirrie shewed specimen of atrophied kidney, in Bright’s disease, in a girl of 7 years of age.

¹ [These rough notes are labelled March 22 but they are found between those for April 12 and those for April 29, and differ in content from an earlier set of notes also labelled March 22.]

Moved by Dr. Ferguson and 2nd by Dr. Dill That the ballot papers time of issuing be deferred till such time as the President and Council may think fit. Passed unanimously.

Dr. Ferguson read notes of laryngitis ultimately requiring tracheotomy.

President: Thought case proper for tracheotomy or laryngo-tracheotomy. 3rd or 4th rings above or below, there we must go, above azygos lobe of the thyroid body. Cut down to trachea, whether to wait to see if venous hemorrhage will cease after few seconds, hemorrhage as full as ever. All veins of head and neck were charged with blood. 42 years of age, cricoid and two upper tracheal rings very cartilaginous or partially ossified. Laryngo-tracheotomy, rings so hard as to be held open with difficulty for tube to be inserted, so that if the operation be successful the patient will probably suffer from some bronchitis or pneumonia after.

Operation as in strangulated hernia should be early, as there is a much more favorable chance for life, as in such cases there is 1st poisoning system by venous blood, 2nd a depressed irritability of lungs. An early operation will obviate this. The inner tube in the tracheotomy tube should not be longer than the other as it excites the patient’s trachea and causes coughing and irritation on each introduction after cleaning.

Dr. Dill—Case of scirrhus of mamma. Girl 22. 17 months ago first began. A small gland in axilla beginning to appear it was decided on removal. As to chloroform, it should be given freely and rapidly at first, the anæsthetic effect is better produced. Removed [?].

Dr. Murney—Case of scirrhus. 47 years of age, originated on surface of gland and involved deep surface of rim. Dr. Dill in substance of gland.}

{Rough minute book:
TWENTY-SIXTH MEETING
April 26th, 1862

President chair, Drs. Stewart, Browne, Patterson, J. C. Ferguson, Dill, Bryce Smith, Arnold, Cuming, W. MacCormac, S. Reid, Bryce, J. Moore, Johnston, Cantrell, Mulholland.

Resolved that the following notice be sent the members of the Society ...

The President for Dr. Pirrie brought forward case of acute rheumatism.

Dr. Ferguson asked cause of death.

Dr. Moore—Case of compound fracture.

Dr. Moore—Case of fibrous tumour
Diagnosis through [os?], ligature, twist.}

Belfast Clinical and Pathological Society

Ninth Session: 1861–1862

President Henry Murney

COMPILER'S NOTE

The above was the last clinical meeting of the Belfast Clinical and Pathological Society as, on the following day, 30 April 1862, it held a joint meeting with the Belfast Medical Society¹ and formed the Ulster Medical Society. The Ulster Medical Protective Association was also deemed to have taken part in the amalgamation² but seems not to have been specifically represented.

LIST OF MEMBERS 1853/54

ARRANGED ACCORDING TO DATE OF ADMISSION.

- ORIGINAL:- Aickin, John, M.R.C.S., (Eng.) *Belfast*
" Armstrong, J. S., M.R.C.S., (Eng.) *Belfast*
" Beck, J. W., C.M., and M.D., (Glas.) *Belfast*
" Bradford, W. J., Surgeon, *Dundalk*
" Browne, John, M.D., and L.R.C.S., (Edin.)
Dundalk
" Browne, Samuel, R.N., M.R.C.S., (Eng.) *Belfast*
" Brunker, E. J., L.R.C.S., (I.) M.D., (Edin.)
Dundalk
" Bryce, Robert, M.D., *Belfast*
" Bryson, J. W., M.D., and L.R.C.S., (Edin.)
Belfast
" Burden, W., M.D., & C.M., (Glas.) Professor
Queen's College, *Belfast*
" Callan, Jos. M., M.D., (Glas.) L.R.C.S., (I.)
Dundalk
" Carlile, Hugh, A.M., M.D., and (T.C.D.) Prof.
Queen's College, *Belfast*
" Clark, Thomas, L.R.C.S., (I.) *Belfast*
" Daly, Edward, L.R.C.S., (Edin.) *Belfast*,
(Resigned March 18th.)
" Dickson, J. S., L.F., Ph., and S., (Glas.) *Belfast*
" Ferguson, J. C., A.M., and M.B., (T.C.D.)
Professor Queen's College, *Belfast*
" Ferres, Charles, L.R.C.S., (Edin.) *Larne*
" Frame, James, L.F., Ph., and S., (Glas.) *Comber*
" Gelston, James, L.F., Ph., and S., (Glas.)
Comber
" Graves, Henry, A.B., and M.B., (T.C.D.)
F.R.C.S., (I.) *Cookstown*
" Halliday, J. H., M.D., (Glas.) L.R.C.S., (I.)
Belfast
" Hamilton, T. W., M.D., (Glas.) F.R.C.S., (I.)
Belfast
" Hanna, H. H., M.R.C.S., (Eng.) *Belfast*
" Hunter, Samuel, M.D., (Edin.) F.R.C.S., (I.)
Belfast
" Jamison, David, M.D., and L.R.C.S., (Edin.)
Newtownards
" Johnston, H. M., L.R.C.S., (I.) *Belfast*
" Lynch, P., M.D., (Glas.) M.R.C.S., (Eng.) *Belfast*
" MacLaughlin, W. R., M.D., (Edin.) L.R.C.S., (I.)
M.R.C.S., (Eng.) *Lurgan*
" Malcolm, A. G., M.D., and L.R.C.S., (Edin.)
Belfast
" Marshall, A., M.D., (Glas.) L.R.C.S., (Edin.)
Belfast
" Mawhinney, James, M.R.C.S., (Eng.) *Belfast*
" Moore, James, M.D., (Edin.) M.R.C.S., (Eng.)
Belfast
" Moreland, Hugh, M.D., and L.F., Ph., and S.,
(Glas.) *Belfast*
" Murney, H., M.D., (Edin.) M.R.C.S. (Eng.),
Dem. Queen's College, *Belfast*

¹ [See page 965.]

² [See page 972.]

Records of the Medical Societies of Belfast 1822–1884

- „ M'Gee, W., M.D., (Edin.) Surg. R.N., *Belfast*
 „ Patterson, James, M.D., and L.R.C.S., (Edin.)
Belfast
 „ Pirrie, J. M., A.B., and M.D., (T.C.D.) L.R.C.S.,
 (I.) *Belfast*
 „ Pollock, W., M.R.C.S., (Eng.) *Dundalk*
 „ Purdon, T. H., A.M., and M.B., (T.C.D.)
 L.R.C.S., (I.) *Belfast*
 „ Ross, Richard, M.D., (St. And.) L.R.C.S., (I.)
Belfast
 „ Scott, W., M.D., and F.R.C.P., (Edin.) M.R.C.S.,
 (Eng.) *Aughnacloy*
 „ Smith, James W. T., M.D., (Q.U.I.) and L.R.C.S.,
 (I.) *Belfast*
 „ Smyth, John, L.R.C.S., (I.) *Belfast*
 „ Stewart, Horatio A., M.D., (Glas.) L.R.C.S., (I.)
Prof Queen's College, Belfast
 „ Stronge, J. W., A.B., & M.B., (T.C.D.) L.R.C.S.,
 (I.) *Belfast*
 „ Thetford, William W., M.R.C.S., (Eng.)
Strangford
 „ Thompson, Thomas, M.D., (Glas.) *Belfast*
 „ Thomson, Henry, M.R.C.S., (Eng.) *Ballylesson*
 „ Young, G. H., M.D., (Glas.) L.R.C.S., (I.)
Hollywood
 Oct. 29, Breakey, John, M.D., (Q.U.I.) M.R.C.S.,
 (Eng.) R.N. *Belfast*
 „ „ Kidd, Abraham, M.D., (Aberd.) M.R.C.S., (Eng.)
Ballymena
 „ „ Moore, William, A.B., and M.B., (T.C.D.)
 L.R.C.S., (I.) *Ballymoney*
 Nov. 19, Boyd, Samuel, L.R.C.S., (Edin.) *Portaferry*
 „ „ Russell, Philip, M.B., (T.C.D.) L.R.C.S., (I.)
Bangor
 26, Macaw, James, M.D., and L.R.C.S., (Edin.)
Bushmills
 „ „ M'Kibben, Robert, M.R.C.S., (Eng.) *Belfast*
 Dec. 3, Kellett, Edward Y., L.R.C.S., (I.) *Ballinderry*
 „ 10, Campbell, John, M.D., (St. Andrews.)
 M.R.C.S., (Eng.) *Lisburn*
 „ „ Kelso, J. J., M.D., and C.M., (Glas.) *Lisburn*
 „ „ M'Cartney, John, L.R.C.S., (I.) *Lisburn*
 „ 17, Croker, George, F.R.C.S., (I.) *Hillsborough*
 „ „ Musgrave, Samuel, L.R.C.S., (Edin.) *Lisburn*
 „ „ M'Cleery, James, L.R.C.S., (I.) *Belfast*
 „ 24, Burton, Bindon, M.R.C.S., (Eng.) *Ballinderry*
 „ „ Knox, Alex., M.D., (Edin.) *Strangford*
 „ „ Playne, Thomas, M.D., (Q.U.I.) M.R.C.S., (Eng.)
Dunmurry
 „ „ Thomson, John, M.R.C.S., (Eng.) *Belfast*
 1854.
 Jan. 7, Black, C. S., M.D., (Glas.) L.R.C.S., (I.) *Belfast*
 „ „ Forsythe, J., M.D., (Glas.) L.R.C.S., (Edin.)
Cullmore
 „ 14, Deverell, W. P., M.D., (Glas.) L.R.C.S., (I.)
Dromore
 „ „ Johnston, Robert, M.D., (Glas.) *Newry*
 Jan. 14, Madden, T., L.F., Ph., and S., (Glas.)
Portglenone
 „ „ Rogan, W. F., A.B., M.B., (T.C.D.) L.R.C.S.,
 (Edin.) and (I.) *Londonderry*
 „ „ Ross, Arthur, M.D., and L.R.C.S., (Edin.)
Ballymena
 „ 21, Brabazon, Philip E., A.B., (T.C.D.) F.R.C.S., (I.)
Downpatrick
 „ „ Forde, Robert, M.D., (Glas.) L.R.C.S., (I.)
Downpatrick
 „ „ M'Bride, Henry, C.M., (Glas.) *Gilford*
 „ „ White, W. M., M.D., (Glas.) M.R.C.S., (Eng.)
 L.R.C.S., (I.) *Downpatrick*
 „ 28, Catherwood, W. H., M.D., (Edin.) *Donaghadee*
 „ „ Hay, Joseph, L.R.C.S., (I.) *Rathfriland*
 „ „ Shaw, William, L.R.C.S., (I.) *Ballynahinch*
 „ „ Smith, John, A.M., M.D., (Glas.) *Newcastle*
 Feb. 4, Murray, Robert, L.R.C.S., (I.) *Rockcorry* (Died
7th February.)
 „ 11, M'Gowan, John, M.D., (Edin.) *Carrickfergus*
 „ 18, Dickson, James, M.D., (Q.U.I.) M.R.C.S., (Eng.)
Ballynahinch
 „ 25, Evans, William, M.D., (Q.U.I.) M.R.C.S., (Eng.)
Downpatrick
 Mar. 4, Nixon, George, M.D., (Gott.) L.R.C.S., (I.)
Antrim
 „ 11, Graham, John, M.D., and L.R.C.S., (Edin.)
Belfast
 „ „ Harrison, J. W., M.R.C.S., (Eng.) *Ardglass*
 „ „ Stewart, Robert, M.D., (Glas.) *Belfast*
 „ 18, Blakely, Samuel, L.F., Ph., and S., (Glas.)
Aughnacloy
 „ „ Fleming, Hans, M.D., (St. Andrews.) L.R.C.S.,
 (I.) *Carrickmacross*
 „ „ Savage, John, M.R.C.S., (Eng.) *Newry*
 Apr. 8, Greenfield, William, M.D., (Q.U.I.) *Hollywood*
 May 13, Rea, Samuel, L.F., Ph., and S., (Glas.) *Belfast*
 „ 20, Read, Thomas, A.B., and M.B., (T.C.D.)
 L.R.C.S., (I.) *Belfast*

Belfast Clinical and Pathological Society
Lists of Members

LIST OF MEMBERS 1854/55
ARRANGED ACCORDING TO DATE OF ADMISSION.

ORIGINAL:—

- | | |
|--|---|
| <p>„ Aickin, John, M.R.C.S., (Eng.) Belfast</p> <p>„ Armstrong, J. S., M.R.C.S., (Eng.) Royal North
Down Rifles, Belfast</p> <p>„ Beck, J. W., C.M., and M.D., (Glas.) Belfast</p> <p>„ Browne, John, M.D., and L.R.C.S., (Edin.)
Dundalk</p> <p>„ Browne, Samuel, R.N., M.R.C.S., (Eng.) Belfast</p> <p>„ Brunker, E. J., L.R.C.S., (I.) M.D., (Edin.)
Dundalk</p> <p>„ Bryce, Robert, M.D., (Glas.) Belfast</p> <p>„ Bryson, J. W., M.D., and L.R.C.S., (Edin.)
Belfast, (<i>died 8th March 1855.</i>)</p> <p>„ Burden, W., M.D., and C.M., (Glas.) Professor
Queen's College, Belfast</p> <p>„ Callan, Jos., M., M.D., (Glas.) L.R.C.S., (I.)
Dundalk</p> <p>„ Carlisle, Hugh. A.M., and M.D., (T.C.D.), Prof.
Queen's College, Belfast</p> <p>„ Dickson, J. S., L.F., Ph., and S., (Glas.) Belfast.</p> <p>„ Ferguson, J. C. A.M., and M.B., (T.C.D.)
Professor Queen's College, Belfast</p> <p>„ Ferres, Charles, L.R.C.S. (Edin.) Larne</p> <p>„ Frame, James, L.F., Ph., and S., (Glas.)
Comber</p> <p>„ Gelston, James, L.F., Ph., and S., (Glas.)
Comber</p> <p>„ Graves, Henry, A.B., and M.B., (T.C.D.)
F.R.C.S., (I.) Cookstown</p> <p>„ Halliday, J. H., M.D., (Glas.) L.R.C.S., (I.)
Belfast</p> <p>„ Hamilton, T. W., M.D., (Glas.) F.R.C.S., (I.)
Belfast</p> <p>„ Hanna, H.H., M.R.C.S., (Eng.) Belfast.</p> <p>„ Jamison, David, M.D., L.R.C.S., (Edin.)
Newtownards</p> <p>„ Johnston, H. M., L.R.C.S., (T.) Belfast</p> <p>„ Lynch, P., M.D., (Glas.) M.R.C.S., (Eng.) Belfast</p> <p>„ MacLaughlin, W. R., M.D., and L.R.C.S., (I.)
M.R.C.S. (Eng.) Lurgan</p> <p>„ Malcolm, A. G., M.D., and L.R.C.S., (Edin.)
Belfast</p> <p>„ Marshall, A., M.D., (Glas.) L.R.C.S., (Edin.)
Belfast</p> <p>„ Mawhinney, James, M.R.C.S., (Eng.) Belfast</p> <p>„ Moore, James, M.D., (Edin.) M.R.C.S., (Eng.)
Belfast</p> <p>„ Moreland, Hugh, M.D., and L.F., Ph., and S.,
(Glas.) Belfast</p> <p>„ Murney, H., M.D., (Edin.) M.R.C.S., (Eng.)
Dem. Queen's College Belfast</p> <p>„ M'Gee, W., M.D., (Edin.) Surg., R.N., Belfast</p> <p>„ Patterson, James, M.D., and L.R.C.S., (Edin.)
Belfast</p> | <p>„ Pirrie, J. M., A.B., and M.D., (T.C.D.) L.R.C.S.,
(I.) Belfast</p> <p>„ Pollock, W., M.R.C.S., (Eng.) Dundalk</p> <p>„ Purdon, T. H., A.M., and M.B., (T.C.D.)
L.R.C.S., (I.) Belfast</p> <p>„ Ross, Richard, M.D., (St. And.) L.R.C.S., (I.)
Belfast</p> <p>„ Scott, W., M.D., and F.R.C.P., (Edin.) M.R.C.S.,
(Eng.) Aghnacloy</p> <p>„ Smith, James, W. T., M.D., (Q.U.I.) and
L.R.C.S., (I.) Belfast</p> <p>„ Smyth, John, L.R.C.S., (I.) Belfast</p> <p>„ Stewart, Horatio A., M.D., (Glas.) L.R.C.S., (I.)
Prof. Queen's College, Belfast</p> <p>„ Stronge, J. W., A.B., and M.B., (T.C.D.) L.R.C.S.
(I.) Belfast</p> <p>„ Thetford, William W., M.R.C.S., (Eng.)
Strangford</p> <p>„ Thompson, Thomas, M.D., (Glas.) Belfast</p> <p>„ Thomson, Henry, M.R.C.S., (Eng.) Ballylesson</p> <p>„ Young, G.H., M.D., (Glas.) L.R.C.S., (I.)
Holywood</p> <p>Oct. 29, Kidd, Abraham, M.D., (Aberd.) M.R.C.S.,
(Eng.) Ballymena</p> <p>„ „ Moore, Wm, A.B., and M.B., (T.C.D.) L.R.C.S.,
(I.) Ballymoney</p> <p>Nov. 19, Boyd, Samuel, L.R.C.S., (Edin.) Portaferry</p> <p>„ „ Russell, Philip, M.B., (T.C.D.) L.R.C.S., (I.)
Bangor</p> <p>„ 26, Macaw, James, M.D., and L.R.C.S., (Edin.)
Bushmills</p> <p>Dec. 10, Campbell, John, M.D., (St. And.) M.R.C.S.,
(Eng.) Lisburn</p> <p>„ 17, Croker, George, F.R.C.S., (I.) Hillsborough</p> <p>„ „ Musgrave, Samuel, L.R.C.S., (Edin.) Lisburn</p> <p>„ M'Cleery, James, L.R.C.S., (I.) Belfast</p> <p>„ 24, Burton, Bindon, M.R.C.S., (Eng.) Ballinderry</p> <p>„ „ Knox, Alexander, M.D., (Edin.) Strangford</p> <p>„ „ Playne, Thomas, M.D., (Q.U.I.) M.R.C.S., (Eng.)
Dunmurry</p> <p>Dec. 24, Thomson, John, M.R.C.S., (Eng.) Belfast
1854.</p> <p>Jan. 7, Black, C. S., M.D., (Glas.) L.R.C.S., (I.) Belfast</p> <p>„ „ Forsythe, J., M.D., (Glas.) L.R.C.S., (Edin.)
Cullmore</p> <p>„ „ Deverell, W. P., M.D., (Glas.) L.R.C.S., (I.)
Dromore</p> <p>„ „ Johnston, Robert, M.D., (Glas.) Newry</p> <p>„ „ Madden, T., L.F., Ph., and S., (Glas.)
Portglenone</p> <p>„ „ Rogan, W. F., A.B., and M.B., (T.C.D.) L.R.C.S.,
(Edin.) and (I.) Londonderry</p> <p>„ „ Ross, Arthur, M.D., and L.R.C.S., (Edin.)
Ballymena</p> <p>„ „ Brabazon, Philip E., A.B., (T.C.D.) F.R.C.S., (I.)
Downpatrick</p> |
|--|---|

Records of the Medical Societies of Belfast 1822–1884

- „ „ Forde, Robert, M.D., (Glas.) L.R.C.S., (I.)
 Downpatrick
 „ „ M'Bride, Henry, C.M., (Glas.) Gilford
 „ 29, Catherwood, W. H., M.D., (Edin.)
 Donaghadee
 „ „ Smith, John, A.M., and M.D., (Glas.)
 Newcastle
 Feb. 11, M'Gowan, John, M.D., (Edin.) Carrickfergus
 „ 16, Dickson, James, M.D., (Q.U.I.) M.R.C.S., (Eng.)
 Ballynahinch
 Mar. 4, Nixon, George, M.D., (Gott.) L.R.C.S., (I.)
 Antrim
 „ 11, Graham, John, M.D., and L.R.C.S., (Edin.)
 Belfast
 „ „ Stewart, Robert, M.D., (Glas.) Belfast
 „ 18, Blakely, Samuel, L.F., Ph., and S., (Glas.)
 Aughnacloy
 „ „ Savage, John, M.R.C.S., (Eng.) Newry
 Apr. 8, Greenfield, Wm., M.D., (Q.U.I.) Holywood
 May 20, Read, Thomas, A.B., and M.B., (T.C.D.)
 L.R.C.S., (I.)
 Nov. 4, Gordon, Alex., M.D., and L.R.C.S., (Edin.)
 Professor Queen's College, Belfast
 „ „ Clarke, J. H., A.M., and M.B., L.R.C.S., (I.)
 Newcastle
 „ „ Holmes G. S., M.D., (Glas.) M.R.C.S., (Eng.)
 Glenarm
 „ „ M'Gowan. R., L.F., Ph., and S., (Glas.)
 Warrenpoint
 „ 11, Dill, R. F., M.D., (Edin.) M.R.C.S., (Eng.) Belfast
 „ „ M'Donnell, R., M.B., and F.R.C.S., (I.) Dublin
 „ „ Wheeler, T. K., M.D., (Q.U.I.) L.R.C.S., (Eng.)
 Belfast
 „ „ Davidson, J., M.D., (Glas.) Belfast
 „ „ Andrews, T., M.D., (Edin.) M.R.I.A.,
 Vice-President Queen's College, Belfast
 Nov. 11, M'Mechan, J., M.D., and L.R.C.S., (Edin.)
 Whitehouse
 „ „ Hannay, R. S., M.D., (Edin.) M.R.C.S., (Eng.)
 Lurgan
 „ 18, Lynn, Jos. M., M.D., (Glas.) L.R.C.S., (Eng. and
 I.) Markethill
 „ „ Hume, G. A., M.D., (Glas.) L.R.C.S., (Eng.)
 Crumlin
 „ „ Warwick, W., M.R.C.S., (Eng.) Belfast
 „ 25, M'Cormac, H., M.D., (Edin.) Belfast
 Dec. 2, Johnston, Aug., M.B., and M.R.C.S., (Eng.)
 Hawkshead, Windermere
 „ „ Johnston, Ben., M.B., and F.R.C.S., (I.)
 Ramelton
 „ 9, Patton, Alex., L.R.C.S., (I.) Tandragee
 „ „ Lamont, Æ., F.R.C.S., (T.) Belfast
 „ „ Clarke, J., M.R.C.S., (Eng.) Belfast
 „ „ MacMullan, C. C., M.R.C.S., (Eng.) Belfast
 „ „ Heeney, F., M.D., (Glas.) Belfast
1855.
 Jan. 20, Taylor, W., L.F., Ph., and S., (Glas.)
 Ballymoney
 „ 27, Gibson, J., L.F., Ph., and S., (Glas.), Killileagh
 Feb. 24, Barnett, J., M.R.C.S., (Eng.) Moneymore
 Mar. 10, Anderson, J., L.R.C.S., (I.) Kilkeel
 „ 24, Black, W., C.M., (Glas.) Ballymena.
 Apr. 14, Maxwell, J., M.D., (Glas.) L.R.C.S., (Edin.)
 Waterford
 „ „ Clugston, W., M.D. and L.R.C.S., (Edin.)
 Ballyclare
 „ 28, Lochrane, Edward, L.R.C.S., (Edin.)
 Middletown

Belfast Clinical and Pathological Society
Lists of Members

LIST OF MEMBERS 1854/55
ARRANGED ACCORDING TO RESIDENCE.

45 RESIDENT:—

Doctors J. Aickin
Andrews (Prof.)
Beck
Black
Browne
Bryce
Bryson
Carlile (Prof.)
Clarke
Davidson
Dickson
Dill
Ferguson (Prof. and President)
Gordon (Prof.)
Graham
Hailey
Halliday (Treasurer)
Hamilton
Hanna
H. M. Johnston (Joint Secretary)
Lamont
Lynch
M'Mullan
Malcolm (Joint Secretary)
Mawhinney
Moore (Vice-President)
Moreland
Murney
M'Cleery
M'Gee
M'Cormac
Patterson
Pirie (Vice-President)
T. H. Purdon (Vice-President)
Read
Ross
Smyth
R. Stewart (Vice-President)
H. A. Stewart (Prof.)
Stronge
T. Thompson
J. Thomson
Wales
Warwick
Wheeler

59 NON-RESIDENT:—

Co. ANTRIM 16

Doctors Nixon, *Antrim*
Burton, *Ballinderry*
Clugston, *Ballyclare*
Ross, *Ballymena*
Kidd, „

Black, *Ballymena*
Moore, *Ballymoney*
Taylor, „
Mccaw, *Bushmills*
M'Gowan, *Carrickfergus*
Hume, *Crumlin*
Playne, *Dunmurry*
Holmes, *Glenarm*
Marshall, *Greenisland*
Ferris, *Larne*
M'Mechan, *Whitehouse*

Co. ARMAGH 5

Doctors M'Laughlin (Vice-President), *Lurgan*
Hannay, „
Lynn, *Markethill*
Lochrane, *Middleton*
Patton, *Tandragee*

Co. DONEGAL 1

Doctor B. Johnston, *Ramelton*

Co. DOWN 26

Doctors Thompson, *Ballylesson*
Dickson, *Ballynahinch*
Russell, *Bangor*
Frame, *Comber*
Gelston, „
Catherwood, *Donaghadee*
Brabazon, *Downpatrick*
Forde, „
Deverell, *Dromore*
M'Bride, *Gilford*
Croker, *Hillsborough*
Young (Vice-President), *Holywood*
Greenfield, „
Anderson, *Kilkeel*
Campbell, *Lisburn*
Clarke, *Newcastle*
Smith, „
Jamison, *Newtownards*
Armstrong, „
Gibson, „
Johnston, *Newry*
Savage, „
Boyd, *Portaferry*
Knox, *Strangford*
Thetford, „
M'Gowan, *Warrenpoint*

Co. DUBLIN 1

Doctor R M'Donnell, *Dublin*

Co. LONDONDERRY 4

Doctors Forsythe, *Culmore*
Rogan, *Derry*
Barnett, *Moneymore*
Madden, *Portglenone*

Co. LOUTH 2

Doctors Browne, *Dundalk*
Pollock, „

Co. TYRONE 3
 Doctors W. Scott, *Aughnacloy*
 Blakely, "
 Graves, *Cookstown*

ENGLAND 1
 Doctor A. Johnston, *Windermere*.

Analysis of Changes in the Roll of Members

Total Members remaining on Roll at October, 1854, 95. Admitted during Session, 30 (this in Nov., 15; in Dec., 7; in Jan., 2; in Feb., 1; in March, 2; in April, 3). Tendered resignation, 6; Resigned by default, 8; Went abroad, 6; Died, 1; Remaining as Nett Number on Roll, at end of Session, 104.

LIST OF MEMBERS 1855/56

I. HONORARY

William Stokes, M.D., Reg. Prof. of
 Physic, T.C.Dublin
 Robert W. Smith, F.R.C.S.I., M.D.,
 Prof. of Surgery, T.C.Dublin
 J. Moore Neligan, Hon. M.D., T.C.D.,
 Fell. King's & Queen's Coll. of
 Phys. Dublin

II. CORRESPONDING

Antrim G.M. O'Connor, M.D.
 Armagh Thos. Cuming, M.D.
 Cavan Chas. Halpin, M.D.
 Donegal R. Little, M.D.
 Down A. Erskine, M.D.
 Fermanagh W. Ovenden, M.D.
 Londonderry T.H. Babington, M.D.
 J.C.L. Carson
 Louth J. Browne, M.D.
 Monaghan A.K. Young, M.D.
 Tyrone H. Thompson, M.D.
 Foreign Fr. Berthold, Teplitz, Bohemia

III. RESIDENT ORDINARY

Mr. Aickin
 Dr. W. Aickin
 Professor Andrews, Q.C.B.
 Dr. Beck
 Mr. Browne, R.N., V.P.
 Dr. Bryce
 Professor Carlisle, Q.C.B.
 Dr. Corry
 Dr. Cuming, Anal. Com.
 Professor Dickie, Q.C.B.
 Dr. Dill, Council
 Dr. Drennan
 Professor Ferguson, Q.C.B., V.P.
 Professor Gordon, Q.C.B.
 Mr. Hanna
 Mr. Harkin
 Dr. Halliday, Treas.
 Mr. Heard
 Dr. Heeney
 M.R. H. M. Johnston, Sec.
 Dr. Malcolm, V.P., Anal. Com.
 Dr. Moore, Council
 Dr. Moreland
 Mr. Mulholland
 Dr. Murray
 Dr. Daniel Murray
 Dr. Murney, Council, Anal. Com.
 Mr. McCleery
 Dr. McCormac
 Dr. McGee, Pres. elect
 Dr. Patterson, Council

Belfast Clinical and Pathological Society
Lists of Members

Dr. Pirrie, Council
 Dr. T. H. Purdon, V.P., Anal. Com.
 Dr. Seaton Reid
 Dr. Thomas Reade
 Dr. Ross, Secretary
 Dr. Smith
 Mr. John Smith
 Dr. R. Stewart, V.P.
 Professor Stewart, Q.C.B., V.P.
 Dr. Stronge
 Dr. Thomas Thompson
 Mr. Wales
 Mr. Warwick
 Dr. Wheeler

Tandragee Dr. Patton
 do Dr. McGowan
 Tynan
 County Cavan
 Cavan see corr. members
 County Donegal
 Lifford see corr. members

IV. NON-RESIDENT ORDINARY

County Antrim

Aghalee Mr. Burton
 Ahoghill
 Antrim Dr. Nixon
 do Dr. Taggart
 Ballinderry
 Ballycastle see corr. members
 Ballyclare Dr. Clugston,
 Ballymena Dr. Ross,
 do Dr. Kidd
 do Dr. Black
 Ballymoney Dr. Latham
 do Dr. Taylor
 Bushmills Dr. Mccaw
 Carnmoney
 Carrickfergus Dr. M'Gowan
 do Dr. Forsythe
 Crumlin Dr. Hume
 Cushendall Dr.
 Dunmurry Dr. Playne
 Glenarm Dr. Holmes
 Larne Mr. Ferris
 Randalstown
 Rasharkin Mr. Diamond
 T'patrick Dr. Graham
 Toomebridge

County Armagh

Armagh Dr. T. Cuming
 B'watertown
 Crossmaglen
 Keady
 Loughgall
 Lurgan Dr. M'Laughlin, V.P.
 do Dr. Hannay
 Markethill
 Middleton
 N'hamilton
 Portadown
 Poyntzpass
 Richill Dr. Davidson

LIST OF MEMBERS
OF THE
BELFAST CLINICAL & PATHOLOGICAL SOCIETY.
(Taken from the Transactions 1859/60.)

Aickin, W., M.D.
Andrews, Professor, M.D.
Anderson, J. C., Surgeon (Kilkeel).
Arnold, Wilberforce, Surgeon.

Babington, T. H., M.B. (Londonderry)
Blakely, S., Surgeon (Aughancloy).
Browne, Samuel, Surgeon, R.N.
Brown, W., M.D. (Derry).
Brunker, E. J., M.D. (Dundalk).
Bryce, R., M.D.
Buckingham, J., Surgeon.

Carson, J. C. L., M.D. (Coleraine).
Cavin, W., M.D., (Coleraine).
Clugston, W. A., M.D. (Ballyclare).
Connor, —, Surgeon (Newry).
Corry, T. C. S., M.D.
Crothers, R., M.D. (Moy).
Cuming, James, M.D.

Diamond, C., Surgeon (Rasharkin).
Dickie, Professor, M.D.
Dickson, J., M.D. (Ballynahinch).
Dill, R. F., M.D.
Drennan, J. S., M.D.
Dundee, J., M.D. (Carmoney).
Dunlop, A., M.D. (Holywood).

Ferguson, Professor, M.B.
Ferris, C., Surgeon (Lame).
Forsyth, J. M., (Culmore).
Frame, J., Surgeon (Comber).

Gordon, Professor, M.D.
Graham, J., M.D. (Templepatrick).
Graves, H., M.B. (Cookstown).
Greenfield, —, M.D. (Holywood),

Halliday, J. H., M.D.
Hanna, H., Surgeon.
Harkin, A., M.D.
Hawthorne, J., Surgeon (Banbridge).
Heeney, F., M.D.
Hodges, Professor, M.D.
Hume, G. A., M.D. (Crumlin).
Hunter, S., M.D.

Jamieson, D., M.D. (Newtownards).
Jeffres, —, Surgeon (Clough).
Johnston, H. M., Surgeon.
Johnston, Aug., Surgeon (Lancashire)

Kelso, J. J., M.D. (Lisburn).
Kennedy, Surgeon (Comber).
Knox, A., M.D. (Strangford).

M'Bride, H., Surgeon, (Gilford).
M'Caldin, J. J., M.D. (Coleraine).
M'Cleery, J. C., Surgeon.
M'Clement, R. C., Surgeon, R.N.
M'Clelland, R., M.B. (Banbridge).
M'Cormac, W., M.D.
M'Gee, W., M.D.
M'Gee, M., M.D.
M'Keag, D., M.D. (Coleraine).
M'Laughlin, W. R., M.D. (Lurgan).
M'Mechan, J., M.D. (Whitehouse).
M'Minn, F., M.D.
Macaw, J., M.D. (Bushmills).
Madden, F., Surgeon (Portglenone).
Mahood, G., M.D. (Enniskillen).
Mawhinney, J., Surgeon.
Moore, James, M.D.
Moore, W., Surgeon (Dungiven).
Moreland, H., M.D.
Motherell, J., M.D. (Castlederg).
Mulholland, C., M.D.
Murney, H., M.D.
Murray, D., M.D.
Musgrave, S., Surgeon (Lisburn).

Neligan, J. M., M.D. (Dublin), Hon. Mem.
Nixon, G., M.D., R.A.A.

O'Hare, Owen, M.D.

Patrick, W., Surgeon (Carrickfergus).
Patterson, J., M.D.
Patton, A., M.D. (Tandragee).
Pirrie, J. M., M.B.
Purdon, C. D., M.B.

Rea, H. P., Surgeon.
Reade, Thomas, M.B.
Reid, Professor, M.D.
Ross, R., M.D.
Rutherford, W., Surgeon (Anahilt).

Scott, W., M.D. (Aughnacloy).
Sharpe, R., M.D. (Coleraine).
Smith, R. W., M.D. (Dublin), Hon. Mem.
Smith, J. W. T., M.D.
Smyth, J., Surgeon.
Stewart, R., M.D.
Stokes, W., M.D. (Dublin), Hon. Mem.

Taggart, J., M.D. (Antrim).
Taylor, W., M.D. (Articlave, Coleraine)

Belfast Clinical and Pathological Society
Lists of Members

Thompson, H., Surgeon (Ballylesson).
Thompson, T., M.D.

Wales, G. F., M.B.
Warwick, W., Surgeon.
Weir, M., Surgeon (Dromore).
Wheeler, T. K., M.D.
White, Barnwell, M.D. (Derry).

LIST OF MEMBERS 1859/60
ARRANGED ALPHABETICALLY
WITH REGISTER OF THEIR ATTENDANCE
AT THE FIRST TWENTY-THREE MEETINGS.

Aickin, W., M.D.	6
Andrews, Professor, M.D.	
Anderson, J. C., Surgeon, (Kilkeel).	
Arnold, Wilberforce, L.K.Q.C.P.I.	5
Babington, T. H., M.B., (Londonderry).	
Blakely, S., Surgeon, (Aughnacloy).	
Browne, Samuel,* Surgeon, R.N., Ex-P.	16
Brown, W., M.D., (Derry).	
Brunker, E. J., M.D., (Dundalk).	
Bryce, R., M.D.	13
Buckingham, J., Surgeon.	
Carson, J. C. L., M.D., (Coleraine).	
Cavin, W., M.D., (Coleraine).	
Clugston, W. A., M.D., (Ballyclare).	
Conner, _ Surgeon, (Newry).	3
Corry, T. C. S., M.D.	5
Crothers, R., M.D., (Moy).	
Cuming, James, M.D., Hon. Sec.	17
Diamond, C., Surgeon, (Rasharkin).	
Dickie, Professor, M.D.	1
Dickson, J., M.D., (Ballynahinch).	
Dill, R. F., M.D., Mem. Council.	15
Drennan, J. S., M.D., Mem. Council.	3
Dundee, J., M.D., (Carnmoney).	
Dunlop, A., M.D., (Holywood).	4
Ferguson,* Professor, M.B.	14
Ferris, C.,* Surgeon, (Larne), V. Pres.	1
Forsyth, J., M.D., (Culmore).	
Frame, J., L.F.P.S., (Comber).	
Gordon,* Professor, M.D., V. Pres.	4
Graham, J., M.D., (Templepatrick).	
Graves, H.,* M.B., (Cookstown).	1
Greenfield, _ M.D., (Holywood).	
Halliday, J. H., M.D., Treasurer.	11
Hanna, H., Surgeon.	3
Harkin, A., M.D.	5
Hawthorne, J., Surgeon, (Banbridge).	
Heeney, F., M.D., Mem. Council.	9
Hodges, Professor, M.D.	
Hume, G. A., M.D., (Crumlin).	1
Hunter, S., M.D.	
Jamieson, D., M.D., (Newtownards).	
Jeffres, _ Surgeon, (Clough).	
Johnston, H. M., Surgeon, Mem. Council.	17
Johnston, Aug., Surgeon, (Lancashire).	

Records of the Medical Societies of Belfast 1822–1884

Kelso, J. J., M.D., (<i>Lisburn</i>).		Wales, G. F., M.B., Hon. Sec.	22
Kennedy, _ (<i>Comber</i>).		Warwick, W., Surgeon.	13
Knox, A., M.D., (<i>Strangford</i>).		Weir, M., Surgeon, (<i>Dromore</i>).	
		Wheeler, T. K., M.D.	
M ^o Bride, H., Surgeon, (<i>Gilford</i>).		White, Barnwell, M.D., (<i>Derry</i>).	
M ^o Caldin, J. J., M.D., (<i>Coleraine</i>).			
M ^o Cleery, J. C., Surgeon.	10		
M ^o Clelland, R., M.B., (<i>Banbridge</i>).			
M ^o Cormac, W., M.D.	7		
M ^o Gee, W., M.D.	17		
M ^o Keag, D., M.D., (<i>Coleraine</i>).			
M ^o Laughlin, W. R., * M.D., (<i>Lurgan</i>).	2		
M ^o Mechan, J., * M.D., (<i>Whitehouse</i>).	1		
M ^o Minn, F., M.D.	11		
Macaw, J., M.D., (<i>Bushmills</i>).			
Madden, F., Surgeon, (<i>Portglenone</i>).			
Mahood, G., M.D., (<i>Enniskillen</i>).			
Mawhinney, J., Surgeon.			
Moore, James, * M.D.	14		
Moore, W., Surgeon, (<i>Dungiven</i>).			
Moreland, H., M.D.			
Motherell, J., M.D., (<i>Castlederg</i>).			
Mulholland, C., M.D.	20		
Murney, H., M.D., Vice-Pres.	16		
Murray, D., M.D.	4		
Musgrave, S., Surgeon, (<i>Lisburn</i>).			
Neligan, J. M., M.D., (<i>Dublin</i>), Hon. Mem.			
Nixon, G., M.D., (<i>Antrim</i>).			
O'Hare, Owen, M.D.	3		
Patrick, W., Surgeon, (<i>Carrickfergus</i>).			
Patterson, J., M.D., Mem. Council.	19		
Patton, A., M.D., (<i>Tandragee</i>).			
Pirrie, J. M., * M.B., Mem. Council.	9		
Purdon, C. D., M.B.	2		
Rea, H. P., Surgeon.	16		
Reade, Thomas, * M.B., Vice-Pres.	5		
Reid, * Professor, M.D., President.	21		
Ross, R., M.D.	12		
Rutherford, W., Surgeon, (<i>Anahilt</i>).			
Scott, W., M.D., (<i>Aughnacloy</i>).	1		
Sharpe, R., M.D., (<i>Coleraine</i>).			
Smith, R. W., M.D., (<i>Dublin</i>), Hon. Mem.			
Smith, J. W. T., M.D.	2		
Smyth, J., Surgeon.	2		
Stewart, R., * M.D.	9		
Stokes, W., M.D., (<i>Dublin</i>), Hon. Mem.			
Taggart, J., M.D., (<i>Antrim</i>).			
Taylor, W., M.D., (<i>Articlam, Coleraine</i>).			
Thompson, H., Surgeon, (<i>Ballylesson</i>).	7		
Thompson, T., M.D.	8		

Those marked (*) thus, are, or have been,
Vice-Presidents.

Belfast Clinical and Pathological Society
Lists of Members

LIST OF MEMBERS 1860/61
ARRANGED ALPHABETICALLY
WITH REGISTER OF THEIR ATTENDANCE
AT THE TWENTY-FOUR MEETINGS.

Aickin, W., M.D., Hon. Sec.	16	Kelso, J. J., M.D., (<i>Lisburn</i>).	
Andrews, Professor, M.D.		Kennedy, _ (<i>Comber</i>).	
Anderson, J. C., Surgeon, (<i>Kilkeel</i>).		Knox, A., M.D., (<i>Strangford</i>).	
Arnold, Wilberforce, Surgeon, L.K.Q.C.P.I.		M'Bride, H., Surgeon, (<i>Gilford</i>).	
Babington, T. H.,* M.B., (<i>Londonderry</i>).		M'Caldin, J. J., M.D., (<i>Coleraine</i>).	
Blakely, S., Surgeon, (<i>Aughnacloy</i>).		M'Cleery, J. C., Surgeon.	2
Browne, Saml,* Surgeon, R.N., L.K.Q.C.P.I., M. Cncl.	14	M'Clelland, R., M.B., (<i>Banbridge</i>).	
Brown, W., M.D., (<i>Derry</i>).		M'Cormac, W., M.D., Hon. Sec.	21
Bryce, R.,* M.D., V.P.	13	M'Gee, W.,* M.D.	8
Buckingham, J., Surgeon.		M'Keag, D., M.D., (<i>Coleraine</i>).	
Burden, H., M.D.	1	M'Laughlin, W. R.,* M.D., (<i>Lurgan</i>).	4
Carson, J. C. L., M.D., (<i>Coleraine</i>).		M'Mechan, J.,* M.D., (<i>Whitehouse</i>).	2
Cavin, W., M.D., (<i>Coleraine</i>).		Macaw, J., M.D., (<i>Bushmills</i>).	
Clugston, W. A., M.D., (<i>Ballyclare</i>).		Mahood, G., M.D., (<i>Enniskillen</i>).	
Conner, _ Surgeon.		Mawhinney, J., Surgeon.	
Corry, T. C. S., M.D., Mem. Council.	2	Moore, D., M.D.	20
Cuming, James, M.D.	12	Moore, James,* M.D.	17
Diamond, C., Surgeon, (<i>Rasharkin</i>).		Moore, W., Surgeon, (<i>Dungiven</i>).	
Dickie, Professor, M.D.		Moreland, H., M.D.	
Dickson, J., M.D., (<i>Ballynahinch</i>).		Mulholland, C., M.D.	15
Dill, R. F., M.D., Mem. Council.	22	Murney, H.,* M.D.	14
Drennan, J. S., M.D., Mem. Council.	4	Murray, D., M.D.	12
Dundee, J., M.D., (<i>Carnmoney</i>).	1	Musgrave, S., Surgeon, (<i>Lisburn</i>).	
Dunlop, A.,* M.D., V.P., (<i>Holywood</i>).	4	Neligan, J. M., M.D., (<i>Dublin</i>), Hon. Mem.	
Ferguson,* Professor, M.B.	19	O'Hare, Owen, M.D.	
Ferris, C.,* Surgeon, (<i>Larne</i>).		Patrick, W., Surgeon, (<i>Carrickfergus</i>).	
Forsyth, J., M.D., (<i>Culmore</i>).		Patterson, J.,* M.D., Vice-Pres.	23
Frame, J., L.F.P.S., (<i>Comber</i>).		Pirrie, J. M.,* M.B., Vice-Pres.	7
Gordon,* Professor, M.D., Pres.	12	Purdon, C. D.,* M.B.	
Graham, J., M.D., (<i>Templepatrick</i>).		Purdon, H., M.D., Jun.	6
Graves, H.,* M.B., V.P., (<i>Cookstown</i>).	1	Rea, H. P., Surgeon.	12
Greenfield, _ M.D., (<i>Holywood</i>).		Reade, Thomas,* M.B.	9
Halliday, J. H., M.D., Treasurer.	10	Reid,* Professor, M.D., Ex-Pres.	19
Hanna, H., Surgeon.		Ross, R., M.D.	1
Harkin, A., M.D.		Rutherford, W., Surgeon, (<i>Anahilt</i>).	
Hawthorne, J., Surgeon, (<i>Banbridge</i>).		Scott, W., M.D., (<i>Aughnacloy</i>).	1
Heeney, F., M.D.		Sharpe, R., M.D., (<i>Coleraine</i>).	
Hodges, Professor, M.D.		Smith, R. W., M.D., (<i>Dublin</i>), Hon. Mem.	
Hume, G. A., M.D., (<i>Crumlin</i>).		Smith, J. W. T., M.D.	
Hunter, S., M.D.		Smyth, J., Surgeon.	
Jamieson, D., M.D., (<i>Newtownards</i>).		Stewart, R.,* M.D.	9
Jeffres, _ Surgeon, (<i>Clough</i>).		Stokes, W., M.D., (<i>Dublin</i>), Hon. Mem.	
Johnston, H. M., Surgeon, Mem. Council.	22	Taggart, J., M.D., (<i>Antrim</i>).	
Johnston, Aug., Surgeon, (<i>Lancashire</i>).		Taylor, W., M.D., (<i>Articlave, Coleraine</i>).	
		Thompson, H., Surgeon, (<i>Ballylesson</i>).	10
		Thompson, T., M.D.	2
		Wales, G. F., M.B.	7
		Warwick, W., Surgeon.	15
		Weir, M., Surgeon, (<i>Dromore</i>).	

Wheeler, T. K., M.D.

1

White, Barnwell, M.D., (Derry).

Those marked (*) thus, are, or have been,
Vice-Presidents.

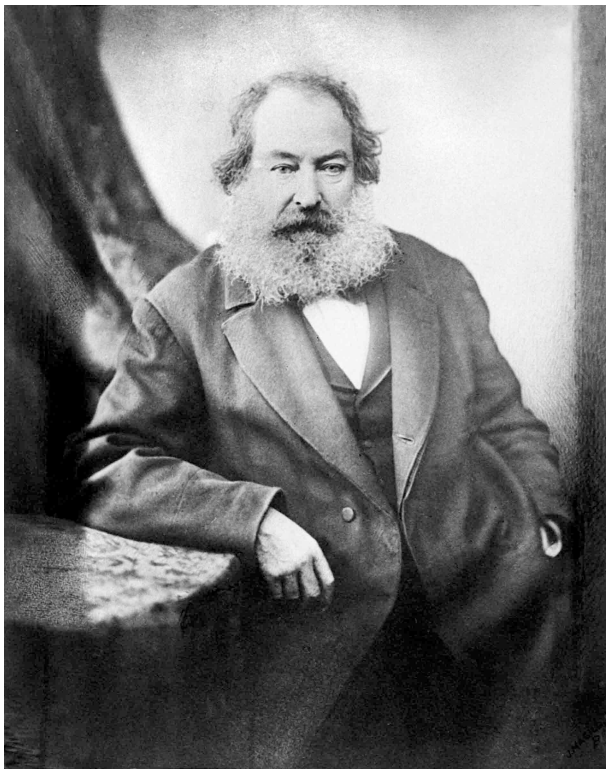
Presidents' Photographs



John Creery Ferguson



Andrew George Malcolm



James Moore



Thomas Henry Purdon

Records of the Medical Societies of Belfast 1822–1884
Presidents' Photographs



James Seaton Reid

Records
Of the
Ulster Medical Protective Association

1859–1862

INTRODUCTION

The Ulster Medical Protective Association was set up in 1859 with the objects “to protect the interests of the profession, in the admission of its members; to sustain the status of qualified Practitioners, and to watch over, and, if desirable, to promote such legislative measures as may seem generally beneficial.”

Unlike a modern body such as the Canadian Medical Protective Association, it did not offer any indemnity to the individual practitioner.

The Belfast Medical Society had taken an interest in wider professional matters and in the seven sessions up to April 1859 had considered the reform of the profession, the Medical Charities Act, the standard of professional education for the medical officers of the Navy, Dr. Gay's dismissal from the Royal Free Hospital, London,¹ and the activities of the Irish Medical Association. It had joined the latter in October 1855 and paid the annual subscription of one guinea for at least that year and the following.

That it was the Society's intention to continue in these activities is shown by Surgeon Browne's remarks in his presidential address in June 1857 in which he said “Should the necessity again arise, as it likely will, this association will still take the lead in contending for our common interests, and in arousing the spirit of our brethren to the assertion of our inalienable rights.”² Despite this, only two years later Browne was taking the lead in setting up the Ulster Medical Protective Association and it is likely that he and his fellow-promoters could see that having a separate body with the potential for a wider membership would allow them greater freedom of action.

The original records of the Association are missing but many of its meetings were reported in the newspapers of the day and these have been extracted and are placed below in chronological order.

The reports get briefer as time goes on and cease after the annual meeting on 9th May 1861. The reason for this is not apparent: perhaps the Association lost momentum, perhaps it no longer wanted the publicity or perhaps it was no longer deemed newsworthy. That it was not dissolved altogether is

shown in the newspaper reports of Professor J. C. Ferguson's presidential address to the Ulster Medical Society in 1862 where it was acknowledged that the Ulster Medical Protective Association had joined with the Belfast Medical Society and the Belfast Clinical and Pathological Society to form the new Society; and Dr. Robert Esler's comments in 1886 that the Association was still active up until the amalgamation and stating that its last meeting was in May 1862.¹

There are two references after 1862 which suggest that even though the association amalgamated with the Ulster Medical Society, it still had some residual autonomy. The first is a comment by Dr J. S. Drennan in his presidential address of 1866 in which he says “Those, however, who may wish to enforce the law against unqualified practitioners, will find facilities for doing so in the Medical Protective Society, which is amalgamated with our own.”² The second is a proposal by the Medical Officers of Banbridge Union that they should send copies of some resolutions dated 21 May 1868 to the “Ulster Medical Protective Association”.³

The Ulster Medical Protective Association amalgamated with the Belfast Medical Society and the Belfast Clinical and Pathological Society to form the Ulster Medical Society.

¹ [See page 159]

² [See page 178.]

¹ [See page 961.]

² [See page 1064.]

³ [Northern Whig, Belfast 1 June 1868.]

TO THE MEMBERS OF THE
MEDICAL PROFESSION IN ULSTER.
Dublin Medical Press July 20 1859

Gentlemen and Brethren—The time has arrived when it becomes our imperative duty to wipe away a reproach that has long been attached to our profession, and to overcome that *vis inertia* which has rendered inoperative our inherent strength. This is to be done alone by union and hearty cooperation.

In Great Britain and several districts of Ireland, medical men have formed themselves into protective associations, and thus, already, have achieved considerable good, as every one who has watched the progress of medical reform must have observed. We might instance the amendments effected in the Medical Registration and Vaccination Acts, and the successful opposition given to several intended legislative measures, all of which would, more or less, have interfered with the rights of our profession. We might also refer to the concessions recently granted to the medical officers of the army and navy, and the contemplated improvements in the English Poor-law Administration, as severally indicating the value of the determined, persevering, and united efforts in the attainment of any claim based upon undeniable rights, and carrying with it popular sympathy—a sympathy, we may remark, which is ever afforded to any cause which rests its demands upon unquestionable justice.

No reform can spontaneously take place; the aggrieved parties themselves must seek to have their grievances removed, hence the medical profession should not imagine that the disabilities under which they undoubtedly labour can be remedied, unless they take not only the first, but the most energetic steps, and act with unanimity and perseverance. Inasmuch as there are professional wrongs, and that hearty coöperation is absolutely necessary to have them redressed, and seeing, likewise, what has been done by united action in other places—so much to their honour and credit—surely, it is not only prudent, but our imperative duty, to join with and assist our brethren in other districts of Ireland and in England in prosecuting our just claims, and in protecting those rights which every member should earnestly prize, and with which the usefulness, the respectability, and the influence of the profession are so intimately connected. With these views, therefore, a society—“The Ulster Medical Protective Association”—has been formed; a provisional committee has been appointed; a code of rules has been framed. In its name, we earnestly solicit the hearty coöperation of the medical practitioners of the North of Ireland, and invite them to enrol themselves members of the Ulster Protective Association.

And here it may be necessary to explain, that, while this association is quite independent of the

Belfast Medical and Pathological Societies, it cannot in any measure, be antagonistic to them. They are principally intended to foster and stimulate professional and scientific pursuits. The new association is entirely a protective one, desirous of enrolling in its ranks every registered practitioner of Ulster, and designed to act in concert with the Irish Medical Association in all matters affecting the general welfare of the profession. Such an association is urgently demanded. Disunion has caused our naturally inherent strength to be inoperative; apathy has allowed our rights to be disregarded, trampled on, or wrested from us. Jealousies have not only lessened our influence, otherwise powerful but have even injured us with the public, so deeply our debtor; for it is obvious that just in proportion as we act with harmony and maintain our position, so will our worth and status be valued and recognised.

The beneficial operations of a Medical Protective Association are not confined to any branch or class of the profession—they alike extend to the highest and reach the humblest member. Every one is concerned, directly or indirectly, in all matters that affect the general interests of the body; and it is, therefore, the solemn duty of all members to see that nothing shall be done which can interfere with its usefulness, honour, or influence. The best interests of society, as well as our personal advantage, demand this individual watchfulness—this coöperation; for it may be justly assumed that, whatever elevates and improves our profession confers a benefit upon the community at large.

We trust we have said enough to induce every person whom we address to join our association; and, as we feel satisfied that it is his paramount duty to do so, we look forward with confidence to the time, not far distant, when the entire profession shall be united in the furtherance of our common cause—then, and not till then, shall we be able to contend successfully for our inalienable rights—then, when the honour and importance of our body are maintained by ourselves, the community must assign to us our proper status, and our usefulness and our services shall be duly estimated and adequately acknowledged.

J. C. FERGUSON, A.M., M.B., Chairman of Prov. Com.
SAMUEL BROWNE, M.R.C.S.E., Secretary, Pro tem
Belfast, June 30th, 1859.

RULES OF THE ASSOCIATION.
Dublin Medical Press July 20 1859

1. That the society now embodied shall be named "The Ulster Medical Protective Association," to the membership of which all registered Practitioners shall be eligible.
2. That the objects of the Ulster Association shall be to protect the interests of the profession, in the admission of its members; to sustain the status of qualified Practitioners, and to watch over, and, if desirable, to promote such legislative measures as may seem generally beneficial.
3. That from and after the 1st of September, 1859, all admissions to membership shall be by ballot.
4. That the annual subscription of members shall be 5s., payable in advance, and shall be due on the first day of May in each year.
6. That the first general meeting of the association shall be held in Belfast, on the first Thursday in September next, when the office-bearers shall be elected. This meeting shall be called by a circular, addressed to each member.
6. That the officers of the association shall be a resident chairman, central committee, consisting of twelve town members, an honorary secretary, and a treasurer, along with three representatives from each county in Ulster. The chairman and one-third of the members of committee shall vacate office each May, but shall be re-eligible at the annual election.
7. That the annual meeting of the association shall be held in Belfast early in May in each year, for the election of office-bearers, and the transaction of general business; such meetings to be called by public advertisement in the newspapers.
8. That at each annual meeting a report from the committee shall be presented to the association, detailing the proceedings of the committee and prospects of the society; the treasurer, likewise, shall submit to the meeting a statement of accounts, duly audited.

EDITORIAL ON NON-QUALIFIED PRACTITIONERS
Belfast Daily Mercury 26 July 1859

A prosecution took place the other day, before a London Police-office, for the purpose of endeavouring to abate a nuisance which is very general, not only in England, but in this country.

By the 40th section of the Medical Practitioners Act, it is enacted, "that any person who shall wilfully and falsely pretend to be, or take, or use the name or title of a physician, or surgeon, or licentiate in medicine and surgery, bachelor of medicine, surgeon, or general practitioner, or apothecary, or any name, title,

addition, or description, implying that he is registered under this Act, or that he is recognised by law as a physician, or surgeon, or licentiate in medicine or surgery, or a practitioner in medicine, or an apothecary, shall, upon a summary conviction for any such offence, pay a sum not exceeding £20."

A Mr. Samuel Nunn, who carried on business in Lambeth as a chemist, druggist, and dentist, had also the word "surgeon" painted artistically over the door, and also on a square of glass in the window. There was no doubt as to his having practised as a surgeon, and that he had no qualification whatever either as a surgeon, physician, or apothecary.

Dr. Ladd, honorary secretary to the London Medical Association, said he examined the printed copy of the register of the properly qualified medical men he then produced, and could not find the name of the defendant in it, and the absence of the name from it was deemed by the act itself a proof of disqualification. He had been to the house of the defendant, and over the door was the number "8," with the word "Surgeon" in large letters; then the name "S. Nunn, Dentist." There was painted on a square of glass in the window the word "Surgeons," the letter "s" being a very small one; and where it could be scarcely perceived, "Prescriptions carefully made up."

The inscription was such as to lead any ordinary person to suppose that Mr. Nunn was a surgeon, and made up prescriptions.

John Owen, a carpenter, residing in Kennington-lane, said that a short time ago he met with an accident and cut his hand, and was induced to go to the shop of the defendant for advice, from seeing the word "surgeon" on the door. He also asked the defendant if he was a surgeon, when he nodded his head in such a way as to lead witness to believe he was. He then examined his hand and arm, and made him up a bottle of lotion, for which he charged him a shilling.

Mr. Humble, a surgeon in the London-road, with whom the defendant had lived as an assistant, was called, and proved that he had no qualification beyond that of a chemist."

On such a state of facts, the London Medical Association instituted proceedings, as they were bound to do, for the protection of the public, and the Magistrate convicted the defendant in the very slight penalty of 40s, and 28s costs—a most inadequate carrying out of the Act.

Now, we are credibly informed that in Belfast, indeed throughout the province, there are a great number of unauthorised practitioners, who drive a profitable trade by butchering, and poisoning, and drugging to death the unfortunate people who are imposed upon by their pretensions. What is our local Medical Society about, that it is not watchful over the interests of the profession and of the public, by instituting proceedings against such persons? The leading

bodies in Dublin have been proverbially neglectful of their duties in this respect; and the local societies have now under the new act ample power in their own hands.

LETTER TO THE EDITOR
Belfast Daily Mercury 27 July 1859

Sir,—In reference to some remarks which appear in a leader of to-day's *Mercury*, relative to the "great number of unauthorised practitioners"—"in Belfast and throughout the province"—"who drive a thriving trade by butchering, and poisoning, and drugging to death the unfortunate people who are imposed upon by their pretensions"—I am happy to inform you that a Medical Protection Association for Ulster has been organised, and will soon be in a position to deal with the gentry in question, and to watch "over the interests of the profession and the public, by instituting proceedings against such persons."

Thanking you for having drawn public attention to this matter, I have the honour to be your obedient servant,

Samuel Browne, R.N., M.R.C.S.E.,
Secretary to the Ulster Medical Protection
Association, *pro tem.* Belfast, 26th July, 1859.

NOTICE TO MEDICAL PRACTITIONERS
Belfast News-Letter 22 August 1859

The PROVISIONAL COMMITTEE of the ULSTER MEDICAL PROTECTIVE ASSOCIATION beg to remind practitioners who have received the "ADDRESS TO THE MEDICAL PROFESSION OF ULSTER," that they should send their names and subscriptions to the Acting Treasurer, Dr. PATTERSON, of DONEGALL SQUARE, BELFAST, before THURSDAY, the 1st of September on which day the first meeting of the Society will take place.

(By order)
WILLIAM M'GEE, M.D.,
Chairman, *pro tem.*
SAMUEL BROWNE, M.R.C.S.E.,
Honorary Secretary, *pro tem.*
Belfast, 18th August, 1859.

NOTICE TO MEDICAL PRACTITIONERS
Belfast News-Letter 30 August 1859

The FIRST GENERAL MEETING of the ULSTER MEDICAL PROTECTIVE ASSOCIATION will be held at the GENERAL HOSPITAL, Belfast, on THURSDAY, 1st Sept., at Twelve o'clock Noon.

Members of the Medical Profession are invited to attend.

(By order of the Provisional Committee)
WILLIAM M'GEE, M.D.,
Chairman, *pro tem.*
SAMUEL BROWNE, M.R.C.S.E.,
Hon. Secretary, *pro tem.*
Belfast, August 29, 1859.

FIRST GENERAL MEETING
Belfast News-Letter 2 September 1859

Yesterday, the first general meeting of the Ulster Medical Protective Association was held in the Library of the General Hospital. There was a large attendance of the members of the medical profession.

Among those present were Dr. M'Gee, J.P.; Surgeon Browne, Dr. Patterson, J. Pirrie, M.D., Surgeon J. S. Dickson, Surgeon Wilberforce Arnold, Surgeon William Hanna, Surgeon William S. Kennedy (Comber), Staff Assistant-Surgeon R. M. Acton (Barracks), Surgeon Harman (Moneyslane), Dr. Rankin (Kirkcubbin), Dr. M. MacCormac, Dr. John Lavery (Maghralin), Surgeon James L. Connor (Moira), Surgeon William M'Gee, Surgeon Gribben, John H. Halliday, M.D., Robert Stewart M.D., H. Murney, M.D., Cunningham Mulholland, M.D., Alex. B. Filson, M.D. (Portaferry), J. Seaton Reid, M.D., Daniel Murray, M.D., Surgeon Henry Whitaker, Surgeon W. Warnick, William Aickin, M.D., J. C. Ferguson A.M., M.B., etc., F. Heeney, M.D., Henry M. Johnston, M.R.C.S.I., Archibald Dunlop, M.D. (Holywood), M. M'Gee, M.D., Thomas Charles S. Corry, M.D., Harrison Hanna, M.R.C.S., John S. Drennan, M.D., Christopher S. Black, M.D., J. W. S. Smith, M.D.

On the motion of Dr. M'Gee, J.P., seconded by Surgeon Browne, Dr. Stewart took the chair.

The Chairman said—Gentlemen, it is an unexpected honour conferred upon me to be called upon to preside over this highly-respectable, influential, and large meeting of our brethren generally. You are all aware, however, by printed circulars, of the object of this Medical Association for Ulster, which is now about to be formed; and this being its first general meeting, our respected secretary *pro tem.*, Surgeon Browne, will explain to you more fully—he being better acquainted with all the details than I am—the objects of the association. I am sure one and all of us are only activated by the one feeling and desire, and that is to uphold the due independence, and status,

and respectability of our common fellowship—and that every one amongst us will feel that any individual in any way harshly used by authorities or otherwise, that we will all feel it as affecting ourselves, and aid the association to the utmost of our power in seeing that justice shall be done to that individual. Ay, so acting, and by bringing ourselves together as one man, we will be doing an essential service, not only to ourselves as individuals, but to the public at large. I will now call upon Surgeon Browne to state the objects of the association.

Surgeon Browne stated that he had received letters of apology from the following persons, who were unavoidably absent:—Dr. Thorpe, Letterkenny; Dr. Babbington, Londonderry; Mr. M'Greevey, Antrim; and Mr. Thelford, Portaferry,

Dr. Filson (Portaferry)—This is dispensary day with some of those gentlemen.

Surgeon Browne—In a very few words, I may introduce the association to your notice, and to the notice of the public, because I think it is well the public should know exactly what position this association intends to assume—not one at all aggressive to the public, as some people seem to think, but one protective of the public, as it is held to be protective of ourselves. You are aware, gentlemen, and I wish the public to be aware, that, for a long time, there has existed in England a Medical Association of Great Britain. In this country also we have had now, for six or seven years, an Irish Medical Association in existence, which numbers now somewhere about 200 members. The membership of that is obtained by paying a certain subscription, and two years back they asked us to join them by the paying of a certain sum. There are the Carrick-on-Shannon, the Cork Medical Protective Association, numbering about eighty members, the Fermanagh, the Limerick, the South-Eastern, and the Wexford Association. These are all in connexion with the Irish Medical Association. However, up till a recent date we have had no connexion with it even collaterally, and we may call this a collateral connexion, seeing that the Medical Association [sic] of Belfast was invited to join them, which we did. I was deputed last June to attend a meeting of the association as representing the Medical Society, and all the medical officers of the medical district about us. I had pleasure in attending that meeting in Dublin from the strong feeling they had towards the gentlemen in the North—that feeling which they expressed at the meeting and afterwards at the dinner in the warmest terms; and I cannot now refrain from mentioning the names of the President, Dr. Whitaker, and the admirable secretary of the Cork Medical Association, Dr. Armstrong. They all appeared most anxious that we in the North should fraternise more than we had hitherto done, and hold out the right hand of fellowship; that we should meet them half way, meaning that we

should form an association in the North, and unite with them in Dublin, and with the other associations in the South and West. I promised, at that period, to bring the matter before my brethren in the North. I fulfilled that intention very shortly after I got into town here; and the details which I shall now lay before you will show what has been done. But before that, I wish for a few minutes to refer to the nature of the association. In the first place, as you will see by the prospectus, it has been stated that our intention is to unite for our mutual protection—for the benefit of the profession, and for the extension of the benefits of the profession to the community. By protection I mean we are to look after parties, and we intend to interfere with the Council of Education which now exists, and see that there is a proper scale of preliminary education for the profession. Secondly—To see that parties of proper character be admitted into the profession. And thirdly—To see that parties who are practising in our profession, but who do not belong to it, shall be at once brought under the law, and made amenable to justice. I believe that this is not only protective of ourselves, but protective of the community, because it is quite clear if we prevent a large number of men from going on through the various districts around us practising in our profession, who have no right to assume the name of medical men, and who have no education for the claim, that we are not only protecting ourselves, but doing a vast amount of good to the community, who are suffering from the interference of these uneducated persons who assume to themselves the name and dignity of doctors. I think, now, that these few words will explain to the public our position—simply to protect ourselves, and also to protect the public. There is no doubt the public are our debtors, and we are debtors to the public in a large measure—we live by them, and while we expect that they will do what is right towards us, we are bound to do good towards the public and to protect them. There is but one other observation that I wish to make regarding the association, and it is this—one of our resolutions goes on to state that we shall be in connexion with the Irish Association. Now it will be, I think, for this meeting to determine on what would be the best way to amalgamate with the Irish Association. There is no doubt that union forms the basis of strength, and that if the Ulster Protective Association joins with the Irish it will be better and stronger than if we remained disunited. At the same time, the Provisional Committee have guarded themselves from that, and have resolved to act as an independent association, except, of course, when a matter affecting our independence arises—such as the introduction of a Bill to Parliament—when it would be necessary to co-operate; whereas many things might arise of a local nature in which we don't need the assistance of the Irish Association, and would require only to be

brought under the cognisance of our own society. Hence, although we are united with the Irish Association, we should also see that we have ourselves so much of independence that we can act on our own behalf without consulting the Irish Association. I think there are no other remarks that I need trouble you with. I will now read to you the various minutes that, from time to time, have taken place at the meetings of the Provisional Committee. Surgeon Browne then read the minutes of the various meetings of the Provisional Committee [not available], and the following address and rules [given above]:—

Dr. M'Gee, J.P., in moving the adoption of the minutes, said—After the statement you have heard from Mr. Browne, I need scarcely detain you by bringing forward any argument—even if argument were necessary—for the formation of such an association. It is to me a matter of surprise that such an association has not long been established. If we had taken the example set us by other learned professions—such as the Bar—we would have done our duty to the public, and our duty to ourselves long ago. It is established for the benefit of us all, young and old; but I would have the youngsters to remember that it is especially for their benefit it has been established. When so many grey heads recommend the establishment of such a course, I think their advice is surely worth something. We have seen in England from day to day the advantages of such an association. We have heard of successful prosecutions, and of the benefit of them. And if we look at home, we see, on the other hand, what we may term the unjust persecution of our profession; and we feel that there should be some person or persons to stand forward and assist them—to defend their rights, and to defend the rights of the profession. With such examples before us we should no longer permit ourselves to be idle in this matter, and to have it said, instead of leading we have been led. It is our misfortune that in this matter we have been preceded by others. We should now set the example, but it is never too late to do well, and, under these circumstances, I think I can best consult the feelings of the meeting by, without any further observations, moving the resolution.

Dr. Filson (Portaferry)—I have very great pleasure in seconding the resolution. I only wonder that we have been so long coming into the field to form this association. I think it was rather discreditable to the medical gentlemen of Ulster not to have had such an association long since. We have seen the noble efforts which have been made on behalf of the profession by the Cork Medical Protective Association; but, as has been said, “Better late than not all.” I trust and hope that the matter will now be entered upon with resolution and determination—(hear, hear)—and that the members of the profession throughout Ulster will give their support to the gentlemen who have under-

taken the formation of the association, and who are exerting themselves in carrying out the object had in view; for the greater the number who join the association the more powerful will be its influence. (Hear, hear.) I would be sorry there should be any member who would hold back from joining this association. All members of the profession will be benefitted by the steps which will be taken by the association; therefore, I trust all will feel it to be their duty to aid in the efforts put forth. (Hear, hear.) There will be great difficulty, I know, in some of the country members attending the meetings, but I trust they will come forward manfully and give the association their best support. (Hear, hear.) I have great pleasure in seconding the motion of Dr. M'Gee.

The Chairman then put the motion, which was passed unanimously.

Surgeon Browne—Our Treasurer pro tem. Dr. Patterson, will now state to you the position of the association.

Dr. Patterson stated that 112 members had paid their subscriptions and joined the association, and he hoped many others would join it. The subscriptions amounted to £28. The number was made up as follows:—County Antrim, 65 members; County Down, 18; County Tyrone, 4; County Monaghan, 3; County Fermanagh, 1; County Derry, 8; County Armagh, 7; County Cavan, 1; County Donegall, 4; total, 112.

ELECTION OF OFFICERS.

Surgeon Browne suggested that the officers elected then should remain in office until May, '61, as it would hardly be worth while to have an election so soon as May next. They might override one of their rules in this instance.

Dr. J. C. Ferguson, Professor Queen's College, begged to move that Dr. M'Gee, J.P., be elected chairman of the committee.

Surgeon Browne begged to second the motion.

The proposition was put from the chair, and passed unanimously.

Surgeon Browne—Our next business is to elect twelve members of committee to represent Belfast; then to elect a secretary and treasurer, and then three members of committee from each county.

It was then arranged that the members for Belfast should be—Surgeon Browne, Dr. Seaton Reid, Dr. J. C. Ferguson, Dr. Stewart, Dr. Murray (Ballymacarrett), Surgeon Dickson, Dr. Heeney, Dr. C. Black, Dr. Murney, Dr. Wheeler, Surgeon Tring, and Dr. Halliday.

Dr. Michael M'Gee begged to move that the twelve gentlemen named be elected as members of the committee.

Dr. Johnston begged to second the motion, which was put and passed unanimously.

Dr. Seaton Reid begged to move that Surgeon Browne be elected as Honorary Secretary. They

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would all admit that it was not a very lucrative appointment, but he hoped Surgeon Browne would be satisfied with the honour. (Hear, hear.)

Dr. Corry had great pleasure in seconding the motion.

The motion was put and unanimously agreed to.

Surgeon Browne—I am thankful to you all for the honour you have done me in electing me as Secretary. It is a troublesome post, but I will do my best to forward the interests of the association. (Hear, hear.) I will endeavour to advance the interests of the profession and the advantage of the public. I trust the younger members will not expect too much from the association. There are many persons who take up little grievances, and who might expect the association to interfere; but there is nothing more easy than for an association to burn their fingers. (Hear, hear.) It is better for members not to expect too much. The association will require to have the premises as clear as possible before they act. I wish the younger members to bear this in mind. As you have elected me as Honorary Secretary, it is now necessary that you fill up my place in the committee by another Belfast member. I beg to move that Surgeon Warwick be elected as a member of the committee.

Dr. Dickson begged leave to second the option, which was put and agreed to.

Surgeon Browne—When the association was temporarily formed, Dr. Patterson kindly consented to act as Treasurer, and I think we cannot do better than to vote him to that office now. (Hear, hear.) I know the great ability with which he discharges his duties, as he has been treasurer to another society. I have great pleasure therefore in moving that he be the treasurer of this Association.

Dr. Michael McGee—I beg to second the motion.

The proposition was then put and passed unanimously.

Dr. Patterson returned thanks in a few words, for the honour which had been done him.

The names of the three gentlemen from each county, from which three medical men had joined the association, were then nominated to be members of the committee. (The names will be found in our advertising columns.)¹

[These were: Antrim.—Dr. O'Connor, Ballycastle; Dr. Kidd, Ballymena; Dr. M'Kee, Randalstown. Down.—Dr. Filson, Portaferry; Dr. Jameson, Newtownards; Surgeon Connor, Moira. Derry.—Dr. Babbington, Londonderry; Dr. Cavin, Coleraine; Dr. Maxwell, Moneymore. Armagh.—Dr. Patten, Tandragee; Dr. M'Kinstry, Armagh; Dr. MacLaughlin, Lurgan. Donegal.—Dr. Thorpe, Letterkenny; Dr. Eames, Dunfanaghy; Dr. Baggott, Malin. Monaghan.—Dr. Fleming, Carrickmacross; Dr. Young, Ballybay; Dr. Donaldson, Clontibret.

Tyrone.—Dr. Scott, J.P., Aghnacloy; Dr. Neville, Dunganon; Dr. Fleming, Omagh. Cavan.—Dr. Taylor, Bailieborough; Dr. M'Gahan, Kingscourt. Fermanagh.—Dr. Maxwell, Derrylin.]

Surgeon Browne suggested that the committee have power to add the names of gentlemen for Cavan and Fermanagh when they might join.

It was agreed that the names of the first who became members of the association from these counties, should be added to the committee.

Dr. Pirrie begged to move that the gentlemen mentioned be appointed members of the committee to represent the different counties.

Dr. Rankin begged to second the motion, which was put and agreed to unanimously.

Dr. Corry thought it was a matter for consideration whether they should not appoint a secretary for the country district. He merely threw it out as a suggestion.

Surgeon Browne remarked that each member of the committee for the counties was a kind of secretary. It would be the business of each of them to communicate upon local matters to the committee, for it was not to be expected that they could always attend from a distance.

THE DUNMANWAY UNION CASE—DR. WALL

Surgeon Browne then read a communication from the secretary of the Cork Medical Protection Association with regard to the case of Dr. Wall, medical officer of Dunmanway Union, who was dismissed by sealed order of the Poor-Law Commissioners, and a medical gentleman sent down from Dublin to take his place, as none of the local medical gentlemen would accept of the position, believing, as they did, that Dr. Wall has been harshly treated. He (Surgeon Browne) thought the case had not been very clearly stated, even in the document which he had read, and he considered the best course for that association to pursue would be to refer the matter to the committee to do as they might think best after getting more detailed information on this subject.

Dr. M'Gee, J.P., in a few remarks, begged to move that it be referred to the committee.

Dr. Pirrie begged to second the motion. The statement which had just been read was very imperfect. He thought they should take no action on it at present.

After some remarks from Dr. Filson, Dr. Heeney, Dr. Dickson and others, the motion of Dr. M'Gee was put and agreed to.

REGISTRATION OF
BIRTHS, DEATHS, AND MARRIAGES.

Surgeon Browne had to lay before them a copy of the Bill brought in last session of Parliament, by Lord Naas and the Attorney-General for Ireland for the registration of births, deaths, and marriages. There

¹ [Belfast Newsletter, 1859, 2 September, page 1.]

was one clause in the Bill which would affect the profession. He referred to the 15th clause which provided that if a medical man neglected to send to the registrar a certificate of a death within eight days, he should be liable to a penalty of 40s, while he was to receive nothing for doing it. That was a penal clause which they should not allow to pass without pointing out the hardship of it. He anxiously desired to see a registration Bill brought in and passed into law; the Bill for Ireland to be framed on the same principles as the law of registration in England. The Board of Guardians had decided upon petitioning the government upon the matter, and when he brought it before the Board, he referred to some points in the Bill which appeared to him to be unconstitutional. But what touched upon their interests most was the fifteenth clause, and they should watch the passing of any law upon the subject, as the present government seems likely to bring in a Bill upon it, for he saw it named in the list to be brought in next session.

Dr. Pirrie moved that the Bill be referred to the Committee.

Dr. Kennedy—I beg to second the motion.

The Chairman then put the resolution, when it was passed unanimously.

Dr. Dickson moved that the Chairman vacate the chair, and that Dr. M'Gee, the newly-elected Chairman of the committee, be called thereto.

Dr. M'Gee, having taken the chair, said it became his duty to return them thanks for the honour which they had done him. He had been so often called upon to return thanks for honours done to him that he really did not know what to say without repeating what he had said on some previous occasion. He had not the slightest idea when he entered the meeting that he should be called to that office, for he naturally believed that it would have fallen upon one who occupied a higher position; but as they seemed to think that he could be of some service, he was willing to take the office, and do all in his power. (Hear, hear.) They had, however, lightened his duties considerably, by the appointment of such an invaluable honorary secretary as Surgeon Browne. (Hear, hear.) As to the formation of that association, he had long thought such was necessary. They had seen, time after time, how the public had made demands upon their time, which was their capital, and the public had again and again forgotten the services rendered to them. In Belfast they had some noble exceptions. The Board of Guardians, at a time when services had been rendered by the medical gentlemen, for which the Board of Guardians then had no power to pay, afterwards proposed to take steps to have them remunerated, and the medical gentlemen refused to accept of anything, and were satisfied with the thanks of the Guardians. He hoped such services would never be required again under such circumstances; but, if their

services were required by the public, the latter should now know that these services must be paid for. Their association could do much to advance the interests of the profession. The Registration Act was one which they could use their influence in urging the Legislature to pass, and it would be of great benefit, not only to the entire public, but would materially serve the profession. Every death occurring in the county would have to be certified, stating the disease which caused it, by a medical gentleman, and no certificate would be received from any but those properly registered; so that it would tend to put down quacks who were not members of the profession. Then, the association would look after having a change made in that clause which affected them personally. If they had had an Association at the time the Vaccination Act passed, they would have had such improvements made in it, and would not have left its provisions such a tax upon the time of medical officers without any commensurate reward. He did not know what the Registration Commissioners did for the protection of the registered members of the profession. They received heavy fees from the members of the profession, and he thought they should look after the interests of the profession better than they did. He would not detain them longer, but begged again to thank them for the honour done him. (Applause.)

Surgeon Browne wished to say that the Hospital Committee, having been applied to, had kindly granted the use of the library for the association to hold its meetings in it.

Dr. Dickson then moved that the best thanks of the meeting be given to Dr. Stewart for his conduct of the chair. No man deserved their thanks more than Dr. Stewart, for, although he had received an appointment which removed him from active practice, yet he never failed to lend his aid to forward the interests of the profession. (Hear, hear.)

Dr. Filson seconded the vote of thanks, which was put, and passed with acclamation.

Dr. Stewart having acknowledged the compliment, the meeting separated.

MONTHLY MEETING

Belfast News-Letter 14 October 1859

The usual monthly meeting of the Ulster Medical Protective Association was held yesterday [13th October 1859], at their room in the Belfast General Hospital. There was a large attendance of members on the occasion. Dr. Heeney occupied the chair. The Honorary Secretary, Surgeon Browne, apologised for the absence of Dr. M'Gee, J.P. He then reported that he had put himself in communication with the Secretary of the London Medical Registration Society, and with the counsel of the Ulster Association, J. M. Thompson,

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Esq., Barrister-at-Law, with the view of carrying out the provisions of the Medical Act against unqualified practitioners.

The Treasurer (Dr. Patterson) reported that the association now enrolled 124 members.

Dr. Hume, of Crumlin, was balloted for, and un-animously elected a member of the association.

The Secretary then brought the case of Dr. Harman, of Ballyward, under the notice of the committee, and he was directed to write to that gentleman, and to convey to him their warm sympathy. The committee, at the same time expressed it as their opinion, that the Poor-law Commissioners had not rendered Dr. Harman justice, in accordance with the evidence, as published in the newspapers.

The Secretary was directed to notify to all the members the propriety of their bringing under the notice of the committee the names of any unqualified persons practising medicine in their several districts, or assuming to be physicians or surgeons without any legal license, that the committee may take prompt measures for punishing such pretenders, as counsel may advise. The secretary was also directed to ask the opinion of their counsel whether medical men holding Government medical appointments, as in the Queen's Colleges, were not, according to law, compelled to register, and to inquire if any certificates granted by them could be held as valid until they had so registered? The last report of the Poor-law Commissioners having been brought under the notice of the meeting, the members unanimously expressed their strong disapprobation of the portion which refers to the appointment of non-professional men as inspectors for medical purposes, and they stated their determination to join with the other Protective Associations to prevent the fulfilment of an intention so opposed to justice, to the rights of the medical profession, and the welfare of the community. Surgeon Browne stated that he had already been in correspondence with Dr. Armstrong, the indefatigable Secretary of the Cork Association, on the subject. It was one which he regarded as of great moment, and which called especially for the notice of every Medical Protective Association; for the profession might rest assured that if the Commissioners' views were once carried out, the dispensary doctors would be in a much worse position than they now occupy, though that is, in many respects, a very unenviable one. The Secretary was then requested to watch the proceedings regarding this question very closely, and to bring up a special report on the subject for the next meeting of the committee.

COMMITTEE MEETING

Belfast News-Letter 11 November 1859

Thursday [10th November 1859], at twelve o'clock, a meeting of the committee of this association was held in the Library of the General Hospital, Dr. M'Gee in the chair.

The following were balloted for and admitted members of the association:—Surgeon Shaw, Grey-abbey; Dr. White, Downpatrick; Surgeon Harrison, Ardglass; Dr. Wm Browne, Derry; Surgeon Phillips, Ballygawley.

A question arose as to the admission to membership of a gentleman who was known to be duly qualified, but did not appear on the list as registered, and after some discussion, it was resolved to let the matter remain over until the gentleman could be again communicated with.

Dr. Patterson announced that the association now comprised 130 paid members, besides some who had not yet paid their subscriptions.

Surgeon Browne said they numbered nearly 140 altogether.

Dr. Patterson said he had been requested to ask if the degree of M.B. from the University of Aberdeen entitled the holder to assume the title of Doctor. It was objected that some gentlemen had "Doctor" upon their doors, when they were only M.B.'s.

Surgeon Browne said the title of "Doctor" had always been given to them by courtesy.

The Chairman thought that this was a case in which they should not interfere. They had in Belfast three or four gentlemen of high standing who were M.B.'s, and it would be preposterous to interfere. When any of them were asked about it, they should direct the applicant to apply to the Council for Ireland. The title of Doctor was given to M.B.'s by courtesy just as that of "lord" was given to the sons of peers; but, if they went into a court of law, they would not get that title.

Dr. Murney said that in Trinity College there was an examination for M.B., and a year after the degree of M.D. was given, upon the payment of the fees, and without any second examination.

Surgeon Browne read a letter from a gentleman who wished to be enrolled if possible. He stated that his name was not on the register of this year owing to his passing after it was made out. He observed that their association was about to give quackery a death-blow. He suggested that the Association should send persons throughout Ulster to find out unqualified persons and have them brought to Justice immediately. (Laughter.) He submitted the names of four persons without any qualification, who styled themselves "doctors and general practitioners," and were practising in his neighbourhood. Surgeon Browne went on to

say that he believed the writer of this letter was registered.

It was agreed that his election be adjourned until the certificate of registration be forwarded.

The general and bye-laws of the London Medical Registration Society were laid on the table, and were ordered to be referred to a subcommittee, to consider whether any of them should be incorporated in the rules of the Ulster Medical Protective Association.

Surgeon Browne said that he, as secretary, had received two letters from their honorary counsel. One was relative to professors in Queen's Colleges, &c., and the other called the attention of the association to the fact that, in a county of Ulster, two members of the medical profession had applied for spirit licenses at a late Quarter Sessions. The Chairman of the county on that occasion felt it his duty to represent the matter to the honorary counsel of the association, and desired him to bring it before the secretary, thinking that it was really a great hardship upon the profession that such a thing should occur. Perhaps the best course would be to refer the matter to the sub-committee.

The Chairman said that when such a report was going before the public, they should understand that men of high rank in Belfast, wine merchants and others, were obliged, for the purposes of trade, and in order to keep their stock correct, to have a retail license. It might just happen that these men, being druggists, wished to be licensed for the sale of spirits of wine, and it would be hard to stamp them as the keepers of dram shops, although they did deal in drachms, until they saw exactly what were the facts of the case.

Dr. Murney—Are they both members of our association?

Surgeon Browne—No; but they are both registered.

Dr. Patterson—It is very disgraceful to the profession.

Surgeon Browne said they had applied to members to send in the names of parties who were practising illegally. He had got some names, and would lay them before a sub-committee; but it would be well for the public to understand that since the association had been established a good many of them had taken to flight from Belfast, and others were trying through subterfuge to escape the observation of the society. He might inform those parties that so sure as the society existed they would be hauled up in a very short time before the public. He understood that one of these men had partly obliterated the name on his premises so that it could not be read, but was still practising and receiving fees. He intended to submit a case to counsel to know how far they could go under the 40th clause. He was quite sure that a man acting, in the capacity of a general practitioner could be

taken up and brought before the magistrates, although he might not assume the title of doctor, surgeon, or anything else.

The Chairman said he had heard of a case lately in England, where the man did not style himself a doctor, but the conviction seemed to have been founded upon his having administered medicine and received money. The 40th clause provided that "if any person should willingly and falsely pretend to be," or take or use the name or title of physician, &c., he should, upon summary conviction, pay a sum not exceeding £20. Now, the first line, he thought, included such cases as were referred to by Mr. Browne. The question was, whether prescribing and giving medicine, and taking payment therefor, would not be pretending to be a practitioner in medicine.

Dr. Wheeler said that sometimes the unqualified man was partner with a qualified.

Surgeon Browne said that in that case the unqualified man was not protected by the qualification of the qualified man, and he would find it to his advantage either to leave off practising or take a qualification.

Mr. Warwick, mentioned a case in which an unqualified practitioner sent in a bill for 30s, and when it was objected to as excessive the payment of it could not be enforced.

Surgeon Browne said the public should understand clearly that in all cases they were protected against quackery, for, if they did not like to pay the money, the quack could not recover it.

The matter then dropped.

Surgeon Browne said he had been requested to bring up a report on a subject of much interest to the profession. In the year 1857 a Bill for the amendment of the Medical Charities Act was introduced into the House of Commons by the Chief Secretary for Ireland, Mr. H. Herbert, having been prepared upon the recommendation of the Poor-law Commissioners, and by the 14th section it was proposed to empower the inspector appointed under the Poor-law Act to discharge the duties of inspectors under the Medical Charities Act, notwithstanding that they might not possess the medical qualification required by this latter Act. That was of course opposed at the time, but in the report of the Commissioners for 1859 they recommended that their inspectors be empowered to act as medical inspectors, and that the medical inspectors should be empowered to act under the Poor-laws, adding that one inspector with medical qualification would appear to be sufficient for the whole of Ireland, except in special cases when others would be employed. He asserted that it was totally impossible for a non-medical man to exercise proper inspection over dispensaries, but the medical inspectors could discharge efficiently all the duties of inspectors under the Poor-law Acts, and if the Commissioners required them all to be medical men, he

was sure the profession would not object; but if they brought forward any such provision again, he, if still a Poor-law Guardian, would give it his most strenuous opposition.

The Chairman said the Commissioners themselves had frequently found it necessary to employ medical men to report on cases requiring professional knowledge; and, in fact, a layman could not perform the duties of inspector under the Medical Charities Act. He was only surprised that they had been so economical as to employ only four or five medical Inspectors for all Ireland. They should have one for each county, and then, let them diminish the number of ordinary Poor-law Inspectors if they pleased.

Surgeon Browne read a letter from the Secretary of the Southern Association, Dr. Armstrong, stating that they intended to make some move in the matter.

The Chairman said that if the Poor-law Commissioners saw there was going to be opposition, they would not press it forward.

It was agreed, on the motion of Dr. Stewart, that a memorial be presented to the Poor-law Commissioners, and to the Chief Secretary for Ireland, Mr. Cardwell, praying that in any proposed Poor-law Amendment Act, the provision for setting aside medical inspectors be not inserted.

THE CASE OF DR. WALL

Surgeon Browne said he had received from the Secretary of the Irish Medical Association copies of the memorial presented from that body to the Poor-law Commissioners, in reference to the case of Dr. Wall, late medical officer of Dunmanway Union, together with the reply thereto. In the memorial, the Council of the Medical Association of Ireland begged to submit for the consideration of the Poor-Law Commissioners some observations on the circumstances connected with the inquiry relative to the death of Jeremiah M'Carthy in the Dunmanway Workhouse Hospital. The Council had been struck with deficiency in the conducting of the inquiry by the Poor-Law Inspector, as shown in the omission to take either the evidence of the deceased's relatives, or that of the porter of the house, which, as circumstances had since shown, might have altered the views of the Poor Law Commissioners. The Council then referred to the inquest held on the body, and proceeded to comment upon the letter of the Commissioners to the Board of Guardians. Having noticed the state of deceased on admission to the hospital, after the lapse of twenty hours from he received the injury, the Council remarks that under such circumstances, although a surgeon might suggest an operation as the only means of giving any chance of life, yet he might feel reluctant to press it on the patient or his friends, when they so strongly expressed their opposition to such a proceedings; this reluctance would be

increased by the conviction that the chances of saving the man's life had been reduced by the delay in bringing him to the hospital. The Council, while they would not deny that blame might be attributable to Dr. Wall in some points; still it appeared to them that the punishment with which his errors had been visited, had been out of proportion to the offence. In conclusion, the Council respectfully ask a withdrawal of the sealed order against Dr. Wall, or a re-opening of the case to admit further investigation.

The following reply was returned:—

“Poor-Law Commission Office, Dublin,
14th Oct., 1859

Sir—The Commissioners for Administering the Laws for Relief of the Poor in Ireland have received the statement relating to the case of Dr. Wall, addressed to them, and signed by you, as Chairman of the Council of the Medical Association of Ireland.

In reply, I am to state that the Commissioners do not feel called upon to enter into correspondence with the Council of the Medical Association, as to the manner in which they discharged their duty in the case of Dr. Wall.

The Commissioners must, at the same time, observe to you, in your capacity of medical officer of the Bray Dispensary district of the Rathdownen Union, that you have addressed to them language which, in their opinion, is not befitting your position as an officer performing a public duty, under the superintendence of the Commissioners. In a matter which no way regards the discharge of your own duties, or the administration of the same in your own district, you state that there has been a great deficiency in the conduct of the late inquiry in Dr. Wall's case on the part of the Poor-law Inspector; you advert, also, to defects in certain documents addressed by the Commissioners to the Board of Guardians, and to their Inspectors in the subject of this case; and you give it as your opinion, that, although blame is attributed to Dr. Wall in some points, the punishment with which his errors have been visited has been out of proportion to the offence.

You are, doubtless, at liberty to form your own opinion of the merits of the case in question from such information as you may possess regarding it; but as the Commissioners cannot consistently with their position enter into explanation with you in defence of their proceedings they submit to your consideration the propriety of not addressing them in future on the subject of their official conduct in any matter which does not concern the administration of the law in your own district. There is a part, however, of your communication of which the Commissioners feel constrained to take more serious notice; they allude to the opinion which you have voluntarily conveyed to them regarding Dr. Wall's conduct in taking active steps to effect the removal of a man, with a com-

pound commiserated [*sic*] fracture of the leg, extending into the knee joint, from Dunmanway Workhouse to an Infirmary at Cork, a distance of forty miles, for amputation; such being the desire of his friends, under circumstances which you describe as making amputation (even in the workhouse) a hopeless expedient. Regarding this part of Dr. Wall's conduct, you observe—"One can readily understand that in such a case from which no favourable issue was then to be expected, the practitioner might be induced to assent to almost any course which appeared grateful to the patient's friends."

The expression of such views by the medical officer of a dispensary district makes it incumbent on the Commissioners to warn him that, if in any similar case to that of Jeremiah M'Carthy he should put in practice, under a dispensary ticket, a course analogous to that pursued by Dr. Wall, the consequences would be very serious to himself, as the Commissioners would, without hesitation, adopt the same measures in his case as those which they adopted in the case of Dr. Wall.

(By order of the Commissioners,
To Dr. Whistler, Bray")

Surgeon Browne, in continuation, said that that letter was characteristic of the Board from which it came. It was an exhibition, he would not say of petty tyranny, but of the course which the Commissioners pursued towards those over whom they thought they had some power. The memorial was not the act of Dr. Whistler, but of the council of which he was the chairman. A single word disrespectful to the Commissioners was not used. There was an admission made which he (Surgeon Browne) would not have made—that Dr. Wall might have been somewhat to blame; but the memorial did not call for the severe language made use of by the Commissioners in their reply. It was not to Dr. Whistler they addressed that language, but to the whole Irish Association; and he trusted the Irish Association would know how to reply to them.

Dr. Stewart said that so far as he knew the facts of the case, Dr. Wall was not to blame in any way whatever,

The Chairman said he regretted that the Commissioners should have seen fit to write such a letter. They had now been told for the second time that their sealed order, when contrary to law, could not be carried out. When they called on Dr. Wall to resign, and when he did resign, that should have been a settlement of the question, and they should not have punished twice by dismissing him under sealed order, after he had been unanimously elected by the Guardians. He was sorry the Guardians did not take their stand on that point and try the question with them.

It was moved by Surgeon Browne, seconded by Dr. Patterson, and agreed to. "That, having heard the

address from the Council of the Irish Medical Association and the reply of the Poor-law Commissioners, this meeting cannot but regret that the Commissioners should so far have forgotten the relative position of themselves and Dr. Whistler as to have written in the incourteous terms addressed to him."

An adjournment then took place.

EXECUTIVE COMMITTEE
Belfast News-Letter 9 December 1859

Yesterday [8th December 1859], the Executive Committee of the Ulster Medical Protective Association met in the Library of the General Hospital, the President, Dr. M'Gee, J.P., in the chair. The other members present were—Professor Ferguson, Dr. O'Connor, Ballycastle; Drs. Murney, J.P.; R. Stewart, Hospital for the Insane; Patterson, Halliday, Dickson, Heeney, Warwick, and Surgeon Browne.

After the transaction of the ordinary business, and the election of Dr. Bernard, of Dungannon, and Surgeon Patrick, of Carrickfergus, as members,

The Secretary brought under the notice of the Committee the meeting of the profession in Ireland, which had been summoned by the President of the Irish Medical Association, to take up certain questions of great interest to the entire medical body of this country. These questions embraced the consideration of the amendments required in the Medical Charities (Ireland) Act: the Poor-law proceedings relative to Doctor Wall's case at the Dunmanway Union: the manner in which Medical Poor-law inquiries are conducted; the letter addressed by the Poor-Law Commissioners to the Chairman of the Council of the Irish Medical Association, &c., &c. Of course these were very important matters for the consideration of the profession, and he quite concurred with the views put forward in the letters he had just read from Dr. Babington, Londonderry, and Dr. Thorpe, Letterkenny, relative to the necessity of sending representatives on behalf of the Ulster Association to the general meeting, called for the 15th inst.

The Chairman and several other members expressed similar views—the Chairman and Dr. Stewart referring specially to Dr. Wall's case, which they considered was one of very great hardship.

Professor Ferguson moved, and Dr. O'Connor seconded, that "The Chairman of the Society, Dr. M'Gee, J.P.; and the Honorary-Secretary, Surgeon Browne, be appointed a deputation to the meeting of the profession at the Limerick Junction, on the 15th instant, and that these gentlemen shall then appear in the name and on behalf of the Ulster Medical Protective Association."

The motion was put and passed unanimously.

The Secretary was directed to put himself in communication with the President and Secretary of the Irish Medical Association, and to lay the replies before a sub-committee to meet on the evening of Tuesday, the 13th inst.

The committee then adjourned.

IRISH MEDICAL ASSOCIATION
AGGREGATE MEETING AT THE
LIMERICK JUNCTION HOTEL
Belfast News-Letter 19 December 1859

An aggregate meeting of the members of the medical profession in Ireland, convened by Dr. Mackessy, of Waterford, President of the Irish Medical Association, was held at the Limerick Junction Hotel, on Thursday night, at half-past seven o'clock. The principal object of the meeting of the meeting was to consider the case of Dr. Wall, late dispensary doctor in the Dunmanway Union, and the course which had been adopted by the Poor-law Commissioners in the case

At half-past seven o'clock Dr. Mackessy took the chair. The Chairman, in opening the proceedings, said that he felt greatly pleased to see present so many gentlemen holding a high rank in the profession. There was one circumstance to which he felt called upon to allude, and which he himself thought of with much pleasure—he meant the attendance at that meeting of a deputation from the Ulster Medical Protective Association, a society which was doing much to advance the position and maintain the high character of the medical profession. They were deeply indebted to those gentlemen for their attendance that night, for, if it had no other good result, it would make it plain that, they were all united and determined not to relinquish their rights without a struggle. The spirit of union was what they most stood in need of, and as long as they were animated by it they might rest assured that nothing could injure their position. It was incumbent upon them to endeavour to preserve this feeling, and they might rest satisfied that as long as they remained united they had nothing to fear from the attacks of any board, no matter how powerful. (Hear, and applause.)

Dr. Harvey, of Cork, moved the first resolution, which referred to the conduct of the Poor-law Commissioners in the case of Dr. Wall as an arbitrary exercise of power, and said that before alluding to the terms of the resolution which he felt honored by having been called upon to propose, he felt bound to express his opinion that the meeting which had assembled that night could not be said to be called together by uncreated motives so much as by a sense of public justice. The large number of medical men who had attended, and many of whom were wholly unconnected with the Poor-law Commissioners,

could not be said to be influenced by self-interest, or by resentment. They were there to affirm a principle, and to complain of what they conceived to be an injustice. Their object was to maintain their independence, and to protect their rights. In this view alone were any observations necessary. They had to complain of undue and improper interference, and of a desire to trample upon the profession; and standing in the position which they occupied, he felt that they would not yield to oppression or injustice. The gentlemen who uttered that document of which they complained—and he would not mention their names, which he wished he did not know—were well aware of the injury which they were attempting to do to the medical profession; and specially to those who were to a great extent under their authority, and unfortunately held office merely during their pleasure. All the members of the profession who for the present filled the position of dispensary doctors or doctors of workhouses were persons of education and principle; and, except in respect of pay, were in no way inferior to those under whose power they were placed. (Hear, and applause.) He did not feel warranted in making further remarks, as he had only taken the opportunity of expressing an individual opinion, and he was anxious to listen to what would be said. (Applause.)

Dr. Jacob, of Maryborough, seconded the resolution, which he felt to be a very important one. As had been said, the question was not merely a medical one; it was a subject upon which every right-minded man would entertain but one opinion. The complaint of that meeting rested upon the broad grounds that an attempt had been made to dictate and to overbear. He had no personal feeling or no animosity to gratify, but he came forward believing that the letter of the Commissioners was a pitiable exhibition of intemperate official feeling. They made an effort to crush and injure a gentleman who, unfortunately for himself, was in their power. But the public would not stand their conduct, nor would the medical profession in Ireland suffer it to pass unnoticed. Too temperate an appeal had been made to their good sense and love of justice, and therefore the Commissioners turned round and acted with unwarrantable severity in a particular case. The medical profession were, therefore, compelled to come forward at that meeting and assert their rights, and were perfectly determined that the public should be made acquainted with the circumstances of the particular case of which they complained. He spoke in the presence of many gentlemen who were employees of the Poor-law Commissioners, and he asserted that the rules of the Commissioners, by which they intended that every dispensary doctor should act, were impracticable and could not be carried out. The Commissioners knew this to be the case; but whenever any gentleman was obliged to transgress these impracticable rules, or

became obnoxious to them in any way, they had only to crush him with their sealed order, which they made out while sitting in their easy chairs by their council table. (Hear, hear.) These were facts, as every person present knew, and he appealed to public opinion. They knew the rules to be bad, though they did not set about remedying them in the best manner, but perpetuated the injustice, which they had lately practised in the case under consideration that night. At Cootehill they visited a gentleman with their displeasure, simply because the severity of his duties and the demand upon his time, made it perfectly impossible for him to visit the hospital before twelve o'clock. This was only another case to add to the number of the acts of injustice which the Poor-law Commissioners had committed. He thought they ought to be given some advice and shown their mistake. They had not good medical advice at present; for he believed that if their medical advisors were bold and fearless, and determined to maintain the rights of the profession, there would be less cause of complaint against the Board. He (Dr. Jacob) believed that the different districts in Ireland should send a committee, consisting of delegates from each, to point out to the Commissioners the mistakes which they were so frequently committing. Could any man of common sense, who understood anything whatever of the duties of a physician, say that he deserved reproof or censure because he did not attend an hospital before twelve o'clock, when he lived in a large district, and might on any occasion be called away to attend a case of childbirth, or some patient in the agonies of death? But the Commissioners need not care for the justice or injustice of their rules. They made regulations, and they seemed determined to carry them into effect regardless of consequences, for they possessed an irresponsible power which enabled them to crush every person who became disagreeable to them. What was the course which, under the circumstances, should be adopted? They should battle for their rights at all hazards. He, as an Irishman, was afraid of no man, and would not be deprived of his privileges or submit to insult. The case of Dr. Wall would, he was sure, be spoken of and explained by some of the speakers to follow him. He had only to deal with the principle that medical men would not stand to see their body attacked by unfair means. He had great pleasure in seconding the resolution. (Applause.)

Dr. Rawdoon Macnamara supported the resolution. He felt it impossible to sit quiet and not assert what he felt to be the privilege of every medical man. He believed that they had just cause for complaint in the fact that the Poor-Law Commissioners had refused to listen to their fair and temperate appeal. They had asked for an investigation upon the same principle as those which were held in courts of law, where no decision was arrived at except on legal evi-

dence. The Poor-Law Board was not, surely, superior in authority to the Courts of Queen's Bench or Chancery, but they assumed a more arbitrary authority; and they had been written to and asked to suspend their judgment in the case of Doctor Wall until they had learned the additional evidence which could be offered, but they replied, stating that they would not hold any communication with the members of the Irish Medical Association. If, however, they had merely contented themselves with this, and had gone no further, he ventured to say that the meeting at which they were that evening assembled would never have been held, and that nothing farther would have been done than remonstrate with them upon their injustice. But they treated the chairman of that association as if he were merely representing his own opinions, and not those of the great number of medical men who formed that, useful and influential society. They sent him a message to the effect which he had stated. It was true that some gentlemen had told him some days ago that it was not the intention of the Poor-law Board to convey such an impression; but, however, their words remained, and it was impossible to weaken their meaning. (Hear, hear.) He confessed that he was more pleased to see that a number of the gentlemen present were under the control of the Poor-law unions than he was to notice that his friend Dr. Jacob, and many others who were wholly independent of the Poor-law Board, were in attendance. He felt sure that the *Ægis* of the British Constitution would be thrown over those gentlemen; and, in any event, they had shown more wisdom in coming forward to confront injustice in a manly way than they would have done by shrinking back from avowing their rights. There was more hope for the confident and self-reliant than for those who crouched under the whip. He felt that these complaints would not that night be made in vain; but that they would find their way to responsive hearts all through Ireland, and would awaken popular indignation and sympathy, that the cry would not be uttered in vain by any British subject—"*Civis Romanus sum*" (Loud applause.)

The resolution was then put and carried.

Surgeon Browne, of Belfast, moved the next resolution, which was to the effect;—"That a petition should be prepared and presented to Parliament," He begged to thank the meeting for the kind manner in which he had been received, and to assure the chairman, who had alluded in terms of congratulation to the union between the medical men of the North and South of Ireland, that on the part of the members of the medical profession in Ulster, and the society they had recently established, everything would be done to keep up the feelings of good-will and sympathy, He was ashamed at a former meeting to be obliged to put himself forward as the representative of the profession in Ulster; but now a society had been formed,

numbering one hundred and forty good men and true, and he felt honored at being made the instrument of conveying to the gentlemen of the Southern districts that night the sentiments of reciprocity and kindness to them which animated the Ulster Medical Protective Association. (Hear, hear, and applause.) He was sure from what had been said they were all determined to maintain their privileges and immunities—not as members of the medical profession only, but as British subjects, and as guardians of the sick poor; for if they were injured or their influence shaken, what would become of the poor? They had inalienable rights, and they would not give them up hastily, without some attempt to defend them. He did not wish to detain the meeting with any views of his own, as he believed that the whole question would be ably argued. He merely put forward the broad principle on which they should act, and he hoped to see their struggle for their privileges terminate successfully. (Applause.)

Dr. Ryan, of Tipperary, seconded the resolution, and referred in a few observations to Dr. Wall's case. He thought Cork should take the lead.

Dr. Harvey suggested that on the committee to prepare the petition should be one gentleman from every deputation who attended that meeting (Hear, hear.)

The resolution was put and carried.

Dr. M'Gee, President of the Ulster Medical Protective Association, felt great pleasure in having the opportunity afforded him of speaking at so influential a meeting in defence of the rights of his brethren of the medical profession in Ireland. He hoped that upon such a subject as they were considering, the union between the medical men of the North and South of Ireland would last long; and he might tell them that the members of the association over which he presided had some time ago determined upon a separate petition of their own. (Hear, hear.) Upon Sir John Arnott having made certain representations to the Poor-law Board some time ago, an inspector was sent down, to make inquiry into the matter. This was the course which upon such occasions the Commissioner uniformly adopted; but it should be remembered that the men upon whom, as inspectors, this arduous duty devolved, were wholly ignorant of the subjects with which they had to deal, and the manner in which they should be handled. He was thoroughly conversant with the workings of the Poor-law and the Medical Charities Act, having been connected with the Poor-law system for many years, and he saw the errors into which they ran by mistaking the manner in which the duties of medical inspectors could be discharged. It was surely to be supposed that to discharge these duties a man required some professional knowledge; but the Commissioners acted as if they believed this was unnecessary in gentlemen who had to deal with

the most important matters. Their mistakes arose, partly from the desire to economise, and also to a very great extent from ignorance. He spoke of the Poor-law Commissioners with all due respect, and he had no desire to say anything which might not appear to be founded strictly upon fact; but he did think that, as an almost irresponsible body with unlimited power, and a great field for its exercise, they were sometimes led into errors which it would be as well for themselves and the public they could avoid. They had now a *locus penitentiae* offered them, and they ought to come forward to remove the slur which had been cast upon their character, and begin a new and better system of administration. (Applause.)

Dr. Johnson, of Kilkenny, briefly seconded the resolution, which was put and carried.

Dr. Howlet moved the next resolution. He regretted that the resolution which conveyed the sentiments of the meeting with respect to the conduct of the Poor-law Commissioners was one which required to be put at that meeting. It was to be lamented that their conduct exposed them to the censure of all right-thinking men both in and outside the profession. Dr. Martin, of Portlaw, seconded the resolution, which was carried.

Dr. Armstrong, of Cork, said he had a paper which was drawn up very kindly by Dr. Johnson, of Kilkenny, and which stated fully the whole case. He would read it by the permission of the meeting. Dr. Armstrong then proceeded to read the paper, which stated that in Dunmanway, in January last, a young man received a severe fracture in the leg. He was brought to the workhouse hospital and placed under the care of Dr. Wall; but though the fracture was very severe, he would not consent to amputation; Accordingly, he remained there without having the limb amputated, owing to his constant refusal to submit to the operation. After some time his friends asked that he should be sent to Cork, and he himself was anxious to go, and he went against the desire of Dr. Wall. The Commissioners complained of Dr. Wall's conduct in not having the leg amputated, and in permitting the patient to go up to Cork to die as he did from the effects of the injuries he received, and they sent a letter to the union calling upon Dr. Wall to resign. He did so and a new election took place, at which, as no other gentleman offered himself, he was re-elected. Some time afterwards another letter arrived from the Commissioners, calling upon him to give up the situation to which he was re-elected. He did so, but at the request of the guardians attended to the health of the inmates temporarily. Again came a note threatening a sealed order, and stating that the Commissioners would send up some gentleman from Dublin to take the office. In the meantime patients died, but notwithstanding the frequent letters of the Guardians the Commissioners seemed determined not to permit

Dr. Wall to be re-elected, and in this matter they acted against the commonly permitted practice of re-electing certain officers of a union.

The Chairman stated that he had had an interview with Mr. Cardwell, and complained of the great injustice done Dr. Wall in inflicting three separate punishments upon him. The Chief-Secretary received him courteously, and listened to him with attention. He also remarked upon the strange circumstance, that though the Commissioners deemed Dr. Wall incompetent, they permitted him to discharge the duties of medical officer for five months after the circumstance complained of occurred. He also alluded to the case of Dr. Whistler. He (the Chairman) thought he might state at this point, that he had received upwards of a hundred letters of apology from gentlemen who were not able to attend.

After some further discussion, Dr. Meade said that it seemed hard that a gentleman who, even if he had been wrong, had only committed a slight error, should be dealt with so harshly. It appeared that the guardians had commenced a subscription for Dr. Wall, and it would be well, perhaps, if others would follow their example. He thought the whole subject should be taken up and attended to by the College of Surgeons.

Dr. O'Brien, of Ennis, moved the next resolution, also referring to the case of Dr. Wall. The principle of the resolution he believed to be one which was embodied in the Parliament of Great Britain, and which was the safeguard of the accused, protecting them from any conviction not founded upon evidence. He would like to know why, with respect to the members of the medical profession, the Poor-law Commissioners do not act upon this principle? Why were medical men punished in an arbitrary manner before it was established that they had made any mistake? The Poor-law Board often constituted itself into a Star Chamber to put down and to ruin a person who had done no real harm; but whom, perhaps, they believed guilty of a trifling indiscretion. As a person who was connected with the Poor-law Commissioners in the capacity of a medical officer, he had believed it his duty to come forward on such an occasion to express the opinions which he held. He believed the Board had an arbitrary and excessive power which should not be intrusted to them in a free country, and which enabled them to crush every one in their employ who happened to offend. (Hear.)

Dr. Bennett seconded the resolution, though a servant of the Commissioners.

Dr. Quinan moved the next resolution, appointing a committee to carry out the objects of the meeting.

Dr. Hanrahan seconded the resolution, which was carried unanimously.

Dr. Brown said that, as the business which related to Dr. Wall's case had been transacted, this was the

place to allude to some matters in connection with the profession which ought to receive the attention of such a meeting. He was very well pleased to hear Dr. Bennett declare that the medical profession were the guardians of the children of the poor. If they would look to facts they would see that from persons having such a duty to discharge it was necessary some petition in favour of making vaccination compulsory should issue, for something should be done to prevent the spread of a loathsome and most dangerous disease, which was now becoming more general than formerly. There should be a compulsory registration of births, in order to make it possible to have compulsory vaccination. (Hear, hear.) The person who was not vaccinated was a focus of contagion, and injured not only himself but his fellow-men. Again, the sale of poisons should be considered carefully, and something should be done to prevent people selling injurious and poisonous drugs, who understand nothing about them or their fatal effect. Dr. Brown concluded by moving a resolution to the effect that a committee be appointed to consider these various subjects, and to prepare a petition to Parliament, praying for an amendment in the existing law. (Hear hear.)

Dr. Magee seconded the resolution, which was carried.

Dr. Brown was then moved to the second chair, and the thanks of the meeting voted to Dr. Mackessy for his kindness in presiding, after which the proceedings terminated.

MANAGING COMMITTEE

Belfast News-Letter 13 January 1860 &

Belfast Daily Mercury 13 January 1860

Yesterday [12th January 1860], a meeting of the Managing Committee of the Ulster Medical Protective Association was held in the library of the General Hospital, when the President, Dr. M'Gee, J.P., occupied the chair. There were present—Dr. Patterson, Surgeon Browne, R.N.; Dr. Heeney, Dr. Halliday, Dr. Stewart, Dr. Black, and Dr. Murney, J.P.

Dr. Browne then read the minutes of the ordinary and special meeting of the association, and afterwards moved that they should be confirmed.

That motion was agreed to.

A ballot was then taken, and Surgeon Jeffers, of Cloughmills, was unanimously elected a member of the association. The Chairman remarked that that name made 134 paid members.

Dr. Browne asked had Dr. Patterson any report to make to the meeting?

Dr. Patterson—I may say that we have expended about £21, and that there are still £13 or £14 in hands.

Dr. Browne said it might be remarked that one of their rules was, that no gentleman could be elected a

member unless he were a registered member of the profession.

Dr. Heeney—Is that one of the rules?

Dr. Browne replied in the affirmative, and said that the society was not only a protective but was also a registration association.

The Chairman explained the law in reference to the case of a man whose name might not appear on the register, and who might have occasion to go to law for the recovery of any claim for professional services which he might have rendered. All he would have to do would be to register, and he would get a printed certificate signed by the registrar, showing that he was registered, and that certificate would be a legal document.

He would get the certificate without fee or reward. On the other hand, suppose a man's name was upon the register, it might be objected that the register was not legal evidence in itself; and in that case, he could get the certificate by applying for it and it would be legal evidence of his qualification.

Dr. Brown said that if a medical man wished to correct the register, it was only necessary for him to send his name and address to the registrar, Dr. Maunsell.

Dr. Halliday—And will the book not be received in evidence in a court of justice?

Dr. Patterson—It will not.

Dr. Browne—A case occurred the other day in England.

The Chairman—Some barristers admit the book, and others may not; but when you have the certificate signed by Dr. Maunsell, Dr. Browne or I can prove the handwriting.

Dr. Browne said they would recollect that, at the meeting of the association on the 8th of December, Dr. M'Gee and himself were appointed as a deputation to proceed to the Limerick Junction meeting. They were instructed by a sub-committee as to what course they were to pursue, and what views to advocate.

They had seen by the local papers that the report of that meeting at the Limerick Junction had been very kindly copied from those papers that had reporters there, and gentlemen could see that the proceedings were of a very satisfactory character, and that the interests of the profession, and especially those of the public, were advocated by the deputation, for they took care that the public should see that the profession were not only fighting for themselves but also for the public.

They found that the public were the parties who suffered most when medical men were assailed; and, consequently, the meeting passed a resolution which had been published, and to which he need not again refer. The deputation was kindly received, and the kindest feeling was expressed by the members of the

profession in the South and West towards the profession in the North, and a determination evinced to cooperate with them in every possible way. The next matter he had to bring before them was that he had forwarded to the General Council of Medical Education, and also to the Branch Council, copies of the memorial which had been prepared as directed, and he would read that memorial. He might, however, say that he had received letters from Dr. Hawkins and Dr. Maunsell, acknowledging the receipt of the copies, and also from Dr. Armstrong, Secretary of the Cork Association, to whom he sent a copy of it also. The memorial was as follows:—

“To the General Council of Medical Education and Registration in the United Kingdom.

Gentlemen—I have the honor to state that I am directed by the Ulster Medical Protective Association most respectfully to represent to you the propriety of having a separate medical register for Ireland, issued in 1860, as they believe that such a step would be a great boon to the profession in this country, as it would enable each member to have in his possession a copy in a cheap form, and of easy reference.

They consider that such a course is essential for the successful working of the Medical Act; and I may state that this was the decided opinion of the aggregate meeting of the medical profession of Ireland, held on the 15th instant, and before which I had the honor of submitting this important question.

Trusting that your honorable Board will give this subject your most favorable consideration. I have the honor to be, gentlemen, your very obedient servant.

Samuel Browne, Honorary Secretary.

Belfast. 28th Dec., 1859

P.S.—This association numbers 140 members, and represents about 400 practitioners. The meeting of the profession referred to represented all of the medical associations and the entire profession of Ireland.’

The next matter to be brought under the notice of the meeting was, that the memorial to the Chief-Secretary for Ireland had been forwarded, and a copy of it sent to the Poor-Law Commissioners; the latter had acknowledged the receipt of it, but there had had been no reply yet from Mr. Cardwell. The following is a copy of the memorial:—

“To the Right Hon. Edward Cardwell, M.P., Chief Secretary for Ireland, &c.

Sir—The Ulster Medical Protective Association having observed in the last report submitted to his Excellency the Lord Lieutenant of Ireland, by the Poor-Law Commissioners, that a suggestion formerly made relative to dispensing with the services of medical inspectors, under the Medical Charities Act, has again been set prominently forth, beg, through us,

most respectfully to state that such a course, if adopted, would prove most detrimental to the welfare of the sick poor, as, from experience, they are decidedly of opinion that the provisions of the Medical Charities Act can be efficiently carried out, alone, under the superintendence of medical inspectors. They would, therefore, humbly and earnestly request that any Bill which may be introduced into Parliament for amending the Poor-law and Medical Charities Acts, shall not contain the objectionable clauses suggested by the Poor-law Commissioners.

We have the honor to be Sir, your obedient, humble servants,

William M'Gee, M.D., Chairman.
Samuel Browne, Hon. Secretary.
Belfast, 4th Jan., 1860."

It would be seen from this memorial that the annotation was more anxious for the good of the public than for the benefit of the profession. There was just another memorial to the Branch Medical Council, on the question of vaccination which he would read:

"To the Branch Medical Council for Ireland.

The humble Memorial of the Ulster Medical Protective Association

Respectfully Sheweth—That memorialists, having had nearly two years' experience of the working of the Vaccination Act in this country, believe that, though it has effected much good, it has failed in accomplishing its intended measure of usefulness, in consequence mainly of its not containing any compulsory powers; they believe, therefore, that no measure for promoting vaccination, especially among the poorer classes, could prove effectual, unless it contained some compulsory provisions to meet the apathy and carelessness of many persons in this country.

Memorialists consequently believe that for this purpose the legislature should, in the first instance, pass an Act for the registration of births and deaths in Ireland, without which any law for compulsory vaccination, it is evident, could not be duly enforced.

That, viewing the question of vaccination as one of very great importance to the community, and believing that to the medical profession properly belongs the duty of pointing out to Government the necessity there is for a more comprehensive measure for promoting vaccination than now exists, memorialists call, most respectfully, but earnestly, upon the Branch Medical Council, as the legal representatives of the medical profession in Ireland, to urge upon the Government that a measure for compulsory vaccination, founded on an Act for registering births and deaths in Ireland, be introduced into the ensuing session of the Imperial Parliament.

William M'Gee, M.D., Chairman.
Samuel Browne, Secretary."

The Chairman thought the question of the sale of medicines by unqualified parties was highly injurious to the well-being of the public, and he had just prepared a short memorial to the Company of Apothecaries' Hall, Dublin, as he believed they had power, at least to some extent, to put a stop to the evil. The memorial was as follows:—

"To the Governor, Deputy-Governor and Directors of the Company of Apothecaries Hall of the City of Dublin.

The Memorial of the Ulster Medical Protective Association

Respectfully Sheweth—That, from the Act 31st Geo. III., cap. 34. as manifested in its preamble, and in sections 16, 18, 22, and 26, it was intended that your Corporation should take measures for preventing unqualified persons from preparing or vending medicines, or opening a shop or wareroom for the retail of medicines; that, having heard and believing that it has become a practice for grocers and other such dealers in various towns and villages in Ulster, to retail to any applicant laudanum and other medicines dangerous in the hands of the ignorant or ill-disposed, your memorialists now respectfully request Your Corporation to put in force the power vested in you by law, so that practices so dangerous to health or to life may be discontinued.

William M'Gee, M.D., Chairman.
Samuel Browne, Secretary."

The Chairman, after referring to the law on the subject contained in the memorial, said that the powers of the Apothecaries Hall as regarded the sale of poisons were limited, but that the committee had not thought it necessary in the memorial to go into the question of poisons.

Dr. Browne—In case we get a reply from the Apothecaries Company, stating that they have no powers in the case, what are we to do? Are we to petition the Government or memorial the Branch Council for Ireland?

Chairman—I think, then, that you should memorial the Medical Council, and petition Parliament too.

Dr. Stewart then moved the adoption of the memorial, and that it should be transmitted to the proper quarter.

Dr. Halliday seconded the motion, which was carried.

Dr. Heeney moved that a memorial should be prepared and forwarded to the General Council, to take steps for regulating and restraining the sale of poisons.

Dr. Patterson seconded the motion.

Dr. Browne then moved that the thanks of the meeting be given to the president, committee, end secretary of the Hull Medical Association for their

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Chairman William M'Gee

kindness in forwarding to them the report of their association for the last year.

Dr. Black seconded the motion.

The proceedings then terminated.

PUBLIC MEETING

Northern Whig, Belfast 10 February 1860

Yesterday [9 February 1860], a public meeting of this important association was held in the library of the General Hospital—William M'Gee, Esq., M.D., J.P., President of the Association, in the chair. There was a good attendance of members.

The Secretary (Surgeon Browne, R.N.) read the minutes of the previous meeting, which were confirmed.

NEW MEMBERS

The following gentlemen were unanimously elected members of the association Dr. M'Conkey, Downpatrick; Dr. M'Clintock, Raphoe; Surgeon Otterson, Magherafelt; Surgeon Frame, Comber.

The Secretary remarked that the strength of the association was pleasantly increasing. He hoped it would soon number 150 or 200 members.

He said that, in reference to the memorial sent by the association to the Dublin Council, regarding the separate publication of a medical register for Ireland, he had received the following reply:—

“Branch Medical Council (Ireland),
35, Dawson Street, Dublin,
20th January, 1860.

Dear Sir,—I have laid your letter and the resolution of the Ulster Medical Protective Association, stating the opinion of that body that the medical register of Ireland should be published separately from the general register, before this council; and I am directed to state that this branch council will bring the subject before the general Council; and, also, that the following resolution was passed by this branch council on the 23d February, 1859, viz.:—

Unanimously resolved—“That it is the opinion of this council that there should be a separate register, in alphabetical order, for England and Wales, for Scotland and for Ireland, respectively; as, in such form, the register will be more easy of reference, more correct, and more saleable, than if there be only one continuous alphabetical register for all; and that such registers may be bound together, or sold in separate parts, as required.”

I am also to inform you that this branch council recognises the importance of the subject of the memorial of the Ulster Protective Association, in reference to a measure for compulsory vaccination, and

will bring it under the consideration of the general council.—I am, yours, truly,

H. Maunsell, Registrar.

S. Browne, Esq.”

Secretary—The next communication I have is from the Chief Secretary, touching the appointment of medical inspectors, and is as follows:—

“Dublin Castle, 18th January, 1860.

SIR,—I am directed to acknowledge the receipt of a letter signed by you as chairman of the Ulster Medical Protective Association, and dated the 6th instant; and I am to acquaint you, in reply, that the question of medical inspection will receive full consideration in any Bill which may be introduced to Parliament on the subject.—I am, sir, your obedient servant,

Thomas Larcom.

William M'Gee, Esq., M.D., 1, Adelaide Place, Belfast.”

Secretary—The next is a reply from the Poor Law Commissioners respecting the same memorial to that which I sent to the Chief Secretary:—

“Poor Law Commission Office,
Dublin, Jan. 7. 1860.

Sir—The Commissioners for Administering the Laws for Relief of the Poor in Ireland acknowledge, with thanks, the receipt of your communication, dated the 6th inst., transmitting a copy of a letter which has been addressed by the Ulster Medical Protective Association to the Chief Secretary for Ireland, on the subject of the proposed Poor Law Amendment Bill.—(By order of the Commissioners),

B. Banks, Chief Clerk.

To Samuel Browne, Esq., M.D., Belfast.”

The Secretary also read the following communication, which explains itself:—

“Apothecaries' Hall, Dublin, Jan. 20, 1860.

Gentlemen,—I am instructed by the governor and court of directors of this hall to acknowledge the receipt of the memorial which has been forwarded, in your name, on behalf of “the Ulster Medical Protective Association,” requesting of the hall to exercise the powers entrusted to it for preventing unqualified persons from preparing and vending medicines, and retailing poisonous drugs.

The governor and court, in reply, beg to inform the association that their Act of Incorporation, “31st Geo. III., chap. 34,” limits their control to unqualified persons “who open shop or practice as *apothecaries*” but leaves the retail of drugs and poisons, with the single exception of arsenic, entirely unrestricted.

In reference to the evils referred to in the memorial, the governor and court are anxiously alive to their enormity, and have been exerting their influence with the Government to introduce a Bill into Parliament to restrict the sale of drugs and poisons to persons who shall be duly qualified and licensed for the purpose.—I have the honour to be, gentlemen, your obedient servant,

C. H. Leet, Sec.

To W. M'Gee, Esq., M.D., &c.; and S. Browne, Esq."

The Chairman said, all the association asked the directors to do was to exercise powers, which, it now appeared, they had not. However, they could reasonably go to Government with this document as evidence.

Dr. Filson (Portaferry)—The Apothecaries' Company tried the question, and were defeated.

Dr. Patterson—When did they try it?

Dr. Filson—Twenty or thirty years ago; and they never could succeed unless they could prove that the defaulters prescribed and compounded medicine as apothecaries.

Surgeon Browne—There is one thing certain, that we will have to take further steps; and, as the Apothecaries' Company is anxious to have it settled, application should be made at once to have a Bill brought in on the subject.

Dr. Dickson—If you mean a Bill to give the apothecaries further powers, I, for one, will oppose it.

Chairman—But it is not to give them further powers; it is merely to restrain unqualified persons from practising.

After some further discussion,

It was moved by Dr. Browne, and seconded by Dr. Filson:—"That, in consequence of the reply of the Apothecaries' Company, a petition be drawn up praying the Government to restrict the retail sale of poisons and drugs to duly qualified persons."

Chairman—We can then petition the Government with regard to the nature of the Bill.

THE MEDICAL CHARITIES' ACT.

The Secretary submitted forms of petitions sent from the Irish Medical Association, and the Cork Association, praying the Government for a more liberal policy towards the medical workhouse officers in Ireland

The Chairman said the power of the Poor Law Commissioners would have to be renewed this year, so that a very suitable opportunity would be afforded for asking Government to take the matter into consideration.

Dr. Stewart moved that the petition of the Irish Medical Association, with such alterations as a sub-committee to be appointed should devise, be sent to Parliament, and that copies be sent to the members

for the borough, with the request that they will support the prayer of the memorial.

Surgeon Warwick seconded the motion, which was carried unanimously.

The following were appointed a committee to draw up the memorial—Dr. M'Gee, Surgeon Browne, Dr. Patterson, Dr. Stewart, and Dr. Dickson,

An application was received from the Newry Chirurgical Society requesting that they might be admitted into the Ulster Medical Association on the condition that they would be allowed to preserve their distinctive character.

Dr. Michael Magee thought the matter could not be settled except at the annual meeting, and the secretary was requested to write to the Newry Chirurgical Society for a copy of the rules and objects of the society.

Dr. Patterson—They can only be admitted individually.

The matter was postponed.

UNQUALIFIED PRACTITIONERS

Surgeon Browne read a communication from a member of the association, requesting the body to take into their consideration the fact that a person is practising in Belfast, as a physician, who is not qualified.

Neither the name of the writer of the letter nor the person referred to were made public.

Dr. Patterson knew the person very well, and if he had prescribed, it was most improper. He had no right to prescribe, he was uneducated, professionally speaking, and should know as much.

The object of the association was the punishment of such people, and little quarter should be shewn them. He would move that the secretary be instructed to write to the person in question that, if he continues to prescribe, action will be taken.

This course was agreed to.

The Secretary brought under the notice of the Society a similar case, the offender being in the county Donegal. This was also communicated to the Association.

It was agreed that the person referred to should be communicated with, and that he be requested to send a reply, in which his qualification to dispense medicine will be set forth.

The meeting then terminated.

LETTER TO THE EDITOR

Dublin Medical Press 28 March 1860

THE MEDICAL ACT

Sir,—As the London Medical Registration Association have made a movement for the purpose of having an amended Medical Act, and as the Provincial and other

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Chairman William M'Gee

Medical Societies have been applied to for their views on the subject, perhaps you will allow me to lay before the profession, through the medium of the "Press," the suggestions which the Ulster Protective Association have made to their London brethren, permitting me, also, at the same time, to express the views I entertain regarding the Medical Act—views which I believe are held by nearly every one who has observed the inoperative nature of that measure.

Whatever the good intentions of the Legislature were in framing the "Medical Act," it is quite evident that these intentions have not been fulfilled. For if we believe that the promoters of that measure wished to benefit and protect our profession, to elevate and improve its status, we must admit that, for so far, their kind wishes have most signally failed.

To what then can we ascribe that failure? Mainly, I believe, to the fact that the Legislature, after many fruitless attempts to reconcile contending colleges and conflicting interests, passed a measure, the machinery of which is altogether too cumbrous and too expensive to work satisfactorily; or it may be that they to whom the working of that machinery was entrusted, do not comprehend it; hence the Councils, in despair I presume, instead of applying themselves to the reorganization of the profession, by the improvement of preliminary, and the equalization of medical education, so as, in time, to render our body uniform and its position more elevated, have frittered away their meetings—few and far between—in unseemly wranglings about paltry rights and the privileges of opposing colleges.

The whole procedure of the Councils, I contend, has been the very opposite of beneficial to those whom they represent and whom they were bound to protect. Their method of applying themselves to business proves that, in business matters, they are not practical men, and hence, after a very large expenditure of money, they have not only not benefited the public, or the profession, to the value of fifty pounds, but have made, I fear, an impression on the public mind that our body does not possess within it the element of self-government.

It is not, however, too late to mend: if the Councils will, with calmness and firmness, set to work continuously, and not at long intervals and by spasmodic fits; if they will remember that they are legislating for the profession of which they are the legalised head, but which they are bound to honour and advance—if they will regard a seat at the council board as one of the highest honour, and not a source merely of emolument—if they will take a delight in serving and consulting the interests of their own profession—and if they will permit the presence of the public press at their discussions; I say, if they will do all these things they may make the existing Act, even with its admitted defects, effect a vast deal of good; but if, on the

contrary, they pursue the course they have hitherto followed, I, for one, must believe that any measure so worked can secure little more than a mockery and a snare.

The following are the amendments for the Medical Act, suggested by the Ulster Medical Protective Association:—

"That the General Council be required to insist upon the degree of B.A. or A.M., as preliminary education, or the subjection of the candidate to an examination embracing a course of instruction equivalent to the aforesaid degrees. And that they shall take steps to equalise and render uniform medical education and examinations.

That the Councils shall appoint an Inspector, at a suitable salary, for each portion of the united kingdom, for the purpose of examining all establishments where drugs are compounded or sold by retail, and with power to destroy all impure articles.

That the Councils shall restrain all unqualified persons from retailing or compounding drugs, and that they shall establish regulations for the safe retail of all poisonous matters, or drugs.

That there should be clear evidence of identity, as well as of qualification, of all persons applying to be registered under the Act.

That the law should be so framed that the simple act of prescribing medically or surgically, with or without a fee, shall be considered an infringement of the statute, as being an assumption of a medical status, position, or title.

That upon any unqualified person having been proved to have prescribed, or pretended to be qualified, the onus of proving his title to practice shall be put upon him, as every registered practitioner can have a certificate of his registration by applying for it.

That the production of the Registrar's certificate shall be deemed sufficient evidence of a medical practitioner being duly registered.

That there should be greater facility for prosecuting and punishing offenders against the provisions of this Act than at present exist.

That, in addition to the general Register, there shall be published a separate Register for each part of the united kingdom at a cheap rate, so as to be procurable by every person desirous of having a copy.

That the 23rd Clause should be struck out of the Medical Act, as it countenances quackery in its worst forms, for it seems anomalous that an act which appears to be intended, and was ostensibly framed to protect the regular practitioner, should be made either openly or covertly to foster the lying systems of homœopathy, hydropathy, or the like."

I have the honour to be, Sir, your faithful servant,

Samuel Browne, Lic.K.&Q.C.P.I.,

Hon. Secretary Ulster Medical Protective Association.

Belfast, 19th March, 1860.

FIRST ANNUAL MEETING
Belfast Daily Mercury 11 May 1860 &
Belfast News-Letter 11 May 1860

Yesterday [10th May 1860] the first annual meeting of the Ulster Medical Protective Association was held in the Library of the General Hospital at 13 o'clock, Dr. M'Gee, J.P., President of the Association, in the chair. Amongst the other members present were—Drs. Pirrie, Patterson, Halliday, Stewart, Warnock, Murney, J.P., Browne, W. Arnold, Michael Magee, Johnston, Corry, Mulholland, Hayes,

Surgeon Browne: (Hon. Sec.) read the report of the first general meeting of the association held in last September, and also the following

REPORT OF COMMITTEE.

“Since the inauguration of the Ulster Medical Protective Association in September last, the committee has held ten meetings—two special and eight ordinary. There were, besides, several meetings of sub-committees for the purpose of business arrangements. The first act of the committee was to frame a code of bye-laws and a programme of business. Early in the month of October the honorary secretary was directed to put himself in communication with the Irish Medical and the Branch Protective Associations, as well as with the London Medical Registration Society, for the purpose of effective co-operation in matters affecting the general interests of the profession. Since that time several opportunities have arisen which enabled the various societies to act in friendly concert.

On the 15th of December, a deputation, consisting of the chairman and honorary secretary, attended the aggregate meeting at the Limerick Junction, a most important assembly of the profession, to represent this association. As a result of the Limerick Conference, the committee sent memorials to the General and Branch Medical Councils on the subject of a separate register for Ireland; to the Chief-Secretary for Ireland, on the necessity of retaining medical inspectors under the Medical Charities Act; to the Branch Medical Council for Ireland, on the subject of compulsory vaccination; to the Apothecaries-hall of Dublin, on the sale of medicine by unqualified persons, and on the required restrictions in the retail of poisons.

The following petition to Parliament, signed by more than two hundred medical practitioners in Ulster, and which was presented by Sir Hugh McCalmont Cairns, was sent forward in March, and a circular was addressed by the secretary to every member of Parliament for Ulster, requesting each to support the prayers of the petition. (This petition has already been published.)

A communication having been received from Dr. Ladd, the Secretary of the London Registration Association, relative to suggestions for amendments in the Medical Act, the following were sent from this association by the committee:—

1. That the General Council of Education be required to insist upon the degree of B.A. or M.A. as preliminary education for medical aspirants, or the subjection of the candidate to an examination embracing a course of instruction equivalent to these degrees; and that they shall take steps to equalise and render uniform medical education and examinations.
2. That the councils shall appoint an inspector for each portion of the United Kingdom, at a suitable salary, for the purpose of examining all establishments where drugs are compounded, or sold by retail, and having power to destroy all impure articles.
3. The councils should have power to restrain all unqualified persons from retailing or compounding drugs, and they should establish stringent regulations for the safe retail of all poisonous matters or drugs.
4. That there shall be clear proof of identity, as well as of the qualifications of all persons applying to be registered under the Act.
5. That the law should be so framed that the simple act of prescribing medically, or surgically, by any unqualified person, for gain, shall be considered an infringement of the statute, as being evidence of the assumption, on the part of the prescriber, of a medical status, position, or title.
6. That upon any unqualified person having been found to have so prescribed, or pretended to be qualified, the onus of proving his title to prescribe or practise shall be put upon him—as every registered practitioner is supplied with a certificate of his registration by the registrar.
7. That the production of the registrar's certificate shall be deemed sufficient evidence of the medical practitioner who holds it being duly registered.
8. That there shall be greater facility for prosecuting and punishing offenders against the provisions of the “Medical Act” than at present exist.
9. That in addition to the general register for the kingdom, there shall be published a separate register for each portion of the United Kingdom, at a cheap rate, so as to be procurable by every person desirous of having a copy.
10. That the 23d clause should be struck out of the “Medical Act” as it countenances quackery in its worst forms, for it seems anomalous that an Act which appears to be intended, and was ostensibly framed to protect the regularly qualified practitioner, should be made either openly or covertly

to foster the lying systems of homeopathy, hydro-pathy, and the like.

The committee have, in several instances, written to practitioners who were not complying with the law, and have induced them to become duly registered.

Recently the committee have received communications from country members complaining of persons in their locality assuming certain medical titles without any right to do so. They now suggest that a circular should be sent to every person so complained of, that he may send to the committee a statement of his exact qualifications, if he possess any.

The committee have received a copy of the Poor Relief Amendment Bill, now before Parliament. They regret that it does not contain several of the provisions for which the association have petitioned, and is, on the whole, not so comprehensive as they hoped it would be. From communications they have received from the President and Secretary of the Irish Medical Association, they are led to believe, however, that the Chief Secretary will make several important amendments in the Bill before it shall become law.

The committee have recently summoned some unqualified persons, practising in Belfast, to the Petty Sessions Court. The case is still pending, as it has been postponed on a point of law. The committee, however, have no doubt of obtaining convictions against the persons in question, and they are determined to enforce the law against all unqualified persons practising medicine, so far as they have the power. The committee having learned by experience that some change relative to the county members of committee should be made, beg leave to suggest that these gentlemen—three for each county in Ulster—should be styled corresponding members of committee, and that they should be summoned to attend at quarterly meetings only. This plan would save your secretary a considerable amount of labour, and the association some expense.

In conclusion, the committee have to report that the association is in a flourishing condition. It now numbers one hundred and fifty-six members, and several gentlemen have signified their intention of joining our ranks. The committee believe that such a course is the solemn duty of every registered practitioner in Ulster who values the rights which belong to our profession. Some there are, no doubt, who will not perceive any good in an association which does not promote their individual interests. Men having such feelings had better not join us. They cannot appreciate the moral power of an intelligent body of men associated for the purpose, not of protecting themselves alone, and the rights of their class, but also for promoting, by their united influence, the best interests of the community at large.'

Surgeon Browne stated that, during the time the association had been in existence, a great deal more

had been done than was stated in the report. They had either got parties to register, or put parties who had been placed in a false position into a proper position. They had also been the means of amalgamating the North with the South of Ireland. There was no doubt that many parties had been disappointed at their not having done more, and many would blame the committee for not having taken up more stringently prosecutions against those who might be considered unqualified practitioners; but it was better, in all those cases, to induce the parties to leave off practice, particularly through the medium of the public press, if possible.

He wished the public to understand that the motive which actuated the association throughout was not to protect themselves at all against unqualified practitioners, because there was not an individual entered upon the registry who had not an opportunity of protecting himself by appealing to the public at large, and stating that he was a registered man. But the public at large would not take the trouble of making that inquiry, and, therefore, it became the duty of that association to come forward for the benefit of the public, and expose parties practising illegally. He believed, if the society would be only worked as actively during the coming year as it had been for the last eight months, they would have a still greater accession of good for the next year, by their acts, and with the assistance and co-operation of other associations. After referring to the valuable assistance which the association had received from Dr. Mackessy, President of the Irish Medical Association, Surgeon Browne concluded by moving the adoption of the report.

Dr. Corby seconded the motion.

Dr. Michael Magee then addressed the meeting at some length on the objects and duties of the association, and expressed himself dissatisfied with the committee for not having prosecuted a larger number of quacks or unlicensed practitioners. They had formed, he said, what was now called the Ulster Medical Association, for the purpose of carrying out the provisions of the Medical Registration Act—an Act that seemed to please few and dissatisfy all, but which, nevertheless, had this much good in it, that it had separated the wheat from the chaff, and had drawn a conspicuous line of demarcation between honest men and knaves. He was sorry to think that the committee had not given sufficient of their time and attention to the exposure of those hydra-headed monsters that had been living so long and so sumptuously, too, on their profession; and he concluded by expressing a hope that during the next year the committee would leave nothing undone to bring up every unqualified practitioner, if not for conviction, at least for exposure, and expel such pretenders from amongst them.

Surgeon Browne, in the course of some observations, said the association had attended to the general interests of the profession, and to every matter in which the community was concerned. He contended that they had done in the limited period of eight months as much good as possibly could be done by people in their position. With regard to the matters complained of, he might state that they wanted the necessary authority. They were now seeking for that authority and power, and when they would get those powers he would assure Dr. Magee and the public that they would be put into active operation.

After some remarks of a similar nature from the Chairman, the report was unanimously adopted.

Dr. Patterson (Treasurer) read a statement of the accounts, from which it appeared that since the formation of the society the income had been £35 1s 10d; the outlay was £27 2s, and there was at present a balance of £7 19s 10d in hands.

Moved by Dr. Browne, seconded by Dr. Corry, and Resolved—

“That the Report just read, together with the Treasurer’s Statement of Accounts, be now received, adopted, and entered upon the minutes.”

A Ballot having then been taken for a Chairman, and the members of Committee going out by rotation,

Dr. M’Gee, J.P., was unanimously re-elected Chairman for the ensuing year, and the following gentlemen were declared the Committee for the same period, viz:—Dr. Murney, J.P.; Surgeon Johnston. Dr. Black. Dr. Cuming. Professor Ferguson, Dr. Stewart, Dr. Heeney, Dr. Dickson. Richard Pring, Esq.; Dr. Halliday, Surgeon Warwick, and Dr. Murray, of Ballymacarett.

The following were also declared the “County Corresponding Members”:

Antrim.—Dr. O’Connor, Ballycastle; Dr. Kidd, Ballymena; Dr. M’Kee, Randalstown.

Derry.—Dr. Babington, Londonderry; Dr. Cavin, Coleraine; Dr. Graves, Cookstown.

Down.—Dr. Filson, Portaferry; Dr. Jamison, Newtownards, Dr. May, Rathfriland.

Cavan.—Dr. Taylor, Bailieborough; Dr. McGaghan, Kingscourt.

Armagh.—Dr. M’Kinstry, Armagh; Dr. MacLaughlin, Lurgan; Dr. Davis, Newry.

Donegal.—Dr. Thorpe, Letterkenny; Dr. Eames, Dunfanaghy; Dr. Bagot, Malin.

Monaghan.—Dr. Fleming, Carrickmacross; Dr. Young, Ballybay; Dr. Donaldson, Clontibret.

Tyrone.—Dr. Scott, J.P., Aughnacloy; Dr. Neville, Dunganon; Dr. Fleming, Omagh.

Fermanagh.—Dr. Maxwell, Derrylin; Surgeon Robert Hayes, Lisbellaw.

Moved by Dr. Halliday, seconded by Dr. Mulholland, and resolved—

“That the grateful thanks of the Association be given to Dr. Patterson for his valuable services, and that he be requested to continue Treasurer.”

Moved by Dr. Michael M’Gee, seconded by Surgeon Gribben, and resolved—

“That the warm thanks of this meeting be given to Dr. Browne for his labours on behalf of this Association, and that he be requested to act as Honorary Secretary for the ensuing year.”

William M’Gee, M.D., Chairman.

Dr. Michael M’Gee having been called to the Chair,

It was moved by Dr. Stewart, seconded by Surgeon Warwick, and carried by acclamation—

“That the best thanks of this meeting be given to Dr. M’Gee, J.P., for his kindness in presiding, and for the many instances in which he has shown his sincere devotion to the honor and interests of the Medical Profession.”

It was then unanimously agreed that a deputation from the association be appointed to attend the meeting of the profession in Dublin on the 4th June next.

The Treasurer then announced that the annual subscription is now due.

The meeting then separated.

Michael M’Gee, M.D., Chairman.

Sam. Browne. Lic. K. and Q. Coll. Phy., &c.,
Honorary Secretary.

At the committee meeting preceding the general meeting the following gentlemen, belonging to the Newry Chirurgical Society, were ballotted for and elected, viz:—Dr. J. Colvan, Dr. J. Morrison, Dr. A. Erskine, Dr. William Starkey, Dr. Joseph Robinson, Dr. Robt. Johnstone, Dr. W. K. Nesbitt, Dr. Joseph May, Dr. Joseph Crawford, Dr. W. A. Davis, Surgeons Thomas Black, Charles Anderson, Thomas Mulligan, James M. M’Conville, Andrew M’Bride, and Arthur M’Court.

Dr. S. T. Haslett, of Laghey, and Dr. Wilberforce Arnold, of Belfast, were also elected members.

COURT PROCEEDINGS

Belfast Weekly News 12 May 1860

Tuesday 8th May 1860

UNLICENSED MEDICAL PRACTITIONERS

Mr. Edward J. Carew of Academy Street; Mr. Robert Johnston of Durham Street; and a Mr. McCloy, were summoned by Surgeon Browne, at the instance of the Ulster Medical Protective Association, “for having on the 3rd May inst. at Belfast, wilfully and falsely pretended to be practitioners in medicine and physicians and that they did supply and prescribe medicine contrary to the 21st and 22nd Vic., cap. 90.”

Ulster Medical Protective Association

1860–1861

Chairman William M'Gee

Mr. Seeds appeared for the prosecution; Mr. Rea appeared on behalf of Mr. Carew; Mr. McLean for Mr. Johnston, and Mr. O'Rourke for Mr. McCloy.

Surgeon Browne, Secretary, and Dr. Patterson, Treasurer, of the Ulster Medical Protective Association, attended to watch proceedings on behalf of that body.

After some conversation between the Bench and the legal gentlemen engaged on both sides, the Bench decided on postponing the case until the 5th of June next, the costs to await the decision of that day.

COMMITTEE MEETING

Belfast News-Letter 18 May 1860

The first meeting of the newly-appointed committee of the Ulster Medical Protective Association was held yesterday, at the Belfast General Hospital, Dr. Stewart in the chair. Present—Drs. Patterson, Murray, Johnston, Warwick, Browne, Dickson, and Mr. Pring. After the confirmation of the minutes of last meeting, it was resolved that the committee shall meet the second Thursday in each month, at three o'clock, P.M., and that the quarterly meetings, to which the "County Corresponding Members" shall be summoned, shall be held on the second Thursdays of August, November, February, and May, either at three o'clock, or noon, as may be found most expedient. It was also resolved that the form of circular read by the Secretary should be adopted, and that a copy of it should be sent to every one against whom a complaint shall be lodged for assuming a medical or surgical title, or for practising without a legal right or qualification to do so. The following is the circular:—

"I am directed by the Committee of the Ulster Medical Protective Association to acquaint you of a complaint which has been made to them, that you assume a professional title and practice medicine and surgery without any legal right to do so, and as your name does not appear in the Medical Register, I have to request that you will forward a statement of your professional qualifications to me, that I may submit the same to the committee. I have also to inform you that, if you do not comply with this request, and continue to practice illegally, the Ulster Medical Protective Association will take such steps in your case as our counsel may advise."

As the Ulster Medical Protective Association feel very anxious to keep up the most friendly relations with the Irish Medical and the other Branch Associations, the committee appointed the Chairman and Secretary, along with Dr. Murray, of Ballymacarrett, a deputation to proceed to Dublin to attend the annual meeting of the Medical Association of Ireland on the

4th of June, and to represent the Ulster Society. It was also resolved to recommend to the members of the Ulster Medical Protective Association that they should use all their influence with the Fellows of the College of Surgeons of Ireland to record their votes in favor of Dr. Mackesy in the vice-chair of the College, as the committee believe that Dr. Mackesy is justly entitled to this mark of respect from his brethren of Ireland for his unwearied exertions in maintaining the honor, respectability, and the best interests of the profession, while they also believe that a more judicious selection could not be made for the important appointment in question. The committee, therefore, trust that every Fellow of this College of Surgeons in Ireland in connexion with this association will vote for Dr. Mackesy, of Waterford, the able, tried, and zealous friend of the medical profession.

COURT PROCEEDINGS

Belfast News-Letter 7 June 1860

NEWS COLUMN

Yesterday, a case of very great importance to the public was brought before the Police Court, at the suit of the Ulster Medical Protective Association, in the name of their honorary secretary, Surgeon Browne. The object of the prosecution was to endeavour to put down the system, too prevalent, of individuals practising as medical men while in no wise qualified for the duties of such an important profession. This class of practitioners, too, very generally placard the walls of our town and its vicinity, as well as neighbouring towns, with indecent bills; and, with the object in view of putting a stop to such, and of protecting the public from quackery, the association took proceedings against certain parties in Belfast, and a report of the trial will be found in our police report in another column [below]. The law has for the present been vindicated; and, as the case heard was the first brought into court, it may prove a warning to others, and be sufficient to deter them from setting themselves forth as "duly qualified medical practitioners" until they first duly register their names in the proper quarter, and so give the public a guarantee that they do not belong to the class generally designated by the term "quacks." The Ulster Medical Protective Association deserves the thanks of the community for having taken up this matter; for, while preserving their own interests they are doing that which will prove equally beneficial to the general public.

LEGAL COLUMN

Edward J. Carew, of Academy Street; Robt. Johnston, of Durham Street; and Michael M'Cloy, Divis Street, were summoned by Surgeon Browne, at the instance of the Ulster Medical Protective Association, "for hav-

ing, on the 3rd May last, at Belfast, wilfully and falsely pretended to be practitioners in medicine and physicians, and that they did supply, and prescribe and supply, medicine contrary to the 21st and 22nd Vic., cap. 90.”

The case had been postponed from a previous day, and came on for hearing.

Mr. J. M. Thompson (barrister), with Mr. Seeds, appeared for the prosecution, and Mr. M'Lean for the defence.

Surgeon Browne, Secretary, and Dr. Patterson, Treasurer of the Ulster Medical Protective Association, attended to watch the proceedings on behalf of that body.

The case of Mr. Carew was the first called on.

Mr. M'Lean stated that his client had been informed that there would be no further proceedings taken in the case, and that Mr. Rea, who had been engaged for Mr. Carew, was now out of town,

Mr. Seeds said it was arranged on Tuesday that the case should be heard that morning.

Mr. Lyons—You are aware, Mr. Thompson, that this is an adjourned summons. The last day it was here the counsel or attorney for the prosecution could not satisfy the Bench that Dr. Browne had a *locus standi* in this court. It is for you now to satisfy us that that preliminary objection was not a right one.

Mr. Thompson said it was a very proper suggestion, and an important matter of inquiry. Counsel then cited several law authorities to show that any party might be the complainant in a criminal offence, unless in cases where the statute particularised who was to bring the complaint.

Mr. M'Lean said if there had been an information sworn in the case he would wish to see it. He believed no information had been made, although it was absolutely necessary such a thing should have been done. He received no instruction in the case at all, and was only acting for Mr. Rea. Surgeon Browne, he believed, could not make a sworn information. He knew of no complaint, and had no complaint to make.

Mr. Thompson said the rule of the law was that they might proceed without any information. If any offence was committed against the statute law, the magistrates were bound to inquire into it.

Mr. Lyons said the Act under which they were proceeding was the lamest he had ever seen; and he thought, for the safety of the Bench, that there should be informations in the case.

Mr. Thompson then drafted an information, embodying the charges against the defendant set forth in the summons.

Mr. M'Lean objected to the information on the ground that it was bad in substance, as it did not set forth a distinct charge against the defendant.

The Bench overruled the objection, and allowed the case to be proceeded with.

Mr. Thompson then stated the case for the prosecution, detailing the charges brought against the defendants, and remarking upon the seriousness of the offences as affecting not only the profession as a body, but the community at large. He also explained the nature of the Act of Parliament under which the prosecution had been brought, and contended that the defendant, by not being entered on the Medical Registry, violated the provisions of that Act.

Constable Cairns, examined by Mr. Thompson—On the 3rd May last, I went to the residence of the defendant, 17, Academy Street. I had previously seen bills of his on walls through the town. When I went into the shop I asked a woman could I see the doctor. She went up-stairs and sent the defendant down to me. On seeing him, I asked if he were the doctor? and he said he was. I told him I had got a very severe cough and a pain in the chest, He opened a door, and told me to go into a little room where there was a lot of empty bottles. He then told me to loose my breast, and he made one of those telescopes (stethoscopes) with an old account-book (Laughter.) He put it to my chest and applied his ear to it. (Renewed laughter.) After talking a lot of “bladders and nonsense” about having got £5 for curing parties in Newtownards, and £100 from the late Marquis of Waterford for medical treatment, he told me I was like a big tree that had grown up without any substance in me. (Great laughter.) I told him I had been with Dr. Corry, and he said—“Corry is no doctor at all”—(laughter)—and that he (Carew) had just got three of his patients that week, for whom Dr. Corry could do nothing, but who were now getting on well under his treatment. He also stated that before he dirtied paper with ink his charge was £5 to a gentleman. I told him I was no gentleman, and he replied that his lowest charge was £1 to a man like me. (Laughter.) I told him I had not so much as £1. I gave him 10s., and he took credit for the other 10s., which I was to pay him when he would cure me. He said he could not make that bargain with me, but that the sooner I would give him the other ten shillings the better it would be for myself. (Laughter.) I was then to give him 5s. the following Saturday, and the other 5s. in the week after. He said there was no mistake but that he would cure me once he took it on hands. He said I wanted “new machinery”—(laughter)—and observed “that there were as many diseases following a man as there were hairs on his head, and that it took a smart man like him to know six of them at a time.” He further stated that there had been three of the foremost doctors in Belfast with him that day getting information from him about curing their patients—(laughter)—and that he would give them none, because they understood nothing about his mode of curing, He gave me a little pill about the size of a pickle of hempseed, and a spoonful of liquid, which I took. I told him I was a stranger in town, and

that I had seen his bills on the corner. I asked him if he had any in the house. He said he had, and gave me one. He gave me this handbill. (This bill informed the public of the efficacy of Mr. Carew's cures; that his consulting department was conducted by "a regularly qualified medical practitioner;" and also, that he charged according to the nature of the case, and the means of the party.) The defendant told me that he gave a man £10 a-year for posting up those bills, I asked him would the medicine do me any good that night, and he said that I must go to him for three days running, and "every other day" until I was cured. I told him I wished a receipt for the 10s. lest my mother might think I had gone on the spree. (Laughter.) He then gave the following:—"I have this day received 10s. from Mr. Thos. Cairns for a cure of a chest affection.—3rd May, 1860. E. J. Carew." He told me he was the doctor when I went into the shop.

Cross-examined by Mr. M'Lean—When I said I was from the country, and a stranger in Belfast, it was a lie. When I said I got the 10s. from my mother it was a lie. It was Inspector M'llroy sent me to Mr. Carew's establishment. He did not tell me to tell the lies. He told me not to let Mr. Carew know that I was a constable. Inspector M'llroy gave me the 10s. I did not know who got M'llroy to act in the case. I was bound to obey him.

Surgeon Browne, examined by Mr. Thompson—I am Honorary Secretary to the Ulster Medical Protective Association. In that capacity I allowed my name to be used in this case, and by directions of the committee. The President of the Association is Dr. M'Gee, J.P., and the Treasurer Dr. Patterson. Professor Ferguson and others are in the council.

Mr. Thompson—I now tender the Medical Registry as evidence. According to the Act of Parliament it was evidence in the case, and the defendant is bound to show that his name is in it or ought to be in it.

Mr. Lyons—Prove it before you tender it as evidence.

Mr. Thompson said they did not require to prove it; the words of the Act were—"Purporting to be a copy." What he handed in purported to be a printed copy, published by authority.

Mr. M'Lean contended that it was necessary to prove it as in the case of any document coming out of the hands of the officer of a court. The Secretary to the Medical Association in Dublin held the original list, and a copy of that should be signed by him, and it would then be very necessary, under the Act, for some one in Belfast to prove the handwriting.

Mr. Dunville thought the words "purporting to be a copy" set the matter at rest.

Mr. Lyons said they would receive it as evidence.

Mr. M'Lean said his next point was that, according to law, any information should set forth the time and place, when and where, the alleged offence was com-

mitted. The information of Surgeon Browne only set forth the time and the residence of Mr. Carew, but did not say where the offence had been committed. He, therefore, called on the Bench to dismiss the case.

Mr. Lyons said that would have been a good point if made before the evidence had been given; but the evidence made up for the want in the information.

Mr. M'Lean would have raised the point earlier, but he could not read the information, and had only just received a copy of it.

Mr. Lyons said they ruled against Mr. M'Lean on that also.

Mr. M'Lean said he then came to his defence. He had only to hand in a certificate or diploma from the Apothecaries' Hall, Dublin, in order to show that the defendant was properly qualified; and he would examine medical gentlemen in court to prove that it was a proper certificate or diploma.

Surgeon Browne, examined by Mr. M'Lean—I could not tell is this (document handed witness) a certificate of the Apothecaries' Hall, Dublin.

Dr. Patterson, examined by Mr. M'Lean—I could not say that it is a certificate of the Apothecaries' Hall, Dublin. Perhaps Professor Ferguson could.

Professor Ferguson, examined by Mr. M'Lean—My opinion is that this is a diploma of the Apothecaries' Hall, Dublin, It is in the name of "Edward J. Carrooe."

Mr. Lyons—What date?

Witness—It is dated 1834.

Mr. Lyons—There has been no evidence given yet as to the man's name.

Mr. M'Lean—I intended to raise that point, but I will now prove that the defendant is the gentleman named in this diploma.

Surgeon Browne, examined by Mr. M'Lean—He had corresponded with the secretary of the Apothecaries' Hall, Dublin, in relation to this matter, and received a letter saying that 'Edward J. Carew' was the same individual who had received a diploma from that hall in 1834 as "Edward J. Carrooe."

Mr. M'Lean said they had the opinion of a late Attorney-General that any gentleman holding a diploma from the Apothecaries' Hall, Dublin, could practise in medicine in any part of her Majesty's dominions.

Mr. Lyons—But show us that Mr. Carew is registered under the Act.

Mr. M'Lean contended that it was not compulsory on any gentleman to register; but he could not recover fees in a civil court unless he had registered.

Mr. Lyons held that the defendant, having set himself forth in the printed bill which he gave Cairns as "a duly qualified practitioner," was bound to register, or to suffer the penalty if he practised.

After some discussion as to this legal point, the defendant said he would register properly under the Act.

Surgeon Browne said that was all they wanted.

The Bench then postponed judgment for one month, in order to allow the defendant to register

S. BROWNE *v.* M'CLOY.

Mr. Seeds said the defendant had left the town, and they would withdraw the case.

S. BROWNE *v.* JOHNSTON.

Mr. Thompson said, inasmuch as the law had been vindicated, they would withdraw this case also.

Mr. Seeds—Or let it be dismissed.

Mr. Carew said it was a hard thing that they should prosecute a man who had a diploma and let others off. He also wished to know if he would not be allowed his costs?

Mr. Lyons said the Bench had postponed the case for a month, and if, in the meantime, the defendant did not register himself, they would give the complainant full costs.

PRESENTATION OF PETITION
Belfast News-Letter 15 June 1860

REGISTRATION OF BIRTHS &c.

On Tuesday [12 June 1860], in the House of Commons, a petition was presented by Sir. H. Cairns, from the Ulster Medical Protective Association, in favor of the Government Birth, &c., Registration (Ireland) Bill, and praying for some alterations.

EXECUTIVE COMMITTEE
Belfast News-Letter 10 August 1860

Yesterday [9 August 1860], a quarterly meeting of the Executive Committee of this association was held in the library at the General Hospital—Dr. Dickson in the chair.

Surgeon Browne, Hon. Secretary, read the minutes of last meeting, which were approved. He went on to observe that both the Registration Bills, which had been before the House of Commons, had been withdrawn. In some measure he was sorry for that, as he thought Mr. Cardwell's might, if it had been passed with certain amendments, have been of great advantage to the public, and in a less degree of the profession. There was a strong probability that a Bill would be introduced next session, and it was their duty to make every exertion with the view of having another measure brought forward. Another Bill in which they had considerable interest—namely, the one for the amendment of the Poor-law—had been entirely changed, and was now simply a continuance Bill to keep the Commissioners in office for two years from September next, when their powers would otherwise

have ceased. It was probable that another Bill would be introduced, and they should be very vigilant as to any clauses introduced which might materially affect the profession.

The Chairman—Is there any necessity for appointing a committee to watch over it?

Surgeon Browne said that the Council, which met every month, would attend to it. He then suggested that the Ulster Society should become connected with the Irish Medical Association, either by payment of a sum of money, or in some other way.

A long conversation ensued as to the rules of the Irish Medical Society, and the feeling of the committee was that, while maintaining their own provincial organisation, they should co-operate with that society in every possible way. Ultimately, on the motion of Dr. Murney, the Secretary was instructed to write to the Irish Medical Association to state that it was the wish of the Ulster Medical Protective Association to co-operate in all matters for the benefit of the profession, and to inquire in what way, in their opinion, they could join in advancing their common object, and also what subscription would constitute members of the Ulster Medical Protective Association members of the Irish Medical Protective Association,

Dr. Patterson, the Treasurer, said that the dispensary medical officers were not supporting the association as they should do.

Surgeon Browne said that they were more called upon to join it than any others. He did not believe the medical officers of dispensaries were under dread of the Poor-law Commissioners, and, from what he had himself heard and seen, he did not believe the Commissioners were at all enemies to the profession. Indeed, on one or two points, his mind was completely changed after the explanations he had heard made.

A letter was read from Dr. Thomas Babington, of Derry, withdrawing his name from the committee and from the association, in consequence of the course taken by the members at the previous meeting in reference to the Poor-law Amendment Bill.

Dr. Patterson said that Dr. Babington was a county infirmary man, and it could hardly be expected that he would remain a member, when the association had not supported the claims of the Infirmary doctors.

Surgeon Browne—I think they took a very wrong view of the clauses they referred to.

The Chairman—It strikes me that they were very favorable to them.

Dr. William Browne was unanimously elected a member of committee, in the room of Dr. Babington.

Dr. Patterson reported that 96 new members had been admitted during the year.

Surgeon M'Gowan, of Trillick, and Dr. Shannon, of Poyntzpass, were balloted for and elected members.

The remaining business was routine.

Ulster Medical Protective Association

1860–1861

Chairman William M'Gee

COMMITTEE MEETING

Northern Whig, Belfast 12 October 1860

The committee of this association met yesterday [11 November 1860], at the General Hospital, Dr. Stewart in the chair.

After the transaction of the ordinary business, Dr. Browne, the Honorary Secretary, brought under the notice of the committee the names of several persons reported as illegally practising medicine, to whom he had sent the approved cautionary notice. From some of these persons he had received satisfactory replies, but in other instances the statements were evasive.

After some discussion, it was resolved to bring these cases under the notice of the next quarterly meeting, in November, that such steps might be taken regarding unqualified practitioners as likely to put a stop to their illegal and dangerous proceedings.

The Secretary likewise read letters from Dr. Quinan, the Secretary of the Irish Medical Association, and from Dr. Mackesy, of Waterford, relative to the commission which is likely to be appointed to enquire into the working of the Irish Poor Law.

The meeting expressed the ardent desire of the Ulster Protective Association to co-operate with the other medical societies in procuring for the country and for the profession a better administration of the law than there is at present; and the secretary was directed to convey to Drs. Quinan and Mackesy the views of the committee on this very important subject.

The chairman then directed attention to a case reported in the local papers recently, relative to a "medical man" having been brought before the magistrates and fined for a trespass, etc., on the County Down Railway. On investigation, however, by the Ulster Protective Association, it was found that the individual in question is not connected with the Medical Profession, as his name does not appear either on the Medical Register or on any authorised professional list.

The committee thanked Dr. Stewart for noticing the case, as they felt the profession had no right to have the person referred to ranked among them.

QUARTERLY MEETING

Belfast Weekly News 17 November 1860

Thursday [15 November 1860], the quarterly meeting of the committee of the above association was held in the library of the General Hospital, at eleven o'clock—Dr. Patterson in the chair. Amongst those present, besides the Chairman, were Surgeon Browne, Dr. Brown (Derry), Dr. Stewart, Dr. Cumming, Dr. Murray, Dr. Johnston, and Dr. Black.

PERIPATETIC PHYSICIANS

Belfast Newsletter 8 January 1861

Peripatetic Physicians—A couple of this class of practitioners have been indefatigably engaged in distributing, throughout those localities of Belfast chiefly inhabited by the working classes of higher and lower grades, their own bills, in which they profess to cure almost every malady—from toothache to hydrophobia. With one disease, always too prevalent, they evidently do not wish to deal in a curative sense—namely, public gullibility. These travelling doctors, in their bills, display intense contempt for grammar, the orthography being, perhaps, an index to the purity of their medicines. Their mode of beating up patients is expert, if not exactly professional. They chalk every door where a bill is delivered, and when the document is called for some hours afterwards, special inquiry is made after the health of the family; and, if no one stands in need of their nostrums, a hope is expressed that so healthy a state of matters may not long continue. There exists in Belfast a Medical Protective Association, with active officers. We commend these peripatetic Galens to their particular attention.

COMMITTEE MEETING

Belfast Daily Mercury 25 January 1861

The monthly meeting of the committee of this society was held yesterday [24 January 1861], at 12 o'clock, in the Belfast General Hospital, when, after the transaction of the ordinary business, it was resolved that a report, based upon the replies received from the medical officers of workhouses and dispensaries in Ulster, in answer to queries recently submitted to them, should be drawn up and submitted to a general meeting of the profession, to be called by public advertisement in the newspapers, and by circular to the members of the committee. It was also resolved that meetings shall be held on the 31st inst., at noon, in the Belfast General Hospital, and that questions relative to the amendments required in the Poor Law, Medical Charities, and Vaccination Acts, should then be brought under discussion. A resolution was likewise adopted directing the secretary to advertise the intended meeting in the *Northern Whig*, *Belfast News-Letter*, and *Daily Mercury*, and also in the *Newry Telegraph* and *Londonderry Sentinel*. The chairman, treasurer, and secretary, having been requested to prepare the report for the general meeting, the committee adjourned.

SPECIAL MEETING

Dublin Medical Press 13 February 1861

AT the annual [sic] meeting of the members of this Association, held in the Library of the General Hospital, Dr. McGee, J.P., in the chair. The other members present were, Dr. Patterson, Dr. Stewart, Dr. Browne, Dr. W. Scott, J.P., Aughnacloy; Dr. Stronge, Dr. Murray, Ballymacarrett; Dr. Scott, Depot Battalion; Dr. M. McGee, Dr. Warwick, and Dr. Arnold.

Dr. Browne, hon. secretary, read the minutes of the previous meeting of committee, after which he stated that he had received letters of apology from Dr. W. Browne, Londonderry; Dr. O'Connor, Ballycastle; and Dr. Davis, Newry.

Dr. Stewart mentioned that he had received a letter from Dr. Filson of Portaferry, apologising for his absence from the meeting.

Dr. Browne then read the following

REPORT OF SUB-COMMITTEE.

“As directed by the Association, at their quarterly meeting held on the 15th of November last, your secretary sent copies of the queries which had been agreed on to the several medical officers connected with workhouses and dispensaries in Ulster. The replies received, and which have been carefully examined by the sub-committee appointed, are in many cases very important, some of the suggestions being exceedingly valuable. Arising out of them, your sub-committee now submit the following suggestions, for the consideration of this meeting:—

“First.—That petitions to both Houses of Parliament should be prepared, copies thereof being sent to the Poor-law Commissioners, praying for the introduction of a Bill for the Registration of Births, Deaths, and Marriages in Ireland, the medical officers of dispensaries being the Registrars under the Act, with suitable remuneration. That vaccination be rendered compulsory, and that each successful case shall be paid for. That a simple and more effectual method of issuing tickets to the sick poor, for medical relief, shall be provided, the form of the ticket stating that the grantor has made himself acquainted with the circumstances of the applicant, it being understood that domestic servants can only obtain such relief at the expense of their masters. That the grantor of a relief ticket shall be able to cancel the same, and that the medical inspector shall have the same power, in any cases submitted for his decision. That, subject to the approval of the guardians, the cost of medicine and attendance in cases of cancelled tickets be paid for by the recipient, or, in default, by the grantor of the relief ticket. That, for the sake of the sick poor and the public, medical officers of dispensaries shall be ex-officio “wardens” for contagious diseases. That no spirit dealers or hucksters be eligible to serve as wardens. That the salaries of the medical officers shall be fixed by the Poor-law Commissioners, and not by the

guardians. That suitable allowance should be made for keep of horse and car-hire. That the amount of writing demanded of the medical officers of dispensaries may, and should be, greatly lessened. To carry out the preceding provisions for the benefit of the sick poor, medical inspectors should not only be continued, but increased in number. These suggestions are in reference to the Medical Charities and Vaccination Acts alone.”

POOR-LAW ACTS

The following are the suggestions, arising out of the replies received, which your sub-committee submit to the meeting relative to amendments in the Poor-law Acts:—“That suitable hospital accommodation, compatible with the wants of the district, should be attached to each union workhouse. That individual members of families should be admitted to hospital relief on medical certificate, without the head of the family being compelled to enter the workhouse. That persons dying in the receipt of poor-law relief may be buried in workhouse grounds at the cost of the rates, on receipt of medical certificate, under the superintendence of the relieving officer. The sub-committee have now only to recommend these suggestions to the notice of the meeting, that the Association, if it see fit, may found resolutions and petitions thereon.”

By order of the Sub-Committee,

SAM. Browne, Hon. Sec.

On the motion of Dr. Patterson, seconded by Dr. Murray, the report was adopted.

Dr. Browne said that their medical brethren would perceive that the Association was earnestly working for their benefit, and he trusted that they would feel the necessity of cordially coöperating with the Association, and supplying the necessary funds to enable the committee to carry out the objects in view. In fact, it was absolutely necessary that their medical brethren should do so. They must know that, in order to send gentlemen to London to look after the rights and interests of the profession when any bill affecting them was before the House of Commons, their medical friends in Ulster would be required to give a helping hand by subscribing liberally to the funds of the Association. Already he was glad to be in a position to state that, from the answers to the queries sent out by the committee, their friends at a distance had promised to contribute; and some of them had gone the length of suggesting that the committee should strike a rate upon them, but the Association had no power to do so. Their medical brethren should bear in mind that it would be themselves that would be benefited by the labours of the Association, and not any of the gentlemen who were upon the committee, who were totally unconnected with dispensaries or workhouse establishments. In reality, he might say that the committee were working more for the public good than for the medical profession; for there was not one

of their objects, if carried out, that would not benefit the sick poor. He hoped there would be no ground for again saying of their medical friends what had already been said by the clever editor of the DUBLIN MEDICAL PRESS—namely, that they were influenced either by cowardice or parsimony in not coöperating for the general good. He believed the time was come to be vigilant and active, and if a decided movement were not made to sustain the interests and the rights of the profession, it, would not be the fault of the committee of the Association.

Dr. M. McGee expressed a hope that medical officers in workhouses and dispensary establishments throughout the country would feel it their duty and their interest to come forward and assist the Association, for he was bound to say that they had not hitherto coöperated with the Association in the manner it had been expected of them. For every shilling subscribed by the members of the Association in Belfast to the funds, the medical officers to whom he had alluded should at least subscribe ten shillings.

Dr. Stronge mentioned as a fact that many dispensary officers were afraid to come forward lest they might be pointed at, or suffer perhaps for their forwardness.

Dr. Stewart said that the principal issue involved in the case was an important one, and he hoped that dispensary practitioners would feel it their interest to come forward and assist the Association. They could not invest their money better than by subscribing liberally to its funds. It was their particular interest to do so, for the medical gentlemen who were working for them on the committee were totally unconnected with dispensary establishments, and had no object in view but to promote the public good and uphold the rights and the dignity of the profession.

It appeared to be the unanimous feeling of the meeting that all medical practitioners connected with workhouses and dispensaries should subscribe at least £1 to the funds of the Association.

The following resolutions were unanimously adopted:—

Moved by Dr. Patterson, seconded by Dr. Murray, and resolved—“That the report of the sub-committee be received and entered on the minutes.”

Moved by Dr. Scott, seconded by Dr. Stewart, and resolved—“That this meeting, approving of petitions to Parliament on the subjects of a Bill for the Registration of Births, Deaths, and Marriages in Ireland; and also for one founded on the preceding, to render vaccination compulsory in all cases, recommend to the Executive Committee of the Ulster Medical Protective Association to have such petitions prepared and presented to both Houses at the proper time.”

Moved by Dr. Murney, seconded by Dr. Michael McGee, and resolved—“That petitions to both Houses of Parliament, embodying the principles of the sug-

gestions contained in the report of the sub-committee just read, relative to all the amendments required in the Poor-law and Medical Charities Acts, be prepared and presented, in the name of this Association, at the most suitable period of the ensuing session.”

Moved by Dr. Warwick, seconded by Dr. Arnold, and resolved—“That, should a committee of the Commons be appointed to inquire into the working of the several poor-law acts, the Executive Committee shall select such members of this Association as they may deem best calculated to sustain the claims of our professional brethren who are officially connected with these Acts.”

Moved by Dr. Stronge, seconded by Dr. Browne, and resolved—“That a fund be raised for the purpose of defraying parliamentary and other expenses, and that the medical officers attached to workhouses and dispensaries in Ulster, and other members of the profession, be requested to subscribe to this fund.”

Moved by Dr. Patterson, seconded by Dr. Stewart, and resolved—“That copies of the Sub-Committee's Report, the resolutions of this day, and of the petitions, when prepared, be sent to the Poor-law Commissioners, and that every legitimate means be used to urge on the Commissioners the adoption of the views of this meeting.”

EDITORIAL

Belfast Daily Mercury 1 February 1861

We have in Belfast a Society that is called the “Ulster Medical Protective Association.” Such a body, we admit, is greatly needed, and if it only discharged its duties independently and fearlessly, it would confer vast benefits on the Profession, and also on the public.

But we observe that while every exertion is made to serve the Profession, no attention whatever appears to be bestowed on the interests of the public. In the report of the Sub-Committee, which we publish, it will be seen that the primary consideration is the Medical Profession. We do not intend to bore our readers by going through the recommendations of the Committee seriatim, but they may judge of the fact that the “Protective Association” is not unmindful of its own interests when it demands for Dispensary Doctors “keep of a horse and car-hire!”

It is far from our intention to be understood as opposed to an amelioration of the Dispensary Doctor's position in Country Districts. On the contrary, we consider that under the new law they are inadequately paid, and exposed to great hard-ships. In fact, the new law is an absolute failure, and does not work anything like so well for the poor as the old Dispensary system.

But what we object to is, that this Association appears to think the poor were made for its profit—

that there is no interest to be consulted but the Medical. We could point to many cases not unworthy of the Association's attention, assuming that in their "Protective" character they desire to maintain the honour and dignity of the Profession.

BELFAST BOARD OF GUARDIANS

Belfast News-Letter 20 February 1861

Yesterday [19 February 1861], the usual weekly meeting of this body was held in the Board-room of the Workhouse—Dr. M'Gee, J.P., in the chair. The other members present were—W. T. B. Lyons, Esq., J.P., David Taylor, Esq., Dr. Browne, J. Hamill, Esq., R. Greer, Esq., D. Walker, Esq., A. Hamill, Esq., S. Tierney, Esq., T. Gaffikin, Esq., Dr. Moore, Jas. Adams, Esq., R. Carlisle, Esq., A. Brown, Esq., G. Jackson, Esq., W. Trotter, Esq., and J. Harper, Esq.

VACCINATIONS

Mr. Boyce, Clerk, submitted the returns from the several district doctors, showing the number of cases in which they respectively performed vaccination during the last six months, and requesting the sanction of the Board for the payment of the doctors for their services.

Mr. Tierney—It is one comfort that we do not know whether these cases were performed or not.

The Chairman—That is the fault of gentlemen who do not attend to their business.

Mr. Tierney—They should all be done at the public dispensary station.

The Chairman—There is a register kept of these cases, and if any gentleman doubts, let him go and judge for himself.

Mr. Tierney—It is a ruinous system that we have adopted.

The Chairman—It is the law, and when you got the law changed you can alter it.

Mr. Tierney—I hope I will do that.

NOTICE OF MOTION

Mr. Tierney submitted the following notice of motion, which he said, he intended to move on that day fortnight:—

"I hereby give notice that I will propose the following resolution, for the adoption of this Board, on Tuesday, the 5th proximo. A meeting having been held on the 31st ult. by a society consisting of a few medical men calling themselves "The Ulster Medical Protective Association," at which it was resolved that they should petition both Houses of Parliament for amendments in the present Poor-laws, the following being the chief amendments that the doctors propose, viz.:—First. That the present medical inspectors should not only be continued, but actually increased in number, at large salaries of—say £500 per annum each. Secondly. That the salaries of the medical officer connected with each union should not be under

the control, or their pay arranged, by the representatives of the ratepayers and guardians of the poor, as is the law at present, but be transferred to the Poor-law Commissioners, and their pay fixed by them (of course, the Boards of Guardians to be the paymasters out of the rates). Thirdly. That each dispensary doctor should get, in addition to whatever pay the Commissioners would fix, also a suitable allowance for the keep of a horse and car hire. Fourthly. That dispensary doctors should be the only parties appointed as registrars of births, deaths, and marriages in Ireland, at a suitable salary, in addition to their other salaries and vaccination fees. Seeing the strong efforts about to be made by the Medical Society (more properly called by the public a Trades' Union Association) to carry out the aforesaid termed amendments, whereby the rates of this union would be largely increased and a fresh mortgage imposed on the property of the union, it behoves us, therefore, as guardians of the ratepayers' money, at once to have petitions prepared for both Houses of Parliament to oppose these intended innovations, as proposed by the aforesaid medical association—the petition to the House of Commons to be forwarded for presentation to Sir Hugh M. Cairns, M.P., and that to the House of lords to the Marquis of Donegall."

Mr. Tierney hoped the Guardians would all attend on that day fortnight.

The Chairman—They will all get due notice of it,

Mr. Greer—These notices are so long that perhaps it is intended to receive tenders for printing them. (Laughter.) What does Dr. Browne say to this notice of motion?

Dr. Browne—Silent contempt!

Mr. Tierney—I will make it not silent contempt before I have done.

Dr. Browne—What business have the Board of Guardians with this matter?

Mr. Tierney—What business have the doctors with it?

The Chairman—Silence, gentlemen.

Dr. Browne—I have not addressed a word to this person.

The Chairman—You have committed a mistake in a term which you employed.

Dr. Browne—I did not say a single word to this gentleman at all.

The matter then terminated.

EDITORIAL

Belfast Daily Mercury 1 May 1861

The Ulster Medical Protective Association, at a meeting held yesterday [31 April 1861], resolved, we are glad to state, to proceed under the Medical Act against Mr. Johnston as not being a legally qualified practitioner. The clause in the Act applicable to this

case is clear and precise. The 40th section enacts that—

“Any person who shall wilfully and falsely pretend to be, or take or use the Name or Title of a Physician, Doctor of Medicine, Licentiate in Medicine or Surgery, Bachelor of Medicine, Surgeon, General Practitioner or Apothecary, or any Name, Title, Addition, or Description implying that he is registered under this Act, or that he is recognised by Law as a Physician, or Surgeon, or Licentiate in Medicine or Surgery, or a Practitioner in Medicine, or an Apothecary, shall, upon a summary conviction for any such offence, pay a sum not exceeding £20.”

This clause is comprehensive and explicit enough, and it remains to be seen whether a person who is not registered under the Medical Act, who is not recognised by law as a “legally qualified Medical Practitioner,” can with impunity describe himself as such in a way to impose on the poor.

This question no doubt intimately concerns the honour, and dignity, and usefulness of the Profession in all its branches; but, at the same time, it vitally affects the interests of the poorer classes, among whom unqualified practitioners principally find their dupes. It is, therefore, in the interests of the poor that we applaud the action of the Protective Association, which, by fearlessly performing its duty, will merit the approbation and support of the public, not to speak of all the members of the Profession who regard its purity, and are desirous of upholding its character.

There is one matter to which we must allude, as suggested by the melancholy case of Mrs. Glynn. Respectable people in humble circumstances have a laudable pride in what is called “paying their way.” They do not like to have recourse to Dispensary aid, or to receive anything like eleemosynary assistance, even in illness, as long as they can pay for medical advice.

This, we repeat, is a highly laudable feeling, and ought to be cultivated and encouraged as much as possible. But like any other good feeling it may be carried too far, or wrongly applied, and thereby expose them to serious injuries. It was this feeling that led Mrs. Glynn to employ Johnston to attend in her confinement. He got his fee, paid two visits subsequently, and left her then to chance—even when sent for, he refused to see her again.

Now, for people in Mrs. Glynn's rank of life there is that admirable institution, the Lying-in-Hospital. They are only able to pay a fee of 5s, 7s 6d, or 10s for attendance during confinement; and the result is, a low class of practitioners, both qualified and un-qualified, are encouraged, who are neither creditable to the Profession nor serviceable to society; whereas, by availing themselves of the great advantages of the Lying-in-Hospital, they can have the first advice in Belfast. They can be admitted into the Hospital or

attended in their own homes, and may repose with perfect security in the consciousness that they have at command, in any extremity, the professional services of gentlemen of knowledge, skill, and experience.

This admirable institution is not sufficiently known among the humbler classes of society in Belfast, and we think some means—by the circulation of handbills, or otherwise—ought to be adopted to make them acquainted with its great advantages. The feeling that parties who avail themselves of its advantages are thereby accepting charitable aid, is one that ought not to be entertained, but those who cannot avoid such a feeling can easily satisfy it by subscribing to its funds the amount of the fee they would otherwise pay, perhaps to an unqualified pretender.

This is a matter of great social moment to the respectable classes of our industrial population. We do not allude to those whose necessities compel them to have recourse to Dispensary aid, but to those who are in comparatively comfortable circumstances, and are desirous of maintaining a respectable independence. It is for the wives of such persons that the Lying-in-Hospital offers advantages it is impossible for them otherwise to obtain.

COURT ACTION

Dublin Medical Press 22 May 1861

BELFAST POLICE COURT.

(Before W. T. B. Lyons, Esq., J.P.)

CHARGE AGAINST A

NON-REGISTERED MEDICAL PRACTITIONER.

Robert Johnston of 117, Durham-street, appeared on summons to answer the complaint of Surgeon Browne, Honorary Secretary to the Ulster Medical Protective Association, “That he did wilfully and falsely pretend to be a surgeon at Belfast, in the county of Antrim, on the 8th of April, 1861, and also on the day previous and on the day subsequent thereto, and did at the same time and place take or use the name or title of surgeon, he, the said defendant, not being a registered medical practitioner within the meaning of the Act 21 and 22 Vic., chap. 90.”

Mr. Seeds and Mr. McLean appeared for the prosecution, and Mr. Young for the defence.

Dr. Patterson and Surgeon Browne attended to watch the case on behalf of the Ulster Medical Protective Association. Mr. Seeds briefly stated the case for the prosecution.

Mr. McLean then produced a card containing the following intimation:—“Mr. R. Johnston, Surgeon, Accoucheur, &c., 117, Durham-street. Particular attention given to the diseases of women and children.”

Eliza Hamilton, examined by Mr. McLean—I know Mr. Johnston; he attended my sister, the deceased; he lives in 117, Durham-street. When my sister took ill, I went to Mr. Johnston, in consequence of a card having been sent to my sister's house. I presented that card to him.

To Mr. Young—I cannot read.

To Mr. McLean—I afterwards gave the card which I presented to Mr. Johnston to Dr. Corry. When I went to Mr. Johnston's house I asked him to come to my sister. I showed him the card I have referred to, and he gave it back to me. I told him how my sister was, and he said if she got worse to come back to him. He afterwards attended upon my sister. My sister died shortly after her confinement. Mr. Johnston was paid for his services before he left the room. He was paid 7s. 6d. That was all he demanded. He keeps a shop—like an apothecary's shop—at his own house.

Cross-examined by Mr. Young—My sister had been ailing for some time. I cannot read that card [produced]. The card given me by Mr. Johnston I brought home. I left it on the shelf in my sister's house. I will not swear that this [produced] is the card.

Mr. Lyons—All that this witness has proved is that the man Johnston attended her sister, prescribed medicine for her, and received his fee. That woman's evidence broke down altogether. She said she left the card on a shelf in her sister's house. She could not say whether the one produced was the one she presented to the defendant or not. It might have been changed fifty times for all she knows of it.

Dr. Corry was next examined, and deposed that he did not know whose handwriting was at the bottom of the card produced, that the deceased died from tetanus, and that he had attended her.

Nancy Hamilton, examined by Mr. McLean—I live in Stanfield-street; the deceased was my sister-in-law; I was in her house when she was confined, but not longer; Mr. Johnston was the medical man who attended her; I called him doctor; I cannot read writing, but I can read what is on this card [produced]. I see on it "Robert Johnston." I never saw the card before: he was present when my sister was confined: he did not prescribe medicine for her while I was there; he got his fee.

Mr. Lyons said he had not yet any proof before him that the defendant intended to pass himself off as a medical man. The evidence of the first witness was, that she had gone to Mr. Johnston's with a card, that he had prescribed medicine for her sister, and that he had received a fee of 7s. 6d.

Mr. McLean—She said she went to Dr. Johnston's, and that, in consequence of her presenting some card, he said: "Come back if your sister is worse." She went back to him, and he attended the deceased during her confinement, and prescribed medicine for her.

The second witness proved that during her confinement he attended deceased.

Surgeon Browne then handed in the Medical Registry, on which the defendant's name did not appear.

Mr. Seeds—We close our case now.

Mr. McLean—No: we will reëxamine the first witness.

Mr. Young objected to this, observing it was quite wrong to reëxamine witnesses in a penal case such as the present, particularly when nothing arose out of the cross-examination.

Mr. McLean said that the statute under which the prosecution was brought was one passed for the purpose of preventing the public being imposed upon by parties pretending to be able to render proper assistance to sick persons.

Mr. Seeds—One of the witnesses proved distinctly that Johnston acted as a medical man, and received a fee for his services.

Mr. Lyons—You have not proved that he was there as a medical man. The evidence is certainly not conclusive on that point. This card is, of course, the main thing to rely upon to show that he went there as a medical man, and the woman who went to him with the card cannot read, and will not swear that was the card she showed to him.

Mr. McLean—We submit that this person keeps a shop in Durham-street, and that that shop is an apothecary's shop—that he has been addressed by the witnesses here as doctor, and answered to that name—that the deceased was in childbirth, and that the card taken by Eliza Hamilton to him was the identical card presented afterwards to Dr. Corry.

Mr. Lyons—The question is, did he practise and wilfully and falsely pretend to be a surgeon. I do not think we have strong evidence of that.

Mr. McLean—We thought it was only necessary to bring him before the court.

Mr. Lyons—Is there any name over his door?

Mr. McLean—No.

Mr. Lyons—If this man is disqualified, I am here to punish him if he has acted as a medical practitioner.

Mr. Seeds then recalled the first witness.

Mr. Young objected to her being examined, and observed that the case for the prosecution, which rested upon the identity of the card, had signally failed.

After some discussion between the Bench and the legal gentlemen engaged in the case,

Eliza Hamilton was recalled, and in reply to questions put to her by Mr. Lyons, stated, with much reluctance, that she was in the room when her sister was confined, that while there the defendant said to her that something was wrong with her sister, and that he would be obliged to use means to remedy it, which he accordingly did in her presence.

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Mr. Lyons said he thought he had now quite enough of evidence for the prosecution to show that the defendant had certainly acted as a medical man.

Mr. Young then addressed the Court at some length for the defendant, contending that no evidence had been given to prove the charge made against his client—namely, that he had wilfully and falsely used the title of surgeon in violation of the Act.

No witnesses having been examined for the defence, and after some discussion between Mr. Young and the Bench as to what “pretending to be” a surgeon meant,

Mr. Lyons postponed judgment in the case for three months, in order to afford the defendant an opportunity of qualifying himself; and if, in the meantime, he should be convicted of practising as a surgeon, he would fine him in the full sum of £20 for every such offence.

Mr. Seeds said that Browne did not wish to press the case, and that he was quite satisfied with the course taken by his worship.

Mr. Lyons—I know myself that all the association want is to have properly-qualified men for the public.

SECOND ANNUAL MEETING
Dublin Medical Press 22 May 1861

On Thursday, the 9th inst., the Annual Meeting of the members of the Ulster Medical Protective Association was held in the library of the General Hospital, at twelve o'clock, Dr. McGee, J.P., in the chair.

The minutes of the previous meeting were read and confirmed, and letters of apology for non-attendance were announced from Dr. Filson, Dr. Kidd, Ballymena; Dr. Davis, Newry; Dr. Jamison, Newtownards; Dr. McIntire, Coleraine; Dr. Neeson, Aghalee; Dr. Maxwell, Derrylinn; Dr. Ferris, Larne; and Surgeon McGreevy, Antrim.

Surgeon Browne, hon. sec., read a letter which he had received from the Secretary of the Irish Protective Association, stating that the next annual meeting of that body would be held on the 3rd June next in the Royal College of Surgeons, when several matters of great importance to the profession and the community in general would be brought forward, and expressing a hope that the meeting would be largely attended by country gentlemen.

On the motion of Dr. McLaughlin, seconded by Dr. Warwick, the letter from the Irish Protective Association was referred to a committee to take whatever steps might be considered desirable in the matter.

Surgeon Browne then read the following Annual Report:

“The Committee, in meeting the members of the Association after the lapse of twelve months, beg to submit the following report of their proceedings.

During the year eleven ordinary and two special meetings have been held, and the following is a summary of the business transacted at these meetings. At the meeting held on the 17th of May, 1860, it was deemed advisable to have a form of notice lithographed, a copy of which the Secretary was directed to send to every unqualified person practising medicine or surgery, and against whom a complaint had been sent in. The annexed notice was therefore adopted:—

‘MEDICAL PROTECTIVE ASSOCIATION.

Sir,—I am directed by the Committee of the Ulster Medical Protective Association to inform you of a complaint which has been made to them, “that you assume a professional title, and practise medicine without any legal right to do so,” and as your name does not appear in the Medical Register, I have to request that you will send to me a statement of your professional qualifications, that I may submit the same to the Committee. Should you not comply with this request, I am directed to say that this Association will take such steps as our counsel may advise in your case.’

The Secretary has reported that he has sent a copy of the preceding notice to twenty-one persons who were reported to the Committee as practising without any legal qualification. In the majority of instances these letters have had a good effect, either in eliciting from the persons complained of satisfactory replies, or in compelling them to abandon open practice. Soon after the last annual meeting the Secretary, by direction of the Committee, prosecuted three persons for illegal practice—one of them was ordered to register or be fined, one fled from town, and the prosecution against one was withdrawn by advice of counsel. But the Committee have the gratification to state that against this same individual, who continued to violate the law, a conviction was recently obtained, inasmuch as he has been directed to qualify for registration, if he can, within three months, or incur the full penalty, and in the meantime he is not to attempt to practise. These results are so far satisfactory that they prove that where an instance of illegal practice can be brought home to an unqualified man he will likely be convicted; but it is evident that the law, as it now stands, should be amended, so that unqualified persons practising medicine could be more summarily dealt with than at present, and with this view the Association lately joined the London Medical Registration Association in a strong and urgent memorial to the General Medical Council, calling upon them to take steps to have the Medical Act, 1858, amended accordingly.

In June the Committee sent forward a petition on the Registration Bill, which was presented to Parliament by Sir Hugh Cairns; and at a special meeting,

held the same month, they adopted a series of resolutions relative to the Registration Bills, then before the House, complaining of the penal clauses against medical men, and respectfully calling upon the Members of Parliament for Ulster to use their influence to have the obnoxious clauses withdrawn. In August both Bills for the Registration of Births and Deaths in Ireland, along with the Medical Charities and Poor-law Amendment Bills, were for the time abandoned.

Again this session, Mr. Cardwell and Lord Naas have introduced Bills for the Registration of Births, Deaths, &c., in Ireland. The Committee, on the part of the Association, have expressed their approval of the general principles of the Chief Secretary's Bill; and as it and that of Lord Naas have been referred to a Special Committee of the House, your Committee have taken steps to have witnesses from this Association examined relative to the contemplated provisions of these measures: meantime they recommend that a form of petition similar to that drawn up by the Cork Association be presented on behalf of our body—

‘TO THE KNIGHTS, BURGESSES, AND CITIZENS IN
PARLIAMENT ASSEMBLED.

The petition of the undersigned medical practitioners humbly sheweth,—That petitioners highly approve of the general principle of the Bill for the Registration of Deaths, Births, and Marriages, brought into your honourable House by the Right Honourable the Secretary for Ireland and Mr. Bagwell, and that petitioners will always feel it their duty to carry out, as far as in them lies, the provisions of the Bill, being convinced that the interests of science, and of their own particular profession, as well as those of the community in general, will be thereby served. That petitioners, however, at the same time, feel that a particular clause (the 43rd) in said Bill, will bear hardly on the profession at large, by imposing a penalty for not furnishing within a limited period a certificate of the death of a party on whom they may have been previously in attendance, and subject them to legal prosecution, even where infraction of the clause may arise from causes over which they in their professional avocations have no control, and thereby, in addition to the penalty, put them to serious costs.

That petitioners, therefore, humbly pray your honourable House to have the said 43rd clause either expunged from the Bill, or so modified, that it will not lead to punishment, for what may be a mere unintentional omission on the part of medical practitioners. And petitioners will ever pray.’

The Committee have recently, through your Secretary, had communications from several influential members of the Legislature relative to having the views of the profession in Ulster brought before the Committee of the House of Commons, now inquiring

into the working of the Irish poor-laws, and specific promises have been given that witnesses will be examined upon those points which affect the medical profession. That your Committee might be in possession of the sentiments of a large number of medical men, and thus be prepared to come before the Legislature with something of a specific character, queries were submitted to every medical officer in connexion with work-houses and dispensaries in Ulster. Replies were returned from a large number, and from these a special report was submitted to an extraordinary meeting of the Association, held in the month of January. At that meeting several important resolutions were passed, but as these have been published in the journals they need not be repeated here.

Since then an appeal has been made to all the medical gentlemen in connexion with the poor-laws in Ulster, asking for subscriptions to aid the Association in defraying parliamentary and other expenses connected with matters specially affecting their interests, and the treasurer will be able to inform the Association in what way the appeal has been responded to. Before closing this report, your Committee may say they have every reason to believe that the Association has done much to promote the interests of the public as well as those of the profession. They consider that in promoting the interests of the medical practitioner, who is called to administer to the wants of the sick poor—whose protector the doctor is—they benefit the entire community. In protecting the humbler classes of society from the rapacity of unqualified persons and sordid quacks—the working classes being peculiarly liable to be victimized by these pretenders—your Committee are convinced the various medical associations have effected unquestionable good, and they hope that this, as well as every other similar Association, will continue their best efforts in pointing out to the Legislature and to the public those matters which their education and experience show to be either beneficial or prejudicial to the community. Hitherto this Association, since its formation, has worked harmoniously with the other medical societies of the kingdom. To the Cork Association and the Council of the Medical Association for Ireland, your Committee are indebted for many useful suggestions and friendly acts, and they beg here to record their thanks to Dr. Armstrong, the indefatigable Secretary at Cork, to Dr. Quinan, the courteous Secretary of the Irish Council, and also to Dr. Mackesy of Waterford, the tried, energetic, and unwearied friend of the medical profession. In conclusion, your Committee trust that the meeting this day will urge upon the entire profession of Ulster the propriety of becoming members of the Protective Association, and thus aid in establishing the position they should hold in society—namely, a united body, protecting their own interests, and at the same time coöperating to

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advance every measure by which the welfare of the public may be promoted. By order of the Committee, Samuel Browne, Hon. Sec.”

Professor Ferguson moved that the report and statement of accounts be adopted and entered on the minutes.

Dr. Rankin seconded the motion, which passed.

Surgeon Browne moved that Dr. Stewart be appointed Chairman of the Association during the ensuing year.

Dr. Michael McGee, in seconding the motion, said the Committee had carefully discharged their duty in watching over the interests of the profession during the past twelve months. It would be well if he could say as much for the profession. There were in Ulster 490 registered practitioners. They had in the county Antrim, of course, including the 85 practitioners in town, 120 members, and in Down there were 81. It must, therefore, be admitted from these calculations that the Association had, comparatively speaking, received very little support from the profession generally.

The motion was then carried by acclamation.

Dr. McGee said he had great pleasure in vacating the chair in favour of Dr. Stewart. From the experience he had had of his valuable services, his energy and strict attention to the interests of the profession—interests by which he could not be personally benefited—they might rest assured that the duties of the chair would be performed in a much more efficient manner than they had been since the formation of the Society. He did not resign the office from any unwillingness on his part to give his services, but having so much time occupied elsewhere, he thought that no man should enjoy the honours of the office unless he performed strictly the duties connected with it, and he felt that during the next year he could not do that. He was sure that Dr. Stewart would be able to perform efficiently all the duties he would be called upon to discharge. He had great pleasure, therefore, in making room for him.

Dr. Stewart begged to tender all present his best thanks for the great honour they had conferred upon him, he must say unworthily. Nothing could give him greater pleasure than doing everything in his power for the advancement of the interests of the profession, and he considered that in advancing the interests of the profession they were advancing the interests of the public at large. He was sorry to hear from Dr. Michael McGee that they had so small a number of members, especially now when bills of such magnitude concerning the interests of the profession at large were before Parliament. He concluded by again returning thanks to the meeting for having appointed him as chairman for the next year.

The committee and officers were then reëlected.

Dr. Stewart was called to the chair, and on the motion of Dr. Ferguson, the best thanks of the Association were offered to the late chairman.

Dr. McGee acknowledged the vote of thanks.

The proceedings then terminated.

COMPILER'S NOTE

Despite the evidence above of an interested and thriving society, no further reports of the proceedings have been found. Dr. Esler suggested in 1886 that the last meeting was in May 1862:

ULSTER MEDICAL SOCIETY
EXTRACT FROM
“PRESENTATION OF PORTRAITS”

Northern Whig 3 August 1886

Dr. Esler then said_ “...The Ulster Medical Society was constituted on 4th May, 1862, by the amalgamation of the Belfast Medical Society—a society which had been in existence from 1806—with the Clinical and Pathological Society, which was originated in 1853 by Dr. Malcolm. Another society, called the Ulster Medical Protective Association, with Dr. Samuel Browne as secretary, was also in active operation up till that time. Its last meeting was held in May, 1862, so that it also merged into the new society.”¹

Its merger into the Ulster Medical Society is also documented in a newspaper report of Professor J. C. Ferguson's opening address:

ULSTER MEDICAL SOCIETY
INAUGURAL ADDRESS

Belfast News-Letter 3 November 1862

Saturday last [1 November 1862], at three o'clock, the first Winter session of this important provincial association of medical practitioners—being an amalgamation of the parent “Belfast Medical Society” (founded in 1822), the “Belfast Clinical and Pathological Society,” and the “Ulster Medical Protective Association”—was inaugurated in the society's rooms, 33, High Street, by an excellent address from the president, Professor Ferguson, of the Queen's College, Belfast.

On the other hand there are two reports which suggest that there was still some activity by the Association after this. The first is from Dr. John S. Drennan's presidential address in 1866 where he says: “Those, however, who may wish to enforce the law against unqualified practitioners, will find facilities for doing so in the Medical Protective Society, which is amalga-

¹ [The fact that he knew about the meeting suggests that he may have had access to the minutes.]

mated with our own”.¹ The second is a newspaper report of a meeting in Banbridge in 1868:

BANBRIDGE UNION MEETING
Northern Whig Belfast 1 June 1868

Banbridge, 21st May, 1868.

At a meeting of the medical officers of Banbridge Union, held at the Downshire Arms Hotel, on the above date—Present—Dr. Malcomson, in the Chair; Dr. Tyrrell, Dr. Harman. Dr. Weir, and Dr. Crawford.

...

3rd. That—“A copy of these Resolutions be sent to ‘The Irish Medical Association,’ and to ‘The Ulster Medical Protective Association,’ requesting their advice as to our future proceedings, and their co-operation with us...”

¹ [See page 1064.]

Records
Of the
Ulster Medical Society

INTRODUCTION

The Ulster Medical Society was formed in 1862 by the amalgamation of the three medical societies already described in this book. There is a regrettable lack of information in the various minutes as to when this union was first contemplated and in particular, how it was negotiated.

It certainly had been anticipated by Malcolm nearly six years before when in a reply to a toast "The Belfast Clinical and Pathological Society, and its founder, Dr. Malcolm" proposed by Dr. McGee at the 33rd Annual Dinner of the Belfast Medical Society on 10 June 1856, he was reported to have said that "he thought the time was not very far distant when one great society might be formed by amalgamating the parent Medical Society and the Clinical together, which might be made productive of enlarged benefits and advantages to the whole profession"¹

Malcolm died three months later on 19 September 1856 of congestive heart failure secondary to rheumatic mitral and aortic valve disease. Presuming that he was aware of the seriousness of his condition when he rose to reply to the toast, it seems reasonable to suppose that he chose his words carefully to reassure those in the future who had to decide the fate of "his" society.

Samuel Browne, R.N., referred to the matter again in his Presidential Address to the Belfast Medical Society on 1 June 1857 when the minutes record "He concluded his excellent address by urging the expediency of a union of the Medical and Clinico-Pathological Societies—the preliminary consideration of this, as of the other measures previously recommended, being left to the Council."²

Council subsequently reported to the annual general meeting on 3 May 1858 that "As it does not at present seem easy to devise any plan for the amalgamation of the two Societies agreeable to the members of both, it is satisfactory to believe that whilst in the promotion of medical science they profess a common object, they have likewise each its own special sphere of utility which it may effectively fill without touching on the province of the other."

Dr. Murney raised the subject with the Society in July 1859 when it was re-referred back to Council but he had to report in August that it was not discussed due to an insufficiency of members at the intervening Council meeting.

The Belfast Medical Society was not attracting subscription-paying members in sufficient numbers to assure its future. The Report at the end of the 1860/61 session "expressed the regret of the Council that the affairs of the Society are not in a more flourishing condition, inasmuch as but one new member had joined during the past year, whilst one had died, another retired, and three others would become free members during the ensuing year."

Meantime, its proceedings were approximating those of the Clinical and Pathological Society. It is true that the former still had the medical library and that the latter still had the pathological museum and the analytical and microscopical committees, but both were now presenting cases at their meetings and both were publishing their proceedings (the Medical Society intermittently).

With similar problems, largely similar activities, and a limited pool of potential members, it made sense to consider amalgamation and the matter was raised again in September 1861 when the minutes of the Belfast Medical Society record "A discussion then took place relative to the advisability of amalgamating the Medical and Pathological Societies, a notice calling attention to same having been placed on the Monthly Paper, when after the greater part of the Members present had expressed their opinion, Dr. Browne moved, and Dr. Pirrie seconded the following motion which was passed unanimously—"That the Matter be referred to the Council to confer with the Council of the Pathological Society and prepare a plan to be laid before the next monthly meeting of the Medical Society"

That the Councils did confer is shown by the minutes of the Belfast Clinical and Pathological Society on 7 December 1861 when the "President reported the results of the labours of the Amalgamated Councils with reference to a union of the two Societies." (Incidentally, this seems to be the only certain reference to the potential amalgamation in this Society's minutes although a ballot, the result of which was announced on February 8th, 1862, may be relevant.)

By 3 March 1862, the Council of the Belfast Medical Society reported that it strongly approved of the proposed amalgamation, and referred to but did not minute the terms on which it would be effected. Later that month, a special meeting of the society was called and the chairman, Dr. Murney, "entered very fully into the subject, explaining the object and aims of the Combined Society as also the terms of subscription and minor matters of detail. He also dwelt upon the advantages of having a central reading room

¹ [Belfast News-Letter, 13 June 1856, p2.]

² [See page 178. This point was omitted from the newspaper reports.]

and making the Meetings of the Society more interesting.”

Rapid progress was made thereafter with four meetings of the society being held in April, the last one on 30 April being held jointly with the Belfast Clinical and Pathological Society. At it the following resolution was approved—“That this Meeting approve of the proceedings already undertaken for the amalgamation of the Medical and Pathological Societies, and hereby declare the union of the respective bodies under the title of the ‘Ulster Medical Society.’”

In his presidential address to the new society on 1 November 1862, Professor Ferguson acknowledged that the Ulster Medical Protective Association was included in the amalgamation but there are no references to this in the minutes of any of the three parent societies.

In 1859 the Medical Society had 55 members and the Clinical and Pathological Society 99, with 31 being members of both. Assuming that the numbers in 1862 were similar, the newly formed Ulster Medical Society probably had about 120 members. It might be expected that the new Society would attract more members and eleven applications for membership were indeed put forward to the first meeting. The initial level of the annual subscription is unknown but a few years later, in an effort to encourage new members, it was suggested that the subscription for town members be reduced to one guinea. While this was significantly more than the subscription for the Clinical and Pathological Society, it was actually less than the subscription to the Medical Society in 1822. The combination of the greater number of members and the higher subscription meant that the Ulster Medical Society was in a stronger financial position than either of its two main predecessors.

Ulster Medical Society
Session 1862–1863
President John Creery Ferguson

ULSTER MEDICAL SOCIETY

SESSION 1862–63

**Copy of Minutes of the Last (Joint) Meeting of
The Belfast Medical and the Belfast
Clinical and Pathological Societies**

30th April, 1862

Special Meeting Medical and Pathological Societies

Present, Dr. Stewart, Chairman, Browne, Smyth B, Cuming, Ferguson (P.), Wheeler, Patterson, Murney, MacCormac, Moore D, Johnston (P.) and Whitaker. (Those marked “P” are members of Pathological Society only).

Dr. Browne moved and Dr. Patterson seconded the following resolution—“That this Meeting approve of the proceedings already undertaken for the amalgamation of the Medical and Pathological Societies, and hereby declare the union of the respective bodies under the title of the ‘Ulster Medical Society’”.

The Ulster Medical Society

Meeting 30th April, 1862

Continued

The new Society having then been formed, Dr. Murney moved and Dr. Cuming seconded the following resolution “that the code of rules of which a copy had been sent to every Member of the Society be the laws of the Ulster Medical Society by which it shall be conducted”—passed unanimously.

The subject of the Annual Dinner having been then taken up, some discussion ensued, and the general feeling of the members being in favour of its taking place about the Commencement of the Winter Session, Dr. Murney moved and Dr. Patterson seconded—That the Annual Dinner be held on the first Saturday in November—passed unanimously. Dr. Murney moved and Dr. Ferguson seconded—That the resolution previously passed for the taking of central rooms for the use of the Society at 33 High Street be confirmed—passed unanimously.

Dr. Browne [moved] and Dr. Patterson seconded—that a subcommittee consisting of Drs. Murney, Patterson, MacCormac, Moore D., and Whitaker (three to be a quorum) be appointed to make the necessary arrangements for suitably furnishing the rooms—passed unanimously.

It was then arranged that the Annual Meeting be held on Saturday 3rd prox. at 3p.m. and that a Circu-

lar be issued summoning the members and signed by Drs. Whitaker and David Moore, as Secretaries pro tem, and that at that Meeting the reports and accounts of the two late Societies be brought forward and the office bearers of the “Ulster Medical Society” for the ensuing year duly elected.

Saturday 4th [sic] May 1862

The first meeting of the Ulster Medical Society was held in the library of the General Hospital, on Saturday 4th [sic] May at 3p.m., when there were present, Professors Ferguson, Gordon, Reid, Drs. Browne, Murney J.P., Mulholland, Corrie, Johnston, McGee J.P., Stewart, Patterson, Pirrie, J. W. T. Smith, W. MacCormac, David Moore, Dill, Brice Smyth, Bryce, Michael McGee, Murray, Scott J.P., (Aughnacloy), Halliday and Whitaker.

Dr. Stewart having been called to the chair; after some preliminary discussion, in which several members joined, and brought forward different subjects connected with the Society, among which the most important was the mode in which the election of office bearers should be conducted; as, however, the rules of the Society clearly defined same, it was decided that the elections take place in accordance therewith.

Professor Reid then moved and Dr. Dill seconded a motion for the adjournment of the meeting, which having been put from the chair, was lost, and Dr. Reade then moved and Dr. Michael McGee seconded, that Professor Ferguson M.D. be president for the ensuing year. Carried unanimously.

The President having taken the chair, the balloting then took place, and the following were respectively elected to the respective offices for the year 1862–63. Vice-Presidents, Drs. Browne and Wheeler, Country Vice-Presidents, Dr. Scott J.P. (Aughnacloy) and Dr. Graves (Cookstown). Council, Drs. Murney, Patterson, Pirrie, Cuming, Reid and William MacCormac. Treasurer, Dr. J. W. T. Smith. Secretary, Dr. Whitaker and Dr. Moore.

Dr. Moore then moved and Dr. Murney seconded “That a circular be issued to the members of the Profession in Ulster, stating the objects of the Society, and calling on them to enrol themselves as Members”. Carried unanimously.

The following gentleman were then proposed by Drs. Murney and Browne, as members, to be balloted for at next monthly meeting, viz Dr. Buckingham, Dr. H. S. Ferguson, Mr. T. Grattan, Mr. E. D. Gribbin, Mr. Morrow (Downpatrick), Mr. Thompson (Ballylesson), Dr. Dunlop (Holywood), Dr. Greenfield (Holywood), Dr. Hannay (Lurgan), Dr. B. Bindon (Coalisland), and Mr. Berry.

Dr. Cuming then read a vote of thanks to Dr. Halliday for the services he had rendered the Pathological Society in his capacity as treasurer of that body, Dr.

Patterson seconded the motion which was carried unanimously.

Dr. Halliday returned thanks and expressed his desire, at all times, to do his best to further the interests of the profession.

Dr. Cuming moved and Dr. Murney seconded a vote of thanks to Dr. William MacCormac and Dr. Moore, Secretaries of the Pathological Society for the services they had rendered that body, carried unanimously, both gentleman suitably acknowledged the compliment.

Dr. Pirrie moved and Dr. Patterson seconded a vote of thanks to Dr. Murney for the trouble he had taken in drawing up a plan for the amalgamation of the Medical and Clinical and Pathological Societies, and for the able manner in which he had carried same to a successful conclusion, carried unanimously, and Dr. Murney having thanked the meeting hoped that the Society would soon be in a flourishing and prosperous condition.

It was then arranged that the Council should meet on Wednesday 8th inst. at 3p.m. and the Secretaries were directed to issue notices accordingly.

J. Creery Ferguson, President

7th June, 1862

Present, Drs. J. C. Ferguson (President, in the chair), Browne, Pirrie, Dill, Patterson, Murney, Michael McGee, Dundee, Mulholland, William MacCormac, Brice Smyth, Stewart, Johnston, Wheeler, Warnock, Whitaker, and David Moore.

Resolved "That the standing orders of the Society, so far as regards the proposer of a member to be balloted for being held accountable for the payment of his subscription, being suspended for this meeting, to enable the proposed members to be balloted for".

The following were balloted for and duly elected viz Dr. H. S. Ferguson Belfast, Dr. Dunlop Holywood, Mr. T. Grattan Belfast, Dr. Greenfield Holywood, Mr. Buckenham Belfast, Dr. Hannay Lurgan, Mr. E. D. Gribbin Belfast, Dr. B. Bindon Coalisland, Mr. Berry Belfast, Mr. H. Thompson Ballylesson, Mr. Morrow Downpatrick.

Resolved, That the Secretaries be instructed to write to the gentlemen elected, informing them of their election and stating amount of subscription and that same is now due.

Resolved, That the Council be requested to report on the proceedings from the formation of Society at next monthly meeting.

Resolved, That (60) sixty keys for inside door be ordered for the use of the Society and that each member be provided with one gratis.

Resolved, That the Secretaries acknowledge receipt of letter from Dr. Armstrong, containing resolution relative to the registration clause in the new Bill of Sir Robert Peel passed by a meeting of the pro-

fession in his locality (Cork), state that it was brought before the meeting, and that steps have already been taken by the Ulster Medical Protection Society to bring the matter prominently forward.

Dr. Stewart gave notice of motion that the circular of ordinary meetings should in future contain a list of the office bearers of the Society.

Resolved "That the Members of the Ulster Medical Society beg to convey to their professional brother, Dr. Thomas Thompson of Wellington Park, Belfast, their sincere condolence and the expression of the deep sympathy with him under the painful bereavement which he and his family have recently sustained" and that the Secretaries be requested to send a copy of foregoing resolution to Dr. Thompson.

John Creery Ferguson, President

5th July, 1862

Present, Drs. Ferguson (President, in the chair), Thomas Reade, Stewart, Mulholland, Browne, Wheeler, Dill, William MacCormac, Murray, Michael McGee, Gribbin, David Moore, and Whitaker.

The minutes of last meeting having been read and confirmed, the report of Council was then brought forward, and after some discussion was adopted, that part of it relating to the library was, however, ordered to be reconsidered by the Council with a view to their marking proper regulations as regards the issue of the books, and seeing what steps could be taken to afford the Society proper security for the safe custody of same.

J. Creery Ferguson, President

2nd August, 1862

Present, Drs. Ferguson (President in the chair), Browne, Wheeler, Murney, Patterson, William MacCormac, J. W. T. Smith, Stewart, Ross, Gribbin, Beck, H. S. Ferguson, H. MacCormac, Arnold, Johnston, Dill, Michael McGee, John Smith, Corry, Brice Smyth, Mr. Aickin, Mulholland, Bryce, Murray, William Hanna, David Moore and Whitaker.

The minutes of last meeting having been read and confirmed, Dr. Rankin (Kircubbin) proposed by Dr. McGee (Michael) and seconded by Dr. Whitaker, and Surgeon Patrick (Carrickfergus) proposed by Dr. Wheeler and seconded by Dr. Whitaker, were elected members of the Society.

The following recommendation from Council was adopted "That the Secretaries be instructed to issue voting papers, on or before the last Saturday in April, in each year, to all members of the Society resident without the Borough-Boundary of Belfast to be returned to the Secretaries on or before the Friday preceding the Annual Meeting of the Society in May, but no vote for Office-Bearers can be received from any member whose subscription for the ensuing year has not been paid".

Ulster Medical Society
Session 1862–1863
President John Creery Ferguson

On the recommendation from Council that the following be substituted for Rule 11 “no member shall ballot, vote at any meeting of the Society or have the use of the library, while his subscription for the current year remains unpaid”;

Dr. Patterson moved, and Dr. Michael McGee seconded, that the Rule be amended as follows “No Member shall ballot or vote at any meeting of the Society while his subscription for the current year remains unpaid, but he shall be allowed the use of the library and rooms for the first three months of the said year, his subscription remaining unpaid”.

On the following motion having been proposed by Dr. Patterson, seconded by Dr. Wheeler “that the reading room be not open on Sundays” it was objected that due notice of said motion had not been given, thereupon the following notice of motion for discussion at next meeting proposed by Dr. Beck, and seconded by Dr. Johnston, viz “That the word daily in the report of the Council presented and passed at last meeting be not confirmed, as including Sunday and that in future the rooms be not open on Sunday.” was handed in; and it was agreed that in the meantime, until the question should be fully discussed the room should be closed on that day.

J. Creery Ferguson, President.

6th September, 1862

Present, Drs. Ferguson (President, in the chair), Patterson, Stewart, Drennan, Cuming, H. Moore, Arnold, Hanna, Gribbin, McCleery, James Moore, Michael McGee, Thomas Reade, Browne, Mulholland, D. Purdon, William Aickin, John Aickin, W. MacCormac, John Smith, Bryce, Patrick, Pirrie, H. S. Ferguson, Warwick, Alexander, Wheeler, Dill, J. W. Smith, Johnston, B. Smyth, Greenfield, D. Moore, and Whitaker.

The minutes of last meeting having been read and confirmed, Dr. Patterson moved and Dr. Wheeler seconded the following motion, “That the word ‘daily’, in the report of the Council presented and passed at last meeting, be not confirmed as including Sunday, and that in future the rooms be not open on Sunday”.

A discussion then ensued in which several of the members took part during which Dr. Michael McGee moved, and Dr. W. MacCormac seconded, the following amendment “That the outer door leading to the reading room and library be closed on Sunday and that a second latch be provided for same to suit the present keys for the convenience of members desirous of visiting the rooms on Sunday”.

A letter from Dr. MacCormac (Henry) was then handed to the President, directed to “the Members of the Belfast Medical Society”, several of the members objected to the reading of same and the sense of the meeting having been taken on the subject, it was decided, by a show of hands, that it should not be read.

Dr. Drennan then moved and Dr. Pirrie seconded the following amendment “That inasmuch as contrary opinions are held by members of this Society, as to the propriety of allowing access to its room upon Sunday, the Society, as a body, consider it inexpedient and unnecessary to make any rule (permission or restriction) on the subject; but allow to each member the right, and afford him the means, of acting in the matter according to his own judgement of what is befitting and convenient”.

A lengthened discussion then ensued, which was terminated by the President putting the amendments to the vote, both having been rejected, the original motion was then put and carried by a majority.

Dr. Browne and Dr. Patterson moved and seconded “That the Secretary be instructed to prepare an address to Dr. Heeney, on his departure for Queensland, expressing the esteem and respect in which he is held by the members of the profession, both in his private and public capacity, and their regret at his departure; and that same be laid on the table for signatures”.

A letter from Dr. Davey of Ballymacarrett having been handed to Dr. Whitaker, he, with the consent of the President, was proceeding to read same, when objections to its reception having been strenuously urged, it was ordered to be laid before the Council for their consideration.

John C. Ferguson, President

October 4th, 1862

Present, Drs. Ferguson (President in the chair), Patterson, Arnold, Beck, Stewart, David Moore, and Whitaker.

The minutes of last meeting were read and confirmed.

Dr. Arnold moved and Dr. Patterson seconded that the following be appended to rule 24, viz “That no rule shall be altered, rescinded, or new one introduced, except a monthly notice of such proposed change have been previously given”. Passed unanimously.

The arrangements to be made in connection with the Annual Dinner were referred to Council and the Secretary directed to summon a special meeting of that body to take the matter into consideration.

J. C. Ferguson, President

Special Meeting called by requisition

October 25th, 1862

Present, Drs. Dill (Chairman), Michael McGee, John Smyth, Corry, William Hanna, David Moore and Whitaker.

The requisition calling the meeting was read by the Secretary as follows “The undersigned members request the Secretaries will be so good as to call a meeting of the town members of the Ulster Medical

Society at the hour of 7 o'clock this day at the rooms, 33 High Street, for the purpose of considering whether the members of the Society, as such, should walk in procession at the funeral of the late Robert Bryce Esquire M.D., or not". R. F. Dill, John H. Halliday, Michael McGee. October 25th/62.

After a few remarks by the Chairman, introducing the subject of the meeting, Dr. David Moore moved and Dr. M. McGee seconded the following resolution, "That the members of this Society be requested to attend the funeral of the late Robert Bryce Esquire M.D. which will take place on Monday 27th inst. at 8½ o'clock a.m." And that circulars notifying same be issued to the town members. Passed unanimously.

J. C. Ferguson, President

November 1st, 1862

Present, Drs. Ferguson (Chair), Gordon, Browne, Dill, J. S. Reid, Hanna, Gribbin, William McGee, Patterson, Wheeler, Best, William MacCormac, Mulholland, J. W. T. Smith, Cuming, Michael McGee, Stewart, Johnston, David Moore and Whitaker.

The minutes of last meeting having been read and confirmed, the President then read an able and instructive address.

Paper.¹ Gentlemen,—The opportunity afforded me by this day's inauguration of the Winter Session of our Ulster Medical Society, I cannot permit to pass by, without again giving expression, however brief and faint, to the feelings of gratitude and pride which your unexpected as unmerited election of me to the honourable position of your President have inspired: gratitude for the courteous kindness of sincere, but, I fear, too partial friends; and pride, that even to them I should have appeared not altogether unworthy of so honourable and so distinguished a mark of confidence. For myself I could have wished that the duties of the Presidential Chair of a Society professionally so important as yours had devolved upon some member—and you have many such among you—more competent and better qualified than its present occupant to perform them efficiently and satisfactorily. When first you called me to this post of honour, I felt, and I still do feel, a consciousness of my own deficiency in many of the almost necessary requisites for such an office. Nevertheless, in an anxious desire to promote the best interests of the Ulster Medical Society, to endeavour, by every worthy means within my power, to establish and maintain it in a position, as well social as professional, worthy of our medical brotherhood of Ulster, I honestly avow I will yield to no man. Hence my resolution was at once taken; for, looking to and depending upon that support and encouragement from my fellow-members which good intentions are ever sure to command, I felt it almost a duty not to shrink from the attempt to fill

this chair, and I hoped not altogether unworthily. To accomplish this during the Session we are now entering on, shall be my chief aim and object; but I trust it will never be forgotten, that for that support and assistance in the performance of my duties, which I feel conscious of needing, I may ever look, perhaps appeal, to your kindness and forbearance, and satisfied am I, never appeal in vain.

Since we last met in this room death has struck down his victim from among us, and the place of our friend and fellow-labourer Dr. Robert Bryce, "knoweth him no more." He had been for many years a member of the Medical, and from its origin took an active part in the proceedings of our Pathological Society. Few of us have not had frequent opportunities of witnessing the good sense, the matured experience, the originality of thought and suavity of temper displayed by him in our discussions. If any of us felt the force and point of the bolt he shot, yet it brought with it no venom, and left no sting behind. His intellect was sound, his heart warm and true, his professional honour unsullied. The words of Horace, believed to refer to his immortal but eccentric friend Virgil, might perhaps not inaptly be applied to him—

Rusticius tonso toga defluit, et male laxus
In pede calceus hæret: at est bonus, ut melior
Non alius quisquam: ac tibi amicus, et ingenium
ingens
Inculto latet hoc sub corpore.

Let then his failings, and if any they were few, "be interred with his bones." Let the memory of his virtues, and they were many, "live after him," and to his ashes Peace.

For many years Belfast has been, I may say, rich in the possession of societies connected with our profession, into the particulars of whose history or circumstances, however interesting, it is not my present purpose to enter. Suffice it to say, that each had its own peculiar object, its own means of working out that object, and that it did so, I believe, assiduously and effectually; each society devoting itself more particularly to subjects connected with the scientific or the practical department of medicine and surgery; or to the guardianship and protection of the best interests of our profession.

'Tis now some time since the idea occurred to some members who have always taken an active part in the working of these societies, that their amalgamation might be effected, not only without impairing the usefulness of any, but rendering the working out of the objects of all, more facile, more agreeable, and at the same time, equally productive of good to our republic. In fact, many of us began to feel that we were rather hampered by what might be, with truth, designated an "embarrass des richesses." This idea spread rapidly among us, until it gradually assumed a palpable and a practical shape, eventuating, as we all now know, in

¹ [Dublin Medical Press, 1862, v , p722.]

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the amalgamation of the three previously existing societies, to form the Ulster Medical Society, in which it is fondly hoped, that all the objects of its predecessors, I may say parents, shall be worked out; where the science of medicine may be pursued with unabated zeal; where the *ars medendi* may secure to itself all the interest, investigation, and attention, which its primary importance and utilitarian tendencies demand; and lastly, where the social status, the best interests and the honour of our noble profession may be jealously guarded and worthily maintained.

With respect to the first two of these objects, it may be that we do not habitually or sufficiently distinguish between them—I mean the science and art of medicine—and, as I have lately seen this well put, and briefly, in a paper on “Art and Science, a contrasted parallel,” by Dr. John Brown of Edinburgh, I would for a moment claim your attention to his “contrast” of them as applied to medicine. He says:

ART,
Looks to symptoms and occasions.
Is therapeutic and prognostic.
Has a method.
Is ante-mortem.
Looks to function more than structure.
Runs for the stomach-pump.
Submits to be ignorant of much.
Acts.

SCIENCE,
Looks to essence and cause.
Is diagnostic.
Has a system.
Is post-mortem.
Looks vice versa.
Studies the phenomena of poisoning.
Submits to be ignorant of nothing.
Speaks.

No doubt this may be somewhat arbitrary, but, in the main I think it is not far from the truth, and it has certainly brevity to recommend it. And with respect to the third, the maintenance of the honour and social status of our profession, that “in union there is strength,” few will deny. We have sought and accomplished this union of the “*membra disjecta*” of our profession in Ulster, and have we not a right to expect the natural consequences? Yes, gentlemen, and if we be but true to the honour and dignity which should be ours, true to what medicine has a right to expect—nay demand—from all who embrace her, true even to ourselves and our own selfish interests, the accomplishment of our union will inevitably confer power—ours it must be to take care and see that that power be well and honourably directed.

Confiding in the truth of the aphorism already alluded to, it occurred to some of our body that our union might be made more perfect, that we might be

brought more frequently and more directly in contact, and other desiderata effected by the establishment of Medical Rooms in a central situation, where a selection from the books of our library, medical periodicals, and a few of the more prominent journals of the day might be always readily accessible, making the rooms more attractive, and affording a convenient and useful rendezvous for the resident as well as country members of our Society.

That this has been carried out successfully, and that all the advantages anticipated from our possessing rooms presenting the attractions alluded to have been fully realized, needs no confirmation from me; but I do feel that to those gentlemen who took so much trouble, and so successfully, in “setting our house in order,” we owe a debt of at least gratitude and thanks. There may, no doubt, be some of us who think that non-professional journals and hebdomadals were superfluous, or not just suited to the atmosphere of these rooms—a matter of taste, about which, proverbially, non disputandum est. But I am apt to think that though most of us may be tolerably well-informed on the passing events of our own locality, yet that it would not be altogether valueless to us, or devoid of interest, that we should see from different points of view what others think and say of the world’s progress. Who that wants to be informed,—and to whom is such information more requisite than to the medical man?—who that wants to be informed on the daily march of events in the great world beyond this little “gem of the sea” of ours, can afford not to read the Times? Or can a man in our day be said to live, and not rather to exist, who, feeling that “*dulce est desipere in loco*” seeks not after his week’s work the solace of conning over the fun and frolic, the wit and wisdom, blended with the sound morality and virtuous purpose of the laughter-loving Punch? Sydenham, a high authority all will admit, when asked by Sir Richard Blackmore what medical reading he would advise, rejoined, “Read Don Quixote, Sir.”

And now I must pray you to bear with me whilst I briefly allude to the points which in my mind ought, and I think are most likely, to constitute the chief objects of our attention in the practical working of our Society. As I before hinted, I would classify them under three heads; as Theoretic Inquiries, or the science of medicine; Practical Facts, or the art of healing; and Professional Ethics.

These subjects, to their utmost limits, come within the scope of our investigations. The meetings of our Society, but more especially those held on Saturday during the winter session, offer favourable opportunities for the production of papers or for discussions on all new discoveries in medicine, or on theories as yet not fully developed or established. And here I hope I shall not be misunderstood, but excused in the liberty I take, when I pray that attention may be given to a careful separation of this class of subjects from what I have

designated Practical Facts. And I feel the rather justified in alluding to this matter, from the natural tendency of most, if not all, men's minds to receive with favour, perhaps partiality, the offspring of their own intellectual workings, and to accept as facts what it may be further investigation on their own part, or an appeal to the less prejudiced judgment of their brethren, might lead them to view in a very different light.

To observe in medicine, or in any other art, a genuine, honest, palpable fact, requires more strength and force of mind than to spin out any amount of fine theory or plausible hypothesis, or to build any number of, as Sydenham calls them, castella in ære, whose architect unfortunately can rarely be said

To know what's what: and that's as high
As metaphysic wit can fly.

In no other science is it more necessary that the process of induction be rigidly observed than in medicine. Let us have our facts first, and on them found our theories. This I believe to be the only path by which truth can be reached—truth, the aim and object of all our inquiries. And truth, to use the pithy words of one of Ireland's eminent sons,—“Truth is to be sought,” says Curran, “by slow and painful progress only. I know that error is in its nature flippant and compendious, hopping with airy and fastidious levity over proofs and arguments, and perching upon assertion which it calls conclusions.” Let us, my friends, endeavour to eschew this “error.” And let us ever remember that the stepping-stones to truth in medicine are well authenticated and unmistakable facts, entities, carefully to be distinguished from, and never to be confounded with, the mere opinions of those who observe and describe certain phenomena, and who are too apt to regard these mere opinions as facts. “Few persons,” says Louis, in his *Researches on Phthisis*, “are free from delusive mental tendencies, especially in youth, interfering with true observation; and I am of opinion that, generally speaking, we ought to place less reliance on cases collected by very young men; and, above all, not entrust the task of accumulating facts to them exclusively.”

We all have heard Cullen's pithy remark—even in his time it is to be feared too well founded—“that there are more false facts than theories in medicine.” And in his *Materia Medica*, he gives us a full and classified statement of the many mistakes and untruths which are drawn from what he calls “false experience.” Dr. Cullen, admitting that these “false experiences” were often mere mistakes of judgment, and not made in consciousness of their falsehood, yet hesitates not to reprobate, and with much severity, the manufacture of facts in medicine; and he concludes with a rather remarkable and trenchant statement: “This leads me to observe,” says he, “that a very fertile source of false facts has been opened for some time past. There is in some young physicians the vanity of being the authors of

observations which are often too hastily made, and sometimes perhaps dressed in the closet. We dare not at present be too particular, but the next age will discern many instances of perhaps the direct falsehoods, and certainly the many mistakes in facts, produced in the present age concerning the powers and virtues of medicine.” “Non meus hic sermo,” Gentlemen. These words, be it distinctly understood, were written so long since as 1789.

But it might suggest itself to inquisitive minds to calculate how far they were applicable to a later period in the world's history. “In this intensely scientific age,” writes one of our own day and generation, “we need some wise heads to tell us what not to learn or to unlearn, fully as much as what to learn. Let us by all means avail ourselves of the unmatched advantages of modern science, and of the discoveries which every day is multiplying with a rapidity which confounds; let us convey into and carry in our heads as much as we safely can of new knowledge from chemistry, statistics, the microscope, the stethoscope, and all new helps and methods: but let us go on with the old serious diligence—the experientia as well as the experimenta,—the forging and directing and qualifying the mind, as well as the furnishing, informing, and what is called accomplishing it. Let us, in the midst of all the wealth pouring in from without, keep our senses and our understandings well exercised on immediate work. Let us look with our own eyes and feel with our own fingers.” In other words, let us observe, record, and prize real facts.

From the long experience I have had of the working of the Pathological Society—whose very memory is still pleasant to me, as its meetings had ever been profitable and instructive—I think I am justified in believing that 'mid the subjects that may hereafter engage our attention “practical facts” will occupy a prominent place, and give to our meetings that interest which they have ever heretofore and deservedly elicited. Few of us, I ween, have attended many meetings of the old Pathological without carrying away with us more knowledge than we brought there; or without, at least, feeling that we had spent one hour of our week well. Nor do I think it would be too much to say that the application of the file to which we were all there subjected, and the necessary but wholesome collision of opinion there elicited, have proved often very effectual in making each of us, if not quite “totus teres atque rotundus,” at least somewhat more “factus ad unquem” than before. Be this as it may, however, it cannot be doubted that, as I have said, on these “practical facts,” carefully observed and rigidly investigated, must all theories be founded, and from them must all safe inferences applicable to the practice of our art be drawn. Judging from the past, may we not confidently look forward to a future copious and comprehensive supply of facts, cases, and objects in every department of medicine and surgery?

For my part, I am sanguine on this point, being satisfied that not only will our former contributors not fail us, but that we may reckon, and confidently, on the new blood transfused into our renovated system. But I would forewarn that “new blood,” and pray it to bear with me, while I suggest to it caution, circumspection, deliberation, even a study of the brilliant exemplar, if I may be excused the personal allusion, that has been set before it in the recorded autopsies of the old Pathological, giving, as they do, if properly appreciated, subjects worthy of the closest imitation, and whilst stimulating to increased industry and exertion on our part, yet proving too conclusively that “non cuius homini contingit adire Corinthum.

Permit me now, Gentlemen, to offer a remark or too on the subject of professional ethics, more especially in connexion with our relations to each other. As in other professions and callings, opposite interests and diversities of opinion lead to controversy and even contention, so in ours are they occasionally—happily not frequently—productive of similar results. Where such arise, I hold that conflicting opinions and views, differing upon points of professional etiquette, should be referred by both parties to a court composed of their peers, where their differences may be impartially and correctly settled; where right will be maintained and wrong set right; where in every case the disputants have such confidence in the court, that they bow to and abide by its decision; where all such investigations and awards are held as strictly private and confidential between the parties themselves and their brethren. Such a court, and such a means of adjusting professional disputes, our Society presents to the profession. I fear it were to take too Utopian a view of life as it is, to entertain the hope that such differences may not, nay will not arise.

If we were all to lay down as our rule of conduct that noble maxim enjoined by “the Great Physician”—“As ye would that men should do to you, do ye also to them likewise,” and in every circumstance of our professional path through life act up to it, then indeed would there be no need of the “court medical,” then were our code of ethics virtually a dead letter. But as “it needs must be that offences come,” all, I think, will admit that publicity is not likely to close or heal the breach, and that the private arbitration of professional friends is best suited to arrange differences satisfactorily, with less personal annoyance or injury to the disputants, and with less chance of discredit or obloquy being reflected on the profession; for I imagine that I but echo the sentiments of the majority in maintaining that bickerings and disputations between individuals must ever reflect unfavourably, or even injuriously, on the entire body.

We all know how almost proverbial for its bitterness and intensity the odium theologicum has ever been—that hatred of a man’s neighbour for the love of

God! Barely less intense, but certainly not less odious where it exists, will the odium medicum be ever found. But from that unhallowed combination, the monster offspring of both, “angels and ministers of grace defend us.” Nor among the means that have been recommended as likely to allay the virulence of, or it may be, even eradicate that malady, the odium medicum, so inveterate where it has unhappily been once engendered, can I on the present occasion pass over unnoticed one in particular,—a remedy which, whilst it will be by most of us recognized as efficacious, will be, I hope, adopted and acted on by all of us to-day as a most wholesome and agreeable specific, if there be such a thing as a specific in our materia medica. The British and Foreign Reviewer puts this so well, that I shall offer no apology for quoting and adopting his words. When speaking of this odious odium medicum, he says: “The true remedy for professional jealousies is frequent intercommunication. A good dinner at the “Royal” would heal the professional feuds of a large town. The man of science who thinks he practices his profession for the sheer love of it may smile at the sensualness of the means, and it may not be the remedy he requires; but most practitioners are the men of the “metier,” and like a dinner of the craft as well as others. We wish there were a medical guild in every large town, with an ample dinner fund; good fellowship would increase and abound, and with it unity of purpose, honour, public and personal esteem.” Gentlemen, these are sentiments and wishes in which, whilst I would urge them on your attention, I for one most heartily concur. Frequent intercommunication, unity of purpose, mutual and self-esteem, leading directly to honour and public respect, were “a consummation most devoutly to be wished.” I have but to add, Gentlemen, that our future meetings during this winter’s session will be held in the museum of the Society, at the General Hospital, every Saturday, at three o’clock.

Dr. McGee (Michael) moved and Dr. Browne seconded the following resolution, “That the address just read by the President be handed to the Secretaries to be printed by the Society, and distributed among the members”. Passed unanimously.

The Treasurer then read a statement of the financial position of the Society from which it appeared that he had received in subscriptions a sum of £62.9s.6d and had paid various accounts amounting to £57.1.6, leaving a balance in his hands of £11.8.-. He also stated that there were subscriptions still due amounting to about £20.- which with the balance in hands would make a total amount of 31.8.- to credit of Society.

Dr. Dill then stated that in consequence of the dis-ease of the late Dr. Bryce, co-auditor of the late Pathological Society he, in conjunction with Dr. Johnston had audited the account of that body and found

a balance remaining in Treasurer's hands amount £18.19.10.

J. Creery Ferguson, President

Report on the Inaugural Meeting and Dinner¹

On Saturday, at three o'clock, the first winter session of this important provincial association of medical practitioners—being an amalgamation of the parent "Belfast Medical Society" (founded in 1822), the "Belfast Clinical and Pathological Society," and the "Ulster Medical Protective Association"—was inaugurated in the society's rooms, 33, High Street, by an address from the President, Professor Ferguson, of the Queen's College, Belfast. The attendance of members on this interesting occasion was large and influential, and the eloquent address of the President was listened to with much attention.

In the course of his practical and excellent remarks, the learned Professor dwelt forcibly upon the subject of "Medical Ethics," and of each member making it his bounden duty to endeavour, not only to keep up, but to add to the high prestige of their honourable vocation—that each should remember that he represented a profession which, of all others, demanded the strictest and nicest sense of honour in their every action individually, and especially so as regarded their bearing towards each other.

He pressed also the necessity of united and active exertion in maintaining the interest and practical usefulness of their weekly meetings for professional discussions, observing, on this head, that already their proceedings, he could avouch, had attracted the attention of their brethren in distant places, and had called forth an expression of opinion more flattering to them as a professional body associated together for the advancement of science, which should be an additional inducement to stimulate them to increased energy in furtherance of objects so beneficial to themselves and the community at large.

At the close of this address, the cordial thanks of the meeting were, on the motion of Dr. Browne, R.N., voted to the President for its ability and excellence, with a unanimous request that he would permit it to be printed and circulated freely amongst the members.

The Treasurer of the Society (Dr. J. W. T. Smith) having next made a financial report of the number of members and state of the funds, which was of a most satisfactory nature, the meeting adjourned until the appointed hour for dinner.

Amongst those who were present at the meeting, besides those already named, we observed—Dr. Patterson, Dr. Whitaker, and Dr. David Moore (joint secretaries); Dr. Beck, Dr. M. Magee. Dr. H. Burdon, Dr. Cumíng, Dr. M'Gee, J.P.; Staff-Surgeon Saunders, 14th Depot Battalion, Belfast; Surgeon Gribben; Dr. Wheeler, Vice

President; Dr. C. Mulholland. Dr. Pirrie, Dr. W. MacCormac, Dr. W. Aickin, Professor Gordon, Queen's College, Belfast, Dr. R. Stewart, Dr. Dill, Surgeon Johnston, &c.

The Dinner

The inaugural dinner took place at five o'clock in the society's well-appointed room, the arrangements connected with which were carried out by Mr. Thompson, of Donegall Place, and in so effective a manner as to afford unqualified satisfaction, the dinner and dessert being everything that the most fastidious could have desired. The wines, too, were abundant and varied, as well as of excellent quality. Covers were laid for twenty-five. Several who intended being present were unavoidably absent, and of this number were Professor Burdon, Dr. Dunlop, &c.

The cloth having been removed, the Chairman (the President) gave, with appropriate prefaces, "The Queen," "The Prince of Wales and the rest of the Royal family," coupled with "The Bride Elect, the Princess Alexandria;" "The Lord Lieutenant and Prosperity to Ireland," to which toast Dr. M. Magee, having been loudly called upon to respond, replied in an excellent and very effective speech. "The Medical Officers of the Army and Navy," responded to by Dr. Browne, who, before sitting down, proposed "The Ulster Medical Society," coupled with the name of the President, the latter replying to it with much effect. "The Belfast General Hospital and the Belfast Lying in Hospital." Dr. Pirrie replied, who, in the course of his judicious and well-received remarks, said he regretted much there was not a better attendance of the staff of the General Hospital at their dinner that day, and at which all should, upon such an occasion, especially have considered it their duty to be present. (Hear.) "The Medical Schools of the Queen's Colleges in Ireland." Professor Gordon's name being coupled with this toast, that gentleman replied to it in a manner which elicited great applause.

The President, in giving the next toast, "The Medical Benevolent Fund Society of Ireland," coupled with the name of Dr. B. Stewart, said he could not do so in a merely formal manner, but would take that opportunity of most earnestly entreating every member of the profession to support that truly valuable society in carrying out its most beneficent and humane objects. (Hear, hear.) The Belfast branch of the society, he said, had hitherto done its duty creditably and liberally; but, though this was the case, yet if each member of the profession would make it his imperative duty to give something, be it ever so trifling, to its funds, a greatly increased aggregate amount would be the result; and the more he reflected on the all important services which this society was rendering, the more earnest desire he felt for its having the means at command for increased usefulness, and would accordingly desire to impress, with the utmost earnestness, upon every member of the profession, even the most straightened

¹ [Tyrone Constitution, 07 November 1862.]

in circumstances, to record his name as a subscriber to its funds. (Hear.) What they would give in this way would never be missed, and hereafter they would have a self-approving conscience for having done their duty towards their poor brethren. (Hear.) He concluded by calling upon Dr. Stewart to reply to the toast as the efficient secretary for a great number of years to this local branch of the society, and who, having shortly done so, begged to propose “The Health of the Vice-Presidents of the Ulster Medical Society.” connecting with it the name Dr. Browne, who was also the zealous treasurer of this branch of their benevolent society.

Dr. Browne replied in an excellent speech.

Dr. Patterson said that, in connection with the toast now given, he would propose “The Health of Dr. T. H. Purdon,” the permanent President of the Belfast Branch of the Medical Society, whose support of that invaluable body could not be sufficiently praised, his donations being really of a princely nature. (Hear.) Dr. Purdon’s health was drunk, accordingly, with the greatest enthusiasm by all present.

“The Memory of the late Drs. Dixon and Bryce”—drunk in solemn silence.

Amongst the other toasts of the evening were—“The Country Members,” “The Secretaries and the Treasurer,” “Dr. Patterson and the Stewards,” &c., &c.—all of which having been duly honoured, and an exceedingly pleasant and harmonious evening spent, the President left the chair, and the meeting separated at eleven o’clock, greatly pleased with the day’s entire proceedings—Northern Whig.

November 8th, 1862

Pathological Museum, General Hospital.

Present, the President in the chair, Drs. Browne, Patterson, Stewart, J. Moore, Cumming, Brice Smyth, Pirrie, Arnold, McGee, Whitaker, D. Moore.

The minutes of the previous meeting having been read and confirmed—it was resolved That the question of the publication of the transactions of the Society be referred to the Council, in order that they may consider same and report thereon at next meeting of Society.

Dr. Browne exhibited a case of congenital double cataract in a boy of six years of age.

Paper:¹ The child whom I now introduce to the notice of the Society is named James Hogan, 5 years of age, a native of Stewartstown, county Tyrone. He was blind from birth till very recently, when I performed the operation for promoting absorption of the cataracts, which it will be perceived have become partially absorbed. The right eye was operated on twenty-six days since, and the left fourteen. This case is an excellent illustration of what I stated to the Society last year, when I exhibited a lad on whom I had recently operat-

ed—namely, the propriety, nay, the necessity, of early operations in cases of congenital cataract, and before the eyes have acquired that rolling or oscillating motion so frequently observed in the eyes of those who have been born with cataract in each eye, and who have not been submitted to treatment until the age of ten years and upwards. The eyes in the child before the Society have not yet acquired much of that unsteadiness, and the little they have will readily be overcome by the use to which the eyes will be put after sight has been perfectly restored; perhaps, I should say, as perfectly as such cases can be restored to vision. I have no doubt that this boy will have good sight, and with the aid of proper lenses will be able to learn a trade and pursue such calling with ease and accuracy. I shall likely have to use the needle again in each eye, so as to promote complete absorption. I may remark that very little irritation—no inflammation—succeeded the primary operation; indeed, in these cases my experience is that inflammation rarely follows the operation.

Dr. Browne read notes of a case of femoral hernia.

Paper:¹ Before I relate the particulars of the case of hernia which I am about to bring forward, and which I deem of sufficient interest to occupy the attention of the Society for a little time, I beg to make a few observations on the subject of strangulated hernia. Every hospital surgeon of any experience must have observed that among all the cases of irreducible hernia requiring operation no two have been alike in all respects, and that in the steps of the operation he has had to be guided by circumstances differing in each case. Hence, every surgeon must be prepared to find something, not only not in accordance with what has been laid down in the books, but also essentially differing from cases of his own foregone experience. Now, the following case will be seen most strikingly to bear out these remarks, and is, I conceive, worthy of being recorded from the peculiar and rare features which it presented:—

Agnes McVeigh, aged 64, was admitted to the General Hospital on the afternoon of the 1st of August last, labouring under symptoms of strangulated hernia. She stated that for some years she had been troubled with a swelling in the right groin, which came on upon any exertion, and gave her great pain, but which she was always able to disperse by pressure and friction over the part when she was in the recumbent posture. She had never worn a truss, as she was ignorant of the nature, and especially of the danger, of the enlargement. About eight days before her admission to hospital, the hernia had come down, and she had not been able to push it up as usual. During that time the bowels had not acted, there was occasional nausea and vomiting, with severe intermitting pain. Three days preceding her reception into my ward the symptoms had become more severe daily, and the part exceedingly tender from

¹ [Dublin Medical Press, 1862, Dec 03, p549.]

¹ [Dublin Medical Press, 1862, Dec 03, p548.]

the continuous efforts that had been made, not by any medical man, to reduce the enlargement. Upon examining her, I found a hard tumour three inches in length by two in breadth, prominent and discoloured, extending above, and in the course of, Poupart's ligament. It was perfectly immovable, and very tender to the touch. The patient had constant nausea and frequent vomiting of bilious matter. I believe the ejecta had been stercoaceous. Her pulse was frequent and feeble, and her countenance denoted great prostration. There was also considerable tenderness over the abdomen, and great intestinal tympanitis. The patient previous to my arrival had been put into the warm bath, but there had not been made any attempt at reduction of the hernia. The history and circumstances of the case pointed out the nature of the affection, and that any attempt at reduction by the taxis would be quite inexpedient and indeed dangerous. I, therefore, determined to operate forthwith. For this purpose the patient was put upon the table and brought speedily under the influence of chloroform; and here I may remark that, as I had frequently observed before, the anæsthetic had the most marked influence upon the heart's action, causing it to beat more slowly and much more powerfully, the volume of the pulse at the wrist having been increased in a remarkable manner. Having made an incision of four inches in length in the course of the long axis of the tumour through the integument, I came down upon the cellular tissue, which was densely infiltrated, and felt under the knife as if it were cutting through brawn. The remaining steps of the operation brought me by a careful dissection of agglutinated tissues, quite inseparable into distinct layers, to the sac, which, contrary to my expectations, was very thin, and exhibited a mass of dark-coloured omentum within it. On opening the sac, a portion of omentum fully as large as half of the closed hand came into view. This I carefully lifted up and searched for intestine, but could not see any. I then put the point of my forefinger upon the seat of the stricture, which I found to exist at Gimbernat's ligament. This I divided by very light touches of the probe-pointed bistoury supported upon my finger. A few touches freed the strictured omentum, so far as to permit me to draw it gently down for the purpose of examining its condition. While doing so, and passing my finger up beyond the strictured point, I detected a small knuckle of intestine which was bound down, strangulated in fact, by a portion of the omentum, or a band of lymph. I then considered it was necessary to open the femoral ring more freely than I had done, so as to enable me to free this piece of gut, and to see its condition. Having enlarged the section in Gimbernat's ligament, I was enabled to bring down by gentle traction the piece of strangulated gut and to free it from its investing band. It was of a clear chocolate colour, and as it and the omentum that had been down were not seemingly much injured by the constriction to which they had for

several days been subjected, I returned the entire mass into the abdomen, and while doing so a considerable quantity of straw-coloured serum, highly coagulable, flowed forth. The wound was then brought together by the interrupted suture, and a compress supported by a bandage was accurately applied. The patient was removed to bed, and a sedative was given. I visited the patient at nine p.m. that evening, and found that although some of the more urgent symptoms and the depression had somewhat abated the bowels had not acted, and there was still rejection of the ingesta. I ordered a full opiate, hot turpentine stupes over the abdomen, and an enema of warm water to be administered with the view of clearing the lower bowel. Next day I found that three enemata had been given, but that the bowels had not acted. The stomach had been comparatively quiet, as she had only vomited twice or thrice during the night. There was considerable prostration, a quick, feeble pulse, and furred tongue. The tenderness over the abdomen had not increased, though the tympanitis had. I directed wine and beef-tea to be given in small quantities frequently, and an enema to be administered through O'Beirne's long tube, hot bran poultice over the abdomen, and a grain of the watery extract of opium, with three grains of calomel, to be given three times a day. The following morning (August 3rd) I found that she had had a restless night, great uneasiness in the bowels, and the countenance showed much distress; the bowels still unrelieved, and a great tendency to reject everything save the wine; pulse 130, feeble and wiry. I then myself introduced O'Beirne's tube its entire length with some difficulty, and threw up twenty ounces of tepid water, with an ounce of oil and half an ounce of spirit of turpentine mixed. In about an hour the lavement came away, and brought with it a large amount of feculent matter and scybalæ. To continue wine, beef-tea, opium, stupes, &c. The 4th, I found that the patient had slept pretty well, that the bowels had acted frequently, and that the more urgent symptoms were greatly relieved. On examining the wound, I observed that the integument and cellular tissue around it were in a sloughy condition, and that, from within the abdomen, there was a copious discharge of deep-coloured serum, mixed with oily matter and shreds of what seemed to be omentum. I ordered a poultice over the wound, and the same treatment as before to be continued, with the addition of four ounces of whisky daily. On the 5th, I found matters progressing satisfactorily, and indeed after that date she gradually improved, though she had occasional attacks of colicky pains with tympanitis. These attacks were always relieved by a mild aperient and carminative draught, and turpentine stupes and warm enemas. For two months from the date of the 6th of August, the wound continued to discharge great quantities of serum with seemingly disintegrated omental fat. Sometimes this discharge very much resembled feculent matter, but

without its odour, sometimes it resembled chopped-up yolk of egg, and occasionally that of the orange-coloured discharge that appears frequently around the wound in a limb with compound fracture. During this time the bowels continued to act per vias naturales, but often required to be stimulated by the draught I have alluded to, or by an enema. Without further prolixity, then, I may say that my patient continued under my care till the 30th ultimo; that the external wound gradually granulated and closed; that some serous discharge continued till about the 20th of October, when it gradually ceased; and that the patient was discharged at her own request on the 31st, hearty and well, a small point of the wound still remaining unhealed.

Remarks.—There are several points of interest in this case which every member will have noticed; to one or two of them, however, I shall refer more particularly. The first is the fact of the piece of gut that was found strangulated in the omentum, and which, if it had not been discovered and freed, would have likely produced a fatal termination to the case. It was not by chance that I was directed to its detection, but by search, as I had experience, through a post-mortem examination, of a case in which I had reduced a strangulated portion of omentum, as it seemed only, but within which and confined by a firm band, I found after death a very small fold of intestine still strangulated. Hence, I make it a point always to search carefully in such cases, whether a piece of intestine may not be held within the omentum that had been protruded.

The next point of interest is, the amount of subacute peritonitis that was present, and the great quantity and persistence of the discharge. I have no doubt that the intestine was not opened by ulceration, but that the discharge which resembled feculent matter was simply the product of the inflamed peritoneum, though probably the piece of omentum that had been strangulated was, in the first instance, disintegrated and cast off. The use of stimulants in such a case would formerly have been deemed unsafe; but their utility in that before us, nay, the absolute necessity for their administration, was most apparent, their action most satisfactory.

The administration of opium I found also of great service; while I may remark that the introduction of O'Beirne's long tube, and the injection of a large quantity of tepid water, with oil and turpentine, was followed by immediate and permanent relief to the most urgent symptom—namely, the obstinate constipation and the excessive intestinal tympanitis.

November 15th, 1862

Present, Drs. Ferguson (Chair), Browne, Patterson, Ferguson H. S., Beck, Gribbin, Reid J. S., Thompson H., Cuming, Pirrie, Johnston, Arnold, and Whitaker.

Moved by Dr. Patterson, seconded by Professor Reid and resolved, "That the transactions of the Society be offered in future to the Dublin Medical Press

for fortnightly publication".

Dr. Browne was requested to write to the Editor of the Press and make the necessary arrangements.

The President read a report of an extraordinary case of pemphigus.

Paper:¹ I should hope that the interest and importance, as well as the infrequency of occurrence of affections similar to the following case, will justify my bringing it before the Society as a simple fact. The generic name of pemphigus has been given to it, as it were, by the common consent of those who saw it earliest. Nor am I inclined to take exception to the name, though I am free to admit that I habitually regard our nomenclature of skin diseases as rather arbitrary. Its characters would, perhaps, justify our referring it to that nosological class rather than any other; but, as its history will sufficiently demonstrate, it differs in many essentials from the recorded descriptions, as well as portraits, of that class of affections, nor would its specific features admit it to be ranked as one of its described varieties. These were so well marked and peculiar as to suggest, and I think merit, the specific designation of "Gangrenosus." I am indebted to our House-Surgeon, Dr. David Moore, for the particulars of its history:—

James Graham, æt. 28, an auctioneer's clerk and porter, married, of temperate habits, was admitted into the Belfast General Hospital, October 15, 1862.

Eleven years ago had an attack of rheumatism, and has ever since been subject to occasional seizures of palpitation of the heart. Four months ago he suffered from pleuritis of the left side, and has since complained of pain in that side, general debility, and loss of appetite. For the past two months he has had a constant and severe cough, attended with frothy whitish expectoration, which became streaked with blood three weeks ago, when the fits of palpitation also increased in severity, and were accompanied with considerable pain, for which he consulted a medical practitioner, who told him that he laboured under organic disease of the heart, which would shortly prove fatal, ordering for him a combination of Dover's powder and uva ursi, with syrup of iodide of iron.

Ten days previous to his admission to hospital a peculiar skin-eruption made its appearance, not preceded by rigors, or any constitutional disturbance proceeding from it, so far as can be ascertained. On its appearance, however, the cardiac pain and palpitation were markedly mitigated in severity, and the cough and expectoration ceased. A few vesicles containing a clear serous fluid, very similar according to description, to those of pemphigus, showed first on the chin and face; for the first three days, few in number and distinct. Soon, however, the whole face became covered, the vesicles becoming confluent, and a similar eruption mak-

¹ [Dublin Medical Press, 1862, December 10, p573.]

ing its appearance on the dorsum of the hands, the rest of the body being perfectly free.

On admission, the face was much swollen and covered with a moist yellow crust, resembling in aspect boiled cauliflower; the eyes closed, and nostrils nearly so; the lips so tumid from the eruption as to necessitate the exhibition of fluid nutriment through an elastic catheter; the back of both hands covered with vesicles similar to those on the face in different stages of progress. At first the vesicles, filled with a clear fluid, gradually increased in size, becoming more opaque and pearly, then livid and burst, coalescing into each other, and covering the whole face with the yellow crust before referred to, from which a thin ichor exuded, presenting a very strong resemblance to the face of a patient in confluent variola about the ninth or tenth day of the eruption.

I may add, that the odour exhaled from the diseased surface was peculiarly offensive, indeed almost gangrenous. Pulse 105, weak, soft, and wanting volume; tongue moist, but could not be protruded; bowels regular; great general distress; in fact, the case presented a very formidable aspect, so much so, as to cause some of my colleagues, who saw it in consultation with me, to form an unfavourable prognosis. He states positively that he has not lately been working in any way with horses, dogs, fowl, or other animals, nor has he been engaged in teasing horse-hair, or come in contact with other animal matters; such inquiries being dictated by the strong suspicion that the phenomena presented in the case depended on the reception into the system of some animal poison. On this day the accompanying drawings of the appearances presented by the face and hands were made by Dr. Moore, and most faithfully do they portray their every peculiarity. I may remark that on referring to the delineations of pemphigus given by Cazenave, Rayer, and Bateman, none of them present even a family likeness to the features of the case of Graham. Wilson's portrait, which I lay before the Society, presents in some points a faint resemblance.

He was ordered, vini ℥xvj.

R. Acidi nitrici dil., acidi muriat. dil. aa. ℥ss. M.

Guttas, xx. 3tiis horis.

Linimentum aquæ calcis to be constantly smeared over the face and hands; beef-tea, milk, &c., to be freely administered, with an opiate at night.

16th: Pulse 95, improved in quality; face more swollen; eyes completely closed; bowels free; takes his wine and nourishment.

17th: Pulse 92; progressing favourably. Pergat.

19th: Pulse 100; swelling of face somewhat subsided, permitting the eyes to be partially opened, showing their conjunctivas highly injected; progressing favourably.

23rd: Pulse 88, fuller and firmer than hitherto. Ordered a chop; wine, ℥xvi. daily; swelling of face, lips, and eyelids much less, permitting the eyes to open

freely but not fully. However, the elastic catheter is still necessary for drinking purposes.

26th: Continues to improve; hands to be poulticed.

28th: Wine reduced to ℥x.; hands to be dressed with simple dressing; physical examination of the heart to-day gives all the signs of permanent patency of aortic valves.

November 1st: Doing well. Pergat.

4th: Dressings to be discontinued, as the hands are almost healed, but few crusts remaining; poultices to be applied to face, lips, and chin, to remove crusts; beef-tea to be discontinued; solid food; wine reduced to ℥vi.; warm bath every second day.

From this date he became Dr. Pirrie's patient. His convalescence has been steady, and I beg leave to introduce him to the members for their inspection.¹

Dr. Browne read case of amputation at shoulder joint with secondary hæmorrhage.

Paper:² Charles Stewart, aged 18 years, a mill-worker, was admitted into the Belfast General Hospital on the morning of the 10th of May last, having sustained, half an hour previously, a severe injury from having been caught in a carding-machine. On examination it was found that the left hand and arm were completely smashed up to within a short distance of the shoulder-joint; the humerus was broken through above the middle, the soft parts being greatly lacerated close up to the axilla, from which the torn ends of the nerves hung down some inches; the deltoid muscle was not extensively injured, though the integuments covering it and the scapula were furrowed deeply by the teeth of the card. But little hæmorrhage had occurred, though the little fellow was labouring under great depression from the nervous shock. Stimulants were given, and when some reaction had been established, chloroform was exhibited about half an hour after admission—the anæsthetic, I may remark, greatly assisting in giving a fillip to the circulation. In consultation with Professor Gordon, I determined to dissect out the axillary artery from the bruised and entangled mass and tie it before I proceeded to disarticulate the humerus, with the view of placing the ligature beyond the point at which it had been greatly put upon the stretch; having done so as high as possible, I made a good flap out of the deltoid muscle and integument, cleared away, as far as practicable, the torn soft parts which had formed the floor or base of the axilla, and then turned the head of the bone out of the glenoid cavity. Three additional arteries were ligatured; the parts, thoroughly cleaned, were put in apposition, and strips of wet lint, with a compress and bandage, were applied.

The patient was then removed to a warm bed, heat was supplied by means of the ordinary hot-water pans, and an opiate administered. The poor lad, I may

¹ [Later died and heart shown to the Society. See page 992.]

² [Dublin Medical Press, 1862, December 10, p574.]

observe, lost no blood in the operation, felt of course no pain during the procedure, and rallied very quickly after. At the evening visit I found that complete reaction had been established—too much, indeed; the pulse was full, 140 beats, the face flushed, and skin hot. Three grains of calomel, to be followed by a Seidlitz draught next morning, were ordered, and a saline mixture was directed to be given during the night. Next day I found that the patient had slept well, the bowels had been freely opened, and, on the whole, he was doing very well. On the 13th, I removed the dressings for the first time, and observed that part of the wound looked sloughy, without an attempt at union by first intention at any point; this, however, I expected, as in these cases where the soft parts have been lacerated and the integument put much upon the stretch, as usually happens in mill accidents, union by primary adhesion is exceptional; unless, indeed, the amputation shall have been made far above the parts that have been so stretched.

Up till the morning of the 18th, almost eight complete days after the accident, everything progressed favourably, when, at five o'clock a.m. on that day, secondary hemorrhage suddenly occurred. The house-surgeon and resident pupils were promptly by the patient, and firm pressure having been applied over the flap and directly on the subclavian artery, the bleeding was stopped. On my arrival at the hospital at six o'clock, I found the little fellow had lost about four ounces of blood, which had trickled slowly at first from under the dressings, and having been observed, the flow was checked before a great quantity was lost; still he was pallid and weak, with a shabby, quick pulse, though he was full of courage!

I carefully removed the dressings and pads that had been applied, and desired the pressure over the subclavian artery to be taken off; there was not, however, any return of the hæmorrhage, nor indeed any sign of it for the hour I remained by the bed-side. Being then satisfied that I should not further interfere with the wound, and hoping also that the bleeding came from some small vessel that had been overlooked at the time of the operation, I applied some fresh dressings, with a light pad and bandage, and left a resident pupil in charge. At two o'clock p.m., a smart return of the bleeding took place, which was restrained by pressure on the subclavian, and which was kept up till four o'clock p.m., when it was removed.

The blood lost on that occasion was estimated at some four ounces. At half-past five a fresh hæmorrhage returned with violence. On my arrival, a few minutes after, I saw the necessity for prompt interference, as the little lad was very pale and weak, with a very feeble, quick pulse. I proceeded, therefore, to open up the wound (the patient under chloroform), while Dr. Pirrie and the house-surgeon kept up pressure on the subclavian. After a considerable amount of search and dissec-

tion among the matted textures, I saw the point from which the bleeding came, evidently the axillary artery, and which threw out occasionally a great jet of blood when, by any movement of the patient, the pressure was relaxed for an instant. With some difficulty I seized the bleeding vessel, not being particular, indeed, to exclude the surrounding tissues, and passed a strong ligature around it, and having tied it, I found that the hæmorrhage was completely arrested. But, to give additional security, I applied a firm pledget of lint to the part after it had been saturated with a strong infusion of matico, and put on light water-dressings and a bandage. On consulting with my colleague, Dr. Murney, who had then arrived, it was deemed advisable to let matters rest, keeping a sharp lookout for any recurrence of the hæmorrhage, and should it return, being prepared to ligature the subclavian in the middle part of its course. Fortunately, however, everything progressed favourably, the ligature came away on the morning of the 26th of May, and the pledget of lint a few days later.

The wound granulated kindly, and healed up completely by the end of June, when the little lad was discharged. I should state that the medical treatment consisted in the exhibition of opium, muriated tincture of iron, with full allowance of wine and beef-tea. I cannot conclude without expressing my thanks to the House-Surgeon, Dr. David Moore, and the Resident-Pupils, Messrs. Joseph Mackenzie and W. A. Browne, for the unremitting care and unwearied attention bestowed upon this interesting case.

Dr. Johnston showed kidney from scarlatina patient and made some interesting remarks thereon.

A discussion ensued in which most of the members took part and Dr. Johnston was requested to introduce the subject for discussion at a future meeting.

22nd November, 1862

Present, Dr. Ferguson (Chair), Drs. McGee, Pirrie, M. McGee, H. S. Ferguson, Browne, H. Thompson, Arnold, Beck, Gribbin, Patterson, Cuming, H. MacCormac, and Whitaker. Also Dr. Saunders 14th Depot Battalion as a visitor.

The minutes of last meeting were read and confirmed.

Dr. Browne read a letter from Dr. Jacob of Dublin regarding the publication of the transactions of the Society and was requested to continue the correspondence and report to next meeting.

Drs. Little of Lurgan and McCrea (Belfast) were elected members of the Society.

Moved by Dr. M. McGee and seconded by Dr. Arnold "That the Council be instructed to purchase a microscope for the use of the Society to be placed in the rooms, 33 High Street, and that a sum not

exceeding £12 be debited from the funds for that purpose”.

Dr. Pirrie moved and Dr. Pirrie [sic] seconded the following amendment, “That the propriety of and possibility of procuring a microscope for the use of the members be referred to the Council for consideration and that they report thereon on this day fortnight”. Amendment carried.

Dr. McGee handed in following notice of motion “That no question shall be entertained by this Society of which due notice shall not have been previously given in the weekly circular, with the exception that on the final meeting in December, February and April any matter or question may be brought before the Society”.

Dr. Browne then brought forward a child 2 years old, who had sustained laceration of the perineum and other serious injuries by having been run over by a dray, and gave a very interesting history of the case.

Paper:¹ A. C., aged 2 years, was admitted into the Belfast General Hospital on the afternoon of the 30th of July last, having been run over by a horse and heavy “float” (ten hundred weight) a few minutes before. On examination, it was found that the wheel of the dray had passed over the upper part of the left thigh and obliquely across the pelvis. The integument of the thigh and abdomen was only slightly abraded; but there was extensive laceration of the perineum, the vagina and lower part of the rectum being laid into one to the extent of three-fourths of an inch. The pubis was separated at the symphysis, and the mucous membrane to the left of the orifice of the urethra was torn to the extent of nearly an inch. The closest examination could not detect any further lesion, and there was not certainly dislocation of either femur. The poor little child, as might be expected, was suffering from great pain and the shock of such a severe injury. Very little bleeding had occurred.

I ordered some wine-why to be administered, with two drops of the tincture of opium every three hours till quiet had been procured and reaction established. I also directed the pelvis and limbs to be rolled in flannels, wrung out of warm water. For some days the issue seemed very doubtful; but at the end of a week the little thing began to take its food pretty freely, and to give evidence that it would not likely succumb to the effects of the accident. During this time, I should remark, there was incontinence both of the urine and fæces. At the end of three weeks the parts around the left hip-joint became hot, tender, and swollen, and I then considered that an abscess was likely to form. After ten days, however, we had clear evidence that spontaneous dislocation at the left hip-joint had taken place, and I was then led to believe that the swelling I have just referred to arose from inflammation within the joint and con-

sequent effusion, and of course displacement of the head of the bone from its socket. The mother of the child, who had remained with it in hospital, about that time became anxious to return to her family, and at the close of five weeks from the date of injury she took her child home (3rd of September). From that date till yesterday I had not seen my little patient, and I now beg to draw the attention of the members to the child’s present condition. There is dislocation of left femur on dorsum of ilium; there is separation at the symphysis of the pubis to the extent of nearly an inch, as the middle finger laid lengthways between the separated portions enters easily with the relaxed integuments into the chasm; there is also complete laceration of the perineum with prolapsus ani, and a large hernia on the right side. The torn mucous membrane has healed up, and the child can now retain the urine quite well, but has not complete command over the sphincter ani.

In conclusion, I may remark that I have brought this case under the notice of the Society for the purpose of showing what an amount of injury even an infant may sustain without fatal results. Considering the patient’s tender years, I fear that little can be done immediately to relieve its deplorable condition. I intend, however, to apply a truss to the hernial protrusion, and after some time I may, perhaps, be able, by operative interference, to remedy the prolapsus ani; but of course we are all well aware that it is most difficult to adjust any appliance, or to perform successfully a plastic operation, such as this case would require, upon one so very young.

With regard to the hip-joint injury, we have no remedy there! I have no doubt but that, at the time of the accident, the bones entering into the composition of the acetabulum were partially separated, as they would easily be in infancy, inflammation and effusion followed, and the head of the femur was displaced, and thus, at the best, the poor little girl must remain a miserable object for life.

Dr. Browne read notes of two cases of penetrating wound of the knee joint.

Paper:¹ The first of these cases, Mr. President and Gentlemen, to which I shall direct your attention is that of a patient recently discharged at his own request from this hospital, and who, I regret to find, has not made his appearance here to-day.

S. T., aged 29 years, was admitted into the Belfast General Hospital on the 27th of last August for erysip-
elatous inflammation of the left leg and thigh, the result of a wound received on the 24th. It appeared that while working with a chisel he accidentally struck it into the thigh, the instrument penetrating to a considerable depth. The wound was situated about three and a-half inches above the patella, and on a line drawn directly

¹ [Dublin Medical Press, 1862, December 17, p600.]

¹ [Dublin Medical Press, 1862, December 17, p600.]

upwards from the superior and outer angle of that bone, thus probably touching, or rather penetrating, the extreme limit of the capsule of the knee-joint. For the first two days after the injury he did not think much of it; but on the 26th great pain in, with considerable swelling around, the knee came on.

On admission to hospital I found great inflammation, of an erysipelatous character, extending from mid-thigh to the ankle of left limb. There was also considerable effusion into the joint. The patient was likewise labouring under a great amount of febrile irritation, tongue dry and red, pulse quick and sharp. Hot stupes were directed to be constantly applied to the limb, and I ordered, after the bowels had been fully cleared out, a combination of tartarized antimony, calomel, and opium; with milk diet, and enforcement of perfect rest of the part. For several days the treatment to which I refer was kept up; but still the patient laboured under great pain of the affected joint and severe irritative fever. On the 4th of September there was a large discharge of synovial fluid from the wound, and the general inflammation of the limb had somewhat abated. As the system was slightly under the influence of mercury I lessened the dose of that drug, but continued the use of full opiates, and ordered for him a diaphoretic mixture. I also then ordered the entire inflamed parts to be painted daily with the strong tincture of iodine, and to be enveloped in a linseed-meal poultice. The discharge from the joint continued to be copious for some time. Occasionally this was simply coloured synovia; at other times it contained purulent fluid mixed with the synovia, and sometimes cholesterine-like matter was mingled with it. During that period the pain of the part continued to be very great upon the slightest motion, and the swelling of the leg was persistent. After the lapse of three weeks the discharge ceased, and I had every hope that the urgent symptoms had been subdued, when acute pain was once more felt in the joint just over the inner part of the head of the tibia; for this I ordered repeated local leeching, and the mercury, which had been discontinued, was directed to be given again. By the middle of October the attacks of inflammation had entirely ceased, the swelling of and around the joint had nearly disappeared, and under the use of the iodide of potassium internally, and the local application of strong tincture of iodine, with generous diet, the patient was brought to a state of satisfactory convalescence, and he was discharged, at his own request, on the 14th of November. He could then bear his weight upon the limb, and had passive motion without pain. Of course he was directed to be most careful of the limb. Perfect rest for some time was enjoined, and when any attempt at using the part was to be made, he was cautioned to desist the moment he felt the slightest pain. I may add that, under all the circumstances of the case, I consider that complete ankylosis of the joint would be for the

patient the safest result. If, however, the joint reacquired the power of flexion and extension, it certainly would be more satisfactory to those who have had the care of this very dangerous and interesting case.

Dr. Browne then introduced a boy who has sustained 2 wounds from a penknife, one in the abdomen, the other in the knee, and described the progress of the case.

Paper:¹ I am now about to show the Society a patient who has been in hospital for nine weeks in consequence of wounds received in a scuffle, but shall first read the notes I have taken of the nature and progress of the injuries:—

James Nelson, a healthy lad, aged 15 years, was brought to the Belfast General Hospital on the evening of the 21st of September of this year, having a short time previously been stabbed by a companion in a quarrel. On examining him I found, an inch and a-half anterior to the end of the eleventh rib, an incised wound, extending an inch and a-half in an oblique line towards the umbilicus. This wound was simply through the integument at its upper extremity, but at the centre and nearly to the lower end, it penetrated the cavity of the abdomen, permitting my finger to enter, and with which I touched the great curvature of the stomach. I found also a wound penetrating the right tibio-fibular articulation, and nearly an inch in extent. The patient did not seem to be suffering much pain from his injuries, nor was there any marked collapse, such as one would naturally expect under the circumstances. These wounds were carefully brought together by interrupted suture and adhesive plaster, supported by pads and bandage; of course I regarded the abdominal injury as of great danger.

I ordered an opiate at once, and directed a grain of opium with one grain and a-half of calomel to be given every four hours; low diet and perfect quiet were also strictly enjoined. Next day I found the young lad fully under the influence of opium; he was free from pain, and without tenderness of the abdomen on pressure, save at the point of lesion. On the 23rd the pills were discontinued, but an opiate was ordered to be given at night and morning. For four days he progressed most satisfactorily, and I did not interfere with the wounds. On the 5th day I removed the dressings, when I found that the wound in the abdominal wall had united by the first intention, but that over the knee had not, and its edges looked thickened and irritable, and on the 27th there was a slight discharge of synovial fluid from it, still the joint was not swollen. On the 29th, the lad felt so well, the abdominal wound being healed, that he was desirous of being permitted to rise for a little. That request I refused to sanction, because the knee seemed a little swollen and tender around the wound, which was

¹ [Dublin Medical Press, 1862, December 17, p601.]

looking rather unhealthy. That night he was seized with a sharp rigor, and acute inflammation was developed in the joint, and on the following morning I found him hot, flushed, and very feverish, with great effusion into the joint. Leeches and hot fomentations were immediately ordered, and lint, dipped in spirit lotion and covered with oiled silk, was directed wherewith to envelope the knee afterwards. I also prescribed the calomel as before, with half a grain of opium in each dose. Up till the 6th of October the synovia continued to flow freely from the joint, when it ceased for some days. During this time an unhealthy fungous-like granulation rose from the wound. Though the knee had been repeatedly leeches, and the medicines had been continued, the acute inflammation was not much subdued. On the 8th I stopped the calomel, and ordered instead of the spirit lotion a cataplasm of linseed-meal to be applied. Up till the 16th the patient did not improve; his appetite, which had been good, had failed; he became somewhat hectic, and the joint was still greatly enlarged, though the pain was not very severe. Occasionally, indeed, it became intense, when a full opiate usually gave early relief.

On the 16th I ordered him to take four grains of the citrate of iron and quinine three times a day, and I gave him improved diet. On the 18th a discharge of coloured synovia, mixed with purulent-like matter and flakes of lymph, took place, and from this the enlargement began to diminish, the pain ceased, and the lad improved in condition. The tonic was continued, the joint was painted over daily with the strong tincture of iodine, and spirit lotion was reapplied. From the 28th to the date of his discharge from hospital this day, a splint was applied so as to keep the knee extended and at rest, as the best I can hope for is a stiff joint. You will now perceive, on examination, that there is still enlargement of the joint, and apparent displacement of the relative position of the tibia and femur. Whether there is much change of structure within the joint I cannot say; but it is a hopeful sign that there is power of moving the part without the slightest pain. It is true that the amount of motion is very little, but that does not convey any jarring sensation to the touch, as if the internal structures were disorganized.

I intend to apply mercurial plaster for strapping the knee, and shall support the part with a bandage.

On the whole, I think I may remark that both of the cases I have brought forward are possessed of considerable practical interest; the latter especially, as it fully illustrates a fact now well known to surgeons, that a penetrating wound of the abdomen, though ever to be regarded as of a dangerous character, need not necessarily be followed by any untoward symptoms. I need scarcely refer to the treatment in the first instance, beyond stating that it was on the opium and not the calomel that I placed my hopes of warding off the peritonitis, the advent of which, for the first few days, I had

reasonable ground to dread.

The history of the progress and issue of the injury of the knee-joint in this case is also of great practical interest, as it shows the danger that is always to be apprehended from a penetrating wound of a joint, especially of the knee; for even, in this instance, the treatment pursued regarding the abdominal wound and the absolute rest, did ward off the very serious results that ensued upon a seemingly trifling wound, and which, in the first instance, was not supposed to have injured the main joint. I may here mention a very interesting case of injury of the knee-joint which I had under my care several years ago. By a direct blow in a fall from a height, a man, 57 years of age, sustained a compound comminuted fracture of the right patella. The joint was opened, so as to admit the finger, and under these circumstances grave doubts were entertained as to the expediency of endeavouring to save the limb. However, the parts were brought together, water-dressing applied, and the limb kept quiet in the straight position. Not one bad symptom supervened, beyond the escape of the synovia, which continued for a few days. In nine weeks the wound had healed up, and the man left the hospital fourteen weeks after the receipt of the injury with an excellent stiff joint, and which has remained firm and sound up till this time.

Dr. W. McCormac thought that the joint in the case exhibited was nearly disintegrated, from the lateral motion of the tibia upon the femur, showing that the lateral, and probably the crucial, ligaments had been partially destroyed.

Staff-Surgeon Saunders said that he thought a starch bandage around the knee and occasional walking would be better than rest and strapping—a mode of treatment he had adopted in a case which he mentioned, and with complete success, especially as regarded the general health of the patient.

Dr. McGee said there were two indications to be observed; first, to prevent inflammatory action; and, in the second place, to reduce the swelling and thickening around the joint; for the former, he thought that rest and quiet were indicated; for the latter, bandaging should be persevered in.

Dr. Whitaker considered that the case alluded to by Dr. Saunders differed materially from the case exhibited by Dr. Browne; the former was one of chronic disease; the latter, the result of direct injury, therefore requiring different treatment.

Dr. Browne briefly replied, reiterating his views relative to rest, mercurial strappings, and bandaging.

Note.—I have seen both of those cases to-day (Dec. 14th), and found that S. T. has a stiff joint, nearly quite ankylosed. The man can walk without pain, and, save a little uneasiness when pressure was made over the inner part of the head of the tibia, I could not detect anything wrong. The joint is of natural size, and the bones are in their proper relative position. He has kept

quiet, and has had the part well bandaged. The lad, J. Nelson, has no pain. The joint is still a little enlarged, but the deformity which existed has nearly disappeared. He can walk pretty well, and has considerable motion of the joint—semiflexion and nearly complete extension. His health is excellent also. He has been very careful, has observed quiet, and has worn mercurial strapping and a starch bandage round the joint since his discharge from hospital three weeks since.

November 29th, 1862

Present, Dr. Ferguson in the chair, Drs. Pirrie, Browne, Dill, Patterson, Michael McGee, Arnold, MacMahon, T. Reade, Cuming, Stewart, W. MacCormac, Whitaker, D. Moore. Visitor, Staff Surgeon Saunders, 14th Regiment, Dr. Eustace, Dublin.

The minutes of the previous meeting having been read and confirmed, Staff Surgeon Saunders read a paper on a case of urethral stricture when the passage presented two strictures, one of six years standing, the other of more recent date, in which Holt's dilator was used successfully and No.10 silver catheter being passed immediately after the operation.

In a short time the man had recovered very satisfactorily.

Paper:¹ A soldier of the 62nd Regt., aged 25, admitted into the 14th Depôt Battalion Hospital, May 16th, on account of two strictures, one of six years' duration, situated in the membranous portion of the urethra, the other of recent date, about two inches more forward. The man complained of difficulty in micturition. After a few days I was enabled, with great difficulty however, to pass No. 6 catheter into the bladder. On the 31st the dilator was introduced, the strictures split, and a No. 10 silver catheter immediately passed into the bladder, which has since been frequently done with perfect ease. On August 13th, two and a-half months after the operation, no trace of the second stricture could be detected.

This method of treatment, so ably advocated by Mr. Holt, has this great recommendation, that while the operation affords rapid, and, in most instances, permanent relief, with a fair prospect of ultimate recovery, it does not involve any risk to life, which cannot be said of the perineal section, as introduced by Mr. Syme. Then, as regards the old method, or that of gradual dilatation, it is not only slow but tedious, and oftentimes most unsatisfactory in its results.

Dr. Browne said that although Staff Surgeon Saunders' paper would shew the value of Holt's dilator in certain cases, he could not agree in the observations with regard to its comparative safety to Syme's perineal section, as Holt's dilator in cases calling for Syme's section was to his mind altogether inapplicable.

Dr. T. Reade considered the dilator would be ap-

plicable only in select cases when there was no disease of the bladder, or urethral inflammation, or where there was no rapid stricture from gonorrhœa; with latter cases the dilatation would incur local and constitutional risks.

He was adverse to other means than delicate handling and gradual dilatation of so tender a part and had never failed save in certain cases when Syme's section was alone applicable. He considered Staff Surgeon Saunders' case as one well suited for dilatation.

Dr. W. MacCormac wished to know if the No. 10 catheter introduced after the operation was left in the urethra or withdrawn immediately.

Mr. Saunders replied that the catheter was withdrawn at once when the water was drawn off, and considered its retention in the passage could do more harm than good. The mucous membrane being uninjured there was no danger of infiltration of urine, and by the sudden relief of the stricture a great advantage was obtained over the gradual mode of dilatation which was not without risk from its frequent repetition even in the most careful hands, and there was also the risk of complete retention with much irritability of the passage after a debouch with an increased liability of false passage. The man was kept ...

Dr. Eustace remarked that Drs. Smylie and MacNamara had used the dilator very successfully in many cases of stricture in Dublin.

Dr. Pirrie showed the morbid parts of a case of stricture of the œsophagus. The stricture extended two and a half inches from the cardiac orifice of the stomach, was two inches in length, and consisted of a deposit of hard cancer ulcerated at the upper part of its mucous surface to the extent of half an inch all round. The passage was narrowed to such a degree as not to permit the passage of a No. 5 elastic catheter. The œsophagus immediately above the stricture was but slightly dilated, no well-marked pouch being formed. During life there was no dyspnoea or stridulous breathing. The recent duration of the symptoms and suffering in so close a stricture were peculiar in the case. She had only suffered pain for 3 months past, and from difficulty of swallowing still more recently. About three ounces of fluid were retained for about ten minutes at a time after swallowing, and were then returned by the mouth.

Although no tumour could be detected through the abdominal parietes Dr. Pirrie thought the seat of stricture was at the cardiac orifice and that the fluid was retained in a pouch of the œsophagus. There was no dyspnoea or stridulous breathing during life.

Paper:¹ The patient, a female, æt. 52, had been admitted into the Belfast General Hospital a few days previously, supposed to be labouring under organic disease of the stomach. She was exceedingly weak and

¹ [Dublin Medical Press, 1862, December 31, p650.]

¹ [Dublin Medical Press, 1862, December 31, p650.]

very much emaciated, and had all the aspect of a patient suffering under malignant disease. She said that she had been only three months ill, that her illness commenced with difficulty of swallowing, which gradually increased, accompanied with a dull pain behind the lower part of the sternum.

On admission, notwithstanding her great emaciation, the most careful examination could not detect any enlargement or hardness about either extremity of the stomach, or indeed about any part of the abdominal viscera. She could swallow nothing but fluids, and of these (beef-tea, wine, &c.), she would take a very small quantity at a time, about half a wineglassful. This she would retain for about ten minutes, and then almost the entire quantity swallowed would be returned by an effort of vomiting, but without any sickness.

Dr. Pirrie diagnosed the probable existence of malignant disease of the cardiac orifice of the stomach, with dilatation of the œsophagus above the orifice. She sank rapidly, and died a few days after her admission into hospital. On examination twenty-four hours after death, the stomach (including both orifices) was found perfectly healthy but very much contracted on itself; but about one inch above the cardiac extremity, there was a dense thickening of the coats of the œsophagus, extending upwards more than an inch, and encroaching upon the calibre of the tube, so as almost entirely to obliterate the passage. Indeed, even after the œsophagus was laid open, the smallest bougie could not be passed through the indurated mass. The lining membrane was extensively ulcerated at, and immediately above, the seat of obstruction. Microscopic examination revealed the existence of the usual characteristics of malignant deposit in the seat of the disease.

Dr. MacMahon had seen the woman casually several times since the commencement of her illness. About four months ago she was in robust health, plump, and was able to swallow freely, it was only about four weeks since the power of swallowing became very much obstructed, when the emaciation became rapid and extreme.

Dr. T. Reade had a case of stricture of œsophagus, doubtless organic, which ran a tedious course of 18 months. Could swallow fluids, lived chiefly on milk. Sank at the last from an extrinsic cause. No P.M.

Staff Surgeon Saunders referred to a case under his care who vomited everything he took. When dying of inanition Dr. Saunders fed him per anum under which treatment he rallied living for some months without taking food by the mouth for at least a considerable portion of the time.

Dr. Reade had found much benefit from injections per anum in such cases.

Dr. Arnold asked Dr. Pirrie if he thought any fluid passed through to the stomach at the later period of the case. Dr. Dill remarked that as far as he knew all

cases of œsophageal scirrhus died of inanition and that any artificial means of feeding them would keep them alive.

Dr. Ferguson differed from Dr. Dill's view and thought that the presence of such an amount of disease in the œsophagus would produce constitutional effects independent of the stomach.

Dr. Pirrie suggested that the dilated pouch of the œsophagus might offer an absorbent surface for food as well as the rectum.

Dr. Cuming stated there could be no doubt that the nutrient enemata disappeared from the bowels, and the inference was manifest.

The Society then considered the question of the presence in the Society's reading rooms of persons who were not members. Resolved, That the Secretary be requested to communicate with Dr. Corry, and request him not to lend his key of the rooms to any person, not a member of the Society.

December 6th

Present, the President in the chair, Drs. Patterson, H. Ferguson, Browne, Beck, W. MacCormac, Dill, Cuming, Stewart, Brice Smyth, Arnold, McCrea, Gribbin, Michael McGee, MacMahon, Corry, D. Moore.

The minutes of the previous meeting having been read and confirmed, two medical gentleman were proposed as members of the Society viz Surgeon McCourt of Belfast (proposed by Dr. Whitaker, seconded by Dr. D. Moore), Dr. McWilliam of Belfast (proposed by Dr. Corry, seconded by Dr. Beck).

December 13th, 1862

Present, the President in the chair, Drs. Patterson, McGee, McCleery, T. Reade, McCrea, Michael McGee, Corry, Beck, H. Ferguson, Stewart, Moore, Dill, Pirrie, W. MacCormac, Murray, McWilliam, D. Moore.

The minutes of the previous meeting having been read and confirmed, a ballot was taken when Surgeon McCourt and Dr. McWilliam of Belfast were elected members of the Society.

Dr. John Moore, Glenarm, was proposed by Dr. Patterson, seconded by Dr. Ferguson, as a member of the Society.

Dr. Moore shewed a specimen of gangrene of the leg from injury, in which amputation had been performed in the middle of the thigh.

The patient a man of over 60 years of age was run over by a car in the street in front of the hospital. He was immediately brought in, when the popliteal space was found to be distended with blood effused from a ruptured popliteal artery. The tumour being very tense, firm, and modulated, occupying and distending the popliteal space. No pulsation could be discovered in the tumour, no bruit detected, no pulsation in the vessels of the leg below the injured point.

Gentle warmth was applied to the limb, bandaged

with cotton wool, and the tumour increasing and extending up the thigh on its posterior aspect, Ceartes compressor was applied to the femoral artery and pressure kept up steadily for three to four days. The swelling gradually beginning to subside the compressor was removed. Gangrene of the foot now began to show itself, extended up the leg, the line of demarcation passing just below the knee. Amputation was performed in the middle of the thigh as the effused blood had burrowed up even beyond that point among the muscles on the posterior aspect, giving a great liability to protracted and unhealthy suppuration or even sloughing of the flap formed at that part.

An anterior and a posterior flap were formed of skin alone, retracted the muscles then divided down to the bone, which was sawed through as high as possible in the face of the stump. One vessel only was tied, another with a patent mouth but from which no blood issued was also tied. The loss of blood was very trifling. The man doing well since. The artery in the amputated part of the limb on being examined shewed no signs of atheromatous degeneration.

Dr. Moore showed a part of the small and large intestine of a woman in whom a very extensive prolapsus of the colon had occurred. The mother of 14 children, 45 years of age, habitually constipated, for seven years past subject to occasional attacks of piles protruding to the size of a walnut unattended with any bleeding.

On pressing at stool having been constipated for four days, a sudden prolapsus occurred projecting externally with much pain in abdomen and prostration. On the evening of the next day she was admitted to hospital when on examination per vaginum that outlet was found free but on examination of the rectum it was found distended with a mass which projected from it turning forwards and upwards to the front of the pubis, twenty one inches in length of a deep chocolate colour, inflamed, with livid dry patches on its outer side consisting of prolapsed colon.

There was much depression of strength, pulse almost imperceptible, abdominal pain, hiccups, nausea.

General warmth applied, oiled lint to prolapsus which was not handled but kept quiet. Ordered wine and opium 2 grains with 3 grains quinine every second or third hour. She improved, strength increased, abdominal pain became less, when she was fully under the influence of opium in which state she was kept.

For eight days there was no movement in the bowels but at the expiration of that time purging set in which was checked for a time by the exhibition of [L?]. Kuro, Catechu and opii but which recurred, became persistent and finally everything swallowed was passed per annum very shortly after. She died 15 days after the admission. The part prolapsed extern-

ally sloughed away being completely separated about ten days after admission after which portions of shreds of broken down membrane came away from the anterior of the intestine with the stools up to two days before death.

December 20th

Present, the President in the chair, Drs. Pirrie, Cumming, Dill, Patterson, Browne, Beck, W. MacCormac, McCrea, Michael McGee, Gribbin, McCourt, Whitaker, D. Moore.

The minutes of the previous meeting having been read and confirmed, Dr. John Moore of Glenarm was elected a member of the Society.

P.M. (Dr. Moore's case continued). On opening the abdomen the cæcum, ascending, transverse and descending colon with the large omentum were found absent. Small intestine seemed dragged somewhat to left side, right side of the abdominal cavity being scantily furnished. Midway between umbilicus and anterior superior spine of ileum (left) the termination of the small intestine was firmly adherent to, and firmly consolidated with the parietal peritoneum for a space of an inch and a half in length, and an inch in breadth, the long diameter vertical.

The small intestine ended at this point and immediately below it in the commencement of the large the invagination was found. Above it for the space of two feet the ileum was deeply inflamed. The part nearest the attachment being filled with clotted extravasated blood, and the coats having, at points here and there, a tendency to break down under manipulation.

Below it, the large intestine for the space of a foot and a half was also much inflamed, its coats having at points the same tendency to break down when handled.

The invagination protruded in a nipple-like form of an inch and a half in length into the upper part of the remaining large intestine, all the prolapsed parts below its inferior margin having been cast off as a slough. The coats of the large intestine surrounding the nipple and those forming its under surface were tolerably firm and less effected by the inflammatory process than other points of it more remote from the seat of stricture, whilst the coats of the small intestine lining the passage through the nipple-like projection were softened by inflammation and ready to break down.

The passage from the ileum through the invagination into the large intestine lay not in the median line but more towards the side of attachment of mesentery to bowel, the tip of the nipple on that side being shorter than the other which projected below it, and curved slightly to that side.

Dr. Cumming thought it important to decide accurately the time of accession of first inflammatory symptoms in the invaginated part consequent on its

stricture.

This could be ascertained with some precision from the history of the case which showed the abdominal pain only commenced when the prolapsed part made its appearance externally, so that the inflammation which resulted in the casting off the prolapsed part only set in after this external tumour appeared. The fact of the tumour turning forwards with a bend or in an elbow-like form would seem to point to the fact that a greater length of intestine might be extended than even that occurring in this case.

Dr. Beck had seen the case on the evening of the day on which the prolapse appeared, and considered it presented a darker aspect and more inclined to gangrene, that would be likely to occur in so short a time. He thought it likely that the invagination had occurred sometime previously, but that the tumour had not made its appearance externally that morning.

Dr. McCrea thought that from the nature of the peritoneal attachment of the large intestine the process of prolapse to such an extent must have been a very gradual one, and that the invagination had occurred and was gradually increasing in extent sometime before its external appearance.

Dr. Pirrie considered it most probable that the intussusception had been sudden in occurrence and had taken place to its full extent at the time, and that there were no symptoms of any previous invagination connected with the history of the case.

Dr. Cuming thought it doubtful that invagination to any extent could occur without giving rise to serious symptoms, with much interference to the functions of the intestine, and to the process of digestion.

Dr. Pirrie exhibited a specimen of cancer of penis in which amputation of the penis had been performed about half an inch from the pubis. Two ligatures were applied. After a time there was slight hæmorrhage which did not return. The inguinal glands were enlarged probably in consequence of the irritation produced by the growth and consequent retention of urine. He considered this case nearly analogous to that of stricture of the œsophagus he had lately shewn the Society.

In both cases there was the same dense fibrous tissue forming the bases of the stricture, in both the same rapidity of growth, and almost complete occlusion of the canal. In the case of stricture of the œsophagus the smallest size of bougie could not be passed from before backwards even when the morbid parts were removed from the body, although it readily passed from behind forwards. In the present case a fine silver probe could not be passed from before backwards through the urethral stricture. The ulceration was also analogous in this case to that present at the upper part of the œsophageal stricture.

Paper:¹ *The patient had, till recently, been a hale and healthy man, always living in the country, and engaged in agricultural pursuits. Within the last year or so has had one or two attacks of retention of urine, occurring after exposure to cold, and a too liberal use of alcoholic stimulants (he is usually very abstemious); these attacks were evidently connected with some enlargement of the prostate. Not till some eight weeks only before the operation did he complain of any pain or uneasiness in the penis. What first attracted his attention was difficulty in passing water, followed by swelling of prepuce and glans, and afterwards by an offensive dark-coloured discharge. The difficulty in micturition gradually increased, till at last he became almost worn out with the almost constant efforts, night and day, to pass water. Any attempt to pass a catheter was followed by very copious hæmorrhage, which also sometimes occurred spontaneously. On the 25th October last he was first seen by Dr. Murney and myself. The penis was swollen and œdematous, with a hard base extending an inch and a-half backwards from the glans; prepuce thickened, and adherent to glans. Entrance for the smallest instrument into the urethra could not be obtained, even after the prepuce was slit open. Recognizing the malignant nature of the disease, amputation was recommended, and being approved of, was then and there performed by Dr. Murney in the usual manner. Notwithstanding the enlargement of some glands in left groin, the patient has recovered well. Dr. Pirrie directed attention to the great similarity existing between the present specimen and one of malignant stricture of œsophagus, which he recently exhibited to the Society, particularly the microscopic character and rapidity of formation in both diseased structures.*

Dr. Michael McGee had a patient sometime ago affected in like manner in whom amputation of the penis was performed. There was much hæmorrhage.

Dr. Browne had also a similar case, but without any hæmorrhage. He had united the mucous membrane of the urethra to the skin of the penis at the line of incision to prevent contraction of the canal. He thought the operation justifiable even with considerable enlargement of the inguinal glands.

Dr. William MacCormac considered the Écraseur a useful instrument in such cases. The urethra first should be dissected from the corpora cavernosa with the knife and then the Écraseur applied.

Dr. McCrea made some remarks to the Society touching the so-called "Sacramental wine" of a certain Mr. Lees Ph.D., a sample of which Dr. McCrea had obtained and subjected to analysis. He found it contained ten percent of alcohol with some foreign colouring matter and was to all intents and purposes "A Bad Claret".

¹ [Dublin Medical Press, 1863, v49, p86.]

Ulster Medical Society
Session 1862–1863
President John Creery Ferguson

Resolved That a Special Meeting of the Society be summoned to take place in the Rooms on next Saturday, 27th inst. at 3 o'clock p.m. to take into consideration the subject of publication of the discussions of the Society.

J. Creery Ferguson, President

**Special Meeting
December 27, 1862**

Summoned in accordance with resolution passed on 20th inst. "To take into consideration the subject of the publication of the discussions of the Society".

Present, Drs. Ferguson (President, in the chair), Cuming, Ferguson H. S., Moore, James, Smyth Brice, Patterson, Moore David, McGee Michael, Arnold, Browne, Dill, Reade Thomas, MacCormac William, Gribbin, MacWilliams, McCourt and Whitaker.

Dr. Browne having stated object of meeting and made some remarks on the history of the subject moved and Dr. Michael McGee seconded the following resolution "That our Secretaries be requested to continue their reports of the discussions at the weekly meetings of the Society with a view of having these reports published in conjunction with the papers that may be brought forward during the session".

An animated discussion having ensued. Dr. Dill moved and Dr. Moore seconded the following amendment,

"That the publications of the transactions in connection with the Ulster Medical Society, be confined to the read or spoken papers, and that the discussions thereon be not published". Amendment put from the chair and lost by the casting vote of the President. Original motion then put and carried in a similar manner.

Dr. Patterson then suggested that as the members seemed so equally divided in opinion, it would be better to allow the reports to be continued as usual during this session, and that previously to the commencement of the next, the matter could be fully discussed and some satisfactory arrangement entered into.

This suggestion not having been entertained by the Meeting, Dr. W. MacCormac moved and Dr. Patterson seconded the following resolution,

"That a Committee of publication be appointed consisting either of the Council or a portion of the Council for the purpose of reviewing discussions held on papers or communications made to the Society before issuing them to the profession in any form". Carried unanimously.

Dr. Reade gave notice of the following motion "That any Member of the Society entrusting his key to anyone not a member shall pay a fine equivalent to one year's subscription".

J. Creery Ferguson, President

January 3rd, 1863

Present, Drs. Ferguson (chair), Cuming, Patterson, William McGee, McCourt, Gribbin, Smyth, T. Reade, Beck, MacWilliams, Pirrie, Moore, W. MacCormac, Stewart, Saunders, Murray, and Whitaker.

The minutes of last meeting were read and confirmed. Payment was ordered for £10.7.8 being amount due for rent, gas, coals, Boy, postage etc.

Dr. W. MacCormac moved and Dr. Patterson seconded "That the Council be requested to take action on resolution of December 27th and that the matter be left in their hands". Carried unanimously.

Dr. McGee (W.) moved and Dr. Pirrie seconded "That no question shall be entertained by this Society of which due notice shall not have previously been given in the meeting circular, with the exception that on the first meeting in December, February and April, any matter or question may be brought before the Society".

Dr. Beck objected and thought that notice should always be given. He moved the following amendment, which was seconded by Dr. Stewart, "That no question shall be entertained by this Society of which due notice shall not have been previously given in the usual printed circular". Amendment carried.

Dr. Reade moved and Dr. Moore seconded "That any Member of the Society entrusting his key to anyone not a member shall pay a fine equivalent to one year's subscription".

Dr. William MacCormac then read a paper on varicocele, in which he entered fully into the causes, effects, and mode of treatment of same. He then detailed the history of a case which he had recently treated on the radical cure plan, with perfect success; and concluded a very interesting paper by stating the difficulties to be met with and the dangers to be avoided in pursuing that treatment.

Paper:¹ *The term varicocele is confined by usage to enlargement of the veins of the spermatic cord, though etymologically the word has a much wider significance. It is not a very uncommon disease; but whether, from its small extent, the little inconvenience it occasions, or its, in some instances, temporary nature, it is not always recognized. The left side is much more frequently affected than the right. Out of 120 cases operated on by Bresalet, only once did the varix occur on the right side. Post met with the malady on both sides but once. Vidal insists to such a degree on its greater prevalence on the left side, that, according to him, the existence of varicocele on the right side would imply transposition of the circulatory organs, which, of course, is a great exaggeration. I myself have known two cases of varicocele occurring on the right side, one of them the subject of the present remarks, without any malposition of the heart existing in either.*

¹ [Dublin Medical Press, 1863, January 28, p85.]

Many circumstances are alleged as inducing the greater liability of one side over the other. A similar predominance of the left side likewise subsists, it is interesting to note, in ovarian varicocele. Morgagni and Sir Astley Cooper account for this by the anatomical peculiarity of the termination of the spermatic veins, the left running into the emulgent vein at right angles to the current of blood in that vessel, the right entering directly into the inferior curve, in a direction almost parallel with the current in that trunk. There are valves, no doubt, in the larger spermatic veins, but when these become morbidly enlarged the valves themselves must cease to act. J. L. Petit has laid great stress on the fact that the left spermatic vein passes under the sigmoid flexure of the colon, and is, therefore, exposed to the pressure of the intestinal contents. Hence the alleged influence of habitual constipation in the production of varicocele. The usually greater length of the column of blood, on the left side, from the left testis, hanging lower than the other, and also the generally greater size of the left organ, are causes that have been cited. The proximate causes, inducing the disease, are often obscure. Venereal abuse, violent exercise, obesity, hernia, and many others, have all been alleged.

Varicocele is essentially an affection of early adult life. It most frequently occurs at from 15 to 25 years of age, rarely later, although Malgaigne mentions some cases as happening after that age. The size of the tumour is variable, and not in proportion to the amount of suffering induced. A varicocele no bigger than a filbert may occasion much constitutional disturbance, while a tumour very much larger may be attended with little inconvenience. Landouzy has seen the scrotal veins equal the femoral in size, while the tumour, as large as the foetal head, descended to the middle of the thigh. According to Nélaton the disease is confined to early and middle life, and dependent, he believes, in a large degree, on the sexual energy and excitement of that period. He considers it to be an affection of no great seriousness, and states that it has a tendency towards spontaneous cure in advanced life. Other authorities look upon it, and I think with truth, as of greater moment, ascribing to it atrophy of the testis, with considerable pain, mental depression, and general debility.

I do not propose to give any account of the various methods of treating varicocele. They have been numerous, from simple support of the parts to the use of the actual cautery, the ligature of the spermatic artery, the extirpation of the venous mass, and finally castration. I shall, therefore, proceed to narrate briefly the particulars of a case, sufficiently interesting, as I conceive, to engage attention.

Mr. M_ a young gentleman, aged 24, occupied at office work, of a lymphatic temperament, general health good, habits temperate, consulted me some time since for a considerable varicocele of the left side, and

as I afterwards, on closer examination, discovered, for a very appreciable enlargement of the veins on the right side. He was unaware of any cause, and did not know the time of its first appearance. He had noticed the varix casually, he said, while taking a warm-bath some months previously. The venous tumour was as large as a hen's egg, descending to, and partially enveloping, the testis. The scrotum was flaccid, while the testis, notably smaller than on the right side, hung fully an inch lower. The veins, much enlarged and increased in number, could be readily distinguished through the thinned integuments, imparting the peculiarly disagreeable sensation of a bag of earthworms.

Mr. M_ complained of dull, dragging pain in the testis and groin, also of pain in the back. These symptoms were much aggravated in the evening, and after unusual effort. He further complained of a change for the worse in his sensations. He was indisposed to take any active exercise, such as walking, reading, gymnastics, in all which he had been previously a proficient. Even moderate effort was productive of much languor and depression. Mr. M. was therefore, as might be supposed, extremely solicitous to submit to any means calculated to rid him of what he justly considered the source of his ill-health.

I determined, in the first instance, to try the effect of palliative treatment, and with that view, during more than three-months, administered the tincture of the perchloride of iron, coupled with cold douches to the part, and the application, during the day, of a well-adjusted suspensory bandage. This treatment improved the general health of the patient, but afforded him very partial relief.

Under these circumstances, the patient being very anxious to be cured, and the case being of sufficient urgency, I thought it right to attempt a radical cure. But first, I explained the possible dangers of the operation, the chance of atrophy of the testis, and the risks to life from phlebitis and purulent absorption.

The mode of operation I selected, and which I shall presently describe, is simple in character. I possessed the valuable assistance of my friend Dr. H. Burden. It was first initiated by Davat and Franc, and is the one recommended by Mr. Curling, as improved on by him, and described in the second edition of his work on "Diseases of the Testis." This method possesses many advantages over that of subcutaneous ligature, originated by Gagnebé, and adopted by Velpeau. There is much less risk of phlebitis, and the consequent evils, while it secures more perfect contraction of the scrotum and veins, and is, moreover, less tedious and less severe.

The operation was performed in a warm room, and the patient was made to walk about for some time previously, in order to render the veins as turgid as possible. The patient also stood during the insertion of the needles.

I employed a narrow-bladed sharp-pointed bistoury, a

thread of strong silk, well waxed, and a couple of needles, about $2\frac{1}{2}$ inches in length, of soft steel, with hardened points.

The first and most important step in the operation was to isolate properly the spermatic artery and vas deferens from the bundle of veins to be obliterated. This I did by grasping the veins, included in a fold of skin, with the fingers and thumb of the right hand, about an inch or an inch and a-half below the external ring. With the right hand the spermatic duct was readily distinguished, as a hard, round cord, very painful when pressed upon, as also the spermatic artery which accompanies it, and which can generally be felt pulsating through the integuments. These parts having been carefully separated were held aside. It is of great assistance, in making this division of structures, to compare the affected with the sound side, and the importance of this preliminary step in the operation cannot, I conceive, be too much insisted upon. If, for example, the entire plexus of veins be taken up, and no channel for the return of blood left, the testis will be apt to waste. And, again, if the spermatic artery and vas deferens be not left intact, atrophy of the gland is the almost certain consequence. This difficulty, however, being overcome the rest of the operation was easy enough. One needle was passed through the fold of scrotum, held in the fingers, from side to side, so as to include the plexus of veins to be occluded between itself and the skin. This needle is to be introduced at the point before indicated, an inch or an inch and a-half below the external ring. The other needle was similarly introduced about eight lines lower down, including, of course, the same veins. Here it was comparatively easy, from the upper needle being first introduced, and from the greater natural separation of the parts. A thread of silk was now wound around the ends of each needle, in a figure-of-eight, with sufficient firmness to occlude the veins perfectly, without at the same time strangulating the skin. The bistoury was then introduced underneath the veins, and between the two needles, and the plexus divided, cutting outwards. Only a drop or two of blood exuded, water dressing was applied, and the patient placed in bed. The operation, as thus described, was performed on April 29th. Quiet was enjoined, and an opiate given at bedtime. On the following morning I found Mr. M. had scarcely slept, owing to pain felt in the testis and groin, caused, doubtless, by pressure on some nervous filaments included by the needles.

On May 1st, all pain had subsided, save slight uneasiness; had slept well during the night; was free from anxiety of every kind, while a large mass of effused lymph could be felt around the ends of the divided veins.

On May 2nd, sixty hours after their introduction, I removed the needles. The lymph occupied the site of operation, while the veins engaged could be felt above and below filled with coagulum. Perfect rest was now

insisted upon, and a full opiate administered to restrain, for a few days, the action of the bowels, which had been previously well cleared out by saline purgatives. On the following day, and subsequently, the patient's condition was, in every respect, satisfactory. I need not enter into much further details. On the seventh day after the operation Mr. M. was able to rise, the parts being supported by an accurately fitting suspensory bandage. In about three weeks almost complete contraction of the scrotum had taken place, the effused lymph was, to a great extent, absorbed, while the diseased veins had become transformed into a cord. In short, the patient was cured, and it is to be hoped permanently, which result the record of former cases gives every reason to expect. Mr. M. visited me about six months subsequently; no remaining evidence of the former disease existed, save a small lump of hardened tissue at the site of insertion of the needles, and a thin cord representing the obliterated veins. The veins on the right side were likewise somewhat diminished in size. He had gained a good deal in weight, and his health, strength, and spirits, were better than he had known them for years.

Dr. T. Reade expressed his complete concurrence with the views put forward by Dr. William MacCormac as to the nature and treatment of varicocele. He had frequently met the disease but never had seen it existing on the right side.

Dr. Patterson recollected some 20 years ago having seen a case occurring in a boy 9 years of age, in whom the ordinary treatments with iodine painting, cold applications and suspensory bandage was useless. A firm plaited flannel bandage was applied and the boy got rapidly better. He thought that in such cases pressure was the only treatment likely to be attended with success.

Dr. Beck thought that ordinary palliative treatment was useless and that it was necessary to have resort to the radical method to ensure a permanent cure.

Mr. Saunders (Staff Surgeon 14th Depot Battalion) observed the disease very often during the examination of recruits, and always on the left side. He esteemed that a sufficient cause for rejection, especially when occurring in those intending to enter the cavalry. He found that variations in temperature causing contraction or relaxation of the scrotum interfered considerably with diagnosis.

Dr. Pirrie thought that the more frequent occurrence of varicocele on the left side was sufficiently explained by the pressure of the sigmoid flexure of the colon on the left spermatic vein. Varicose veins, he stated, occurred more frequently in the left than in the right leg.

The President called the attention of the members to the effect which varicocele would have when present in persons presenting themselves for life

insurance.

Dr. Pirrie would not reject for varicocele, but thought it evinced deficient power of circulation and general delicacy of constitution. He therefore would not consider the subject of a varicocele as a first class life.

Dr. Reade considered that in cases where the varicocele was not large, or produced uneasiness, or where there was not much or severe work to be undergone by the person, he would consider that the disease, per se, would not constitute a sufficient objection to returning the person as a first class life.

Dr. McGee (William) thought that in any case of varicocele the person affected therewith should not be considered as a first class life, and that in cases where the varicocele was so extensive as to require operation, he would reject the person altogether.

Dr. W. MacCormac replied that as varicocele was found to have no relation with varices in other parts of the body, and was in many instances a merely local disease, depending on local causes, it did not, of necessity imply general weakness, or want of tone in the constitution. He, therefore, thought that when varicocele did not produce any pain or incontinence, or interfere with the patient's daily avocations, it was not to be considered a ground for rejection in life assurance; the more so as the disease has in many cases a tendency to spontaneous cure.

J. Creery Ferguson, President

January 10th, 1863

Present, Drs. Ferguson (President, in the chair), Patterson, Ferguson H. S., McCrea, Cuming, MacCormac William, McGee Michael, Reade Thomas, Dill, Gribbin, Beck, and Whitaker.

The minutes of last meeting were read and confirmed. Dr. Beck read the notes of a case of tumour occurring on the labium mistaken for venereal affection and stated that the woman with whom the affection occurred was about 50 years of age, mother of a large family and that the tumour had been gradually increasing in size for some months. That previously to his examination of it, it had been seen by another member of the profession who had pronounced it to be of venereal origin, that he was of the same opinion until he examined it closely, when he found that the base was moveable and that he could squeeze some matter through its ulcerated apex. He cut down upon it and with a slight pressure removed the mass which consisted of the ordinary sebaceous secretion thickened and waxy. Dr. Beck then referred to the difficulty of diagnosis in some cases of this kind.

The President thought that in such cases, great care should be exercised and that no statement as to the nature of disease should be made unless the diagnosis had been previously well made only.

Dr. W. MacCormac thought the mistake was one

which might readily be made on a superficial examination, as the tumour referred to presented some of the characters of an Hunterian chancre. He thought, however, that its situation ought to have suggested caution as chancres of that kind are comparatively rare on the female genitals and their diagnosis proportionately difficult.

Dr. Moore brought forward the case of a little girl who had met with an injury in a mill. The thumb had been cut across, the bone severed about half an inch beyond the metacarpal phalangeal articulation, as if with a bone forceps, the soft parts having been also cut through.

The bone projected half an inch beyond the soft parts which had been torn. On examination Dr. Moore thought that the best course was to remove the metacarpal bone of the thumb at its carpal articulation and bring the soft parts together which he accordingly did, leaving a portion of the fleshy part of the ball of the thumb which could only be slightly approximated, as a covering.

Dr. Moore also brought forward a case of tumour on the upper eyelid, projecting into socket on outer side of the orbit, in which he operated, and removed it. He found the sack so thin and delicate that not withstanding the greatest care, it was ruptured, and required some troublesome dissection to remove it without leaving any of it adherent. Dr. Moore then made some remarks on the general principles to be observed in such cases and stated that particular care must be observed lest any of the tumour remain, as when such is the case fungoid growth almost invariably spring there from.

Dr. Beck would wish to know why Dr. Moore thought it necessary to remove the metacarpal bone in the former case. He had seen a considerable number of mill accidents in which injuries even greater than that related by Dr. Moore had been sustained, and yet no operation was required and the parts healed in a short time and left the parts injured in a surprisingly useful condition. He, Dr. Beck, thought in injuries of the hands or face, where the parts were so largely supplied with blood vessels, that an effort should, in almost every case, be made to retain the parts so injured and give the patient a chance of preserving them.

Dr. W. MacCormac said that very often the soft parts are more injured than would appear on a cursory external examination.

The President remarked that he was quite sure that Dr. Moore would be glad of this discussion, as it would give him an opportunity of satisfying the members present as to his reasons for the line of treatment he pursued; he (the President) had no doubt that Dr. Moore's explanation would be found most satisfactory.

Mr. Saunders (Staff Surgeon 14th Depot Battalion)

remarked that in gun-shot wounds of the hand he found that the amount of reparation by the natural process, was often surprising. In the great majority of cases, the less interference, unless to bring the parts together, the better for the patient.

Dr. Pirrie thought in the case under consideration it would have been as well to have given the finger a chance.

Dr. Dill thought that Dr. Beck went too far in his statement and that perhaps in this case, as in many others, the best chance of giving the patient a useful hand lay in the operation.

Dr. Moore replied and stated that from his experience in such matters, he thought that the operation was necessary, that the bone protruded too far beyond the soft parts, and that the latter were too much torn to form a good covering for the bone. He did not like secondary operations which generally turned out unsatisfactorily, and therefore thought that it was better to perform the operation in question, which still left the patient a very useful hand.

J. Creery Ferguson, President

17th January, 1863

Present, Drs. Ferguson (President, in the chair), Patterson, Ferguson H. S., MacCormac W., Gribbin, Pirrie, McCrea, Dill, Beck, McGee Michael, MacCormac, MacWilliams, and D. Moore.

Dr. David Moore in the absence of Dr. Murney brought forward the report of a case of Wutzer's operation.

24th January, 1863

Present, the President (in the chair), Drs. McGee (Michael), Beck, Gribbin, McCrea, Dill, McCourt, Patterson, Cuming, Pirrie, MacWilliams, and MacCormac W.

Dr. Beck read a case of perforation after turning in order to complete delivery. His paper was most interesting and practical. He also shewed a loop of woollen tape attached to a whale bone rod, which he found very useful when employing traction on leg of child as it did not slip, and the force could be applied equally.

Paper:¹ *In order to understand fully the following case, it will be necessary to make a few remarks on the two previous confinements:*

Mrs. Q_ , a strong, healthy, apparently well-made woman, engaged me to attend her in her fourth confinement, informing me that her previous child, the third, had been dead born, after a very severe and protracted labour. Her fourth labour commenced at seven in the evening, and terminated at half-past four in the morning—nine hours. There was nothing remarkable in this labour; everything was natural, and proceeded very well till towards the conclusion of the labour,

when the pains began to flag, and I had to give a dose of secale cornutum. This had the desired effect; the labour terminated favourably, and she made a good recovery. This child was an average-sized female. In her next, the fifth, confinement the pains set in strong at seven in the evening, continuing strong and regular, but with little effect, all night. In the morning, judging that the natural efforts would not be sufficient, I sent for the forceps. Before they arrived, an energetic pain sent the head, with a snap and a plunge, which were distinctly audible, off the promontory of the sacrum and into the cavity of the pelvis. Another pain or two settled the matter, and again a female child was born. The placenta soon followed. But this time she had a smart attack of metritis, from which, however, she made a good recovery. I attribute this attack of inflammation to the prolonged pressure sustained by the uterine wall, between the head of the child and the promontory of the sacrum, and I believe it would not have occurred had the forceps been applied, as I had wished, a few hours before they were sent for, and the uterus assisted during the immense exertion necessary to drive the head over the promontory of the sacrum. This child was so much larger than the previous one as to account for the extra difficulty. Her next labour, to which I wish more particularly to direct your attention, set in about two o'clock in the day. The pains were slow at first, but became stronger, more regular and energetic, as time wore on. During the night, finding the progress not at all satisfactory, nor in proportion to the state of the soft parts and the character of the pains, I came to the conclusion that something ought to be done. Finding the os uteri soft, well dilated, and very easily dilatable, I determined on turning. This I had done several times before, and with, at least, the advantage to the mother of terminating the labour speedily, which, in some cases, is a great thing gained. I cannot say so much as to its advantage to the child. On proceeding to turn I found no difficulty in introducing the hand and laying hold of the foot, but that was all I could do. Though I had it fairly in my hand I could produce no effect on the position of the child by pulling. While I was insinuating my hand and finding the foot, I ascertained that the head was large and hard, well ossified; the vertex towards the left sacro-iliac junction, and, during each remission of the uterine action, it retired before the hand much easier than I expected; still I could produce no effect on the position of the child.

I therefore withdrew my hand under the conviction that the forceps would be useless, and that perforation was the thing necessary to be done, and the sooner it was done the better. So firm was this conviction that I did not attempt to apply the forceps, though I had them at hand at the time. I explained the matter, as far as was necessary, to the husband, and requested him to bring another medical man. He brought another, who, after examining and considering the case, advised

¹ [Dublin Medical Press, 1863, v49, p215.]

chloroform or opium to be administered, and that after that we should wait five or six hours to see what would turn up; at all events to do nothing immediately. I differed entirely from all this. I was for immediate delivery, and gave the following reasons:—1st. She had already been twenty-four hours nearly in good, strong, regular, energetic labour, and the child's head was still above the brim of the pelvis. 2nd. The patient's strength was beginning to fail; and, 3rd. I had a vivid recollection of the narrow escape she had after her last confinement from inflammation; in short, I believed it absolutely necessary for her safety that she should be delivered immediately, and proposed to do so myself, either by turning or perforation, if he was agreeable, or that he himself should try the forceps first. Turning was at last agreed on. I again laid hold of the foot easily, but neither of us could produce any effect with the naked hand. The loop was then cast round the ankle, and, after a very unusual amount of strong pulling, we succeeded in getting down first one foot, then the other. This is the loop and whalebone contrivance [exhibited] that I have found to answer best for turning when the hand cannot retain its hold on the foot. The arms next gave us considerable trouble; however, they were produced; but, just as I had anticipated, we were as far off our point as ever. The head was still above the brim of the pelvis, and there it would remain notwithstanding an amount of pulling and jerking that led me to fear we were about to break the neck and leave the head in utero, as was done in a celebrated case which some of us may remember. After many ineffectual attempts to move the head with the hands, the forceps were tried in vain, and it was found to be necessary to evacuate the brain with the perforator, &c., before we could succeed in extracting it.

This child was a male, and still larger than either of the other two. The placenta soon followed, and our patient recovered without an unfavourable symptom. There are two reasons why she made a good recovery this time as contrasted with the last:—1st. She was more frightened and took better care of herself. Those of us who practise midwifery know how difficult it is to get even a very sensible, strong-minded patient to take the proper care of herself, unless when she is thoroughly frightened; but 2nd, and chiefly, though she was twenty-four hours ill in this labour, and only sixteen hours in the previous one, yet here the head had never descended into the pelvis, and the pressure which the walls of the uterus sustained between the head and the pelvis was more general, distributed over a larger surface, and though longer continued, was not particularly severe on any one point; whereas in the former labour the wall of the uterus was severely pinched or jammed at a point opposite the sacrum, in consequence of the partial descent of the head, and I have no doubt, it was from this point the inflammation set out in that case. Had we waited six or eight hours longer in this case, I

much doubt I would have had a very different story to tell as to the result. The lesson I would draw from this case is, that as soon as we can make up our minds that the natural efforts will be insufficient to bring forth a living child, the sooner we interfere to assist Nature in delivering the patient the better. In this case I would have had no hesitation in perforating at once, as being the easiest and safest, as well as the speediest method of delivering the mother from her trouble. I must confess I felt scarcely justified in inflicting on the uterus the great amount of physical violence necessarily incidental to this case of turning, particularly after coming to the conclusion that the child had not the shadow of a chance of being born alive. However I am glad, under all the circumstances, it had its chance—more particularly as it served to satisfy the religious scruples of both my patient and my medical confrère. Indeed mothers themselves who are unfortunate enough to have experienced three or four cases like this, will not suffer you to do anything but perforate, if they can help it. I could give the notes of a case where I was sent for by the mother, expressly, as she coolly informed me when I arrived, to perforate a fourth child, and I was scarcely permitted to attempt to deliver, first by turning and then by the forceps; but I did so under the energetic protests of the mother, who had been thoroughly exhausted by suffering; and though almost breathless, kept constantly crying out, “don't hurt me; but open the child's head at once, as I know nothing else will do;” and I had to open the child's head as a dernier resort, as nothing else would do. And let me remark that this patient was not a nervous woman, easily frightened, but a strong-minded, sensible woman, with more patience than is usually manifested under these circumstances.

Dr. Dill considered that Dr. Beck's paper corroborated his own view as to the impropriety of turning in a narrow pelvis. He differed from a prominent authority (Dr. Simpson) on that point, Dr. Simpson believing it possible to turn when the ant-posterior diameter of the pelvis was not less than 3 inches. Dr. Dill on the contrary thought it better practice and safer to the mother to perforate at once without turning.

Dr. Beck stated in reply that he would not attempt version except when it could be readily done. He does not think it a favourable operation for preservation of child. He therefore would perforate at once, where the head was too large or the pelvis too small. He was, likewise, opposed to Dr. Simpson's views.

Dr. M. McGee then proceeded to read an account of two cases illustrative of conservative surgery.

Paper:¹ The notes of the two following cases, in my humble opinion, may not unreasonably be designated illustrations of conservative surgery. Some time ago I

¹ [Dublin Medical Press, 1863, v49, p215.]

was requested to visit, in all haste, John M., who was represented to me to have lost his hand by the bursting of a rifle barrel. I saw him about six hours after the accident; the hand had the appearance of half-charred wood; the thumb was in its full length greatly contused; the index finger blown off; the remaining three denuded of all flesh, except the first metacarpal phalanx of the second finger which was partially covered.

The hand was lacerated half way up to the annular ligament.

The hæmorrhage was in this, as generally in all such cases trifling, but evidently arterial.

From the description of the injury all would concur with me that it was one demanding immediate amputation. I went prepared for and determined on operating. On informing my patient that he must allow me to do so, in order to save his life, I was bluntly but resolutely told by him that he never would submit to such a thing.

Not being able to convince him of its urgent necessity, I left after desiring his friends to use cold-water dressing to the part, with the expectation that I would have it all my own way when next sent for. I visited him the next morning, and, although he suffered very much the preceding night, he still adhered to the resolution of keeping the hand, I could not altogether abandon the man in his then pitiable condition. I took off, after a great deal of opposition on his part, the fingers, leaving on, much against my wish the metacarpal phalanx of the second finger, drew the hand together with a small roller, and recommended cold water to be kept constantly poured over it.

This would seem to some as if committing my unfortunate patient altogether to the salutary operation of the *vis medicatrix naturæ*.

On the third day he complained greatly of sharp pains in the part, and felt very uncomfortable from symptomatic fever.

I gave him two grains of opium every night, ordered the cold water to be continued as before. This course of treatment was regularly carried out with very little change, until suppuration commenced, which, in a short time, became very copious and offensive. Left off the cold water, used hot-water dressing and poultices, and allowed him a liberal quantity of wine and beef tea. At the end of a week the discharge was less in quantity and healthier in quality. The yeast poultices were then applied and persevered in for some time, until healthy granulations appeared in the palm. It was ultimately dressed with a stimulating ointment.

I attended him better than two months. He can now, strange to say, write with the thumb and metacarpal phalanx of the second finger, and in many other respects finds it very useful to him.

Shortly after attending to the above case, John, a labourer, aged 22 years, of a very healthy appearance, was brought to my place, having got his hand entangled

between the wheels used in propelling a threshing machine. The thumb and two first fingers were severely contused, and in a great measure stripped of their natural covering. The third and little fingers, with their metacarpals, were comminuted; the other metacarpal bones were very much exposed on the palmar side.

Recollecting the agreeable but quite unexpected result of a similar but more serious injury, I took away the third and little fingers, with their metacarpals, and left remaining half of the hand with thumb and fingers, then appearing in almost a hopeless condition. The subsequent treatment was much the same as in the former case. He was well in six weeks. Immobility of the fingers continued for some time longer. He is now able, with very little inconvenience, to work at his ordinary calling.

For several years I had the practice of a large district of country, where several mills were pretty regularly at work dressing flax. My experience in treating injuries of the hand received in them, and otherwise, has been rather considerable.

I am now fully convinced, from what I have seen, read, and heard of such accidents, that it would be much better if more conservative and less radical surgery were practised, and the operator to study more the future benefit of his patients, and less his own credit, in forming a neat stump. We would then have that inestimable appendage to man, the hand, in many cases, wholly or in part, preserved to and in possession of its owner, instead of being so generally, and I fear unnecessarily mutilated, knowing as we do that wounds in those parts are comparatively easily healed, being so plentifully supplied with blood-vessels and nerves.

Dr. Beck agreed with the views put forward by Dr. McGee. Under even most unfavourable circumstances, he would be most unwilling to amputate any portion of the hand. Dr. Beck then instanced several cases of injury of the hand, in which extraordinary success had followed attempts at conservative surgery.

Dr. W. MacCormac thought that every possible chance should be given in order to preserve any portion of an injured hand, but in so doing, the general health and condition of the patient were not to be overlooked; as they much affect the favourable termination of such cases. In injuries happening to mill workers, he had frequently noticed that wounds would apparently heal up by the first intention, and afterwards the adhesions would break down, unhealthy suppuration set in and the case terminate unfavourably.

Dr. Pirrie thought that every chance should be given in order to preserve as much as possible of an injured hand.

The President thought that the marked tendency of

the present day was towards conservatism in surgery. Dr. Cuming asked if it were observed in practice that bad results often followed the non-performance of operations in cases of severe injury apparently requiring such. He thought that purulent absorption, irritative fever, or other accidents might ensue.

Dr. Beck had had large experience in the treatment of such injuries and had never seen bad results follow the attempts to preserve the hand.

Dr. McGee briefly replied.

Dr. Dill then exhibited a heart which had been removed from a patient who had died in hospital, who had sometime previously been under Dr. Ferguson's care for a pemphigoid eruption of the skin, and from which he had recovered and left the hospital.¹ The patient had suffered from the heart disease for some 10 years. On examination Dr. Dill had found extensive dullness in the pre-cordial region, a murmur with the second sound. There was much dyspnoea, the lower extremities were swollen and the urine albuminous. The heart was found to be considerably dilated but not much hypertrophied, weight 233. 2drs. There was extensive deposit in the aortic valves which also extended into the ventricle for about an inch on one side, all the other valves were healthy. The hydrostatic test shewed insufficiency of the aortic valves. The President, while the patient was under his care, observed a murmur with both sounds of the heart and the other sounds of patent aortic valves. He had then no dyspnoea or cardiac distress.

Dr. Cuming thought it would be interesting to know how far the therapeutic means displayed to remove the skin affection affected the fatal issue of the case. It appeared that on the disappearance of the skin disease the heart symptoms were suddenly and severely aggravated. He thought the application of amoxa would have been worthy of a trial as a therapeutic means to combat the heart disease. The treatment employed by the President was mainly feeding and wine. With reference to the amoxa it did not imitate exactly the natural derivative supplied by the affection of the skin.

Dr. Patterson was acquainted with a gentleman affected with heart disease, in whom the formation of an ulcer greatly relieved the distress, while its subsequent appearance was soon after followed by death.

Dr. Dill observed with reference to a remark of the President, that when he, Dr. Dill, examined the patient, although he suspected its presence, he was not able to distinguish a murmur with the first sound, as the bruit with the second sound was so loud and prolonged as quite to conceal that with the first.

J. Creery Ferguson, President

January 31st, 1863

Present, the President (in the chair), Drs. Dill, Gribbin, W. MacCormac, McCrea, J. Moore, MacWilliams, Patterson, Pirrie, Saunders, Brice Smyth, Stewart.

The minutes of the previous meeting were read and confirmed.

Dr. Dill introduced an elderly woman who had become a hospital patient of his a few days ago. He said that she had been employed for years in a looking glass factory, in which she wrought a good deal with mercury; she has a tremor—a palsy—all over, which she ascribes to this occupation. He considered the tremor different from that of paralysis agitans, and chorea; and suggested as an interesting point to decide, whether the disease was caused by mercury or was sui genesis. He is adopting the same principles of treatment as in any other nervous affection, and is, therefore, using iron and quinine. He believed that the vapour alone of mercury was sufficient in producing such symptoms. He called attention [to] the fact that when the trembling parts are supported in anyway, the motion ceases.

The patient, in reply to questions of the members of the Society, stated that she was 42 years of age. She had been, for twenty-three years working at the business, that she had been obliged to handle, very often, the quicksilver-refuse, that her hands used to be blackened with this, that she had been thus engaged daily, that the tradesmen wrought only a day or two in the week, but were nevertheless, affected with fetor of the breath. That, first of all, she had had a “burning” sensation in the stomach, then lightness of the head, “sleepiness” in the lower limbs, occasional trembling of the knees, that two years ago she had been wet in a shower of rain after which her teeth loosened, and they had not since become fixed. That at present she suffered from a pain in the left shoulder, that she had been getting worse for the last six months, and had given up working three months ago.

The President said that, in consequence of the manufacturing being conducted at ordinary temperatures the mercury must be vaporised in exceedingly minute quantities, if at all. He had known pure chorea attributed to the vapour of mercury. It would be impossible to account the vagaries of nervous disease. He did not think it had been clearly proved that this was a case of mercurial tremor or that it was the result of mercury in the vaporised state. He leaned to the use of Iodida potassii in mercurial poisoning.

Dr. W. MacCormac thought there was no doubt of this being mercurial palsy; that the woman had got a chill, her secretions had stopped and her present affection had come on. This case shewed very plainly the fallacy competed by those who attributed symptoms of tertiary syphilis to mercury. Here was a woman as strongly under the mercurial influence as she well could be, in whom none of the phenomena of tertiary syphilis were exhibited. The mercury, in an

¹ [See page 975.]

oxidised condition might have been absorbed through the hands.

Dr. MacWilliams remembered seeing a case in which iodide of potassium has been useful.

Dr. Saunders remarked that it was a strange thing that the disease was so rare, so many people being exposed to its cause. In many persons in whom mercurial treatment has been pushed to extremities, no such symptoms had appeared.

Dr. J. Moore introduced a case of elephantiasis occurring in a young fellow of twenty-two, or so. Both legs were greatly enlarged. The patient stated that the left leg had been enlarged since he was very young, and that he remembered when the right one was perfectly well—about five years ago.

He had always lived with his parents in the vicinity of Antrim. He felt no pain, or tenderness on pressure in any part of the limbs. It was ordered that a cast of his limbs should be taken.

Dr. J. Moore had met with a similar case in the neighbourhood of Ballymena, not, he thought three miles distant from the residence of the present patient. He thought the kidneys were affected, but believed that there was nothing the matter with the urine. Perspiration was good. In the Ballymena case, the biggest leg was not so big as the smallest in this case.

Mr. McCourt had met with a case of this disease at Gracehill which is in the same district. The legs broke up, there was frightful discharge, and the patient died.

Dr. W. MacCormac said the disease was generally attributed to inflammation of the absorbent vessels and glands, that it was unusual in both limbs. Amputation he said was useless in initial stages, it only hastened the outbreak in another portion of the body. It was to be observed that in this case the disease commenced at different periods in the two limbs. In the intercalated form of the disease—the E. Græcorum—the senses were affected, in this boy they were sound.

The President looked on elephantiasis as an inflammatory disease, this as the chronic stage of it. In it the absorbent and venous systems, and the areolar tissues were affected. He would treat it locally by almost constant vapour baths, and he would push the iodine treatment to extremity. He would be disinclined to use pressure bandages. He observed that on the foot there were tumours like *molluscom tuberosum*.

Dr. Pirrie exhibited pieces of *Laminaria digitata*, intended as a substitute for the sponge-tent. He had selected two pieces of as nearly as possible the same size. One he had immersed for twenty four hours in water; it had expanded both longitudinally and laterally to nearly double the size of the other. The irregularities of the surface disappear as the pieces

swell. When swollen they are elastic. The profession was indebted to Dr. Sloan of Ayr for the introduction of this agent.

J. Creery Ferguson, President

Pathological Room

February 7th, 1863

Present, the President in the chair, Drs. Thomas Reade, Beck, Dill, W. MacCormac, MacWilliams, McCrea, Patterson, Michael McGee, Cuming, McCourt, D. Moore.

The minutes of the previous meeting having been read and confirmed, a letter from the Editor of the "Dublin Medical Press" was read relative to the reprinting of the transactions of the Society and offering to throw off a hundred copies of the size of the Report of the Medical Benevolent Fund, at the rate of a guinea per sheet. The Secretary was instructed to write the Editor and inform him that the Society would accept his terms.

Two accounts, one for twelve months July 1862/63, subscription "Northern Whig", £1.6.0; one of "Musgrave Brothers" of £3.14.2½ were passed and payment ordered by the President.

Dr. David Moore exhibited the recent parts of a case of fracture of the base of the skull, and detailed the facts of the case.

Dr. Thomas Reade thought a fracture of the base of the skull of any magnitude was a necessarily fatal accident. He was not aware of any preparation which would shew bony union of a fractured base, and lead to the inference that recovery had taken place.

The President enquired as to how the force acting laterally on the skull, would produce a transverse fracture of the base.

Dr. W. MacCormac remembered a case of very extensive fracture of base of skull; the subject of it was a sergeant upon whose head a metal butt of many hundred weight fell while he was engaged in moving it, crushing his head laterally between it and another butt which was lying on the ground. The direction of the force was lateral, though fracture of the base of the skull was transverse, with a fissure extending backwards on either side from the petrous part of the temporal bone towards the occipital foramen.

Dr. D. Moore remarked that the course the fracture took in the instance brought forward was that taken by all the extensive fractures of the base he had seen, and this course seemed to obtain irrespective of the direction of the force, and mentioned the case of a man who had fallen from a considerable height, alighting on the vertex of the skull. Whilst in hospital he shewed the usual signs of fractured base, and on post-mortem examination a transverse fracture was found which pursued almost the same course as the one under discussion.

A communication was read from Dr. Scott, Aughna-

cloy, on the use and mode of action of Ergot of Rye.

Paper:¹ To the physician regularly or even occasionally engaged in the practice of midwifery or the diseases of females, there are, I think, few subjects better deserving of accurate attention than the action of ergot of rye, and perhaps emetic medicines generally. The questions involved are deeply interesting, and demand the most careful consideration, and certainly can alone be answered satisfactorily by obtaining the results of a large number of cases (from trustworthy sources) treated by ergot, ipecacuanha, and other emetics.

The readers of the medical journals have seen that Dr. Hewitt, of London, propounds, at least in meaning, these queries:—Whether, in cases of marked ergotic effect, that effect be coexistent with vomiting or nausea? In cases where ergot has been given without effect, is there an absence of vomiting or nausea? Ipecacuanha or any other emetic being given, are the contractions of the uterus intensified thereby or increased in frequency? During a rather extensive midwifery practice, extending over twenty years, I have exhibited ergot of rye, previous to the expulsion of the fœtus, and with the object of exciting uterine action, more than one hundred times. The result, with a single exception, invariably answered my most sanguine expectations. I have repeatedly asked others for their opinions on the subject, and almost invariably received replies in substance confirmatory of my own experience. Not long since a most intelligent practitioner, in a neighbouring county, engaged in a large obstetric practice, said in my hearing, “I have been frequently disappointed in the use of every medicine I ever ordered, save ergot of rye, that never failed me.” All this, of course, only goes to establish the value of the ergot, which, I suppose, nobody questions, and that, in a considerable number of cases, failure was almost unknown, leaving the question of the coexistence of the ergotic effect and vomiting untouched. I can, however, most certainly reply that in the cases above-mentioned vomiting and nausea were the exception, and not, I am persuaded, of more frequent occurrence than in cases where no ergot was administered. Having only seen, some six years since, an individual case where the ergot failed to accomplish the object contemplated, and having taken no note of the matter, I am unable, of course, to say anything with respect to whether, in those cases where no ergotic effect is produced, vomiting and nausea be also absent. That uterine contractions are intensified, if not aroused, by emetic medicines, I presume there can be little doubt. In one case I witnessed, what I did not anticipate, powerful uterine contractions immediately following a sickening dose of tartar emetic. But whatever the relation (if any) of uterine action to vomiting or nausea, it is I think tolerably clear, from the results

of the cases above referred to, that there is no very strong foundation for the recent statement of the Lecturer on Midwifery, at St. Mary’s Hospital, “that ergot given without producing vomiting will generally be found useless as a parturifacient.”¹ Whether there be any immediate or remote connexion between imperfect contraction of the womb and puerperal fever, I am still in doubt; but I never had an opportunity of observing a case of the latter where I was aware that ergot had been administered, and it certainly did not make its appearance in any instance where, owing to personal attendance from the commencement, I knew that proper contraction of the womb had taken place. I attach great importance to ergot in the treatment of hæmorrhage after delivery, so much so that, some years since, I adopted the practice, in every case where, from existing symptoms or past experience, there was reason to fear hæmorrhage, of giving a dose of the ergot immediately preceding or subsequent to the birth of the child, and with invariable success; indeed, to this practice I principally attribute the agreeable fact that, save when a student in a lying-in-hospital, I never saw a fatal midwifery case.

To the want of careful selection and due preparation I believe should be nearly altogether attributed the occasional unsatisfactory effect, or rather want of effect, of ergot in exciting uterine action. I cannot help thinking that, if it were cut into small pieces, or bruised in a mortar immediately before use, then boiled for about six or eight minutes and administered warm, the just expectations of the physician would hardly ever meet with disappointment, to say nothing of the benefit conferred on the patient.

My sole object in forwarding this communication is because I think the whole subject eminently deserving of the best attention of our Society, especially in its more practical aspect, and that I am really desirous of learning how far the members may coincide, or the reverse, with the remarks so crudely and hastily placed before them.

Dr. Michael McGee had given Ergot for the last twenty years, and in the same manner as Dr. Scott, and regretted to have to state that from experience he had been often disappointed in it, in the proportion of six cases out of ten in which it was given.

Dr. Beck had much experience of Ergot. He had used it 400 times in 2,000 cases. If it failed he thought failure due to its being employed in inappropriate cases. It should not be given till the uterus had made some progress itself in the labour, the os well dilated, and then only when the pains were not “up to par”. He considered the Etherial tinct. was not to be depended on. The Ergot should be recently bruised as it does not keep owing to an acarus forming on it but Cam-

¹ [Dublin Medical Press, 1863, v49, p342.]

¹ See *Lancet and Dublin Medical Press, &c.*, of last week.

phor would preserve it from the acarus.

His mode of prescribing it was to make an infusion of *zij* of the Ergot, and divide that into three doses, with an interval of twenty minutes between them. He could not class Ergot as an emetic as he had met with vomiting as often where Ergot was not given, as in those cases when it was administered, and besides vomiting was frequent whenever the pains were strong in cases where Ergot was not required. It was most valuable in cases of post-partum hæmorrhage. As to its stated effects on the child itself, he thought it could only arise where Ergot had been given at a very early stage of labour and continued long enough to act as a poison to the child. He had never seen such effect.

Dr. Patterson had used Ergot for the last thirty years and thought all junior practitioners should be cautioned against its indiscriminate use. It should only be used when the cervix is well dilated, the passages soft, and free from any obstruction to the passage of the child. In cases of retained placenta or of hæmorrhage he invariably gave a dose of Ergot, when the child was about to be expelled. If Ergot was given too early there was a risk of rupture of the uterus, a case of which in consequence of the incautious use of Ergot he had heard Dr. Hamilton of Edinburgh commenting on.

Dr. Thomas Reade remarked that Dr. Beattie of Dublin had written a paper on the subject, in which he recommended Ergot to be given only in latter stages of labour, or after birth. Where an apprehension of hæmorrhage exists, he advises a dose of Ergot just before delivery to guard against it.

Dr. Cuming confessed he was startled by the number of cases in which Dr. Scott used Ergot, and Dr. Beck also used it very frequently. Now in 100 cases he had never used Ergot at all. The statistics of midwifery shew that abnormal cases as a class occur but once in 33 times, and he felt surprised that in an ordinary physiological process as childbirth was, Dr. Beck should feel called on to add Ergot so often.

Dr. Michael McGee did not use Ergot in one case in 30.

Dr. Johnston asked if there were any connection between imperfect tertiary contractions and puerperal fever.

Dr. McCrea considered that puerperal fever was less owing to deficient uterine action than that the deficient action was due to the cause which at the same time gave rise to the puerperal fever.

Dr. Beck thought he could trace a distinct connection between rigid contraction of uterus after birth, and the absence of puerperal fever.

Dr. Dill could not agree with Dr. Beck as to Ergot being the most efficacious agent.

J. Creery Ferguson, President

Pathological Room

February 14th, 1863

Present, the President in the chair, Drs. Dill, Patterson, Browne, Michael McGee, Pirrie, Corry, W. MacCormac, Beck, Cuming, Staff Surgeon Saunders.

The minutes of the previous meeting having been read and confirmed, Dr. D. Moore shewed a fœtus in utero of eight months gestation, the uterus and content having been obtained from the body of a female who had died of acute pleurisy. The child and placenta were both in a natural position—that of the child was the second position of labour the occiput to the right obturator foramen, the right hand was placed on the top of the head. Would the hand present in the progress of the labour?

Dr. Pirrie said that when labour would begin the head would be projected forwards and the hand would most probably recede.

Dr. Beck said that when the hand came down with the head, it was placed usually at the side of the head and face, and not on the vertex.

Dr. Cuming asked if in such a case section of the abdomen would offer any chance of life to the child.

Dr. Michael McGee quoted the case of a fœtus which had been cut out of the uterus at the end of the period of gestation, the mother having died from convulsions. The child lived and grew up to manhood.

The President remarked that in the present case the woman had died not from a disease of very short duration but more lingeringly, which would doubtless have an effect on the vitality of the fœtus. That death had occurred more suddenly than was anticipated, and in the middle of the night, even had a *sectio abdominis* been contemplated in such a case, and a surgeon ready when the final event occurred to take advantage of every moment he considered the chances of the child's life would even then be very problematical.

Dr. Corry exhibited a case in which a congenital tumour of the size of a small orange projected from the centre of the occipital bone of a child a few days old. A narrow neck, rather firm and somewhat moveable connected the tumour to the bone. The tumour itself was tense, elastic and devoid of pulsation, of a reddish colour at the position nearest the pedicle, the remainder was more purplish in hue.

Dr. Beck met with two such cases, in one the child was still-born from difficult labour, the side of the head presenting the remains of the cyst of such a tumour as he conceived the one before the Society to be, with a little round hole in the centre of the parietal bone communicating with the cavity of the arachnoid. In the second case, the tumour was situated on the occiput and presented a very similar appearance to the case before the Society.

Dr. W. MacCormac thought the tumour was rather of the character of nevus, as the pedicle was moveable rather freely on the parts beneath. There was a

marked difference of colour in different parts of the tumour and the absence of pulsation might be accounted for by the tumour being composed chiefly of enlarged vein.

Dr. Browne considered the case was one of spina bifida, that the tumour was lined by the arachnoid, and filled with its fluid, it was partially translucent. That the tumour could not be lessened in size by pressure as the foramen in the bone was of small size. In spina bifida affecting the inferior extremity of the spinal canal although the opening was large, the tumour was but little affected by pressure.

[The following paper by Dr. J. W. Beck is recorded in the Dublin Medical Press but not in the minutes. The discussion is recorded in both.]

Paper:¹ Having practised midwifery now for upwards of twenty-seven years, and having registered every case as it occurred for sixteen years and seven months of that period, I find that I have considerably above 2000 cases on my register. Case No. 1000 was delivered by me on the 3rd day of August, 1855, and in these 1000 cases I have administered the secale 126 times. Case No. 2000 was delivered by me on the 16th day of July, 1862, less than seven years afterwards, and in this second 1000, I have administered the same drug 170 times; in all, 296 times in 2000 cases. Now, as I know positively that I administered the secale cornutum 296 times, in a practice extending over sixteen years and two months, I presume I was justified in assuming, as I did at our last meeting, that I had administered this agent “about 400 times” in a midwifery practice of upwards of twenty-seven years.

With regard to its effects on the mother—I have registered them in four degrees as follows:—First, where it had apparently no effect at all. Second, where it had very little or very doubtful, if any effect. Third, where it had a decided effect, such as was expected and required. And lastly, where the effect was remarkably and perhaps unexpectedly rapid and energetic. Of the first, I find no effect in 15 cases; a very little or doubtful effect in 42; the good effects expected in 223; and an extraordinarily energetic action in 16 cases. Now, as these remarks were written down immediately after each case, I think they are much more to be depended on than any vague general impression, and the result appears very favourable to this drug when administered in appropriate cases.

I need not enter into the consideration of what constitutes an appropriate case for its use, but I may remark that it should never, under any circumstances, be given in the early stage of labour, before the os uteri is well opened, no matter what the pains may appear like. There are few things more annoying to the accoucheur than to be in attendance, for perhaps a day

or two, on a patient who considers herself in labour, and who is continually urging him to do something for her; and moreover, bad as this is with a primipara, it is still worse and more embarrassing, when it occurs, as it sometimes will, with the mother of five or six children, who considers herself a judge of labour. In a case like this the os uteri may be little if at all dilated, and the process of dilatation may be so very slow as to be scarcely perceptible, although the pains may be very severe on the patient.

Now, in a case like this, secale should not be given (at this stage, at least), as it will be sure to disappoint you in any good effects you may expect from it, and this warning is the more necessary as it is just such a case as the young practitioner is tempted to give it in. I have given it under such circumstances myself several times, but never with any benefit or satisfaction; and this leads me to remark that perhaps the report of my register would not have been so favourable as it is had it contained a list of all the cases, “about 400,” in which I administered it. I had the experience of about ten years of its use to guide me before I commenced this register; and this experience was valuable in enabling me to select the cases in which its use would be most appropriate; notwithstanding all this, however, I observe that in some of the cases where the effects are marked nil, the remark is made that it was administered too soon; so that I consider this a point worth insisting on. It seems to show that we do not always benefit as fully as we ought by our experience. On the other hand, however, I may remark, as illustrating the benefit of experience as a guide in the selection of cases proper for its administration, that of eight cases that were perforated in the 2000, in only three was secale tried; and these three occur early in the first 1000. I may observe, as a further illustration of the same thing, that the proportion of cases in which it was necessary to use the forceps after the secale, diminishes as the register advances, averaging less in the second 1000 than in the first.

If, on the contrary, the labour be in an advanced stage, the parts soft, moist and cool, and there exists no great mechanical obstruction to the advance of the fœtus—in short, in any case where it may be desirable to increase the muscular action of the uterus, either before or after parturition—its use is clearly indicated. But where the uterus has already acted energetically and failed to do its work, it is clearly inadmissible, as administering it in this case would be like the overdriving of a tired horse, and mischief must ensue.

For post-partum hæmorrhage I again repeat there is no remedy equal to it. The more I have used it, the more dependence I am inclined to place in its use. I have given it 41 times after the birth of the fœtus for hæmorrhage, retained placenta (though I always proceed to remove it by the hand), or a known lax state of the uterine tissues, tending to hæmorrhage, and I find

¹ [Dublin Medical Press, 1863, v49, p597.]

the effects marked good in all these 41 cases. In making this assertion I do not ignore position, pressure, temperature, &c., but my subject is at present the action of *secale*, and not uterine hæmorrhage.

With regard to the effects of the *secale cornutum* on the child. I have long since come to the conclusion that it has no injurious effect on the child as a poison, and the registry seems to me to confirm this opinion in a remarkable manner. In every case, except one, where the child is marked dead-born, or as having died shortly after birth, there is a perfectly sufficient reason to account for death without the necessity of falling back on the *secale*, and in this one case, though I am not perfectly satisfied as to the cause of its death, I by no means feel inclined to attribute it to the *secale*. There were twenty children at the full term, who were either born dead, or died shortly after birth, after the administration of the *secale*. Of these, eleven were delivered by the forceps and three perforated. This, I presume, is sufficient to account for these fourteen deaths without blaming the *secale*. Of the remaining six, one was putrid when born, another had been turned, the third was a case of placenta prævia, and the child died from hæmorrhage, the fourth child was born with a rigid state of the voluntary muscles, a kind of rigid catalepsy, but more like rigor mortis than anything else. The abdomen was enormously distended and tympanitic; it lived an hour, dying out quietly. The fifth child was very large, and the labour was very slow, consequently the pressure was very great and long continued. Twenty-six hours severe pressure during labour is enough to account for the death of this child. It might have been saved by the forceps, but as a rule I don't use them while the child is making any advance at all. The sixth child, though born after a labour of thirty-five hours, still seemed to me, I must admit, unlike the previous one, to have suffered no pressure sufficient to produce its death. It lived, at least the heart beat, for half an hour, but all the means I could use were unsuccessful in producing even an attempt at respiration, still I am not inclined to attribute this death to any poisonous effect of the *secale*, as I have seen two children besides die out in a very similar manner where no *secale* had been used.

I shall now address myself to a question which has been raised here as to the connexion there may be between a lax state of the uterine tissues as promoting or facilitating the absorption of putrid matter through the uterus and the production of puerperal fever; in other words, how far the administration of *secale* may, by promoting the contraction of the uterus, prevent the absorption of its putrid contents, on the absorption of which puerperal fever may be supposed to depend.

There are four deaths of mothers in these 296 cases. The first death occurred in a primipara, aged above 40 years, who was delivered by the forceps of a very large and extremely putrid child. She complained of nothing

but prostration, gradually sank into a state of coma, and died in four days. I have no doubt this death was from putrid infection. How far the *secale* tended to prevent its occurrence I can't say. It is marked as having produced very little, if any, effect. The second death was from hæmorrhage. It was a case of placenta prævia. I was called by a member of this Society to turn. I did so. She died on the twenty-seventh day after delivery. The third death was that of a patient with inflammation of the bowels, who was delivered of a four months' fœtus after eleven days' constipation, and died the next day from exhaustion. The fourth death was a primipara, delivered with great difficulty after a twenty hours' labour. The effect of the *secale* is marked "very good;" but I had evidently despaired of her being able to deliver herself, as the child was born while a messenger was away for the forceps. She died thirteen days afterwards of what is marked "putrid fever." These are all the cases of death, or puerperal fever, that occurred among the cases where *secale* was given. Whether the evidence educed from them may be pro or con I don't know, but you may take it quantum valeat.

There is just another point I would say a word or two on before concluding, and that is, the proper method of preserving and administering the *secale* itself. It is a drug the active properties of which are very easily destroyed by damp. It is also very liable to be attacked by an acarus or mite, particularly when damp. It should be procured in substance whole. I have no faith in its powder, or tincture, or extract, or anything else, but itself. After it is procured, it should be carefully dried, and put into a well-stoppered bottle, with a small piece of camphor. If this is done it will keep sound and active for a long time. The camphor seems to have the effect of preserving it from the attacks of the acarus. Again, a new parcel of the drug should never be placed in the bottle along with the old. What remains of the old stock should be taken out, the bottle well washed and dried, and your new lot, well dried over a stove, if possible, placed in it on the top of a little bit of camphor. I believe that it is from neglecting to preserve this valuable drug properly, or from prescribing some of its fancy preparations, that it so often disappoints the expectations of some practitioners as to cause them to lose faith in it. I have no hesitation in saying that if you can procure a sound lot of this drug, and preserve it in the way I have directed, you will be very seldom disappointed in its action if administered in the following manner, and I again repeat, only in appropriate cases. I know that latterly when it failed in my hands even once, and particularly if twice in succession, I was inclined to look for the cause in the bottle, and more than once found it then in the bad quality of the drug.

The way I administer the drug is as follows: I take two drachms, always fresh powdered as required, and boil it in eight or ten ounces of water for about five minutes. I administer this in three or four doses, as hot

as it can be swallowed, with from twenty minutes to half an hour between each dose. Generally two or three doses are sufficient to produce all the effects required, sometimes one dose will do. If the first or second dose produces little or no effect, you will generally find the third or fourth will produce as little, and I don't believe it is even useful or necessary to go beyond this two-drachm dose, even when the first or second dose is thrown off, as it sometimes is. When it is thrown off, it is not because it is an emetic in the ordinary sense of that word, though it has been called one. It excites the uterine action, and this action (or rather the stretching of the os uteri caused by this action) excites or produces the emetic effects on the stomach, precisely as occurs in cases when no secale has been given. Some one relates the case of a married woman who always vomited while in coitu, and I had a patient myself whom I could make retch at pleasure by touching the os uteri with the tip of the finger, although she could give no explanation herself as to the cause of the retching, or as to why she retched, yet the result of the touch was invariable. I made the discovery accidentally while examining her by the tactus eruditus. I had an opportunity of ascertaining some year or two afterwards that the os uteri had lost this peculiar irritability.

Dr. Beck's paper on Ergot—Discussion

Dr. Cuming considered that unless the cases Dr. Beck had met with in practice differed materially, at least in a great number of them, from those met by other medical men he thought Ergot was too freely administered. It was in the memory of practitioners of standing, that at one time formerly it was customary to give a glass of whiskey, and ninety drops of tincture of opii to every woman on delivery. Now this was never thought of. He supposed the exhibition of the above draught did no harm but cases are at present imagined to proceed as well without it. Dr. Beck might exhibit a small dose of arsenic to each of his cases without making any change on a favourable issue. He uses a drug largely that has in other hands been productive of bad effects, and which has a decided effect on the nervous system, evidence of nausea and depression.

Dr. Michael McGee has had experience in 3,000 cases of midwifery. In his early practice he gave the drug more frequently than now, first to accelerate delivery and second to save time. He thinks the good effects he then ascribed to the drug would have appeared in its absence. Could it not have been dispensed within some cases of Dr. Beck's. In some cases where the uterine action has declined, it is injurious to both mother and child, and has sometimes acts as a sedative merely. Where he has given Ergot he has met with hourglass contraction in a few cases but never when the drug was absent. He agreed with many points in Dr. Beck's paper but could not endorse all

his good opinions of Ergot.

Dr. Pirrie agreed with Dr. Beck that when Ergot failed, the fault lay more in the faulty keeping and preparation of the drug than in the drug itself. He would not agree with Dr. Beck in giving Ergot in cases of retained placenta, as it [is] very liable then to give rise to hourglass contractions. He was a pupil in the Rotunda in Dublin when Drs. Hardy and McClintock made their experiments on the action of Ergot. The conclusion they arrived at was that Ergot was productive of bad effects on the child, and the rule was that unless birth was accomplished in two hours after its first administration, the forceps should be applied. It was a most valuable agent in post-partum hæmorrhage. He had seen mischief in cases which were unsuitable for the exhibition of the medicine, but this should not be charged to the drug itself.

Dr. Browne considered the value of the paper lay in some measure on its clearness and candour. If Dr. Beck's instructions were followed, the drug good, and cases suitable, the practice inculcated would be found to answer expectation. He considered that if Ergot were given six or eight hours before the birth of a child, there would be a great risk of still-birth. He would endorse almost all the statements of Dr. Beck.

Staff Surgeon Saunders in cases of post-partum hæmorrhage never omitted the early application of the child to the breast, as there is no better excitant of uterine contraction. The infusion should be prepared on the spot from freshly powdered Ergot, and given cold. He has found the infusion given cold to act better, and it is well known that a small draught of cold water will often excite uterine action.

Dr. Dill said he should scarcely have thought it necessary to rise on the present occasion were it not to state that he did not fear to meet, and even measure swords in a friendly way with Dr. Beck on this or any other question. He thought it better to debate the point now, rather than like him to take a week to barb an arrow or direct a shaft.

Notwithstanding what Dr. Beck had said in defence of Ergot of Rye as the very best agent in the hands of an accoucheur for checking post-partum hæmorrhage, he was still disposed to reiterate and advocate pressure and the free application of cold as the first, superior and most effective agents we have at our command. Pressure over the uterus can always be promptly applied by the hands and cold water, (ice if possible) should never be far off. Whereas Ergot required time for preparation and still longer after its administration till its influence, if any, was felt. He need scarcely allude to Dr. Beck's hypercriticism regarding the fact that he did not mention or recommend horizontal position as the first thing to be attended to. It was not necessary to tell him that the patient was supposed to be already in that position and when Dr. Beck did introduce the point in an elab-

orately written paper and attempted critical argument, why did he not inform the Society how the head should be lowered and the hips elevated. This Dr. Dill had always in such cases been in the habit both of practising and teaching. Indeed he held that the head be very much lower below the level of the body, and the hips at the same time considerably elevated. This would appear the more necessary when it was known that the saving of a single drop of the vital fluid in such cases of the utmost importance, and this position it should be admitted was calculated to accomplish the object. There were few specifics in medicine but he would be dishonest to look on Ergot as one of that class and that it exercised great influence over the womb in contracting its muscular tissue but he was not prepared to admit that it should be placed either in the class of poisonous emetics.

**Pathological Room
February 21, 1863**

Present, the President in the chair, Drs. Browne, Dill, Cuming, McCrea, Charles Purdon, McCourt, Gribbin, Johnston, Staff Surgeon Saunders.

The minutes of the previous meeting having been read and confirmed Dr. Charles Purdon exhibited a specimen of soup he had caused to be made for the use of the inmates of the "Deaf and Dumb Institution" of which he had medical charge. He stated that the pupils were particularly liable to strumous affections, phthisis chiefly, with a large mortality. The diet was abundant and generous, and with tonics, expectorants, and cod liver oil, freely [used], constituted the treatment formerly pursued. Owing to its inefficiency he had introduced the use of the soup laid before the Society, which for the past four months had been used daily as part of the food of the pupils, the cod liver oil so freely administered before being at the same time discontinued.

The result had exceeded his expectations a wonderful exemption from phthisis and asthma generally having been enjoyed for the past four months by his patients, who had become fat and healthy looking.

The following are the constituents of the soup

Rx	Flax seed	℥[ss?]
	Bran	℥i
	Beef	℥xii
	Groats and Vegetables	
	Water	Oij

The flax seed and bran are boiled in water for two hours, strained, and the fluid then boiled with the beef and vegetables for a sufficient time with water enough to give two pints of soup.

The President introduced a case of large abdominal tumour in a boy _ years old and asked the opinion of the Society as to its nature, and the probable result.

Dr. Browne considered the tumour to be connected

with, and confined to, the mesentery, mesenteric glands and spleen; to be malignant from the cachectic appearance of the patient and the rapidity of its progress. There was little or no fluid present—he could detect no fluctuation anywhere. Has at present a case under his care in which effusion had twice occurred from malignant disease of the abdomen. Prognosis unfavourable.

Dr. Dill thought that the tumour was not due to malignant disease, but to a strumous enlargement of the mesenteric glands, that the spleen was not involved, that there was considerable effusion, but that it had not been detected from the imperfect means of examination the Society had had, as the boy was recumbent in a large basket and had not been placed in the erect posture, and that the tumour itself was not so large as to fill the abdomen to the extent existing in the case, without much effusion. In the prognosis he agreed with Dr. Browne.

The President had been unable to detect fluid; if any, he thought it was slight in amount. The enlargement raised considerably even in twenty four hours. Tympanites would account for much of it. In addition to the morbid deposit in the mesentery and its glands, there was a tumour which occupied somewhat of the site of the spleen, but which was not in his mind splenic, differing from that viscus in size, in form, and somewhat in site.

He considered the morbid process had also extended to the spleen. It was a common site of tubercular deposit. Where was the æriform effusion? Was it confined to the intestinal canal, or did it exist in the peritoneal cavity as a secretion from the sero-membrane. The presence of air in the intestine itself would be sufficient to account for the amount of the swelling. The bowels were in good order and evacuation regular. The pressure of the tumour on the abdominal veins would account for the œdema of the limbs and scrotum.

The President next exhibited a case of pulsating tumour of the thorax and asked for the opinion of the Society as to its nature.

Dr. Cuming said such a pulsating tumour might be produced by an aneurism, by malignant disease of the lung, or by the pointing of a pleuritic abscess, to which a pulsation had been communicated. The absence of dyspnœa, dysphagia, of any bruit, of differences in the radial pulse would to some extent militate against the idea of aneurism. The history of the case is not that of pleuritic abscess. From the imperfect means of examination of the case afforded Dr. Cuming he felt inclined to avoid any opinion on it, but so far, it seems to be probably a case of cancerous affection of the lung.

Staff Surgeon Saunders said that the paroxysmal attacks of dyspnœa on exertion he considered an important feature in the case, which seemed to him to

be one of aneurism. It was not necessary in aneurismal swellings to have a murmur, or alteration in radial pulse, or any indication of heart disease. He remembered a case of aneurism in a soldier which opened into the trachea.

During life the only symptom observable was an asthmatic state of respiration. A few days before death the lips became perfectly pale and bloodless, shewing an accumulation or partial stagnation of the blood in some of the internal organs.

In another case the aneurism presented on the root of the left lung, and the only symptoms during life were those of difficulty of breathing with some bronchitis. Swellings such as the one before the Society were obscure but from a cursory examination he leaned to the idea of aneurism.

Dr. Johnston thought the case one of aneurism. Presence of bruit was not necessary. Malignant disease would scarcely account for the circumscribed pointing of the tumour, and with it there would be more constitutional disturbance. The extensive dullness might be partly accounted for by partial pleuritic effusion. He considered the case very similar to one brought some years ago before the notice of the Society by the late Dr. Malcolm.

The President looked on the case as one of large aneurism. He remembered the case alluded to by Dr. Johnston and thought the present very similar. The extensive dullness would be explained by the size of the aneurism and also by some pleuritic effusion, which he looked upon as slight in amount. That there was some effusion he judged from the enlargement of the right side of the chest, as aneurisms per se do not produce such enlargement. The lung was yet to a certain extent permeable by air for the swelling rose and fell on inspiration and expiration as if swelled by the lung on inspiration and allowed to subside on expiration.

He considered the seat of origin of the aneurism to be between the point of escape of the aorta from the heart, and its arch, for where it seated higher up, it would give rise to bronchial irritation from pressure on the bronchi.

If seated lower, near the heart, it would produce derangement of the aortic valves, the aortic patency so common in aneurism close to the heart. These signs were wanting in the case.

The history shewed severe shooting pains down the back and up to the shoulder at its early stages from pressure on the vertebræ. At present the patient complains of stomach pain around chest and waist from pressure on intercostal nerves, and of pain on pressure on the whole anterior part of the right chest indicating that the mischief has extended to the tissues of the anterior wall of the thorax.

J. Creery Ferguson, President

Pathological Room

February 28th, 1863

Present, the President in the chair, Drs. Thomas Reade, Dill, Patterson, Johnston, McCrea, MacCormac, McCourt, McWilliam, Gribbin, Smith, D. Moore, Staff Surgeon Saunders and Mr. Poppelwell (Assistant Surgeon).

The minutes of the previous meeting having been read and confirmed, Dr. Browne introduced a patient in whom he had performed Holt's operation for the relief of urethral stricture, a few days before. He was now able to introduce easily a number twelve catheter.

Staff Surgeon Saunders said the operation where performed had always proved satisfactory as far as he was aware. It was unnecessary to retain a catheter in the canal. Mr. Holt objected to its being done. As to rupture of the mucous membrane it was questionable if it occurred in every instance, the only part ruptured would be that situate within the extent of the stricture itself. The rupture would extend no further unless the dilator were too large in calibre for the canal. The operation had the recommendations of being simple in character, and free from hæmorrhage, or infiltration of urine as far as the cases yet recorded could shew. He hoped the unsuccessful cases would be duly reported as otherwise the true value of the operation could not be ascertained.

Dr. W. MacCormac thought it almost impossible for the membrane to remain unruptured under the sudden extension. At first sight the operation would seem a dangerous one. Dr. McNamara of Dublin had operated in forty cases and save in one, there were no symptoms or urinary fever. Mr. Stapleton of Dublin had failed in one case. The danger lay in the conversion of an ordinary stricture into a traumatic one which was the case in this operation. A few months only had passed since the operation was first recorded, and the period was as yet too early to set the cases down as entirely successful in which it has been done.

Staff Surgeon Saunders said much of the success depended on the after-treatment. A catheter must be passed regularly each week for a month, then once a month and subsequently every two months till cure is complete.

Dr. Browne considered the more recent cases of stricture were those suitable for Holt's operation, here the stricture was less firm, softer and more readily split, and the mucous membrane more safe and not so liable to be ruptured as in cases of old hard cartilaginous strictures in which latter class of cases the membrane may be ruptured.

Dr. Johnston thought that the gradual dilatation of this stricture would yield a more permanent cure than its sudden rupture. He would expect a worse contraction than the first would occur afterwards.

Dr. McCrea thought Dr. Johnston's remarks consonant

with the principles of surgery, the old plan of gradual dilation was used on the principle of absorption of the effused lymph being induced. He could not understand how after the sudden dilatation lymph would not be effused and the contraction occur again. Sudden symptoms of the stricture might succeed in two ways; first by rupture of muscular fibres if the stricture was cause of their contraction. Secondly by rupture of the old and hardened lymph in the latter case the liability to the continuity of the stricture being renewed would exist, and hence a considerable time must be permitted to elapse before we could pronounce that there was no tendency to contraction again.

Dr. Browne said that after the operation the catheter was used for some time to prevent re-contraction, but that the advantage of the operation consisted in the facility with which a large instrument could be passed at once afterwards, thus procuring at once what would require perhaps months to effect by the plan of gradual dilatation, a great saving of time, of suffering and anxiety to the patient, and also of the risk attendant on catheterism during those spasmodic attacks of retention which are so liable to attack persons labouring under stricture on exposure to cold and wet, or during excesses of any kind.

Dr. W. MacCormac considered Mr. Holt's operation more suited for old and hard strictures than for the more recent, which was readily curable by the old method. It was in the former class of cases that Mr. Holt himself recommended this plan. Mr. Smylie's modification did away with the objection that it was necessary first to pass a No. 2 or 3 catheter before Holt's operation could be performed, the modification consisted in a No. 1 or No. $\frac{1}{2}$ elastic catheter with a stilette over which on being passed through the stricture the elastic catheter was withdrawn leaving the stilette which now served as a guiding-rod over which silver instruments of small size could be passed till the stricture was sufficiently dilated to permit the passage of the dilator.

Dr. T. Reade said in many cases of stricture the process of gradual dilatation was a very slow one. In these the apparatus in the hands of an operator who was thoroughly conversant with the anatomy of the urethra and of experience in dealing with stricture would prove useful. Experience so far was favourable to it. He would caution all junior practitioners against the least haste in dealing with the urethra, an organ which required the utmost care and delicacy of touch in the manipulation of instruments passed into it.

The President remarked that as to the pathology of stricture, there were few membranous tissues that would admit of greater dilatation than the mucous. In the forcible dilatation the adventitious deposit of lymph would be ruptured, but he would not expect the mucous membrane to be ruptured also, at least

generally. He considered that the healing up of the adventitious tissue would be followed by its absorption and not by an increase of the deposit, any tendency to which would be obviated by the subsequent passage of an instrument.

Dr. Browne exhibited a specimen of a fibrous tumour removed from the lower part of the front abdominal wall of a middle aged male patient. When six years old he was bitten by a horse immediately over the pubis. The wound healed and in its site when a boy a small tumour presented itself of the size of a marble. It increased slowly, never larger than a small egg until eighteen months since when it rapidly began to increase in size and lately to ulcerate at two points. When removed the tumour was of the size of a small coconut. It was subcutaneous and easily removed on the skin being cut through, from the cavity of its attachment to the surrounding parts. Its texture was fibrous, presenting at some points the character of the recurrent fibroid tumour and it would be likely to return.

Dr. T. Reade said he had some years ago a case of a large tumour in a child two years old, in which he had been much deceived as to the facility with which the tumour would be evolved. Mr. Smylie of Dublin saw the case with him and stated as his opinion that the mass on incision through the skin would easily enucleate.

J. Creery Ferguson, President

Pathological Room March 7th, 1863

Present, the President in the chair, Drs. Stewart, Patterson, Reade, McGee, Graves, Cuming, McWilliam, Whitaker, Gribbin, D. Moore, Staff Surgeon Saunders, Mr. Poppelwell.

The minutes of the previous meeting have been read and confirmed, Dr. William MacCormac's motion, "That a sum of £5.5.0 be paid to Lewis of London for a supply of books during the ensuing year on loan to the Society" was discussed when it was resolved, That the matter be entrusted to the Council to make due enquiry and conclude such negotiation as may seem right.

The President brought forward a patient presenting a difficulty of diagnosis and asked for the opinion of the members of the Society upon it.

Dr. T. Reade asked were there any circumstances in the case which would give rise to any objection to the diagnosis, aortic aneurism. The case seemed to him obscure, as far as he could judge from the imperfect means of examination, and he would like to hear the President's opinion of the case before the members of the Society would state their individual views.

The President said that a case of aortic aneurism at least to his mind had been before the Society at last meeting. There, there was a pulsating tumour in the

right chest localising the mischief. In this case before the Society at present, there was no tumour observable anywhere. The sounds of the heart diminished in intensity either upwards or downwards from the base of the heart. The heart was enormously enlarged, with permanent patency of the aortic valves, patency due to an aneurismal dilatation of the artery separating the valves, which might be perfect per se, from each other.

He looked upon the case then as one in which there was a great enlargement of the aortic arch so large as to give rise to permanent patency and an occasional bruit with a first sound. The dilated arch pressed the innominate upwards and partially prevented the entrance of blood into it.

The heart was an example of hypertrophy with dilatation, the latter very great, the former but trifling. The heart sounds could be heard in the left back which was the case only when dilatation existed.

The point of dullness on percussion at the right side of the sternum was defined and there was no impulse there.

Dr. McGee did not consider the pulse presented at the wrist the peculiar undulation of that of aortic patency.

Dr. Graves said the case was a difficult and interesting one. From the imperfect access he possessed of making a careful examination he should think the case one of enlarged heart, with a tumour of some sort, he would not say what, pressing on the circulation of the right side.

The President said he had never met with a case in which he considered the peculiar pulse of aortic regurgitation better marked, sometimes amounting to *frémissement cataire*. He did not consider the aortic arch was equally engaged. There was no solid tumour connected with it. There was no cough, dyspnoea or dysphagia to lead to such an inference.

Dr. Cuming thought that the cause of the obstructed circulation might be found in the vessel itself. Patency so marked would argue disease in the valves and a portion of the fibrous vegetation having become detached would give rise to the obstruction.

Staff Surgeon Saunders

Pathological Room

March 14, 1863

Present, the President in the chair, Drs. Stewart, Patterson, Dill, Cuming, McCrea, Gribbin, McWilliam, Little, D. Moore.

The minutes of the previous meeting having been read and confirmed, Dr. McCrea gave notice of the following motion, "That the Secretaries be instructed to disavow the account of the supper of the Ulster Medical Society, so called, as it appeared in the daily papers recently."

[This may be the report complained of:¹

The Belfast Medical Society and the Royal Marriage.—March 10 being the festival of the marriage of the Prince of Wales and the Princess Alexandra, the members of the Ulster Medical Society supped in their rooms, High Street, to inaugurate the auspicious event. The President, Professor Ferguson, occupied the chair. The usual loyal toasts being disposed of, "The Health of the Prince of Wales and the Princess Alexandra of Denmark" was then given. Dr. Pirrie responded to this toast. He contrasted the conduct of the present Prince of Wales compared to his predecessor, and asserted that, owing to the good management of his father, the late Prince Albert, the country had been saved to the extent of about £50,000 per annum. He hoped they would live long and be happy, and be blessed with a numerous progeny. "The Constitution." Dr. Michael M'Gee eloquently dwelt upon the advantages arising from a good sound education. He expatiated at some length on the benefits arising to society by having the mass of the people educated, and eulogized the form of Government we live under. "Medical Education." Professor Gordon spoke to this toast. He was proud to say that the medical standard of education had been raised to such a height that no person could be a legally qualified practitioner unless he was educated, and that the Government deserved the thanks of the community for passing an Act making it incumbent for the medical man to be registered, so that the scholar and the man of science could be known from the quack and the impostor. Dr. Smith then proposed "The Health of the Secretaries, Drs. David Moore and Whitaker," who, in brief and humorous speeches, returned thanks for the compliments passed on them. "The Health of Dr. Patterson." This gentleman, who has always been so active and zealous member in every movement where the honour and dignity of the profession required his services, returned thanks in a very feeling and efficient speech. "The Health of Drs. Beck and Cuming" being then given, Dr. Patterson alluded to the papers brought forward by those gentlemen before the society, and complimented them on the active parts they had taken in the discussions, and their zeal and attention to the workings of the society. The President then give "The Junior Members." Dr. Gribben, at the general request of the meeting, spoke to this sentiment briefly, but in eloquent and appropriate language. The meeting broke up at a late hour, all having passed off in a most satisfactory manner.]

Dr. Little of Lurgan exhibited a diseased testis which six weeks ago he had removed from an infant, 14 months old. The child who 4 months ago had received an injury of the testis; from the mother's account by having come forcibly in contact with the crinoline of

¹ [Northern Whig, Saturday 14 March 1863.]

the nurse. The testicle slowly and steadily increased in size in spite of the remedies employed—iodine, strapping etc. By and by the health began to suffer and as a collection of serum had formed at the bottom of the tunica vaginalis, below the tumour, it was drawn off by the trocar. The relief of the tension so produced diminished the restlessness and feverishness of the child for the time, but as they returned after a few days and continued well marked, Dr. Little considered the removal of the testicle would afford a chance of a favourable issue, while on the other hand were it permitted to remain the result was certain to be unfavourable. Accordingly, six weeks ago, the tumour was removed, and the child improved in health after the removal till the tenth day when it became feverish, refused its food and had tenderness of abdomen. Diarrhoea set in, tympanites, and on the sixteenth day, death.

Dr. Little remarked that the case determined a point of which he was previously uncertain, namely, whether or not a child of so early an age as 14 months could recover from a serious operation. He looked upon the operation as a serious one in this case as the tumour was of the size of a small orange, yet the child did well apparently for ten days after the operation. He wished for the opinion of the Society in the case.

The President said that from the history of the case he should consider the course run by it was not altogether that occurring when abdominal disease was unsuspected before the operation. That death was due to peritonitis, perhaps subacute at first, from inflammation extending along the track of the operation, and engaging at length the peritoneum. The history was not like that of ulceration and perforation of the intestine, as death would then occur much more suddenly and supervene more immediately with early symptoms of peritoneal inflammation. The tumour consisted of tubercular deposits in the testicle.

Dr. Little said that no doubt a mesentery studded with tubercular deposits would be more liable to inflammation than a healthy one but if the inflammation extended from the wound, he would expect it to make its appearance before ten days had elapsed. He should think that if inflammation were to follow the operation in such a case as the present, the time of its appearance would be the same as in cases of hernia, on the second or third day, and that period passed he should conclude the patient comparatively safe. As to whether the removal of such a tumour would increase or aggravate the tendency to deposit in other organs of the body he should like to hear.

Dr. Cuming remarked that in strumous diatheses there was a marked tendency to the development of phthisis after surgical operation for the removal of diseased joints, etc., and that cases in which the chest affection is only slightly marked will frequently be hurried into rapid phthisis if operative interference

with a diseased joint, for example, has been practiced, and quoted a case falling within his own knowledge in which a young person in whom the chest symptoms were so slightly marked as to give rise to a difference of opinion on the subject between two medical men, had yet succumbed to a rapid phthisis following a surgical operation on a strumous joint, and that in so short a period as five weeks. In the case at present before the Society, a child of tender age might readily sink from so large a development of tubercular matter in one organ as had probably occurred judging from the morbid specimen at present under our notice, and this in so tender an organ as the peritoneum.

The President said he would however be slow to accept the idea that a child, in the case of strumous deposit in the abdomen, would die in six days from acute inflammatory action.

J. Creery Ferguson, President

Pathological Room

March 21, 1863

Present, the President in the chair, Drs. Stewart, Patterson, Michael McGee, Cuming, Gribbin, Corry, McCrea, W. MacCormac, McWilliam, Beck, Whitaker, D. Moore.

The minutes of the previous meeting having been read and confirmed, the following report from the Council was read and approved of. "That having written to Messrs. Lewis and Knipton of London, and Mr. Fannon of Dublin for information regarding their Libraries and having received communications from each of them, the Council have entered into arrangements with Messrs. Lewis for a regular supply of books to the Reading Rooms for one year."

Dr. McCrea then brought forward the motion which was seconded by Dr. McWilliam, "That the Secretaries be instructed to disavow the report of the supper of the Ulster Medical Society, so called, as it appeared lately in two of the daily papers." After some discussion the following amendment was proposed by Dr. Patterson, seconded by Dr. William MacCormac, and passed viz "That the Society recommend that no reports of any entertainments given by the members be published in the newspapers unless through the Secretaries, and that it disapproves of the publication of the report of the supper of the 10th instant."

J. C. Ferguson, President

Pathological Room

March 28th, 1863

Present, the President in the chair, Drs. Patterson, Pirrie, Gordon, Gribbin, McCrea, McWilliam, W. MacCormac, Whitaker, D. Moore.

The minutes of the previous meeting having been read and confirmed, Dr. Gordon exhibited a specimen of hypertrophy of the fang of a tooth, and stated the facts in connection with the case.

Dr. Gordon exhibited a specimen of “chronic mammary tumour” recently removed from the breast of a female of 29 years of age, and read notes of the case. Dr. Gordon read notes of a case in which amputation had been performed for compression and dislocation of the ankle joint, and exhibited the removed part.

Samuel Browne V.P. Chairman

Pathological Room

April 4, 1863

Present, Dr. Browne V.P. Chair, Drs. Stewart, Dill, Patterson, McCrea, Arnold, McWilliam, Gribbin.

The minutes of the previous meeting having been read and confirmed, the Secretary stated that the report from the Council embodying the rules drawn up in reference to the books from time to time received from Lewis’ Lending Library, would be laid before the Society at next meeting. Dr. Browne then exhibited a specimen of diseased knee joint for which amputation had been performed in the lower third of the thigh, and stated the facts in connection with the case.

Dr. Dill asked if in this case there were any circumstances which obviated the adoption of treatment to produce ankylosis of the joint. He considered that at a certain stage of the disease all cases should be treated with a view to ankylosis. Within the present year one case in particular had come under his notice, that of a man who had been dismissed from the County Infirmary as he would not submit to amputation for the removal of a diseased knee joint. He was admitted subsequently into this hospital under the care of Dr. Murney, and the result was an ankylosis of the joint with a firm serviceable limb. The man was a butcher by trade and could be seen daily in Hercules Street walking about in the pursuit of his business.

Dr. Browne stated that when his patient was admitted to hospital the disorganisation of the joint and disease of the articular ends of the bones had proceeded too far to admit of ankylosis. Whilst performing the amputation, the incision made passed through large abscesses in the muscular tissue of the thigh communicating with knee joint.

Dr. Browne then in the absence of Dr. Gordon exhibited a specimen of diseased knee joint for which amputation of the thigh had been performed by Dr. Gordon, and stated the facts in connection with the case.

J. Creery Ferguson, President

Pathological Room

April 11, 1863

Present, the President in the chair, Drs. Stewart, Patterson, Dill, McCrea, Beck, Gribbin, D. Moore, W. MacCormac.

The minutes of the previous meeting having been read and confirmed, Dr. Beck exhibited a variety of different-sized instruments which he had from time

to time devised, as occasion occurred, for the removal of foreign bodies from the different passages—the nares, ear, rectum, vagina, œsophagus etc., and stated cases in which they had severally been successfully used.

Dr. W. MacCormac then laid the following rules to regulate the circulation of the books received from Lewis’ Lending Library before the Society—viz

Rule 1. The Secretary shall order fourteen volumes at a time, to be renewed every three months, the date of ordering to vary should the Council deem it expedient.

Rule 2. The Books, before being issued in circulation, are to lie one week on the Table of the Society for the inspection of the members.

Rule 3. Members may have one volume at a time for a period not exceeding two weeks. A penalty of three pence per day will be exacted from any member retaining a work, without renewal for a longer period. The loan may be renewed at the termination of the specified time if no member had applied for the work.

Rule 4. Any member losing or injuring a work will be required to replace or pay for it.

Rule 5. A member wishing to read a particular work can have it ordered by inserting the name in a proposal book to be provided for the purpose. Should the number of volumes inscribed exceed fourteen the Council shall have the power of selecting which books should be ordered.

Rule 6. Members will receive the Books in the order in which their names may be written down. The member, who in accordance with Rule 5, has requested a Book to be ordered shall always be entitled to the first perusal of the work.

Rule 7. No member may have his name inscribed for more than three volumes at a time.

Rule 8. A list of the works which have been ordered is to be placed in a conspicuous part of the Society’s rooms.

Rule 9. Should any book be allowed to lie on the table for three days without being claimed, the member whose name appears next on the list may have the work on applying to the Secretary.

James Patterson

Pathological Room

April 18, 1863

Present, Dr. Patterson in the chair, Drs. Browne, Dill, Staff Surgeon Saunders, Gribbin, McWilliam, W. MacCormac, D. Moore, Stewart.

The minutes of the previous meeting having been read and confirmed, Dr. Browne read the history of a case of fibrous tumour of the uterus terminating fatally after pregnancy.

Dr. Dill asked if in the progress of the case any other course could have been pursued than that

adopted, and if the induction of premature labour would not have been advisable.

Dr. Browne said the question of induction of premature labour would not have escaped attention, had not the patient been from under observation from the 12th May till the 21st September last at which latter period the time for such interference had gone by.

J. Creery Ferguson, President

Pathological Room

April 25, 1863

Present, the President in the chair, Drs. Stewart, Patterson, Browne, Dill, McWilliam, Arnold, McCrea, Gribbin, Mr. Johnston, Drs. Whitaker, D. Moore.

The minutes of the previous meeting having read and confirmed, Dr. Browne read notes of a case of urethral stricture, in which "Holt's operation" by sudden dilatation had been performed. Dr. Browne remarked that the experience of this case, with that of the case previously brought before the Society, confirmed the view he had entertained that there was no fear of contraction of the parts ruptured following the operation.

Dr. Browne then read notes of a case of traumatic tetanus in which the issue had been favourable, and stated his belief that recovery was due more to the "vis medicatrix" than to the means employed by Art.

Dr. Dill shewed a portion of an umbilical cord of a foetus, which had arrived at the full period of gestation, on which a knot had been formed in utero.

James Patterson, President

Annual Meeting

2nd May, 1863

Present, Dr. J. C. Ferguson (President, in the chair), Drs. Scott (Aughnacloy), Dill, McWilliam, McCrea, Rankin (Kircubbin), Cuming, Patterson, Moore, William MacCormac, Wheeler, Gribbin, Arnold, Murray, John Smyth, James W. Smith, David Moore, and Whitaker.

The minutes of last meeting (annual) were read and confirmed.

The report from Council for the past year was then read, received and confirmed.

The Treasurers report was received and adopted.

The election of officers for the ensuing year was then proceeded with by ballot when the following gentleman were duly elected.

President

Dr. Patterson

Vice President (town)

Dr. J. S. Reid

do (country)

Drs. Scott (Aughnacloy) and Little (Lurgan)

Council

Drs. Arnold, Cuming, Mr. Gribbin,

Drs. MacCormac (W.), McCrea, and Mr. James

Smyth

Treasurer

Dr. J. W. Smith

Secretaries

Drs. D. Moore and Whitaker

Dr. Moore (D.) resigned the office of Secretary.

Dr. Dill handed in the following notice of motion, "That it be not necessary, in future to pay the annual subscription before taking part in the May meeting."

Votes of thanks were passed to the outgoing President, Treasurer and Secretary which were suitably acknowledged.

James Patterson

ULSTER MEDICAL SOCIETY

SESSION 1863–64

Monthly Meeting

June 6th, 1863

Present, Drs. Patterson (President, in the chair), Cuming, MacCormac, Gribbin, Arnold, McCrea, Burden H., McWilliam, Beck, Reade, Moore D.

The minutes of last meeting having been read, it was moved and seconded, "That they be confirmed."

Amendment moved and seconded "Dr. Dill's name be expunged from the list of Vice Presidents, in consequence of his not having been legally elected by a majority of votes as required by the rules of the Society." Amendment put and carried.

A letter was read from Dr. Reade resigning the office of Vice President and thanking the Society for their kindness in electing him.

Dr. Reade's resignation was accepted.

A letter was read from Dr. Dill resigning the office of Vice President.

The President then left the Chair which was taken by Dr. Arnold.

Dr. Reid was elected Vice President, Dr. McCrea Secretary in room of Dr. D. Moore and Dr. H. Burden Member of Council.

Dr. W. MacCormac then read an interesting paper on M. Baradue's theory of the causation of death in cases of severe burns.

Dr. Beck remarked that he had seen a case in which no vesicles had formed and which he did not think the shock was sufficient to cause death although the patient sank rapidly.

Dr. H. Burden thought that M. Baradue's line of practice was founded on insufficient data; in cases of eczema there was a great exudation of fluid yet fatal results did not occur.

Dr. W. MacCormac remarked that in cases of eczema there was not a rapid abstraction of fluid as in burns.

Dr. Arnold thought that M. Baradue paid to little attention to the shock attendant on severe burns.

Dr. D. Moore thought that the shock to the nervous system and the acute prostration consequent thereon, were the principal causes of a fatal result in cases where such occurred.

James Patterson, President

July 4th, 1863

Present, Dr. Patterson, President in the chair, Drs. Ferguson, Wheeler, MacCormac William, McWilliam, Smyth, Brice, Gribbin, Burden H., Smith J. W., Warwick, Grattan T., and Whitaker.

The minutes of last meeting having been read and confirmed, Dr. Pirrie was elected Vice President of the Society.

Dr. H. Burden read notes of a case of midwifery in which turning was much facilitated by the use of a simple instrument which was exhibited by Dr. Burden and its mode of application explained. This instrument had been contrived by Professor Burden some 12 years ago and in his hands had also been found to answer the purpose for which it was intended.

A conversation ensued in which most of the members joined, and expressed their approval of the views expressed by Dr. Burden, though some suggested that an instrument almost similar had been seen by them many years previously to its construction by Professor Burden.

James Patterson, President

August 1st, 1863

Present, Drs. Patterson (President in the chair), Arnold, Reade, Smith, James, McWilliam, McCrea, Gribbin, Burden H., and Whitaker.

The minutes of last meeting having been read and confirmed, the proposal to add to the library "Lawrence's Lectures on Surgery" and "Syme's Observations on Surgery" fell to the ground, owing to the absence of the proposer and seconder of these books.

It was then moved and seconded, "That 'The Times' be substituted for 'The Daily Telegraph' in the new room." A desultory conversation ensued in which most of the members joined; after which the proposal was unanimously agreed to.

James Patterson, President

Special Meeting

September 4th, 1863

Present, Drs. Reade (Chair), Ferguson J. C., Ferguson H. S., Moore James, Cuming, Patterson, Keown, McCrea, Rankin, Gribbin, McGee Michael, MacCormac William, and Whitaker.

"Summoned by special requisition of Council" to consider the propriety of entertaining the Medical Officers of the Channel Fleet. Dr. Reade (Thomas), in the absence of the President, having taken the chair called upon the Secretary (Dr. Whitaker) to state the circumstances under which the meeting was summoned and whether any and if so what steps had been taken in the matter.

Dr. Whitaker having briefly stated the facts of the case and that no steps had as yet been taken in the matter, expressed his regret at the absence of the President with whom the idea had originated and who would, had he been present, have given the Society his views on the subject.

Dr. McCrea objected to the Society taking any part in the contemplated dinner, and thought that it would be better to let the matter drop.

Dr. Michael McGee strongly supported Dr. McCrea.

Dr. James Moore thought that it was only proper that the members of the Society as such should shew proper courtesy to their brethren of the Navy and in no way he thought, could it be better done than by inviting them to dinner.

The President having entered the room, took the chair, and having apologised for his unavoidable absence stated fully his views and expressed his opinion in favour of the proposed dinner.

Dr. T. Reade proposed and Dr. Moore seconded and on a division it was resolved "That the Medical Officers of the Channel Fleet be invited to dinner on their approaching visit."

James Patterson, President

Dinner to the Medical Officers of the Channel Fleet by the Ulster Medical Society.¹

On the 10th inst., at seven o'clock, the members of the Ulster Medical Society entertained their brethren of the vessels comprising the Channel Fleet to a dinner in the Society rooms, High-street. There were between thirty and forty members of the Association present. Dr. Patterson, the President of the Society, occupied the chair; and Drs. Wm. McGee, J.P., Reade, and J. Moore acted as croupiers.

There were present at the dinner—Dr. Andrews, Vice-President Queen's College; Dr. McGee, J.P.; Dr. Moore, Dr. Browne, R.N.; Dr. McMechan, Dr. Keown, R.N.; Dr. Wheeler, Dr. Mulholland, Dr. A. H. Cooke, Royal Antrim Artillery; Dr. Stewart, Dr. Henry Ferguson, Dr. Patrick, Carrickfergus; Dr. Gribben, Dr. McCormac, jun.; Dr. David Moore, Dr. Dundee, Carrmoney; Dr. Whittaker, Dr. Hanna, and Dr. Lytle, Lurgan. The guests were—Dr. Anderson, 60th Regiment; Dr. Bayfield and Dr. Popplewell, 14th Depot Battalion, and the Medical Officers of the Fleet. Apologies were received from Dr. Stephenson, Dr. Drennan, Dr. Clarke, Dunmurry; and Dr. Kennedy, Comber.

The Chairman proposed "The health of the Queen," which was drunk with enthusiasm.

The Chairman said the next toast he had to propose was that of "The Prince and Princess of Wales."

The toast was received with hearty applause.

The Chairman next proposed "The Lord Lieutenant and Prosperity to Ireland," which was enthusiastically received.

The Chairman said the next toast on his list was, although not the principal toast of the evening, something similar to it. It was essential on all such occasions as the present to propose the toast of "The Army and Navy," which he did with a hearty good will.

Dr. Cunningham of the 60th Regiment responded on behalf of the army, and he was sorry to say that he happened to be the senior member of the medical staff of

the Belfast garrison present on that occasion. It was owing to the exertions of the Medical Society of Ulster that they had attained their present position in the army, and he was sure he might be allowed to say that he had heard his native town of Belfast spoken of as one of the foremost towns in which a soldier could live, and where he would meet with kindness and sincere hospitality (applause).

Dr. McGee, J.P., responded on behalf of the navy.

The Chairman—Gentlemen, I have now the most pleasing duty to perform, and I am sure you will all most cordially join with me by filling a bumper to the toast I am now about to propose (hear). The presence of the Channel Fleet in the waters of our Lough naturally suggests to our minds how deeply we are indebted for the freedom we enjoy to the unconquerable bravery which has ever characterized the British Navy. If we possess all those constitutional blessings which give stability to a state by rendering its citizens secure in the enjoyment of those rights and privileges, must we not admit that, amongst other agencies at work, the British Navy has been most potent—has most nobly contributed by its illustrious services, to confer those inestimable blessings, and I will say, to secure them to us (applause). Gentlemen, we must all feel proud in honouring that flag which has triumphantly braved for "a thousand years the battle and the breeze" (hear). We identify ourselves with its glory—we rejoice in its principles—we honour its renown—we regard it as the best safeguard against a foreign foe, to protect what is Great Britain's boast, "happy homes and altars free" (applause). When we consider the extent of the dominions ruled over by our gracious Queen, upon which the sun is never privileged to set—the magnitude of the trade connected with our colonial establishments—we cannot fail to see the mighty interests which are involved in our retaining, at all hazards, the proud empire we have so gallantly won—the supremacy of the seas. In this I am sure we are all agreed, and it is most agreeable to my feelings to give expression to sentiments in which I know you all so heartily concur. Gentlemen, it is our peculiar privilege on this occasion to have amongst us guests who have always with zeal and fidelity shared in its dangers, though I must say they have not equally participated, as their merits entitled them to, in the rewards. It would not be seasonable, on a festive occasion like this, to enter upon professional grievances. Recently considerable ameliorations have been effected, and I do hope that the Government will soon grant full justice to our brethren in the service, justice to which their education, their zeal, and fidelity preëminently entitle them. But, gentlemen I will not detain you longer. I know you all feel as I do, anxious to do honour to our guests; and I will manifest my anxiety to honour them by refraining from any further observations, and calling on all of you to join me in a hearty response to the health of the "Officers of the Channel Fleet," who

¹ [Dublin Medical Press, 1863, September 16, p378.]

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President James Patterson

have honoured us with their company this evening.

The toast was drunk with “three times three.”

Dr. Sloggett, of her Majesty’s ship Edgar, said that, in the absence of the senior medical officer of the squadron, the duty devolved upon him to reply to the toast which had been so kindly received by the company present. He only regretted that he was not enabled to do full justice to the sentiment; but he hoped they would forgive him (hear). The professional gentlemen of the navy felt acutely the want and the advantage which their brethren enjoyed on shore. He alluded to the professional meetings such as were held by the Ulster Medical Society. After some remarks on professional matters, in which Dr. Sloggett stated that there were yet many means open for improvement in the medical service of the navy, he concluded by thanking the meeting for the kind manner in which the toast had been received (loud applause).

Dr. Smyth, of H.M.S. Royal Oak, next proposed the toast of “The Ulster Medical Society,” coupling with it the name of Dr. Patterson, the President.

Dr. Patterson returned thanks. He regretted that on this occasion there was not a larger number of medical practitioners present. The ball which took place that evening had prevented a few members from attending; but still they were glad to have an opportunity of welcoming the medical officers of the Channel Fleet, and also the medical officers of the garrison. He hoped if the Channel Fleet would again visit Belfast two or three years hence that there would be a meeting of the medical profession, which would not only fill the room in which they were at present assembled, but would fill the Minor-room of the Ulster Hall (applause). He begged to thank them for the kind manner in which the toast had been received.

The toast of “The Press” having been proposed and responded to, the company separated.—Northern Whig.

October 3rd, 1863

Present, Drs. Patterson (Chair), Ferguson, Stewart, William MacCormac, Smyth.

Dr. Stewart moved, and Dr. J. C. Ferguson seconded, “That the annual address of the President and dinner thereafter be held on the first Tuesday in November.” (the 3rd)

Society’s Rooms

November 3rd, 1863

Present, Drs. Patterson, Ferguson, MacCormac (William), Wheeler, Keown, Arnold, McGee (Michael), Cuming, Dill, Gribbin, Browne, Whitaker, Saunders.

The President then delivered his opening address. He shewed that the interests of the public and the profession are identical. He regretted that more members of the profession did not join the Society. He referred to the great progress of the profession during the present century, and referred to Registra-

tion Act. He insisted on the necessity of preliminary education.

He deprecated the small remuneration which medical men received in the country. He expressed an opinion that any great change must come through the profession itself. He disclaimed the idea of a new Act, and recommended pressure on the Medical Council. He pointed out that corrections ought to be made in the Medical Register, and shewed some discrepancies between it and the Medical Directory. He mentioned several cases shewing the difficulties in the way of correct Registration.

He recommended uniformity of education and examination and referred to the great change for the better that already occurred. He alluded to the vexed question of the admission of reporters; and proposed a compromise, that the Council should publicise a digest of their proceedings.

Paper:¹ GENTLEMEN, I cannot proceed with the few observations which it is my duty to address to you on the opening of the second session of the Ulster Medical Society, without sincerely expressing how sensible I am of your kindness in electing me to the honourable position of your President. I appreciate highly, indeed, the honour you have conferred on me, the more so, as it was entirely unanticipated on my part; but I accept it, and feel gratified for it, as an evidence of kindly feeling, both personally and professionally, on your part, which it shall always be my pride and happiness to cultivate and cherish.

I certainly have taken a warm and anxious interest in the re-construction of the Medical Society on its present basis, and I shall always deem it a privilege to coöperate with my brethren in rendering its organization more perfect and in extending its sphere of usefulness, so that it may become what we all earnestly desire to make it—an institution worthy in all respects to represent the profession in Ulster. It is indeed with pleasurable feelings that I can congratulate you on the progress the Society has made, and on the position to which it has already attained.

It is indeed true, that, in glancing over the list of members we find many omissions,—the names of many gentlemen, in town and country, are, I may say, “remarkable for their absence;” still, I doubt not, when our objects are better known—our motives in associating together better understood—that our Society will be more truly appreciated and supported.

In fact, Gentlemen, for what are we labouring? for what purposes do we assemble here? Are they not the most laudable—the interests of our noble profession, and, therefore, the interests of the public. We pursue no mere selfish objects, and I identify the interests of the

¹ [An Address delivered at the Second Annual Meeting of The Ulster Medical Society, November 3, 1863. By the President, James Patterson, M.D., Edin. Booklet printed by Alex. Mayne, High Street. 1863.]

public with the interests of our profession, because I emphatically hold that, rightly understood, both interests are the same. In ages of comparative ignorance and darkness, when medical knowledge was in its infancy, enthralled by superstition, and struggling to attain an intellectual existence, who, I ask, were the greatest sufferers? Why, the public at large. And now that medical knowledge has attained a position we have just reason to be proud of—now that crude theories have been sifted by experience, and ascertained knowledge systematized into a science, the onward progress of which has been along an illuminated path, each succeeding stage becoming more brilliant, though the wayside has been too frequently bestrewed with martyrs—now, I ask, when in this age, superlative for its genius on almost every subject, medical men occupy the foremost rank, and medical science is cultivated with the most distinguished success, who are the greatest gainers? Why, I answer, the public at large. This is what I wish was better understood. If the public reflected for a moment, this truth would be irresistible. By patient study, by laborious practice, by profound researches we can acquire no knowledge which does not directly tend to the public advantage. In fact, no profession is more prominently absolved from the charge of the pursuit of selfish interests than ours is, because all our efforts to uphold professional interests, in like manner as all our studies, have but one object in view—to render our services more useful and valuable to the public.

It is this consideration which must free us from any imputation that in associating together we have mere selfish ends in view. We legitimately avail ourselves of the principle of association, which is a distinguishing feature of our age, because by no other means could the laudable objects we contemplate be so efficiently promoted. A unit is of little avail, but in combination units become all-powerful. Individually, professional men, scattered over the country, have few opportunities of imparting, *viva voce*, their experiences to their brethren, or of aiding in sustaining professional interests. Our Society is designed to supply this great want. We associate together for mutual improvement, such as always must follow a free interchange of ideas and experiences. In our social principles and relations reside the great springs of improvement, the stimulants to vigorous and efficient exertion. The healthy impulses and influences to be derived therefrom we desire to render available, and, therefore, our Society exists.

I would earnestly entreat our brethren who have not as yet joined us, to reflect a moment on their own position and on the advantages our Society offers. We can lose nothing, but gain vastly, by enlarging the sphere of our observations; at the same time, we have the gratifying knowledge that we are members of a Society—one great object of which, among others, is to uphold our profession in its true honour and dignity. These considerations, I sincerely trust, will induce the

profession generally throughout Ulster to join our Society, and thereby strengthen its powers of usefulness. By union we have already accomplished much that has proved most beneficial alike to the profession and the public; but a vast deal remains to be achieved.

While, however, I am indulging in fond anticipations respecting an accession of membership, I cannot but pause, with a sad feeling, to notice the loss we have sustained since we last assembled here. Two young and most promising members (Surgeon W. Hanna, and Dr. Greenfield of Holywood,) have been suddenly taken from among us, and there is too much reason to believe they fell martyrs to the faithful and fearless discharge of their professional duty; and therein consists their most honourable epitaph. When death walks the earth, it is the peculiar privilege and duty of medical science to arrest his progress and stay his footsteps. In this warfare our brethren have never yet been false to their profession and timidly shirked the post of duty because it was at the same time a post of danger. Under God's good Providence we all exist and labour, and under that all-abiding Providence it is incumbent on us to use the light of science and of experience in counteracting disease and casting back the shadow of death. Should we, in thus labouring, incur infectious diseases and receive the seeds of death, it is the penalty of our profession, and our best consolation will be found in the reflection, that we have been faithful in the fearless discharge of our duty.

This is a melancholy subject, Gentlemen, one that unhappily obtrudes itself too often in our daily avocations; and I will now revert to what I was alluding to before the thought of membership introduced it. I was endeavouring to show the manifold advantages to be derived from the association of professional brethren together in such a Society as this. In this age, little, indeed, is to be gained without such a union of individual means as association implies. To associated action we are indebted for all the beneficial changes that have been already effected respecting the status and interests of our profession. As an instance, allow me to refer to the Registration Act, not by any means a perfect work of legislation, but still containing much that is salutary, together with the germs of great future improvement.

At the beginning of this century, how many men practised throughout the United Kingdom, even in populous and wealthy districts, without any medical qualification whatever—how many without medical education at all! This state of things has been gradually changing, and there is ground for the expectation that it will one day become amongst the things which belong to history. I do not desire to represent the medical profession of our time as standing very far above that profession in the last century. It may be doubted if there are at present, throughout the empire, as many great physicians as there were in the several generations of

the last century. That is a question which it would not be easy to settle. But whatever may be the comparative merits of the heads of the profession in the contrasted periods, it is clearly beyond doubt that there is, at the present time, an infinitely greater proportion of well-educated, useful, skilful, trustworthy practitioners spread over the country than at any previous time.

Yet, the most ardent wishes are but our duty, both for the sake of the profession itself and for the benefit of the public, that this happy progress may continue to take place to a far greater extent than can yet be boasted of.

While, however, the signal improvements on the race of general practitioners throughout the country, in the past years of this century, is a subject for hearty congratulation, it must be confessed that that very improvement is fast destroying—at least in most parts of England—the old, most useful, and respectable order of country physicians. It is true that it was the imperfect qualifications of the general practitioners, in the country and in the smaller towns, that made the provincial physicians so necessary, and that it is hardly possible to regret the rise of that amount of skill, among general practitioners,—which has rendered the services of physicians out of our great cities less necessary. It was throughout England, chiefly, that this body of physicians was to be met in former times. In Ireland and Scotland they were more thinly scattered, and therefore, perhaps, less change in that respect is discoverable in these latter portions of the United Kingdom.

The decline of this body is not so much to be regretted on account of superior skill—it is to be regretted because they held all along a high social position, such as the general practitioner cannot always attain. There can be no doubt that the decline of this body of physicians impairs, somewhat, the progress which, in other respects, the medical profession is making towards a higher social position. The knowledge of this fact renders it the more incumbent to contribute what is in their power to forward this progress of the medical profession towards the position which it ought to hold in the social scale.

In the ardour of multifarious professional study, at the medical schools, it is sometimes forgotten how essential it is that men should possess such an amount of literature as is indispensable, in this country, to place one in a right social position. It is needless for the utilitarians to declaim against classical attainments—the law which, in our islands, exacts a knowledge of classical literature as the price of admission to the circle of the best society, is unalterable as that of the “Medes and Persians.” In short, the general diffusion of classical attainments, in the medical profession, is necessary to the complete usefulness of its skill in the art of healing to the public. Let the heads of our medical schools look to the matter in this light—let them give up weighing the utility of Greek and Latin to medical men in the

abstract—let them turn their attention simply to the greater usefulness awaiting the medical profession as a body in proportion as the whole members collectively rise in the scale of social life.

The chief difficulty which presents itself, opposing the general rise of the whole profession in the social scale, is the small remuneration to be obtained for professional services in the poorer districts of the country. How can we look for men of good preliminary education to engage in a profession which so often yields but a miserable pittance in return?

A classical education, even at a moderate cost, is within the reach of every one who is ambitious of entering the medical profession. It is not necessary that this kind of education should be profound, but it must be, at the very least, respectable—considerably greater than it averages at present throughout the profession.

It is of no use to debate whether this kind of accomplishment be the best fitted to make good surgeons or physicians, that is no part of the question. In my own opinion it forms the best preliminary we have, and it is certainly the kind of education which alone will have the effect here under consideration—namely, to raise the whole profession in its social condition.

Ignorance of literature is fatal to a man's pretensions, in this country, to gain a position in society. No man must be allowed to take up medicine or surgery without first showing his competency to study, not merely what is requisite for professional duties, but such subjects as fit him to hold a place among the educated of the land. If it could be proclaimed to the public that every regular member of the medical profession has proved himself both competent to study, and a proficient in study, how great would be the effect on the estimate of the character of the medical body!

Were all taint of the illiterate removed from the medical profession, a higher tone of feeling would of necessity succeed. There must be no quackery within the profession itself. The essential rules of medical etiquette must prevail. If ignorant quackery cannot be put down, it can be kept at arm's length. There must be no coquetry with the homœopaths.

To attain such a golden age as I am pointing at, there is little more requisite than a firm determination on the part of the profession itself. Little more can be got by legislation; what we have got has disappointed many, but those who are thus disappointed expected a great deal too much from this source.

Though the Medical Act has done little absolute good as yet, if the profession be resolute to compel its administration, there is in it much power for good. People are very apt to over-estimate the power of an Act of Parliament. During the long years which medical reform was in agitation, it seemed as if nothing was necessary but to get the various contending parties to agree on the clauses to be embodied in the Act, and that the Act, once passed, would determine things to run smoothly in

strict accordance with its stipulations.

Considering the sanguine ideas formerly entertained of the benefit to be derived from this Act, the whole matter seems to be a complete failure. But to those better versed in the nature of the difficulties which beset the medical profession, and in the complicated relations in which it is involved, the Medical Act appears in a brighter light, not, indeed, as an immediate cure for all the evils which were complained of, but as an instrument, by the patient employment of which a great amelioration may be finally accomplished. That end will be attained, not by seeking new powers from the legislature, but by a well-directed judicious pressure on the General Council from without by the profession, so as to aid that body to carry out such measures as are truly in the spirit of the Medical Act.

The Registration is in itself a mighty measure of medical reform. The value of an exact list of all the men throughout the United Kingdom who hold a legal qualification to practise can hardly be overrated. Compare this Register, issued by the authority of the General Medical Council, with the Medical Directory in its earlier editions. Why, in the Directory there was found every quack doctor, self-dubbed a physician or surgeon, who had boldness enough to impose on the publisher. Small as the corrections on the Register have been since its publication, it can be seen, by consulting the published minutes of the Council, how much trouble and expense has been required to accomplish even that little.

The case of Richard Organ should be known to the profession, as showing the difficulties which present themselves to the Council in the execution of the duty assigned to them. Richard Organ appears to have got his name placed on the Register by some inadvertence; he was afterwards detected in an attempt to get the license of the Edinburgh College of Physicians by personation—that is, by getting another person to appear in his stead. He was struck off the Register by the General Council, but, on application to the Court of Queen's Bench, the Council were required to show cause why his name should not be restored; that is, an action at law had to be sustained in behalf of the proceeding. The Council finally gained the suit. In the proceedings of the General Council, at their last meeting, it will be found that Organ had applied to the Society of Apothecaries, of London, to be examined for their license, and that the Society had sought the advice of the Council on that point—the advice given being, that his application should be refused.

In the same proceedings will be found five or six cases besides, illustrative of the difficulties attendant on the purification of the Register, and of the energy which the Council has shown in the execution of that part of their duty. It is in particular a subject for congratulation, that, at their last meeting, the Council erased from the Register the name of Samuel La'Mert,

on account of an indecent and unprofessional treatise, and falsely pretending that his son, a licentiate of the Edinburgh College of Physicians, was joint author of the same. By proceeding in this manner, it cannot be doubted but that a great purification of the profession will be accomplished.

It has been made a ground of complaint against the Council, that they do not institute proceedings against registered persons who contravene the provisions of the Medical Act, or against non-registered persons who assume medical titles without qualification. Their answer to the former part of this complaint is contained in a report published in the proceedings for 1859—namely, that their functions, in respect to accusations, are judicial, and that they cannot combine the office of accuser with that of judge; and further, that the Act does not empower them to assume the part of accusers.

With respect to the second part of the charge, it appears that the Council think the present Act defective, as they propose, in a Supplemental Act, to make the clauses against the assumption of medical titles more stringent. Even, however, with this change, it will be necessary for accusers to step forward and prosecute. Thus it appears that district associations, for the prosecution of offenders, cannot be dispensed with.

One of the great objects kept steadily in view, by the earnest partisans of medical reform, was uniformity of education and qualification throughout the profession. If that great object has not yet been effectually obtained by the exertions of the Medical Council, it cannot be denied that at least a signal improvement has been accomplished on the state of things, relative to this point, which existed before the passing of the Medical Act. In so far as respects regulations, the Council have pretty well succeeded in getting uniformity to a minimum standard of education and examination. Under any circumstances, absolute uniformity, after so many years of rivalry and contrariety of interests, could not be looked forward to except as the effect of several years of watchful superintendence.

It is to be remarked, that the only way in which the Council can compel a refractory licensing board to conform to its rules, is by a complaint to the Privy Council, and, if the Privy Council see fit, it may suspend the right of that licensing body to confer a qualification. This rule seems simple enough in words, but it is found to be both costly and tedious to carry the rule into effect. It is one of the parts of the Medical Act on which amendment is proposed in the alterations suggested by the Council.

It is, beyond all doubt, both the interest and the duty of the members of the medical profession at large to back the Council in the exercise of this part of their functions. It is only by the voice of the profession that any offending board, be it of great or small name, in the Empire, can be compelled to pay respect to the rules enjoined by the General Council; and there can be no

doubt that the voice of the profession will weigh far more effectually in putting down opposition, on such points as uniformity of regulation and examination, than appeals to the Privy Council.

At present, unquestionably the proceedings of the General Council are far too little known or attended to by the profession at large. The minutes, as published, are too little interesting to entice men busy with their daily routine of practice to spend time in their careful perusal. Some means should be taken without delay to create a larger interest throughout the profession with respect to these proceedings.

It is seen that a difference of opinion exists among the members of the Council as to the expediency of admitting reporters to give publicity to all their proceedings. Without debating that question, or giving any decision regarding it, there might surely be, in the meantime, a compromise by employing some one to give an intelligible digest of the proceedings, including at least a sketch of the more important debates. Let those among the members of the Council who oppose the admission of reporters consider this point, for they may depend on this, that unless something is done to give an interest to the proceedings of the Council, the cry for the admission of reporters will break through all opposition.

It might be well to try an interesting digest of the proceedings and arguments before having recourse to a verbatim report. In whichever way this debate is ended, the final result must be, that the voice of the profession will much more largely influence the votes of the members of the Council on important questions, so that no overbearing corporation or licensing board will be able to restrain the Council from carrying out whatever regulations tend to the general benefit of the medical profession and of the public at large—that is to say, objects which are strictly in the spirit of the Medical Act itself.

Dr. M. McGee moved and Dr. Arnold seconded “That the thanks of the Society be given to the President for his valuable address, and that it be printed at the expense of the Society for distribution among the members.”

Dr. McGee gave a notice of a motion for the first Saturday in December “That the Medical Students be not admitted to the meetings of the Society.”

James Patterson, President

General Hospital November 7th, 1863

Present, Drs. Patterson, Reade, Cuming, Moore, Gribbin, McCrea.

The minutes of the previous meeting were confirmed.

The President then read a communication in reference to a proposed testimonial to Dr. McKay.

Some conversation ensued among the members in reference to the reports of Annual Meeting and Dinner of the Society.

Dr. David Moore moved and Dr. McCrea seconded “That an advertisement be inserted in the Banner and Morning News repudiating the report which appeared in those journals.”

Dr. Reade moved and Dr. Cuming seconded the amendment “That Dr. Arnold’s attention be called to the unauthorised report in ‘The Banner’ and that he be requested to attend on next Saturday to inform the Society if the report in question had his sanction.” After some conversation, the amendment was carried.

The President read a circular from the National Lifeboat Association on the subject of the resuscitation of the apparently drowned. It was agreed that the question should be taken up on Saturday November 21st.

James Patterson, President

November 14th, 1863

Present, Drs. Patterson (Chairman), Ferguson, Moore, Pirrie, Stewart, T. Reade, Little (Lurgan), D. Moore, W. MacCormac, H. Burden, McWilliam, Gribbin, Bryce Smyth and Whitaker.

Dr. D. Moore stated that he had been requested by Dr. Arnold to express his great regret that the report in question should have appeared in the Banner. Dr. Arnold was not aware that any rule bearing on the subject had been adopted by the Society.

Dr. W. MacCormac brought forward an account of a case of laceration of the urethra caused by a fall from a height of four or five feet on the perineum, and described the injury which was received thereby; he entered fully into the case, and gave a detailed account of the treatment he pursued which was attended with most satisfactory results.

Paper:¹ MR. F., the subject of the present remarks, is an athletic young man, about twelve stone in weight. Some weeks ago he sustained a very severe injury of the perineum in the following remarkable way. He was attempting to open a window of a house from the outside, there being in front of the window an area. It was dark at the time, and unaware of the existence of the area, Mr. F. stepped right into it. Across the area, from the street to house, stretched an iron gas-pipe, about an inch and a half in diameter. On this Mr. F. fell, coming astride the pipe with all the force derived from a fall through about five feet, and so exactly that he remained balanced for about a minute, his feet not touching the ground, in indescribable agony, unable to speak or move. I subsequently examined the place where this accident occurred, and I saw the iron gas-pipe bent for about a couple of inches out of its course, while at its insertions the very masonry was loosened.

¹ [Dublin Medical Press, 1864, January 13, p30.]

What I have described took place about ten o'clock on Friday evening, the 11th of September. Mr. F. was able, strange to say, to walk home, a distance of half a mile. He then tried, with much straining, to pass water, but failed, only blood came away. The following morning about nine a.m. I was summoned to see him. No urine had been passed since the accident. Mr. F. had spent the night without sleep and in great pain. The bladder was distended, the dulness reaching nearly as far as the umbilicus. The scrotum was as large as a cocoa-nut, and very black. The perineum was swollen, the swelling being limited posteriorly by the superficial perineal fascia. The skin of the scrotum and perineum was scarcely abraded.

At first sight I feared considerable extravasation of urine might have taken place through an injured urethra, and that I would not be able to relieve the distended bladder. With but little trouble, however, I introduced No. 12 gum-elastic catheter, and drew off about two quarts of urine, leaving the instrument in. After an interval of two hours I drew off nearly a quart more and removed the catheter. I then ordered one grain of opium to be taken every four hours until the intense pain should abate, and hot stupes to the scrotum and perineum. In the evening hæmorrhage from the urethra set in, which was with difficulty restrained by the nitrate of iron internally, and local cold applications. I did not introduce the catheter this evening for two reasons—1st, because Mr. F. had drunk scarcely anything during the day; and, 2nd, because the bleeding from the canal might be again induced. On Sunday morning and evening I introduced the catheter. The blackness and swelling were on the increase, and in the afternoon a severe rigor took place. From these symptoms I judged that some extravasation of urine had probably taken place. That evening I sought the advice of my friend Dr. Browne, and we agreed on consultation to defer active measures till morning, in the hope that the symptoms would abate. On Monday 14th, the scrotum was so much swollen and so black that it seemed as if gangrene would take place in it if something were not speedily done. I, therefore, with the assistance of Dr. Browne, made an incision in the raphe from the most dependent part of the scrotum back to the central point of the perineum, three and a half inches long and two inches deep, but not quite into the urethra, knowing that urine, if extravasated, would speedily and easily make its way into the wound at the nearest point. The relief afforded by the incision was almost instantaneous. There was no urinous smell in the wound, and bloody serum alone drained away. On Monday morning and evening I found it necessary to draw off the urine, the patient being quite unable to make water, and each time I introduced the catheter with increasing difficulty. On Tuesday, therefore, I decided that it would be well to allow the catheter to remain in as long as the canal would tolerate its presence. I hoped that I might

perhaps in this way avert the formation of a urinary fistula, but I failed in the attempt. On Wednesday 16th, I noticed a small hole in the bottom of the wound, through which I was able with a probe to feel the catheter, but I did not remove it until Saturday morning. On Saturday evening Mr. F. passed water for the first time without the assistance of the catheter, but, as I had anticipated, almost entirely by the wound.

I need not trouble the Society with a daily report of the case after this date. The treatment was directed towards preventing the formation of a traumatic stricture and thus allowing the fistula to close. I passed a full-sized bougie every day, and it was noteworthy how much the calibre of the canal would contract at the site of injury in the space of twenty-four hours. This tendency, however, gradually diminished. At the same time the perineal incision was closing up, and the quantity of urine that flowed by the wound lessened until it came drop by drop. On the 13th of October, all the urine for the first time came by the natural channel. I continued to pass the bougie, as the canal still exhibited a great tendency to contract. Subsequently, Mr. F. left town, but through my instructions he was able to pass a bougie himself, which he did every second day. On the 5th November, I heard from my patient; he expresses himself as quite recovered. The parts have regained their natural appearance and size, the wound is quite healed, and the tendency to contraction in the urethra continues to diminish. This case I consider interesting for the following reasons:—First, the violence of the fall producing so little external injury, the force of impact of a body 12 stone in weight falling through five feet being equivalent to about 24 cwt. Second, the extreme relief afforded by the incision, deep and long, made through the swollen parts. Third, the anticipation of the formation of a stricture which is all but certain to follow a wounded urethra, thus allowing the fistula which had formed the opportunity of closing up speedily.

Dr. Thomas Reade was surprised that no infiltration of urine took place, as it rarely happened that in cases where so much violence had been applied that infiltration to a large extent did not take place. He also thought that incisions into the distended scrotum should have been sooner resorted to.

Dr. D. Moore wished to know whether the swelling arose from extravasated urine, blood, or serum.

Dr. Pirrie thought that the urethra was injured in the first instance and not ruptured, and that the swelling was due to the violence inflicted on the part and not to extravasated urine. He also wished to know whether ulceration of the canal might not have taken place and so caused the opening into the urethra.

Dr. T. Reade thought that there was no laceration of the urethra, that inability to pass urine was not caused by the injury to the urethra but by the shock and extravasation round the neck of the bladder.

Dr. D. Moore thought that the catheter should have been retained in the bladder as to often great difficulty occurs in its reintroduction. It might in this case have prevented the formation of the urinary fistula which afterwards occurred.

Dr. Ferguson thought that no sufficient cause had been brought forward except the original injury to account for the formation of the fistula in 3 or 4 days afterwards.

Dr. W. MacCormac did not make incisions earlier as there was not at first sufficient swelling, or any certain evidence of extravasation of urine. He made the incisions when he found that the scrotal swelling and blackness was increasing, and that a severe rigor had occurred. The incision was freely made but not into the urethra. There was no urinous smell, only bloody serum drained off.

He concluded from that if extravasation had taken place, it must have been only a drop or two and this view was confirmed by the formation subsequently of a fistulous communication with the wound in the urethra while the catheter was being retained.

He did not allow the catheter to remain in permanently in the first instance because not having found any difficulty in passing the instrument, he did not think that the urethra was injured to any extent or that there would be any difficulty in again introducing it should the patient be unable to pass water for himself.

James Patterson, President

Pathological Room November 21st

Present, the President, Drs. Arnold, Dill, Keown, T. Reade, D. Moore, Ferguson J. C., Stewart, Gribbin, W. MacCormac.

Dr. Arnold objected to that part of the minutes of the last meeting which referred to him.

Dr. M. McGee's letter was read by Dr. McCrea and referred to Council. Dr. McCrea gave the following notice of motion: [page here blank].

A letter from Dr. Arnold was read. Dr. Ferguson moved and Dr. T. Reade seconded that the letter be referred to the Council.

Dr. Dill then gave an account of a case of aneurism of the abdominal aorta and exhibited the diseased parts. Dr. Dill stated in reply to Dr. Ferguson that no absorption of the vertebræ could be detected.

Professor Ferguson said that the early symptoms were exactly those of aneurism. The œdema was to have been expected. The paralysis is a more frequent concomitant of a later stage of the disease when the vertebræ begin to be affected. What was the cause of death? The effusion was almost cadaveric. The lungs were emphysematous, which fact accounts for the clear percussion sound but renders improbable the occurrence of pleural effusions. Might the effusion

into the abdomen be the cause of death?

Dr. D. Moore thought this was a good illustration of the method by which a natural cure is affected. When the man was in the Dreadnought, the aneurism was evidently in a different state from that in which it was in the General Hospital. The filling up of the sac with concentric layers of clots accounts for the absence of symptoms in the later stage of the disease. The breaking up of the clot may have caused the failure of the circulation in the lower extremities.

Dr. T. Reade said that there was, on record, several cases in which effects analogous to those of ligature had been produced by the pressure of the sac on the artery. A preparation in Guy's Hospital illustrated this.

Professor Ferguson would have considered it strange if the aneurism, situated as it was under the pancreas, and covered with serous effusion had yielded any better marked signs.

Dr. D. Moore could not see how, when the causes that gave rise to bruit did not exist, there could be a bruit.

In reply to Dr. Saunders, Dr. Dill said that there was no difference between the femoral and radial pulsation. In reply to Professor Ferguson he said that all the distress present was dyspnoea.

Pathological Room November 29th, 1863

Present, the President, Professor Ferguson, Drs. T. Reade, W. MacCormac, Keown, H. Burden, McGee, Gribbin, D. Moore, Pirrie, Warwick, Cuming, Whitaker, McCrea, Stewart.

The minutes of the previous meeting were read and confirmed.

The report of the Council in reference to Drs. W. McGee and Arnold having been brought up; Dr. Cuming moved and Dr. Keown seconded that it be adopted. Professor Ferguson moved "That Dr. W. McGee's original letter be cancelled, and that the Secretaries be requested to acknowledge this letter of today and to express the satisfaction with which it was received by the Society; that the consideration of that part of the Council's report which refers to Dr. Arnold can be deferred till next Saturday." The amendment was carried.

Professor Ferguson gave an account of a case brought before the Society at a previous meeting in which operation of tracheotomy was performed over year and a half previous to death. He read the report furnished by Dr. Murney.

Professor Ferguson said that from the first this case was un-promising, and that tracheotomy was evidently [done] the time when it was

Dr. T. Reade said that the most striking thing in the case was the ease with which the operation was performed. Dr. Reade once performed this operation on a patient in articulo mortis who had previously

been to no purpose advised to have the operation performed. The patient lived for two years after the operation. A very deep incision was necessary to reach the air passages. The patient died with pneumothorax.

Dr. Cuming said the variations in depth at which the trachea was reached was considerable.

Dr. McGee had operated on a case in which the patient was almost departed.

Professor Ferguson enquired how in Dr. Reade's case the patient was able to speak immediately after the operation and not afterwards.

Dr. Reade said that the voice was present until the tube was inserted.

Dr. D. Moore said that the turgidity of the cervical veins and of the very vascular thyroid body would make a great difference in the depth of the trachea.

Thomas Reade V.P.

Pathological Room

December 6th

Present, Dr. T. Reade V.P. (in the chair), Professor Ferguson, Drs. Dill, McWilliam, MacCormac, D. Moore, Cuming, Stewart, McCrea.

Dr. MacCormac stated that no further communication had been received from Dr. Arnold, and that the Council presented again its former report.

Dr. Ferguson moved, and Dr. Cuming seconded, that the report be adopted. The report was adopted.

Dr. W. McGee deferred the consideration of his motion till some future occasion.

At the suggestion of Dr. McGee the Society recommended the Council to make a list of members.

Dr. W. MacCormac stated that the Council was already making arrangements for this purpose.

Professor Ferguson gave an account of a case of pleuritic effusion. Dr. Dill saw him early in Summer, when there was great dyspnoea, with pain over right lung, dullness on percussion in subclavicular region, no splashing sound, but raise in amphoric vocal resonance. He looked on it as tubercular pleurisy. Dr. Dill again saw him weeks subsequently when the dullness had greatly extended.

The patient was introduced, and examined by several members. The measurements of his chest taken on the present occasion were, on the right side $19\frac{1}{8}$ in., on the left, $17\frac{7}{8}$ in. The prominence of the right intercostal spaces had considerably diminished since Dr. Ferguson's last examination.

Professor Ferguson suggested a number of queries in reference to the case. The first was the origin and cause of the hæmoptysis.

Dr. Cuming thought tubercular deposit was the cause, and that the left lung was probably being affected in a similar manner.

Dr. Dill also thought that the cause was tubercular.

Dr. T. Reade in consequence of length of this

thought that ...

Second what gave rise to the gaseous and fluid effusions into the chest if it existed.

Dr. T. Reade had heard the splashing sound in his own person, on one occasion, when on horseback. He had at this time what was considered incurable disease in the chest, and had had an attack of hæmoptysis.

Professor Ferguson thought that there was no tubercular deposition and that disease was acute and sthenic, in fact acute pleuritis. That both air and fluid were formed from the pleural sac. He thought that there had never been a fistulous opening, as in that case, the effusion would consist of atmospheric air, which never has been known to be absorbed, as the air in the present case had been. He thought that the sudden occurrence of hæmoptysis was evidence of the acute nature of the disease. There is no morbid respiratory sound at present. May not any slight irregularity in the sounds heard be accounted for on the ground that the left lung is also subject to pressure.

He attributes the altered sounds of the heart to the displacement. He thought that the sounds heard on the right side were transmitted through the fluid from the left side.

Dr. Cuming said it is evident from the signs of improvement at present He still thought that this had been phthisis. He thought that it was improbable that there had been a fistulous opening. The compression of the lung against the vertebral column ...

Dr. T. Reade thought this case worthy of future observation. He did not think this case phthisical. He thought that serous membranes could give out air. He mentioned a case of the late Dr. Drummond in which air had been frequently removed from the peritoneal sac.

Dr. Dill mentioned another recorded case which he thought worth comparing with the present case.

James Patterson
President

Pathological Room

December 13, 1863

Present, the President, Professor Ferguson, Drs. Saunders, T. Reade, Keown, Stewart, MacCormac (W.), McCrea, Cuming.

Dr. Cuming read a paper on a case of progressive muscular atrophy.

Dr. Thomas Reade referred to a paper of his own anterior to the publications of Roberts and Nagel. His case was symmetrical. The corresponding muscles on the two sides of the body were affected. There was, he thought, no fatty degeneration in his case. He tried all the remedies recommended and found that the magneto-electric current was most efficacious. He has obtained a very favourable result. Dr. Burden suggested an explanation that the only source of degen-

eration lay in some affection of the spinal marrow and was intimately connected with nutrition. Robert's thought it was a disease of the muscles. Disease of the spinal marrow had been frequently detected by the microscope.

Professor Ferguson saw Dr. Reade's case. The difficulty is to account for the case on physiological principles. He did not think the disease peripheral, and accounted for our not finding an explanation in the central nervous system by the very imperfect state of our knowledge of the pathology of the central nervous system. The symmetrical nature of the disease in Dr. Reade's case was against the idea of peripheral disease. He thought the disease quite different from paralysis and functional in its nature—a lack of nutrition. Circumstances in this case favoured Wilson Phillips idea of the irritability of the nerves, and electric current.

Dr. W. MacCormac thought that remarkable certain cases recently described in Germany, in which *Trichinella spiralis* had been found in the muscles throughout the body.

Dr. Cuming thought that the fact of the cutting of one of the roots being attended with general weakness of the muscles was against the idea of any dissecting action. Here is a fatty degeneration. We don't refer fatty degeneration of the liver to the nervous system.

No *Trichinella spiralis* had been detected in any of the cases, although submitted to the examination of imminent microscopists. There was in their cases fatty degeneration.

Dr. Cuming in reply to Dr. Ferguson said that examinations were unanimous on the exhibition of fatty degeneration, and that there was always fatty degeneration in the wasting of a muscle.

Dr. Saunders asked if there had been an *arcus senilis*.

Dr. Thomas Reade saw a case of paraplegia in which the patient was in fuller face than any man in the Pathological Room.

James Patterson, President

Pathological Room
December 19th, 1863

Present, the President, Drs. Stewart, Dill, Cuming, Gribbin, D. Moore, McWilliam, Whitaker, McCrea, Keown.

Dr. Dill gave an account of two cases of placenta prævia in which immediate delivery had been affected with favourable results.

Dr. Gribbin suggested the propriety of administering stimulants in these cases.

Dr. McWilliam referred to the recently recommended practice of partial detachment of the placenta.

Dr. D. Moore thought that partial separation would be injurious.

Dr. Cuming said that the only question of interest in the first case was as to the propriety of administering ergot of rye.

Dr. Dill, in reply to some observations of Dr. D. Moore, stated that the difficulty of turning was much greater in the earlier months of pregnancy than in the later. He thought the loss of time was the great objection to the use of ergot. The sickening influence of the drug was also objectionable.

David Moore, Chairman

Pathological Room
January 2nd, 1864

Present, Drs. D. Moore (in the chair), Moore, Gribbin, McWilliam, McCrea, Dill.

It was resolved that the windows be painted as to partly prevent the rays of light from coming in.

It was also resolved that a cast of the diseased parts in Dr. Moore's case should be prepared.

Dr. Moore gave an account of a case of *Fungus Hæmatodes*.

Dr. Dill referred to the greater prevalence of this form of malignant disease in young people. He had seen the disease mistaken for abscess.

It was moved, seconded and carried that Dr. D. Moore be requested to open the discussion on the resuscitation question.

James Patterson, President

Pathological Room
January 9th, 1864

Present, the President, Professor Ferguson, Drs. Browne, Whitaker, McWilliam, Stewart, Keown, McCrea, Dill, MacCormac.

Dr. Browne gave an account of a case of fracture of the skull, and exhibited pieces of bone which had been removed. He mentioned a case in which great relief had been produced by trephining in a case of suppuration.

The president referred to the greater frequency of trephining thirty years ago, and the success which had often attended the operation.

Dr. Dill said that the place in which the fracture had occurred was the most invulnerable part of the skull. He had seen a case in which the central part of the right parietal had been driven in by a spade. There were no marked symptoms. The patient recovered, and lived for at least twenty years, with the fissure persistent. At various times during the healing of the wound, portions of the brain had oozed out. The fissure was an inch and a half deep.

Dr. Browne then described a case of strangulated hernia. "There was a tumour of the size of a walnut in the right groin. There was vomiting, but no symptoms of peritoneal inflammation. The taxis had been tried in vain. On division of the margin of the external ring, the hernia could be reduced, but the stricture still

remained.

By delicate manipulation Dr. Browne succeeded in dividing the stricture which had affected only a portion of the intestinal cylinder. The stricture was in the neck of the sac." In another case of Dr. Browne's the taxis, aided by chloroformization had succeeded, although the strangulation had lasted for eight days. He advocated early operation.

Dr. Keown referred to the practise turning the patient upside down.

In reply to Professor Ferguson Dr. Browne said there would be no case in which a surgeon could refuse operation.

James Patterson, President

January 16th, 1864

Present, Drs. Patterson (in the chair), Cuming, Gribbin, William MacCormac, Stewart, Whitaker, Dill, and Moore.

Dr. W. MacCormac stated that he thought Dr. Sylvester's plan of restoring the apparently dead simpler than that of Dr. Marshal Hall and equally effective.

Dr. Cuming thought that when vitality is very low, the patient should not be raised up suddenly. He believed that the drawing of the arms and elevating the shoulders would be attended with beneficial effect.

Dr. Moore agreed with Dr. Cuming in thinking that Dr. M. Hall believed that when the patient was put on his side, the chest expanded.

Dr. Dill related a case which had recently occurred in the General Hospital and in which the patient recovered from the effects of submersion. He believed that if the heart's action had ceased all efforts at resuscitation were useless. He did not believe in Marshall Hall's treatment at all, more especially in the treatment of stillborn children in which he had had great experience, and thought that artificial respiration, heat in the form of hot baths, with an occasional sprinkling of cold water, was by far the better mode of action. He also believed that the tying of the umbilical cord was often particularly useful.

Surgeon Gribbin thought that the allowing a few drops of blood to come away from the funis on tying it was a powerful adjunct to the warm bath and friction.

Dr. Dill while not differing from Surgeon Gribbin as to the advisability in some cases of allowing a few drops of blood to escape, thought that where vitality was low such a proceeding would be attended with much risk.

Surgeon Gribbin explained that he only adopted such a course in the case of children of a full habit of body.

Dr. Cuming thought the circulation through the placental circulation ought to be kept up as long as

possible in anæmia cases and that it was not in his opinion wise to divide the cord while the pulsation was low and the breathing feeble.

Dr. Moore thought that in those cases the cord should not be divided while the placental circulation continued.

Dr. Dill thought that the tying of the cord often caused increased vitality in very weak children.

Dr. Moore postponed the further consideration of his case of fungus hæmatodes.

Reade, V.P

Saturday January 23rd, 1864

Present, Drs. Reade (in the chair), Thompson, Keown, Stewart, Gribbin, McWilliam, Whitaker, MacCormac (W.), McCrea, Cuming, Moore.

Dr. Whitaker brought up a report from the Council in reference to the microscope which Dr. McGee had lent to the Society, and which he now asked to be returned. It was resolved that, in as much as Dr. McGee's microscope although more than a year in the keeping of the Society, had been very little called for, it is inadvisable for the Society, at present, to purchase a microscope. It was also resolved that the thanks of the Society should be given to Dr. McGee for his kindness in lending his microscope.

Dr. Keown read a paper on the influence of a ship's malaria in the production of pulmonary diseases.

Paper:¹ *Gentlemen,—The influence of miasmata or malaria in the production of the severest forms of fever on board ship are well known to the profession, and the medical history of our navy has from time to time presented us with not a few melancholy instances in which the ships' companies have been prostrated by fearful attacks of yellow fever, cholera, and dysentery.*

The morbid agency of ship malaria in the production of diseases of the lungs is far less common—not that sailors are exempt more than others from lung disease—but disease of this kind becoming endemic among a large ship's company is known to me only in two instances, both of which happened at the same time, and both of them in the Mediterranean station in 1860–61. It is not my intention to enter on the interesting and but little understood subject of malaria; but supposing it to be composed of gases, which, being absorbed by the lungs, give rise to diseases, such as typhus and the several forms of infectious fever, as also the exanthemata; the wonder is that the lungs should not always be the parts first affected; yet experience points to the blood as first suffering the toxical effects of miasmata, and subsequently the different organs of the body.

An attempt has been made to divide malaria into organic and inorganic; the first giving rise to infectious diseases; the last being confined to the bodies affected. No doubt there is some truth in this, but we so often

¹ [Dublin Medical Press, 1864, April 6, p355.]

find the two together that it is seldom possible to separate them, and so far as the following remarks go, I shall not venture to present them in their distinct forms.

A great element of strength has been added to our naval power by the introduction of steam into large ships; but at the same it has introduced an element of weakness by adding considerably to our sick lists. In warm climates this is particularly felt, more especially in the line of battle ships. If these are frequently under steam and supply themselves with fresh water by the distillation of sea water, we can easily fancy the effects of such great heat with moisture acting on the wood-work of the ship, and the carbon and sulphur of the coal, and if, in addition to this, the ship is found to have black pitchy-like matter in her hold, we need not look further for the elements to produce disease. Most of you know that the ship's company and officers sleep on the lower fighting deck, and on the orlop deck below that one.

Now, at sea it is necessary to close the ports, and you can fancy from 700 to 1000 persons so situated would soon rob the air of its oxygen, and we can easily imagine, in the case of a ship like the *Cressy* that I am about to lay before you, that certain combinations of hydrogen and carbon, and hydrogen and sulphur, would tend to vitiate the air and consequently poison the blood, independent of the marsh malaria that subsequently appeared on board in the specific form of remittent and intermittent fevers.

My object at present is to relate to you as briefly as I can the effects in one particular ship of ship-malaria on the textures of the lungs, and incidentally to notice other grave forms of disease that arose at the same time from the same malaria and the miasmata external to the ship. H.M.S. *Cressy* of 80 guns, originally built for a sailing-ship, had roomy gun-decks, but her cockpit and holds were crowded and badly ventilated, and her stoke-hole, when long under steam in hot weather, rose to 140° F., prostrating the stokers and engineers. My first impression of her was that she should never have been sent abroad.

However, in April, 1859, at Sheerness, she was hastily manned. Our crew had been gathered from all quarters, and many of them carelessly examined at the outposts from which they were sent. Out of an average crew of 760, 511 were under 25 years of age, and for the most part inexperienced in sea life, and deficient in the physical growth and endurance required for good men-of-war sailors, still I must also say that many ships were not better off than ourselves in this respect. Some misunderstanding with our good friends the French determined the Government to increase the Mediterranean Fleet, so we left England in June, 1859, and arrived off Naples in September, visited Palermo, and returned to Naples in December. The winter of that year was unusually stormy and wet, and the state of the air markedly malarious to us and all visitors to Naples.

Ten miles from Naples is *Baiae*; we went there in January. The neighbourhood of this place is noted in ancient as well as at the present time for its malaria. The safest time to visit such places is in winter. Now, I am thus particular in noticing hurriedly these matters to show you that we had an external malaria for a time to contend with; and let me say, while looking back at that land of antiquity and celebrated fables, with its hot-baths, of Nero, the Elysian fields, Lake Fusaro, and Avernus, that I have wandered over its dreary and deserted fields, and I believe the air was more agreeable to me than that of Belfast. So much for the nasal influence of malaria.

Thus, before the period when my story commences, the ship's company had suffered from malaria at Sheerness and off Naples at the end of the first year. The following, taken from the nosological returns, are a few of the most important diseases connected with this subject, which, I think, will best indicate our sanitary state previous to the appearance of the pulmonary endemic among us:—

Typhoid fever, 1; continued, 3; remittent, 3; intermittent, 26; bronchitis, 6; pleuritis, 4; pneumonia, 1; phthisis, 2; catarrh, 234; cynanche, 27; dysentery influenza, 34; diarrhoea, 171; erysipelas capitis, 3; modified variola, 2; epilepsy, 8. At the end of this year the daily sick list amounted to about ten per cent. of all hands.

The history of this pulmonary disease has reference only to the commencement of the second year of our commission, and that was in April, 1860, extending to May, 1861, when the ship was paid off. During this period of little more than thirteen months, 180 cases of pulmonary disease appeared, the number so unusual and the disease so peculiar in its features, will, I trust, be sufficient excuse for giving it an importance worthy of your consideration.

When lying in the sheltered harbour of Malta, the crew seemed unusually susceptible of atmospheric changes. At that time I was disposed to attribute this to their previous exposure to the malaria while off Naples, and subsequently to trace the pulmonary disease to the catarrhs that had prevailed on board the ship; but subsequent experience left no doubt in my mind that all along the ship herself was the chief source of the sickness. The malaria, I think, tended also to induce a large number of the bowel complaints which prevailed at all seasons. Great care had been taken to have the ship's decks, engine-room, and bilges, kept clean; yet it was only in August of this year that, while clearing out the forehold, a great quantity of black mud was found beneath the water-tanks. Something similar was found also in the *St. Jean D'Acre*, the other ship similarly affected. Here, then, as far as could be seen, was the *fons et origo malorum*.

The crew were favourably situated for the preservation of their health—lightly worked, well and carefully

clad—nearly all the time on fresh provisions—the food sufficiently abundant, but rather deficient in variety; still it was the same as in other ships. The unavoidable crowded condition of the lower decks at night was the same as in all large ships; the men were placed in hammocks near the deck above them, and the heat and closeness of the air were often oppressive.

The Admiralty have lately reduced the number of guns and men in all ships, so as to give greater space for ventilation, and in the course of time we may expect further improvements in the sanitary regulations of our ships.

In April there were 24 cases of catarrh and cynanche; in May fewer; but now the lung disease became prominent, and at the end of June quarter stand thus—Bronchitis, 4; pleuritis, 1; pneumonia, 3; phthisis incipiens, 5; equal to the whole number that are noted in the first year.

We remained at Malta until the middle of June, either in harbour or with occasional cruises off that island. During July we were cruising about the Ionian Islands and coast of Greece. There appeared to be an improvement in the general health of the crew so far as the total number added to the sick list was concerned, but not in the class of pulmonary diseases; ten were added to the list, bearing for the most part a bronchitic character. We were at Malta during August, and 18 more were added. On the 30th we sailed for Naples, and during September only 7 fresh cases appeared; altogether 36 cases in this quarter, of whom 15 were sent to hospital, and 4 invalided. During the fourth quarter, and third of the disease, we were either anchored or cruising off Naples, or at Palermo for a few days, and also at Messina for fourteen days. In this sheltered port the disease seemed to pass more rapidly out of its subacute stage. In October 10 were added; November, 16; December, 7; one of these was a case of relapse.

I have stated that the prevalence of catarrhal affections in the first quarter of this year seemed to have implanted the seeds of this lung disease, because I remarked at the time that they became markedly adynamic, especially where the throat was affected. In May, three patients, who were in the first instance affected with catarrh, then showed pulmonary disease, and a considerable number subsequently, in the winter season, when the cold N.E. wind prevailed, while off Naples, were in the first instance preceded by catarrh. Perhaps if the ship had been sufficiently quiet at all times to examine patients, there might have been detected earlier the very first symptoms of local congestion; as it was, the usual times, with frequent exceptions, however, for using the stethoscope were half-past nine p.m. and during Divine Service on Sundays.

The following table shows the number of catarrhs and tonsillitis during each quarter as compared with the total amount of pulmonary disease during the same periods. They are all fresh cases:—

		Catarrhal	Pulmonary
1860—	First quarter	112	—
„	Second do	36	13
„	Third do	18	36
„	Fourth do	50	33

So far as this goes no necessary dependence seems to exist, the one on the other,—yet it was more than probable that catarrh aided the action of the malaria, and tended to the development of the disease in certain cases, and indeed anything which reduced the physical powers seemed to invite the attacks of this insidious malady.

We commenced 1861 without a prospect of improvement; our ship's company were evidently physically deteriorating; 12 fresh cases appeared in January, and the sick list amounted to nearly ten per cent. of the crew. We were still off Naples. In February, although the weather was fine, catarrhal affections of the tonsils and catarrh with slight fever were common; 21 fresh cases were added to the list, the sick list increasing to 13 per cent. of the crew. During March pulmonary disease was more prevalent than in any previous month; 49 cases were added. It will be seen by the following table that the total number in this quarter equals the whole of the previous nine months, and also shows the progressive increment of the disease:—

First quarter of 1861—Pneumonia, 62; pleuritis, 13; bronchitis, 2; phthisis incipiens, 5; invalided, 5; sent to hospital, 35; discharged to duty, 19.

We left Naples on the 1st March, and arrived at Malta March 5th, with a sick list of 137; of these the most important were—febris remittens, 2; febris intermittens, 3; chest disease, 22; catarrh, 23; tonsillitis, 6; venereal, 28; diarrhœa, 16; phlegmonæ, 15; and variola, 1. It is not surprising that with a list of more than 20 per cent., that pulmonary disease should be then more prevalent, and so it remained during March in the sheltered harbour of Malta. On the 6th of April we left Malta for Gibraltar (the ship was ordered home) with a sick list of 100; of these 30 were chest disease; in this month only 9 fresh cases were added, two of the most acute cases were in boys aged 16. We arrived at Gibraltar on the 16th; after this only 2 new cases occurred.

During the passage to, and while at Gibraltar, there was a great improvement in all our cases, including the invalids, for passage home on board.

We left Gibraltar for England on 25th, and arrived at Plymouth May 8th. A marked daily improvement appeared in nearly all the cases of chest disease. The prospect of getting home no doubt had a good effect. When at Plymouth our daily sick list was reduced to 48, 9 of that number being lung diseases. The subsidence of the disease as we approached the Atlantic, and its final departure in the Atlantic, are very remarkable. This

table shows the beneficial effects of the Atlantic air:—

Added at sea after leaving Malta—14 pleuro-pneumonia.

Added while at Gibraltar—2

Added after leaving till arrival at Plymouth—none.

I have always been impressed with the healthful influence of the Atlantic air as compared with that of the Mediterranean; whether that depends on its having a larger portion of ozone I am unable to say, but the fact is so.

The cases of relapse did not exceed ten per cent., and were chiefly pleuritic.

I am unable to state the fate of those left at Malta, and of those invalidated from time to time, but the mortality, as far as I know, has been small, only one case died on board, and two in the hospital, while we were on the station. I think that the various forms of the disease might be classed under the head of endemic pleuro-pneumonia. But I feel that any terms I have used for the subacute and chronic forms of the disease imperfectly describe it; in these cases the pulmonary tissue took on a silent congestive action with every probability of its terminating in tuberculization. That appeared to be the most probable, and in many cases, I believe, the actual climax of the uncured disease.

I have learned since leaving the Mediterranean that the patients sent to hospital with this pulmonary disease from the St. Jean D'Acre and Cressy apparently communicated the disease to other patients in the wards who had been admitted for other affections. If this is proved, it will form a very remarkable feature in connexion with this malady.

The symptoms—The commencement of the pulmonary disease, so long as it was confined to the lungs alone, was very insidious. In many cases of convalescents from other diseases, when no progress was made to health, and yet no complaint made of the chest, I considered it advisable to examine the chest, and have found passive congestion existing with shallow breathing and dulness on percussion. Sometimes it has commenced with catarrhal symptoms, or flying pains about the chest, or diarrhoea, or persistent cephalalgia, and a sense of malaise, loss of appetite, or an actual feeling of exhaustion; the pulse small and frequent, followed by slight febrile reaction after the patient was placed in bed. It was seldom confined to one lung alone; the lower lobes have been nearly in all cases the parts first affected, and the left most markedly so. But even in the same cases not unfrequently sub-crepitating râles were heard in the apices of both lungs. During the progress of the disease pain has been generally referred to the part affected, but more frequently the patient complained of a sense of constriction or weight across the chest; the pain when acute was generally in the lower borders of the lungs, and where persistent local pleuritis was detected. The lower anterior and lateral parts of the left lung have been most remarkably affected. In

the chronic cases, requiring constant counter-irritants to divert the pleuritic affection, inability to lie on this side has at the same time been complained of.

The respiration, frequently shallow and bronchial at first, was accompanied with puerile breathing in the upper lobes, and in the middle sometimes sibilant râles. Increased resonance of the voice, with bronchophony, dulness on percussion, and the heart's action extensively diffused, with loss of expansion in the parts affected, were the second earliest indications of the disease. It almost seemed as if the congestion followed partial paralysis of the lung textures. Certainly all through the course of the disease, and in the daily investigation of it, the loss of capacity, evidenced by the attempts to take a full inspiration, were the most prominent ocular proofs of diseased action going on. The cough has been generally slight, short, and occasional, and seemed to cause no uneasiness, unless there were accompanying bronchitis or tonsillitis; most frequently the cough seemed to depend on subacute inflammation about the larynx. The expectoration was, with few exceptions, scanty and mucoid, and furnished no decided evidence of pneumonia. The exceptions were where bronchitis became prominent, and then it appeared thick, glairy, and even purulent. The rusty expectoration of pneumonia only appeared in one case terminating in the suppurative stage; this was a fatal case.

A dusky hue of the face I have often noticed on their first application; in a few cases it was very remarkable; the pulse, except where there was pyrexia at the outset, was frequent, soon becoming weak, but still frequent; headache was a common attendant, with restlessness at night, but rarely were night-sweats complained of. The pyrexia in a few cases, especially those with pleuropneumonia, was accompanied with the hot pungent skin and headache so well known. But these were not so persistent as might have been expected, considering the amount of local inflammation. They generally subsided by the third day, or even sooner, leaving probably a night exacerbation to follow. As the disease progressed it was attended with wasting of the body as a general rule, and the patients complained much of debility and occasional dyspnoea. The stage of consolidation, either in large portions or partial, whatever its real nature might be, existed in all the cases invalidated, and in those treated on board was slow in disappearing. In the few cases of acute pneumonia the tissues were early and rapidly restored to their normal state, or a permeable one, attended with weakened expansive powers. In such cases the system appeared to possess energy enough to rapidly eliminate the poison, and early restoration to health followed. The chronic stage on board was attended by detached localized inflammation of some part or portion of one or both lungs, and in the few cases of relapse it has been confined to one lung alone, or portion of one. 23 are noted in which pleuritis

at first was the most prominent part of the disease, the majority of these subsequently showed some pulmonary congestion. One feature in these was remarkable, the left pleura fifteen times out of twenty was the part chiefly affected. Why it should be is not very apparent. Perhaps the heart's motion and its proximity might aid this; pleuritic affections were liable to return again. It seemed in some cases as if the pleuritic inflammation saved the lungs. Effusion into the pleura was not detected in more than four cases, but it is more than probable that in many of the cases pleuritic adhesions took place.

Intercurrent attacks of diarrhœa and dysenteric diarrhœa were common both in the earlier and later stages of the disease. Nothing was more common than patients, especially in the first quarter of this year, to complain only of diarrhœa, and in three or four days' time attention was directed to the chest.

There are few things in a ship give greater proof of the want of good health in the crew than the prevalence during the year of bowel complaints. A comparison of this year with the previous one shows 316 as against 189 of the previous year; and they were generally slower in yielding to treatment than before. The treatment, taken as a whole, was directed to the support of the patient, especially after experience showed the local origin of the malady, chiefly arising, I think, from a ship malaria. The consequent supervention of pneumonic congestion, depending upon the presence of a morbid poison in the blood, and affecting, first of all, subjects predisposed by constitutional debility, and in some few by the poison germs of other diseases deteriorating the quality of the blood; all these causes tending to make the disease more intractable, especially in the locality of its origin. In a few cases, not exceeding I believe five, where there were pleuro-pneumonia, high fever, oppressed breathing, and a full pulse, I have not hesitated to bleed once from the arm, and with the best effects, and by following this up with antimony and small doses of calomel, until the system showed its effects, the disease has been cut short (let me just say that the fatal case on board was not bled). In cases presenting less urgent symptoms leeches have been applied to the part most affected, and where leeches are plentiful, I think they are preferable to the use of the lancet in nearly all cases. The majority of the acute and subacute cases have been treated at first with a mild course of mercury combined with ipecacuan until the gums showed its effects, or while stethoscopic signs of inflammation existed. As the character of the disease became more fully understood, the pil. hydrar. was given with the quinx sulph.

From the first, and during the progress of the disease in its various stages, much relief was obtained from the use of turpentine epithems, sinapisms, and blisters, besides occasional opiates and aperients. These formed the leading points of the treatment in the acute

sthenic cases. A few days under treatment always showed a tendency to fall into asthenia. Wine and nourishing diet were early given, being, in my estimation, the best part of the treatment. But few of the cases were long confined to bed, not alone for want of room, but where the patients were well enough to move about I thought it better for them, as I observed that the confinement to the recumbent position induced congestions on the posterior surfaces of the lungs.

The stage of asthenia was the most difficult to deal with. How these vital organs were to be brought to a state of health with the means at hand on board ship gave serious cause for consideration. The state of the blood, its defects and wants, we are left to conjecture on; but it was evident from the weak pulse and partially consolidated state of the lungs, that an agent was required of no ordinary kind, and being at a loss for that, I have given the potassæ iodidi, gr. ii. cum decoct, cinchonæ, or the quina sulph. gr. ii., ter in die. Instead of this, the following has been tried:—Tinct. ferri muriat. m.xx.; potassæ chloratis, gr. v., with vegetable tonic infusion ter in die with no particular success.

During the latter part of January, also in February, as our quinine ran short and the tinct. ferri mur. is easily made on board, I have been in the habit of giving it in doses of m xv., with hydrargyri bichloridi, gr. 1-12th, and a little syrup bis ter in die. This seemed to answer as well as anything else, and I believe that the tonic and alterative doses of the bichloride to be tolerably efficient in producing a new action in the lungs, and probably with the iron tend to change the unhealthy state of the blood. A moderate quantity of the potassæ iodidi may be useful; but after a time I think it tends to thin the blood and weaken the stomach. The cod-liver oil with quinine was given. It was apt to disagree with the bowels, but after a time it was taken with good effect in supporting the patient, if it did not act as a remedial agent. Dry-cupping was very frequently used in the chronic cases, but I found it far inferior to sinapisms in giving relief. I am by no means satisfied that the plan of treatment above detailed is the best. If I had these patients on shore with more ample means at command, plenty of good milk and vegetable food to give them, and means used to keep up a free action of the skin, but little medicine would have been required. I have had doubts all along as to the propriety of giving mercury except in very acute cases; but whatever plan of treatment may be adopted, one must feel that in the locality of the disease we have to contend with the malaria and its depressing effects on our patients; so that, as a general rule, the removal of the patients from the ship or station appeared to me the best thing that could be done for them.

I will not further trespass on your time by entering on the preventive measures used, this would bring us to the domain of naval hygiene; a subject I think of great importance to all who take an interest in the mainten-

ance of that naval supremacy we desire always to possess. It would naturally be expected that a larger than usual amount of other diseases would appear during the period I have spoken of—(viz., thirteen months), and they will be found to greatly exceed that which happened in other ships on the station.

The nosological synopsis shows that out of a total of nearly 2000 cases of all kinds placed on the sick list, that besides the 180 pulmonary cases there were 13 of continued fever; 2 remittent; intermittent, 23; variola, 3; epilepsy, 3; insanity, 2; delirium tremens, 4; cephalalgia, 25; catarrh, 213; cynanche, 54; laryngitis, 1; morbus cordis, 3; dysentery, 15; diarrhœa, 301; syphilis, 139; gonorrhœa, 13; orchitis, 26; rheumatism, 108; ophthalmia, 15; phlegmonæ and abscess, 303; ulcers, 95; simple debility, 19; scurvy, 2.

The St. Jean D'Acre was the other ship similarly affected, she carried 100 guns, was much superior in every way to the Cressy, roomy and well-ventilated. The disease appeared in her before she left the coast of Ireland, and she was kept much longer in commission than the Cressy. On inquiry I found that with the exception of 12 cases of hæmoptysis, the disease was nearly identical in its features with that in the Cressy. The surgeon writes to me: "It was astonishing how rapidly they got well on approaching the Channel; men with habitual weak pulse, emaciated and short-winded, got well rapidly as the temperature became reduced."

In the Lancet for this month I find that this subject has been brought before the Epidemiological Society of London by Dr. Bryson, the present Medical Director-General of the Navy, and he gives the following comparative table of two large ships not affected by this endemic, they are placed first on the list. It has reference only to the year 1860, and includes half of the period I have referred to:—

Ships	No. Crew	Sick cases in year	Lung	Bowel	Fevers	Ulcers
Marlborough	1145	937	129	64	10	75
Agamemnon	840	881	241	58	17	30
St. Jean D'Acre	815	1601	401	171	136	115
Cressy	720	1483	298	254	12	102

"The deaths from disease, were in the St. Jean D'Acre and Cressy twice as numerous as in the Marlborough notwithstanding the smaller crews of the former."

Dr. Thompson said that in his time in the Navy, lung disease was very prevalent.

Dr. Reade did not see why the malaria should not influence the ordinary affections of different organs to which different men are subject from changes of climate. The observations of Dr. Keown made the propriety of sending cases of chest affections to the Mediterranean doubtful.

Dr. Cuming remarked on the absence of intermitting from Dr. Keown's report. He pointed out an analogy between Dr. Keown's cases and typhoid pneumonia arising from overcrowding.

Dr. Keown then exhibited the Resuscitation Apparatus in use before Drs. Marshall Hall and Sylvester's methods were introduced. He recommended Sylvester's method because heat could be readily employed which he considered the most important means.

James Patterson, President

30th January, 1864

Present, Drs. Patterson (Chair), Dill, Keown, Scott (Aughnacloy), D. Moore, Whitaker, and Thompson.

Dr. D. Moore introduced a patient presenting a very interesting example of Bronchocele, and having some remarks on the subject, wished to know what treatment the members present would advise him to adopt.

Dr. Keown suggested that strips of plaster round each lobe would be very useful. Iodine painted externally might be of advantage as also food dietary. He thought that Iod. Potass. when pushed too far did harm by impoverishing the blood.

The President, Dr. Patterson, related a case in which Bronchocele had occurred after great loss of blood from miscarriage, pulse always kept at 150, the patient seemed to suffer from lung disease, but eventually recovered and the Bronchocele disappeared.

Dr. Scott thought that no good could be derived from treatment. He thought that it might be well to introduce an exploring needle to determine the contents of the tumour. He referred to a case in which a young woman came to him suffering from Bronchocele. He passed a lancet into the tumour and a quantity of serous fluid at once flowed out. The Bronchocele was considerably lessened but no permanent advantage ensued. He thought that no external rubbing or application could be of use.

Dr. Dill suggested that the presence of fluid might be detected by the transparency of the tumour, but having examined it, he could not determine its presence.

Dr. D. Moore thought that pressure could not readily be applied without interfering with the circulation through the large vessels of the neck. He also thought that it could be rather dangerous to open the tumour as a large vein or artery might readily be wounded and thereby give rise to troublesome hæmorrhage.

Dr. Keown would not expect to find any large vessel at all superficial in that neighbourhood, the veins which ramified externally could readily be avoided.

James Patterson, President

**Pathological Room
February 6th, 1864**

Present, the President, Professor Ferguson, Drs. J. Reade, Stewart, Keown, W. MacCormac, Whitaker, Saunders, McCrea, Messrs. Gribbin and Grattan, Drs. Browne, D. Moore.

The President proposed Mr. Croskery as a member of the Society.

Dr. Whitaker then read a paper on the British Pharmacopœia and the changes introduced therein.

Paper:¹ *The British Pharmacopœia having been at length published after a lengthened interval, during which its appearance was anxiously looked for by the profession, and especially by those engaged in the practice of pharmacy, and its use having been enjoined by the Medical Council, it appeared to me that there were many and cogent reasons why a review of its leading formulæ, more especially with regard to the changes therein introduced, and a statement of the new remedies which had been thought worthy of a place in our National Pharmacopœia might not be unacceptable to the members of this Society, many of whom from the exigencies of an extensive practice and the want of time thereby entailed, and others from want of inclination, might not care to wade through the dry details of the different medicines therein ordered, but content themselves with prescribing the ordinary simple remedies which they had heretofore proved and found useful.*

In the remarks which I am about to make, I have endeavoured to bring prominently before your notice those medicines which are in general use, to point out the changes in the formulæ for preparing them, and to call attention, more particularly, to any alterations which may have been made in their strength, as I am aware that with you, Gentlemen, the most important consideration is the safety and welfare of your patients, and it matters little to you in what manner the different medicinal compounds are prepared, so long as they are what they should be, what they profess to be, and answer the purpose for which they are intended; while I have bestowed merely superficial notice upon those pharmacopœial preparations, which, though interesting enough to those engaged in practical pharmacy, present few points of interest to, and are rarely ordered by, the practitioner in medicine or surgery.

In the first place, to begin with the preface of the Pharmacopœia, the Medical Council in it refer to the difficulties inseparable from the compilation of one British Pharmacopœia for the first time—a Pharmacopœia which would satisfy and meet the wants of the medical profession of the three kingdoms. In the preparation of such a work, the representatives of London, Dublin, and Edinburgh, would each be ready to do battle for their respective compounds; and when we reflect that years ago an attempt was made by the three Colleges of Physicians to effect a union of the respective

Pharmacopœias of these countries, and that after a lengthened correspondence it was found impossible to reconcile the differences existing between these bodies, or to bring their views on the subject of the medicinal preparations which should be introduced into the Pharmacopœia into any approach to unanimity, it is not at all surprising that even with the authority of the Medical Council to enforce conformity, it was difficult to reconcile the different opinions held by the representatives of those bodies on the Pharmacopœia Committee.

I have no doubt that in a wordy conflict of this kind the Irishmen on the Committee were not the least backward in expressing their opinions freely, and if we may judge by the Pharmacopœia itself, not the least successful in urging the claims of the preparations of the Dublin Pharmacopœia, and showing to their colleagues the intrinsic merit which many of them unquestionably possessed.

One of the first points which strikes the reader of the Pharmacopœia, more especially if an Englishman,¹ is the fact that it is entirely written in English; where a Latin name is introduced, as in the case of all the simples and compounds mentioned in the Materia Medica, by way of apology an English name is also affixed; I suppose, lest the person studying the book might find much trouble in mastering the two or three words of Latin therein introduced. The Pharmacopœia Committee had no choice, however, in this matter, as a resolution had been passed by the Medical Council previously to their appointment, “that it be an instruction to the Pharmacopœia Committee that the Pharmacopœia be published in the English language, with the list of Materia Medica and compounds in the Latin language.”

I, for my part, think that while the directions as to the preparing of medicines might be given in English, still that it would have been much better to have ordered the different substances of which they are composed in Latin. So long as prescriptions are written in Latin, and I see many and valid reasons why they should be so, it would be well to accustom, as much as possible, compounders to the use of the language which they would meet in prescriptions, and if they could not read the Latin in the printed formulæ, what chance would they have of reading it in the handwriting of even the best writer among us, not to speak of the miserable scrawls which unfortunately too often they have to decipher. My idea is, that the compounders of medicine should be forced to a higher standard of education, and that the language of the Pharmacopœia should not be lowered to meet their ignorance.

*Next, as regards the weights, the drachm and scruple having been now abolished, I would wish the opinion of the Society as to the respective value to be apportioned to them. I presume that in Ireland the *z*i. means, and still will mean, 54.68, and the *ʒ*i. 18.22 grs.,*

¹ [Dublin Medical Press, 1864, v51, p189, 246, 323.]

¹ The London Pharmacopœia was always published in Latin.

while in England they will mean respectively 60 and 20 grs., when ordered, as I have no doubt they will be, more especially by the older practitioners, for many years to come.

The Medical Council say: "The Council in resolving to adopt for pharmacy the imperial ounce and pound could not assimilate the subdivision of the ounce to that of the fluid ounce without substituting a new medical grain for the troy grain, hitherto the medical as well as the standard grain of the kingdom. This alteration they did not consider advisable. It has therefore appeared to them a necessary consequence that the drachm and the scruple, the old denominations of weight between the ounce and the grain of pharmacy, must be abandoned, since they can no longer exist as both simple multiples of the latter and integral parts of the former. Accordingly, all who prescribe and dispense medicines are recommended to discontinue henceforth the use of the drachm and scruple weights." To have carried out their doctrine fully—viz., that no weight should be introduced which was not both a simple multiple of the grain and an integral part of a higher weight, it is quite evident they should have abolished the ounce of 437.5 grams. To weigh a large quantity expressed in grains will now require some trouble and calculation, the more so especially as in the Pharmacopœia the compilers seem to ignore the ounce, except where it is ordered by itself or its multiples, or its divisors by two or four, and order even for large quantities by grains. 1440 grains bring ordered in one formula, the calculation necessary to reduce this sum to ounces of the ordinary avoirdupois weight would, in my mind, give more trouble than could occur, in any circumstance, from keeping to the old troy weight.

Another objection arises from the fact that in the great majority of the preparations the components are ordered by the ounce, and hence much trouble occurs when we wish to know the number of grains in a given quantity; thus, Tincture Opii is ordered to be prepared by Opium one ounce and a half in a pint of proof spirit. Now, to find the number of grains of opium in the ounce requires some trouble and calculation: with the troy weight it would have been at once evident.

Had any change been necessary from the old troy weight, in use in England and Scotland, I think that the Council should have adopted the decimal system. I believe they did not wish to do so, lest Parliament should at some future time introduce a system of that kind into use throughout the kingdom. It would have been well for them boldly to have set the example and have made 1000 grains a standard weight, and those above and below multiples or integral parts of it. It is a course which must sooner or later be adopted, even in this country, where we are so adverse to change. The subject of the weights alone would require almost a separate paper, I therefore hurry on to the more important consideration of the Pharmacopœia itself.

In commencing the consideration of the Pharmacopœia itself, I cannot do better than bring under your notice an extract from the preface regarding the arrangement of its subject matter, as the Committee on it describe more fully and accurately than I could the resolutions which they formed, and which they have well carried out in detail:—

"It was resolved that the British Pharmacopœia should consist of two Parts and an Appendix; the first Part to consist of the *Materia Medica*; the second of the *Preparations and Compounds*; and the Appendix of articles which are employed for the chemical processes in the second Part, but are not themselves used in medical practice, and of preparations solely intended for the chemical examination of the articles contained in the first and second Parts. The *materia medica* contains, in its simplest pharmaceutical form, every definite medicinal substance, whether obtainable in ordinary trade or prepared by the chemical processes in the second Part, which the Committee of the Council found, on careful inquiry, to be so far approved in practice as to be entitled to a place in a National Pharmacopœia. Under each article are given—1, a Latin pharmaceutical name by which it may be prescribed, and an English name for use in describing the processes in the second Part; 2, its definition, together with its chemical symbol, if it be a substance of definite composition, its botanical name if it be a plant, or its botanical source if procured from a plant, and also, in most cases, a reference to a correct figure of the plant, and a statement of the quarter whence the article is obtained; 3, the characters by which it may be distinguished from all other articles of the *materia medica*; 4, the tests by which it may be ascertained to be of due strength and free from known impurities or adulterations; and, 5, the preparations of which it is an active ingredient.

"The second Part comprises processes for the forms in which medicines may be used in extemporaneous prescriptions, and for articles in the *Materia Medica* obtained by chemical operations. The Committee of the Council took into consideration the question, whether the late transference of the manufacture of most chemicals from the pharmaceutical chemist to the chemical manufacturer might not be a reason for withdrawing a great part of the chemical processes from the Pharmacopœia. On mature consideration it was resolved to retain them; and the Council approved of that resolution. The contents and construction of the appendix do not require further explanation."

To give one or two examples of the *materia medica*, or first division of this work, I will select the first drug mentioned therein, gum acacia, and I find it described thus, "Acacia—Gum Arabic." One or more undetermined species of acacia linn. A gummy exudation from the stem; collected chiefly in Cordofan, in Eastern Africa, and imported from Alexandria.

Characters.—In spheroidal tears from half an inch

to an inch in length, nearly white, and opaque from numerous minute cracks, or in shining fragments; brittle, bland, and mucilaginous in taste, soluble in cold water. The solution forms, with subacetate of lead, an opaque white jelly.

Test.—The powder does not become blue on the addition of solution of iodine.

Preparation.—Mucilage.

On turning to the Dublin Pharmacopœia I find it thus mentioned, “Acacia vera Gum, Arabic tree. The gum—The true white gum is yielded by acacia verek; other species contribute to form the gum Arabic of commerce.”

Now, I have accidentally selected the substance which, of all others in the Dublin Pharmacopœia, is most fully described; in general, a line containing the official Latin, with the English name for same, and the part of the plant used in medicine, is all that is offered to us; for further information we must consult our dispensaries. On the other hand, the Materia Medica division of the British Pharmacopœia is so complete that a dispensatory is almost useless, or at least in the one case it is indispensable, in the other it is unnecessary to the pharmacien.

Again, in the Materia Medica of the Dublin Pharmacopœia, we had only mention made of the simple drugs and chemicals, and no reference whatever was made to the compounds for which formulæ were given; in the British Pharmacopœia we have not only every simple drug and chemical in use in medicine, but also every compound, for which a formula is given in the second division of the work, with its characters, tests for its purity, specific gravity, if a fluid; and principal preparations into which it enters.

Let us take Liquor Ammonia Acetatis. I find it thus described in the Dublin Pharmacopœia, “Ammonia acetatis liquor (ammonia acetatis aqua). Take of Sesqui-carbonate of Ammonia in fine powder, two ounces and a half, or a sufficient quantity. Dilute Acetic Acid, three pints. To the acid introduced into a bottle gradually add the sesqui-carbonate of ammonia to saturation, and dissolve by shaking, but without the aid of heat;” while in the British Pharmacopœia I find it first at page 15, where by the way it figures as ammonia acetatis liquor, and again at page 267 as liquor ammonia acetatis.

As the Pharmacopœia is arranged alphabetically, this disarrangement of the components of the name gives rise to needless confusion; the name applied in the Materia Medica division should have been carefully reproduced, without any change, in the second part.¹ To return, ammon. acet. liq. is described fully at page 15, thus: “Solution of Acetate of Ammonia, Acetate of Ammonia, NH₄ O, C₄ H₃ O₃, dissolved in water.

Characters.—A transparent colourless liquid, with a

saline taste. Treated with caustic potass it gives off an ammoniacal, and with sulphuric acid an acetous odour.

Tests.—Specific gravity 1.06. One fluid ounce treated with excess of hydrochloric acid, and evaporated to dryness by a water bath, leaves a residue of hydrochlorate of ammonia weighing 100 grains. It has no action on litmus, and is not rendered turbid by a solution of lime. Diluted with four volumes of water it gives no precipitate with chloride of barium or nitrate of silver. This solution contains about five times as much Acetate of Ammonia as Liquor Ammonia Acet. Lond., and six times as much as Liq. Ammon. Acet. Dub. and Edin.” Its preparation is thus described at page 267.—“Take of strong solution of ammonia three fluid ounces and a half, or a sufficiency; acetic acid, ten fluid ounces, or a sufficiency; mix gradually, and if the product is not neutral to test paper make it so by the addition of the proper quantity of either liquid.”

Now, Gentlemen, could anything be more explicit and satisfactory, both to the prescriber and compounder, than the manner in which this article has been described. It leaves nothing to be desired, and, in many cases, will, I have no doubt, produce marked improvement in compounding, more especially among English chemists not members of the Pharmaceutical Society, who, unfortunately too many of them, entirely ignorant of chemistry, or even of the first principles of their business, and it is a shame that it should be so, will have facilities for the study of the chemistry and natural history of the pharmacopœial products put before them, of which, if they do not take advantage, they will only have themselves to blame.

I should add that the London Pharmacopœia always gave more or less instructions for examining the purity of the drugs and chemicals therein mentioned; the Dublin Pharmacopœia never did. The reason of the difference is to a great extent obvious.

I find that I am taking up too much time in preliminary matter, and therefore must hurry on to that part of the paper which more especially interests you.

In the Materia Medica division of the Pharmacopœia we find that the following medicines have been added to the list of those contained in the Dublin Pharmacopœia:—

Acid. Phosphor, dil.	Lini Farina.
Ammon. Benzoas.	Lithiæ Carbonas.
___ Phosphas.	___ Citras.
Acid. Sulphurosum.	Mori Succus.
Aconitia.	Myristicæ Adeps.
Aconitum (the leaves and flowering tops).	Nectandra.
Aloes, Barbadoes.	Oleum Copaiba.
Anethum Graveolens.	___ Coriander.
Armoracia.	___ Rutæ.
Arnica Rad.	Podophylli Resina.
Atropia.	Podophyllum.
Aurantii, Aqua.	Potassæ Citras.
	___ Permanganas.

¹ Numerous instances of a similar kind occur throughout the work.

Balsamum Peruvianum.	Potassii Bromidum.
Beberix Sulphas.	Pterocarpus.
Bela.	Rosa Canina.
Cassia Fistula.	Sabadilla.
Cocculus Indicus.	Sambucus.
Collodion.	Artemisia Santonica.
Conii Fructus.	Santonine.
Cusparia.	Sapo Mollis.
Cusso.	Scammonii Radix.
Digitalinum.	Sevum preparatum.
Fel Bovinum.	Soda Caustica.
Ferri Arsenias.	Soda Arsenias.
___ et quinx Citras.	Stramonii Folia.
___ Perchloridi Liquor.	Styrax Præparatus.
___ Phosphas.	Sulphur Præcipitatum.
Filix.	Terebinthina Canadensis.
Jalapax Resina.	Ulums.
Kamela.	Veratria.

I will, in the first place, consider those articles of the *Materia Medica* which are not officinal in the London or Edinburgh Pharmacopœias, and afterwards proceed to the consideration of such as are derived from either of these sources.

Acid Sulphurosom, a solution of sulphurous acid in water, is an article which, though very little used in this part of the country, is, nevertheless, looked upon by many as a valuable external agent in skin affections of a parasitic character; it is, as you are aware, a powerful deoxidizing agent. One great disadvantage in using this preparation would arise from the uncertainty regarding its strength, as it does not keep well. I do not think that it possesses any great advantages over a solution of one of the alkaline hyposulphites, which could be extemporaneously prepared and be ordered of a uniform strength.

Aconitia is the new and much less elegant name for Aconitine, the active principle of the *Aconitum Napellus*. A formula is given for its preparation, and it is introduced to prepare the *Unguentum Aconitiæ*.

Arnica Root, introduced for the preparation of the Tincture of Arnica, has some reputation as a remedy in the treatment of bruises, &c. Heretofore the tincture of the flowers was invariably used for that purpose, and I have been informed with good effect. Dr. Garrod has recently instituted a series of experiments which seem conclusively to prove that the application of the tincture of arnica root to extravasated blood is not one whit more useful than that of plain spirit. Whether the tincture of the flowers would be a better preparation or not I do not know, but I am inclined to think that very little difference would be observable in their effects. I have never seen tincture of arnica ordered internally. Arnica root was in the *Materia Medica* of the old Dublin Pharmacopœia, from which it was expunged in the last edition.

Beberix Sulphas was first introduced to notice by

Dr. Douglas Maclagan of Edinburgh some twelve or fourteen years ago as a valuable tonic and antiperiodic; in fact, it was intended to take the place of quinine. It was extensively tried, but has almost fallen into disuse; it is not, I believe, to be compared to quinine in its antiperiodic qualities, and possesses no advantage, except that of cheapness, over that drug; while by the great majority of practitioners it was not found to answer their expectations, and was consequently discarded. Its appearance in the British Pharmacopœia will again bring it into notice.

Bela—The Indian Bael, has been strongly recommended as an agreeable astringent; particularly useful in diarrhœa and dysentery, especially in hot climates. It has not been much used in this country, and I do not think that it should have been placed in the *Materia Medica* until further trials had proved its efficacy. I have been told by those who have used it in India that it is a comparatively mild drug, and that no reliance should be placed on its use in acute dysentery, though it probably would be of use to those suffering from chronic diarrhœa, or a relaxed state of the bowels.

Collodion—I need scarcely refer to this well-known and valuable application; a formula has been given for its preparation.

Ammonia Benzoas and *Ammonia Phospha* are both introduced, they are little known and seldom used preparations. The former has no advantage over the Benzoic Acid except its greater solubility, and is used in similar cases; the latter, whatever may be its theoretic, has yet to prove its practical utility. It is said to be useful in some urinary and other diseases in which uric acid or urate of soda is formed.

Conii Fructus is introduced for the preparation of *Tinctura Conii*: although we know that the fruit, as well as the leaves of the plant, contains the conœia, I am at a loss to understand why the tincture is ordered to be prepared from the fruit, while for the preparation of the succus and extractum conii the leaves are directed to be used.

Kousso appears under the name of *Cusso*. I need not say anything concerning it, its use as an anthelmintic is well known.

Digitaline has been introduced, it will enable a dose of digitalis to be ordered in a small-sized pill; its uniformity of strength will be a recommendation in its favour; a formula has been given for its preparation; it is, however, so dangerous a medicine that most practitioners will hesitate to order it, more especially as the slightest overdose causes such violent nausea and prostration.

Fel Bovinum Purificatum, I need not more than mention, it is familiar to us all, and is worthy from its general use of a place in the Pharmacopœia.

Ferri Arsenias, as also *Sodæ Arsenias*, are both useful compounds, they can be readily ordered in pills, and their use in skin disease, more especially that of the

Arseniate of Iron, will be at once evident.

Ferri et Quinæ Citras, long known and extensively used, has many advantages over the ordinary preparations of quinine. I need not make any remarks concerning it; you will be glad to see its value at length recognized.

Ferri Phosphas, long used in America, has at length become naturalized with us. In the present day, when the use of phosphates has been so much recommended, and when most practitioners are ordering these medicines, this salt will prove a useful addition to our *Materia Medica*, though its insolubility in water will prevent its general adoption.

Kamela is the remedy so much vaunted for the cure of tape-worm; for a while, like kousso, it was in great demand, and largely used for that purpose. I do not think that it will prove of much greater value than some of our old and well-known remedies; and as it is now seldom used, I think that it might have been, with propriety, omitted from the *Pharmacopœia*.

Lithiæ Carbonas and Citras owe their introduction to the researches of Dr. Garrod, and have been recommended by him for gouty affections; the former, from its sparing solubility, is used more especially in the preparation of the effervescing bicarbonated water; the latter, from its solubility, is more in demand for mixtures, in which it can be ordered with other substances, which in all probability are more useful than the lithia itself.

Nectandra (Bebeeru Bark) is introduced for the preparation of the bebeerix sulphas, to which I have alluded.

Oil of Coriander has been heretofore but little used; it is pleasant to smell and taste, but inert, and not so useful as the great majority of our essential oils.

Podophyllum is introduced to prepare the Podophylli Resina, a preparation which was imported from America about three years ago, and has proved itself a good and useful cholagogue cathartic.

It is a useful addition to our *Materia Medica*. I could have wished that a formula for pills had been introduced with this medicine as a component part; an active purgative mass, of which five grains would have been a full dose, might have been ordered with advantage.

The chief, and indeed only, objection to the use of the resin of podophyllum is the depressing effect which too often follows its administration. This, however, would in some cases be an advantage.

Potassæ Citras is an elegant neutral salt.

Potassæ Permanganas is introduced for the preparation of the liquor potassæ permanganatis.

Potassii Bromidum was officinal in the London *Pharmacopœia* of 1836. It is a salt almost analogous in its uses and mode of administration to the iodide of potassium, over which it seems to possess little if any advantage.

Artemisia Santonica and *Santonine* are good and useful old-fashioned remedies, particularly useful in the treatment of ascarides, and worthy of a place among our vermifuges. The latter is the active principle of the former, and possesses all the active properties of the plant. It is almost tasteless.

Soda Caustica, in my opinion, has no advantage over the *Potassa Caustica*.

I have now hastily gone over in detail the new articles introduced into the *Materia Medica* of the British *Pharmacopœia*. In a paper of this kind it is quite evident that I could merely bring before your notice the more important characteristics of each.

I will now proceed to the consideration of those substances which, though not officinal in the Dublin, were so in either the Edinburgh or London *Pharmacopœia*.

Officinal in both the London and Edinburgh *Pharmacopœias*, we have *Barbadoes Aloes*, *Anethum Graveolens*, and *Armoracia*, for none of these can I see any great necessity.

The *Barbadoes Aloes* may be more active than the *Socotrine*, though this is denied on good authority. I think, however, that the latter would answer all the purposes for which aloes would be prescribed.

The *Anethum Graveolens* presents no advantage over the *Fennel* or *Aniseed*; while the use of *Sialogogues* has gone so much out of date that the *Armoracia* must fall back on its stimulant properties in order to deserve its resuscitation.

Aqua Aurantii Florum, *Balsamum Peruvianum*, and *Cassia Fistula* have been introduced. Of these I will merely remark that while the *Aqua Aurantii Florum* is perhaps one of the nicest vehicles with which we are acquainted for the administration of medicine, the *Balsam of Peru* appears to me to present no advantages over the *Balsam Tolu*, and the *Cassia Fistula* is almost useless, except to make up bulk.

Cusparia is a valuable addition to our non-astringent vegetable tonics.

Myristicæ Adeps, commonly called *Oil of Mace*, has been introduced; it is an elegant flavouring substance, which is all that can be said in its favour.

Oleum Copaibæ is a more elegant form than the *balsam copaiba* in which to administer that drug.

Oleum Rutæ is not much used, either as an anti-spasmodic or emmenagogue; it is inferior to many other similar preparations.

Pterocarpus Santalinus and *Rosa Canina* require little *Pharmacopœia* notice; the former is only used for its colour and flavour; the latter to make the *conserva rosæ*.

Sabadilla is introduced to prepare *veratria*.

Sambucus is used to prepare the *aqua sambuci*, which is said to be emollient.

Sapo Mollis is introduced, though I cannot see for what purpose.

London *Pharmacopœia* we have—

Atropia, an alkaloid so useful in affections of the eye, that it could not readily have been omitted.

Succus Mori, the only use of which is to make the syrupus mori; it has no medicinal properties, and might well have been omitted.

From the Edinburgh Pharmacopœia we have—

Cocculus Indicus, which makes an ointment particularly useful in some scalp affections.

Filix Mas, introduced for the preparation of the oil now called the liquid extract of male fern; you all know its great value as an anthelmintic.

Jalapæ Resina is a powerful cathartic, the alcoholic extract of radix jalapæ.

Lini Farina is described as “the seeds ground and deprived of the oil by expression.” I have no doubt that the crushed linseed, with the oil retained therein, acts much better and forms a nicer poultice.

Aconitum Napellus.—The leaves only of this plant have always been ordered by the Edinburgh, the root by the Dublin, while both were ordered by the London Pharmacopœia. In the British Pharmacopœia both are officinal; the leaves are used for the preparation of the extract, the root for the aconitine, tincture, and liniment of aconite. I cannot see why the root would not have answered all purposes.

The first preparations in the British Pharmacopœia are the acids. Of these little need be said. To make gallic acid, only one formula is given, the former and better of the two in the Ph.D. The hydrocyanic acid is of the same strength as formerly, containing two per cent of real acid. As the hydrochloric acid is ordered to be prepared, the resulting solution would contain very little of that gas. Directions should have been given to heat the mixture.

Dilute nitro-muriatic acid is ordered in place of the strong. Dilute phosphoric acid has been introduced from the Pharm. Lond.; it is a little stronger than that previously ordered. As a good useful medicine, which has been gradually getting into use, I am glad to see it in the Pharmacopœia.

The Aromatic Sulphuric Acid is not as strong as the same preparation in the Ph.D., which contained about one-third more sulphuric acid, nor as the dilute sulphuric add now ordered.

Formulæ have been given for the preparation of citric and tartaric adds respectively. Acidum sulphurosum has been introduced, and a formula given for its preparation. The dilute acids—viz., hydrochloric, nitric, and sulphuric, have been diluted so as to bring them to nearly the same strength in acid. The Dilute Hydrochloric Acid is now one-fourth stronger than formerly. Dilute nitro-muriatic acid is somewhat weaker than the other dilute adds in the proportion of 93 to 100.

A formula has been given for the preparation of Aconitia. The Alumen Exsiccatum, a comparatively unused preparation, has been retained.

Ammonia Bensoas and Ammonia Phosphas have

been introduced, as previously noticed. All the aromatic waters have been prepared by distillation from the fruit or seeds, except aqua menthæ piperitæ and aqua menthæ viridis, which are ordered to be made from the essential oils in a similar manner. The waters thus made will be more finely flavoured than those of the Ph.D., but not so easy of extemporaneous production; and I am afraid that in very few establishments will the waters be prepared in strict accordance with the directions of the Pharmacopœia.

Aqua Camphoræ, the old Mistura Camphoræ, is now ordered to be prepared by suspending pieces of camphor in a muslin bag in water. It will not be so good a preparation as the old.

A formula is given for Nitrate of Silver, which, did the apothecary adopt and do an extensive business therein, at the ordinary prices of the day, would largely curtail his profits.

Atropia and Beberia Sulphas have both formulæ given for their preparation.

The old Subnitrate of Bismuth, which has received so many names, has at length been called Bismuthum Album. As the carbonate of bismuth is also white and much used, though not officinal, mistakes might occur from this source, though no harm could thereby be done, and it would make little difference to either prescriber or patient, still even the slightest error should be avoided.

Calcis Hydras has been introduced in place of calx recens testa; its only use is to prepare the aqua calcis.

The Cataplasmata have been introduced from the Ph.L. almost word for word. They are cataplasma carbonis, conii, fermenti, lini, sinapis, sodæ chloratæ. As neither the medical man nor apothecary ever, at least in this country, make up cataplasms, I cannot see the use of their introduction.

A formula is given for preparing collodion.

The Confectio Piperosis is slightly changed. It has not so much pepper by one-fourth, and otherwise is not as nice as the old preparation. Confectio Scammonii fortunately has not undergone the slightest change, while the Confectio Sennæ has been improved.

Confect. Sulphur has one-sixth more sulph. and one-half less cr. tart.; the Confect Terebinth, a nasty preparation, remains unchanged.

In the Decoctions we find the decoctum aloes compositum unchanged. I do not think that it could have been improved. Decoctum cinchonæ flavæ has been introduced in place of decoctum cinchonæ, which was always made from the pale bark; and here I may add that in the British Pharmacopœia cinchona flava is invariably ordered where the pallida was previously. I think that this is a proper course. We all know that the cinchona flava contains a much larger quantity of quinia than any of the other barks. Decoctum granati is introduced from the Ph.L.; its properties as an anthelmintic have been much vaunted; the root, either

fresh or dry, is ordered. Most practitioners who have tried it consider the dry root to be inert. If there be a doubt in the matter, it would have been better to have ordered it fresh; a difficulty, however, would arise as to the procuring it in this state.

In the decoctum hæmatoxyli cinnamon has been advantageously ordered to flavour it.

Decoctum Pareiræ and decoctum taraxaci have been added to our list; the former is in pretty general use, the latter is generally preferred in the form of fluid extract, as the decoction spoils so readily. They were both officinal in the Ph.L.

A formula is given for the preparation of Digitaline.

In the Plasters, emplastrum calefaciens has been greatly changed, and to some extent improved. As ordered in the Ph.D. it never made a nice plaster. The principal objection to the present formula is, in my mind, that infusion of cantharides in boiling water is an uncertain preparation, and that the plaster so prepared will not be sufficiently irritant. Emplastrum galbani and emplastrum picis have been reintroduced from the Ph.L. I do not think much of either of them.

In the Enemas we have introduced enema aloes, forty grains to ten ounces, and enema opii, one-half drachm, tinctura opii to two ounces. The enema fœtidum has been very properly made six times as strong as the former preparation, and now has six drachms tincture of assafœtida to six ounces, while the enema catharticum is continued under the name of enema magnesiæ sulphatis. All the enemas, except the enema tobaci, are ordered to be made with mucilago amyli.

In the Extracts we have a large addition to our previous stock; it will be sufficient to name most of them. Many of them are very useless. We find extractum aconiti, anthe midis, calumbo, hæmatoxyli, jalapæ, kramerix, humali, nucis vomicæ, quassiæ stramonii, and taraxaci. We have now two watery extracts of aloes (Barbadoes and Socotrine); one would have been quite sufficient. We have extractum colchici and extractum colchici aceticum. The old favourite, extractum colocynthidis compositum, omitted from the last edition of the Ph.D., again comes before us. It is almost identical with the pilula colocynthidis composita, over which, to my mind, it possesses little advantages. It is weaker than the latter, and contains one grain of scammony in seven, while the pill contains one in three. Under the head of extracts we have the new liquid extracts, which are gradually rising in professional esteem. They are extractum belæ liquidum, the form in which the Indian bael previously referred to is ordered; the extractum cinchonæ flavæ liquidum, a valuable preparation, containing in one ounce the watery extract of four ounces of cinchona flava; the extractum ergotæ liquidum, a watery extract of the ergot, containing the active properties of one ounce of ergot in one ounce of the fluid, the oil having been previously removed by treating the

ergot with ether; extractum filicis liquidum, the so-called oil of male fern; extractum opii liquidum, containing one grain extractum opii in twenty—a nice preparation, an imitation of the liquor opii sedativus of Battley, about the same strength as tinctura opii, but differing from it in containing only the watery solution of the opium, hence it is said not to be so stimulating; extractum Pareiræ liquidum, containing in one fluid ounce the properties of an ounce of the drug; and extractum sarsæ liquidum, an elegant preparation, in which the active principle of two ounces of the sarsaparilla is contained in one ounce of the fluid, hence it is twice as strong as the ordinary fluid extract of sarsaparilla of the Dublin Pharmacopœia.

We have a formula for the Fel. Bovinum Purificatum; also formulæ for the preparation of Ferri Arsenias, Ferri et Quiniæ Citras, Ferri Bosphas; to each of these I have previously referred. We have no change of importance in the old preparations of iron.

In the mercurial preparations, hydragyrum cum magnesia has been omitted; the name of calomel has been retained, it is now also called the sub-chloride, while corrosive sublimate is the chloride. In writing prescriptions, the officinal and not the chemical name should be used, as otherwise serious mistakes might occur.

In the Infusions little change has been made. Cloves have been omitted in preparing the infusum aurantii. The infusum cinchonæ flavæ is ordered to be prepared with half the quantity of bark previously ordered in the infusum cinchonæ of the Dublin Pharmacopœia, in which also the pale bark was used.

Infusum cuspariæ and infusum cusso have been introduced. In ordering the latter I think that it would have been well to have ordered a full dose of kousso, and made eight ounces of the infusion. Infusum digitalis has been made half the strength it formerly was; it is now prepared with thirty grains digitalis leaves to ten ounces water. Infusum dulcamaræ, infusum lupuli, infusum serpentariæ, and infusum uvæ ursi have been introduced; none of them call for special notice.

The infusum gentianæ has been considerably changed; it is now directed to be prepared as in the Edinburgh Pharmacopœia. Proof spirit is poured upon the gentian, orange-peel, and coriander. After two hours the water is added, and after a further delay of two hours, the infusion is strained off. It thus takes four hours to make. I do not see why all the infusions might not have been prepared in the usual way, or why the infusion of gentian should be an exception; it will keep pretty well, and therefore will be always ready-made when wanted, but there are other infusions which might also have had spirit added with advantage. I think that all should have been prepared on one uniform plan.

A formula has been introduced for the preparation of the Jalapæ Resina.

In the Liniments, we have *linimentum aconiti*, a most powerful preparation. 20 oz. aconite root is ordered to be digested with 80 oz. spirit of wine, and 1 oz. camphor added to the percolated fluid. The directions for preparing this liniment are somewhat vague. *Linim. Belladonnæ* is also a very strong preparation made in a similar manner. In both these liniments the active principle of one ounce of the drug is supposed to be contained in the same quantity of the liniment. *Lin. Camphoræ* and *Lin. Camphoræ Compositum* retain their old places and formulæ. *Lin. Cantharidis* is made one-fourth stronger, and is further improved by its preparation with ether and acetic acid in place of olive-oil. Its name, however, should have been changed, as it is not now what is commonly called a liniment. *Liq. Cantharidis* or *Vesicous* would have been better. *Lin. Chloroform*, prepared by mixing equal parts of chloroform and camphor liniment, is an elegant preparation. *Lin. Iodi* is merely a very strong solution of iodine with iodide of potassium in spirit. One quarter of an ounce of iodine is dissolved in five ounces of rectified spirit; it will prove a useful external application.

Lin. Saponis is improved by the addition of oil of rosemary, and is now prepared with rectified spirits and a small quantity of water, in place of proof spirit heretofore ordered.

Lin. Terebinthinæ Aceticum might have been greatly improved, had the compilers of the *Pharmacopœia* adopted the formulæ given for St. John Long's liniment, which would have given them an elegant preparation, much used, and presenting many advantages.

In *Liquors*, *Liquor Ammoniaë Acetatis*, is, as you are already aware, six times stronger than that of the *Dublin Pharmacopœia*. In general, apothecaries in this country have been in the habit of preparing it of this strength, and diluting it when required for use; I cannot see any valid reason for increasing its strength so much.

The *Edinburgh Pharmacopœia* always ordered it to be prepared in the same manner as the *Dublin*, the *London* ordered it a little stronger.

The *Liquor Ammoniac fortior* is slightly stronger than that of the *Dublin Pharmacopœia*, its *sp. gr.* is now .891. *Liquor Arsenicalis* (Fowler's solution) is now prepared with eighty grains arsenious acid to twenty ounces (in place of seventy-two grains). It now contains four grains to one ounce in place of three three-fifths; this is a very proper change, I think that it might have been further improved by substituting a definite chemical compound such as the *Arseniate of Potash* for the merely mechanical solution here ordered. As, however, this preparation has been so long known and approved, I suppose the compilers of the *Pharmacopœia* thought it better not to make a change. *Liquor. Morphiaë Muriatis* is also changed, it now contains four grains in place of four and a half in the ounce. *Liquor. Atropiæ* is ordered to be prepared with four grains to

the ounce, this is too weak; eight grains to the ounce would have made a much more useful preparation. *Liquor. Calcis Saccharatus*, a new preparation, in which advantage has been taken of the increased solubility of lime when sugar is present, is twelve times stronger than the ordinary *Aquæ Calcis*. *Liquor. Ferri Perchloridi* is introduced for the preparation of the *Tinctura Ferri Perchloridi*, than which it is four times stronger. It will also be useful as a styptic. *Liquor. Plumbi Sub-Acetatis* is somewhat stronger than the old; its *sp. gr.* is 1.26. *Liquor. Potassæ* remains unchanged. *Liquor. Potassæ Permanganatis* has been introduced; its power as a disinfectant is so well known, and its topical use has been often attended with so much advantage, that it could not readily have been overlooked. *Liquor. Sodæ Arseniatis* is a solution of four grains *Anhydrous Arseniate of Soda* in one ounce of water. *Liquor. Strychninæ* is a solution of *Strychnia* of the same strength in *Hydrochloric Acid* and water with a little spirits.¹

I may add, that in the *Liquors* where dangerous substances are ordered, the strength of the solution is invariably four grains to the ounce. I cannot see why the tests for *Liquor. Potassæ Mistura Creasoti* has been introduced from the *Edinburgh Pharmacopœia*, it is an excellent form for the administration of creasote. *Mistura Guaiaci*, a useless preparation of *Guaiacum Resin*, *Sugar and Gum* has also been introduced, it was officinal in both the *London* and *Edinburgh Pharmacopœias*. *Mistura Scammony* is an elegant form of administering *Scammony*, little known in this country, but making a particularly nice mixture. It is prepared by rubbing up four grains of *Resin of Scammony* in two ounces of milk. It has long been officinal in the *Edinburgh Pharmacopœia*. The other mixtures remain almost unchanged.

I pass on to the consideration of the *Pills*, and find *Pilula Aloes Barbadosis* and *Pil. Aloes Socotrinæ*, in each of which preparations one grain of the respective aloes is present in every two grains of the pill mass. I cannot see the advantage of having two preparations so much alike, prescribers can, however, have their choice; though I think that in the great majority of instances in the country they will prefer the *Socotrine Aloes*, which they have been so long accustomed to use. *Pil. Aloes et Assafœtida* is a new preparation introduced from the *Edinburgh Pharmacopœia*, it is composed of equal parts of *Aloes*, *Soap*, and *Assafœtida*, and has been heretofore much in use. *Pil. Cambogiæ Co.* is a new and active preparation, containing one grain each of *Aloes* and *Camboge* in every five grains of the mass; it was offici-

¹ *Liquor. Arsenicalis*, &c., are given at foot of directions for their respective preparations, while those for *Liquor. Ammoniaë Acetatis*, *Liquor. Ammoniaë fortior*, &c., are given in the *Materia Medica* division.

nal in the London Pharmacopœia.¹ Pil. Colocynthis et Hyosциami has been introduced from the Edinburgh Pharmacopœia, and is a well-known and useful pill. Pil. Ferri Carbonatis, containing four grains Saccharated Carbonate of Iron in each five-grain pill, and Pil. Ferri Iodidi are both introduced, the former from the Edinburgh Pharmacopœia; the latter is new, and contains one grain Iodide of Iron in 3.6 grains of the pill mass. Pil. Saponis Composita is now called Pil. Opii, a change of which I do not approve, the old name was useful in many cases where the prescriber did not wish to appear to order opium. Oftentimes Pil. Opii grj. mitte xj. is ordered, that will now mean pills, containing one fifth of a grain of opium in each. Pil. Plumbi cum Opio is now introduced from the Edinburgh Pharmacopœia, it is a very useful and much used pill; in each four grains there will be three grains acetate of lead and a half grain of powdered opium. The other pill masses are so slightly, if at all changed, that none of them requires special notice.

Formulas have been introduced for the preparation of Plumbi Acetas, Podophylli Resina, Potassæ Chloras, Potassæ Citras, Potassæ Permanganas, and Potassii Bromidum, to these I need not refer, they are all prepared by the chemist on the large scale. Antimonial Powder is now easily prepared by mixing one ounce of the oxide of antimony (SbO_3) with two ounces of the precipitated phosphate of lime. In the former preparation we had a complicated mixture of the Oxide of Antimony, Antimonious Acid, Antimonite of Lime, and Phosphate of Lime.

As to the inertness of the latter there can be little doubt; whether the oxide of antimony will answer the purpose for which the antimonial powder is intended, I do not know. The James's Powder has in my opinion but little to fear from this rival. Pulvis Aromaticus has been improved, it now resembles the Pulvis Confectionis Aromatici, which, though not officinal, has long been in general use. Pulv. Cretæ Aromaticus has now one grain of prepared chalk in four, in place of one in three as formerly; the name has been changed from Compound to Aromatic Chalk Powder. Pulv. Cretæ Aromaticus c. Opio and Pulv. Ipecacuanhæ c. Opio have not been changed except in name.

Pulv. Kino Compositus has been introduced from the London Pharmacopœia, and contains one grain powdered opium in twenty grains; some powdered cinnamon is added as an aromatic with advantage. Pulv. Scammonii Compositus has now one grain of scammony in two grains of the powder, formerly it contained one in four, it also contains twice as much jalap as heretofore.

Pulv. Tragacanthæ Compositus is a new and inert pre-

paration, officinal in both London and Edinburgh Pharmacopœias.

Under the head of Spirits we have Spiritus Ætheris composed of one part ether and two parts of spirit, it was officinal in the Edinburgh Pharmacopœia.

Spirit. Ætheris Nitrosi, for the preparation of which a new and simple formula has been given.¹ Spirit. Cajuputi, an entirely new preparation, made from the oil by dissolving it in spirit; it will prove a good stimulant, easily miscible with other fluids. Spirit. Camphoræ, the old Tinctura Camphoræ, is now one-eighth weaker than formerly.

Spirit. Chloroform, a new preparation, consisting of one part chloroform dissolved in nineteen parts of rectified spirit, useful when we wish to order chloroform.

Spirit. Juniperi, composed of the oil of juniper dissolved in spirit, not nearly so aromatic as the former preparation of the Dublin Pharmacopœia. Spirit. Lavand. is introduced from the Edinburgh Pharmacopœia, and is merely a solution of the oil in spirit.

Spirit. Peppermint, Spirit. Rosmarini, and Spirit. Myristicæ correspond to their respective essences in the Dublin Pharmacopœia.

We have the Succus Corni, Succus Scoparii, and Succus Taraxaci, all new and valuable preparations.

We have Suppositories introduced, they were not officinal in any of the Pharmacopœias, they are Suppositoria Acidi Tannici, containing two grains tannic acid in each, and Suppositoria Morphia one-fourth grain in each, and are ordered to be prepared with white wax and lard. Cocoa Butter would in my mind have been a much better substance, and have given much less trouble to the compounder. Prescribers will in general prefer ordering Suppositories, with different ingredients and of different strengths, without reference to the Pharmacopœia.

The Syrups are little changed. Syrupus Aurantii Floris, Syrupus Ferri Phosphatis, Syrupus Mori, Syrupus Sennæ, Syrupus Papaveris, Syrupus Rheados, have been introduced; of these the three last-mentioned were officinal in both London and Edinburgh Pharmacopœias.

The Syrupus Mori was officinal in the London only, while the others are new. Syrupus Aurantii Floris, commonly called Syrup of Capillaire, is an elegant flavouring syrup; the Syrupus Ferri Phosphatis is a new and useful preparation, by far the best made in which the phosphate of iron can be administered; the Syrupus Mori is useless except as a colouring ingredient, and might well have been omitted; the Syrupus Sennæ is an agreeable and useful preparation; while I do not believe much in the medicinal properties of either the Syrupus

¹ Pil. Colocynthis Composita has been improved by the addition of an extra quantity of scammony, it now contains two grains of powdered scammony in every six grains, formerly it only contained one grain in the same quantity.

¹ Spirit. Ammonia Aromaticus, a nicer preparation than the old Sal Volatile, it scarcely contains so much ammonia. Spirit. Armoraciae, reintroduced from the London Pharmacopœia, it was omitted in the last edition of the Dublin, and contains the spirit of the armoracia combined with some good aromatics.

Papaveris or *Syrupus Rhœados*, and they are both very liable to vary in strength. The *Syrupus Aurantii* has been spoiled, it is now prepared by mixing the *tinctura aurantii* with simple syrup; the formula given in the Dublin Pharmacopœia made a much more elegant syrup. The *Syrupus Limonis* is a great improvement on the *Syrupus Acidi Citrici* (Dublin Pharmacopœia). The *Syrupus Ferri Iodidi* has been improved, as a thicker syrup is now ordered than that previously directed by the Dublin Pharmacopœia; it will consequently keep good for a much longer time.¹ None of the other syrups require special notice.

I now proceed to the consideration of the Tinctures. The *Tinctura Aconiti* is now one-fourth the strength of that previously ordered by the Dublin Pharmacopœia. In the note affixed to it is stated in error to be one-half the strength. *Tinctura Aloes*,² *Tinctura Benzoin Compositæ*, *Tinctura Castor*, *Tinctura Cinnamomi*, *Tinctura Guaiaci Ammoniata*, *Tinctura Kino*,³ *Tinctura Lobeliæ Ætherea*, *Tinctura Serpentariæ*, and *Tinctura Valerianæ Ammoniata*, have all been introduced from the Edinburgh and London Pharmacopœias, in both of which they were officinal. They require little comment, most of them have long been in general use among us, and are reproduced without any material alteration. *Tinctura Cinnamomi* is now made nearly one-half stronger than previously.⁴ *Tinctura Serpentariæ* has been made one-half stronger. *Tinctura Guaiaci Ammoniata* and *Tinctura Valerianæ Ammoniata*, the latter a good and useful antispasmodic, though not increased in strength, are improved by their preparation with the Aromatic Spirits of Ammonia, in place of Rectified Spirits and Liqueur Ammonia. *Tinctura Lupuli* of the Edinburgh Pharmacopœia has been substituted for the *Tinctura Lupulinæ*. *Tinctura Quinæ Composita* has been introduced from the London Pharmacopœia, it is an elegant preparation, in which the sulphate of quinine is dissolved by tincture of orange peel; too much quinine has, however, been ordered, eight grains to the ounce, which is rather more than the tincture will dissolve. *Tinctura Arnicæ Radicis*, *Tinctura Sabinæ*, and *Tinctura Senegæ*, not heretofore officinal in any of the Pharmacopœias, have been introduced. To the first I have already alluded, the others require no special mention. I think they should prove good and useful preparations. *Tinctura Cinchonæ Flavæ* has been substituted for the *Tinctura Cinchonæ*, in which the pale bark was used. Of the Tinctures of the Dublin Pharma-

copœia few have undergone material change. *Tinctura Belladonna* as now ordered is only half strength of the former Tinctures. *Tinctura Camphoræ* is now called *Spiritus Camphoræ*. *Tinctura Capsici* is ordered to be prepared with rectified in place of proof spirit, and is now only half its former strength. *Tinctura Cardamomi Composita* is slightly changed, it is more aromatic, and has raisins entering into its composition. *Tinctura Ferri Sesquichloridi* is now only one-fourth the strength of the former Tinctures of the Dublin Pharmacopœia. *Tinctura Iodi* as now ordered, while containing the same quantity of iodine, only contains one-fourth the quantity of iodide of potassium.

Tinctura Lavandulæ Compositæ is now coloured with sandal wool in place of cochineal; this is a very proper change, as this tincture is ordered to colour the Liqueur Arsenicalis. Heretofore the Arsenious Acid destroyed the colouring matter of the cochineal, as you are aware it would do with any animal matter, and a muddy solution, uncertain in colour, was the result; now no change will take place. I can see no necessity for two Tinctures of Lobelia, the old tincture made with rectified spirit might have been expunged when the ethereal was introduced. *Tinctura Opii Camphorata*, now called *Tinctura Camphoræ c. Opio*, contains two grains of opium in one ounce, formerly it contained two and one-third grains, otherwise it is the same. *Tinctura Zingiberis* is little more than half the strength of the former tincture.¹ *Tinctura Opii* remains unchanged, as do most of the other Tinctures.

The greater majority of the tinctures are ordered to be prepared by digesting the ingredients of which they are composed in spirit for forty-eight hours, and then percolating them. Though this method is very convenient for the apothecary, I do not think that as good Tinctures will thus be formed as by the previous method of digesting them for fourteen days. I may, however, be prejudiced in favour of the old method. The Pharmacopœia invariably orders that when the percolation is completed enough of the menstruum should be added to make up the original quantity of fluid, this will, of course, in many instances weaken materially the strength of the tincture. Hence, though the same quantity of the respective drugs be ordered, the new tinctures will be weaker than those formerly prepared.

Lozenges not heretofore in the Dublin or London Pharmacopœias are now introduced, they are -

Trochisci Acidi Tannici, having one-half grain, Tannic Acid in each lozenge.

Trochisci Bismuthi, having two grains Bismuth in each lozenge.

Trochisci Catechu, having nearly one one-fourth grain Catechu with a little Capsicum in each lozenge.

Trochisci Morphicæ, having one thirty-six grain Mor-

¹ It is now not so strong as formerly, as it does not contain more than three and a half grains to the drachm.

² *Tinctura Aloes* is ordered to be prepared from Socotrine Aloes and Extract of Liquorice, it contains eleven grains of aloes in one ounce.

³ *Tinctura Kino* is a good and useful astringent, difficult to keep from its readily becoming gelatinous.

⁴ It takes the place of *Tinctura Cinnamomi Composita*, a much more useful preparation, in which ginger and cardamom seeds were ordered with the cinnamon.

¹ *Tinctura Conii* is made from the fruit, formerly it was officinal in both the London and Edinburgh Pharmacopœias, and was prepared from the leaves, in the same proportion as now ordered.

phiæ Hydrochloras in each lozenge.

Trochisci Morphix et Ipecacuanhæ, having one thirty-six grains Morphix Hydrochloras, with one-twelfth grain P. Ipecac in each lozenge.

Trochisci Opii, having one-tenth grain Ext. Opium in each lozenge.

Of the above the last three were officinal in the Edinburgh Pharmacopœia. As these lozenges are all in general use, I think that it was wise to ensure uniformity of composition by giving formulæ for their preparation.

Among the Ointments we have the Unguentum Aconitiæ, Atropiæ, and Veratriæ, all new preparations, ordered to be prepared¹ by eight grains of the respective alkaloids, and adding one ounce of lard. Ung. Calomelanos, also now prepared by mixing eighty grains of Calomel with one ounce lard.

Ung. Gallæ c. Opio and Ung. Hydrargyri Ammoniati, both useful ointments, are introduced from the Edinburgh and London Pharmacopœias, the former is prepared by adding thirty-two grains powdered opium to one ounce of gall ointment.

Ung. Cocculi has been introduced from the Edinburgh, and the Ung. Belladonnæ from the London Pharmacopœia, the latter has very properly been made much stronger; it now has eighty grains of the extract mixed with one ounce lard, formerly it had only one drachm in four ounces. Ung. Terebinthinæ is a preparation almost similar to the Linim. Terebinthinæ, and might well have been omitted.

Ung. Antimonii Tartarati is now double its former strength. Ung. Hydrargyri Iodidi Rubri has very properly been reduced in strength, it now contains sixteen grains to one ounce, in place of one drachm to seven drachms.²

The other ointments have been little changed. Ung. Simplex is changed, though not improved in colour. Some of the ointments introduced into the Pharmacopœia are, I cannot help thinking, comparatively useless. I cannot see any use for the Ung. Atropiæ, and though the Ung. Calomelanos is useful in many cases, the prescriber would generally prefer to order whatever quantity of Calomel he thought fit in each particular case. The name Unguentum Hydrargyri Ammoniati should have been changed, the salt is a Chloro-Amidiæ of Mercury, and contains no Ammonia. Ung. Precipitatum Album, the ordinary name would have been much better.

A formula has been introduced for the preparation of Veratria.

We have introduced from the London and Edinburgh Pharmacopœia the Vinum Aloes, containing sixteen grains Aloes in one ounce; Vin. Antimoniale, containing two grains Tartar Emetic in one ounce, and

¹ Dissolving in spirit or rubbing up with oil.

² The formula for making Ung. Citrini is much improved, it will now make a good ointment, which will keep well.

Vin. Colchici, all well known preparations.

Vin. Ferri is introduced from the London Pharmacopœia, and contains eight grains Tartarated Iron in one ounce.

Vin. Ipecacuanhæ has been made one-fourth weaker, and Vin. Opii is the same strength as Tinct. Opii.

I need only name the preparations of Zine now officinal. They are Zinci Acetas, Zinci Carbonas. Zinci Chloridum, Zinci Oxidum, Zinci Sulphas, and Zinci Valerianas.

I have now finished the consideration of the preparations of the British Pharmacopœia, and need only call attention to the Appendix, which contains in one division the chemicals employed in the preparation of medicines, though not themselves used in medical practice; in the other, the tests ordered for the chemical analysis of the different preparations contained therein.

We miss from the British Pharmacopœia the following preparations heretofore officinal in the Dublin:—

Sodæ Acetas.	Ung. Cupri Subacet.
Morphiæ Acetas.	— Picis Liquid.
Calcii Chloridum.	— Plumbi Iodidi.
Zinci Chloridum.	Spt. Ammonix Fœtid.
Decoct. Dulcamaræ.	Empl. Ammoniac.
— Lini Comp.	Cupri Ammon. Sulph.
— Myrrhæ.	Syr. Croci.
— Pyrola.	— Morphix Acet.
— Uvæ Ursi.	— — Muriat.
Spt. Etheris Oleosus.	Liq. Antimonii Tartar- izati.
Infus. Menthæ Viridis.	Tinct. Ferri Acetatis.
— Juniperi.	— Cubebæ.
— Pareiræ.	— Guaiaci
— Simarubæ.	— Matico.
Arsenici et Hydrg. Hydriod.	Ferri Valerianas
— Liquor.	Quinæ —
Plumbi Iodidi.	Acetum Cantharidis.
Sulphur Iodatum.	— Colchici.
Mist. Ferri Aromat.	— Opii.
Hydrarg. c. Magnes.	— Scillæ.
Plumbi Nitras.	Acid. Acet. Camphorat.
Stanni Pulvis.	

There are also a few other substances seldom used and of little importance (as indeed are most of the foregoing) omitted from the Pharmacopœia. In looking over the list we will regret the loss of Hoffman's Ether, Donovan's Solution, Iodide of Lead, Aromatic Iron Mixture, Tincture of Acetate of Iron, and the Valerianate of Quinine from our Materia Medica. All the decoctions above-named, except that of Myrrh, which is a useless preparation, rarely ordered, appears in the British Pharmacopœia as Infusions. In the list of Infusions omitted, we find Inf. Menthæ Viridis, an agreeable menstruum in irritability of the stomach; Inf. Juniper,

which, as a good diuretic, was a nice vehicle in which to administer other medicines of a similar kind; Inf. Pareira, very properly now ordered in the form of Decoction, and Inf. Simarubæ, which was a comparatively useless preparation. In the Ointments, Ung. Picis Liquid, though a very nasty preparation, was often particularly useful, and Ung. Plumbi Iodidi was much used as a discutient, especially when applied to glandular enlargements.

I have in the foregoing paper endeavoured to place before you the more salient features of the British Pharmacopœia. After all, as you see, the changes have not been more extensive than we had a right to expect. As a rule the medicines when changed have been made weaker, and when a contrary course has been pursued, a special notice to that effect has been affixed. I regret that the Committee who prepared it should have seen fit to change the names of most of the alkaloids; thus Aconitia, Beberia, Quinia, have been introduced in place of the much more elegant names Beberina, Quinina, Aconitina. As the termination *ine* is used in chemistry to express an alkaloid, and most of us are accustomed to consider it as the active principle of the particular plant to which it may refer, I think that it would have been well not only to have retained it, but to have endeavoured to obtain uniformity by introducing it where it had not been hitherto in use; thus Morphina might have been called Morphina. Iodinium has been changed to the much less elegant Iodum; Liquor Chlorinii is now called Liq. Chlorig.

Other changes in nomenclature have also been adopted, to which time will not permit me to refer. Greater care should have been taken to prevent errors in the printing of the Pharmacopœia. At page 317, "Scammonizæ Resina" is translated "Resin of Jalap."

The Council in the latter part of their Preface say: "In conclusion, the Council warn all apothecaries and pharmaceutic chemists, that on the publication of the British Pharmacopœia it will be necessary, in order to discharge safely their duties to the public, that they should duly alter or destroy all pharmaceutic preparations made according to previous and now altered formula." I cannot but think that it would have been better had they fixed a day when the Pharmacopœia would have come into general use. They delayed the publication of it until a special Act of Parliament could be procured to compel its adoption, and surely they might readily have mentioned a date on and after which it would have been imperative upon all apothecaries and chemists to compound thereby; failing this, I think that it was the duty of the compounders of medicine to lose no time in complying with the order, they had legally no alternative but to do so. In all the first-class houses in the metropolis this course has been adopted. It would have been presumption on their part to have disobeyed the law, and have waited until they thought that the members of the profession had become acquainted with

its contents. The medical men are almost as well able to make themselves masters of its contents as are the apothecaries, and for those who cannot, or do not choose to do so, it is very easy for them to write Ph.D. quite as easy and much more regular than for those who wish to order the new formula to write Ph.Br. As you may have seen, owing to the strength of the great majority of the preparations when changed having been lessened, greater risk must necessarily be run by compounding from the Dublin, when the British Pharmacopœia is intended, than by pursuing the contrary course.

I have trespassed so long on your attention that I must now conclude, and thanking you for the patience with which you have listened to me, express my regret that the paper which I have now read was not more interesting, and that I could not, without wearying you, or reading another paper, have gone more fully into the details of the British Pharmacopœia.

Dr. Browne asked in reference to non-pharmacopœial medicines hitherto in use if the apothecaries would be obliged to abstain from keeping them.

Professor Ferguson remarked that as a free British subject he asserted his right to kill as he liked.

Mr. Grattan congratulated Dr. Whitaker on the paper which he had read.

It was proposed by Dr. Browne and seconded by Professor Ferguson that Dr. Whitaker with Messrs. Grattan and Pring be appointed a committee to draw up a synopsis of the changes most important to practitioners which have been introduced to the new Pharmacopœia.

It was also passed that Dr. Whitaker be requested to publish in a separate form the paper just read.

James Patterson, President

Pathological Room February 13th, 1864

Present, the President, Drs. Browne, Stewart, Whitaker, Little, Mr. Grattan, Drs. Cuming, D. Moore, W. MacCormac.

Mr. Grattan brought up the report of the Pharmacopœia Committee.

Dr. Browne made some further remarks on a previously reported case of hernia. On the 15th of the month, the man was seized with fæcal vomiting, and fæces began to appear at the wound. It was a case of ileus, and depended on a loaded state of the lower part of the intestine, as an enema gave relief. The wound afterwards became healthy and the man was well till the 28th. He had been for years subject to somewhat similar attacks. At the last mentioned date the former symptoms were renewed and aggravated. A poultice was placed on the abdomen, hydrocyanic acid was administered, and an enema given. On the 5th inst. he was discharged from [hospital]. There is

at present a fistulous opening in the locality of the wound. The man's safety depends on the regular administration of enemas.

Dr. Browne then brought forward a case of lithotomy by median section. He referred to another case which occurred in 1858 and in which he had removed a stone by a similar operation. He had also removed a foreign body in a similar manner.

The present patient had been treated two years ago for urinary irritation. Dr. Cuming found in the urine crystals of ammoniaco-magnesia phosphate, pus globules and crystals of oxalate of lime.

By the lithometer the calculus was found to measure $\frac{7}{8}$ of an inch. After removal the stone measured $3\frac{1}{4}$ inch in its short circumference and $3\frac{1}{2}$ inches in its long circumference. The diameter measured respectively $\frac{11}{8}$ ths, $\frac{10}{8}$ ths and $\frac{7}{8}$ ths inch. It weighed 5 drachms, and it consisted of oxalate of lime covered with some phosphatic deposits.

Three days after operation the urine came away by the urethra. In this case the density of the stone was an objection to the employment of lithotrity.

An advantage of this operation is the slight danger of wounding large vessels. There is also little danger of infiltration of urine. It avoids also wounding the prostate. This case shews the possibility of extracting a moderately large stone without making lateral section. In the old median operation the incision was made into the bulbous part of the urethra.

Dr. David Moore strongly condemned lithotrity.

Dr. Browne expressed himself in favour of lithotrity in proper cases.

James Patterson, President

20th February, 1864

Present, Drs. Patterson, Stewart, W. MacCormac, J. Reade, Keown, Cuming, H. Burden, D. Moore, Croskery, and Whitaker. Staff Surgeon Saunders was also present.

Mr. Croskery was unanimously elected a member of the Society.

Dr. Cuming read a paper "On recent researches on Inflammation."

Dr. Reade quite agreed with Dr. Cuming in thinking that the views formerly put forward on inflammation, were in many respects untenable, but did not see that the new theories led in anyway to an improvement or modification in the treatment thereof.

Dr. H. Burden thought that though, in the case related by Dr. Cuming, the fifth nerve was paralysed, still that the sympathetic nerve which accompanies it, might have been intact and thereby the inflammation of the conjunctiva have ensued. He also objected to the statement that the sympathetic nerve of the neck had been divided with little loss of nutrition to the parts thereby supplied.

Dr. W. MacCormac wished that Dr. Cuming would

continue the subject in another paper.

Dr. Keown asked Dr. Cuming how he thought the pain was occasioned where no nerve fibrils were interfered with.

Dr. Cuming in reply thought that pain might be occasioned by interference with a part over which some nerve fibril had control without any direct disturbance of the nerve itself. In answer to Dr. Burden he thought that the absence of laceration shewed that the sympathetic nerve had not been interfered with. Dr. Cuming also thought that while new views on the subject of inflammation would not change the local treatment that they might materially modify the remedies given internally.

James Patterson, President

[27th February, 1864]

Present, Dr. Patterson (President in the chair), Professor Ferguson, Dr. William MacCormac, Thompson, McWilliam, McCrea.

The President read a communication from Dr. McKesy.

Professor Ferguson then gave an account of a case of bronchial diphtheritis. The patient suffered from the symptoms of a cold on Tuesday. On Wednesday ... when ... saw him, there was great dyspnoea, full compressible and irregular pulse. Some substance was expectorated which on examination turned out to be a cast of the air passages. The cast appeared to reach from the larynx to the bifurcation of the trachea. The second cast appeared to him a second edition of the first.

The chest was resonant on percussion. The respiratory murmur was heard here and there, sonorous and sibilant rales. The fauces were reddened, but there was only a spot of lymph exudation visible in this region. The dyspnoea was not so great as would have been the case if the larynx had been affected, and there was no pneumonia.

Professor Ferguson connected the case with the reigning epidemic in which there is a tendency to lymph exudation from mucous membranes. He directed attention to the fact, that the exudation of lymph is not an occurrence confined to the passages of large diameter. He considered all these effusions of lymph were produced in the same diseases, and that the differences between them arose from differences in the form of the fever.

The President said that in this case there had been loss of voice for six months before the acute symptoms came on.

Dr. McWilliam said the former belief was that the disease was till lately unknown in Britain.

Professor Ferguson said that this idea arose from our ignorance of the disease. The present disease was asthenic whereas what had long ago been described Bulonnean was sthenic. He did not think that there

was any connection between the chronic and acute affection in the present case. He thought that exudate of this kind was invariably acute. Death in diphtheritic affections is caused by the fever.

James Patterson, President

Pathological Room

March 5th, 1864

Present, the President, Drs. Little (Lurgan), McWilliam, McCrea, Mr. Grattan, Dr. Browne.

The President reported that Sir H. Cairns had presented the petition in favour of retiring allowances to Dispensary Medical Officers.

Dr. Little then gave an account of three cases of inguinal hernia.

Dr. Browne suspected that the first case was varicocele of the round ligament. He thought the operation should generally be performed as soon as possible.

Dr. Browne presented his case of calculus. The wound has healed quickly and the case gets on well.

James Patterson, President

Belfast Newsletter 9 March 1864 p3

The Ulster Medical Society.—Dr. Patterson yesterday received the following letter from Sir Hugh Cairns:

19, Eaton Place, London.

7th March, 1864.

Dear Dr. Patterson

The newspapers would show you that I duly received and presented the Petition of the Ulster Medical Society to the House of Commons on the 1st last.

Ever faithfully, H. M. Cairns.

March 12th

Present, the President, Drs. Thompson, Reade, Stewart, D. Moore, McWilliam, Dill, Cuming, Croskery and Whitaker.

Dr. D. Moore brought forward a case of abdominal tumour of three years standing and gave an interesting account thereof. He entered as fully as possible into the history of the case and thought that the swelling was due to the enlargement of the liver and spleen by the deposition of tubercle therein; he also stated that tubercle was present in the lungs and that the effusion formed no part of the abdominal swelling.

Dr. Reade referred to the difficulty of diagnosis in such cases, and while he thought that tubercle might have been deposited in the liver did not believe that the great expansion of the lower ribs was due thereto. He referred to a post-mortem of a case of phthisis, in which great dullness was present at base of both lungs of the patient, when it was found that the liver was fatty and enlarged, thereby distending the ribs. He had little doubt that in the present case, effusion

of fluid had taken place. As to treatment he thought that painting with Iodine, Chalybeates internally, with nutritious diet gave the best chance of success.

Dr. Cuming thought that no treatment would be of any avail. He agreed with Dr. Reade in thinking that the difficulties of diagnosis were almost insuperable. He could not attribute the whole of the tumour to the liver and believed that the spleen was also engaged. He also thought that some fluid was present, though not in sufficient quantity to be of any importance.

The President referred to a case almost similar to that of Dr. D. Moore, which terminated fatally, treatment similar to that recommended by Dr. Reade had been tried, but was of no avail.

James Patterson, President

Pathological Room

March 19th, 1864

Present, the President, Drs. D. Moore, Gribbin, Whitaker, McCrea.

Dr. Whitaker introduced the corrected proof of the Summary of the New Pharmacopœia. It was resolved that Dr. Whitaker send a copy of the Summary to members of the Society, with a request that they will specify the Pharmacopœia according to which they wish each prescription to be filled.

James Patterson, President

Pathological Room

April 2nd, 1864

Present, the President, Drs. D. Moore, W. MacCormac, Whitaker, McCrea, and Mr. Brooke the celebrated tragedian who was introduced by Dr. Moore.

Dr. Moore exhibited a patient in whom the scalp had been severely injured. The bone beneath had also necrosed. The patient was insensible when brought into hospital, but under proper treatment gradually recovered.

Dr. Moore lately removed the dead bone which included a part of the internal table. Dr. Moore drew attention to the pulsation of the brain, which he described as evidenced by the pulsatile issue of blood from the gap in the bone. Dr. Moore also mentioned a case in which the whole of the upper surface of the calvarium had been denuded. Granulations were springing up from the whole surface of the wound.

Dr. Moore then exhibited a case of ganglion of the wrist. The ganglion had had removed from it a considerable number of cartilaginous bodies, and was still discharging them.

Dr. W. MacCormac enquired why Dr. Moore had made two incisions instead of one and why he did not try force as a means of expulsion.

Dr. D. Moore gave an account of a remarkable case of congenital syphilis.

James Patterson, President

Pathological Room

April 9th, 1864

Present, the President, Professor Ferguson, Drs. W. MacCormac, Croskery, Whitaker, McCrea.

Dr. Whitaker read a paper by Dr. Scott of Aghnacloy on the curative effects of Glycerine and Bismuth.

Professor Ferguson thought that the effect of the mixture was merely mechanical.

Dr. W. MacCormac mentioned the use of Bismuth as an injection in certain cases of glands.

Dr. Moore brought forward a peculiar case of accident which required amputation of the arm. The forearm had been severely lacerated. An attempt had been made to save the limb but the recurrence of hæmorrhage and a swollen state of the limb necessitated amputation. Since the operation the patient has had rigors. The operation was performed four days after the accident.

Professor Ferguson enquired what were Dr. Moore's reasons for anticipating the favourable result from the attempt to save the limb.

Dr. Moore stated that although the ulna was destroyed, the radius was intact, the skin on the radial side of the arm was unhurt, and the man had the use of the thumb and two fingers. Under these circumstances he thought it mete to give the patient a chance of keeping his arm.

James Patterson, President

April 16th, 1864

Present, the President, Drs. Moore, Stewart, Gribbin and Whitaker.

Dr. Moore brought forward a case of necrosis of the bones of the carpus which occurred in a woman of about 40 years of age.

He entered into the history of the case, and stated that a swelling had taken place on the back of the wrist about 3 or 4 years, that matter had formed therein, fistulous opening ensued, and the hand became flexed and entirely useless. He removed the joint and the parts healed by the first intention.

Dr. Moore then referred to a case of fibro-cellular tumour of the tongue upon which he intended to operate in a few days.

Dr. Moore then shewed a tumour which he had recently removed from a gentleman's brow, and entered into the history, and treatment he adopted in such cases.

James Patterson, President

April 23rd, 1864

Present, the President, Drs. Stewart, McCrea, Ross, McWilliam, D. Moore, Croskery, Moore and Whitaker. Dr. Rea (H.P.) proposed and seconded by Drs. McCrea and Whitaker.

Dr. Whitaker moved and Dr. McWilliam seconded "That a special meeting of the Society be called for next Saturday to consider the present condition of

the Society." Carried.

Dr. Ross read a report of a case of intra-uterine polypies. He detailed the steps of the operation, which was successful.

Dr. Moore referred to the Laminaria Digitata as particularly useful in dilating the os.

Dr. McCrea asked what was the appearance of the tumour.

Dr. Ross stated that the tumour consisted of [calx?] surrounded by numerous fibrils.

Dr. Moore referred to a case of disease of the tarsus, in which he had removed all the bones except the astragalus and os calcis. He shewed the patient. He also stated that he intends to cut the Tendo Achilles.

Dr. Moore shewed the case of injury of the skull to which he had formerly called attention.

T.R., V.P.

April 30th, 1864

Present, Dr. Reade (Vice President, in the chair), Professor Ferguson, Drs. McCrea, Gribbin, McWilliam, Warwick, Smith, D. Moore, Croskery, Cuming, Stewart, and Whitaker.

The election of Dr. Rea was postponed till Saturday the 7th inst.

Professor Ferguson referred to the little interest that appeared to be taken in the proceedings of the Society, and regretted that the attendance of members on so important an occasion should be so limited.

He wished to know why the meetings of the Society should be so badly attended as they had latterly been. A desultory conversation ensued in which most of the members took part.

Dr. Smith apologised for his non-arrival at the time for commencing the meeting and entered into a general statement of the pecuniary condition of the Society.

Professor Ferguson moved, and Dr. McCrea seconded, "That a special meeting of the Society be called for Thursday next at 3p.m. to be held in the library of the General Hospital to receive a report from Council on the state of the Society and that the notice be marked 'most urgent'".

Drs. Stewart and Cuming were appointed Auditors. Carried.

James Patterson, President

May 5th, 1864

(Special Meeting)

Present, Drs. Thomas Reade (V.P. in the chair), Stewart, Smyth, D. Moore, W. MacCormac, Gribbin, Croskery, J. W. T. Smith, Brice Smyth, and Whitaker.

Dr. Stewart moved, and Dr. Brice Smyth seconded "That the report from Council be received and adopted."

Dr. Smyth (Sec) entered into a detailed statement of

Ulster Medical Society
Session 1863–1864
President James Patterson

the accounts of the Society.

Dr. W. MacCormac moved, and Dr. D. Moore seconded “That the ordinary subscription for town members be reduced to one guinea.” Amendment put and lost. Original motion put and carried.

Dr. Stewart moved and Dr. J. W. T. Smith seconded “That the Council be recommended to dispense with the services of John McCann and terminate their subscription to the two local papers.”

Drs. William MacCormac, J. W. T. Smith and David Moore were appointed to review the books and journals of the Society.

May 7th, 1864 [Annual Meeting]

Present, Drs. Patterson, President in the chair, Moore, W. MacCormac, McCrea, D. Moore, Smith, Cuming, Whitaker, B. Smyth, Surgeon Croskery, Gribbin, John Smyth and Whitaker.

The minutes of the meeting of the 30th and of the last Annual Meeting were read and confirmed.

Dr. H. P. Rea was unanimously elected a member of the Society.

Dr. McCrea moved and Dr. D. Moore seconded “That the minutes of special meeting be confirmed.”

Dr. W. MacCormac moved and Dr. Whitaker seconded “That the minutes of last meeting so far as the annual subscription are concerned be not confirmed. That the subscription for ordinary members be one guinea per annum for the future, and that life members do pay half a guinea subscription.”

Original motion was withdrawn, amendment carried unanimously.

The following gentleman were elected office bearers for the ensuing year.

President

Dr. Stewart

Vice Presidents [Town]

Dr. Moore, Dr. Smith (J. W. T. S.)

Do (Country)

Dr. Scott and Graves

Members of Council

Drs. Drennan, H. S. Ferguson, B. Smyth, Dill, Wheeler and Ross

Treasurer

Dr. Cuming

Secretaries

Drs. Whitaker and Croskery were elected.

Surgeon Gribbin was requested to see to the circulation of the Journals.

Drs. Wheeler and John Smyth moved and seconded a vote of thanks to the President which was carried by acclamation.

The President returned thanks in suitable terms. A vote of thanks was moved and seconded to the Sec-

retary and Treasurer for their services during the past year.

Robert Stewart, Chairman
6th May 1865

Ulster Medical Society
Session 1864–1865
President Robert Stewart

ULSTER MEDICAL SOCIETY

SESSION 1864–65

June 4th, 1864

Present, Drs. Stewart (President in the chair), Patterson, W. MacCormac, Moore and Whitaker.

There was no business transacted.

July 2nd, 1864

Present, Drs. Stewart (President in the chair), Patterson, JW Smith, Cuming, D. Moore and Whitaker.

A desultory conversation took place regarding the best means to bring the Society into good working order.

August 6th, 1864

Present, Drs. Stewart (President in the chair), Browne, W. MacCormac, Rea, Moore, McCrea, and Whitaker.

Minutes of last meeting read and confirmed.

A communication was read from Mr. H. Hyndman with regard to M. Rayouot whom he described as an unqualified practitioner calling himself Dr. Medicine. After some discussion Secretary was directed to write to Mr. Hyndman declining on the part of the Society to interfere in the matter.

September 3rd, 1864

Present, Drs. Stewart (President in the chair), McWilliam, H. Burden, H. P. Rea, Gribbin, and Whitaker.

The minutes of last meeting having been read and confirmed, ...

COMPILER'S NOTE

The Minute Book here contains a number of empty pages. Given the existing apathy, it seems likely that there were no meetings in that time.

THE ULSTER MEDICAL SOCIETY.
THE ANNIVERSARY DINNER.¹

The anniversary dinner of the members of the above Society took place on the 1st instant, in Mr. Thompson's rooms, Belfast. Amongst those present were—Dr. Stewart, President of the Society, in the chair; Dr. MacCormac, Professor Ferguson, Q.C.B.; Dr. James Moore, Vice-President; Dr. Pirrie, Dr. Cuming, Treasurer; Dr. Harkin, Dr. McCrea, Dr. David Moore, Dr. William MacCormac, Dr. Michael McGee, Dr. Whitaker, Secretary; Dr. McWilliam, Surgeon John Smyth, Dr. H. Rea.

Letters of apology were read from the medical officers of the garrison—Staff Surgeon-Major Docker and

Assist.-Surgeon Bayfield—both of whom had been specially invited as guests, but who much regretted that prior engagements prevented them from being present on this occasion. Dr. T. Reade, Dr. Drennan, and Surgeon Gribbin were also unavoidably obliged to be absent. The usual loyal toasts having been given, they were succeeded by "The Medical Departments of the Army and Navy." The President in proposing this toast said, he regretted much that there were no members of either branch of the service present this evening to call upon to speak to it; he could not, however, permit the opportunity to pass by without observing that their brethren in the army particularly had still every reason to feel deeply aggrieved and wronged in respect of the inexcusable conduct of the military authorities, in regard to the Queen's Warrant of 1858, having rendered it to all intents and purposes a dead letter, the consequence of which was, that candidates of any spirit were thus prevented from coming forward in sufficient numbers to fill the vacancies in existence, and not only this, but to cause both surgeons and assistant-surgeons to resign their commissions. This was the worst policy imaginable, and sooner or later it would be found to be so (hear).

"The Medical Faculties of the Queen's Colleges," which was very ably spoken to by Professor Ferguson.

"The Medical Charities of Belfast," responded to by Dr. Pirrie and Dr. William MacCormac, on behalf of the General Hospital; Dr. David Moore for the Dispensaries; and Dr. H. Rea for the Belfast Union Hospital.

"The Ulster Medical Society," responded to by the Vice-President of the Society.

"The Royal Medical Benevolent Fund Society of Ireland." Dr. Cuming, having been generally called upon, replied to this toast very effectively.

"The Officers of the Society," responded to by the several officials present.

"Our Absent Members, and, in particular, Dr. Patterson," one of the most valued members of the Society, whose absence on the present occasion, owing to a recent severe domestic affliction, was much sympathised with by all present.

"The General Practitioners of Belfast, coupled with the name of Surgeon Smyth," who responded in an excellent speech.

Some further toasts having been given by the members generally during the evening, Dr. M. McGee, of the number, who spoke very largely and eloquently on several subjects, the company separated much pleased with the entire arrangements of the day, and the very satisfactory manner in which Mr. Thompson had fulfilled his important part upon the present occasion.

April 23rd, 1865

Present, Drs. Stewart (President in the chair), Moore, Gribbin, W. MacCormac, D. Moore, Rea, Surgeon N. Moore and Whitaker.

¹ [Dublin Medical Press, 1864, November 16, p499.]

As there was no business to be transacted, a desultory conversation took place among the members as regards the position of the Society etc. after which—

Drs. D. Moore and H. P. Rea were elected Auditors of accounts.

Surgeon N. Moore resigned his appointment as Librarian to the Society, as he found that his time was so fully occupied that he could not properly attend to the duties of the office.

Robert Stewart, Chairman
6th May, 1865

May 6th, 1865 [Annual Meeting]

Present, Drs. Stewart (President in the chair), Patterson, W. MacCormac, McCrea, D. Moore, Cuming, Surgeons Nevin Moore, Gribbin, and Whitaker.

The minutes of the last Annual Meeting and of the 23rd ult. were read and confirmed.

The Accounts for the past year having been duly audited were passed. The Treasurer made some remarks on the financial position of the Society, and the probable result of the next year's income.

President

Dr. Moore

Vice Presidents

Drs. MacCormac (W.) and Patterson

Dr. MacCormac resigned the office. Dr. Drennan was elected in loco.

Country Vice Presidents

Dr. Scott and Moore

Members of Council

Drs. Whitaker, Harkin, H. S. Ferguson, D. Moore, Browne and Murney

Dr. MacCormac moved and Dr. Patterson seconded that the Treasurer be requested to continue his valuable services for the ensuing year.

Dr. Whitaker then tendered his resignation.

Dr. Cuming moved and Surgeon Gribbin seconded the appointment of Dr. McCrea as Secretary. Carried unanimously.

Dr. MacCormac moved and Dr. D. Moore seconded "That Mr. Richard Watson, the house steward of the hospital, be elected librarian at a salary of £10 per annum." Carried unanimously.

Dr. Cuming moved and Dr. W. MacCormac seconded "The President leave the Chair and Dr. Patterson take it." A Vote of thanks to Dr. Stewart for his unwearied attention to the interests of the Society and the exertions which he has made during his year of office.

Robert Stewart, Chairman
2nd September 1865

ULSTER MEDICAL SOCIETY

SESSION 1865–66

462 Notice of meeting on 3rd June 1865

President.

Dr. Moore.

Vice-Presidents.

Dr. Drennan.

Dr. Moore (Glenarm).

Dr. Patterson.

Dr. Scott (Aughnacloy).

Members of Council.

Dr. Browne.

Dr. Whitaker.

Dr. Murney.

Dr. D. Moore.

Dr. H. S. Ferguson.

Dr. Harkin.

Treasurer.

Dr. Cuming.

Secretary.

Dr. M'Crea.

The Second Meeting of the present Session will be held in the General Hospital, on Saturday, the 3rd of June, at Three o'clock, P.M.

Business

Dr. D. Moore will introduce a child with a large tumour on the side of the chest.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to either of the Secretaries.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretaries, with their qualifications and Subscription.

Signed by order,

John M'Crea, M.D.
Secretary.

Belfast, 1st June, 1865.

464 Letter (presumably addressed to the members).

June 2, 1865.

Sir

The Council of the Ulster Medical Society is anxious to secure a regular distribution of the Periodicals.

I am, therefore, instructed to request that you will be so good as to inform the Librarian or the Secretary of any irregularity that may occur in your supply.

I am,
Your obedient Servant,
John M'Crea, M.D.
Secretary.

General Hospital

June 3rd, 1865

Second Meeting

Present, the President, Drs. Reade, D. Moore, N. Moore, McCrea, Stewart.

The President returned thanks for the honour the Society had conferred on him.

Dr. D. Moore introduced a child with a large tumour on the upper part of the side of the chest. The tumour commenced about 14 months ago in the axilla. At first it subsided but afterwards increased for 5 months. During the next 4 months it was about the size of a hen's egg. At this period it was open. It has been increasing for six weeks with great rapidity. An exploratory opening lately made gave exit to serous fluid. He considered that it consisted of cysts and might become malignant. He therefore considered the question of removing it worth consideration.

Dr. Reade would have no hesitation about removing it. Explore first and if contents be serous withdraw them. This would diminish the size of the tumour and facilitate its removal.

Dr. Reade also mentioned a remarkable case in which he had removed an enormous tumour from the side of a child's chest.

The President considered it a multi-locular tumour with a tendency to encephaloid degeneration. Make a number of openings in it; reduce the size of it by this means. Explore with the finger inserted in one of the openings. Avoid the axillary vein which is often connected with tumours like this.

Dr. D. N. Moore looked on the tumour as non-malignant.

Dr. D. Moore: The child's age, the absence of adhesions, the mobility of the skin, the freedom from affection of the cervical glands are against the idea that the tumour is malignant.

On the motion of Dr. Stewart seconded by Dr. D. Moore it was resolved that the salary due the late librarian be paid.

Robert Stewart, Chairman
2nd September 1865

463 Notice of meeting on 1st July 1865

President.

Dr. Moore.

Vice-Presidents.

Dr. Drennan.

Dr. Moore (Glenarm).

Dr. Patterson.

Dr. Scott (Aughnacloy).

Members of Council.

Dr. Browne.

Dr. Whitaker.

Dr. Murney.

Dr. D. Moore.

Dr. H. S. Ferguson.

Dr. Harkin.

Treasurer.

Dr. Cuming.

Secretary.

Dr. M'Crea.

The Third Meeting of the present Session will be held in the General Hospital, on Saturday, the 1st of July, at Three o'clock, P.M.

Business

Dr. Ross will read a paper on the Fevers of Ireland.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary of Council not later than Wednesday morning in each week.

487 Detached fragment of the above page.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to either of the Secretaries.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretaries, with their qualifications and Subscription.

Signed by order,

John M'Crea, M.D.
Secretary.

Belfast, 29th June, 1865.

466 Notice of meeting on 24th July 1865

President.

Dr. Moore.

Ex-President.

Dr. Stewart.

Vice-Presidents.

Dr. Drennan.

Dr. Moore (Glenarm).

Dr. Patterson.

Dr. Scott (Aughnacloy).

Members of Council.

Dr. Browne.

Dr. Whitaker.

Dr. Murney.

Dr. D. Moore.

Dr. H. S. Ferguson.

Dr. Harkin.

Treasurer.

Dr. Cuming.

Secretary.

Dr. M'Crea.

A Special Meeting of the Society will be held in the General Hospital, on Monday, the 24th of July, at Three o'clock, P.M.

Business

To take measures, if thought advisable, to promote the appointment of a Medical man as Coroner.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to either of the Secretaries.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretaries, with their qualifications and Subscription.

Signed by order,

John M'Crea, M.D.
Secretary, Belfast, 22nd July, 1865.

General Hospital

July 24th

Special Meeting

Present, the President, Drs. Stewart, Patterson, Drennan, Dill, Wheeler, Whitaker, D. N. Moore, McWilliam, McCrea.

Robert Stewart, Chairman
2nd September 1865

467 Notice of meeting on 5th August 1865

[Top of page missing.]

Secretary.

Dr. M'Crea.

The Fourth Meeting of the Society will be held in the General Hospital, on Saturday, the 5th of August, at Three o'clock, P.M.

Business

The Coronership.

The vacancy in the Medical Inspectorship of Factories.

Dr. Ross's Paper on "The Fevers of Ireland."

The President will exhibit an enormous Tumor removed from a Lady's Breast.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John M'Crea, M.D., Secretary.
Belfast, 3rd August, 1865.

General Hospital

August 5th, 1865

Fourth Meeting

Present, the President, Drs. Patterson, Stewart, Reade, D. Moore, B. Smyth, McCrea, Holden (visitor).

The President brought under consideration the Coronership, and a notice from Mr. Baker that an appointment of assistant to Dr. Thompson, the Medical Inspector of Factories would shortly be made.

The President shewed an encephaloid tumour of the mamma, which he had removed by enucleation and without the assistance of chloroform. The wound had healed by the first intention almost entirely. The tumour had been nearly nine years growing.

Dr. D. Moore remarked on the absence of affection of the lymphatics, and said that this more common the case in encephaloid than in schirrhous affections.

Dr. Reade thought it worth considering whether or not an operation ought to be performed even in

necessarily fatal cases, in order to make the mode of death less painful. Dr. Reade was not prepared to subscribe to Dr. D. Moore's opinion that affection of the glands was less likely in encephaloid.

Dr. Reade called attention to a circular asking for subscriptions for a monument to the late Professor Ferguson. He thought that a public meeting should have been summoned.

Robert Stewart, Chairman
2nd September 1865

468 Notice of meeting on 2nd September 1865

[Top of page missing.]

Secretary.

Dr. M'Crea.

The Fifth Meeting of the Society will be held in the General Hospital, on Saturday, the 2nd of September, at Three o'clock, P.M.

Business

Dr. Smith will shew a diseased Brain.

Dr. Ross will read a paper on the "The Fevers of Ireland."

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John M'Crea, M.D.
Secretary.

Belfast, 1st September, 1865.

**General Hospital
September 2nd, 1865
Fifth Meeting**

Present, Drs. Stewart (Chairman), Smith, Ross, Gribbin, Holden, McCrea.

The man was admitted to hospital on April 1st of this year and went out. He was re-admitted on 17th June. He had acute pain over right temporal bone. Tongue thrust to right side. Ptosis of right eye. Pain diminished under use of Iodide of Potassium but still there was slight difficulty of speech. On August 1st readmitted. Health bad. Hiccup. Great constipation. Muscles of deglutition much affected. His left side was weak. Paralysis of left arm but not complete. Died of asthenia on August 27th. From the incompleteness of the paralysis a tumour at base of brain was suspected.

On P.M. adhesion of cerebellum at junction with Crus to petrous bone just below internal auditory

meatus. A tumour on medulla oblongata. This pressed on eighth, seventh and ninth pairs of nerves. Hypoglossal obliterated. The tumour was an enlargement of one half of the medulla oblongata.

James Moore M.D.

465 Letter to members

September 22, 1865

Sir

A Special Meeting of the Society will be held at the General Hospital, on Saturday, the 23rd instant, to consider the following advertisement:—

Belfast Union

Wanted, a legally qualified Resident Medical Officer for the Infirmary etc. of the Workhouse at a Salary of £45 per annum with first-class rations.

Testimonials to be lodged with me before Eleven o'clock A.M. on Tuesday the 3 proximo. when personal attendance of the candidate is required.

Information as to duties, &c., may be known on application to Dr. Seaton Reid.

(By order of the Board),

William F. Boyce, Clerk of the Union
Board-room, Workhouse, Sept. 20, 1865.

John M'Crea, M.D., Secretary.

**General Hospital
September 23rd, 1865
Special Meeting**

Present, the President, Drs. Stewart, Patterson, Drennan, Cuming, MacCormac, Whitaker, D. N. Moore, D. Moore, McCrea, Murray, Dill, Gribbin.

The following advertisement was read

Belfast Union

Wanted, a legally qualified Resident Medical Officer for the infirmary etc. of the Workhouse at a Salary of £45 per annum with first-class rations. Testimonials to be lodged with me before 11 o'clock a.m. on Tuesday the 3 prox. when personal attendance of the candidate is required.

It was moved by Dr. Patterson and seconded by Dr. Stewart and unanimously resolved "That the Society express its decided opinion that the remuneration proposed is entirely insufficient to recompense such Medical Officer for duties requiring his entire time, and that the offer of such salary is derogatory to the Medical Profession at large."

Dr. Drennan moved and Dr. Gribbin seconded

That the resolution be published in an advertisement in the Belfast papers of Monday and Tuesday.

James Moore M.D.

Advertisement¹

ULSTER MEDICAL SOCIETY.

A Special Meeting of the above Society

was held on Saturday, September 28rd, Dr. Moore, President, in the chair.

An advertisement issued by the Belfast Board of Guardians, announcing that a legally qualified Resident Medical Officer is wanted for the Workhouse Infirmary, and offering a salary of £45 per annum for such office having been read, it was resolved—

“That the Society express its decided opinion that the remuneration proposed is entirely insufficient to recompense such Medical Officer for duties requiring his entire time, and that the offer of such salary is derogatory to the Medical Profession at large.”

COMPILER'S NOTE

The four extracts below provide some background to the advertisement and responses from others.

BELFAST BOARD OF GUARDIANS
25 July 1865
AN ADDITIONAL OFFICER.²

Mr. Gaffikin said he thought Mr. Newett, the resident surgeon and apothecary, had too much by far to do. They had two eminent consulting physicians, but then the actual work which devolved upon Mr. Newett was excessive, and immediate arrangements should be made for the employment of another permanent assistant in that department. The duties of the situation were much heavier now than when the gentleman was first appointed, and there no less than 93 cases admitted to hospital last week. It was said that, with the advance of wages, the number of applications for admission to the hospital would diminish. Now the converse of this seemed to be the case, for the admissions had for some years past annually increased. It did not matter what wages a man had if when or his family became ill, he had nothing past him. The average cases per week in '61 were 50, and for aggregate cases for the year were 553; in '62 there were 77 cases weekly, and a total of 683 for the year; in '63 there were 99 cases weekly, and 752 were attended to during the year; in '64 the cases were 94 weekly, and 765 for the whole year. For the present year there had been 96 per week.

The Chairman thought the consideration of the matter should be deferred till the return of Dr. M'Gee, who was at present in the Isle of Guernsey. Dr. M'Gee had made inquiries, and had a report to submit on the subject.

The matter then dropped.

¹ [Medical Press Advertiser, Second Series, 1865, September 27.]

² [Belfast News-letter, 1865, July 26.]

BELFAST BOARD OF GUARDIANS

5 September 1865

REPORT OF THE HOSPITAL COMMITTEE.¹

Mr. Gaffikin then read the following report of the above committee:—

“We, your committee summoned to inquire and report on the medical staff of the workhouse, met today, when there were present—Messrs W. M'Gee, M.D., Thomas Gaffikin, James Entwhistle, and Robert Carlisle—John Hamill, Esq., occupying the chair.

After mature deliberation, and having also considered the letters of Drs. Reid and Mulholland, we beg leave to report that, in accordance with the views set forth in Dr. Reid's letter of the 22nd May, 1865, we recommend the appointment of an additional legally qualified resident medical officer, at a salary of £45 per annum, with rations and quarters. The details of his duties to be as set forth in the 1st, 2nd, 4th, and 5th paragraphs of Dr. Reid's letter.”

[In the discussion, Mr. Gaffikin said] Since that time [25 July] Dr. Newett had taken ill, and they had two young men employed in his place, doing the same work as he himself had done. Surely, with nearly 1,000 sick, they should have a resident surgeon, who would visit the wards and look after the patients daily.

BELFAST BOARD OF GUARDIANS

19 September 1865

APPOINTMENT OF ANOTHER MEDICAL OFFICER.²

Mr. Gaffikin moved that advertisements be inserted in the local papers for a properly qualified medical officer, at a salary of £40 a-year, for the union. He said that, with respect to the necessary accomplishments of the medical officer, Dr. Reid would be prepared to acquaint the Clerk as to how the advertisement should be published. He thought the scale of duties should be made public also. The salary which they offered was very small, and it was his opinion that a better qualified officer could be obtained for a higher salary. If that were the case, he would be prepared to vote for an increase of the salary.

Dr. M'Gee seconded the motion. The duties, he said, were to be learned from the Clerk; and with regard to the increase of salary, the Poor-law system did not allow them to increase it at present. It appeared to him that the salary was a small one; but, to satisfy some of the economists at the Board, he took a mean between the salaries which had been suggested by Dr. Reid—£40 or £50. He would propose that a salary of £45 be given.

¹ [Belfast News-letter, 1865, September 6.]

² [Belfast News-letter, 1865, September 20.]

PROFESSIONAL ESTIMATE OF
PROFESSIONAL SERVICES.¹

Our experience of medical men as arbitrators for their own profession is not, we are sorry to say, to their credit, and we have a text for comment in our columns to-day worthy of attention. It is seldom that medical men are placed in a position to require their estimate of the value of professional services, and we are sorry to say it is well for their brethren that it is so, for in many instances there is no taskmaster so unreasonable, no employer so ungenerous, and no paymaster so mean and little-minded as your ex-doctor. The Cork Board of Guardians has hitherto derived peculiar lustre from its connexion with a certain retired apothecary, who from time to time refreshes his stock of public magnanimity by an attack on his medical brethren, the officers to the union, and his example has raised up competitors in the same line in Belfast. It appears that the Belfast Board of Guardians also keep a medical Cerberus whose especial role it is to snarl over every morsel which his medical subordinate gets, and, if possible, to prevent him getting anything at all. The Board want an assistant medical officer; they require the highest qualifications and unremitting labours, and they appeal to Dr. Reid and Dr. McGee to assess the value of a doctor's education and brow sweat. These gentlemen are well bestowed with this world's goods, they know not hunger, hard-work, or fatigue, and they think a medical man well and fully paid for a year's work by the sum of £45, or as one of them expressed it, "only two-thirds of what they would give a bricklayer or carpenter." The *Banner of Ulster*, in a just and well deserved condemnation of the conduct of these gentlemen, says—

"The public service, of which we speak, is a lottery, and it has always surprised us how a profession so learned, so gifted, so self-denying, so essential to public well-being as the medical profession undoubtedly is, could rest content with the "blank" in the lottery that has been awarded to it.

"The poor curates of the Established Church, miserably remunerated as they are, must give way to the medical profession. We take a case in point, one that obtrudes itself under our own note. The Belfast Board of Guardians wanted an assistant medical officer, and on Tuesday last they took the matter into consideration. The munificent salary offered was £40 a year, for a medical gentleman fully qualified, not only as a Physician, but as an Apothecary!

We are told in the report that Dr. Reid's estimate of the money value of the services of

such a gentleman ranged from £40 to £50 a year, and then Dr. McGee being desirous of conciliating 'the economists at the Board' was content to strike a mean, and propose that £45 should be given! But while he did this he added, that 'he thought the salary should be at least £1 a week, which was only two-thirds of what they would give a bricklayer, or carpenter, or any other good artisan!'

"Now, is not all this very miserable—excessively humiliating? Here we have medical gentlemen of considerable standing, and in such affluent circumstances as makes them independent of their profession as a mere income, chiming in with the wretched views of those who depreciate the medical profession. We do not blame the public at large. We believe the public as a whole, fairly value professional advice, and are willing to pay for it. But in this case what can the public do? What can the Board of Guardians do?

"They see their superlatively accomplished and eminent physician, Dr. Reid, estimating his younger brother's services at from £40 to £50 a year, as affording him ample remuneration for all the toil, study, and pecuniary outlay he has expended in acquiring his diplomas—in qualifying himself—in fact, to be installed as a fully qualified professional gentleman, and as such Dr. Reid's equal. Then comes in Dr. McGee, and he tries to mend his hand—he will strike a mean—he thinks £40 too low, while £50 will not please 'the economists at the Board'—so he fixes on £45, after the example of the sage who fixed St. Patrick's birth day.

"Now, when we find medical gentlemen, who, from their position, experience, and influence ought naturally to be looked to as the persons to uphold the honour and dignity of the profession—when we find them the first to make little of their own profession, and award it the paltriest of remuneration, how can we censure laymen if they imbibe their ideas of professional value from them? We cannot. We would be at once met by the palpable fact that the very utmost value Drs. Reid and McGee placed on the services of a properly qualified physician and apothecary for the Belfast Union was £50 a year—modified to £45!

"It is an 'ill bird that fouls its own nest,' and, we regret to say it, the medical nest has been sadly fouled by the old birds. Had the heads of the profession—the colleges with their influences—upheld the rights of the profession, instead of looking after selfish interests, there would be a different tale to be told now."

¹ [Dublin Medical Press, 1865, September 27, p310.]

We cannot look upon the course adopted by Drs. Reid and McGee with as favourable an eye as the journal we have just quoted.

We cannot believe that the ex-doctors, both of whom have occupied responsible offices in the profession, did not know the value of work to be done or of the responsibility to be incurred, and we must assume that they wished for the good opinion of cheeseparing ratepayers, who only know that they don't like to pay, and who care nothing what the object is, or how it is carried out. The good will of this class is more valuable to Dr. Reid and Dr. McGee than the approval of their professional brethren or the public approbation of honourable men, and they are welcome to the exchange.

The resolution come to by the Ulster Medical Society, which will be found in our advertising columns, shows that they have forfeited the former, and even their own colleagues cannot in their hearts accord the latter. We only wish that these gentlemen could as easily dispense with the titles which identify them with the profession as they have abandoned the *esprit de corps* which should bind them to its interests.

General Hospital
October 7th, 1865
Sixth Meeting

Present, the President, Drs. Patterson, Stewart, Whitaker, Ross.

The President shewed a fatty tumour which had been removed from the hip.

James Moore M.D.

General Hospital
November 4th
Seventh Meeting

Present, the President, Drs. Stewart, John Moore, David Moore, Whitaker, McCrea, Patterson. Dr. Ross read a paper on the fevers of Ireland.

Dr. John Moore would wish to know what opinion Dr. Ross entertained of the value of Tartaric Emetic in fever. The cases which he had observed in the ship of seaboard where he had been lately were brought from Belfast.

Dr. Ross could classify under some one of the three heads Typhus, Typhoid, and Relapsing Fever every case of fever that he had met with. He would never use Tartaric Emetic except in cases of violent delirium in strong people.

Dr. D. Moore would give large doses of Tartaric Emetic in the cases mentioned—say two grains every three hours.

The President referred to the great mortality after forty years of life.

James Moore M.D.

November 18th, 1865

Eighth Meeting

Present, the President (in the chair), Drs. Stewart, Wheeler, Patterson, H. P. Rea, D. Moore.

The President brought forward an account of 4 cases of Nævi, upon which he had operated during the last few weeks. He detailed the steps of the operation, the difficulty which he had met within one of cases and the uniformly successful results of the operation.

James Moore M.D.

469 Notice of meeting on 5th August 1865

The Ninth Meeting of the Society will be held in the General Hospital, on Saturday, the 2nd of December, at Three o'clock, P.M.

Business

The President will give an account of a case of Gun-shot Wound.

Drs. Patterson and Ross will give an account of a case of Tubercular Meningitis.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John M'Crea, M.D.
Secretary.

Belfast, 1st December, 1865.

December 2nd, 1865

Ninth Meeting

Present, the President, Drs. Stewart, Patterson, John Moore, Cuming, W. MacCormac, McCrea, Ross.

Dr. Patterson exhibited a brain which had undergone tubercular meningitis. Dr. Ross read some notes of the case.

Dr. J. Moore made some observations on the infrequency of the disease in adult life, and the suddenness with which effusion may occur.

Dr. Cuming said that a peculiarity of this case was that the granulations appeared to four or five observers to be grey. He had thought himself that there was a yellow tinge in them.

Dr. Patterson mentioned that the lips had been convulsively drawn up so as to expose the gum. This was on the same side as the squint and large tubercular deposit.

The President gave an account of case of gunshot wound of the right hand, in which amputation of the

hand had been successfully performed, and the fore-finger and thumb had been saved. Age 65 years.

James Moore M.D.

December 16th

Tenth Meeting

Present, the President, Drs. Stewart, J. Moore, W. MacCormac, McCrea.

Dr. McCrea resigned the secretaryship.

Dr. Stewart moved and Dr. MacCormac seconded that Dr. J. Moore be requested to act as Secretary pro tempore until a permanent Secretary should be appointed. The motion was carried.

James Moore M.D.

470 Notice of meeting on 13th January 1866

The Eleventh Meeting of the Society will be held in the General Hospital, on Saturday, the 13th of January, at Three o'clock, P.M.

Business

The President will give an account of a case of Gun-shot Wound.

Drs. Patterson and Ross will give an account of a case of Tubercular Meningitis.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John S. Moore, M.D.

Hon. Sec., pro. tem.

Belfast, 11th January, 1866.

13th January, 1866

Eleventh Meeting

Present, the President, Drs. Cuming, Drennan, David Moore, Nevin Moore, W. MacCormac, Patterson, Reade, John Moore and Whitaker.

It was proposed by Dr. Thomas Reade and seconded by Professor Cuming that Dr. John Moore be appointed Secretary to the Society. Carried unanimously.

Dr. Drennan exhibited the liver of a boy aged 16 years who had died from cirrhosis, and read a detailed statement of the history of the case and its treatment.

The President exhibited a leg which he had amputated some days ago, which had been crushed by a railway carriage passing over it.

Dr. David Moore presented a child 10 months old suffering from constricted anus.

James Moore M.D.

471 Notice of meeting on 27th January 1866

The Twelfth Meeting of the Society will be held in the General Hospital, on Saturday, the 27th of January, at Three o'clock, P.M.

Business

The President will bring forward a case of Amputation of part of the Hand.

The President will show a Large Tumor removed from the neighbourhood of the Parotid Gland; also, a Fatty Tumor removed from the Shoulder.

The President will show a large Tumor of the Breast.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John S. Moore, M.D.

Hon. Sec.

Belfast, 25th January, 1866.

27th January, 1866

Twelfth Meeting

Present, the President, Dr. Stewart, Dr. W. MacCormac, and Dr. John Moore

The President in absence of Dr. Browne brought forward two cases of his of amputation near the shoulder joint.

He also exhibited a fatty tumour which he had removed from a lady's shoulder and also a case of partial amputation of the hand.

February 10th, 1866

Thirteenth Meeting

Dr. Moore, President in the chair. Members present Drs. Reade, Stewart, Patterson, Whitaker, McCrea and John Moore.

The President exhibited an enormous fatty tumour which he had successfully removed from a lady's breast. It weighed several pounds. He also shewed one which he had removed from the region of the parotid gland.

472 Notice of meeting on 24th February 1866

The Fourteenth Meeting of the Society will be held in the General Hospital, on Saturday, the 24th of February, at Three o'clock, P.M.

Business.

The President will detail a case of very large Abscess of the Back.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D.

Belfast, 22nd February, 1866.

Hon. Sec.

473 Notice of meeting on 10th March 1866

The Fifteenth Meeting of the Society will be held in the General Hospital, on Saturday, the 10th of March, at Three o'clock, P.M.

Business.

The President will show an extra large prepuce.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D.

Hon. Sec.

Belfast, 8th March, 1866.

March 10th, 1866

Fifteenth Meeting

Dr. Moore (President in the chair), Drs. Stewart, Patterson, Smith (J. W. T.) and Whitaker.

A case of spina bifida having been introduced in which a tumour the size of an orange was placed over the lumbar vertebra, Dr. Moore (President) would be inclining to pass a double thread through the tumour though he did not think that it would be of much avail. Still it was in his opinion the only chance for the child.

Dr. Smith produced an ovarian tumour which he considered a well marked specimen of schirrhous, removed from a woman who suffered from dyspnoea and who died some 24 hours after admission to hospital from bronchitis. Some other tumours of a cystic character were also found in the abdomen.

The President shewed an elongated prepuce which he had removed and detailed the reasons which led him to remove it and the steps of the operation which was very successful.

Payment of [?'s] account was ordered.

474 Notice of meeting on 24th March 1866

The Sixteenth Meeting of the Society will be held in the General Hospital, on Saturday, the 24th of March, at Three o'clock, P.M.

Business.

Professor Cuming will bring forward notes of a case of Meningitis and show Recent Parts.

Dr. Smith will read notes of a case of Pneumo-Thorax from perforation of Pleura and exhibit Recent Parts.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D.

Hon. Sec.

Belfast, 22nd March, 1866.

March 24th, 1866

Sixteenth Meeting

Present, Dr. Patterson (in the chair), Drs. Stewart, Drennan, David Moore, Rea, John Moore, and Professor Cuming.

Professor Cuming brought forward a case of meningitis and exhibited the recent parts.

475 Notice of meeting on 7th April 1866

The Seventeenth Meeting of the Society will be held in the General Hospital, on Saturday, the 7th of April, at Three o'clock, P.M.

Business.

Dr. Smith will read notes of a case of Pneumo-Thorax from perforation of Pleura and exhibit Recent Parts.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D.

Hon. Sec.

Belfast, 6th April, 1866.

7th April, 1866

Seventeenth Meeting

Dr. Moore (President in the chair), Drs. Stewart, Patterson, J. W. T. Smith and Rea.

Dr. Smith exhibited the lung of a man who had died of pneumo-thorax and read history of case. No tubercle had been detected in the lung during life but hard tubercular deposits were found on post-mortem examination. The immediate cause of death was congestion of the left lung after the perforation had taken place. The perforation took place from a cavity in right lung which cavity was not detected during life.

476 Notice of meeting on 21st April 1866

The Eighteenth Meeting of the Society will be held in the General Hospital, on Saturday, the 21st of April, at Three o'clock, P.M.

Business.

Dr. Moore will bring forward a case of Amputation of the Arm.

Dr. W. Mac Cormac will give an account of some operations in which he employed Dr. Richardson's method of inducing Local Anæsthesia.

And will also give an account of a successful operation for Strangulated Inguinal Hernia occurring in a man upwards of 80 years of age.

And will exhibit the recent parts in a case of extensive Fracture of the Skull, occurring in a person formerly the subject of Fracture of the Pelvis and Laceration of the Urethra.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D.
Hon. Sec.

Belfast, 19th April, 1866.

21st April, 1866

Eighteenth Meeting

Drs. Patterson (in the chair), Drennan, Stewart, William MacCormac and John Moore.

Mr. R. H. Newett was proposed by Dr. Patterson and seconded by Dr. William MacCormac and unanimously elected member of the Society.

Dr. William MacCormac read notes of several cases in which Dr. Richardson's method of inducing local anæsthesia which consists in causing a stream of ether spray to play upon the part [was used.] The first

case was that of a girl on whom an operation for onychia was performed without the slightest suffering on the part of the patient. Similar results were experienced in several other cases of the same kind. Amputation of finger and removal of part of metacarpal bone without any sensation of pain, and equally successful were two other cases of partial amputation of the hands and removal of piles etc.

Dr. MacCormac states that Dr. Richardson can only lay claim to having perfected the instrument as others had previously attempted to do so viz Dr. Hardy of Dublin. Dr. Drennan was of opinion that the anæsthetic effect of ether spray was owing to the sedative action of the medicine rather than to the cold produced, and recommended its application to other cases than operations viz neuralgia etc.

Dr. W. MacCormac gave an account of a successful operation for strangulated hernia occurring in a man upwards of 80 years of age. He also exhibited the recent parts in a case of extensive fracture of the skull occurring in a person formerly the subject of fracture of the pelvis and laceration of the urethra.

John S. Drennan M.D.

477 Notice of meeting on 5th May 1866

The Nineteenth Meeting of the Society will be held in the General Hospital, on Saturday, the 5th of May, at Three o'clock, P.M.

Business.

Election of Office-Bearers for ensuing year.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D.
Hon. Sec.

Belfast, 3rd May, 1866.

May 5th, 1866

Nineteenth [Annual] Meeting

Dr. Moore (President in the chair), Drs. David Moore, McWilliam, Stewart, Patterson, Whitaker, Cuming, McCrea and Mr. Newett.

The accounts were audited by Drs. Whitaker and Patterson.

Dr. Drennan was unanimously elected President.

Drs. Ferguson and William MacCormac Vice Presidents.

Drs. Greeves and Scott Country Vice Presidents.

Drs. Stewart, Patterson, McCrea, Whitaker, Murney and H. P. Rea were elected Members of the Council.

It was moved by Dr. Patterson and seconded by Dr. Cuming and unanimously resolved that Dr. John Moore and Mr. Newett be elected Joint Secretaries for the ensuing year.

It was moved by Dr. Stewart and seconded by Dr. Whitaker that Dr. Cuming be requested to continue as Treasurer.

Dr. McCrea gave notice of his intention to propose that Dr. Manley be elected a member.

Dr. James Moore, President for the past year, delivered his address on vacating the Presidency. The address was published in the local papers.

Paper.¹ Dr. Moore then addressed the meeting before resigning the chair, when he shortly reviewed some of the more salient occurrences during his year of office, observing that at the fortnightly meetings of the Society there were always most interesting pathological specimens and cases brought forward, which underwent the fullest and freest discussion; nor could such be over-estimated in a practical point of view, and this not only to the members themselves, but especially so to the medical students who had the privilege of being present at those discussions, and so afforded the benefit of the matured skill and judgment of their seniors.

He then referred to the great value of the circulation of the several medical periodicals of the day amongst the members, which was one of the many advantages of their body, and which it was so desirable should be carried on with the strictest attention and regularity, their due circulation being, in point of fact, the back-bone, he might say, of the Society.

The subject of "increase of wages" was then touched upon. All skilled and unskilled classes in the community were now, he observed, demanding and obtaining increased remuneration for their time and skill, but the hardest worked and most expensive and responsible of all professions and callings, as theirs confessedly was, continued to be the worst remunerated as usual. But what must be considered a most serious injustice to their junior medical brethren, and also to the rate-payers themselves, was the well-known fact of tradesmen and mechanics, earning from two to three pounds a week, obtaining for their wives and families advice and medicine from the dispensaries, who were well able to pay for both. The Dispensary Medical men and Board of Guardians should resolutely set their faces against the continuance of so great an abuse as this palpably was, the time having fully come for their doing so.

The office of coroner for the Belfast district, so legitimately belonging to their profession, he stated, had since their last annual meeting become vacant, upon which a special meeting of their Society had been called by him to consider the propriety of supporting one of

their brethren to fill it, and which had been unanimously resolved upon; but subsequently it was discovered that the Town Council had in their own hands the power of appointing a Coroner for the borough of Belfast exclusively, and who had appointed a most excellent and judicious one in the person of Dr. Dill. Dr. Campbell of Lisburn, another equally deserving and well-qualified practitioner, having been elected by the Parliamentary voters for the other portion of the district, so that thus two of their body were now exercising that important office in this locality, which was a great point gained for their profession.

During the past year two of their Society, he sincerely regretted to say, had been removed by death from amongst them—Professor Ferguson and Dr. Hunter—both gentlemen in the truest sense of the term, and of highly cultivated intellects, and both deeply mourned for as men and as brethren for their always honourable and exemplary conduct and great ability as medical practitioners. He might also name Dr. Catherwood of Donaghadee, who had lately paid the last debt of nature, and who was a truly Christian and worthy man.

Two of their Society had during the year taken their leave of Belfast, and removed to practise elsewhere—he alluded to Drs. Strong and Hanna, the former to Dublin, and the latter to one of the distant colonies.

The "Royal Medical Benevolent Fund Society of Ireland" was then brought under notice, with the view of impressing the obligation which devolved upon each member of the profession of subscribing to it, so as to enable its disinterested managers to accomplish the largest amount of good possible, but which could not be done unless each and all gave that most excellent Society their countenance and best support, and of which it was so eminently deserving.

The President, after referring to some other matters of detail, concluded his very appropriate and well-received address by observing that, in relinquishing the chair he then occupied, it was with the greatest gratification he handed it over to Dr. Drennan, who not being present, he might the more freely speak of his exalted worth both as a citizen and a member of their profession, deeply learned, and of the most sterling principles; and also to make the passing remark that the new president's father, the celebrated Dr. Drennan, obtained for Belfast the title of the "Athens of Ireland" by reason of his distinguished literary attainments.

Their president, then, for the ensuing year might truly be said to be "the worthy son of a most worthy sire."

One more remark he had to make which was his being enabled to announce that during the ensuing year a large infusion of new blood might be expected into the Society, several of their younger brethren having recently intimated to him their intention of joining it.

¹ [Dublin Medical Press, 1866, May 16, p526.]

Ulster Medical Society
Session 1865-1866
President James Moore

On the motion of Dr. Cuming, Dr. Stewart took the second chair.

Dr. Cuming referred to the pleasure he had in listening to the excellent address with which they had been favoured by the outgoing President. He begged to move "That the best thanks of the meeting be given to their late President for the able and zealous manner in which he had fulfilled his official duties, and his readiness at all times to advance the Society's best interests."

Dr. Patterson had much pleasure in seconding Professor Cuming's motion. The motion was put from the Chair and carried by acclamation.

John S. Drennan, President

Ulster Medical Society
Session 1866–1867
President John Swanwick Drennan

ULSTER MEDICAL SOCIETY

SESSION 1866–67

478 Notice of meeting on 2nd June 1866

The Twentieth Meeting of the Society will be held in the General Hospital, on Saturday, the 2nd of June, at Three o'clock, P.M.

Business.

A Special Report on the state of the Library.

Certain matters connected with the future interests of the Society.

Dr. Mac Cormac will give an account of a case in which Tracheotomy was performed for the removal of a pickle of Indian Corn.

Also of an amputation at the Knee Joint for a Gun-shot Wound of the Leg.

Also of an amputation of the Arm close to the Shoulder Joint. He will exhibit the parts removed in each case.

John Moore, M.D.
Hon. Sec.

Belfast, 3rd May, 1866.

June 2nd, 1866

Members present, Dr. Drennan (President in the chair), Drs. Stewart, William MacCormac, John Moore and Newett.

The President briefly expressed his thanks for the honour the Society had done him by electing him as its President.

A report from the Librarian was read pointing out the present inefficient arrangements with regard to the distribution of the periodicals, and other matters connected with the library.

Dr. Stewart moved and Dr. MacCormac seconded the following Resolution "That the President together with Drs. Cuming, Murney, Newett and John Moore be appointed a Committee to take charge of all matters connected with the management of the library and to report concerning them from time to time to the Society as they may consider necessary."

Dr. Newett brought under the notice of the Society the present state of the wax casts belonging to the Society, and suggested that they should be renovated.

Dr. Newett proposed and Dr. John Moore seconded that Dr. Manley be elected a member of the Society.

Dr. John Moore proposed and Mr. Newett seconded that Dr. Wales be elected a member.

Dr. John MacCormac proposed and Dr. Stewart seconded that Mr. H. Johnston, Surgeon, be elected a member.

John S. Drennan, President

479 Notice of meeting on 5th July 1866

President.

Dr. Drennan.

Vice-Presidents.

Dr. W. Mac Cormac.

Dr. Scott, Aughnacloy.

Dr. H. S. Ferguson.

Dr. Greaves, Cookstown.

Members of Council.

Dr. Stewart.

Dr. Whitaker.

Dr. Patterson.

Dr. Rea.

Dr. Murney.

Dr. M'Crea.

Treasurer.

Dr. Cuming.

Secretaries.

Dr. John Moore.

Mr. R. H. Newett.

The Second Meeting of the Present Session will be held in the General Hospital, on Saturday, the 7th of July, at Three o'clock, P.M.

Business

To ballot for:

Mr. T. J. Cantrell.

Dr. A. Dunlop.

Mr. H. M. Johnston.

Dr. H. C. Manley.

Dr. Angus Porter.

Dr. H. S. Purdon.

Dr. G. F. Wales.

Dr. Cuming will give an account of a case of Fibrinous Concretion of Heart, and exhibit recent parts.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to either of the Secretaries.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretaries, with their qualifications and Subscription.

Signed by order,

John Moore,
R. H. Newett,
Secs.

Belfast, 5th July, 1866.

Second Meeting

July 7th, 1866

The President in the chair. Members present, Drs. Thomas Reade, Whitaker, Patterson, H. P. Rea, John Moore, MacCormac, Murney, Dr. Nevin Moore, Stewart, Professor Cuming, McCrea, Messrs. Gribbin and Newett.

The following gentleman were elected members, Mr. T. J. Cantrell, Dr. Dunlop, Holywood, Mr. H. M. Johnston, Dr. H. C. Manley, Dr. Angus Porter, Dr. H. S. Purdon, Dr. Wales.

It was moved by Dr. Patterson and seconded, that the Council should take immediate steps regarding the furniture in the new rooms.

Report from Council was read stating that the hours of attendance of the Librarian were from

10a.m. till 1p.m. and recommending that the books be still kept in the present library, and that the periodicals be placed on the table in the new rooms for a month after their issue.

Dr. Thompson of Bangor was proposed by Dr. Cuming and seconded by Dr. Whitaker.

Dr. McDonnell was proposed by Dr. W. MacCormac and seconded by Dr. D. N. Moore.

John S. Drennan

480 Notice of meeting on 4th August 1866

President.

Dr. Drennan.

Ex-President.

Dr. James Moore.

Vice-Presidents.

Dr. H. S. Ferguson.

Dr. Scott, Aughnacloy.

Dr. W. MacCormac.

Dr. Graves, Cookstown.

Members of Council.

Dr. Stewart.

Dr. Whitaker.

Dr. Patterson.

Dr. Murney.

Dr. M'Crea.

Dr. Rea.

Treasurer.

Dr. Cuming.

Secretaries.

Dr. John Moore.

Mr. R. H. Newett.

The Third Meeting of the Present Session will be held in the General Hospital, on Saturday, the 4th of August, at Three o'clock, P.M.

Member to be Proposed:

Alexander H. H. M'Murtry, M.D., Q.U.I., Belfast.

Members to be Ballotted for:

Henry Thomson, M.R.C.S. Eng., Bangor.

Dr. McDonnell, Belfast.

Morbid Specimens.

Dr. Cuming will exhibit specimen of Fibrinous Concretion of Heart.

Dr. Cuming will read case of Pericarditis, with unusual Cerebral Symptoms, and exhibit recent parts.

Case to be Read.

Dr. J. W. T. Smith will read notes of case of unusual local Spasmodic Affection.

Members in arrear are requested to forward their Subscriptions to the Treasurer.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with either of the Secretaries of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to either of the Secretaries.

Membership.—Persons wishing to be proposed for Membership will please forward their names to either of the Secretaries, with their qualifications and Subscription.

Signed by order,

John Moore, R. H. Newett,
Secs.

Belfast, 2nd August, 1866.

Third Meeting

August 4, 1866

Present, the President in the chair, Professors Reade and Cuming, Drs. Patterson, McWilliam, Manley, Messrs. Thompson, Cantrell and Newett, Dr. John Moore.

Dr. Alexander H. H. McMurtry was proposed by Dr. Cuming.

Dr. Henry Thompson, Bangor, was elected unanimously.

Dr. Cuming exhibited a specimen of fibrinous concretion of the heart, and read a paper on a case of pericarditis with unusual cerebral symptoms and exhibited the recent parts.

John S. Drennan

481 Notice of meeting on 1st September 1866

The Fourth Meeting of the Present Session will be held in the General Hospital, on Saturday, the 1st of September, at Three o'clock, P.M.

Members to be Proposed:

Henry Talbot Higginson, M.D., Edin., Lisburn.

Henry Brown, L.R.C.P., & L.R.C.S, Edin., Belfast.

Alexander H. H. M'Murtry, M.D., Q.U.I., Belfast.

Members in arrear are requested to forward their Subscriptions to the Treasurer.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with either of the Secretaries of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to either of the Secretaries.

Membership.—Persons wishing to be proposed for Membership will please forward their names to either of the Secretaries, with their qualifications and Subscription.

Signed by order,

John Moore,
R. H. Newett,
Secs.

Belfast, 2nd August, 1866.

Fourth Meeting

September 1, 1866

Present, the President in the chair, Drs. MacCormac, Whitaker, Thompson Bangor, and Mr. Newett.

Dr. H. H. McMurtry was unanimously elected a member of the Society.

Ulster Medical Society
Session 1866–1867
President John Swanwick Drennan

The Secretary was directed to publish in the next notice-sheet, that the meeting of the Society would, for the first time, be held in the new rooms in the Charters Wing of the hospital, and to request a large attendance of the members.

Dr. Whitaker proposed and Mr. Newett seconded that Henry Brown Esquire L.R.C.P. and L.R.C.S. Edinburgh be elected a member of the Society.

Dr. MacCormac proposed and Dr. Thompson seconded that Dr. Henry Talbot Higginson of Lisburn be elected a member of the Society.

John S. Drennan

482 Notice of meeting on 6th October 1866
The Fifth Meeting of the Present Session will be held in the General Hospital, on Saturday, the 6th of October, at Three o'clock, P.M.

Business.

Member to be Proposed:

Josias W. Patrick, L.R.C.P., & L.R.C.S. Edin., Carrickfergus.

Members to be Ballotted for:

Henry Talbot Higginson, M.D., Edin., Lisburn.

Henry Brown, L.R.C.P., & L.R.C.S. Edin., Belfast.

Papers to be Read.

Dr. J. W. T. Smith will read notes of a case in which there was a peculiar Spasmodic Affection.

Dr. Seaton Reid will read a paper on the recent Cholera cases in Belfast.

Members in arrear are requested to forward their Subscriptions to the Treasurer.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with either of the Secretaries of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to either of the Secretaries.

Membership.—Persons wishing to be proposed for Membership will please forward their names to either of the Secretaries, with their qualifications and Subscription.

Signed by order,

John Moore,
R. H. Newett,
Secs.

Belfast, 4th October, 1866.

Fifth Meeting

October 6, 1866

Present, the President in the chair, Drs. Whitaker, Patterson, Dill, McMurtry, John Moore, Professors Reid and Cuming, Drs. McWilliam, H. P. Rea, Brice Smyth, S. H. [sic] Purdon, and Messrs. Johnston and Newett.

Henry Talbot Higginson M.D. Edinburgh and Henry Brown L.R.C.P. and L.R.C.S. Edinburgh were un-animously elected members.

Dr. Cuming proposed and Mr. Newett seconded Josias Wilson Patrick L.R.C.P. and L.R.C.S. Edinburgh for membership.

Dr. Reid read his paper on the recent cholera cases in Belfast:

Paper:¹ Mr. President and Gentlemen,—You are aware that several medical men have agreed with me in stating that cases of Asiatic cholera had been seen by us in Belfast, and I have thought my placing before you some information regarding these cases might be interesting, the more especially as one of them had struggled successfully against the disease in my hospital, and thus afforded an opportunity of noting particularly the course of his disease. I shall notice the cases in the order of their occurrence, premising that the three first cases resided very near each other, but that no intercourse could be traced:—

Case 1.—On the morning of the 10th of August I was requested by Dr. Murray, of Ballymacarrett, to see a dispensary patient, called Thomas O'Neill, aged 45, who had left Huddersfield on the 6th, in which town another Irish labourer, called Heard, died of cholera on the 12th. O'Neill spent the greater part of the 6th in Liverpool, where cholera was epidemic, arrived in Belfast on the 7th, but made no complaint of illness till diarrhœa set in at right p.m. of the 9th, followed by vomiting at two a.m. of the 10th, and by cramps at four. I saw him at nine; his eyes were sunken; the pupils half dilated, with a dark areola around the lids; his tongue cold, and voice husky and feeble; the hands were cold, blue, dry and shrivelled, as were also his feet; his pulse was barely perceptible, and the respirations hurried and noisy. The evacuations had all been thrown out.

We saw him again about one in the afternoon. He was then pulseless, less sensible, colder, and more livid, unable to open his mouth perfectly; there had been no more vomiting or purging, and the catheter found no urine. He died at two, about eighteen hours after he took ill.

The body was interred immediately, the house whitewashed, and the clothing destroyed.

Case 2.—On the morning of the 12th, Dr. Murray asked me to see Edward McGowan, aged 40, living in Keenan's-court, a few yards from the house near Quinn's-entry, in which O'Neill had died. This man was attacked with diarrhœa at ten p.m. on the 11th of August, followed by vomiting at two a.m. of the 12th, and by cramps at four, and Dr. Murray found him in a state of collapse at five. I saw him between seven and eight o'clock, when he was very blue, cold and pulseless, and he died about nine. All the evacuations had been thrown away in this case also.

¹ [Medical Press and Circular, 1866, October 31, p432.]

Case 3 When Dr. Murray was returning from McGowan's he was asked to see James McGowan, aged 27, living in No. 71, Short Strand-street, and believing him to be ill with cholera, requested future evacuations to be preserved. It happened that when I was looking for Edward McGowan's residence, I was taken to James' house, who was not related to Edward. James' bowels had acted at nine a.m. and four p.m. of the 11th, and he felt nauseated in the afternoon. He had taken during the day only one glass of whisky. He went to bed at nine, began to vomit about one a.m. of the 12th, and diarrhœa set in at once with profuse and very frequent evacuations. No urine was passed after three o'clock, and the cramps set in about eight. Through Dr. Murray's foresight, I was enabled to see an evacuation, which was almost colourless and distinctly "rice-water" in appearance. He consented to enter the cholera ward of my hospital, and was removed there in the recumbent posture about nine o'clock.

On admission his pulse was 120 and feeble; his nose and tongue were cold; his voice husky and feeble, and his hands, limbs, and scrotum livid and cold; his eyes sunken and surrounded by a dark areola, and his pupils half dilated.

He was placed in a warm bath for twenty minutes at 103 F., which gave him great relief, and was well rubbed with hot towels on leaving it; then clothed in a long flannel shirt, and had his arms enclosed in long ribbed woollen gauntlets, vessels of hot water placed in his bed, and large sinapisms applied along the entire spine and over his epigastrium. He expressed himself often as being greatly relieved by the warm bath, which also improved the temperature of his body and tongue, and gave volume to his pulse.

He got at once ten grains of calomel and three of opium, and was directed to take ten grains of calomel every hour for four doses.

Positive orders were given that in addition to the calomel, he was to be allowed to take nothing into his stomach except a tablespoonful of water every half hour, because I had so repeatedly found such directions beneficial in allaying the vomiting of English cholera, and of the Relapsing Synocha fever, that I invariably endeavour to enforce them when treating Asiatic cholera.

My wishes were most efficiently carried out by my assistants, Drs. Farelle and Lindsay, and the patient willingly co-operated.

No vomiting took place till four in the afternoon, so that the medicine had remained on an absorbing surface for seven hours.

A report of his condition was taken every two hours during the day and night by my very intelligent assistants. I shall not trespass on your time by reading them in detail, but confine myself to placing before you a condensed summary of them as entered by myself in my morning and evening reports:—

I learned at nine in the evening that he had vomited a greenish fluid repeatedly between four and six o'clock, that at the latter hour his pulse was barely perceptible, and his hands cold and livid. These symptoms of increased collapse appeared to have been benefited by the use of small quantities of hot whisky punch, for I found his pulse 126, and of fair strength, his nose, tongue, feet, and hands warm and dry. The bowels had not acted since admission; he had passed no urine, and the catheter found none. He complained much of thirst and of his continued restlessness, and had suffered much from cramps.

He had now taken six of the ten-grain doses of calomel. He was directed to take ten grains every two hours for two doses, and then every four hours; to have large sinapisms over the epigastrium and the entire length of the spine, and to take half an ounce of whisky in an ounce of milk every two hours, and if restless at one in the morning, to get two grains of opium.

At nine in the morning of the 13th his pulse was 126, feeble; his tongue, nose, and body warm and dry; his lower gums were coming under the influence of the mercury; he had vomited ten times during the previous twelve hours; had passed no urine, nor had his bowels acted.

The calomel powders were continued every four hours, and a drachm of blue ointment rubbed every four hours into each arm-pit, and iced whey given in small quantities as a drink.

At noon the bowels had acted three times, and there was bile in the evacuations. At six in the evening his pulse was weaker: his hands and feet cold and livid; he had vomited repeatedly a bright green fluid of acid reaction, and he was very listless and tossing much about.

At nine in the evening his pulse was 122, and feebler than in the morning; the bowels had not acted since noon; he had passed no urine, and the catheter again got none.

A blister was applied over the epigastrium, and he got some calcined magnesia in mint water; the inunction was continued, and a drachm of blue ointment, rubbed up with two ounces of olive oil, was injected into the rectum. The calomel, of which he had now taken 120 grains, was discontinued.

On the morning of the 14th his pulse was 114, feeble; and his hands, feet, and body colder, although his tongue and face were warmer; the bowels had not acted again, nor had he passed any urine; he had vomited a yellow fluid eight or ten times during the night; he was more drowsy, though still intelligent; his gums more under the influence of mercury, and his voice still choleraic.

At noon I found his pulse fuller and stronger, and his colour improved; he had only vomited twice; the bowels had not acted, nor had he passed any urine, although asked to do so. Every precaution had been

taken to obtain any that passed when the bowels were acting, or at other times.

Believing that reaction had now really set in and that everything depended on a restoration of the urinary secretion, he was directed to take two drachms of the very efficient diuretic mixture of the hospital every half hour in iced whey, and to have a large sinapism over his loins. I need not say how gratified we all were to find at nine in the evening that after a suppression of the secretion of urine for eighty-four hours, he had passed one ounce about an hour before, having then used about eight ounces of the diuretic mixture. The urine was coagulable by heat and nitric acid, and became a dark or purplish colour on the addition of the acid. Professor Parkes states that this peculiar pigimentary discoloration on the addition of acids, the nature of which is not yet decided, is present with the first urine passed in all cases of Asiatic cholera, and that, in fact, it is the best diagnostic mark of the existence of the disease in doubtful cases.

His bowels had acted twice; he had vomited a yellow fluid five times; his pulse was 110, and feeble.

The inunction was continued, and the mercurial enema repeated; a large sinapism kept on the loins till the skin was returned, and the body well rubbed with dry cloths every two hours.

On the morning of the 15th the pulse had fallen to 80, and was full and strong, and the temperature everywhere good; the respirations were now counted for the first time, and found to be 14; he had vomited eleven times, and had hiccup for several hours. The mercurial enema was returned without any fæces, and he was unable to pass any urine.

A pint of tepid water was thrown into the rectum, where it remained for half an hour, and then passed off with fully a pint more of semi-fluid bilious matter, but unaccompanied with any urine.

At nine in the evening his pulse and respirations were the same, and his temperature everywhere good; he had slept much during the day and was very drowsy; he had vomited eight times, but retained several spoonfuls of bread and milk; the bowels had acted twice, and at half-past five he passed two ounces of urine of a sp. gr. of 1.015, acid, and slightly coagulable.

In the hope of re-establishing thoroughly the renal secretions, four ounces of whisky and eight ounces of the diuretic mixture were directed to be taken during the next twelve hours in a quart of iced whey, and some lemon juice given after his magnesia mixture, in the hope of checking the vomiting.

On the morning of the 16th his pulse was 84, full and strong, and the respirations 16; his tongue dry, his gums sorer; he had vomited nine times; taken his diuretic mixture, and retained a fair amount of his bread and milk; he had passed 13 oz. of urine during the night, neutral in its reaction, and of sp. gr. 1.014, slightly coagulable, and foetid when heated. The bowels

had acted twice, evacuations viscid bile and some blood. Being still much oppressed, a blister ten by four was applied to the nape of the neck for four hours, and followed by a hot poultice.

At nine in the evening his pulse was 88, and respirations 16; the bowels had acted three times, first evacuation pure blood, the second composed of bile and blood, and the third less bloody. He had secreted seven oz. of urine, which was alkaline, sp. gr. 1.015, and with a trace of albumen. Believing that the blood indicated a congested condition of the intestinal tract, he was directed to take half an ounce of castor oil during the night.

On the morning of the 17th his pulse was 90, and respirations 18; the evacuations from the bowels were bloody and scanty, but he had passed 30 oz. of urine during the night, which was alkaline, sp. gr. 1.015, and free from albumen, but fearfully foetid on being heated. On this day the vomiting ceased and did not return, and the evacuations from the bowels ceased to be bloody.

On the 18th I found that, notwithstanding the secretion of 63 oz. of urine during the previous twenty-four hours, his pulse was only 86, and his respirations barely 16. He had passed one yellow evacuation free from blood, and complained of being drowsy; his pupils were dilated and there was some muttering delirium.

A blister was applied over the forehead, and he was directed to take twelve forced inspirations every half hour, with the object of dilating the lungs to their fullest extent, and thereby purifying the blood. I decided also on establishing a freer secretion from the intestinal surface by the daily administration of castor oil.

On the 19th his pulse was 88, his respirations 16. The bowels had acted five times, without any blood, and he secreted 105 oz. of urine during the previous twenty-four hours, acid, of sp. gr. 1.010, and not coagulable. He was more sensible; his memory improved, and he was free from delirium; his tongue moister and cleaner. The blister rose well, and Professor Cuming very kindly ascertained for me that the serum of the blistered surface contained a larger proportion of urea than recent experiments have shown to be always present in the blood. The forced inspirations, castor oil, and diuretic mixture were continued, and he had fowl broth, with a large amount of parsley in it.

On the 20th his pulse was 86; the respirations 18; the bowels had acted five times, evacuations fluid and bilious; he had passed 95 oz. of urine in twenty-four hours, acid, and of sp. gr. 1.010, and faintly coagulable; but his tongue had again become dry, and there was some delirium. In addition to the other treatment he was now directed to take 2 oz. of green tea during the next twenty-four hours, infused in a quart of water.

On the 21st his pulse was 80, and the respirations 18; the bowels had acted five times, and the evacuations were very yellow; he had passed 111 oz. of urine

during twenty-four hours, sp. gr. 1.014, acid. There was no delirium; he felt better, and his intelligence was improved. His castor oil, green tea, diuretic mixture, and forced inspirations, were continued.

On the 22nd the pulse was 84, the respirations 19; the bowels had acted four times; he had passed 120 oz. of urine during the previous twenty-four hours, acid, and sp. gr. 1.010. Same treatment continued.

On the 23rd his pulse was 89, respirations 16; bowels had acted four times; the urine amounted to 102½ oz., acid, sp. gr. 1.013; his intelligence had improved much, and his tongue was clean and moist all over. No change in treatment, except that he was allowed to leave bed.

On the 24th his pulse and respirations were about the same; his bowels had acted six times, and he had passed 126 oz. of urine, and was declared convalescent.

Case 4.—This patient was a female, called Sinclair, aged 38, who was admitted into hospital from Hudson's-entry, at seven p.m. of the 17th August. She stated that she had been attacked with diarrhœa at five A.M. of the 15th, followed by vomiting at nine, and that cramps were associated with these symptoms on the forenoon of the 17th. She had been seen by the dispensary medical officer, Dr. Rea, about two, who directed her removal to hospital. On arrival she said that her bowels had been very loose during the day till about five o'clock, that she had vomited four times, and had the toes separated from each other by the cramps. She was pulseless at the wrists, her tongue was cold, her nose cold and livid, and her voice feeble. Her eyes were sunken and surrounded by a dark areola, and the pupils rather dilated.

She was placed in a warm bath, which for a time improved the heat of the body, and made her tongue warm. On leaving the bath she got ten grains of calomel and three of opium; had sinapisms applied along the entire spine and over the epigastrium, and was clothed in a long flannel chemise, and ribbed woollen gauntlets over her arms, dry friction applied to the extremities, and pans filled with hot water placed in her bed.

At nine p.m. she was still pulseless; the hands, arms, body, and feet were warmer, but the face, the nose, the tongue, and the breath were cold; she had retained three ten-grain doses of calomel, the two last of course without opium; she had not vomited, nor had the bowels acted. Ten grains of calomel were directed to be given every four hours, and a teaspoonful of whisky with a tablespoonful of iced whey every half hour.

At eleven p.m. she passed a scanty evacuation, of the consistency of gruel and a pale drab colour, but no urine.

On the 18th she remained pulseless, with her hands cold, livid, shrunken, and sodden, and her feet warm. Her tongue and breath were cold; she had neither vomited nor passed urine since admission, nor did the catheter get any; the pupils were rather contracted; her

intelligence perfect; the areola continued around the eyelids, and she had suffered severely from cramps in her legs during the night. The treatment was continued.

At noon she was still pulseless, but less intelligent; she had a slight convulsion before her death, which took place about four. This patient was seen in the hospital by Drs. Murney and Johnstone, who agreed with me that it was a case of Asiatic cholera.

Case 5.—I was requested by Dr. Porter to visit one of his dispensary patients about noon on the 11th of September, whom he believed to be suffering under Asiatic cholera. He lived at No. 6, Bow-street, Belfast, was called Patrick Wilson, and aged 50. I learned from the very accurate and minute notes taken by Dr. Porter, that he had been attacked with diarrhœa at two in the morning, followed by vomiting at eight, and soon afterwards by cramps. When I saw him his voice was husky and feeble; his tongue and breath cold; pulse barely perceptible, and his eyes sunken, with a dark areola around the lids; his hands were cold, blue, and shrivelled, and the cramps very severe.

I had no hesitation in agreeing with Drs. Porter and Henry Johnstone that this man was suffering under Asiatic cholera. I recommended his removal to hospital, as he was lying on straw in the corner of a room in which there was no fire. He consented to go; but when his friends saw the kind of conveyance sent to remove him in, they would not allow him to enter it.

Dr. Porter attended to him most sedulously, and did everything in his power to promote his recovery. Various attempts at rallying took place, but in the evening he was found pulseless, colder and more livid, and less sensible; and he died about one in the morning of the 12th, twenty-three hours after he took ill. At one of Dr. Porter's visits he saw a distinct "rice-water" evacuation. He passed no urine after eleven a.m. of the 11th. Nine hours after death Dr. Porter found his hands, wrists, and face of a bluish colour: his ankles and parts of his legs purple, with some blue spots on his toes, and his chest still warm.

Case 6.—Since the foregoing histories were read before the Medical Society, a woman called Rose M'Cullough, aged 40, was admitted to hospital at 7 p.m. of the 9th October; she had been drinking for several days before the 5th, when diarrhœa and vomiting commenced. On admission her skin was cold, as also her tongue, eyes sunken, with a dark areola, pulse 126. She stated that she had felt pains in the calves of her legs and hands; but as she did not call them cramps, and the symptoms being less intense than in other cases, I did not pronounce her at first to have Asiatic cholera, and after giving her a warm bath, I administered the medicines used in Case 3, but less frequently. The bowels had become quiet, but the vomiting was very frequent.

The catheter obtained half a drachm of urine, which on being examined on the morning of the 10th was found to be acid, not coagulable, but gave with heat and

Ulster Medical Society
Session 1866–1867
President John Swanwick Drennan

nitric acid a distinct brownish colour. This discoloration alarmed me, as Parkes' opinion of its diagnostic value, already quoted, had been supported by Case 3.

I shall not detail the reports taken every two hours, but limit my notice of this case to stating that the symptoms became gradually more intense, till she died in unmistakable collapse at one o'clock of the 11th. Rigor mortis occurred in fifty minutes. The vomiting had continued most distressing. The bowels acted only three times after admission, and then scantily. The secretion of urine was also very scanty, the catheter never obtaining more than three drachms, which was found coagulable on every occasion but the first, acid in its reactions, and gave always a dark or purplish discoloration with nitric acid and heat.

I am so impressed with the importance of this discoloration of the urine, that I trespass on your space with a very brief notice of some other cases, which corroborate the opinions of Professor Parkes and Dr. Warburton Begbie of its diagnostic value.

Case 7.—A boy called Peter Carty, aged 8, was admitted into my hospital at midnight of the 14th October, from the same locality in which McCullough had lived, but no intercourse was traced. I saw him about an hour after admission, and found him pulseless, cold, livid, and with all the symptoms of collapse, after sixteen hours' vomiting, diarrhœa, and cramps. The catheter got no urine till about noon of the 15th, when a few drops were obtained, which being placed on white paper was found acid, and gave a distinct purple colour with nitric acid. He passed into the stage of consecutive fever. The urine was tested on every occasion it was obtained by the catheter, or passed by himself, and was invariably found coagulable and giving discolorations varying from pink to dark purple. The urinary secretion was restored to the extent of eight ounces daily, and a profuse discharge also of bile; still he became gradually less sensible and died.

Anne Downey, aged 54, who had suffered from renal dropsy, was sent into hospital in consequence of having had vomiting and diarrhœa for two days, without cramps, but with great failure of the heart's action; ultimately becoming pulseless and cold, death taking place twenty-nine hours after admission.

Dr. Warburton Begbie, in his paper in the *Edinburgh Journal of Medicine* for November, 1849, states, "that he had examined the urine in cases of diarrhœa, and so-called choleroïd diarrhœa, and had never found albumen, epithelium, and bile in such cases," bile being at that time considered to be the cause of this discoloration of the urine.

In Downey's case her urine was examined, and found acid, albuminous; but no discoloration followed the tests applied in the other cases. This case was not returned as one of Asiatic cholera, as I believe that renal disease was the cause of her death. Rigor mortis had not commenced at the end of two hours.

[After] which an interesting discussion followed.

John S. Drennan

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President.

Dr. Drennan.

Ex-President.

Dr. James Moore.

Vice-Presidents.

Dr. H. S. Ferguson.

Dr. Scott, Aghnacloy.

Dr. W. Mac Cormac.

Dr. Graves, Cookstown.

Members of Council.

Dr. Stewart.

Dr. Whitaker.

Dr. Patterson.

Dr. Murney.

Dr. M'Crea.

Dr. Rea.

Treasurer.

Dr. Cuming.

Secretaries.

Dr. John Moore.

Mr. R. H. Newett.

The Sixth Meeting of the Present Session will be held in the General Hospital, on Saturday, the 3rd of November, at Three o'clock, P.M.

Business.

Member to be Ballotted for:

Josias W. Patrick, L.R.C.P., & L.R.C.S, Edin., Carrickfergus.

The President's Address, it being the commencement of the Winter Session.

To make arrangements for the Annual Dinner.

Members in arrear are requested to forward their Subscriptions to the Treasurer.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with either of the Secretaries of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to either of the Secretaries.

Membership.—Persons wishing to be proposed for Membership will please forward their names to either of the Secretaries, with their qualifications and Subscription.

Signed by order,

John Moore,
R. H. Newett,
Secs.

Belfast, 1st November, 1866.

November 3rd 1866

Present, the President in the chair, Drs. Pirrie, James Moore, A. Dunlop, Cuming, Patterson, Browne, Thomas Reade, McCrea, B. Smith, John Moore, J. S. Reid, H. P. Rea, McWilliam, Wales, Whitaker, Stewart, MacCormac, Surgeons Gribbin, McCleery, Johnson and Newett.

Josiah Wilson Patrick L.R.C.P.E. and L.R.C.S.E. was unanimously elected a member.

The President read his address which was listened to with attention and elicited the applause of the Society.

Paper:¹ Gentlemen,—In conformity with a custom which has been generally, if not invariably observed, I proceed to address to you a few remarks at the commencement of our Winter Session. Whilst by no means affecting originality, or aspiring to the dignity of an Inaugural Discourse, these may serve to direct the attention of our more recently elected members to the principal objects of this Society, and the best means of effecting them.

I have already taken the earliest opportunity of expressing my sense of obligation for the honour of being appointed your President for the current year, and I need now merely repeat that it was an honour quite unsolicited on my part, but only the more prized for its being spontaneously bestowed. I should have sincerely rejoiced if some more distinguished member of the profession had been at this time selected for the office—not only for the increased dignity to have been thereby reflected upon it, but for the substantial benefits which talent and influence installed in this chair might have conferred on our Association at a somewhat critical period of its existence.

You are aware, gentlemen, that this society, judging from the decrease in the number of its subscribers and the diminished attendance at its meetings, has fallen off somewhat of late from the position it formerly held, and which, from its designation as the “Ulster Medical,” it would even seem called on to assume. On the causes of this declension I shall not enter, if for no other reason than because I am really very imperfectly informed as to their nature and extent. Amongst them, undoubtedly, cannot be reckoned any want of ability or energy on the part of my predecessors in this chair, or the other official members of the Society. Nor can I for a moment suppose that there has been, at any time, a lack of inclination amongst the practitioners of this locality to maintain an institution so capable of diffusing professional information, and advancing their own claims to confidence and respect.

Let us conclude then that our society has been merely suffering of late from a little temporary “Asthenia”, indicative of no serious organic disease or senile debility, and easily removable by some simple measures for imparting additional warmth to its members and increasing the force of its cerebral circulation. The copious supply of new blood infused into it during the present year will doubtless contribute much to its convalescence, whilst we have already had proof, in the proceedings of our Summer Session, that there is no decline whatever in the vitality of the old.

Amongst those who formerly co-operated with us, we have to lament the recent death of a respected associate in the person of Dr. Halliday. He died comparatively young, and the arduous duties of Dispensary Medical Attendant, which he so sedulously discharged, and which had latterly pressed very heavily upon his strength and spirits, hastened in all probability his passage to the grave. He filled for several years the office of Treasurer to the Clinico-Pathological Society, and took a frequent part in its discussions, and those of the older “Medical.” In token of respect for his memory the members of this Society attended his funeral, and his professional and personal worth was still more vividly attested by the thronging together of his poorer friends, as the earthly remains of their kind “District Doctor” were carried to the tomb.

With the exception of this loss on our part, and some others less recent, we meet here to-day under circumstances specially propitious. The room, which by the kindness of the Hospital Committee, had been for many years devoted to our exclusive use, has been of late partially applied to other purposes. For this restriction, however, we have received in the convenient and capacious apartments in which we this day assemble for the first time a much more than equivalent return. In them we possess not only a large, well lighted, and commodious place of meeting and reading-room, but space sufficient for the suitable arrangement of our collection of pathological portraits, casts, and specimens. Whether it may be advisable hereafter to transfer our library also hither must depend on circumstances, and will be a question for future consideration. The Society must feel truly grateful, and will, I presume, express its acknowledgements to those to whom we are indebted for this very valuable endowment. To Mr. Charters, the munificent donor of this wing of the hospital, to the Hospital Committee, who have conceded this portion of it to our use, and to our worthy Vice-President, Dr. William MacCormac, at whose suggestion and by whose intercession it was mainly obtained—to each and all of these we are certainly deeply indebted, and owe the expression of our warmest thanks.

Among the other valuable results of this seasonable acquisition, we have now that portion of our revenue, recently expended on the rent of hired rooms, at our disposal for other purposes. Of these there is surely none more eligible, none more urgent, than the improvement of our defective library, by the addition to it of books of sterling professional value. One of the primary objects of the Society, as stated in its fundamental rules, is “to afford its members increased facilities of consulting the best medical works and periodicals,” but in consequence of restricted resources, that object has been of late very imperfectly accomplished. A substitute for the purchase of new works was attempted by the hiring of them from a lending library. But however a means of this kind may answer as a supplement

¹ [Dublin Medical Press, 1866, November 22, p528.]

tary one, or for the procuring of publications of comparatively trivial interest and the lighter literature of the day, it affords very inadequate facilities for the serious study of elaborate treatises, and none whatever for the consulting of voluminous and systematic works. For such purposes a permanent and progressive library is absolutely necessary, and most of us can only hope to enjoy such a possession by holding it in common. At no time more than the present has there been required on the part of every member of our profession, who wishes to promote its advancement or uphold his own credit, an acquaintance with its scientific history and actual progress. The spirit of free inquiry, that motive spirit of the age, is acting in no field more energetically than that of medicine. Deny or deprecate the fact as we may, medical theory and medical practice, too, are at present in a state of transition. No doctrine, however venerable, no statement, however often attested, but must submit now to fresh scrutiny, and to the confirming, destroying, or emendatory hand of the strictest criticism, armed with new instruments of research. The number of able and ardent inquirers in every department of our art was never before so great, and the press teems with the results of their investigations. He who ignores these results, who in the midst of all this sifting of old opinions and seeking for new truths, rests satisfied with the traditionary formulas of medical faith, will soon find he is behind the time, and has forfeited his claims to consideration even as a "practical man." His shallow dogmatism may impose upon others yet more ignorant than himself, but he will be held in no esteem by the only real judges—the well-instructed members of his own profession. I say, then, that were this Society merely an economical instrument for communicating through books and periodicals the accessions to medical knowledge that are continually being made, and the course of the ever-flowing currents of medical philosophy, it would be amply deserving of our support. We have here a comfortable reading-room open at convenient hours; we have secured the services of a competent librarian, at hand most of the day for the receiving and giving out of books; a complete catalogue has been lately drawn up, and a more satisfactory mode of circulating the journals adopted. In short, for the formation and maintenance of a useful and creditable medical library, we want nothing now but sufficient funds and their judicious expenditure.

But this Society was not intended to be merely a Book-Club. It has important objects besides that of furnishing us with other men's opinions, however valuable these may be. It is meant for the expression, discussion, and diffusion of our own. The comparatively short period of time to which our meetings are limited is an obstacle to the introduction of theoretical questions requiring lengthened exposition or prolonged argument, but has been found quite sufficient for the reporting of interesting cases, for the exhibition of patholo-

gical specimens, and for instructive commentaries on both.

Medical experience is constantly presenting, if not absolutely new subjects for notice, though such not unfrequently occur, at least novel relations of, and inferences from, the old. Every busy practitioner meets with striking and suggestive cases, with points in pathology, or with results of treatment worthy of record and subsequent reflection. To determine the true worth and bearing of such incidental facts nothing can more effectually contribute than the submitting of them to minds of kindred pursuits, whilst at the same time free from the bias which so often unconsciously attaches to the original observer. "Truth, like a torch, the more it's shook it shines." Its flame gathers strength, and its light flashes farther for the motion, whilst in its swift passage from mind to mind it throws off the adventitious particles which at first obscured its lustre, and becomes at length a pure effulgence—a lumen siccum never afterwards to be extinguished.

An acute, though unpremeditated question, an apt analogy or a pertinent counter-instance, may often aid effectually in defining a dubious fact or dissipating a nebulous hypothesis. Nor is the utility of our discussions to be measured by their more immediate or obvious results, or the length to which they are carried. Short suggestions may be thrown out in the course of them to be afterwards worked upon and tested, tacit assumptions may be quietly corrected, or a new importance suddenly imparted to some half-forgotten observation or train of thought. In a word, the simultaneous action of different minds on the same subject is often the shortest, simplest, and most decisive means of ascertaining its real import and value. As a criterion it operates "tuto et cito," and here, at least, we will anticipate always also "jucundé." The differences and the concurrence of the inquirers alike aid in the discovery and development of truth. The one stimulates the desire, the other strengthens the capacity for attaining it, whilst the very seeking of it in common augments the sense of its importance. On disputed points of theory or practice, a society like ours has, of course, no pretensions to be considered an ultimate tribunal. As a court of opinion, however, we may sometimes properly assume the functions of a grand jury, and quash the bills submitted to our scrutiny, or remit for further trial. Perhaps an occasional interchange of single papers or collected transactions between ourselves and other kindred societies might prove conducive to the common objects of both.

On questions of professional etiquette and personal difference—should such unfortunately occur—our council might, I think, advantageously continue to occupy the place filled by that of a former society, and act as a court medical for their amicable arrangement. All who have the dignity of the profession at heart would certainly prefer a reference to some such friendly arbitra-

tion to exposing their personal grievances or dissensions before an indifferent public. On this subject, I may observe that the code of medical ethics drawn up by the Belfast Medical Society is still extant, and worthy, I think, of adoption by our own.

In the relations of our profession with the public at large such a Society as this might, it appears to me, render material service to both parties, and occupy a higher position than ours has yet held. Whilst, gentlemen, no other body of citizens, I assert, confer such an amount of public benefit in so liberal and self-denying a spirit, we medical men are undoubtedly deficient in some of the chief elements of popular consideration. Very few of us are affluent—most of us of comparatively small means, and this “*res angusta*” must tend to impair the social estimation in which we are held, especially in a community where wealth is not only the general object of exertion, but too apt to be esteemed its highest reward and the prime standard of value. Nor can we boast of imposing titles, or corporate political influence. In short, we want all the coarser elements of power, and it is therefore not surprising if we be sometimes treated as the weak. Now, the mere associating of ourselves together, be it only for scientific objects, must strengthen at least our moral claims to consideration by exalting our character as a class. But it may do more than this: By cultivating among ourselves a certain laudable “*esprit de corps*,” and common methods of action, it will enable us, on the good old principle of “*vis unita fortior*,” more effectually to maintain our professional status and defend our professional rights, should either become the object of depreciation or attack.

I by no means wish to convert the Society into a trades’ union for the maintenance or advance of wages—though trades’ unions themselves have their strong points of justification. I would not even desire much of our time to be spent in discussions on the subject of fees. But even here, inasmuch as we are all, I presume, quite willing, individually, to accept such offerings, it might not, I think, be anywise inconsistent with professional delicacy if, as a united body, we should come to some understanding as to their suitable amount. There is an unpleasant ambiguity about that polite Latin word, “*Honorarium*,” and an occasional disagreeably close translation of it by our patients, which an authoritative definition of the term by ourselves might help to amend. Our junior brethren at least might find it not unfrequently desirable to be able to refer for an ample meaning to a recognised medical dictionary.

On matters of public hygiene and medical police, this Society might, I conceive, sometimes originate valuable suggestions, or at least offer valuable advice when consulted by our municipal or other local authorities. As a sort of standing counsel on such questions, its services if required would, I am sure, be always gladly rendered. That there is no indisposition to allow its due weight to professional opinion on matters regarded as

within its province, I may refer to a late occasion where an important point in the administration of the adjacent hospital was mainly determined by an appeal to medical authority.

It is quite true that on some subjects in sanitary science—as, for instance, the preventive and curative management of the formidable epidemic now within our boundaries—we may fail to be unanimous, and our deliberations may thence yield in their result but an uncertain sound. But we should not, in my opinion, fear to let such discordance be known. “*Doctors differ*,” no doubt; it is only theologians and lawyers who always agree—but we seldom differ for difference sake, but simply because the subjects on which we are called on to pronounce are often of a kind in which positive knowledge is at present unattainable. On such matters difference of opinion amongst “*experts*” implies serious grounds for hesitation, and the proper inference to be drawn from it is the propriety of caution in action. The warning thus conveyed may be in itself most salutary, if only by discrediting the more presumptuous counsels of the sciolist and the charlatan. With regard to quackery itself, whether public or private, I do not believe it can ever be extinguished, or even materially repressed by legislative enactments. It is a necessary consequence of the imperfections of our art—a natural expression of impatience with them. Health is a jewel of such inestimable value—in such universal request—that when the mine of knowledge proves unable to furnish it, the gutters of ignorance and imposture will ever continue to be raked in the futile hope of finding it there. The best, if not the only means, in my opinion, of discountenancing the unprincipled empiric, is to maintain and try to elevate still further our own character, individually and collectively, for candour, philanthropy, and science. Those, however, who may wish to enforce the law against unqualified practitioners, will find facilities for doing so in the Medical Protective Society, which is amalgamated with our own.

I have now, gentlemen, sketched feebly, and, I fear, tediously, the nature and purposes of our Society, as I conceive they are or might become. I had intended a discourse of another kind, and haply of more general interest; but on reflection it seemed that, at this particular juncture in the lifetime of our association, it might be expedient to recall the objects of its existence, and attempt to impress them afresh on the attention of its godfathers and guardians. Certainly without a lively sense of these, and a steady conviction of its capacity for effecting them, we are little likely to secure for the “*Ulster Medical Society*” length of days or energy of action. But *possunt qui posse videntur* and worked and wielded with a will we shall make of it, I feel assured, a powerful instrument for advancing knowledge, promoting friendly feeling, and maintaining professional credit. Even in aiming at such ends, we shall not only merit the support of our own body, but become

Ulster Medical Society
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President John Swanwick Drennan

entitled to the esteem and countenance of the general public.

Dr. James Moore on behalf of the Society returned thanks to the President. Dr. Patterson proposed that the address be published, Dr. Cuming suggested the propriety of its publication in the local papers. Dr. Dill was opposed to the publication of such addresses in the news-papers. Drs. Thomas Reade and MacCormac spoke in favour of Dr. Cuming's suggestion.

Dr. James Moore moved and Surgeon Gribbin seconded that the President's address be given by the council to the news-papers for publication which was agreed to.

Dr. John Moore proposed a vote of thanks through Dr. Wales to the donor of some pathological paintings, lately presented through Dr. Wales. Professor Reid seconded this and it was unanimously adopted.

Dr. James Moore expressed his intention of presenting to the Society a bust of the late Dr. McDonnell.

Surgeon Gribbin addressed the meeting on the subject of a grievance under which he considered himself to suffer by his having been brought to an inquest at which he was not examined and for his attendance at which he received no fee. This matter was referred to the council to [assess?].

Dr. McCrea presented a copy of a memorial sent by Dr. Rea to the authorities of Dublin Castle complaining of a fee of £1.1.0 having been tendered to him for 4 days attendance at the court of Quarter Session. This was referred to the council also.

John S. Drennan

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President.

Dr. Drennan.

Ex-President.

Dr. James Moore.

Vice-Presidents.

Dr. H. S. Ferguson.

Dr. Scott, Aghnacloy.

Dr. W. Mac Cormac.

Dr. Graves, Cookstown.

Members of Council.

Dr. Stewart.

Dr. Whitaker.

Dr. Patterson.

Dr. Murney.

Dr. M'Crea.

Dr. Rea.

Treasurer.

Dr. Cuming.

Secretaries.

Dr. John Moore.

Mr. R. H. Newett.

The Seventh Meeting of the Present Session will be held in the General Hospital, on Saturday, the 17th of November, at Three o'clock, P.M.

Business.

Member to be Proposed:

John Martin, L.R.C.S.I.

Paper to be Read. by Dr. Browne

On a Case of Injury to the Liver and Kidney, with fatal termination, caused by a vehicle accident.

Members in arrear are requested to forward their Subscriptions to the Treasurer.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with either of the Secretaries of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to either of the Secretaries.

Membership.—Persons wishing to be proposed for Membership will please forward their names to either of the Secretaries, with their qualifications and Subscription.

Signed by order,

John Moore,
R. H. Newett,
Secs.

Belfast, 15th November, 1866.

November 17, 1866

Present, the President in the chair, Drs. Stewart, Browne, Patterson, John Moore, Wales, William MacCormac, Mr. Newett, McCrea and D. N. Moore.

The minutes of the former meeting were read and confirmed.

The minutes of the last meeting of Council held on the 15th inst were also read and which stated that the members of the Council were perfectly satisfied with the explanation given by Dr. Dill in reference to a complaint made by Mr. Gribbin and were further of opinion that Dr. Dill's conduct in his official position as Coroner was not a subject which came within their jurisdiction. The subject of medical fees for attendance at Quarter Sessions Court was also brought under notice, it having been fixed by the Authorities at Dublin Castle at £1.1.0 per day.

Dr. Browne read an interesting paper on the case of a boy who had met with an accident from a cart passing over him, by which both the right kidney and liver were lacerated. The boy survived this serious accident from October 4th to November 7th and ultimately sank from abscess involving the injured kidney and destruction of the surrounding parts.

The Secretaries were directed to summon a meeting of Council for Wednesday next the 21st inst.

Proposed by Dr. Patterson that John Martin L.R.C.S.I. be elected a member of the Society.

John S. Drennan M.D.

485 Notice of meeting on 1st December 1866

President.

Dr. Drennan.

Ex-President.

Dr. James Moore.

Vice-Presidents.

Dr. H. S. Ferguson. Dr. Scott, Aughnacloy.
Dr. W. Mac Cormac. Dr. Graves, Cookstown.

Members of Council.

Dr. Stewart. Dr. Whitaker.
Dr. Patterson. Dr. Murney.
Dr. M'Crea. Dr. Rea.

Treasurer.

Dr. Cuming.

Secretaries.

Dr. John Moore. Mr. R. H. Newett.

The Eighth Meeting of the Present Session will be held in the General Hospital, on Saturday, the 1st December, at Three o'clock, P.M.

Business.

Member to be Ballotted for:

John Martin, L.R.C.S.I.

Pathological Specimen.

Mr. H. M. Johnston will exhibit specimen of Cancer of the Uterus.

Cases to be Read.

Dr. H. S. Purdon will read case of Tertiary Syphilis, and exhibit portion of Diseased Bone.

Dr. John Moore will read case of Inversion of the Bladder.

Recommendation from the Council.

That the Medical Journals lie on the tables in the New Rooms of the Society for a fortnight after receipt.

Members in arrear are requested to forward their Subscriptions to the Treasurer.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with either of the Secretaries of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to either of the Secretaries.

Membership.—Persons wishing to be proposed for Membership will please forward their names to either of the Secretaries, with their qualifications and Subscription.

Signed by order,

John Moore,
R. H. Newett,
Secs.

Belfast, 28th November, 1866.

1st December, 1866

Members present, the President Dr. Drennan in the chair, Dr. Cuming, H. Brown, Dill, W. MacCormac, McWilliam, Moore, John Moore, Patterson and Stewart, Messrs. Johnston and Newett. Staff Surgeon Major Crocker was also present.

The minutes of former meeting were read and con-

firmed.

The recommendation of Council "that the journals be permitted to lie on the tables in the new rooms of the Society for a fortnight after receipt", was taken into consideration and referred again to the Council for further consideration, and a special meeting of the Society was directed to be called, the day of meeting being left to the Council to determine.

It was proposed by Dr. Patterson and seconded by Dr. John Moore that Mr. John Martin L.R.C.S.I. L.A.H. be elected a member of the Society. Elected unanimously.

Mr. H. M. Johnston exhibited a specimen of malignant disease of the uterus.

Dr. Dill considered that the case had not been malignant in the first instance but had become so.

Dr. Reade suggested that the specimen be submitted to microscopic examination which Professor Cuming undertook to do.

Dr. John Moore read a case of inversion of the bladder. Mr. H. M. Johnston related a similar one which occurred in his practice some years ago. Dr. W. MacCormac referred to the extreme rarity of such cases especially in adults, the few cases on record nearly all occurred in children. Dr. Patterson had seen one case which had been under Dr. Simpson's care in Edinburgh.

W. MacCormac V.P, Chairman
December 15th, 1866

524 Notice of meeting on 11th December 1866

President.

Dr. Drennan.

Ex-President.

Dr. James Moore.

Vice-Presidents.

Dr. H. S. Ferguson. Dr. Scott, Aughnacloy.
Dr. W. Mac Cormac. Dr. Graves, Cookstown.

Members of Council.

Dr. Stewart. Dr. Whitaker.
Dr. Patterson. Dr. Murney.
Dr. M'Crea. Dr. Rea.

Treasurer.

Dr. Cuming.

Secretaries.

Dr. John Moore. Mr. R. H. Newett.

A Special Meeting of the Society will be held in their Rooms, at the General Hospital, on Tuesday next, the 11th December, at three o'clock, P.M.

Business.

To receive the Report of Council on matters referred to them at last Society Meeting.

Members in arrear are requested to forward their Subscriptions to the Treasurer.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with either of the Secret-

Ulster Medical Society
Session 1866–1867
President John Swanwick Drennan

aries of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to either of the Secretaries.

Membership.—Persons wishing to be proposed for Membership will please forward their names to either of the Secretaries, with their qualifications and Subscription.

Signed by order,

John Moore,
R. H. Newett,
Secs.

Belfast, 6th December, 1866.

11th December, 1866

Special Meeting of Society

Members present, Dr. Drennan (President in the chair), Drs. Stewart, Patterson, William MacCormac, Moore, Pirrie, Murney, H. Thompson, Stephenson, Whitaker, D. N. Moore, John Moore, McCrea and Mr. Newett.

The President explained the object of the present meeting of the Society which had been called for the purpose of making such arrangements as would facilitate the members having access to the journals and to appoint a deputation to wait upon the Hospital Committee to ascertain the exact position of the Society with regard to the new rooms which have been set apart for the Society's use.

Dr. Patterson moved that rule 24 with reference to the journals be carried out. Dr. Stewart seconded it.

Dr. Murney suggested that the Society should allow the periodicals to remain on the table of the present library and to use it has a reading room to which he believed the Hospital Committee had not the slightest objection.

Drs. William MacCormac, Pirrie and Murney (joint Trustees with Mr. Girdwood for the erection of the new Wing to the hospital, the donation of Mr. Charters) were present and concurred in stating that both rooms in the basement of the wing had been specially prepared, and were intended for, the Society's use: all the expenses of preparation having been defrayed out of a supplementary grant of £500 from Mr. Charters. Under the circumstances this statement being considered quite satisfactory, the intention of applying to the Hospital Committee as to the Society's tenure of the Rooms was abandoned.¹

Dr. Stephenson stated that the elliptical table at present in the library was a gift of the late Mr. John Aicken to the Society and Dr. Patterson stated that he had purchased on behalf of the Society the seats which match the table together with six chairs which

¹ [Item 488 has the same date and almost identical wording to this paragraph, and so has not been separately transcribed.]

are still the Society's property.

John S. Drennan

525 Notice of meeting on 15th December 1866

President.

Dr. Drennan.

Ex-President.

Dr. James Moore.

Vice-Presidents.

Dr. H. S. Ferguson.

Dr. Scott, Aghnacloy.

Dr. W. Mac Cormac.

Dr. Graves, Cookstown.

Members of Council.

Dr. Stewart.

Dr. Whitaker.

Dr. Patterson.

Dr. Murney.

Dr. M'Crea.

Dr. Rea.

Treasurer.

Dr. Cuming.

Secretaries.

Dr. John Moore.

Mr. R. H. Newett.

The Ninth Meeting of the Present Session will be held in the Society's Rooms, at the General Hospital, on Saturday next, the 15th December, at three o'clock, P.M.

Business.

Pathological Specimen.

Dr. Smith will exhibit a Brain, the subject of recent and extensive hæmorrhage.

Case to be Read.

Dr. Murney will give the particulars of a case in which he performed Pirogoff's Amputation, and show the parts removed.

Members in arrear are requested to forward their Subscriptions to the Treasurer.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with either of the Secretaries of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to either of the Secretaries.

Membership.—Persons wishing to be proposed for Membership will please forward their names to either of the Secretaries, with their qualifications and Subscription.

Signed by order,

John Moore,
R. H. Newett,
Secs.

Belfast, 14th December, 1866.

526 Notice of meeting on 15th December 1866

President.

Dr. Drennan.

Ex-President.

Dr. James Moore.

Vice-Presidents.

Dr. H. S. Ferguson.
Dr. W. Mac Cormac.

Dr. Scott, Aughnacloy.
Dr. Graves, Cookstown.

Members of Council.

Dr. Stewart.
Dr. Patterson.
Dr. M'Crea.

Dr. Whitaker.
Dr. Murney.
Dr. Rea.

Treasurer.

Dr. Cuming.

Secretaries.

Dr. John Moore. Mr. R. H. Newett.

A Special Meeting of the Society will be held in their Rooms, at the General Hospital, on Saturday next, the 22nd of December, at three o'clock, P.M.

Business.

To consider the Financial State of the Society, and other matters.

Members in arrear are requested to forward their Subscriptions to the Treasurer.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with either of the Secretaries of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to either of the Secretaries.

Membership.—Persons wishing to be proposed for Membership will please forward their names to either of the Secretaries, with their qualifications and Subscription.

Signed by order,

John Moore, R. H. Newett,
Secs.

Belfast, 14th December, 1866.

Society's Rooms

22nd December, 1866

Members present, Dr. Drennan (President in the chair), Drs. Cuming, Dill, Moore, D. N. Moore, John Moore, Patterson, William MacCormac, Stewart and Mr. Newett.

The minutes of former meeting were read and confirmed.

Dr. William MacCormac stated that he had submitted the minutes of former meeting which referred to the Society's tenure of its new rooms, to Drs. Murney and Pirrie in writing and both these gentleman agreed with him that it was correct.

The Treasurer then laid before the Society a statement of its Receipts and Expenditure for the year.

John S. Drennan

486 Notice of meeting on 5th January 1867

President.

Dr. Drennan.

Ex-President.

Dr. James Moore.

Vice-Presidents.

Dr. H. S. Ferguson.
Dr. W. Mac Cormac.

Dr. Scott, Aughnacloy.
Dr. Graves, Cookstown.

Members of Council.

Dr. Stewart.
Dr. Patterson.
Dr. M'Crea.

Dr. Whitaker.
Dr. Murney.
Dr. Rea.

Treasurer.

Dr. Cuming.

Secretaries.

Dr. John Moore. Mr. R. H. Newett.

The Tenth Meeting of the Society will be held in their Rooms, at the General Hospital, on Saturday next, the 5th January, at Three o'clock, P.M.

Business.

Mr. H. M. Johnston will read a case of Strangulated Hernia in which he operated, and which terminated fatally. He will also exhibit the strangulated portion of bowel.

Dr. Smith will read a case of Uremic Poisoning, and exhibit the recent parts.

Dr. W. Mac Cormac will give an account of a case of Dislocation of the Humerus, in which he effected reduction after eleven weeks, and will exhibit the patient.

Members in arrear are requested to forward their Subscriptions to the Treasurer.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with either of the Secretaries of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to either of the Secretaries.

Membership.—Persons wishing to be proposed for Membership will please forward their names to either of the Secretaries, with their qualifications and Subscription.

Signed by order,

John Moore,
R. H. Newett,
Secs.

Belfast, 3rd January, 1867.

5th January, 1867

Members present, Dr. Drennan (President in the chair), Drs. Reade, Murney, Smith, William MacCormac, H. Brown, Whitaker, David Moore, Cuming, John Moore, Messrs. Martin, Gribbin and Newett.

Dr. William MacCormac presented a patient to the Society and read the details of his case in which he had affected reduction of a dislocation of the humerus eleven weeks after the accident had happened.

[Paper: See page 1524.]

Ulster Medical Society
Session 1866–1867
President John Swanwick Drennan

451 **Letter from Mr. Henry Greer**

31 High Street Belfast
January 5th 1867

Dear Sir

I enclose a prospectus of the Belfast Athenaeum which I propose directing myself and expect to get into the new rooms 22 Castle Place early next week.

In connection with this I respectfully request that you will make the following proposition to the Ulster Medical Society.

“If the members of this Society to the number of fifty subscribe 31/6 each annually I offer them all the privileges of the institution in so far as the Reading room and Smoking room exist or may exist and I may mention that it may never be in my power to make this offer again as there are several other societies which have promised to use the Rooms when ready if I can accommodate them. I give you therefore the first offer”

H.G.

January 19, 1867

Present, the President Dr. Drennan in the chair, Drs. Stewart, Patterson, Croker, and Messrs. Gribbin and Newett.

The minutes of last meeting were read and confirmed.

The Council reported that it was not advisable to entertain Mr. Greer's proposal concerning the Athenaeum.

There was no further business transacted.

John S. Drennan

February 2nd, 1867

Present, Dr. Drennan (President in the chair), Drs. Stewart, Patterson, Murney, Wales, Smith, H. Brown, John Moore and Mr. Newett.

Dr. Smith read the history of a case of cirrhosis of the liver, in which the operation of tapping had been performed several times in order to remove the fluid which had accumulated in the abdomen. On the last occasion that operation had been performed by Dr. Murney at Dr. Smith's request. Towards the end of the operation a considerable amount of blood flowed through the cannula and notwithstanding every effort to arrest the flow, by passing a needle deeply through the walls of the abdominal parietes and twisting a ligature round it, it was evident that internal hæmorrhage was still progressing and the patient sank a few hours afterwards.

A post-mortem examination was obtained which shewed that in the operation which proceeded that which terminated so unfortunately, a portion of peritoneum had been injured, and a circumscribed point of adhesion not larger than the cannula, had taken place between it and the abdominal parietes where

the trocar had entered. As the same point was again selected for aspiration a vein was wounded, and from this unique accident the fatal hæmorrhage took place.

Dr. Murney had not been able to find the record of any similar case in all the journals to which he had access.

Dr. Moore stated that his father who had great experience in tapping seldom selected the same spot for a second operation. Should such a case occur in his practice he would pass a [joile?] needle deeply and twist a ligature round it.

Dr. Murney presented a patient in whom he had performed Pirogoff's amputation of the foot sometime ago and from which an excellent stump resulted.

John S. Drennan, President

16th February, 1867

Members present, Dr. Drennan (President in the chair), Drs. Reade, Cuming, Stewart, Moore, W. Mac-Cormac, H. Browne, McMurtry, John Moore and Mr. Newett.

A telegraphic message having been received from Dr. Porter regretting his unavoidable absence, the reading of his paper was consequently deferred to next meeting.

No other business was transacted.

John S. Drennan

529B *Notice of meeting on 2nd March 1867*

President.

Dr. Drennan.

Ex-President.

Dr. James Moore.

Vice-Presidents.

Dr. H. S. Ferguson.

Dr. Scott, Aghnacloy.

Dr. W. Mac Cormac.

Dr. Graves, Cookstown.

Members of Council.

Dr. Stewart.

Dr. Whitaker.

Dr. Patterson.

Dr. Murney.

Dr. M'Crea.

Dr. Rea.

Treasurer.

Dr. Cuming.

Secretaries.

Dr. John Moore.

Mr. R. H. Newett.

The Fourteenth Meeting of the Society will be held in their Rooms, at the General Hospital, on Saturday next, the 2nd of March, at Three o'clock, P.M.

Business.

Dr. Porter will read a Paper on Phagedænic Chancre of Dorsum Penis, followed by Sclerotitis and Keratitis.

Dr. W. Mac Cormac will give an account of three cases of Hæmorrhoides, operated upon by the clamp and the Actual Cautery, and will also give particulars of a case of Strangulated Femoral Hernia successfully operated upon.

Members in arrear are requested to forward their Subscriptions to the Treasurer.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with either of the Secretaries of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to either of the Secretaries.

Membership.—Persons wishing to be proposed for Membership will please forward their names to either of the Secretaries, with their qualifications and Subscription.

Signed by order,

John Moore, M.D.
R. H. Newett,
Secs.

Belfast, 28th February, 1867.

2nd March, 1867

Members present, Dr. Drennan (President in the chair), Drs. Reade, Stewart, Cuming, W. MacCormac, Whitaker, McMurtry, Moore.

Dr. Porter read a case of Phagedænic Chancre of Dorsum Penis followed by Sclerotitis and Keratitis.

Paper:¹ *On the 16th of last December, A. C. M., a married mechanic, was brought to me for a sloughing sore on the dorsum of his penis, which he first noticed as a small abrasion a fortnight before. On examining, I found it to be about the size of a florin, the surface an ashy grey, discharging a greenish ichor; the edges ragged and high, and the base flabby, nonindurated. The cellular tissue of the prepuce was infiltrated to a great extent, but the dorsal lymphatics did not appear in the least implicated, nor had he at this time any sign of bubo in either groin.*

On questioning him as to his habits and health he told me he occasionally drank freely, was exposed to heats and colds, had a variable appetite, and was not accustomed to very good food. The bowels were regular. He was not aware of suffering from any complaint but the one for which he wished me to treat him, and was not aware of ever having had venereal disease before. He was in a painfully nervous state, and this he attributed to loss of sleep. He had been poulticing the sore on his own responsibility for several days, and had also drugged himself with senna and salts; his pulse was quick and thready, his tongue creamy, and his complexion sallow.

With the assistance of his companion, I put him slightly under the influence of chloroform, and freely cauterized the chancre with strong nitric acid; applied a piece of lint dipped in a mixture of glycerine and water, over this oiled silk, and a small, light bandage, in which I included the swollen foreskin; ordered him to

keep a poultice of linseed meal to the sore during the night, and renew it next day; to support the yard on his abdomen by means of handkerchiefs; and get to bed as soon as practicable. I gave him twenty grains of Dover's powder to be taken at eight o'clock, and prescribed five-grain doses of Plummer's pill, night and morning. On his leaving he appeared much more tranquil, the pain of the operation having almost passed away.

On Tuesday, the 18th ultimo, according to arrangement, he called with me; had of necessity been at his work the preceding day, but had not suffered much pain: had slept well during the night, and did not appear in the least agitated or nervous; his bowels had been freely opened in the morning; the ulcer was now deeper than the skin, and discharging thin yellow pus; the edges were high and the margin inflamed. Into the centre of the ulcer I dropped a little of the red oxyde of mercury, and having smeared the intact skin with a mixture of collodion and glycerine, applied a weak lotion of nitric acid, and bandaged up the penis against his abdomen. Prescribed the compound decoction of sarsaparilla, in one ounce doses, three times daily. Before he left, I found on enquiry a large bubo had appeared in his right groin—the side corresponding to the larger half of the chancre on the dorsum penis. I recommended a poultice of linseed meal to be kept to it, and the weak nitric acid lotion to be renewed to the chancre when required.

On Thursday, the 20th ultimo, the ulcer presented a red granulating surface, with healthy pus; the edges were less inflamed, and level with the sound skin. Ordered frequent applications of black-wash; the bubo was large and painful; I opened it, and obtained a good quantity of curdy matter, very dark coloured; he experienced great relief from this; I then painted the skin over and about with tincture of iodine; I stopped giving him the compound calomel pill, as he had now taken in all half a drachm of it, leaving him on the compound decoction of sarsaparilla as his only medicine.

Christmas day, the 25th ultimo, the ulcer was healing rapidly; his general health was good; he had been living more generously for the previous four or five days, and taking his food with relish; had slept well, and did not appear to suffer from febrile excitement.

On the 27th ultimo the new skin had begun to form from the edges, the bowels kept regular, and the appetite and spirits good; I painted the bubo with tincture of iodine; it had almost disappeared, as had the swelling of the prepuce.

On the 28th ultimo the ulcer was nearly healed, there being but the size of a groat of granular surface.

On the 29th ultimo the ulcer was covered with new skin, except a very minute patch; no traces of the bubo remained, save a little hardness. On this date he discontinued the compound decoction of sarsaparilla as recommended. He now left me, thinking he was cured.

¹ [Medical Press and Circular, 1867, p310.]

On the fourth day of this month (January), he came back to me complaining of a sore throat; he thought he had caught cold, and evidently had.

On examining his throat I found the uvula full and congested, with a similar condition of the right tonsil, and diffuse erythema of the fauces, but could not detect ulceration of any kind. He was feverish and nervous, and seemed to apprehend something unpleasant.

Recommended frequent alum water gargles, and gave him a powder composed of two grains of calomel with twenty grains of Dover's powder, to be followed in the morning by a dose of salts; his bowels had not been acting for two days, and this condition seemed to aggravate his symptoms. Before leaving, he directed my notice to the smarting of his eyes, and congestion of the conjunctivæ, which, however, was very slight

On the 5th inst. the chancre was quite healed; the throat was slightly better, but the conjunctiva of the right eye was greatly inflamed, that of the left eye less so; I touched the palpebral portions of the membrane with the stick nitrate of silver; gave twenty grains of Dover's powder; ordered two leeches to the temple, and dreading the possibility of syphilitic poison having something to do with this acute attack, immediately put him on the bichloride of mercury, prescribed in the following form:

℞ Hyd. bichlor. gr. ii.

Tr. hyoscyam. zii.

Vin. colchici.

Vin. ipecac. aa. ℥ss.

Infus. gent. co. ad ℥iv. M. ft. mist.

A teaspoonful to be taken in a glass of water three times daily as directed; recommended as nourishing food as his means would permit of, warm clothing, and, as far as possible, avoidance of exposure.

He had to leave off work on this date, owing to the intense pain; his nervousness was excessive, and the application of the caustic seemed to excite him very much.

On the 7th inst., he came to me in great alarm, saying his eye was much worse; he was suffering extreme pain in the brow and temple, which at times he referred to the deeper structures of the ball; he had most marked photophobia of the right eye; the tears ran from both on examination, but principally from the right one, the left conjunctival membrane seemed much improved, and the congestion greatly lessened, but on the right side the inflammation had extended, and the subjacent tunic become involved, as indicated by the straight pink coloured vessels to the inner side of the cornea, which were visible for a limited extent, running from the margin of the blueish white ring, and terminating in the capillary net work of the conjunctiva; the pupil was at this time dilated.

The soreness of the throat had passed away; his bowels were regular, but his appearance was haggard and worn from want of sleep. Ordered two leeches to

his temple, and twenty grains of Dover's powder to be taken at bed time; the bichloride of mercury mixture he was taking regularly.

On the 8th inst. the inflammatory action of the left eye had disappeared, while in the right eye it had decreased in the conjunctiva, but increased and extended in the sclerotic to the inner side of the cornea, round which the blueish white ring had become more opaque; the cornea itself was still clear, with the pupil contracted. He had great dimness of vision; intolerance of light, and profuse flow of tears, supra-orbital pain, and severe headache, accompanied by a good deal of febrile excitement. Recommended a full dose of Dover's powder, and hot fomentations to the eye, the other treatment being strictly pursued.

The following day (9th inst.) he returned in a state of distraction, more, however, from the dread of evil results than any pain he suffered. On raising the lid I found the whole cornea had become opaque, completely obscuring the pupil, he could not see at all with this eye. The pink coloured vessels of the sclerotic were very distinct to the inner side, while very little congestion remained in the capillaries of the conjunctiva. Prescribed ten drops of the tincture of perchloride of iron every hour, the bichloride of mercury being continued as before, and as a collyrium:

Ext. Belladon. gr. xx

Zinci Sulph. gr. xl.

Aquæ distill. ℥iv. M.

The full of a small syringe to be injected under the lids four times daily, while with me I used some of this to his eye, and though painful at the time, he experienced great relief after it, accompanied by intense itching. Recommended a blister behind his right ear, and gave him a Dover's powder to take at bed time.

I did not see him on the 10th inst., but visited him at his own house on the 11th; his friends had refused to give him his medicines, or otherwise carry out my instructions. I then found it necessary to tell his wife the previous history of his case, in order that she might afterwards permit him to go by my advice.

On exposing the eye, considerable congestion of the conjunctival capillaries, more diffuse and extensive inflammation of the sclerotic membrane on all sides, less opacity of the cornea, and a more dilated pupil, were the appearances observed; though the pupil was now apparent he could not in the least degree distinguish light from shade. The treatment was now resumed, and the blister applied.

On the 12th inst. I learned that all directions had been strictly attended to, the changes presented by the eye were more general redness of the conjunctiva, and deeper colour in the radiating capillaries of the sclerotic, the condition of the cornea remaining unaltered; his pulse was sixty in the minute, steady and full; his tongue clean; appetite good; and nervous excitement much less; his throat he did not now complain of, nor

did it present an unhealthy state; on this occasion some extract of Belladonna was smeared round the orbit of his affected eye.

The 13th inst., the conjunctival congestion was less, and confined to the inner side of the membrane, there was less opacity of the cornea, and greatly diminished vascularity of the sclerotic; the pupil was more dilated; the tongue was clean; pulse 65, regular; his throat was rather inflamed-looking; he appeared in excellent spirits; had a good appetite, and was now, as recommended, taking two bottles of porter in the day; ordered a cathartic pill to relieve constipation.

On the 14th inst. the inflammatory action of the membranes was rapidly decreasing, the sclerotic vascularity remained round the margin of the cornea, but the colour of the vessels was much lighter; the cornea itself had begun, to regain its transparency, the pupil was large, his general health and spirits kept good, his bowels had been freely moved, and his throat seemed better: he now stated he could discern light and shade with the diseased eye.

On the 16th inst. the improvement in the eye was marvellous: the cornea was almost quite clear again, the pupil was widely dilated, the redness of the conjunctiva was very slight and confined to the neighbourhood of the inner canthus; the radiating vessels of the sclerotic were still visible, but less distinct; his health and spirits continued excellent, he had a keen appetite, his tongue was clean, and his throat much better.

On the 17th inst. the improvement developed in the eye within the space of twenty-four hours was such that he could again distinguish objects; the opacity of the cornea had become absorbed, and it had almost returned to its normal state; a lingering inflammatory blush still remained in the sclerotic; the neighbourhood of the inner canthus seemed to have a little more redness than on the preceding day, but it appeared he had gone out into the cold air, and this may have accounted for the latter symptom.

On the 18th inst. he could see quite as well with his right eye as with the unaffected one, but the weakness which still remained prevented his looking at any object for more than a minute at a time. The sclerotic vessels still imparted a pink hue to the white of the eye; all conjunctival redness was gone. The blueish-white ring which encircled the cornea had greatly diminished. The bichloride of mercury was finished.

On the 19th inst. the cornea was quite transparent, but considerable vascularity remained in the sclerotic. His health kept good, and he had commenced to take cod liver oil. Did not renew the corrosive sublimate, of which he had taken, in all, two grains.

On the 21st inst. the eye was much stronger, and the sclerotic vascularity greatly lessened; the bowels had been freely moved. The cod liver oil seemed to agree with his stomach. The right tonsil was inflamed, and caused him some uneasiness in swallowing.

He was at his work the following day; he felt his eye getting stronger, and his throat better; he had applied a mustard and linseed poultice externally to it during the night, and received great relief from it.

On the 25th inst. every trace of inflammatory action had left, and the eye presented a normal appearance. He could now see almost as well as ever he had done. His throat being still a little troublesome, was cauterized with a strong solution of nitrate of silver. He kept in excellent health, and found the cod liver oil agreed well with him, as did the tincture of perchloride of iron, of which he was now taking fifteen drops three times daily.

The next day his throat, though better, was again cauterized. His eye was being strengthened by douches of cold water applied night and morning.

On the 28th inst. his throat was cauterized, and appeared greatly improved. He did not find any injurious effects from being at his work.

On the 30th instant his throat was much improved, and he could swallow without pain. I recommended him a mixture of chlorate of potass and tr. of steel, with infus. of quassia. I now considered him free from the malady for which he originally came to me, and discontinued my visits, believing the throat affection to be due merely to simple congestion of the mucous tract.

In reviewing the history of the case, some peculiarities may be observed, while the treatment adopted is perhaps deserving of a little consideration.

Mr. Henry Lee has described four varieties of chancre viz., the Hunterian or true, the non-indurated or soft, the phagedænic, and the gangrenous or sloughing chancre; the third is most like the form presented in the foregoing report, but yet materially different. Mr. Lee in speaking of it says—"It produces suppuration, generally of one inguinal gland only, which yields an inoculable secretion. It is not followed by constitutional syphilis, and may be treated by local means."

In this patient it has been seen that one inguinal gland only suppurated, but that constitutional symptoms ensued, and these—neither preceded nor accompanied by any eruption of the skin—were confined to the right side of the body, and supervened on the healing of the primary sore; that there was no induration, and the chancre exhibited the process of ulcerative inflammation (vide "A System of Surgery," edited by T. Holmes, M.A., &c., vol. i., p. 461). It was seen that the right tonsil and uvula were congested and swollen, while no ulcers could be detected on any portion of the mucous membrane of the mouth or throat. These facts, together with the nature and course of the diseases which attacked the eye, do, I think, give an uncommon aspect to the whole case.

As noticed, the treatment pursued was successful, and throughout unattended by ptyalism, or other indications of mercurialization, which were carefully watched for, in order that the use of mercury might be

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suspended or stopped should such arise. From the first, the strength was supported by a nourishing diet, and the irritation allayed by full doses of Dover's powder. A small amount of Plummer's pill was administered at the early stage, but merely with the object of acting on the skin, liver, and bowels, not as a prophylactic. The cauterization with strong nitric acid, and the subsequent local applications, having been attended by good results, and unaccompanied by any considerable amount of inflammation or constitutional disturbance, give sufficient evidence in their own favour. When the eye affections became apparent and the mercurial treatment was indicated, a mixture containing corrosive sublimate, in combination with henbane, colchicum, and ipecacuanha, as already observed, was adopted, the blood being at the same time strengthened by tincture of steel, in large and frequent doses, and this supplemented by cod-liver oil. The speedy resolution of the inflamed membranes, and the improvement which took place in the general health, may be spoken of as consequent on the treatment to which the system was subjected.

Professor Cuming complemented Dr. Porter on this his first paper presented to the Society and characterised it as being especially well written, but was of opinion that the eye affection which followed was not a consequence of the syphilitic disease but a mere coincidence.

Dr. William McCrea coincided in opinion with Dr. Cuming and looked upon the inflammation of the eye as not syphilitic.

Dr. Reade thought there might be some connection between the two ailments and considered the case as one worthy of further observations.¹

Robert Stewart, Chairman,
16th March, 1867

528 Notice of meeting on 16th March 1867

President.

Dr. Drennan.

Ex-President.

Dr. James Moore.

Vice-Presidents.

Dr. H. S. Ferguson.

Dr. Scott, Aghnacloy.

Dr. W. Mac Cormac.

Dr. Graves, Cookstown.

Members of Council.

Dr. Stewart.

Dr. Whitaker.

Dr. Patterson.

Dr. Murney.

Dr. M'Crea.

Dr. Rea.

Treasurer.

Dr. Cuming.

Secretaries.

Dr. John Moore.

Mr. R. H. Newett.

The Fifteenth Meeting of the Society will be held in their Rooms, at the General Hospital, on Saturday next, the 16th of March, at three o'clock, P.M.

Business.

Dr. W. Mac Cormac will give an account of three cases of Hæmorrhoids, operated upon by the clamp and the Actual Cautery, and will also give particulars of a case of Strangulated Femoral Hernia successfully operated upon.

Members in arrear are requested to forward their Subscriptions to the Treasurer.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with either of the Secretaries of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to either of the Secretaries.

Membership.—Persons wishing to be proposed for Membership will please forward their names to either of the Secretaries, with their qualifications and Subscription.

Signed by order,

John Moore, M.D.

R. H. Newett,

Secs.

Belfast, 14th March, 1867.

16th March, 1867

Members present, Drs. Stewart (in the chair), Drs. Reade, Patterson, Dill, Cuming, William MacCormac, McWilliam, Wales, John Moore, Mr. Newett, Dr. Smith, Porter, H. Brown.

Minutes of former meeting read and confirmed.

Dr. William MacCormac gave an account of three cases of hæmorrhoids on which he had operated by the clamp and the actual cautery, and also gave the particulars of a case of strangulated femoral hernia successfully operated on.

The operation for piles was illustrated by a well-executed drawing of the diseased parts.

The first case operated on was J.E. æt. 43. Had suffered from the complaint for twelve years, at times it amounted to agony. Exhausting hæmorrhages took place and his general health was broken down.

The bowel having been emptied by an enema, the patient was placed on his left side, and the pile taken hold of by a pair of forceps with which it was drawn downwards.

Its base was then partially snipped through with a pair of scissors and the remainder enclosed in the clamp. The pile having been then removed with the scissors, the actual cautery was then applied, and the bowel returned to its place.[$\frac{3}{4}$ grs?] of opium with [3 grs?] of Tannin were ordered every third hour.

¹ [See further remarks on page 1086.]

After the first hour all pain and uneasiness subsided. The fourth day after the operation a draught of castor oil followed by a tepid water injection caused the bowels to be opened without suffering. He was discharged twelve days after the operation quite cured and most thankful.

The other cases did not differ materially from the foregoing.

Drs. Dill and Reade made some observations on the cases.

John S. Drennan, President

March 30th, 1867

Present, the President in the chair, Drs. Cuming, Patterson, Stewart, Reade, Moore, Dill, Wales, Henry Browne, Porter and Mr. Newett.

The President read papers on a case of tubercle of the brain and on a case of abscess of the liver. Preparations were exhibited and a discussion ensued.

John S. Drennan

April 13th, 1867

Members present, Dr. Drennan (President in the chair), Drs. Stewart, Patterson, Moore, H. Brown, William MacCormac, H. Purdon, Dill, John Moore and Mr. Newett. Dr. Croker, Staff Surgeon, was also present.

Minutes of former meeting read and confirmed.

Dr. Moore exhibited an elongated prepuce which he had removed by circumcision from a gentleman who was about to get married, and to the duties consequent on such a state, the encumbrance would have presented a serious obstacle to their proper performance.

He also exhibited a diseased testicle which he had removed. The subject of the operation received a blow from an Aunt Sally stick on the testicle sometime previously. This was followed by severe inflammation and a swelling which never entirely disappeared.

Ulceration at length took place and an amount of disorganisation to such an extent as required removal of the diseased organ.

Dr. William MacCormac read a case of inguinal hernia which occurred in a woman and on which he had operated. The subject was a domestic servant age 52 years. The rupture had existed from childhood. On the 3rd inst. strangulation of the bowel took place and for a time she concealed the nature of her ailment. Stercoraceous vomiting occurred when the case was seen by Dr. Pirrie. Not being able to reduce the strangulated bowel, he sent for Dr. MacCormac and it was agreed to place the patient under chloroform and should the taxis not prove successful, to proceed at once to divide the stricture. Not succeeding, the operation was undertaken and on opening the sac the portion of bowel forming the rupture was found to be the cæcum with the vermiform appendix. Consider-

able difficulty was experienced in returning the bowel which was at length accomplished. This was followed by great relief and all the urgent symptoms subsided. For the first twenty-four hours she continued to progress most satisfactorily but afterward unfavourable symptoms appeared. The wound shewed no tendency to heal but it was not till the 7th, four days after the operation that alarming signs presented themselves when rapid sinking came on and she died at 8 p.m. on that day.

A P.M. was obtained which failed to throw much light on the cause of death. The bowels were distended with air but there were no signs of general peritonitis. There was some lymph at the constricted portion of the bowel but no perforation and Dr. MacCormac was still unable satisfactorily to account for the cause of death in this case. He considered it his duty to bring the case forward as from such as terminate unfavourably more may often be learned than from those which end well.

Dr. Moore, Dr. Cuming and the President made some observations on the case.

John S. Drennan, President

26th April 1867

Members present, the President in the chair, Drs. Reade, Stewart, Patterson, Cuming, H. Brown, John Moore and Mr. Newett.

Minutes of last meeting read and confirmed.

Dr. Cuming proposed and Dr. Patterson seconded that Dr. Fagan be elected a member of the Society. Elected unanimously.

The Secretaries were directed to summon a Special Meeting of Council for Thursday 2nd May at 12 o'clock to prepare the Annual Report for the Society and to transact such other business as may be brought before it.

Dr. Patterson proposed and Dr. Stewart seconded that Drs. Whitaker and H. Brown be appointed Auditors for the ensuing year. Carried unanimously.

James Patterson, Chairman
1st June 1867

Annual Report of Council

The Council has much pleasure in submitting to the members of the Society their Report for the year just terminated.

Twenty meetings have been held at which the following instructive papers were read, pathological specimens exhibited, and interesting cases presented.

Papers by Professor Cuming on pericarditis with unusual cerebral symptoms.

Professor Seaton Reid on recent cholera cases in Belfast.

Dr. John Moore on a case of inversion of the bladder.

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Dr. J. W. T. Smith on a case of unusual local spasmodic affection, on uræmic poisoning, and on cirrhosis of liver where fatal hæmorrhage followed tapping, performed at his request by Dr. Murney.

Dr. Porter on phagedenic chancre of dorsum penis followed by sclerotitis and keratitis.

Dr. William MacCormac on cases of hæmorrhoids operated on by the clamp and actual cautery, and on cases of hernia operated on by him.

Pathological specimens exhibited by Professor Cuming of fibrinous concretion of the heart.

Dr. Browne a ruptured liver and kidney resulting from a wagon passing over the body of a boy.

By Dr. James Smith a brain the subject of recent and extensive hæmorrhage.

Dr. James Moore an elongated prepuce and a diseased testicle which he had removed.

Patients were presented by Dr. William MacCormac where reduction of the humerus had been effected eleven weeks after the accident.

Dr. Murney where he had performed Pirogoff's amputation of the foot.

Fourteen members joined the Society during the year, Drs. Drennan and Wheeler becoming life members. The Society has lost by death one of its oldest and most respected members, Dr. McMechan of Whitehouse.

One case of misunderstanding between two members of the Society was referred to the Council and amicably arranged.

The following is the attendance of members at meetings of Council: Dr. Drennan 15, Dr. James Moore 7, H. S. Ferguson 0, William MacCormac 14, Scott 0, Graves 0, Stewart 12, Patterson 10, McCrea 1, Whitaker 3, Murney 3, H. P. Rea 1, Cuming 8, John Moore 15, Mr. Newett 19.

On the 6th October the Society entered into possession of the new Rooms which have been set apart for its use and on the 11th December a Special Meeting of the Society was held when the following minute was entered on the records of the Society: Drs. William MacCormac, Pirrie and Murney, joint Trustees with Mr. Girdwood for the erection of the New Wing of the hospital, the donation of Mr. Chartres were present and concurred in stating that both rooms in the basement of the Wing had been specially prepared and were intended for the Society's use all the expense of preparation having been defrayed out of a supplementary grant of £500 from Mr. Chartres.

The Council regret to state that though they have given their best attention to the circulation of the periodicals they have been unable to make as satisfactory arrangements as they would desire.

It would further desire to call the Society's attention to the fact that the Library Room of the Society being now so occupied by the Committee of the General Hospital as to render it unavailable to the mem-

bers as a reading room for which purpose it was originally set apart; the Council are of opinion that their claims upon it should be laid before the Committee and a distinct undertaking arrived at in the subject.

John Moore M.D., Secretary
1st May 1868 R. Stewart, Chairman

Society's Rooms

4th May, 1867

Annual Meeting

The President in the chair, members present, Drs. Thomas Reade, Stewart, Patterson, Cuming, William MacCormac, Whitaker, H. Brown, T. H. Purdon, James Smith, Brice Smyth, John Moore, Messrs. Newett and Martin.

Dr. Monck of Holywood was elected a member of the Society having been proposed by Dr. James Moore and seconded by Dr. Patterson.¹

The minutes of last Annual Meeting were read and confirmed.

The Report of the Council for the past year was read. It was then moved by Dr. Drennan and seconded by Dr. William MacCormac that the Report just read be adopted and entered on the minutes of the meeting. Carried unanimously.

The Treasurer then laid before the Society a statement of its accounts for the past year.

The members then proceeded to the election of a President and Office Bearers for the ensuing year.

Dr. Seaton Reid was unanimously elected President of the Society. Drs. Thomas Reade and James Smith, Vice Presidents for Town, Drs. Kelso of Lisburn and H. Thompson of Bangor, Vice Presidents for Country.

The following were elected Members of Council, Drs. Patterson, Stewart, William MacCormac, T. H. Purdon, Whitaker, Brice Smyth.

Dr. Cuming was requested to continue as Treasurer and Dr. John Moore as Secretary to the Society, which both consented to do.

Dr. Thomas Reade proposed that the best thanks of the meeting be given to Dr. Drennan, the retiring President, for the admirable address which he had delivered (and which at the Society's request has been published), for his constant attendance at the meetings of the Society, and for the uniformly kind and efficient manners in which he had discharged the duties of his office which has been such as to give entire satisfaction to every member of the Society: and he only regretted that the Rules of the Society were such as to preclude his re-election, a proposition which he believed would have met with the unanimous wish of the members. Dr. Patterson seconded the proposition which was carried by acclamation.

¹ [This seems to be Charles Edward Beresford Monck.]

Dr. Drennan replied and expressed the pleasure he would at all times feel in affording to the Society all the aid which was in his power to bestow.

Dr. Stewart moved and Dr. Thomas Reade seconded that a vote of thanks be tendered to Mr. Newett for the valuable services which he has rendered as joint Secretary to the Society, and from which post he now reluctantly retires owing to the pressure of his other engagements.

489 Newspaper Clipping—Report of Annual Meeting.

Ulster Medical Society.—The annual meeting of this society was held at their rooms, in the General Hospital, on Saturday last, when the council's report for the past year was laid before the members. Twenty meetings of the society had been held, at which instructive papers were read, pathological specimens exhibited, and interesting cases presented. Fourteen new members joined the society since last annual meeting; and the council regrets to record the loss of one of its oldest and most esteemed members, Dr. M'Mechan, of Whitehouse. Dr. Seaton Reid was unanimously elected president for the ensuing year; Drs. Thos. Reade, J. W. Smith, Kelso (Lisburn), and Thompson (Bangor), vice-presidents.

The following were elected members of council Drs. Patterson, Stewart, William MacCormac, H. S. Purdon, Whitaker, and Brice Smyth. Professor Cuming was requested to continue as treasurer, and Dr. John Moore as secretary, to the society. Dr. Thomas Reade moved a vote of thanks to Dr. Drennan, the retiring president, for the admirable inaugural address which he had delivered, for his constant attendance at the meetings of the society, and for the uniformly kind and efficient manner in which he had discharged the duties of his office, which was seconded by Dr. Patterson, and carried by acclamation. A vote of thanks was proposed by Dr. Stewart, seconded by Dr. Reade, and passed unanimously, to Mr. Newett for the valuable services he had rendered as joint-secretary to the society, and from which office, owing to the pressure of his other engagements, he now retires.

Ulster Medical Society
Session 1867–1868
President James Seaton Reid

ULSTER MEDICAL SOCIETY

SESSION 1867–68

491 *Request to attend a meeting of Council.*

[Undated.]

Sir

You are requested to attend a Special Meeting of Council, to be held in the Society's Rooms on Wednesday the 15th inst.¹

To take into consideration the circulation of the Journals.

The propriety of changing the day and hour of Society's Meeting and other important business.

Your attendance requested

John Moore,
Hon. Sec.

Circulation of Journals.²

1 Dr. Henry Browne	York St.	Lancet, Press & D.J.
2 Dr. Wales	York St.	
3 Dr. David Moore	Donegall St.	
4 Dr. Angus Porter	Donegall St.	Press.
5 Mr. H. M. Johnston	Donegall St.	D.Q.
6 Dr. Beck	North St.	
7 Dr. McMurtry	North St.	
8 Mr. Newett	General Hospital	
1 Dr. Drennan	Chichester St.	Med. Chirur. Dub. Quart. Edinburgh Journal. May 1867
2 Dr. James Moore	Chichester St.	Lancet
3 Dr. Patterson	Donegall Sq. E.	
4 Dr. McCrea	Alfred St.	
5 Dr. Nevin Moore	Donegall Sq. S.	Ed. J. Dub. Q. Med. Press
6 Dr. Gordon	Howard St.	
7 Dr. H. Burden	Alfred St.	
8 Dr. Wheeler	Clarence Place	
1 Dr. Dr. Stewart	Asylum	Dub. Quart.
2 Dr. Whitaker	High St.	
3 Mr. Pring	Cornmarket	Edinb.
4 Mr. Cantrell	Castle Place	
5 Surgeon Smith	Castle Place	
6 Dr. Fagan	Donegall St.	
1 Dr. Stephenson	Wellington Place	
2 Dr. Cuming	Wellington Place	Lancet: Times & Medic Chir.
3 Dr. Thomas Reade	Wellington Place	
4 Dr. Charles Purdon	Wellington Place	
5 Dr. H. S. Purdon	College Sq.	
6 Dr. Ross	Wellington Place	
7 Dr. Harkin	College Sq.	

¹ [The only 'Wednesday 15th' in 1867 is that in May.]

² [Extracted from the Belfast Clinical and Pathological Society Council Minute book. Placed here because of the included dates and the mention of 'the circulation of the Journal' above.]

8 Dr. Murney	Donegall Sq.	Lancet & Times.
1 Dr. Dill	Fisherwick Place	Dublin Quarterly May 1867. D. G. & Press.
2 Dr. Pirrie	Fisherwick Place	
3 Dr. H. S. Ferguson	Fisherwick Place	
4 Dr. Seaton Reid	Glengall Place	Times
5 Dr. James Smith	Glengall Place	
6 Dr. Brice Smyth	College Sq.	
7 Dr. Brown	Howard St.	
8 Dr. William Mac Cormac	" "	
1 Mr. H. P. Rea	Gr. Victoria St.	
2 Dr. Mulholland	Botanic Road	
3 Dr. Manley	Whitehouse	
4 Mr. McCleery	Clarence Place	
5 Dr. McGee	College Sq.	
6 Mr. Gribben	Cromac St.	
7 Dr. McWilliam	Victoria St.	
1 Dr. Kelso	Lisburn	
2 Dr. Higginson	Lisburn	
3 Dr. Thompson	Bangor	
4 Dr. Dunlop	Hollywood	
5 Dr. Monck	Hollywood	
6 Dr. Patrick	Carrickfergus	
7 Dr. Murray	Ballymacarret	
1 Dr. Andrews	Queen's College	
2 Dr. Grattan	College Sq.	
3 Dr. Hurst		
4 Dr. Thos. Thompson		
5 Dr. Mac Cormac		
	Dr. Hayes	
	Dr. W. Hannah	
	Dr. H. Moore	
	Dr. Berry	Shankill
	Mr. Markin	College Sq.
	Dr. Murray	Falls Rd.

[There are another eight pages of names and places of residence which have not been transcribed. The names have often similarly been divided into groups of seven or eight, perhaps representing sub-groups through which the journals were circulated. This might suggest that the Society bought a number of copies of each journal to reduce the time a member had to wait for the arrival of the current issues.]

490 *Request to attend a meeting of Council.*

Undated.

Sir

You are requested to attend a Meeting of Council, to be held in the Society's Rooms on Wednesday next the 22nd inst.¹

John Moore,
Hon. Sec.

¹ [The only 'Wednesday 22nd' in 1867 is that in May.]

492 List of Officers of the Society, Session 1867–68.

President.

Dr. Seaton Reid.

Ex-President.

Dr. Drennan.

Vice-Presidents.

Dr. Thomas Reade. Dr. Kelso, Lisburn.

Dr. James W. T. Smith. Dr. Thompson, Bangor.

Members of Council.

Dr. Patterson. Dr. Whitaker.

Dr. Stewart. Dr. Bryce Smyth.

Dr. W. Mac Cormac. Dr. H. S. Purdon.

Treasurer.

Dr. Cuming.

Secretary.

Dr. John Moore.

**List of Present Members of Society
And Dates of Joining**

1822	June 8th	Dr. Stevenson	Life Member	1842
1825	Aug 1	Mr. Walkington	Dead	
1826	July 3	Mr. John Grattan		1846
1828	May 1st	Dr. Henry MacCormac		1848
1813	May 4th	Dr. Hurst		1815
1832	Jan 2nd	Dr. Thomas Thompson	Dead	1852
1834	Nov 3rd	Dr. William Burden		1854
1836	May 2nd	Dr. Andrews		1856
1839	Mar 4th	Dr. Patterson		1859
1839	July 1st	Dr. Kelso, Lisburn		1859
1840	Sept 7th	Dr. Stewart		1860
1841	May 3rd	Dr. Thomas Reade		1861
1841	Nov 1st	Dr. Dill		1861
1842	Dec 5th	Dr. Browne R.N.		1862
1843	Feb 6th	Dr. Gordon		1863
1843	May 1st	Dr. Beck		1863
1843	May 1st	Dr. Seaton Reid		1863
1845	Aug 4th	Dr. Pirrie		1865
1845	Nov 3rd	Dr. Mulholland		1865
1846	Sept 7th	Dr. Drennan		1866
1846	Nov 2nd	Dr. Wheeler		1866
1847	Oct 5th	Mr. McCleery		1867
1847	Oct 5th	Dr. Murney		1867
1849	Dec 4th	Dr. J. W. T. Smith		1868
1849	Mar 5th	Dr. McGee		
1849	Dec 3	Mr. John Smith		
1851	June 4th	Dr. James Moore		
1854	Dec 6th	Dr. Harkin		
1856	June 2nd	Dr. Cuming		
1858	June half	Dr. Whitaker		
1858	July 5th	Dr. Ross		
1859	Dec	Mr. Pring		
1857	Nov 15th	Dr. Charles Purdon		
1860	Sept 3rd	Dr. Henry Burden		
1861	June 3	Dr. Murray		
1861	Aug	David Moore		
1861		W. MacCormac		

1862	June 7th	Dr. H. S. Ferguson		
1862	June 7	Mr. Gribbin		
1862	June 7	Mr. Grattan		
1862	Nov	Dr. McCrea		
1862	Dec 13	Dr. McWilliam		
1862	Dec 20	Dr. John Moore		
1864	May 7	Dr. H. P. Rea		
1864		Dr. Nevin Moore		
1866	Apr 21	Mr. Newett		
1866	July 7	Dr. Angus Porter		
1866	July 7	Mr. Cantrell		
1866	July 7	Mr. Manley, Whitehouse	Resign	
1866	July 7	Dr. H. S. Purdon		
1866	Aug 4	Mr. Thompson, Bangor		
1866	Sept 1	Dr. McMurtry		
1866	Oct 6	Dr. Henry Browne		
1866	Oct 6	Dr. Higginson, Lisburn		
1866	July 7	Dr. H. M. Johnston		
1866	July 7	Dr. Wales		
1866	July 7	Dr. Dunlop, Holywood		
1866	Nov 3	Dr. Patrick, Carrickfergus		
1866	Dec 1	Mr. Martin		
1867	Apr 26	Dr. Fagan		
1867	May 4th	Dr. Monck, Holywood		
1861	July	Dr. Brice Smith		
1867	Aug 2	Dr. Hayes		
1867	Aug 2	Dr. Hannah		
1867	Aug 2	Mr. H. Moore		
1867	Aug 2	Mr. Berry		
1867	Aug 2	Dr. Thompson, Donaghadee	Resign	
1867	Dec 6	Dr. Hill		
1867	Dec 6	Dr. D. Johnston		
1868	June 15	Mr. Thomas Ball		
1868	June 15	Dr. Frederick E. Beck		
1868	June 15	Dr. J. Walton Browne		
1868	June 15	Dr. Reuben Bolton		
1868	June 15	Dr. Richard Barnett		

493 Notice of meeting on 1st June 1867

The First Meeting of the Society, for the present Session, will be held in their Rooms, at the General Hospital, on Saturday next, the 1st June, at Three o'clock, P.M.

Business.

Specially to consider a recommendation of Council to change the day and hour of the Society's Meetings.

Paper to be Read:

Dr. H. Brown will read a Paper on the New Edition of the British Pharmacopœia.

Members in arrear are requested to forward their Subscriptions to the Treasurer.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with either of the Secretaries of Council not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to either of the Secretaries.

Membership.—Persons wishing to be proposed for Membership will please forward their names to either of the Secretaries, with their qualifications and Subscription.

Signed by order,

John Moore, M.D., Secretary.
Belfast, 29th May, 1867.

494 *Funeral of Dr. Thomas Thompson*

Undated.

The Members of the Society are requested to attend the Funeral of the late Dr. Thomas Thompson, whose remains will be removed from Elmwood Church, on Saturday Morning next,¹ at Nine o'clock, for interment in the New Burying-Ground.

John Moore, M.D.
Secretary

First Meeting Society's Rooms, 1st June, 1867

Present, Dr. Patterson in the chair, Drs. H. Brown, Whitaker, McMurtry, Fagan, McCrea, Wales, Dill, William MacCormac, Monck, Stewart, David Moore, Nevin Moore, John Moore, Messrs. Newett and Gribbin.

Minutes of last ordinary meeting read and confirmed.

The circular summoning the meeting was read and also a minute of Council Meeting in which it was recommended to change the day and hour of Society's meetings from Saturday at 3 o'clock p.m. to Friday at 7.30p.m. This recommendation was proposed as a resolution by Dr. William MacCormac and seconded by Dr. Dill. It was carried unanimously.

The Secretary was directed to have placed on the circular summoning next meeting, the day and hour to which the meeting had been changed, and notice of confirmation of resolution making such change.

The Secretary stated that as authorised by the Council he had engaged a man to distribute the journals and deliver the circulars at a remuneration of three shillings a week.

It was unanimously agreed to, that a letter of condolence be addressed to Miss Thompson on the death of her Father, one of the oldest members of the Society, and that the Secretary be instructed to write it.

Dr. H. Brown read part of an elaborate and most carefully written paper on the new edition of the British Pharmacopœia in which he brought before the members the omissions, the changes and the additions which have been made in the Pharmacopœia. He will conclude his paper at next meeting of Society.

J. Seaton Reid, Chairman

Second Meeting Society's Rooms, 6th July, 1867

Present, the President (in the chair), Drs. James Moore, Thomas Read, Patterson, Wales, H. Brown and John Moore.

Dr. James Moore exhibited a large tumour which he considered to be of a malignant nature, and which he removed from the right mamma of a lady on the 30th ult. The tumour was of about five months growth and had attained an enormous size, it was comparatively painless and the constitution had not suffered much. Several surgeons had been consulted and different opinions expressed both as to the nature of the tumour and the propriety of its removal. As the tumour was perfectly free and moveable, and the weight of the mass a source of great discomfort, it was at length decided to remove it which was done accordingly.

The hæmorrhage attending the operation was not nearly so great as might have been anticipated and was easily controlled. The patient has since progressed most favourably and the wound is healing kindly.

Mr. James Moore further detailed the history of a case of nevus in a child in which he had operated by means of passing a current of electricity through the tumour. He thought this was the first case in which this method had been tried in this country.

The following gentleman were proposed as members of the Society by the Secretary and seconded by Dr. Patterson: Dr. Hayes, Dr. H. Hanna, Mr. H. Moore, Mr. Berry.

J. Seaton Reid, Chairman

496 *Notice of meeting on 2nd August 1867*

The Third Meeting of the Society, for the present Session, will be held in their Rooms, at the General Hospital, on Friday Evening next, the 2nd of August, at Half-past Seven o'clock.

Business.

Members to be Balloted for.

Dr. Hayes.

Mr. H. Moore.

Dr. H. Hanna.

Mr. Berry.

Professor Cuming will exhibit Patient, the subject of "Addison's Disease."

Pathological Specimen.

Mr. H. M. Johnston will exhibit a very remarkable case of Ruptured Uterus, in which adhesion had taken place between its fundus and the inferior surface of the liver.

Paper to be Read:

Dr. M'William will read notes of a remarkable case of Intercostal Paralysis.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary not later than Wednesday morning in each week.

¹ [Probably 1 June but cemetery records say buried 30 May.]

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D., Secretary.

Belfast, 31st July, 1867.

Third Meeting Society's Rooms, 2nd August, 1867, 7.30p.m.

The President in the chair. Members present, Professor Cuming, Drs. H. Brown, Dill, Fagan, William MacCormac, D. Moore, John Moore, Patterson, H. S. Purdon, H. P. Rea, Wales and Whitaker, Messrs. H. M. Johnston, Martin and Newett.

Minutes of former meeting read and confirmed.

Dr. Wales requested permission to introduce a patient, who was in waiting, and who was suffering from an unusual form of paralysis especially of the muscles of the pharynx, and which gave rise at times to great debility from her inability to swallow. He was anxious to ascertain the opinion of the members of the Society in reference to her case and any plan of treatment they might suggest.

Professor Cuming, Dr. Dill and others were of opinion that the case was one of hysteria, and that the remedies usually applied for that disorder might be found beneficial in this case.

Professor Cuming detailed the history of a case of Addison's disease and introduced the patient whose skin presented a very peculiar mottled appearance, some portions of the skin presenting an appearance whiter than natural and others the darkened appearance peculiar to this disease. He did not consider that the connection between the disease of the suprarenal capsules, and the bronzed skin had been yet established, but inclined to the view that is now held by most pathologists, that it depends upon an alteration of the blood discs which become broken up and this pigmentary matter becoming deposited in the skin.

Mr. H. M. Johnston laid before the Society the uterus and liver of a patient who had died in the Union Workhouse from rupture of the former during labour. She had been an inmate of the hospital for some time and her abdomen was so large that her confinement was looked forward to with some degree of apprehension. When labour set in it was weak and powerless, during the first 24 hours the pains were few and feeble but the os began to dilate and the fundus descended. The breech presented. Little progress was made during the next 24 hours, the woman being able to walk about the ward; there being no urgent symptoms present to demand interference, and pulsation of the cord having ceased it was deemed

better to wait in hopes that expulsive pains would come on and delivery be effected by natural means. About 48 hours after the commencement of labour he received a note from the Resident Surgeon requesting his attendance when he found on his arrival that she had suddenly expired a few minutes before. It was evident that rupture of the uterus had taken place, as the child had been dead for some time and the patient in a ward surrounded by others no interference was then attempted.

A post-mortem examination was made next morning when a large rupture of the uterus was found to exist from which the breech and lower extremities of the child had escaped into the abdomen. But the most remarkable point was that the liver was found enormously enlarged and diseased and that between the fundus of the uterus and the inferior surface of the liver close, firm and extensive adhesions had been formed preventing all expulsive efforts of the uterus and causing the fatal termination of the case. An interesting discussion followed in which nearly all the members present took part and the case was considered one of the most remarkable on record.

Dr. Dill was of opinion that earlier interference and delivery might have given the patient a better chance than the delay which had taken place. Dr. D. Moore and others were of a contrary opinion and believed it would only have hastened what in any case must have terminated fatally. Dr. H. Brown had examined the liver microscopically and found the disease to be malignant.

As the above case fully occupied the time of the Society Meeting on the motion of Dr. Patterson was unanimously resolved that an adjournment meeting be held on Friday evening the 16th inst. to hear Dr. H. Brown's paper on the new British Pharmacopœia which was on today's circular for this evening.

The following gentleman having been balloted for were elected unanimously members of the Society: Drs. H. Hanna and Hayes, Messrs. Berry and H. Moore. Dr. Smith proposed and Dr. John Moore seconded Dr. Thompson of Donaghadee as a member of the Society.

J. Seaton Reid

500 Notice of meeting on 16th August 1867

An Adjourned Meeting of the Society will be held in their Rooms, at the General Hospital, on Friday Evening next, the 16th instant, at Half-past Seven o'clock.

Business.

Paper to be Read:

Dr. H. Brown will read the concluding part of his paper on the New British Pharmacopœia. Subject,—“The Additions.” Specimens of the most important will be exhibited.

Ulster Medical Society
Session 1867–1868
President James Seaton Reid

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D., Secretary.

Belfast, 14th August, 1867.

Third Adjourned Meeting Society's Rooms, 16th August, 1867

An adjourned meeting of the Society held this evening, present Professor Cuming in the chair, Drs. H. Brown, Fagan, D. Moore, James Moore, Wales and Whitaker, Messrs. Berry, Martin and Newett.

Dr. H. Brown read the concluding portion of his paper of the new edition of the Pharmacopœia.

495 Notice of meeting on 6th September 1867
The Fourth Meeting of the Society, for the present Session, will be held in their Rooms, at the General Hospital, on Friday Evening next, the 6th instant, at Half-past Seven o'clock.

Business.

Recommendation from Council.

That the Members of the Profession attending the Social Science Congress be entertained by the Society.

Pathological Specimens to be Exhibited.

Professor Cuming will exhibit recent parts in case of Abscess of Lung.

Dr. W. Mac Cormac will exhibit parts removed in case of Fracture of Spine; and will also exhibit parts removed in a case of Fracture of the Skull.

Dr. Smith will exhibit specimen of Cirrhosis of Liver.

Paper to be Read:

Dr. M'William will read notes of a remarkable case of Intercostal Paralysis.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D., Secretary.

Belfast, 4th September, 1867.

497 Letter to the members.

10 Carlisle Terrace
Belfast, 9th September, 1867

Sir

I have been directed by the Council, to inform you that the Society, at its meeting on Friday last, resolved to entertain such of the Members of the Profession as may visit Belfast at the approaching Congress of the Social Science Association.

The form of Entertainment was referred to the Council, who decided that it should be a Dinner, and I have to request your assistance and co-operation in this manner.

An answer, not later than the 12th instant, will oblige,

Your obedient Servant,
John Moore,
Secretary.

Fourth Meeting Society's Rooms, September 1867

No minutes recorded.

499 Letter to the members.

10 Carlisle Terrace,
20th September, 1867.

Sir

I beg to inform you that the Annual Dinner of the Society, to which the Members of the Profession visiting Belfast in connexion with the Social Science Congress have been invited, will take place on Wednesday next, the 25th instant, in The Rooms of the Church of England Young Men's Association, Clarence Place, at Six o'clock.

John Moore, M.D.
Honorary Secretary

498 List of toasts at the Annual Dinner

"THE QUEEN."

"THE ARMY AND NAVY MEDICAL DEPARTMENTS."

The Vice-President.

Staff-Surgeon Major Fjennell.

Dr. M'Gee.

"THE PRESIDENT OF THE HEALTH SECTION OF THE SOCIAL SCIENCE CONGRESS."

The President.

Sir James Y. Simpson.

"SANITARY SCIENCE."

Dr. Samuel Browne, R.N.

Dr. Elliott.

Dr. Mapother

“THE PRESIDENT OF THE ULSTER MEDICAL SOCIETY.”

Sir James Y. Simpson.

“Medical Coroners”

Dr. Stephenson.

Dr. Lankester.

Dr. Davy.

“THE HUMANE TREATMENT OF THE
INSANE AND IMBECILE.”

Dr. Mac Cormac.

Dr. Skae.

Dr. Kidd.

515 Newspaper Clipping—Annual Dinner

Yesterday, the members of the medical profession attending the Social Science Congress in Belfast were entertained by the above society in the Clarence Buildings, Clarence Place. The following is the list of those present:—

Sir James Simpson, Edinburgh; Sir Robert Kane, Cork; Sir James Murray, Dublin; Drs. Lankester, London; Macadam, Edinburgh; Skae, Edinburgh; Mapother, Dublin; Aveling, Sheffield; Elliott, Carlisle; Beveridge, Aberdeen; Down, Earlswood; Hardwick, London; Robinson, J.P., Fintona, Tyrone; Stewart, Lucan; Kidd, Dublin; Mackesey, Waterford; Surgeon-Major Crocker, 3d Buffs; Assistant-Surgeon Crisp, 3d Buffs; Drs. Ffennell, Shaw, Madras Army; Duncan, Trench, Liverpool; Baylis, Birkenhead; Leeper, Robinson, Leeds; S. S. Bartley, Morris, Baltimore, U.S.; Davys, Curgenvin, London; Holden, Glenarm; Martin, Seaton Reid, Drennan, William MacCormac, Cuming, James Moore, Whitaker, S. Browne, R.N.; Fagan, M'Williams, Wales, Stewart, Wheeler, Higginson, Lisburn; Kelso, Lisburn; Gordon, MacCormac; M'Gee; John Moore, Patterson, Browne, Murney, Mulholland, Pirrie, Thompson, Donaghadee; Dill, Dunlop, Holywood; Harkin, Thomas Reade, Johnstone, Porter, and H. S. Ferguson; Messrs. Berry, Pring, and Martin.

The chair was occupied by Dr. Seaton Reid, President of the society.

Dinner having been partaken of,

The Chairman said—Before the more formal business of the evening commences I may state that it is the wish of the council of our society that as far as possible the list of toasts entered on the programme should be adhered to, and the duty of placing the first of these before you now devolves upon myself. Sir James Simpson, guests, and members of the Ulster Medical Society, knowing that I am surrounded by a number of educated gentlemen, all of whom belong to the medical profession, I feel that it would be quite superfluous in me to make many preparatory remarks respecting the toast I have now to place before you, because I am aware that there is no class in the community more competent to appreciate the eminent virtues displayed by the Sover-

eign of these realms than the medical profession, and certainly none who more fully admit the beneficial influence her example has exercised over all classes of the community. Who among us has not heard of the intellectual dignity with which she presides over the deliberations of her Privy Council, of the unceasing anxiety she there exhibits that even-handed justice should be dealt out to all classes and grades of her subjects, of the scrupulous jealousy with which she has guarded the honour and interests of the nation, and, above all, of the unparalleled wisdom she always displayed in the numerous political crises of our country? or need I recall to your recollection how often she has manifested the most intense sympathy for those families into which some sudden calamity or affliction had gained access, whether such was found in the family of the President of a powerful nation or in the humbler cottage of a suffocated miner? Have we not known her on all such occasions manifest the liveliest sympathies of a woman when necessity required it—the generosity of a Queen; or if I ask you to remember what must have been one of the most magnificent sights ever witnessed by the inhabitants of this country, when our Queen did not deem it beneath her dignity to receive in her park her maimed and emaciated soldiers returning to their homes after fighting the battles of their country, and when, addressing some kind words of sympathy to each, she placed, with Queenly grace, around their necks those badges of honour, to become heir-looms in their families, and tell of the deeds of valour they had performed. Now, when such have been the virtues and the graces of our Queen, has she not proved herself worthy to reign over an Empire on which the sun never sets? Gentlemen, I will not insult you by asking you to be loyal to such a Sovereign, because I know right well that there does not exist in the breast of one of you an atom of disloyalty, and I do feel a deep gratification when, on behalf of the medical profession of Ireland, I am able to tell these eminent guests who are here from other parts of this Kingdom that, with the wave of disloyalty which so recently swept over a portion of this island, there was not found associated the name of one single member of the medical profession. (Cheers.) Gentlemen, we were not loyal because we were wealthy, and had property to lose in the conflict, but we were loyal because the virtues of our Queen had enshrined her in our hearts. Knowing all this, I feel certain that, when I ask you to join me in wishing long life and happiness to the illustrious lady who wields the sceptre of these realms, I shall receive in return from you all a righty hearty response. Gentlemen, the toast is, “Her Majesty the Queen.” (Applause.)

The toast having been drunk,

Dr. THOMAS READE proposed “The Army and Navy Medical Departments.”

Staff Surgeon-Major Fennell responded on behalf of the army, and Dr. M'Gee, J.P., on behalf of the navy.

Ulster Medical Society
Session 1867–1868
President James Seaton Reid

Chairman—Gentlemen, the next toast that I have been requested to submit is that of Sir James Simpson, President of the Health Section of the Social Science Congress, to which high office he was elected on account of his great intellectual attainments; and the anxiety he has always shown to promote the happiness of his fellow-men. No one could have heard or read the eloquent and beautiful address he delivered at the Congress yesterday without being convinced, from the masterly manner in which he dealt with the various topics he referred to, that the Society had only honoured itself by placing him in the eminent position he was in. The biographers of all great men almost invariably inform us that their hero had in early life displayed some mental peculiarity, or trait of character, which foreshadowed his future greatness. As I do not know anything of the early life of Sir James Simpson, I am unable to tell if he had shown any of those peculiarities; but, be this as it may, I am certain you will all agree with me when I say, that from the moment he came before the medical world, whether as an author or a teacher, he evinced an originality of thought and invention, associated with the will and the power for the practical application of his discoveries, that placed him at once amongst the most eminent men of his day. It was, no doubt, this originality of his genius that led him to apply chloroform as an anæsthetic, and which placed at the disposal of his professional brethren the most efficient means of relieving pain; thus conferring on mankind one of the greatest boons they had ever received, and clothing himself with imperishable fame. But, not content with the laurels he had thus acquired in the department of science with which he was more immediately connected, his power of invention led him to invade the domain of practical surgery, and to place at the feet of the operative surgeon a means of restraining hæmorrhage superior to any within his reach; for I believe I speak the mind of every impartial surgeon who has tried acupressure, that it is in all respects equal, and some respects superior, to the ligature. Nor did his versatility of genius and originality of thought allow him to remain content with the pre-eminent position thus acquired in both medicine and surgery, but they led him into the field of archæology, and here again his high mental endowments have enabled him to make discoveries that have placed him on an equality with our countryman, Petrie. And, gentlemen, I believe that I speak the mind of every member of the medical profession when I say that, when the annals of medicine for the present century shall have been written, no name shall stand out more prominently on the page of history than that of Sir James Simpson, both for originality of invention and the practical application of his discoveries. But, Sir James, we trust it will be many long years before you become food for the historian; and that you may be long spared that vigour of mind and body which have enabled you, among the toils of a most fatiguing

department of practice, to carry on those researches which have made you a benefactor of mankind. Gentlemen, the toast is, "Sir James Simpson, President of the Health Section of the Social Science Congress." (Loud cheers.)

Sir JAMES SIMPSON was received with loud applause and cheers. He said he was glad he had been induced to come to Belfast to meet the Ulster Medical Society. It was a great thing to grasp the hands of many men who had been his dearest friends, and of other men amongst them—Sir James Murray—whom he had long known, but had never seen till then. It was not to be expected he would make a long speech. He came to Belfast suffering from the effects of a horrible tempest. He had spoken about air and the necessity of it, but he could tell them he had had a great deal too much of it. (Laughter.) Sometimes a doctor got too much of his own medicine, and he had, indeed, got too much of his. It had been said by the chairman that he did not know anything about his early history. They had a Member of Parliament for Edinburgh, Mr. Maclaren, and many years ago, he was almost ashamed to think how many, when he (Sir James Simpson) became a candidate for the chair of midwifery, which he now occupied, he was opposed by Mr. Kennedy, of Dublin; and he could give them his word for it, if he had had a vote he would have given it to Mr. Kennedy, for he deserved it better than he did. (Laughter.) Mr. Maclaren came one day to him (Sir J. Y. Simpson) and asked him had he any certificates as to qualification for the chair. He told him he thought the best certificate would be his early history, and that ten years ago he was driving his own father's breadcart. (Loud applause.) He did not think that discreditable. (Renewed applause.) The chairman had alluded to some of the things he had done; but when he looked back he thought he might have worked at many things better, and many things more important; and he would just say one thing, and that was, that he was sure the gentlemen there would ever find that the study of his profession was the greatest rest possible. (Applause.) He had known very little of their sanitary matters, but he had gained a great deal of information from Dr. Browne's paper, and a great deal from the discussion that followed it. He had heard more of sanitary matters than he ever knew in his life before—(laughter)—a poor person to be president of the section—a scholar, and not a master of the subject. He had learned from the paper that here they executed two men every day by the bad state of their sewers. He had no doubt the day would come when they would not turn all their sewerage into the bay of Belfast. The day is coming when all that filth would be turned into human food. They did not know until they looked at it how much tillage and agriculture would do. He had read of a little very badly-tasted root that grew in Chili, and which still grew there wild upon the mountains, which under cultivation had come to be converted into a building of Irishmen. (Laughter.) It is

literally true; for the potato had become converted into millions of Irishmen who steamed over the country away to the west, to which their aspirations were; and when they thought of that little Peruvian root and what it had done, they might well think that the filth of such towns as Edinburgh and Belfast would yet become the food for thousands and millions more. He thanked the chairman for the manner in which he proposed the toast. He had great pleasure in meeting the members of that society, and he would remember that night as one of the bright and white nights of his life. (Applause.)

Dr. M'GEE, in a brief speech, gave the toast of "The Health of the Medical Coroners," coupled with the names of Drs. Lankester and Dill.

Dr. Lankester rose, and was received with loud applause. It gave him great pleasure to be present that night to meet the members of the Ulster Medical Society. He was glad the holiday he had taken had brought him to Belfast, and brought him to meet his friends that evening, and he was much obliged for the kind manner in which they had associated his name with the toast of "The Medical Coroners." This subject was one of great importance. None but medical men should occupy the office of coroner, and he believed they were indebted to Mr. Buckley, the editor of the *Lancet*, for having first advocated this matter. He was the first man who devoted himself to showing that medical men were the men for the office, and there could be no doubt of the truth of the statement at all. The great mass of evidence brought before coroners' courts was of such a kind as could only be understood by men instructed in medical science, and in which justice must be defeated where the coroner has no knowledge of the evidence. He remembered one of his friends told him if he carried out the principle that coroners were to be instructed in medical knowledge, it would just be the same with regard to the Judge—he ought to be medical also. Well, he (Dr. Lankester) would not hesitate to pick up the gauntlet thus thrown down, and say it was most important that the Judge should be instructed in the science of medicine. He thought the education of the Judges was deficient; and, until they got what was called a medical education, they were not properly qualified for the bench. It was impossible for a coroner properly to discharge the duties of his office without being a medical man, and their present relation to the Coroner's Court was not so much that the medical profession should be appointed coroners as that the general community should know more about the natural laws which govern the world. The education of our lawyers is in mathematics, Greek, and Latin, but these give no idea as to the cause of death. The question was coming up very strongly at the present time whether or not the coroner should be educated in those natural laws by which our lives are governed. The medical professors should band themselves together more strongly than they did, and let it be seen that it was the future

well-being of mankind they were considering. The fact was that in many cases a coroner who did not possess medical knowledge was often misled, and a great amount of crime had been passed by the incompetency of the ordinary legal coroner to weigh the value of the medical evidence presented. Dr. Lankester very urgently demanded that this question should be thoroughly ventilated, as it was one of the greatest importance, and sat down amid loud applause.

Dr. Dill having spoken, Dr. Browne, R.N., proposed the toast of "Sanitary Science," coupling with it the names of Dr. Mapother, Dublin, and Dr. Morris, Baltimore, to which those gentlemen responded.

Dr. MACCORMAC then gave the "Humane treatment of the insane and imbecile," to which were coupled the names of Dr. Skae and Dr. Kidd.

Dr. KIDD, Editor of the *Dublin Quarterly Journal* having acknowledged the toast,

Sir J. Y. SIMPSON proposed "The health of the President, Dr. Seaton Reid."

The President having responded, the proceedings were brought to a conclusion.

Fifth Meeting, 5th October, 1867

Present, Dr. Thomas Reade in the chair, Professor Cuming, Drs. Stewart, William MacCormac, H. Brown, Porter, H. S. Purdon, McWilliam, John Moore, Messrs. Martin and Newett.

Dr. H. Brown introduced a patient labouring under progressive locomotor ataxy and read notes of the case.

Paper:¹ Mr. M. J., aged twenty-eight, single, well-made, and about six feet in height, consulted me in August last. After a very careful examination, I considered him labouring under locomotor ataxy, or Duchenne's disease; but, as I had never seen a case before, I thought it advisable to consult some of my medical friends, and he was seen by Dr. W. MacCormac and Professor Cuming, both of whom considered the case one of locomotor ataxy. The symptoms first began about ten years ago; but for the last four years they have greatly increased, during which time he has been under treatment (at one time or another) of various kinds, without receiving benefit.

His attention was directed to his feet at a very early stage of the affection, and he found that in walking, a constant watch was absolutely necessary to enable him to progress with any degree of satisfaction. The habit of walking with his head in a downward direction he could not account for; but he was certain that up till his eighteenth year he had not noticed anything peculiar in his gait, and was not in the habit of "hanging his head." At present, when walking, he resembles a person under the influence of liquor, throwing his feet out without

¹ [*Dublin Quarterly Journal of Medical Science*, 1868, v45, p480.]

any precision, and they fall heavily upon the ground. His feet, even to himself, seem to fall “all of a piece,” and when they come in contact with the ground a sensation is conveyed to him, so that he imagines it possesses no firmness, and he is obliged to use a staff to prevent himself from falling. Under no circumstances could he walk in a straight line.

In damp weather every bone seems dislocated, and the muscles of the legs are much more beyond control than in dry bracing weather. He dreads this relaxation much, for it is with the utmost difficulty he can at all progress. The limbs seem to be well nourished. No diminution in the sensibility of the cutaneous surface can be observed. The points of compasses or other sharp-pointed instrument, can be perceived with exactness; and I took care that the eyes were obscured during this examination. He can flex and extend the legs with great force. When the leg was extended, neither Professor Cuming nor I could flex it. When seated and requested to raise a leg into the horizontal position, he can do so without any assistance; but his eyes are steadily fixed upon the limb during this movement. He cannot stand upon one leg, nor can he stand when his feet are close together, without the aid of a staff, and then only with difficulty. He cannot bring the feet into close approximation without considerable shuffling; and, if he be requested to close the eyes when standing with his feet together, he is seized with a sensation of dread lest he fall, and he opens the eyes after momentary closure with delight at finding himself still standing upon terra firma.

The upper extremities are well nourished. For some time he has been very much troubled with “a burning” of the hands, which causes great annoyance; and, as he is a book-keeper, he requires to bathe the hands frequently in cold water to ease this painful sensation, which is always attended with profuse sweating. He can write with his wonted facility, except in the morning, when the right hand is rather tremulous, but this usually disappears in half an hour or an hour after commencing business. There is no paralysis of the upper extremity. In order to test his strength I got him to lift a bale of tow—weighing one hundred and a quarter—and this he could have carried upon his back, but for a tendency to fall which he experienced, owing to the want of control over his lower members. He told me he could lift even more than the above weight, and that his strength in this respect was as good as could be.

In the lumbar region an acute burning pain is sometimes felt, which often continues for an indefinite time, and a painful spot can frequently be pointed out, but not always. Percussion, however, causes not the slightest pain; and the spinous processes may be pressed upon without eliciting pain. When pressing the lumbar spines on one occasion, however, pain was felt, and he expressed it—as if burned with a heated sharp-pointed iron.

This is the region of greatest weakness, and he is obliged to wear a bandage and stays to afford support, else he could not walk. To use his own words—“without the stays he would fall in two.”

Over the frontal region a dull heavy pain is almost a constant companion, and, at times, confusion of ideas accompanies it. Noise in the head troubles him very much, and is greatest after rising in the morning. This noise he compares to water heard falling from a considerable distance. In order to remove a feeling of stupor he is obliged to wash his face in the coldest water obtainable, every morning, at least three or four times, and this process is repeated several times during the course of the day.

When exposed, during the transaction of business, to the open air, and then confined to office work, the stupor becomes most unpleasant, and ablution is the only relief he can obtain. There is constant singing in the ears, and the sense of hearing has become blunted of late. The pupils contract perfectly upon the stimulus of light; they are larger than usual, but there is no impairment of vision, nor does he complain of visionary spectra.

The senses of taste and smell are unaffected.

When spoken to in a loud or commanding manner he loses all control; and he has frequently been nearly run over on the street from his inability to move when shouted at. At night, it is with great difficulty he can cross from one side of the street to the other, and his gait is much more unsteady, for an obvious reason. His digestion is excellent, and the bowels are never confined. There is no paralysis of the rectum. The bladder possesses its tonicity, and the urine is voided with ease, but he requires to wait a little before the process of emptying commences. This process requires no straining, however.

Sleep is disturbed by frightful dreams, and he invariably awakes at three o'clock in the morning. Seminal emissions occur at least three or four times in the week, and exhaustion is very great after these. There is no incontinence of urine at night. I have inquired whether he has had any of the shooting pains which “come on and go off with the rapidity of lightning, or of the electric spark,” and find at no time have they been observed. I have observed his articulation, and consider it slightly muffled of late, but it is distinct. He confesses it is not so good as it formerly was.

He has never been guilty of excess of any kind.

His father is alive, and has attained the age of sixty-seven. His mother died a short time ago at the age of sixty-two. For the last two months of her life she was unconscious, or nearly so; and is supposed to have died of some heart affection. This is all the information I can obtain in reference to her death. She was very healthy previously to an attack of rheumatism, from which she never got quite well. His brother, who is a few years younger than the patient, is a healthy young man.

As regards treatment, various remedies have been employed from time to time, by others and by myself, without any appreciable benefit. He has taken strychnia, phosphorus, iron in various forms, iodide of potassium, and tonics in every shape and form, without any good result. Liniment of iodine was applied to his back previously to consulting me, electricity, and no end of other means proving quite impotent to remove, or even slightly benefit his condition. His affection was considered to be paralytic by some who saw him early, and others thought it was inflammation of the spinal cord or its membranes.

More benefit has been obtained from cod liver oil, and a good wholesome diet, with a liberal use of sweet milk, than from all other means combined. I advised nightly ablutions of the genitals with cold water, and great good has resulted from this practice.

Under the use of some lauded remedies the patient lost ground; iodide of potassium increased the debility, although he got only a grain and a half twice daily. An occasional bottle of porter, with the generous diet, have caused an increase in his weight of several pounds within a very short time.

At present (19th March, 1868,) the condition of the patient is much the same as when seen by the members of the Ulster Medical Society in October. He is getting a pair of spring stays made, and he hopes to be able to walk with greater ease. The generous diet is still continued, and the patient considers his condition "at a stand-still." I can observe no change myself; but he is decidedly stouter than when I first examined him.

—October 16, 1867.

Dr. McWilliam read the notes of an unusual case of paralysis of the intercostal muscles.

Dr. Porter read remarks on the termination of a case of phagedænic chancre, notes of which were read before the Society at a former meeting.¹

Paper:² When criticising the former portion of my paper on this case, some members of the society expressed the opinion that the absence of any cutaneous eruption rather disproved a connection to exist between the morbid conditions of the eye and the primary sore.

Mr. Henry Lee (in his letter to the editor of the MEDICAL PRESS AND CIRCULAR, of April 17th, 1867), attributed the eye affections to debility of the system. On the 6th of last March, the missing link was supplied by the development of a tuberculous eruption, disseminate in character, and located as follows:—Three spots on the forehead, three under the hair of the head, one on the chest, a number between the shoulders, one behind the right thigh, and two in a semi-ulcerated condition, to the left side of the nose; there were also four irregular spots on the chin. Some of these patches were sore,

¹ [See page 1070.]

² [Medical Press and Circular, 1867, October 30, p401.]

others of them intensely itchy. His ears were very painful, and discharging a scanty quantity of serum; both tonsils were deeply ulcerated; his tongue was slightly furred, but his appetite was good, and his bowels were regular. The throat was thoroughly cauterized with the stick nitrate of silver. He was still taking cod liver oil. Recommended a renewal of the corrosive sublimate (the use of which had been suspended), also twenty drops of tr. of steel, to be taken three times daily, and occasionally a full dose of Dover's powder at night, to be followed by Gregory's mixture next morning.

On the 10th of March the spots had begun to wither up; their colour also had altered from a bright-red to a copper hue. No fresh ones had appeared. From the left ear a black fœtid discharge, and from his right ear a white starchy matter oozed freely; the ulcers on his tonsils were less unhealthy looking, but were again cauterized, and ten grains of chlorate of potass was ordered to be taken each morning before breakfast.

On the 10th of March no new spots had appeared, and the old crop seemed to be dying away. His throat was considerably better; his complexion was very dusky, and his spirits were dull. He suffered a good deal by his ears, the discharge from which was much lessened, and frequently became concreted. On May the 10th, Dr. W. MacCormac kindly accompanied me to visit the patient, at which time his general appearance was better. Dr. MacCormac then agreed with me in considering the case one of true constitutional syphilis. The eruption on this occasion had died away to a considerable extent, but slight ulceration of the tonsils still remained. His ears were much better. Some of the concatenating glands were enlarged, as they had been for a few weeks previously.

Since then I have seen the subject of this paper, and am happy to state not a trace of the old disease remains, and that he now enjoys perfect health.

Dr. William MacCormac exhibited parts removed in a case of fracture of the spine.

R. Stewart, Chairman
22nd November, 1867

516¹ Notice of meeting on 1st November 1867

President.

Dr. Seaton Reid.

Ex-President.

Dr. Drennan.

Vice-Presidents.

Dr. Thomas Reade.

Dr. Kelso, Lisburn.

Dr. James W. T. Smith.

Dr. Thompson, Bangor.

Members of Council.

Dr. Patterson.

Dr. Whitaker.

Dr. Stewart.

Dr. Bryce Smyth.

Dr. W. Mac Cormac.

Dr. H. S. Purdon.

¹ [Also Item 501.]

Ulster Medical Society
Session 1867–1868
President James Seaton Reid

Treasurer.

Dr. Cuming.

Secretary.

Dr. John Moore.

The Sixth Meeting of the Society, for the present Session, will be held in their Rooms, at the General Hospital, on Friday Evening next, the 1st of November, at Half-past Seven o'clock.

Business.

Pathological Specimen

Mr. H. M. Johnston will exhibit a Specimen of Ulceration of Cartilages of Knee Joint, and one illustrating Intra-capsular Fracture of Neck of Femur.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D., Secretary.

Belfast, 30th October, 1867.

Sixth Meeting, 1st November, 1867

Dr. Samuel Browne in the chair, members present, Drs. H. Brown, Fagan, Porter and John Moore.

In absence of Mr. H. M. Johnston who was to have exhibited a specimen of ulceration of cartilage etc., no business was transacted.

502 Notice of meeting on 22nd November 1867

The Seventh Meeting of the Society, for the present Session, will be held in their Rooms, at the General Hospital, on Friday Evening next, the 22nd instant, at Half-past Seven o'clock.

Business.

Members to be Proposed.

Dr. Hill and Dr. David Johnston.

Pathological Specimen

Dr. James Moore will exhibit a Penis which he amputated.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order, John Moore, M.D., Secretary.

Belfast, 21st November, 1867.

Seventh Meeting, 22nd November, 1867

Dr. Stewart in the chair, Drs. Samuel Browne, Dill, Whitaker, H. Brown, and John Moore.

Dr. S. Browne read a communication from Dr. Curgenven Secretary of a newly formed Society for the Prevention of Venereal Diseases and requesting the assistance and cooperation of the Ulster Medical Society. The communication was referred to the Council.

Dr. Hill was proposed by Dr. Whitaker and seconded by Dr. Dill and Dr. David Johnston was proposed by Dr. Dill and seconded by Dr. Whitaker.

503 Notice of meeting on 6th December 1867

The Eighth Meeting of the Society, for the present Session, will be held in their Rooms, at the General Hospital, on Friday Evening next, the 6th instant, at Half-past Seven o'clock.

Business.

Members to be Balloted for.

Dr. Hill and Dr. David Johnston.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D., Secretary.

Belfast, 4th December, 1867.

Eighth Meeting, Friday 6th December, 1867

Dr. Patterson in the chair, members present Professor Cuming, Drs. Stewart, James Moore and John Moore.

Drs. Hill and David Johnston having been duly proposed and seconded at former meeting of Society were balloted for and unanimously elected members of the Society. The Secretary was directed to receive in future the weekly periodicals direct and issue them without delay to the members of the Society.

James Patterson, Chairman

504 Notice of meeting on 20th December 1867

The Ninth Meeting of the Society, for the present Session, will be held in their Rooms, at the General Hospital, on Friday Evening next, the 20th instant, at Half-past Seven o'clock.

Business.

Dr. James Moore will exhibit a Cancerous Penis which he amputated.

Dr. James Moore will give an account of his recent visit to Arcachon, Gironde, France, a new favourite resort for invalids suffering from chest affections.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D., Secretary.

Belfast, 18th December, 1867.

Ninth Meeting, Friday 20th December, 1867

Dr. Patterson in the chair. Members present, Drs. Stewart, James Moore, H. Brown, Fagan, Wales.

Dr. James Moore exhibited a cancerous penis which he had amputated and narrated the history of the case.

He also gave an interesting account of a recent visit to Arcachon, Gironde, France, a new favourite resort for invalids suffering from chest affections.

505 Notice of meeting on 3rd January 1868

The Tenth Meeting of the Society, for the present Session, will be held in their Rooms, at the General Hospital, on Friday Evening next, the 3rd instant, at Half-past Seven o'clock.

Business.

Recommendation of Council.

That the Transactions of the Society be published in The Dublin Quarterly Journal of Medicine, and that the papers intended for publication be furnished to the Secretary.

Pathological Specimens.

Dr. Drennan will exhibit Kidneys with diseased Supra-Renal Capsules, and read notes of case of simulate Abdominal Aneurism.

Professor Cuming will read notes of a remarkable case of Empyema.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D., Secretary.

Belfast, 1st January, 1868.

Tenth Meeting, 3rd January, 1868

The President in the chair. Members present, Professor Cuming, Drs. Stewart, Wales, David Johnston, Hill, Fagan, James Moore, Messrs. Newett, Patterson and John Moore.

Dr. Drennan sent for exhibition kidneys with diseased super-renal capsules:

Paper:¹ Dr. Cuming exhibited the supra-renal capsules of a patient who had been in hospital under the care of Dr. Drennan. The capsules were greatly enlarged, and contained large cheesy masses, having the characters of tubercle. The lymphatic glands in the neighbourhood were also tuberculous. There was no discolouration of the skin or of the mucous membranes. The patient had suffered principally from abdominal pain and gastric irritability.

Dr. James Moore exhibited a fibrous tumour which he had removed from a patient's breast.

Professor Cuming read notes of a remarkable case of empyema.

Paper:² The following case is, I think, of sufficient interest, in a diagnostic point of view, to make it desirable that it should be recorded.³

Neal Kennedy, aged thirty-five, unmarried, labourer, was admitted into the General Hospital July 30th, 1867.

History.—Several members of his family died of tubercular diseases. Seven years ago he had been a patient in this hospital, the only record of his case to be found being the name of the disease for which he was admitted—"Hydro-pneumothorax"—and the period during which he was an inmate—namely, fourteen days. From this illness he states that he completely recovered. Two years ago he passed through an attack of typhus fever, for which he was treated in the Union Hospital of this town. With these exceptions his health has been always good; habits regular and temperate. He is a well-built man, pale, slightly bald, with an intelligent countenance, and rather prominent eyes.

About six months ago he began to suffer from pain in the left side, which he describes as having been of a catching character, lie continued to be able to work for some months after the commencement of the pain. His strength and appetite, however, gradually failed, and his breathing became oppressed. He placed himself under medical treatment, and was blistered and purged without any benefit.

At present he complains principally of weakness; he has some diarrhoea; no pain in side; very little cough, and the dyspnea is not at all considerable. His appetite is tolerably good; decubitus on back or left side; he sleeps pretty well.

Physical examination.—The left side of the thorax is observed to be dilated, its intercostal depressions ef-

¹ [Dublin Quarterly Journal of Medical Science, 1868, v45, p483.]

² [Dublin Quarterly Journal of Medical Science, 1868, v45, p44.]

³ Reported by Mr. Robert S. Hudson, clinical clerk.

faced anteriorly, and no respiratory movements visible. A soft, painless, inelastic tumour is observed external to the left nipple; its diameter at the base is about two inches, and it covers portions of the seventh, eighth, and ninth ribs; the skin covering the tumour is not discoloured, nor is there any pulsation in it.

The impulse of the heart is visible on the right side, below, and rather external to the nipple. On palpation no vocal fremitus is to be felt in the left side, except close to the spine posteriorly. The circumference of the left side, on the level of a line passing from the spinous process of the seventh dorsal vertebra over the nipple, is $21\frac{1}{2}$ inches; that of the right 19 inches.

On percussion absolute dulness is found to extend over the entire left side, and for about an inch beyond right margin of sternum. No respiratory sounds are audible, except in the neighbourhood of the spine; no vocal resonance. Respiration puerile on right side. There is distinct bulging in the epigastric and hypochondriac regions, owing evidently to displacement downwards of the diaphragm and of some of the abdominal viscera. Some tenderness on pressure is complained of in the left hypochondrium, where the depressed and resistant diaphragm can be readily recognized by the finger.

Pulse 72; in the right wrist tolerably full and soft, in the left very small—a fact to which my attention was first drawn by one of the students who surrounded the bed. A similar difference, but not so marked, was observed in the carotids. No murmur with the action of the heart; sounds normal. Pupils equal.

After consultation it was determined that the thorax should be tapped, as there could be no doubt of the existence of pus in the cavity of the pleura. Before the period arranged for the operation, however, he began to bring up by coughing considerable quantities of pus, and I hoped that in this way the entire contents of the pleural sac might be evacuated. During two days and nights the matter continued to be expectorated; the entire quantity got rid of in this way amounting to fifty-six fluid ounces. The impulse of the heart was now visible at a point higher than before by about an intercostal space, and the circumference of the left side had diminished by three-quarters of an inch, being now $20\frac{3}{4}$ inches. The amount of the expectoration was, however, diminishing a good deal, and the constant efforts to bring it up had become very distressing to the patient. He was totally unable, from this cause, to lie down or get any sleep. The pulse rose to 116, the difference in the two sides being still considerable; but it was thought rather less marked than it had been previously, and an inflammatory flush had appeared in the left hypochondrium, where tenderness had been previously noticed on pressure, pointing to the probable danger of perforation of the diaphragm in that situation. Under these circumstances I thought it would be unwise to delay any longer the puncture of the thorax.

The operation was performed by my friend and colleague, Dr. William MacCormac, the opening being made through the tumour and in the eighth intercostal space. At the time of the operation, and during the two subsequent days, 173 fluid ounces of good pus, devoid of odour, flowed from the opening. The operation was followed by considerable relief of the general symptoms; the patient was able to lie down and get some sleep. The intercostal depressions became now manifest; the heart passed over to the left of the sternum; the left radial and carotid pulses acquired fulness, and by the end of the third day no difference could be any longer observed in them. Indeed, more than one of the various medical men who had kindly examined the patient with me at different times, before the paracentesis, and while the inequality existed, on being asked to compare the pulses in the two wrists, were inclined to consider that the left was now rather the fuller and stronger. The discharge gradually diminished to about two ounces daily; the appetite and strength improved rapidly.

Without entering into details of the progressive changes which ensued, I may now give an account of the physical examination of the chest a fortnight after the chest had been tapped. The girth of both sides had diminished—that of the right side being now $18\frac{1}{4}$ inches, that of the left $18\frac{5}{8}$ inches. Taking the level of a line passing from the spinous process of the eighth dorsal vertebra through a point an inch below the nipple, we find that above this line the left side is resonant on percussion—duller than the right—but still moderately resonant. Within the same space vocal resonance and fremitus are distinctly recognizable, and the sounds of respiration are audible, being somewhat weaker and more harsh than those of the opposite side. There is no trace of r le of any kind, nor is there any friction sound.

Below the line mentioned vocal resonance and fremitus are altogether absent; 110 respiratory sound whatever is audible. On percussion we find amphoric resonance in front when the patient lies on his back, and some dulness at the most dependent part posteriorly. The situation of the resonance and dulness changes with any change in the position of the patient, but does not reach a higher level than that of the line above mentioned. Pus flows pretty freely from the wound when the patient leans well forward, and a probe introduced through the wound can be moved freely in a large cavity. It was now evident that the lung had expanded considerably, but not sufficiently to fill the entire side, and that it had become adherent to the thoracic parietes, leaving between its base and the superior surface of the diaphragm a loculus filled with air and matter. The heart's sounds were quite normal, and unaccompanied by any echo or splashing.

With the diminished circumference of the upper part of the thorax, the bulging at and below the base became more noticeable, and a curious phenomenon

became observable—namely, a depression of the prominent portion of the epigastrium and hypochondria, during inspiration, and an elevation during expiration; both these movements being the opposite of those observed during health. This depression was more evident when a somewhat forcible inspiration was made, and was much more marked on the left side, but even on the right side it was distinctly observable both by inspection and palpation. The amount of discharge was now about one fluid ounce daily. There was scarcely any cough; respiration free; appetite good, and strength fair. The patient remained up the entire day, and walked a good deal about the ward in which he was. From this period until he left hospital there was little change in the symptoms. The bulging diminished gradually, but the abnormal condition of the respiratory movements continued, although no longer recognizable, except when the hand was placed on the surface of the epigastrium or hypochondria. He continued to improve steadily, with the exception of some inflammation of the lymphatics of the right leg, which yielded readily to rest, and the application of the flannel bandage recommended by Sir Dominic Corrigan. He was able to remain some hours daily out of doors, and left hospital at his own request at the end of September.

About the end of October I visited him, at his own request, at his mother's house, in a filthy little street in one of the oldest and most neglected parts of the town. I found that he had been for some time getting worse; he had not been able to get nutritive food, and he had ceased to take the cod-liver oil which had been prescribed for him. The discharge had increased and become very offensive in smell, and diarrhoea had set in, with a good deal of irritability of stomach. There was scarcely any cough; no expectoration; and the condition of the chest was very little changed. I advised him to go to hospital again, which he wished to do. However, about a fortnight after I learned that he was dead.

I have not entered into any account of the treatment, as there was nothing worthy of remark in the measures employed. Tonics—a moderate amount of stimulants and cod-liver oil forming the staple of the treatment.

Remarks.—All observers agree as to the fact of the pulse remaining unaffected in cases of empyema. A case by Larrey, in which extreme feebleness of the pulse in the large arteries coincided with cardiac displacement, is quoted by Walshe,¹ who is not inclined to consider that there was any mutual dependence between the two circumstances. Murmurs with the sounds of the heart have been observed, probably dependent on torsion of the aorta, in cases of great cardiac displacement, and an instance² is given of empyema of the left side, in which an aortic bruit, the result no doubt of pressure, was audible from the last rib upwards along

the left side of the spine for about five inches. I am not aware, however, of any case being on record in which a difference in the pulses was noticed. In a recent and excellent work¹ on diseases of the lungs, the equality of the radial pulses is referred to as a diagnostic mark which may be relied on in cases of doubt as excluding the idea of empyema. Had the empyema been a pulsating one, as in the well-known cases reported by Dr. M'Donnell,² the diagnosis might have become very embarrassing. It would be easy to suggest modes by which this phenomenon may be caused. My own opinion inclines towards seeking for the explanation in some narrowing of the arteries by torsion or otherwise, inasmuch as the absence of any evidence of venous congestion puts the idea of its having been caused by direct pressure of the fluid out of the question. Whatever be the explanation, however, the possibility of the existence of an inequality of the radial pulses in a case of empyema, the inequality disappearing after the evacuation of the fluid, is a fact of some clinical importance.

The alteration in shape and movements observed at the base of the thorax and at the upper part of the abdomen evidently depended on the condition of the diaphragm. The paralysed and probably degenerated condition of this muscle, caused by the long-continued pressure, and probably, also, by the effect of the inflamed state of the pleura, prevented the action which is normally exerted on the base of the thorax by the fibres which arise from the ensiform cartilage, and from the cartilages of the lower ribs—an action which is antagonistic to any forward movement of that region. Besides, the depression of the diaphragm, as well as of the upper abdominal viscera in contact with it, owing to the great mechanical pressure exerted by the superincumbent mass of fluid, would tend powerfully in the same direction. It was very remarkable, however, that the bulging should have continued after the removal of the great bulk of the fluid. This can only, I think, be accounted for by supposing that the diaphragm had contracted some adhesions with the parts with which it had been brought into contact during the continuance of the pressure. Duchenne,³ criticising Dr. Stokes' observations⁴ on the condition of the diaphragm in some cases of empyema, observes, with justice, that paralysis of this muscle must, of necessity, be followed by an increase of its natural convexity, and by its becoming more elevated in the cavity of the thorax, owing to the action of the abdominal muscles. Some cause must accordingly have been in operation to retain the muscle in its anomalous position.

The explanation of the reversal of the usual respiratory movements is also to be looked for in the passive

¹ Diseases of the Lungs, 3rd ed., 1860, p. 263

² M'Donnell. Dublin Journal of Medical Science, Vol. xxvi., p. 437

¹ Fuller. Diseases of the Lungs, 2nd ed., 1867, p. 184

² Dublin Journal of Medical Science, Vol. xxv., p. 1.

³ De l'Electrisation Localise. 2dc1 ed., 1861, p. 727

⁴ Dublin Journal of Medical Science, Vol. viii., p. 197

condition of the diaphragm, allowing it to yield to the action of atmospheric pressure when a partial vacuum was formed in the chest by the action of the other respiratory muscles during inspiration, and the elevation during expiration to the pressure exerted by the lungs then acted on by the elasticity of the thoracic parietes.

Duchenne¹ suggests that valuable indications may be drawn in cases of empyema from a deficiency of isochronism in the movements of the thoracic and abdominal walls during inspiration and expiration, and gives some cases of empyema observed by Racle and others, as well as by himself, in which the hands placed one on each hypochondrium were moved in contrary directions during respiration—that placed on the sound side being elevated during inspiration and depressed during expiration, while that placed on the side where copious effusion existed was moved in the contrary direction. When this phenomenon is observed, he thinks that the diagnosis of paralysis of one-half of the diaphragm may be made, and that a probability is established, as had, indeed, been suggested by Dr. Stokes, of the effusion being the result of an acute inflammatory process, and not a simple hydrothorax. In this case Duchenne's sign did not exist, the action of the diaphragm—although the empyema was single—being null on both sides. At the same time some weight must be attached to the great amount of malposition of the diaphragm, altering completely the direction of its muscular fibres.

James Patterson, Chairman

506 Notice of meeting on 17th January 1868
The Eleventh Meeting of the Society, for the present Session, will be held in their Rooms, at the General Hospital, on Friday Evening next, the 17th instant, at Half-past Seven o'clock.

Business.

Dr. William Mac Cormac will give an account of a case of Popliteal Aneurism.

Dr. John Moore will read notes of Complicated Cases of Midwifery.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D., Secretary.

Belfast, 15th January, 1868.

Eleventh Meeting, 17th January, 1868

Dr. Patterson in the chair, Drs. Stewart, James Moore, McMurtry, Fagan, William MacCormac, Wales and John Moore.

Dr. William MacCormac gave an account of a case of popliteal aneurism treated by compression:

Paper:¹ Daniel Dobbin, a man twenty-seven years of age, pale and thin, of a lymphatic temperament and peevish disposition, was admitted to my wards in the General Hospital, on Sept. 25, 1867. His occupation is to drive a spring-cart, and he states that four months ago he fell off the cart, striking the step in his descent. He felt his leg very painful for some time, but the limb afterwards perfectly recovered.

About six or seven weeks before coming to hospital he noticed a feeling of stiffness in the right ham, followed by the appearance of a small tumour as large as a bean, which rapidly increased in size.

On admission we found an aneurism filling up the right popliteal space, and fully as large as a medium-sized orange. There was a bruit, and strong distensile pulsation, which could be readily controlled by pressure upon the artery in the groin, and whilst the pressure was kept up the sac could be emptied almost completely. The leg was œdematous, the pulse 60, and rather weak, the heart sounds are natural, and the tongue is quite clean.

The treatment at first consisted in gradual compression, and then an attempt at complete, which only proved partially successful.

Carte's compressor was first employed, but the restlessness and fretful disposition of the patient continually disarranged the apparatus, and I found Signoroni's tourniquet more efficient and more manageable, as well as more readily borne by the patient.

On the 7th October, twelve days after admission, compression having been maintained more or less perfectly for about ten hours each day, it is reported that, although perhaps somewhat firmer and smaller, the tumour is but very slightly altered since admission, and for the last five days scarcely any change has taken place. I therefore determined to try the method of complete compression, and effect, if possible, a rapid cure. I ascertained that a pressure of four pounds readily controlled the femoral, and devised the following arrangement, which was simple and efficacious. I suspended directly over the patient's groin a short round bar of iron, 8 lbs. weight, by means of a cord attached to the ceiling, and into this cord was inserted a piece of India-rubber, so arranged as to reduce the pressure of the iron to four pounds, and to steady the apparatus at the same time. A round button, about an inch in diameter, of polished mahogany, was attached to the end of the bar next the skin. All that was necessary was to lay this upon the artery, just below the pubis, and with hardly

¹ Loc. cit., p. 728, et seq.

¹ [Dublin Quarterly Journal of Medical Science, 1868, v45, p484.]

any effort of attention the pulsation in the tumour could be kept completely and absolutely arrested. As it was hopeless to expect a patient such as mine to stand the pain, and exercise the needful restraint for any length of time, I was compelled to keep him slightly under the influence of chloroform during the whole period. At a quarter before five, then on the 7th, the pressure was commenced and maintained perfectly for five hours. A few jets of blood, however, in spite of our efforts, occasionally passed, in consequence of the man's struggles. The pressure was then removed for a few moments to examine the condition of the tumour, when it was still found beating. During all this time Richardson's ether spray was directed at intervals on the tumour for about twenty minutes at a time, thoroughly freezing the skin over it. This was frequently repeated, until it was deemed no longer safe, as vesication, accompanied by considerable congestion of the part, took place. The compression was resumed, with the addition of forcible flexion of the knee.

After seven hours' trial of these combined methods, the tumour still pulsated, but much less strongly, and no pulsation whatever could be detected in the superficial femoral. For eleven hours, in short, almost complete compression was kept up. The tumour, however, still pulsated, but not forcibly. The collateral circulation has sprung up, and the attempt had now to be abandoned.

The next day, the 9th, a very faint pulsation could be felt in the femoral. The pulsation in the tumour is very strong, but it feels much firmer.

On the 13th compression of the common femoral was kept up for about twelve hours by Signoroni's tourniquet, and on removal no pulsation was to be felt in the aneurism, nor did it return for eleven hours. Compression was then re-commenced, and maintained as effectively as possible until the 17th, on which day it was kept up from 8.30 a.m. till 9 p.m. On removing the compressor no pulsation whatever could be felt for one minute, and then it returned faintly. On the 21st the pressure was again applied from 9 a.m., till 5 p.m. On removal the aneurism still faintly pulsated, but during the night the pulsation suddenly and finally ceased, and there was no return so long as he remained in hospital. He discharged himself on the 9th December, and the tumour was then becoming gradually absorbed.

Several cases have been recently published by Drs. Mapother of Dublin, Murray of Newcastle, Vanzetti of Padua, and others, showing the advantages of completely arresting the current of blood through the sac in the treatment of aneurism. The treatment of aneurism by compression, a triumph which we owe to the Dublin School of Surgery, has hitherto been based upon the theory that successive layers of fibrine were deposited in the sac, and that to facilitate the cure a certain diminished current of blood must be allowed to pass through the aneurism. If the views now put forward be correct the obliteration of an aneurism is obtained by

the clotting of the blood contained in it, and its subsequent contraction and organization, procured by complete occlusion of the current, and arrest of all movement in the aneurismal sac, for a longer or shorter period of time. In one case mentioned by Dr. Mapother an ilio-femoral sac was obliterated after pressure for four hours and a half on the common iliac, combined with distal pressure on the superficial femoral. In another case of popliteal aneurism pressure on the femoral proved successful after nine and a half hours. At Newcastle an aneurism of the abdominal aorta underwent the process of consolidation in three quarters of an hour, while in another case some twenty minutes are stated to have effected complete cure. The cases reported by Dr. Vanzetti of Padua are, if possible, more striking. They are a traumatic aneurism of the palmar arch cured in thirty minutes, and an aneurism of the femoral cured in less than ten hours.

This method of treatment seems little short of a revolution of that generally accepted, and so indeed it is. In connexion with this matter I read, with great interest and pleasure, some remarks made by my friend Dr. Geoghegan at the late meeting of the British Medical Association in Dublin. He said he had been extremely intimate with Dr. Bellingham, and had seen nearly all that surgeon's cases treated by compression, and for a long series of years had strenuously contended against the principle that the true mode of curing aneurism consists in the mere diminution of the current of blood flowing through the sac. In the discussion which then took place Mr. Ernest Hart, the author of the article "Aneurism" in Holme's Surgery, stated "that he felt convinced that this method of rapid cure by complete compression was destined to become generally adopted as the mode of treatment, par excellence, of surgical aneurism, and that it was almost as great an improvement upon the slow method of treatment as compression itself was upon the method of the ligature."

In the case just narrated I believe the plan of continuous and complete compression would probably have proved immediately successful had it been more efficiently applied. We had, however, in our patient a very unmanageable person, who resisted our efforts in place of co-operating with them, and in his struggles from time to time a small jet of blood must have gained admission. The only hope of speedy and complete success is in the thorough stoppage of the flow of blood to the aneurismal sac. As it was, I believe a partial clot formed, and this, though insufficient at the time permanently to fill up the sac, proved adequate after the lapse of some days, and was the cause of the sudden cessation on the 21st. I believe the very complete manner in which the collateral circulation was established also aided, in a large degree, to protract the cure, as by that means blood was freely supplied to the sac by the distal extremity of the vessel. No direct pressure could prevent this, owing to the situation of the aneurism fill-

ing the popliteal space, and forcible flexion could not be maintained sufficiently long to effect the same object. I should, therefore, in giving this method another trial, effect if possible compression on the efferent vessel, and if that were impracticable, try, in any case, to procure occlusion of the sac without preliminary partial compression, and without affording time for the collateral circulation to supply the sac with blood. The temporary obliteration of the superficial femoral vessel, which never again became restored in size, is an interesting feature in the case. I should mention that the application of the ether spray, which was kept up for a lengthened period each time, seemed to have no other effect than the production of a troublesome superficial slough, which left behind it an ulcer very difficult to heal.

Since writing these remarks I have read a paper by Mr. Samuel A. Cusack, published in the Dublin Quarterly Journal for November, 1859, in which he describes an instrument of simple construction for applying graduated pressure by means of weights to the artery. He mentions that in the first case in which he tried it a cure of a case of popliteal aneurism was effected in twenty-six and a half hours. Although it is not mentioned as such, it is probable that in this instance we find an early example of the effects of complete compression.—January 17, 1868.

Dr. John Moore read the notes of three cases of labour followed by hæmorrhage and two placenta prævia.

507 Notice of meeting on 31st January 1868
The Twelfth Meeting of the Society, for the present Session, will be held in their Rooms, at the General Hospital, on Friday Evening next, the 31st instant, at Half-past Seven o'clock.

Business.

Pathological Specimens.

Professor Cuming will exhibit two specimens of Cardiac Disease, and give an account of a Case presenting some features of Clinical interest.

Mr. H. M. Johnston will exhibit a Gangrenous Leg which he amputated.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D., Secretary.

Belfast, 29th January, 1868.

Twelfth Meeting, 31st January, 1868

The President in the chair. Members present, Drs. William MacCormac, Fagan, Wales, McMurtry, Thomas Reade and Johnston, and Mr. H. M. Johnston.

Professor Cuming exhibited two cases of cardiac disease and gave an account of a case presenting some features of clinical interest.

Paper:¹ On Mitral Regurgitation not arising from Organic Disease—The possibility of the occurrence of regurgitation, through the mitral valve, independently of organic disease of any portion of the heart, is a question of great pathological and practical interest. The recognition of the characteristic murmur of mitral regurgitation is generally, and, no doubt, in the great majority of instances, rightly regarded as indicative of serious organic disease. There is reason to believe, however, that inorganic or functional murmurs are of more frequent occurrence than has been hitherto supposed. Functional disturbance of the heart, being usually a remediable affection, there is rarely an opportunity for examining the state of the valve, except in cases in which organic disease has existed. Various observers have, however, been struck by the apparently anomalous circumstance of the left auriculo-ventricular opening and its valve being found, on examination, to be perfectly healthy in cases in which murmur, apparently caused by valvular incompetence, had been heard during life. Such cases can be accounted for only by one of two explanations—either that a mitral murmur may be generated without regurgitation, or that derangement of the valvular function may be brought about by functional causes.

As far as regards the former of these two hypothesis, I have taken for granted that the existence of a systolic bellows-sound, possessing the usual characters of a mitral murmur in respect of situation, maximum intensity, and direction of transmission, necessarily involves regurgitation through the left auriculo-ventricular opening. This, which is the almost universal opinion among physicians who have paid special attention to cardiac diseases, is in opposition to the opinion of no less eminent an observer than the late Dr. Todd. Todd believed that a murmur might be engendered at the mitral valve in consequence of the deposition of lymph on its ventricular surface, the competence of the valve remaining quite unaffected, and, of course, no reflux taking place into the auricle; and even held that this condition of the valve could be distinguished from a condition producing incompetence by a special modification of the auscultatory signs. This opinion of Todd has been regarded with little attention, and has not been adopted, as far as I am aware, by any considerable authority on cardiac disease. Indeed, although it is generally admitted that roughening of the endocardium in the neighbourhood of the arterial orifices may give rise to systolic murmur, it is impossible to conceive how a

¹ [Dublin Quarterly Journal of Medical Science, 1868 vol45, p309.]

mitral murmur can be generated of sufficient intensity to be audible below the scapula, unless a current of blood flows through the imperfectly closed valve.¹

The second hypothesis will be discussed after the account of the subsequent case, which bears upon the question, and has some interest in connexion with it.

CASE I.—R. C., aged thirty-three, was admitted to the General Hospital on July 30th, 1867, suffering from dropsy. She was married, and the mother of three children.

She had been a healthy woman until four months ago, when she was suddenly frightened, she being then advanced in pregnancy; she did not miscarry, but from that time she began to suffer from palpitation, and soon after her confinement œdema of the lower limbs became evident. The heart symptoms and the dropsy had continued since, occasionally much relieved by treatment.

There was considerable anasarca and dyspnea, and she complained much of palpitation. The urine was not albuminous. A systolic bellows murmur was audible on placing the stethoscope over the heart, loudest at the left apex, and distinctly audible at the inferior angle of the left scapula. Its intensity diminished as the stethoscope was removed from the left apex. The heart was very often examined by the clinical class, and no doubt was entertained as to the case being one of well-marked regurgitation through the mitral valve. There was no diastolic murmur nor any bruit in the large vessels. The jugulars were somewhat turgescient, but did not pulsate, and the intensification of the second sound, pointed out by Skoda, was not observed. There was nothing remarkable in the progress of the case. It was necessary occasionally to puncture the legs and thighs to relieve the dropsy. There was much pulmonary congestion, a good deal of severe dyspnea and distress, and she expectorated frequently small quantities of dark blood. The symptoms were ameliorated occasionally for a time, but no permanent improvement took place.

I learned that about three weeks before her admission she had been discharged from hospital after having been an inmate for nearly four weeks. She had been admitted under the care of Dr. Ross for symptoms of a similar kind to those under which she now laboured, but much less in degree. Dr. Ross also regarded her disease as incompetence of the mitral valve.

On October 1st she was transferred to the care of Dr.

Drennan, who took charge of the ward in which she was, according to the system of rotation pursued in the Belfast Hospital, and she remained under his care until her death, on November 1st, 1867. It is to his kindness that I was enabled to obtain the examination after death.

The post mortem was made under circumstances of difficulty, and only the heart could be removed. It was examined carefully; the aorta and the pulmonary and tricuspid valves were found to be perfectly healthy; the mitral valve was well formed, and quite free from any evidence of disease, except a very slight thickening, about the size of a small shot near the free edge of its anterior flap. The circumference of the left auriculo-ventricular opening was found to be three inches and six lines; that of the right, three inches and eleven lines. The cavities seemed quite normal as regards capacity and shape, and the muscular structure of the heart was firm and well coloured. The carnæ columnæ were well developed and firm, and nothing abnormal could be discovered in the chordæ tendinæ. I exhibited the heart, and read the notes of the case, at a meeting of the Ulster Medical Society, and it was carefully examined by several members of considerable experience in pathology and anatomy who were present, and the unanimous opinion was, that there was no evidence of their being anything whatever abnormal in its condition. The heart was specially examined with reference to the suggestion which has been put forward by some observers¹—namely, that atrophy of the muscoli papillares and smallness of the chordæ tendinæ may become important causes of valvular incompetence, but with an entirely negative result.

The appearance of the valve, as well as the symptoms and physical signs, presented a remarkable resemblance to Case I., published in the first of the admirable papers on "Diseases of the Heart," by Dr. M'Dowel.² In Dr. M'Dowel's case, however, great dilatation of the left ventricle, and softening of its muscular tissue, existed, a condition which, as has been insisted on by Dr. Gairdner, may produce regurgitation through the auriculo-ventricular opening without the existence of any disease of the valve. No such change existed, however, in this case.

Observations.—It is of interest to observe that the first symptoms of ill health occurred subsequently to the patient having been frightened, the fright having taken place when she was in the pregnant state, a condition in which the nervous system is probably unusually susceptible of injurious influences of this kind. In chorea, a disease not unfrequently observed in pregnant women, mitral murmurs are occasionally observed, and these are attributed, with much proba-

¹ "If the bellows-sound be purely regurgitant, its position is strictly at the apex; it becomes in a marked way faint as you proceed to the base of the heart, and it is distinctly audible beneath the left scapula; and, in addition, the sign pointed out by Skoda, exists—namely, a marked intensification of the second sound. If the bellows-sound be not regurgitant, you hear it well up to the base of the heart; you hear it only feebly, or not at all, at the left scapula, and there is no intensification of the second sound. I may add that, in this latter case, the heart's disturbance, and the sufferings of the patient, are in a marked manner less than in the former."—Clinical Lectures by Dr. Todd, 2nd ed., p. 77.

¹ Bristowe. Brit. and For. Med.-Chir. Rev., Vol. 20, p. 229. Peacock on some of the Causes and Effects of Valvular Disease of the Heart, 1865, p. 59.

² Dublin Quarterly Journal of Medical Science, Vol. 14, p. 354.

bility,¹ to disordered innervation of the muscular apparatus connected with the valve. The idea naturally suggested itself that the valvular derangement might have been caused by the strong mental impression giving rise to spasmodic action of some of the papillary muscles. The influence of mental emotion in causing spasm of so partial an extent as that which produces strabismus is well known, and there is nothing inconsistent with our knowledge of the very limited and local phenomena which may be engendered by nervous impressions in this supposition. Of course, antecedently, it would be highly improbable that spasmodic action should continue persistently for so considerable a period, and should give rise to phenomena of a character so regular and uniform. Intermissions and irregularity would be much more likely to occur, and for this reason Dr. Bristowe, in an elaborate paper on inorganic mitral murmurs, previously referred to, dismisses somewhat summarily the notion of spasmodic action having any influence in the causation of mitral regurgitation, and attribute the incompetence to the dilatation of the ventricle, and atrophy of the chordæ tendineæ and musculi papillares. Yet it may be reasonably doubted whether we are enabled altogether to exclude such a mode of causation. Instances have been observed both of continuous and of rhythmic spasm,² of a nature quite as extraordinary as would be involved in such a supposition. The constantly recurring irritation of the blood entering the cavity of the ventricle might possibly bring about a constantly recurring spasmodic action. Indeed, an excellent observer has suggested that even the inorganic murmurs which are so frequent at the aortic orifice may be referred to perverted innervation.³

Besides, it is impossible to refer the case which follows, and several of the cases recorded by Dr. Hayden, in a paper to be afterwards referred to, to a dilated condition of the ventricle, unless, indeed, we are prepared to admit that a condition of dilatation, so considerable as to give rise to regurgitation, is capable of being rapidly produced and rapidly removed, a view which is not consonant with pathological or clinical experience. In this case there was certainly no appreciable dilatation. It is, no doubt, difficult to pronounce

definitely on the absolute capacity of a ventricle, but any considerable dilatation would be readily recognized. It is curious, that out of six cases which are adduced by Dr. Bristowe in support of the dilatation theory, two are cases in which the dilated condition of the heart was only inferred and not actually observed at the post mortem examination; and as regards the condition of the musculi papillares and the chordæ tendineæ, in three of the six the actual condition on which so much stress is laid was also not observed.

A point, however, of much greater practical importance is the occurrence in this case of marked pulmonary congestion and of anasarca. In a very able paper, read at the recent meeting of the British Medical Association in Dublin, Dr. Hayden dwells on the absence of pulmonary engorgement as an important element in the diagnosis of inorganic mitral murmurs. It is impossible to comprehend why a regurgitation from functional derangement, of the valve should not be accompanied or followed by the same disturbance of the circulation as would be brought about by a similar amount of regurgitation owing to actual changes in the structure of the valves. Indeed, it would seem more probable that the obstacle to the return of blood from the lungs would be, *cæteris paribus*, greater in some of the former cases, as the incompetence of the valves would be occasionally produced rapidly, and even suddenly, while in a large proportion of cases of organic change the incompetence would be of slow and gradual growth. Nor is there any reason why inorganic regurgitation should not be of very considerable amount. The fact, no doubt, is that the amount of pulmonary congestion, and the date of its appearance, are regulated by the amount of the incompetency, by the state of the ventricle, and by the general condition of the patient. It is very probable that several of Dr. Hayden's cases would have exhibited signs of pulmonary and systemic congestion had the regurgitation not yielded to treatment.

The anasarca and congestion of the lung, which existed in my case, cannot be attributed, I believe, solely, or even mainly, to the condition of the valve. The feeble, ill-nourished, and anemic state of the patient was, no doubt, powerfully instrumental in the production of the dropsical condition. But that there was a difficulty imposed upon the heart was shown by its firm and well-developed character of tissue. Indeed, a condition of what may be called relative hypertrophy seemed to have been induced. The heart might have been reasonably expected to share in the prevailing atrophy and wasting of the body. It was, on the contrary, an organ such as might have belonged to a strong, healthy woman. This points towards a cause having existed which kept up an abnormal stimulation of its nutrition, and renders it probable that had life been much prolonged actual hypertrophy would have been produced.

CASE II.—Mitral Regurgitation of a Temporary Kind.

¹ Walshe. *Diseases of the Heart*, 3rd ed., p. 96.

² *The Nervous System*, by Sir Charles Bell, 1830, Appendix, p. 41 and 42. Parry, quoted by Romberg *Diseases of the Nervous System*. Vol. i. p. 287.

³ "It is certain that, even when spanemia and anemia exist, functional murmur is commonly confined to cases characterized by palpitation—a result of nervous irritability—and that profuse venesection, hemorrhage, and other causes of spanemia, are also productive of palpitation, and of exalted nervous excitability. Therefore, without denying that an anemic and spanemic condition of the blood must necessarily facilitate the production of vibration and murmur, it seems to me probable that these functional murmurs are more closely connected with perverted innervation and disordered contractility of the valves and large vessels than with a mere alteration in the condition of the blood."—Fuller. *Diseases of the Heart and Great Vessels*, p. 47.

A gentleman, aged thirty-three, married for about two months, of strictly moral and temperate habits, and who had always enjoyed excellent health, was seen by me in consultation with Dr. Newett, of Moneyglass. He suffered from great exhaustion, and from a feeling of faintness when he sat up more than a few minutes at a time. He had injudiciously taken purgative medicine with the idea of his illness being the result of biliousness, and, in consequence, the bowels were rather relaxed. There was no evidence of active disease of any kind; the tongue was clean, pulse 80, and very soft, and there was some appetite. On examining the heart a soft bellows-murmur was heard at the left apex, transmitted towards the left axilla, but quite inaudible at the base of the heart, and only faintly audible at the right apex. He had never had any rheumatic affection, nor any symptom of cardiac disease, and he had been examined for life assurance a short time previously by an excellent and careful stethoscopist, who had not detected any abnormal condition of the heart. Under these circumstances, I inclined to the opinion that the murmur was of functional origin, an opinion which was verified by the progress of the case, as under tonic treatment and rest he completely regained his strength, and the murmur gradually subsided. I had an opportunity of examining his heart a few days ago, and found that its action and sounds were perfectly normal, and free from any trace of murmur.

The conclusions to which a consideration of the last two cases and observations lead are—firstly, that mitral regurgitation may be produced without organic disease of any kind, and—secondly, that it may in some instances give rise to the same physical signs and to the same general symptoms as regurgitation from organic causes.

Mr. H. M. Johnston exhibited a gangrenous leg which he had amputated. It had occurred as a sequel of fever.

508 Notice of meeting on 14th February 1868
The Thirteenth Meeting of the Society, for the present Session, will be held in their Rooms, at the General Hospital, on Friday Evening next, the 14th instant, at Half-past Seven o'clock.

Business.

Dr. William Mac Cormac will give a short account of a Case in which he performed an Early Operation for Cleft Palate, and for Hare Lip.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for

Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D., Secretary.

Belfast, 12th February, 1868.

Thirteenth Meeting, 14th February, 1868

Present, Professor Cuming, Drs. Fagan and John Moore.

Adjourned the meeting till this day week.

508 Notice of adjourned meeting on 21st February 1868

An Adjourned Meeting of the Society will be held in their Rooms, at the General Hospital, on Friday Evening next, the 21st instant, at Half-past Seven o'clock.

Business.

Dr. William Mac Cormac will give a short account of a Case in which he performed an Early Operation for Cleft Palate, and for Hare Lip.

Dr. John Moore will read a Paper on The Influence of Flax-Spinning on the Health of Mill Workers.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D., Secretary.

Belfast, 19th February, 1868.

Thirteenth Adjourned Meeting, 21st February

Dr. William MacCormac in the chair. Members present, Drs. Hill, H. S. Purdon, Fagan, McCrea, Johnston and John Moore.

Dr. William MacCormac introduced a patient in whom he had operated for cleft palate and for hare lip nearly two years ago, and gave a description of the case.

He also described a case of operation for hare lip which he performed in a child eight days.

He also exhibited a testicle which he had removed for medullary disease.

Dr. John Moore read a paper on “The Influence of Flax Spinning on the Health of the Mill Workers of Belfast”.

Paper:¹ One of the objects of this Association being “to collect statistical evidence of the relative healthiness of different localities, of different industrial occupa-

¹ [Published in the Transactions of the National Association for the Promotion of Social Science, 1867, p508, having been first read to that society during its meeting in Belfast in 1867.]

tions, and generally of the influence of external circumstances in the production of health or disease," I should regret exceedingly were its Meeting at Belfast to be permitted to separate without any information being laid before it on these important subjects in relation to our local manufactures, which employ so many thousands of hands, and which has raised Belfast to the proud position which it now occupies. I have thought that the experience of one who has medical charge of more than three thousand of our mill workers might not be devoid of interest to those who labour for the improvement of the working classes. So far as my experience goes, and it has been gathered from a wide field of observation, I believe that the manufacture of linen yarn and linen, in relation to the health of those engaged in it, will be found to bear a favourable contrast with that of any other in the kingdom.

The manufacture of linen may be said to begin when the farmer, after "pulling," "watering," and "grassing" the flax, delivers it at the scutch mill to be prepared for market. It is here, namely in the scutch mills, that the greatest danger to life and limb in the whole process of the manufacture is to be found. Scattered here and there in remote rural districts, removed from the eye of any Government Inspector, the revolving machinery, too often without sufficient safeguards, frequently makes sad havoc of the hands and arms of those employed in that department of the linen manufacture. It is, however, with the manufacture of linen yarn and linen, as carried on in the spinning mills and weaving factories of Belfast, that we are at present engaged; and here, as I have stated, that without exposure to the influence of any noxious gases or emanations, without any un-natural or constrained positions, and without excessive muscular exertion, the employment will be found, if not one of the most lucrative, at least one of the most healthy in the whole range of our manufactures.

The first process to which the flax is subjected is that of "roughing," and those who perform that operation are accordingly called "roughers." The process consists in drawing the fibres of the flax across a coarse iron comb. The atmosphere in which they work is certainly not one of the purest, the dust and fine particles of the flax load the air, and consequently a good deal of bronchial irritation results. The floating particles, however, are so unlike, for instance, those to which the grinders of Sheffield are exposed, that they are comparatively harmless. From the roughers the flax is passed to the machine boys, whose task it is to fasten it between two iron plates by means of screws, and pass it across a machine where it is subjected to a further process of combing or dressing.

This, with the exception of the carding, to be afterwards mentioned, is, perhaps, the most dangerous position to which any of the mill-workers are exposed; it is amongst the machine boys that the greater number of

accidents occur, and I am seldom without one or more of them under my care for wounds and laceration, and, too often, mutilation of the fingers and hands. This results, no doubt, to a great extent from the fact that boys will be boys, and that their familiarity with danger breeds contempt, and the carelessness that consequently arises leads to these deplorable results.

The machine boys, like the roughers, are exposed to an atmosphere loaded with dust and floating particles of the flax. The sorters next take up the process, and their occupation closely resembles that of the roughers; their business is to subject the fibre of the flax to a further process of combing, and more care and skill is required on their part, to arrange and sort the different qualities of flax submitted to them.

There is no machinery employed either by the roughers or sorters, the operations of both being performed by hand; they are, consequently, free from those dangers which must always result from being in close proximity with revolving machinery, no matter how securely it may be guarded.

Roughers, sorters, and machine boys are all exposed to an atmosphere which, I believe, might be rendered much purer and more wholesome than it is; a little engineering skill applied in that direction, by directing a current of air so as to carry away the impurities, would certainly be a step in the right direction.

The flax having gone through the hands of the roughers, machine boys, and sorters, is then sent to the preparing room, where it passes through a series of more complicated operations, and receives the first twist into yarn. The toil in all these operations is light, care and attention being what is required on the part of those engaged. So far as my observation extends I have not succeeded in discovering any disease which arises specially from, or can be traced to, the nature of the occupation of those employed in the "preparing room."

Before speaking of spinning properly so called, there is another operation to which that portion of the flax which has been separated by roughing, by machines, and by sorters, and which is called tow, is subjected, namely, carding; this I look upon as the dustiest, most disagreeable, as well as the most unwholesome and most dangerous of all the departments connected with the spinning of flax. Accidents, when they do occur, in connexion with the carding machine, are generally of the most frightful character, and fatal in their results.

The remarks made on the desirableness to improve the atmosphere of the machine-room and the hackling-shop apply with still greater force to the carding-room; fortunately, fewer hands are employed in it than are engaged in any of the other departments of the manufacture.

The process of spinning comes next to claim our attention. And here we find a complete transition of circumstances; passing from a cool dry atmosphere, loaded with floating particles and impurities, we enter

a heated atmosphere charged with vapour—in fact a vapour bath—with a temperature from 80 degrees to 85 of Fahrenheit's thermometer. More than 30 per cent, of the workers are employed in this department of the manufacture.

As it is in the machine-room that little boys are employed, it is in the spinning-rooms that little girls are engaged, and here it is that the tender form of childhood is often in danger of being taxed beyond what it is able to bear. The diseases found to prevail and to spring from employment in the spinning department are anæmia, onychia, and the deformity of the foot—a species of talapis.

Those who have been long in the atmosphere of the spinning-room generally become pale and anæmic, and consequently pre-disposed to those ailments which spring from such a state of the constitution.

Children placed there early and compelled to keep upon their feet the entire day, as the nature of their employment obliges them to do often, suffer from the young and tender bones, which form the arch of the foot, being crushed and flattened.

The onychia of mill-workers prevails to a great extent amongst the spinners. It is a most inveterate disease, and requires for its remedy a most painful operation, either the dissecting out or wrenching out the entire roots of the great toe-nail. It results, I believe, from the custom which is universal here with that class of going barefooted while at work; the water which has filtered through becoming more or less impregnated with the brass and other metal of the machinery, when any accidental knock lights up inflammation, it comes to act as an irritant and poison, and hence results the painful and tedious ulceration around the great toe-nail which requires so severe a remedy.

There is also a form of papular eruption to which the spinners are liable upon the face and arms, caused, I believe, also by the water through which the threads have been drawn. It is one which does not cause any derangement of the general health, and for which a remedy is seldom sought.

I have now to speak of the last process in the manufacture of linen yarn, namely, reeling. It consists in causing to revolve a number of pieces of wood arranged around a central axis, and by means of which the yarn is unwound from the bobbins on which it has been spun, and formed into hanks, which when made into bunches is ready for the market. No machinery is employed in this department, the reels being turned by those employed upon them. In this department more muscular effort is required than in any other, and from the peculiar exertion necessary to keep the reels in motion, I believe that hernia will be found to exist in this class to a considerable extent.

I have thus endeavoured to describe, with the utmost brevity and, as I fear, very imperfectly, the various operations and processes in which the mill-work-

ing population of Belfast is engaged, and to trace, as far as possible, any injurious influences which those operations may exert upon the health and well-being of those engaged in them. Bronchial irritation does result to those employed in several of the departments, but contrasting the number thus affected, with others exposed, as agricultural labourers for instance, to the vicissitudes of the weather, I am of opinion, that as few cases of chest affection will be found amongst the mill-worker as amongst the same number of any other class in the community. I believe, however, there is great room for improvement in purifying the atmosphere of the carding-rooms, machine-rooms, and hackling shops.

From the foregoing statements you are likely to conclude that the mill-working population of Belfast is a remarkably healthy class, but I regret to say that the very opposite of this is the true state of the case. A large amount of sickness prevails amongst them, but its cause must be sought for in other reasons than the nature of the occupation in which they are engaged. I believe we shall not find much difficulty in discovering the root and source of their great bane. Any one who will take the trouble to visit some of our spinning mills at the approach of meal hours, and examine the food which has been brought to sustain them during the day, to look into the tin vessels and see the fluid, which can hardly be called tea, infused frequently from the evening before, allowed to remain all night in metallic vessels, warmed up again not only for breakfast but for the mid-day meal, it becomes at last to resemble tobacco water more than anything else, and from the examination one turns away both sad and sickened. Improvement of the food of the mill workers must underlie all attempts to improve their general health.

An effort has been made in this direction by Dr. M'Cosh and others, and, thanks to the persevering and indefatigable efforts of Mr. T. P. Corry, the experiment has, to a great extent, proved successful. By means of the cooking dépôt which he has built, the working classes are enabled, in the locality in which that dépôt is situated, to obtain good, nutritious, and well-cooked food, on more reasonable terms than they could themselves prepare it. I had hoped that the system might have been extended in Belfast as it has been in Glasgow, and Messrs. Johnson & Carlisle kindly placed a dining-hall at Brookfield Mill, which they suitably fitted up, at our disposal for that purpose; the experiment, as such, was successful, and though difficulties in the details have caused, I regret to say, a suspension of its operations, sufficient was done to show that if placed within reach of the mill workers they would gladly avail themselves of its benefits.

I trust that ere long others will follow the example Mr. Corry has so nobly set, and that in those centres around which our busy hives of industry are clustered, there may be placed institutions similar to that which

he has placed in Dock Street. Another still more important point, and closely connected with the foregoing, is the education of those girls who are to become the wives and mothers of the working classes, in domestic duties. Trained from early youth through hard and constant toil, to spin, to reel, to weave, they are left entirely ignorant of domestic economy, and are expected to be able to practise that which they have never had an opportunity to learn.

I have endeavoured to ascertain as far as possible the actual amount of sickness which does exist amongst our mill population, but the shifting nature of that class, and the frequency with which they leave one establishment for another, render it difficult to arrive at an accurate result. I find that about forty per cent, of those actually engaged apply for medical relief during the year, and that not less than twenty-five per cent, of those who do seek medical aid seek it on account of gastric derangement, clearly traceable to the want of proper food and dietary arrangement; all the meals of a large proportion consisting of tea, resulting from the facility with which it can be prepared, and not from inability to procure more substantial nutriment.

J. Seaton Reid

510 Notice of meeting on 6th March 1868

The Fourteenth Meeting of the Society, for the present Session, will be held in their Rooms, at the General Hospital, on Friday Evening next, the 6th instant, at Half-past Seven o'clock.

Business.

Dr. William Mac Cormac will give an account of Two Cases of Strangulated Femoral Hernia upon which he recently operated.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D., Secretary.

Belfast, 4th March, 1868.

Fourteenth Meeting, 6th March, 1868

The President in the chair. Members present, Drs. William MacCormac, Cuming, H. Brown, Fagan, Hill, Wales and John Moore.

Dr. William MacCormac gave an account of two cases of strangulated femoral hernia upon which he recently operated; one terminated fatally and in

which case the portion of strangulated bowel was exhibited.

Paper:¹ In bringing forward the history of these cases I do not expect to advance anything that is novel upon such a subject as hernia, which has so long occupied the attention of the best anatomists and surgeons. I merely wish to record the details of cases in certain respects not unimportant, and add, perhaps, a little to the common stock of knowledge. I would also wish to urge my conviction as strongly as I could that to operate early is to give the patient the best chance of recovery. Now-a-days, no surgeon would, I conceive, make repeated and forcible attempts to reduce a strangulated intestine. After a judicious and reasonably prolonged effort had been made to reduce the protruded part without operation, and had failed, there is hardly anything to justify much further delay. I have never lost a patient, nor seen any untoward symptom follow an operation from its having been performed early, while every surgeon must have reason to deplore the fatal consequences which ensue but too often from the long continuance of strangulation of the intestine.

Besides, if one form of hernia more than another requires the prompt recourse to the knife it is femoral hernia. The anatomical conditions under which it occurs sufficiently explain this fact.

CASE I.—Martha Kelly, a thin delicate woman, about forty-eight years of age, and the mother of seven children, was admitted to hospital under my care on the morning of the 26th October, 1866, shortly after midnight, with strangulated femoral hernia of the left side. The patient told that for the last twenty years she has suffered from her malady, and that it made its appearance in consequence of her lifting a heavy weight just before her confinement. Something, she said, "gave way with a crack," and just as her child was being born she felt a similar sensation; and when she got out of bed afterwards a lump suddenly appeared. The woman states also that an abscess, which required to be opened, formed in the same situation. She had worn a truss, but the swelling often came down. There was no great difficulty at any time in returning the parts to the abdomen—into which led, the patient states, a large opening—until the 24th inst, at 11 p.m., whilst at stool the hernia came down, and the woman could by no effort of her own return it. A medical man was sent for the next day. He tried the taxis, prescribed castor oil, and the application of ice, without success. The castor oil was followed by two evacuations from the bowels, but the swelling remained as before. The taxis was then a second time tried without avail, and the patient recommended to go to hospital. My colleague Dr. Murney was present when she was admitted, and he made an effort at taxis whilst the patient was in a warm bath, but without making any change in the tumour;

¹ [Dublin Quarterly Journal of Medical Science, 1868, vol45, p487. As will be seen, the published paper contains three cases.]

and as the symptoms did not appear very urgent advised an opiate and rest in bed, until I should pay my visit in the morning.

At ten o'clock, when I first saw the case, I found the patient had slept but little, her face wore a sunken, anxious look, tongue much furred, pulse 100, and weak. She had vomited three times some bilious matter. A good deal of pain was felt both in the tumour and abdomen, and the neck of the sac was very sensitive. On examining the left groin I found an oval tumour, the bulk of half a lemon, situated transversely beneath Poupart's ligament. The swelling was not tense, was nodulated, and had the feeling of containing omentum, except at one point, where there seemed to be intestine.

After a consultation, at the suggestion of Professor Gordon, an enema was given, which brought away much flatus, and the ice was reapplied. In the afternoon the patient's condition was not at all improved, and therefore I considered it expedient to operate without further delay, as strangulation had now subsisted about forty hours.

The patient having been first put under chloroform the taxis was tried, but I failed to produce the slightest effect on the bulk of the swelling.

An incision was therefore immediately made, about two and a-half inches long, in the vertical axis of the tumour, but rather to the inner side. The fascial layers were divided in the usual manner, and the sac exposed. On opening this a small quantity of serum flowed away and omentum was seen. The sac was then more freely opened, and on introducing the finger a very tight stricture was felt at the crural ring, beneath which the finger nail was insinuated with trouble.

The constriction was divided with the greatest care, and with much difficulty, cutting upwards and inwards, at the junction of Poupart's and Gimbernat's ligaments. The protrusion, however, could not be returned, and on seeking for the cause it was found that the omentum was attached by old adhesions to the posterior part of the sac. These were separated with care, and another attempt made to return the parts, which proved unsuccessful, until Poupart's ligament was partially divided, the edge of the knife being directed upwards. Three sutures were inserted in the wound, a pad and spica bandage applied, and the patient removed to a warm bed, when a large opiate was administered.

That evening the patient was restless and uncomfortable. She was ordered a grain of opium and a grain of calomel every fourth hour.

The next morning I found she had slept well, and felt easy; pulse 120. She is to have chicken soup, and the pills at longer intervals.

On the fourth day, the 29th, the pulse was 110; bowels had been freely open the night before with great comfort to the patient. She had slept well, and had eaten an egg for breakfast. On dressing the wound it

was found to have healed throughout by immediate union. The patient became rapidly convalescent. She was slightly salivated, having, however, taken in all five pills, each containing only one grain of calomel. The inferior angle of the wound subsequently reopened at one point to discharge a few drops of pus, but otherwise the wound thoroughly and immediately healed. She was discharged from hospital in fair health, better than she had enjoyed for many years, and wearing a light truss.

CASE II. differs from the last case considerably. The notes from which I have extracted the following account were very fully and accurately taken by Mr. Price, one of my clinical clerks. The patient was much older-looking than her real age—sixty years. She was the mother of seven children, and had evidently suffered many hardships. The hernia was of recent date, and was very small. She first noticed a lump in her groin about a month ago, when she had an attack of cramps and vomiting. Since this attack she has but seldom got out of bed, as she suffered much from nausea and constipation, with weakness and loss of appetite. The lump sometimes was felt, and sometimes not, in the groin—probably the patient did not know the importance of the local ailment.

On the 11th February, 1868, at eleven o'clock in the morning, she suddenly took ill with severe cramps in the belly, and vomiting, not being able to retain either food or drink. A medical man was sent for some time after, who employed the taxis without avail, and then she was sent to hospital, where she was admitted under my care at nine a.m., on the 14th. I saw her a few minutes after, and found her in an extremely weak condition, surface cold, face anxious, skin yellow, voice tremulous and feeble, pulse 120 and thready, tongue much coated. Since the first appearance of the symptoms she has vomited almost continuously, even on drinking cold water, and there has been no action of the bowels. In the right groin there is a little hard lump, not much larger than a cob-nut, just beneath Poupart's ligament. Great pain was felt in the part, and also at the umbilicus.

The case appeared to be one that would brook no delay. The tumour was very tense and small, the symptoms were very urgent, and strangulation had subsisted seventy hours. The woman was at once removed to the operating theatre and chloroform administered. No attempt at taxis was thought expedient, and herniotomy directly proceeded with. A vertical incision, commencing just over Poupart's ligament was made, some fascial layers divided on the director, and a lobule of fat about as large as a hazel-nut exposed. This resembled extremely a piece of omentum, and caused much embarrassment in the course of the operation. By careful isolation of the neck of the tumour this fat was shown to be external to the sac, being contained in the fascia propria. The falciform border being exposed it was divided, cutting directly upwards, and an effort made

to return the hernia without opening the sac. In this we entirely failed, and it became necessary to open the sac. This was accomplished with great care and some difficulty. A few drops of dark red serum flowed, and a very small bit of intestine, almost black in colour, and completely adherent to the sac by recent lymph adhesions, was laid bare. The adhesions were cautiously broken through with the finger and the handle of the scalpel. The director was then introduced beneath Poupart's ligament, as the finger or even the nail could not be inserted, and the stricture freed by simply pressing the knife against its edge in a vertical direction. The intestine now receded of its own accord, the thickened sac was cut away, the wound closed by three sutures, and dressed in the usual manner. With regard to the after-treatment, it may be simply comprised in the statement that the patient was let alone. No medicine was given of any kind. Soda water and ice were freely taken to relieve the sickness following the chloroform, and so soon as this had subsided the patient was given some nourishing soup. Next day, the 15th, the pulse had fallen to 90, and the countenance had lost its anxious expression. The abdomen was distended with flatus, but not tender, except in the region of the wound. The sickness and vomiting had quite abated. On the 16th, the patient complaining of much uneasiness in the groin, the dressings were removed, and the wound was found united by the first intention throughout. The skin around had become inflamed, and was of a dark red colour. The sutures were removed, and the cicatrix yielded in the centre to the extent of a line's breadth, giving exit to nearly a tablespoonful of sanious pus.

Next day the patient was found to have been completely relieved. She had slept well, the tongue was cleaning at the edges, and the pulse fallen to 84. The skin was cool, all sickness had disappeared. No pain was felt in the abdomen, which was still, however, much distended with flatus.

On the 20th, the seventh day after operation, the patient's general condition is reported very satisfactory. A small quantity of rather fetid pus was daily discharged from the wound, which was syringed out with carbolic acid lotion with great advantage. The bowels had not been open since the operation, and an enema of soap and water was directed to be given. A plentiful discharge of both feces and flatus followed, to the great relief and comfort of the patient. On the 22nd February the patient was pronounced convalescent. She eats, drinks, and sleeps well. The bowels had been moved naturally, and the wound was secreting a few drops only of healthy pus. Soon after she was discharged from hospital quite cured of her hernia. She was, however, advised to wear a truss.

Case III., extremely interesting in many respects, proved a fatal one, and a post mortem examination was obtained. We have in this instance an illustration of the most forcible kind of the disastrous results of

delay in procuring relief for a strangulated intestine, and an example given where the symptoms merely of disease were treated, and the cause of those symptoms completely overlooked. The account of the case is taken from the very faithful notes of Mr. Chambers, clinical clerk.

Mrs. G., thirty-two years of age, the mother of several children, was admitted under my care on the evening of Friday, February 28th. She had previously enjoyed an immunity from all serious illnesses, but had never been very strong. Between two and three years ago she first noticed a little lump in the left groin, which came and went at intervals, and was occasionally attended by cramps and pain. For three months the menses had disappeared, as she had again become pregnant, and during the 6th, 7th, and 8th of February she suffered from profuse hemorrhage and other symptoms of miscarriage. The bleeding from the vagina continued until within three days before admission, reducing her to a very weakly state.

On Friday, February 21st, whilst washing, and having to make considerable exertion, the lump in the groin suddenly increased in size and became very painful, while shooting pains were felt extending from it through the abdomen. The next day she was much worse, the pain had increased in severity, and assumed a constricting character at the umbilicus. She began to vomit, and from Saturday the 22nd, at 2 p.m., all food and drink was rejected by the stomach. The bowels were constipated, not having been relieved since Friday morning. On Sunday a medical man was called in, who prescribed her a mixture for the purpose, she stated, of checking the vomiting and opening the bowels. Different mixtures were from time to time ordered, also Seidlitz powders, sinapisms, turpentine stupes, and linseed poultices, and all without affording any relief. Matters proceeded from bad to worse until Friday morning, the 28th, when the patient herself called attention to the presence of a tumour in her groin, which on examination proved to be a hernia, and the cause of the symptoms. Shortly afterwards the woman was sent to hospital.

On admission the patient presented the appearance of a person forty-five years of age. Her face was shrunk in all its features, pale, wrinkled, and very anxious, the angles of the mouth drawn down, the surface was quite cold, the extremities clammy, and the hands blue. The respirations were 25 per minute, the pulse was 120, and almost imperceptible. In short, nearly complete collapse had taken place. The intelligence was perfect. There was little or no local or general tenderness on pressure. The woman complained only of deadly sickness. The vomiting has continued without intermission since the commencement of the symptoms, and the matter ejected is now of a most offensive description, being intolerably fetid. The tumour lies below Poupart's ligament, which it slightly

overlaps. Its long axis is transverse, and measures two inches and a-half, while from above downwards it is about one and three-quarter inches. There was no tension, and, as before stated, little or no tenderness evinced on pressure.

My opinion was that the taxis should not be attempted, and that an operation, although the result was hardly doubtful, should be attempted. After some chloroform had been administered an incision, nearly vertical, was made over the tumour, and after dividing several layers of fascia a dark fatty tumour, the size of a walnut, and quite smooth and glistening upon the surface, presented itself. It was extremely difficult to decide as to whether this was a mass of omentum or not. I considered, however, after a careful examination of its appearance and relations, that it was only thickened sac, and proceeded to divide it on the director. Two lines depth of tissue were cautiously divided, and the intestine became visible, completely adherent to the sac by recent lymph. No serum escaped. The adhesions readily gave way before the handle of the scalpel, when the incision into the sac had been enlarged, and a small knuckle of the intestine was exposed, almost black in hue, but it had not lost its resilient appearance or glossy surface.

The stricture was relieved by pressing Sir A. Cooper's knife against some fibrous bands felt with the finger, and dividing them almost directly upwards. The stricture was comparatively superficial and easily divided, and there was no bleeding. The intestine was readily returned. Sutures were now inserted, and the wound dressed.

The patient was then removed to bed, surrounded with warm water jars, and given ice to suck. Next morning the report is that there had been no vomiting since the operation, but the surface was still cold. She has had a continual desire to go to stool, and feels as if she had frequent motions in the bed, no assurance persuading her to the contrary. She has been very restless, constantly tossing about, and throwing the clothes off her. She was ordered to continue the ice, to have four ounces of port wine, a few spoonfuls of soup occasionally, and in addition a grain of opium every third hour. She afterwards got more wine and opium, and in addition hot punch, combined with the warmth externally.

The next day, in spite of all that could be done, the collapsed condition increased, the pulse became slower and slower, and weaker and weaker, till it ceased to be perceptible. The surface became stone cold. The jactitation was excessive, and painful to witness. She complained of no pain, and answered questions slowly but with intelligence. Towards the last there was some muttering delirium. She finally sank some thirty-two hours after the operation. If the fatal result was not retarded, it certainly was not hastened in any way by the surgical proceeding.

A short time afterwards a post mortem examination

was procured. The parts involved in the operation were carefully dissected and the falciform border of the fascia lata exposed. It was then seen that Hey's ligament had been divided for about two lines depth, upwards and very slightly inwards. Neither Poupart's nor Gimbernat's ligaments had been touched. The crural ring barely admitted the forefinger. On laying open the abdominal cavity the small intestine, greatly distended with gas, bulged out. The crural ring was closed by a coil of comparatively healthy gut, whilst the portion which had been strangulated was discovered removed about three inches to the right side of the opening. The whole intestine seemed injected and inflamed, but there was very little effused lymph and no serum contained in the cavity of the abdomen.

About three feet of small intestine were now carefully removed for subsequent examination. Towards the lower portion of the ileum the seat of strangulation was clearly seen. About two-thirds of the circumference of the bowel at its convexity was sacculated, a deep sulcus forming its boundary. The part appeared as if it had been tightly tied by a cord, and afterwards set free. More lymph was seen near this than elsewhere, and the included portion was quite black. There was no sign whatever of extravasation, and in fact none had occurred. The amount of congestion and inflammation of the bowel was much more intense below this point than above it. The intestine was now opened along its mesenteric attachment. At the seat of stricture, for the greater part of its extent, there was a projecting rim caused by the constriction, but through a distance of about half an inch at two places, the mucous and muscular coats had completely ulcerated through, nothing remaining but the serous, which was quite translucent. At one point for a line's breadth the serous coat also had given way, but it must have done so during the process of removal.

In the first of these examples the hernia was of ancient date, the opening through which it came was comparatively large, and the symptoms which followed strangulation were not very acute. It was proved during the operation that there was an impossibility of effecting any good by the taxis, or of reducing the hernia, except en masse, without opening the sac. The patient, too, had most confidently asserted, and, as she had suffered from rupture for twenty years, it might be presumed she ought to know, that the hernial protrusion completely disappeared when she lay in bed, and that she could pass her finger up through a large sized hole into the belly. The adhesions discovered during the operation were old and required a careful and troublesome dissection to liberate the parts. It was only too after a free division of the ligamentous structures composing the crural ring that reduction could be effected without force. It requires but little consideration to arrive at the conclusion that it is better to incise the site of stricture as often and as freely as may be neces-

sary rather than handle the intestine much, or attempt to squeeze it through an insufficiently relieved stricture. Of course, for the future strength of the abdominal wall, it is important to make the incision as limited as possible, but at worst a free incision will result in a mere infirmity, whereas much manipulation of the contents of a rupture, morbidly inflamed as they usually are, is a source of extreme risk to the patient's life.

In the second case the hernia was quite recent, and the symptoms complained of by the patient were much more urgent. I only feared that, after the length of time that had elapsed from their commencement, I might find the intestine irretrievably damaged. A few hours will, as we know, in some instances suffice to produce mortification of the gut. In neither of the first two cases could reduction be accomplished until the division of the deeper structures was effected. In neither was the falciform border the constricting cause.

The third case forms a striking contrast to the others. It may seem almost unnecessary to dwell upon the importance, the absolute necessity in fact, of determining the presence or otherwise of hernia in cases of vomiting and constipation. In this instance, however, the medical man was not aware during a period of six days that there was a rupture, and the woman was treated by means calculated to benefit her, perhaps, had the cause of her malady been other than what it was, but only tending to injure seriously her chances of recovery from strangulated femoral hernia. Besides, much valuable time, which is a matter of greatest importance, was lost. I would wish to add that it is not sufficient, especially with those in the humbler ranks of life, simply to inquire if there be a lump in the groin, and rest satisfied with the patient's assurance that there is none. Oftentimes persons of this class are liable to overlook, or attach little importance to, the presence of such tumours, and even if of long standing, will sometimes forget or ignore their very existence. We know, too, how far feelings of false delicacy will carry some women. Nothing save a careful examination made with one's own hands, and eyes if needful, will suffice.

The examination of the parts after death renders this case doubly interesting. The evidences of general peritonitis were distinct, but not to so large an extent as I have frequently seen them. The patient seemed rather to die from the collapse induced by the disease, and her state, weakened as it was by the recent abortion, did not offer the same amount of resistance and power of reaction. The woman did not, I consider, die of the operation, which did not seem to affect much the progress of her case in any way, save by giving relief from the vomiting. The way in which she died appeared to me almost identical with that in a fatal case I witnessed of strangulated femoral hernia where no operation had been performed. In both instances intense restlessness and jactitation, pervading coldness, muttering delirium, from which the patient could be

aroused, and comparative absence of local tenderness and pain were very noticeable.

I send round a preparation of the intestine at the strictured part; it shows very beautifully the primary yielding of the mucous and muscular coats of the bowel. The thinned layer of serous membrane still remaining could very easily have been ruptured had any great effort to reduce the tumour by the taxis been employed.

In Mrs. G.'s case the falciform border alone was incised in an upward direction, and very slightly inwards. Vidal insists that this forms the constant cause of strangulation. Dupuytren must have thought the same, for he cut upwards and outwards, while Guthrie and Velpeau cut directly upwards, when relieving the stricture.

I performed a somewhat similar operation, in every instance, by means of an almost vertical incision, inclining slightly towards the umbilicus. The stricture was incised in nearly the same direction as the external wound. By avoiding all cutting or sawing motions, and simply pressing the edge of the knife against the tense fibrous tissues no risk of injuring an important part can occur.

A circumstance pointed out by Key was very well marked in the two latter examples. In both a quantity of fat, simulating the omentum very closely, was contained in the layers of the fascia propria, and it was a very difficult matter to discover what it really was.

The more one sees of hernia, and especially of femoral hernia, the more, I think, one becomes impressed with the necessity for early operative interference. It is not the operation, but the want of operation that proves fatal. Ill directed, and too often repeated efforts at taxis, conjoined with unnecessary delay, are only too frequently the fatal elements present in hospital cases of hernia. I opened the hernial sac in all three examples, and the condition of the contents proved that it was best to have done so.

The advantages of opening the hernial sac are great and apparent, whilst any proportionate disadvantage accruing from such a course is, to me at least, by no means so plain.—March 6, 1868.

J. W. T. Smith

511 Notice of meeting on 20th March 1868

The Fifteenth Meeting of the Society will be held in their Rooms, at the General Hospital, on Friday Evening next, the 20th instant, at Half-past Seven o'clock.

Business.

Pathological Specimen

Dr. J. W. T. Smith will read notes of a Case of Cancer of Stomach and Liver, and exhibit the recent parts.

Paper to be Read.

Dr. Hill will read a Paper on a Case of Suppression of

Urine complicating Pregnancy.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D., Secretary.

Belfast, 18th March, 1868.

Fifteenth Meeting, 20th March, 1868

Dr. J. W. T. Smith in the chair. Members present, Drs. Stewart, Hill, H. Brown, Professors Cuming and Dill, Drs. Murray and John Moore.

Dr. Smith read notes of a case of cancer of stomach and liver and exhibited the recent parts.

Dr. Hill read a paper on a case of suppression of urine complicating pregnancy.

Paper:¹ M. B., aged thirty-five years, mother of six healthy children, had a severe attack of some chest affection, from which she never regained her former strength.

Shortly afterwards she became pregnant, and when about four months gone she experienced pain in making water, at the same time passing very little. The symptoms gradually increased in urgency, notwithstanding various methods of treatment, till the pain prevented her from sleeping, and she did not pass more than three ounces of urine in the twenty-four hours, which, however, latterly became highly concentrated. She did not complain of cough, though otherwise she presented a phthisical aspect.

At seven months labour occurred, with complete relief to her urgent symptoms, but immediately phthisis became developed, and she sank twelve days after delivery. The case was adduced as one showing the remarkable power which pregnancy possesses of keeping the symptoms of phthisis in abeyance. No explanation of the pain could be offered, but Dr. Smith, who had seen the case in consultation, suggested that it might have been caused by the irritation of the bladder by the concentrated urine.

Professor Dill exhibited a cephalotribe and the head of a child which he had extracted therewith. He believed the case was the first in which that instrument had been employed in Belfast or in the North of Ireland, and described the ease with which he was enabled by its assistance to extract the child.

Dr. H. M. Johnston exhibited the heart and lungs of a child whose death had taken place suddenly and

where it was difficult to say what was the cause of death.

Thomas Reade

512 Notice of meeting on 3rd April 1868

The Sixteenth Meeting of the Society will be held in their Rooms, at the General Hospital, on Friday Evening next, the 3rd instant, at Half-past Seven o'clock.

Business.

Paper to be Read.

Professor Cuming will exhibit recent parts in Case of Aneurism of the Thoracic Aorta, and will read notes of the case.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D., Secretary.

Belfast, 1st April, 1868.

Sixteenth Meeting, 3rd April, 1868

Dr. Thomas Reade in the chair. Members present, Professor Cuming, Drs. Whitaker, Wales, Fagan, D. Moore, James Moore, H. Brown, John Moore, Murney, H. M. Johnston.

Professor Cuming read notes of a most interesting case of thoracic aneurism and exhibited the recent parts.

Paper:¹ James Sterling, aged thirty-eight, labourer, married, was admitted into the Belfast General Hospital, January 25th, 1868.²

Family History.—The patient and one sister are the only surviving members of a family of seven, the others having died young. Father died of fever; mother of dysentery.

History.—He has always been temperate and healthy; has never had syphilis. He was engaged at easy work until lately, when he got employment in a ship-yard. Here he was often obliged to lift and carry heavy weights. He was engaged about seven weeks in this employment, when he began to notice a whistling in his breathing, and to observe that his breathing became difficult when he carried heavy burdens. The whistling at first was observed only during expiration, but afterwards with both inspiration and expiration. The sound became gradually louder, and was increased by exertion and by going into the cold air from a house. The

¹ [Dublin Quarterly Journal of Medical Science, 1868, vol45, p496.]

¹ [Dublin Quarterly Journal of Medical Science, 1868, v45, p304.]

² Reported by Mr. Andrew Hegarty, Clinical Clerk.

first symptoms of noise and difficulty of respiration were noticed about the end of December.

Present Symptoms.—The respiration is distinctly but not loudly stridulous, and there is no dyspnea when the patient is perfectly quiet. On the slightest exertion, however, such as sitting up or turning in bed, the stridor becomes loud, and distressing dyspnea is felt, which is still further increased by walking, and the stridor becomes audible at a considerable distance from the patient. The dyspnea is not influenced by position. He has a troublesome cough, which has nothing peculiar in its sound, and a scanty glairy expectoration. Tongue clean, appetite good, bowels regular; he sleeps pretty well; pulse 75, when quiet and in the recumbent position, but greatly accelerated by exertion. The patient is pale, and has an anxious expression, but is tolerably stout and well nourished, although he states that he has latterly lost flesh; voice slightly husky, but not impaired in strength.

Physical Examination.—A prominence is observed at the junction of the second rib with its costal cartilage, and the sternum is somewhat convex and bulging at a point corresponding to this. No thrill or pulsation is perceptible; percussion over the prominence elicits a dull sound, but only when the stroke is made on the side furthest from the sternum; every where else the sound is quite normal; on auscultation the stridor seems loudest at the sternal notch; no difference in the respiration can be noticed on examining the two sides. There is a slight prolongation of the first sound at the base of the heart, hardly amounting to murmur. With this exception there is no abnormal sound to be detected. I made a laryngoscopic examination, but the patient did not bear the mirror well, and the attempt was productive of so much dyspnea that it was not repeated; as far as it was seen the larynx seemed healthy. He seemed much benefited by the application of a couple of leeches to the trachea every alternate night, and by a little paregoric. Complete abstinence from exertion was enjoined.

February 21st.—Some streaks of blood were observed for the first time in the sputum, and a little was noticed occasionally during the subsequent fortnight, the quantity never exceeding a few drops in the day. I ventured to make the diagnosis of aneurism, and in a clinical lecture delivered at this time on this and two other cases of aortic aneurism which happened to be under my care in hospital at the same time, I drew the attention of the students to the positive and negative results which the examination of the patient gave us.

1st. Prominence and slight dulness at a particular part of the chest 2nd. Stridor and dyspnea of recent origin, and greatly aggravated by exertion.

On the other hand we had total absence of auscultatory signs, of pain, of characteristic cough, of any marked alteration of voice, of dysphagia, of inequality of the pulses or of the pupils, and of any venous congestion. With regard to the prominence and dulness, I

attached little weight to its presence, as there was no pulsation or thrill or bruit detected over it, and I based the diagnosis mainly on the symptoms of dyspnea and stridor, the larynx being free from disease, and the probabilities being greatly against tumour, owing to the age and health of the patient. I ventured also to say that the aneurism must press upon the trachea itself in consequence of the respiratory sounds being equal in both sides. I suggested that possibly the hemoptysis might depend on a very minute perforation, as had been observed in some cases, and that an early and rapidly fatal issue was to be apprehended. The further progress of the case may be briefly recorded.

March 3rd.—The attacks of dyspnea, which, being previously only aroused by exertion, had now begun to appear without any apparent cause, and were of a very severe character. They occurred usually in the evening, and distressed and alarmed him very much; but they did not occur oftener than once in the twenty-four hours, and a day sometimes passed altogether without any of them supervening. I spoke to him of the possibility of tracheotomy becoming necessary during some of these attacks; however, he naturally objected very strongly to the idea.

March 4th.—After a quiet night he seemed at visit to be tolerably easy. Before I left hospital, however, I was summoned by a nurse to see him, and found him in a deplorable condition, gasping for breath, making desperate efforts to get air into the chest, the lips livid, the skin covered with cold sweat, the pulse rapid and feeble, and the stridor accompanying the respiration of the loudest description. When he saw me he said that his heart was breaking. Several members of the staff who happened to be in hospital came to see him, and agreed that tracheotomy was urgently required to avert the imminent danger of suffocation.

While we were speaking he suddenly exclaimed "Thank God! I am better," and for a few minutes seemed relieved, but the dyspnea returned with increased severity, and it was clear that he could not survive any prolongation of his terrible sufferings. He consented to the operation, which was performed by Dr. W. MacCormac, assisted by Dr. Murney, and in the presence of Dr. Smith and of myself. The breathing became at once easier, but there was still a good deal of dyspnea, which continued during the night. He was able, however, to lie down and was much relieved. He was placed in a small ward, and the air was kept saturated with the vapour of boiling water.

From this period he had no suffering whatever from dyspnea. There was some cough and expectoration of a bronchitic character for a few days owing to irritation of the air passages. He had a little morphia at night and slept well. His appetite was fair, and he was easy and comfortable, and expressed himself hopefully as to his recovery. He was able to get up and sit at the fire without any distress from the exertion, an effort which,

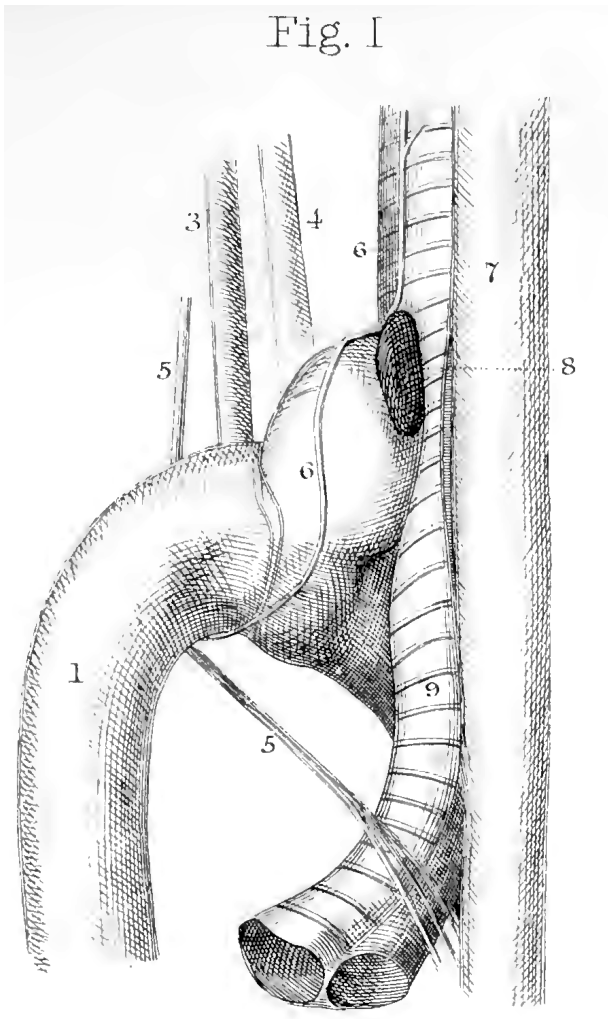


Fig. I.—The descending aorta, and a portion of the arch are turned aside to expose the aneurism.

The numbers refer to the same objects in both figures:—

1, aorta; 2, innominate; 3, subclavian; 4, carotid; 5, pneumogastric of left side; 6, recurrent nerve of same passing over the aneurism—a branch from this nerve is seen passing to the deep cardiac plexus; near it is a small filament from the sympathetic to the same plexus; 7, œsophagus; 8, an enlarged bronchial gland; 9, trachea, 10, opening into aneurismal sac.

during the previous month, would have brought on severe dyspnea. On the morning of the 23rd I entered the ward accompanied by Dr. Henry Brown and some students. He expressed himself as being very well, and was anxious to be allowed to go to a larger ward, in which he had been previous to the operation, so as to have the society of the other patients. While speaking a few drops of blood came from the opening in the trachea, which he wiped away, remarking that this was the first blood that had appeared since the operation. In a moment a gush followed; he coughed up a large quantity, which came both through the mouth and through the opening; the breathing was accompanied with a loud gurgling sound, and after a few minutes of

Fig. II

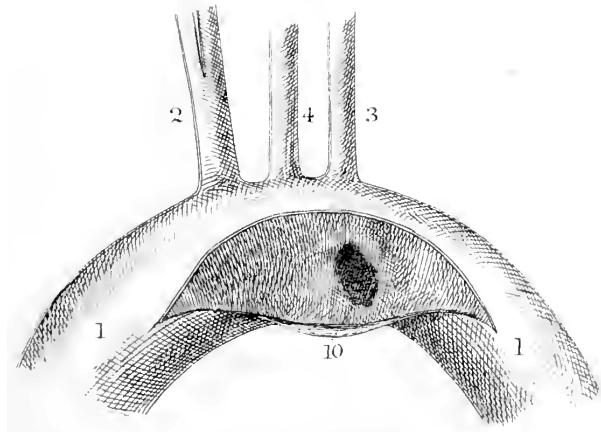


Fig. II.—The aorta laid open to show the opening into the sac.

this frightful scene, which seemed horribly long, he was dead, the heart continuing to beat for some time after respiration had apparently altogether ceased.

Post mortem.—The body was plump, and a good deal of subcutaneous fat existed. The lungs were found to contain a large quantity of blood in the air cells and bronchi, and collapsed very imperfectly. An aneurism was found pressing upon the left side of the trachea, and springing from the posterior part of the transverse portion of the arch of the aorta, below and beyond the origin of the subclavian artery. The parts were removed and were dissected with great care. The aneurismal tumour, which was about the size of a large walnut, and which is figured in the accompanying plate, had produced a considerable amount of pressure upon the side of the trachea, and had caused a projection into it which diminished its calibre considerably. There was an opening into the trachea through which a No. 4 catheter could be passed. The recurrent nerve of the left side, as well as a branch from it to the deep cardiac plexus, was found to be compressed, diverted from its course, and closely adherent to the left side of the tumour. Another small nerve, from the sympathetic, going to the same plexus, was also found adherent to the aneurism, and is figured in the plate. On the right side of the tumour a large cardiac branch of the right vagus seemed to have suffered also, but to a less degree than the recurrent. It was thickened, adherent to the tumour, and was probably pressed upon by it. The interior of the aorta showed a considerable amount of atheroma, especially in the neighbourhood of the opening into the sac. The parts beneath the prominence which had been observed during life were examined, and it was found that no cause existed within the thorax for the bulging. It had been probably brought about by the action of the scaleni, being more forcible than usual in consequence of the difficulty of breathing,

Ulster Medical Society
Session 1867–1868
President James Seaton Reid

or it was perhaps of congenital origin.

Observations.—The points of most interest in this case are:—Firstly—The possibility of arriving at a correct diagnosis of aneurism from symptoms in the absence of any physical sign derived from the organs of circulation. The case resembles closely one related by Professor Gairdner, in his work on Clinical Medicine¹—a work to which the profession is indebted for much valuable information on this interesting and difficult subject. In Dr. Gairdner's case the patient died from suffocation, notwithstanding the performance of tracheotomy, the aneurism remaining unruptured. This termination was caused by the refusal of the patient to submit to tracheotomy at an earlier period, and I have no doubt that a similar termination would have occurred in my case had the operation been much longer deferred.

Secondly—The interesting practical fact of the great relief which was afforded by the tracheotomy. Not only were the urgent symptoms which threatened speedy dissolution at once mitigated, but the patient had the inexpressible comfort of being completely free from the distressing dyspnea which every exertion had caused. He passed the remaining days of his life in what might be relatively considered ease, the suffering from the wound in the trachea being quite inconsiderable.

He was able to get up and sit at the fire for some hours daily without any suffering being caused by the necessary effort, and in all probability his life was somewhat prolonged, for the exertion which the paroxysms necessitated might have brought about an earlier rupture.

Thirdly—The almost complete integrity of the vocal functions while the respiratory functions were so seriously interfered with, and the recurrent laryngeal subjected to so much pressure. That laryngeal spasm was induced by exertion is evident, and it is difficult to get a satisfactory physiological explanation of why the voice was not to any considerable extent impaired. The slight huskiness which was noticed was not greater than occurs in cases when cough has existed for some time.

Fourthly—The interference with the nerves going to the cardiac plexus. It is possible that this may be in some cases the cause of the symptoms resembling angina, and of the disturbance of the circulation, which have sometimes been observed in connexion with aneurism. This interesting physiological point is only capable, however, of being worked out when the influence on the movements of the heart possessed by the vagus and the sympathetic system is much more clearly known than at present.

Fifthly—The explanation of the dyspnea and stridor. It was probably mainly dependent on two causes: the direct narrowing of the trachea produced by the lateral pressure on it by the aneurismal tumour, and the

spasm induced by the increased pressure on the left recurrent nerve, which was brought about by acceleration of the circulation, leading to augmented arterial tension.

The former was probably the cause of the stridor observed when the patient was quiet, which was accordingly tracheal; the latter by giving rise to laryngeal spasm was the cause of the aggravation of the symptom when exertion was made.

Mr. H. M. Johnston exhibited a bowel where the operation for strangulated hernia had been performed and where sloughing of the bowel for nearly nine inches had taken place. She survived the operation about nine months with a fistulous opening.

J. Seaton Reid

513 Notice of meeting on 17th April 1868

The Seventeenth Meeting of the Society will be held in their Rooms, at the General Hospital, on Friday Evening next, the 17th instant, at Half-past Seven o'clock.

Business.

Paper to be Read.

Dr. John Moore will read a paper on Mortality following Confinement.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D., Secretary.

Belfast, 15th April, 1868.

Seventeenth Meeting, 17 April, 1868

The President in the chair. Members present, Drs. Wales, Porter, Hill, James Smith, Cuming.

Professor Cuming exhibited a cancerous liver.

Dr. John Moore read a paper on mortality following confinement.

519 Notice of meeting on 1st May 1868

President.

Dr. Seaton Reid.

Ex-President.

Dr. Drennan.

Vice-Presidents.

Dr. Thomas Reade.

Dr. Kelso, Lisburn.

¹ Case I. p. 455.

Dr. James W. T. Smith.

Dr. Thomson, Bangor.

Friday to Monday. Carried.

James Cuming

Members of Council.

Dr. Patterson.

Dr. Whitaker.

Dr. Stewart.

Dr. Bryce Smyth.

Dr. W. Mac Cormac.

Dr. H. S. Purdon.

Treasurer.

Dr. Cuming.

Secretary.

Dr. John Moore.

The Annual Meeting of the Society will be held in their Rooms, at the General Hospital, on Friday Evening next, the 1st May, at Half-past Seven o'clock.

Business.

To receive Report of Council. The Report of Auditors. The election of new Office Bearers. The transaction of such other business as may come before the meeting. The installation of the President.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D., Secretary.

Belfast, 29th April, 1868.

Annual Meeting, 1st May, 1868

Present, Drs. Stewart, in the chair, William MacCormac, Dill, John Moore, Hill, Fagan, Porter, David Johnston, Whitaker, Cuming, McCrea, Rea and James Moore.

The minutes of last Annual Meeting were read and confirmed.

The Annual Report was then read. Moved by Dr. James Moore and seconded by Dr. William MacCormac "That the report now read be adopted". Carried.

The Treasures report was next laid before the Meeting with the Auditors report. Moved by Dr. James Moore and seconded by Dr. Dill "That the reports now read be adopted". Carried.

The election of office-bearers for the ensuing year was proceeded with by ballot, when the following gentleman were duly elected.

President

Dr. Cuming

Vice-President (Town)

Drs. Whitaker and McCrea

Ditto (Country)

Kelso and Dunlop

Council

Drs. Patterson, Stewart, James Moore, Sgns. M. Porter, Fagan

Treasurer

Dr. William MacCormac

Secretaries

Drs. John Moore and Hill.

Moved by Dr. James Moore and seconded by Dr. Patterson That the night of meeting be changed from

ULSTER MEDICAL SOCIETY

SESSION 1868–69

First Ordinary Meeting, June 1st, 1868

Present, Dr. Cuming, the President in the chair, Drs. Patterson, David Moore, Fagan, Angus M. Porter, Whitaker, Mr. Cantrell, Dr. Monck of Holywood and Dr. Hill.

Dr. Hill proposed and Dr. Whitaker seconded "That Mr. Ball be admitted a member of this Society."

Dr. Cuming proposed and Dr. Patterson seconded "That Dr. J. Walton Browne and Dr. Frederick E. Beck be admitted members of this Society."

Dr. Whitaker proposed and Dr. Angus M. Porter seconded "That Dr. Bolton be admitted a member of this Society."

Dr. Patterson proposed and Dr. David Moore seconded "That Dr. Barnett be admitted a member of this Society."

Dr. David Moore moved that the Librarian be requested to call in all the books belonging to the Society before the 1st July in order that the library be inspected; it was resolved that the following gentleman be the committee, Drs. David and John Moore and Hill.

Dr. David Moore introduced a patient affected with local œdema of some years standing, the progress of which he proposes observing and bringing before the Society at some future time.

Dr. Monck of Holywood exhibited some pearl-like calculi which had been passed from the bowel. He related the history of the case and stated that in his opinion they were gall-stones. Dr. Cuming undertook to examine them for next meeting.

Dr. W. MacCormac exhibited a fibrous tumour removed from the cervix uteri. Up until seven years ago the patient had enjoyed perfect health except that she was greatly pained at her menstrual periods when she had also very profuse discharge. After this date, however, she gradually failed in health until about 3 years ago, from which time until her admission to hospital she became rapidly worse. She then complained of pain in the back—loins—thighs—was emaciated—face œdematous—much troubled with vomiting—had profuse leucorrhœa and fœtid discharged from the vagina—difficulty in micturating which sometimes required the use of the catheter, especially at the menstrual term. She suffered much when she attempted to sit up and had in fact the cachectic aspect of malignant disease and her general condition was almost hopeless. On separating the labia a white glistening tumour was observed which seemed no-

where adherent to the vagina and was slightly moveable. It was removed by torsion and considerable difficulty was experienced in getting it out of the vagina. The tumour weighed 10 oz. and on section presented the appearance of white fibrous tissue. After removal the patient made a rapid and complete recovery and was as if snatched from out of the jaws of death. The vaginal discharge and vomiting ceased and she shortly recovered strength and left the hospital.

As time would not permit of the reading of Dr. Angus M. Porter's paper it was moved by Dr. Patterson, seconded by Dr. Whitaker, and unanimously agreed to that the next meeting of the Society be summoned for Monday 15th inst. instead of the first Monday in July.

Communications from Drs. Malcolmson and Crawford, Banbridge, were referred to the Council.

James Cuming M.D.

514 Notice of meeting on 15th June 1868

[Top of page missing. This would be the adjourned meeting mentioned above.]

[Members to be Balloted for.]

Thomas Ball, Esq.,
Fred. E. Beck, L.R.C.P.E.
J. Walton Browne, B.A., M.D.
Reuben Bolton, M.D.
Richard Barnett, M.D.

Pathological Specimen.

Dr. Murney will exhibit interesting specimens of Renal Disease.

Cases to be Read.

Dr. Angus M. Porter will read notes on Peculiar Cases of Syphilis.

Dr. Angus M. Porter will exhibit a number of Needles removed from different parts of the body.

Dr. John Moore will move—"That application be made to the Registrar-General for a fuller account of the causes of the mortality of Belfast and its district than that now published."

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with the Secretary not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to the Secretary.

Membership.—Persons wishing to be proposed for Membership will please forward their names to the Secretary, with their qualifications and Subscription.

Signed by order,

John Moore, M.D.,
James Hill, M.D.
Secretaries.

Belfast, 11th June, 1868.

Ulster Medical Society Second Ordinary Meeting, June 15th

Present, Dr. Cuming (the President) in the chair, Drs. Monck, William MacCormac, Whitaker, Rea, Angus M. Porter, Thomas Reade, John Moore and Hill.

The minutes of the former meeting having been read and confirmed, Dr. John Moore introduced a patient, the subject of a well-marked epileptic aura. He is twenty-six years of age—married—and apparently of a nervous temperament. Does not appear to have had any epileptic attacks till at the age of seventeen years: since which time he has been so much and almost continuously troubled with a peculiar sensation in his right thumb that he is even desirous of having it removed. Has had only three or four epileptic fits and these at long intervals, but he keeps up continuous pressure by means of a cord on his thumb, and believes that the fits would be very frequent were the pressure removed. There is no history of hereditary disease.

Dr. Angus M. Porter read notes on peculiar cases of syphilis.

Paper:¹ Case 1.—Mr. L., a young, unmarried Scotchman, of fair complexion, and free living habits, contracted the disease in Dublin about ten days before coming for advice. Had never suffered from syphilis previously. Five days after connexion he noticed an inflamed spot on the upper part of his foreskin.

On September 22, 1867 (the date of his first visit), the appearance of the sore was so indefinite, that it was impossible to determine whether it was specific or not; a dry elliptical chafe being the form it assumed. Recommended rest, a mild purgative, and, locally, cold water dressing.

24th.—The dorsal part of the foreskin was considerably inflamed. The sore, on being exposed, presented a suppurating surface. There was no constitutional disturbance nor any enlargement of the neighbouring glands.

26th.—The ulcer was covered by dark sanguineous matter, the edges raised and hard. The prepuce was much swollen, but the system remained perfectly tranquil. The strong nitric acid was carefully applied, and then water dressing.

He did not come back till October 2, when, on examination, the surface of the sore was found clean, the margin, however, remaining high and indurated—there was complete absence of pain or irritation. The healing process did not seem to have commenced as yet. For the first time he appeared depressed, and had a bilious look. The various glands still remained unaffected.

Prescribed one 5 grs. Plummer's pill, to be taken each night for a week, and large doses of decoction of sarsaparilla daily, the topical remedy being altered to blackwash.

Next day he returned much better, the ulcer looking healthy.

He continued to improve till October 9, when he complained of soreness and stiffness in his right groin, for which a spica bandage was employed, and rest recommended. The chancre had begun to heal rapidly, but considerable hardness remained around the edges. Some red oxyde of mercury was dusted freely over it.

16th.—The chancre had disappeared, leaving a fine purplish skin behind it, surrounded by slight induration. The patient still complained of tenderness in the groin. He was continuing to take large quantities of the sarsaparilla decoction.

He now left, promising to return as soon as convenient, which he did on November 5, when he reported himself as completely cured. There was no hardness remaining to indicate the situation of the chancre, and the abortive bubo had quite disappeared. Up to the present he has enjoyed excellent health.

In this gentleman's case, which, from its persistency and difficulty of cure, was undoubtedly one of a specific nature, at least one feature of interest occurred, and that was the presence of induration unsupplemented by any form of secondaries. This hardness, as has been noticed, was not the result of a cicatrix, nor incidental, but evidently characteristic of the form of ulcer which it accompanied, inasmuch as it occurred a considerable time before the healing process commenced, and subsided on the disappearance of the sore.

Case 2.—Mr. A. G., of Belfast, occupied as a clerk, of dark complexion, bilious temperament, regular habits, young, and unmarried.

On October 2, 1867, he first sought advice for three non-indurated, flat, round, ulcers, two of which were situated on the mucous surface of the right side of his foreskin, and one on the left side. A large bubo had formed in the left groin; considerable constitutional disturbance was also present. He stated that he had not had connexion for six weeks, and that it was two since he first noticed the sores.

He had never been the subject of venereal disease prior to this attack. On drawing back the foreskin, he experienced intense pain; a good deal of smegma had consequently been allowed to collect, and keep the chancres in a foul condition. After the removal of all the secretions by warm bathing, the strong nitric acid was freely applied, followed by cold water dressing. Pressure, by means of a pad and spica bandage, was put upon the bubo, and perfect rest inculcated.

The following day (Oct. 3) the chancres were looking clean and not so sore, the bubo, however, was causing him considerable inconvenience. He was now recommended to use blackwash as the local remedy, and the following internal medicines:—

R Hyd. bichloridi, gr. ii.
 Infus gentianæ co., ℥viii. M.
 Ft. mist.

¹ [Medical Press and Circular, 1868 July–December, p25, p50.]

Sg. A teaspoonful at each meal, and 20 drops of the tincture of perchloride of iron three times daily. His diet to be plain and nourishing, and his mode of living regular. His bowels being confined, two teaspoonfuls of the liquid extract of senna was prescribed to be taken at bed time.

October 5th.—The aperient had acted freely, which gave him some relief. The chancres were looking better, and not causing much annoyance. The bubo, however, was intensely painful, and the system considerably disturbed.

His next visit was on October 11th, when the chancres did not seem to be doing so well, this it appeared was owing to his own dread of drawing back the fore-skin to dress them. Some red precipitate was now applied to each of them.

14th.—The change, which had taken place in the sores was most satisfactory, and the patient now felt less difficulty in applying the dressings himself. The bubo, which had pointed, was freely opened, and a large quantity of thin pus allowed to escape. The general disturbance of the system had greatly abated.

16th.—The chancres were almost healed, but the bubo continued to discharge watery matter, and was still very painful, especially when walking.

19th.—The chancres had quite disappeared; but the affected groin continued to resist all attempts to bring about a healthy condition. The diseased gland was reopened, and covered with a linseed poultice. A considerable quantity of thin serous matter subsequently drained away.

25th.—The oozing had nearly ceased, so pressure was substituted for the poultice, by means of a sponge pad and close fitting truss. At this time his general health was unimpaired.

November 3rd.—Mr. A. G. left to fill a situation in England, and had apparently quite recovered from the disease for which he was treated. He felt in excellent health, and had ceased to take the prescribed medicines. Scarcely any trace of the bubo remained.

26th.—A letter came from him, stating that the glands of his neck were swollen, and his throat sore. The general tone of his letter indicated despondency.

In reply, the following treatment was recommended—

℞ Pil Plummeri ʒi
Div in pil duodecem

Sg. One 3 times daily, with a wineglassful of decoction of sarsaparilla. Ten grains of chlorate of potass (in water) night and morning; and twelve grains of Dover's powder every second night, also a gargle containing astringents.

December 4th.—There was another communication from Mr. A. G., to say that he was no better. In answer, I advised him to take two teaspoonfuls of cod-liver oil three times daily, and to persevere with the remedies already prescribed.

Subsequently, finding no improvement in his state of health, he went under medical treatment in England.

January 20th, 1868.—He returned to Belfast, having become impatient and discouraged by the obstinacy of his maladies. His face was now covered with pustulæ, while over his trunk and limbs a squamous eruption had become thickly developed; some of the spots were bright red, others purple, and the remainder copper-coloured. His tonsils and the back of his throat were extensively ulcerated.

He was greatly dejected in spirits, and suffering from a severe cough which, on examination of the chest, proved bronchitic. His bowels were pretty regular, his tongue clean, skin moist, and pulse normal. Whilst in England, his medicines had been altered, with the exception of the Plummer's pills. He objected to take any more mercury although he had never been salivated, nor otherwise felt the unpleasant effects of this drug. Owing to his pertinacity on this point, I thought I would give the terchloride of gold and sodium a fair trial. Accordingly, he was recommended to take one of Grötzner's pills, with two teaspoonfuls of cod-liver oil three times daily; and, for the cough, an anodyne pectoral mixture containing the dilute mineral acids and muriate of morphia., together with expectorants. His throat was thoroughly cauterized with nitrate of silver, and a strong astringent gargle prescribed for frequent use.

Feb. 3rd.—He seemed in a somewhat better condition, as regarded his general health. The cough had become easier and less frequent. His appetite had improved, and he rested more comfortably at night.

The pustular rash on his face had increased, especially on the chin and forehead; where any spots had died away, a deep purple stain remained.

8th.—He was almost free of the bronchitis, and in better spirits, though he was somewhat alarmed at seeing a new form of rash present itself—viz., roseola of a very bright colour, principally situated on the chest and arms. The appearance of his face was very disagreeable on account of the confluent nature of the pustules, which in some places were discharging a yellowish matter. He had now taken 57 of the pills, or better than 2 grs. of the terchloride of gold and sodium (which quantity of corrosive sublimate I have seen remove equally severe cutaneous eruptions, and in a shorter time). Not having noticed any marked beneficial effects from this preparation, I deemed it judicious to adopt the following (without consulting my patient on the subject):—

℞ Liq. hydriod hyd. et arsenici, ʒss.
Syr. Simplicis, ʒiiss. M.

Sg. A teaspoonful in water with each principal meal. The cod-liver oil being continued.

His hair had commenced to fall out in large quantities, for which symptom Erasmus Wilson's prescriptions were adopted—viz.,

R. Ung. hydr. nit. ox., ℥i.
Adipis odoratæ, ℥iii.

Sg. To be rubbed well into the roots of the hair at bedtime:—

R. Ol amygdalæ dulcis, ℥i.
Liq. Ammon. fort., ℥i.
Spts. rosmarinæ, ℥ii.
Aq. Mellis, ℥ii. M.

Sg. To be sponged about the roots of the hair each morning.

16th.—A slight improvement was observable in the general condition of the patient, yet the cutaneous eruptions were very perceptible. With the hope of aiding their removal, one part of citrine ointment, in two of simple cerate, was directed to be rubbed on them each night.

March 14th.—The patient's general health had become very good. The skin affections were quickly disappearing, leaving the surface of the body covered with scales and crusts of various shades and sizes. The hair had ceased to fall out.

29th.—A vast improvement had taken place in every feature of the case. No ulceration of the throat remained, though on rising in the mornings a peculiar dryness was felt which a drink of cold water immediately relieved. The medicines were still continued.

April 16th.—No trace of cutaneous disease remained save some slight red marks on the face. The patient's appetite and general health were good, and he appeared in excellent spirits. All medicines were now omitted.

Mr. A. G. paid his last visit on April 20th, on which date every symptom of the disease had vanished.

In this case the plurality of the chancres, the absence of induration, and the late development of the roseolar rash, are points of some interest, as well as the absence of ptyalism during a lengthened course of mercurial treatment. It may be well to remember that cod-liver oil was administered throughout.

Case 3rd necessarily includes two parties—husband and wife.

On January 11, 1868, Mr. D. came to get advice for what appeared to be herpes preputialis. He said he had been treated for the same affection some three years before, and that the late Dr. Halliday cured him in a very short time. He remembered the name herpes to have been used by Dr. Halliday on that occasion.

The gentleman's regular habits, and unimpeached character, seemed to place him beyond suspicion of impurity of mind or body, still great caution was required in answering his pointed questions, as he seemed in greater dread of the disease than its condition at the time warranted, or his past experience should have admitted of. Considering that the patient should be prepared for the possibility of evil consequence, I reserved judgment, and suggested the likelihood of his having contracted the disease in a foul

privy, which hint he willingly accepted, as furnishing a respectable fons et origo mali.

He had been away on business in the south of Ireland, and two days before coming to me he first noticed itching of the prepuce. He was a most temperate and regular man, as already mentioned, and lived happily with his wife (who at this time was about seven months pregnant).

Rest, repeated bathings, the application of dilute lead lotion, and a mild purgative, were the remedies advised.

On January 14th he was quite free from the local disease, no irritation whatever remaining, but nocturnal perspirations had become a great source of discomfort to him; for this he was recommended to sponge with tepid water impregnated with sulphuric acid.

He returned on February 4, suffering from marked febrile symptoms (hot dry skin, headache, constipation, and quick pulse). For two days he had observed a bright scarlet rash (roseola) to come and go on his chest and abdomen. On examination the glandulæ concatinatæ were found enlarged, copper-coloured stains were discovered at the flexure of his right elbow and the back of his neck, his forehead had become very rough, but not discoloured. His throat was simply erythematous. The glands of each groin remained unaffected.

Corrosive sublimate in compound infusion of gentian, to be taken with cod-liver oil, as in case 2, also 15 grs. of Dover's powder each night, rest, and plain nourishing diet constituted the treatment at this stage of his illness. He was recommended strong alum water gargle for his throat.

Eleven days later (February 15), on visiting Mr. D. at his own house, I was glad to see that a great improvement had taken place in his health. The cutaneous disorders were dying away; his throat was much better with the exception of a small ulcer which had attacked the left tonsil.

The glands at the back of his neck were not so perceptible, and the stains mentioned before were not so distinct. He stated that he had derived considerable benefit from sponging with the acidulated water. He complained now of his eyes being rather sore, and his sight weak, but I could not detect any morbid appearances.

His wife had now unfortunately become a sharer in his sorrow, and evidently a partaker of the forbidden fruit. Her chest was as red as the shell of a boiled lobster; the glandulæ concatinatæ greatly enlarged, and the throat very sore, but not ulcerated. She was depressed in spirits, and feverish. She readily submitted to an examination, when for the first time she became aware of a number of ragged ulcers on the mucous surfaces of the labia. To the inside of each thigh was a patch of vesicles, which were highly inflamed and intensely itchy. A thick row of pustules extended up from the fundament to the end of the coccyx.

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There was no tenderness in either groin, nor could any hardness be felt, the chancres, also, were free from induration.

After cauterizing all the chancres with nitric acid, and the pustules and vesicles with nitrate of silver, the parts were all stuped with poppy-head water, then dilute lead lotion on lint covered with gutta-percha tissue was applied, and the patient kept in bed. The internal medicines consisted of iodide of potassium in six grain doses, with three drachms of fluid extract of sarsaparilla in water, three times daily; ten grains of Dover's powder occasionally at bed time, and full doses of liquid extract of senna, as an aperient, when required. For the throat a powerful astringent gargle was ordered, containing tannic and the mineral acids.

February 18th.—Some superficial ulcers which had formed on the tonsils were burnt with lunar caustic. Calomel was dusted on the vulva and perinæum.

On the 23rd inst., considerable improvement had taken place, both locally and general. The calomel seemed to have thoroughly withered up the pustules, and the condition of the chancres had so far improved, as that no annoyance was experienced. The throat was again touched with nitrate of silver, and the other remedies continued.

On March 14th, Mr. D., who had been away on business, and persevering with the prescribed treatment, returned, complaining of severe rheumatism in his right arm, which he could not bend nor raise to his head. Febrile disturbance, ulceration of the tonsils, weakness of sight, and falling out of his hair, were the accompanying symptoms. He was now recommended Donovan's solution, and stimulating applications to the hair, as in Case 2. The following liniment greatly relieved the pain in his arm:—

℞ Lin. aconiti.
— Bellad.
— Chloroform.
— Opii aa. ℥ss.
— Camph., co. ℥ii. M.
Ft. linim.

The ulcers on his tonsils were being daily brushed with a strong solution of nitrate of silver, and thereby improved rapidly. Two days later (March 17) Mrs. D.'s right arm became affected in precisely the same way as her husband's, when the same embrocation as was used in his case proved equally efficacious in the removal of pain.

In the course of a week both parties were perfectly free from this latter symptom.

Both patients continued to improve from this forward, save as regarded the ulcers of the throat, which in each case seemed difficult of cure.

On April 14, a bald ulcer appeared on the right side of Mrs. D.'s tongue, for which she was recommended chlorate of potass in ten gr. doses, as was also her husband.

23rd.—The lady was confined of a very fine healthy son, free from any mark of disease or delicacy. For it she had a plentiful supply of milk, of which it partook freely.

Her mouth and throat had quite returned to a normal state. All remedies were now dispensed with, it being considered unnecessary to further continue their use.

Mr. D., who had been travelling on business from the preceding Saturday, arrived home on April 25th, and, I may say, almost recovered. His hair had ceased to fall out. No cutaneous eruption whatever remained, but the throat was still slightly troublesome, and his sight still impaired. I ordered him a strengthening eye-wash, and told him to continue the chlorate of potass and the oil, which he did till the end of the month, when, being apparently cured, he left off taking anything in the shape of medicine.

In this last case, or joint case as it may be termed, the first peculiarity noticed was the herpetic character of the primary disease, and the rapidity with which it was cured, contrary to the law of specific sores; secondly, the occurrence of night perspirations (generally looked on as a late symptom of constitutional syphilis) five days after the first appearance of local disease, or as soon as the latter was removed; thirdly, the development seventeen days later of secondaries (roseola, copper-coloured stains, and erythema of throat), the lymphatic ganglia of the groin remaining unaffected. Fourthly, the presence of vesicles in the lady's case on the inner surface of each thigh, precisely similar to those which were observed on the prepuce of her husband, and the absence, as with him, of glandular enlargement in either groin. Fifthly, the almost simultaneous attack of rheumatism in the two persons; and, lastly, the equally satisfactory results which attended the treatment of the one by iodine and the other by mercury; and the untainted condition of their infant when born.

Dr. Angus M. Porter exhibited a number of needles and portions of pins which he had removed from different parts of the body of a young hysterical female.

Dr. John Moore moved, and Dr. Hill seconded "That application be made to the Register-General for a fuller account of the causes of the mortality of Belfast and its district than that now published."

After a considerable amount of discussion the matter was referred to the Council.

(signed) James Cuming, President

520 Notice of meeting on 6th July 1868

President.

Dr. Cuming.

Ex-President.

Dr. J. Seaton Reid.

Vice-Presidents.

Dr. Whitaker. Dr. Dunlop, Holywood.
Dr. M'Crea. Dr. Kelso, Lisburn.

Members of Council.

Dr. Stewart. Dr. Angus M. Porter
Dr. Patterson. Dr. H. P. Rea.
Dr. James Moore, Dr. Fagan.

Treasurer.

Dr. W. Mac Cormac.

Secretary.

Dr. John Moore. Dr. Hill.

The Third Meeting of the Society will be held in their Rooms, at the General Hospital, on Monday Evening next, 6th July, at Half-past Seven o'clock.

Business.

Dr. M'Crea will introduce some patients with Arterial Disease.

Pathological Specimens

Dr. Murney will exhibit interesting specimens of Renal Disease.

Dr. Cuming will exhibit a specimen of Aneurism of one of the Cerebral Arteries.

Case to be Read.

Dr. John Moore will read notes of a case of accidental death.

Business.—Members possessing Cases or Observations of special Clinical or Pathological interest, are requested to communicate with either of the Secretaries not later than Wednesday morning in each week.

Morbid Specimens, for Chemical or Microscopic examination, should be forwarded to either of the Secretaries.

Membership.—Persons wishing to be proposed for Membership will please forward their names to either of the Secretaries, with their qualifications and Subscription.

Signed by order,

John Moore, M.D.,
James Hill, M.D.,
Secretaries.

Belfast, 2nd July, 1868.

Ulster Medical Society Third Meeting, July 6th

Present, the President (Dr. Cuming) in the chair, Drs. Dill, Fagan, McCrea, William MacCormac, J. Walton Browne and Hill.

The minutes of the former meeting having been read and confirmed, Dr. McCrea introduced a patient suffering from thoracic aneurism, who was examined by several gentleman present. After the patient had retired Dr. McCrea stated that she had come to him complaining of a burning pain in the dorsal region between the scapula which afterwards became more deep seated or more in the centre of the chest: and on examination he found a well marked aortic murmur following the first sound of the heart, and a distinct bruit in the left subclavian artery, but the prin-

cipal point of interest—and the one he was desirous of bringing before the members—was that the disease had gone so far without any well marked symptoms of aneurism—or much inconvenience. No difference was observed in the pupils nor in the radial pulses. No dyspnoea, no dysphagia, no angina. Digitalis and iron had given her great relief. Acetate of lead had had a fair trial but it proved of no service.

Dr. Dill said that though it wanted, as Dr. McCrea had stated, the principal symptoms yet it had the symptoms viz pulsation and prominence of the chest.

The President said there was no doubt it was strange what large arterial tumours could exist without dysphagia or dyspnoea. He had been a good deal struck by a method of treatment introduced by Dr. Tufnell of Dublin and more lately upheld by Dr. Waters of Liverpool viz complete rest, and he did think that absolute rest was worthy of a trial in this case.

Dr. William MacCormac then presented to the President for the Society a copy of J. Sampson Gamgee's "History of a case of successful amputation at the hip joint." On the motion of Dr. Dill seconded by Dr. McCrea it was unanimously resolved "that the best thanks of the Society be given to Dr. MacCormac for the book."

Dr. Cuming then shewed a preparation with an aneurism situated at the junction of the left anterior cerebral and the anterior communicating artery of the Circle of Willis and remarked how difficult it would be to make a diagnosis in such a case. The preparation was obtained in the dissecting room at Queen's College.

James Cuming

Ulster Medical Society Fourth Meeting, 3rd August

Present, Dr. Cuming the President in the chair, Drs. Reade, William MacCormac, McCrea, David Moore, Rea, Porter, and Hill.

The minutes of the former meeting having been read and confirmed, the Secretary read a report from the Council concerning a motion brought forward some time ago by Dr. John Moore and which had been referred by an ordinary meeting to the Council to consider and report upon.

"At our second meeting this session it was moved 'That application be made to the Registrar General for a fuller account of the causes of mortality of Belfast and its district than that now published.' And the motion having been referred to the Council they have now to report that 'After having obtained information from Dublin as to the manner in which the statistics of mortality are compiled there, they do not think it expedient that the application be made at present.'"

It was moved by Dr. Angus M. Porter and seconded by Dr. McCrea and agreed to "That the Report presented by the Council be adopted."

Thereafter at the request of the President who had to leave, Dr. Thomas Reade took the chair when Dr. William MacCormac read a paper upon lateral lithotomy with reference to a case operated upon by him, and which will be fully reported in the Transactions.¹

Dr. McCrea asked had pyæmia not likely been the cause of the fatal result.

Dr. MacCormac said he thought the fatal result was due simply to exhaustion, and not to any inter-current disease.

To this result the large abscess in the perineum which had formed previous to operation had to a great extent contributed. Whether the local or general condition of the patient were taken into account, no more unfavourable case could have happened, and the condition of the boy was such as not to admit of any delay.

James Cuming

Special Meeting, 1st September

Present, the President in the chair, Drs. McCrea, Whitaker, James Moore, H. Brown, and John Moore.

The President stated that the meeting was called for the purpose of giving the members an opportunity of expressing their views on the propriety of entertaining the Medical Officers of the Channel Fleet now about to visit Belfast.

It was moved by Dr. McCrea, and seconded by Dr. James Moore "That the calling of this meeting by the President be approved of."

It was moved by Dr. John Moore and seconded by Dr. Whitaker, "That it is not admissible at present to undertake an entertainment."

James Cuming

Special Meeting, 3rd September 1868

Present, Dr. Cuming (the President in the chair), Drs. Patterson, Fagan, Drennan, Dill, John Moore and Hill.

The President explained that at the ordinary meeting of Council yesterday it was deemed expedient that an entertainment should be given to the Medical Officers of the Channel Fleet and that if a sufficient number of promises could be obtained a special meeting should be called.

This meeting then showed that it was the desire of a number of members that a Dinner should be given and it remained now to determine the time, and other particulars.

It was moved by Dr. Patterson and seconded by Dr. Dill that Monday next at 6.30 o'clock be the day and time of entertainment. Agreed to.

It was moved by Dr. Drennan and seconded by Dr. Dill that Drs. Patterson, H. S. Ferguson and Dill together with the President and Secretaries form a Committee to make all the necessary arrangements.

It was suggested that the Annual Dinner of the Society be held now so as to enable the members to entertain the Medical Officers of the Fleet.

James Cuming

518 Letter to the members.

September 5th, 1868.

Sir

The Annual Dinner of The Ulster Medical Society has been fixed for Monday, September 7th, at Half-past Six o'clock, in the Clarence Rooms, May Street, so as to enable the Society to entertain the Medical Officers of the Channel Fleet.

If you have not already expressed your intention to be present, you are requested to communicate as soon as possible with

Your obedient servants

John Moore, M.D.

James Hill, M.D.

Secretaries

Ulster Medical Society, September 21st

Present, Dr. Cuming in the chair, Drs. David Johnston, Fagan, John Moore, H. Brown and Hill.

The minutes of the former regular meeting with those of the Special Meetings having been read and confirmed, Dr. Cuming introduced a patient suffering from progressive locomotor ataxy and gave the history of the case.

Dr. David Johnston then read a paper on a case of acute hydrocephalus in which he had succeeded in getting a post-mortem examination. It will be fully reported in the Transactions.

Paper:¹ *J. M., aged five years, an apparently strong, healthy, well-nourished boy, was seized with an attack of vomiting and purging on the night of the 16th of December last. There was nothing remarkable in his previous history, except that for a month or so before his illness he never liked to remain alone, and his mother remarked in him a great dislike to allow his head to be combed. The vomiting and purging continued up to the evening of the 17th—the day on which I first saw him. He had a hot skin, quick pulse, with great depression and nausea. The vomiting and purging subsided during the evening after the application of a mustard poultice over the abdomen and a few sedative powders.*

18th.—He appeared dull, but the pulse was lower and the skin cooler; he slept well during the night; he had commenced to take a little arrow-root and milk; his tongue was slightly furred, and he complained of headache.

19th.—Headache increased; abdomen retracted; with slight dulness of hearing and intolerance of light and sound.

¹ [Not found.]

¹ [Dublin Quarterly Journal of Medical Science, 1869, v47, p467.]

I now requested a consultation, which the parents of the boy readily agreed to, calling in Professor Cuming, who examined the patient very closely, and gave it as his opinion that he was labouring under an attack of hydrocephalus. Four leeches were ordered to be applied, one to each temple and one behind each ear; the bowels to be kept open with small doses of calomel and scammony: the hair to be taken off and cold applications to the head. The leeches appeared to produce no effect; the deafness, headache, and intolerance of light increased.

The sickness of stomach had now entirely disappeared. For the ensuing two weeks nothing of importance occurred. He sometimes sat in his cot and amused himself with toys and with his little brother and sister. He took almost as much food as when in health. One night during this time the hall door was closed forcibly, producing a great noise; he gave a sudden start and piercing cry, and appeared frightened; complained of pain in the head, and ever afterwards remained completely deaf.

Jan. 3rd.—When I called to see him he was seated on the servant's knee labouring under an attack of convulsions of the right side, which passed off in the course of half an hour, but the power of the side never completely returned, and during the course of the following month the leg and arm of the same side passed into a state of complete paralysis; but he always complained of increased sensibility of that side. His appetite remained good; his bowels were alternately relaxed and constipated. He was losing flesh rapidly.

About the 1st of March his bowels got very much relaxed; the stools and urine were passed involuntarily. A bed-sore formed over each trochanter and one over the sacrum. Emaciation was now extreme. He lay in a state of semi-consciousness. The pupils were widely dilated, but sensible to the stimulus of light. He was unable to speak; the tongue was clean and was protruded, without any divergence. His power of taste was remarkably acute, so much so that he was able to detect five drops of the syrup ferri iod. in a glass of milk.

During April and May nothing of importance occurred with him, with the exception of the formation of a few boils on the head, which suppurated freely, and discharged a large quantity of healthy pus.

In June there appeared to be a slight reaction in his system, the bedsores healed, and he improved a good deal in his general appearance.

The appetite was good; he could take during the day a raw egg, above a pint of new milk, and a cup of panada. About the first week of July his bowels got suddenly constipated, the appetite bad; he refused to take any food, except a teaspoonful of milk. The head symptoms increased. He now lay quite motionless up to the time of his death, which took place on the morning of the 12th of July, after an illness of nearly seven months. During his long illness he had grown in height remarkably; his mental state seemed to have been a complete

blank; he never spoke, but made some slight inarticulate noise when anything was presented to him which he disliked.

The post mortem was made on the following day by myself, in the presence of Dr. Cuming.

Body extremely emaciated; a large boil on the scalp, underneath which the pericranium was somewhat thickened and reddened. Head apparently disproportionately large. On opening the skull there was an almost entire absence of vascularity. The calvarium was thinner than usual, but ossification was complete. The dura mater was very tense, and on slitting it open the brain protruded. The convolutions were flattened; the brain-substance remarkably anemic and very soft. No fluid whatever was found externally. On removing the brain when the infundibulum was cut across, a jet of fluid gushed through the canal, which was quite pervious. The general ventricular cavity was found to be enormously distended by a limpid fluid amounting in quantity to twelve ounces. The ependyma of the ventricles formed a distinct firm membrane somewhat opaque and flocculent.

The brain-substance beneath it was almost diffluent and remarkably anemic. The choroid plexuses were less vascular than usual, and the membrane thickened and opaque. Some granulations were noticed on the arachnoid, especially along the course of the branches of the middle meningeal artery. These on examination presented the character of tubercular granulations.

The most interesting points in this case are:—

- 1st. The beginning of the attack with vomiting and purging.
- 2nd. The long duration of the illness, although an apparently acute attack.
- 3rd. The partial paralysis, one side only being affected, although the pressure must have been general.
- 4th. The preservation of some of the special senses with the entire destruction of others.

Finally. The possibility of the continuation of life with a brain almost diffluent and subject to so much pressure.

(signed) James Cuming

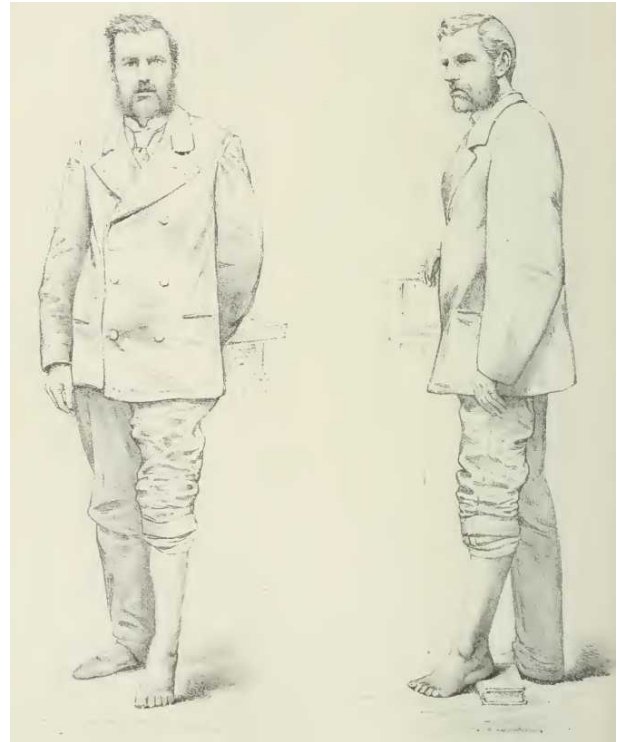
On Excision of the Ankle-Joint, being an Account of the Second Case in which that Operation was Performed in Britain. By Henry Murney, M.D., M.R.C.S., Eng., &c., &c.; Surgeon Belfast General Hospital.

COMPILER'S NOTE

No meeting is recorded for 5th October 1868 but Dr. Murney states that he presented the patient on that date. He also states that he presented the case to the Belfast Clinical and Pathological Society in 1857. That meeting also is not recorded but notice of it will be found on page 685.

Paper:¹ W. C., aged fifteen, was admitted to the Belfast General Hospital 10th May, 1856, labouring under disease of the left ankle; states that on the 26th December, 1854, he experienced most acute pain in the joint, accompanied by swelling. The pain was much aggravated by pressure or motion of the joint; believes he must have hurt or strained it, but cannot recall the exact occasion; from this time he never completely recovered the use of the articulation. He was treated at first at home, but matters becoming worse he was admitted into hospital, where he had rest, and afterwards counter-irritation. He was discharged on the 24th June a good deal improved. A fresh accession of suffering caused him to seek readmission on the 14th February, 1857. He is a delicate, strumous-looking subject, smart and intelligent. As yet the appetite is good; he sleeps well, and he has not lost flesh. There is considerable swelling around the ankle, especially at the sides of the articulation, but there is no swelling or tenderness to indicate that the astragalo-calcaneal joint is involved. The slightest motion causes pain for a considerable time. The joint was put up in splints to give complete rest, afterwards starch bandage was applied for the same object; mild counter-irritation, and then more severe irritants were resorted to, with temporary benefit. But after two months' trial his general health was beginning to suffer, and his appetite to fail. It was quite apparent operative interference was now necessary, and a consultation was held. All agreed on the propriety of removing the diseased parts, but some difference of opinion existed as to whether the case was an appropriate one for excision, or whether a better prospect would be afforded by amputation at the lower part of the leg. The principal difference being how far the tibia was involved, it was finally arranged that the articulation should be opened, and if, as was hoped, the disease was of limited extent, excision would be performed; but if it occupied much of the leg bone amputation must be resorted to. On the 21st April, 1857, the operation was performed as follows:—

An incision was commenced at the posterior margin of the tibia, about an inch and a half from its lower extremity, and carried downwards below the malleolus, then curved forwards and outwards across the instep to the outer malleolus, behind which it was carried straight up along the fibula as high as the incision at the inside of the limb. The vertical portions of this incision were cut down to the tibia and fibula at once; that across the instep was carried through the extensor tendons and the dorsalis pedis vessels. A ligature was applied to the bleeding artery, and the lateral ligaments were cut. Now that the joint was open it was determined to excise. The saw was applied to the neck of the astragalus, and the bone cut obliquely downwards and backwards, emerging at the posterior part, and slicing



off the trochlear surface with the upper portion of the facets for articulation with the malleoli. The remainder of these were taken off with the bone forceps, and lastly, the lower articular surface of the tibia with a very thin layer of bone, and the two malleoli was removed with the saw.

The synovial membrane had undergone the brown fibro-gelatinous degeneration, and the cartilage was completely removed from several points of tibia, fibula, and astragalus, while that which remained was much thinned and readily separated from the subjacent bone.

The parts were brought together by sutures, water dressings applied, and the limb placed on a splint which had a foot-piece attached at a slightly obtuse angle, it extended from the popliteal region beneath the heel forwards to the toes. His after progress was most satisfactory, in six weeks the wound entirely closed, two sinuses only remaining open. The splint was removed and starch bandage applied. He was discharged from hospital on the 29th June, 1857, nine weeks after operation.

In the Winter Session of 1857-58 his case was detailed at, and the lad exhibited to, the Belfast Clinical and Pathological Society.¹ The sinuses had closed for some months; he could lean his weight on the limb in walking, but used a stick; he had a pony, and could ride a considerable distance without pain.

He was lost sight of from that time till the autumn of 1868, when on account of the very useful limb he had it was considered of interest to exhibit him at the meet-

¹ [Dublin Quarterly Journal of Medical Science, 1870, v49, p97.]

¹ [Not found but see Item 387 on page 685.]

ing of the Ulster Medical Society on October 5th, when the following description of his condition was given:—

He is now twenty-seven years of age, muscular and strong; has enjoyed uninterrupted good health since he left hospital; is active and fond of walking, and considers the left is stronger than the right limb; does not use a stick; in progression there is a slight halt, but not more than is frequently observed from a corn.

This, to the ordinary observer, would be attributed to a slight in-turning of the toes of left foot, as when he walks the right foot is turned out, the left is placed straight. On examination there is considerable deposit of new tissue between the bones which were cut. The foot is slightly extended. This makes the toes and anterior part almost of proper length, but the heel is one inch and a half higher than its fellow, which he remedies by placing a wedge-shaped piece of cork wood in the heel of his boot.

The power of extension of the toes is as complete as in the opposite limb, and sensation is also perfect.

The first excision for disease of the ankle in Great Britain or Ireland was performed by Mr. Henry Hancock, in the Charing Cross Hospital, in January, 1851, and proved most satisfactory in every way. This case was the second, and, as described, the result has exceeded the most sanguine expectations, the patient not even requiring the support of the usual side irons for weak ankles. Since 1851 Mr. Hancock has never ceased to advocate this operation, and has frequently performed it. It has also been resorted to by other surgeons.

In a course of lectures delivered at the College of Surgeons, England, in 1867, on the Anatomy and Surgery of the Human Foot, Mr. Hancock¹ says:—

“I find that the ankle-joint has been excised thirty-two times for disease by British surgeons.

That the ages of the patients operated upon varied from four to forty-two years.

That the sexes given show the proportion of sixteen males to six females.

That of the thirty-two patients operated upon twenty-one recovered with good useful limbs, seven died, two suffered secondary amputation and recovered, whilst the result of two was doubtful.

The proportion of deaths consequently is a fraction above twenty-one per cent., a large proportion, I must admit, when compared with that of Syme's amputation. But it is not in reality so great when we inquire more closely into the matter; for instance, of the seven deaths four are reported to have died of consumption, of which disease one is stated to have been suffering at the time of operation; another died of the effects of syphilitic poison in the system. We can scarcely, therefore, attribute the deaths of these four consumptive patients exclusively to this operation; consequently, if we make allowance for them, we find the death-rate of average

cases ten instead of twenty-one per cent., while the mortality of amputation of the leg for disease in civil surgery is twenty-six per cent.”

Since that time the only case recorded is one of a partial excision performed by Mr. J. D. Hill, at the Royal Free Hospital.¹ It has proved successful, but not being a complete excision of the joint, it cannot be added to Mr. Hancock's table, so that the number now stands thirty-three operations, “with good useful limbs” in twenty-two of them.

I was fully satisfied with the progress of the case after operation, and with the usefulness of the limb when the patient was shown to the Clinical and Pathological Society nine months after excision; but I was astonished to find such strength, capability for divers movements, and absence of deformity when I saw him in 1868. As I had been urged to amputate, and not excise, I cut the extensor tendons, as already stated, but it is worthy of being noted how completely the power of extension of the toes was restored. I should also call attention to another matter. It is held, and properly so, that the dorsalis pedis and the plantar vessels should be studiously avoided. The first named was cut, yet no appreciable lowering of temperature or other unfavourable symptoms followed.

I have frequently sought for cases which would hold out a good prospect for excision, but as yet only succeeded in this one instance. Profiting by the experience of the thirty-three resections which have been performed, if about to operate now I would avoid the tendons and dorsalis pedis artery, not as absolutely essential for the well-being of the patient, but considering it desirable to cause as little injury as possible compatible with complete removal of the entire diseased articulation.

October 12th

Present, Dr. Cuming the President in the chair, Drs. Wales, John Moore, McCrea, William MacCormac, and Hill, with visitors Surgeon Barclay and Assistant Surgeon Lamb H. M. 54th Regiment. Dr. Whitaker also present.

The minutes of former meeting having been read and confirmed Dr. McCrea introduced a patient who a few days before felt a throbbing commence in her chest and immediately on putting her hand to her neck she detected a tumour pulsating violently.

On examination at different times it is found to vary, sometimes having a loud bruit with the first sound of the heart, at others no bruit. The most remarkable feature seemed to be its sudden origin for it appeared to be merely an enlargement of the thyroid gland.

Dr. John Moore then showed a tumour which he had removed from the uterus and read notes of the

¹ Lancet, 1867, Vol. ii., p. 62.

¹ [Medical Times and Gazette, Vol. i., 1868.]

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case. On section it presented the well-marked characteristics of a fibrous tumour. He had removed it by his fingers.

Dr. John McCrea then read a paper on “Recent Doctrines in Vital Dynamics” and showed that it was now the generally received opinion that much of the force was developed in the blood.

James Cuming

November 2nd

Present, Dr. Cuming (President) in the chair, Drs. Thomas Reade, William McGee, MacCormac, Dunlop, Wales, H. P. Rea, Andrews, Stewart, H. Brown, McCrea, S. Browne, Ross, J. W. Browne, McWilliam, Angus M. Porter, Drennan, Dill, Murray, David Moore, David Johnston and Hill. Visitors Dr. Lamb 54th Regiment and Dr. Dixon and several students.

The Treasurer made a report of the state of the funds of the Society which was adopted.

The President then delivered his Inaugural Address.

Paper:¹ GENTLEMEN—It is a portion of the duty which devolves on me, as President of this Society, to address to you some observations introductory to our Winter Session.

In the first place, permit me to return you thanks for the honour which you have conferred upon me in electing me to this chair. Nothing could be more gratifying to me than such a spontaneous mark of regard coming from my professional brethren, and I had no hesitation in accepting it, knowing that I could rely on your kindness and consideration to aid me in the discharge of duties for which I might otherwise have felt myself inadequate.

Sixty-two years have elapsed since this Society was founded; for we are the legitimate successors of those who originated the Belfast Medical Society in 1806, although its continuity was temporarily interrupted before its re-organization in 1822. In 1862, the Clinical and Pathological was amalgamated with the Medical Society, and the name of Ulster Medical Society adopted. From that period the meetings have been more frequent, and the number of contributions from the members have considerably increased.

We owe much to our predecessors in this Society. They formed and transmitted to us an admirable collection of works, amounting to above five thousand volumes, and including a large number of rare and curious works, which are invaluable to the student of the history of medicine. They have handed down to us also gifts still more precious in the memory of lives honourable to their profession and useful to the community in which they lived. The annals of a town which has produced many distinguished citizens, record no names which deserve a more honourable place than those of

Drennan and M'Donnell, who were among the original members of this Society.

In 1806, the medical profession in Belfast numbered nineteen members; the town contained 22,000 inhabitants. Now there are eighty-one practitioners of medicine, and the population of the town probably exceeds 150,000.

The period of the foundation of the Society was one of great intellectual activity in medical science. Jenner's great discovery of vaccination had been first announced eight years before, and was rapidly making its way into public notice. Hunter's famous treatise on the blood and on inflammation, which changed the face of the existing pathology, had been published in 1794. Abernethy was in the meridian of his unequalled reputation. Astley Cooper and Charles Bell were rapidly rising into eminence. Dupuytren had just been appointed to the Hotel Dieu, where his surgical ability was so long unrivalled. Laennec, to whom our art owes more than probably to any single man of either ancient or modern times, was commencing the investigations which have rendered such imperishable services to the science and practice of medicine. Cuvier was in the zenith of his fame.

The whole method of investigation had also undergone a complete change. Authority was no longer regarded as paramount. The ancients, it is true, had been long dethroned, but, in their stead, more modern masters had arisen, whose teachings had acquired a sway over the minds of physicians almost equalling that exercised by Hippocrates or Galen. Twenty years before, the celebrated Cullen related an anecdote, in a lecture which he delivered in the University of Edinburgh, which shows how the authority of Boerhaave was enough to weigh heavily on the freedom of inquiry. “My friend and patron, George Drummond (Provost of Edinburgh), came to me,” he said, “requesting seriously that I would avoid differing with Dr. Boerhaave, as he found my conduct in that respect was likely to hurt myself and the university also.” He adds, with characteristic prudence, “I promised to be cautious; and upon every occasion I spoke very respectfully of Dr. Boerhaave.” Now, with the growth of science, and with the development of new means of investigation, the received opinions were examined with a freedom and minuteness which had been before unusual, and from which results of the highest value soon flowed. Looking back on the state of knowledge at the beginning of the century, we can recognize the vast strides which have been made in every department of medicine.

Now, this very progress, of which we are justly proud, has been made a subject of reproach to the profession of medicine. The pharmacopeias of past generations have been disinterred, and the public made merry with such complex formula as the Aqua Cœlestis and the Mithridate Andromachi. The opinions, often, it must be admitted, crude and fantastic enough, of the

¹ [Dublin Quarterly Journal of Medical Science, 1868, v46, p276.]

earlier physicians, have been cited as evidence that medicine has been practised without any solid foundation for its precepts and methods. In reality, however, this only proves that the growth of medical science has been accompanied by errors and imperfections, such as are known to have occurred in abundance during the development of other branches of knowledge. The history of astronomy, of chemistry, of geology, afford us multiplied examples of speculations as baseless as those of Paracelsus or Van Helmont. Besides, it must be remembered, that physicians could not be mere curiosi naturæ—could not be content to be simply spectators of phenomena. They found themselves in the presence of formidable maladies, of devastating epidemics, and these they had to meet with the best means at their disposal. In the face of difficulties and danger, often of the most urgent character, sometimes of even appalling magnitude, they had to act with the limited knowledge which they possessed. No doubt many of their principles were erroneous, and much of their practice useless, some even mischievous, but still their knowledge was always vastly in advance of the popular notions of their day.

It is easy to point out mistakes into which they have fallen, just as it is easy to discover defects in the criminal legislation of our ancestors, in their notions of political economy, and in many of their methods of administration; but we know how incomparably better than anarchy is even an imperfect system of government; and in estimating the value to the world of the medical art of earlier times, we must bear in mind the extreme ignorance of medical subjects which was shared by the foremost intellects of their generation.

When the student of the history of medicine is wearied and disheartened by the laborious trifling and the idle discussions of his predecessors, let him turn to the pages of the most eminent contemporary authors, and learn their opinions on kindred subjects, and he will rather wonder at the acuteness and penetration of the earlier physicians. It is only by investigations of this kind that we can calculate the true position which the cultivators of medical science have held in relation to the general progress of human knowledge. It may not, accordingly, be devoid of interest, if I allude to some of the opinions on medical subjects held by several of the foremost thinkers of modern times; selecting only those philosophers who have given serious attention to questions connected with our art, and who have given deliberate expression to their views. Nor need we search for our examples among the followers of Aristotle and the ancients; we can find them in abundance among those most deeply imbued with the new methods.

Probably we could find no more typical representative of modern thought and of the spirit of modern investigation than Bacon. He, more than any man of his generation, had thoroughly broken with antiquity.

Bacon had a high idea of physic, and a genuine respect for physicians, although, according to a custom which is not altogether unknown even in the present day, he was fond of lecturing them on their shortcomings, and of giving them a good deal of perfectly well-intentioned advice.

“Medicine,” he tells us, “is a science which hath been more professed than laboured, and yet more laboured than advanced.” He advises physicians to raise their thoughts above common cures to the subject of prolonging and renewing the life of man, and he brings against them a charge, which has certainly not often been repeated, of prescribing in too simple a manner, and of not combining together a sufficient number and variety of drugs. In addition, however, to his criticisms, he has given an elaborate exposition of his own views as to the means by which life may best be prolonged and renewed. It may be interesting to touch upon some of his opinions on this subject, as an example of how a problem of this kind was dealt with at the beginning of the seventeenth century by one of the foremost intellects of modern times.

Life, according to Bacon, may be effectually prolonged by a combination of ten operations. Of these the first is,¹ “The operation upon the spirits to renew their freshness.” This is to be accomplished by various means, of which the principal is the daily use of from three to ten grains of nitre. This remedy refrigerates and condenses the spirits, and he conceives it to have been specially created for that object.

The second operation is the exclusion of the external air from the surface of the body. This is to be effected by closing as completely as possible the pores of the skin. For this purpose astringent baths are to be used, and the surface of the body smeared with oil. Passing over the intermediate operations, we come to the ninth, which is, perhaps, the most curious of the whole. It is entitled, “The operation upon the inteneration of the parts which have become dry, or the softening of the body.” It is intended to counteract the drying and hardening of the body, which occurs as age advances; and is to be effected by baths and by anointings.

“In the fable,” he informs us, “of the restoration of Pelias to youth, Medea, when she pretended to set to work, proposed to accomplish it by cutting the body of the old man to pieces, and boiling it up in a cauldron with certain drugs. Some boiling may perhaps be required for the purpose, but the cutting to pieces is unnecessary.”

The best bath, according to Bacon, is one composed of the warm, fresh blood either of man or of animals; but as this is somewhat loathsome, it may be replaced

¹ “Historia Vitae et Mortis.” In this and in the following quotations I have used, with a few slight alterations, the version of Headlam, given in the edition of Bacon’s works by Spedding, Ellis, and Heath.

by other substances of a nutritive character. The Baconian prescription for this unique bath is that it should be composed of the fatter kinds of flesh, such as beef and pork, with oysters, milk, butter, yolks of eggs, wheatmeal, and wine sweetened with sugar or honey. To these should be added salt, saffron, mastic, myrrh, and myrtle-berries.

“The operation will become far more powerful if the proposed bath (which I hold to be the principal thing) be attended by a course and order of four operations. First, before bathing, rub the body and anoint it with oil mixed with some thickening substance, that the power and moistening heat of the bath, rather than the watery part, may enter the body. Next, get into the bath, and remain there about two hours. After the bath cover the body with a plaster of mastic, myrrh, tragacanth, diapalma, and saffron, to keep in the perspiration as much as possible, till the soft matter has by degrees become solid, and keep it on for twenty-four hours or more. Lastly, after taking off the plaster, anoint the body with a mixture of oil, saffron, and salt. Renew the bath with the plaster and unction as before every fifth day, and let the process of softening the body continue for a month.”

I think it would be difficult to find anywhere a series of directions more likely to injure the health, or more directly antagonistic to sound notions about the animal economy, than those which we have quoted from the father of modern experimental philosophy.

About the same time that Bacon was announcing this discovery to the world—a discovery which was, in his eyes, so important, that he advanced the treatise containing it to an earlier place in the *Instauratio Magna*, so that no time should be lost in making it public—Harvey, then lecturer on anatomy and surgery at the College of Physicians, was announcing his immortal discovery of the circulation of the blood. Indeed, it is stated that Harvey was physician to Bacon himself, as well as to James I., and that he had formed a low estimate of Bacon’s powers, having probably judged of them from the character of his physiological speculations. “He writes philosophy like a Lord Chancellor,” Harvey is reported to have said in derision.

Physiological subjects were treated of at much length by another illustrious philosopher, Descartes, who may be regarded as standing in the same relation to modern psychology that Bacon does to modern experimental philosophy. Descartes, who was a man of spotless character, had, like Bacon, studied the means of ensuring longevity, and had arrived at the conclusion that the surest method of preserving life is not to fear death.¹ He was well acquainted with the circulation of the blood, and his advocacy of Harvey’s views contributed powerfully to bring about their acceptance throughout Europe.

He published a treatise on man, which was the fruit of fifteen years of anatomical study and observation, in which he explained his views as to the manner in which the circulation was maintained.

There is, according to Descartes,¹ a non-luminous fire contained in the pores of the substance of the heart which renders it so extremely hot that the blood on entering it becomes at once dilated, and brought to the condition of vapour. In this gaseous state it is sent to the lungs, where it is cooled and restored to the liquid state, and in this condition returned to the left side of the heart. No sooner, however, does it again enter the heart than it is again rarified by the fire contained in that organ, and in this way is driven into the arteries.

Descartes made some considerable discoveries in physics, but it is evident that his fifteen years’ study had not enabled him to much advance our knowledge of vital processes.

It is well known that the benevolent mind of Berkeley, one of the most acute of modern metaphysicians, was filled with the notion that in tar water, made by pouring a gallon of cold water upon a quart of tar, he had found a panacea for all the ills of humanity. So profoundly was he impressed with the importance of his favourite remedy, that we find him declaring:²—“As the old philosopher cried aloud from the housetop to his fellow-citizens, ‘Educate your children.’ so, I confess, if I had a situation high enough, and a voice loud enough, I would cry out to all the valetudinarians upon earth, ‘Drink tar water.’”

He even attributed to this wonderful fluid a subtle influence on the development of the intellect. “Nor is it only useful,” he says, “to the bodies of infants, it hath also a good effect on their minds, as those who drink it are observed to be remarkably forward and sprightly. Even the most heavy, lumpish, and unpromising infants appear to be much improved by it. A child there is in my neighbourhood, of fine parts, who at first seemed stupid and an idiot, but by constant use of tar water grew lively and observing, and is now noted for understanding beyond others of the same age.”

When we remember that this passage was published in 1752, when Cullen and William Hunter were teaching medicine and anatomy, we shall have no reason to doubt that, on their own ground, the physicians of the day were more than a match for the metaphysicians.

Coming to more modern times, we may select, as a final instance, the greatest speculative philosopher of Germany, the celebrated Kant. Kant had the singular misfortune to be impartially and eminently wrong, both in what he believed about medicine and in what he disbelieved. He was an enthusiastic admirer of the absurd Brunonian system, which hardly survived its birth, and of the puerilities of Beddoes; and he was strongly

¹ Au lieu de trouver le moyen de conserver la vie, j’en ai trouvé une autre plus sûr, c’est celui de ne pas craindre la mort. Œuvres de Descartes par Cousin.—Tome i., p. 112.

¹ L’Homme. Œuvres. Tome iv.

² A Letter to T. P., Esq., containing some further remarks on the virtues of tar water, and “Farther Thoughts about Tar Water.”

opposed to what has proved an inestimable blessing to the human race—the practice of vaccination.

It would not be amiss, when we are lectured by some of our contemporaries on the defects of our art, to remind them of the errors into which men greater than they have fallen when they ventured into our domain, and to counsel them to learn humility from the example of Bacon, of Descartes, of Berkeley, and of Kant.

I have adduced these instances, to which it would be easy to add many others, not with the idle notion of depreciating the labours of the great philosophers to whom I have alluded, but to show the inherent difficulties of the study of medicine, the danger of regarding the facts or generalizations derived from other sciences as adequate to its elucidation, and the absolute necessity for a minute and accurate as well as comprehensive knowledge of the phenomena of disease before venturing to even speculate upon its theory, much less to meddle with its practice.

It was acutely remarked by Bichât that pathology, the science of disease, has no exact analogue among the physical sciences. Physiology bears the same relation to living bodies that astronomy, mechanics, and the other branches of natural philosophy do to inert matter. But there is no pathology of any of the physical sciences. We cannot suppose gravitation to be variable in its operations, or chemical affinity as liable to diseased action. Nor can we conceive these forces as susceptible of being influenced by medicaments.

Accordingly the processes of disease must be studied by and for themselves, and they, as well as the modes of modifying them, and of restoring healthy action, must be made the subject of special investigation, which is to be conducted according to the general principles which govern all scientific research, but which must not be dominated by ideas derived from any other branch of inquiry.

Even as regards the impression produced on the mind, there is a marked difference between the contemplation of vital phenomena and that of the operation of the physical forces. The study of life and of its manifestations conveys the idea of tumultuous action and energy, of effort sometimes bathed, sometimes victorious, of a strife and turbulence, so to speak, compared with which the majestic regularity and unvarying precision of the physical forces seem the type of serene and immutable power.

When chemistry and physics, and anatomy and psychology, have said their last word, we are still only on the threshold of medicine, and it is from a neglect of this important truth that so many mistakes have been committed. There is no doubt that many of the ablest physicians have proposed theories which have not borne the test of subsequent investigation, but there was this important peculiarity with regard to most of these theories, that the experience and sagacity which their authors had acquired by watching the working of

diseases and of remedies saved them from falling into such disastrous errors of practice as those which we have noticed.

It has been stated with regard to Sydenham that while his system was very often bad, his practice was generally good. Probably at the present day our practice is in advance of our theory. We all allow ourselves a certain latitude in speculation, but we hold fast by the practical facts which have been gained to us by centuries of observation, and which are none the less valuable because they are often purely empirical. I believe no man living can fully explain why and how opium acts, and yet every physician knows its effect, and how to get from it the maximum effect with the minimum of risk in cases where he considers it to be useful.

Now when we find that the leaders of thought and of progress in their generation fell into the egregious blunders to which we have adverted, we can form some faint conception of the chaotic condition in which the notions of the uneducated mass of the people must have been with regard to medical subjects. Even now, with the vastly greater facilities for the acquisition of knowledge which the spread of education has afforded, we are all aware of the great number of popular errors which we have occasionally to combat, of the vigour and intensity of popular prejudices, and, at the same time, of how easily a large portion of the world can be dazzled by any specious or confident pretender. When we reflect on homeopathy and hydropathy; when we think of the hundred delusions not more baseless, although generally infinitely more mischievous, which have flourished and been forgotten, we see with what flimsy theories large numbers of the community can be satisfied. And when we think of the cancer-curiers, and of the consumption-curiers of the countless knaves who prey upon other forms of human infirmity, we can form some notion of the enormous value of our profession to the world, if it possessed merely the negative merit of protecting our fellow-creatures from these cruel, ignorant, and rapacious charlatans.

I should be sorry, however, to be supposed to throw any imputation on the motives of many of those who are incredulous regarding the value of the art of medicine. No doubt in numerous instances this incredulity is the result of genuine conviction, in others the fruit of an imagination too active and soaring to be trammelled by mere facts. Many have “been driven, by strong benevolence of soul,” far beyond the regions of common sense and of daily experience. Not very many years have elapsed since I entered upon the study of medicine, and yet during that period, hardly exceeding three lustres, I have witnessed the rise and fall of several all but infallible remedies for various diseases. I have read several publications, before which, in the opinion of their authors, the whole structure of medicine was destined to fall as speedily as the walls of Jericho did before the trumpets of Joshua. I have been solemnly advised,

may warned, to devote my attention to as many systems of cure as would have given me full occupation in their investigation, could I have looked forward to years as numerous as those of “the many-wintered crow,” or, as might be hoped for from Bacon’s bath, were it as efficacious in producing longevity as it is undeniably disgusting.

The fact is, that while with our present knowledge no great generalization is as yet possible, we have ample scope for the most far-reaching and penetrating intellect in the work which lies at our hand.

A distinguished writer has attributed to the study of medical science an important influence in the development and cultivation of one of the most remarkable intellects of modern times. “No science could have been chosen more happily,” says Dugald Stewart, “to prepare such a mind as that of Locke for the prosecution of those speculations which have immortalized his name; the complicated and fugitive, and often equivocal phenomena of disease requiring in the observer a far greater portion of discriminating sagacity than those of physics, properly so called; resembling, in this respect, much more nearly, the phenomena about which metaphysics, ethics, and politics are conversant.”¹

Even to ascertain what the disease is under which his patient labours, a physician must have an exact knowledge of healthy structure and function, so as to recognize the character and extent of the deviations from them; he must be familiar with the vast range of diseases which have been known to occur, so as to be aware of what is possible; he must possess delicate and experienced tact to be able to ascertain and elicit the symptoms which are present; and as the facts upon which his conclusions must be based are often incomplete, sometimes apparently contradictory, occasionally even wilfully withheld from him, he must possess a power of nice discrimination, and a thoroughly trained logical faculty, to be able to arrive at a correct conclusion as to what the disease is most likely to be, and how far he is warranted in acting on the probability so arrived at. It is essential, also, that his knowledge should be so thorough as to be always and in every emergency at once available for use, a requirement which necessitates such a familiarity with both principles and details as is only to be gained by long and earnest study.

All of us have had experience of the immense amount of time and patience necessary to gain a proper knowledge of human anatomy. We know the wide field embraced by physiology and pathology, by medicine and surgery, and what labour it requires to traverse it with anything approaching completeness. We know the amount of time and attention which it is necessary to devote to the acquisition in the wards of an hospital of some practical familiarity with the daily

duties of the life of a medical practitioner; and, reflecting on this, we see how scanty, in reality, is the period allotted to professional studies, and how impossible it is to curtail it by giving up any considerable portion of it to other than professional subjects. We see, too, how essential it is that every one who attempts to master this vast department of human knowledge should come to its study with his reasoning powers, as far as possible, already disciplined, with his faculties of attention, of abstraction, of comparison, and the like, already exercised and sharpened by a sound and well-directed preliminary education. To such students the acquisition of knowledge is easy and delightful, and from such students we may fairly expect additions hereafter to our knowledge of sterling and solid value.

Within the last few years, and in a great degree, it must be owned, in consequence of the action of the General Council of Medical Education, a considerable advance has been made towards the establishment of a better and more comprehensive standard of general and professional education. Few questions are of greater public importance than this; for everything which tends to increase the efficiency of the members of the medical profession has a direct and obvious bearing on the well-being of the community in which they are to exercise their art.

Even, however, among some of the ablest and most enlightened advocates of improvements in our present system, there are signs of a tendency to attach undue importance to those branches of learning which are high in public estimation, and of which the cultivation may be regarded as favourable to the maintenance and advancement of the prestige and the social position of the profession.

I cannot, for example, attribute the vigorous efforts which have been made to establish the Greek language as an essential part of the preliminary education of medical students altogether to a conviction of its importance in promoting the ultimate ends of medical education. A superficial acquaintance with Greek is, it would seem to me, comparatively worthless; and any large or thorough knowledge of the masterpieces of its poetry, philosophy, or history, is, as regards the medical student, practically unattainable—indeed, is practically unattained by the immense majority of those who have received what is ordinarily understood to be a liberal education. The arguments which are employed by the advocates of Greek seem to take for granted that the ordinary student will be enabled to at least read the great works of its literature with ease, and that he will derive a high kind of gratification, as well as of æsthetic culture, from the exercise of this power. In addition to this, he is expected to become better acquainted with the principles of universal grammar and with philology and to obtain a more complete mastery over the resources of his own language; and these advantages, it is said, will be cheaply purchased by the admittedly irk-

¹ Dissertation of the Progress of Philosophy since the Revival of Letters.

some and protracted exertions necessary to master the elements of the language.

I am quite willing to acknowledge that a large and thorough knowledge of classical languages and literature is an indispensable element in the highest culture; and if the circumstances of the country or the position of the profession warranted us in demanding this knowledge from every aspirant to the rank of a medical student, I should welcome any effort in the direction of a result so desirable. But I do not think that the preparation for an ordinary matriculation examination has any considerable effect in this direction. The beauty and perfection of form of the ancient masterpieces can only be felt when the language in which they are contained has become so familiar to us that no effort on our part is necessary to enable us to understand the meaning of the words, and when we have attained to some comprehension of ancient modes of thought and feeling. That this is the result of a partial study of Greek is not likely to be asserted by any one who is familiar with the facts. I think that a more thorough knowledge of Latin, if, in addition the student were required to be acquainted with a modern language, would suffice amply for the grammatical training, and for the æsthetic culture, which are, no doubt, indispensable parts of high education.

It would not be difficult to show to any one, whose mind is not biased by the traditional reverence for classical learning which has imbued so profoundly most of our theories of education, that the study either of the French or of the German language is, as a means of educating the critical faculties, not very much inferior to that of Greek; while as an end—as conferring the power of completely and readily understanding the works written in either of these two modern languages—compared with a similar mastery of the ancient tongue, the balance of advantage is so vastly against the Greek as to preclude the possibility of any serious comparison. In fact, with the exception of its value in enabling the student to more readily understand scientific terminology, Greek may be regarded as an intellectual luxury; and it may be worth observing that in medicine we have really no scientific terminology, in the proper sense of the words. Our names of diseases do not express their systematic relations, as the nomenclature of chemistry does with respect to the substances with which that science is concerned, and, indeed, in the present state of our knowledge, it is highly desirable that we should not attempt the formation of a systematic terminology, so that on this ground also Greek cannot be regarded as necessary.

Again, a more extended and more fruitful use might be made of the valuable means of training which the natural and experimental sciences afford. The study of these sciences tends to develop and strengthen precisely those powers and faculties which are constantly called into requisition during the exigencies of professional

life. Exact observation of facts, careful reasoning, and rigorous scientific method are derived almost of necessity from a sound and judicious training in these sciences. It is essential, however, to bear constantly in mind, in the consideration of this important question, that whatever be the means employed for the purpose, the education of the faculties, in the true and limited sense of the word education, is the important thing. Without this even considerable erudition or extensive knowledge of the facts of natural science will be of little use to the student; nay, may even overburden his undeveloped intellect—

Like Saul's plate armour on the shepherd boy,
Encumbering and not arming him.

With regard to the question of the granting of medical degrees, the Council has done good service. It is probable, as has been observed by Adam Smith, that no examination ever has been, or ever can be, devised, which will give an absolute security to the public that he who has passed it is thoroughly competent to practise medicine. That degrees and diplomas have sometimes been conferred on men who were neither wise nor judicious is probably no secret either in the profession or out of it. But every effort should be made in the interest of justice and of humanity, that as far as is possible a degree should be a *bonâ fide* evidence at least of the acquirements of its possessor. It is quite clear, accordingly, that no competition should be permitted between the corporations who possess the privilege of granting them. No body should be allowed to attract candidates for its qualification by a less extended curriculum, or a less strict and searching examination than those of its rivals. This would at once and finally extinguish the artificial distinction between medical and surgical qualification, which has been a fertile source of evil to the profession.

And now, gentlemen, laying aside the consideration of questions which are specially interesting to ourselves, and regarding the wider one of the position of medicine throughout the world, I think we have ample grounds for congratulation and hope. Never have inquiries and investigations been prosecuted before with such wealth of scientific appliances, or over so many countries, or by men of such different culture, or under circumstances of so great diversity. Never were intellects of a higher kind engaged in the study of our art. And, what is still more hopeful, we find that with much observation there is little theorizing. Men are now content to proceed upon the solid ground of experience and fact, anxious rather to

“Lay great bases for eternity,”

than to erect unsubstantial and unenduring fabrics of speculation.

Looking forward to the future of our art, I think of it as going onward in sedulous, intelligent, honest investigation of the myriad varieties of the action and suffering of the human body; in the unceasing search after

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the means by which disease may be lightened or removed, proceeding slowly, it may be, but always on the solid basis of patient, unwearied observation, un-
hasting, but also unresting.

I think of it, not as quickened by higher motives or directed towards nobler aims than now, for humanity and benevolence are of the essence of the profession of medicine; but as ever gaining truer conceptions of the processes of health and of disease, and deeper insight into their nature; as laying broad and deep the foundations of a structure of knowledge from which, in “an ampler ether, a diviner air,” wider views of life and of its manifestations may be obtained.

I think of the conditions of health becoming defined; of the seminal principles of disease becoming recognized; of some medical Newton of the future unveiling for us the mystery of vitality; and, finally, of the noblest and crowning triumph of our art, in the discovery of better, surer, and wider means of preventing, mitigating, or curing disease.

“So from the root
Springs lighter the green stalk, from thence the
leaves
More æry; last, the bright consummate flower”

Dr. Reade moved that the best thanks of the company present be given to the President for his very eloquent address, seconded by Dr. McGee and carried unanimously.

Moved by Dr. Whitaker and seconded by Dr. Thomas Reade and carried unanimously that the President allow the address to be printed.

James Cuming M.D

[Undated]

Present, Dr. Cuming in the chair, Drs. Thomas Reade, Berry, J. Walton Browne and Hill.

The minutes of former meeting having been read and confirmed, as none of the gentleman who were to read cases were present the meeting was adjourned.

James Cuming M.D

521¹ Notice of meeting on 7th December 1868
The Third Meeting of the Winter Session will be held in the Library, General Hospital, on Monday Evening next, 7th inst., at Half-past Seven o'clock.

Business.

Dr. Murney will give the particulars of a case of Fracture of the Spine, and exhibit injured parts.

Dr. Mac Cormac will give a short account of two cases of Ovariectomy, and exhibit the tumours extirpated in each instance.

Mr. Johnston will give the details of a case of Carotid Aneurism, and exhibit the morbid specimen.

(By order of the Council),

John Moore, M.D.,
James Hill, M.D.,
Honorary Secretaries.

December 5, 1868.

Ulster Medical Society, December 7th 1868

Present, Dr. Cuming in the chair, Drs. Stewart, Murney, Pirrie, William MacCormac, Wales, Porter, McCrea, David Johnston, Core, J. Walton Browne, Fagan, H. M. Johnston, Messrs. Moore and Hill.

The minutes of the former meeting having been read and confirmed, Dr. Murney read notes of a case of fracture through the laminæ of the 4th cervical vertebra. The man lived 32 hours and the case was adduced as an instance where had the fracture occurred a little further out so as to damage the inter-vertebral foraminæ death would have been instantaneous. In this case trephining which has been suggested in fracture of the vertebræ would have been of no use whatever, in fact it might have hastened death.

Dr. MacCormac then gave the particulars of two cases of ovariectomy and exhibited the parts removed. In introducing the subject he gave a most interesting historical sketch of the operation. In the former case wire ligature of the pedicle was resorted to; in the latter the clamp was used.

Dr. MacCormac could not help thinking that the use of the ligature in the first case had something to do with the death. Both cases ended fatally.

Dr. Pirrie was sure every member of the Society would sympathise with Dr. MacCormac in the untoward result.

After some further observations from different members, Dr. H. M. Johnston read notes of a case of aneurism which had been rapidly fatal.

Dr. Murney then read notes of a case of fracture of the skull which terminated fatally in about 16 hours.

James Cuming (Chairman)

Ulster Medical Society, December 21st

Present, Dr. Cuming the President in the chair, Drs. Murney, Wales, William MacCormac, Fagan, Berry, H. Brown, Thomas Reade, D. Moore, A. M. Porter, John Moore and Hill.

Dr. Murney read notes of a case of hernia which ended fatally. It was peculiar in this respect that though there was a very tight stricture there was entire absence of any urgent symptoms. The man was 60 years of age and the rupture existed from boyhood. Fifteen months ago the hernia came down and had to be returned under chloroform. The pulse never rose above 76 either before or after the operation, there was no tenderness and hardly any vomiting. On

¹ [Item 522 is identical.]

P.M. examination a considerable quantity of bloody serum came from the wound and the bowels were glued together by recent lymph. He showed the recent parts.

Dr. William MacCormac then read notes of a case of hernia which was remarkable for the urgency of the symptoms without the hernial tumour being either tense or tender. It was that of an old woman about 70 years of age who for the last 10 years at least had been troubled with a rupture. It had never caused much inconvenience but never wholly disappeared. She was admitted to hospital on the 18th December and stated that at about 2a.m. she had been suddenly roused from sleep by sickness and pain and enlargement of the tumour. Before coming to hospital a medical man had tried to reduce the hernia. When seen she appeared to be in a state of collapse—the surface was cold—face pinched—pulse small, quick, weak. She had also well-marked epigastric pain which troubled her even after the operation. There was a tumour the size of a large orange in the right inguinal region but it was neither tender nor tense. Although the strangulation had not existed long, yet as the symptoms were urgent it was deemed right to operate at once. This was done in the usual way. Beneath the hernia a small knuckle of intestine quite black was observed. The stricture was very tight. The omentum adhered largely to the sac thus accounting for the tumour never wholly disappearing. She never rallied from the state of prostration in which she was when admitted but died on the following Sunday. Immediately after the operation she had three free evacuations from the bowels. She was ordered opiates.

On P.M. examination the bowels were found congested but there was no serum or lymph. There was, however, a large clot of effusion beneath the peritoneal covering of the stomach along the lesser curvature which Dr. MacCormac asked the President to describe.

The President said that when Dr. MacCormac asked him to see the stomach he thought it well worthy of investigation and accordingly he had it very carefully dissected. On the outside was found a large mass of extravasated blood and on careful examination of the parts, a small aneurism was found on the splenic artery. This at once suggested that the extravasation might be from an aneurism of the gastric artery. The only possible explanation is that the excessive straining and vomiting caused rupture. A small opening was found and it is purposed to examine it microscopically to ascertain if it be recent.¹

Dr. David Moore thought that the rupture had probably taken place before admission thus causing the shock for the state of the bowel did not appear to be such as to give rise to so urgent symptoms.

Dr. Murney thought that atheroma was pretty general throughout the arterial system—possibly other hæmorrhages may have occurred.

The President then asked if any one present had seen such a case when Dr. Bartley said he had once seen a man who appeared to be suffering from internal hæmorrhage. There was increasing debility and death occurred in three days. Blood was found in the peritoneum but although all the vessels were closely examined the source could not be ascertained.

Dr. William MacCormac then exhibited a tumour of the tibia which he had removed from a patient 21 years of age. He had been in good health till 14 months previously when thickening commenced on the outside of the knee. On admission to hospital he had an irregular lobed tumour involving the upper two-thirds of the right leg. It was 26 inches in circumference while the thigh above the knee was only 13 inches. It had an elastic feel with an obscure sense of fluctuation and had a dull aching pain and the lad presented altogether a cachectic appearance. It was considered to be a medullary cancer and accordingly the limb was amputated. Till shortly before admission there had been no œdema of the foot and the movement of the knee joint had been perfect.

Lister's carbolic oil was used for a dressing and complete union occurred in a very few days.¹

As the ordinary time for the meeting had been already exceeded it was moved by Dr. Murney, seconded by Dr. John Moore that the President's communication regarding the sphygmograph be postponed.

James Cuming M.D

Ulster Medical Society, January 4th 1869

Present, Dr. Cuming (the President) in the chair, Drs. J. W. Smith, J. W. Browne, James Moore, Rea, McWilliam, B. Smyth, H. S. Purdon, Mr. Berry, and Dr. Hill.

Dr. Cuming exhibited and described Marey's sphygmograph and took tracings of the radial pulse from different patients.

Dr. H. P. Rea asked what the utility of it was expected to be. Dr. Cuming said that till Physiologists had definitely determined the cause of the pulse it would not be of much service, but ultimately he had no doubt it would be of great benefit.

Dr. James Moore then shewed a tumour which he had removed being the third from the same lady. The first weighed about 7 pounds and was of slow growth. It was removed about 3½ years ago. The second was likewise perfectly removed about 2½ years ago. This one commenced about 3-4 months ago and its growth has been comparatively rapid. Though the first was a perfectly innocent growth, he had grave

¹ [See page 1127.]

¹ [See page 1136 for subsequent history.]

doubts about this one, and feared a similar or more noxious tumour would soon return.¹

Ulster Medical Society, February 1st 1869

Present, Dr. Cuming (President) in the chair, Drs. Dill, William MacCormac, McWilliam, Porter, John Moore, J. W. Browne and Mr. Berry.

Dr. Cuming exhibited recent parts in a case of acute peri- and endo-carditis.

Dr. John Moore read notes on 7 cases of puerperal convulsions.

(Signed) James Cuming
M.D

Ulster Medical Society, March 1st

Present, Dr. Cuming the President in the chair, Drs. Gribbin, A. Porter, Fagan, Browne, John Moore, and McWilliam.

Dr. Fagan read a paper on a case of hydroureter.

Dr. John Moore read notes of a case of meningitis.
James Cuming

24th March 1869

A Special Meeting of the Society was held for the purpose of taking into consideration Dr. Brady's Bill for the Superannuation of Dispensary Medical Officers, which is at present before Parliament.

The President in the chair. Members present, Drs. James Moore, McCrea, Whitaker, David Moore, H. Brown and John Moore.

The following resolutions were unanimously agreed to.

First Resolution. Moved by Dr. James Moore and Seconded by Dr. Whitaker That ...

Seconded Resolution. Moved by Dr. John Moore, Seconded by Dr. H. Brown That ...

5th April 1869

The President in the chair. Members present, Drs. Drennan, Thomas Reade, William MacCormac, H. Brown, Wales, David Johnston, James Smith, Stewart, Fagan, Porter and John Moore.

Dr. Drennan moved in feeling terms the following resolution which was seconded by Dr. Stewart and unanimously agreed to:

That at this our first meeting since the death of Dr. Patterson we feel called on to express our deep respect for the loss this Society has sustained by his demise and to record the respect in which we hold his memory as one of its most valuable members. In the Ulster Medical Society and proceeding ones of like kind we always found in him an active, intelligent and friendly counsellor and cooperator whilst by the general community he was recognised as a useful citizen and a man of stainless integrity.

We would hope that this our unanimous expression of esteem for her husband's character may afford some slight solace to his widow in her present great affliction.

The Secretary was instructed to convey to Mrs Patterson a copy of the Resolution.

COMPILER'S NOTE

The following two papers were published immediately before the President's report of rare spinal disease. They are not to be found in the minutes and hence have been inserted here.

Aneurism of the Coronary Artery of the Stomach.

Paper:¹ Dr. Cuming exhibited the stomach, spleen, and portion of the peritoneum of a patient who had been operated on for strangulated hernia by his colleague, Dr. William MacCormac.² The patient, a female, aged sixty, was almost moribund on admission into hospital, and died soon after the operation. She had complained of severe pain in the epigastrium for some days before death. When making the post mortem, Dr. MacCormac had found a dark mass above the lesser curvature of the stomach between the layers of the peritoneum. On examining the specimen which had been placed in his hands, Dr. Cuming found that the mass consisted of coagulated blood, which had been furnished by the rupture of a small aneurism, situated on a large branch of the coronary artery of the stomach proceeding towards the cardiac end of that viscus.

The blood, which was about three or four ounces in amount, was contained between the folds of the lesser omentum.

Loss of Speech in Typhoid Fever.

Paper:³ DR. ROSS read a paper on the subject of typhoid fever, its history and symptoms, from which we extract the following interesting cases:—

CASE I.—A young lady, aged eleven years, born in India, was attended by me for typhoid fever in the early part of 1868. The enteric affection was very severe—diarrhea, melæna to a large amount, and extreme tympanitis. She was conscious, put out her tongue when required, and took her food and stimulants well. Her pupils were remarkably dilated, but the unusual phenomenon in her case was that for three weeks she was unable to speak a single word, and even after this prolonged period she only very slowly recovered her speech. She got quite well in about four months, but the case was very tedious and very unmanageable.

CASE II.—A female, aged eighteen, passed through a very severe attack of typhoid fever under my care. The complications in the form of bronchitis and pneumonia and diarræa and tympanitis were most intractable and

¹ [See page 1137 for further history of probably the same patient.]

¹ [Dublin Quarterly Journal of Medical Science, 1869, v47, p469.]

² [See page 1126.]

³ [Dublin Quarterly Journal of Medical Science, 1869, v47, p470.]

tedious. They had, however, yielded to treatment, and we were in hopes that we had gotten our patient, so to say, out of the wood, though in a very prostrated and emaciated condition. When suddenly, without any previous warning, she was seized with right hemiplegia with relaxed muscles and loss of speech. After weeks of careful nursing, nutritious diet in the fluid form with wine and chalybeates from the first appearance of the palsy, she was able to speak, but at first only in the simplest monosyllables. Muscular power was slowly regained, and now, ten months after her illness, she is able to walk very well, but she has only partial use of her right hand and arm.

What was the cause of the hemiplegia in this young girl? I account for it in this way: the blood supplied to the brain was vitiated and impoverished; cerebral nutrition was impaired. Then followed softening of the brain, and immediately antecedent to the paralysis rupture of nerve fibres.

The President introduced a patient and gave a most interesting history of his case which was that of a rare form of spinal disease.

Paper:¹ B. M., aged 40, pork-cutter. Healthy and vigorous man. Had usually once a-year a drinking-bout of about a fortnight's duration, but was temperate in the intervals. Had been drinking for nearly a fortnight, when he observed on a cold evening in the beginning of May, 1867, when driving on an outside jaunting car, that his hands had become numb and white as far as the second joints of the fingers. When he reached home he found that he was unable to lift a cup, although he could lift anything which he could grasp in his hand. On the next day he had a good deal of spirits, and went to the seaside when he fell asleep on an exposed wall. On awaking he was chilly and shivered, and he found the numbness increased. On the following day when on the street he found that he had some difficulty in walking, and went home to bed. On the succeeding morning he found on getting out of bed that he could not stand. He dressed, however, and was helped on a car and went to the house of a medical man.

I saw him for the first time nearly a week after. He was then totally devoid of power of voluntary motion below the neck, except that he could impart a slight movement to the right shoulder. His sensation was perfect. There was no abnormal sensibility, and no pain or uneasiness. Deglutition and articulation were perfect, but respiration was greatly embarrassed, mainly by an accumulation of mucus in the larger tubes, which he found it impossible to get rid of, as he was unable to cough.

No involuntary movements could be excited by pinching or tickling. He was covered with a profuse drenching perspiration which formed a prominent symptom throughout the case. Pulse 126; tongue furred,

but moist, he could relieve the bladder and the bowels. I found it impossible to make any observation regarding the presence of tenderness, as he had been blistered from the nucha along the whole spine, besides having a large blister on the chest, and being profusely salivated. I subsequently found that no tenderness existed, and the blisters, contrary to my expectation, as the patient could only lie on the back, healed rapidly and well, and neither then nor at any period during his illness had he a bedsore. He slept little, and badly; urine examined and found normal. The prognosis was of course unfavourable, and I ordered merely two grain doses of iodide of potassium every six hours. To my surprise I found him alive on the following day. For some days there was very little change, except that the respiration became gradually easier. He was still, however, in such a condition that when turned on the right side the distress became so great and urgent that he had to be at once laid on his back.

From this period a progressive change in his symptoms occurred. Gradually he began to suffer from involuntary and spasmodic contractions of the muscles of the lower extremities occurring occasionally, and from darting pains in the lower limbs. The power of motion gradually and slowly returned; at the end of three months he was able to get out of bed, and his progress has since gone on slowly, but uninterruptedly towards the regaining of his muscular power. His first attempt at motion caused him a good deal of pain. His general health always continued during his protracted confinement, excellent, and no bedsores formed. At present, nearly two years after the commencement of his illness, he walks slowly but steadily; he is easily upset by an obstacle, but he can walk about for a considerable period with occasional rests. His hands present a well-marked example of the "main en griffe" of Duchenne, and he experiences much difficulty in flexing the metacarpophalangeal articulations; indeed, he can only do this to a very limited extent. The muscles though wasted preserve a moderate bulk, and he is able to shave, although with much difficulty, and very slowly. There is a slight tendency to constipation, and urination is a little slow at the commencement, but he is otherwise in excellent health, and is undoubtedly steadily improving, he is not at present under any medical treatment whatever.

I do not feel myself able to pronounce definitely on the nature of the spinal lesion which existed, and of which traces are still present, but I have regarded the case as one of sufficient interest to be recorded. I am disposed to consider that the affection was mainly, if not entirely of a congestive character. The combination of symptoms present consisted of complete paralysis of a paraplegic form, no tingling, no increased reflex excitability, no pain or tenderness, power over the bladder, and rectum, profuse drenching perspiration, appetite and digestion normal, sleep imperfect, and dysp-

¹ [Dublin Quarterly Journal of Medical Science, 1869, v47, p471.]

nea from inability to cough. Subsequently pain, spasms of the lower limbs, peculiar deformity of hands.

Dr. William MacCormac exhibited the left half of the lower maxilla which he had removed from a young woman for osteosarcoma. The case done well.

Paper:¹ The operation for the removal of one-half the inferior maxilla is a surgical procedure both difficult to perform, and of comparatively rare occurrence. It is only in more recent times, indeed, that patients afflicted with disease of the lower jaw received surgical aid in any shape. And to British surgery is due the merit of the innovation, Mr. Anthony White having performed resection of a portion of the lower jaw in 1801, several years before Dupuytren or Cusack commenced the series of brilliant successes which established the operation as a sound and safe surgical proceeding. The number and size of the vessels involved render the risk from hemorrhage, both immediate and consecutive, very great—so much so that many amongst the earlier operators recommended the ligature of the carotid as a preliminary step in the operation, Probably in no operation of the kind is an artery of the importance of the internal maxillary placed in such dangerous proximity to the knife, nor could there be one more difficult to secure should it be wounded. Without further preface I will give a short account of a case in which I performed this operation.

Ellen M'Cappin, aged twenty, a healthy country girl, was admitted recently to the General Hospital under my care. About two years ago, not having experienced any previous illness, she noticed that the left lower jaw was swollen. From this date it continued to increase gradually and without pain.

On examination the left side of the lower jaw from the bicuspid teeth to the sigmoid notch is found to be involved in a very hard irregular tumour. It is felt on both sides of the maxilla but projects more externally, where three distinct prominences, continuous with each other, can be distinguished. One of extreme hardness covers the ascending ramus as high as the notch; another, the size of a small hen's egg, also very hard, projects beneath the body of the bone, whilst the third, elastic and comparatively soft, involves the whole of the alveolar border. The tip of the coronoid process, the angle of the jaw, and articulating head of the bone, alone appear uninvaded by the growth. The third or wisdom tooth, never made its appearance. The second molar got loose, and was extracted some time ago; and the first molar I removed myself, thinking, possibly, it might thus give exit to fluid from the elastic tumour on the alveolus. As none came away, the cystic nature of the growth was excluded from consideration.

The diagnosis before operation as to whether this tumour might be fibrous, cartilaginous, or myeloid, was

almost impossible. I thought it probably fibrous or fibro-cartilaginous, with deposit of bone, judging from its extreme hardness. The discrimination of the nature of the growth was, however, of no practical importance to the patient, as there could be no doubt as to the necessity of the removal of the affected portion of the jaw, which I decided to disarticulate.

The patient having first been fully chloroformed, the first bicuspid tooth on the affected side was extracted, as in this situation, it was decided to divide the bone. A nearly rectangular incision was then made commencing opposite the lobe of the ear, proceeding downwards to the angle, and thence across the body to within half an inch of the symphysis. All the soft parts down to the bone were divided in this first cut. The facial artery and a mental artery being wounded, were at once taken up and tied at both ends. The flap thus formed was carefully dissected up, the knife being kept close to the bone, and in this way, and also by having commenced the vertical incision so low down, the parotid duct, and the chief branches of the facial nerve, escaped injury. The outer surface of the tumour being now thoroughly exposed, the jaw was cleared at the point of section in front of the mass, and divided with a small saw cutting from below upwards. The operator to do this must stand behind the patient, the head being thrown back, and the section is thus effected with great ease, as the lower jaw is steadied against the upper, and the soft parts can readily be held aside, and incur no such risk of injury as when the end of the saw is inside the mouth. When the bone was nearly cut through, a bone forceps completed the separation by dividing the alveolar process.

The jaw was now everted, and the edge of the knife being kept scrupulously close to the bone, the deep fasciæ and the mylohyoid and internal pterygoid muscles were dissected off the inner surface. By depressing the jaw forcibly the attachments of the temporal muscle were brought into view and severed; then the bone was rotated outwards, and the external pterygoid muscle divided with the utmost caution. The joint was opened in front, its capsular and other ligaments severed, and the tumour removed. Only two other small arteries required ligature, and three ounces of blood were certainly not lost during the operation. The influence of the chloroform was maintained throughout. The wound having first been bathed with carbolic lotion, was closed with six interrupted sutures, inserted through the whole thickness of the cheek. Carbolic dressings were applied, but no plugs of lint introduced internally, which serve, I think, no useful purpose, form a nidus for the collection of foul discharges, and are painful and difficult to remove. The only instruments I had occasion to use during the course of the operation were a scalpel, saw, and cutting forceps, and from the first incision to the insertion of the last suture, and application of the dressings, the time occupied was exactly twenty-four

¹ [Dublin Quarterly Journal of Medical Science, 1869, v47, p472.]

minutes. The after-progress of the case proved very satisfactory. The wound united by adhesion. There was nothing complained of by the patient but soreness in the throat, which lasted only two days. One week after the operation she sat up perfectly convalescent, all the stitches and ligatures removed, and the wound almost quite healed. The small amount of deformity is very surprising, and the situation of the incision and cicatrix are quite invisible when the patient is looked at in front, in fact it would be difficult for a stranger to tell from which side the jaw had been excised. There is now no retraction of the remaining portion of the maxilla, and the inferior incisors correspond exactly to those in the upper jaw. On making a section of the jaw the tumour is seen to spring from its interior, distending the bone in all directions, somewhat irregularly, or more to the outer side, as before mentioned. It is of a uniform white colour, dense, and firm to the touch, and contained spicula of bone. In the centre of it is a small tooth, which is the missing wisdom tooth. To the unaided eye its characters are those of a fibroid growth, and the microscope shows that it contains fibres and elongated nucleated cells. There is every reason to hope that the disease, having been completely extirpated, will not return.

Dr. James Smith detailed the history of a case of heart disease which had terminated fatally.

Ulster Medical Society, 19th April 1869

Present, Dr. Cuming (the President) in the chair, Drs. J. W. T. Smith, Browne, Seaton Reid, Thomas Reade, William MacCormac, McWilliam, J. Walton Browne, Ross and Hill.

It was moved by Dr. Seaton Reid, seconded and agreed to that Drs. Brice Smyth, H. S. Purdon and Hill form a committee to examine and report on the state of the library at the Annual Meeting.

Dr. Smith then [read] notes of a case of abscess of the lung.

Paper:¹ Mr. E. had occasionally consulted me during the last ten years. With the exception of an attack of acute gout in one foot six years before, his ailments had been of a very trivial kind.

He was forty-four years of age, of middle height, well built, and possessed great physical strength. He was of active habits, and fond of field sports. I saw him on 29th August, 1868. He had been ill for eight days with cough and occasional chills; was feverish and restless at night, and unable to sleep in consequence of the hard frequent cough; his appetite was bad, his pulse 100, and his tongue was much coated. A careful examination of his chest could detect no cause for his cough; the respiration, although somewhat quickened, was perfectly natural, and his heart sounds were healthy.

When looking into his throat to see if there was any cause of irritation there, he coughed, and I immediately felt a gangrenous odour. He himself had felt it occasionally during the two days when coughing. I concluded that he had an abscess of the lung, and explained so to him.

I visited him next day, and saw the expectoration of the previous night—about three ounces of dirty yellow-coloured pus mixed with blood. His chest was again carefully examined, but nothing abnormal was heard. It was not till the 2nd September, five days after I first saw him, that there were any stethoscopic signs of disease. On this day pleuritic friction sound and crepitus were heard about one and a-half inches below left nipple. During the next ten days these sounds gradually extended upwards, and on the 15th were audible over the whole front of the left lung to within two inches of the clavicle. The expectoration at night had increased to eight or ten ounces, and was often very offensive; it varied in colour from greenish yellow to grey, and was sometimes mixed with a good deal of blood.

On the 20th Dr. Seaton Reid saw him in consultation. He concurred in my opinion of the case, and recommended small doses of turpentine and ether, in addition to the quinine and mineral acids previously ordered. At the end of a fortnight the stomach became irritable, and the medicines were discontinued; friction sound and coarse crepitation were now also heard below left axilla. On the 6th October there was a slight attack of gout in one foot, which disappeared in a few days. On the 15th he was suddenly seized with an acute pain in the left side; he was unable to lie down; his respirations very frequent; pulse 130. He was relieved by full opiates, and in a day or two loud friction sounds were heard at the back, from the spine of the scapula downwards. He had been now ill eight weeks, had lost much flesh, and the expectoration had not diminished. He was ordered quinine and tincture of muriate of iron every four hours. From this time a gradual amendment took place, and in four weeks he was able to be removed to the country. Here he steadily improved in health, and gained flesh. Cod liver oil had been added to the quinine and iron.

He returned to town about the middle of December, feeling almost well; he was within a few pounds of his usual weight, the cough was almost gone, and the expectoration was reduced to about a drachm in the night; except that a few clicks were heard on full inspiration in front of the left lung, and that it was somewhat less resonant, all abnormal sounds had disappeared.

About Christmas I met him in the street; he appeared to be, and said he felt, quite well. On Tuesday, 5th January, having felt well and walked out the day before, he had a severe rigor, and vomited. I saw him soon after; his face was flushed and heavy, pulse 120, no change in the lung since last examination. On the

¹ [Dublin Quarterly Journal of Medical Science, 1869, v48, p666.]

8th there was a slight puffiness at the outer angle of left eye, and he could not move in bed from pain in the lower part of his back and right hip. On the following day there was some fulness here which gradually increased, and extended down the thigh. On the 12th free incisions were made behind the trochanter and on the outside of the thigh, which gave exit to a quantity of intolerably fetid pus, mixed with bubbles of air. On the 14th he was seized with severe pain below the right nipple, and friction sounds were heard here. The swelling at left eye was opened, and discharged an ounce of pus. He was quite sensible, but in a state of great prostration; he had profuse sweats, and his breath had a sickly odour of pus. On the next day there was evidence of matter in the ankle-joint. He lingered till the 18th, when death terminated his sufferings.

Although an examination of the body was not obtained, there is, I think, little doubt, that the case was one of deep-seated abscess of the left lung. The course of the disease, the gradual development of the signs of pleuro-pneumonia limited to one lung, and the peculiar character of the expectoration, cannot well lead to any other conclusion. It is worthy of note, that although a careful examination of his chest was made daily, no physical sign of disease was heard till five days after he was first seen. The termination of the case was very unexpected. The supervention of pyemia in such a case must be of rare occurrence, especially when restoration to health seems almost assured.

After some remarks on the case by Dr. Seaton Reid, who had seen the man, by Dr. Thomas Reade and the President, the President proceeded to give an account of the case of the late Dr. Patterson.

Dr. Browne then read the particulars of a case of acute necrosis of the thigh requiring amputation.

It was then proposed by Dr. Hill, and seconded by Dr. Smith that Reynolds System of Medicine be added to the library.

J. W. T. Smith, President

Annual Meeting, 10th May 1869

Present, Dr. Cuming (President) in the chair, Drs. Stewart, J. W. T. Smith, William MacCormac, Whitaker, Murney, Harkin, David Johnston, John Moore, J. W. Browne, H. Brown, Porter, Fagan, Ball and Hill.

The minutes of the former Annual Meeting having been read and confirmed, Dr. Hill (Secretary) read the report of the Council which on the motion of Dr. Hill, seconded by Dr. Fagan, was adopted.

The report of the Library Committee was then read and adopted.

Dr. MacCormac then read the Treasurer's report.

Moved by Dr. Murney and seconded by Dr. J. W. T. Smith that the very satisfactory report now shall be adopted.

The election of office bearers then took place with the following result viz

President

Dr. J. W. T. Smith

Vice-Presidents

Drs. John Moore, Murney

Council

Drs. Stewart, H. Brown, Fagan, McCrea,
H. S. Purdon, Whitaker

Treasurer

Dr. William MacCormac

Secretaries

Drs. Hill and A. M. Porter

The new President having been installed it was moved by Dr. Stewart and seconded by Dr. Murney that the best thanks of the Society are due to Dr. Cuming our late President—unanimously adopted.

Moved by Dr. Stewart and seconded by Dr. William MacCormac That it be an instruction to the Council to report for the future, at the Annual Meeting, the attendance of its members during the Year, and that such be read at each Annual Meeting before proceeding to the elections of Council. Carried unanimously.

J. W. T. Smith, President

3rd May 1870

Ulster Medical Society
Session 1869–1870
President James William Thomas Smith

ULSTER MEDICAL SOCIETY

SESSION 1869–70

Ulster Medical Society, June 1st 1869

Present, Dr. J. W. T. Smith (President) in the chair, Drs. Cuming, William MacCormac, Fagan, Ball, Hill and Porter.

Dr. Smith read notes of a case of cerebral meningitis.

Paper:¹ Simon Corcorin, a policeman, aged 32, was brought to hospital in a state of unconsciousness on the evening of the 10th of May. All that could be learned about him was that he had been ailing for a day or two, but not off duty, and that shortly before admission he had vomited, and then became insensible. I saw him about two hours after. He was very restless and incessantly turning from side to side, his head felt hot, his face was flushed, his eyes were closed, and he resisted any attempt to open them, the pupils were neither contracted or dilated, skin cool, pulse, 80. Had vomited once since admission to hospital. He slept none during the night, but was somewhat more conscious the next day, as he put out his tongue when asked. When raised up in bed he appeared to suffer pain in the back of his neck. Pulse 68; regular. He was still very restless, and some leeches were applied to his head with difficulty.

During the two following days he gradually recovered consciousness, and on the 13th was able to give some account of his illness. He had been on duty on Saturday 8th, and exposed for six hours to a cold east wind. On the following day he felt chilly, and had pains in his head and back. On Monday he attended the Police Court as a witness, and when there became sick, and remembered nothing after till he found himself in hospital.

May 14th.—There is a loud mucous r le in the trachea, and large bronchi, and the breathing is occasionally stridulous; the chest is resonant on percussion, and some sonorous r les are heard in both lungs. He does not appear to suffer from dyspnea. Pulse, 72; respirations, 28.

On the 16th the chest was quite free from mucus; he complained but little of his head, and answered questions sensibly. During the next four days he slept little, was delirious at night, and had almost constant hic-cough. The pulse remained steadily at 60.

On the 21st, having slept well all night from an opiate, he became suddenly affected as on the 14th, the mucus was in such quantity that asphyxia seemed imminent; the face was livid, and the pulse rose to 120. Towards evening this passed away; he was free from

pain, but said that his head felt numb, and as if at some distance from his body. He remained for the four following days in a state of great prostration; he often talked incoherently, but when spoken to answered sensibly. He always insisted on getting out of bed to pass water, and drank milk freely.

26th.—Had passed a fair night, breathing perfectly quiet. About mid-day the paroxysm of dyspnea recurred with great violence; in fifteen minutes the features were quite livid, there was a general convulsion, followed by rigidity, and in a few minutes he was dead.

Post mortem.—The head alone was examined. The mass of the brain was healthy and firm, but when sliced, the surface of the white matter showed many red points. The lateral ventricles contained about two ounces of turbid serum. The central substance was healthy, except the corpus striatum, which seemed a little softened at the base; the arachnoid in front of the pons and upper part of the medulla oblongata was opaque, and the sub-arachnoid tissue here, was infiltrated with pus, and recent coagulated lymph. The membranes over hemispheres and other parts of the brain were healthy.

Although the post mortem appearances were such as are commonly found in cerebral meningitis, there was an absence of the more characteristic symptoms of that disease. The headache was never severe, and was only complained of when the patient was questioned. There were no muscular twitchings, rigidity, paralysis or convulsion, except what occurred immediately before death. The attacks of dyspnea were a peculiar feature in the case. The first occurred early in the disease, and indicated, I considered, that the lesion was in close proximity to the eighth nerve near its origin. The attacks recurred with increased severity, and the third was the immediate cause of death.

J. W. T. Smith, President

Ulster Medical Society, July 1st

Present, Dr. J. W. T. Smith (President) in the chair, Drs. Cuming, Murney, H. Brown, Porter, Hill and D. Johnston.

Dr. Murney read notes of a case of extravasation of urine.

Dr. David Johnston exhibited an acephalous f etus.

J. W. T. Smith, President

Ulster Medical Society, 3rd August

Present, Dr. J. W. T. Smith President in the chair, Drs. Murney, William MacCormac, Whitaker, Stewart, J. W. Browne, H. Brown, H. S. Purdon, Mr. Cantrell, Drs. Hill, McWilliam and Porter.

Dr. H. S. Purdon read a paper on discolouration of the skin.

Dr. Murney exhibited recent parts in a case of amputation for railway injury of leg.

¹ [Dublin Quarterly Journal of Medical Science, 1869, v48, p668.]

Moved by Dr. Murney and seconded by Dr. Whitaker "That it be an instruction to the Council to consider their minute of 28th June with reference to Mr. Monck's alleged misconduct and to report at the next meeting."

J. W. T. Smith

Ulster Medical Society, September 7th 1869

Present, Drs. J. W. T. Smith (President) in the chair, S. Browne, Stewart, Cuming, Whitaker, H. P. Rea, McWilliam, W. MacCormac, Fagan, James Moore, Wales, Porter and Surgeon Bartley (of the 54th Regiment).

Minutes of last meeting read and confirmed. Report of Council read and commented on.

Report of Council.

"Moved by Dr. Stewart and seconded by Dr. W. MacCormac that the Council, whilst strongly reprobating the conduct of Mr. Monck, is glad to find, that for some time he had ceased to be a member in accordance with Rule XIX, and that therefore, the Society would appear to be precluded from further action."

Proposed by Dr. Whitaker and seconded by Mr. MacCormac "That the Report of Council be adopted." Passed.

Professor Cuming exhibited a rare specimen of cardiac disease.

Mr. William MacCormac exhibited or introduced a patient in whom he had performed, most successfully, excision of half the tongue, the operation having been accomplished by means of the *Écraseur*.

Paper:¹ COMPLETE extirpation of the tongue is an operation of comparatively recent date, and although in the present instance only one-half the organ was removed, the difficulty of the operation is thereby increased rather than diminished. I have brought the particulars of this case under the notice of the members of this Society, because the operation is comparatively rare, the present being the first instance in which it has been performed in this hospital, and because I am able to demonstrate in the person of the patient himself, whom I present to you for inspection, how successful is the result, what complete comfort he has gained, and how trifling is the interference either with the power of articulation or deglutition.

Before operation this man suffered great pain, could only swallow with much difficulty, and, in short, was partially starved. Now he will tell you he eats, drinks, sleeps with complete comfort, and even though this relief be only temporary, it is for the time being complete.

The mode of operation I adopted was the submental. By means of a median incision between the chin and the hyoid bone and the separation of the *genio-hyoid*, *mylohyoid*, and *genio-hyoglossus* muscles from each other, I was able to pass my finger to the base of the

tongue, the thickness of the tongue proper, or somewhat less than three-quarters of an inch intervening between my finger and the epiglottis. Through this opening, by means of a strong Liston's needle, I carried first a piece of whipcord, and then, by means of it, the chain of Chassaignac's *écraseur* to the position where I desired to effect the division.

I will now give a brief history of the case:—

John Corry, sixty years of age, was admitted to hospital on account of painful ulceration of the tongue. He smokes to excess. About six months ago his tongue became sore and ulcerated, and until the present time the ulcer became gradually larger and more painful. On examination I found a ragged oval ulcer the size of a florin occupying the posterior third of the right margin of the tongue, and stretching back to the pillars of the fauces. Around its base was an indurated mass, extending nearly to the median line. There was slight enlargement and tenderness of the sub-maxillary glands on the affected side. The sore itself presented a most unhealthy appearance, and was exquisitely painful. Both deglutition and the power of speech were materially impeded.

The patient urgently asked for relief at any cost of suffering, and accordingly, on August 10th, 1869, I proceeded to remove one half of the tongue. The patient was chloroformed, and an incision made two inches in length in the median line just above the hyoid bone. With very little trouble the submental muscles of the tongue were separated from each other, and the finger reached the base of the organ. A curved Liston's needle, carrying a piece of whipcord, was passed through the centre of the tongue, emerging just above the root of the epiglottis. The needle being withdrawn, was armed with another cord, and through the same opening made to emerge at the side of the base of the tongue. It was now withdrawn, leaving a loop of cord, through which the free end of the first cord was passed, and drawn out through the wound. A loop of cord thus encircled the right half of the base of the tongue, and served to carry the chain of the *écraseur* into the required position. Another cord was adjusted after a similar fashion, passing up through the submental wound, and passing down to it again at the *frænum* so as to embrace the tongue longitudinally. By means of this a piece of strong catgut was adjusted and attached to another *écraseur* similar to Malgaigne's, of the ordinary kind recommended for such operations. This catgut had been tested beforehand, and was considered trustworthy, although it gave way during the operation, and led to some embarrassment. This was overcome by making the transverse section first, and then adjusting the chain of the *écraseur* so as to make the longitudinal section in place of dividing the tongue in both directions simultaneously. It only now remained to divide the lateral attachments of the tongue to the floor of the mouth, and the complete separation of one half the

¹ [Dublin Quarterly Journal of Medical Science, 1869, v48, p707.]

tongue was effected, the section being made on all sides clear of the disease. The division was effected at the rate of one click of the *écraseur* handle per quarter minute. No bleeding whatever occurred from the divided surfaces, and although unnecessary delay was caused by the operation being performed in three stages and with one *écraseur*, it was completed in two hours. After the preliminary steps were completed, the administration of chloroform was abandoned.

Had I to perform this operation again I would certainly use, in preference to all else, Chassaignac's *écraseur* and articulated chain. It has a sawing alternate sort of motion which divides the tissues better, with less risk of hemorrhage, than either the wire rope, or cord, or catgut, which, in point of fact, is not strong enough. Had the entire tongue required removal, two applications of the *écraseur*, one vertical, the other horizontal, would have completed the extirpation in less time, and with greater ease. I would also divide the gustatory nerve as a preliminary step, in accordance with Mr. Hilton's recommendation.

The subsequent progress of the patient was everything that could be wished. The same evening when I visited him he was not depressed, nor was there any bleeding. There was a copious secretion of glairy saliva. On the 14th, four days after operation, the report mentions that the patient was "quite easy, no shock or fever, pulse 88. Wound in the neck perfectly healed, except at one point, where there exuded a few drops of pus. He takes arrowroot, and drinks milk, rinsing out the mouth with carbolic acid gargle. He was able to sit up." Next day the wound beneath the chin was found to be completely healed. The state of the tongue and mouth perfectly satisfactory, and he felt so well as to be able to go out of doors. In short, he was reported perfectly convalescent. In a few days more the wounded surface of the tongue healed also, and he felt an amount of ease and comfort, together with absolute freedom from pain, to which he had been long a stranger. I have only kept him in the hospital, somewhat against his will, in order that he might be able to show himself to you to-night, when you will be able to judge of his condition.

The patient here presented himself for the inspection of the members. He expressed the warmest gratitude for the change in his condition, which was now everything that he could desire. He could speak in such a way as not to attract remark, and looked extremely well. On examining the mouth it was difficult to imagine so large a portion of the tongue had been removed, and no trace of diseased action anywhere remained. The portion of tongue removed, exactly one-half of the organ, was also exhibited.

Nothing could well be more satisfactory than the result achieved, and although the disease will almost inevitably return, the poor man will enjoy a period of complete immunity from suffering. His former condition may be realized when I tell you he begged that

some operation should be attempted, even though he should die during the course of it, or immediately after, his sufferings were so unendurable. When we contrast this mode of operation with that of Mr. Syme, who divided the lower lip, chin, and lower jaw, holding its halves asunder while the base of the tongue was swept across with the knife, or the diseased parts dissected out, we cannot wonder at that surgeon strongly objecting to the propriety of attempting this operation, although he himself was one of the first to perform it.

Regnoli successfully extirpated large portions of the tongue by pulling it down through a large wound made along the inner border of the lower maxilla from one angle to the other; and Mr. Gamgee and other surgeons have likewise adopted this method. These are, however, most severe procedures compared with that introduced by Chassaignac in 1850, to whom the invention undoubtedly belongs. The *écraseur* divides the tongue with great ease, and it is necessary not to permit the instrument to do its work too quickly. The long periods, extending to forty-eight hours, which were consumed in Chassaignac's first operations, are by experience found needless, but I would exercise much caution in going to the opposite extreme, when all the advantages of the method will be lost.

Mr. Nunneley, as he mentions in his address delivered to the British Medical Association at Leeds, has since practised M. Chassaignac's operation with great success, having performed it some nineteen times. Mr. Jessop, in a letter to the British Medical Journal of September 4th, 1869, establishes Chassaignac's claim to priority, which Mr. Nunneley had seemed to assume for himself. Before Chassaignac, Jules Cloquet had described this operation, using the ligature in place of the then unknown *écraseur*.

Mr. William MacCormac narrated three cases of strangulated hernia upon which he operated, giving interesting details of each.

The thanks of the meeting were accorded to him and Professor Cuming for their instructive and interesting contributions.

Dr. Samuel Browne read a letter from Dr. Martin of Portlaoise (President of the Irish Medical Association) in reference to the introduction of scientific matter into the Association so as to have a similar basis to that of the British Medical Association at the same time remaining distinct from the latter corporation.

Dr. S. Browne, whilst advocating the object of the letter, desired to ascertain the feeling of his professional brethren in Belfast for the subject.

Professor Cuming thought the change should succeed but he considered that it would be putting the members at a disadvantage not to give them time for consideration on the subject. Still he questioned if medical science could easily be shoved into a society of the character of the Irish Medical Association.

Dr. McWilliam thought an Irish branch of the British Medical Association would be better.

Mr. MacCormac agreed with Dr. McWilliam.

Several remarks followed from other members whereupon the President stated that the proposition did not appear to be favourably considered.

Dr. S. Browne then said that he would write and state the foregoing remarks to his correspondent (Dr. Martin).

J. W. T. Smith

23rd November 1869

Present, Dr. J. W. T. Smith President in the chair, Drs. Stewart, Cuming, Murney, MacCormac, John Moore, McWilliam, Fagan and Hill.

Dr. William MacCormac showed a tumour of the tibia which he had removed by amputation through the knee joint and gave the history of the case.

It was diagnosed by Dr. MacCormac and his colleagues as a benign growth, but the microscope showed that it had characters of a malignant type. It will be interesting to watch the further history of the case.

Dr. MacCormac also referred to a somewhat similar case where he had removed the leg for a malignant growth and the history of which he detailed to the Society on the 21st December last.¹ He stated that the case had turned out as he expected unfortunately, the patient having died recently with every appearance of secondary malignant growths on different parts of his body.

Dr. William MacCormac then showed some calculi which he had removed by lithotomy. He also showed the patients. Dr. William MacCormac then detailed the history of a case in which he had excised the head of the humerus.

Dr. William MacCormac then gave the history of a case of injury of the elbow joint in which he excised a part of the humerus containing the fractured parts of the bone along with the head of the ulna and radius. About 4 inches of the humerus was removed. The parts of bone removed were shown.

J. W. T. Smith

Ulster Medical Society, 21st December 1869

Present, Dr. J. W. T. Smith President in the chair, Drs. Cuming, William MacCormac, McWilliam, John Moore, Wales, Fagan, McMeekin, Porter and Hill.

Dr. John Moore read a paper on craniotomy and detailed the history of six patients in whom the operation had been performed altogether twelve times at different periods.

Dr. Cuming then showed a preparation of abdominal aneurism.

J. W. T. Smith

Ulster Medical Society, January 4th 1870

Present, Dr. Smith (President) in the chair, Drs. Hill, John Moore, McWilliam, Fagan, J. W. Browne, and Porter.

The President read notes on a case of "Erysipelatous after labour". The erysipelatous patch occurred near the anus where piles were situated. In 4 days the eruption crept over the right loin. In a week it had extended over both buttocks. The primary treatment consisted of Quinine, Milk, Eggs, Wine, and Tincture of Muriate of Iron together with the local application of Caustic. No medicine at first seemed to have any effect. Dr. H. S. Ferguson recommended the use of Bisulphite of Soda which had to be discontinued owing to the diarrhoea produced by it. Stimulants, nourishment and opiates then constituted the treatment. The patient was out of danger at the end of a month but not thoroughly well for several weeks after. It was subsequently discovered on enquiry that the nurse in this case had recently been attending a lady suffering from erysipelatous.

Dr. McWilliam next read notes of "A Case of Scarlatina during the progress of which labour occurred". The patient received contagion whilst attending upon her child. She nourished her infant for ten or twelve days after its birth. This infant was in utero for two days during the scarlatinal poisoning of the mother. It was born free from the disease and remained so. The patient is now ill in typhus.

Dr. John Moore then read notes of "A Case of Paraplegia" and gave P.M. results. The only treatment from which benefit was derived was the subcutaneous injection of morphia. There was swelling of the limbs, which Dr. Thompson of Lisburn diagnosed as consequent on a pelvic tumour. The P.M. proved his diagnosis correct.

John Moore

Ulster Medical Society, January 18th 1870

Present, the President (Dr. Smith) in the chair, Drs. John Moore, James Moore, Stewart, Whitaker, Thomas Reade, J. W. Browne and Porter.

The President exhibited a heart with extensive disease and gave a history of the case. The woman in whom the disease occurred exhibited many peculiar signs and symptoms. The diagnosis was clear as to mitral regurgitation. The signs over aorta were not healthy. The pneumonia which was present shortly disappeared.

The P.M. revealed disease of the aortic, mitral and tricuspid orifices. The condition of the aortic orifice was worse than might have been expected from the signs during life. The rarity of systolic murmur was corroborated by this case. There was no dropsy present. The pneumonia must have been acute as it resolved itself in hospital. There was an absence of the peculiar pulse of aortic regurgitation. There was minimal thickness of the mitral valve.

¹ [See page 1126.]

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The case was afterwards commented upon by Dr. Thomas Reade and other members.

Dr. Angus Porter next read a portion of a paper on “Syphilis”, which was followed by comments from Drs. James Moore and Reade.

John Moore

Ulster Medical Society, February 1st 1870

Present, Dr. John Moore (Vice-President) in the chair, also Drs. Thomas Reade, H. P. Rea, McCrea, H. Brown, Porter, McWilliam and H. M. Johnston.

Dr. John Moore read a paper on the “Recent Epidemic of Scarlatina” and went into statistics of the cases, from which it appeared that in 66 families, 132 instances of the disease occurred. As regarded the sequelæ 6 cases were followed by suppurating glands and three times that number by dropsy.

A discussion then took place on the question of Weekly Returns of the Causes of Death etc., from the dispensary Medical Officers, Dr. John Moore urging the necessity of increased facilities in this respect.

The general remarks made by the members present appeared to be opposed to Dr. Moore’s views.

J. W. T. Smith

Ulster Medical Society, 1st March 1870

Present, Dr. Smith (President) in the chair, Drs. John Moore, William MacCormac, James Moore, McWilliam, H. Brown, H. S. Purdon, Mr. Cantrell, Drs. Porter and Hill, and as visitors Drs. Dougherty, Armstrong and Mackenzie.

The peculiar case of monstrosity at present being exhibited in town was introduced by Dr. H. Brown who gave an interesting account of the case.

Mr. William MacCormac then gave an account of a case of acute periostitis of the tibia in which it had been found necessary to amputate. The amputation was performed through the knee joint.

At the time he appeared to be in a desperate condition and Mr. MacCormac believed that the reason the boy had escaped pyæmia was that the operation was performed through the knee joint instead of through bony tissue. The specimen was exhibited.

Dr. William MacCormac then showed a patient from whom he had removed a bony tumour of the jaw. The operation was performed only a fortnight ago and yet union has taken place sufficiently strong to allow the boy to masticate.

Dr. James Moore then gave particulars of a case of fungus hæmatodes and at the same time alluded to several operations for the removal of tumours from the same patient. These were brought before the Society last year.¹

Dr. MacCormac then read a paper on cases of syphilis after which it was resolved to hold a Special

Meeting on the 8th March to discuss the Contagious Diseases Act.

J. W. T. Smith

Ulster Medical Society, 8th March 1870

Present, Dr. Smith President in the chair, Drs. John Moore, William MacCormac, McWilliam, Wales, Cumming, Fagan, McGee J.P., Ross, H. Brown, Murney J.P., Walton Browne, Mr. Cantrell, Dr. Hill and as visitors Drs. Dougherty, Armstrong, Bacot and Croker.

The President having stated that this was a Special Meeting called for the purpose of discussing the Contagious Diseases Acts, introduced the subject by laying before the Society a résumé of the various agreements brought forward for and against the acts.

After a long discussion it was proposed by Dr. McGee J.P. “That in the opinion of this Meeting it is expedient to take action for the extension of the Contagious Diseases Acts to the civil population”. Seconded by Dr. Murney and carried with only two dissentient votes. It was further resolved

That the operation of the Contagious Diseases Acts of 1866 in the naval and military towns to which it had been applied has been attended with much success on checking the amounts and severity of the diseases against which it was enacted.

That it has tended to increase morality and to diminish open vice without legalising the latter.

That owing to its operation being confined to only a few towns, and to the imperfect manner in which the provisions of the acts have hitherto been carried out its effectual working is greatly impeded.

That deploring the prevalence of these diseases in this town and in the population of this country,

We believe that such laws should be enacted as shall extend the principles of the said acts to the civil population of the United Kingdom.

It was also resolved that every member of the Society should have an opportunity of signing the document before taking any steps towards publishing the resolution.

It was also resolved that these resolutions be embodied in a Petition to Parliament.

J. W. T. Smith, President

Ulster Medical Society, April 12th 1870

Present, Dr. Cumming in the chair, Drs. Murney, W. MacCormac, James Moore, H. Brown, Anderson, Porter (Secretary).

Dr. Murney gave a very accurate and interesting account of a case of malignant disease of the thigh, necessitating amputation. The operation was performed almost at the joint; the head of the femur and both trochanters being left. The tumour for which the operation was performed occupied the middle third of the thigh and previous to operation became adherent to the bone. Dr. Murney stated that it had formed

¹ [See page 1126.]

within five weeks and that in the month of February it had attained the size of a cocoa nut. Today the patient is reported as doing well and having spent a good night.

In reply to Dr. Moore, Dr. Murney said that the superficial appearance of the tumour, at first, was that of an encysted tumour.

Dr. Moore thought that an exploratory operation might have been adopted to determine beforehand the true character of the tumour.

Dr. Murney remarked on Dr. Moore's observation that the nature of the growth removed on the 1st February had helped to determine him in the course pursued.

Dr. Murney then exhibited a morbid specimen of knee joint disease, implicating the head of the tibia especially at its inner side. Amputation was performed immediately above the condyles of the femur as extensive disease was found in the bones of the joint. One of Teale's operations was adopted. Up to the present the lad had done well. Carbolic dressings were used.

Dr. W. MacCormac next exhibited a diseased tibia (with extensive loss of periosteum and bony substance) which he had removed by amputation of the leg through the knee joint, from a young female child. Previous to operation a diseased condition of the joint was ascertained.

The patient's health having begun to suffer Dr. MacCormac decided on taking off the limb which he did this morning at the site mentioned. The condyloid end of the femur was discovered to be perfectly sound. The stump was well washed with carbolic dressing. Dr. MacCormac concluded by remarking on the advisability of forming the posterior flap first.

J. W. T. Smith

Ulster Medical Society, 26th April 1870

Present, Dr. Smith President in the chair, Drs. Cum-
ing, John Moore, William MacCormac, McWilliam,
Harkin, J. W. Browne, Fagan, H. Brown, Porter and Hill.

Minutes of last meeting read and confirmed.

Dr. Murney exhibited a specimen of brain diseased by alcohol.

Dr. Harkin related a case of scarlatina in a dog.

Dr. Fagan exhibited a specimen of hydatids expelled from the womb in which brandy and ergot were employed.

J. W. T. Smith

Annual Meeting Ulster Medical Society, 3rd May 1870

Present, Dr. J. W. T. Smith President in the chair, Drs. John Moore, Stewart, McWilliam, Gribbin, W. MacCormac, Fagan, J. W. Browne, H. P. Rea, H. Brown, and Porter.

Dr. Porter read the report of the Council.

Dr. W. MacCormac then read the report of the Treasurer.

Moved by Dr. John Moore and seconded by Dr. Gribbin that the report of the Council be adopted.

Moved by Dr. Stewart and seconded by Dr. Hill that the report of the Treasurer now read be adopted.

The members then proceeded to elect office bearers with the following result

President

W. MacCormac M.A., M.D., L.R.C.S.L., M.R.S.A.

Vice-Presidents

Drs. Stewart and Murney

Council

Drs. Porter, Hill, McWilliam, Fagan, Browne, Rea

Treasurer

Dr. J. M. Pirrie

Secretary

J. Walton Browne B.A., M.D.

Dr. Smith having left the chair it was taken by Dr. William MacCormac.

Proposed by Dr. Stewart, seconded by Dr. Gribbin and carried unanimously that the best thanks of the Society be given to Dr. Smith for the valuable services rendered by him to the Society during the past year.

Proposed by Dr. Smith and seconded by Dr. John Moore that the thanks of the Society be given to the retiring Secretaries, Drs. Hill and Porter.

It was moved by Dr. Hill and seconded by Dr. Smith that in future there be only one Secretary to the Society.

Proposed by Dr. John Moore that the privileges of Life Membership be not accorded to future members.

Moved as an amendment that the privileges be extended only to members of 30 years duration.

It was then moved by Dr. Stewart that the subject relating to the privileges of Life Members be considered at the next Annual Meeting.

Moved by Dr. Stewart and seconded by Dr. Hill and passed that "Journals" do lie upon the table of the library for a period of one week, in order that they may be consulted by the members of the Society before being circulated.

Moved by Dr. John Moore and seconded by Dr. Gribbin that the day of meeting be changed from Tuesday at 7.30p.m. to Saturday at 3.30p.m.

Dr. J. Walton Browne and Dr. Hill were appointed to examine the Museum during the summer.

Dr. H. Brown and Dr. Fagan were appointed a Library Committee and requested to examine and report upon the condition of the library.

Robert Stewart, Chairman
13th May 1870

Ulster Medical Society
Session 1870–1871
President William MacCormac

ULSTER MEDICAL SOCIETY

SESSION 1870–71

Special Meeting, Belfast General Hospital, 15th May 1870

The President (Dr. MacCormac) in the chair, present, Drs. Stewart, Dr. Whitaker, Dr. Brice Smyth, Dr. H. S. Purdon, Dr. J. E. Beck, Mr. Grattan, Mr. Pring and Dr. J. Walton Browne.

“For the purpose of considering the laws about to be made as regards the compounding of medicines in this country.”

Mr. Grattan said that by the laws of the Pharmaceutical Society of England, all persons prior to the year 1867 who had been occupied as druggists, would be allowed by passing a very modified examination to practice as a properly qualified Apothecary and be put upon a level with the Licentiates of the Apothecaries Hall, Dublin.

Dr. Whitaker had no objection to members of the Pharmaceutical Society of England coming over to Ireland and practicing as Apothecaries, but he had a decided objection to men, who had formerly been mere druggists, passing a modified examination, coming over to practice in Ireland as Apothecaries and at once putting themselves upon the level with the Licentiates of the Apothecaries Hall (Dublin).

Dr. Whitaker urged upon the Society to take steps to represent to Government to see that the standing of the Candidates for the membership of the Pharmaceutical Society should not be lowered.

Dr. Whitaker proposed and Dr. Stewart seconded that a Sub-Committee consisting of Drs. MacCormac, Walton Browne and Messrs. Grattan and Pring be formed to draw up a memorial to Parliament.

Petition written and forwarded to Thomas McClune Esq. M.P., 17 May 1870

To the Right Honourable and Honourable the Members of the House Of Commons in Parliament assembled

Petition of the Ulster Medical Society humbly
sheweth

That for the last seventy-nine years the practice of Pharmacy in Ireland has been exclusively carried on by the Licentiates of the Apothecaries Hall Dublin, to whom the special privileges were accorded by Act of Parliament.

That during that time Pharmacy in Ireland was and still continued to be conducted in such a manner as to give satisfaction and confidence both to the Medical profession and to the public.

That it has been brought under the notice of your petitioners that a Bill to amend the laws relating to Pharmacy in this country has been laid before your honourable house.

That your petitioners would earnestly deprecate any change which would tend to lower the standard of special pharmaceutical knowledge at present required to be possessed by Licentiates of the Apothecaries Hall, Dublin.

That your petitioners consider that any person (not at present qualified to do so) wishing to open shop in Ireland for the practice of Pharmacy or compounding of medicines, previously to his being admitted to do so, should follow a prescribed course of study in matters relating thereto, and give prove by examination of his fitness for the discharge of pharmaceutical duties.

Your petitioners therefore humbly request your honourable house to take into consideration this memorial.

Signed upon behalf of the members of the Ulster Medical Society.

W. MacCormac P.R.C.S.I., President
J. Walton Browne B.A. M.D., Secretary

Ulster Medical Society Special Meeting, 23rd May 1870

Dr. MacCormac (President) in the chair. Present, the Mayor (Dr. Samuel Browne R.N.), Drs. Murney, H. P. Rea, Stewart, Thomas Reade, H. Brown, Hill, McWilliam, Cuming, Whitaker and Dr. J. Walton Browne. Also Mr. Grattan.

To consider 1. The new Medical Act Amendment Bill. 2. The question of the representation of the Medical Profession in the Medical Council. 3. The new Irish Pharmacy Bill.

The President pointed out the purpose of the Medical Act Amendment Bill, and read over several clauses.

Moved by Dr. Cuming and seconded by Mr. Grattan that for the satisfactory working of the new act it is necessary that the Apothecaries Hall of Ireland should cease to be one of the Medical Authorities, and no longer send a representative to the Medical Council. That the Apothecaries Hall should be [devoted] to the science and practice of Pharmacy, and that their function as a body competent to license practitioners of Medicine and Surgery should be cancelled by the act.

Second resolution. Proposed by Thomas Reade, seconded by Dr. Stewart and resolved, That we decidedly disapprove of the too absolute powers given to the Privy Council of negating any schemes proposed for adoption to the Privy Council by the Medical Council.

Third resolution. Proposed by Dr. Whitaker and seconded by Dr. Hugh Porter Rea. That the Diploma

of Licentiates granted by the Examining Board be an Imperial Diploma and bear nothing on the face of it to show in what part of the United Kingdom it was granted; and that the second column in schedule three be expunged and also the portion of clause fourteen bearing on the subject.

Moved by Dr. Stewart and seconded by Dr. Hill That the foregoing resolution be embodied and forwarded to Parliament.

W. MacCormac, President
November 5th 1870

First Meeting 5th November 1870

Dr. W. MacCormac in the chair, Drs. J. Moore, W. McGee, Drennan, H. S. Purdon, Ball, Fagan, W. Browne, Harkin, McWilliam, H. P. Rea, Mr. Wood, Dr. T. H. Reade, Dr. Wales, Mr. Grattan, Dr. H. Anderson, Dr. H. MacCormac, Dr. Stewart, Dr. Murray, J. M. Pirrie, Dr. F. E. Beck, Dr. H. M. Johnston.

Minutes of previous meeting having been read the President Dr. W. MacCormac gave the opening address—Surgical experience gained during the present war.¹

Second Meeting 19th November 1870

Present, Dr. Stewart in the chair, Drs. Browne, Reade and John Moore.

Dr. John Moore was to have read a paper upon pyæmia but as the meeting was very small the reading of the paper was postponed until this day fortnight.

Third Meeting of the Society 3rd December 1870

Present, Dr. Stewart, Vice-President, in the chair, Drs. MacCormac, John Moore, Fagan, Brice Smyth, McWilliam, and Murney.

Dr. John Moore read notes of a case of pyæmia occurring in the person of a millworker who had received a laceration of hand requiring removal of a finger which was performed in the Belfast General Hospital where the patient was retained until the wound was nearly cicatrized.

The symptoms of pyæmia set in a fortnight after the dismissal from hospital, the case terminated fatally.

Dr. Murney, J.P., gave the history of a case of excision of the shoulder joint for necrosis of the humerus.

Dr. Murney exhibited the recent parts of a case of luxation of the femur at the lower margin of the ischiatic foramen.

Dr. Murney also exhibited a patient with an extensive healing surface on the dorsum of the hand on whom he had transplanted skin four times.

John Moore, Chairman

Fourth Meeting December 17th 1870

Drs. John Moore; in the chair, H. MacCormac, John Smyth, H. S. Purdon, MacWilliams, J. Walton Browne, A. M. Porter.

Dr. H. MacCormac read the first portion of his paper entitled “Some remarks on the more recent progress of anatomical science—general and comparative.”

Paper:¹ *Some Remarks on Structure and Function, in Advocacy of the Spiritual Origin and Direction of Life, in Contradistinction to Blind Brute Force and Automatic Will.*

Anatomy, human and comparative, general and special, in its present state of approximate perfection, is the result of the labours of a long series of inquirers. Aristotle, that great genius, made it, among so many other matters, the subject of his careful attention. He did not understand the action of the muscles, although he noticed their development, as it varied in different classes of animals. On Erasistratos of Ceos devolved the credit of determining that, in order to act, a muscle must needs contract;² also the discredit if, indeed, it be true, of dissecting men alive. Galen pointed out that blood filled the vessels and the heart, showed how lesions of the nerves and medulla implicate muscular action, and even induce paralysis. Passing over some fourteen centuries of barbarism and contention, we come to Berengarius, of Bologna, a city which he was constrained to leave, charged with having examined the bodies of a couple of Spaniards ere the vital spark had fled. This able anatomist, by his multiplied inquiries, paved the way for his successor Vesalius who, singular to relate, incurred a like evil repute in respect of a Spanish nobleman by him erroneously imagined to be dead, and only escaped through the intercession of Philip II., on condition of a journey to Jerusalem, perishing on his way back.

Servetus first appears to have made known the cardio-pulmonic circulation, and likewise the depuratory action of the lungs. Eminent as a philosopher, happening to differ on a speculative point from a no less eminent divine, he was by him and others, infamous and almost incredible to relate, entrapped and burnt alive, a frightful example of the irony of fortune, in that he who lavished the divine gifts of genius on his species should experience destruction as the requital in return. Malpighi distinguished himself in numerous particulars, among the rest by the employment of the microscope in anatomy.

Harvey's demonstration of the greater circulation, at or about the year 1618 or 1619, was simply and truly the result of the admirable application of anatomical knowledge. He was not, indeed, the first to detect the valvular structure of the veins, but he was clearly the first to deduce from that structure the immensely

¹ [Not found but see his book *Notes and Recollections of an Ambulance Surgeon*, London, J. & A. Churchill, 1871, for his experience.]

¹ [Dublin Quarterly Journal of Medical Science, 1871, v51, p371.]

² Marey, *Du Mouvement dans les Fonctions de la vie*, p. 9-11.

important inference that registers his name in the records of our kind.

Valsalva, and his pupil Morgagni, both made amplest contributions to anatomical science in their time. The discovery of the pancreatic duct has been ascribed to Wirsung, as well as to Eustachius, who made known to us in detail the tubes which bear his name. Pecquet detected the chyliiferous ducts, while Rudbeck and Bartholinus determined the constitution of the lymphatics. Ruysch was indebted to Swammerdam for a knowledge of the material which he employed in making his admirable injections. Having disposed of his first museum to the Russians, Ruysch, who had been meanwhile disabled by a fall, employed himself in the formation of a new one, a task in which, it may prove of some interest in these days of lady doctors to remember, he was most ably assisted by his youngest daughter. Not those great men only whom I have named, but many others, as Albinus, Winslow, Vicq d'Azyr, Stahl, Hoffmann, and others, by their zealous toil and persevering industry, very greatly added to the sum of our attainments. Of Haller, indeed, it is difficult to speak in terms of moderate eulogy, so great were his achievements in almost every branch of anatomy and physiology.

Few observers, however, whether English or foreign, surpassed the Hunter brothers in respect of the interest and importance of their inquiries. Their collections, the Hunterian Museum of London in especial, are replete with evidence of their vast research, and can never, I think, entirely lose their value, however far reaching may prove the results of future inquiry. The world has endorsed the well earned repute of these our medical fathers, some of whom, though now securely illustrious, paid dearly enough for the position to which it has been their great good fortune to attain.

Anatomy is the science of organization, the knowledge of what Haller tersely styles the fluid and solid parts.¹ Organic unity is the great, the momentous fact of living nature. Initiated by the Greeks, its truth seems now admitted by every investigator. There is no origin or beginning in the body, observes wise Hippocrates, the parts, all of them, are equally, both beginning and end, for in a circle there is no beginning.² A like remark might be applied to the living functions which, in fact, are solidary of each other, without beginning as without end. Geoffroy Saint Hilaire attached less moment, however, to the organs, with their variable forms and functions, than he did to their composition, together with, as he named them, the four laws of organic life, to wit, the theory of analogues, the principle of connexion, elective affinities, and the balance of the organs them-

selves.¹ Every organism, indeed, undergoes, or if you will, performs, a series of acts from birth to death, various, however, as the conditions of life and organization themselves vary.²

According to Milne Edwards, speaking of the constituents of the living frame, the form and disposition of the different tissues and dimensions of the organic molecules or globules, are alike in all animals. The diameter of the molecules he lays down as $\frac{1}{300}$ of a millimetre.³ The fundamental material of all the tissues, nerves, bones, muscles, and connective tissue alike. Dr. Lionel Beale, who has isolated it by submitting it to the action of the ammoniacal solution of carmine, terms bioplasm, or living plasm, germinal or growing matter.⁴ It is particularly abundant, he tells us, in the muscular tissue of the heart, where new tissue is incessantly formed to replace that which so rapidly wears away.

Bichat reckoned up fourteen several tissues, leaving out, singular to relate, the cellular tissue, most important and generally diffused of any, since it is, in fact, the common matrix or mould of that by which and in which each and every structure is imbedded, pervaded, and enclosed, the basis of bone, the bulk of the viscera, arteries, veins, nerves, and absorbents.⁵ The occurrence of emphysema after certain wounds, the custom once common of fraudulent butchers in blowing up meat, and of horse chaunters in filling up the hollow above the eye in aged horses before selling them to unwary customers, as well as the practice of a wretch in London who used actually to blow up the subcutaneous cellular tissue in a little boy, whom thus distended, he exhibited as a show, all go to prove the great pervasiveness of the cellular tissues.

Van der Hoeven reduces all the tissues to eight, as the conjunctive, vascular, adipose, nervous, corneous, cartilaginous, muscular, and elastic.⁶ The cellular, vascular, and nervous, Meckel esteems the fundamental tissues.⁷ Rudolphi unites with Haller in dividing animal structures simply into solids and fluids,⁸ assigning, however, as Aristotle did before him, the preponderance to the fluid.⁹ If one, however, would have other than the merest general ideas, one must, perforce, isolate the tissues.¹⁰ No animal, save man, the anaploterium excepted, observes Cuvier, has an uninterrupted series of teeth.¹¹ And man, too, I would say, is also the only

¹ Primae Lineae, cap. i.

² πάντα δμοίως ἀρχή και πάντα τελευτή, κύκλου γραφέντος ἀρχή ουκ εὔρεθη. De Locis. The subject is adverted to by Le Clerc, Part i., Book ii., of his history, as well as by his continuator Friend, and writers on the history of medicine generally.

¹ Mémoire sur la Structure des Tissus, cited by Meckel.

² Marey, Du Mouvement dans les Fonctions de la Vie, p. 8.

³ Physiologie.

⁴ The Mystery of Life, p. 36.

⁵ Drummond, First Steps to Anatomy, p. 44.

⁶ Handbuch der Zoologie, Band i., s. 9.

⁷ Anatomie Générale, Jourdain and Breschets tr., p. 103, 121.

⁸ Grundriss der Physiologie, i. Band, s. 66.

⁹ πολὺς γὰρ υγρὸς, De Generatione Animalium.

¹⁰ Vous pouvez considerer chaque organe en masse, mais il est absolument necessaire d'en isoler les tissus si vous avez envie d'analyser avec rigueur sa structure intime. Additions à l'Anatomie Generale de Xav. Bichat, Elemens Anatomiques.

¹¹ Regne Animale.

one in which the incisors form a right angle with the plane of each jaw.

The facial angle on which Camper laid so much stress, and which the Greeks so greatly exaggerated in their ideal statuary, according to Meckel, is seventy-five in the Mongolian and eighty degrees in the Caucasian man. Our erect stature, although at a great expenditure of means, may be said to be exclusively our own. And half the head, which is the case with no other creature, a fact, so far as I know, first stated by Winkelmann, in his admirable essays on art, is placed above the plane of the orbit. In other respects man, as Huxley insists,¹ shares certain morphological conditions with other animated organisms, but, when classed, each group displays structural characters common to the members of that group only, and isolating it from all others. Thus, among the vertebrates, mammals possess two occipital condyles, a well ossified basioccipital, each ramus of the mandible composed of one bone articulated with the squamous element of the skull, and non-nucleated red blood corpuscles.

The basis of medical science, observes Pinel,² reposes on facts, it is so also in anatomy, it is so in everything. But, as Aristotle says, we must proceed from the simple to the complex, from the better to the less well known, just as in dealing, for so he puts it, with³ coins, ὄσπερ νόμισματα. Science, in truth, is progressive ever. But while the inquirer busies himself with one portion, the rest is advancing ceaselessly, so as to render it difficult to retain everything within his grasp.

Without impeachment of the claims of any, a more remarkable person than Bichat has never, perhaps, adorned the great cause of anatomical research.

And however well-founded may prove the undoubted merits of our Homes, Hewsons, Pritchards, Carpenters, Goodsirs, Busks, Bowmans, Hassalls, Ralphs, Bennetts, and others, to Bichat is certainly mainly owing the foundation of modern general anatomy. Born in the department of the Ain, he removed at an early period of his career to Paris, where, having been one day called upon without any special preparation or previous notice, to report, *vira voce*, a lecture of Desault, the person charged with that duty having failed to appear, he acquitted himself so admirably that the great surgeon at once received him in his house and treated him as a son. Struck with the masterly manner in which Pinel had treated of the serous and mucous membranes, Bichat himself took up the topic, and, some time after, published his book on the Membranes, followed, in succession, by his *Life and Death*; and lastly, his *General Anatomy*.⁴ A fall down the stairs of the Hôtel Dieu, resulting in fever and death, to the infinite regret of every one, brought

Bichat's indefatigable energies to a close, and, at the comparatively early age of thirty-one, robbed the world of the ablest and most philosophical anatomist for his years that had ever lived. His writings, though somewhat over copious, are replete with keen inference and admirable research. It was Bichat's ambition to found medicine on anatomy, and doubtless, had he lived, he would at least have striven to compass his design. Those who have nothing to say, observes one of his biographers,¹ are prone to tell you that everything has been said. It is quite otherwise, however. Before the man of true genius and observation the fields of discovery extend far and wide. To him, indeed, nature delights to unseal her hidden treasures, treasures that remain hidden to the idle and inapprehensive. As it is, Bichat has left amplest materials for thoughtful investigation, and, as thus, has bequeathed a heritage which, or at least much of which, must, I think, for ever endure.

It seems to be a condition of progressive thought and action that the inquirers of one age shall conduct a series of investigations to a given point, when others shall take them up, and, perchance, achieve results which to the first are simply unthought of and unknown. Such, in effect, have proved the issue of the labours of Dr. Lionel Beale and M. Charles Robin, both ardent cultivators of histological and general anatomy, as contrasted with and supplementing those of Xavier Bichat. Older anatomists were at least excellently well acquainted with the general outline, the bones, muscles, nerves, vessels, and viscera of the living frame. Bichat, however, showed that there were other things to be considered also, and came forward with his famous, but at the same time somewhat artificial, division, into symmetrical organs or those of animal life, and the non-symmetrical or those of organic life, the first comprising the brain, spinal marrow, their nerves, and appendages, the second including the vascular system, great sympathetic, digestive, respiratory, and renal apparatus.²

Dr. Beale's most recent exposition appears in his work, *The Mystery of Life*, setting forth his reasons for dissenting from those who esteem structure and function merely correlations of matter and the ordinary material forces of nature, resultants, in fact, of the non-living world, instead of, as he states in his treatise on protoplasm, a power, force, or property of a special peculiar kind, temporarily influencing matter, and its forces, but different from, and not merely correlative with, them. I most cordially concur with Dr. Beale that Life is not the result of the brute forces of nature, and proceed at once to cite from his truly important remarks on bioplasm. Connected with every tissue, he tells us,³ are certain oval, circular, or irregular masses. These soft structureless masses, differing from matter

¹ Introduction to the Classification of Animals, p. 8.

² Nosographic Philosophique, 6ième ed., Tome i., p. xciii.

³ Historia Animalium, lib. i., cited by Van der Hoeven.

⁴ Anatomie Generale. Nouvelle édition.

¹ Notice Historique, par Scipio Pinel.

² Meckel, Anatomie Generale, Jourdain's tr., Tome i., p. 94.

³ Mystery of Life, p. 35.

in every other state, he terms bioplasm. By subjecting tissues, immediately after death, to the action of carmine in ammonia, bioplasm is obtained of a deep red colour, while the tissue, nerve and muscle alike, remains colourless. The aspects of bioplasm, thus coloured, Dr. Beale has set forth in his admirable plates. This important constituent of living bodies, being normally colourless, has even been passed over as of no moment, its presence regarded as accidental, and every trace of it omitted in text-books. Five times as many bioplasts exist in the heart, owing to the activity of the changes in its muscular tissue, as in ordinary muscular fibre. Some bioplasts go to form muscle, others nerve. Others again form connective tissue, but nerve bioplasm cannot be distinguished from that which makes up muscle, or either of them from connective tissue bioplasm. At an early period indeed, when the heart, in this instance speaking of the hyla or tree toad, is represented by spherical bioplasts, there is not a vestige of muscular or nervous tissue, but merely the living matter by which alone the formation of such tissue is possible. As development advances, however, the bioplasts recede from each other, and tissue appears. But the bioplasm does not disappear. It continues to take up nourishment, which is converted into bioplasm, and thence, *pari passu*, into tissue. Into Dr. Beale's further remarks on the distinction which he draws between life and mere physical force, I need not here further enter. Not only on these grounds, however, but in respect of his remarks on minute nerve structure, his treatise deserves the most careful study.

The humoral pathology and physiology once so extensively in vogue, was perhaps too summarily dismissed. In strictness, the humours, the blood, are solidary, in fact, part and parcel, in respect of life and function, of the tissues. The solids are made up of various ingredients, principles, in truth, anything but homogeneous, which M. Robin divides into three classes.¹ They constitute the simple principles of biology, not less essential in the interpretation of living facts to the anatomist, than are those of chemistry and natural philosophy to the student of physics.² The determination of muscular action and creation of power through the mere fiat of the will, is one of the most wondrous particulars nay, the most wondrous particular, of animal life. It is a power shared by the whole animal creation, but how it takes place we neither can know nor imagine. It is accomplished, at least speaking of the voluntary muscles, through no brain action, no conscious or unconscious cerebration, seeing that there is nothing of the sort considered as a mental act, but through a direct volition of the intelligence.

Felted and welded together, the anatomical elements make up the basis of the individual. They comprise the

variously formed cells, fibres, and tubes. Cell structure, excessively diffused, includes the red and white blood corpuscles, the elements of bones and nerves, with those of the central nerve substance, ganglions and epidermis. Elementary muscular fibres vary as they belong to those of organic or animal life, to borrow the language of the writer of the very able summary in the *Revue*. The connective and elastic tissues are also constituted of special fibres. There are tubiform elements in the nerves of animal life, white filaments of the great lymphatic, the myolemma which envelops the fascicles of the muscular fibres of animal life, capillaries, glands, parenchymatous structures, and lastly, the tubes which go to make up the nerves. M. Robin discriminates carefully between the tissues and their anatomical elements, invisible to the naked eye, wherein life's fire doth mainly burn. The red blood globules are of an infinite and hitherto quite unsuspected complexity, form indeed the immediate element, as Claude Bernard terms it,¹ of our ever-renewed organic perfectibility. The histological elements which compose the living organism, as formed by the red globules, are not laid down at random.² Like elements combine with like to form tissues which, in their turn go to make up organs of severally varying structure, complexity, and use.³ Assimilation and disassimilation, homoimorphy and heteromorphy, absorption and secretion, substitution and interpolation, proceed on a predetermined plan ceaselessly and without pause together. Old materials are shunted off into the venous current, while, again, new blood discs for instant use are formed within the arterial current itself.⁴

Philosophical anatomy strives as best it may to explain the processes of growth and decay, amid two orders of forces, vital and general, at work ceaselessly, and, whatever may be said, in only too many respects one as little known and understood as the other.⁵ The same thought is somewhat differently expressed by Chevreul, when he observes that living bodies are so much the more complex by reason of adding general physical qualities to the special conditions of their vitality.⁶ And thus it is that the sum of the latter may be divided into consenting and opposing forces of complex and varying energies.⁷ For the principle of vitality, life itself simply designates organic activity considered as a

¹ M. Papillon, *Travaux de M. Robin*, *Revue des Deux Mondes*, July, 1870.
² Robin et Verdeil, *Traité de Chemie Anatomique et Physiologique*.

¹ *Element de Perfectionnement Organique. Leçons sur la Physiologie et la Pathologie du Systeme Nerveux*. Tome i., p. 49.
² Les elements histologiques ne sont pas entassés pêle-mêle et sans ordre. Les éléments de même nature s'assemblent pour former les tissus, comme les tissus de nature différente s'associent pour constituer les organes. *Id.*, p. 63.
³ Beale, *Structure and Growth of Tissues*. Lecture I.
⁴ Hassall, *Microscopic Anatomy*. Vol. i., p. 80.
⁵ L'anatomie philosophique suit un organe à travers toutes les variations qu'il a pu éprouver. Ducrotay de Blainville, *Principes d'Anatomie Comparée*, p. 5.
⁶ *Journal des Savans*, 1847, cited by M. Robin.
⁷ Jede Spannkraft kann man sich in eine spannende und eine hemmende Kraft zerlegt senken. Wundt, *Lehrbuch der Physiologie*, p. 17.

whole.¹ There is an uninterrupted correlation not only of the interior parts but of the inward and outer organs, in such wise that one proves, as it were, the virtual exponent and unvarying outcome of the other.² The able zoologist or anatomist, some Cuvier of the present, from a given organ or merest fragment, were it, will detect genus and species, even age and sex, as well as the distribution in the order of space and time, with almost unvarying certainty and correctness. The general tendency of histological inquiries, what Leydig would term the comparative doctrine of tissues,³ observes Müller,⁴ has been to refer to cell formation the actual genesis of the tissues themselves. This process, however, must surely ensue in the very centres of nutrition, those minute cellular structures, as Goodsir terms them,⁵ already existent in the texture of organs. The sections of minute structure which Leydig gives, as in regard of the dog, calf, eel, bird, and cæcilia annulata, in particular, are, I think, of great interest, and go far, perhaps, to constitute his important treatise, as was that of Swammerdam longo intervallo before him, a veritable outline of the vast superficies of living nature.

Evolution and nutrition belong to each and every anatomical element, and yet, one is very distinct, indeed, from the other. For anatomical elements, when they first appear, are not what they afterwards become. They gain in volume, assume forms more perfect, which again in turn, pass away. In fine, organic phenomena, in their relations to the anatomical element, may be summed up under four divisions, to wit, nutrition, evolution, contractility, and innervation. In some mere human machine one motor commonly suffices, but in the living organization many factors, numerous forces, endless complications, countless elements, are at work constantly in the effective, ceaseless furtherance of the different processes of life.⁶ Every organized substance, according to M. Robin, determines in its neighbourhood new anatomical elements, forms of activity, by means of segmentation, gemmation, and the fruitful action of the blastema. A minute nucleus, surrounding itself with solid matter, continually elaborates those cells, fibres, and tubes which contribute to, in fact, constitute, the never ceasing manifestations of organic life and being.

¹ Le nom de vie ou de vitalité est réservé pour désigner le mode d'activité propre à l'organisme considéré dans son ensemble comme un tout unique. Robin, Histoire Naturelle de Vegetaux Parasites, p. 56.

² Correlation telle que la disposition anatomique des parties internes se traduit au dehors par la disposition des parties externes. Id. propre, p. vii.

³ Lehrbuch der Histologie, Vergleichende Gewebelehre Vorrede.

⁴ Physiology, Balys tr., p. 1,428.

⁵ Pathological Observations, Centres of Nutrition.

⁶ Les parties intérieures sont les appareils qui se subdivisent en organes lesquels se groupent en systèmes divisibles en tissus et humeurs susceptibles d'être ramenés à un certain nombre d'éléments anatomiques ou organiques et de principes immédiats. C'est à ce tout formé par la réunion de toutes ces parties, qu'on donne le nom d'organisme.—Robin, Hist. Nat. p. 27.

Blastemas are various as there are tissues, in other words, the anatomical elements of each given tissue permit amid their interstices those generative fluids, from which similar elements spring. Organic corpuscles, which but an instant before had no existence, are produced in ceaseless molecular affluence, how, we know not, unless, as I conceive we are bound to do, we ascribe it to a predetermined will and power which, in the entire living structure as in its several parts, act in virtue of an archetype, devised by a Divine intelligence and unalterable skill.¹ The amœba, for example, takes food into its interior, and, without a single visible digestive organ, in virtue of some inexplicable power, selects what it needs, while it rejects what it can do without.²

The possession of life, indeed, were it in the very humblest organism, some mere rotifer or gregarinid, imparts an interest which as thus it shares in common with the greatest. Van der Hoeven, in his elaborate treatise, the result, he tells us, of the labour of six of the best years of his existence, expresses himself with emphasis on the subject of the almost inconceivable perfection everywhere manifested in the structure of the minutest creature of the organic world.³ Those who under a high magnifying power have watched the varied movements of living matter will not, says Beale, be easily brought to believe that such phenomena are due only to physical and chemical agencies.⁴ In any and every case, however, having done our best, we must, perforce, fall back on the implicit declaration of empirical experiential law, that is to say, on unity of plan with diversity of detail. Happily, says Mr. Huxley,⁵ there is a criterion of morphological truth, a sure test of all homologies, the study of a real and not merely an imaginary development, proves that the doctrine of unity and, as I would add, of a predetermined plan, is not mere fancy, but the expression of absolute law, the utterance of well established facts.

M. Robins' doctrine as to the genesis of anatomical elements in the heart of the blastema itself, is not admitted by every one, for example, not by Virchow, who would refer the origin, or at least, the extension of cells, to proliferation, and of other elements to metamorphosis. But anatomical elements, not to speak of morbid products, are often so dissimilar, muscular fibres and nerve tubes resemble each other so little that

¹ La connaissance d'un être tel que l'homme, a existé avant que l'homme fit son apparition, car l'intelligence divine, en formant l'archétype, avait la prescience de toutes ses modifications.—Owen, Principles of Comparative Osteology. French Ed. p. 12.

² Nicholson, Manual of Zoology, Nature of Life.

³ Die Natur hat in dem Baue des thierischen Körpers eine unbegreifliche Kunstfertigkeit an den Tag gelegt. Nicht nur der Körper in ganzen, ja nicht nur seine grobern Theile, Sondern selbst die kleinsten Theile der Organe sind Werkzeuge und das anatomische Messer zeigt uns bis zur einfachsten Faser nichts als zweckmas-sigeingerichtete Theile.—Handbuch der Zoologie. Band 1, S. 9.

⁴ The Mystery of Life, p. 71.

⁵ On the Study of Zoology.

one hesitates to concede their production to cell origin. There is, in truth, genesis by substitution, that is to say, the wasted elements are redissolved in the circulating medium and dissipated, while others are taken into their place. In fine, the anatomical element is the true arena, the very keystone, so to speak, of material existence, enwraps the secret springs, those hidden energies, whose multiple sum we term life. M. Robin lays claim to the discovery of lymphatics in the brain, the structure of ganglions, the distinction between nerve tubes and cells.

A remarkable feature of his views is that morbid growths, some, if not all, tumours, cancers, cysts, and others, are not so much new growths as a sort of hypergenesis of existant normal tissues. He is very surely in error, however, as to tubercle, since this is not the extension of any living tissue, whatever, but simply, as I assume to prove and show, the deposit of unoxidized retrograde carbon, unoxidized and unexcreted by reason of the habitual respiration of air more or less prerespired. In sum, M. Robin has rehabilitated the humoral pathology, not, indeed, the blind irrelevant pathology of the past, but a pathology purified and adjusted to living realities. The blood, in truth, is the arena of existence, the laboratory wherein transformations ensue, which no chemist hitherto has weighed in his balance, no physiologist detected with his lens. There is no virus either, as apart, the fluids only, M. Robin affirms, become virulent.

In other respects, the fast and fluid parts are solidary of each other, since what is fixed at one instant becomes fluid in the next, and conversely. There is no vital principle, then, as apart from the play of phenomena under providentially regulated control. But a vital principle, as thus, there most surely is. Matter, force, the sun's light and heat, the electric spark, per se, no more originate and discharge the processes of life than they do the confection of our food, the putting on or off of our daily attire. In every thing we witness the, in fact, miraculous harmony and consent of the various processes of the organism. In these controlled, indeed, and regulated by a higher power, may we alone discover the only true solution of the enigma of life. Everything, this premised, may be said to result from the play of the energies of the ultimate particles of the organism,¹ otherwise, as to the principle of the principle, the causation of the cause, the inner mysteries of life and being, we know or can know directly nothing. They are there, but reach them we may not. We can do little other or better than observe, but yet with all our insight, our utmost care. In us and about us there exist nothing but wonders. We proceed a little length, we attain to some faint inklings, but the arcana of existence we are all unable to resolve. And yet to us none the less belong the city of man's existence, the habitat of a

¹ De l'Approximation des Parties Organiques et de l'Organisme à l'Accomplissement d'Actions déterminées, cited in the Revue.

living soul. Ours, in truth, is a right marvellous organism, but, much as we may talk and write about it, of the intimate essence and secret springs of that organism we shall never here, I fear, know more than we do of the state of the dwellers in Arcturus or the condition of the inhabitants of Algarob.

Fifth Meeting 31st December 1870

Present, Dr. Stewart, Vice-President in the chair, Drs. H. MacCormac, Cuming, John Smith and Fagan.

Dr. H. MacCormac read the second portion of his paper entitled "Some remarks on the more recent progress of anatomical science—general and comparative." [See paper above.]

After some remarks from the President, Dr. Cuming stated that he would communicate with the Editor of the Dublin Quarterly Journal with the aim of having Dr. MacCormac's paper published in the next issue of the journal.

The Vice-President wished it to be put upon the notice paper for next meeting that a ballot be taken to fill up the vacancy caused by the departure of H. Brown, L.R.C.S.E from Belfast.

Dr. Stewart also stated that he would propose Dr. Pearsall, L.R.C.S.I. be elected a member of the Society.

W. MacCormac, President
March 25th 1871

25th March 1871

Ordinary Meeting of the Ulster Medical Society

Present, Dr. W. MacCormac (in the chair), H. MacCormac, Stewart, Dill, Hill, McGee J.P., Reade, Fagan, J. W. Browne, John Moore, McWilliam, Cuming.

The President gave a very interesting account of the new St Thomas' Hospital of London.

After the President had given his lecture he resigned the Presidential Chair. Dr. McGee, V.P., then moved that an address from the Medical Society be presented to Dr. W. MacCormac.

Drs. Thomas Reade, Murney, Stewart, Hill, John Moore were appointed a Sub-Committee to draw up and present an address to Dr. MacCormac.

8th April 1871

Dr. Stewart (in the chair), Drs. Browne R.N., J. Walton Browne, James Hill, Fagan, H. S. Purdon.

Dr. Browne R.N. read notes of case of malignant tumour of thigh. The case necessitated amputation which was performed by Dr. Browne upon the 6th April 1871 at the junction of the upper and middle thirds. The tumour was exhibited which proved to be "recurrent fibroid" a microscopical examination of the tumour having been kindly made by Professor Redfern.

Dr. Stewart then brought up for consideration the New Medical Bill.

Drs. Reade, Browne R.N. and Murney were appointed

a deputation to wait upon Thomas McClune M.P. relative to the Medical Bill.

Dr. McGee R.N. was appointed as a Deputation to wait upon Mr. McClune relative to the Lunacy Regulation Bill.

Robert Stewart M.D., Chairman
22nd April 1871

22nd April 1871

Dr. Stewart (in the chair), John Moore, H. S. Purdon, John Fagan, Hill, Pearsall, J. Walton Browne, John Grattan, Murney J.P.

Dr. Murney gave a short résumé of the Medical Bill now before Parliament. Dr. Grattan (of Dublin), a visitor to the Society, offered to bring the Bill before the notice of the College of Physicians.

Proposed by Dr. Stewart that Dr. Murney in conjunction with the Council draw up a Medical Bill and transmit it to the College of Physicians.

Dr. Stewart introduced the Lunacy Bill. Dr. McGee R.N. and Council to deliberate upon the Lunacy Bill.

Dr. Murney introduced two patients upon whom the operation of skin transplantation had been performed.

Annual Meeting 1871

Present, Drs. Stewart (in the chair), McCleery, H. S. Purdon, MacWilliam, Gribbin, Murney, Fagan, McCrea, Wales, Mr. Browne, Proctor.

Dr. Murney proposed and seconded by Dr. Fagan that the length of time for Life Membership be extended from 20 to 30 years.

Dr. Gribbin proposed as amendment and seconded by Dr. McGee that no change as regards the Life Membership be made at present (passed).

Dr. Murney proposed that a sub-committee consisting of Drs. Hill, Walton Browne and Murney be appointed to look after the Museum.

Dr. Murney and Fagan presented their report regarding the condition of the library.

Dr. Murney proposed that a special meeting of the Society be summoned to look over duplicate copies of books and that a list of duplicate copies be prepared, so that they may be sold.

Dr. Walton Browne read the report of Council, moved by Dr. Hill and seconded by Dr. Gribbin that the report of Council be adopted.

Dr. MacWilliam reported that he had obtained £16.16.0 remaining uncollected from last year.

The Meeting then proceeded to the election of office bearers.

Dr. McGee moved and Dr. Gribbin seconded that Dr. Murney be elected President for the ensuing session. Passed unanimously.

Dr. Stewart and Dr. S. Browne were elected Vice Presidents.

Council Dr. MacWilliam, H. S. Purdon, Hill, Wales,

Porter, McClurg.

Dr. Stewart and Dr. Wales [proposed and seconded] that Dr. Fagan be elected Treasurer.

Dr. H. S. Purdon proposed and Dr. Gribbin seconded that Dr. Walton Browne be elected Secretary.

Robert Stewart, Chairman
22nd November 1872.

ULSTER MEDICAL SOCIETY

SESSION 1871–72

Session 1871–72

First Meeting November 4th 1871

Present, the President (Dr. Murney J.P.) in the chair, Dr. McGee P.R.N.A., Dr. Browne R.N. J.P., Dr. John Moore, Dr. Stuart, Dr. Fagan, Dr. MacWilliams.

Dr. Murney (the President) returned thanks to the Society for the honour conferred upon him of having elected him as a President for the ensuing session, and drew the attention of the Society to several matters which may probably come before Parliament during the present year namely sanitary matters, and the "Contagious Diseases Act".

Arrangements were made for the Annual Dinner to be held up on Wednesday the 15th of November 1871 at 6.30 o'clock p.m.

The President, Dr. Browne R.N. and Dr. Patterson were appointed as a Committee to make arrangements for the Annual Dinner.

Dr. H. S. Purdon brought forward his case of general leprosy, and exhibited the patient who suffered from anæsthesia and tubercles; he had been treated at several hospitals in London.

Dr. Murney exhibited a specimen of epithelioma of the forearm which necessitated amputation.

Dr. Murney also exhibited the portion of bone removed in a case of excision of the shoulder joint and exhibited the patient. The patient is now capable of a certain amount of motion at the joint.

Proposed by Dr. McGee and seconded by Dr. Fagan that the Library Committee draw up a list of duplicate books which may be sold.

Henry Murney, Chairman

Second Meeting November 18th 1871

President in the chair, present Dr. H. S. Purdon, Dr. McClurg, J. W. Browne, Hill, Fagan, McGee R.N., John Moore, Dr. Stewart, S. Browne, Gribbin.

Dr. McKeown (M.D. L.U.I.), Dr. B. H. Spedding and Dr. Fergus Brown were proposed as members of the Society to be balloted for at next meeting of the Society.

Dr. Browne R.N. brought forward a case of excision of the elbow joint and exhibited the patient.

The President (Dr. Murney J.P.) then read notes of a case of excision of the knee joint and exhibited the portion of bone removed.

Dr. H. S. Purdon exhibited Piffard's Cutisector and Bayne forceps for epilation

Henry Murney

Third Meeting of Society Saturday 2nd December 1871

President in the chair, present Drs. MacWilliams, H. S. Purdon and Fagan.

The President introduced a patient on whom he had performed the operation of tracheotomy fourteen years ago and who still requires to wear the cannula.

Dr. H. S. Purdon exhibited specimens of [Oly atheril?], a remedy he has introduced into the treatment of certain forms of skin disease and especially successful in the destruction of acari scabies.

The President proposed and Dr. Purdon seconded the rescinding of Rule 11 as presented on the notice paper; passed unanimously.

The Council was requested to review the rules of the Society and report thereon.

Dr. Fagan was requested owing to the smallness of the meeting to hold over the reading of his notes on the present epidemic of small-pox.

Henry Murney, M.D.

Fourth Meeting 16th December 1871

President in the chair, present Drs. Stewart, McGee R.N., John Moore, McWilliam, H. S. Purdon, Murray, Fagan, Hill, J. W. Browne, James Moore, McConnell.

Proposed by the President and seconded by Dr. Fagan that Rule 11 be rescinded; passed unanimously.

Proposed by the President and seconded by Dr. John Moore that the commencement of Society's year be changed from the 1st of May until the 1st of November, and that a subscription of 10/6^d be payable upon 1st May to carry the Society over until the 1st of November 1872.

Both resolutions confirmed.

Ballot was then taken for the following gentlemen: Dr. B. H. Spedding, Dr. Fergus Brown, Dr. W. A. McKeown, Dr. John James Charles, all of whom were declared duly elected.

Dr. Fagan read notes upon the present epidemic of variola. The members after the reading of the paper made a number of interesting remarks upon variola.

Henry Murney, M.D.

Fifth Meeting 6th January 1872

The President (in the chair)—Dr. McGee P.R.N.A., John Moore, Fergus Brown, Charles, Hill, Murray, J. W. Browne, Bennett, Stewart, Spedding, Cuming, McConnell, McCred, McKeown.

Proposed by Dr. McGee that a letter of condolence be drawn up [by] the President, Dr. Hill and the Secretary and transmitted to the friends and relatives of the late Dr. McWilliam.

Dr. Murney (the President) exhibited an extensively lacerated arm, requiring amputation.¹

¹ [See page 1149 for subsequent history.]

Proposed by Dr. Hill and seconded by Dr. B. H. Spedding that James McMeekin be elected a member of the society.

Dr. Murney (the President) exhibited Nélaton's probe and related the particulars of the case in which he had used the probe with success.

Dr. McCred brought forward his proposition that a committee be appointed to consider the position of professional fees in Belfast. Dr. McCred proposed the following committee be appointed to consider the position of the fees: the President, Drs. Cuming, John Moore, Pirrie, Murray, Fagan, McCred, Hill.

Henry Murney M.D., President.

Sixth Meeting 20th January 1872

Present, Dr. Murney President in the chair, Drs. Stewart, Magee J.P., Wales, J. W. T. Smith, McCrea, Moore, John Moore, Charles and Hill.

The minutes of former meeting having been read and confirmed the President stated that the letter of condolence to the friends of the late Dr. McWilliam has been drawn up and was to be forwarded immediately.

Dr. McCrea stated that he had been unable to call a meeting of the committee appointed to consider the state of medical fees in Belfast but that he hoped to do so early in the following week.

Dr. James T. Smith then related the history of a case of pneumonia complicated with pericarditis and effusion into the pleural and pericardial cavities and ending in death. He also brought under the notice of the members Dieulafoy's pneumatic aspirator which he had used in this case to withdraw the fluid from the pleural cavity. The case was chiefly remarkable for the progressive intensity of the inflammation which at first was confined to the lower part of the lower left lobe.

After remarks on the case by several members, and an examination of the aspirator a ballot was taken for Dr. McMeekin Esq L.R.C.P.S. etc. and he was declared duly elected as a member of this Society.

The President having stated that Dr. J. Walton Browne had tendered his resignation of the Secretaryship Dr. James T. Smith proposed and Dr. John Moore seconded a motion to the effect that the best thanks of the Society be given to Dr. Browne and that the members accept his resignation with regret which was passed unanimously.

It was then proposed by Dr. Murray and seconded by Dr. McCrea, that Dr. Hill be requested to accept the office which having been supported by the members present he accordingly did.

Henry Murney M.D., President.

Ulster Medical Society 7th Meeting 3rd February 1872

Present, Dr. Murney (President) in the chair, Drs.

Cuming, Stewart, Gribbin, John Moore, Charles, McMeekin, McConnell, Fergus Brown and Hill.

The minutes of former meeting having been read and confirmed, Dr. Charles proceeded to give an account of a case of avulsion of the right arm and scapula by a mill accident in a boy about 10 years old; the parts mainly required trimming and although there was no hæmorrhage from the axillary artery a ligature was put on it as a safeguard. The boy made an excellent recovery.

Dr. Cuming then related a case of aneurism of the aorta extending from the 9th dorsal vertebra downwards into the right iliac region, distending enormously the opening for the blood vessels in the diaphragm, also sending a small process to the left side. The parts were exhibited.

Henry Murney M.D., President

17th February 1872.

Ulster Medical Society 8th Meeting 17th February 1872

Present Dr. Murney (President) in the chair, also Drs. McGee J.P., John Moore, James Moore, Charles, Fergus Brown, Walton Browne, McMeekin, Fagan, H. S. Purdon and Hill.

Dr. Fergus Brown then exhibited a child about 6 months old, presenting a curious malformation of the hands, both of which wanted the thumbs, and presented a turning upwards and inwards somewhat similar to talipes varus in the foot.

The general opinion was that it was inadvisable to interfere by any operative measures.

Dr. John Moore then give an account of a fractured base of skull which terminated fatally, and in which on P.M. examination a fracture of the calvaria of oldstanding was discovered.

It appeared that the man during life was particularly susceptible to the influence of drink, becoming at times quite maniacal—the fits however easily passed off under the influence of opiates.

A ballot was then taken for two members of Council when Dr. J. Walton Browne and Dr. Charles were duly elected.

Proposed by Dr. Hill and seconded by Dr. William McGee that Churchill's Medical Directory for 1872 be added to the library.

Notice was given that it would be proposed at next meeting that the Medical Register be added to the library.

Henry Murney M.D., President

2nd March 1872.

Ulster Medical Society 9th Meeting 2nd March

Present, Dr. Murney President in the chair, Drs. Cuming, Fergus Brown, Spedding, McCrea, Charles, Gribbin, Murray, Fagan, David Johnston, Stewart, James Moore, H. Johnston and Hill.

Ulster Medical Society
Session 1871–1872
President Henry Murney

The minutes of former meeting having been read and confirmed, Dr. Cuming proceeded to relate the particulars of a case of aneurism of aorta extending into abdomen which caused death by rupturing into left pleura.

In the absence of Dr. Browne, the President then related the case of a man æt 58 who fell from a height on the 2nd February and who died on the 25th after having suffered from symptoms of pyæmia.

On post-mortem examination a fissure was discovered across the right parietal bone, and corresponding with the fissure the brain surface presented an erosion covered with pus.

On cutting up the brain no abscesses were discovered. The other parts of the body were not examined.

Dr. James Moore then related the particulars of a case of scrofulous disease of knee joint in which he performed amputation of the thigh by a modification of the circular operation.

It was moved and seconded that the “Medical Register” for this year be added to the library.

It was moved by Professor Cuming and seconded by Dr. Gribbin and unanimously resolved that those periodicals which were incomplete through some of the posts having gone astray be completed.

Dr. McCrea then read the report of the Fee Committee, and as the time of the meeting has expired the discussion thereon was postponed until next day of meeting.

Henry Murney, President

16th March 1872

Present, Dr. Murney (President in the chair), Drs. Stewart, William McGee, Charles, Gribbin, Walton Browne, Spedding, Fergus Brown, Murray, John Moore, James Moore, McCrea, D. Johnston and Hill.

The President related the particulars of a case of injury requiring amputation of shoulder joint to which he had referred on 6th January.¹ For many weeks he continued to do well.

On the 7th of February the bed was raised and on the 9th he was permitted to get up. He was also up on the 10th. The ligatures, with one exception and that a small one, had come away.

At 3 p.m. on 11th got a message that hæmorrhage had taken place and on visiting him at once it was found he has lost about 2 ounces of blood although he was collapsed but that might be consequent from the fright. Ice was applied and rest enforced.

From 11th February till 4th March a watcher was continually with him.

On 23rd February—till which time the man ate and slept well—at 4:30 a.m. hæmorrhage again occurred to the extent of 6 ounces. At 9:30 a.m. after consultation

it was resolved to postpone operation measures till the bleeding should lessen which it did on the same day.

On the 27th he had a rigor. Also on 28th and 29th and 2nd March. Hæmorrhage again occurred and a rigor in the afternoon 3rd March 2 p.m. Slight hæmorrhage evening also. Also a recurrence on the fourth and he died same evening. On P.M. examination no clot was found.

The rest of the time was taken up with the consideration of the report of the Fee Committee which was adjourned till next meeting.

Henry Murney M.D., President
13 April 1872

Ulster Medical Society 13th April 1872

Present, Dr. Murney (President) in the chair, Drs. Stewart, Wales, Gribbin, Fergus Brown, McMeekin, Cuming, Walton Browne, Charles, McKeown, McCrea, John Moore and Hill

The minutes of former meeting having been read and confirmed it was moved by Dr. Wales seconded by Dr. Murney and resolved that a copy of the resolution of 20th April 1848 with the addition of the words “one guinea” be drafted out and circulated among the members of the profession for signature and approval.

A ballot having been taken for Dr. William Aickin he was unanimously elected a member of the Society.

The consideration of the report of the Fee Committee having been concluded the President proposed that the tariff be printed and laid before the Society at its next meeting.

Dr. McKeown then exhibited some patients on whom he had operated for various degrees and varieties of convergent squint and made remarks thereon.

In consequence of the amount of business to be transacted it was resolved to hold an extra meeting on Saturday the 20th inst.

Henry Murney M.D., President
20th April 1872

Ulster Medical Society 20th April

Present, Dr. Murney, President, in the chair, Drs. Stewart, Wales, John Moore, Gribbin, Spedding, H. S. Purdon, Charles, McMeekin, McCrea and Hill.

The minutes of former meeting having been read and confirmed, Dr. Charles proceeded to exhibit the following specimens viz.

- 1 Intracapsular fracture of neck of femur, and ossification of tendon of iliocostalis and psoas muscles of opposite side.
- 2 Malacosteon.
- 3 Chronic rheumatic arthritis of neck and hip joints
- 4 Fracture of tibia and fibula
- 5 Colloid cancer of stomach.
- 6 Tubercular peritonitis.

¹ [See page 1147.]

He gave a description of each, but as all the specimens have been obtained in the dissecting room he could not give the history of any of them.

The specimens themselves were exceedingly interesting and the President in the name of the Society thanked Dr. Charles for bringing them forward.

Henry Murney M.D., President
27th April 1872

Ulster Medical Society Concluding Meeting of Session 27th April 1872

Dr. Murney, President, in the chair, also Drs. Stewart, Wales, John Moore, Spedding, David Johnston, Fergus Brown, Walton Browne and Hill.

The minutes of former meeting having been read and confirmed, Dr. Johnston exhibited a subclavian artery taken from a man who had died of hæmorrhage 10 days after amputation at the shoulder joint on account of injury. The examination of the vessel showed that the hæmorrhage had not come from the main vessel but probably from a comparatively small branch which had been cut very close to the trunk.

He then exhibited a fracture of the spine which had occurred by a man falling off a house top. On admission to hospital though the nature of the injury was quite evident he did not present all the signs of grave spinal injury yet he only lived 36 hours.

John Moore also exhibited an enlarged heart, a hepatized lung, carcinoma of uterus and diseased kidneys but as the time was limited no discussion was given.

Doctor Wales then read a paper on positional pulmonary crepitus in which he described a fine crepitus like that of pneumonia heard on inspiration only and only in certain positions of the body. Having noticed this in several instances, and that it never led to serious consequences, and having been so frequently puzzled with it, he brought the subject under the notice of the Society in 1869–70.¹

He stated that his further experience only confirmed his former opinion that we frequently meet with pulmonic crepitus in practice which was attributed to pneumonia, limited no doubt, but treated as such; that if the patient's position had been altered and he was again examined the crepitus would be found to have disappeared but on resuming the former position it could again be heard.

He had not altogether made up his mind as to the theory of the phenomenon but it was no doubt interesting.

As the subject appeared to be altogether new to the members it was not discussed but all promised to be observant so that they might express an opinion should Dr. Wales bring up the subject at a future meeting.

The President then in a few words thanked the members for their attendance during the session and said that the next meeting will be held in November for the election of officer-bearers but that if anything of moment should occur in the meantime, he would summon an extraordinary meeting.

Henry Murney, M.D., President

Special Meeting called by circular held 14th August 1872 to consider the propriety of asking the British Medical Association to hold its Annual Meeting in August 1873 in Belfast.

Present, Dr. Murney President in the chair, Drs. Pirrie, Dill, M'Crea, John Moore, Walton Browne, Cuming, Stewart and Hill.

Moved by Dr. Dill seconded by Dr. Pirrie that thanks are due to the President for calling the meeting.

Moved by Dr. Pirrie that the Association be invited to meet be raised, seconded by Dr. M'Crea—negated by 5 to 4.

Annual meeting 1872

Held upon the 2nd November 1872

Dr. Stewart in the chair, Drs. John Moore, W. McGee, Spedding, J. J. Charles, Fagan and J. W. Browne.

The report of Annual Meeting of 1871 was read and adopted.

¹ [Occasion not identified.]

Ulster Medical Society
Session 1872–1873
President Henry Martyn Johnston

ULSTER MEDICAL SOCIETY

SESSION 1872–73

OFFICE-BEARERS
FOR THE SESSION 1872–73

President:

H. M. JOHNSTON, L.R.C.S.I.

Ex-President:

HENRY MURNEY, M.D., J.P.

Vice-Presidents:

J. W. T. SMITH, M.D. and ROBERT STEWART, M.D.

Members of Council:

J. W. BROWNE, M.D.	JOHN J. CHARLES, M.D.
W. A. M'KEOWN, M.D.	PROFESSOR CUMING, M.D.
H. S. PURDON, M.D.	B. SPEDDING, L.R.C.P. S. Ed.

Treasurer:

JOHN FAGAN, L.K.Q.C.P.

Secretary:

JOHN MOORE, M.D.

LIST OF MEMBERS, 1872–73.

Aickin, Wm., M.D., M.R.C.S.Eng.
Andrews, T., M.D., L.R.C.S.I., F.R.S.

Ball, T., L.R.C.P. Edin., L.A.H.
Barnett, R, M.D., M.R.C.S.Eng.
Beck, J. W., M.D., M.Ch., L.A.H.
Beck, F., L.R.C.P.&S.Edin., L.A.H.
Bolton, Reuben, M.D., L.A.H.
Browne, Sam., R.N., L.K.Q.C.P.I., M.R.C.S.Eng.
Browne, J. W., M.D., M.R.C.S.Eng.

Cantrell, T., L.A.H.
Charles, J. J., M.D., L.R.C.S. Edin.
Core, Wm., M.D., L.R.C.S. Edin.
Corry, T., M.D., M.R.C.S.Eng.
Croker, S., M.D., F.R.C.S.I.
Cuming, James, M.D.

Dill, R. F., M.D., M.R.C.S.Eng.
Drennan, J. S., M.D., L.R.C.S.I.

Fagan, J., L.K.Q.C.P.I., L.R.C.S.I.
Ferguson, H. S., M.D., M.R.C.S.Eng.
Filson, A., M.D., M.Ch.

Garde, T. W., L.R.C.P.&S.Ed., L.A.H.
Gordon, A., M.D., M.R.C.S.
Grattan, T., L.A.H.
Gribbin, E. D., L.R.C.P. Edin., L.F.P.S., and L.A.H.
Harkin, A., M.D., M.R.C.S.Eng.
Hayes, B. E., L.R.C.P. Ed., M.R.C.S.Eng.
Johnston, H. M., L.R.C.S.I.
Johnston, D., M.D., M.R.C.S.Eng.

Martin, J., L.K.Q.C.P.I., L.R.C.S.I.
Moore, James, M.D., M.R.C.S.Eng.
Moore, John, M.D., M.R.C.S.Eng.
Mulholland, C. M., M.D., M.R.C.S.Eng.
Murney, H., M.D., M.R.C.S.Eng.
Mac Cormac, H., M.D., L.R.C.S.I.
Mac Cormac, J., L.R.C.P.&S.Edin.
M' Cleery, J. C., L.R.C.S.I., L.A.H.
M'Connell, A., L.R.C.P.&S.Edin.
M' Crea, J., M.D., L.R.C.S. Edin.
M'Gee, William, M.D.
M'Keown, W., M.D., M.Ch.
M' Meekin, J., L.R.C.P.&S.Edin.

Pirrie, J., M.D., L.R.C.S.I.
Porter, A. M., M.D., L.R.C.S. Edin.
Pring, R., L.A.H.
Purdon, C. D., M.B., F.R.C.S.I.
Purdon, H. S., M.D., L.R.C.S.I.

Reade, T., M.B., L.R.C.S.I.
Reid, J. S., M.D., L.R.C.S. Edin.
Ross, R., M.D., L.R.C.S.I.

Scott, J., M.D., M.Ch.
Smith, J. W. T., M.D., L.R.C.S.I.
Smyth, J., L.R.C.S.I.
Smyth, B., M.B., M.R.C.S.Eng.
Spedding, B. H., L.R.C.P.&S.Edin.
Stewart, R., M.D.

Thornley, John George, M.D. Q.U.I., L.R.C.S. Ed.
Torrens, H. B., M.D., L.R.C.S.I. Edin.
Tyrrell, R. J., L.K.Q.C.P.I., L.R.C.S.I.

Wales, G. F., M.D.
Wheeler, T., M.D., L.R.C.S.I.
Whitaker, H., M.D., M.R.C.S.Eng.

The First Meeting of the Society was held in the Library on Saturday 11th November 1872.

The Chair was occupied by the President, H. M. Johnston, L.R.C.S.I., who briefly thanked the Members of the Society for the honour they had done him by electing him President for the ensuing year; he referred to the improved state of the Society, as

marked by the increasing numbers attending its meetings, and the interesting Papers which had been read at them, during the past two years, under the Presidency of Drs. Smith and Murney.

He promised to do all in his power to maintain, and if possible to still further advance, the interests of the Society, as he had been long connected with it, and his interest in its prosperity had not diminished.

Members present Drs. Stewart, Murney, Smith, H. S. Purdon, McKeown, J. W. Browne, John Moore, Charles, Messrs. B. Smyth, Spedding, F. Brown and Gribbin.

The President then read notes of a case of a patient suffering from enlarged prostate gland and retention of urine and also exhibited the bladder and the enlarged gland.

Dr. Charles stated that from his observations in the dissecting room that he did not consider enlargement of the prostate to exist to such a large extent as some authors represented it, and he also said that the specimen before the Society was the largest he had ever seen. Dr. Murney also stated that it was his opinion also that enlargement of the prostate in men advanced in life was not so widespread as was commonly supposed.

The President next exhibited a specimen of stricture of the œsophagus causing ulceration of the aorta and causing death by hæmorrhage. He stated that six cases of this disease had been under his care within the last few years.

Dr. Murney stated that the question of gastrotomy had recently been raised in the treatment of cases of impassable stricture of the gullet.

Dr. John Moore said that he had seen a patient in St Thomas' Hospital in whom Mr. Le Gros Clarke had performed this operation and was afterwards present at the post-mortem examination. From what he had seen he was not favourably impressed with the operation and would not be inclined to repeat it.

He said he recently had a case under his care where the patient has been from Tuesday to Saturday unable to swallow anything. He succeeded in passing a very small catheter into the stomach and feeding him for some time after which he could swallow and left the hospital greatly improved.

The Second Meeting of the Society was held in its Library on Saturday 30th November.

The President in the chair. Members present Drs. William McGee, Stewart, Smith, McCrea, Charles, J. W. Browne, Croker, David Johnston, Messrs. McConnell, Spedding, F. Brown and assist. Surgeon Johnston 78th Highlanders.

Dr. David Johnson introduced a patient suffering from occasional attacks of dyspnœa and stridulous breathing. There was some swelling over right sternoclavicular articulation. No bruit could be heard, but

several members considered the case to be one of the thoracic aneurism.

Dr. John Moore read the following Paper on Gun-shot and other Wounds: On Sunday, the 18th of August, J. M_, aged 17 years, P. C_, aged 15 years, J. S_, aged 21 years, and P. D_, aged 10 years, were admitted into the Belfast General Hospital under my care. The first three were suffering from gun-shot wounds of the thigh, M_ received a ball about the middle of the thigh, S_ another a little above the patella, and G_ one at the junction of the middle and lower third, the latter passing transversely across the limb from without inwards. The two former were wounded in front, the point of exit in S's case being the centre of the popliteal space. In the three cases the balls passed right through the limbs without lodging, and must have impinged very closely on the femora, as the balls had passed through the entire thickness of the limbs. The only points worthy of note in these cases were, first, that all the wounds inflicted being in the lower extremities, it is evident that the constabulary, who were the firing party in this case, were desirous of avoiding inflicting fatal injury, and aimed low. All these cases did well; there was no inflammation nor tumefaction following the wounds, nor any constitutional disturbance. The treatment consisted in rest, syringing the wound with carbolic acid lotion, and lint wet with the same lotion, laid on the wound. In the beginning of September the wounds had closed; the patients were allowed to move about, and a few days afterwards discharged.

With the lad, D_, however, it was otherwise. In his case, the bullet entered the right foot, just below the internal maleolus and passing through the astragalus and calcis, made its exit at the insertion of the tendo Achilles. As the ankle joint had escaped injury, and from the youth and healthy constitution of the lad, I determined to give a trial to conservative surgery, and to save, if possible, his foot. Nothing could be better than his progress for the first fortnight; the slight inflammation which followed was subsiding, and the suppuration which had been established was of a healthy character, when about this time, unfortunately, there was admitted a case of foul tertiary ulcer into the same ward; and from that time the character of the wound assumed a different aspect; it became unhealthy looking; inflammation spread up the limb, and abscesses formed, which when opened discharged putrid pus. He became irritable, his pulse rose to 140, and his appetite declined. It soon became evident that it would be impossible to save the limb. The next question was when to operate, and where to amputate. His then condition (September 3) was very unsatisfactory, and an erysipelatous blush extended above the knee, with threatening abscess of that joint. The sloughing state of the soft parts about the heel rendered it impossible to find covering at that joint, if

amputation there had been decided on. He was ordered all the nourishment he could take, with wine, quinine, and opium. On the 12th September his general condition had improved somewhat, and the inflammation around was diminished, so I amputated his leg at the junction of the upper and middle third by the usual method adopted here—skin flaps and circular incision through the muscle.

During the week after operation his condition was very shaky, he had slight rigors, and the knee joint still threatened to suppurate. In fact pyæmic symptoms manifested themselves. By careful attention to diet, by allaying irritation, with opiates, by a liberal allowance of stimulants, and especially by quinine, these symptoms subsided, and he was discharged on October 2nd with a good stump, having been 46 days in Hospital.

I am glad to be able to leave on record that this was the only limb lost during those disgraceful proceedings, which attracted to our town such an amount of unenviable notoriety; and that not a single death occurred in the General Hospital resulting from those riots.

S. J. W_, aged 20, was admitted on 20th September, he had received a gunshot wound in the back, the ball entering close by the posterior edge of the left scapula, and emerging under the middle of the clavicle of the same side, close by the sub-clavian artery. There was no chest complication, no emphysema, nor hæmoptysis. There was very little shock from the wound, and he recovered without an unfavourable symptom. The interesting point in this case was the curious track the ball must have taken, and the narrow escape he had for his life.

S. D_, a good-looking girl of 18, was admitted with a bullet wound of shoulder. She had been leaving, under compulsion, one district of the town, and seeking refuge in another, when she was met by a man who presented a gun at her. As she was within speaking distance, and not thinking that he really meant to shoot her, she said to him, half jestingly, "If you do now I'll tell," when the ruffian fired, the ball entering the shoulder at the posterior edge of the deltoid muscle; and, after grazing the humerus, glanced off without fracturing the bone, or entering the chest. This seemed to me to be the most diabolical of all the crimes which came to my knowledge as having occurred during that unhappy period. She too, made a good recovery, and has not suffered any permanent injury resulting from her wound.

Three cases of wounds from revolvers were admitted. In fact the first of the riot cases were two such admitted under Dr. Murray. The first one was that of a lad who was shot in the left forearm the ball striking and fracturing the ulna. The ball in this case could not be detected, and still remains in the arm; but the wound healed and the fracture united.

The second case was a bullet wound of left groin. It entered close by the saphenous opening, and taking an inward course, emerged at the fold of the perineum just marking the scrotum. He also was Dr. Murray's patient.

The third revolver wound was in the calf of right leg. He received his wound behind; the opening was very small, and I failed to touch the bullet with a probe; and I believe it still remains, without giving him any trouble.

One case was admitted in which a charge of large shot had been received over the head, face, and neck. One had crossed the track of the carotid vessels, another passed through the right cheek and through the tongue, lodging in the left gum. I extracted several others from the forehead and scalp.

Three cases of stabs were treated.

H. G. A_, residing in M_, had served in the army, and fought all through the Crimean War, was passing down North Street, which was in a crowded and disturbed state at the time, when a charge of mounted constabulary came down; and while endeavouring to make his way into a door, received a sword thrust which transfixed the axilla, entering through the latissimus dorsi, and coming out at the edge of the pectoral muscle. He was carried to the Hospital in a fainting state, and was in complete collapse when he arrived. His clothes were saturated with blood; and while he was being placed in bed, and his clothes removed, his bowels became relaxed, and he appeared moribund. He seemed as if he had bled to death.

I placed my thumb firmly in the wound, and by the free administration of stimulants with warm milk and hot water pans placed around him, he returned to consciousness, but so bloodless and weak was his condition that no operative interference could be attempted. Under those circumstances I plugged the wound with pledgets of lint, as firmly as possible, placed a bandage tightly round the limb, which restrained all hæmorrhage; a tourniquet was put around the shoulder, and a student was placed in charge of the case, and arrangements made to place a ligature on the vessel should further bleeding occur. A good opiate procured him a quiet night, and I found in the morning that there had been no return of the bleeding.

On removing the plugging on the second morning, about thirty-six hours after his admission, no blood followed, and complete blocking up of the vessel of the limb seemed to have taken place. There was no pulsation in the axillary or brachial artery, there was some degree of numbness of the arm, and its temperature was lower than the other limb.

Considerable inflammation followed, an erysipelatous blush spread over the upper arm, and an inflamed cord of lymphatics extended from the elbow

up to the axilla. Suppuration became established, and a large quantity of pus escaped from the wound. Several of the glands in the axilla suppurated, and I opened them. Notwithstanding so much local mischief, there was little constitutional disturbance. He took food, and slept well. The inflammation of the arm gradually subsided, the purulent discharge ceased, and the wound closed. He was discharged with good use of his arm, and is now following the laborious occupation of a pavior.

William M_ was admitted with a circular spot of blood, about the size of the palm of hand, on right side of vest, with a triangular puncture in the centre, which on examination was found to pass through the seventh intercostal space on right side of sternum. It was a bayonet wound, but not deep; he was more frightened than hurt, and was discharged in a few days with the wound healed.

Patrick R_ when admitted was found suffering from a penetrating wound of abdomen. It had been inflicted by a dagger, and penetrated on the outside of the right rectus muscle, extending about two inches on a level with the umbilicus. The finger passed into the abdominal cavity, but the bowels seemed to have escaped injury. The edges of the wound were brought carefully together and covered with collodion. On the day after admission the stomach became irritable, there was some abdominal tenderness, these symptoms increased, the pulse became more frequent, the abdomen became tympanitic. For several days his state was most critical. The treatment consisted of opium, ice with turpentine fomentations, and under it the severity of the symptoms gradually subsided, and he was discharged well.

Matthew L_ when admitted presented a sad aspect, he had been unmercifully beaten about the head and face, his countenance was so disfigured that it would have been impossible to have recognized him. The bones of the face felt as if they had been separated from one another, and the left superior maxillary bone was fractured, as was the left horizontal ramus of the lower jaw. Notwithstanding the severity of the injuries inflicted he made a rapid and good recovery, with but little deformity.

Ten other cases less severe were admitted into Hospital. They consisted principally of scalp wounds, fractured ribs, and contusions.

One hundred and twenty cases were treated by the House Surgeon and resident staff, none of which call for special notice.

Dr. James Smith exhibited a specimen of thoracic aneurism and read the notes of the case.

Dr. Torrens was proposed as a member of the Society by Dr. John Moore.

The Third Meeting of the Society was held in its Library on Saturday 14th December 1872 at 4 o'clock

The President in the chair. Members present Drs. Stewart, H. S. Purdon, J. W. Browne, J. W. T. Smith, Charles, Croker, Porter, John Moore and Wales, Messrs. McMeekin, Spedding and Gribbin. Assist. Surgeon Johnston 78th Highlanders was also present.

Drs. Torrens and Bolton were elected members of the Society and Dr. Filson of Portaferry and Dr. Tyrrell of Banbridge also.

Dr. Porter introduced a patient with great deformity of chest. There was considerable projection of sternum with corresponding falling-in of the costal cartilages. The boy was healthy and did not suffer except from the deformity which it caused. Some of the members were of opinion that a considerable improvement might be affected by a proper mechanical apparatus.

Dr. McMeekin read a most interesting paper on a case of induced labour in a patient who had on two previous confinements been delivered by craniotomy. In this case both mother and child done well.

This operation, formerly vague and uncertain in its results, has now assumed a definiteness and precision that bring it completely under the control of the physician.

A few years ago when labour had to be artificially induced, the membranes were separated—they were punctured—a bougie was inserted, or some other means were used to provoke uterine contraction, and the rest was left to chance. The physician went home till labour had fully set in. This might occur in from twelve hours to a week, there being no certainty about it. The child was often expelled without warning; and any untoward circumstance, such as prolapse of the cord, or a malpresentation, caused its death. Now an induced labour can be so managed as to limit and define the time expended, so that as Dr. Barnes quaintly says—"It is just as feasible to make an appointment at any distance from home to carry out at one sitting the induction of labour as it is to cut for the stone."

The necessity or advisability of this operation can only be judged of, in the case of obstruction, by an examination of the pelvis, or by the history of antecedent labours. In the following case I was amply justified, I apprehend, in having recourse to this particular mode of operative interference.

Mrs._ aged 32 years, has been married eleven years. She had seven previous pregnancies. One, the first, terminated naturally. During her second pregnancy she fell down a flight of stone steps, alighting on the sacrum; was considerably injured, and confined to bed, by the fall. Gestation, however, went on till full term, but labour had to be terminated by craniotomy. Her third and fourth pregnancies ended in abortion at about the end of 3 months. Her fifth went on till full term, when craniotomy was again resorted to. Her sixth was a 7 months' child, labour in this

instance being artificially induced, but the offspring perished in the birth.

At the termination of her seventh pregnancy at full term, she came under my care for the first time; when, after consultation, I performed craniotomy, this being the third time she had been subjected to this operation. During my attendance on her I examined the pelvis to find out the nature of the obstruction, and discovered that the promontory of the sacrum protruded across the brim of the pelvis, reducing the antero-posterior diameter. Whether this was the result of the fall already referred to, or was an ordinary malformation, I cannot say—probably the former, since the first labour terminated naturally.

After her recovery, I advised her, should she have the misfortune to become pregnant, to consult some medical man, giving him the history of her case, 3 months at least prior to full term, so that a living child might possibly be extracted, that her feelings as a mother might not be outraged, and that the doctor might be saved from the performance of a revolting and disagreeable duty.

In a short time she again became pregnant, and at the end of the third month of gestation I was sent for, and found her suffering from uterine pain and hæmorrhage, threatening a miscarriage. I congratulated her on the prospect of getting off so easily this time, but notwithstanding her previous obstetric experience, so intense was her love of maternity, that she begged of me to try and avert the impending calamity. Under the influence of rest and opium the hæmorrhage ceased, the pain subsided, and pregnancy went on as usual. She then engaged me to attend her in her approaching accouchment, giving me *carte blanche* as to what means I should employ.

Dr. Barnes' theory on this subject is so plausible, and the results of his practice so satisfactory, that I determined to put them to the test of experience. I accordingly followed his instructions to the letter, both as to the time and the method of induction.

First, *as to time*. He divides gestation into two parts. "During the first part, terminating at 6½ or 7 months, or at the end of 180 or 200 days, it is scarcely probable that a viable foetus will be expelled. To induce labour within this period is really to bring about abortion. Between 200 and 230 days is a period of very doubtful viability, and the physician should postpone interference until after the latter date, when the operation may be undertaken in the interest of both mother and child." The best time, he says, is "250 days after the termination of the last menstrual period, when the cases are few in which with ordinary care a child may not be delivered alive."

Second, *as to method*. He introduces an elastic bougie into the uterus at night, allowing it to remain till the following day, when uterine action will usually have set in. At an appointed time in the evening he

proceeds to accelerative means, using for this purpose hydrostatic dilators; but as you are all doubtless familiar with his method, I need not further explain it.

Reckoning from the date supplied by my patient, the 250th day occurred on the 31st October last. Accordingly, at 8 p.m., on the evening of the first November, I inserted an elastic bougie between the membranes and the uterine wall, pushing it up for about six inches, coiling up the lower end, and in order the more effectually to keep it in situ I plugged the vagina (this latter was perhaps unnecessary, and is not recommended by Barnes). I then administered an aperient, and told her if the plug or the bougie came away to send for me. Everything remained as I had left it till the next morning. I called at 11 a.m., and found that slight pains occurring at long intervals had set in.

To remain in bed, and send for me when the pains became stronger. Was sent for at 2 o'clock on same day, and found the pains increased in force and frequency and the os slightly dilated. I now proceeded to accelerative means. After some difficulty I succeeded in introducing number 2 dilator, and expanded it with tepid water. The act of introducing I found difficult. The os was so high up that I could barely reach it with the index finger of the left hand, and when I attempted to introduce the dilator into the uterus, on a metallic rod, as directed, the os receded beyond my reach; and it was not until I had introduced the left hand into the vagina, that I effected my object. Once in, however, and distended with water, it did its work admirably.

In an hour the os was dilated to an extent equal to the diameter of the medium bag, and the latter was expelled by uterine action into the vagina. Having now felt that the presentation was natural, I adapted a binder to the abdomen, to keep the head in apposition to the cervix, and prevent the cord from being washed down by the escape of the liquor amnii, ruptured the membranes, and allowed part of the water to escape.

I next introduced the largest bag—this time without difficulty—and sent for Dr. Croker, who had kindly consented to be present at the termination of the labour. On his arrival, the os was fully dilated, and as the pains were now strong, and the head unable to pass the brim unaided, I applied the forceps, and without any trouble delivered the patient of a living child. The placenta gave no trouble; the patient was able to leave her bed in a week; and the child is now strong and healthy.

Dr. John Moore said he looked upon the operation for the induction of premature labour as one of the greatest triumphs of surgical art, an operation that saves lives which must be sacrificed without it. In a patient of his own, whom he had twice delivered by craniotomy, the induction of premature labour saved

her next child, now a strong healthy boy. He had assisted the President in a case where the pelvis was so filled with a tumor that labour was brought on about the sixth month: in this case of course the child was lost.

Mr. Gribbin stated that he had attended a patient, in whose case premature labour had been induced on a previous occasion, but the child died. She passed through a natural labour, and he could not discover any cause for the previous operation.

The President stated that in the case to which Dr. John Moore referred, the tumor, which was the cause of obstruction, afterwards disappeared, and the woman was delivered at the full period of a living child.

The members were unanimous in thanking Mr. McMeekin for his paper, which they considered a most valuable one.

Dr. McMeekin exhibited at the same time Dr. Barnes's dilators which he had employed in accomplishing delivery.

Dr. Spedding read notes of a case of ligature of internal piles the discussion to which was adjourned till next meeting.

The Fourth Meeting of the Session was held in the Library on Saturday 4th January 1873.

The President in the chair. Members present Drs. Stewart, Murney, James Moore, John Moore, H. S. Purdon, McCrea, Charles, McMeekin, Torrens, J. W. Browne, McKeown, Scott, Messrs. Spedding, Ball, Garde, Aickin, Fagan, Bolton and F. Beck.

Mr. Garde was proposed by Dr. McCrea.

Drs. J. Scott and Croker were elected members of the Society.

Dr. H. S. Purdon introduced a patient suffering from favus. 13

W. H. at 12, admitted at the Hospital for Skin Diseases under the care of Dr. H. S. Purdon, for Favus, which had existed for several years. On examination, the scalp was observed covered with the peculiar sulphur-coloured, cup-shaped eruption characteristic of favus. Some of the crust examined manifestly showed the stroma of the fungus, the *achorion*. Alopecia of a permanent nature was observed on vertex of scalp. The boy was strumous, in which people the secretions, and naturally the perspiration, is acid—just the soil, so to speak, upon which a vegetable growth will flourish. The treatment adopted was removal of hair by Bazin's forceps, then a solution of the bichloride of mercury rubbed in, after which sweet oil was applied.

The following paper on Hæmorrhoids, which was read by Mr. Spedding, at the Third Meeting, was now brought up for discussion, as agreed upon:

In June last a gentleman aged 46, who had resided a number of years abroad, consulted me with reference to his general health, but more particularly hop-

ing to be relieved of old-standing internal piles, which had given him much trouble for several years back. He gave the following history.

Had always been strong and healthy, but, while abroad, had been much exposed to vicissitudes of temperature, irregular life, sleeping in the open air in marshy districts, from which he contracted ague. At this time, about 10 years ago, he used occasionally to suffer much from periodical attacks of piles, which bled a good deal, but, being very strong at that time, he did not mind it much.

At the time I saw him he looked sickly, weak, and worn, face and lips pale, general anæmic appearance, appetite bad, action of the heart slow, feeble, but regular. He had been getting much worse within the past 12 months. Whenever he attempted to walk, even a quarter of a mile, the piles came down and gave him great pain in getting them up again. The most troublesome symptoms were constant tenesmus, and frequent micturition the latter disturbing his rest three or four times a night.

On examining after defecation, an oval tumour somewhat larger than a hen's egg was seen encircling the whole of the anus, the long axis being antero-posterior. This was divided by four sulci into four separate pouches which were of a venous blue colour. A little pressure got all up again, and, on introducing the finger, the four parts of this hæmorrhoidal prolapsus could be felt about an inch and a quarter above the verge of the anus.

I considered that ligature would afford the best means for a radical cure; and, in a few days afterwards, I proceeded in the following manner.

Having cleared out the bowels by an enema, the patient pressed down the whole mass; I then introduced my left fore-finger into the rectum, and having felt the upper margin of one of the piles, the left lateral one, I guided a nevus needle, armed with double strong ligature silk, to that point, and pushed it through the base of the pile, bringing it out at the outer margin of the sphincter, a few lines internal to the junction of the skin to the mucous membrane. The threads were then taken out of the eye of the instrument by my assistant, and each half of the pile *tightly* tied, one end of each ligature was cut, the other allowed to remain outside the anus; the anterior pile was treated in the same manner. I did not think it advisable to touch the right lateral or posterior pile at this juncture, fearing subsequent inflammation, and determined to wait until the first half should come away.

I therefore pushed the entire mass, half of which was ligatured, and the remainder, which was not, back into the rectum, put up a morphia suppository, and gave an opium pill. During this operation there was not a teaspoonful of blood lost, no pain was complained of, except when the needle was being shoved

through, and during the act of tightening the ligature. The patient slept well, had no uneasiness until the third day, when he had retention (partial) of urine, and some pain over the bladder. Warm stupes and a couple of large doses of tincture of hyoscyamus and nitric æther relieved this symptom without the use of the catheter. Ordered one grain of opium night and morning.

4th Day—Bowels opened by castor oil, the untied part alone came down.

6th Day, one ligature and half a pile came away.

7th Day, another; and eighth, the remaining two.

In a few days subsequently I sent him to the country; but before the prescribed time was expired he was back again most anxious to get rid of the remainder of his trouble, as he said he felt “half cured.”

I tied the right lateral and posterior piles, the only remaining ones, on the 12th August, in precisely the same manner as I had done in July. He complained of no pain ten minutes after the ligatures were applied, and had not a single untoward symptom. On the eighth day the strangulated part came away en masse, consisting of four ligatures and four half piles. In a couple of weeks all uneasiness disappeared from the rectum, and ocular and digital examination failed to detect any trace of hæmorrhoids. It is now three months since I have seen this patient, but I had this week a most gratifying letter, in which he contrasts his present with his former unhappy condition.

He has, he writes, grown fat; can walk five miles without feeling fatigued; has not the slightest difficulty in micturition or defecation, which annoyed him so much formerly. He also states that a dizziness in his head, which he had before the operation, has almost left him, and that he does not feel any more uneasiness from his old-standing affection.

The President said Mr. Spedding was anxious to obtain from the members an expression of opinion as to the most effectual treatment of internal piles, and how far any of them had used the clamp, or fallen back upon the old plan of ligaturing.

Mr. Spedding said he might mention that the case was a most inveterate one of ten years' standing. The chief inconvenience of the patient was from the incessant diarrhœa produced by internal piles, and the frequent micturitions. He could not walk two or three hundred yards without a whole mass, the size of a turkey egg, passing down. The application of the ligature was altogether free from pain, except momentarily when tightening it. He had got a letter from him a fortnight ago, stating that he has not the slightest inconvenience or uneasiness, and had perfect control over his bowels.

Dr. James Moore said he had a good deal of experience, and never found the ligature fail when judiciously used. He would recommend it strongly; it was not half enough used.

Dr. Charles said the method adopted in Paris was by inserting a gutta percha tube filled with cold water, and thus applying pressure to the piles.

President.—Do you know anything of the result of such treatment?

Dr. Charles.—All I know is that, as a rule, the French have given over ligaturing, thinking this method preferable.

Dr. Murney said he had practised the application of the ligature a good deal, and he believed it was the only operative treatment to adopt for internal piles. He had been present when other members of the profession made use of acid, or the clamp and he did not think them nearly so satisfactory as the ligature. At the period of the application of the ligature, the patient experiences a little pain; but he did not think he would suffer much if the medical man did not include much of the mucous membrane. He had found that sitting upon a pan of hot water was sufficient to relieve the patient from all annoyance for four or five days. He agreed with Dr. James Moore, and considered the ligature the safest, and best, and least painful or annoying to the patient. Hæmorrhage followed more frequently after the clamp than after the ligature.

Dr. M'Creagh said it was a question in many cases whether the operation should be performed at all. He had seen operations performed when he thought it would have been much better to have left the piles with the patient. A gentleman had proved the value of this opinion in his own person. He had been operated on several times. He said to him (Dr. M'Creagh) one day—“I will have a headache to-morrow morning; when I had my piles I would bleed half-a-pint, and then be all right.” His experience was that the piles were a sort of safety-valve for his liver. There might be cases which would necessitate an operation; but it is a local operation for a constitutional disease.

Mr. Spedding exhibited a foetus, which was examined and commented on by the members present.

Dr. Murney then proceeded with his report on the *post mortem* examination of Isabella Kerr and Jane Toner. Before doing so, he said, a report of the examination had appeared in the public papers; but as the evidence had been given before an unprofessional jury, it was not so full and technical as the members of the Society might desire.

1st January, 1873.—The bodies of Isabella Kerr and her servant, Jane Toner, were superficially examined on Monday, the 30th December, at 6 p.m., by Doctor Dunlop and myself, with a view to form some opinion as to when the murders were committed. Jane Toner lay on her back in the hall, her dress and underclothing were disarranged, so that the limbs, so far as the lower parts of the thighs, were exposed; the face was turned slightly to the left side; countenance pale, expression placid, left arm extended, right close by

the side, fingers of both hands tightly clenched. The rigor mortis was extremely well marked in all parts. The body of Isabella Kerr was arranged with more care, and covered with a blanket and counterpane. The rigor mortis was much less marked, and was evidently passing off; from this we inferred that in all probability Toner was dead a shorter period than Kerr. Yesterday it was elicited by evidence in various ways that in all likelihood Toner was killed about 9 p.m., on the 29th, or 21 hours before our examination. I am of opinion that Kerr was murdered before that, perhaps two or three hours. The *post-mortem* was made at 2 p.m. on the 31st; Dr. Dunlop assisted. Dr. Johnston of Holywood kindly took notes. We found:

The body of Toner was that of a woman aged apparently about fifty years, well nourished. There were no marks of injury on the trunk or extremities. On the right side of the neck were two slight scratches, quite superficial, and at least two or three days old. There was one slight wound in the scalp, half-an-inch long, situated at the vertex, a little to the right side. On reflecting the scalp there was a contused spot, the size of a shilling, about an inch posterior to the left parietal protuberance. On removing the skullcap there was an extravasation of blood, about two ounces in quantity, between the dura mater and the bone. The dura mater was then reflected, and the brain removed; every portion of it was perfectly healthy. No fracture could be found in the calvaria or base.

Chest and Abdomen.—The heart was normal in size; the right side was distended with venous blood; the left was empty; the ventricle was very much contracted; the lungs were healthy; there was not a single pleuritic adhesion. The abdominal viscera were healthy. The stomach contained a quantity of partially-digested food; this was carefully examined for the odour of spirits, or wine, but none could be detected. On examining the vagina, the hymen was found unruptured.¹

Examination of Isabella Kerr was commenced at 3 p.m. Her body was also well nourished, in good condition, a very old woman. There were no marks of injury on the trunk or extremities. The face and forehead were fearfully smashed; the nasal bones were not only broken, but the nasal cartilages were completely driven in to the nasal fossæ. The superior maxillæ and malar bones extensively comminuted. The frontal bone was exposed from a little below the frontal eminences, almost to the margins of the orbits, and was extensively smashed. On pressing the hand on face or forehead, there was the feeling of a bag of pebbles. Altogether a more frightful-looking object can

scarcely be imagined. On reflecting the scalp, two contused spots, each about the size of a shilling, were found situated at the back part of the head. On the removal of the calvaria, there was an extensive extravasation of blood on the surface of the dura mater. This membrane was intimately adherent to the bone at some points, so much so that it tore off in some places. There were two spots of extravasated blood, each about the size of a sixpence, one on the anterior, the other on the upper surface of the right hemisphere. The brain substance was healthy. The fracture of the frontal bone was now found to extend through the outer parts of the orbital plates, converging, passed through the lesser wings of the sphenoid, and met in the sella turcica. The anterior surfaces of both hemispheres were torn by the broken edges. These broken portions were quite moveable. There was no injury to the middle or posterior fossæ.

In the Chest.—The heart was of normal size and appearance. Here again the left ventricle was much contracted. The bicuspid valves were healthy; but the aortic semi-lunar valves were much thickened, and of almost bony hardness. The lungs were perfectly healthy, and here we had another example of an individual without a single pleuritic adhesion.

Abdomen.—All the abdominal viscera were healthy. The kidneys were small, but quite normal.

In consequence of a report that fluid which was found beneath the head of Toner, as she lay in the hall, was, according to some, vomited matter, according to others, port wine, I brought my microscope with me, and while the jury were viewing the house and bodies, made examinations—1st, of this fluid, and found it to be unmistakably blood; 2nd, of stains on the surface of the “salamander,” believed to be the weapon with which the fatal blows were struck, and found them to be certainly blood; 3rd, of hairs on the surface of the “salamander,” and found they were brown in colour, and corresponded with the colour of the hair of Toner; one was fully ten inches long, and was, therefore, most probably the hair of a woman. 4th, an examination of several stains on the inside, and also on the outside, of a waterproof cloak in charge of a constable, and alleged to be the property of Mary Raw, now under arrest. In this case, as the spots were dried, I made two demonstrations, one with simple syrup, the other with plain water. I saw clearly by the microscope that it was blood; but the prisoner states that her cloak was soiled by having been placed incautiously in a butcher’s shop below a dead calf.

Dr. Murney continued to say that in the case of Jane Toner there was but one blow struck. In the other case there was a fearful smashing, and at least four or five blows must have been given. The struggle took place evidently close to the door of the water-closet, to which the old lady had probably gone down

¹ It was currently reported that the perpetrator of the murders was a man, who had left the Croft dressed as a female. The coroner suggested that if this were true, rape might have preceded her death; hence the examination.

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with a candle in her hand. Lying on one side of the hall was a bed-room candlestick, and on the opposite side an extinguisher and a piece of candle. The struggle was apparently continued from that into the kitchen, where the fatal deed must have been perpetrated, for there are several clots of blood there. On three sides of the wall there are stains of blood. The body, he believed, was allowed to remain in the kitchen, until the murderers had a carouse—for from the number of bottles and other appearances in the house, it was evident they had a carouse. The parties had evidently been in search of plunder, for drawers had been burst open, and their contents littered about. That the parties had slept in the room that night was evident from the fact that lights were seen in the room several times during the night. That they had been sick during the night was evident, as there was a quantity of saliva, or some vomited matter, on both sides of the bed. Two persons had apparently been in the room, as they had used a wash-basin for defecating in, and the defecated matter was from two individuals—the one costive, the other as of a person who had taken medicine.

President.—In Toner's case did you find any fracture?

Dr. Murney.—No.

President.—Do you think her death was immediate?

Dr. Murney.—No. I think it possible, from the injuries she sustained, she might have lived for hours.

President.—In the other case, do you think death was instantaneous?

Dr. Murney said he thought so. One branch of the case he had not mentioned. The body of Miss Kerr was not laid in the scullery or pantry in the way murderers red-handed would have arranged it, for the limbs had been decently disposed, and the body placed upon its back, and a blanket, such as would be used in the kitchen for smoothing purposes, placed over the body and head. It looked to him that this disposition had been made in the morning after their night's rest, shortly before their departure. The explanation of that might be that the kitchen window is low and any person walking on the outside could see the interior, and therefore they carried the body to the nearest apartment, where it could not be so plainly seen from the outside.

Dr. James Moore.—Where did Toner bleed from?

Dr. Murney.—From a small wound in the head at the vertex.

President.—Was there any effusion of blood upon the brain matter?

Dr. Murney.—There were two ounces between the dura mater and the bone.

Dr. Stewart.—Was the expression of her countenance placid?

Dr. Murney.—It was.

Dr. John Moore said he had asked Dr. Murney to bring this matter forward, as he thought it would be a matter interesting to the Society, as a professional body.

After some further discussion, the meeting adjourned. Dr. Murney's further notes in this case, read at a future meeting, are given in this connection, as follows:—

6th January, 1873, 4 p.m.—I have just returned from the Police Office, where I examined with the microscope a stain on a piece of calico, called a "garter," in charge of constable Compton, but could not make out blood globules. As one of the witnesses who had seen the Raws between Holywood and Belfast on the 30th ultimo, had stated that one of the women had a piece of cloth tied round one of her fingers, I was asked by Mr. O'Donnell to look at Charlotte Raw's hand for marks of injury. I found two most trivial abrasions on posterior surface of left index finger, and one on posterior surface of right middle finger; they are fully 8 or 10 days old, and are almost healed.

7th January, 1873, 10 a.m.—Examined with the microscope stains on a dress, and also on a piece of linen in charge of head constable Bodley; made two demonstrations of each; used glycerine and water with two, and syrup and water with two—got blood in each.

The globules were shrivelled and contracted; in one demonstration only did the globules expand, and assume a circular outline. Some very pale stains were shown to me on a chemise which may have been blood; I did not examine them microscopically, as if I had found globules it might have been said they were menstrual.

10th January, 1873, 11 a.m.—Examined spots on a smoothing iron, which was found on the lobby, about a foot from Toner's head; it was given into my charge by the coroner on yesterday. I made four microscopic demonstrations—viz., two with glycerine and water, and two with simple syrup and water; in each case I got shrivelled and contracted blood corpuscles, but undoubted blood. I also found a hair with colouring matter; so I assume it was from Jane Toner. The presence of blood and brown hair on the salamander, and also on the smoothing iron, point to both weapons having been used in the murder of Toner. Miss Kerr's hair was very grey, but her injuries were all on the forehead and face, none of them were on the region of the hair, consequently I had nothing but blood stains to indicate the weapons used in causing her death.

Fifth Meeting of the Society was held in its Museum on Saturday 18th January 1873.

Dr. Murney in the chair, members present Drs. James Moore, John Moore, McKeown, Stewart, McCrea, J. W. Browne, D. Johnson, Charles, Scott and Spedding.

Dr. Spedding introduced a patient with tumour in neck which was considered to be glandular enlargement and likely to end in suffocation.

The patient said the tumour was growing on her neck for seven years. She first observed it beginning to form close to the jaw; but it was gradually getting nearer the middle of the neck. When she first observed it, it seemed almost the size of a cherry; and sometimes it was soft, and sometimes hard.

The Chairman said he would be happy to hear any remarks from any of the members on the tumour.

Dr. John Moore.—It is one of those glandular swellings, and I don't think it is full of fluid, at least of that cystic character. I think the termination of it will be suppuration.

Dr. James Moore.—I would think it is enlargement of the glands. I do not say there is no cystic; but I have my doubts about it. My views lean to its being enlarged glands.

The Chairman.—The result of my examination led me precisely to that conclusion. There may be a little fluid deeply seated; but that it is enlarged glands I am satisfied, at least so far satisfied, that I would not perform any operation.

Mr. Spedding.—About three weeks ago, when she came first, it was far softer, and there were fluctuations; but since I commenced to treat her, it has got firmer in the feel. I have no doubt in my mind there was a large quantity of fluid—it appeared fully that there was, when touched.

The Chairman.—Had I such a case in my charge, my treatment would be, to apply a very weak solution of iodine, with some glycerine.

Mr. Spedding.—I added a little glycerine, but it certainly did nothing for its removal.

Dr. McKeown.—For these glands which are in a state of chronic inflammation, some surgeons have advised excision, as being less likely to produce an ugly scar, than allowing them to suppurate. I have seen a great many photographs of patients operated upon by Dr. Pean, of Paris. He states that the results are most satisfactory, both as regards personal appearance, the improvement of the general health, and the prevention of tedious suppuration; and that he has never had a single bad case. I know of one case in which a suppurating gland was removed by him from below the angle of the jaw, and with the best results. Not a bad symptom followed. I look upon a gland enlarged and inflamed almost as a foreign body, and to be treated as such. In operating in dangerous regions,

Dr. Pean uses the knife as little as possible—he rather gouges or tears the gland out. He prefers security to brilliancy, and the results are altogether in his favour.

Mr. Spedding.—It was my own opinion that it should be removed by the knife.

Mr. Garde was elected a member of the Society on the motion of Dr. Mc'Crea.

Dr. McKeown exhibited several cases of disease of the eye, and read the following paper on iridectomy.

Before entering upon a consideration of the various diseases in which the operation of Iridectomy is indicated, I think it well to give a short sketch of the history of the subject.

Iridectomy has been known and practised since the time of Wenzel, who first performed it in 1780. From that date until the time of Von Graefe, its application was mainly limited to those cases in which the object was simply to make a new passage for the rays of light, and hence the operation was termed “the operation for artificial pupil.” By Graefe it was elevated to the rank of a therapeutic agent, and by his writings, teaching, and practice, it has come to take its place as one of the most useful in surgery.

It is interesting to know the chain of reasoning by which a surgeon comes to adopt a particular operative procedure, not theretofore practised. Previous to the adoption of Iridectomy for glaucoma, he had practised it in cases of extensive ulceration of the cornea, rebellious to treatment, and he attributed its beneficial influence to the diminution of tension, thus allowing the weakened tissue to receive a freer supply of nutritive material, and favouring the formation of a firm cicatrix, through the relaxation of the corneal tissue resulting. Observing that one of the main symptoms of glaucoma was an increase of tension, he inferred that if iridectomy exerted its favourable influence in ulceration of the cornea, through diminution of the intra-ocular tension, a similar action might take place in glaucoma. That the relief of tension should be the aim of the surgeon became evident to Graefe.

He clearly established, by the aid of the ophthalmoscope, which had just been discovered by Helmholtz, the presence of changes in the interior of the eye, which could only be accounted for by increased pressure—viz., spontaneous pulsation of the central artery of the retina, and excavation of the optic papilla.

He believed that the internal pressure was the ultimate cause of glaucomatous blindness, and that the permanent relief of tension should be the aim of the surgeon. He found in numerous cases temporary amelioration, by frequent evacuation of the aqueous humour, and finally resolved to try iridectomy, hoping to secure more permanent results. His hopes were realized. His title to the honour of being the first who gave a thorough description of glaucoma in all its varieties, and of being the discoverer of a successful method of treating it is indisputable.

Various explanations have been offered of the *modus operandi* of iridectomy in relieving tension. I will mention some of them.

1st. That iridectomy exerted a curative influence by diminishing the secreting surface for the aqueous. The ciliary body and anterior part of the choroid, and not the iris, are the main secreting organs.

2nd. That the curative effect results from freeing the iris from the pressure of the lens, which is pushed forward by the vitreous. This view is even more untenable than the first, because glaucoma may occur in eyes in which the lens is absent.

3rd. That iridectomy relieves the choroidal circulation, and facilitates the interchange of fluids between the vitreous and aqueous humours through the exposed zonule of Zinn. I really cannot see how the presence or absence of the iris can in any way affect the transit of fluids through this membrane, which is entirely independent of it.

4th. That, regarding glaucoma as a serous choroiditis, excision of the iris quite up to its peripheral attachment opens up lymphatic spaces behind the attachment of the iris to the membrane of Descemet, which lymphatic spaces communicate with a sort of intra-ocular serous membrane between the choroid and sclerotic, and which is, like other lymphatic spaces, lined by an endothelium; thus, by iridectomy, a communication is made between the anterior chamber and these lymphatic spaces, and the serous hypersecretion gets free from the posterior hemisphere of the eye. This opinion is advanced by Sichel, jun., and is based upon microscopic researches by Schwalbe. Sichel compares iridectomy to a thoracentesis for relief of pleuritic effusion.

5th. That iridectomy exerts its influence, not in consequence of the excision of the iris, but because of the sclero-corneal section; and this opinion is based upon clinical results, obtained by Professor Quaglino of Naples. I am not aware that any explanation of this diminution of tension from a simple sclerotomy has been given by the professor; but Wesker attributes it to the formation of a "cicatrix de filtration,"—meaning by this, I suppose, that the contents of the aqueous chamber filtrate through the cicatrix more readily than through the normal structures, causing thus a permanent drain of the fluids of the eye outwards.

It is evident that the question is far from being settled. The fact, however, that the tension is in most cases diminished by the operation, is now admitted by the most eminent oculists, and the practice of iridectomy has been extended over the whole civilized world.

But Graffe's labours and discoveries, in relation to glaucoma, did not rest here. He showed that the disease might be secondary to many other diseases of the eye, and that in many cases the unfortunate termination of ocular affections was owing to the grafting of a glaucoma upon the original malady. There are few diseases of the eye which may not be the starting point of glaucoma. Amongst them maybe mentioned

inflammation of the cornea, of the iris, of the choroid, retinal hæmorrhage, traumatic cataract, prolapse of the iris, staphyloma pannus, and dislocation of the lens. Most of these cases, however, differ from primary glaucoma in this respect—that the cause of the glaucoma can be traced to some source of irritation, and that iridectomy is not applicable in all such cases; but that the treatment should be rather directed to the removal of the ascertained source of irritation.

For so far, in speaking of therapeutic iridectomy, I have only referred to it as an agent to secure diminution of tension, and applicable to glaucomatous diseases, and to cases of ulceration of the cornea, to lessen even normal pressure. The following is a summary of such cases:—

- (a) Simple glaucoma.
- (b) Acute inflammatory glaucoma.
- (c) Chronic inflammatory glaucoma.
- (d) Secondary glaucoma, resulting from weakening of the cornea through previous ulceration.
- (e) Partial staphyloma of the cornea and iris.
- (f) Corneo iritis, and serous iritis, with deep anterior chamber, increased tension, and contraction of visual field.
- (g) Some cases of pannus.
- (h) In cases of extensive ulceration of the cornea. Here the normal intra-ocular pressure, acting upon the weakened part, retards the supply of nutritive material necessary for repair, and causes greater tendency to extensive sloughing. Iridectomy is meant to diminish this normal pressure, to facilitate the regeneration of the tissue, and, besides, to afford an aperture for the entrance of light, in case the ulcerated part should be opposite the pupil.
- (i) In cases of traumatic cataract, where glaucomatous symptoms arise from excessive swelling of the lens, and pressure upon the posterior surface of the iris, and in which the lens is not so completely cataractous as to admit of complete removal, or in which it may not be deemed prudent from the general condition of the eye to perform the more severe operation of linear extraction, iridectomy may be performed.
- (k) In cases of partial dislocation of the lens, with glaucomatous symptoms, in which a portion of the iris is pressed upon, removal of the section of the iris most pressed upon may afford relief.
- (l) In cases of conical cornea, with the double object of relieving tension, and affording entrance of light by a part of of the cornea least changed in curve.

In all these cases, save perhaps in partial dislocation of the lens, the section should be large, and made in the sclerotic, so that the inner margin of the wound should be quite at the periphery of the anterior

chamber; and the whole of the segment of the iris corresponding to the section should be removed. Each case of partial dislocation of the lens should be judged on its own merits, and if iridectomy should be deemed suitable, the portion of the iris pressed upon should be excised. With respect to the treatment of conical cornea by iridectomy, I may remark that I include it here inasmuch as it has been treated by many in this way; but I am disposed to regard the treatment by producing a central ulceration of the cornea and cicatricial contraction, as having most evidence in its favour. I may note a very important point in the manner of performing iridectomy for partial staphyloma of the cornea and iris. I believe that the great cause of the glaucomatous tendency in this disease is the alternate traction and relaxation to which the healthy iris and, indirectly, its ciliary attachment, is subject, through the variations in size of the staphyloma dependent on muscular pressure during use of the eye. A vicious circle is always in operation. The traction on the iris is the link in the chain whereby variations in the bulk of the staphyloma leads to secreting activity. Therefore, in performing iridectomy, the segment of healthy iris attached to the staphyloma on both sides should be excised. The case of Minnie T_ is an example of the success of this plan.

I have now to speak of another class of cases, in which the tendency of the disease is rather to diminution of tension, and atrophy of the organ, and in which iridectomy has an effect directly opposite to that brought about by it in glaucomatous diseases. You have all, no doubt, witnessed the gradual extinction of vision, and shrivelling of eyes under attacks of iritis, irido-choroiditis, and corneo-iritis. The diseases named, when they take this unfortunate course, have this in common—that the iris is very extensively implicated; that it becomes degenerate by long continued inflammatory processes; that it has extensive attachments to the capsule of the lens; and that the communication between the anterior and posterior chambers has become obstructed. How, you will ask, can you expect from iridectomy, in conditions such as those, an effect diametrically opposite to that which you claim for it in glaucomatous diseases? It is necessary to bear in mind that glaucomatous diseases are characterized by hypersecretion of a serous character, whilst the diseases with a tendency to atrophy of the organ are plastic. The two classes are not absolutely separate. We find cases which form a link between them, which are neither truly serous nor plastic, and which exhibit a change of character in different stages. Thus you may find an iritis so far plastic as to form adhesion, and so much serous as to cause considerable increase of tension. Let us take, however, a typical case, and study the causes in operation. The plastic deposit in the tissues ultimately

interferes with the free circulation in the vessels, and in consequence of their constriction, a stasis takes place in the circulation, the iris loses its normal appearance, and changes in physical character, becoming either fibrous, felty, and very resistant, or so rotten as to tear on every touch of the forceps; the secreting power is diminished, the nutrition of all the humours dependent on the vascular supply suffers, and hence the atrophy. An important factor in the result is doubtless the adhesions. The pupil cannot contract and expand, and hence a constant source of irritation of the iris is in operation. There may be frequent recurrences of inflammation on the slightest cause, and with every attack, fresh lymph deposits, so that, finally, the pupillary margin, if not entirely adherent, becomes so, and the iris, not unfrequently, attached by a considerable portion; and in some cases where the plastic character of the inflammation is very marked and extensive, by the whole of its posterior surface to the capsule of the lens. If any retro-iritic space remains, the communication between the anterior and posterior chambers being cut off, the aqueous humour secreted mainly by the ciliary processes is collected behind the iris, bulges that structure forwards, assists in impeding the flow of the circulating fluid, presses upon the iris, lens, and ciliary, tends to produce a stasis in the choroidal circulation, and leads ultimately to deep-seated complications. The lens may become opaque; the inflammation may extend to the ciliary processes and choroid and then truly the disease becomes one of the most formidable to which the eye is subject, and too frequently to irreparable loss of vision. The tendency of an inflammation of this character is generally to atrophy of the organ. You will readily understand, now, how an iridectomy will, in many cases of this kind, when performed in time, lead to an improvement in the nutrition of the organ, and consequently, to an increase of tension. When the retro-iritic span is not entirely obliterated, or when it is distended with aqueous the iridectomy opens up the communication between the two chambers, restores the balance between the different humours of the eye, relieves the iris, lens, and ciliary processes from pressure of accumulated aqueous, and frees the iritic and choroidal circulation. Before resolving upon iridectomy, however, it is necessary to make a very careful examination of the field of vision. Should the patient, with an eye becoming atrophied, not perceive readily the light thrown upon the eye in different directions, then there is reason to believe in the existence of a detachment of the retina, and in such a case any operation is contra-indicated. So, should the whole of the posterior surface of the iris be attached to the lens, and the peripheral portion be retracted, then experience teaches that generally an iridectomy is not beneficial, either in opening a passage for the rays of light, or in

improving the condition of the organ. There are exceptions, however, to the general rule. The case of R_ M_, appended, is a notable example. He had been completely blind for eight months, from an inflammation affecting the cornea and iris; the pupil was entirely closed; pretty extensive opacities of both cornea, leaving, however, the upper part in the right eye, and the inner part in the left eye pretty clear; left eye quite soft to the touch; anterior chamber almost entirely gone; iris of a dirty colour, and soaked as it were with inflammatory deposit, and adherent to lens by most, if not all, its posterior surface; field of vision in both eyes good. In the left eye I performed two iridectomies; the iris was quite rotten. However, I succeeded in tearing away sufficient of the iris and exudations to make a passage for the rays of light. The pupil did not close, and he came to be able to read number 12 of Quillen's types at a few inches. The operation on the right eye restored vision sufficient to enable him to count fingers readily. The tension of the left eye, which had been so notably diminished, soon reached the normal, and now, after a lapse of two years, his vision has remained in the same satisfactory state as after the operation. I note this case particularly, as it is one in which authors would lead you to believe that the operative procedure should have been extraction of the lens with dilaceration of the iris and false membranes; and I cannot avoid thinking that the iridectomy secured for the patient a result which would have hardly been attained by the operation mentioned. As regards the operation of extraction of the lens, combined with iridectomy and dilaceration of the membranes, I may remark, as a strange fact, that I never saw such an operation performed by any oculist in Paris or London, although for a year I diligently watched their practice, and never missed an operation at which I could possibly be present. There must have been cases enough. I can only draw one inference, viz.—that although we have a few brilliant results recorded, yet they are so exceptional, that oculists with an established reputation deem it more prudent not to interfere, the percentage of failures being so great.

Iridectomy is performed for purely optical purposes in the following cases:

1. Opacities of the cornea over the pupil.
2. Closed pupil, the result of inflammation at some considerable I, time previously.
3. Zonular Cataract.
4. Limited central opacities of the lens capsule.
5. Even in hard senile cataract, with cortical substance not affected.

In one case, that of M_ P_ iridectomy succeeded in restoring vision, when any other procedure would have almost certainly failed.

6. In some cases of partially dislocated lens, iridectomy is performed as a preliminary to other oper-

ations, or as a stage of another operation, or as an essential to the accomplishment of a particular object.

(a) As a preliminary measure before operating for cataract by discission, in persons between 20 and 35 years of age. The lens is less likely, in swelling, to irritate the iris, and cause either a traumatic glaucoma, or iritis.

(b) As a stage in Von Graefe's and some other modes of extraction, to facilitate the exit of the lens, and to diminish the chance of an iritis.

(c) Iridectomy is the usual rule in dealing with cysts of the iris, or foreign bodies lodged in it.

An interesting conversation took place on the cases exhibited, after which the meeting adjourned.

The Sixth Meeting of the Society was held on Saturday, 1st February, 1873, in the Society's Room, General Hospital,—the President in the chair.

The Chairman said some members had suggested that they should go back to the original period of meeting, once every week, which would give them more time for the discussion of the various matters that would come before them. He would be glad to hear the opinion of any gentleman who had anything to say on the subject.

Dr. Cuming said if there could be material enough he could see no objection.

Dr. James Moore said he would like to see weekly meetings, but he would also like to see students introduced. They did so many years ago, and it served as a great stimulus, and been of great service to the students.

Dr. John Moore said a notice was up in the College hall that students were welcome to their meetings.

The Chairman said it might be better to defer the consideration of that subject for a week.

This suggestion was agreed to.

Dr. Cuming, in presenting a specimen of Aortic Aneurism, observed that the case presented unusual pathological interest, owing to the fact that it had become practically cured by treatment. It possessed also some clinical interest from the fact that, although of considerable bulk, equal to a small orange, it had never given rise to any symptoms whatever during life.

The history of the case could be supplied in a few words. The man was in the hospital about six months. He came in with an attack of bronchitis. On examining his chest, he came upon an aneurism of the aorta, of which the physical signs were perfectly clear and manifest. The man never complained of any symptom such as are so usually engendered by aneurism, nor at any time during the remainder of his life was there any sign of pressure on any part. Indeed, he was quite unaware of its existence. He told the patient there was something abnormal there, and the man expressed his readiness to do anything that was con-

sidered desirable. He was put under a course or iodide of potassium, without any apparent benefit. He then tried the plan, recommended by Tufnell, of absolute rest, with the use of a very restricted diet. The man submitted to this, and Dr. H. S. Purdon, who succeeded Dr. Cuming, carried on the treatment of the case in the same way for more than two months. The effect was that the physical signs were remarkably improved when Dr. Cuming again took charge of the wards, but the man's health began to sink, so that although the pulsation entirely disappeared, the patient was in such a condition that it was quite impossible to pursue any form of treatment whatever. His lungs became congested; he got cystic inflammation, and began to sleep badly, and his nervous system was in a state of intense irritation. He gradually sank under his misfortune, without having complained in any way of the aneurism, which had now become so solid that no one could possibly have diagnosed its existence. There was simply, as regards physical signs, an area of dullness at the upper part of the sternum, corresponding to the bulk of the tumour. After his death his friends allowed them to make a *post mortem*, and they found this large aneurism occupying the entire space between the innominate and carotid arteries, and about the size of an orange, which is almost completely filled with consolidated fibrin.

Dr. James Moore then exhibited a case of laceration of the elbow, and pointed out the importance in the operation of keeping the nerve from the end of the stump. He also explained how hospital gangrene had interfered with the success of his operation.

The meeting then adjourned.

The Seventh Meeting of the Society was held on Saturday, 15th February, 1873, in the Society's Room, General Hospital, the President in the chair.

Dr. John Moore proposed that the meetings of the Society be held weekly, so long as there was matter to come before them for discussion.

Dr. Fagan seconded the motion, observing that there was abundance of most interesting matter that might be discussed, and if the meetings were held only fortnightly, several important subjects would have to be omitted.

Dr. James Moore supported the resolution, and said that twenty years ago the meetings were weekly, and were well attended by the bulk of the members of the profession, and by thirty, forty, and sometimes fifty students, who were greatly benefited by what they heard.

Mr. Gribbin moved, as an amendment, that the meeting should continue to be held fortnightly.

Mr. Garde seconded the amendment.

The Chairman put the amendment, which was lost, only the mover and seconder voting for it.

The original motion was then carried.

Dr. John Moore introduced a patient suffering from irreducible dislocation of the thumb. He explained that the patient received the injury by a fall. When brought to the Hospital he was put under chloroform, but nothing would reduce it.

The Chairman.—How did it occur?

The Patient.—One Saturday evening, about 4 o'clock, the wind blew off my hat, and as I was running to catch it I tripped, and threw out my hands to save myself.

Dr. John Moore.—I can replace it easy enough, but it will not remain in its place. It immediately springs back.

Dr. Charles.—There is a peculiar instrument used in Paris for reducing the dislocation of the thumb. Two blades are brought together with leather, and I don't know any way in which you could apply such force to the thumb as by it. The instrument, which is a French one, is not by pulleys.¹

The Chairman.—This is a most interesting case in a practical point of view, for we are to take into consideration his trade and business. Now the point is, would you advise Dr. Moore to interfere further, or just leave it alone, allowing the man to suffer whatever inconvenience may result from the injury? We all know that the difficulty of reducing such cases is very great indeed.

Dr. Wales.—There seems to be very little shortening, and he has perfect power of motion. He can apply his thumb fully to the palm. The projection below does not interfere with freedom of motion towards the palm; and, no matter what his business is, I would let it alone.

Mr. Spedding.—I must express my disagreement with Dr. Wales. I really think that although he has a tolerable amount of power of approximating his thumb to his fore finger, operative interference would be beneficial in the case. I think that possibly excision of the tendon, and perhaps the head of the metacarpal bone of the thumb would be attended with great benefit.

Dr. Bolton.—I think the operation Mr. Spedding refers to would be preferable to letting it remain as it is.

Dr. Charles.—I would be inclined to try reduction under chloroform in the first place, and if that failed, to cut through either one or both of the lateral ligaments; and if that also failed, to remove the head of the metacarpal bone. He would then be able to use his thumb almost as well as ever. He will never have a strong thumb as it is.

Dr. John Moore.—That is what I should be inclined to do, viz., to excise the head of the metacarpal bone; but then the question is whether it is not better to let

¹ [See page 1194 for a description.]

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well enough alone. He was under chloroform, but it always springs back as if there was some elastic tissue between the bones. Some thought the head of the metacarpal bone was broken and tilted round.

Dr. Charles.—Would a splint not have been of some use?

Dr. John Moore.—No; we thought no splint would be of use.

The Chairman.—I am under the impression that in a case of the kind, it is very much a matter for the man himself; because, if he can follow his trade, I would be slow to suggest an operation.

Dr. H. S. Purdon introduced a patient, the subject of Graves' disease. In explaining the symptoms, he said:—

C_ W_, 35, weaver, and unmarried, was admitted into the Belfast General Hospital on January 6th, 1873.

History.—She states that about three months ago she noticed a swelling in her neck, but which caused neither pain nor uneasiness beyond the unsightly appearance it produced. She was in the habit of drinking large quantities of water, which seems, from her description, not to have been hard or calcareous. Her catamenial periods have all along been perfectly regular, and neither in excess nor in diminished amount.

On admission she was placed under the care of Dr. Cuming, who found she was suffering from Exophthalmic Bronchocele or "Graves' Disease." There was hypertrophy of the thyroid body, soft to the feel, and the right lobe slightly more enlarged than the left, a loud systolic bruit heard on auscultation, a pulsatory thrill all over the surface of the enlargement, palpitation of the heart, and slight exophthalmia; at least the eye-balls were not completely covered by the lids during sleep. The pulsation of the deep-seated vessels of the neck were visible, and there was some stomachic derangement, nausea and vomiting but no diarrhoea. As a rule, the patient was sleepless. She was slightly hysterical and anæmic. Her pulse was very high, 135 pulsations per minute. There was not much difficulty in breathing or swallowing, except when very solid food was taken, which had to be well masticated before being swallowed. She complained of pressure of gland on larynx, voice unchanged, eyes brilliant, and strong light "hurts them," temper irritable.

Treatment.—She was ordered by Dr. Cuming, on the 7th January, the following recipe.

℞ Tinct. Aconitii, ℥ xvi.
Syrup, ℥ iii.
Aquæ, ℥ ii.

Half an oz. every third hour. This lowered the pulse. Subsequently she had chloral to procure sleep; and, to prevent constipation, fluid magnesia, followed by iron. The iodide of lead ointment was applied to gland.

On the 1st February Dr. H. S. Purdon came on duty, under whom she was placed. On February 2nd, he ordered the following. Pulse then 130 per minute.

℞ Tinct. Digitalis, ℥ iiss.
Tinct. Ferri Perchlor, ℥ ii.
Aquæ, ℥ vi.

Half an oz. ter in die, ex aquæ.

She continued to take it, and on February 4th the pulse had decreased to 120. On the 5th it was 100, and on the 12th the pulse was down to 86 beats per minute.

All along she complained of intense thirst, and want of sleep at night, for which she was ordered a draught of bromide of potash, to be taken at bed-time. Since she came into Hospital the swelling of the thyroid has greatly subsided, and the nausea and vomiting have entirely disappeared, the eyes are looking better, and, on the whole, she continues to improve. The pulse is falling steadily.

The Chairman.—How long has she been labouring under this?

The Patient.—It is three months since I first observed it.

Dr. Purdon.—Dr. Wales told me he has had a case of the same disease.

Dr. Browne.—Regarding operative interference in this case, I remember where a case of the same kind was brought to the Hospital, and the case was afterwards taken to a certain medical man, and he tapped the cyst. We had great trouble in bringing the patient through.

The Chairman.—I tapped that case, and I remember my own surprise at the time. I looked upon it as a case of hydrocele of the neck. The patient was brought from the country, from the neighbourhood of Castledawson. On tapping it, a quantity of fluid came out. There was a quantity of serous fluid. I thought my diagnosis correct; but, to my disappointment and surprise, the whole thing collapsed, and in two or three minutes blood began to ooze, and the cyst filled up, and was greatly distended. Then my difficulty was to know whether in tapping it I had wounded a small artery, or whether such was the character of the lining membrane of the cyst, that it immediately poured out blood. It swelled up enormously. Of course I did not know what dangerous symptoms might accrue, and hence I brought the patient here.

Dr. Browne.—Dr. MacCormac's opinion was that the surgeon had wounded one of the arteries, and the only thing that would benefit at all was the application of ice. I know we had ice applied for three days. She had all the symptoms of pyæmia but she rallied.

Mr. Gribbin.—In reference to the present case, I believe that if you follow up the patient's history, you will find she has not got sufficient pabulum, which is sufficient to account for all the symptoms. According to my humble judgement it is not a case of Graves'

disease at all. In fact I might condense in a nut-shell the essence of what I wish to convey, by saying that it is a case that has arisen entirely from an insufficiency of food, and if she was supplied with sufficient food for a while, it is very probable the tumour would disappear. What calling does she follow?

Dr. Purdon—She is a weaver. She is getting good diet now.

Dr. Wales.—I have had a case of a similar character. It is very hard to get positive information with regard to these cases.

In this case, if the sequence of the symptoms continue, it would be hard to say whether it is a case of what is called simple goitre, or Addison's disease. I agree very much with Mr. Gribbin.

A Member suggested the use of iodine.

Dr. Purdon said that in ordinary goitre, iodine had a very beneficial action; but if they gave iodine in cases of what was supposed to be Graves' disease, it was very injurious, and weakened the patient still further.

The Chairman said there were on the paper two or three cases of great interest. He hoped that the students would make a point of attending, for the matter discussed at the meetings was of great practical interest.

The meeting then adjourned.

The Eighth Meeting of the Society was held on Saturday evening, 22nd February, 1878, at four o'clock, in the Society's Room, General Hospital,—the President in the chair.

Dr. Core was elected a member of the Society.

Dr. M'Keown gave notice that at next meeting he would propose that the business of the Society should be done in sections, and that one section shall be a sanitary one, and consist of the medical dispensary officers of the town, or as many as choose to take part in it, who will prepare a report monthly, or bi-monthly, to be published in the newspapers.

Dr. M'Crea said that last year the Society and some committees took a great deal of trouble in preparing a scale of fees. He had been asked several times whether copies of it could be easily procured, but had been unable to answer.

The President.—Here they are on the table. We had them here at the last meeting, when they were distributed to the members.

Dr. J. W. Browne read the following notes of cases of Peritonitis, following the introduction of a tangle tent into the uterus. The first case resembled one of strangulated hernia, a tumour existing in the groin, which, on operation, was found to be an obliterated hernial sac.

Case I.—Mrs. W., aged 46 years, was admitted into the Belfast General Hospital on the 18th January, 1878, under the care of Dr. S. Browne.

She states that she was married when 16 years of age, and had two children; the first child was dead born; the second lived to the age of two years. Since the birth of the last child she had menstruated regularly; the last menstrual period being upon the day of her admission to Hospital. She had always been subject to constipation of the bowels, and usually required large doses of purgative medicines.

On admission, she was found to be suffering from a muco-purulent discharge from the vagina, and complained of great pain over the region of the uterus. The discharge had been persistent for the past six months. Ordered an injection of permanganate of potash, to be used twice daily, which was found to have no beneficial effect. Dr. Browne, upon examination by the speculum, found a patulous condition of the os uteri, and a thick muco-purulent discharge coming from the uterus. He diagnosed the case as one of Endometritis, and ordered an injection of sulphate of zinc and tannic acid, to be used thrice daily; also some tonics. This treatment was continued until the 29th January, without any beneficial result, when Dr. Browne resolved to dilate the os uteri by means of a sea-tangle tent, so as to treat the cavity of the uterus by nitrate of silver or nitric acid.

The smallest sea-tangle tent was introduced at 10 a.m. upon the 29th January, and was removed at 4 p.m. She was ordered an aperient draught, to be taken at bed time.

January 30th, 10 a.m.—Bowels freely acted upon. A large sized tent was introduced, which was intended to remain in situ until the following morning; but it had to be withdrawn at 7 p.m., owing to a severe rigor which supervened.

Ordered pulv. doverii, gr.x. h. s.s.

January 31st, 10 a.m.—Pulse 86. Complains of pain upon pressure over the region of the uterus. There is a profuse muco-purulent discharge from the uterus. She has been vomiting since 8 a.m. Ordered an enema of turpentine and castor oil, which brought away a small quantity of fæces; also

R Calomel, gr. i
Pulv. Opii., gr. ¼
Ext. Gent., q. s.
fiat pil.

One every fourth hour.

R Liq. Morphiae
Spt. Amm. Aromat. ana, ʒss.
Aquæ, ad. ʒi
fiat haust. s.s.

4 p.m.—Vomiting has ceased since she took the draught. Pain over the uterus increased. Pulse 120, temperature 104°. Pills were ordered to be taken every second hour; six leeches to be applied a little above Poupart's ligament upon each side, emp, Lyttæ 5 by 3 inches over the region of the uterus, also an enema of castor oil and turpentine in the evening.

February 1st.—Pulse 100, strong; tongue furred; slept some during the night; vomiting commenced again during the morning; pain over the uterus still continues; blistered surface to be dressed with dilute mercurial ointment, and a light linseed meal poultice to be applied over the abdomen. The enema administered yesterday evening brought away no fæces. The morphia draught to be repeated immediately, and the patient to have arrowroot, brandy, and milk during the day.

6 pm.—Pulse 100 and full; vomiting still continues; excessive pain upon pressure over the region of the uterus. This evening a small tumour was detected in the right groin, which the patient states has existed for the past three months, and has increased slightly since the vomiting commenced. This tumour was diagnosed to be a femoral hernia, and believed to be the cause of the vomiting and constipation.

The patient was brought under the influence of chloroform, and the taxis gently used, but this failed in reducing the tumour.

A consultation was called at 10 p.m., Drs. Murney, James Moore, John Moore, and Dr. Browne being present, when it was decided to operate the following morning, should the symptoms denoting a strangulated hernia continue. The pills were ordered to be discontinued, and brandy and arrowroot to be given during the night. A hypodermic injection of morphia was also ordered, should the patient not sleep.

February 2nd, 10 a.m.—Pulse 110; slept a little; vomiting continued during the night; no motion from the bowels has taken place; pain over the region of the uterus not so intense; required to be catheterized during the night.

A consultation was summoned, and it was determined to operate immediately.

Operation.—The usual incisions for the relief of a femoral hernia were made by Dr. Browne, and the various fasciæ divided. Upon opening the sac it was found to be the thickened remains of a hernial sac, containing a small quantity of straw-coloured serum, and no intestine. Dr. Murney passed a director through the femoral ring into the cavity of the abdomen.

The usual sutures were used to close the wound, and a pad of lint and bandage applied.

After the operation she was ordered—

℞ Calomel

Pulv. aromat. ana, gr.ii.

fiat pulv. s.s.

A poultice to be applied over the abdomen.

1 p.m.—Vomiting still continues. A draught of liq. morphia and aromatic spirit of ammonia to be given at once.

6 p.m.—No motion from the bowels; abdomen tympanitic; vomiting continues; ordered an injection of turpentine and castor oil, to be repeated at

11 o'clock, p.m. if bowels have not acted, also a draught containing brandy and hydrocyanic acid every 4th hoar,

11 p.m.—Vomiting still continues; bowels have not yet acted; enema administered with O'Byrne's long tube, which brought away a little flatus, but no fæces.

February 3rd, 7.30 a.m.—Slept none during the night; vomiting still continues; one minim of creosote was now given every fourth hour.

10 a.m.—No vomiting since 8 a.m.; pulse 110, and very weak; brandy to be continued; the discharge from the uterus has ceased to-day.

3 p.m.—Vomited a quantity of stercoraceous matter. The creosote pill was continued, and champagne substituted for the brandy.

6 p.m.—Champagne seems to remain in her stomach longer than any other stimulant; no motion from the bowels; vomiting continuing.

10 p.m.—Patient very weak, and sinking; vomiting a quantity of matter resembling coffee grounds.

February 4th.—Patient died at 4 a.m.

Post mortem examination, performed by Dr. John Moore, sixteen hours after death:—

On opening the abdomen the bowels were found matted together, and the colon in the right iliac region was firmly adherent to the peritoneum, covering the iliacus muscle, evidently the result of recent inflammation.

There was a quantity of fluid in the abdominal cavity resembling feculent matter, but without the odour of fæces. This fluid was tinged with bile, and mixed with flakes of lymph. The bowels were distended with flatus, and some scybala were found in the upper part of the sigmoid flexure.

An obliterated sac was found occupying the femoral ring. The sac was the size of a filbert. There was no cellulitis or inflammatory action of the uterus or its appendages.

Case II.—A similar case occurred when I was house surgeon to the Belfast General Hospital (1868-69),

A female was admitted suffering from a uterine tumour. The os uteri was very small, and a sponge tent was introduced to dilate it. Seven hours after the introduction of the tent a rigor occurred. Fourteen hours afterwards a very abundant muco-purulent discharge flowed from the uterus. The tent was then withdrawn. The patient complained of great pain over the region of the uterus and abdomen.

In 48 hours from introduction of the tent, the usual symptoms of peritonitis set in, and the patient died. In this case no *post mortem* was held.

Remarks.—In the British Medical Journal, for July, 1871, there is the history of a case of acute inflammation of the hip joint, following the introduction of a sea-tangle tent. Pain in the joint came on a short time after the introduction of the tent. The patient died, and, upon a *post mortem* examination, a large abscess

was found in the hip-joint. There was no pelvic cellulitis.

Dr. Cooper Forster considers that several of the rapid deaths which have occurred after the introduction of a sea-tangle tent, have been cases of rapid pyæmia, consequent upon abrasion of the mucous membrane of the uterus.

The President.—In discussing the cases, we may deal with them together in some points, and separately in others. The analogy between my case and that which Dr. Browne has placed before us lies only in one point, that is as regards the hernia. The point in regard to the uterine inflammation, and whether it was from the sponge tent, are separate points for discussion; but so far as the hernia is concerned, the analogy between my case and his lies in that. This preparation was removed from the patient, who was in the Union Infirmary, on the 14th February, 1872, and who I found was labouring under the symptoms of strangulated hernia. I found a small tumour in the left groin. I had her removed into a small ward, and directed that preparations should be made for operating upon her. I had the assistance of Dr. Murney and Dr. John Moore. We cut down in the left groin to what we thought right to be classified with hernia. However, when we had cut down, we were rather puzzled to know what we had come upon, and we could not well make up our minds what it was. Finding we could not, with safety to the patient, return it, we determined to relieve the stricture, and leave the part lying outside. She lived from the 14th to the 20th, and had still symptoms of peritonitis and strangulation, except that a day or two before her death, copious evacuation took place from her bowels. I made a *post mortem* examination, and found there were symptoms of peritonitis, and a mixture of lymph, which might be taken at first sight for thin fæces. Upon examining the seat of hernia, we found an obliterated hernial sac. Looking upon it as a hernia, and not being able to return it, what we did was to relieve the stricture, and leave it as it was. She died from peritonitis; and I may mention that at one point there was a perforating ulcer, surrounded by a gangrenous state of the intestine. There was another point struck me as a matter of interest, that is, how the old lady lived so long after perforation, Nature was making a bold attempt at effusing lymph in the neighbourhood; but how she lived for six days, after perforation of the bowels, was extraordinary. It is possible there might have been some bowel affection, and that that gave rise to the symptoms, and that the perforation took place during the time she was under treatment in the Infirmary.

Dr. John Moore.—It was not an inflamed tumour. There was that peculiarity which was seen in Dr. Browne's case, that there was a measure of obscurity from the absence of the tenderness you would have expected.

The President.—I think this case resolves itself into two points, so far as our discussion is concerned. It would be a pity we should lose sight of the hernia, which can come up again, and that we should not thoroughly discuss the advisability of introducing these tents into the uterus. I think we should ask the members present what is their experience in dealing with such cases.

Dr. M'Keown.—Though unfortunate cases may occur, in regard to the introduction of the tent, still I do not see that there is any great reason for condemning the practice utterly. With respect to the sponge tent, I think it should be altogether discarded, and I think a clean smooth piece of laminaria digitaria would be preferable. I remember reading some time ago a paper, by Dr. Kidd, on the use of laminaria digitaria, cut into small pieces, and introduced side by side.

Dr. John Moore.—I think, Mr. President, there are a number of cases that have been already recorded of the irritation, and constitutional disturbance, and fatal results following from the introduction of the tangle tent. I think the history of this case is so clear, that I do not know how we can arrive at any other conclusion than that it was the exciting cause. There was a rigor following within a few hours of its introduction. I saw the patient during life, and was present at the *post mortem*. The occurrence of hernial tumour is one of these incidental things that come to be of when we meet them. It is only a warning to us to look out and be more careful in the employment of a mode of treatment that has not unfrequently terminated fatally.

The President.—Some member of the Society stated a case where peritonitis set in from the use of Simpson's sound.

Dr. M'Crea.—That has happened several times.

Dr. Murney, J.P.—I saw both these cases—that operated on by the President, and the one that has been the subject of Dr. Browne's paper. They are the only cases in which I have seen the old hernial sac without contents the subject of an operation. You have arranged that, for the present at least, the discussion should be confined to the uterine branch of the topic. I had under my charge some time ago, a patient in whose case I was desirous of dilating the os, and introducing one of the tangle tents, which was followed with most unsatisfactory results. She had a most severe attack of inflammation. A somewhat allied case is pretty well known to most of us, viz.—where the menstrual secretion is retained. I have operated upon some cases, without any fatal result; but several such are on record, and I fancy it would be a somewhat allied case to that of an operation on the cervix with a tangle tent. I would be much more cautious in the use of either sponge tent or tangle tent now, than a few years ago.

Dr. Brice Smyth.—I have never seen any bad effects.

Mr. Spedding.—Although I have no experience of the tangle tent, I cannot quite understand how we interfere with the uterus so much latterly. I think the recent system is to use intra-uterine injections, and, in fact, to manipulate more freely with the uterus than they were accustomed formerly to do. I think myself, and Dr. Walton Browne will agree with me, that we both very freely use carbolic acid in the dispensary for ulcerations, pass it freely up the cervix, and that has never been followed by any unpleasant result. I have done it frequently, and within the last few weeks I saw Dr. Playfair's suggestion of swabbing the whole of the uterus out with an instrument with a long handle, and inserted as far as possible, with cotton wadding, saturated with carbolic acid. I cannot see why any evil effects should follow the use of the tangle tent, when one can use such a powerful caustic to the uterus.

The President.—Have you found it successful?

Mr. Spedding.—Well I have not found it as successful as one would believe from reading Dr. Playfair's lecture, in point of causing a cessation of the discharge; but I have found it productive of no unpleasant symptoms, such as rigor, &c.

Mr. Gribbin.—What strength do you mix the solution of carbolic acid? Do you form it from the crystal?

Mr. Spedding.—Yes. It is simply dissolved by heat, and kept fluid by a few drops of water, a little glycerine, say a drachm or half a drachm.

Dr. M'Keown.—I think, as a rule, the more powerful, the less dangerous.

Dr. M'Crea.—I think there is, perhaps, a reaction setting in against what Mr. Spedding speaks of. I think the tendency at present is not to interfere with the uterus so much as Sir James Simpson and his pupils did. There is some little risk in using these tangle tents, which is owing to not attending to the size of the tent. If a tangle tent be put in through the canal of the cervix, and be allowed to swell in the cavity of the uterus, the end becomes bulbous, and there is some little difficulty in extracting it. You should select a small tent, as small as can be used, and afterwards come up if necessary. I think the danger is not sufficiently attended to of putting in a larger one,—that forms this bulbous extremity, which causes great difficulty in extraction.

Dr. Murney.—We have to thank Dr. Browne for bringing these cases before us. I do not believe there could be two more valuable cases placed on record than those brought before us to day. They are most valuable in regard to our knowledge of the treatment of uterine affections. I think the fashion of the day, as led by Sir James Simpson, has been rather in favour of too much manipulation, and interfering with the uterus too freely. It is, therefore, much to the advancement of obstetrical surgery that cases of this

description should be placed on record. If every case was recorded, physicians would be more careful than many of them are at present. The other cases of hernia are interesting too, and it might be well to have a further discussion in regard to them at a subsequent meeting. There are so many points in connection with these two cases of hernia, that I would suggest we should take up the matter at the next meeting.

The meeting then adjourned.

The Ninth Meeting of the Society was held on Saturday, March 1st, in the Society's Room, General Hospital—The President in the chair.

Members present Drs. H. S. Purdon, Whitaker, Fagan, J. W. Browne, M'Crea, Torrens, Brice Smyth, D. Johnson, Charles, Scott, John Moore, Messrs. Garde and Spedding and Dr. McKeown.

Dr. M'Keown gave notice that, at next meeting, he would move the following:—"That a Committee, to be called a Sanitary Committee, be appointed to report quarterly to this Society upon the sanitary condition of Belfast; that such reports and the discussions thereon be published in the daily papers, for the information of the public, and of our local boards, and for that purpose that the representatives of the press be admitted. That such of the local officers of dispensaries and charitable institutions of this town as are members of this Society shall be ex-officio members of the Sanitary Committee."

Dr. Henry Samuel Purdon introduced a patient suffering from progressive muscular atrophy, and read notes of the case:—

The President.—What age is the patient?

Dr. Purdon.—About fifty.

The President.—He does not look that. We will be glad to hear any remarks on the case.

Dr. Fagan—I think the subject has been well nigh exhausted by Dr. Purdon; but it seems to me that, in such cases, we are frequently disposed to look to the nervous centres rather than to the peripheral extremities. Where the thing is local, very often the origin of the disease is in the extremities, and not in the nervous centres; and, if treatment were more specially directed to them, we would, I feel sure, have frequently better results than at present. This condition frequently occurs from too much heat or too much cold interfering with the intimate processes that go on in the tissues, the nerve supply being somewhat interfered with, wasting going on, and a corresponding repair not carried on in it. That is indicative of the disease being in the peripheral extremities; and if physicians directed their attention to them rather than to the nervous centres, their treatment would be often attended with better results.

Mr. Spedding.—I think this a typical case of the disease, and I am afraid that the prognosis is very serious for the patient, inasmuch as he is getting

gradually worse, and it has lasted above the ordinary mean duration of fatal cases. I think the mean duration of fatal cases is under $5\frac{1}{4}$ years from the commencement of the disease. Roberts has analysed 106 cases, in the course of which he ascertained the mean duration to be five years and two months. Duchesne has advocated the galvanization of the inferior vital ganglion of the sympathetic, and he has stated he has seen good results from the vital ganglion being stimulated.

Dr. McCrea.—I think we could hardly expect much from that. There have been few post mortems in connection with this disease—only 12 or 14, I believe. In two of these cases the cord was examined by Dr. Lockhart Clarke. To examine the cord properly is a difficult pathological work. In these cases, there has been found disease of the anterior roots, and in some of the cases degeneration of the spinal cord. I think we may infer from the few cases in which post mortems have been held, that if they were more general in cases of this kind, disease of the spinal cord would be found in most cases. There is hardly evidence that the disease was a peripheral one. In those cases where something was observed in the spinal cord, it was observed without any minute examination. I would be slow to agree with the statement of Dr. Fagan that this is a peripheral failure. As to treatment, if anything is to be gained, it will be by stimulation of the muscles.

Dr. Browne—From my reading, I believe the disease to be central instead of peripheral.

The President.—I have had an opportunity of observing three cases—one of them lay for a long time in the lunatic department of the workhouse. The appearance of the upper extremities was a fac-simile of the case that has been shown to the Society. The muscles of the lower extremities became atrophied by degrees, and the patient sank by gradual exhaustion. There were no symptoms that developed themselves of any disease of the nervous centres.

In another case the patient came to me from Portadown; and the third case is at present in the Union. In the last case the disease is now rather in the incipient stage. The patient did not come in to be treated, but finding I was likely to discharge him, he drew my attention to the drooped condition of his hands. My experience in the other cases led me to look at the ball of the thumb; for from my experience the atrophy commenced in the muscles of the ball of the thumb. The disease has not progressed further up than the elbow. If I can keep hold of him, I will be glad to bring him down, and to show him to the Society. I must say there certainly seems to be a complete freedom of any disease of the nervous centres. One is led, in looking at the cases, first to enquire as to whether they had been in the painting trade. We have not much to boast of in the way of treatment. Unless we

had a very good patient, we would scarcely persevere so constantly with electrifying as to lead to any practical result. I am afraid we could not take the credit to ourselves of pursuing that treatment to a satisfactory issue in the hospital. I would be inclined to think that the disease is paralysis of the muscles, from lead. Some of the patients complain of neuralgic pains.

Dr. Purdon.—The patient complained of something like an electric shock passing from the middle-finger up.

The President.—Have you tried electricity?

Dr. Purdon.—Yes; for three months, but with no beneficial result. I think cod liver oil is a good thing.

Dr. McCrea read notes of several cases of idiopathic neuritis:—

The recorded cases in which distinct evidence of Idiopathic Neuritis of spinal nerves has been obtained are not numerous. Among them are three or four cases of Herpes described by Barenprung, and others, in which, death having occurred from other causes, post mortem examination revealed serious lesions of the nerves supplying the herpetic parts. Barenprung's theory is that the herpes depends on irritation of trophic fibres, which start from the ganglia on the posterior roots. He does not, however, consider that grave disorganisation of the nerves is necessary to explain all his cases, for he cites some as examples of the results of peripheral irritation. Similarly, Dr. Lockhart Clarke (see his article on Diseases and Injuries of Nerves in Holmes's System of Surgery) does not look on Neuritis as the only nerve disorder which causes herpetic eruptions, for he speaks of these as resulting from neuritis and neuralgia. And, indeed, the general retention of the terms Herpes Zoster and Unilateral Herpes, shows that no very settled opinion is held as to the nature of the change in the nerve.

I have endeavoured to gain some information on this point by examining carefully some cases of the disease in a more advanced stage than that in which they ordinarily come under notice: that is, after the healing of the skin. I need hardly say that many observers have remarked the occasional occurrence of annoying sequelæ, such as numbness, tingling, pain, hyperæsthesia, and anæsthesia. But I think a mistake has been committed in considering these as occasional, passing and non-essential. In *all* advanced cases that I have seen, local nervous derangement, more especially anæsthesia, has supervened at some period, and has persisted.

I have seen, during the last two years, twenty cases of Herpes following the course of nerves. Of these, one is still recent; one is in a child, from whom I have not been able to obtain satisfactory information; and seven others I have lost sight of and been unable to trace. The eleven remaining I have examined in their advanced stage. In none has the cuta-

neous affection appeared be either the beginning, the end, or the principal part of the process. Herpes Zoster and Unilateral Herpes are quite inadequate expressions, not to speak of the special inaccuracy conveyed in the terms "Zoster" and "Unilateral." The necessity for a new name for the disease becomes more evident from the consideration that herpes is not the only cutaneous phenomenon known to be associated with local nerve affections; for lichen, acne, pemphigus, urticaria, and erysipelas, as I have myself seen, have, at times, a similar association.

After the healing of the skin, the general condition of the part may be described as presenting hyperæmia, pigmentation, and hyperæsthesia. Then the vascularity diminishes, there are depigmentation, and anæsthesia. These two sets of conditions may be found mixed in different proportions, according to the stage which the disease has reached.

Case 1. A woman, aged 30, was first seen on December 18, 1872. A zone of skin, 3 inches broad, entirely destitute of pigment, extends around the body above the umbilicus. It completely surrounds the body, except a handbreadth at the spine. The upper and lower edges of the zone, which are almost straight lines, are not darker than the neighbouring healthy skin, as sometimes occurs in leucoderma. Every part of the zone is completely insensible to pricking and pinching. She says that seven years ago she was seized with an acute pain in this region, that a "red flash" appeared on the site of the present whiteness, that then an eruption "like pox" came out all over it, that this eruption never extended, and that it faded away slowly, and was followed by anæsthesia and blanching. She gave this history without any leading questions from me, and the inverted commas mark expressions of her own.

Case 2. A girl, aged 17, was seen on December 14, 1872 for amenorrhœa. I noticed on the right side of the chest and below the level of the axilla, a characteristic series of herpetic marks extending from the spine to the middle line in front. Some of them are pits, but most of them are merely blanched spots. The point of a pin when pressed with considerable force excites almost no sensation in some of these, and in all the sensibility is far below that of the surrounding skin. The disease commenced six years ago, when she was told by her medical attendant that she had shingles. She has quite recently complained of numbness of the right leg. A year before the appearance of the eruption, I treated her for chorea of the right side. Mr. Hutchinson, in the second series of cases of Shingles, attributed by him to Arsenic (*Med. Times and Gazette*, 1869, Vol. I., Case 14) mentions, without, however, tracing any connection between the two diseases, a case in which chorea and shingles occurred in the same person. Dr. Borelli, of Turin (quoted in Dr. Brown-Séquard's article in Holmes's System of

Surgery) records a case in which neuroma and chorea were intimately associated. I saw lately a case of neuralgia, in the site of an extracted tooth, in which each recurrence of the neuralgic fit (it came on once in the twenty-four hours) was associated with violent, involuntary rhythmical movements of the arm and leg of one side. So that the connection hinted at above between the shingles and the chorea is not so fanciful as at first sight it looks.

Case 3. A boy, aged 8, was brought to the Dispensary on April 22, 1872. The right side of his neck was covered with an eruption of Herpes. The cutaneous branches of the upper cervical nerves were all represented by the ramifications of the herpes. The courses of the superficialis colli, the auricularis magnus, the occipitalis minor, and of the acromial and cervical branches of the cervical plexus, were sketched by vesicles on the skin. On December 23, I examined him. A multitude of white marks were seen in the site of the herpes. Portions of the original eruption have left no vestiges, and no nervous grouping can now be traced. Some of the spots are quite insensitive; all are much more so than the surrounding skin. This is a comparatively recent case; in which it would be rash to infer that the changes are complete.

Case 4. A girl, aged 9, came to the Dispensary with a zonular herpes on May 30, 1872. The eruption, preceded by a few hours of severe pain, had appeared the day before. It surrounded the body, except a handbreadth at the middle line in front. The lower edge of the zone was two fingers' breadth above the level of the umbilicus. In the handbreadth above this, on the right side, was a half zone of white spots, evidently representing an old herpes. I again examined this child on January 2, 1873. In the white spots of the old herpes, sensation was very much deadened. The new one was red and very sensitive, except a few spots here and there over it, which were less sensitive than natural.

Case 5. A man, aged 60, was first seen on June 7, 1872. A severe pain in the right side ushered in a dorso-intercostal herpes of the same side. On December 26, the only traces left of the original eruption were a few white spots, much more insensible than the surrounding skin. He had considerable pain in a zone above the herpes.¹

Case 6. A girl, aged 4, was seen on January 7, 1873. Her mother stated that eight months ago she had had shingles. She had, when I saw her, a dark coloured

¹ Since I wrote the above I saw two recent cases in which an allied phenomenon occurred. In one, a case of inferior intercostal herpes, deep pressure with my finger in the spinal groove caused a pain in the epigastrium on a higher level than the eruption; movements of the patient's body produced the same effect. In the other case, one of superior cervical herpes, when the finger was, with firm pressure, run down alongside of the superior cervical spines, a pain was felt in the occipital region, at a spot where there was no eruption.

half zone, with irregular edges, passing around the body and slightly downwards from the spine to the sternum, crossing the inferior angle of the scapula and passing below the nipple. The dark zone was thickly mottled with white spots. Some of them were pits, but the majority appeared only as patches of whitened skin. Although a pin was firmly pressed against the white spots, the child never winced. When the pin was pressed with much less force on the healthy skin the child instantly cried out. The brown skin was, in several places, unduly sensitive.

Case 7. A woman, aged 45, was seen on May 5, 1872. She had a right herpes, commencing at the spine, passing around the body slightly downwards, below the mamma, and on to the middle line. She has had uneasy sensations in the side ever since. She was again seen on December 24. The half-zone shewed extensive white spotting on the dark ground of her natural complexion. The insensibility of the spots is great everywhere, but more so in front. In this case, as in others, on applying the point of a pin alternately to the healthy and diseased parts it was necessary to accompany each touch by a word. I said "That," and "That." Otherwise, at those times when no sensation was excited, the patient would be confused. The value of this simple expedient will be fully appreciated on trial.

Case 8. A woman, aged 40, was first seen on October 7, 1872. After a night of severe pain there appeared a half zone of herpes, reaching from the lower dorsal vertebræ, around the left side, downward and forward toward the umbilicus. There was sharp fever.

On December 24, the eruption had faded, leaving a half zone of marks—those in front white, those behind red. The white ones had lost sensation; the red ones were little different from the surrounding skin. Marked tenderness, on deep pressure at the spinal end of the herpes, persisted.

Case 9. A woman, aged 40, had been treated by me in the beginning of 1872, for syphilis. I again saw her in September. She then had a series of herpetic crusts, commencing on the right side near the lower lumbar spine, passing across the right iliac crest in a slightly curved direction to the trochanter, and throwing out a few crusts even below the trochanter. There were also a few crusts above and in front of the anterior superior spine of the ilium, and a few nearer the middle line, and on a lower level than the last. It was undoubtedly unilateral herpes. At the same time there was commencing paralysis of the right limb and numbness of the left. There was acute pain referred to the right external iliac region; this I considered the herpetic pain. Iodide of Potassium was prescribed for her. I then lost sight of her for a considerable time. I afterwards found that she had become unable to come to the Dispensary. After a difficult search for

her, she came to me on January 16. I found that after leaving me she had completely lost the powers of sensation and motion in the lower extremities; she had then improved under the use of Iodide of Potassium. On the above date there was no general anæsthesia or paralysis of the limbs. The herpes had left much fewer traces than usual. These were whitish spots that could barely be distinguished from the surrounding skin. In a few of them sensibility was dull, but in the majority I could detect no difference from the sensibility of the region. Points of interest in this case are that the herpes was associated with a grave neurosis; that it appeared not on the side of dulled sensation, but on that of acute pain; and that it underwent a much more favourable course than usual, this result happening under the use of Iodide of Potassium.

Case 10. A boy, aged 13, was seen on January 16, 1873. Two years ago he had a unilateral lumbar herpes preceded by severe pain. The affected skin remained red for a long time. At the date of examination the white marks were large and numerous beyond the common. The insensibility was greatest in the anterior spots, and existed in many places between the spots. There was no spinal tenderness.

Case 11. A man of sixty was first seen for Hepatic Abscess in November last. He had been jaundiced for a year. He called my attention to a loss of power in the upper arm. He could flex the elbow and carry the arm across the chest. He could not raise the arm from the side, draw it backwards, or extend the elbow. The muscles of the shoulder and arm were much wasted, especially the deltoid. There was a severe pain, referred to the point of the shoulder. An almost linear herpes reached from the interpinos space below the vertebra prominens, across the spine of the left scapula. It continued in the same linear form down the back of the arm, and the outer side of the forearm to the wrist. There was tenderness on deep pressure at the spinal end of the herpes. On January 18, the eruption had almost disappeared. The wasting of the arm had progressed. There was hardly a vestige of the deltoid left. The general mal-nutrition of the arm made it difficult to obtain evidence as to whether the anæsthesia in the track of the herpes was greater than in the surrounding skin. At no period in the case did the patient's keeping his eyes fixed on the arm facilitate movement. Nor did faradisation appear to have the least effect on either the deltoid or triceps. This case runs counter to Barensprung's statement that herpes is not associated with paralysis.

The preceding cases present the following noteworthy features—

1. In all, there was evidence of disorganisation of the nerves of the affected part.

2. In one, the disease could not be considered as confined to the posterior root of the nerve, for the efferent fibres had also ceased their function.

3. In two cases there was association with a general neurosis.¹

My cases also illustrate several other interesting points in connection with herpes, on which, however, I need not dwell, as they have been noticed by previous observers. Those who wish to obtain further information will find full summaries and copious references up to a recent date, in Dr. Lockhart Clarke's article on Diseases and injuries of Nerves, in Holmes's System of Surgery, and in the last edition of Dr. Tilbury Fox's Skin Diseases. The *London Medical Record* also has given an account of some still more recent foreign papers on ophthalmic herpes.

After observations from several of the members on Dr. M'Crea's paper, the proceedings terminated.

The Tenth Meeting of the Society, for the present Session, was held on Saturday evening, March 8th, in the Society's Room, Belfast General Hospital. Dr. H. M. Johnston, President, in the chair.

Dr. MacCormac, Ann Street, was elected a Member of the Society.

Dr. M'Keown, in pursuance of notice given at a previous meeting, moved:—

1. "That a Committee to be called a Sanitary Committee be appointed to report quarterly to this Society upon the Sanitary condition of Belfast; that such reports, and the discussions thereon, be published in the daily papers for the information of the public and of our local boards, and that for that purpose the representatives of the press be admitted."

2. "That such of the local officers of dispensaries and charitable institutions of this town, as are members of this Society, shall be ex-officio members of the Sanitary Committee."

Dr. M'Keown went on to say,—For some time before the beginning of the Session he had intended to bring forward a motion with a view to having some radical changes made in the constitution of the Society, as it was well known it did not work so satisfactorily as could be desired; but as the President was appointed to the position he held, so as to endeavour to put new life into the Society, he deferred taking any action in the matter.

Besides, he thought it better that changes should be introduced gradually, and not hurriedly. It struck him, however, that there was one change or improvement which might now be introduced with advantage. He thought it would be desirable to graft on the Society a Sanitary Committee for Belfast, and the more so, as sanitary matters were at the present time receiving special attention from Government and Societies in large towns, as in Dublin. Well, if attention to such matters were necessary anywhere, it was in Belfast;

for he thought few towns in Ireland were in a worse sanitary condition, as the medical officers of the dispensaries could testify. He often felt, when administering medicine to dispensary patients, that it was useless to give them medicine so long as they lived in the places they did, where the light of the sun was excluded, and where they were constantly surrounded with filth and dirt, and pollution of every kind, and where the atmosphere was reeking with dreadful odours, and filled with smoke—where everything was calculated to generate and propagate disease. These poor people could not help themselves. The medical officer might give them whatever directions he pleased; but in many cases without the least benefit, owing to the dreadful surroundings of the patients.

Any of them who had read with care the reports of the sanitary officers of the Town Council, would feel it was the merest sham. They would see in the reports that in a particular district so many houses had been whitewashed, so many pigs killed, and information of that description, whereas they all knew that one could not turn into any quarter of the town without having all the senses offended. He believed that the neglect of sanitary matters was the principal cause of disease in the town; the other great causes being intemperance and immorality. If the sanitary condition of the town were improved, and the two other matters he had referred to attended to, there would be very little disease, and affairs would look very gloomy for the doctors. He suggested therefore that the dispensary medical officers, who know most about the condition of the poor and the causes of disease in operation, should be appointed members of this Committee, whose reports should be drawn up quarterly and submitted to the general public, and not merely to the members of the Society. If this proposal were adopted, the Town Council would have very little excuse for not having the town put in proper condition, and the sanitary officers would be stimulated, and owners of property would be coerced into keeping their houses in good repair, first through fear of exposure, and then through fear of loss. Dr. M'Crea made an admirable suggestion with respect to the way in which such a report should be made out. It was that a list of the poor streets of the town should be printed, and that each medical officer should note opposite the streets the nature of the disease there prevalent, even specifying the numbers of the houses. The constitution of the Sanitary Committee should, he thought, be pretty much as he had indicated. At first he thought the medical dispensary officers should be the only members of it, but afterwards it occurred to him that the medical officers of public boards in town could render valuable aid. He also thought it would be well to add one or two other members of the profession in town. He did not feel it

¹ A curious remark is made by Schwartz (*Diss. de Zonâ Serpiginosâ Halæ*, 1745, p. 17) who says that he saw three instances, which followed violent fits of passion.

necessary to say anything more on the subject, but was sure the matter would commend itself to their judgment, as calculated to render good service to the town.

The President had no doubt that in a short time a good deal of attention would be directed by Parliament to sanitary legislation, and he thought it would be for the benefit of the Society if it did something to show its position, and the services it was calculated to render to the sanitary condition of the town.

Dr. John Moore had much pleasure in seconding the resolution. He had taken some interest in this question, and had for a number of years been trying to bring it before the Society. About six years ago, it would be observed by reference to the reports, that he brought forward a motion, which was seconded by Dr. Hill to the effect that application be made to the Registrar General for a fuller account of the causes of mortality in Belfast than that published. He believed that the movement then made resulted in their getting a tolerably satisfactory weekly report of the causes of death.

Dublin had been for some years previously in possession of a tolerable statistical account of the causes of death within its bounds. The movement then made by the Society resulted in getting weekly returns, and they now got returns of the number of deaths from small pox, measles, fever, &c., which were accessible to all. They could take a still further step in advance, and get a registration, not only of deaths but of diseases, for slight epidemics passed over the town frequently, inflicting a great deal of disaster. The registration not only of deaths but of sickness would be a desirable thing. In seconding the motion, he merely endorsed the general principle, without binding himself to all the details. As to what had been said about the publication of the reports, that might be settled at a future stage; the details could be arranged afterwards.

Dr. M'Crea.—I think the carrying out of the suggestion contained in the resolution would be most useful to the community. There will perhaps be a little trouble in starting the matter, but I think it is worth all the trouble. The registration of diseases I consider more important than of deaths. At the dispensaries we have warnings of rushes of disease, before the ordinary practitioners of the town generally are made aware of them, and we have warnings of the decline of certain diseases before others—indeed we are in possession of a large amount of information, which, for want of being tabulated, is allowed to go to loss. If the Society adopts any means of making that information available, it will be conferring a great boon on the community. I would hardly be disposed to agree with the proposition to admit the press, as it would give an opening to a number of movements I would have an objection to. We could achieve all the objects that are

to be gained, by furnishing our own reports to the papers, if necessary.

Dr. M'Keown.—That is not necessarily an essential part of the resolution.

Dr. M'Crea.—Otherwise I join heartily in the movement; indeed I have spoken about it several times, and consider it calculated to effect much good. It will no doubt be a little troublesome, but it may be put into such a shape as to give little trouble to the dispensary men.

The President.—I have no doubt that if once started, and in action, it would be both appreciated by, and bear weight with, the authorities of the town.

Mr. Spedding.—Is it the wish of the Society that the Committee should be formed?

The President.—I have heard no objection offered yet.

Mr. Spedding.—We have already a great deal of gratuitous labour—indeed, we have plenty to do; but if this would be the first step in leading to the appointment of a medical officer of health for the town of Belfast, I would support it.

Dr. M'Keown.—Lord Hartington will bring in a bill in reference to it this Session, and it is likely the dispensary officers will be the officers for the district. So, the sooner they get into harness the better.

The President suggested that Dr. M'Keown and Dr. M'Crea be requested to act as secretaries to the Committee, and that they also be requested to draw up a scheme for the working of the movement, and obtaining the required information. Both gentlemen intimated their willingness to accede to the President's suggestion.

Mr. Spedding asked what duties would be expected of the Dispensary officers.

Dr. M'Crea said they would be on the Committee, and would consequently have a part in fixing those duties.

Dr. M'Keown.—The duties will resolve themselves to this; viz, to putting down the names of the places in your district you consider defective in sanitary arrangements, and the diseases you attribute to those defects; and, with a view to fixing a mark on the right quarter, in some cases the numbers of the houses that are nests of disease will require to be specified. All the medical officer will have to do, will be to black-ball the bad ones, for the list of the streets will be made out, and furnished to him. The resolution was then passed in the following form:—"That a Committee, to be called a Sanitary Committee, be appointed to report quarterly to this Society upon the sanitary condition of Belfast; that such reports be published in the daily papers, for the information of the public, and of our local boards; (2) that such of the medical officers of dispensaries and charitable institutions of this town as are members of this Society shall be ex-officio members of the Sanitary Committee."

On the motion of Dr. J. W. Browne, seconded by Dr. Brice Smyth, the names of Dr. Wales and Dr. David Johnston were placed on the list of the Committee.

Dr. Brice Smyth then read the following notes of a case of puerperal convulsions:—

As puerperal convulsions is one of the most frightful and dangerous complications of parturition (though fortunately not a very common one) I thought that a few notes of a case that occurred under my care in the Lying-in Hospital would not be without interest to this Society.

Sarah Adams, a primipara, aged 20 years, who was then in the eighth month of her pregnancy, was admitted into the Lying-in Hospital on January the 30th, at three o'clock, p.m. I understood from Dr. M'Crea, who brought her to the Hospital that the convulsions had commenced that morning at eight o'clock. When I visited her about half-past three she was in a violent convulsion, her face was pale, greatly distorted, frothing mouth, jerking the limbs. Each attack lasted about two minutes between the seizures, the patient was quite insensible, and there was no interval of consciousness between the fits; the feet and ankles were œdematous, swelled, the countenance heavy and stupid, the pulse quick and weak, she was unable to swallow anything and upon examining the womb I thought I could detect signs of impending labor, although there was no contraction to be felt through the abdominal wall, and the os was not dilated, and the patient exhibited no signs of pain, I had a consultation with Dr. Pirrie, and we agreed to administer chloroform by inhalation, which, for a time, appeared to diminish the frequency and violence of the attacks; we also gave a large stimulating injection which evacuated the bowels; but, although the chloroform was given freely at intervals, the convulsions increased rather than diminished in violence and frequency, but there was no sign of active labour, and the patient's strength was going fast. We decided that the only chance of saving her was by forcibly emptying the womb of its contents. I had noticed that although the os was not appreciably dilated, yet it was not in that rigid unyielding state so common to primiparæ.

Dr. Pirrie kept her well under chloroform, and I gradually introduced my fingers, one after another, within the os, stretched it by separating them and forcing them slowly on, ruptured the membrane, and succeeded in passing the whole hand into the womb, then pushing my hand up to the fundus, I grasped the child's feet and brought them down; but I now found I had another complication to deal with, as the head was Hydrocephalic, and resisted all my efforts to get it out of the womb; I had then to perforate, and the patient was delivered without further trouble. After delivery there was very little hæmorrhage, and no more convulsions.

January 31st No more convulsions have occurred since delivery; the patient is still unconscious; have had to use the catheter and draw off about a quart of smoky urine, loaded with albumen; pulse quick and feeble.

February 10th she was able to leave the Hospital, being quite recovered.

The President.—There are no cases possessed of more practical interest, especially to men in charge of public institutions, than cases of convulsions; and I would, therefore, be glad to hear any remarks any of the members may have on those cases. I am sure few of us who have been connected with public institutions but have had experience of them.

Dr. John Moore.—You have stated that puerperal convulsions are a frightful complication in labour, and more particularly in public institutions. I think they are even more frightful when they occur in private practice. I have seen a good number of these cases. I have about ten before my mind at present, and I believe that though so frightful, they are not fatal. Out of the ten cases only one patient died. Dr. Smyth states this occurred at the 8th month of pregnancy, and that apparently the convulsions were the first symptoms of the case. He has given us a description of the successful termination of a difficult case he treated; but I do not think this one exception breaks through the rule. I found the efforts to induce labour were so irritating to the patient that they only increased the convulsions, and when I had been foiled in my efforts to induce it and desisted, I have found the patient come through. That is one of the points to which I would ask the Society's attention; viz. that, so far as my experience goes, though this was a successful case, it is an exceptional one; and where there is no dilation of the os, and no symptoms of commencing labour, I think the plan is to treat the patient simply for an attack of convulsions, and wait for labour to come on. If labour has come, it is your business to hasten it, and I think from the description we have had here from Dr. M'Meehan, as to the induction of premature labour, Barnes' dilators might be very serviceable in such cases. The only other point is, in regard to the question of bleeding, which is one of the things in regard to which there has been a greater revolution in the mode of treatment than in regard to any other point. We have, I think, abandoned the lancet too much in the treatment of puerperal convulsions. The last time I performed that operation in a case of puerperal convulsions, I resorted to it through the persuasion of an older practitioner than myself, and certainly from the moment the patient was bled, a change came over her countenance, and a modification of the convulsions followed, and she made a good recovery. I think the lancet should not be abandoned, if other symptoms would indicate the necessity for resorting to it—as in the case of a full plethoric per-

son. I can only express my thanks to Dr. Smyth for the interesting paper he has given us.

Dr. Croker.—I have met with several cases of these puerperal convulsions, and formerly the invariable treatment was bleeding. In the Dublin Lying-in-hospital, many years ago, it was the constant resort, but now-a-days bleeding does not seem to be so frequently used. In some of the cases that came under my notice, I found purgatives, such as croton oil, useful. I may say that I listened to the paper with great interest.

The President.—Dr. Croker, have you any experience of emptying the uterus by the dilatation of the os?

Dr. Croker.—Yes. I have been present when several cases of that sort were treated, where the membranes were separated, and a small catheter introduced to bring on irritation of the womb.

Dr. M'Crea.—I saw this case before coming into the hospital. I am inclined to think that labour had commenced. I think I detected a difference in the state of the os in two of my examinations. Another interesting point is, that the woman had anasarca for two or three weeks before the convulsions came on. At the time I saw this case, I thought it a very formidable one, and I think Dr. Smyth and Dr. Pirie deserve credit for pulling her through, as convulsions are very dangerous at this stage.

I would say this is rather an argument against Dr. Moore's idea that we should not bring on labour where we have the convulsions. I think public feeling in this country, as well as of the profession, has undergone some change since Dr. Richardson's celebrated paper on blood-letting—we are more in favour of it than formerly.

I saw in a French Journal statistics given of papers treated in different methods. Formerly the treatment which gave the best results was general blood-letting; and the most unsuccessful treatment of all was chloroform; an equally unsuccessful mode being revulsion.

Dr. Moore was singularly successful in his cases; for it appears by the *Journal*, that, out of 300 tabulated cases, there was a mortality of 40 per cent.

The President.—Does it take any notice of emptying the uterus?

Dr. M'Crea.—It does not. From all I have read of the experience of other people, I would rather be disposed to use Barnes' dilator, than to get the uterus evacuated.

Dr. John Moore.—That takes twelve hours.

Dr. M'Crea.—He says you can put your means in operation for induction of labour, and come back in twelve hours, when labour would be on.

But I would suggest the dilation of the os at once, and even introduce the hand. The treatment of puerperal convulsions, as I understand, would be a dilation

of the os by Barnes dilator at once, and then an operation.

The only rational pathology of the disease we have, is that it is pressure on the renal vein that produces the mischief; and, if so, why not remove that pressure? If that be the theory, it is surely rational to get rid of this pressure as soon as possible, and when that is done, you have only to contend with the already vitiated state of the blood.

Dr. John Moore.—There is much that might be said on the other side of the question. In the first place, I do not think it is pressure on the renal vein, for there are other things that press on it, and no convulsions result.

Dr. Browne.—In one of the old numbers of the Transactions of the Society, there is an account of a case of puerperal convulsions, treated by Dr. Corry. He used chloroform first, and afterwards bled the woman twice within 8 or 12 hours, and with a happy result. This case is recorded in the Transactions of 1860.

The President.—I have seen cases where the exhibition of the chloroform seemed certainly to control them.

Dr. John Moore.—Always, as far as I have seen. Chloral also would control them.

The President.—There are many points of interest before us in the paper, and one I was not aware of before. He states that the mortality is in proportion to the early stage of pregnancy at which the convulsions occur.

Dr. M'Crea.—You will see it in Cazaux.

The President.—Looking on the convulsions in puerperal, as an eccentric matter, I think on the whole they would be less likely to be benefitted by bleeding.

Dr. M'Crea.—But is it eccentric? Is it not from the fouling of the blood by the urea?

Dr. Brice Smyth.—In some cases, blood-letting might be of use, but in the cases I referred to the patients were poor, pale, dejected, worn down people. The bromide of ammonium is considered very good.

The President.—If we go in for blood-letting for puerperal convulsions, why not in cases of convulsions after scarlatina?

Dr. M'Crea.—Richardson recommends it. He speaks highly of blood letting in all cases of uremic poisoning.

Mr. Spedding.—Had the temperature been taken in any of the cases of puerperal convulsions? It was well-known that in cases of uremic poisoning the temperature was low.

The President.—That suggestion is very important. There is still a fine field in these cases of puerperal convulsions open for investigation in regard to some specific and determined line of practice.

The meeting adjourned.

The Eleventh Meeting of the Society was held on the 15th of March, in the Rooms, at the General Hospital. The President in the chair.

Members present Drs. Stewart, H. S. Purdon, Charles, McCrea, John Moore, Bolton, Messrs. Garde, Gribbin and Spedding.

The Secretary reported the death of Dr. Murray, a member of the Society, during the week and stated that in accordance with the custom in such cases he had issued a circular to the members requesting them to attend the funeral which took place this forenoon.

It was then moved by Dr. Stewart and seconded by Dr. Gribbin and passed unanimously that the Secretary be instructed to write a letter of condolence from the Society to the widow of Dr. Murray.

On the motion of Dr. Purdon, seconded by Dr. Stewart, Dr. M'Keown was elected a Member of the Council in the room of Dr. Hill, who has removed to England.

Dr. Corry was elected a Member of the Society.

The President showed an interesting specimen of an after-birth. The woman gave birth to a blighted fœtus which had attained four and a half months, and afterwards in ten hours she gave birth to a full grown child. The placentæ of both children were continuous, except that a portion of one placenta was degenerated and decomposed. The labour was favourable, and the patient was going on well.

He had brought the after-birth for examination as he considered it presented some features of interest. Though there were two bags of membranes, there was only one after-birth. The after-birth of the blighted fœtus became continuous with the after-birth of the full grown child. One portion of the after-birth was completely degenerated and decomposed. So far as his experience went, the case was an exceptional one, though he believed there were cases of the kind on record.

He then exhibited the specimen and explained that the one placenta ran into the other. He asked the woman if she was conscious of any change, and she said that from about the fourth or fifth month her health was not good; and she had abdominal pains over the uterus; but there was no hæmorrhage at the fifth month. This was her third confinement, she being a married woman.

Dr. John Moore said there was nothing new under the sun, and pointed to a cast of three children at one birth whose case had been brought before the Society many years ago by Dr. Bryce, who was present at the birth. It would be seen from the history of the birth of those triplets, which was preserved in their records, that they had gone through somewhat similar stages to these referred to by the chairman in the present case.

The President.—They perished at different periods?

Dr. John Moore.—Yes; there was arrest of development.

The President.—In this case there was evidence that the conception took place at the same time, because there is only one after-birth.

Dr. John Moore.—In some cases there is only one bag of membranes. There could have been only one bag of membranes in the case of the Siamese Twins and the Double-headed Nightingale. Sometimes the placentæ are separate, and lead to rather inconvenient mistakes with medical men. When a placenta follows the birth of a child, medical men sometimes take for granted that the labour has terminated; and it is not pleasant to be called back to finish one's work, as has sometimes been the case where the doctor has been misled by the after-birth, and has failed to detect a second child in the uterus.

Mr. Gribbin said that some years ago a case happened in Eliza Court, off Eliza Street. He had been told there had been a mid-wife in attendance. The child had presented buttocks, and a child was born dead. The placenta came away. He made an examination; and found the os completely closed, but detected as he believed the head of another child. In 72 hours after the birth of the first child, a messenger came for him; and on going he found the patient very ill. Another child came away, head foremost, living and well. The mother, who was a waterman's wife residing in Eliza Court, was still alive and well.

The President said that was an exceptional case. The first afterbirth was completely separate from the other.

Mr. Gribbin.—Yes. That is liable to lead a man to a mistake, if he does not carefully examine the abdomen, it is very easy for the medical man to fail to detect a second child, if it is small; and if the woman has a large abdomen. I recollect another case in Corporation Square, or rather Tomb Street A child was born, and in some hours afterwards the medical man was sent for again, and another child was born. I attended the same woman afterwards. The birth of one child was all right, but in the course of half-an-hour another came. They were both full grown, and had come to the full time.

The President remarked that, in the case exhibited by him, there could arise no dispute in reference to conception, for conception must have taken place at the same time, owing to there being only one after-birth.

Dr. Charles read notes of the following:—

Diastasis, or separation of the epiphyses of the acromion and coracoid processes of the scapula. The first specimen I exhibit is a left scapula and a portion of the left clavicle, which were taken from the body of a female, aged 77. The outer end of the acromion process is separated from the rest of the scapula by an oblique line, more than an inch behind the apex; it

is drawn inwards and forwards, but its connections with the clavicle are still intact. The coracoid process also appears to be obliquely broken across within half an inch of its root. The union between the fragments of both processes is simply fibrous. I may add that I could learn very little concerning the history of the case.

With regard to the true nature of this specimen, two theories may reasonably be maintained. One of these is that fracture of the acromion and coracoid processes has occurred; and the other, that the epiphyses of these processes have been separated by violence from the rest of the scapula, or have never been united to it by bone. In favour of the first view it may be stated that the separate pieces are larger than we usually find the epiphyses of these processes. However, on the other hand it may be urged:—

1. That fracture of these processes is extremely rare;
2. That there is no history of fracture, though the history, it must be admitted, is very defective; and
3. That diastasis or epiphyseal separation is more likely to have taken place, since both processes are involved.

Dr. Hamilton, of New York, whose treatise is probably the best work on fractures extant, states that “there is some reason to believe that a true fracture of the acromion process is much more rare than surgeons have supposed, and that in a considerable number of cases reported there was merely a separation of the epiphyses; the bony union never having been completed. If such fractures or separations occurred only in children, very little doubt might remain as to the general character of the accident; but the specimens which I have found in the museums, and the cases reported in books, have been mostly from adults. It is more difficult, therefore, to suppose them to be examples of separation of epiphyses, but I am inclined to think that in a majority of instances such has been the fact.”¹

Sir W. Fergusson coincides with Dr. Hamilton. He remarks that “the acromion process may be broken, but the accident is of rare occurrence.” He further says “I have dissected a number of examples of apparent fractures of the end of this process, but in such instances it is doubtful if the moveable portion had ever been fixed to the rest of the bone.”²

It cannot then be positively affirmed whether we have in the specimen before us fracture or diastasis of the acromion and coracoid processes; though, in my opinion, the weight of evidence is decidedly in favour of the latter hypothesis. If the view be adopted that these processes were fractured, we must undoubtedly, I think ascribe the cause to direct violence, such

as the passage of the wheel of a cart over the shoulder, or a severe blow or fall upon it,

Dr. John Moore mentioned a case which had come under his observation. A man was pitched from a horse, and there was some dislocation of the shoulder-joint. He found it easy enough to replace the dislocation, but the difficulty was to keep it in its place.

Dr. M’Crea.—As to the case referred to by Dr. Charles, I can hardly understand how the fragments would have been kept so exactly in their place, if it had been a case of fracture. The apposition appears to have been almost perfect.

Mr. Gribbin said he knew a person in his locality in whose case the head of the bone jumped out occasionally.

Mr. Spedding believed that the case mentioned by Dr. Charles was not a fracture.

Dr. Charles read the following notes:—

Vas aberrans joining the ulnar artery. This specimen is interesting more in an anatomical than a surgical point of view. It is a very rare variety of vas aberrans, which was discovered last month in the Anatomical Rooms of the Queens College, during the dissection of the body of a female, aged 30 years. In the arm (right) you will observe that a slender artery, five inches and a half long, arises from the brachial, a little below the middle of the humerus, and two inches below the lower border of the teres major muscle, and accompanies the brachial on its inner side to the neck of the radius, where it joins the ulnar a quarter of an inch from its origin. It is pervious throughout, being with injection like the brachial, but it gives off no branches. The brachial, radial, and ulnar arteries are normal as to their position and number of branches, except that the anastomotic, which should arise from the brachial, is absent.

In the left upper extremity the arteries had a normal arrangement.

Quain, even in his large experience, speaks of having met with only nine instances of *vasa aberrantia*; and those all ended in the radial except one, which joined the radial recurrent; but it was in that case a branch of the ulnar. He states, however, that Monro and Meckel had each observed a single instance in which the *vas aberrans* terminated in the ulnar directly.¹ Cruveilhier has, on occasions, seen a *vas aberrans* joining the ulnar.²

Dr. Charles further remarked that, as far as he knew, there were only four instances recorded of a *vas aberrans* joining the ulnar.

The President.—It is possible that might cause a complication in case of an operation.

Dr. John Moore.—An additional ligature would answer.

¹ A Practical Treatise on Fractures and Dislocations, p. 208, 4th ed., 1871,

² System of Practical Surgery, p. 271, 3rd edition 1852.

¹ The Anatomy of the Arteries of the Human Body, pp. 265, 266, 1844.

² Traité D’Anatomie Descriptive, 4th edition, Tome 3, p. 131, 1871.

The President.—You might possibly take up the wrong artery.

Dr. Charles also read the following notes:—¹

VAS ABERRANS JOINING THE RADIAL ARTERY.

In the left upper extremity I exhibit the radial arises from the inner side of the brachial about two inches above the elbow, crosses the brachial (or ulnar-interosseous) immediately below the elbow, and lies superficial to the pronator radii teres as far as its insertion; but from this point it takes its normal course. Arising from the brachial, half an inch below the lower border of the teres major is a slender vessel, a *vas aberrans*, which is four inches and a half long; it lies on the inner side of the brachial and joins the radial one inch below its origin in the arm.

HIGH ORIGIN OF THE RADIAL ARTERY.

It is a curious coincidence that there were lately, at the same time, in the Queen's College Anatomical Rooms, five upper extremities in which the radial had a high origin; two of these I exhibit. In the first, a right upper extremity, the radial arises from the inner side of the brachial trunk at the insertion of the coraco-brachialis, and accompanies the brachial (ulnar-interosseous) to the elbow, where it crosses to the outside of that vessel. It is then placed superficial to the pronator radii teres, and assumes its normal position in the lower half of the forearm.

In the second—also a right upper extremity—the radial takes origin from the inner side of the axillary close to the head of the humerus, crosses the brachial about the middle of the arm, and then lies superficial to the pronator radii teres till it reaches the middle of the forearm, from which point it maintains its usual relations. In one of the other three arms the radial arose from the brachial at the same place as in the first arm I have exhibited; but it passed between the two heads of origin of the pronator radii teres, instead of over them.

Quain accounts for such cases by supposing a *vas aberrans* to have originated in the arm and afterwards to have joined one of the arteries of the forearm below its origin from the brachial at the bend of the elbow. The sequence of changes which occur during the development of a high origin of the radial, for instance, appears to be the following:—The artery arises from the brachial at the usual place—over the neck of the radius—but at an early period, from some unknown cause, it becomes obstructed for a short distance below its origin. A *vas aberrans* then grows downwards from the axillary or brachial and terminates in the radial below the point of obstruction. At this stage the radial possesses two roots; the upper, which takes origin from the main artery of the limb usually in the middle or upper third of the arm; and the lower, which is connected with the inferior end of

the brachial, and transmits very little blood. Subsequently the obstructed portion of the radial, that is, its inferior root, becomes obliterated, and eventually disappears entirely, so that in the adult, the radial seems to arise directly from the brachial above the elbow.

It will be remarked that altogether I have referred to six instances of abnormal arrangement of the arteries of the upper extremity which occurred in five bodies. One was a case of *vas aberrans* in the right arm; the remaining five were cases of high origin of the radial—four in the right, and one in the left arm. In only one body was the disposition of vessels abnormal in both arms, and in that body, on the right side, the radial arose from the axillary; and, on the left, from the lower third of the brachial, but it was afterwards joined by a *vas aberrans* an inch below its origin. This disposition of arteries in the arms supports the view of Bichat and Quain in opposition to Meckel, who held that “lateral symmetry, the most powerful of all (kinds of symmetry) is maintained even in malformations.”¹

The existence of two large arteries occasionally in the lower part of the arm, either from the high origin of the radial, ulnar, or interosseous, or from the presence of a *vas aberrans*, should be carefully borne in mind by the surgeon who, for any purpose, requires to ligature the brachial. The safe, practical rule to be followed in all such cases is: 1st., that if after ligaturing the brachial, another large vessel can be felt pulsating beside it, a second ligature should at once be applied; and, 2nd., that to stop hæmorrhage in the forearm or hand, the wound should be enlarged and the bleeding ends of the vessel ligatured, else, though the brachial be ligatured, blood may be still conveyed to the wound through one of the arteries of the forearm, arising abnormally from the brachial or axillary above the point of ligature.²

EXOSTOSES OF THE OUTER EXTREMITY
OF THE CLAVICLE.

Two specimens. Clavicle (right) No. 1, was taken from the body of an aged male. On the anterior margin of its outer end there is an irregular bony growth, one inch and a half from side to side, and half an inch from before backwards. It projects forwards and slightly downwards into the substance of the deltoid. Clavicle (left) No. 2, belonged to an aged female. It presents a slender osseous growth, whose root, about half an inch wide, is joined to the anterior margin of the bone nearly an inch from its outer end. This growth is more than an inch long, and is very much curved outwards and slightly backwards and upwards, so that it almost touches the acromion process of the scapula. I think we may regard both bony tumours,

¹ [Two more are described on page 1228 et seq.]

¹ Quoted by Quain in his *Anatomy of the Arteries of the Human Body*, page 265.

² A Description of some of these Abnormalities also given in the *Journal of Anatomy and Physiology*; June, 1873.

more particularly the former, as ossifications of some of the fibres of the deltoid which arise from the clavicle.

The practical point in connexion with these growths is that the surgeon is liable to mistake them during life for the ends of a broken clavicle or for the callus of an old fracture. Indeed, in the dead body, before the soft parts were removed, there was some difficulty in diagnosing the growths on one of these clavicles. However, careful examination of the upper surface of the clavicle, as well as the history of the case, renders it sufficiently easy to tell the difference.

CALCAREOUS DEGENERATION OF THE ARTERIES OF THE BACK OF THE LEG.

The posterior tibial and peroneal arteries which I exhibit were taken from the body of a man, 74 years of age. They are rigid tubes almost from their origin to their termination. The calcareous deposit, though originally confined, according to Rokitansky,¹ to a new layer which lined the vessels, has now encroached to such an extent on all the arterial coats, that they form merely a thin and incomplete covering for the calcareous tubes. Lining the interior of the vessels is a soft cellular layer, which sends irregular projections into the bore of the tubes, and these have served in some places, no doubt, as points of attachment clots of blood. As might be expected, the arteries contain scarcely any injection; indeed in some parts they are almost impervious. From this we can understand how imperfect in such cases must be the supply of blood to the lower extremity, and how liable the feet must be to senile gangrene and low forms of inflammation. The arteries of the other leg were equally and similarly affected.

This is in accordance with the opinion of Sir W. Paget and others,² who believe that calcareous as well as fatty degeneration takes place in corresponding arteries and to the same extent in each. The posterior tibial and peroneal arteries very frequently undergo this variety of degeneration, even when some of the larger arteries are almost free of it. This was the case in the body of the man from whom these vessels were removed; his aorta and iliac arteries being only affected to a slight extent. No doubt calcareous degeneration is very common in the arteries of the aged, and especially in those who have been subjects of the syphilitic poison; but it is seldom one sees arteries more calcified than those before us.

The President asked were there any symptoms of impeded circulation. ?

Dr. Charles.—No. The leg seemed to be fairly nourished for a man of that age. He was 74 years of age.

¹ Manual of Pathological Anatomy, page 267, 1852. Sydenham Society's Edition.

² Manual of Pathological Anatomy, by Drs. Jones and Sieveking, p. 351, 1854.

Dr. Charles then read the following note:—

A REMARKABLE EXTRA-CAPSULAR FRACTURE
OF THE NECK OF THE FEMUR.

This specimen was removed from the body of a male of about 60 years of age. The line of fracture encircles the base of the neck of the femur, passing through the anterior intertrochanteric line in front, and through the bottom of the digital fossa behind; and, as is usual in extra-capsular fracture, the great trochanter is fractured along its line of attachment. The neck of the femur lies horizontally, and is deeply lodged and firmly impacted in the upper end of the femur, so that the force which produced the fracture must have been very considerable. The chief feature of interest, however, in this specimen, is the immense growth of new bone around the base of the neck of the femur, immediately outside the line of fracture. This new bone is composed chiefly of cancellated tissue, and projects, more especially below, in the form of stalactitic processes, somewhat resembling those so commonly met with in chronic rheumatic arthritis. The breadth of the great trochanter from before backwards is more than doubled, so that during life this sign, which was, I believe, first pointed out by Professor Gordon, must of itself have sufficed to establish the existence of extra-capsular fracture.

Dr. Charles said he might add, that they could always diagnose extra fracture by an increased breadth.

The President.—Would not you expect that person would have a shortened limb, but could walk about?

Dr. Charles.—Yes; but the amount of motion was diminished.

The President said he was sure they were all very much obliged to Dr. Charles, for these interesting cases before them. Some of them were interesting in a theoretical and anatomical point of view; while others, especially the last two, were interesting rather in a practical point of view. These cases were well worthy of being placed on record, and would certainly add to the interest of the Transactions.

The meeting then adjourned.

Robert Stewart,
Chairman
22nd March 1873

The Twelfth Meeting of this Society for the Session was held in the General Hospital, on Saturday, March 22nd 1873. Dr. Stewart V.P./the President in the chair.

Members present Drs. McCrea, J. W. Browne, James Moore, Core, David Johnston, John Moore, Whitaker and Mr. Garde and H. M. Johnson.

Minutes of last meeting read and confirmed.

The Secretary read the proof sheets of the reports of the first three meetings of the session which were approved of.

Mr. H. M. Johnson exhibited a small cyst which he had removed from between the eyes of a gentleman. The contents were found to consist of hair.

Dr. McCrea read notes of two cases of hepatic dropsy successfully treated.

Paper:¹ A discussion at the Medical Society of the College of Physicians some months ago directed attention to the diversity of opinion that exists on the value of tapping in hepatic ascites. Recent authors, also, appear to be divided in their views on this subject. Murchison considers the operation a *dernier ressort*, while Habershon and Ward recommend early tapping.

The two following cases (besides presenting other interesting features) have this in common, that in both the operation was performed, and in both the results were favourable.

Case I.—A child, aged three years, was brought to the Belfast Dispensary on December 2, 1872. He was rachitic, and belonged to a very rachitic family. He had been sickly for the greater part of the preceding summer, having lost appetite and become emaciated. When I saw him, the abdomen was distended with fluid; the urine was scanty, and free from albumen; the bowels were regular. On the next day I drew off, by tapping, two quarts of fluid. The liver could now be palpated with facility. It was very much and uniformly enlarged, firm, inelastic, smooth, and not tender. The edge was rounded and free from indentation. After the operation he was ordered a mixture containing iodide of potassium and sweet spirit of nitre guarded by a little carbonate of potash. This he took for three days without perceptible effect, and the fluid was again accumulating. I then prescribed for him eight grains of sal ammoniac every three hours. On December 23rd I drew away three pints of fluid. Shortly before the operation I ascertained that the medicine had not been regularly taken, owing to its unpleasant taste. We found, however, that he took it easily when well diluted. The first few doses had a most marked effect in increasing the quantity of urine. The fluid ceased to form in the peritoneum, and the liver progressively lost bulk. On January 13th the sal ammoniac was dissolved in an iron and chlorate of potash mixture, which was continued for two months. There is now no ascites; the liver appears to be normal; the general health is good; the appetite, before wretched, is now excellent; the face is plump, and the cheeks are rosy. All through the case the hygienic surroundings were bad.

In other respects, besides treatment, this case is interesting. Trousseau (*Syd. Soc. Ed. of Lect.*, Vol. v., p. 56) says of rachitic children:—"Sometimes there is dulness in the lower and lateral parts of the abdomen. This dulness occurs along with fluctuation, and reveals a certain amount of effusion into the peritoneum. Cases of this kind are rare, and a great amount of ascites is

never met with. This is a fact which was noticed by Glisson, by whom none of the symptoms of the disease seem to have been overlooked." And in the next paragraph he points out that real hypertrophy of the liver is an exceptional occurrence in rickets, many of the cases of so-called hypertrophy being merely displacements of the organ downwards. As to the hypertrophy, however, some eminent authorities are against him. Glisson is quoted by Frerichs (*Syd. Soc. Ed. of Frerichs on the Liver*, Vol. ii., p. 175), as having long ago observed, "*Hepar in rachitide laborantibus prægrande est.*" In the same place Bianchi and Portal are given as authorities for a similar statement. What is the exact nature of the liver affection in rickets? Rokitansky speaks of it as lardaceous. Frerichs says that he has seen rickets complicated with waxy liver only once, but with fatty liver frequently. The characteristics described above, as existing in my patient, were not those of fatty liver. Tanner (*Diseases of Infancy and Childhood*, p. 300), says that the enlargement is due to an albuminous or amyloid material. Dickinson, in a paper published in vol. lii. of the *Medico-Chirurgical Transactions*, says that the enlargement of the viscera in rickets is due to a deposit different from amyloid degeneration, and that it bears some analogy to the affection of the bones.

I am not aware that sal ammoniac had been hitherto used for rachitic liven In amyloid liver, Budd tried it successfully, and recommended its use, while Frerichs objected to it and other neutral salts, on the ground of their tendency to start an exhausting diarrhoea and aggravate the cachexia. It is possible to form a plausible theory of its utility if we bear in mind that in contact with an alkaline fluid like blood it will generate free ammonia, and that this will pass through the liver, on which it will exercise its solvent properties before being diluted with the whole mass of the blood. This theory would apply especially to the removal of amyloid deposit, a material which Friedrich and Biermer have shown to be closely related to fibrine; for we have the authority of Richardson (see a paper read before the Med. Soc. of London, November, 11, 1872), for believing that deposited fibrine may be removed by the action of ammonia.

This case also illustrates the diuretic properties of sal ammoniac, which I think are not so generally appreciated as they ought to be. Böcker (quoted in Parkes on the Urine) has shown that it increases all the constituents of the urine. I lately saw its diuretic action powerfully displayed in another case of ascites from enlarged liver in a rachitic child. A large accumulation of fluid was removed in a fortnight, although the medicine was most irregularly administered. The irregularity of administration, however, gave me an opportunity of putting beyond all doubt its diuretic effects on my patient. In this last-mentioned case I cannot appreciate much change in the liver, but I have it still under observation.

¹ [*Dublin Journal of Medical Science*, 1873, v 56, p 109.]

Case II.—A man, aged thirty-five, came to me in May, 1870. There was nothing important in his history. He was slightly jaundiced, and had ascites. His liver was large, firm, tender, and with a regular surface; it was frequently the seat of a dull pain. The urine was scanty, but not otherwise unhealthy. He had a tendency to slight purpuric attacks, which turned up every now and then. Diuretics and purgatives failed to make any impression upon the ascites. We found, however, that broom, digitalis, and iodide of potassium slightly increased the quantity of urine, and that quinine and iron had a good effect on his general health. He lived at the sea-side, and was most carefully nursed. He had a generous diet, with a moderate allowance of sherry. After a progress which I need not detail, the legs and the lower and posterior parts of the lungs became œdematous.

On July 13 I drew away by tapping twenty-seven pints of fluid. The operation was repeated in a fortnight. We finally settled down to a weekly operation. There was one exception to this. At a period when he was free from purpura, I prescribed a pill, containing blue pill, digitalis, and squill. The period for tapping was shortened from seven to five days. After this the weekly operation sufficed. The period for operation was determined by the state of the lower limbs and kidneys. I never waited for distressed breathing to occur. When the lower limbs, which, of course, diminished in size after each operation, refilled as far as the thighs, or where an abrupt diminution of urine occurred, I tapped. The last operation was in the latter part of October. Fifteen operations were performed, and quantities of fluid varying from twenty to twenty-seven pints were drawn off at each operation. When the abdomen was emptied on the last three occasions I observed that the liver was markedly increasing in size. After the fifteenth operation the fluid somewhat abruptly ceased to accumulate. A small quantity was poured out, and remained perceptible for months—even, indeed, after the general health had been restored. The œdema disappeared, and the left lung, which had been dull on percussion from the clavicle to the nipple, cleared up. My patient now, after a lapse of two and a-half years, is robust and energetic, and has digestive powers beyond the common, no food coming amiss to him. The only drawback is that his liver remains large; but as a marked accession of bulk was nearly contemporaneous with improvement, I am the less uneasy on this account.

The following advantages may be claimed for early tapping in hepatic ascites:—

1. It relieves intra-portal pressure. The backward pressure generated in the portal system by hepatic obstruction seeks vent in various directions. In one man diarrhœa, in another bleeding piles, and in another an ulcerated leg relieves the liver. It is unfortunate if the *vis medicatrix naturæ* makes a therapeutical

error, and causes a hæmatemesis. It is not quite so bad if the peritoneum is the safety valve. Tapping unweights this valve, and relieves intra-portal pressure.

2. The removal of the pressure which the effusion exercises on the liver will facilitate the development of collateral circulation through the more healthy parts of the viscus.

3. The relief of the abdominal tension will make it easier for the vena cava, vena azygos, and parietal abdominal veins to establish a collateral circulation between the abdomen and the chest.

4. The removal of tension from the vena portæ and its branches will promote the absorption of remedies.

5. We clear away an impediment in the way of the digestion and absorption of nutriment, which must be seriously affected by abdominal distension.

6. We relieve the kidneys, and these organs are not slow to exhibit signs of relief by increased activity after each tapping.

7. In ordinary cirrhosis we relieve the liver of a pressure that is assisting the morbid processes, which produce contraction.

8. We keep relieved other important organs, the distress of which makes tapping, at least, an absolute necessity.

9. We avoid the danger of typhoid peritonitis, which sometimes attends late tapping.

The doctrine of delay is put by Murchison thus:—"When the ascites has embarrassed the breathing, and not till then, you must draw off the fluid by the operation of paracentesis. The tapping may have to be repeated, but the rule is always to delay it as long as possible, until, in fact, there is danger of the respiratory function becoming seriously interfered with by the pressure of the fluid." The reason which he gives is to avoid the great drain of albumen. And yet, he says, that the operation frequently causes the albumen to disappear from the urine. Surely this is considerable compensation. Besides, as I have already pointed out, the pressure of the fluid cuts off the supply of fresh albumen to the system, by interfering with assimilation. Frerichs puts the same argument for delay in a slightly different shape. He says that the pressure of the ascitic fluid on the vena portæ lessens the rapidity of effusion, and that by paracentesis we give up this advantage. If it be an advantage it is easy to retain it; a tight binder could be used throughout the intervals between the tapplings to keep up the pressure. But would this be judicious? It is noteworthy that in many of the cases recorded by Frerichs, the high pressure generated in the portal system broke out in the gastro-intestinal tract in a flux, which was the immediate cause of death.

In conclusion, the impression left on my mind, both by the cases above-mentioned and by others which were under my observation for short periods only, is, that we may hope for better results in liver dropsy by

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looking on tapping, not merely as a palliative, but even as a radical method of treatment.

The President said Dr. M'Crea had given some very interesting information in regard to this matter. Their object was to prevent tapping as long as possible.

Dr. M'Crea said the patient was sent by Dr. Stokes, who sentenced him to an early death. He mentioned that he had seen one case in which the fluid had ceased to accumulate after the ninth tapping. That was the only case in which he had seen a good result from tapping. He saw the patient after recovery, and he said the recovery was due to the frequent tapping.

Dr. John Moore said there was a case occurred here, where a second tapping, which was done in the place of the first, wounding the vein of the peritoneum, and eventually hæmorrhage occurred, he would be inclined to go the breadth of the tenura from the former spot.

The President.—Did any of the members present know any case of recovery after tapping?

Dr. John Moore said, yes; one or two. There was a case of a woman who lived in Carnlough. She got perfectly well after he had taken 14 or 15 pints from her.

The President.—How often did you tap her?

Dr. John Moore.—Three times.

Dr. David Johnston said he had one case of Hepatic Dropsy, a little girl of ten years of age, and she got well quickly after a dose of a little scamina and grey powder.

The President.—Had any of the members present any experience of sal-ammonia.

Dr. David Johnston said he had never tried it.

Dr. James Moore said he had listened with great interest to what had been said. He had, like Dr. Stokes, the idea of not going too far. He recollected his father and the late Mr. Wilson having a lady, and they tapped her forty-seven times. She died of another affection. The quantity they took away from her was beyond anything.

Dr. Browne said he recollected reading in the "Journal" relative to the treatment of diseases of the liver by Sal-ammonia. He tried it two or three times in regard to dispensary children, but he never followed it up. It was laid down in all surgeries that they should tap at the same point, and this person was tapped at the same point, and died.

The President said with regard to the enlargement of the liver in children, he did not know whether Dr. M'Crea would regard it as of the same nature. However, his attention had been drawn to it by examining children affected by caries and hip disease. Almost invariably he found, no matter how emaciated, a great enlargement of the liver; and such enlargements had not been attended with dropsical symptoms. But of late, when he had a case of hip disease or caries in children, on examining the liver, he had almost invari-

ably found it enlarged. Of course, this case had been treated by nourishment and iron. He regarded the remarks about Sal-ammonia as useful, and as calculated to draw attention to a medicine which of late had fallen into disrepute; certainly it was more used by the old practitioners than by the modern school.

Dr. M'Crea felt grateful for the flattering way in which the paper had been spoken of. He thought the cases would be interesting ones to bring forward before the Society. In the case in which he tapped fifteen times, he only tapped once on the same spot. He made fifteen distinct wounds, and he thought that what Dr. Moore told them should increase their caution in that respect. As to the number of tapplings that had been performed, they would see in the dissection to which he had referred, a case in which an old woman was tapped ninety times.

After some desultory conversation, the meeting adjourned.

Robert Stewart, Chairman
12th April 1873

The Thirteenth Meeting of the Society was held in the Rooms, in the General Hospital, on Saturday, the 29th March. The President in the chair.

Members present Drs. Stewart, David Johnston, James Moore, John Moore, J. W. Browne, J. J. Charles, Torrens, Spedding, Garde, and Dr. Johnston 78th Highlanders.

Dr. Johnston, of the 78th regiment, exhibited a case of aneurism:—

Lance Corporal_ 32 years of age, 78th Highlanders, who was a musician in the Band, and played, the bass trombone, was about two o'clock in the afternoon of 5th February, 1873, found lying in a latrine, surrounded by a pool of blood, which was coming from his mouth and nose. When brought to Hospital, immediately afterwards, he was dead. He performed his duties to the day of his death, and he had never reported himself sick, and till within a couple of hours of his death he had continued to practice at blowing a wind-instrument; but the washerwoman states she had several times observed his linen to be stained with blood.

Sectio cadaveris, 22 hours after death:

Body.—Fairly nourished, great pallor of lips, periosteal thickening of both tibia, cicatrices of ulcers on penis, induration of separate glands of groin, no sub-occipital induration.

Head.—Not examined.

Thorax.—Old and very extensive adhesion of pleura on both sides.

Both lungs intensely congested, lung substance healthy, pericardium healthy, empty.

Heart.—Some hypertrophy of left ventricle. No valvular disease; an aneurism about the size of an orange, springing from the arch of the aorta, com-

municating by two small openings with the trachea just above its bifurcation. These openings presented a nipple shaped appearance on the internal surface of the trachea. Except a small quantity of clot close to the ulcerations, there were no clots in the vessels or heart. A syphilitic deposit (gummata) studded the aneurismal pouch as well as the entire surface of the aorta.

Abdomen.—Stomach filled with blood; mixed with undigested food.

Dr. Charles said the aneurism was on the first stage of the arch of the aorta. If it had been on the second stage, it would have pressed more on the trachea than it does; it would also have pressed on the thoracic duct, the recurrent laryngeal nerve, and the œsophagus; and the probable result of this would have been inanition, spasm of the laryngeal muscles, and cough, with dysphagia.

Dr. Stewart said it was very remarkable that the man was blowing his wind-instrument a couple of hours before the thing occurred, and yet never experienced any difficulty or distress.

Mr. Spedding observed, that the patient's washer-woman said that there was some blood on his shirt.

The President said they were much obliged to Dr. Johnston for the very interesting case; and the interesting statement that accompanied it. There were many interesting points in connection with it, especially about the man being able to continue his occupation up to the very time of the occurrence, and that he exhibited so few symptoms.

Dr. Johnston, 78th Regiment, said bandsmen were slow to report themselves sick, for they were afraid that the doctor would order them to the ranks; and then they would lose their pay for being bandsmen.

Some conversation regarding some deposits which appeared on the specimens exhibited then took place. Dr. Charles gave the opinion that they were either fatty deposits or syphilitic gummata. He was rather disposed to think they were the latter.

The President exhibited a specimen of a liver, for the purpose of shewing the effects of syphilis in connection with the liver. He said some time ago he had a patient named W_, aged 41, who had laboured under syphilis for nine years. He had never been in health from the time he had the primary sore and secondaries. He lay in the union, suffering from enlargement of the liver, and partial ulcers. He had nodes, one of which suppurated on the cranium. The president then shewed the liver, which appeared to be affected with waxy degeneration. He also exhibited a patient who was suffering from the same form of disease. The patient, he said, had been suffering from syphilis for nine years, and is a shoemaker by trade. He got mercury for the primary symptoms, but not since. He is now suffering from nodes, syphilitic synovitis, and enlargement of the liver. He had another

patient lying up in the wards named J_ L_. He had been suffering from syphilis for five years; at present he had enlarged liver well marked, partial sores, and nodes. These cases are illustrative of the tertiary group.

The other patient of Dr. Johnston was then introduced, and stated that, nine years ago, he got primary sores; and five months ago he got nodes in the head.

The President.—He has also syphilitic synovitis in both knee joints. Had you ever eruption of the skin?

The Patient.—Yes.

The President said there was no dropsy; and what was characteristic of the enlarged liver in syphilis is, it was free from pain, and there was no jaundice. The patient had nearly all the symptoms; he was a man who drank largely, and the only difference between his case and that of L_ was in regard to the time, and the grouping of the symptoms. It was known years since he had a primary sore, and he says he only took mercury for the sore, and that he has never been in health since then; that he had been addicted to drink and dissipation; and that he had eruptions of the skin, sore throat, and about nine months ago a partial croup began to shew itself. He was in Frederick Street Hospital about twelve months suffering from rheumatism, and was noticed in the Journal at that time. He was supposed to be labouring under some affection of the liver, but he did not know the exact thing that was spoken of in regard to it. There were some features of interest in connection with the paper Dr. M'Crea submitted: the absence of ascites, the absence of jaundice, and the freedom from any pain. It also bore the character of amyloid enlargement of the liver. He would give an opportunity next week of discussing L_'s case more fully. The latter was suffering from necrosis of the frontal bones—nodes. He had a liver larger than this produced, no jaundice, no ascites. The case of W_ bore many analogies to those two. Were you ever in Frederick Street hospital except once?

The Patient said, no; that he had been under Mr. Spedding's care frequently.

Mr. Spedding said he was a pensioner and a shoemaker, and he remembered giving him cod-liver oil. Where did you get the mercury?

The Patient.—I got it from Dr. Bell. I was in the regiment of the 4th Hussars,

Mr. Spedding.—Were you abroad?

The Patient.—I was.

The President said he considered these three cases formed an interesting group. W_ was suffering from diarrhœa, which was the immediate cause of death. On post mortem examination, they found enlargement of the liver, and the cuticle and the kidneys diseased, and the tubular portion encroached upon by the disease. The case of L_ exhibited the same symptoms, and he expected to place it before them that day week.

The President asked Dr. Johnston, did he give any mercury in the army ?

Dr. Johnston.—Very little. In our own hospital one doctor gives it another does not,

The President—As a rule?

Dr. Johnston.—I think the majority do not give mercury.

Mr. Guard, to the President.—What treatment did you adopt?

The President said he had adopted giving them a more generous diet than the usual infirmary diet—sweet-milk, and large doses of iodide of potash.

Mr. Spedding remarked that in his experience an enlarged liver was very frequently the sequela of other diseases besides syphilis. He fancied, when they took into consideration the large number of patients that suffered under syphilis, and had no enlarged liver, they could hardly attribute it to the syphilis. He had seen a great many cases of syphilis, and very few cases of enlarged liver. He had at present under his charge the wife of the man L_, to whom the President referred, and she had an immense number of syphilitic convulsions, when she came under his charge.

She was put under a course of iodide of potassium, and she had quite recovered from the convulsions. His wife was a most miserable object; she had nodes in her head; she had got no treatment beforehand—before she came to him—and he gave her large doses of iodide of potassium three times a day, and the convulsions disappeared, and she began taking cod-liver oil.

The President.—Had she any mercury ?

Mr. Spedding.—I think not. She had convulsions twice in twenty-four hours for a month before I was called in, and under large doses of iodide of potassium, after she was slightly iodized, she gave it up, and I gave her cod-liver oil.

Dr. Charles said the case was a most interesting one. With regard to amyloid degeneration of the liver, although it does not always follow syphilis, he thought it was more frequently a sequence of that disease than of any other. Fatty degeneration of the liver is generally believed to accompany or to be associated with scrofulous and tubercular affections.

The President said in cases of syphilis, and of caries, he had not been in the habit of examining the livers of children, but lately he made a habit of examining them, and he discovered enlargement of the liver.

He thought, if physicians made a practice of examining livers in case of syphilis, they would find enlargement more frequently than they did. The President then read an extract in which Berkley Hill said amyloid degeneration is one of the most frequent changes in syphilitic liver, and it is identical with that occurring through the influence of other diatheses.

The parts of the liver so affected, are throughout rather smooth, pale, and semi-translucent, the translucent part turning brown with iodine; but sometimes the hepatic disease attracted little attention during life.

Mr. Spedding.—Do I understand you to say that a large number of children with strumous diseases, and that had not previously had syphilis, are affected with enlargement of the liver.

The President.—Yes; but Dr. Charles remarks that that degeneration is supposed to be of a fatty nature; whereas that resulting from syphilis is supposed to be more of a waxy or amyloid character.

President exhibited a specimen of ulcers of cartilages, with caries of the osseous substance underneath. The patient suffered three years in great pain, and was obliged to get the lump amputated. He was very much reduced; there was complete disorganisation of the structure of the joint, and he suffered a great deal from pains of the limbs. He never saw a man suffer less from general symptoms, since the operation. The President went on to shew that the recovery of patients after an operation in the Union hospital he attributed to the good air there. This patient did not appear to suffer from any scrofulous pain, he was making a good recovery, and gave little trouble.

The Fourteenth Meeting of the Society was held in the Society's Rooms, General Hospital, on Saturday, April 5th. Dr. Stewart V.P./the President in the chair.

Members present Drs. Aickin, Charles, McKeown, James Moore, Corry and John Moore.

Dr. Aickin read the following notes of a case of twin labour, with unusual complications.

The following cases being somewhat curious, and out of the ordinary routine of midwifery practice, I thought them worthy of recording in the annals of this Society.

The first case was that of Mrs. W_, whom I attended in five previous confinements. She informed me about the fourth month of her pregnancy that she would be requiring my services again, and from information she gave, I calculated the time she should be delivered—the 5th November, 1872; as I thought, and now believe, her statements accurate. I consider she carried her pregnancy to the extent of twenty days over the standard time, as she was not taken ill until the 25th; thus making the period of gestation 300 days.

I have notes of her previous pregnancies, to compare the length of time they extended to; and only in the first was there any appearance of extension of time; but I think it may have been a mistake, as the other calculations came very closely, or before the expected time:

1864—November	14;	December	2	+	18	days
1866—July	24;	July	18	—	11	„
1867—December	1;	November	29	—	2	„
1869—January	15;	January	2	—	13	„
1870—September	11;	September	12	+	1	„
1872—November	6;	November	25	+	20	„

On the 24th August (3 months before delivery), I had occasion to call and see her in Hollywood, where she usually spent the summer. I found her in a state of great discomfort and distress, owing to her breathing being very short and oppressed. On examination I found the abdomen very much swollen; in fact, larger than I had ever seen her at full term of pregnancy. Although the limbs and body generally seemed large, it was not the appearance of œdema, but rather of plethora. The veins of the labia were distended, taking bulk of both together, to about size of a large goose egg. On examining per vaginam, which I had to do in semi-erect attitude on account of the breathing, to my great surprise I found the cervix uteri completely obliterated, and the os somewhat dilated, so that I introduced the point of my index finger with ease, and felt the head of child. On again inspecting the abdomen I saw the surface was very smooth and round, with greatly distended skin. Further I could not feel the presence of any part of child, so that, independent of the internal examination, I could have easily mistaken the condition of abdomen as that of ascites. However, it appeared one of rapid accumulation of liquor amnii, but so distended had the uterus become that I told the patient to send for a nurse, and, as it would be likely she would be confined within two or three days, to send for Dr. Dunlop, who would be at hand when she should take ill. Accordingly the next night, the doctor was summoned, as she had regularly recurring pains; but as they were not strong, the doctor left, after remaining an hour or so, and did not see her again. I prescribed her diuretics and purgatives, which acted so well on the swelling that on the 3rd September, ten days after, she was quite relieved; and on the 10th she came to town to be confined under my own care, bringing her nurse with her, believing, as I did, that her delivery might take place at any time, and also considering that we both must have made a great mistake in our calculations. However, a new feature arose which surprised me very much; she remained in town from the 10th to 28th of September, 18 days, during which time I had the opportunity of examining her several times. The uterus, which had been perfectly globular, with neck absorbed, had gradually returned to its more normal state, the os closed, and a neck formed again, measuring at least half-an-inch. From these signs and a general improvement in her other symptoms, I considered it probable she would now go on to her full time, November 5th, and allowed her to return to

Hollywood, from which she again returned on the 6th November, day after calculated time. At *this time*, there was still some neck on uterus. After this I wondered very much at the delay; and on the 23rd found her again in a very weak state, breathing difficult, owing to enormous distention, but this time from presence of something more solid in the abdomen than before. The os was now slightly dilated as before, and I told her she was certainly this time on the verge of confinement. On the second morning after—25th, I was sent for. I was only in the house about an hour when the first child a female, was born without anything unusual happening. Ascertaining the presence of another child, I placed a bandage on her, and after waiting about an hour without pains coming on, I gave a few 15 drop doses of liquor ergot; but with little effect. There was a state of tonic contraction which gave the patient constant pain, but not recurring or increasing like labour. I now thought, after about three hours waiting, that if the liquor amnii, which appeared to distend the abdomen as much as ever, was evacuated, the uterus would act. Accordingly, I proceeded to rupture; but, in trying to do so, I found my finger went through something like straw paper, the membrane not tearing asunder as usual before the rush of waters, but leaving a hole, the size of my finger. This I did not understand, so I carefully examined the protruding watery tumor, as I thought it, again, and pressed the finger further up when I found it passed through something thicker and pulpy; when some fluid began to trickle down; and finding it was blood, I desisted from further interference in that quarter, and examined all over the protruding soft tumour, and came to the conclusion that it was the placenta of the second child attached to the anterior lip of the uterus; but how it was pressed down before the head of the child as a tumor resembling the distended membranes, I cannot well understand. In this condition of things, I thought it wise to have some help, and after some 2 or 3 hours delay, Dr. Pirrie came to my aid, and on consultation, we considered it advisable to deliver at once, by passing the hand up past the placenta and rupturing the membranes behind the child. This was done successfully, and the two feet secured and drawn down. The delivery was finished very speedily; and, in a minute after, two very large and distinct placentæ were expelled along with a lot of coagula, membranes, &c. A mass sufficient to frighten any juvenile practitioner out of his senses. One of the placentæ was a very fine specimen of the battledore variety; the second child, a male, never breathed, and all efforts to assist it were unavailing. After settling our patient, and retiring to another room, Dr. Pirrie said very significantly “that there was a great lot to heal there,” which prediction was too truly verified, as with the shock of the operation, and the very large discharge of the lochia, a thoroughly

anæmic state of the body was produced, ending in sleeplessness, jactitation and puerperal mania, causing death by exhaustion, despite all kinds of stimulation and food, on the 8th December, 13 days after delivery. About the most extraordinary part of the case relates to the weight of the children. The dead child was weighed with a small night-dress, the other with a roller on. The separate weights were: male child, 11½ lbs.; female child, 10¼ lbs., allowing ¾ lbs. for the clothing, and this is ample. The combined weight of the two children amounted to 21 lbs., a weight unexampled, as far as I can ascertain, in the annals of midwifery.

Points of interest:

- 1st. Accumulation of liquor amnii, causing
- 2nd. Obliteration of neck of uterus.
- 3rd. Recurrence of neck on uterus when liquor amnii diminished.
- 4th. Prolonged gestation, of which the history of case leaves little doubt.
- 5th. Position of placenta of second child.
- 6th. Battledore placenta.
- 7th. Extensive surface, off which the two placenta came, leaving little chance of life if mouths of vessels left draining. Each placenta measured something like 9 or 10 inches by 6 inches.
- 8th. Excessive weight of children.

The second case is one of peculiar interest, as it is of very rare occurrence. In the absence of a medical friend I was sent for to attend a lady, on the night of the 4th March last. While waiting back and forward in the room I heard from a relative a very dismal account of the patient's weakness and state of constant debility. For the previous 3 or 4 months she had been living in the country, but owing to her constant vomiting and pain in stomach after eating, persistent from the commencement of her pregnancy, she had come to town to be under the care of her medical friend, whose place I was taking in the emergency. She was treated by him with considerable success, as she obtained marked relief of the urgent symptoms, but some sickness remained to the very last. The condition she was in when first under his treatment was extreme nervous debility, sleeplessness, pain after eating, vomiting almost everything, anæmic, great depression, tongue red, and irritable appearance. Pulse ranging from 100 to 110.

I arrived in the house about eleven o'clock, and on seeing the patient found her as described by relative, very weak and extremely nervous. However, labour proceeded, and after waiting about one and half hour a fine healthy boy was born, which could not have weighed less than 8 or 9 lbs. In the course of 10 or 15 minutes I felt the placenta being nicely expelled, and when through the vulva I twisted it until the membranes were turned out; but I thought some further membranes must be attached to the other side, and

so twisted it again; but as it would not come I introduced my finger gently, in order to make sure of bringing all away at the same time, grasping the contracting uterus in my other hand. Suddenly the membranes, as I thought, became released; but instead of a twisted cord of membranes, I found attached to the end of this an ovum of about six weeks growth, about the size of a large hen egg, and the true cord which I had been twisting (mistaking it for membranes) attached to the same placenta which appeared to have supplied circulation to both. I placed all carefully in an empty chamber, intending to have the specimen for exhibition to the Medical Society; but an hour after (having in the interim gone down to take some refreshment) the nurse told me, when I asked her take care of the specimen for me, that she had already disposed of it, and it was past recovery. I was very sorry, as it was so perfect.

The history of the case is this. The lady was ill with morning sickness and symptoms of pregnancy in the month of May last, and considered herself towards the latter end of the month to be about six weeks pregnant. About this time (25th May) she received a fright, caused by receiving news of the death of a near relative; this was followed by some hæmorrhage, a large amount, lasting only some hours. About a week after she returned home from Belfast (where she had been on a visit) and joined her husband, when she must have become pregnant a second time, the first ovum not being expelled; but remaining with a certain amount of vitality, and acting as an irritant to the uterus all along, as evidenced by the constant and excessive sickness and symptoms almost resembling ulceration of stomach, her great debility and nervousness. Her time of delivery corresponds with the date of hæmorrhage.

Points of interest:

1. Placenta common to both ova, when it was evident there were two distinct conceptions.
2. Persistent sickness, after quickening usually relieved.
3. Ovum not expelled;
4. Or same not causing abortion of self and second ovum.
5. Enough vitality left in ovum not to decay itself, and yet not sufficient to develop ovum.
6. Acting as a foreign body.
7. Child born, being strong and vigorous, and above average notwithstanding mother's bad health, and presence of ovum which might have caused its expulsion at any date.

In reply to the President, Dr. Aickin said he was going to rupture the membranes of the second child; however, in putting his hand through the membranes, his fingers passed through a membrane, as he thought, but it was thin like paper; then, as no water came, he returned and pressed it up again, and his fingers

passed through what he believed to be a second membrane,—that was the placenta of the second child, because the head was right above this membrane and pressing it down in a body.

The President observed that it struck him, it was the placenta of the second child that was passing down. Instead of coming upon the membrane of the second child, he came upon the placenta of the first.

Dr. Aickin said the first child was lying behind, and the back was perfectly free.

The President.—Was there an appearance of a fœtus in the second ovum?

Dr. Aickin.—There was, quite distinct. The second child is still alive.

The President.—When did the birth take place ?

Dr. Aickin.—Two hundred and eighty-one days after. Four days after the hæmorrhage she returned home to her husband, and this occurred two days after.

Dr. M'Keown.—What was the position of the blighted ovum in relation to the placenta ?

Dr. Aickin.—It was a small placenta; and it seemed to be attached to one margin of the placenta.

Dr. M'Keown.—Was there one child.

Dr. Aickin.—Yes; it was twelve inches long.

Dr. M'Keown said it looked as if there were probably two placentæ after all, and that the second had been atrophied.

Dr. Charles observed that this case resembled the one brought before the Society a short time ago by the President. He fancied the two placentæ had been separate at one time, but as they got larger they came in contact, and their vessels interlaced.

The President.—And that there were two distinct conceptions?

Dr. Charles.—I think so, but they were nearly contemporaneous.

Dr. Aickin.—There is no doubt of that, There has been evidence of that in the medical jurisprudence, in which cases are recorded of white and black children being born at the same birth. Of course, they must have been distinct.

The President said he brought a case before the Society some weeks ago, in which there was a patient confined in the Union, and the first child was a blighted fœtus of about five months, and the second child was full grown and lived, and there was one placenta for both. There were two cords attached to the one placenta, and the blighted fœtus was born twelve hours before the full grown child. There was a decomposition of about the fourth section of the placenta.

In reply to Dr. M'Keown, Dr. Aickin said there was no sign of any second placenta. The surface of the placenta was quite even, and presented no injury of any part. There was no line of demarcation between one bit of the placenta and another.

The President (to Dr. Charles)—Would you imagine that, there being a placenta for the first ovum, it should have become attached to the placenta of the new conception?

Dr. Charles.—Yes. The two placentæ might come in contact, and their vessels interlace. I do not say that the vessels anastomosed.

Dr. M'Keown said he believed there had been two conceptions at the same time, and that one of the ovæ became blighted, and there had been two placentæ. On one of the placentæ becoming no more necessary, it atrophied, then the other placenta occupied all the space.

The President said he thought that in the first case where Dr. Aickin introduced his finger to make examination for the second child, he had no doubt come in contact with the placenta of the first slipping down.

CASE OF RUPTURE OF THE VAGINA.

Dr. Corry shewed the uterus and vagina of a woman who had died that morning. Unfortunately he was unable to give a complete history of the case. The deceased had employed a drunken midwife to take charge of her during her confinement. The process of the labour being slow, though the pains it seems were strong, the midwife endeavoured to expedite matters by the administration of ergot and the irritation of the os uteri, &c., with her hand. During one of her manual operations the head of the child disappeared, and the pains subsided. Opium, for some reason was now given, but the labour pains did not return. After waiting for two days from the recession of the head, the friends called him in and wished him to deliver the woman. When he saw her, she was almost *moribund*, and very shortly afterwards died before he had time to make the necessary arrangements prior to instrumental interference. He performed Cæsarean section, and found the child lying free in the peritoneal cavity. He removed the uterus and the greater portion of the vagina.

Dr. Charles, at the request of the members, examined the specimen. The uterus he found firmly contracted and showing no signs of injury externally. The right side of the vagina as well as the peritoneum covering the upper part of it was completely lacerated from the uterus downwards for at least four inches. The edges of the laceration were irregular, softened, and ecchymosed; but the rest of the vagina was tolerably healthy.

The interior was exposed by carrying an incision through the anterior wall in the middle from the fundus of the uterus to the lower end of the vagina. It was now evident that the rupture involved the vagina only—no trace of laceration being detected anywhere in the uterine walls. The interior of the uterus presented the usual appearances observed at this period (12 or 14 hours) after death during parturition. The surface was raw and somewhat uneven, with shreds

of membrane and clots of blood attached. The site of the placenta near the fundus was readily recognizable; and the mouths of the sinuses were seen open and pervious.

Dr. James Moore (to Dr. Corry)—When you passed your fingers up the vagina and found the head of the child, where were the feet and body?

Dr. Corry.—All in the peritoneal cavity. When I opened the abdomen I came upon its buttock. The membranes were all round its body, but the waters had escaped. The rupture must have been very considerable, for the child escaped. The nurse said that just as pain was coming upon her, and the child's head was coming down, the head escaped backwards.

The President.—The os, as far as I can see, seems perfect. There is no injury of the os or of the uterus itself. The laceration likely took place first, and the contraction of the uterus afterwards.

The President (to Dr. Corry)—Had she any children before?

Dr. Corry.—She had six or seven.

The meeting then adjourned.

Robert Stewart, Chairman
12th April 1873

The Fifteenth Meeting of the Society was held in the Society's Rooms, General Hospital, on Saturday, the 12th of April. Dr. Stewart V.P./the President in the chair.

Members present Drs. D. Johnson, Charles, McCrea, Aickin, J. W. Browne, Bolton, John Moore, Messrs. Fagan and Gribbin, Spedding, Garde and Dr. McKewen.

Dr. John Moore exhibited a patient injured by the late collision on the County Down Railway; he suffered then from concussion of the spine, was treated in the hospital, went home, and resumed his work as a carpenter; but he felt that he was not the man he was before, not being able either mentally or physically to apply himself to his work. He was one of those that received the largest compensation, which showed that the doctors were not wrong in their opinion that the injury he received was of a permanent character. There was a want of power in the lower extremity, and a wasting in one of the limbs: he was still improving.

The President exhibited a case of extra-capsular fracture. The patient was in the Union Hospital about a year, and was aged 76. She had the usual signs of extra-capsular fracture; she died of gastroenteritis. She lost her appetite, and then got diarrhoea, which is the general form of death with old bed-ridden people in the Union. He had remarked that extra-capsular fracture gave rise to gastroenteritis, and ended in diarrhoea. The point was, whether the neck of the bone was impacted in the trochanter, or whether bony union had taken place.

Dr. Charles said the line of fracture through the neck was well marked. The great trochanter had been splintered from the neck having been driven into it by the weight of the body, as the thigh came into contact with the ground.

The President said the form of death with old bed-ridden people was general derangement of the stomach and bowels. He attributed it very often to sameness of diet. Another thing he remarked in poor houses, was that these people lived about two years.

The President also showed a case in which he made a *post mortem* examination. The patient was admitted on the first of April, and died on the tenth. When he saw him in the ward, he had not sent for the House Surgeon, which showed he was not suffering from any great uneasiness; but when he examined him he told him he suffered from difficulty in making his water. When examining his abdomen he was amazed at an enormously distended tumour, and he came to the conclusion that it was distended bladder. He seemed not to be suffering any urgent symptoms from such enormous distention. The resident surgeons were of the opinion that it was some form of abdominal tumour. He (the President) drew off an enormous quantity of water perfectly clear. On paying a visit to him last Sunday, he was in bed, and he introduced the silver catheter, and the patient told him he would prefer to keep the water to having it introduced.

He introduced it with great ease; but when he came to the neck of the bladder, he found the usual obstruction to get the catheter over the tumour, and with the introduction of the silver catheter, there came away a considerable quantity of blood. No violence had been used; the water was clear, though some blood came. He got typhoid symptoms, and gradually sank in four or five days. He allowed the urine afterwards to dribble away; and did not interfere with it, and he had continued bleeding. On the day he died, he introduced the gum elastic catheter with considerable ease, and drew off a quantity of bloody urine. He came to the conclusion that, in passing the catheter, he had passed it over some form of cancerous tumour, and that, in using the silver catheter, he had hurt the bladder or tumour, which gave rise to irritation. When he made the *post mortem* examination, he did not open the bladder; but the outside appearance would go to sustain the opinion he held, because he found enlarged glands through the whole pelvis. The case was very interesting. He believed that, if he had let the man alone, he might have lived longer. He remembered a similar case where a private patient was affected with what he believed to be cancer in the lower part of the bowels. His bowels were becoming distended, and they were anxious to have an evacuation. He gave the patient an enema, but immediately after it the patient suffered a shock,

which he showed was owing to the injection going into the cancerous mass which brought on death in twenty-four hours. He thought from these experiences, if the patients were let alone, they would be better.

Dr. Charles.—Perhaps the rectum had been softened by disease and the injection went into the peritoneal cavity.

The President said the water was perfectly clear before the introduction; but, after the introduction of the silver catheter, blood came.

Mr. Gribbin thought that the President had acted perfectly right in the matter. It was his duty to find out what was the matter, and do what he could, and, if bad consequences resulted, he was not to blame.

Dr. M'Crea thought that at the time the doctor used the catheter the disease might have been in a very advanced condition. He asked, was the dribbling relieving the bladder?

The President.—It was. He had gone on for a month with that dribbling.

The bladder was then shown to the meeting.

Dr. John Moore said he quite agreed that it would be right in these cases to leave the patient with distended bladder; however, should absolute retention take place, they would hardly have time to reach him until there would be a rupture of the bladder, it was a most interesting case.

Dr. David Johnston mentioned a case of a man about fifty years of age, from whom he drew three quarts, of water; he had an enlarged prostate. He (Dr. Johnston) was not in his house for a week, and during that time no water passed. The man took an attack of diarrhoea, and he took off the same quantity of water, but a very violent attack of cystitis set in. He had seen several cases of this kind.

Dr. Charles thought the President was quite right in using the catheter. He thought it would be right in such cases not to take away all the urine at once when there was such a large quantity in the bladder; and, by this means, they might avoid cystitis following.

Dr. M'Crea said there was a possible explanation of cystitis coming on after the relief of the bladder. Pressure would prevent congestion, and he thought pressure of the urine would prevent it as long as it was there. There was one point in connection with leaving water in the bladder; very often they were leaving ammoniacal urine; where it had time to become ammoniacal, they should draw it off.

Dr. John Moore thought that where they had that enormous distention, it was certain to produce cystitis; but gradual withdrawing of urine, and letting it down by degrees, was worthy of consideration.

Dr. Charles was requested by the President to make a special examination of the parts. The following is his report:—

The prostate gland is very much hypertrophied, though the "middle lobe" of some anatomists is not prominent. The urinary bladder is enormously enlarged and contains about half a pint of bloody urine with clots of blood; its walls also are thickened, and the mucous membrane inflamed, more especially in the neighbourhood of the neck of the organ. The ureters as well as the pelves of both kidneys are greatly distended; and the kidneys themselves as a consequence are enlarged, pale, and flabby, though the secreting tissue of these organs is nearly normal in size and quality.

The urine contained in the ureters and pelves of the kidneys is of a healthy color. It may be added that the penis is about twelve inches long, that Cowper's glands are three or four times the average size, and that the vesiculæ seminales are large and of a hard consistence.

FEES.

Dr. Aickin called attention to the fee paid to medical witnesses at the Assizes. It was only one guinea. He thought one guinea was far too little.

The President said that the case was deserving of consideration. If Dr. Murney was there, he could give some information on the point. There was a ruling made that, if the practitioner lived in town, he could only receive a guinea a day.

Some conversation took place about this matter, and it was considered desirable that steps should be taken with a view to getting the fees increased.

The President proposed Dr. Thornley as a member of the society.

The meeting then adjourned.

Robert Stewart, Chairman
19th April 1873

The Sixteenth Meeting of the Society was held in the Society's Rooms, General Hospital, on Saturday, the 19th of April. The President in the chair.

Members present Drs. Stewart, H.S. Purdon, Charles, Scott, McKeown, Dr. D. Johnston, Cuming, Wales, Spedding, John Moore and Dr. Johnston 78th Highlanders.

Dr. Thornley was unanimously elected a member of the Society.

Dr. Charles exhibited, on behalf of the President, dissected specimens of (1) the urinary organs of the man whose case had been discussed at last meeting; (2) a polypus of the uterus, with pelvic abscess, and (3) a ruptured male urethra.

The President said that the first was a case which he had explained last week. He had made a *post mortem* examination of the man into whom (it would be recollected) he had introduced the silver catheter, and whose bladder was so much distended. On opening the bladder he found evidences of cystitis, as shown by the injection of the mucous membrane of

the bladder, and the bladder was filled with coagulated venous blood.

Dr. Purdon remarked that with regard to chronic cystitis there was a new treatment which had been adopted. It had been found, where the urine was very ammoniacal, and the ordinary known remedies had failed, that the best results had been found from injecting the diseased bladder with healthy urine; which, it was said, had a beneficial effect upon the diseased mucous membrane of the diseased bladder.

Dr. Wales did not think that the President did any harm in introducing the catheter, and he did not think they would be justified in assuming, from what had happened in this case, that the introduction of the catheter in such cases is injurious.

Dr. John Moore differed from some of the members. The cause of cystitis was great distention of the bladder, and if they allowed it to go on they were only allowing it to go on towards a fatal termination. As to the question of withdrawing the entire water from the bladder, or leaving some of it, it was one that needed some consideration. He thought there was something in the point of gradually withdrawing the fluid; at least, in emptying the bladder partially, and letting it down by degrees.

Dr. Charles adhered to the opinion he expressed last week, that the President was justified in using the catheter.

President.—You would not approve of allowing the water to dribble away?

Dr. Charles.—No.

Dr. Stewart thought it would have been a dereliction of the President's duty as a professional man if he had not taken the course he did.

Other members expressed a similar opinion.

Dr. Charles read notes of the President's second case, a polypus of the uterus, associated with pelvic abscess.¹ He said:—

The uterus is larger than an adult unimpregnated uterus, being four inches and a half long, and two inches and three quarters broad near the fundus. Attached to the inner surface of the fundus, and growing downwards, is a round rod-like polypus, two inches and a half long and about an inch in diameter. The polypus is composed principally of muscular tissue, and covered by the mucous membrane of the uterus. Its lower extremity projects between the lips of the os uteri and is softened, irregular and slightly decomposed. On carefully tracing the Fallopian tubes from the uterus, the ovaries are found firmly adherent to the sides of the uterus and very much altered in appearance. The left ovary lies nearer the vagina than the right, and is made up of a number of cysts which communicate freely with one another. The right ovary is only slightly affected. On the right side of the

uterus and running downwards below the ovary, and by the side of the upper end of the vagina is a large pelvic abscess. The large vessels of these organs are seen lying in it. The omentum is very much thickened and adherent to the uterus and ovaries as the result of peritoneal inflammation. From the position of the ovaries one might infer that the pelvic abscess followed the last pregnancy—probably from the use of forceps during parturition.

Dr. Cuming.—It would seem to me, so far as a cursory examination could go, that the structure of the uterus was healthy, and that this muscular growth had been rather a coincidence, and that from some cause pelvic abscess set in; then peritonitis resulted.

Dr. John Moore.—You think there had been no violence, before you saw patient, in any attempt at treatment.

The President.—No.

Dr. John Moore.—You know peritonitis would follow introduction of a tent.

The President.—The third case of which Dr. Charles has given us a dissection, is one from the body of J_ B_. I found it difficult to get any account of his state before, except that he had gone to the Dispensary medical attendant on Saturday. He told him he was labouring under rupture. The catheter was introduced in the Union Infirmary on Sunday evening, and on the following day I saw him in the wards of the Infirmary. I then found gangrene of the central portion of the scrotum, with a great swelling. He had been a man of very dissipated character. His wife was in the asylum, and he was living with a woman of disreputable character, a well-known character—one who was noted for having robbed people. The catheter was introduced, and a quantity of bloody urine was drawn out. The catheter was introduced afterwards into the bladder. We retained it for a few days, and finding the urine was not going through the catheter, but through a ruptured urethra, we drew it out. Urinary fever set in and the patient died, with symptoms of the usual typhoid state. It occurred to me whether he could possibly, in any connection whilst sleeping with this woman, or by any cause of his own, have ruptured the urethra. The cause of the rupture was the obscure feature of the case. I have not been able to ascertain that it was caused by any instrument.

Dr. Wales.—I would be inclined to think it was a mechanical rupture caused by an instrument.

Dr. John Moore.—The case is a very extraordinary one, and I think it is one of three I have seen. I am not able to give an explanation where violent inflammation of the scrotum came on without any known cause. There was a case in the hospital here, where there was apparently a rupture of the urethra in a case of hernia, and when he was admitted into the hospital he presented all the appearance of urinary

¹ Dr. Redfern made a beautiful dissection of this specimen and has had it placed in the College Museum.

inflammation of the penis. The penis was swollen, was in the same condition, and it turned out that it was inflammatory effusion that had taken place. I saw an old medical man die of the same thing. I think there is no laceration in that urethra, and that it was inflammation of the tissues around it, and I think the sloughing state in which the scrotum was, was inflammation raised up by a distended bladder and spreading to the surrounding tissues.

Dr. Johnstone.—You remarked that he had swelling of the scrotum when he went to the dispensary doctor?

President.—Yes; he represented to Dr. Martin that he was suffering from rupture.

Dr. Johnstone.—I think there has been an old hernia before, and that is what he meant.

Dr. D. Johnston.—I would be inclined to think with Dr. Wales that there was a mechanical rupture.

Dr. Wales.—If I understand you, there was not only swelling of the scrotum but discolouration.

President.—Yes; he was in a complete state of gangrene when I saw him.

Dr. Charles.—I think the patient must have been for some time in a bad state of health; and that the rough passage of a catheter along his urethra, which probably had been somewhat softened by disease, gave rise to that laceration or slough.

President.—May I not have lacerated the urethra?

Dr. Charles.—You may.

Dr. Cuming.—Any man that could tell what had not been there from looking at that *post mortem* would be a clever fellow.

The meeting then adjourned.

The Seventeenth Meeting of the Society was held in the Society's Rooms, General Hospital, on Saturday, the 26th of April. The President in the chair.

Members present Drs. Stewart, Murney, McCrea, Charles, McKeown, David Johnston, Croker, James Moore.

Some conversation took place regarding holding monthly meetings during the summer months. It was generally agreed that it would be advisable, to keep up the interest.

Dr. James Moore moved that they continue to meet once a month every first Tuesday, at Eight o'clock, during the summer.

Dr. Stewart seconded the motion, which was passed.

FEES.

Some conversation took place regarding the fees paid to medical officers attending as witnesses at the Assizes. Dr. Murney said this matter was entirely in the hands of the Attorney-General for the time being. The fee he repeatedly received was two guineas. When Mr. Sullivan was Attorney-General he gave instructions to the Crown Solicitors that when a

medical man was to give evidence in his own town he was only to receive one guinea; but that when brought out of his own town for some distance, he was entitled to two guineas. He (Dr. Murney) found it a great hardship in this hospital, where they attended to the people gratuitously, and then attended before the coroner, and were afterwards obliged to attend at the Assizes. He thought one guinea quite too little.

Dr. M'Keown.—It is a great pity we could not refuse to go. We could refuse to make a post mortem examination.

Dr. Murney.—Yes; but then the coroner could bring in another practitioner from outside.

The President.—Two guineas are little enough for "countrymen." Would it be any use to frame a resolution on the point?

Dr. Murney.—Yes, I think it would be very desirable. I think the Attorney-General would be glad to listen to any remonstrance I believe he has entire control of it.

Dr. M'Keown.—You should endeavour to make the fee three guineas for countrymen, and two guineas for townsmen. I don't see why a country practitioner should go and spend a day for less.

Dr. M'Crea.—I frequently got three guineas for it at Downpatrick. The last time I was there I got two guineas and my travelling expenses.

Dr. James Moore.—The Tyrone people gave me five guineas a day. I was there for some days, and got five guineas.

The President, the Secretary, Dr. Aickin, Dr. Murney, Dr. Croker were appointed a committee to bring forward a resolution on the question.

SPINAL INJURY.

Dr. Murney.—On the 25th January last, a young man, twenty-two years of age, a sailor, was admitted to the hospital, suffering from injury to the spine. He had been engaged in furling the jib sail, and fell on the deck. He lit on the level surface of the deck, directly on the spine. He found he was paralysed from the region of the upper part of the chest downwards. He had the use of his arms, and had sensation downwards to the region of the nipples. Below that there was an entire loss of sensation and motion. There was priapism. On nipping him he had no sensation whatever. On making a careful examination of the spine no fracture could be detected; but from the line to which the loss of sensibility extended, it was evident it was somewhere in the upper dorsal region. Respiration was mainly diaphragmatic. On the 28th of January the urine was first noticed to be ammoniacal in character. The passage from the bowels was at all times involuntary, to his death, and he required the regular introduction of the catheter. The urine was drawn off at short intervals; he was under the influence of bi-chloride of mercury in February. At that time a certain degree of hyper-æsthesia was presented, bed-sores

made their appearance on the 3rd of February. On the 8th of February a bed-sore, about a crown piece in size, affected the sacrum. On the 28th of February he had rigor, and he died on the 27th of March. The seat of the fracture was fifth dorsal vertebra, and there was compression of the cord.

(The doctor here exhibited specimen.)

Looking at the spine you will see a certain degree of tension. The length of time the poor fellow lived was the most interesting feature in connection with this case. There was fracture of the laminae.

The President thought there was commonly pain of the spine. He asked was that from the accident?

Dr Murney.—I think from the accident.

Dr. M'Crea.—Is that sharp pain on the fifth?

Dr. Murney.—It is on the fifth.

The President.—Did you see a private case where a publican in town died off much quicker than I thought? He lived only twenty-four hours. We thought he might live for some days. The class of symptoms that you have described in this case are very much the same as in the case I refer to.

Dr. Murney.—The symptoms in that case were not much more marked than in this case. In your patient the man still had marked priapism. He passed no urine from the time of the occurrence previously.

The President.—The man was sitting on a barrel in his public-house, under the influence of drink, and talking with those around him, and he slipped. He complained of being unable to rise. They took him up in a rough manner, took him up stairs, put him in bed, and sent for a doctor. But he was so intoxicated that the doctor could make nothing of him in regard to the injury. That was about ten o'clock at night. At six o'clock in the morning he was considerably recovered, and told the doctor that he had no feeling down below, and said, "I think, doctor, I have no belly on myself." In the evening I saw him about seven o'clock, and at that time there was no evidence whatever of approaching death. Dr. Murney gave a pretty good diagnosis in regard to the possibility of his dying in two or three days. They were making arrangements about his will. When they asked him to sign his will, and he said he would defer it to the morning. They saw the muscles of the face and neck contract, and in a few minutes all was over. That was in one hour and a half from the time I saw him.

Dr. Murney.—I think in that case there must have been effusion of serum pressing the cord, in addition to the compression which resulted from the falling.

The President.—He had perfect feeling in the upper membranes, but complained of intense neuralgic pains shooting down each arm and forearm.

Dr. Murney.—The injury in that case was much higher up than in this.

Dr. M'Crea.—It is not at all improbable that it was effusion of blood that extended up the spinal cord.

The President.—He was speaking sensibly up to eight o'clock and at ten there was a message brought to me that he was dead.

Dr. James Moore.—You say they took him up roughly. Might he not have got severe injury in their so doing—turning and twisting?

The President.—I am sure the way he was taken up must have had an effect on him.

Dr. James Moore.—The reason I say this is, that I had a case which to some extent appears analogous. I was sent for to see Lord Massereene, who insisted on being kept quiet by his attendants. If he had been roughly treated, and allowed himself to be lifted and laid as some of them wanted, he would not have held out as he did.

The President.—How long did he live?

Dr. Moore.—He died on the night of the tenth day.

The President.—Where was he injured?

Dr. Moore.—About the sixth or seventh cervical. He was paralysed from the arms all down; his bowels and bladder refused to act. He somehow had no sensation, though his mind was perfectly clear from the beginning to the end, and he could take his food well.

Dr. Croker.—What was the accident?

Dr. James Moore.—He was on a grassy soft sloping embankment going to bring a yew tree close to a stake that was close by.

In pulling, the tree and the stake gave way together, and he toppled down off the soft grassy bank over a wall, on a walk, where some stones had been laid for making a rockery in her ladyship's ground, the back of his neck came against sharp stones. He was paralysed and his mind was clear for eight days.

Mr. Spedding thought that these cases of spine fracture were most interesting in a practical point of view, as they showed the utter uselessness of the operation of trephining that was often sought on. In all cases the cord was so much injured, cut across or depressed, that often the depressed bone was elevated. He questioned if the operation of trephining had any effect whatever.

Dr. James Moore.—I quite agree with you. To dig down into the spinous process of a bone is a useless work.

Dr. Charles.—Fracture in most of the cases referred to occurred at the most common seat. There is no part where fracture occurs more frequently than at the fourth or fifth dorsal vertebra, and you can understand the cause of that, from the anatomy of the part, the body of the fourth dorsal being the smallest of all the dorsal; hence it is most commonly fractured.

Dr. M'Crea.—I don't see that there can be such an extreme objection to giving a man a chance by trephining. For you cannot know whether the cord is injured or not till you try, and the case is fatal any way.

The President.—Dr. M'Donnell, of Dublin, first introduced trephining, but not with great success, and of late it has fallen into disuse.

The Eighteenth Meeting of the Society was held in their Rooms, on Tuesday evening, May 6th, at eight o'clock, the President in the chair.

The report of the Sanitary Committee was handed in, and a query sheet arranged to be forwarded to the Dispensary Medical Officers and others.

Dr. Murney exhibited a specimen of fracture of spine and read notes of case.

VERY RARE TUMOUR OF THE THYMUS GLAND.

Dr. Charles exhibited a tumour of the thymus gland, which had been removed from the body of a female, aged 15 years. The tumour was of the size and shape of a small orange, and was found lying in the anterior mediastinum on the right side of the pericardium. Dr. Charles had not made an incision into the tumour, as Dr. Redfern intended to examine it microscopically; but he stated his belief that it would prove to be of the nature of the sero-cystic sarcoma of Brodie or of those tumours described by Paget as "cysts proliferous with vascular growths." He referred to cases related by Sir Astley Cooper and Mr. Simon in their Essays on the thymus gland. He thought the tumour exhibited corresponded in most of its characters to the one described by Mr. Simon.

(Merely a general account of this tumour is given here, as Dr. Redfern will probably describe it in detail in one of the Journals.)

CONTUSION OF THE BRAIN BY CONTRE-COUP.

At a subsequent meeting, the President brought forward an interesting case of injury to the brain. A man received a severe blow on the left side of the forehead, and was received into the Union Hospital, suffering from the usual symptoms of so-called concussion of the brain. In a few days he recovered, so as to be able to walk about. But nearly a fortnight after the accident, symptoms of compression of the brain showed themselves, accompanied by several convulsive attacks. He continued to get worse, and sank comatose about three weeks after he met with the injury.

Dr. Charles described the post-mortem appearances. The frontal bone on the left side, near the frontal eminence, presented a well-marked indentation of the outer table as large as a four-penny piece. On the corresponding part of the inner table there was only a slight mark or depression. Directly behind the injured spot of bone the brain was very soft, and presented a small abscess, about the size of a large pea. The remainder of the same hemisphere—more especially the posterior lobe—as well as the whole of the cerebellum, was softened, and showed evident signs of congestion. Over the posterior lobe of the left hemisphere the membranes were inflamed and much

thickened, and in the cavity of the arachnoid there were nearly three ounces of greenish yellow pus. The right hemisphere was normal in appearance; and there was no injury to the skull visible, except that to the frontal bone already described. It will be remarked that the injury to the brain was greatest, not beneath the part struck, but at the point directly opposite to it, on the same side and at the same level. It was clearly, therefore, a contusion of the brain by *contre-coup*.

ADDENDA.

Page 28 {1164}.—The description of the French instrument for reducing dislocations of the thumb, referred to by Dr. Charles, should have been:—It consists of two blades of wood, joined together like those of a pair of scissors, but working in the opposite direction. To each of these is attached a piece of leather, cut transversely, so as to leave narrow slips. By an ingenious contrivance the slips of the two pieces interdigitate in such a manner that the thumb can be inserted between them, and very firmly grasped when the handles have been brought together. With this instrument, a large amount of force can be readily applied to the thumb.

Page 59 {1181}.—Dr. M'Crea's paper on "Tapping in Hepatic Ascites" appeared in the Dublin Monthly Journal of Medical Science, August, 1873, and has not been reprinted in the Transactions of the society.¹

SYNOPSIS

OF THE

BUSINESS OF THE ULSTER MEDICAL SOCIETY,

SESSION 1872–73.

FROM THE NOTICE PAPERS.

First Meeting, Saturday, 16th November, 1872.—The President will exhibit cancerous disease of œsophagus, resulting in rupture of descending aorta; also, diseased prostate and kidneys.—Dr. J. W. T. Smith will exhibit and give notes of a case of aneurism of transverse portion of aorta bursting into trachea.

Second Meeting, Saturday, 30th November, 1872.—Dr. J. W. T. Smith will read notes of a case of aneurism of the aorta causing ulceration of the trachea, and will show the parts.—Dr. Brown will exhibit a case of fractured spine, and give a history of the case.—Dr. M'Meehan will read notes of a case of induced premature labour.—Dr. Spedding will read notes of a case of ligature of Hemorrhoids. He will show a tumour which

¹ [See page 1181 for a transcription of the published paper.]

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he removed from a patient, and will exhibit an acephalous foetus.—Dr. John Moore will read notes of gunshot and other wounds treated in the General Hospital during the riots in August last.

Third Meeting, Saturday, 14th December, 1872.—Dr. Brown will exhibit a case of fractured spine, and give a history of the case.—Dr. M'Meekin will read notes of a case of induced premature labour.—Dr. Spedding will read notes of a case of ligature of hemorrhoids. He will show a tumour which he removed from a patient, and will exhibit an acephalous foetus.—Dr. John Moore will read notes of gunshot and other wounds treated in the General Hospital during the riots in August last.—The President will exhibit a case of abscess of tibia, and read notes of case.

Fourth Meeting, Saturday, 4th January, 1873.—Dr. H. S. Pardon will introduce a patient suffering from favus.—Dr. Murney will give an account of the post-mortem on the victims of the recent murder at Holywood.—Dr. John Moore will conclude his paper on gunshot and other wounds treated in the General Hospital during the riots in August last.—Dr. Browne will exhibit a diseased wrist joint, for which amputation of hand was performed.—The President will exhibit specimens of abscess of tibia, of hypertrophied heart, and of cancer of stomach.

Fifth Meeting, Saturday, 18th January, 1873.—The President will exhibit specimens of hypertrophied heart, and of cancer of stomach.—Dr. James Moore will exhibit a lacerated hand which he amputated.—Professor Coming will show a case of aortic aneurism, and give history of case.

Sixth Meeting, Saturday, 1st February, 1873.—Recommendation of Council:—"That the Meetings of the Society be held weekly instead of fortnightly, as heretofore."—The President will exhibit several pathological specimens.—Professor Cuming will exhibit a case of aortic aneurism, and read notes of case.—Dr. James Moore will exhibit a case of laceration of elbow, requiring amputation of arm.—Dr. M'Keown will read notes of cases of iridectomy on patients introduced at last Meeting of Society.

Seventh Meeting, Saturday, 15th February, 1873.—To consider the desirability of holding weekly meetings of the Society instead of fortnightly, adjourned from last meeting.—Dr. John Moore will introduce a patient with obliterated brachial artery from wound in axilla; also a case of irreducible dislocation of thumb. He will also exhibit a strumous testis which he excised.—Dr. H. S. Purdon will introduce a patient the subject of Graves's Disease.—Dr. Browne will read notes of a case of peritonitis following the introduction of a tangle tent into the uterus. (The case resembled one of

strangulated hernia, a tumour existing in the groin, which on operation was found to be an obliterated hernial sac.)—The President will exhibit an obliterated hernial sac from a case of obstructed bowels, in which the operation for hernia was performed; also a specimen of post partum pelvic abscess, opening into ilium.—Dr. M'Crea will read notes of cases of idiopathic neuritis.—Brice Smyth, M.B., will read notes of a case of puerperal convulsions.—Dr. Charles will exhibit and describe the following recent specimens:

1. Fracture of the acromion and coracoid processes of the scapula.
2. A *vas aberrans* of the arm
3. A remarkable extra-capsular fracture of neck of femur.
4. Calcified arteries of back of leg.
5. Bony growths on the outer end of the clavicle.

Eighth Meeting, Saturday, 22nd February, 1873.—The business consisted of the reading of papers postponed from previous meeting.

Ninth Meeting, Saturday, 1st March, 1873.—Dr. M'Keown will move—(1) That a Committee, to be called the Sanitary Committee, be appointed to report quarterly to this Society upon the sanitary condition of Belfast. That such reports, and the discussion thereon, be published in the daily papers for the information of the public and of our local boards, and for that purpose that the representatives of the press be admitted.—(2) That such of the Medical Officers of Dispensaries and Charitable Institutions of this town as are members of this Society, shall be ex-officio members of the sanitary committee.—H. S. Purdon will show a patient with "Progressive Muscular Atrophy."—Papers will also be read by the President, by Drs. John Moore, M'Crea, Brice Smyth, and Charles.

Tenth Meeting Saturday, 8th March, 1873.—Dr. M'Keown will move the appointment of a Sanitary Committee, postponed from last meeting.—Dr. Charles will exhibit several recent pathological specimens, and give histories of them.—Brice Smyth, M.B., will read notes of a case of puerperal convulsions.

Eleventh Meeting, Saturday, 15th March, 1873.—Dr. Johnston, 78th Highlanders, will exhibit a case of aortic aneurism, with syphilitic deposit.—The President, Dr. Charles, and Dr. John Moore will also exhibit pathological specimens.—Dr. M'Crea will read notes of two cases of hepatic dropsy successfully treated.

Twelfth Meeting, Saturday, 22nd March, 1873.—Dr. M'Crea will read notes of two cases of hepatic dropsy successfully treated. (Adjourned from last meeting).—Dr. Aickin will read notes of two twin labours with unusual complications.

Thirteenth Meeting, Saturday, 29th March, 1873.—The President will exhibit a diseased knee-joint, for which he performed amputation of thigh,—Dr. John Moore will exhibit an abscess of brain, resulting from concussion.

Fourteenth Meeting, Saturday, 5th April, 1873.—Dr. Murney will show a case of fractured spine, and read notes of it; and also give the particulars of a case of fractured skull, and show the brain.—Dr. M'Keown will read notes of several interesting ophthalmic cases.

Fifteenth Meeting, Saturday, 12th April, 1873.—Dr. Murney will exhibit several pathological specimens.—Dr. Corry will exhibit a ruptured vagina, and give a history of the case.—Dr. John Moore will read notes of a recent visit to the Infirmaries of Edinburgh and Glasgow.—Dr. M'Keown will read notes of a case of tertiary ulceration of throat with treatment.

Sixteenth Meeting, Saturday, 19th April, 1873.—The President will exhibit a specimen of intra-uterine tumour, associated with pelvic abscess.—Also the pathological appearances presented in a fatal case of ruptured urethra with extravasation of urine.

Seventeenth Meeting, Saturday, 26th April, 1873.—Recommendation of Council—"That meetings of the Society be held during the summer on the first Tuesday of each month, at Eight o'clock in the evening."—To receive report of Sanitary Committee.—Dr. Murney will exhibit a case of fractured spine, and give history of case.—Professor Cuming will show a malignant abdominal growth, and give history of case.—Dr. John Moore will exhibit a calculus extracted from the urethra of a boy; also the head and fragments of a humerus of a case in which he performed amputation at the shoulder joint. Will introduce a patient who had compound fracture of skull, with depression; and one with compound dislocation of wrist-joint.

Eighteenth Meeting, Tuesday, 6th May, 1878.—Dr. Charles will exhibit and describe an exceedingly rare tumour—a *cystic sarcoma* of the thymus gland.—Professor Cuming will show a malignant abdominal growth, and give history of case.

Annual meeting 1873 [November?]

Present, H. M. Johnston President in the chair, Drs. Stewart, H. S. Purdon, Brice Smyth, Charles, McKeown, McMeekin, J. W. Browne, Core, Spedding, Garde, J. W. Smith, John Moore and Fagan.

Minutes of last Annual Meeting read and confirmed.

The Secretary read the Annual Report of Council which was ordered to be entered in the minutes of the Society.

The election of office bearers for the ensuing year was then proceeded with.

S. Browne L.K.Q.C.P.I. R.N. was unanimously elected President.¹

Drs. J. W. T. Smith and Murney Vice Presidents

Drs. Charles, McKeown, Brice Smyth, H. S. Purdon, Spedding and McCrea were elected Members of Council;

Dr. John Moore was requested to continue his services as Secretary and Dr. Fagan as Treasurer. Drs. Spedding and Whitaker to act as Auditors.

REPORT OF COUNCIL

The Council has much pleasure in stating that the progress of the Society during the past year has been most satisfactory. The increased interest of the two previous years has not only been maintained but exceeded.

Ten new members have been enrolled; and eighteen meeting of the society held: the meetings were well attended and the papers read, the specimens exhibited, the patients introduced, the cases narrated, together with the discussion following them, were unusually interesting.

The Council regret to have to record the loss of three of its most estimable members, Drs. Thomas Reade, Pierre and Murray.

The former was one of its oldest members and long occupied a most prominent position in the profession in this province. His researches on the effect of the poison of syphilis on nervous tissue were the first to point out that these tissues were not exempt from the ravages of that disease. He had a high social position and was greatly respected.

Dr. Pirrie was cut off in the prime of manhood and in the midst of his labours. His genial, pleasant face will long be missed from the meeting of the Society; a consultant in the department of medicine which he had made his own namely obstetrics. He willingly placed his services at the command of his professional brethren and was ready to accompany them at all times and to all places and often without hope of fee or reward. He was much loved and deeply regretted.

Dr. Murray was an industrious, painstaking and skilful practitioner and had formed a large circle of friends.

The Council look forward with interest to the approaching meeting of the British Association for the Advancement of Science to be held in Belfast in August next and would recommend this Society to

¹ [Although Samuel Browne was elected at the Annual Meeting, subsequent records show John Moore signing the minutes as President. Samuel Browne was not at the Annual Meeting and it seems probable that he refused the position.]

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make arrangements for providing suitable entertainment for the distinguished members of the profession who will no doubt visit our town at that time.

The appointment of a Sanitary Committee to watch over and report upon the condition of the Town will it is hoped be attended with advantage by not only affording the public some knowledge of sanitary science but by pressing upon the authorities the necessity of attending to conditions which impair the health of the community and increase its death rate.

The council regret the delay that has occurred in the publication of the Transactions which arose from causes beyond their control, but hope that very shortly the complete volume will be in the hands of the members

John Moore, President
4th November 1874

ULSTER MEDICAL SOCIETY

SESSION 1873–74

The First Meeting of the Society was held on Saturday 15th November 1873.

The only members present were Drs. Charles, J. W. Browne and John Moore.

As several students were present Dr. John Moore introduced a patient whose elbow joint he had excised on the 9th July last.

Paper.¹—The patient, a fine healthy-looking lad, aged thirteen years, while following his occupation of attending to a machine in a paper manufactory, had his left elbow caught between a strong projecting pin on a revolving roller and the frame of the machine, whereby the humerus was broken just above the condyles, and the condyles themselves split and comminuted, the external one being partially driven out through a wound about two inches long, situated just over it.

It was evidently a case for operative interference, and excision of the joint was decided on. The patient was placed under the influence of chloroform, and an incision made to the outer side and parallel with the ulnar nerve, which was carefully separated with the surrounding tissues from the internal condyle, and drawn, by means of a retractor, inwards and out of harm's way.

Another incision was now carried across the joint so as to connect the wound made by the accident with the first incision, and thus render the operation the same as that by the old H-shaped incisions. The articulating end of the ulna was cleared and sawn off, leaving the head of the radius intact; the fractured condyles and comminuted portions of bone were easily separated, and the fractured end of the humerus trimmed with the cutting forceps. The wound having been cleared, the edges were drawn together by wire sutures, and the arm placed on an angular splint. The wound healed kindly, and there was very little constitutional disturbance.

He was discharged on the 13th September, with the wound completely healed, with power of flexion to a right angle, and with perfect use of hand and arm. He is now following his former occupation, with but little inconvenience from the injury he suffered.

The Second Meeting of the Society was held on Saturday 29th November.

Dr. McCrea in the chair, members present Drs. Charles, McKeown, Bolton, J. W. Browne and John Moore.

Cases published under the title "Transactions of the Ulster Medical Society" in the Dublin Journal of Medical Science, 1874, v57, p385.

December 1873

Amputation and use of Esmarch's Means of Restraining Hæmorrhage.—The PRESIDENT read notes of the following case:—M. P., aged forty-five, a stout strong man, was engaged on a ladder at his employment as a carpenter, when it slipped, and he fell from a height of more than twenty feet, fracturing the left femur immediately above the knee-joint, separating and splintering the condyles with complete dislocation of the fragments, and a large wound opening into the joint. The case was one demanding immediate amputation, to which the patient readily consented. It was determined to try Esmarch's method of restraining hæmorrhage and an elastic roller was carried from the toes to the upper portion of the thigh, a pad of lint having been previously placed over the wound. Chloroform was then administered, and when the patient was fully under its influence, a band of vulcanized India rubber was carried round the limb, and fastened by hooks attached to each end. The roller was then unwound, and the limb amputated as close to the injured parts as the state of the wound would admit, the bone being sawn through about the junction of the lower with the middle third. There was scarcely a trace of blood to be seen during the formation of the flaps, which were of skin, or the division of the soft parts and separation of the limb. A ligature was placed upon the femoral and the constricting band removed. Two small vessels spouted and required ligature, and there was some regurgitation from the femoral vein, which also had to be tied. Not more than two ounces of blood were lost during the operation. The wound healed by primary adhesion, except at the angles where the ligature lay; the last separated on the fifteenth day; the completion of feeding was effected in three weeks, and the man discharged at the end of four weeks from the receipt of injury.

In this case, though the man was stout, plethoric, and robust, with a thick limb, there was no symptom of local congestion or other evil resulting from pressing back into the circulation the blood contained in his limb, and he had lost none from the accident. A tendency for the edges of the wound to slough has sometimes been supposed to result from the application of the elastic bandage, but in this case the wound healed most kindly, and his progress to recovery was uninterrupted.

Dislocation of Hip-joint Reduced by Flexion and Rotation.—The PRESIDENT stated that on the evening of the 21st November, 1873, he was requested by Dr. Newett to see with him a patient, whose left hip had been dislocated by the upsetting of a cart in which he had been riding home from Belfast. The usual symptoms of that accident were well marked. Reduction was

¹ [Dublin Journal of Medical Science, 1874, v57, p385.]

effected by grasping the ankle firmly and flexing the leg upon the thigh, and then carrying the thigh upwards towards the abdomen, and on rotating the limb outwards it slipped into its place with the greatest ease. The simplicity and facility of this plan of reducing these hitherto troublesome dislocations, and its advantage in this case were so striking as to induce him to bring it under the notice of the members of the Society.

Noma Pudendi.—DR. FAGAN introduced a patient, who was under his care at the Belfast Children's Hospital, suffering from the above. The disease had assumed a malignant form, and was arrested only by the free application of the strong nitric acid.

He remarked that, in his experience of such cases, the only effectual and safe treatment was the immediate application of some powerful caustic, with tonics and stimulants internally. The dressings used were of a stimulating character. The child above exhibited was nearly well, but a drawing represented the disease on admission at its worst stage.

Ulster Medical Society. The Fourth Meeting of the Society was held on Thursday January 1st 1874.

The President (Dr. John Moore) in the chair, members present Drs. Stewart, Charles, J. MacCormac and H. S. Purdon.

Dr. Whitla who was proposed at the last meeting was balloted for and duly elected a member of the Society.

The President remarked that he had been in communication with the Secretary of the British Medical Association with the object of having our Society associated thereto.

Dr. Stuart proposed and Dr. Charles seconded the following resolution "That the British Medical Journal be added to the list of those taken by the society."

A committee consisting of the President, Drs. Stewart, Charles, MacCormac and H. S. Purdon was appointed to make arrangements about the Annual Dinner to meet at Thompson's on Monday 5th inst at 4 o'clock p.m.

The President then read a paper on "A case of labour complicated with abnormal presentation and contracted pelvis."

Paper:¹—The PRESIDENT said:—On Saturday, the 1st November last, I was consulted by Mrs. W. with regard to the propriety of the induction of premature labour. She stated that she was in the eighth month of pregnancy with her fourth child, and gave me the following history of her previous confinements:—

Her first was premature, and the child was dead some time; this labour was, notwithstanding, terminated by the aid of the forceps. Her second confinement was at full term, and she had to be delivered by craniotomy. Her third labour was "induced" at the eighth

month, but even this did not succeed in saving her child, as her delivery had to be accomplished by the forceps, and the child only gave a gasp and expired.

Under such circumstances I arranged to visit her on the following Monday and make a careful examination of the pelvis and inform her what I should advise her to do. She was unwilling to have labour induced, as she suffered more from it than in her previous confinements; she was of low stature and of slender build. Before the hour for my appointed visit on the Monday, I received a message to say that she was ill, and requesting me to call at once. On my arrival I found that labour pains had commenced, so the first problem was solved most satisfactorily, as on examination I found the cavity of the pelvis so contracted, and the promontory of the sacrum so projecting, that the normal space was diminished by more than an inch. I concluded that she was nearly correct with regard to her time, as a considerable portion of the cervix uteri was still undeveloped. The head was found presenting. At one o'clock, three hours after my first visit, some progress had been made, the pains were recurring at regular intervals, and the os was dilated to the size of a crown piece, the membranes still unruptured. The uterus and child still kept high and did not descend into the pelvis. At four o'clock, on calling, I found the patient getting into bed from the night chair on which the membranes had ruptured, and, on making an examination, I found the cord still pulsating lying in the vagina, with a hand and arm projecting beyond the head.

As commencing labour had solved the first problem which the case presented—namely, whether it was one for "induction of premature labour," or whether she should be allowed to go on to the full period of pregnancy, so the second problem was now solved—viz., what method of delivery should be selected. At this stage of the labour, when it was not improbable that craniotomy might have to be resorted to, I requested the assistance of Dr. David Johnston, who kindly aided me. As the uterine contractions were fortunately not violent, I found but little difficulty in the introduction of the hand into the uterus, but considerable difficulty in finding a foot, as the child seemed twisted in a most peculiar manner; having succeeded, however, and bringing one down, the head did not revolve, and there was now in the vagina a hand, a foot, the cord, and the head at the brim. As the foot seemed most inclined to return to the cavity of the uterus, I placed a loop of tape around the ankle which kept it under control. The absence of strong uterine contractions was very favourable for remedying this mal-position, which a little manipulation and perseverance accomplished, and the breech and body were at length brought down and the arms were relieved. The pulsation in the cord was becoming very feeble, though it could still be felt, but all our efforts to get away the head, by any manoeuvring or traction compatible with the life of the

¹ [Dublin Journal of Medical Science, 1874, v57, p385.]

child, failed. I succeeded, however, in extracting it without reducing it, but only to see it make one or two feeble efforts at respiration and then expire. The child was a male, and as large as an average one at the full period.

Dr. J. MacCormac asked if the deformity was in the sacrum.

Dr. Charles gave some interesting facts regarding the different measurements of the pelvis.

The PRESIDENT, in reply, said that the deformity was occasioned by the sacrum, and he thought that the best pelvimeter was the finger.

Dr. H. S. PURDON remarked that Dr. Murphy, of London, in his work on Midwifery, advised the student not to trust to pelvimeters, however ingeniously contrived, and held that time and a close attention to the symptoms which present themselves decide upon the line of treatment to be taken.

John Moore
January 15th 1874

Ulster Medical Society. The Fifth Meeting of the Society during present session was held on January 15th 1874.

The President in the chair. Members present Professor Dill, Drs. Stewart, McCrea, Walton Browne, Fagan, McKeown, Charles, Garde, McConnell, Gribbin and H. S. Purdon.

It was agreed that Drs. McCrea and Fagan be appointed a subcommittee to see if a suitable room could be obtained in a central position for a reading room for the use of members.

Dr. Charles exhibited a specimen of gastric ulcer.

Paper:¹ DR. CHARLES exhibited a very interesting specimen of ulcer of the stomach. The patient, aged fifty, had been in the Union Hospital. The stomach was contracted to about one-third of its original size, and all its coats greatly thickened. A small ulcer was also apparent. He had examined microscopically for cancer, but the result was negative. The heart was also atrophied. Dr. McCrea asked if there was any history of syphilis, or if he had examined for amyloid deposit.

Dr. Fagan thought that there was some peculiar tendency to atrophy generally, as other organs were said to be smaller than normal.

Dr. McKeown held that excessive tea drinking, as well as abuse of alcoholic stimulants, was injurious; indeed he thought the former led to disease of the mucous coat of the stomach much more frequently than the latter.

Dr. H. S. Purdon stated that the prolonged abuse of alcoholic drinks gave rise to a catarrhal state of the stomach in the final instance, followed by a new growth of connective tissue, which finally pressed on and oblit-

erated the follicles, causing an inveterate form of dyspepsia. He also stated that the modes of death from gastric ulcer were generally held to be three in number—by perforation, by opening into a blood vessel, and thus inducing hæmorrhage, and by debility and exhaustion consequent upon the vomiting and non-absorption of food. He held that in cases of gastric ulcer sugar was very injurious, and that cancerous patients with ulcer of the stomach seldom vomit more than a small portion of their food; whilst Dr. Davis had pointed out that when cancerous disease of the stomach had existed for several months, the patient will often go from four days to ten without a passage from the bowels, and still the abdomen will be lank and empty.

The President thought that, if the ulcer had arisen from the abuse of ardent spirits, similar cases would be often met with; whilst the specimen exhibited was very rare and interesting.

The Secretary read notes of two cases of lupus erythematosus.

Paper:¹ DR. H. S. PURDON made the following observations on this comparatively rare disease:—I have had two cases of lupus erythematosus recently under treatment, and rather than describe them separately I will take this opportunity of saying a few words on the disease. Both patients were females—one, Mrs. T., aged fifty. In her case the disease occurred on the chin, commencing ten years ago as a small red spot, which became covered by a tenacious scab, nearly impossible to remove; it slowly spread, and when seen by me was about the size of a two shilling piece, mottled at one side—this white appearance being due to the growth of new white fibrous tissue. Her family history was bad, phthisis having carried off several of her relations. The treatment adopted was frictions with juniper tar soap, painting the part afterwards with a calamine lotion. Subsequently I prescribed a weak iodide of sulphur ointment, and tonics internally. The disease, after five months' treatment, is now cured. My other case, which I attended at the same time, occurred in the person of Mary P., aged twenty, a mill worker. Both cheeks were attacked, as was also a part of the left ear. The skin was red; orifice of gland ducts plainly visible, and filled with "horny exuvizæ," bearing out the view of Hebra that the disease is, in the first instance, an affection of the sebaceous glands, or a seborrhæa congestiva, as he calls it. In this case I ordered a preparation containing oil of cade, and a mixture of iron, wine, and Fowler's solution. The disease is slowly improving. When the disease occurs near the scalp permanent baldness is produced. In both these cases the disease will terminate in a white depressed cicatrix. Biett called this disease erythema centrifugum; but, as Erasmus Wilson observes, "at a first glance the patch appears trifling; its stationary

¹ [Dublin Journal of Medical Science, 1874, v57, p390.]

¹ [Dublin Journal of Medical Science, 1874, v57, p388.]

habit and resistance of treatment excite suspicion that it is something more than common erythema, and its disposition to occasion atrophy of the skin proves it to be more serious in its nature, and when it fortunately disappears spontaneously, the white cicatrix indicating the removal of the papillary layer of the derma, or, on the scalp, the destruction of the hair follicles, declares its relation to lupus." I recall to mind the case of a young lady who was under my care for this disease some four years ago, and it made sad havoc of her face; both sides were involved, and the hair all gone at both temporal regions. The disease under notice often attacks the fingers and toes, and is then confounded with chilblains; it is sometimes associated with lupus non-exedens. In lupus erythematosus, as well as in lupus non-exedens, the capillaries going to a lupus papule or patch are twisted round the clubby kind of cells. In the first mentioned variety it is the true skin that is chiefly involved; whilst in the other, or non-exedens, it is the connective tissue of the skin that is affected. As pointed out by Volkman in lupus erythematosus, the skin is often at first covered by a leafy crust, generally symmetrical. Where the nose and both cheeks are affected it has been compared to a butterfly with wing expanded. This crust adheres tenaciously to the reddened skin, and has often an unctuous feel. If this crust is removed the skin underneath is found red and apparently purely papillary, the latter appearance, by aid of a lens, is seen to be due to a number of minute orifices closely set together, which are the openings of sebaceous glands much dilated, and the crust is caused by their secretion. Volkman holds that in addition to the seborrhœa there is infiltration of lymphoid elements. I may say that in my recent case I was able to point out all these characters to the gentlemen attending my clinique at the skin hospital. The treatment has already been touched on; however, it has been suggested to remove the crusts by lint soaked in oil, and then washing the diseased part with a good lather of soft soap. If this fails strong liquor ammoniæ or liquor potassæ is applied, or iodine, iodide of potassium and glycerine pencilled on the part; others prefer Rochard's ointment, composed of calomel, iodine, and conium ointment. Carbolic acid has also been tried. As in the other varieties of lupus, internal remedies are useless, it is to local means we are to trust.

Dr. M'Crea considered that constitutional treatment was most important in all forms of lupus, and held that the disease was generally connected with scrofula.

DR. WALTON BROWNE mentioned a curious skin affection occurring on the fingers and toes, chiefly the latter, in the boys who are sent on board the "Gibraltar" training ship in Belfast Lough. The skin becomes red, vesication then occurs, and an indolent ulcer ensues. He thought the disease allied to erythema gangrenosum; that it was not chilblains was proved by the fact that it occurred during summer as well as winter. He had found resin ointment and good diet the best plan of

treatment. When the toes were attacked the ankles usually became œdematous.

DR. H. S. PURDON replied that he thought the local treatment of lupus, especially by what is called "heroic" means, the best plan, and had no faith in a "soothing" plan of treatment, except at first, when symptoms of irritation were present. He noticed that erysipelas had cured lupus vulgaris of the face. Dr. Purdon referred to Dr. Theodore Veiel's treatment of lupus. The best results being obtained by chloride of zinc in solution in alcohol and applied to the affected parts, which had in the first instance been blistered. This treatment is very painful, and not likely to be submitted to by Irish patients.

John Moore, Chairman
Ulster Medical Society. The Sixth Meeting of the Society was held on Thursday evening January 22nd 1874.

The President in the chair. Members present Professor Dill, Drs. Aickin, Stewart, Fagan, Walton Browne, Stewart, Whitla, David Johnson and H. S. Purdon.

Dr. David Johnson proposed and Dr. Walton Browne seconded a motion "That Dr. McMurtry be re-elected a member of the Society."

Dr. Whitla exhibited a horseshoe kidney and Dr. David Johnson gave notes of a case of postpartum hæmorrhage.

Paper:¹ DR. WHITLA, house surgeon, Belfast General Hospital, read the following notes:—

Maria C., aged seventeen, unmarried, certified to be labouring under gastric fever, was admitted into hospital on 3rd December, under care of Dr. H. S. Purdon. She had been in good health until five days previously; had menstruated only once, and that was five months ago.

On her admission she was very weak and restless; face pallid; eyes staring, and respiration quick and panting; skin cool and dry; temperature 98.1°; pulse rapid and weak; tongue moist and coated, with red papillæ projecting; but the most prominent symptom was persistent vomiting. In this state she remained for seven days, in which she was treated for an attack of gastritis; sinapisms over the stomach. Liquor bismuthi produced little change. Afterwards oxalate of cerium was given with benefit.

On the 12th December some œdema about the ankles appeared. Her urine was examined and abundance of albumen found in it. There was no doubt now about the nature of the disease. The œdema spread rapidly. She got gradually worse. On the 15th January she lost power of one upper extremity. On the following day the corresponding lower limb was paralysed, and on the evening of the same day she died, being comatose for some few hours. The only food that

¹ [Dublin Journal of Medical Science, 1874, v57, p391.]

remained on the stomach was buttermilk.

DR. FAGAN, from the appearance presented, considered that the cortical substance of the kidney was changed. He did not think a horse-shoe kidney a rarity, nor would its shape interfere with the due discharge of its functions.

Dr. Aicken thought the specimen was a curiosity. It had two pelves and connected ureters.

Professor Dill stated that he had often met with great irritability of the stomach in cases of Bright's disease, he had found the new preparation called "Koumis" succeed in allaying the irritability, and he supposed that the buttermilk that the patient took acted in a similar manner.

DR. H. S. PURDON said that the patient from whom the kidney exhibited was taken had been under his care in the hospital. The dropsy was not urgent; in fact, the vomiting was the most pressing symptom, and he had to treat symptoms. The oxalate of cerium succeeded in checking it. The only food she lived on for many days was buttermilk. He had tried the koumis in two cases of diabetes, but not in Bright's disease. He thought that the great irritability of the stomach and constant vomiting in this case were due to retained urea, which, as pointed out by Todd, often gave rise to retching and irritability of the mucous membrane of the stomach. He noticed that persons who had undergone the "Banting" system for the cure of corpulency were very liable to Bright's disease, from absorption of the fat that surrounds the kidneys, and he believed that the case under discussion was one of tubal or epithelial nephritis, affecting mainly the epithelium of the tubes and ultimately producing the large smooth white kidney. In addition, Dr. Purdon said that there existed slight hypertrophy of the left ventricle; and in these cases it had been found by Dr. Galabin that the arterioles corresponded in all respects to those of the granular kidney; and the state of the minute capillaries, often apparently fatty, with more or less hypertrophy of the muscular coats of the arteries, is due to increased arterial pressure, as proved by the sphygmograph. The epistaxis and hæmorrhage in the retina, or even cerebral hæmorrhage, are due to the degeneration in the walls of small vessels.

DR. WHITLA, in reply, said that the diarrhœa which had existed for a few days in the case might be explained on Johnston's theory, viz., that the retained urea was excreted by the intestines as carbonate of ammonia, and that the buttermilk would act as a neutralizing agent and sedative, which might account for the patient's craving for it.

Paper:¹—DR. DAVID JOHNSTON brought under the notice of the Society, the case of a patient aged 21, whom he had attended in her first confinement. The labour was natural; but pains feeble; child still-born. He

left her doing well at 2 o'clock p.m.; sent for at 6 o'clock p.m., and then found more or less oozing; emptied the uterus, and, when the loss had stopped, left. Again visited the patient at 10 o'clock p.m., being sent for; there was profuse hæmorrhage; pulse feeble, indeed nearly imperceptible; emptied the uterus of several clots, and, as the case was urgent, he injected 2 ounces of the perchloride of iron in 20 ounces of water, which, for the time, arrested the hæmorrhage. In about half an hour it recommenced; he then repeated the injection, and obtained the assistance of the President. The patient at this time was in great danger; tossing her arms about, sighing and restless. He injected the iron solution for the third time, 2 ounces to about 8 ounces of water. He thought that his first injection had produced little effect, as he had to do everything himself; but the others succeeded in stopping the hæmorrhage. Some surgeons look on the injection of iron as a dangerous remedy, but, in his case, the patient made a good recovery, there was no tenderness over the uterus at all. Ergot failed completely in this case.

Dr. AICKEN said that if the placenta be soft, in the expulsion from the uterus, it sometimes tears and leaves part behind, and from this internal portion and its attachments oozing may take place. In a case of his, he had tried a sponge wrung out of vinegar and rolled round the uterus, which immediately brought on the uterine contractions.

Dr. Fagan noticed the beneficial effects of transfusion, in cases of severe post-partum hæmorrhage.

PROFESSOR DILL considered that the case under the notice of the Society was very interesting, and from what he could gather from the remarks of Dr. Johnston, the iron injection had suited best. He did not think that as yet we could pronounce a verdict, so to speak, on the value of the perchloride of iron. In this case, the hæmorrhage arose from want of contractility of the uterus, as was proved by the hæmorrhage coming slowly and gradually. In such a case the injection of iron is useful. If such a case presented itself in his practice he would, in the first instance, attack it by the application of cold. He seldom had seen a case of post-partum hæmorrhage that did not yield, if treated promptly, to the sudden application of cold, especially iced water, if it could be obtained, if not, then a handful of salt might be added to the water. In some cases the hæmorrhage could be anticipated by the character of the labour pains. If they are feeble and irregular, hæmorrhage may be expected. Ergot of rye, he thought, was useful only in some stages of labour, and ought to be given when the pains were feeble, giving rise to irregular contractions of the uterus. The drug was especially serviceable during the last three or four pains, just before expulsion. At this stage it certainly occasioned good contraction of the uterus, and he had little faith in ergot after the expulsion of the child. The circulation when quickened in those of a full habit of body—as shown by a quick pulse,

¹ [Dublin Journal of Medical Science, 1874, v57, p392.]

often gave rise to hæmorrhage. In such cases previously to labour much could be done in the way of treatment, by quietness, by keeping the patient cool, and administering those remedies which quiet the heart's action, as digitalis. Want of coagulability of the blood was another cause of hæmorrhage. In such cases gallic acid is useful. The Professor had formerly held the idea that when a patient died from post-partum hæmorrhage, it was generally the medical attendant's fault. Recently he had seen, chiefly in consultation, some three or four cases which were fatal, and he had changed his opinion, and chiefly for the reason that in all these patients there seemed to be a general varicose condition of the veins in the limbs and elsewhere, showing disease of the venous system. These cases were very dangerous, and he held that there was probably the same state of the uterine veins. In conclusion, he thought it might be worth while trying the plan of applying a tourniquet to the extremities, to stir up the blood in cases of post-partum hæmorrhage.

The PRESIDENT stated that during the 26 years he had practised his profession, he had been peculiarly exempt from cases of post-partum hæmorrhage, and had only one death from this cause. The case under notice was, what might be called, an extreme case, at the verge of death, and the treatment adopted was not only proper, but necessary. He had, in similar cases, compressed the aorta; but he believed that the injection of the solution of iron was more rapid and suitable. On examining the parts afterwards, the vagina would hardly admit the finger, showing the contracting power of the iron.

John Moore

Ulster Medical Society. The Seventh Meeting was held on January 29th.

The President in the chair. Members present Drs. Walton Browne, Charles, Murney, Cuming, Whitla, James Moore, Garde and H. S. Purdon.

A subcommittee consisting of the President, Drs. Smith, Murney, Whitla and H. S. Purdon were appointed to examine into the state of the library.

Dr. McMurtry was voted for and duly elected a member of the Society.

Dr. Murney exhibited a specimen of diseased knee joint and read notes of an interesting case of post-mortem.

Paper:¹—DR. MURNEY exhibited a diseased knee-joint which required amputation at the lower third of the thigh, and gave the following history of the case:—The patient was a female, aged 24. About four years previously she had, as he believed from the description given, acute synovitis of the knee, which passed into the chronic stage, accompanied by occa-

sional exacerbations. The swelling of the joint never completely diminished. Some four months since, ulceration of the cartilages commenced, and she then sought admission into the Belfast General Hospital. Last Saturday, January 24th, he amputated the thigh. She slept soundly the night after the operation; previously she had required large doses of anodynes; she is now progressing favourably. Upon examination the cartilages show extensive ulceration, in some places the cartilage of incrustation is completely gone. Moreover, the head of the tibia is eroded and greatly diseased. Some surgeons might think that excision should have been employed, but his experience, derived from the General Hospital, was opposed to that operation.

The first case of excision of the knee-joint performed in the General Hospital was in 1850, by the late Dr. H. Stewart, and since then the results of the operation had been very unsatisfactory. Dr. Murney thought that excision of the elbow-joint gave much better results, and held that excision of the knee-joint was not a suitable operation, when the patient belonged to the working classes, whilst amongst those in a better position in society the results were more hopeful. In the former he preferred amputation; with regard to the production of a "stiff joint," he thought that it might be tried in certain cases, and was better than excision.

Dr. James Moore stated that he was not in favour of the operation of excision.

Dr. H. S. Purdon proposed and Dr. Murney seconded the following "That Andrew Spence L.R.C.P.&S. Edin., Henry Murray M.D. L.A.H., Samuel McKee M.D. M.Ch., William Rankin L.R.P.&S. Glasgow, be elected members of the Ulster Medical Society."

Case published under the title "Transactions of the Ulster Medical Society" in the Dublin Journal of Medical Science, 1874, v57, p394.

January 1874

Delirium Tremens.—Dr. H. S. PURDON read the following notes of a case:—

Ordinary cases of delirium tremens are generally well within 48 hours, by inducing sleep. Occasionally, however, more obstinate cases arise. The following are the notes of one that has recently been under treatment in the general hospital.

Francis P., aged 48; married; by employment a publican; a powerful and well-made man, was admitted into hospital on January 7th, 1874, labouring under delirium tremens. He had been a "heavy drinker," and drank more than usual a short time before his being taken to hospital. The assistance of the police had to be obtained by his friends, so as to bring him to us. After his admission, he was quiet, but became very violent when anyone entered the cell in which he was confined. He was prevailed on to take a chloral draught at night,

¹ [Dublin Journal of Medical Science, 1874, v57, p396.]

and slept 4½ hours. Next day he was very violent, dangerous, and delirious, had hallucinations of both sight and hearing, and was suspicious of everyone. The straight jacket had to be put on him; however, during the evening he became quieter, and the jacket was removed.

January 9th.—Again became very violent and delirious, so as to necessitate the use of the straight jacket. Tongue is now moist and creamy; skin perspiring (hitherto it was dry); pulse 80, and soft; bowels moved; urine normal. Has not slept, although on the 8th and 9th he had chloral in ʒi doses, which had little or no effect, indeed it seemed to make him worse, and to increase the heart's action.

10th.—Much the same. Was ordered a mixture of opium and tartar emetic, and a purge of jalap powder.

11th.—Somewhat better; complains of "noise in the ears," and wishes his "brain to be examined," will submit, and requests his head to be "cut open," inclined to pray on every opportunity.

12th.—From this date till 17th, much quieter; bowels regular; appetite good; tongue clean; pulse fair. Occasionally quite rational, but always in a melancholy state. Ordered ergot, bromide of potassium, bromide of ammonium, iodide of potassium, in a bitter infusion.

17th.—When seen this morning he was very low. Muscles somewhat rigid; pulse weak; body bathed in sweat; won't open his eyes; complains of people talking to him. Ordered an enema of 10 grains of quinine and starch, and blister to neck. From the first (with the exception of one day) till 16th inst., he had ʒiii of whiskey given in milk, eggs and beef-tea.

18th.—Better; the stimulant (brandy) he had yesterday, during the sweating stage, roused him up, and stopped the sweating. Ordered to-day, a purgative of jalap and calomel, and the cold water douche. This profuse sweating may be due to vaso-motor nerve paralysis, and, as remarked by Anstie, prolonged alcoholic poisoning induces degenerative changes, due to direct chemical influence of alcohol upon the nervous tissue, causing paralysis of the nerves that preside over nutrition.

19th.—At the suggestion of Dr. Wales, under whose care he had been on former occasions, he was ordered some claret daily.

Jan. 24th.—Patient sleeps well, eats well, and seems in good bodily health, but still complains of hallucinations of sight and hearing, which, however, he knows perfectly well are false.

As in all cases of delirium tremens, there was in this patient well marked tremor and quivering of the tongue. The obstinate nature of the attack might be due to perverted nutrition of the brain, from the circulation of impure blood. As pointed out by Tanner, there is, in severe cases, often an increase of urea, with diminution of phosphates in the urine. Dr. Laycock, who has investigated the disease under notice, thinks that sleepless-

ness is not so serious a matter as is supposed in delirium tremens.

No doubt there are two forms of this disease, viz.:—The acute and the chronic, the latter usually attended by mental and bodily depression. It is a curious and well known fact, that nearly all delirium tremens patients imagine that they see the devil, at some part of their illness. My patient thought that several devils surrounded him, urging him by voice to attack his attendants.

Dr. Blandford writing on auditory hallucinations (Journal of Medical Science, January, 1874) such as existed in the case I am describing, as well as hallucinations of sight, states that "the patients tormented by voices were more than commonly stout, and that hallucinations of sight belong to the acute rather than to the chronic stages of insanity."

He defines the distinction between hallucinations and illusions to be "that an illusion is said to be a false interpretation of a real sound, while an hallucination is a false perception of a fancied voice or sound when there is no sound at all in reality." Dr. Barclay, on this subject, holds that "in the strict application of terms, the word hallucination implies that no object is present to stimulate that organ to which the idea formed in the mind is referred; while in illusions, existing objects which, in the first instance, produce the stimulus are clothed by the mind in characters more or less foreign to their true nature, and so blended with the sensation originally produced, as to give rise to the belief that the resulting idea is wholly derived from the external impression."

With regard to the treatment of delirium tremens, as debility is generally exhibited, nourishment, such as plenty of milk, eggs, and, in some cases, a moderate allowance of stimulants is, I think, necessary. I have remarked that when the patient is pale, thin, and not a confirmed tippler, and has not the greasy unctuous skin "reeking with volatile fatty acids," so characteristic of the drunkard, that Graves' plan of treatment by tartar emetic and opium, succeeds very well; however, opium sometimes stimulates, even when guarded, so to speak, with antimony. A good purgative is a capital preparation for this, or indeed any plan of treatment. Chloral is useful, and is now the popular remedy for delirium tremens, but, as remarked in this case, does not always agree, and often seems to stimulate the heart and brain. Red pepper in twenty grain doses has not succeeded in my hands, nor has bromide of potassium. I have had no experience of the tincture of digitalis in ½ ounce doses, as recommended by Jones of Jersey, nor of the hypodermic injection of caffeine, except in neuralgia. For the tremor and "unsteadiness" that remain after an attack of delirium tremens, the oxide of zinc in two grain doses thrice daily has done good, or, if the appetite is bad, quinine given with the ammoniated tincture of valerian, may be ordered. I believe that when renal con-

gestion occurs the disease is very often fatal, ending in convulsions, coma, and death. In conclusion, my chief object in bringing this case under the notice of the society, is not that I have anything new to offer in the way of pathology or of treatment, but to elicit the views of the members as regards the treatment, etc., of, I am sorry to say, a very common disease.

Ulster Medical Society. Eighth Meeting of the Society was held on February 11th.

The President in the chair. Members present Drs. Dill, Stewart, Fagan, McMurtry, Charles, Gribbin, Spedding, Scott and Hon. Secretary.

Before the business of the meeting commenced the President brought under the notice of the Society the death of an old and valued member Dr. William McGee J.P. and it was proposed by Dr. Stewart and seconded by Dr. Dill that the Secretary be directed to write a letter of condolence to the deceased gentleman's family.

The following were then balloted for and duly elected members of the Society viz. Andrew Spence L.R.C.P. Edin., Henry Murray M.D. L.A.H., Samuel McKee M.D., William Rankin L.R.P.&S. Glas.

Dr. Fagan exhibited a specimen of cancer removed from breast and Dr. Dill showed a tumour expelled from uterus.

Paper:¹ DR. FAGAN exhibited a specimen of cancer which he had removed from the breast of a female, aged thirty-two, unmarried. About three months ago the patient first noticed the tumour, and felt pain in the affected part. She exhibited no cancerous diathesis. Some surgeons do not approve of the removal of scirrhus, but Dr. Fagan held that in this case operative interference was not only suitable but necessary, the case being most favourable in all respects for excision. There was only one gland enlarged in the axilla, and that from irritation.

SURGEON GRIBBIN considered it judicious to remove not only the diseased mass, but also any enlarged glands that existed. He had under observation a patient who had been operated on in the General Hospital twelve years ago, and the disease had not returned.

Dr. Spedding believed that the younger the patient, the more liable she was to an early return of the disease.

DR. M'MURTRY doubted the necessity for operative interference in such cases, and did not see clearly the reason why some surgeons thought it so desirable to operate, as he held that the local cancerous deposit resulted from constitutional conditions which could never, he thought, be removed. After removal of the cancerous mass, other local deposits were very apt to occur.

DR. CHARLES said that if the glands in the axilla were

enlarged, they should be removed, and this enlargement was generally due to cancerous material being carried to them. Many eminent authorities looked on cancer as a local disease, and held that prompt removal was necessary. It is impossible to remove all the enlarged glands, as the lymphatics pass from the axilla to the thorax behind the sternum.

PROFESSOR DILL believed cancer to be a blood disease, which could not be removed. From his own experience he held it to be bad practice to remove a scirrhus breast, as he had generally seen the disease return not only rapidly, but in a more malignant form, and then the disease had no material, so to speak, on which to expend itself. He had seen scirrhus of the breast removed from a female, aged twenty-six, and return inside one year; it was again removed, and she died from the same affection in a year and a half. Two of his own patients who had scirrhus of the breast, which had not been operated on, lived upwards of ten years.

Dr. Scott asked if any of the members had any experience of condurango given in this disease.

The President remarked that, from his experience, he undertook no surgical operation with more hesitation than that of the removal of a cancerous breast, owing to the great liability of the disease to return, and he had never met with a case where it did not show itself again.

Paper:¹ PROFESSOR DILL exhibited a tumour expelled from the uterus. He said that the patient was aged fifty-six; her catamenia ceased at fifty. Last year she thought that her menstrual periods had recommenced, as the loss occurred monthly, accompanied with pain. The uterus descended so low that it could be seen and felt, and the patient's daughter had often returned it with her finger. He was called in consultation.

The patient had lost a good deal of blood, and the hæmorrhage still continued. The tumour was at the vulva, and its size, as was apparent to the members, was that of a goose egg, and of the shape of the uterine cavity. Tumours of this kind were usually fatal to the patient, and connected with the uterus. In structure it was musculo-fibrous. The pedicle was only the size of a large blood-vessel.

DR. CHARLES thought that the tumour had originally occurred in the uterine walls, which had given way when the growth had fallen into the cavity, and got moulded to its shape. This would also account for the absence of a pedicle.

John Murray

Ulster Medical Society. Ninth Meeting during present session was held on February 19th 1874.

The President in the chair. Members present Drs. Barnett, Dill, Fagan, Murray, Rankin, J. W. Browne, Sped-

¹ [Dublin Journal of Medical Science, 1874, v58, p73.]

¹ [Dublin Journal of Medical Science, 1874, v58, p74.]

ding, Moore, Stewart, Wales, Johnston and H. S. Purdon.

The minutes of previous meeting having been read and confirmed, a discussion on the aspirator then took place in which the President, Drs. Dill, Fagan, Browne, Purdon, Moore and Spedding joined.

Paper¹—DR. H. S. PURDON said that he had recently read Dr. Dieulafoy's book on the aspiration of fluids, and was much struck with several of the statements contained therein. For instance, that if a congested lung be punctured, the needle may be left in situ, and a few drachms of blood abstracted, thus producing a true blood-letting of the affected organ. Dr. Purdon's experience of the aspirator was very limited, as he had used the instrument only in some eight or nine cases of pleuritic effusion. The patients were all males, and were under treatment in the Belfast General Hospital. In about half the number the effusion was purulent, and in such cases he did not think the aspirator so useful. He punctured near the inferior angle of the scapula. Now, when the trocar and cannula were formerly used, we were directed to select a high site—for this reason, that when nature produced a fistulous opening, such a situation was chosen. Two of his cases were complicated with tubercle, in which, of course, the treatment by aspiration was only palliative. In another case the disease was hydro-pneumo-thorax, and from this patient four pints of clear fluid were drawn off. The amphoric echo was present before tapping, after which operation metallic tinkling occurred. However, as the fluid again accumulated, this disappeared. In this same case no fluid was obtained on the first puncture, which was at the back, and where one would expect the fluid to gravitate to, but it was obtained anteriorly. It is not always possible to draw off all the fluid, as difficulty of breathing, pain in the chest, and troublesome cough occur. In some, bloody expectoration takes place, which is said to indicate puncture of the lung. In patients where the effusion is of small quantity, the fluid may occupy a conical portion of the pleural cavity—near, say, to the axilla, and when both resonance and respiration are wanting. Dr. Purdon next referred to "Damoisseau's curve," which, it is said, tends towards estimating the amount of fluid effused—namely, when the fluid is being absorbed, and reaches a level of seven centimetres above the nipple, the line of dulness is horizontal, and when the effusion is less, the line of dulness is curved, the highest point being at the side, from which it gradually falls as it approaches the median line towards the spine.

PROFESSOR DILL stated that he was satisfied that the aspirator was the most important instrument introduced of late years. He had formed a high estimate of the aspirator, and within the last three months he was sent for in consultation to see a lady residing in the

country, who was aged about fifty, suffering from strangulated umbilical hernia. Every effort was made to reduce the rupture, but without success. He thought it a fair case for using the aspirator, which he had sent him from town. The hernia was fully the size of an infant's head. The intestine was filled with air. After using the fine needle and aspirator, immediate relief was afforded, and the tumour collapsed. The patient ever since had done well.

Dr. Fagan had used the aspirator in a great number of cases, but he thought that, like all new instruments, its powers were overrated.

However, he had found it very useful in cases of abscess, when the collection of pus was large, and when it was desirable to draw off the fluid gradually. A child, aged six, was under his care in the Children's Hospital, with hip-joint disease, which had caused a large abscess in front of the thigh, and to open which in the usual way would have been nearly impossible. He used the aspirator daily, and thus removed the pus. In some cases the abscess burst afterwards. He had used the aspirator in a case of effusion into the knee-joint with good results, and the fluid could not be removed by the ordinary methods of treatment. In this case he drew off an ounce of serum, with immediate relief, and the patient recovered well without any one bad symptom.

DR. JAMES MOORE had used the aspirator for abscess in the outer parts of the thigh in a woman, an inmate of the Hospital for the Insane. As the patient was troublesome, he did not like to open it in the usual manner. He drew off 16 ounces of thin pus. He looked on the aspirator as a most valuable instrument.

The PRESIDENT thought that, in introducing the needle, in some cases a little incision through the skin might be useful, as it was not always safe to plunge into an abscess, especially with a large needle. He had tapped a knee-joint with the aspirator. In hernia distended by flatus the small puncture was to be preferred.

Dr. Barnett read a paper on fracture of inferior maxilla and exhibited casts of bone etc.

Paper:¹ IN 1836, a man named Macdonald, a coachman in the service of a gentleman residing a few miles from Belfast, returning one evening to his master, was waylaid and knocked down; when on the earth his assailant gave him a kick with a heavy shoe, which fractured the lower maxillary bone at the symphysis. The man was admitted into hospital, but, at the end of three months' treatment, union of the fractured surfaces had not taken place, and he was discharged. He was now placed under my father's care.² There was a space of half an inch between the extremities of the fractured bone, one extremity being drawn in towards the base of the tongue. The four incisor teeth and abve-

¹ [Dublin Journal of Medical Science, 1874, v58, p74.]

¹ [Dublin Journal of Medical Science, 1874, v57, p397.]

² [Also Richard Barnett, described as a dentist in Professor Richard Clarke's book A Directory of Ulster Doctors, Belfast 2013, UHF.]

oli containing them having exfoliated, the most anterior teeth that presented themselves were the right and left canine teeth. A ligature of silk was tied firmly around the canine tooth of that portion of the bone which was drawn inwards toward the base of the tongue by the action of its attached muscles. One assistant had charge of this—another, by means of a small instrument, like a fork, fitted to the neck of the other canine tooth, pressed that portion of the bone backwards, and so reduced the fracture as to leave the mouth free from anything that would interfere with the subsequent steps of the operation.

Bees' wax was softened and placed in a frame suited for taking impressions from the lower maxilla. This was carefully introduced into the mouth, and an impression taken of the space in the front where the incisor tooth had been, and of all the remaining teeth on both sides.

From the cast now taken a frame of silver was made, which fitted all the teeth of the lower maxilla, and dipping down from the apices of the canine teeth on each side to fit the space between these teeth. The silver capping-frame was now introduced into the mouth, and found to fit the crowns and exposed surfaces of all the teeth, and the space in front; but the man had no command over his jaws, and there was a strong involuntary lateral movement which was to be overcome, or the steps hitherto taken would have been useless.

A strong silver bar was now soldered on the outside of the frame, and in a vertical position, so that when the month was closed, this bar passed between the buccal surface of the superior molar teeth and the cheek of that side of the frame to which it was soldered. This effectually prevented lateral movement in the opposite direction, which may be readily understood. A second bar was now attached to the opposite side of the frame, having the same relation to the superior molar teeth on that side. There could now be no lateral movement to either right or left side.

It now remained to make arrangements for feeding him, and that was managed in the following way. A silver bar was soldered to that part of the frame which covered the apices of the canine teeth, thus leaving a considerable space from the inferior margin of that bar to the frame covering the surface of the gum, and through this space he was fed. This bar also strengthened the frame, which at this part most required it, as it was more liable to injury at the central part.

This apparatus—consisting now of a frame, fitting all the lower teeth and gums, having two side bars in a vertical position, and one bar in the centre, passing from the apex of one canine tooth to the other, the space for feeding the patient being underneath this bar—was placed in situ, and the bandages passed round the vertex of the cranium in the usual manner. The patient, being directed not to interfere with the mecha-

nism or disturb the bandages, went to the country.

At the expiration of six weeks he returned, and the bandages being removed and the instrument taken out of his mouth, it was found that he could open and shut his mouth at pleasure, the teeth on the right side and left being on the proper level. However, as yet the union was principally cartilaginous, and would yield in a short time if left without support. The bones at seat of fracture were now rubbed, the one against the other, to cause irritation and excite more rapid ossification; and the frame being thoroughly cleansed—an operation it required very much—was replaced in the mouth, and the bandages applied as before.

He returned in three weeks, and it was found that he had the perfect use of the lower maxilla. He was recommended to keep the frame in his mouth for another fortnight, and then to return it; and as he was going to seek a new service in a distant locality, he was requested to call on a medical gentleman who resided in that neighbourhood, and who was much interested in his case, but he neither returned the frame nor revisited any of those gentlemen who had exhibited so much interest in his case.

Oblique Fracture of Lower Maxillary Bone.—On Dec. 24, 1872, I was asked by Dr. James Moore to see a boy, Christopher White, aged fourteen, then in the General Hospital.

A fortnight before, the lad had fallen out of one of the port-holes of the "Gibraltar" training ship, a depth of 17 feet, into a boat alongside, and Dr. Moore being on board the ship at the time, had him removed same day to hospital.

The lower maxillary was fractured obliquely, internally from a point beneath the right lateral incisor, running outwards toward the left canine tooth, the left central and lateral incisor teeth and their alveoli being also carried away at the time of the injury, leaving an ugly fissure.

An external wound under the symphysis, communicating with the cavity of the mouth, was almost healed when I saw him. The smaller portion of the bone was drawn in and downwards by the depressor muscles of that side, and there was a considerable amount of motion between the affected parts.

In order to restrain the voluntary and involuntary motion of the parts, and, at the same time, give room for the introduction of food, I made a vulcanite splint. I passed a waxed silk ligature between the bicuspid teeth on the left side; and while an assistant, by means of this ligature, reduced the fracture, and, at same time, retained the base of the bone in position, I introduced a metal tray of suitable wire, filled with soft wax, into the mouth, and thus obtained an accurate impression of all the teeth and contiguous gums, including the seat of fissure, having also taken an impression in wax of the teeth of the superior maxilla. From these impressions, plaster of Paris models were made—those marked No. 1

now on the table.

A vulcanite splint was now made to fit accurately all the teeth of the lower maxillary—to cap them, and to descend over the gums and alveoli, both internally and externally. The superior surface of this splint was carved out, so as to fit the grinding surfaces of the superior molars when the jaws were closed. On the left side a block of vulcanite was carried in a vertical direction, so as to fit the outside of the left upper molars when the mouth was closed, the object of this being to prevent all lateral motion.

On the 27th December this apparatus was introduced into his mouth. A piece of gutta-percha, previously softened in warm water, so as to take the mould of the external soft parts, was placed outside, under the base of the bone. This was semi-lunar in shape, and gave great support, some cotton wool being placed between the skin and the surface of the gutta-percha. Bandages were carried over the crown of the head, and around the neck, so as to steady all.

The following day I filled the upper surface of the splint at one part, so as to let the incisor and canine teeth on the right side through its surface. This made it more comfortable. The patient fed himself on soups and other fluid food, through the hole that can be seen by examining the models on the table. This space corresponds with the loss of teeth at the time of injury.

Two or three times a week the splint was removed from his mouth, cleansed with a tooth-brush, water, and soap, a mouth-wash, containing tincture of myrrh, being used at the same time.

Feb. 12, 1874.—The lad returned to his ship, able to do without the splint, and to give a very good account of a beefsteak; and the parts remain in a satisfactory condition at present date, fourteen months after fracture.

John Moore

Ulster Medical Society. The Tenth Meeting during present session was held on February 26th 1874.

The President in the chair. Members present Drs. Stewart, Spedding, Charles, Whitla, Purdon, Wales, J. Browne and Rankin.

Dr. Whitla exhibited a forearm removed that day.

Dr. Charles showed several interesting specimens of osteo-arthritis of shoulder and hip joints.

PAPER:¹ DR. CHARLES exhibited some interesting recent specimens of this disease. He thought that the name of chronic rheumatic arthritis was bad, as the affection was never attended by any of the complications of rheumatism, such as heart complications, nor was the disease gouty. In some of the specimens of the shoulder-joint which he showed to the members, the head of the humerus was enlarged, and had a porcel-

laneous deposit. In others the biceps tendon was removed or flattened, whilst in one case there existed also fatty degeneration of the muscles of the thumb and fingers. The cause of dislocation at the shoulder was the removal of the supra-spinatus muscle by absorption. The capsule of the joint then became softened, as also the infra-spinatus, and the remaining muscles drew the bone upwards. The name of osteoarthritis, Dr. Charles thought, did not bind one to look on the disease as rheumatic or gouty.

Dr. Whitla said that the fatty degeneration of the muscles of the hand observed in one of the specimens might be accounted, for by the fact that motion was greatly impaired, and thus the muscles degenerated and atrophied. In this case there was also deposit about the finger-joints.

Dr. Spedding read notes of cases of cystitis.

PAPER:¹ MR. President and Gentlemen,—I do not pretend to bring anything new or original before you to-night in the treatment of cystitis, but merely to record the result of four cases, all treated upon the same plan, by a remedy which was twenty-nine years ago extolled in the writings of Dr. Robert M'Donnell, of Montreal, in such a manner as to warrant one in giving it a fair trial.

It consists of injecting the bladder with a weak solution of nitrate of silver at short and repeated intervals.

This practice, though possibly known to all of you, is, I venture to state, very rarely adopted, inasmuch as I do not remember any of my professional brethren so treating this disease during my studentship, or since I entered into practice.

The disease is so common that all men who have an extensive field for clinical observation must have noticed how little good effect is produced by the use of various internal remedies which from time to time have been recommended for the cure of sub-acute and chronic inflammation of the bladder. The effect of the use of nitrate of silver injected into the diseased bladder has been so successful in my hands that I think it may be interesting and instructive to read the notes of each case before this Society.

CASE I.—John M'Alister, engine driver, married, aged thirty-two, consulted me on the 20th March, 1873. He stated that about eighteen months previously he commenced to suffer from severe pain in making his water, and being in Edinburgh at the time, became an indoor patient of the Royal Infirmary of that city for a period of six weeks. Here he was treated by internal remedies, and being unimproved, left for Belfast. Shortly after his arrival he consulted me, complaining of frequent desire to micturate, and great pain in doing so, the stream often stopping, and some blood coming away from the urethra. The symptoms of stone were so strongly marked that I passed the sound three times, with a neg-

¹ [Dublin Journal of Medical Science, 1874, v58, p76.]

¹ [Dublin Journal of Medical Science, 1874, v58, p69.]

ative result. Upon his second visit he brought me a specimen of his urine, on allowing which to settle in a test tube it took on a four-fold arrangement, the lowest fourth being blood, next pus, next tenacious mucus, the supernatant fluid being clear urine, having a strong alkaline reaction. I put him on a mixture of nitrohydrochloric acid, tincture of hyoscyamus, and infusion of buchu, an opiate, and a hot hip bath at bedtime. Continued this for three weeks with no benefit, the urine presenting exactly the same appearance, and being as alkaline, as before. I, then, determined to inject his bladder with a solution of nitrate of silver. I passed a No. 8 elastic catheter, drew off the decomposed urine, and applying a half-ounce glass syringe to its outer end, injected twelve drachms of the solution (which was gr. ii. of the nitrate to a fluid ounce of distilled water). It gave no pain, but felt, as he said, rather warm; he went home, had his usual opiate, ten grains of Dover's powder, and a hot hip bath, and next day reported that he had slept better than he had done for several weeks. He came back every fifth or sixth day, and had altogether nine such injections. Upon each visit he brought me a specimen of the morning urine. The blood disappeared altogether after the second injection, and the mucous and pustular discharge was greatly diminished. At the end of the third week of this treatment he had to rise only twice at night to urinate, whereas he was formerly up every hour. After the ninth week he stated that he felt quite well, and when I examined his urine under the microscope there was not a trace of blood, mucus, pus, or epithelium to be found. In May, 1873, he went to work. I cautioned him against the cold and the abuse of stimulants, to which he had been very partial, and lost sight of him until July, when I received a letter of thanks from him, stating that he was quite well. He was at this time an officer's servant in the South Down Militia, at Newtownards, where he was fortunate enough to escape the usual amount of marching drill, &c., in connexion with the annual training.

I was greatly disappointed when, early in September, 1873, he again applied to me, having, after an interval of three months' apparent cure, had a recurrence of all his symptoms in their most aggravated form. He gave himself up to dissipation after his discharge from the militia, drank whiskey for weeks without intermission, slept out in the cold, and got his bladder into such a state of acute inflammation that I could not again attempt the injection of caustic. Nothing could now check the progress of the disease. Blood, mucus, and pus came away from the urethra, even without making water; he emaciated rapidly, an uncontrollable diarrhœa set in, followed by uræmic symptoms, and he died, I believe, a victim to his own folly, early in December, 1873.

CASE II.—Ellen P., aged twenty, married, mill-worker, consulted me on the 3rd June, 1873. She stated that she had always enjoyed good health until a short time, some four or five weeks, after her marriage. She

had then to give up her work as a weaver, owing to a constant burning heat in her private parts, and a frequent desire to make water. Micturation pained her so much that she generally retained her urine for many hours from the dread of undergoing suffering. This state of things had continued for three months, and had been getting gradually worse, when she placed herself under my care. Upon examination per speculum I found the vagina highly inflamed, and the seat of a copious purulent discharge. On introducing the forefinger, and pressing upwards against the bladder, this patient screamed with pain. I drew off some urine for examination; it was normally acid, but upon allowing it to settle in a test tube it was more than one third pure pus. I diagnosed the case to be one of gonorrhœal cystitis, which the unfortunate bride had unconsciously contracted from her husband. I commenced treatment by injecting the bladder twice a week by an ordinary half-ounce glass syringe, with a solution of nitrate of silver, two grains to the ounce of warm distilled water. The first two injections gave a slight burning pain, followed by a desire to urinate, and were only retained a few minutes. The third injection, on the ninth day, gave no pain, and was retained altogether. This patient got ten such injections, with about four days' interval, and each specimen of urine which she brought to me contained less and less pus and mucus. She said that she could retain her water much longer, and was able, after the sixth injection, to sleep all night without requiring to urinate. In six weeks she was cured completely of her bladder derangement, but the vaginal discharge continued. This quickly yielded to the frequent use of the syphon syringe and astringent lotions. She has now continued quite well for six months, and has had no return of any bladder symptoms.

CASE III.—Christina D., a healthy married woman, aged thirty-two, and mother of six children, consulted me early in May, 1873. She stated that about twelve months previously she had over-heated herself while on a pleasure excursion to the sea-side, and that she got a chill by sitting on the grass and rocks. A few days afterwards from her account I gathered that she must have had acute cystitis, for which she received no treatment of any kind for three weeks, when she applied to a medical man, and took several bottles internally, without any benefit. She then tried another physician for a considerable time, and finally came to me, thinking herself incurable. To be brief, I found hers to be a bad case of chronic cystitis, with alkaline urine, containing large quantities of blood, pus, and tenacious mucus, together with phosphatic gravel. She was becoming emaciated from the pain and frequent calls to urinate during the night. As she had taken so much medicine internally without any benefit, I determined to treat her mainly depending upon the injection of nitrate of silver. I did so just as in the two former cases, and the result was most favourable. In the third week, after six injections,

the mucus and pus disappeared, and the blood was only visible when an occasional "attack of gravel" appeared. I then gave her a half-ounce glass syringe, and directed her to inject the bladder with a quarter of a pint of warm water every night, to which was added a tea-spoonful of laudanum. Being an intelligent woman, she did this properly, and after persevering in the treatment for four months, she became perfectly cured, and has remained well ever since.

CASE IV.—E. J., a gentleman, aged thirty, consulted me in June, 1873. He complained of scalding and pain, and frequent micturation, which he attributed to an imperfectly cured gonorrhœa which he had contracted several months previously. The discharge per urethram was little more than an ordinary gleet, but his urine showed chronic inflammation of the bladder, having a considerable deposit of pus and the characteristic tenacious mucus; the microscope revealed epithelium scales in great numbers; reaction slightly alkaline. I tried this patient with nitro-hydrochloric acid and infusion of buchu for one week, without any benefit, the condition of the urine being exactly the same as before its use.

I now injected his bladder in precisely the same way as case No. I.—viz., with two ounces of warm distilled water, containing four grains of nitrate of silver, and after the fifth injection had the gratification of finding him quite well, without the use of any internal remedy, save an opiate the night of each injection. It is now six months since the pus and mucus disappeared from his urine, and as I examined it very recently under the microscope, I am in a position to say that he is as well as before the attack commenced.

Remarks.—From the foregoing four cases I have come to the conclusion that we have in nitrate of silver a most potent remedy in the cure of cases of sub-acute and chronic cystitis. The injection causes little, if any, pain, and can be employed in cases of acid or alkaline urine. I am also of opinion that gonorrhœa, especially in women of the middle and lower classes, is a much more frequent cause of cystitis than has hitherto been thought.

DR. WALES believed that the nitrate of silver was serviceable in such cases as those described by Dr. Spedding, but he was at a loss to know how that remedy could be beneficial in the case described as being associated with phosphatic deposit in the urine. In cases of gonorrhœal cystitis the treatment recorded would be very useful.

DR. WALTON BROWNE remarked that Mr. Erichsen had mentioned the use of nitrate of silver in the treatment of cystitis. He had also tried it, and found it useful. Carbolic acid had, in some of his cases in dispensary practice, been serviceable.

DR. CHARLES thought that the best method of washing out the bladder was that described by Bryant. He had injected balsam of copaiva into the bladder in such

cases as those recorded.

DR. H. S. PURDON held that for chronic cystitis local treatment was the most important, and also that the urine should not be allowed to accumulate, as in cases where there was enlarged prostate or stricture. Acute cystitis was rare, as an idiopathic affection. He noticed a case, recorded by himself in the Dublin Medical Journal, where the disease was cured by the injection of normal urine.¹

The PRESIDENT believed that cases of cystitis were not very common. The nitrate of silver was an old remedy. The injection of balsam of copaiva, he thought, might give rise to formation of calculus, by some of the balsam remaining in the bladder.

R. Stewart, Chairman
5 March 1874

Ulster Medical Society. Eleventh Meeting of the Society was held on March 5th.

Dr. Stewart in the chair. Members present Drs. Whitla, Browne, Spedding and Purdon.

Dr. Whitla exhibited several interesting pathological specimens.

Paper:² Pericarditis.—DR. WHITLA exhibited a beautiful specimen of pericarditis, the whole surface of the heart as well as pericardium being covered by a thick deposit of lymph. There was also congestion of the lungs. He looked on this specimen, which had been taken from a patient under Professor Cuming's care, as an example of idiopathic pericarditis, as there was no rheumatic or syphilitic history or symptoms. The kidneys were also healthy. He intended to send the specimen to the Anatomical Museum of Queen's College, Belfast.

John Moore.

Ulster Medical Society. The Twelfth Meeting of the Society during present session was held on March 12th.

The President in the chair. Members present Drs. Wales, Charles, Purdon, McMurtry. Surgeons Whitla, Rankin and Spedding.

Dr. Whitla exhibited a diseased liver and ovary.

Paper:³ Abscess of Liver.—DR. WHITLA read the following notes:—Mary Bodel, aged thirty-five, married, mother of one child ten years old, was admitted to hospital on Monday, 2nd inst., suffering from typhoid fever. She was conscious and freely told her history. Had been in tolerably good health until seven days before admission, when her husband knocked her down and kicked her; she stayed out all night, and from that time had been complaining, but kept at her usual work

¹ [Dublin Journal of Medical Science, 1873, v56, p287.]

² [Dublin Journal of Medical Science, 1874, v58, p77.]

³ [Dublin Journal of Medical Science, 1874, v58, p77.]

for a week, when a very severe pain in the back compelled her to remain in bed; she got worse, and finally presented herself at the hospital, being attended by two physicians, who told her she had fever before seeking admission.

She had ceased to menstruate for seven months, having previously menstruated every fourteen days. Before admission some discharge came from the vagina, which, from the description given by the friends, seemed to be muco-pus. She had never suffered from jaundice, or complained of pain over the region of the liver. Never had any symptoms of ulcer of the stomach; no history of old diarrhœa. She had always resided in Ireland. Her friends stated that about one year previously her legs had swelled.

On examination, the skin was hot, tongue furred, head-ache, great pain in the back, sickness of stomach, no appetite, a good deal of thirst, cheeks circumscribed red, and face hectic in appearance, with great prostration, and temperature 103°. No eruption was visible. She had angular curvature of the spine in the upper lumbar region, and marks of old contusions. On percussing chest and abdomen negative results were found. No tenderness was felt anywhere except over region of uterus. Her most prominent symptom was an agonizing pain in the vagina, which was so distressing as to concentrate all her attention, and her friends believed she had contracted venereal disease from her husband, and attributed all her illness to this; there was no discharge.

March 3rd.—Morning temperature 102.2°; spent a bad night, seemed dull and stupid; the bowels having been up to this time in a fair condition, she was now attacked with diarrhœa, which lasted for two days, but was not very severe. Matter passed away involuntarily, she lay on her back with her knees drawn up, spoke little for hours, and would suddenly start exclaiming that the bed was on fire, and complaining of the pains in the vagina and back.

March 4th.—Morning temperature 101.9°. Had been very restless during the night; kept in the same position during the day; constantly kicking the bed clothes off; and, at 5 p.m., had a smart shivering fit, which lasted about ten minutes; did not speak. Her eyes were filled with mucous deposit; and now and then muttering delirium showed itself, and her pulse was too slow and full for fever. This last group of symptoms looked so like a cerebral case that the physician in charge pronounced it to be a brain affection. Her menstrual flow commenced; she had menstruated eight days before, being the first time for seven months.

March 5th.—Morning temperature 99.9°; much as usual all day; shivering repeated, but not so severe, lasting only a few minutes; no diarrhœa; no tenderness over the abdomen. Though speechless she was evidently conscious.

March 6th.—Morning temperature 100°, evening tem-

perature 102.4°. She remained as on the previous day, half comatose, till the morning of the 8th, when she died.

TEMPERATURES.

	Morning	Evening
March 2nd,	—	103.0°
„ 3rd,	102.2°	102.8°
„ 4th,	101.9°	—
March 5th,	99.9°	101.8°
„ 6th,	100.0°	102.4°
„ 7th,	—	—

Post-mortem.—No marks on the body; no evidence of suppuration anywhere, old or recent; in pretty fair condition. Head.—Membranes seemed somewhat congested; brain quite healthy. Fluid was found in both ventricles to the extent of one-half drachm; it was red and turbid. On microscopic examination it was found to contain many exudation-corpuscles and blood-cells. The folds of the choroid plexus seemed to be matted together in each cavity. Every part seemed otherwise healthy and free from even congestion. Chest.—Lungs perfectly healthy, structure entire, unusually pale. Heart very small in size but healthy; all the valves normal; vessels quite consistent with health; pleura and pericardium normal. Abdomen.—On opening this cavity everything seemed right, but on putting the fingers under the liver to tilt up its lower border, they went through into a great bag of pus, from which about three pints of thick creamy laudable pus escaped. The floor of the abscess was formed by a membrane composed of the thickened peritoneum and capsule; its roof by the burrowed out interior surface of the right lobe of the organ. When the purulent matter flowed away, the liver substance appeared like a coarse sponge riddled with cells. No membrane lined the greater abscess, nor was any trace of one found in the numerous recesses forming its roof.

On cutting into the organ little of its structure seemed left, it melted down at the gentlest touch, and pus oozed from every incision, except over a space about the size of the clenched fist of the left lobe, which was healthy and about twice as much tissue round this, only a little softened. On the upper surface of the organ the peritoneal covering was much thickened and blended with capsule and pus in quantity bagged between them and the proper liver substance. Gall-bladder was filled up by nine calculi, the largest of which was as big as a pigeon's egg; all weighed nearly half an ounce. Thick yellow pasty bile covered over these, and completely occupied the bladder. Ducts.—No dilatation of the ducts; no trace of ulceration of the mucous membrane of the gall-bladder or ducts. The ducts were followed to their smallest visible termination, and appeared quite healthy. The biliary ducts were patent. Adhesions.—There were no adhesions of the

liver to any of the surrounding parts, not even to the diaphragm. Peritoneum.—In every place clear and glistening, except over the liver, where it was thickened and matted together with the capsule. Stomach.—Apparently quite healthy, no marks. Intestines were removed, from stomach to rectum, and examined, but not slit open; they were healthy, no marks of ulcerations or congestion of the patches of Peyer. The rectum contained a quantity of bright yellow feculent matter. Spleen quite healthy and of fair size. Pancreas normal (rather firm). Kidneys apparently healthy, the right one, lying in fossa on right lower lobe of the liver, over the abscess; was quite sound; its capsule firm, no adhesions; their structure was continuous, and no trace of abscess discernible.

Uterus and Ovaries.—The uterus was congested, its mucous membrane gorged, and a little blood found in its cavity—pointing clearly to death having taken place during a menstrual period. The “os” was patent and admitted the tip of the finger; something like slight ulceration was visible. A polypus hung down from the ceiling of the uterus a little way into its cavity. No purulent matter was visible either in the uterus or vagina, which latter was a little congested, but otherwise quite healthy. In the left ovary was a series of cysts and small abscesses. The peritoneal covering was thick, and a loop of small intestine was bound to it, also some mesentery. In this matting of the intestine and ovary, traces of adventitious old adhesion bands were seen, placing beyond a doubt the long standing of the disease here. On dissecting the intestine carefully off the ovary, pus, or a fluid undistinguishably like it, oozed out from several little openings. The ovary was as large as a hen’s small egg. On cutting, it was seen to contain cysts filled with purulent-looking matter. Right ovary not so much diseased as the left. It contained one large cyst, which dissected cleanly, and contained about zii. of thick, pasty, white material, not unlike pus. This cyst appeared to be the ending of the Fallopian tube. Two or three small spherical bodies, as large as peas, turned out on section of both ovaries. They were firm, made up of laminated white structure, which was pearly and glistening, like spermaceti, and peeled into distinct layers like an onion.

On cutting across the veins on each side of the uterus not a drop of pus was found in them. One large vessel coming from the ovaries was filled with firm coagulum of fibrin. Fallopian tubes presented no unusual appearance, being almost impervious to a fine probe. Urinary bladder, healthy. Pott’s curvature.—The abscess of the liver was found to have no connexion whatever with this. The most careful dissection failed to trace anything here but firm bony ankylosis and normal tissue in every sense of the word. No traces of contusions were visible over the region of the liver, no broken ribs or ecchymosis. The contusions on each side of the spine were faintly seen on admission, and noth-

ing but the patient’s complaining would have caused them to be observed. All the tissues in their neighbourhood were free from disease or congestion.

DR. WALES said that all the symptoms recorded by Surgeon Whitla, and also the temperature, pointed to the disease as being typhoid fever.

Dr. Charles thought that a good deal might be said in favour of the abscess being pyæmic, especially as there were no ulcers in the intestines, or, again, the abscess might be idiopathic. An ulcer in the stomach sometimes caused pyæmic abscess of the liver, or the suppuration in the ovary might occasion blood poisoning; the only objection to the latter view being the absence of abscess in the lungs.

Dr. H. S. Purdon believed that a very common cause of abscess of the liver was ulceration of the bowels, especially in tropical countries (dysentery being the chief disease), and in which absorption takes place from the ulcers in the colon. The older authors held the opposite view, that the ulceration in the intestines was due to the vitiated bile from liver disease, and that the reason the colon was chiefly attacked was owing to the fæces being longer retained there.

Dr. McConnell said that it should be borne in mind that in pyæmia typhoid symptoms are always present.

The PRESIDENT remarked that the specimen struck him as a pyæmic abscess, and he believed that pyæmia could occur without a broken surface. The gall-stones showed that there was some previous hepatic mischief.

The President read a paper on pyæmia.

Ulster Medical Society. The Thirteenth Meeting was held on March 19th 1874.

The President in the chair. Members present Drs. MacCormac, Bolton, Smyth, McMurtry, Spedding, Whitla, Fagan, Charles, H. S. Purdon, J. W. Browne.

Dr. Charles introduced a patient with fracture of humerus.

Dr. MacCormac read a paper on “Strages Medicorum” (or exercise for the heart).

Paper:¹ “Neque imitare malos medicos qui in alienis morbis profitentur tenere se medicinæ scientiam, ipsi se curare non possunt.”—Cicero, Epistolæ ad Familiares.

THE word heart, at least in the English vernacular, has a two-fold signification, one applying to the physical heart through whose instrumentality the blood is constrained to circulate, the other to the moral heart, “the man within the breast,”—briefly, the sum of human feelings, duties, and affections. As the moral heart dwindles and declines by reason of insufficient scope and effort so, I maintain, does the physical.

I am aware of no treatise, ancient or modern, within the range of medical literature, in which, in short, no writer by whom, exercise as such for the heart

¹ [Dublin Journal of Medical Science, 1874, v58, p83.]

has been expressly recommended. And it is only after years of speculation and inquiry, coupled with the opportunities which hospitals and private practice confer, that the extreme, nay, the imperative necessity of exercise for the heart has come to command my most earnest attention.

The occasion, however, which perhaps more than anything else elicited this conclusion was the case of a medical man one, indeed, among many, who was an especial sufferer from the heart's irregular and excessive action with, however, entire absence of actual appreciable structural disease. Reflecting earnestly on the matter during the waking hours of the night, all at once it flashed upon my perceptions that the symptoms adverted to were to be ascribed were, in fact, alone ascribable, to simple inadequacy of the heart's action, owing to, and arising from, the insufficiency of general effort, that effort in which the heart, in common with every organ, is bound to take a part, and live.

I am only too well aware of the striving, anxious existence which so many medical men are required to lead. One's sympathies, in truth, are lacerated when one comes to think of those, the many, who within a comparatively recent period, have been snatched away by a condition vaguely termed "disease of the heart," yet not the less one in only too frequent instances, fatal to physician and patient alike. The number of those so cut off, were people only once made sufficiently aware of it, would indeed startle the least reflecting.

It is a common saying, and here at least one apposite enough, that we often cannot see the wood for the trees. For most true, indeed, it is that persons engaged in a daily routine of given action very frequently fail to discern facts which lie, as it were, at their feet, and before their very eyes. It is hard, in truth, to get out of the rut.

But why, it may be asked, regard being had to functional irregularity of the heart at least, why should we not endeavour to remedy a state of things so disastrous. It is easy to ask. First, if you care to do so, invite a lawyer to revise the code; a divine to change his creed. One will, perhaps, reply that the code is perfect; the other, that his creed is not fallible. But the doctors, why the doctors are mainly like the rest of the community, and do not, in general, care for change or inquiry until, at least, they know the reason why. In short, human nature is conservative, and, for the most part, dislikes nothing so much as novelty.

It might be imagined that the heart, in incessant, or nearly incessant action, as it is at all times, was exercised abundantly. But it is really far otherwise, for the ordinary cardiac action is virtually a passive one, needs, in fact, to be supplemented. Increased periodic effort, in reality, is needful, in order effectively to promote the circulation and æration of the blood. It is also further requisite, in respect of the integrity of the heart's action itself, requisite, in short, to prevent this

all important viscus from sinking into languor and relative inaction, as well as to equip it for any sudden encounter or unwonted demand upon its energies. Now, if not entirely unaware, we are too often, at least, almost entirely heedless as to the really pressing necessity there is for vigorous supplemental effort in aid of the ordinarily still and, as contrasted with its requirements, over passive life of the heart.

The malady, then, to which I would here desire especially to advert, if indeed malady it may be termed where structural change is not necessarily present is one, nevertheless, productive of much distress, and very often real danger. Fatty heart, weak heart, feeble heart, flaccid heart, conditions more or less concurrent, name them as you will, conditions attendant on our civilization, so esteemed, do not, however, much trouble navvies, sailors before the mast, common soldiers, or labourers afield. The derangement, as I have said, is for the most part functional, and yet is productive of greater suffering and potential risk than what in many cases attend actual structural cardiac disease itself. In a word, the action of the heart has become enfeebled, its action is no longer normal, but has become shabby and degenerate instead. Women, it is true, at least speaking of more dangerous extremes, are far from being exempt, but the causes or, at least, some of the causes, which conduct to weak heart are, on the whole, less common among them than among men. In any case, whatever may be alleged in respect of the relative liability of the sexes, I have no hesitation in affirming that too long sustained mental effort, coupled with insufficient bodily effort, and, therefore, insufficient heart's action, and inordinate personal indulgence, taken altogether, suffices fully to explain the greatly increased frequency of destructive functional cardiac insufficiency.

The literary classes, lawyers, clergymen, teachers, and others, are very far indeed from being exempt, but medical men, I have arrived at the conclusion, prove especial sufferers, to such an extent, indeed, as fully, I conceive, to justify the heading which I have selected. For a time, and so long as he remains young and active, trudging about on foot, and obliged to rough it a good deal, the "doctor" gets on well. The heart, like the rest of the economy, is constrained to exert itself, has no time, in short, to relax, and become fat and flabby. By-and-bye, however, the doctor gets into request, is borne about on wheels in his all too comfortably cushioned box, consumes highly azotised fare, drinks a generous glass of wine, but otherwise does no work, at least such work as nature requires and as a medical man, himself a victim, recently wrote to me, "comes to suffer for his sins of omission and commission accordingly."

It is, in fact, impossible, under such circumstances, that the heart should escape. This so important organ, failing adequate muscular effort, like the rest of the body, grows fatty, flabby, faint, and weak, until some

day, a greater strain being laid upon its energies than usual, nay, perhaps without any strain at all, it gives up work for ever. Possibly, nay, probably, there was no structural, at least no serious structural change whatever, no regurgitation, no aortic or mitral insufficiency, but, coddled and cockered to excess, the heart pretermitted effort, simply because it was no longer equal to effort. In strictness there was not much to do, but that much it had become unable to perform. Insufficient general action then leads to insufficient cardiac action, and insufficient cardiac action, in its turn and, in the long run, leads to death.

The especial case, one however out of many, already adverted to was that of a physician, who had been engaged in a treatise involving laborious inquiry and protracted research. He rose early, in fact at four in the morn, in order, as he hoped and believed, to gain time, and not to trench upon the daily routine of his professional duties, arranging notes, consulting a multitude of authors for long hours together, and that without partaking of food or refreshment of any kind. Locomotion in the way of his business was performed in a carriage or on horseback. As for foot exercise or other protracted bodily effort, there was little or none of it. The result, after this regimen had been pursued for some time, was the production and progressive increase of faltering in the heart's action. It was not, indeed, severe or distressing at first, but eventually it became both, until at last the anguish proved such as perforce to constrain a complete, or all but complete, abstention from all desk work. There then ensued a partial amendment, but on resuming literary effort the symptoms, as described, recurred, with fresh aggravation and increased persistence. In the street or on the highway, whether walking or riding, they often sufficed to bring the sufferer to a complete standstill, occasionally even the nights were passed without sleep, spent, indeed, in pacing up and down the apartment, or sitting on the bedside until it was time, so far as might be, to resume the business of the day. On one occasion there was a risk of drowning, the heart's action having become so irregular and distressing, while bathing in deep water, as to render it no longer possible to swim. Happily, the sufferer could float, and with the water awash with his face, he drifted with the tide towards the open sea, until his companions, wakening up at length to some dim perception of danger, put off in a boat, and enabled him to return.

Life, in fact, had grown burthensome, and the patient, doctor though he was, no longer knew exactly what to do. At last a little light became visible amid the darkness, and the first result of this new insight was to discontinue literary work, at least for the nonce, entirely. Relinquishing riding and driving as exclusive modes of conveyance, lengthy walks were taken, the lofty hills were clomb, the sea-shore was frequented, and daily recourse was had to the oar, the dumbbell, the

club, and other moderate gymnastic efforts. The sufferer, when in the country, would also descend from the saddle or the driving seat, and run a mile or a couple of miles at a stretch, as the horse trotted slowly along. In other respects, the appetite was left sharpset; the breakfast, however, was abundant, but the dinner was invariably sparing. At first, indeed, all this proved a little difficult, but by degrees nature accommodated herself to every restriction as persevered in, not only for months, but for years. The once so persistent and sadly worrying cardiac irregularity gradually, but completely, ceased, yielding place to a prolonged, and, it is believed and hoped, a lasting immunity. Late or early the labours of the desk are now pursued without a colour of inconvenience. No day, however, is permitted to pass without its complement of bodily effort, and, as for the food restrictions, they have long become habitual. In a word, a most distressing, not to say dangerous, infliction has disappeared, and the whilom sufferer, although no longer what would be esteemed young, goes through an amount of bodily and mental effort not very usual at any period of life.

The weak, the fatty, and the flabby heart, one condition or all, is, indeed, the especial malady of indolent persons. I speak of bodily indolence, in persons of easy circumstances and, commonly at least, it does not assail the hardworking, the abstinent, and the poor. Members of the medical profession, as already stated, so far at least as my observation extends, are peculiar victims. Many, alas, too many, are they beside whose couch I have sat who perished of it, while others there are who, to my cognizance, now labour under it. Writers on diseases of the heart are full of details of structural cardiac disease, while this so serious, because destructive, affection is left, I speak of weak and fatty heart, I do not say entirely, but comparatively, unheeded. One, for example, shall carefully examine a given heart, and discover no aortic or mitral insufficiency, no buzz, no bruit, nothing at least from a stethoscopic point of view, calculated to awaken serious solicitude, and yet the possessor of this heart peradventure shall perish suddenly. Exercise for the heart, setting forth its absolute indispensability, is the heading of no essay, the title of no book, at least as known to me; nevertheless, there is no subject whatever more deserving of careful consideration and attention. In respect of the treatment, I desire to be explicit. Every species of guarded prolonged muscular effort, as digging, hoeing, rowing, reaping, felling, chopping, ploughing, is useful, but, to those who labour under functional heart affection, walking, though not to excess, not too fast and not unduly far, over hilly unequal surfaces, swinging the arms, unembarrassed by bond or stay, in the open air, is the best of any. An hour before breakfast and an hour before dinner, one or both, are the preferable periods of the day. Exercise develops and strengthens the cardiac muscular fibres, ærates the blood, at the same time fat

is sparingly developed, and, coupled otherwise with cautious and abstinent habits, the heart's action becomes reliably even and, without defaillance, equal to all life's proper exigencies.

By this thoughtful, sparing, and cautious regimen, enough of everything and yet not too much, ne quid nimis, the heart no longer saddled, swaddled with useless fat, flabby or feeble, will be found, amid all the varying requirements of this complex, often trying existence, to discharge to admiration its daily allotted task. Living too fast, indeed, as some are fond of saying—why, we cannot live too fast, provided only we live nobly and well. An hour, or I shall say two hours, out of the twenty-four, is not too much, is it, to devote to open air life and effort, in order to promote the healthy action of the most vitally essential integer of our wondrous organism, the heart. Yes, indeed, he, qui ipsi sibi sapiens prodesse non quit, nequidquam sapit.¹

Robert Dill, Chairman

Case published under the title “Transactions of the Ulster Medical Society” in the Dublin Journal of Medical Science, 1874, v58, p73.

March 1874

Paper:² Dr. M'Crea exhibited a cigar-shaped calculus, which had been extruded from the bladder of a female. The calculus was originally about an inch and a half long, and three-eighths of an inch in diameter at its thickest part.

The woman had declined to submit to the removal of the calculus. One day she could not “pass water,” for which she took gin in repeated doses for two days. At last the force generated dislodged the stone from her urethra. It broke in falling, but the principal portion is one inch long.

She had invented the new operation of hydrostatic extrusion.

Fourteenth Meeting was held upon the 2nd April 1874.

Present, Dr. Dill, J. Fagan, J. J. Charles, J. W. Browne, Dr. Rankin.

Dr. J. W. Browne read notes of a case of puerperal convulsions.

Paper:³ DR. WALTON BROWNE brought under the notice of the Society a case of puerperal convulsions that had occurred in his dispensary practice. He believed that the point of interest in the case was that the convulsions, which were more than ordinarily severe, ceased immediately after puncturing the membranes, and allowing the liquor amnii to escape. He had tried various remedies, but they were unsuccessful.

PROFESSOR DILL remarked that bleeding in convulsions

had been too much set aside of late years, not only in this affection, but in other diseases. He thought that convulsions were due to one of the following conditions—1. Hyperæmia; 2. Anæmia; 3. Toxæmia. When the os uteri was rigid, bleeding should be resorted to. Braun, of Vienna, recommends benzoic acid and counter-irritation over the kidneys.

Dr. Fagan thought that the urine should have been examined in the early stage.

SURGEON RANKIN said that treatment directed to the kidneys in the early stage, in the case under notice, would not have been of any service.

DR. CHARLES stated that benzoic acid is converted into hippuric acid, which acts as a diuretic.

Dr. James Moore exhibited a fatty tumour which he had removed from the back of a man aged 45 years.

Also a scirrhous removed from the mammary gland of a man aged 74 years.

James Murray

Ulster Medical Society.

The President in the chair. Present Drs. Cuming, Purdon, William Browne, McCrea, Dill, McKeown.

The President proposed J. K. Houston M.D. as a member of the Society.

Ulster Medical Society. The Concluding Meeting of the present session was held on April 30th.

The President in the chair. Members present Drs. Fagan, H. S. Purdon, Charles, Rankin, D. Johnston.

John Knox Houston M.D. was balloted for [and] unanimously elected a member of the Society.

Surgeon Rankin gave the notes of a case of paralysis agitans treated by hypodermic arsenic.

Paper:¹ SURGEON RANKIN brought under the notice of the Society a case of paralysis agitans, occurring in a man aged seventy-two, by occupation a carpenter, and which disease he had treated by the hypodermic injection of arsenic. The patient, he said, first came under his care for bronchitis, he then complained of great and increasing tremor in both hands and arms. This lasted for some time. He could not even lift a cup of water to his mouth. Tonics were tried, which improved the general health, but had no effect on the shaking. About this time Mr. Rankin saw a notice in the Dublin Medical Journal regarding the hypodermic injection of arsenic in similar cases, and it occurred to him to give that remedy a trial. He made a solution of equal parts of water and the liquor arsenicalis, of which he injected subcutaneously into the neck 5 minims every second day, to commence with. After the third injection the patient was able to lift a tumblerful of water to his mouth, and could close both his hands without tremor. He complained after the second injection of tenderness

¹ Cicero, Epistolæ, lib. viii.

² [Dublin Journal of Medical Science, 1874, v58, p77.]

³ [Dublin Journal of Medical Science, 1874, v58, p81.]

¹ [Dublin Journal of Medical Science, 1874, v58, p82.]

of the conjunctiva of both eyes, showing that the arsenic was beginning rapidly to take effect. He can now (April) work at his employment. Whether the improvement will remain permanent or not it is difficult at present to say.

Dr. Charles asked what advantage the hypodermic injection of arsenic had over giving the medicine by the mouth.

DR. H. S. PURDON said that one objection he had to the hypodermic injection of arsenic (which he had tried in psoriasis) was, that it was apt to occasion little superficial abscesses; however, the remedy seemed to act more rapidly when administered subcutaneously. As for it (the Fowler's solution) not disordering the stomach when so given, he believed that if the compound spirit of lavender was left out in its preparation, and ordinary care used in its administration, derangement of the stomach was seldom likely to occur when the remedy was given by the mouth. For neuralgia and tremor, the hypodermic injection of caffeine had succeeded well.

Dr. Fagan introduced a patient with a rare affection of shoulder joint.

Dr. Charles read notes of a case of intussusception.

Case published under the title "Transactions of the Ulster Medical Society" in the Dublin Journal of Medical Science, 1874, v58, p73.

April 1874

Pruritus Vulvæ—DR. H. S. Purdon called attention to the disease known as pruritus vulvæ, or prurigo pudendalis. It was frequently due to irritation arising from uterine or bladder ailments. Sometimes ascarides in the rectum, especially in children, travelled into the vagina, causing the disease; and in such cases the irritation they produced often led to masturbation. Diabetes was another cause, the saccharine urine producing a fungoid growth, shewn by aphthæ, due to the presence of the fungus, the *oidium albicans*—the same growth that caused "thrush" in the mouth. In such cases sulphurous acid lotion, carbolic acid, and glycerin, or even borax, were useful. The tearing of the parts by the patient caused excoriations and an eczematous eruption, which had to be treated by nitrate of silver and astringents. Females were said to have miscarried from this form of pruritus. Pruritus of the anus was often associated with pruritus of the vulva, due to the same cause, viz., parasitic growths; the fact that both situations are naturally moist favours a vegetable growth.

Ulster Medical Society

Annual Meeting, November 4, 1874

Present, Dr. John Moore (President) in the chair, Drs. Stewart, McCrea, H. M. Johnston, H. S. Purdon, Fagan,

James Moore, J. W. Browne, Core, Spedding, and Charles.

Minutes of last Annual Meeting read and confirmed.

The President read the Annual Report of Council, when it was moved by Dr. Stewart and seconded by Dr. H. S. Purdon "That the report now read be adopted". (Carried.) The Office Bearers for the ensuing session were then selected.

President

Dr. Charles D. Purdon

Vice presidents

Dr. Stewart and H. S. Purdon

Council

Drs. McCrea, J. W. Browne, Spedding,
H. M. Johnson, Murney and Core

Hon. Treasurer

Dr. Fagan

Hon. Secretary

Dr. J. J. Charles

Dr. Stuart moved "That the best thanks of the meeting be given to Dr. Fagan, Treasurer, and to Dr. H. S. Purdon, Secretary, for their valuable services during the past session". Dr. Charles seconded the motion, which was carried unanimously.

The Treasurer's report having been read, Drs. Whitaker and Spedding were appointed Auditors.

Dr. James Moore having been called to the chair, it was moved by Dr. Stewart and seconded by Dr. Spedding "That Dr. John Moore, the retiring President, deserves the most cordial thanks of the Society for the efficient manner in which he discharged the duties of his office". (Passed by acclamation.)

REPORT OF COUNCIL

The Council in presenting to the Society their report for the past year regret to state that the attendance of members has to some extent fallen off, though in their opinion the papers read, the cases described, and the morbid specimens exhibited, were not of a less interesting character than those of preceding occasions.

The Society has to regret the loss, during the past year, of one of its oldest, most respected, and most influential members—Dr. William McGee, J.P. He was formerly President of the Society and Mayor of Belfast. From the high position he held in his profession as well as from his social standing among his fellow townsmen, he exerted a great influence on questions of sanitary science and others affecting the medical profession. He was beloved and respected by a wide circle of friends, and was followed to the grave by a large number of his professional brethren.

During the past session seven new members joined the society; and eighteen meetings were held, the average attendance at which was $7\frac{1}{2}$.

There were ten meetings of Council, and the atten-

dances of members was as follows:—Dr. John Moore 10; Dr. Stewart 7; Dr. Charles 7; Dr. H. S. Purdon 6; Dr. Fagan 5; Dr. Spedding 4; Dr. McCrea 3; Dr. Smith 1; Dr. Murney 1; Dr. McKeown 1; Dr. H. M. Johnston 1; and Dr. J. W. T. Smyth 0.

The Transactions of the Society were published in the *Dublin Monthly Journal of Medical Science*, and have since been reprinted and distributed among the members.

During the meeting of the British Association in Belfast, the members of the Association belonging to the medical profession were invited to a breakfast held in Thompson's Rooms, Donegall Place.

The visitors were:—Dr. William Carpenter, of London; Professor W. Wilde, of Dublin; Sir Duncan Gibb and Drs. Wood and Hare, of London; Professor Gluge, of Brussels; Dr. Michael Foster, of Cambridge; Dr. Cleland, of Galway; Professor Macalister, of Dublin; Dr. Muirhead, of Glasgow; Drs. Pye-Smith and Thomas C. Charles, of London; Dr. Caton, of Liverpool; Dr. Stewart, of Dublin; Dr. Corfield, of London; Professor Redfern and Dr. Thomas H. Purdon, of Belfast; Dr. O'Dwyer, of the 13th Regiment; Dr. Ashe, of Derry; and Dr. Grimshaw, of Dublin.

Thirty members of the Society were present:—Dr. John Moore, in the chair, Drs. C. D. Purdon, Dill, Seaton Reid, Ferguson, Henry MacCormac, Fagan, McCrea, McKeown, McConnell, H. S. Purdon, Brice Smyth, Cuming, Spedding.

After breakfast, claret and champagne were served. The President then proposed "The Queen" a toast which was heartily responded to. "The British Association and its Medical Members" was then drunk; it was responded to by Sir W. Wilde, Dr. Michael Foster, and Dr. Carpenter. "The Queen's University" was the next toast: Professors Cleland and Redfern responded. "Our Foreign Visitors" was proposed by Professor Cuming and responded to by Professor Gluge. "The Ulster Medical Society" was proposed by Dr. Carpenter and responded to by the President.

John Moore, Chairman.

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Session 1874–1875
President Charles Nicholas Delacherois Purdon

ULSTER MEDICAL SOCIETY

SESSION 1874–75

**Ulster Medical Society. First Meeting
November 10, 1874**

Present, Dr. Charles D. Purdon (President) in the chair, Drs. Murney, Stewart, James Moore, John Moore, McCrea, McKeown, Bolton, Ball, Spedding, F. Beck, and J. J. Charles. Dr. Moss was introduced as a visitor by Dr. Stewart.

The President postponed the delivery of his opening address to the next meeting.

Dr. Murney exhibited a man on whose shoulder he had made several skin grafts, and he promised to give the members an opportunity of seeing the case again at a further stage of its progress.

W. Whitla, L.R.C.S. Ed. exhibited a large multi-locular cystic tumour of the ovary taken after death from a patient in hospital, and give full details of the history of the case.

Dr. James Moore then exhibited and give a brief account of a malignant tumour which he had removed from the thigh of a woman aged 62 years.

C. D. Purdon, Chairman
December 3, 1874

**Ulster Medical Society. Second Meeting
December 9, 1874**

Present, Dr. C. D. Purdon (President) in the chair, Drs. John Moore, Stewart, Fagan, J. W. Browne, Houston, Beck, H. M. Johnston, Spedding, Rankin, Whitla, and J. J. Charles.

The President delivered the opening address of the session on “The past medical charities of Belfast as compared with the present”.

Paper.¹ *Gentlemen, I thank you for the office to which you have elected me, as in so doing you have shown your desire to renew your acquaintance with old practitioners; and as one of that class, occupying the position I now hold, and standing in the place in which we are assembled, I cannot help taking a retrospective view of what has passed during my years of school, study, and practice here.*

The contemplation of these circumstances has so impressed me with the great changes that have taken place in this town amongst the medical practitioners and charities during the last fifty years, that I hope you

will not consider the time misspent if I bring before you this evening the medical charities that have existed here, and some of the eminent men who gave their time and services to benefit the inmates, and contrast them with the modern ones and the eminent practitioners of the present day.

When Belfast was a mere village in comparison with its present size—its inhabitants numbering some 17,000—there existed but very few charitable institutions, and also very few medical men; but they, though small in number, were remarkable for talent and philanthropy, as it was mainly owing to their exertions that this hospital owes its existence.

Need I mention the name of one of its founders, who, though, departed nearly fifty years, still lives in the memory of many of the seniors among you as a bright ornament of the profession—a man who, though commencing practice late in life, through the power of his intellect and energy of his character, soon rose to the highest eminence? This was Dr. Stephenson, sen., who at the beginning of his career was a Presbyterian clergyman, officiating in the Ards, but on account of theological disputes with the Synod, resigned his charge; and, notwithstanding that he was in middle life, commenced the study of medicine in Scotland, where he took his degree, then settled here, and was soon extensively engaged in practice, succeeding Dr. Halliday, sen., who was then retiring from active business.

Dr. Stephenson, being very benevolent, attended the poor in conjunction with the late Dr. M'Donnell, and in 1792 a dispensary was established, which relieved the Belfast Charitable Society and Infirmary from any further expenditure in the external department. In the year 1797, seeing that fever was being imported from Portpatrick, he was foremost in advocating a fever hospital, which was at once established according to his plan in conjunction with the dispensary, premises being taken in Berry-street, where, in the first six months, he attended seventy-three patients, and was so skilful in his treatment of fever that of the first sixty patients admitted not one died, and out of the seventy-three only three died.

These prompt measures having caused the fever to abate, the hospital was closed, and no institution of the kind existed until 1799, when a fever hospital and dispensary were established in West-street, where the poor received gratuitous advice. Dr. Stephenson was also one of the first physicians attached to the General Hospital when it was removed to this place. He continued to practise until advanced age compelled him to relinquish his profession, and died at a ripe age—over ninety years. He was always well known by his appearance and dress, as he was rather high in the shoulders, and always wore knee breeches and black stockings, white tie, &c., which was the usual dress of medical men at that time. He was brusque in manner, but uni-

¹ [The Irish Builder, 1875, v17, 1 January, p10. The Editor said “The address, though dealing with the subject of Medical Charities, furnishes many interesting items connected with the lives of popular professional men of historic note as also with the erection of buildings, with which the names of some of our eminent architects of the past are associated... For these reasons, and for others of a sanitary nature, we think the address, as a whole, will not be out of place in the pages of this journal.”]

formly kind to all who excited his sympathy. He died as he had lived, an honour to the profession, and was succeeded in his practice by his son, the late Dr. R. Stephenson, of whom we may say that his entire public life was devoted to upholding the dignity of the profession; and in him we found not only a kind friend as well as a skilful adviser, but also a fine advocate, and all of us who knew him had often reason to be glad that there was a Robert Stephenson.

The next eminent person attached to this institution was Dr. M'Donnell, who was also active in the foundation of this charity, and enjoyed an extensive practice amongst the higher classes. He was a learned and deeply-read practitioner, with a philosophical and inquiring turn of mind, often risking his life in the search for information. He, too, has passed away, after attaining an advanced age. In his appearance he was somewhat remarkable, clothed in drab-coloured knee-breeches and white stockings, white tie, &c., driving in an old gig hung on "C" springs, reading a book by the aid of a magnifying glass which he held in his hand, with his well-known servant, Mick, beside him. He used to boast that he never carried an umbrella, and exposed himself to all weather.

The next I have to mention belonging to this staff is Dr. S. S. Thompson, justly celebrated as a skilful and accomplished physician, who added to his medical pursuits the pleasing study of music, and so skilled was he in it that he was elected permanent president of the Anacreontic Society, a friend, and almost father, to many among us who are now the seniors of the profession. He was also found ready to assist in difficulty, professional or otherwise, and his conduct through life, both to his brethren and the public, was ever in accord with the motto on his coat of arms—"Honesty is the best policy." He, too, has passed away, leaving affectionate recollections of his worth.

Another talented physician attached to this hospital was A. G. Malcolm, whose whole mind was given to the study of his profession; but just as he was beginning to attain an eminence, which foreshadowed a distinguished future, such as he well deserved both by his contributions to the literature of his Profession and his skill in healing disease, he was cut off; but, though dead, he speaketh to the pupils of this institution in the exhibition which has been founded, and which bears his name. I forbear to mention the names of other medical men who have acted as physicians to Belfast charities, as we still enjoy the pleasure of their society, and the advantage of their skill, and I hope that we as practitioners, and the public as patients, may long continue in possession of that society and skill.

I will now draw your attention to another class of practitioners attached to local charities, the first of whom I will mention is one long since passed away, and the record of his talents and experience has been but dimly preserved and handed down—I mean Dr. Hal-

liday, sen., formerly an eminent medical man here, whose advice was sought in all quarters by rich and poor, high and low. He first came to Belfast as surgeon to the Cameronian Regiment, and his skill was so soon acknowledged that he left the army and settled here, becoming the consultant of the entire county, and was in such demand that he was able to fix his own remuneration of one guinea per mile. Of him it is said that he always attended a consultation in court dress, by way of sustaining the dignity of the profession, I suppose; but being too often called in only when the case had become hopeless, he used frequently to express his opinion of this neglect in his quaint way by saying, "I am like a huntsman, always in at the death."

He was succeeded in practice by Dr. Stephenson, sen., and his son, who, however, did not continue many years in the profession, being early confined to the house by disease. The next in order is Surgeon Comins, who practised in this town, besides holding the post of Deputy-Inspector General of the Forces, and, if my memory serves me rightly, he was also surgeon to the infirmary of the Belfast Charitable Society. He was the first in Belfast who performed an amputation of both legs at the same time, which was thought so extraordinary an operation as to be published far and wide in the newspapers. The sequel to the operation, consisting of the death of the patient, was, however, not noticed. It is said of him that, being of a money-making turn of mind, he kept a flock of ducks at the military hospital, which were fed on the poultices after the patients had quite done with them. These ducks he used to send to the market, but the public having discovered that something was rotten in the state of Denmark (or rather in the state of the ducks), the secret of their diet leaked out, and thenceforward as long as the doctor remained here, ducks were as a drug in the market.

Dr. Drennan also was one of the first attendants of the Belfast Charitable Society. He practised here for some time, and rose to eminence. A great deal of his time was devoted to this society, and I may mention that it was he who introduced inoculation in the north of Ireland. He was of retiring habits, an elegant scholar and poet, and the record of his professional attainments and work may be found in the transactions of this noble institution.

I will now turn to one who, being everything to me, it will, I trust, prove an apology for bringing him under your notice this evening. Of him I will only say that his abilities and character were recognised and appreciated by all who knew him. I need hardly mention the name of Henry Purdon, sen., formerly one of the first surgeons of this place. He came here as staff-surgeon, having charge of the military hospital. As he had great experience in foreign service, he soon became distinguished as a skilful operator, and was for a long time one of the surgeons at this hospital, as also to the Belfast Charitable Society. During his professional

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career he was invariably the friend and adviser of his brethren, and, though he has long passed away, his place is supplied by his son, Dr. Purdon, once the surgeon of this institution, as well as the colleague of some who are still engaged within its walls; and now the father of the profession in the town.

Another celebrated man was Staff-Surgeon Forcade, who for a long time gave his services to the poor in this town. His skill in operating and in treating those under his care was well known and acknowledged by all. He, too, has passed away, and left but kindly recollections to those who knew and esteemed him. Another pillar of the profession was the late Surgeon D. Moore, who, after being employed in the Royal Navy during the war with Napoleon, settled in Belfast when peace was proclaimed, and gave the benefit of his great experience to the patients of this hospital as surgeon, to which he continued until advancing years caused him to resign his place to his son, Dr. James Moore, who combines in his person the skill of the surgeon with the talent of the painter; all he lacks is the taste of the poet. There is but one more of the many eminent men who were associated with this charity whom I will mention (for to speak of all as they deserve would occupy more time than we have at command), and that is the late Dr. J. M. Saunders, who was cut off in the prime of life, just as he was rising to great eminence in his profession, leaving a void in this place which it took a long time to fill; and still our remembrance of his thoughtful care of the sick, and his tenderness in treating and skill in prescribing and operating throw a halo around the memory of James Saunders. But having had enough of those gentlemen who gave their skill for the use of these institutions and the advancement of science, I will now speak of the institutions themselves.

In the middle of the last century, Belfast, through the intelligence and energy of its merchants, who laid the foundation of its present prosperity, began to be of commercial importance, which naturally attracted numbers of labouring classes as well as vagrants from all parts of the North, and these became so numerous as to demand the attention of the leading inhabitants of the town and adjoining country, a meeting of which gentlemen, consequently, was held in the "George" on the 20th day of August, 1752, to consider the question of building a poorhouse, hospital, and church, the necessity for which is shown by the following resolution, passed at a subsequent meeting:—"Resolved that, whereas a poorhouse and hospital are greatly wanted in Belfast, for the support of vast numbers of real objects of charity in this parish, for the employment of idle beggars who crowd to it from all parts of the North, and for the reception of infirm and diseased poor; and whereas the church of Belfast is old and ruinous, and not large enough to accommodate the parishioners, and to re-build and enlarge the same would be an expense grievous and unsupportable by the ordinary method of

public cesses. Now, in order to raise a sum of money to carry these good works into execution, the following scheme has been approved of by the principal inhabitants of said town and gentlemen of fortune in the neighbourhood who are friends to promote so laudable an undertaking."

This scheme was a lottery, by which they were to raise a certain sum of money, the tickets to be sold in the principal cities and towns of the empire; but as the scheme did not receive much encouragement in London, and the tickets were cried down, the committee sent over to London Messrs. Gregg and Getty, with the power of an attorney, "to promote the execution of the scheme and at the same time arrangements were made for obtaining subscriptions, that by their assistance the lottery might be carried out; and, in order to restore public confidence in the scheme, the following advertisement was inserted in the papers:—"Whereas it hath been maliciously reported that the Belfast charitable scheme was to be given up, the managers think proper to give this public notice that the same is without grounds, and that they have taken proper measures to carry the said scheme into effect." Notwithstanding this advertisement, the scheme was still decried in London, and legal proceedings had to be taken against purchasers to make them pay for their tickets.

At last a sum of money having been obtained, a committee was appointed for the purpose of drawing up a memorial for presentation to Lord Donegall, asking him to grant a piece of ground to the society. He having acceded to this request, plans were invited from parties in England and Scotland as well as Ireland, stating to them the sum to be laid out on the building for poorhouse and hospital as £3,000, which sum was found sufficient, as the inhabitants of the country round about furnished stone, sand, lime, and water gratis. The plans having been received, were exhibited in the market-house for the inspection of the gentlemen in charge of the undertaking and inhabitants. After considerable discussion, three of the plans were selected, and sent to Dublin to Mr. Cooley, who was to improve on them. Finally Mr. Cooley's plans were adopted for a poorhouse to accommodate 36 inmates, and an hospital to contain 24 beds.

The foundation-stone was laid on the 7th August, 1771 ("a day memorable for many glorious events in the history of this nation"), and five guineas were enclosed in it. The buildings, when finished, had, in addition to the hospital and poorhouse, assembly-rooms for the use of the townspeople and profit of the charity. About the 17th September, 1774, the hospital was opened for the admission of the sick, who were admitted from the several districts into which the town was divided. Foreigners also were admitted into the infirmary "on the consideration that they pay for their support and medicine." The physicians and surgeons, being asked if they would be pleased to attend such for-

eigners gratis, made reply, "As we have already contributed by subscription to your charitable institutions, and offered gratuitously our attendance on the indigent sick of the town and parish of Belfast, we cannot at present undertake to enter into foreign engagements, the extent of which might involve us in a business very different from that which we intended when our services were offered to your society."

In addition to receiving the sick into the infirmary, an extern department was established, at which a physician and surgeon attended each Tuesday and Saturday, for the purpose of giving advice and assistance to such persons as came within the rules of the society. Wards were also allotted for the treatment of lunatics; and we find, from an entry in the committee-book, that one of the lunatics was to be handcuffed and chained by the leg. The physician and surgeon attended by rotation three months at a time. Drs. Stephenson, Ferguson, Halliday sen., Apaley, Halliday jun., Drennan, and Bankhead; Messrs. Campbell, Bowen, Comyns, M'Clurney, Marshall, Purdon, White, M'Clelland, Anderson, Gelston, and Montgomery, were some of the first attendants of this noble institution.

I may here mention that in this establishment were made the first trials of inoculation and vaccination in the North of Ireland, as may be seen by the following resolution, passed by the committee on 4th May, 1782:—"Resolved unanimously, that the thanks of this committee be given to Dr. Drennan for his introduction of the plan of inoculation, which has been adopted by the society, and that Mr. Bristow be requested to notify to the public the adoption of the plan." The plan was considered of such value that on the 1st June, 1782, we find the committee passing this resolution:—"Resolved, that thanks be returned to Dr. Drennan in the public papers for the scheme of inoculation introduced by him into the house, and that Mr. Crombie do wait on him and acquaint him with the resolution; and that he send it to the papers, provided the doctor doth not oppose it." Vaccination was tried by Dr. Halliday jun., as the entry in the committee-book, 29th of March, 1800, attests:—"Dr. Halliday jun. attended, and proposed that the children of the house, or as many of them as had not the small-pox, may be inoculated for the cow-pox, upon the assurance that it is not infectious; that it is an easier disorder than the small-pox, as certified by a number of most respectable physicians in England. Resolved, that the experiment be tried on a few of the children in the house, provided that the parents of the children freely consent thereto."

For many years this society continued the only charity in the town; but gradually other institutions became established, which relieved its expenditure and enabled the committee to restrict their admissions to the poor and diseased; and within the last few years, through the munificence of the late John Charters and Edward Benn, new wings have been built for the

accommodation of children and the sick, and at present there exist four commodious wards for adults and two for children, containing upwards of forty beds for patients labouring under chronic diseases. These are under the care of Dr. Ferguson and myself.

The dispensary was established in 1792, thereby enabling the Belfast Charitable Society to close its extern department, as by its means the poor were attended at their own residences. It rapidly became popular, and in the first four years and four months 2,406 patients received advice and assistance; it has been developed by the Poor Laws into two extensive dispensaries, attended by seven medical gentlemen.

The fever hospital, as before stated, was first established in Berry-street, being attached to the dispensary, with which it continued to be associated for years, and proved most effectual in checking the epidemic at that time raging in Belfast, on the abatement of which fever it was closed; and no hospital for infectious diseases existed until 1799, when it was re-opened in West-street, in charge of two physicians (increased in June, 1819, to three), two consulting physicians, two surgeons, and an apothecary.

Finally, on the 18th August, 1817, the hospital was removed to the present building in Frederick-street, when four physicians and four surgeons were appointed to attend regularly. Of late years it has been enlarged by the liberal donations of the late John Charters and Sinclair K. Mulholland, who have built two large wings; so that now it may be said to rank foremost among the charities not only of Belfast, but of the North of Ireland.

The Lying-in Hospital was opened in 1794, and supported by subscriptions from ladies in the town and county. About forty-live years ago it was removed from its original site in Donegall-street to its present position. Its attendants are too well known and remembered to require any mention on my part. However, I may say that it is at present in charge of Drs. Smith and Burden, the latter of whom has retired from active practice to enjoy the rest so well earned by his attention to suffering humanity.

The Chapel-lane Dispensary was opened in 1827, for treating especially diseases of the eye, and, through the talent and exertions of its two medical attendants, became thronged with patients. It was at last closed, after continuing several years, soon to be succeeded by a similar institution, which continues to the present day.

These that I have mentioned were the medical charities which existed when Belfast was but small in comparison with its present importance. As population increased, charitable institutions sprang up, gaining for Belfast a reputation for benevolence which extends over the entire kingdom. The first in order of these more modern institutions is the asylum for the treatment of the insane, established in 1829, and at present

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under the care of a gentleman whose reputation is more than European, Dr. Henry MacCormac, consulting physician to the asylum, who is most ably assisted by the resident medical officer. Dr. Stewart, considered one of the first physicians in Ireland for ministering to a mind diseased.

Next comes the Ophthalmic Hospital, built by the benevolence of a lady whose name is enshrined in the records of almost every local charity; and I am sure when I mention Lady Johnson you will all join in the wish that she may long live to witness the good results that spring from her philanthropy. This hospital is under the care of the Drs. Browne, who are well known to you all.

Another institution which has grown to colossal proportions is the hospital for infectious and contagious diseases, adjoining the Union Workhouse, and under the Poor Law management, the principal medical officer of which, Dr. J. S. Reid, is so well known and appreciated that he requires from me nothing further than the mention of his name.

An hospital for cutaneous diseases, established in 1864 as a dispensary, is now, through the donations of the late Edward Benn, about to be removed from its present site to a new and handsome building in Glenravel-street, beside another institution founded by the same large-hearted man, the Ulster Hospital for Diseases of the Eye, Ear, and Throat; these two are respectively attended by Dr. H. S. Purdon and Dr. McKeown.

Still another hospital, founded by Mr. Benn, is the Samaritan, for diseases of women and children. It is under the care of Dr. M'Mordie; in addition to which we have two other hospitals for children, which are, through their attendants, contributing much to alleviate the suffering of the young; and, finally, there is just now established, through the benevolence of the late Samuel Martin, an hospital for children labouring under chronic diseases. It is built in a healthy locality near Belfast, on ground purchased by him, and given, with the building, to the committee of the Belfast General Hospital.

Having now mentioned the old and new medical charities of Belfast—all of which are, under the judicious care of their several attendants, labouring to check disease, relieve suffering, and promote health,—it only remains for me to conclude my brief sketch of their history with the hope that the gentlemen who gave their time and skill to them may attain the position and reward their merit deserves, and continue to enjoy the respect and affection of the public when he who now addresses you has in his turn passed away.

Dr. John Moore then moved that the best thanks of the meeting be given to Dr. Purdon for his very interesting address. The motion was seconded by Dr. Stewart and carried by acclamation.

H. W. Johnson L.R.C.S.I. next moved that Dr. Purdon be requested to allow his address to be published in the medical journals and in the local newspapers. Dr. Stewart seconded the motion, which was carried.

John Moore, Chairman
December 16, 1874

**Ulster Medical Society. Third Meeting
December 16, 1874**

Present, Dr. Charles D. Purdon (President) in the chair, Drs. Stewart, John Moore, H. S. Purdon, Barnett, McKeown, J. W. Browne, Houston, Core, Fagan, Bolton, Whitla, and J. J. Charles. Dr. McKenzie was introduced by Dr. Houston as a visitor.

W. A. McKeown M.D. exhibited a patient in whom he had performed a small iridectomy with good results.

J. J. Charles M.D. exhibited and described a recent specimen of necrosis of the jaw from phosphorus. The patient was a female aged 28 years, and had worked in a Belfast Match Manufactory for several years.

J. K. Houston M.D. read an able paper on necrosis of the cranial bones, and detailed the history of a case he had seen in the Union Infirmary.

He exhibited the necrosed frontal bone, and, from the appearance of it and the soft parts which surrounded it, he inferred, in accordance with Virchow's views, that the necrosis was the result of the syphilitic virus, though there was no history of such.

Some of the members coincided with Dr. Houston's opinion, but others thought it possible that the necrosis might have a strumous or even a local origin.

Paper:¹ THIS affection is almost always set down as being of syphilitic origin. Certainly, in the great majority of cases, this is true; however, I cannot doubt that scrofula more frequently determines necrosis and exfoliation of the cranial bones than is supposed.

The correct diagnosis of these cases is of great importance, as upon it depends the prognosis, whether hopeful or otherwise. When the previous history throws no light whatever on the case, and when the nature of the disease is not suspected by the patient, it is especially difficult to make a safe diagnosis; and the grounds upon which this may be accomplished are worthy of careful consideration. To Virchow, perhaps, the most careful investigation of the changes which take place in connexion with syphilitic deposit in bone and periosteum is due; and from the researches of that eminent author we are enabled to discern such marks and characteristics as shall lead us to determine, from the nature of the lesion, per se, whether it be of syphilitic or strumous origin.

All the changes which occur in bones or periosteum affected with syphilis have their starting point in the same pathological phenomenon, namely, a deposit of

¹ [1875 *Dublin Journal of Medical Science*, v59, p64.]

syphilitic lymph or syphilomatous matter, a substance consisting of cells and nuclei. This deposit occurs between the periosteum and the bone, in the medullary cavity, and in the Haversian canals and lacunae. In the case of the skull, it is laid down either underneath the pericranium, in the diploë, in the Haversian canals, or between the bone and dura mater.

Now it is upon the changes which take place in this material that all the subsequent characters which the disease assumes depend. If this lymph is of a firm or plastic character, then hard nodes, exostosis, thickening, and hypertrophy of the bone result. If, on the other hand, it is of the soft variety, with a tendency to break down and disintegrate, then ulceration, caries, and necrosis ensue.

Suppose we have a case of necrosis attacking the bones of the skull, how are we to determine, apart from the history of the case, whether its nature is syphilitic or strumous?

In the first place, Virchow lays it down, as a rule, that syphilitic necrosis is essentially a dry one, that is to say, it is not attended with suppuration. It seems probable that, after the syphilitic matter has done its work in separating from the bone both pericranium and dura mater, in a case where both tables are affected, that it is then disintegrated and re-absorbed, leaving the affected portion of bone dry and exposed. While these changes are occurring on the surface and underneath the bone, the matter which had been deposited in the Haversian canals and diploë also becomes disintegrated and undergoes absorption, forming carious spots in the necrosed portion, which give it a characteristic worm-eaten appearance. In the second place, the mode of separation of the sequestrum is very characteristic in syphilitic cases. A formative process occurs around the dead portion. A thin, vascular substance, according to Virchow, is first formed round the circumference of the diseased spot, and this subsequently undergoes ossification, and so the thickness and density of the edge of the living bone are increased. A process of this kind is never observed in scrofula. In scrofula the Haversian canals and lacunæ of the living bone around the dead portion are, indeed, found enlarged and numerous, and filled with a lowly organised lymph, showing a marked tendency to suppuration; but no true marginal ossification occurs. According to Goodsir, Küss, and Virchow, it is by the production of this pus, in cases of scrofula, that the dead bone is separated and floated off.

The following case will serve to illustrate some of the distinctive characters mentioned in this brief outline, and it is especially interesting, inasmuch as the history gives us little or no information regarding its nature.

Mary Duffy, aged thirty-eight, came under my care in the Union Infirmary, on the 15th of March, 1874. She was suffering from necrosis of the bones of the

skull. Her family history is the following;—Her father died of pulmonary consumption, and her mother is living and healthy. Ages not known. Had three brothers and one sister. The sister died at the age of seven years from consumption, and one of her brothers, aged four, died from the same affection.

She states that she was married when eighteen years of age, and that her husband is dead. The cause of his death is stated to have been disease of the liver, and ascites. She has had six children, five of whom are living and one dead. The child died at the age of three months, from gradual wasting or marasmus. Those living are all healthy. The first child was born a year and six months after marriage, and she never had an abortion. Such, then, is the family history.

And, now, we come to consider the history of the disease itself. She began to complain about seven years ago, and then, for the first time, fell into delicate health. She remembers no serious illness from which she suffered up till that date. Severe shooting pains then began to be experienced over the crown of the head, and these lasted for nearly one year. Then the left side of the neck became painful, and soon a soft, fluctuating tumour was noticed, which quickly broke and discharged, and that before any swelling was observed upon the scalp. The deep and excavated opening produced in the neck did not heal up for a long time, the ulceration process extending in one direction while the sore healed in another. The original tumour was anterior to the sternomastoid muscle, and near to the angle of the jaw, and the cicatrix extends from that point down the whole length of the muscle, and along the surface of the clavicle to its inner extremity.

A tumour was next observed over the right parietal bone, which assumed the size of a large marble before the skin ulcerated over it. From the opening over this tumour a small piece of bone was discharged, about four years ago. About two years ago a lump was observed high on the frontal bone. This remained stationary for a year or so, still, however, discharging a little watery fluid from very small openings. These tumours were all painful, the pains being subject to exacerbations at night. During August, 1873, she states that the frontal bone was first noticed getting bare. When she came under my care, she was in an extremely cachectic condition, pulse frequent, and very feeble, and a large portion of the frontal bone exposed and dry. There were three other ulcers over the upper part of the right parietal, the base of each showing a piece of dead bone. Very little suppuration was observed.

As she was suffering a good deal from pain and sleeplessness, I ordered a 2-grain opium pill every night at bed-time, and prescribed for her a mixture, consisting of equal parts of the syrup of the iodide of iron and compound tincture of cinchona, and of this she was to take a teaspoonful three times daily, after meals. Her diet included one egg, half a pound of beef-steak, and

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President Charles Nicholas Delacherois Purdon

three pints of sweetmilk daily. Soon signs of great improvement began to manifest themselves, and with these separation of the dead bone commenced. The piece of the frontal which necrosed measured four and a half inches by three inches, and consisted of both tables of the skull. In the bottom of the very large ulcer which remained, the brain could be seen and felt pulsating, separated from the external air by the membranes and dura mater, the latter being covered, however, by very abundant and healthy granulations. Around the sore the living bone was thickened and formed a very prominent ridge. This ulcer rapidly healed up, and a tolerably firm cicatrix was produced. From the openings over the parietal bone several pieces of the external plate were discharged. I saw this patient again on the 6th of October, and she was then walking about, and apparently in excellent health, having improved exceedingly in flesh and colour. She stated, however, that the sores on the side of the head had not yet healed up completely.

In considering this case, we are constrained to believe that the syphilitic poison alone produced the varied lesions here present, although the history, family or otherwise, sheds little light upon the subject. There seems, however, to have been a hereditary predisposition to consumption in her family, and whether the phthisis of her father or the liver disease of her husband had a syphilitic origin or not remains an important question.

In reviewing the facts of the case, as we have them before us, there are several points which claim our attention. And first of all the age at which disease commenced. This, according to the woman's own statement, was over thirty years.

Now, we know that the first manifestations of scrofula are extremely rare after thirty years have been attained, whereas tertiary syphilitic lesions are much more frequently met with after this period of life than before it. Then we have an account of a peculiar solitary tumour occurring in the neck, which, from its nature and form of cicatrix, we cannot but regard as a soft, cellular node. With respect to the disease in the bones, we note, particularly, that it was attended with little suppuration, that we have distinct evidence of those changes, both in the living bone and in the sequestrum, so ably investigated and figured by Virchow, and so characteristic of the presence of the syphilitic as distinguished from the scrofulous element.

Dr. Houston then exhibited the specimen.

DR. J. MOORE congratulated Dr. Houston on his first paper being such an able one. He coincided with him in regarding the necrosis in his case as of syphilitic origin.

Dr. J. W. BROWNE stated that, some years ago, he saw in hospital, under his father's care, a case in which "dry" necrosis of the frontal and parietal bones occurred in a young man, from a fall on the vertex, though he had no history of syphilis.

Dr. J. Fagan thought the necrosis might have been caused by an injury inflicted on the head when the patient was unconscious, perhaps from drink; and, accordingly, she would afterwards have no recollection of the occurrence when stating her history.

DR. J. J. CHARLES said the necrosis was most probably syphilitic, but he did not consider the facts which had been adduced by Dr. Houston sufficient to make the diagnosis a matter of certainty, more especially as the history of the case pointed distinctly to struma as the cause.

He thought a comparatively slight blow might produce necrosis in a strumous individual. He believed Virchow's views on this subject had not been sufficiently corroborated to place them beyond question. Indeed, he regarded it as very difficult, if not impossible, to state dogmatically, from the appearances of the parts alone, whether the disease was due to syphilis, struma, or a local injury.

The PRESIDENT coincided with Dr. Houston's opinion as to the origin of the necrosis. He referred to the case of a young man in whom necrosis of the bones of the cranial vertex resulted from struma.

C. D. Purdon, Chairman
December 30, 1874

**Ulster Medical Society. Fourth Meeting
December 30, 1874**

Present, Dr. Charles D. Purdon (President) in the chair, Drs. J. W. Browne, Fagan, J. J. Charles, and James Moore.

J. Fagan L.R.C.S.I. introduced a patient on whom he had performed Syme's amputation and exhibited the parts removed. He related the history of the case and at the same time denounced the use of the gouge in the treatment of caries.

One or two of the members present took exception to some of the principles he had enunciated, and considered the gouge very useful in suitable cases.

Paper:¹ THERE are some features in the case which I have just now presented to you, Mr. President, which I consider sufficiently interesting to induce me to lay the particulars of it before this Society:—

R. M'C., aged eleven years, was admitted on the 24th February, 1874, under my care, to the Belfast Hospital for Sick Children. He suffered from chronic sub-acute inflammation of ankle-joint and tarsal bones of left foot, which presented the characteristic appearances found in such affections. The contour of the joint was destroyed by the inflammatory thickening of the surrounding tissues, the integument glazed, and here and there of a purplish colour; three or four sinuses gave out an unhealthy discharge, one of which led down to a piece of necrosed bone on the back of the astragalus.

¹ [1875 Dublin Journal of Medical Science, v59, p257.]

The history I got from the lad was, that about a year previously, while running on the street, he fell, and knocked his ankle against the corner of the curbstone; he suffered great pain at the time, and in a few days had to take to his bed, where he remained for some weeks. After a time he began to walk on it, but it still kept tender, and a couple of months before I saw him it began to assume the appearance it had on admission.

After keeping him in hospital for about five weeks, without much benefit from the treatment employed, I determined (with the concurrence of my colleagues) on removing the piece of necrosed bone; and accordingly, on the 2nd March, after applying Esmarch's elastic band, and putting him under chloroform, I made a deep incision, about one inch and a quarter long, over the necrosed bone. The parts were perfectly bloodless, but a clear serous fluid oozed in pretty large quantity from the morbidly thickened tissues; I then applied the gouge, and removed what I considered necessary; in doing so I felt the bone very soft and friable. The wound was then washed out with a weak solution of carbolic acid, a pledget of lint left in it, and cold lotion applied. The next day the pain in the foot was intense. He got an opiate, and had water dressing applied. The edges of the wound now began to gape and look unhealthy, and in a few days began to slough; charcoal poultices were applied, and he got his opiate three times daily.

The sixth day after the operation he had a rigor, the foot became enormously swollen and inflamed, and an abscess pointed anterior to the external malleolus, which I opened, giving exit to a large quantity of purulent matter. This only wrought temporary relief. The foot was still exquisitely painful to the touch; large exuberant granulations, which bled freely on the slightest provocation, filled up the wounds, and an ichorous discharge, filled with fat globules, kept constantly oozing from them. As he now began to suffer from hectic, loss of appetite, and sleeplessness, I considered it necessary to remove the foot, but the mother not consenting to the operation the boy was taken home. After keeping him for about a fortnight she took him back again, and on the 25th May I performed Syme's amputation, assisted by my colleague, Dr. Brice Smyth, and our consulting surgeon, Dr. Browne. There was some oozing through the dressings, but not sufficient to cause any alarm; during the day he took plenty of milk, and slept well that night. I put him on the following mixture, which I am in the habit of using after operations:—

Bicarbonate of soda, 180 grains.

Dandelion juice, 4 drachms.

Water to 8 ounces. Mix.

Sign. No. 1.

Sulphate of quinine, 8 grains.

Tartaric acid, 120 grains.

Water to 4 ounces. Mix.

Sign. No. 2.

Two tablespoonfuls of No. 1 to be taken with one of No. 2 during effervescence.

I find this mixture to be extremely grateful to the patient, while its febrifuge properties I believe to be most beneficial at the time. With the taking of it the temperature and pulse were lowered, the tongue began to clean, and the bowels were gently acted on.

On the third day after the operation I removed the dressings; the wound looked healthy; there was slight discharge of healthy pus; after being well syringed with a solution of carbolic acid the stump was again dressed as at first. This process was gone through daily for about three weeks.

At the end of a fortnight the ligatures came away, and new skin began to bridge over the wound here and there. In three weeks the wound was healed over except at either extremity, where there was a pretty free discharge of pus oozing through exuberant granulations. I began to touch these with nitrate of silver, and applied pressure to them by means of wet strips of lint. After a short time they were very much improved, and he left the hospital a little over a month after the operation.

There are several points in this case, Mr. President, that to my mind are of some interest, and well worthy of consideration. The first is the propriety of interfering by operative procedure; and, if such be considered advisable, what are the next means to be adopted?

In this case the disease was of considerable standing, the inflammation set up at first by the violence of the fall in the synovial lining of the joints, spread, and involved the bone tissue. If properly treated at first, the result in all probability would not have followed, but circumstances were not in the boy's favour; he was poor and ill-cared for; and had he even got the proper advice, he had not the means of carrying it into effect.

Now I believe that in such affections as the one I have just described, and indeed in all chronic diseases of bones and joints, our line of procedure must be very much influenced by the circumstances of individual cases, and what might be considered injudicious and bad practice in one set of cases would be the best in another.

In cases similar to the one under consideration I believe we are justified in resorting to operative means, after giving a fair trial to a milder line of treatment, and such I consider in its true sense "conservative surgery." The course usually taken by such cases is, that after spending a considerable time in one hospital or another—in some cases, perhaps, with benefit—they go home for a time, only to return again with the disease more extended, and demanding greater sacrifice of parts than if operated on in the first instance. Among patients belonging to the more favoured classes of society such a course of practice, for obvious reasons, should be the exception.

In considering the means to be adopted when resolved on interfering, let me say that had I a similar

case again under my care I would not follow the same line of treatment. The operation of gouging diseased bone is, I think, too lightly recommended, and from what I have seen of it in the practice of others, and experienced in my own, I venture to hope that in course of time the museum will be considered a fitter place for the gouge than in the hands of the surgeon. I look on the operation as at once unsatisfactory, clumsy, and unscientific, possessing few redeeming features, but a great many to condemn it.

As usually performed it is a process of digging in the dark, there is no precision in it, and if one succeeds in his object of removing the diseased part it is generally at the expense of a much larger portion that very soon dies; or if, as in the case under consideration, the disease be seated in one of the short bones, the destruction of one or more in its neighbourhood.

Some will say that this wholesale condemnation of the gouge is not warranted, seeing that it is still in such general use by the most distinguished surgeons, and that there are certain localities where disease is seated in bones that cannot be reached so effectually by any other means.

I grant that cases do now and then occur requiring the use of the gouge, but I hope to see such improvements in surgical appliances that diseases of bones will be dealt with with the same precision as those in the softer structures, and that when mechanical means fail medicinal applications will come to the aid of the surgeon, and will enable him to lay aside so clumsy and unscientific an instrument.

There were a few other points in this case, Mr. President, that struck me as interesting. You will observe by looking at the parts removed that the lower ends of the tibia and fibula were in a highly inflammatory state, and, notwithstanding, the case progressed most favourably after the great exciting cause was removed.

The flabby granulations at the extremities of the wound, and the formation of several small abscesses about the stump, resulted from the breaking down of the unhealthy pulpy tissue that remained in the flap after the amputation. As much as possible of this substance should, I believe, be removed at the time of the operation.

In performing the operation there are two points that specially claim the attention of the operator, and which, if carefully looked to, will prevent that unpleasant and comparatively frequent result—sloughing of the flap. The first is, when making the incision across the sole of the foot, after entering your knife over the inner malleolus, to give it a sweep forward, and by this means preserve as much as possible of the plantar vessels; the next is, when reflecting the heel flap, to keep as close to the bone as possible—in fact, to scrape the tissues from the bone, and by this means the small muscular branches are preserved intact. I had occasion to tie but two vessels, the anterior tibial and peroneal, and

although the posterior tibial was visibly pulsating on the face of the flap, I could not make out its cut end, and did not like to disturb the parts looking for it when there was no hæmorrhage.

This fact is a proof of how simply sometimes a large artery can be sealed up, and so far advocates the method of torsion which is now getting into such deserved repute. The stump is now, as you have seen, in a condition to bear nearly the whole weight of the body, and with a properly constructed boot the boy will experience comparatively little inconvenience from the loss of the foot.

JAMES MOORE, M.D., said the stump they had just seen was an excellent one, and reflected credit on the operator. He did not approve of the gouge unless in exceptional instances.

J. J. CHARLES, M.D., thought the case before them was one of caries rather than of necrosis. He could not agree with the reader of the paper in his universal condemnation of the gouge. He believed the best surgeons would give it a trial before proceeding to amputate the foot—more especially if the patient was of a healthy constitution, and the caries confined to a limited area, say one of the tarsal bones. He thought it a good rule, in such cases, to expose the diseased part fully by free incisions.

Not to be hypercritical, he might mention that some surgeons would have preferred in this case excision of the astragalus, or of the ankle-joint, or Pirogoff's operation, since the os calcis was quite healthy. But, under all the circumstances, perhaps Syme's operation was the best.

The PRESIDENT stated that there are cases in which the gouge is the most judicious plan of treatment for caries. He referred to Mr. Solly's opinion in favour of the use of the gouge.

J. J. Charles M.D. exhibited a recent specimen of gangrene of the lower lobe of the left lung, the result of pneumonia in a cachectic constitution.

He also showed a specimen of extensive calcification of the mitral valve of the heart, and give details of the history of the case.

Paper:¹ Dr. Charles exhibited several interesting specimens which he obtained from the Queen's College Anatomical Rooms.

1. Gangrene of the Lung.—The disease in this specimen was confined to the lower lobe of the left lung. In it there was a cavity large enough to contain a body four inches in diameter; and suspended in its interior, in a sanious liquid, was a shreddy, tinder-like substance, of a dark greenish colour, and of a sour, unpleasant odour. On examination the gangrenous mass was shown to consist chiefly of the elastic fibres of the lung. The wall of the cavity was thick, firm, and composed of white

¹ [Dublin Journal of Medical Science, 1875, v60, p72.]

fibrous tissue, which formed an efficient boundary for the diseased structures, and separated them entirely from the comparatively healthy lung around. Pneumonia and extensive pleuritis existed on both sides of the chest.

History.—T. R., forty-four years of age, and of a broken-down constitution. On admission into hospital November 5, 1874, he complained of a slight cough, with dark sputa. The signs and symptoms of pneumonia increased in violence, and the sputa came to possess a foetid odour. His strength gradually gave way, notwithstanding the use of stimulants and the application of blisters. Death occurred after he had been eleven days in hospital.

2. Extensive Calcification of the Mitral Valve of the Heart.—In this specimen there was a ring of calcareous matter along the line of attachment of the mitral valve. For the most part the calcareous material was covered by endocardium, but in some places it formed sharp projections into the left ventricle. There was hypertrophy, with dilatation of both sides of the heart.

History.—J. M., aged sixty-five, received into hospital Oct. 8, 1874, in a weak state. His condition then was:—Face livid, with ascites and œdema of the limbs; considerable dyspnoea, but scarcely any cough; urine 1032, with some albumen and a large quantity of urates; systolic basic and apex murmurs. He seems to have derived only temporary relief from treatment, and he died sixteen days after admission into hospital.

3. Dropsy of the Fallopian Tubes.—This specimen was removed from the body of an unimpregnated female, who was forty years of age, and died from bilateral pneumonia. The uterus was small (four inches by three), and the os would only admit a probe. The mucous membrane was congested near the entrance of the Fallopian tubes, and beneath it, about the middle of the posterior wall, was a fibrous tumour of the size of a pea. The cervix was long, and contained a colloid liquid. The arteries were larger and more tortuous on the right side than on the left.

The Fallopian Tubes.—Both tubes were distended at their distal extremities to form cyst-like tumours, which were filled with a thin colloid liquid. The inner and outer ends of the tubes were occluded, owing to a thickening and folding of the mucous membrane, probably from inflammation.

The right tube was seven inches long, and the cyst-like dilatation two inches long and one broad.

The left tube was five inches long, and more contracted at certain parts than the right, and its outer distended portion was three inches long and one inch and a half broad, and closely attached to the ovary.

The right ovary was nearly normal in size, but its glandular portion was pale and atrophied.

The left ovary almost normal.

History.—No history of any symptoms having been referred to the diseased organs could be discovered.

Remark.—In this case both Fallopian tubes were nearly equally affected. This, according to Graily Hewitt,¹ is the rule.

4. Fibrous Tumours of the Uterus, with Cysts of the Cervix Uteri.—The uterus was taken from the body of a female who was sixty years of age, and died from “the decay of nature.” It was dragged down to the left side, so that the right Fallopian tube was half an inch higher than the left. This displacement was, no doubt, due to the adhesion of the left Fallopian tube to the lower part of the body of the uterus, as well as to the presence of a large tumour on the same side. The body of the uterus was thin, and five inches long. A fibrous tumour (intra-mural) occupied the fundus, and measured two inches from side to side, one inch from above downwards, and half an inch from before backwards. This growth was surrounded by a capsule of fibrous tissue, to which it was but loosely connected, at its lower and back part, by a very fine pedicle of blood-vessels and muscular tissue. Two other tumours (sub-mucous), of the size of peas, lay on the left side of the fundus, near the entrance of the Fallopian tube. In the Broad ligament, one inch to the right of the uterus and above the Fallopian tube, there was another tumour (sub-peritoneal), as large as an almond; and in the left half of this ligament, near the rectum, was a fifth, which was attached to the lower part of the body of the uterus by a long pedicle, and was of the size of a large walnut. Lastly, on the left side of the lower half of the body of the uterus were two more small (intra-mural) tumours. In all there were at least seven tumours—two peri-uterine, or sub-peritoneal, three intra-mural, and two sub-mucous. On section each of these presented almost the same structures, being made up principally of coarse bundles of muscular tissue, with connective tissue. In the cervix uteri there were several mucous polypi containing a glairy fluid.

(The two specimens last described were exhibited during the session 1873-74.²)

Paper:³ In November, 1873, my attention was directed to an extraordinarily small stomach in an aged male subject in the Queen’s College Anatomical Rooms. The whole body was much emaciated, and the heart very small, being considerably smaller than the closed fist of the body.

The intestines were very pale, and only a little more than half the normal size, and the villi in their interior were so much atrophied as to be hardly visible. The liver and other abdominal organs were small, but healthy, and the lungs normal.

The stomach maintained most of its ordinary relations to surrounding parts; but as it lay somewhat more vertically than usual, it was confined almost entirely to

¹ The Diseases of Women, p. 560. 1872.

² [Page 1179.]

³ [Dublin Journal of Medical Science, 1875, v59, p200.]

the left hypochondriac region. After its removal from the body with a portion of the duodenum, it presented the following characters:—In appearance it closely approached its primitive condition of a tube, with a pouch on one side. It could scarcely be said to possess a "fundus," the splenic end projecting little, if at all, to the left of the œsophagus; and the curvatures were but slightly marked, both borders being straighter than usual. The pyloric extremity was much thicker than the rest of the stomach, and for an inch and three-quarters from the pylorus it was of nearly uniform diameter throughout, resembling in form and size a portion of hypertrophied intestinal tube.¹ There was no apparent difference in size between the pyloric end of the stomach and the duodenum. The principal dimensions of the stomach, when slightly stretched, were as follows:—

A B.—Greatest length from most prominent point of splenic end to pylorus, six inches;

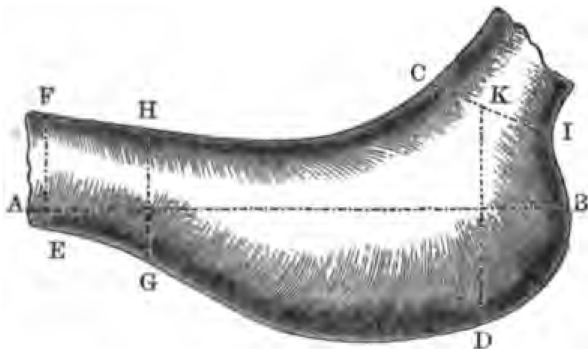
C I.—Diameter of cardiac orifice, one inch and a-half;

K D.—Greatest depth from cardiac orifice to great curvature, two inches and three-quarters;

E F.—Diameter at pylorus, a little more than one inch and a quarter;

G H.—Diameter, one inch and three-quarters to left of pylorus—about one inch and five-eighths.

On making an incision parallel with, and near to



the small curvature, all the coats were found to be thickened to a greater or less extent, more especially at the pyloric extremity, where the section had almost the colour and consistence of fibro-cartilage, and was twice as thick as at the cardiac orifice. The serous coat was of an opaque white colour, and presented no marks of ulceration. The muscular coat was much hypertrophied. The mucous membrane was pale and thick, and thrown into longitudinal rugæ along the great curvature. On the anterior wall, close to the small curvature, and two inches and a-half from the pylorus, was an ulcer of the size and shape of a four-penny piece, which involved only the mucous and submucous coats; its edges were sharp cut and not raised, and the surface

smooth and of a greyish colour.

Microscopical Appearances.—The microscopical examination was made by Dr. T. Cranstoun Charles, in the Brown Institution, London, under the direction of Dr. Klein.

The stomach was left in methylated spirit for several weeks, and a number of pieces were then cut from it at different parts, and hardened in absolute alcohol. These were next embedded in wax, and then vertical sections made in the usual way. After having been stained in hematoxylin solution, and immersed in oil of cloves, the sections were mounted in Canada balsam.¹

All the coats were observed to be more or less hypertrophied, but the greatest increase was in the submucosa. Here the thickening was due to a deposit, or new growth, of an imperfectly fibrillated tissue, resembling connective tissue in an early stage of development. Towards the mucosa the growth consisted entirely of lymphoid corpuscles, which replaced in great part the muscularis mucosa; but towards the muscosa the tissue became fibrillated like imperfectly developed fibrous tissue, the fibrillation being best marked close to the muscular coat.

The mucosa was slightly thickened, and the muscosa more so, but little or no increase could be detected in the fibrous element of the latter, while the lymphatic spaces were observed to be greatly increased in number and in capacity.

The blood-vessels were few in number, and the elastic tissue was nowhere increased in quantity.

History.—For the history of the case I am indebted to the medical practitioner in attendance. I give merely a slight sketch of it, as the symptoms and treatment were in no way peculiar:—

August 27, 1873.—W. M., aged seventy-three, presented himself to-day, suffering from occasional vomiting, pain in the epigastric region, and some eructations, with considerable tenderness on pressure over the epigastrium. No blood observed in the vomited matters. The disease was diagnosed to be ulcer of the stomach. Accordingly, trisnitrate of bismuth and compd. kino powder were prescribed, and a sinapism ordered to the epigastrium. He was to take daily a pint of milk mixed with lime water.

September 8.—As the vomiting had been very frequent, emplastrum lyttæ was applied to the epigastrium, but had to be repeated every other day for eight days before vesication could be produced.

September 19.—Since the blister rose yesterday, the patient commenced to improve; and from this date till October 20 he continued better—indeed, he recovered so far as to be nearly free from pain and vomiting, except on one or two days (October 10), when these symptoms returned.

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¹ From this peculiarity in its shape, Professor Macalister, of Dublin, when I showed him the stomach, observed the strong resemblance it had to the stomach of the *myrmecophaga*.

¹ See Dr. Klein's paper in Quar. Jour. of Microscopical Science. Vol. XIII., p. 377.

October 20.—The vomiting, with occasional diarrhoea, again supervened, and continued with a few intermissions till his death. Remedies seemed to have little effect in checking the symptoms, and his body became more and more emaciated until November 7th, when he died from exhaustion.

Remarks.—There can be little doubt the above case is an example of that rare disease which has been variously designated as cirrhosis, plastic linitis (Brinton), fibroid infiltration (H. Jones), and sclerosis (Snellen). In it, as in such cases, “there is evidently an exudation occupying the areolar tissue of the stomach, and gradually undergoing a change, in which its development into a low grade of fibrous tissue (like that of a fibroid tumour) is accompanied by a constant decrease of its bulk and increase of its density. The contraction and hardening thus brought about not only seriously damage the function of an organ to which mobility is essential, but they obstruct its circulation, and probably its innervation also; and they inaugurate grave lesions of its mucous and serous coats.”¹ “While the loss by ulceration of a variable extent of the whole thickness of this (mucous) coat is so frequent and dangerous a result of this kind, as really to constitute what might almost be called a termination or event of the malady.”²

According to this view, then, the ulcer is to be considered a consequence of the cirrhosis, and not the primary disease, as some might be inclined to imagine. Besides, we do not find the stomach so much contracted, and its coats infiltrated for so great an extent, in a case of simple ulcer.

Dr. Habershon relates the particulars of a case in which the stomach was very much contracted (six inches by two), and presented internally an ulcer and a villous growth. He believes the changes in the stomach were produced “by inflammation of the mucous and submucous tissues, leading to very slow ulceration in one part; in another to the development of contractile tissue in the substance of the membrane, and producing contraction of the whole organ.”³ This case bears a close resemblance in many respects to the one I have described above; and I think it might with good reason be regarded as an instance of cirrhosis, though Dr. Habershon does not appear to consider it as such.

Cruveilhier gives a plate⁴ of a small stomach with considerable thickening of its pyloric half, due, in his opinion, to hypertrophy of the fibrous and muscular tissues. Perhaps this case, too, would now be looked upon as an example of cirrhosis. In another plate⁵ he delineates a very much contracted stomach, which was taken from a patient who had died from cholera.

¹ Brinton on Diseases of Stomach, p. 271. 1864. See also Rindfleisch's Pathological Histology. Syden. Society, pp. 329 and 416. 1872.

² Brinton, *op. cit.*, p. 268.

³ Diseases of the Alimentary Canal, p. 92. 1857.

⁴ Anatomie Patholog. du Corps Humain, 27 livr., Pl. I.

⁵ *Op. cit.*, 14 livr., Pl. I.

With regard to the difficulty of causing vesication in the case above described, I may add that when exhibiting the stomach before the Ulster Medical Society, in 1874, one of the members remarked that he had on several occasions encountered the same difficulty in producing vesication over a subjacent intensely inflamed organ; and that he was generally unable to do so until the inflammation had somewhat subsided, so as to be a source of less irritation internally than the blister was externally. It has been suggested to me, since then, that the cause of the blister not producing any effect in this case might be ascribed to the fact that the system was at the time in too weak a condition to respond to its irritation.

J. W. Browne M.D. then made some interesting observations on partial dislocation of the head of the radius in children.

John Moore, Chairman
January 13, 1875

Ulster Medical Society. Fifth Meeting January 13, 1875

Present, Dr. Charles Purdon (President) in the chair, also Drs. Stewart, John Moore, McCrea, McKeown, Spedding, Fagan, Core, Whitla, and J. J. Charles.

W. A. McKeown, M.D. introduced an aged patient from whom he removed a tumour which involved the eye, eyelids, and orbit. He believed the tumour was of a cancerous nature, but as it had been kept for some time, it was difficult to form a decisive opinion regarding it.

B. H. Spedding, L.R.C.P. & S. exhibited what he considered a “cancerous bladder” taken from the body of an aged female.

The bladder was very much contracted and its walls greatly thickened, but the urethra, uterus, and vagina were healthy. The kidneys had not been examined.

Some of the members thought that the patient had likely suffered from an affection of the kidneys which caused death, and that the changes in the bladder were in all probability due merely to cystitis.

J. J. Charles, M.D. related the particulars of an interesting case of scrofulous pyelitis, and showed the parts. Two of the members thought the case one of calculus pyelitis in its origin, though no calculi had ever been discovered by the patient.

Joseph Mark, M.D. was proposed as a member by B. H. Spedding L.R.C.P. & S. The motion was seconded by Dr. John McCrea M.D.

John Moore, Chairman
January 27, 1875

Ulster Medical Society. Sixth Meeting January 27, 1875

Present, Dr. John Moore (in the chair), Drs. James

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Moore, Barnett, McCrea, Stewart, Cuming, Whitla and J. J. Charles.

Joseph Mark, M.D. was elected a member of the Society.

J. McCrea, M.D. read a paper on “Rest of the Lung in Phthisis” which elicited an interesting discussion.

James Moore, M.D. exhibited a leg which he had lately amputated for malignant disease of the upper ends of the fibula and tibia.

Professor Cuming proposed A. Dempsey, M.D. as a member of the Society.

C. D. Purdon, Chairman
February 10, 1875

**Ulster Medical Society. Seventh Meeting
February 10, 1875**

Present, Dr. John Moore (Ex-President) in the chair, Drs. Stewart, Core, C. D. Purdon, Mark, Fagan, and J. J. Charles.

A. Dempsey, M.D. was unanimously elected a member of the Society.

J. Fagan, F.R.C.S.I. introduced a patient on whom he performed amputation of the thigh, and read notes of the case. He also shewed a patient from whom he removed a urethral calculus by incision and made some remarks on the operation.

Some of the members took exception to the reader’s views on the removal of calculi from the urethra and thought incision should always be the “derriere resort” in such cases.

W. Whitla, L.R.C.P. being absent, Mr. Moorhead give a short account for him of a case of rupture of the liver from external violence.

John Moore, Chairman
February 24, 1875

**Ulster Medical Society. Eighth Meeting
July 24, 1875**

Present, Dr. John Moore (Ex-President) in the chair, Drs. Cuming, Dill John W. Browne, Stewart, C. D. Purdon, Dill [sic], McCrea, Whitla, Dempsey, and J. J. Charles.

Professor Cuming, M.D. exhibited a specimen of aneurism of the heart and detailed the history of the case.

The President read a paper on the “Factory Reports of the last two Epidemics of Smallpox, and the means which proved successful in checking its ravages”.

Paper:¹ *The epidemic of 1871 came on so unexpectedly that it found us almost unprepared, and from the long interval that had elapsed since the last attack the public had forgotten the necessary precautions to prevent its progress; consequently, when the parties were attacked, vaccination and isolation were not suffi-*

ciently attended to, and the disease progressed so rapidly amongst the labouring classes that the Poor Law Commissioners issued a circular to the Poor Law Guardians, requesting them to send & copy to all proprietors of mills and factories, asking them to have all their hands examined, to see if any required vaccination.

And, in order to show how necessary this request was, I may state that in those mills in which this recommendation was attended to (I may mention that it was attended to in very few), and where 12,413 hands were employed, 666 were found requiring vaccination; also in those warerooms in which the notice was attended to, and 1,044 hands employed, 136 required vaccination. The medical gentlemen who examined them informed me that numbers presented themselves, saying they had been vaccinated, but, on examining their arms, the cicatrices were found not to be the true ones; and if the inspection had been carried out in the way the Commissioners intended, the results would have been similar to that in the Ligoniel district, which formerly suffered severely. This district has within its boundaries four mills, one print works, one damask manufactory, and two bleach greens, and contains about 5,000 inhabitants. The medical officer vaccinated and re-vaccinated every one that could be induced to allow him to do it; but at the Old Park Print Works the operatives would not submit until the outbreak took place, when they were all vaccinated, and the spread of the disease became checked. During the year preceding he re-vaccinated 495 cases, as well as vaccinated 173 new ones, and the consequence was that in the entire district, except the Old Park Print Works, there were only five cases of small-pox; and you might have drawn a line where his district commenced, and that of the town ended; for on the other side, in a street adjoining, the epidemic was raging. During this time the dispensary officers were actively engaged in vaccinating all that could be persuaded to allow it, but with little apparent benefit, owing to the operatives coming out of hospital while in the infectious stage of the complaint, and trying to get into their work again, and in some cases too successfully. At this time, when the complaint had caused a complete panic amongst the workers, Mr. Baker—himself a medical man—seeing that the directions issued by the Poor Law Commissioners were unsuccessful in checking the progress of the disease, and knowing that the mills and factories were too often hot-beds of the disease, made such representations to the Secretary of State that he was instructed to call into action the services of the certifying surgeons, in order to check the progress of the epidemic. Accordingly, he drew up the following circular:—

“Factory Inspectors’ Office.

“Dear Sir,—It appears that many persons employed in factories have never been vaccinated, and that the

¹ [Dublin Journal of Medical Science, 1875, v59, p558.]

Number of Persons employed in Mills, Factories, &c., in Belfast, who were attacked with Small-pox in the Epidemics of 1871 and 1874.			
1871 Number of Hands Employed In Mills, Factories, &c	Number attacked with Small-pox In the Epidemic Of 1871	1874 Number of Hands Employed in Mills, Factories, &c	Number attacked with Small-pox in the Epidemic of 1874
In Spinning Mills and Weaving Factories, In Warerooms,	32,521 1,774	674 34	33,799 1,508
In Tobacco Factories,	264	2	222
In Pork Store (Cutters),	245	None	178
In Felt Works, ¹	150	None	167
Total	44,318	837	45,550
			135 (103 adults, and 32 young persons.) 11 adults. None. None. None. 176, (137 adults, and 39 young persons)

present spread of small-pox is, in some instances, due to this neglect; the Certifying Surgeons, scattered over the country and possessing considerable influence with the people among whom they reside, have peculiar opportunities, incidental to the discharge of their duties, for ascertaining and remedying this evil.

“The Secretary of State, therefore, directs us to suggest to you, whenever any person, under 16 years of age, applying for a certificate, has not been vaccinated, to represent both to the parents and the employers the danger thus incurred. An employer would be showing only due regard for the interests of his workpeople if he made vaccination a condition of employment: for so indifferent are many people to the risk of infection that they may be found working, even though there may be one among them with the eruption out at the time.

“We shall be glad to hear from you the result of your efforts in this matter.

“We are, Sir, yours truly,
“Alexander Redgrave,
“Robert Baker,
H.M. Inspectors of Factories”

This circular was signed by the Inspectors, and sent to each certifying surgeon in the kingdom, who at once followed the instructions, not only in examining each applicant, and causing those that required vaccination to be vaccinated, but also prevented those that were infected from entering the mills, &c. The beneficial effects of these measures were very soon apparent, and in a very short time the epidemic began to decline, and soon passed away. These sanitary precautions continued to be used as directed, and each year about 8,000 young persons were examined; and in the interval that

¹ The number attacked in other employments need not be given here.

elapsed between the two epidemics of 1871 and 1874 upwards of 1,000 young persons were detected who were either unvaccinated or required to be re-vaccinated, on account of being unsuccessfully operated on; and now scarcely a week passes without from two to four persons being detected and required to be re-vaccinated. The consequence is that the disease that has just passed away, in place of being the scourge that it formerly was, only assumed the character of a slight epidemic. I append the statistics of the two epidemics.

Professor Dill, M.D. give an account of a case of hydramnios with an anencephalic fœtus. Exhibited the fœtus which was aged 7 months, and presented a spina bifida and talipes varus of the right foot.

Paper:¹ A Case of Hydramnios, with an Anencephalous Fœtus. By Professor Dill, M.D.

Mrs. K., aged twenty-two, came first under my care in the early part of the year 1874, for simple ulceration of the os uteri, and having received the necessary treatment, she soon recovered.

I discovered from herself that shortly before this she had had a premature confinement, the details of which I am unable to state. I may say, however, she is of opinion that the womb owed its recent condition to the manner in which the fœtus on that occasion was removed.

On the 15th of January, 1875, Mrs. K. again called upon me, to secure my attendance at her confinement, which she expected would take place on or about the 10th of April, and she appeared to be in good health and spirits.

On the 23rd of February I was requested to visit her, which I did at 11 o'clock a.m. I found that labour had set

¹ [Dublin Journal of Medical Science, 1875, v59, p560.]

in, that she had been complaining through the most of the night and all that morning, and that labour was now pretty well advanced.

I ascertained, on making the necessary inquiry and examination, that she had reached the thirty-second or thirty-third week of utero-gestation; that the abdomen had latterly increased in size very rapidly: that it was globular in form, and prominent at a point immediately below the umbilicus; that there was great tenseness of the abdominal parietes, and that the surface did not present the usual irregularities which are recognised in the normal condition of pregnancy. The foetal movements were believed to be absent, but, if present, they were so very feeble as scarcely to be felt, and this condition had existed a fortnight. Mrs. K. had suffered considerably from pain over the abdomen, especially in the left side, between the false ribs and the crest of the ilium.

There was œdema of the lower extremities, and the labia were very large and pain fully distended. On examining the vagina, the lower segment of the uterus was found to be more than usually distended; the os was dilated; the membranes were so tense, strong, and full, as not only to present an obstacle to their descent, but also to render it impossible to discover the present-ing parts within.

Under these circumstances there could be no difficulty in arriving at the diagnosis that we had at least a well-marked case of hydramnios, and this opinion having been formed, there was as little difficulty in determining the appropriate treatment—namely, puncturing the membranes.

This having been done, although vessels supposed to have been sufficiently large were brought into requisition, the quantity of liquor amnii was so great, that after filling the vessels to the amount of over two gallons, I believe fully an equal quantity of the waters escaped over the bed and the floor. The lady was soon heard to express her alarm at the sudden and marked decrease in her size; at the same time she stated she had obtained great relief. The abdomen and uterus were promptly grasped by the nurse, whilst I, in making a vaginal examination, discovered a small foetus lying across the mouth of the womb; the lower extremities were easily seized hold of, brought down, and the foetus extracted in a short time. The placenta followed in a few minutes.

The child (a female) was happily still-born, as there were deficiencies of certain parts. It appeared to have arrived at the seventh month. The case altogether presented some features of importance. The foetus was an interesting variety of monstrosity, being anencephalous.

In this case there was not the total want of the bones at the upper part of the cranium, but the skull ran backwards so abruptly as to leave no forehead, and little space for the encephalon.

There was also existing a spina-bifida, extending from the nape of the neck to the upper lumbar vertebræ. The membrane over it had evidently given way in utero, and the fluid had poured into the amnion. The foetus bore another mark of deformity—namely, talipes varus of the right foot, which is often found to co-exist with evident derangement of the nervous centres, as in acephalous, hemicephalous, and spina-bifida subjects.

Such cases are, fortunately, comparatively rare. In a large and lengthened midwifery practice I have only met with three anencephalous monsters, and the liquor amnii was found to be in excess in all. Many explanations have been offered to account for the anencephalous foetus, but I think such cases go far to confirm what Professor Rudolphi believed to be the true origin, or cause—namely, embryonic hydrocephalus. He has described an embryo, on the upper part of whose head was a vesicle ready to burst; a second, in whom the envelopes of the brain had burst, the pieces floating round the base of the skull; and a third, in whom these floating remnants were partly gone, thus verging on the common acephalous, as we find when born at the full period of gestation.

This opens up another subject for interesting inquiry—namely, the origin of the excessive quantity of the liquor amnii which accompanies the anencephalous foetus, and which may also accompany spina-bifida.

I am of opinion that the excessive quantity of liquor amnii will not be found to exist unless the sac containing the fluid either in the head or spine bursts and pours its contents into the amnion. All the cases and preparations bearing on this point which have come under my notice would accord with this theory.

John Murray, Chairman
March 10, 1875

Ulster Medical Society. Ninth Meeting March 10, 1875

Present, Dr. John Moore (Ex-President) in the chair, also Drs. Stewart, Core, J. W. Browne, Fagan, Dempsey, Whitla and J. J. Charles.

J. J. Charles, M.D. exhibited a recent specimen of “Hydatidiform Mole”.

W. Whitla, L.R.C.P. exhibited an upper extremity which had been removed that day at the shoulder joint by Dr. Murney.

The whole of the soft parts had been lacerated to an extraordinary extent in one of the mills in town.

John Moore, Chairman, March 24, 1875

Ulster Medical Society. Tenth Meeting March 24, 1875

Present, Dr. J. Moore (Ex-President) in the chair, also Drs. Stewart, Fagan, Dill, Whitla, Dempsey, Scott and C. D. Purdon and J. J. Charles.

J. Fagan, F.R.C.S.I. read notes of a case of what he considered acute inflammation and suppuration of the sacro-iliac synchondrosis and introduced the patient.

J. M. J. Scott, M.D. gave the history of a case of encephaloma of the testis and exhibited the gland.

Professor Dill, M.D. read a paper on puerperal convulsions.

C. D. Purdon

**Ulster Medical Society. Eleventh Meeting
April 14, 1875**

Dr. C. D. Purdon (President) in the chair, also Drs. J. W. Browne, Dempsey and J. J. Charles.

Dr. C. D. Purdon gave an account of a case of ovarian neuralgia in which he had found Sal Ammoniac very useful.

J. J. Charles, M.D. exhibited a dissection of the parts in an old dislocation of the elbow.

Paper:¹ In the body of a strong muscular male, aged forty-four, both bones of the left forearm were dislocated backwards. The extremity affected was almost as well nourished as the other. The forearm could not be flexed to an angle less than 100°, but it could be abducted to a right angle. Adduction was much less extensive than abduction—the parts being made more tense in the former movement, but relaxed in the latter. The external condyle was on a lower level than the internal.

The pronator radii teres, in addition to its normal origin from the internal condyloid ridge and internal condyle, was firmly attached, along with the common tendon of the flexor muscles, to the inner prominent edge of the trochlea, but that portion of it which lay between the condyloid ridge and the trochlea was quite pale and atrophied from disease, and very unlike the rest of the muscle. Its second head having taken origin, as usual, from the coronoid process, the muscle ran nearly horizontally to its insertion. The median nerve was much flattened, and the brachial artery somewhat contracted, where they lay over the prominence of the trochlea.

Consequently the radial and ulnar arteries were not so large as in the other extremity. The brachialis anticus had contracted adhesions to the anterior surface of the trochlea and capitellum. The anterior ligament was entirely absent, except below, where it was attached to the ulna and the lower surface of the trochlea and capitellum, but its place was taken above by the brachialis anticus. The triceps was normal; and the anconeus was adherent to the posterior surface of the orbicular ligament, which seemed to form the most important part of its origin. The posterior ligament had the usual connexions, and was made tense by a small degree of flexion. The internal and external lateral ligaments, as well as the orbicular, were almost normal.

The internal condyle of the humerus was very prominent, whilst the external was almost entirely concealed. The coronoid process gave attachment to the usual muscles, but was displaced backwards and slightly outwards, so that its apex projected into the lowest part of the olecranon fossa. One or two small pieces, however, had been broken off the outer portion of this process, and were situated on the outside of the great sigmoid cavity. The large sigmoid cavity was occupied by a small quantity of adipose tissue, and the cartilage lining it was considerably altered. The head of the radius was somewhat enlarged, and retained its ordinary relations and connexions with the ulna, but was dislocated backwards and slightly outwards, so as to articulate with a cavity formed for its reception on the posterior surface of the humerus outside the olecranon fossa. Besides, the head of the radius articulated above with a strong process of new bone, which, being attached to the posterior aspect of the humerus outside the olecranon fossa, took the place of the capitellum and served as a point d'appui for the radius superiorly. There was also a smaller process of new bone on the back of the internal condyle to articulate with the inner part of the coronoid process.

It will be observed, then, that the radius and ulna were displaced farther upwards on the outside than on the inside. The force, therefore, which produced the luxation must have tended to abduct the forearm, and, at the same time, to drive the radius and ulna upwards—hence the obliquity of the lower end of the humerus.

History unknown; but as the man was frequently inebriated, it is believed he received the dislocation in a mêlée. The accident likely occurred from sixteen to twenty years before his death.

Dr. J. W. Browne proposed “That the best thanks of this Society be accorded to our worthy President for the dignified manner in which he has occupied the chair this session, and for his gentlemanly bearing towards every member of the Society”.

Dr. J. J. Charles seconded the resolution, which was passed unanimously.

Dr. Purdon having replied, the meeting separated.

**Ulster Medical Society Special Meeting
July 9th 1875, at 7:30 o'clock**

This meeting was called in accordance with the wish of the Council which met on the 7th inst., “To consider the proposed Pharmacy Bill, and, if necessary, adopt a petition to Parliament regarding it”.

In the absence of the President, Dr. J. W. T. Smith was called to the chair. There were also present Drs. Whitaker, James Moore, Ross, Core, Ball, Fagan, Whitla, Spedding and J. J. Charles and Mr. Pring.

Mr. Pring having explained the different clauses of the Bill, Dr. Whitaker read a Petition to Parliament containing objections to the Bill.

¹ [Dublin Journal of Medical Science, 1875, v60, p74.]

The Petition having been modified at the suggestion of members, Dr. James Moore proposed and J. Fagan F.R.C.S.I. seconded the resolution "That the Petition now read be adopted".

Passed unanimously.

Dr. Ross then moved "That two Petitions be [prepared?] and one forwarded to Lord O'Neill for presentation to House of Lords, and the other to Mr. Corry for the House of Commons: and further that a printed copy be sent to each of the Irish Members".

This resolution was also passed.

Annual Meeting Session 1875-76

Present, Drs. John Moore in the chair, John MacCormac, Whitla, Fagan, Core, Wheeler, Dempsey, Ball, Bolton, Spedding, J. W. Browne.

The minutes of the Annual Meeting of 1874 were read and confirmed.

Dr. J. W. Browne, Secretary *pro tem* read the report of Council. Proposed by Dr. Spedding and seconded by Dr. Fagan that the report of Council be adopted and entered upon minutes.

Dr. Fagan, Hon. Treasurer, then read a statement of accounts.

The following office bearers were then elected.

President T. K. Wheeler M.D.

Vice Presidents G. F. Wales M.D. & Richard Ross M.D.

Council Dr. Spedding, Dr. John Moore, Dr. Core, Dr. Whitla, Dr. Murney J.P., Dr. John MacCormac.

Secretary J. Walton Browne B.A. M.D.

Treasurer John Fagan L.R.C.S.I.

The two following gentlemen were proposed as members of the Society; to be balloted for next week. Dr. B. Coates, House-Surgeon, Royal Hospital, proposed by Dr. John Moore, seconded by Dr. Fagan. Dr. S. Merrick, Resident Superintendent, Belfast Hospital for Insane, proposed by Doctor John Moore and seconded by Dr. Fagan.

The Secretary to communicate with Dr. Torrens regarding his subscription in arrears (two years).

Proposed by Dr. Dempsey and seconded by Dr. John MacCormac that copies of the rules be printed and presented to each member upon joining the Society.

Thomas K. Wheeler

Council Report 1875-76

The Council have much pleasure in submitting ...

ULSTER MEDICAL SOCIETY

SESSION 1875–76

The First Meeting of Ulster Medical Society 17 November 1875

President (Dr. Wheeler) in the chair, Drs. John Moore, Ross, Whitla, Fagan, J. Walton Browne, Core, J. W. T. Smith, Dr. Dempsey, McKeown, Coates.

The members proceeded to ballot for S. B. Coates, House-Surgeon at the Belfast Royal Hospital, and Dr. R. S. Merrick as members of the Society. Both gentlemen were elected unanimously.

Dr. Wheeler (the President) thanked the members of the Society for their kindness in electing him to the chair.

Dr. Fagan L.R.C.S.I. read a paper upon a case of calculus of the urethra and also related the leading symptoms of a second case.

He exhibited the calculi removed; also Durham's urethral forceps.

Dr. J. W. T. Smith related a case in which a calculus was lodged at the neck of bladder and Smith Thompson [sic] pushed it back into the bladder, remarking that it was easier to extract the stone than to push it back.

The President mentioned two cases of calculi which had occurred in his practice.

The President read notes of cases of puerperal convulsions. He brought forward the history of five cases.

All treated without bleeding. He advocated the early evacuation of the contents of the uterus, and free purgation.

Dr. J. W. T. Smith also approved of the treatment recommended by the President. Dr. Smith had not been satisfied with the use of chloroform in convulsions.

Dr. Ross used hydrate of chloral in these cases with good effect. He had no faith in bleeding.

Dr. J. W. Browne stated the causes of convulsions as laid down by Barnes; also some peculiar symptoms noted in case No 5.

Dr. Dempsey mentioned that bleeding is still in vogue at the Coombe Lying-In Hospital.

Dr. McKeown related a case of chronic disease of the kidneys in which bleeding was used.

Dr. Core also declared a case which had occurred in the Union Hospital.

Dr. John Moore has had ten cases of convulsions in his practice. He does not approve of puncture of membranes in the early months of pregnancy.

Dr. Moore has also bled with effect; he would not like to give up using the lancet. He has also used chloral largely and efficiently.

Dr. Whitla brought forward a case of atropine poisoning. Patient had taken $\frac{1}{4}$ grain of atropine. Four and half grains of [asseum?] were given inside five hours.

Thomas K. Wheeler

Second Meeting 1st December 1875

President (Dr. Wheeler) in the chair, Drs. Whitla, J. W. Browne, Coates, Dempsey, John Moore, Wales, Mac-Cormac, Core.

Dr. Whitla read a paper entitled "Uræmia", endeavouring to prove that uræmic "poisoning" may occur also in connection with diseases of the liver.

Paper:¹ *At the last meeting of the Ulster Medical Society we enjoyed the privilege of listening to the President's most interesting and valuable series of cases of puerperal eclampsia. The paper, which was an essentially practical one, was all the more valuable because the author chiefly confined himself to his most successful treatment of this very formidable and too often fatal affection. If I err not, he stated at the beginning of his remarks that it was not his intention to enter into the pathology of the disease. The few remarks in this paper on "uræmia" are merely intended as a preface to one on Puerperal Eclampsia.*

With the symptoms of this poison (uræmia), and its most frequent cause, Bright's disease, it is wholly unnecessary to take up the time of a Society like this, where every one is so thoroughly acquainted with them, and it is merely my intention to show that the different forms of Bright's disease, or desquamative nephritis, are not the sole causes of this affection. Excluding diseases of the chest, there is no class of cases more common in the medical wards of an hospital than diseases of the kidneys; and perhaps next to these would come the various affections of the liver, especially cirrhosis and cancer. During the early part of last year there were in hospital several patients dying from Bright's disease, and at the same time there happened to be an unusual number of structural liver cases in the wards; and I was forcibly struck with the similarity of the symptoms of these two very different and opposite affections.

By closely watching the progress of a few patients in the advanced stage of kidney disease one becomes familiar with nearly all the phases of chronic uræmia, but here a condition presented itself identical in all respects with this, yet arising during the progress of an essentially different disease. At first I was led to believe that in these cases the kidneys were diseased in addition to the liver, but in some instances where I had the opportunity of making post mortem examinations I found these organs healthy and free from any organic change. In May, 1874, Dr. Murchison's Croonian Lectures on the functional affections of the liver were published in the Lancet, and in one of these valuable productions (which I regret being unable to lay hands on at

¹ [Dublin Quarterly Journal of Medical Science, 1876, v61, p107.]

present) he clearly points out a most important function of the liver.

Dr. Murchison, supported by high Continental authority, states that one of the chief duties of the liver is to lay hold of the effete albuminous compounds, the products of wear and waste in the blood, and to reduce these to their most soluble form, urea, in order to present them to the kidney in a condition capable of being easily and rapidly eliminated. According to these authorities, one may say, if I understand them aright, that it is the liver which manufactures the urea, the office of the kidney being merely to throw it out after its elaboration; consequently, when this function of the liver is deranged, these products are not reduced to urea, but the process stops short, and intermediate compounds—tyrosin and leucin—are formed, substances which the kidney cannot so easily eliminate, and which consequently accumulate in the blood and give rise to the same symptoms as urea, from which, in chemical composition and physiological effect, they differ little, and may be practically regarded as modifications of this substance possessing lesser solubility.

When I use the words “uræmic poisoning,” I wish it then to be understood that I refer to two similar conditions produced by two very different causes—in one the diseased kidney refuses to throw out the already manufactured urea, in the other the healthy kidney is unable to excrete the deleterious products of disintegrating albumen less oxidised than urea. The present state of our pathological knowledge does not enable us in all cases to discriminate clinically the causes at work in producing these identical conditions, especially as we have reason to believe that both factors are operating in the majority of cases of uræmia.

Cirrhosis, by destroying the secreting texture of the liver, produces this derangement of its function, and the consequent retention of these substances gives rise to symptoms of uræmic poisoning. The convulsions and other symptoms met with in the rare disease, acute yellow atrophy of the liver, Dr. Murchison looks upon as owing to these poisons; and, if I mistake not, he goes so far as to say that this form of poisoning is not the uncommon wind-up of the long train of symptoms met with in cases of advanced structural disease of the liver. He believes in this way, too, is accounted for also the typhoid condition which characterises many of the profound lesions of the system. An excellent example of this typhoid condition, associated with symptoms of uræmia, presented itself in the case of Mary B., which I had the honour of bringing before the Society in April, 1874. In this case no trace of disease could be detected anywhere; her delirium was considered to be owing to typhoid fever; the patient died after a few days illness, evidently from some mysterious blood poison; and on opening the abdomen four-fifths of the liver was converted into a bag of pus, though not a single symptom pointed to this organ during life.

Of a considerable number of cases of cirrhosis of the liver, and a few of cancer of this organ which I watched in hospital and kept under observation after leaving it, in the majority death from uræmia occurred. Though these facts are very interesting from a pathological point of view, they are not of much practical importance if only occurring in the last stage of a disease, nor of much diagnostic value, since the affection is obvious before their development. But I am satisfied that uræmic poisoning may be the first symptom of structural disease of the liver, and it seems possible that it may arise also from a purely functional affection of this organ; and I hope to lay this before the Society in my next paper as an explanation of the pathology of puerperal eclampsia in those cases characterised by absence of structural kidney disease.

When we know positively that advanced structural disease of the liver nearly constantly ends in uræmic death (provided the patient be not cut off by some complication), and when we, over and over again, find in the bodies of persons dying from other causes livers largely diseased and extensively destroyed, without a single symptom pointing to derangement of this organ during life, it is easy to see of what vast practical importance this cause of uræmia becomes.

Long ago every obscure disease characterised by the presence of coma and convulsions was put down to apoplexy, but in later days, since the researches of Dr. Bright, it seems the fashion to class them as diseases of the kidney; it is not a very rare thing to hear of sudden deaths preceded by coma and convulsions, especially in children, where the post mortem examination reveals no traces or disease in either brain or kidneys; and we find it sometimes noted as a matter of little moment that the liver is found much enlarged.

In my own short experience of nearly two hundred autopsies during the last two years, I can recall but a few cases where this now seems to me the most satisfactory explanation, though at the time I could offer none.

I will refer to my notes of one case. In January, 1874, a man, aged thirty-nine years, was admitted to the Belfast Royal Hospital suffering apparently from bronchial affection. He had been ill about a week. On examining his chest no evidence of disease was detected, though he suffered from considerable dyspnoea, and had a harsh barking cough. His body was evidently well nourished. Owing to the absence of physical signs, acute tuberculosis was suspected, and merely expectant treatment adopted. He remained in the same condition till about the tenth day after admission, when sudden coma set in, with convulsions, from which he recovered under purgatives and the use of the blanket-bath—only, however, to be attacked the next day, when he died, after being nine hours comatose, with frequent convulsions. During life his urine was examined, but with negative results; unfortunately, tyrosin and leucin

were not tested for. Careful examination showed complete absence of either casts or albumen.

Autopsy twelve hours after death.—Lungs healthy; nothing in them to explain the cause of the dyspnœa. Brain healthy. Kidneys—weight, normal; appearance, healthy; consistence, a little firmer than natural—left slightly lobulated. Liver fatty; weight, nearly seven pounds; under the microscope, cells filled with oil.

I could form no idea of the cause of death after examining every organ in the body; it seemed probably renal, till the kidneys were carefully examined under the microscope, but no disease was found in them. This case, read in the light of more recent pathology, is, perhaps, capable of explanation.

Looking at urea or its modifications as toxic poisons, and keeping in mind some of the most important functions of the liver, we are able to afford an explanation of many things very difficult to otherwise understand. Like many other poisons, after a time the system becomes very tolerant of its action, and the nerve centres, accustomed to the gradually-vitiated blood, are in a condition ready, as it were, to rebel at a moment's notice on the least additional increase of poisoned pabulum; when matters are thus evenly poised, suppose any trivial cause interferes with the function of the liver, the last straw is laid on, and the result is—a convulsion. On the other hand, we see patients smitten down and prostrated with this poison, and watch the progress of Death as he comes slowly and steadily on grasping his victim, who succumbs quietly, and passes away without one struggle. Is it not possible that two organs are at fault in the first case, and only one in the latter? Indeed, it may even come to be a disputed question whether the kidney alone, by its disease, is capable of producing death from uræmia.

Shortly after the first dawn of light was shed upon the pathology of kidney diseases, to find albumen and casts in the urine of a patient was to give him a very limited term of existence; now we know these are not incompatible with a lengthened and enjoyable period of life. We put under the microscope two samples of urine from different patients the subjects of this disease; we see in one here and there a few small scattered casts, and these, too, found with difficulty; yet this patient may have but a few weeks to live, while in the other we find the field studded over with casts of such magnitude as to prove they are the models of tubes devoid of all epithelial or excreting tissue, and full of oil and fat cells, evidently from a gland whose structure is apparently almost destroyed; nevertheless, its owner may live and enjoy life for a good long time till perhaps cut off by some unexpected complication; we have no more reason to wonder at this than at the case of a patient who dies from a slight contraction of the mitral valve, while his neighbour lives with his mitral no longer a valve but a mere slit, till old age carries him home. Yet these admit of an explanation if we knew it; and is it

not possible that the life of a diseased kidney is depending upon its liver? If so, a very material point is gained in prognosis and treatment. A word about the uræmia of scarlatina. My experience is far too limited to generalise, but perhaps I shall be borne out in stating that convulsions occur more frequently in this form of desquamative nephritis than in the acute affection, the result of exposure and other causes. Dr. Samuel Fenwick and others have found in the stomach tubes and the Lieberkühnian follicles of the intestines in the bodies of patients killed by scarlatina, changes which prove that a process takes place in the epithelial lining of these glands analogous to the desquamation occurring on the surface of the body, while a very eminent authority affirms that this is the true pathological explanation of the lesion of the kidneys which, he says, is caused by the shedding of the epithelium lining in scarlatina, the convoluted tubes of these organs. But I can go one step further, as I hope, from changes which I have noticed in scarlatinal blood, to demonstrate under the microscope, before the conclusion of this session, that the epithelial lining of the blood vessels of the body suffers the same destruction as the cuticle, and that partially broken-up cells and nuclei corresponding to the pavement on the fenestrated coat of Henle are sometimes to be found in the circulating fluid during the early desquamative stage of scarlatina.

Many things go to show that at this stage of the disease the blood is charged to excess with excrementitious matters, consequently great extra work is required of the liver to elaborate urea from these, which work the liver does, though more quickly and less perfectly than it should, and the resulting modifications or substitutes for urea cannot be thrown out sufficiently rapidly by the kidneys, already overtaxed and unhealthy, and uræmia results. If, then, this state of matters exists, we see what a very important part the liver plays in the uræmia of scarlatina.

The hypothesis of a condition somewhat like this will go far to explain many cases of puerperal eclampsia characterised by the absence of structural kidney affection. Supported by the researches of Murchison and others, whose labours have thrown considerable light upon the functions of the liver, one may venture to hope, as these functions are better understood and more generally known, that many of the pathological difficulties surrounding diseases of the kidneys will be cleared away. That cases of disease in these organs are turning up now and then which baffle every scientific explanation the practice of most men will confirm; and it is not unlawful, having tried in vain to elucidate them by the light of all that is now known of renal pathology, to turn to the investigation of the conditions of other organs and there seek for hidden associations which may assist us. It was my intention to read the notes of a few cases of this kind which have given me some trouble, but I have already trespassed too much

upon my reader's time, and will conclude by briefly referring to one.

Nearly three years ago a physician in the country sent me a specimen of urine from a patient who had slight anasarca, and requested me to make a careful examination of it. Its specific gravity was 1012. On the addition of nitric acid it was found to contain nearly half the depth of the test tube of albumen; but, notwithstanding the most careful investigation, no traces of casts could be detected; his urine continued highly albuminous for some months, when I saw him and found him a man of fifty-five years of age, in excellent health and spirits, and capable of his usual amount of work—in fact, quite as well as he had been for years, excepting a trouble which I shall mention presently. There was no anasarca, heart, or liver affection. A sample of his urine has been sent me nearly every month since then—sometimes more frequently; it has always been highly albuminous, oftentimes alarmingly so; much time has been spent in examining it microscopically, but only once were anything like casts found in it; it has been examined repeatedly by other microscopists with the same result.

This case seemed worth recording owing to the remarkable absence of microscopic evidence of structural disease; the urine of a healthy patient examined so often and searchingly as his would hardly fail to show some well-formed casts occasionally. Last Christmas morning I received a sample of his urine, which contained one-third albumen; next day I received a letter stating he had been out shooting, exposed to frost and snow. Crystals of tyrosin have been found occasionally, and once little masses of leucin, in his urine, and, strange, the only trouble he ever experiences is owing to violent and excruciating attacks of hepatic colic, which reduce him very low indeed for days. Last time I examined him the extent of hepatic dulness in the mammary, axillary, and scapular lines was normal, and neither atrophy nor enlargement of the liver could be detected.

The supposition of a waxy kidney will not satisfactorily account for this state of matters, the only evidence of disease of this organ being found in the quantity of albumen passed daily; and it is worth while remembering the fact that if a healthy man fasts for twenty-four hours and then eats a quantity of highly albuminous food, such as eggs, large quantities of albumen appear in his urine; as the liver, having too much work to do, permits some of this substance to pass through in a condition unfit for supplying the wants of the blood. When blood so charged with this crude albumen reaches the kidneys it is at once purified by these excretories.

Is it going too far to suppose that some structural or functional derangement of the liver might convert this transient occurrence into a permanent symptom? If not, albuminuria with uræmia might be accounted for

in many cases of puerperal eclampsia where careful microscopic examination reveals no casts.

But in a subject like this there is such scope for theorising that it is well to keep in mind the danger of passing through the region of the probable into the domain of impossibility. We arrive at much more accurate conclusions about the function of the liver from closely and narrowly watching the symptoms in cases where this organ is very extensively diseased than by any series of experiments on the lower animals, where many unfavourable conditions are necessarily induced, and the physiologist will soon learn that from clinical medicine alone must he seek for further light upon this subject. The facts stated upon the high authority of Dr. Murchison and others show beyond doubt that the liver is intimately associated with the elaboration of urea; and if these few remarks ever lead anyone to turn to the liver for an explanation of the many obscure cases of uræmia, its object will be more than fulfilled.

About the diagnosis of uræmia from brain disease, apoplexy, alcoholic poisoning, &c., considerable difficulty is sometimes met with, especially in those cases where a sudden attack is experienced for the first time, and where no history of any renal trouble can be found. In such cases great assistance will be had from careful examination of the condition of the heart, as nearly always distinctive modifications of the heart sounds will be heard, as reduplication of one or both, intensity of second sound, &c., differences also in the arterial tension and cardiac impulse.

Of these none seem so constant or remarkable as muffling of the first sound. In a very interesting case of uræmia, which I saw with Dr. Bell, at Bangor, in June, 1875, in a lady aged forty-six years, the first sound was entirely absent for four days after the cessation of the convulsions, returning suddenly after a strong purgative; it seemed as if due to the resistance offered by the swollen artery to the entrance of blood during the contraction of the left ventricle, so that no wave of sufficient strength to beat against the wall of the artery occurred.

Dr. J. W. Browne read for Dr. Coates (who was suffering from indisposition) a paper upon a case of vesical calculus.

Thomas K. Wheeler

Third Meeting 15th December 1875

Present, the President (Dr. Wheeler) in the chair, Dr. Fagan, Dr. Dempsey, Drs. John Moore and J. W. Browne.

Dr. Fagan read notes of a case of excision of the elbow joint and exhibited the recent parts.

Dr. John Moore read a paper entitled "Prisons and Prisoners" detailing some very interesting matters regarding the County Antrim jail.

Ulster Medical Society
Session 1875–1876
President Thomas Kennedy Wheeler

Dr. Wheeler proposed and Dr. Fagan seconded Dr. Robert Esler as a member of the Society.

Coates, Whitla.

Thomas K. Wheeler, M.D.

Fourth meeting 5th January 1876

The President (Dr. Wheeler) in the chair, Drs. Core, Coates, Whitla, J. W. Browne, John Moore. Several students were present.

Dr. Esler was elected unanimously a member of the Society.

Dr. Coates read for Dr. Murney a case of vesical calculus. Paper amongst the transactions.

Dr. J. Walton Browne read a paper upon a case of cysticercus cellulosæ.

Dr. Coates exhibited a cystic tumour of the kidney.

Thomas K. Wheeler.

19th January 1876

The President (Dr. Wheeler) in the chair, Drs. John Moore, J. W. Browne, Coates, Esler, Dr. Dempsey, Dr. J. W. T. Smith, Dr. Spedding. Several students were present.

Dr. John Moore described a case of spina bifida which was treated by the introduction of the aspirator. Death ensued one week after the evacuation of the fluid.

Dr. J. W. Browne read notes of a case of partial dislocation of the head of the radius.

Dr. J. W. T. Smith exhibited the lungs of a man who had died owing to an attack of double pleuritis.

Dr. Browne exhibited Stokes' instrument for the treatment of granular lids.

Thomas K. Wheeler

Sixth Meeting 2nd February 1876

President (Dr. Wheeler) in the chair, Drs. John Moore, J. W. Browne, Esler, Whitla, Aickin, Dempsey, Spedding, Fagan.

Dr. John Moore related an interesting case of complete paralysis of the body, probably the result of myelitis of the cord.

Dr. Spedding related the history of two cases of intestinal obstruction.

Dr. Walton Browne exhibited Field's artificial membrana tympani.

Thomas K. Wheeler

Seventh Meeting 16th February 1876

Present, (Dr. Wheeler in the chair), Drs. Dempsey, Fagan, Core, Spedding, Coates, J. W. Browne, Aickin, John Moore, Dr. D. Johnson, Dr. Dempsey [sic]. Several students were present.

Dr. Aickin read a paper upon intestinal obstruction advocating the use of a hydrostatic pressure enema placing the head and shoulders downwards, allowing the fluid by gravitation to find its way along the colon.

Dr. Coates read notes of two cases of fracture of the cervical vertebræ.

Thomas K. Wheeler

Eighth Meeting 1st March 1876

Present, (Dr. Wheeler in the chair), Drs. Fagan, J. W. Browne, Coates, Dempsey, Esler, McConnell, Dr. D. Johnston.

Dr. Fagan read a paper upon amputation of the thigh in which he applied torsion to the femoral and dressed the wound with carbolized [tar?] and catgut sutures. The wound healing almost by the first intention.

Dr. J. Walton Browne read a paper upon a case of uterine hæmorrhage.

Thomas K. Wheeler

Ninth Meeting 5th April 1876

Present, Dr. Wheeler (in the chair), Drs. Esler, Whitla, John Moore, J. W. Browne. Several students were present.

Dr. John Moore read notes of a case of tetanus and introduced [the patient] who had been successfully treated by chloral.

Dr. John Moore exhibited a patient upon whom he had performed Syme's amputation at the ankle joint.

Tenth Meeting 12 April 1876

Drs. Wheeler (in the chair), Coates, J. Walton Browne, Fagan, Ross, Dempsey. Several students were present.

Dr. Fagan read notes of a case of excision of the knee joint and exhibited a number of photographs of the parts he had operated upon.

Eleventh Meeting

Present, (Dr. Wheeler) in the chair, Drs. Ross, J. W. Browne, Whitla, McCrea, Coates, John Moore, Fagan, Spedding.

Dr. Fagan exhibited two patients upon whom he had performed excision of the knee joint, the cases were very favourable. Dr. Fagan will bring them under the notice of the Society at some future period.

Dr. J. W. Browne proposed a vote of thanks to the President and Dr. McCrea seconded it. Dr. Wheeler returned thanks.

The President proposed a vote of thanks to Dr. J. W. Browne and Dr. Whitla seconded the vote of thanks.

Annual Meeting held in the Library of the Hospital on Friday Evening November 3 1876.

Present, Drs. Wheeler (President), Fagan, Spedding, J. Moore, Beck junr, Esler, Coates & Whitla.

Dr. Fagan (Treasurer) read his report and explained that owing to some fourteen members not having paid their subscription, he did not balance his books but hoped that next month he would be in a

position to wind up his accounts and report to the Society the result. His report was considered satisfactory and adopted.

Secretary's report and Council report: Dr. Fagan explained and apologized for Dr. Browne's absence. Dr. Browne had asked him to state to the Society that the Council not having requested him to prepare a report, he had not done so. No report then being read it was agreed to ask Dr. Browne to prepare one for next meeting.

Office Bearers: Richard Ross M.D. was appointed unanimously to act as **President**. Dr. Wales and Dr. J. W. Browne as **Vice-Presidents**. Dr. Fagan to continue as **Treasurer**. W. Whitla to act as **Secretary**.

Council. Drs. Spedding, John Moore, F. Beck, S. B. Coates, H. Murney and W. S. Core.

The President introduced the question of the time of meetings and whether this should be monthly or fortnightly. After some general discussion it was unanimously agreed to have the meetings (when possible) every fortnight, and the evenings to be Tuesdays at 8 during the winter, and monthly during the summer (till July 20).

Dr. Spedding proposed that arrangements should be at once made about the Annual Dinner which should be held before Xmas. This was agreed to and a dinner committee of the following gentlemen appointed: Drs. Murney, Fagan, Moore, Spedding and Whitla.

Proposed by Dr. Fagan "That in case the proposed change takes place (in dispensing with a messenger) a suitable Librarian should be appointed, salary to be fixed by the Library Committee. Seconded by Dr. Moore and carried unanimously.

Proposed by Dr. Wheeler seconded by Dr. Spedding that following gentlemen act as Library Committee: Drs. Murney, Moore, Fagan, Coates and Whitla.

After a discussion about the advisability of dispensing with the services of the messenger it was agreed that nothing could be done as the matter was omitted to be put in the circular of the meeting and Dr. Fagan gave notice that he would move the question next meeting.

Thomas K. Wheeler M.D.
November 7/77

Membership Ulster Medical Society 1876

[Listed at the back of the 1862-1884 Minute Book.]

Dr. Henry MacCormac	Fisherwick Place
Professor Andrews	Queen's College
Dr. Kelso	Lisburn
Professor Dill	Fisherwick Place
Professor Gordon	Howard Street
Dr. Samuel Browne	College Square
Professor S. Reid	Glengall Place
Dr. Mulholland	Botanic Road
Dr. T. K. Wheeler	Clarence Place

Dr. McCleery	Clarence Place
Dr. Murney J.P.	Linenhall Square
Dr. J. W. T. Smith	Glengall Place
Dr. James	Chichester Street
Dr. Cuming	Wellington Place
Dr. A. Harkin	College Square
Dr. Whitaker	Clarendon Place
Dr. Ross	Wellington Place
Dr. Charles Purdon	Wellington Place
Mr. Pring R. W.	Corn Market
Dr. Gribbin	Crummock Street
Dr. John Moore	Carlisle Circus
Dr. H. S. Purdon	Beckenham Place
Dr. Wales	York Street
Dr. Dunlop	Hollywood
Dr. Fagan	College Square
Dr. Martin	Clarendon Place
Dr. B. Smith	College Square
Dr. Hayes	Carlisle Circus
Dr. D. Johnston	Carlisle Circus
Dr. Ball	Donegall Place
Dr. F. Beck	Clarence Place
Dr. J. W. Browne	College Square
Dr. R. Boulton	York Street
Dr. R. Barnett	Wellington Place
Dr. J. McCrea	Howard Street
Dr. R. Esler	Pakenham Place
Dr. S. Merrick	Lunatic Asylum
Dr. J. Smith	Donegall Street
Dr. W. Aiken	Murray Terrace
Dr. J. W. Beck	North Street
Dr. W. S. Core	York Street
Dr. T. Corry	Donegall Pass
Dr. G. Crooker	Mountpottinger
Dr. S. B. Coates	Royal Hospital
Dr. A. Dempsey	Donegall Street
Dr. J. S. Drennan	Chichester Street
Dr. H. S. Ferguson	Fisherwick Place
Dr. T. W. Garde	Falls Road
Dr. H. W. Johnston	Donegall Street
Dr. J. Mark	Donegall Street
Dr. S. McKee	North Street
Dr. McConnell	Falls Road
Dr. McKeown	Glengall Place
Dr. McMeekin	Mountpottinger
Dr. J. M. Scott	Donegall Square
Dr. B. Spedding	Carlisle Circus
Dr. A. Spence	Donegall Pass
Dr. W. Whitla	Victoria Place
Dr. T. Grattan L.A.H.	Dr. O'Malley
Dr. Pirrie	Dr. Graham
Dr. Strachan	Dr. McIvor
Dr. A. Reid	Dr. Fisher Anderson
Dr. W. S. Speer	Dr. T. C. S. Corry

ULSTER MEDICAL SOCIETY

SESSION 1876–77

First Meeting

The 1st ordinary meeting of the Society was held in the Belfast Royal Hospital on Tuesday evening November 14th 1876.

Present, Drs. Ross (President), Wheeler, James Moore, John Moore, Merrick, Core, F. E. Beck, Beck, Snr., Mr. Grattan, Dr. Gribbin, Esler, Coates, Dempsey, Spedding, J. W. Browne, Whitla.

On the motion of Dr. Browne Dr. Wheeler (in Dr. Ross' absence) took the chair. Dr. Ross entering the meeting Dr. James Moore moved in an elegant and complimentary speech a vote of thanks to Dr. Wheeler for his valuable services during the past session as President. This was seconded by Dr. John Moore and passed with acclamation.

On the motion of Dr. Browne the President, Dr. Ross, took the chair and thanking the Society for the honour of representing them, delivered in an eloquent address the opening lecture of the session.

Paper:¹ Gentlemen,—My first duty, in taking this chair as President of the Ulster Medical Society, is to return you my cordial thanks for the honour you have conferred upon me in electing me to the office. I can unaffectedly say that I would have preferred that your choice had fallen upon some one else who had higher claims than I have. Indeed, I at first hesitated to accept the position, but on hearing that my appointment was desired by a number of my professional brethren, I felt that I would be wanting in a due appreciation of their kindness if I refused so flattering a compliment. I will take this opportunity of making a few observations upon the value of such an institution as the Medical Society, if worked properly. Our worthy ex-President, Dr. Wheeler, notwithstanding the demands upon his time, has shown us a good example in his regular attendance at, and in the interest he has taken in, the meetings during the past Session.

The friction of mind with mind, as iron upon iron, sharpens our faculties and promotes our professional improvement. No one can attend our meetings—listen to clinical facts accurately recorded—see disease or the effects of medical or surgical treatment in the living man—examine morbid specimens in which are exhibited the destructive effects of injury or pathological processes—keep himself informed in medical literature by our circulating library—and fail to find his mind more enlightened and his feeling of self-confidence increased when he holds the scales of life and death in his hands. Knowledge in our profession, as in every

other department of human activity, is endless, and, no matter how great our information, we shall always have much to learn. Some one has written, "In earth there is nothing great but man; in man there is nothing great but mind and we, to whose care is committed this wonderful microcosm, may well magnify our office, but it all the more becomes us to develop, by every means within our reach, our intelligence, skill, and proficiency. The course of nature is doubtless unalterable; but the Almighty has conferred mind on man enabling him to be an interpreter of nature, and by his knowledge of natural laws capable of modifying one law by another. Bacon said that "man commands nature by obeying nature." Nature makes water flow down, but man makes it flow up a hill to fill a reservoir, by modifying, not interrupting, the laws of nature. Likewise in scientific medicine, if we get clear ideas of nature's laws in man and in his environment—or, to go more into detail, if we study man mentally and physically, in health and in disease, acquaint ourselves with his surroundings, the air he breathes, his food, his drink, the accidents to which he is exposed, what is favourable and what is unfavourable to his health—abundant opportunities will be afforded us of bringing to pass results which, but for man's intervention, unaided nature would not bring to pass.

One word upon another advantage of our Association, and I have done. It is as true of individuals as it is of nations, that with the increase of relations and mutual knowledge suspicions and enmities decrease. Our meetings here for the advancement of medicine and surgery, our discussions, and each of us making it our motto, "Gladly would he learn and gladly teach," must tend to the promotion of kindly feelings and goodwill in the members of the Society:—

Friendship is no plant of hasty growth,
Though planted in esteem's deep-fix'd soil:
The gradual culture of kind intercourse
Must bring it to perfection.

Dr. Browne read the Council report of last session which was unavoidably omitted at the Annual Meeting.

It was unanimously adopted.

Dr. Coates read notes of cases of acute rheumatism treated by salicylic acid with remarks on the acid etc.

Paper:¹ Case I.—James Drain, a healthy man, aged about eighteen years, a ticket-collector on a railway, admitted Thursday, 21st September, 1876; had been ill and totally unable to work for six days previous to his admission.

On admission, his hip, knee, ankle, elbow, and right wrist-joints were affected, tender and swollen, the slightest motion causing extreme pain; tongue furred;

¹ [Dublin Journal of Medical Science, 1877, v63, p97.]

¹ [Dublin Journal of Medical Science, 1877, v63, p98.]

copious acid perspirations; had a mitral murmur, which, however, we have reason to believe, existed previously.

At 12 noon, on 21st September (day of admission), his temperature was 102.9° (almost 103°); pulse 83 (normal pulse 55). He was ordered salicylic acid, grs. xv. every hour; this was continued, with but one intermission of an hour, for 14 hours, when the temperature had fallen to 99°; pulse 75. When he had taken the tenth dose the pains had almost disappeared, and at the twelfth dose he could move the limbs freely. On the evening of the 22nd September (day after admission) he had a slight return of the pains, which, however, disappeared at once on the administration of a few doses of the acid. On September 26th he was ordered quiniæ sulph. grs. ½ three times a day, and he left hospital on 3rd October quite well.

Case II.—Lizzie Gamble, a healthy woman, aged thirty, a domestic servant, admitted on 12th August, 1876. She was able to trace her present illness to a severe wetting received about two weeks previous to her admittance.

On admission she was suffering intense pain—knee, ankle, shoulder, and elbow-joints were affected; perspiring freely; tongue furred; bowels constipated; no heart affection. She was put under treatment at 10 30 p.m. on 12th August, and the joints having been bound up with cotton wadding, she was ordered grs. xv. salicylic acid, to be repeated each hour for six hours. At 10 30 p.m. the temperature was 100.8°; pulse 98; and at 3 30 a.m. on the next day, at which time the sixth dose of the acid was given (five hours from its commencement), the temperature was 98.4°; pulse 92. After she had taken two or three doses of the medicine the pains began to disappear, and at the sixth dose she was able to move all the joints freely. She convalesced satisfactorily, getting a few doses of the acid at more remote intervals, then sulphate of quinine for a few days, and left hospital well on 2nd September.

Case III.—Sarah J. Thompson, a healthy woman, domestic servant, aged twenty-three, admitted 15th September, 1876; had been five days ill and confined to bed previous to her admission.

On admission, knees, ankle, shoulder, elbow, and wrist-joints were affected, the pain being of so excruciating a character that she was incapable of the least motion—all the symptoms of acute rheumatism being exceedingly well marked in her case. The joints were enveloped in cotton wool, and at 9 p.m. she was put under treatment, being ordered grs. xv. salicylic acid every hour till eight doses had been given. When the treatment was commenced, Sept. 15, 9 p.m., temperature 103°; pulse 110. Sept. 16, 9 a.m., temperature 100°; pulse 105. Sept. 16, 9 p.m., temperature 99°; pulse 96. When she had taken three doses the pains began to disappear, and when she had taken eight doses were almost gone.

An incident in this patient's case illustrates very well "the rapidity with which the salicylic acid acts"—viz., at 9 p.m. on the 15th Sept. she was unable to make the slightest movement, and at 6 a.m. on the 16th, nine hours after, she, in the temporary absence of the nurse from the ward, got out of bed and walked across the floor—just as she expressed it—"to see what she could do."

She had a slight relapse on the 18th, which was easily cured by a few 10-grain doses of the acid. She convalesced satisfactorily, and left hospital on 7th October.

I will now take the liberty of reading a few general remarks on salicylic acid, its doses, mode of administration, &c.

It is obtained from willow bark, and is only slightly soluble in water, but is soluble in rectified spirit, and in solutions of alkaline carbonates, forming in the latter case salicylates. Indeed, it is used most extensively in the form of the salicylate of soda by Dr. Frerichs, of Berlin, Professor Gairdner, of Glasgow, &c. When pure, salicylic acid consists of shining white needle-shaped crystals, which have a very slight smell—indeed, when perfectly pure, no smell. The advantage of the pure acid is that it can be given internally in considerable doses without any of those unpleasant results which have followed the use of the ordinary commercial acid.

As to the dose in the above cases, the quantity usually given was 15 grains every hour for 8 and in one case for 14 hours. In cases of typhoid fever, Professor Frerichs gives 5.0 grammes (77 grains) in a single dose, each day at 12 noon, with a view to counteract the usual evening rise, with the result of reducing it in 80 per cent, of the cases. Very large quantities have been taken without any deleterious effect. In one case, that of a patient of Dr. Stricker, of Berlin, 22 grammes (340 grains) were taken in 12 hours.

Large doses in some patients produce symptoms allied to cinchonism—viz., buzzing in the ears, and even temporary deafness. The latter occurred to a slight extent in two of the cases treated here. However, the symptoms disappeared very soon after the discontinuance of the medicine.

It may be ordered as a powder; here it has almost exclusively been used, prescribed with a little tinct. of orange and water, giving particular directions as to the bottle being carefully shaken before each dose is measured out. I think it is a matter of importance that it should be given in a proper state of dilution, and have found that when three or four ounces of water were given with each dose the danger of nausea was reduced to a minimum—indeed, in none of the above cases did it give any trouble. Milk should not be given, either immediately before or immediately after any of the doses of the acid, as it seems particularly to disagree.

It seems to make little difference whether the pure acid be given or one of its alkaline combinations, as the

salicylate of soda; the latter has not, however, been tried here. Salicin has been used very extensively by Dr. T. Maclagan, of Dundee, who speaks of it in the highest possible terms. He says of it that "the relief of pain is always one of the earliest effects produced;" that "in acute cases relief of pain and fall of temperature generally occur simultaneously;" that "in subacute cases the pain is sometimes decidedly relieved before the temperature begins to fall;" that "the more acute the case the more marked the benefit produced," &c. I believe these observations are equally true of salicylic acid. Dr. Maclagan gives in an average case grs. xv. to grs. xx. of salicin every hour. As to the effect of either of these drugs on cardiac complication, so frequent in acute rheumatism, I think it can hardly be denied that medicines which cut short the disease, as I think there can be no doubt they do, must render the liability to these complications much less.

In conclusion, I may state that in a very few cases the administration of these medicines has been alleged to have produced rather alarming symptoms. In all probability, in these cases the symptoms were due, not to the acid, but to its being impure. It is a well-known fact that the impure acid contains carbolic acid; also that in poisoning by carbolic acid the urine has a characteristic olive-green colour; that there is stertorous breathing, a burning sensation in the mouth, fauces, and stomach, followed by vertigo, and a feeling of intoxication, great lowering of temperature, and feeble pulse. Now, in the cases which have been reported "of symptoms of poisoning produced by salicylic acid," and markedly so in the cases recorded in this week's *Lancet* by Dr. Tuckwell, of Radcliffe Infirmary, Oxford, the above are almost the exact symptoms which he ascribes to the use of the salicylic acid, but which, I think, we have ample proof to show are due to its impurities, particularly the carbolic acid.

Dr. Core had tried the acid in two cases both of which were very satisfactory. He gave in 6 doses in one case 120 grains and from what he saw and read believed it was the best remedy for the disease.

Dr. Esler tried the acid in one case and was satisfied with its result which was most marked.

Dr. Spedding used the acid in one case only where he could narrowly watch its effects. Though he had given it in several dispensary cases he could not answer for its action. He found in the case referred to that the acid produced in 10 grain doses every hour very alarming apoplectic symptoms. He was satisfied thoroughly as to the purity of the article and he attributed the symptoms to the toxicological effects of the acid.

Dr. Beck, Snr., had very large experience in the treatment of acute rheumatism and he at various periods believed he had found the "true remedy" but after a time he became convinced he must resign

each for another until now he could hardly say which was the most favourable. On the whole he leaned to the alkaline treatment.

Dr. Merrick felt from the pathology of the disease that the alkaline treatment was the safest.

Dr. John Moore thought the treatment of the disease was anything but satisfactory. Contrasted the vagueness of medical theories with the definite results of surgery.

Dr. J. W. Browne was not satisfied with the efficiency of the acid in acute rheumatism. He referred to the cases treated in Charing Cross Hospital and did not believe it had any effect in reducing the temperature.

Dr. Wheeler who highly approved of the alkaline treatment did not agree with Dr. Moore and others who advocated the expectant treatment. He believed much could be done in acute rheumatism. The relief of pain by opium as experienced in his own case was very satisfactory.

Dr. Whitla (Honorary Secretary) thought that before the efficacy of a remedy could be thoroughly established the nature of the disease must be carefully studied.

Acute rheumatism was a disease which in many instances was observed to abort and he believed in a large percentage of cases it did "cut itself short". This explains the history of the treatment; lots of remedies have been warmly advocated as specifics mainly owing to this peculiarity. He believed no conclusion could be safely arrived at till a large mass of evidence was collected.

Dr. Gribbin had used various remedies with varying success; the alkalis were in his hands most successful. He agreed that many cases of acute rheumatism did abort without any remedy.

Dr. Ross (President) in thanking Dr. Coates for his paper said he had appealed to the thermometer and pulse undeniable indications in the treatment of the cases.

He had himself, he believed, introduced the acid into the hospital and was satisfied with its results but he did not believe the best effects would be produced by such large doses. He found most benefit from 10 grain doses every 3 hours.

The motion of the Treasurer was then very freely entered into and after a very general discussion it was agreed to allow the distribution of the journals to go on as before and all the new journals remaining on the table of the Hospital for 1 week before going out.

Members proposed: Dr. Strahan (by Dr. Spedding and Browne) and Dr. Pirrie (by Dr. Esler and Dr. Wheeler).

It was decided that the Annual Dinner would come off on Wednesday 8th December at 6

Richard Ross
November 28th 1876

Session 1876 & 77

Second Meeting 28th November

Present, Doctors Ross, John Moore, Fagan, F. Beck, Browne, Esler, Gribbin, Coates, Pirrie, McKee, Dempsey and Whitla. (12)

A ballot was taken for each of the following gentlemen and they were elected members of the society: Doctors Strahan, G. Pirrie, O'Malley, Graham.

The Treasurer made a statement explaining the condition of the funds of the Society.

The Secretary was directed to communicate with Doctors Murray and Hayes and inform them of the rule bearing upon the subscriptions of the members.

Dr. Beck read notes of a case of tertiary syphilis and exhibited a piece of bone expectorated by the patient.

Paper:¹ Mr. W. came under my care some nine years ago. He was suffering from a chancre, which turned out to be of the true Hunterian character. It left for over three months after it healed the little hard button-like base so characteristic of these sores. He was treated with five-grain doses of the compound subchloride of mercury pill three times daily. The sore was dressed with a mild ointment, composed of the red oxide of mercury.

To all appearances the case did well; the sore healed up without any bubo being produced; the induration likewise disappeared. Some twelve months afterwards he called upon me; he was now suffering from well-marked secondary symptoms in the form of a sore throat, spots on his legs, &c. I put him on five-grain doses, afterwards increased to eight grains daily, of pil. hydrarg. He was also ordered a mixture containing iodide of potash, iron, and a bitter infusion. Under this treatment he made a rapid recovery. I made him continue the medicine for over five months more or less continuously, until every trace of the syphilis had disappeared.

For a number of years he kept quite well, when he again, for the third time, came under my care. This time he was suffering from a well-marked tertiary spot upon his forehead up among the hair; severe pains about his head, neck, and shoulder; his throat also was sore, and his general appearance was very bad. I ordered him a mixture of iodide of potash, ammon. cit. of iron, and infusion of gentian; told him to take extra nourishing diet, and keep himself warmly clad. In spite of all my efforts, the spot on the forehead enlarged, sloughed, and only healed after I removed a piece of necrosed bone about the size of a half-crown; the piece consisted of the outer portion of the frontal bone. In trying to heal the sore I had some difficulty; what eventually closed it up was lint soaked in a saturated solution of chlorate of potash, with oiled silk over. After this little operation he came round rapidly. Some two years

passed, when he appeared again, for the fourth time, three months ago. This time he complained bitterly of his throat—nothing else. It was impossible to see down the throat, owing to his having a creak or stiffness in his neck; head, neck, and shoulders seemed as if made of one piece. I tried every means that I could think of. When I tried to bend back the head, he bent his whole body backwards, and the pain was very severe; his breath was very offensive. I came to the conclusion that he was suffering from severe ulceration, complicated with some destruction of bone. He was again ordered the iodide of potash and iron mixture—his throat to be well sprayed with Condy's fluid. He reported himself worse and worse for a period of six weeks. I was getting uneasy about what would be the ultimate result of the case. Blood and mucus were coming up very frequently, and the pain was becoming intolerable, when suddenly one night he wakened up, choking, and coughing up mouthfuls of blood. When trying to cough up the blood and get breath, a lump of something came away, all covered with a clot. His wife and he examined it, washed it, stuck their nails into it, and came to the wise conclusion that it was bone, and so it was. On minute examination it proved to be the whole anterior portion of the body of the axis. Since this happened he has gone on well, and is, as far as I or he can know, quite recovered, and at his business. I should add that several pieces of mucous membrane were expelled a few days after the bone came away.

I think this case is peculiar from the fact of the tertiary symptoms being so well-marked and so severe, although he was treated secundum artem both for primary and secondary. He was, in the first instance, kept on mercury until the total disappearance of the induration—I always make it a point to do this—and in the next stage, or secondary, he was kept well under treatment until all symptoms had cleared off. That he really was free from syphilis was more or less proved by the fact of his wife having had several children subsequently all healthy, and nursed by herself; moreover, she herself never showed any symptoms of the disease. Lastly, it seems strange how such a portion of bone could come away, and yet the patient make such a good recovery.

The majority of the members present considered the specimen to be part of an upper cervical vertebra.

Dr. Gribbin, speaking on the treatment of syphilis, said after a long experience he never treated a case of syphilis without opium. He believed, from numerous cases brought before him, that the absence of this drug caused eventually tertiary symptoms to arise, and that in a very large percentage of cases of tertiary syphilis, on inquiry he found there had been no opium used. He ventured, he said, no explanation, but had so often remarked this he thought it right to mention it.

Dr. Fagan considered the specimen to be the altered body of the axis. He thought that, as regarded the off-

¹ [Dublin Journal of Medical Science, 1877, v63, p189.]

spring, the period most favourable for transmission was about the time the primary sore healed.

Dr. J. Moore referred to the exanthematous theory of syphilis, mentioning the debt the profession owed to Jonathan Hutchinson for his labours in this field. He related some cases of congenital syphilis which came under his notice in the County Prison, and which seemed to get well without any treatment after running the course of an ordinary feverish attack.

The President (Dr. Ross), in thanking Dr. Beck for his paper, agreed with the remarks made, but considered that, from what they knew at present of the nature of syphilis, it would not be justifiable to allow the congenital affection to run its course without treatment.

Dr. Beck replied to the remarks made.

Dr. Browne (J. W.) read notes of a case of tapping where the bladder was opened in the parieties above the pubes and per rectum. He exhibited the patient who was in a state of convalescence. The wound was completely healed. There was some matter coming from the umbilicus the cause of which Dr. Browne explained was an abscess under the pectoral muscle which travel downwards.

Paper:¹ Joseph Bryant, aged forty-three, a foundry labourer, residing at Coar's-lane, Belfast, was admitted into the Belfast Royal Hospital, under my care, upon the morning of the 27th May, 1876, suffering from retention of urine. He gave the following history:—He had been a hard liver all his life. Twenty-three years ago he had an attack of gonorrhœa, the acute symptoms in a short time yielding to treatment, but followed by a gleet, from which he has suffered up to the present date. For the cure of the gleetish discharge he has used various injections recommended by sympathising friends.

Six years since he noticed the stream of urine becoming small, and slightly twisted, and after a drunken spree he was seized with retention of urine. A medical man in town catheterised him with difficulty, lacerating the urethra considerably. From that time till four years since he laboured at various periods—when exposed to cold, or indulged in the use of alcohol—under attacks of retention of urine, which were always relieved by the use of opiates and warm baths.

Some years since he was admitted into hospital, under the care of my colleague, Dr. Murney, suffering from retention of urine. Dr. Murney, after several attempts, succeeded in passing a No. 1 probe-pointed catheter. He remained under treatment thirteen weeks, and was treated by the method of gradual dilatation. Before his leaving hospital Dr. Murney was able to pass a No. 9 bougie. Three weeks after leaving hospital the stricture commenced to contract, and in a few months the stream of urine was smaller than it had been previously.

Upon the 24th May, three days before his admission under my care, he had been drinking to excess, and was exposed to the cold; and upon the morning of the 25th May he was seized with retention of urine. Some medical man endeavoured to catheterise him, but failed.

He was admitted into hospital upon the 27th May, at 11 a.m. The house-surgeon gave patient a warm bath and an opiate. At the expiration of an hour, no urine being voided, the house-surgeon and pupil on duty each endeavoured to pass a catheter, but without success, a quantity of blood flowing from the urethra. He was ordered a warm bath, and liq. opii sed. zss every four hours. The opium was continued until 7 grs. had been taken.

At 2 p.m. I visited the patient, and found the bladder distended above the umbilicus. He was suffering great agony; pulse, 120; temp., 101°. I ordered the rectum to be packed with ice, and to take tinct. ferri perchl. mins. xx. every half hour. At 4 p.m., patient suffering great pain, no urine has been voided; the ice in the rectum had to be discontinued, as it produced great depression. I now tried to pass a catheter, but failed. Dr. Murney met me in consultation at 4 30 p.m., and chloroform being given, he endeavoured to catheterise patient, but failed. The man was suffering greatly, the bladder fully distended; and taking into account the man's previous history, I feared that, as he was probably labouring under organic disease of the kidneys, uræmic symptoms might arise, and owing to the strong spasmodic efforts of the bladder, rupture of that viscus would occur. Dr. Murney agreed with me upon immediate action, and at his suggestion I performed the supra-pubic operation for tapping the bladder, and drew off three and a half pints of highly-coloured urine. I tied the canula in the bladder, and ordered gr. 1 of opium every fourth hour. Beef-tea and milk ad libitum.

27th May (evening).—Pulse, 75; temp., 100.4°; patient greatly relieved; has slept some; urine to be drawn off every fourth hour.

28th.—Pulse, 78; temp., 100.4°; patient under the influence of opium; slight tenderness upon pressure over the right and left iliac regions. Continue treatment, with the addition of linseed meal poultices over the abdomen.

29th.—On arriving at hospital my resident pupil informed me that three hours previously the canula had been removed from the bladder, but by whom I could not ascertain—the patient blaming the nurse, and the nurse stating the patient had removed it. However, at 9 30 a.m., out it was. Upon examination I found a diffuse redness over the region of the bladder. The patient complained of a burning pain in the pelvic cavity; pulse, 120, and very weak; temp., 101°; evidently urinary extravasation had taken place. Dr. James Moore saw patient in consultation, and he also tried the catheter, but failed. Continue opium and linseed poultices, and have a warm bath. At 3 30 p.m. the patient was

¹ [Dublin Journal of Medical Science, 1877, v63, p191.]

very weak, and the diffuse redness over the abdomen had become extensive. I determined to get into the bladder by some means.

Three methods presented themselves:—(1). Puncture through the rectum. (2). Opening the membranous portion of the urethra through the perinæum. (3). Endeavour to pass a catheter through the abdominal puncture into the bladder.

Taking into account the man's debilitated constitution, and, as I said before, the probability of organic disease of the kidneys, I at once discarded the idea of perineal section. I first very gently tried to pass a catheter into the bladder through the abdominal wall, but failed in finding the opening in the bladder. I now determined to puncture the bladder through the rectum, which operation I performed in the usual manner with Cock's trocar and canula. Drawing off ten ounces of highly-coloured urine, I tied the canula in the bladder.

He was ordered gr. 1 of opium every four hours; linseed meal over the abdomen, and brandy ʒss. every hour, with milk ad libitum. Evening.—Pulse, 134; temp., 102°; diffuse redness over the right flank, and slight pitting upon pressure. Two free incisions were made, giving exit to some fluid possessing a strong urinous odour.

30th.—Pulse, 127; temp., 101°; abdomen tender upon pressure. The diffuse redness has now extended to left iliac region; it is much less upon the right side.

31st.—Pulse, 116; temp., 100°; tenderness all over the abdomen. Some urine flowed to-day per urethram, and a little per rectum, by side of canula; diffuse redness not so extensive, but of a darker hue.

1st June.—Pulse, 110; temp., 102°; complains of less pain upon pressure over the abdomen. Drew off eight ounces of urine through the canula, having a highly alkaline reaction, and containing a large quantity of mucus. Some urine passed per urethram to-day.

2nd.—Pulse, 100; temp., 100.2°; tongue furred; tenderness over abdomen increased; complains of pain over region of bladder, and along the dorsum of the penis, which is inflamed. The canula was withdrawn to-day.

3rd.—Pulse, 100; temp., 101°; passing urine, one tablespoonful at a time, every half hour; pain and redness around the abdominal puncture; matter is evidently forming.

4th.—Pulse, 98; temp., 100°; pus flowing freely from the abdominal puncture; urine comes more freely per urethram. Ordered the wound in the abdomen to be syringed with Condy's fluid. Bowels constipated; ordered a stimulating enema.

5th.—Pulse, 100; temp., 98°; had my attention drawn to-day to an abscess which had been slowly forming over the region of the right pectoral muscle; urine coming pretty freely per urethram; patient's expression greatly improved.

I need not detain the members by a detailed account of his daily progress. From June 5th he suffered from constipation of the bowels, which was relieved by enemata. Upon the 13th he was seized with diarrhœa, frequently passing ten and twelve fluid stools in the twenty-four hours. Nearly every remedy in the Pharmacopœa was tried to check the diarrhœa, which eventually yielded to a mixture containing acetate of lead, acetic acid, liq. morphia, and tannic acid. He complained frequently of tenesmus of the lower part of the rectum, and a peculiar burning pain. This was relieved by an enema of liq. bismuthi and starch. His pulse varied greatly during his illness, as also did the temperature. The general average of the pulse was 115, and the temp. 101°.

The abscess over the pectoral muscle, upon the 19th June, was found extending downwards; in a few days it got into the sheath of the rectus abdominis, and eventually discharged itself at the umbilicus. Upon the 24th June I succeeded in passing a No. 4 gum-elastic catheter into the bladder, which I tied in and retained. In the course of twenty days I was able to pass a No. 11 bougie. All urine had now ceased to flow per rectum and through the abdominal puncture. The patient during his long illness was, fortunately, able to take a fair amount of nourishment, which consisted of milk, eggs, and brandy. Upon the 7th August he was discharged from hospital, passing urine in a good stream, and feeling wonderfully strong. I saw this patient upon the 8th November, 1876; he was then able to get about the house, and walk a distance of half a mile. The umbilicus looked red and inflamed; the wound in the abdomen had quite healed; no urine coming either through the abdominal puncture or per rectum.

The members present congratulated Dr. Browne upon the success of his case.

Richard Ross

1876–77.

Third Meeting Tuesday 19 December 1876

Present, 17. Drs. Ross (President), Wheeler (Ex.), John Moore, McKeown, Wales, F. Beck, Dempsey, Pirrie, Stratton, O'Malley, J. W. Browne, Fagan, Spedding, Esler, Coates, Murney, Whitla (Secretary).

The following resolution was proposed seconded and carried. "That having heard with very great sorrow of the melancholy death of Doctor John McCrea we hereby recorded our sincere sympathy with those friends who mourn the demise of one whose life was so valuable and whose removal from our midst is felt to be such a loss not only to his relatives but to society generally and more especially to the Medical Profession of which he was a distinguished member. And especially do we desire to express our deep sympathy with Mrs McCrea and her children who have been so suddenly bereft of a loving husband and affectionate father."

The Secretary was requested to forward to Mrs McCrea a copy of the above.

Dr. McKeown gave a most instructive and able description of operation for trichiasis and entropion describing and figuring a new operation which he had adopted with success.

Paper:¹ Dr. McKeown stated that the observations he was about to make were meant to refer only to those forms of trichiasis and entropion which resulted from cicatricial changes in the conjunctiva, so common in granular ophthalmia. He commented on various operations—the operation of scalping, or, in other words, cutting off the margin of the lid with the roots of the hairs, he considered to be now no longer a legitimate operation, as we had a choice of several methods which were conservative and not destructive. The destruction of odd hairs by caustic or cautery should not be thought of, as, in the contraction of the tissues which ensued, other hairs would probably be caused to deviate. The endeavour to correct the intertwining of the hairs on the margins of the lids by removing a piece of the skin of the lid, so that the contracted skin would act as a counteracting force to the contraction of the conjunctiva, was generally most unfortunate in the end. The contraction taking place on both the outside and inside of the lid usually brought about a diminution in the depth of the lid, and when this took place to any considerable extent, the lid ceased to be a sufficient cover and protection for the eye during sleep. It was usually only by a great loss of skin that sufficient “tilting” forwards and outwards of the margin of the lid could be secured. He referred particularly to Arlt Jaesche’s operation, which consisted in detaching a very narrow strip of the outer margin, containing the cilia, leaving only a narrow attachment at the inner and outer canthus, and then transplanting this band to a higher level on the lid, the way being prepared for this change of position by the removal of a semilunar fold of skin adjacent. It was well known that this operation was very satisfactory in the great majority of cases; but it was acknowledged to have some drawbacks—viz., 1st. The liability of the narrow band to slough, in consequence of its two very slender connexions with the rest of the lid; 2nd. The loss of skin; 3rd. The very protracted and painful character of the operation. Dr. McKeown then demonstrated a mode of operation free from all these objections, and which consisted in the fact of gliding the whole skin of the lid with the hairs upwards, whilst the tarsal cartilage and conjunctiva were pulled downwards. In Arlt’s operation there is, on the contrary, the transplantation of only a narrow band. The operation is performed as follows:—The lid being supported and made tense, by a flat horn protector, introduced between it and the eye-ball, the operator enters Graefe’s narrow knife at one extremity of the lid, at the margin between the cilia and

Meibomian ducts, and pushes the knife vertically into the lid as far as he can conveniently, and then cuts along to the other extremity of the lid, still following the line between the cilia and the Meibomian ducts. The point of the knife must not be made to emerge through the skin. In this way the lid is completely split, and the two layers will glide freely on each other. The next step of the operation consists in passing through the tarsal cartilage, which is contained in the conjunctival layer, three strong threads, one at the middle point, and the two others near the outer and inner extremity, respectively, at the distance of about a line or a line and a half from the margin. By means of these threads the cartilage is pulled down towards the cheek, and, when sufficient traction has been made, the threads are to be attached to the cheek securely by adhesive plaster. After the first strip of plaster is placed over the threads, the ends are to be turned up over the plaster and another strip superposed. In this way the threads will not slip. A strong thread is then passed through the outer or cutaneous layer, not far from the cilia, its point of entry and exit being both in the skin, and at equal distance from the hairs. By this thread the skin layer, with the hairs, is drawn up, and then the thread is secured to the forehead by plaster. A little nicety is required in so inserting this thread and making traction that the hairs may be tilted outwards and upwards, and raised sufficiently, but a knowledge of this can only be attained by experience and a careful observation of each operation. The degree of separation between the margins of the outer and inner layer can be regulated at the will of the operator. It is well to have a separation to the extent of two lines at the least. As regards the thread passing through the skin layer, it is advisable not to allow it to remain more than two or three days, whilst those passing through the tarsal cartilage may remain several days longer. The insertion of the threads is an essential in this operation. If not done, the elevator of the lid, which still remains attached to the tarsal cartilage, would, in all probability, draw the cartilage up inside the skin layer, so that the hairs would be just as badly placed as before. The operation may be modified in various ways. For instance, in thickening of the cartilage and deformity, the cartilage may be grooved, pared, or otherwise dealt with, as Streatfield and others have proposed. Dr. McKeown concluded by stating that he frequently operated in the manner described, and always with the best results. The operation might be performed in a few minutes, whilst for Arlt Jaesche’s half an hour or upwards was required. No skin was removed, and, consequently, there was no scar, and no tightening or contraction of the lid. Sloughing was not to be dreaded as in Arlt Jaesche’s operation, as both the cutaneous and inner layer had most extensive vascular connexions with the adjacent parts. And, finally, when the healing process is completed, it would require a practised eye to detect that anything had been done.

¹ [Dublin Journal of Medical Science, 1877, v63, p297.]

Dr. Murney said he had operated by the older methods, especially by that of Arlt. The operation now described was entirely new to him. He approved of the principle.

Dr. M. Moore had been present at some of the cases while Dr. McKeown operated. He was glad to hear of their success, and thought the operation a great improvement. It was simple, expeditious, and highly satisfactory; and, were he called to operate himself, he would decidedly follow Dr. M'Keown's plan.

Dr. J. W. Browne had considerable experience in operating for trichiasis and entropion, which he did by the older methods. As regarded the operation described, he had seen Dr. Perceval Wright operate by a method which seemed to him very similar to that of Dr. McKeown, about nine years ago.

Dr. Wales was pleased with the ingenuity of the operation. He thought it was a decided improvement upon the older methods.

Dr. Wheeler commented upon its principle, which he thought was a sound one, and must be followed with a better result than the more elaborate and complicated operations.

Dr. Ross (the President) endorsed the remarks of the members present. To him the operation seemed a decided success. He reviewed the older operations, and agreed with Dr. M'Keown.

Dr. Esler said that, having had the advantage of being a former pupil at the Eye, Ear, and Throat Hospital, he had seen Dr. M'Keown's method of operation carried into practice, and could bear testimony to the fact that it was expeditious in the performance and highly successful in its results.

Dr. Murney read notes of a successful case of ovariectomy (operated upon in the Royal Hospital) and exhibited the cyst which he had removed.

Paper:¹ Dr. Murney described a case of ovariectomy, performed by him on the 23rd November, resulting in recovery, the wound being almost entirely cicatrised, and the patient out of bed on the 24th day from operation.

The leading facts of the case were:—A widow, aged thirty, otherwise healthy looking, who had never been pregnant, seven years since noticed a small movable tumour in the left side of the abdomen. From May, 1876, this rapidly enlarged. Early in October she had acute pain in the abdomen, which continued for several days, and which compelled her to seek admission into hospital. For some time prior to operation the pain had subsided, but the abdomen was so large she could not approach the recumbent posture.

23rd. Nov.—The patient having been chloroformed, an incision was made from a short distance below the umbilicus to about one-half inch above the pubis. On exposing the tumour its anterior surface was found to

be adherent to the parietal peritoneum. These adhesions were broken down by the finger and the sac punctured by the canula. Twenty pints of the usual ovarian fluid were drawn off. The diminished mass was now readily drawn through the wound, as there were no adhesions binding it posteriorly. A Liston's needle, armed with dentist's silk, was passed through the pedicle (which was short) and the two ligatures tied, then another ligature was carried round the two, the pedicle cut, and the uterus allowed to fall back into the pelvis. The ends of the ligatures were carried out through the lower part of the wound. The right ovary was healthy. Six sutures brought the incision together. A pad of lint, saturated in carbolic oil, laid on, then a dry pad and a flannel roller. A suppository of half a grain of hydrochlorate of morphia administered, and repeated at bedtime for eight days, when one quarter grain was used for four nights. After this no further anodynes were required.

	Temperature		Pulse	
	9 a.m.	9 p.m.	9 a.m.	9 p.m.
23rd Nov., ...	98.4°	100.8°	86	92
1st day, ...	100°	100.8°	104	120
2nd day, ...	99.2°	98.4°	110	115
3rd day, ...	99.2°	99.2°	108	100
4th day, ...	98.2°	98.4°	100	100
	Normal afterwards. Steadily came down.			

Measurements of Abdomen.

	Before Operation.		After.
	30 days	5 days	26 days
Circumference at umbilicus,	39½	41	28
Pubis to umbilicus,	7½	9	4½
Pubis to ensiform cartilage,	17	19½	10
Umbilicus to ensiform cartilage,	9½	10½	6
Umbilicus to anterior superior spine, on each side,	9¾	10½	5

On the fourth day there was slight action of the bowels without medicine.

On the fifth two sutures were removed, and menstruation commenced and continued for three days.

On the sixth the remaining sutures were taken out.

On the twentieth the ligatures came away.

On the twenty-fourth she was out of bed for the first time.

In addition to the large sac containing the fluid which was drawn off, the tumour was made up of four other sacs, small, and the contents were much more viscid and much more opaque than the first mentioned.

¹ [Dublin Journal of Medical Science, 1877, v63, p291.]

Dr. J. W. Browne congratulated Dr. Murney upon what he said was the first known case of ovariectomy in the North of Ireland. Other cases, he believed, had been successful; but this was the first published one. He detailed two fatal cases in the Belfast Royal Hospital. He approved highly of the details of the operation, which he would exactly follow, were he called on to operate.

He censured Dr. Wells' trocar and canula as a delusion. He saw it used in three cases, and in all it failed in its object. He did not think that tapping a few days before the operation would lessen the shock to the patient's system, nor did he think it would facilitate, in any way, any step of the operation.

Dr. John Moore, in congratulating Dr. Murney upon the success of his operation, referred to the successful case of Dr. Thompson of Lisburn—the first, he stated, in the province of Ulster. He had thought this a most suitable case for operation, and so it had turned out. As regarded tapping, he thought that tapping before operation would prevent the surgeon distinguishing between the cyst and the peritoneum—a most important point. He was present at the operation, and would say there was not a detail upon which he thought he could improve. Drs. Stebbing and Wheeler saw no advantage in tapping.

Dr. McKeown reviewed the history of the operation, and referred to the great success of Spencer Wells and others. As regarded the remarks of Dr. Browne, he thought that when a man of such vast experience in ovariectomy as Wells—experience which could not be hoped to be within the reach of any present—approved and used constantly in his practice any instrument, he thought they were called upon to follow him.

Dr. Fagan congratulated Dr. Murney, not so much on the success of his operation, as for his superior diagnostic powers, which were well shown by his selection of so suitable a case for operation. The mere mechanical quality of doing an operation well, was, he held, no test of true ability in a surgeon, while acute diagnostic powers entitled him to the highest rank. Why it was that many operations of great merit had fallen into disrepute was, he believed, due to the bad selection of cases for operation—not to the operation itself. He was present at an operation for ovariectomy a few years ago at a London hospital. The patient was under the operation for two hours or more. The cyst was adherent throughout. The surgeon, in the most dexterous and fearless manner removed it, and the patient died two hours afterwards. It then occurred to him had the surgeon been as acute in diagnostic powers as he was dexterous and fearless in the use of the knife, he would have rejected it as unsuitable for operation. The opening of the abdominal cavity should not be considered, as it usually was, so formidable an operation. He saw every week in the journals reports of successful cases of abdominal section for cases of intussusception, of ovariectomy, and, occasionally, of Cæsarean section. When

suitable cases were selected, and ordinary care taken in its performance, he believed ovariectomy should not be attended with much more risk than ordinary amputation.

Dr. Whitla (Secretary) did not approve of the theory of tapping a few days before the operation to lessen the shock. He narrated three instances where serious collapse followed tapping, and on the third day alarming inflammatory symptoms supervened from incomplete evacuation of the contents of the cyst. Many such cases were published by Mr. Wheelhouse of Leeds, and he thought it unjustifiable to subject the patient to a double risk, but he approved of tapping as an aid to diagnosis.

1876–77

Fourth Meeting Tuesday January 2nd 1877

Present, Drs. Ross (President), Wales and Browne (Vice-Presidents), Fagan (Treasurer), Whitla (Secretary), Murney, Grattan, Core, Coates, Esler, McIvor, Pirrie, Strahan, Spedding.

A ballot was taken and Dr. Adam Reid and Dr. McIvor were elected.

Dr. Fagan read notes of a case of malignant tumour of the orbits and illustrated it with water drawings and photographs.

*Paper:*¹ Daniel Macklin, a young anæmic child, aged seven years, was admitted under my care at the Children's Hospital on the 13th October. He was suffering from diarrhœa at the time, and was delicate for four or five months previously. There was a tumour on the left temporal region, limited by the boundaries of that fossa. The eye was protruded and ecchymosed, and he sometimes complained of it as being painful and itchy. The only history I could get in connexion with the case was that, about six weeks previous to my seeing him, the eye was noticed to be somewhat more prominent than its fellow, and the temporal region somewhat fuller than the opposite one. The only cause the parents could assign for this condition was that, a short time previously, while hammering something with a poker, it rebounded, giving him a sharp blow on the temple. It caused acute pain at the time, but did not afterwards trouble him. Careful manipulation of the swelling conveyed an indistinct sense of fluctuation, as if matter existed deeply in the tissues. This was my diagnosis at the time, and it was confirmed by some other medical men who saw the case with me. That it was a case of deep-seated chronic abscess I considered most probable for the following reasons:—First, the history of the case would point to the blow on the temple as being the exciting cause; next, the symptoms following might be those of inflammation, of a sub-acute form, of the deep cellular tissue, the matter formed being bound down by the dense structures in the temporal region, made its

¹ [Dublin Journal of Medical Science, 1877, v63, p380.]

way through the parts that offered least resistance. This I believed to be through the sphenomaxillary fissure into the orbits. This condition of things, I satisfied myself, could account for the protrusion of the eye-ball and the swelling in the temporal region. Accordingly, after a few days, when I got the lad's health into a better state, I put him under the influence of ether, and made an incision over the great wing of the sphenoid, right down to the bone. Nothing came away but a little blood. I then passed a narrow-bladed knife along the outer wall of the orbit, back into the sphenomaxillary fissure, and with the same result. Water-dressing was applied, and the lad put back to bed. No bad effects followed the wounds made in exploring the parts. They healed up in a few days. When I satisfied myself that the swelling was not due to an abscess, I was inclined to look on it as malignant. The only treatment I now employed was to protect the parts, keep them clean, and support the child's constitution. The temporal enlargement went on steadily increasing. The eye-ball became still more protruded, the conjunctiva very vascular and swollen. The cornea, at first clouded, became ulcerated, and covered with crusts of dried secretion; the tears flowed over the cheek, and were of a dirty, muddy character. He slept pretty well, and eat well, and complained only occasionally of pain. This was his condition on the 29th, about a fortnight after his admission, and at this time I noticed a swelling in the right temporal region, of the same character as the other, in its earliest stage. In two or three days this increased, and the right eye-ball began to protrude. I had now no doubt about the malignancy of the affection, and acquainted the parents of the hopelessness of the case. The child was removed home, and I did not see him until November 20th, when I got photographs taken. He then presented the appearance that is pretty well shown in the likeness—that is, the former condition of parts very much aggravated. He appeared completely broken down in constitution, and exhibited in his appearance what is supposed to be the characteristic cancerous cachexia. His appetite was bad; he became peevish and irritable; his sleep was restless and irregular, and he sometimes awoke with a scream. Three days before his death he got a short, teasing cough, the lower extremities became œdematous, and he complained of difficulty of breathing and pain about the chest. He died on the 9th December.

This case, Mr. President, I have found to be most instructive. It shows that no matter how careful the surgeon may be in considering the causes and symptoms, he may be mistaken in his diagnosis; and, what is of more importance still, he may hold out hopes, or predict gloomy results, only to find himself and his patient disappointed in the end, or, taking hasty action on his decision, he may cause an unnecessary sacrifice of parts. In this particular case the action taken on the diagnosis could not in any way leave it in a worse con-

dition, while it assisted very much in throwing more light on the subject. The importance of forming a correct diagnosis is more evident when one of the limbs is the subject of a similar tumour, and that the question of amputation has to be taken into consideration in its treatment. Mr. Holmes, in speaking of the difficulty of establishing a diagnosis between ostitis and malignant disease, says that he has known at least three cases in which amputation at the hip-joint had been contemplated for a malignant affection of the femur, which turned out afterwards to be of a simple inflammatory nature. And after going over the various symptoms that aid one in their diagnosis in such cases, he says one practical consideration must occur to the mind of anyone charged with the responsibility of a case of this kind—viz., that no operation ought to be performed while any doubt whatever rests on the diagnosis. If the case is one really of cancer, the operation is, at the best, of doubtful value; if it is ostitis, it be worse than superfluous. Dr. J. W. Browne said he had the advantage of seeing the patient, and when he saw him he thought it was a case of abscess at the back of the orbit, pushing forward the eye-ball, and that it was the result of the injury, which was so clearly stated by the parents.

He said there were cases narrated by Mackenzie and others where soft cancer (encephaloid disease) had immediately followed injury. He considered this case one of these, and pointed out the resemblance between this and strumous disease, the differential diagnosis between them being that in cases of strumous disease, where the eye-ball bursts, it collapses, while in the encephaloid it increases in size. The disease had probably commenced in the brain or ethmoid bone.

Dr. Dempsey thought that if the disease had commenced in the brain cerebral symptoms would have shown themselves.

Dr. Wales saw two cases of cancer in young children of cerebral origin. In both death resulted from secondary deposits—in one in the thoracic, and in the other in the abdominal viscera, and in both cases no cerebral symptoms showed themselves, the children remaining clear till the end.

Dr. Coates thought if this was a case of cancer, it was certainly most unusual in one so young.

Dr. Whitla said Dr. Fagan had referred to the use of the ordinary hypodermic syringe which he (Dr. Whitla) had tried in this case to clear up the diagnosis. He had used it often, and never saw it fail to detect pus in any case where the after-course showed there had been pus. He saw it recommended first for the diagnosis of fluid in the pleura.

He used the syringe in this way—after seeing the piston was air-tight, he half filled the cylinder with water, introduced the needle into the suspected abscess, and injected three or four drops of water to clear the needle, then a few turns of the screw brought the pus ascending through the clear water in the cylinder. He

thought that, in ordinary practice, it was vastly superior to the aspirator. The needles which he used he had made by Gardner of Edinburgh. They were of extreme fineness, and caused little pain.

Dr. Murney exhibited a compressed fracture through the knee joint of three months standing removed the week before. The man was progressing very favourably.

Paper:¹ Dr. Murney exhibited a specimen taken from a patient who had sustained a compound comminuted fracture through the knee-joint three months ago, by the falling of the framework of a ram. The injury was followed by intense collapse, in which condition he was admitted into hospital, and it was the unanimous opinion of the surgeons that it would be unwise to amputate, the patient was so low.

In this condition he remained for some days; and when the question of secondary amputation came to be considered, he was so prostrated by the profuse discharge which poured from the wound, as well as by a most obstinate and wasting diarrhoea, night-sweats, and loss of appetite, that the question of operation could not be entertained till about three weeks ago, when he amputated by Carden's method, and the patient made an excellent recovery, being now nearly convalescent.

The specimen showed that the patella was removed, and the section made through the lower-third of the femur at its junction with the middle one-third. The fracture was T-shaped. The inner condyle of the femur was detached, the outer was externally rotated, and partially united to the shaft. The knee-joint was found partially ankylosed, being united by a kind of fibrous or ligamentous union, and which never could have been of any service to him. Three or four pieces of bone exfoliated, and became sources of great irritation.

Dr. Fagan asked if the fracture had been diagnosed at first as passing through the joint; if so, after the shock had passed off, he thought primary amputation should certainly have been performed. The fact of his surviving, and the after-history of the case, proved this. With Dr. Murney's remarks about tying large veins he quite agreed, but preferred torsion. He had twisted the femoral four times, and was pleased with the result.

Dr. Coates (House Surgeon) said the idea of primary amputation could not be for one moment entertained. The shock lasted for five days, during which he was fed upon stimulants.

Dr. Wales thought the case interesting from a medical point of view, and inquired was the liver enlarged or the urine albuminous?

Dr. Browne, who had seen the patient a few days after the injury, when he first came under his care, found the limb up in the long splint, which he at once

changed for Macintyre's. The liver was enlarged. Urine contained no albumen; discharge was profuse, and symptoms of pyæmia soon showed themselves. He was told amputation was out of the question from the first. The diarrhoea was most obstinate. He found lead and opium had some effect; but this soon produced drop-wrist, and marked the gums, and had to be discontinued. He was most anxious to amputate, but never saw a suitable opportunity. The patient then passed into the hands of Dr. Murney, and it was not for some time after this that any hope of a successful operation was entertained.

Dr. Ross thought the case had a very successful termination. He always looked upon the knife as an opprobrium; but, certainly, it seemed to him, in this case, that it had saved a life. He questioned very much the issue if the knife had been used at first, from the description which he had heard of the patient's condition.

Dr. Spedding read notes of puerperal convulsions the discussion on which was postponed till next meeting.

Paper:¹ THE coincidence of meeting with two cases of puerperal eclampsia within the same week, last summer, induced me to take notes of them at the time, with the view of bringing them before this Society. They are peculiarly interesting, inasmuch as they appear to be typical cases of the two great varieties of this disorder, the first being of the apoplectic kind occurring before delivery, and the other of the epileptic form occurring after the complete termination of labour.

CASE I.—On the morning of the 12th June I was called upon to assist Dr. Newett, of Ligonieil, in a case of difficult labour. Upon my arrival Dr. N. informed me that his patient, a very stout, plethoric woman, aged thirty-one, a primipara, had been about two days in labour, first stage, but that during the last twelve hours she had been in convulsions, which were at first tonic, but had then become less severe, although recurring at very frequent intervals. When I saw her she was in an insensible condition, with excessive muscular twitching; pulse about 140, and very feeble. The head was at the brim; the os rigid at the edges, but soft and thin all round. The only chance of the patient's life appeared in immediate delivery, but the modus operandi occupied our serious attention.

The os uteri would only admit the index finger to the second joint, and showed no signs of dilating. The state of the pulse put blood-letting out of the question; and remembering that craniotomy had a prejudicial effect in such cases, by exciting reflex action and thus increasing the paroxysms of convulsions, we decided upon incising the os sufficiently to enable the hand to be introduced for the purpose of performing podatic version.

¹ [Dublin Journal of Medical Science, 1877, v63, p382.]

¹ [Dublin Journal of Medical Science, 1877, v64, p175.]

I should here state that the bowels had been freely opened by doses of *pulv. jalap co.* and croton oil, and that the patient had been cupped upon the nape of the neck. I put her fully under the influence of chloroform, and Dr. Newett introduced a Lund's abscess knife within the os, and cut backward in the median line to the extent of about half an inch. He then gradually dilated the os with two and then three fingers. In about ten minutes he was enabled to introduce the hand, and he brought down the feet without much difficulty. The incision did not extend into the fundus, although great traction by the forceps was required to disengage the head. We left her free from convulsions, but semi-comatose, and with stertorous breathing, which continued for eight hours afterwards, when consciousness gradually returned, and I was gratified to learn that she made a good recovery within ten days, without the occurrence of any inflammatory symptoms. I should have said that before labour set in there was considerable œdema of the legs and face, and that the urine contained a large quantity of albumen.

CASE II.—On the 19th June last, I was hurriedly summoned to visit Mary Edmonds, a young woman, aged twenty-four, who had, I was told by the messenger, been delivered of her first child that day, about six hours previously. I found her in a severe epileptic convulsion, quite unconscious, frothing at the mouth, face livid, and having to be held in bed by three persons to prevent her falling out. The history I got from her sister was, that she had been always healthy, never had had any fits, and that she had an excellent confinement, being only ill three hours. The urine contained no albumen, and the only cause I could assign for the attack was, that the day before she slipped off the curb-stone and got a severe shake; afterwards she walked home somewhat frightened, and that night it brought on labour, about a fortnight before she expected it. I at once administered an injection of soap, warm water, and turpentine, in the meantime sending in haste for chloroform. The enema produced no apparent effect, the convulsion continuing with great severity for more than half an hour. I then put her under the influence of chloroform, which had a marked effect in controlling the convulsion. A second, however, succeeded the first, which only lasted ten minutes; and at the commencement of the third, I decided, in the extremity, of bleeding from the arm, inasmuch as the pulse was full, or rather bounding, and about 120. This I did to the extent of about 35 ozs., from the right median basilic vein. The fits continued, though severe, and only lasting a couple of minutes.

At 11 p.m. I met in consultation the medical gentleman who had attended her in her confinement the same forenoon. He had been out of town during the afternoon, and was much surprised and grieved at the untoward turn the case had taken, having, as he said, rarely attended an easier or more natural first case. We

placed calomel and croton oil on the tongue, which the patient could not swallow; ordered a fly blister to the nape of the neck, and sinapism to the chest and feet. She continued convulsed at intervals during the night, and died the following morning at 10 a.m., twenty-four hours after delivery.

With regard to blood-letting in the second case, I have to observe that, although it is not so generally recommended in convulsion occurring after delivery, I felt justified in trying it in this case, from the following reasons:—The character of the pulse, the absence of any post partum discharge, the fact that the patient was unable to swallow any sedative medicine, and especially from the fact that the anæsthetic had failed to produce any permanent effect. Monsieur Charpentier, of Paris, in a valuable thesis, written three years ago, endeavours to show that the mortality in this affection was thirty-five per cent, treated under the old treatment of general bleeding, and only eleven per cent, in those treated by anæsthetics, foremost amongst which ranked chloroform and chloral. The fact that doctors differ is well shown in the opinion of several eminent obstetricians on the question of prognosis in this affection—Paget, Blot, Dugés, and others asserting that eclampsia occurring after delivery is far more amenable to treatment than other forms; while Ramsbotham, Churchill and other eminent observers hold the very opposite opinion.

On these various subjects, which are pregnant with interest, I await with a degree of pleasure the views of the different members of this Society.

Richard Ross

1876–77

Fifth meeting Tuesday January 16th

Dr. Ross (President), T. K. Wales, J. W. T. Smith, J. W. Browne, John Fagan, Fred Beck, S. B. Coates, Pirrie, Strahan and Whitla—Secretary.

An extended discussion arose from Dr. Spedding's paper on "Eclampsia Puerperal" in which the members present joined after an opening speech from Dr. Ross. The remarks will appear in the transactions.

Paper:¹ The PRESIDENT opened the discussion with a review of the symptoms and treatment of the affection. He said that owing to the importance of early treatment too much attention could not be paid to the value of the premonitory symptoms, and foremost among these was headache. This headache he found was always severe and constant; it was to be noticed in a large percentage of all cases of puerperal convulsions; it was to be noticed, too, at an early date—often, indeed, before dizziness, motes, and other sensations complained of by the patient—next was seen œdema of the face and fingers, and albuminuria. The attack then supervened; at first, tonic contraction of the muscles of

¹ [Dublin Journal of Medical Science, 1877, v64, p177.]

the body followed by clonic convulsions, especially of the muscles of the face, and, after an interval of variable duration, partial obliteration of consciousness or coma, more or less complete. This condition of matters generally brought on labour, a process requiring for its satisfactory and safe termination that balance of all the forces found in healthy parturition. He was glad to state that the mortality had very considerably fallen since the practice of free blood-letting had fallen into disuse. As regards the pathology of the disease, there was great room for difference of opinion. He would direct attention, in the first place, to the state of the blood in pregnancy. All observers agreed, to the nature of its composition, that it was "watery," the well-marked anæmia of this condition being familiar to all. Secondly, he would remind them of the altered and increased arterial tension; and, thirdly, of the hypertrophy of the heart. Now, what did these three things produce? temporary cerebral congestion—the principal element in the disease. This afforded an explanation of how bleeding was sometimes beneficial; there was also œdema of the cerebral tissue, and this effusion pressed upon the vessels and finally produced anæmia of the tissue. He thought, then, that it was high time to give up the practice of bleeding, since it directly produced anæmia of the brain substance; he thought it might be possibly of good in some cases, but he never met such; and he thought the high rate of mortality was chiefly, if not solely, owing to this practice. His own treatment consisted in free and speedy purgation; the form of purgative he found most suitable was that which acted most speedily and efficiently, and he gave it in large and repeated doses. As regards the use of chloroform, he highly approved of it in some cases, and the rule which guided him in its administration was, to wait for threatening convulsions, and anticipate them with the anæsthetic. Chloral hydrate he found very useful sometimes, especially in the post partum variety of eclampsia. Hypodermic injection of morphia he had used, and seen used with good results, its chief advantage being the rapidity of its action, and the ease with which it could be administered. The most important and serious part of the treatment was, what to do with the uterus and its contents. He would say, rupture the membranes, and induce by all means speedy contraction of the organ; he did not like to interfere with the os. The best rule, he thought, that could be laid down for this part of the treatment was, as soon as possible, to empty the uterus.

DR. F. E. BECK said he never bled in convulsions coming on, during, or after labour. He had seen cases where this treatment was adopted, and it seemed to him with anything but good results, so that he never did intend to extract blood. As regarded the pathology of the disease, he believed in the reflex theory, which seemed to him the most rational and satisfactory. He had now attended upwards of 4,000 cases of labour containing

several (he did not recollect how many) cases of puerperal convulsions, and, he was glad to say, he never lost a case from this disease. He believed in purgatives, and in watching for symptoms; if we looked out in every case for the first warnings of the attack, our treatment, he believed, would be much more satisfactory and successful.

Dr. J. W. BROWNE said he believed the pathology of the affection was almost entirely identical with that of Bright's disease in the acute stage. Doubtless, very good authorities differed from this—a circumstance which lead him to believe that there might be two classes of the disease. He detailed some cases which he thought supported this view, one of which the ex-President, Dr. Wheeler, had seen with him. He hardly thought he could say that bleeding was unsuitable in every case. Doubtless, recoveries were recorded. The difference in the mortality did not necessarily depend upon the disuse of the blood-letting; in some hands it was succeeding even yet.

Dr. J. W. SMITH said that the President had not referred to the uræmic theory of puerperal convulsions. No doubt, cases of this affection, when no albumen has been found in the urine, had been recorded, and he supposed it was to such that the theory advocated by the President referred. Although he did not deny the occasional occurrence of such cases, he looked upon them as exceptional and comparatively unimportant. In his own experience he had met with no case in which the urine did not contain a large amount of albumen, and was also scanty. He believed that, in the great majority of attacks of puerperal eclampsia, the kidneys were in a state of passive congestion, or in a condition very similar to acute Bright's disease. This condition he looked upon as resulting from the mechanical pressure produced, by pregnancy, on the renal veins and inferior cava. In support of this opinion he referred to the fact of the frequency of eclampsia in primiparæ when the parts are resistant, and to the fact, that the albumen does not appear until the later period of pregnancy, when the pressure on the veins is greatest. He had seen cases in the later months of gestation where, the urine being scanty and albuminous, intense headache and slow pulse appeared to indicate that convulsions were imminent, and where they were averted by free purgation, mustard poultices to the loins, and such other treatment as would be adopted in similar conditions in Bright's disease. As regards the cases which had been brought before the meeting, and which had originated the discussion, he could not agree with the treatment pursued. He certainly believed that in all these attacks it was desirable to empty the uterus with as little delay as possible, but in many cases labour had not yet begun, or had but little advanced, and a precipitate attempt to deliver would be attended with great danger both to mother and child. Bloodletting had been recommended in these cases by many eminent authorities, but he

never used it, and had no reason to regret that he had not done so. He had lately seen three cases in consultation. In the first the patient had suffered from convulsions in her first pregnancy. She again became pregnant, and at the end of seven months anasarca appeared with albuminous and scanty urine. Two days afterwards convulsions set in, but no sign of labour. The bowels were freely opened, the membranes ruptured, and chloral given by enema. The fits recurred at longer intervals and ceased entirely 36 hours before the birth of a living child, which took place three days after the first convulsion. The urine of this patient was repeatedly examined after her first pregnancy, and was quite free from albumen. In the second case the patient's urine became albuminous in the last month of pregnancy, and she had a convulsion soon after labour commenced. The bowels were acted upon, and the membranes ruptured; there was no recurrence, and she was delivered in a few hours of a living child. In the third case the patient, when seen, was comatose, and craniotomy was performed. The convulsions continued for several hours after delivery and then ceased, the patient becoming quite conscious and promising a good recovery, but congestion of the lungs set in on the 4th day, and death occurred in 48 hours. Albumen, no doubt, was occasionally found in the urine of pregnant women, and no evil results followed, but he had seen no case of puerperal convulsions when it was absent from the urine.

DR. T. K. WHEELER agreed with Dr. Smith. He had seen no case of puerperal convulsions in which there was not more or less albumen in the urine, generally a large amount, and he, therefore, believed that the kidneys were at fault in many, if not all cases. His first case occurred about 25 years ago; he had met many since then, and all were primiparæ except one. He detailed the particulars of a patient who had convulsions in one labour, and next time showed all the symptoms—albuminuria, anasarca, &c., but with free purgation no convulsions followed. His experience was altogether against blood-letting; he became early influenced in this way by hearing a paper which the late Dr. Pirrie read before the Society many years before. His practice was to induce labour, losing no time in having the uterus emptied, and he purged freely. Of the various drugs which he had tried with this intention, he had given all up for croton oil—it was the safest and speediest, and by far the most effectual. The form in which he generally administered it was:—2 drops with 1 drachm of compound jalap powder in 8 powders; 2 immediately in wafer paper, and the remainder to be given as circumstances indicated. These he looked upon as the main points; then the administration of chloroform, as the President had recommended, he found very useful in modifying the frequency and force of the convulsions. Believing that the explanation of the eclampsia lay in its uræmic character, and that the convulsions

only occurred when the urea was changed into carbonate of ammonia, he had tried tartaric acid as an antidote, and was sometimes struck with the rapidity of its action, but it was not to be relied on. Benzoic acid he thought more favourably of; in addition to its acid reaction, it stimulated the renal organs, and in that way often proved very beneficial.

DR. WHITLA (Hon. Secretary) had heard the remarks of the President with interest, especially those touching upon the pathology of the disease, which, however, he did not agree with. But he thought it a step in the right direction, as he had not once referred to the kidneys. There were few diseases or conditions upon whose pathology a greater variety and difference of opinion existed; indeed, in looking over the history of the subject he found that most of the organs of the body had been, at one time or other, seized upon as the parts at fault.

Excluding those cases where pregnancy supervened upon Bright's disease, much, he thought, yet remained to be learned. He had satisfied himself that a study of the functions of the liver would throw much light upon many such cases. The albumen of the food, after its absorption, must be changed into colloid albumen, else it will pass out of the vessels as readily as it gained admission into them—in other words, crude albumen must be assimilated to the albumen of the blood, otherwise it cannot circulate with it, but is instantly picked out by the kidneys, and washed away in the urine. This assimilating process takes place in the liver. Now, anything which interferes with this function of the liver prevents the albumen undergoing the necessary change, and determines its appearance in the urine, where it is readily detected, leading constantly to the conclusion that these organs are the seat of the disease; while, if rightly interpreted, he thought it was but evidence that they were fulfilling their function efficiently. In puerperal eclampsia were seen the very conditions which would be expected to disturb the functions of the liver, especially in first cases. Speaking of the actual cause of the convulsions and coma, he referred to a paper which he read before the Society upon "Uræmia in Liver Affections" (Dub. Monthly Journal February, 1876).¹

The liver manufactured the urea out of the effete products of wear and waste, the office of the kidney being merely to throw it out after its elaboration. Consequently, when this function of the liver was deranged, these products were not reduced to urea; but the process stopped short, and intermediate compounds—tyrosin and leucin—were formed, substances which the kidney could not so easily eliminate, and which, therefore, accumulated in the blood and gave rise to symptoms similar to poisoning by urea, from which substance, in chemical composition and physiological

¹ [Page 1237.]

effect, they differed little, and might practically be regarded as modifications, possessing lesser solubility. In respectfully submitting this theory to the consideration of the Society, he ventured to hope that they would see in it a satisfactory explanation of some cases of puerperal albuminuria with convulsions otherwise difficult to clear up. As regarded the difference of opinion about treatment, this might be explained—one authority strongly condemning bleeding as almost certain death, while recommending copious and excessive purgation. He saw no difference in such cases; one bleeds by the bowel, while the other opens a vein, and good results might follow each. Either would effectually help to unburden a loaded liver in its action.

On the motion of Dr. Wheeler seconded by Dr. Ross, the following Microscopic Committee was appointed: Dr. J. W. Browne, Fagan, Coates, Wales, Core and Whitla, the latter to act as convener.

On the motion of T. K. Wheeler seconded by J. W. T. Smith, Professor Cunningham was proposed as an Honorary Member of the Society.

Dr. Fagan exhibited a patient upon whom he had operated for disease of the tarsus. He postponed reading the notes of the case till next meeting.

Richard Ross

Session 1876–77

Sixth Meeting 30th January 1877

Present, Drs. Ross, Wales, Moore John, Dempsey, Coates, Core, Esler, Whitla, Spedding, F. E. Beck, Dr. Johnston

The question of an election of an Honorary Member (Professor Cunningham) was discussed and it was the wish of majority of the members present to postpone his election to next meeting when Professor Redfern, proposed by Dr. Esler, should be balloted for at the same time. In the meantime the Secretary was directed to look for any rule bearing upon the subject.

Dr. Pirrie and Dr. McKeown whose names appeared in the circular (convening the meeting) for the reading of papers did not present themselves at the meeting.

Dr. J. W. Browne read notes of a case (treated by silver wire sutures) of fracture of the lower jaw.

Paper:¹ J. M., a carpenter, aged twenty-two years, was received into the Royal Hospital under my care upon the 25th September, 1876, suffering from a double fracture of the lower jaw, caused by a blow which he had received during a drunken row ten hours previous to admission.

Upon examination the house-surgeon found that there was a double fracture—one being vertical, and upon the left side of the jaw, and close to the symphysis; the other oblique, and situated at the angle of the right side. The mucous membrane in the neighbourhood

of the angle was extensively lacerated, and there was constant bleeding from this point. The tissues over the region of the hyoid bone and thyroid cartilage were swollen and tense. The patient complained of great difficulty in swallowing, and breathing was much impeded. The right side of jaw was depressed; the teeth hung one inch below the level of the teeth upon the opposite side. The hæmorrhage was checked by the local application of tinct. ferri, and evaporating lotions were ordered to be applied over the upper part of the neck and face; he was also ordered a mixture containing sulphate of magnesia, tartar emetic and liq. morphiæ. No splint or bandages were used to keep the fragments in position, as the most trifling pressure caused a sense of suffocation.

During the following six days there was high inflammatory fever and severe constitutional irritation. The respiration was seriously affected—so much so that I told the house-surgeon to be prepared to perform tracheotomy. Upon the eighth day I endeavoured, by means of the usual gutta-percha splint, to get the fragments into position, but without success, as the patient was still unable to bear the slightest pressure. Upon the twelfth day the inflammatory symptoms had subsided, and not being able to advance the teeth to the proper level by means of the usual appliances, I determined to treat the case by means of a silver suture. The patient having been chloroformed, the central and left lateral incised teeth were extracted. With a shoemaker's awl two holes were drilled, one upon each side of the vertical fracture, as low as possible in the body of the jaw, so as to allow of a good purchase being made upon the fragments when the suture would be introduced. One end of a medium-sized piece of silver wire was passed through one of the openings and carried into the mouth; the other end of the wire was carried through the second opening, so that in front of the jaw there was a loop of the wire, the free ends being in the mouth. By making traction upon the ends of the wire, the fragments came into fair position. Then, by means of the wire twister—used by Baker Brown in cases of ovariectomy—the ends of wire were very firmly twisted; the loop in front of the jaw was brought well home; the fragments then came well into position. The twisted wire, which was now close to the frænum linguæ, was cut off closely, and a piece of lint placed over it to prevent the tongue being irritated. Ten weeks later the wire was removed by cutting it across upon the inner side of the jaw, and making traction with a pair of necrosis forceps. Complete union had taken place, and the teeth occupied their normal position. There was a little thickening in the neighbourhood of the fractures, which would be absorbed in short time.

DR. ROSS congratulated Dr. Browne upon the issue of his case. He said he exhibited great originality in the treatment, showing his readiness to meet troubles as they presented themselves.

¹ [Dublin Journal of Medical Science, 1877, v64, p182.]

Dr. BECK would not use the awl so freely. He recommended the use of a small trochar and canula, such as he used for perforating the lobule of the ear.

Dr. DEMPSEY agreed with Dr. Browne about the great difficulty in maintaining the fragments in position by the old gutta-percha splint. He had treated a case where this was nearly impossible.

Dr. WALES was pleased with the treatment. He said the result commended itself, and he saw no reason why the same course should not be instantly adopted if the older treatment failed in keeping the fragments in position.

Dr. M. MOORE found that the force which caused the fracture in these vases caused more injury to the soft parts, and with him this seemed the difficulty to be contended with. He did not object to any treatment which was sufficient to hold the fragments in position. He had never met with a case in which the milder methods failed him, consequently he had no experience himself in the wire suture. He thought that cases would now and then turn up which no experience would meet, and these must be treated by other methods than those generally laid down.

Dr. Anderson, proposed by Dr. Whitla seconded by Coates, Dr. Speer, proposed by Dr. Esler seconded by Secretary, were to be balloted for next meeting.

Richard Ross

Session 1876

20th February 1877 Seventh Meeting

Present, Drs. Ross, Wheeler, John Browne, Core, McConnell, Strahan, Coates, McKeown, Esler, Whitla, Dempsey, Pirrie

Drs. Speer and Anderson were balloted for and elected.

Dr. Coates exhibited a brain extracted from a patient the recipient of a severe accident.

Dr. McKeown read a paper on a new operation for detachment of the retina.

Paper:¹ DR. M'KEOWN made some observations of a practical character on the surgical treatment of detachment of the retina. He referred to the plans of Bowman and Graefe—viz., the tearing of the retina, so as to open up a communication between the subretinal space and the vitreous humour, and stated that the results were generally so unsatisfactory that he preferred to allow the patients to suffer from the disease, rather than bring surgery into disrepute by practising unsuccessful operations.

For some time he had been thinking that it would be far better to secure, if possible, a permanent opening from the sac beneath the conjunctiva. In that case a retreat of the retina would take place, and improvement of vision result. At last a case, so bad as to justify him in performing an operation, theretofore untried,

and still offering some prospects of success, presented itself.

The following are the particulars:—

Thomas M'Kane, aged seventy, residing near Moneymore, consulted Dr. M'Keown, at the Ulster Eye, Ear, and Throat Hospital, on the 13th October last (1876). He stated that the left eye had been blind for fifteen years. There was a cortical cataract, with total loss of perception of light, from some deep-seated disease. The right eye had been very bad for a year. He could distinguish light from darkness, and could see white objects with bright light shining on them, but could not go about. On ophthalmoscopic examination, a very large detachment of the retina was observed. Only a very small piece of undetached retina could be seen at the upper part, all the rest being either detached or hidden by the detached part, The disc could not be seen. Still the detached retina retained its sensibility, the patient being able quickly and accurately to discern light thrown on the eye from the different direction.

October 14th.—Lifted flap of conjunctiva and exposed sclerotic between internal and inferior rectus, then, with a Graefe's knife, cut out a piece of sclerotic and choroid, about one line in diameter. That was the diameter of the perforation produced; but the diameter of the outer surface of the sclerotic removed, was very much larger. A large quantity of fluid escaped. The conjunctival flap was reapplied and secured in situ by a suture.

15th.—Great improvement. Could count fingers easily in different directions three to four feet, and could discern distant objects. The optic disc could be seen quite well, and the retina for a considerable distance around. The detachment had retreated, and did not seem now to be much elevated from the choroid. In cases of detachment it is generally found that bright illumination is necessary for vision. At dusk or by artificial light he could not see to move about.

Nov, 9th.—Vision has been becoming more misty lately. Exposed the site of the operation; found perforation quite closed; removed another small piece.

January, 1877.—Patient visited Dr. M'Keown this month. He had been able to move about quite well ever since. He has been using strong convex glasses, from which he derives much benefit.

Shortly after this case—viz., in the month of December, Dr. Wecker brought before the profession, in the *Annales d'Oculistique*, a new plan or treatment, which had been used by him, and some seven cases were reported. It consisted in passing a fine gold thread through the sub-retinal space, and securing it there by twisting its two ends outside on the conjunctiva. Dr. M'Keown remarked that if this treatment turned out to be tolerated, it would altogether change many of the prevalent notions about the danger of the contact of foreign bodies with the vascular tunic of the eye. At least, until more evidence were forthcoming, he would

¹ [Dublin Journal of Medical Science. 1877, v64, p441.]

prefer a plan that was not likely to do harm, and to which little objection could be taken. A case soon came before him, in which it came to be a question between the drainage method of Wecker and a subconjunctival drainage through a sclerotic opening. The patient was a gentleman of about seventy-five years old, an invalid for many years, a sufferer from chronic bronchitis and weak heart. His right eye had been hopelessly blind, for a number of years, from detachment of retina by rupture of a vessel; and his left eye, sometime about September, 1876, came also to be affected with a small detachment by serous fluid above. The detachment gradually increased in extent, and ultimately the fluid, in obedience to gravity, descended and detached the retina extensively below, and to the outer and inner side. Dr. M'Keown advised an operation. The patient afterwards consulted Mr. Wilson, who also advised an operation, and spoke of Wecker. It was ultimately arranged that Mr. Wilson and Dr. M'Keown should consult together regarding the method to be employed. On the 31st January, 1877, Dr. M'Keown performed the following operation, assisted by Mr. Wilson:—After exposing the sclerotic between the external and inferior rectus, he thinned the sclerotic over a considerable space; a little flap of the thinned sclerotic was then lifted up and doubled back, and secured by gold-thread suture to the sclerotic. The choroid, of course, was cut, and a large quantity of fluid escaped. In this manner a little trap-door was made into the sub-retinal space. The conjunctiva was replaced and the gold thread hidden from view.

The object in lifting up the flap and tying it back, was to have, as part of the margin of the opening, the inner surface of the sclerotic, which it was surmised might not so readily unite to the rest of the margin, being a sort of serous surface as it were. For sometime the vision was greatly improved, the field of vision being restored; but afterwards matters took a turn for the worse, and the vision relapsed. From the time of the operation the gold thread was not seen, and whether it lost its hold and allowed the little flap to slide back and re-unite, or whether the opening gradually contracted and closed, it was not possible to determine.

DR. M'KEOWN said he felt satisfied that a permanent opening in the sclerotic, beneath the conjunctiva, offered the best hope for these cases, and it was simply a question whether such could, by any means short of the presence of a foreign body, be secured. When he had further experience he would communicate it to the Society.

At the date of publication of this, Dr. M'Keown reports that a short time since he was informed that Thomas M'Kane visited Belfast, in quest of glasses, and that he walked through the streets alone with confidence. As to the other case Mr. Wilson and he had some correspondence regarding further treatment, and it was arranged that the retina should be cut by plunging

Graefe's narrow cataract knife through it. This was done on two occasions, but little change resulted in the vision.

Dr. Esler read a paper upon oakum as an antiseptic dressing.

Paper:¹ MR. PRESIDENT AND GENTLEMEN.—The value of oakum as an antiseptic dressing was first brought under my notice by the late Dr. John M'Crea, who had been for some time using it extensively; and to this, as to all other subjects which he took up, was applying himself assiduously in observing, and noting carefully what he observed, as the result of his experiments. Hence it is more as a tribute to the memory of my late friend that I come before you with these few and imperfect notes, than from any claim I have from my own brief experience, to ask you to take my opinion for anything but what it is worth. At the same time I hope to be able to put before you as many facts as will stimulate an instructive conversation.

Oakum, as you are, no doubt, all aware, is simply tarred rope reduced to its original state of flax or hemp, with the addition of the tar. Any of us who have been a voyage round the world, or even a shorter circuit, may have observed that the idle time of the sailor is often filled up by the occupation of oakum-picking; and in gaols, workhouses, and penitentiaries, it is made an occupation of profit. Old ships' rigging can be bought at about 17s. per cwt., and the oakum, when picked, sells at 22s. per cwt., so that the difference represents labour. The original use to which oakum was put was to caulk the crevices of wooden ships; but modern iron vessels, excepting the decks, do not require, nor will they be satisfied with, such a soft substance to mend their breaches—so that, I suppose, the primary use of oakum was to save life; but, more recently, it has been applied to life-saving in quite a different capacity. During the American war, carded oakum was employed extensively in the dressing of wounds; and, subsequent to that time, the surgeons to the Children's Hospital in Great Ormond-street, London, introduced it to this country.

Early in the year 1870, The Lancet drew the attention of the profession to it, as used by Mr. Pollock, at the St. George's Hospital, and gave it as their opinion that it would supersede other methods, and one reason was its low price, quoting it, as prepared by Bell of Oxford-street, at 1s. per lb., but you will observe that the price which I have paid for it is a little more than 2¼d. per lb. About the year 1870, Professor Lister put the antiseptic qualities of oakum to the test, and found it to answer his expectations; his observations are recorded in The British Medical Journal of January of the following year. Trélat, a French surgeon, also used it some five or six years ago, and I suppose that, at the present time, it is to be found in the wards of most of the hospitals of

¹ [Dublin Journal of Medical Science. 1877, v64, p324.]

this country; but it is because I do not think that its true value has been ascertained, that I wish to press its use upon your attention. Why it is in use in our hospitals, or by whom it was introduced, perhaps few of us have paused to inquire; but it may be enough for us to know that, having it there, it is a suitable agent, in many respects, with which to surround suppurating wounds. And we hope to be able to show that, as an antiseptic agent, it is superior to any other ready-made substance we possess.

My observations have been made first, in the Union Infirmary, and subsequently, but more minutely, in the Ulster Hospital for Children, and they have been in the following class of cases:—Amputations, abscesses, ulcers, cutaneous erysipelas, phlegmonous erysipelas, and burns. The number of cases of the first class in which I have used this dressing have been in two major and several minor amputations. Either of two methods may be adopted. In the first, the dressing is made as simple as possible. A single strip of lint soaked in carbolic or spirit lotion, applied next the wound, with a roll or two of bandage to hold it in position, and the stump then surrounded with oakum and another bandage if necessary, or you may apply the oakum next the wound, and this method is less objectionable than would at first sight appear; and, for reasons to which I shall presently allude, the flax may be much preferable to cotton in contact with a granulating surface. The advantage of this dressing is, that for stumps it is simple of application, it makes a soft pad on which to rest, and, what is of the greatest importance in the wards of an hospital, it effectually keeps down any offensive odour—and more, its effect seems to be to destroy the putridity of the discharge, while the pleasant tarry smell is strongly suggestive of the sea, of ships, and of fresh air. In most of the cases in which I have seen it applied, healing has taken place by the first intention, and this is, no doubt, partly accounted for by the freedom with which the serum is discharged from the wound, and by the prevention of ingress to any substance which would favour decomposition.

In a Chopart's amputation, in the Children's Hospital at present, you may see the result of this dressing. I am applying it next the wound; it has kept perfectly sweet. And this I attribute to the antiseptic properties of the oakum in which the stump was enveloped.

In Abscesses.—I have opened some dozens of abscesses where the only subsequent treatment was a pad of oakum bandaged over the part; and, in every case where there was not diseased bone underneath, the result was more satisfactory than I have ever seen from any other treatment. I will instance one case, that of a labourer, aged about fifty:—The abscess was gluteal, and had grown to almost the size of his head; the skin and muscles were enormously distended. So tedious did I expect the healing that I thought of introducing a drainage tube or plug, but having faith in oakum, I

applied a good large pad over the part after evacuating the contents, directed the man to lie on it, so that any discharge might drain into the oakum. The shrunken skin and relaxed muscle, in a few days, seemed to fit into their places, the opening healed without a blush of inflammation, and in a week the man was in his usual health. In some cases it is desirable to poultice for some time before using the knife, and we all know how troublesome it is to continue this for any length with linseed meal, and many surgeons have a great dislike to these oily applications. Liston said, nearly forty years ago, that "hot dressings, filthy unguents, greasy poultices, stimulating plasters, and complicated bandages must give place, very soon, to the elegant substitute for a poultice," referring to isinglass plaster, "and to careful position of the injured part;" and added that it was so long since he used these filthy compounds that his nurses had forgotten how to make them. Now in oakum we have the material for an antiseptic poultice, in abscesses or inflammatory attacks, by simply dipping it in hot water and covering it with waterproof tissue.

In speaking of Erysipelas, I need not refer to the many specifics which, from time to time, are recommended and vaunted, nor to the difficulty experienced sometimes in controlling the disease, nor will I allude to the constitutional treatment which should not, in any case, be neglected, but simply to the local application of oakum as a remedy, and I will instance a case or two, in both the cutaneous and phlegmonous stages, in illustration of what I have observed in treatment with this material. The first happened in the Accident Ward at the Union Infirmary, where a strong man, who had been recently admitted, presented one morning the characteristic appearance of the erysipelatous inflammation; the left side of his face, but especially his eye, was most effectually disfigured. I was accompanied by the house surgeon, to whom I said, "What would you do for this man?" His reply was, "Apply a pad of oakum." So I said, "A pad of oakum let it be." The following day there was scarcely a trace of the inflammatory action present, the swelling had subsided, and there was no return; the application was kept on, however, for several days.

A strumous boy had a true erysipelatous blush on the wrist of the left arm. Next day it had extended as far as the insertion of the deltoid; the limb was surrounded by oakum; the inflammation was arrested at the spot then affected; the arm got well; metastasis followed, however, and the face was attacked a couple of days subsequently. The same application brought about the same result, and I find that Dr. M'Connell is so well pleased with the line of treatment that, when I visited the Infirmary a few days ago, he had several erysipelatous patients encased in oakum. So much for the cutaneous variety. And in the deeper and more serious stage of the same disease—viz., the cellululo-cutaneous, where abscesses have formed, or sloughing is taking place, I

am of opinion that oakum is simply invaluable.

The first case, in illustration, which I will mention, was that of an elderly man whose right leg was very extensively involved. The first abscess formed over the fibula, the next above the knee, and another in the vicinity of the groin. I used the knife freely; and, as I had before my mind's eye several cases of poulticing and extensive sloughing, I decided on enveloping the limb in oakum only. No other application of any kind was employed; the patient was anæmic, and the prognosis of the gravest kind. The effect of the dressing was to most thoroughly keep down any smell. Almost immediately healthy action set up, not an unfavourable symptom was present by the end of a week, and the recovery was rapid and satisfactory.

The second case was that of a female lunatic; the part affected was the left leg; the course pursued was the same; and, as far as the leg was concerned, the healing process went on, but bed-sores formed, and the drain on the system was so great that death resulted; but the comfort, the simplicity of the application, and the comparative absence of putrid odours, during a long illness, were results not to be lightly valued.

Oakum in Treatment of Burns.—I need not say a word, by way of introduction, as to the offensive nature of the discharge from burns and scalds, and any means of controlling or lessening this will be hailed by the surgeon and by his staff of dressers with pleasure. Now, I venture to state that one of the best agents we possess for this purpose is oakum; its value as an antiseptic is even more marked in this class of cases than in the former. And while I would rather not have a burnt case in an accident ward, yet, were I obliged to do so, I would simply surround the patient with plenty of oakum, make the dressings so thin and simple that the discharge would flow freely into the tarry mass; and by renewing this sufficiently often, the matter will be prevented emitting that characteristic odour of burns which is so overpowering, and the labour of the dresser will be much lightened.

I have thus treated about a dozen cases of burns, some of them very extensive, and in all the smell was so thoroughly kept under that the patients were not more to be dreaded in a ward than any other surgical case with an extensively abraded surface. Nor need there be any hesitation about applying it next the burn without any other substance intervening. And it does not seem to be so difficult to get it detached as lint; but surgeons' lint, in common use, which should be made of flax, is composed altogether of cotton. You know there is a popular notion that cotton is an exceedingly bad application to sores, that it causes great irritation, and that linen is preferable, and these popular notions are invariably based on correct observations. We may pause here for a moment to inquire is there any cause for this. When we place a fibre of linen and one of cotton under the microscope, we might infer that the cot-

ton would be the less irritating of the two, as its fibres are not so sharp or well defined. Indeed the cotton, although flat, has a perceptible thickness at the edges, is rounded, and somewhat like a thin tube flattened; the flax is not so tubular, not so well defined or rounded, and is sharper; but if, after examination in the dry state, we apply moisture, the cotton fibre is found to twist in a spiral manner; and, perhaps, it is this hydroscopic power of twisting, when moistened, that gives cotton its irritating qualities, and the absence of this quality in the flax which makes it strip off granulating surfaces so easily.

To briefly sum up. The conclusions at which I have arrived, regarding oakum as a dressing, are that:—It is cheap; it is clean; it is easily applied; it is equal to any, and in many respects superior to most other dressings of the same class; and that it is antiseptic. I have not tried to demonstrate by experiment, apart from clinical observations, this last quality, but I intend to do so. And only that it is a wrong method to enter upon an investigation with a preconceived notion, I would state my conviction that it will be found to present a barrier to the ingress of spores or sporules, or whatever germ life infests the atmosphere, and which are such a bugbear to a large school of operating surgeons. Should this opinion prove to be correct, it will be just simplifying Lister's antiseptic method, the principle being exactly the same, as tar and carbolic acid stand side by side as therapeutic agents.

Tar is very complex in its composition; it is an altered resin and an empyreumatic oil, in which the following substances are found:—Creasote, paraffin, picamar, and eupion. It is obtained by the destructive distillation of the *pinus sylvestris*, and at gas works, which is a huge destructive process of the old pine forests, as they appear to us in the form of coal beds.

As a therapeutic agent, tar is used principally in chronic skin diseases; its influence on mucous membranes is sometimes well marked; and, in the form of inhalation, the oil of silver pine often gives satisfactory results in chronic bronchial affections.

Tar water long enjoyed a reputation as a specific in numerous diseases: it is made by shaking up one part of tar with, four parts of water. The celebrated Bishop Berkeley entertained the notion that, tar water was a certain remedy for every form of disease. And as the old philosophers cried aloud from the housetops to their fellow-citizens—"Educate your children," so the bishop said that if he had a situation high enough, and a voice loud enough, he would cry to ail the valetudinarians upon earth—"Drink tar water." I would not be quite so enthusiastic regarding this tarry preparation, oakum; but, by this paper, my appeal to all who are practising surgery is—"Try oakum dressing."

Had we to manufacture our dressings from the *pix liquida*, it would be both troublesome and expensive, but the sailor has done this for us with another object

in view. And after the rigging has served its purpose on board, and carried the sails which wafted the A 1 at Lloyd's under a tropical sun to many a foreign port, it is sent on shore for our convicts and paupers to prepare, for a short but useful course of service, in the wards of our hospitals. We intend to try it, pay for it, and use it, until we find something to supersede it.

Dr. J. W. Browne congratulated Dr. Esler upon his paper, especially referring to the microscopic features treated in it. He had been using oakum since 1875. He had seen his friend, Dr. Fagan, use it in 1871, and was much pleased with it. Since then he used it for everything himself—for amputations, burns, &c.

He believed it was first introduced by Sayer; its great beauty was in its elastic and antiseptic properties. In the treatment of burns he did not apply it immediately to the skin, but used a fold of lint saturated, with a solution of sulphate of iron (5 grains to the ounce).

DR. DEMPSEY saw a Dublin surgeon use oakum five years ago for all his amputations, which seemed to him to modify, repair, and promote union in a satisfactory manner. He used it himself after the opening of deep abscesses, and was much pleased with it.

DR. COATES saw it used in hospital extensively, but chiefly as a deodoriser, but he thought it had several objectionable qualities; as a dressing he did not think it suitable. In the hospital, sometimes, burns were dressed under the spray; this he thought advisable, and he recommended the practice of putting carbolic acid into the dressing of Carron oil.

DR. STRACHAN stated he had, in the Union Hospital, frequently seen Dr. M'Crea use the oakum as an application to ulcers with very good success.

Dr. M'CONNELL said he was at present using the oakum as an application to indolent ulcers, and he found, in some instances, that it changed their action in twenty-four hours.

DR. M'KEOWN thought, from listening to the paper, that the oakum could not possibly be an irritant. Any dry clean substance was preferable to a poultice. As to the question of germs, this, he thought, had to be settled. No doubt good results followed the treatment of those who advocated antiseptic surgery; this, he thought, resulted from the fact that all who had germs on the brain took a great amount of care in dressing their cases. Speaking of ophthalmic surgery, he said here Lister's spray could not be used. Ophthalmic surgeons never dream of germs. Of eye operations lasting ten or twenty minutes, take one hundred cases, and at the very utmost five will show any traces of suppuration. He thought quite too much had been made out of this germ question, but in the end good would result in making men more careful of their dressings. He referred to Hebra's views on erysipelas. He thought that, as regarded the application to ulcers, the pressure was the main point, not the antiseptic quality of the

oakum.

DR. WHEELER, in thanking Dr. Esler for his paper, said he believed that oakum would supplant cotton-wool; he had long given it up for tow, the wool makes such a hard doughy pad, but oakum was decidedly better than either. He never used cotton lint when he could get old linen.

The election of Honorary Members was postponed till next meeting.

Thomas K. Wheeler

Session 1876–77.

20th March 1877 Eighth Meeting

Present, Dr. Wheeler in the chair, John Moore, James Moore, Dempsey, Fagan, Esler, Beck, Anderson, McIvor, Harkin, O'Malley, and several students. J. W. Browne.

Dr. Fagan read a paper upon excision of the knee joint and exhibited three patients upon whom he had performed the operation.

Paper:¹ MR. PRESIDENT,—I have shown you this evening three children on whom I performed excision of the knee-joint. I consider the cases interesting, as they are, so far as I know, the only ones of the kind that have been brought under the notice of the members of the Ulster Medical Society.

I also consider it to be the duty of every surgeon, no matter how limited his experience of the operation may be, to record the result of his observations, in the hope that, by thus increasing the store of facts bearing on the subject, more definite rules than those already existing may be laid down for the guidance of surgeons on this much-vexed question.

Mr. MacCormac, of St. Thomas's, a former member of this Society, in a paper on the "Relative Merits of Excision and Amputation" (1868), says:—"There is almost no established surgical procedure regarding which such wide differences of opinion exist, or about which controversy has more hotly raged."

The first case I will record is the one I last operated on, and although on it I expended most care in carrying out all the details of the operation and after-treatment, it is the least successful of the three.

In two of the cases the operation has been done a year and a half, in the third a year. Observations made after the lapse of so much time are of very great interest regarding one feature of the subject in the case of children—for it is urged by some as a powerful argument against the operation that after it there is arrest of growth in the limb. You will have observed that such is not the fact in the cases I have just now shown you.

CASE I.—Alexander Cardwell, aged five years, was admitted to the Children's Hospital, under my care, in the month of October, 1875. About four months previ-

¹ [Dublin Journal of Medical Science, 1877, v64, p393.]



Fig. 1.

Case N° 1.



Fig. 2.



Fig. 1.

Case N° 4.



Fig. 2.

ously the mother noticed him limping in the mornings; about a month afterwards she observed the knee somewhat enlarged. She applied some simple remedies and paid no further heed to it for some weeks more, when she was advised to take the boy to the hospital. The only cause she could assign for his state was a fall on a heap of bricks, and she supposed his knee came against the corner of one of them.

He was subjected to the stereotyped treatment followed in the subacute or chronic inflammation of joints. The joint was carefully strapped with soap-plaster and securely placed on a M'Entyre's splint. He remained under treatment in hospital for upwards of two months, when the mother had him removed. He was re-admitted, under my care, on the 14th March, 1876, when he presented the following symptoms:—

The leg was very much flexed and wasted, the joint enlarged and globular, the ends of both femur and tibia enlarged and very painful on pressure. He was losing flesh rapidly, suffered from irritative fever, sleeplessness, loss of appetite, and had painful startings of the limb at night. His general condition improved after his admission, but that of the knee was no better. Fig. 1, Case I., is a very faithful representation of his case a few days before operation.

On the 11th of April I removed the joint in the following manner:—The child being fully under the influence of ether, and Esmarch's elastic band applied, I began my incision at the back of one condyle, and bringing it just under the patella, terminated it at the back of the other condyle; I reflected the flap with the patella, and, having seized the latter with lion forceps, carefully dissected it out. I next freed the lateral ligaments, flexed the leg on the thigh, and pushed the tibia forcibly forwards; by this manoeuvre the crucial ligaments were put well on the stretch—then, by directing the edge of my knife in a line with the tibia, I cut on its articular surface behind the spine, and in this manner severed them without in any way endangering the vessels behind.

I then pushed the end of the femur forwards and

cleared it of surrounding tissue, as far as the point at which I was about to apply the saw. With a Butcher's saw I removed the lower end of the femur, in a horizontal line, from a point about a quarter of an inch below the upper edge of the trochlear surface in a direction from before backwards. I next removed a thin slice from the tibia, including little more than the articular surface, sawing from behind forwards; then, with a curved scissors and forceps, I removed all the pulpy and fatty tissue exposed in the wound. The elastic cord, was next removed; I twisted a few arteries, which spouted. There was pretty free oozing from a number of articular twigs which I could not seize with the forceps, as they were buried in the adjacent fibrous tissue; there was also considerable oozing from different points of the sawn surface of the bone. To all these points I applied the actual cautery, and by this means completely arrested the hæmorrhage; I then freely swabbed the parts with a solution of chloride of zinc (gr. xv. to ℥i.), and placed two pieces of carbolised tow in the back of the wound with the ends hanging out at either angle, I brought the bones into apposition without any difficulty, and closed the skin wound with five points of carbolised catgut suture. The limb was then washed, dried, and dusted over with powdered oxide of zinc, and after a flannel bandage had been applied from the toes to the groin, it was placed on a splint that was already prepared for it.

Dr. P. H. Watson's plaster-splint was the one used, and I consider it the most suitable of any yet devised for the purpose. When the plaster had set I removed the child to a bed prepared for him, and ordered a little hot brandy and water, which I find to be an exceedingly good sedative for children after operations.

After closing the wound I placed an ice-bag over it, and had cold sponges applied at each angle to absorb any discharge of blood or serum that might flow from it. I left it exposed in this way for five hours, when there was scarcely any discharge. I then carefully packed all round the wound with carbolised tow, put a pad of the same material over the joint, and a bandage over all, in this way rendering the parts perfectly secure. The limb was placed on a pillow between sand bags.

April 12th.—Pulse 136; temp. 101; had a restless night; vomited two or three times; bowels moved twice. Slung the limb to-day from a Salter's swing.

13th.—Pulse 130; temp. 100.3; slept pretty well; takes plenty of milk; looks bright and happy.

14th.—Pulse 120; temp. 100; slept well; takes his food well.

15th.—Pulse 120; temp. 100.2; slept well; eats well and looks well.

16th.—Dressed the limb to-day (the fifth after operation) for the first time. There is scarcely any swelling, no appearance of inflammation, and only a slight serous discharge into the tow. The wound appears uniting by the first intention. I removed the tents from

the wound, and some of the tow in contact with it that was soiled by the discharge. I introduced fresh tents, and padded round the joint as before. The boy was sitting up in bed two days after the operation, and from that time complained of no pain whatever.

30th.—Since last notice the limb has been dressed every second or third day. The wound is quite healed, his health good, and he has suffered, no pain.

May 26th.—I removed the splint to-day. There was some excoriation of the skin over heel. The limb was in good position, but as the bones did not appear to be quite firmly united, I put it up again in the same splint.

June 17th.—He is very much improved in every way since last notice. He can raise the foot from the bed with ease. The limb was carefully put on a back splint, and he was taken to the country.

July 22nd.—He was again admitted into hospital. The cicatrix has an unhealthy appearance; a sinus leads from the inner side of it for about an inch deeply under the skin, and the outer end of it for an inch has ulcerated. He is not able to raise the limb from the bed. There is no mobility, but there is evidently a retrograde condition of the connecting medium of the bones.

The treatment I employed was securing the limb firmly on a splint, applying some stimulating dressing to the wound, and giving him iron and cod-liver oil with suitable nutritious diet.

August 10th.—Was taken home to-day very much improved in health. The ulcers were not yet healed; splint still kept on limb.

September 8th.—Was again admitted into hospital. He is still improving in his health. The same treatment carried out. About a week after his last admission the cicatrix, was completely healed, and, for the first time, presented a truly healthy appearance, and caused him no pain when pressed on. He began to walk, about the ward, at first with the aid of the beds, but after a little was quite independent of any support.

On the 12th October, just six months after the operation, he left the hospital quite restored to health, and with a very useful limb. The amount of shortening, on the most careful measurement, was about half an inch; and the angle at the joint just sufficient to render progression most easy.

Six months ago he left hospital a good example of a successful case of excision, as is fairly represented in Fig. 2, Case I., of the accompanying Plate.

Neglect of both his limb and his constitution has left him in the condition you have just seen him. The angle has approached more a right angle, and, as he can only approach the toes to the ground, progression is very much interfered with.

CASE II.—Ellen Templeton, aged six years, was admitted, under my care, on the 1st September, 1875.

About a year and a half previously she first complained of pain in the knee, for which she was treated. Some time after she got a fall on the injured knee, mak-

ing matters worse. About eight months before her admission to hospital the knee began to contract; she complained of painful startings of the joint occasionally through the day and every night when going to sleep; and for the past three or four months could not bear the weight of the body on the affected limb. Latterly her health began to break down; she had enlarged glands under the jaws, suffered from otorrhœa, and had an unhealthy strumous appearance. The joint was enlarged and globular, and very painful on pressure, especially on the outer side of the patella and over the ends of femur and tibia.

The child's general condition was much improved by her stay in hospital before the operation.

On the 28th of September I excised the joint in the manner described in the last case, except that I did not use Esmarch's band, nor apply the cautery so freely.

There was a considerable loss of blood during the operation, and about four hours after it I was sent for, as she was in a very restless and weak condition. The sheet was soiled with blood, which I found was coming out between the upper end of the splint and the buttock.

I removed the bandage and tow-dressing from the wound, and found slight oozing from its internal angle; as the quantity coming away was slight, I did not further interfere, but left the part exposed, applied an ice-bag, ordered a sedative draught, and a little iced milk and brandy for drink.

29th.—She slept a little through the night. There was no further bleeding. Pulse 156; temp. 99.6; she looks brighter. I stopped cold application, and applied a pad of carbolised tow and a bandage.

30th.—Pulse 154; temp. 100; slept pretty well; vomited a couple of times; started occasionally in her sleep, and complained of pain in the knee.

October 1st.—Pulse 146; temp. 99.4; slept well; had her bowels moved; took an egg for breakfast, and had some milk and brandy through the night. I looked at the wound to-day, and found it so healthy, and with scarcely any discharge from it, that I did not consider it necessary to remove the dressing. She complained of an itching sensation in the groin under the splint; this, I believe, was due to the irritation caused by the hæmorrhage and cold applications after the operation.

3rd.—Pulse 138; temp. 100; is much improved in every way. I dressed the wound to-day; it was nearly healed up by the first intention, except at angles where the tents were kept in for drainage. There was no swelling or inflammation about it.

From this date the case progressed favourably. The wound after a short time was entirely healed; and on the 29th November—just two months after the operation—I removed the splint.

There was slight abrasion of skin over dorsum of foot and back of thigh, which healed in a few days.

Notwithstanding the fact that the splint and dressings were saturated with blood, and the cold applica-

tions used to check the hæmorrhage, no uneasiness followed; it never interfered with the satisfactory progress of the case.

The union seemed to be perfect. I put the limb again on a splint, and in about a fortnight allowed her to move about on crutches. She left the hospital about four months after the operation.

A slight abscess formed over the head of the tibia, but after being opened gave no further trouble.

It is now a year and a-half since the operation was performed. The limb is about half an inch shorter than its fellow. She has been attending school and enjoying herself at her games like other children. Her general health has been the best, and the limp in her gait is the only apparent evidence of her having undergone so serious an operation as excision of the knee-joint.

CASE III.—Ellen Wilson, aged nine years, was received into the Belfast Hospital for Sick Children, in August, 1875, and placed under my care.

Her mother gave me the following history:—Three years previously she was thrown over a form at school and got her knee hurt; it was painful and lamed her for a considerable time. She used a liniment, but was not particular in keeping the limb at rest.

About a year and a-half ago she was in the habit of skipping a great deal, and again complained of pain in the injured knee. Whatever treatment was employed gave her temporary relief.

Nine months before I saw her the limb began to contract. She was placed under a doctor's care for some time, but as she was gradually getting worse, the mother had her removed to hospital.

The condition of her joint was the same as in the first case, but her constitution was much healthier.

On the 15th September I removed the joint in the manner already described; no bad symptoms occurred during her progress towards recovery. I removed the splint on the 4th November. Union was perfect. Three weeks after this I allowed her to get about on crutches, and she left the hospital, able to walk without any support, between three and four months after the operation.

It is now a year and a-half since the operation. There is about half an inch shortening. She is the type of a healthy child, and can walk any reasonable distance without being fatigued.

The pathological condition of the joints was what is usually observed as the result of chronic inflammation.

The tissues around the articulation had degenerated and were infiltrated with gelatinous matter, inside the joint the synovial membrane was in some parts thickened and pulpy, in other parts highly vascular, and extended in fringes over the cartilages. The cartilages in most parts had lost their polish, and showed here and there pinhole depressions.

In Cases I. and II. the cartilages suffered most, being completely absorbed at one or two points, and at others

very much thinned. In Case II. there was a small circumscribed abscess in the joint, as well as considerable disease in the end of the femur. After removing the recognised extent (by the saw) I had to use the gouge to remove two carious spots—one in the centre, the other at the side extending up to the epiphysis.

In all the cases the side of the cartilage resting on the bone had depressions over it, into which projected little masses of granulations. The articular lamella was highly vascular, and, in parts, softened, and was easily removed from the super-imposed cartilage. The ligaments in some places were degenerating, and, in Case II., the crucial were partly destroyed.

Before making any remarks on the subject of excision, I will give the history of a case of chronic knee-joint disease treated by the expectant method. It is a typical one of a very large class, and will serve to illustrate my remarks on the subject further on:—

CASE IV.—Thomas Shannon, twelve years of age, was admitted into hospital three years ago, suffering from disease in knee-joint. About a year previous to his admission he fell down the school stairs and hurt his knee. No special care was bestowed on it; the mother thinking he was affected with “growing pains.” However, as the pains and swelling of the joint increased, and the limb began to contract, she took him to hospital.

After two months' stay his general condition was very much improved, but the state of the joint was much the same. At this period I proposed excision, but the parents would not consent to it.

Fig. 1, Case IV., conveys a pretty accurate notion of his state at that period.

He was removed to the Throne Hospital, and remained there for nearly six months.

The greatest care was bestowed on the treatment of the joint affection, while he was exceptionally well-circumstanced for the improvement of his general health. Notwithstanding, the disease slowly progressed, the joint became more swollen and tender; the painful startings more frequent and severe. A small abscess formed just under the knee, but did not communicate with the joint. After he had spent a year in hospital the mother took him home, when he got rapidly worse. Suppuration of the joint took place, sinuses formed around it, the leg became contracted on the thigh, his constitution was completely worn down by suppurating fever, and a year after leaving hospital he was re-admitted to have the limb amputated. Fig. 2, Case IV., is a good representation of his state at this time.

After he was a few days in hospital some ignorant friends prevailed on the mother to prevent the limb being removed. Since that time he has been dragging out a miserable and painful existence.

The probabilities are that he will very soon die from the effects of the disease, or, if he should survive, it will be with a shattered constitution and crippled for life.

You will have observed, Mr. President, from my report, that in each case the disease originated in the receipt of some slight injury, and that the destructive changes commenced in the articular ends of the bones, the inter-articular tissues becoming secondarily engaged. Also, that the subjects of my operations were under nine years of age, a period when any interference with the growth of the bone would be detrimental to the use of the limb in after-life.

In treating the subject of excision, I will direct myself more especially to the consideration of these points, as well as to some of the conditions that should influence the surgeon in the selection of his cases for this operation.

Excision of the knee-joint is not a new operation. Mr. Filkin, of Northwich, performed it as far back as the year 1762; and although practised occasionally by some of the more advanced surgeons of the French school, it was only lately, through the labours of Sir William Ferriusson, that it became an established surgical procedure in this country.

Like every other novelty in the domain of medicine, as well as surgery, excision of the knee became the fashion, and its indiscriminate application by some surgeons to all kinds of knee-joint affections brought the operation into disrepute. This developed another party—the anti-excisionists—who discountenanced the operation altogether, and a hot contest was carried on for some time between the advocates on both sides.

At the present time excision of the knee as an operation is looked upon by surgeons as a justifiable procedure in conservative surgery.

To my mind, successful results depend mainly on the careful selection of cases; the important point the surgeon has to decide on being, what is and what is not a suitable case for operation.

The surgeon who views his cases with a mind free from prejudice will meet amongst them some that are suitable for the expectant treatment, others for excision, and others for amputation; and in recommending each of these methods as he sees fit, he will best serve his patient's welfare, and will not bring any special line of treatment into disrepute.

Mr. Spence, in the last edition of his *Surgery*, when comparing the results of his first operations with those lately performed by him, says:—"This favourable change in the results of my excisions of the knee, is, I believe, greatly due to the experience of former years having led me to exercise great care in selecting proper cases for the operation, and in eliminating those in which the nature of the disease or its complications, the age, or debilitated state of the patient, seemed unfavourable for such an operation."

In making a selection, three points have to be taken into consideration—viz., the state of the constitution, the condition of the joint, and the age of the patient. A careful examination of all the organs should be made,

and the surgeon influenced by the result.

The more healthy the constitution, the more favourable is the case for the operation.

Regarding the condition of the joint, it is found that the operation is most fatal in cases of injury and acute disease.

In the treatment of the subacute or chronic disease as ordinarily met with, the nice point for the surgeon to decide on is—in which stage of the disease, and under what circumstances, should he adopt the expectant method, in which recommend excision or amputation. We may here dispose of the two extremes of this condition. In the initiatory stage the expectant is the best and only justifiable means of treatment; while in the advanced condition of the disease, where the bones are involved beyond the epiphysis, the soft parts degenerated and riddled with sinuses, and the constitution depraved, amputation is the only mode of treatment that ought to be entertained.

The cases that require most careful consideration before recommending any particular line of treatment, are those holding a middle position, of which there are two kinds. One, generally known under the name of "white swelling," has been fully described by Sir B. Brodie. In this condition the disease begins in the synovial membrane, is usually idiopathic, progresses silently; in many cases there is an entire absence of painful symptoms, and the constitution is generally depraved. I have frequently met with such, but have no experience of the treatment by operative interference.

Mr. Barwell recommends a stimulating treatment—such as friction, passive motion, and iodine injections. I am disposed to agree with Mr. Holmes in advocating excision in this class of cases, where the bones are not very extensively involved, and the constitution fairly good.

The other condition of joint belongs to a class of which the cases I have shown you this evening were fair examples when first brought under my notice, the symptoms and pathological condition being somewhat alike in all of them.

The disease, originating in some trivial injury, manifested itself as an articular osteitis—the cartilages, synovial membrane, and ligaments being secondarily involved.

I may here remark that if more care was bestowed on the simple joint-injuries occurring to children—by twists and blows, falls down stairs, off chairs and tables—we would witness fewer painful cases of disorganised knee-joint than present themselves so frequently at our hospitals.

The course I pursue in cases similar in their nature to the ones I have shown you, is as follows:—

If the symptoms are not very urgent and point to the disease as limited to the articular ends of the bones, or involving but slightly the other joint structures, I adopt in every case the expectant method; if, after a

fair trial of this, the condition is much the same, or but slightly improved, I am mainly influenced in the further treatment of the case by the social condition of the patient.

Amongst the well-to-do classes the patient has all the advantages of suitable appliances, is placed under skilled supervision, and, most important of all, the courses of treatment can be continuously carried out under the most favourable hygienic conditions.

Contrast this with the case of the child of the poor person similarly affected. If treated in hospital he may be discharged after a lengthened stay very much improved, or, to all appearance, cured, but want of care on the part of ignorant parents, a too-early return to his employment or his active games, together with want of proper nourishment for his originally feeble constitution—all tend to light up again the smouldering embers of the disease, and he returns to hospital a second time in a worse condition than the first.

While in the one case there is a fair prospect of a cure by natural processes after a lengthened period of treatment, in the other such prospect is but very slight, and, I believe, that for it excision of the joint before the disease has advanced too far, and while the constitution keeps good, is the best method of treatment to adopt.

No matter how favourable the surroundings, if after a fair trial of the expectant method the symptoms increase in severity, and the condition of the patient be gradually becoming worse, both as regards the local affection and the general constitution, excision of the joint is, I believe, the best and only line of treatment that should be recommended.

The train of symptoms and ultimate result are well exemplified in Case IV., which is a good type of its class. In it the expectant treatment was rigidly carried out for a considerable time. Excision was proposed at a suitable period, and rejected; amputation at a later period was proposed, and rejected; and, from the mother's statement a few days back, I believe the boy to be in a dying condition.

Of the many objections that are urged against the operation, I will now deal with one that is considered a strong one in the case of children—viz., that there is an arrest of growth in the limb.

Dr. Watson, an authority on the subject, says:—"In children I have hitherto regarded amputation as a preferable operative procedure, and shall continue to do so until I have had satisfactory evidence that the limb grows, or that the short and shrunken limb is capable, with the aid of a wooden pin, to support the weight of an adult body more satisfactorily than a thigh stump and a wooden leg."

You have, in the cases exhibited here this evening, evidence that the operation can be performed without interfering with the growth of the limb. Two of the cases are good examples of the splendid results that

may be obtained by the operation, and their shapely and useful limbs would form a pleasing contrast with the results of the expectant treatment, or amputation, as exemplified by a wooden leg, or a crippled limb and a shattered constitution.

In my description of the operation you will have noticed that I was careful in making the section of bone wide of the epiphyseal cartilages in both femur and tibia; by so doing I avoided interference with the main source of the growth in the bones, while I effectually removed the diseased structures.

In Case I. the ultimate result is not so satisfactory as I anticipated; the usefulness of the limb will be interfered with owing to the bad angle at which it is placed.

This condition I do not attribute to any fault in the operation. You will remember that his convalescence was rather tedious, and that a considerable time after the wound was healed and the bones firmly united, the cicatrix ulcerated, and the bond of union between the bones began to degenerate.

Under general tonic treatment and rest he improved, and left the hospital, after a lengthened stay, in quite as good a condition as the other two cases. When leaving I put the limb up in a Bavarian splint, and cautioned the mother not to let him put his foot to the ground, but to get about on crutches. The child was neglected and let do pretty much as he liked. Through want of care and nourishment the constitution became impaired, and the same degenerating changes began to take place in the bond of union between the bones, while the weight of the body forced the limb into the angle at which it is now set. This degenerating change in the new connecting medium I look on as analogous to rickets, and should be treated in a similar manner to that affection.

As regards special treatment in this case all, I think, that can be done for him at the present time is to try and prevent his condition getting worse, and then, after the limb has attained its full growth, the propriety of straightening it by taking out a wedge-shaped piece of bone may be entertained.

His case is very instructive, as showing the necessity there is for the greatest care being bestowed on every case, not alone as regards the immediate after-treatment, but until such time as that there can be no doubt about the healthy character of the connecting medium.

I feel that this paper has reached to too great a length for one evening, notwithstanding I have passed over a host of important points in connexion with the operation. There is one other point I will notice before concluding—viz., the comparative mortality of excision and amputation.

A very great deal has been written on this aspect of the subject, and elaborate statistics compiled to suit the advocates of either operation; and after puzzling oneself with piles of evidence for and against, it is refresh-

ing to light on the following expression of opinion of so able a surgeon as Sir W. Fergusson:—

“Allowing, however, that excision was somewhat more fatal, supposing that one life was lost for every six legs saved, was not the gain worth the risk?”

It was partly a question for the patient. Instrument-makers had certainly contrived some most ingenious and elegant limbs of cork, willow, and ash; but people, as a rule, preferred the old-fashioned flesh and blood article, and were willing to run some risk in order to retain it.”

Dr. JAMES MOORE had seen this operation performed by Sir William Fergusson, Syme, Liston, and in the Belfast Royal Hospital; but the cases were principally adults. As a rule, for this operation you have scrofulous subjects to deal with; but, in children, this rule does not hold good for joint diseases generally. He believed, in properly selected cases, it is a good operation, but, on the whole, he does not recommend it.

DR. DEMPSEY, while speaking favourably of the operation, and thinking well of these particular cases, said he believed that the great care and trouble in looking after and attending to the patients, was an objection to the operation.

DR. JOHN MOORE said that it would be an advantage, in judging of the value of an operation, to see the cases at a later period, as the growth of the limb cannot be judged fairly of for some time. He said he was struck by the number of maimed children turned out of school. After a careful reflection on the numerous cases of other surgeons, which he had watched, he came, to the conclusion that it is only in children and young adults that the operation is at all admissible. On the whole he did not look upon the operation with a favourable eye. He did not agree with Sir William Fergusson, that six limbs were worth one life. He preferred life to limbs, and thought that with their admirable anatomical mechanic's (Adam Sloan's) assistance, they could turn out better cases by amputation than by excision. He considered that we were on the border-land of a change in knee-joint treatment, and that incision would take the place of excision. In many cases, he thought, a good free incision productive of the highest good; it relieved tension and evacuated matter, the presence of which was fatal to union or repair.

DR. F. BECK had not been struck favourably with the operation hitherto, but would be inclined, from Dr. Fagan's cases, to adopt the method of excision, but only in children or young adults; as to him, in adults, it still seemed unjustifiable.

DR. ANDERSON referred to the success of Mr. Croft, and stated that he had heard him say that old excisions were turning up now and then, and gave considerable trouble in after-operations.

DR. HARKIN thought excision a better operation than amputation, and that the case of No. 1 was surgically successful; had the child been under happier auspices,

the result would have been equal to the others. He did not think the limb would become shortened when the epiphyses were left intact, and the arterial supply not interfered with. He supposed Liston's method had been adopted.

DR. WHEELER said in all cases he thought conservative surgery should be tried first, and then excision, and, failing this, amputation should be performed. He thought it of great importance that the patient should be left as long as possible in the convalescent home. As regarded statistics, he placed no reliance in them, and his experience of surgeons amounted to this, speaking generally, that the man who advocated excision operated at an earlier date than the amputator—so early, it was anxious to have a good list of successes, as to sacrifice life in cases where conservative surgery would have turned out a sound limb; while, on the other hand, the blind believer in the *vis medicatrix naturæ* waited till the stage of exhaustion had set in, and his excision often failed. He thought the cases before the Society spoke for themselves.

DR. ESLER thought the operation not only justifiable, but, in carefully-selected cases, imperative. The successes here, he thought, proved that the cases were judiciously selected; he agreed with Dr. Wheeler that many excised before there was justification for such a proceeding.

The Secretary reported the decision of Council about Honorary Members (to be dropped) and the paper with the remarks will appear in the transactions.

Richard Ross

Session 1876–77.

Ninth Meeting 1st May 1877

Present, Dr. Ross (in the chair) Dr. Wheeler, Drs. Wales, O'Malley, Strahan, J. W. Browne, Esler, Whitla, D. Johnson, McIvor.

Dr. Harkin read a paper on cases of hydatidiform mole pregnancy and exhibited specimens.

Paper:¹ MR. PRESIDENT,—Mrs. C. Stewart, aged twenty-two, the patient from whom the specimen before you was discharged, sent for me on the evening of Monday, 16th April last. I found her complaining of great stomach sickness, of debility, and of an abdominal tumour, for the relief of which she informed me that she had passed the previous three weeks in a special hospital, having left only on that morning.

I deferred any further examination till daylight, and again saw her on Wednesday, 18th ult.; she was then pale and anæmic; had an extensive ragged ulcer on the os uteri, and a tumour of pyriform and symmetrical shape, soft and elastic, extending from the pubis up to and several inches beyond the umbilicus. Her breasts were enlarged and painful. She informed me that she

¹ [Dublin Journal of Medical Science. 1877, v64, p330.]

considered herself pregnant from November, 1876, having to wean her child in consequence; had great sickness of stomach from January; and that, on July 15th, after a smart hæmorrhage, she had discharged a fleshy substance the size of an egg, evidently the embryo. Her health then got worse daily, and she continued to enlarge up to the moment I saw her. Being satisfied, from the history of the case, from the physical signs, and from my previous personal knowledge of the patient, that I had a case of vesicular degeneration of the chorion villi and placenta, I prescribed an infusion of *secale*, given in repeated doses; slight pains began soon to show themselves, accompanied with some hæmorrhage; and, at the end of a week, I found her weak, having voided large clots, and with strong expulsive pains. Finding the os uteri enlarged, I dilated, and, with pressure from the left hand over the fundus, about three pints of pearly vesicles came away, some of them buried in the nidus of a degenerated portion of placenta. I then ordered some stimulants, and fluid ext. of ergot, which soon put a stop to the hæmorrhage, and the patient is now progressing favourably to recovery.

Her previous history is instructive:—She was married in December, 1874, and became pregnant in the beginning of the next year; she sent for me in April, 1875, for a flooding that had commenced in the March previous; for this she got relief; I saw her again early in June, when she presented an appearance similar to that described to-night; and on 23rd of same month she discharged about two pints of pearly-like vesicles, nearly as large as grapes, and, like that fruit, attached by pedicles to a central stem. After this occurrence she menstruated regularly for nine months, became again pregnant, and gave birth to a living child at the full period. I should not be astonished to learn that she had completed a similar cycle in three years hence, and, perhaps, afforded subject for a similar communication to some learned body like your own.

I can refer to a third case which occurred in a very healthy woman twenty years since, the mother of several children, the first step in which case was a slight accident producing uterine hæmorrhage, and some three months afterwards a discharge of those peculiar bodies I had then preserved in turpentine, as I show them, but they are now dried up and not very instructive. In a fourth case of mole, which I watched for four months after the loss of the embryo, the patient passed a large heavy substance like gutta-percha; the placenta increased, and hardened by deposits of very firm material. As to the causation of those abnormal bodies, most medical authorities affirm that they are the products of conception, and not at all of the nature of the true hydatid. It is to Cruveilhier that the credit is due of first making this distinction. The most general opinion agrees with the teaching of Barnes and Graily Hewitt, that the disease consists in a perverted development force; and that after the detachment or destruction of

the embryo, the chorion villi, continuing in connexion with the uterus, maintain a slow growth; and that the vesicular bodies are thus the result of dropsical swelling of the chorion villi.

DR. M'IVER asked Dr. Harkin's opinion as to whether the death of the embryo was the cause of the hydatids or the converse.

DR. WHEELER approved of the treatment with ergot, and thought that the vesicles were produced after the death of the fœtus; he had met three cases in practice.

DR. HARKIN was of opinion that the blood which went to form the fœtus went to form the hydatids after its expulsion.

Dr. J. W. Browne in the absence of Dr. James Moore exhibited the larynx of a case of cut throat.

Richard Ross
May 30 1877

Session 1876–77.

30th May Tenth Meeting

Present, Dr. Ross (President), Drs. Wheeler (Ex-President), Wales and J. W. Browne (Vice-Presidents), Fagan (Treasurer), Whitla (Secretary), McConnell, Coates, (Newett and H. Purdon as visitors). Dr. Esler.

Dr. Whitla exhibited a patient upon whom the operation of amputation through the hip joint had been performed some 2 years previous.

Paper:¹ Dr. Newitt, under whose care she had been, being present as a visitor, the Chairman asked him for the history of the case.

DR. NEWITT then read the following notes:—

Mary Millar came under notice, for the first time, on April 3rd, 1873. She was then suffering from severe erysipelas of thigh, from which she recovered, having been treated with iron.

On June 16th, of same year, fracture of the thigh occurred while in the recumbent posture. The fracture was the result of scrofulous disease of the femur.

The limb was put up in as easy a position as possible, without any idea other than that of ease and comfort to the patient, as her health was so low that a termination in death seemed inevitable. She was in every way, made as comfortable as circumstances allowed of. Medicines were given to sooth and support. In the course of some weeks the broken ends of the femur made their way through the integument in front of the thigh. The smell of the decomposing bone was very bad, and it was with difficulty that the air of the apartment could be kept pure—iodine, allowed to evaporate, and Condy's fluid were used for this purpose. She became much emaciated and extremely feeble, and continued so for months. Death appeared certain. The treatment was simply directed to her comfort. Great care was taken to prevent bed-sores, to keep the atmosphere pure, to

¹ [Dublin Journal of Medical Science. 1877, v64, p443.]

soothe her; and tonics were given when admissible.

Matters continued, as described, until January, 1874. During that month hæmoptysis occurred, and there was crepitation at the apex of one of the lungs. Gallic acid and sedative mixtures were used in treating the hæmoptysis.

During the summer of 1874 she improved a good deal; and the idea of removing the limb first occurred to me. The idea was, however, given up, in consequence of her health again failing. She commenced again to improve during the winter of 1874. I determined—her consent having been obtained—to prepare her for an operation, which should take place with as little delay as possible. I recollect being delighted that her stomach tolerated cod-liver-oil. I gave her this remedy, also a mixture of quinine, perchloride of iron, and in sol. chl. potass, also sedatives; and I looked carefully after the purity of the atmosphere.

On the 13th February, 1875, Drs. M'Connell, Whitla, and myself, proceeded to amputate the limb at the upper third of the thigh. The patient was extremely emaciated, although improved from what she had been some months before. When we were about to proceed, the question arose whether or not we should. The patient's desire for the operation, and the conviction that it was her only chance for life, the continuation of which—with the inability to move out of bed, necessitated by the presence of an extensively diseased limb, with a large mass of decomposing bone, which was polluting the atmosphere—was very cheerless; this consideration, I say, convinced us that it was our duty to operate.

Dr. Whitla having applied Esmarch's bandage, Dr. M'Connell most carefully administered chloroform. I made the flaps anterior and posterior, in the upper third of the thigh, by transfixing and cutting downwards. We found all of the tissues brawny and infiltrated; the bone was like a piece of rotten stick, as thick as a finger; I cut it through with a scalpel. I then proceeded to assist Dr. Whitla, who was attending to the arteries. He grasped the femoral artery with a forceps; I tied. The artery was brittle and apparently infiltrated with scrofulous matter; it broke with the tying like a piece of pipe-shank. The case looked hopeless. We felt certain we should leave her dead behind us. Dr. Whitla dissected the artery up about half an inch or more, and succeeded in tying it. Dr. Whitla then proceeded to remove as much of the diseased femur as possible, and ended the operation by disarticulating and removing the head of the femur. The flaps—which had been extended by me—were then brought together and dressed. About one hour after the operation the patient commenced to vomit. The vomiting continued, interrupted only by snatches of sleep, until the following Friday morning—the operation was performed on a Saturday. Administration of any aliment or medicine by mouth was impossible, as the presence of a piece of ice

on the tongue intensified the vomiting. I became most excited and interested in the case; and, whenever I was disengaged, I ran up to see her. I injected milk into her bowel several times each day. The vomiting having ceased, her stomach retained a little milk and lime-water. The emaciation and debility, at this time, were indescribable.

Having commenced to improve, she—to use an expressive phrase much used—“never looked behind her.”

DR. WHITLA had assisted Dr. Newitt, and thought the notes read did not certainly overdraw the picture of the difficulties which presented themselves. As had been stated after the incisions were made, and the scalpel went through the bone, in making them Dr. Newitt asked him to take charge of the head and neck of the femur which he grasped with the lion forceps and disarticulated, a very easy matter, as the bone was extensively diseased, and came away in pieces; he then found that the acetabulum was diseased, and a sequestrum could be felt lodged in its floor. Going out to the county for an amputation of the thigh, as Dr. Newitt had written to him, it never occurred to him to bring a gouge with him, so he used the handle of the lion forceps as a gouge, and removed the greater part of the acetabulum till the finger, introduced into the bottom of the wound between the flaps, struck upon the thickened pelvic fascia.

The flaps being made for upper-third amputation were much too long, and their appearance was characteristic; they were riddled with old sinuses, and just looked like conical slices cut out of an amyloid liver, in which one could scarcely recognise any structure. In this lay the femoral artery, and the spot at which it was eventually tied, after two attempts, was close under Poupart's ligament. The aspect of affairs at this stage was, as Dr. Newitt says, truly indescribable, and I must say that though the result is excellent, if I knew I could foresee every difficulty as they now rise vividly before me, I would be very slow in undertaking such again.

Before and after the operation the case seemed to me almost hopeless, and it was only Dr. Newitt's strong sense of duty, and the feeling that he must make some effort to prolong life, that caused the operation to be consented to, and I have no doubt death must have followed but for his self-denying exertions in the after-treatment.

The patient having undressed, the stump was exposed, and presented an excellent appearance; the low inflammatory deposit in the flaps had disappeared, and the parts looked as in a typically successful amputation through the joint. The patient was strong and healthy, and able to earn a livelihood.

Dr. ROSS congratulated Dr. Newitt, and those who gave him their aid, upon the issue of the case, from Dr. Newitt's and Dr. Whitla's description, and what he saw, the success was a very decided one; he looked upon

such a result as a triumph of surgery. The stump was excellent.

He agreed with Dr. Whitla that the after-treatment had much to say with the result; and he thought the free mountain air did a great deal.

DR. DEMPSEY was surprised that no serious consequences followed the removal of bone in the acetabulum.

DR. ESLER made some remarks about the flaps; he had on one or two occasions noticed a flap liquify—literally melt away—when infiltrated as these were, and consequently he would not hesitate to operate on this account.

DR. BROWNE, in speaking about the flaps, reviewed the different operations at the hip-joint, and advocated the anterior and posterior ones. From the history of the case he thought it possible that the cause of fracture was owing to acute necrosis; in this Dr. Coates and the Secretary joined him.

DR. WALES was gratified to hear the details of this case, and commented upon the operation and its difficulties. He thought the persistence of the enemata treatment deserved great praise, and had much to say to the result, which was brought about by the entire removal of all the diseased bone.

DR. M'CONNELL said, during the operation he thought the patient was at one time over from the chloroform; he was surprised at the time at the small quantity of blood lost—this was owing to the way the elastic ligature was applied, being more round the pelvis than the thigh, and above the ischial tuberosity.

Dr. Whitla exhibited from patient who had worn a tracheal tube 46 years, the trachea and larynx which he had removed after death.

Tracheotomy had been done 46 years previous by Dr. H. Purdon who being present as a visitor gave the early history.

Paper:¹ The Secretary (DR. WHITLA) exhibited a larynx and trachea which he removed from a patient a few days before, upon whom the operation of tracheotomy had been successfully performed about forty-six years previously, and a tube worn all that time. Dr. Henry Purdon was the operator, and as he was present he would call upon him to kindly give some particulars of the early history to the members of the Society. The specimen showed a healthy air-tube in every respect, save the little aperture into the trachea where the skin and mucous membrane became continuous. He had dissected the muscles carefully, and found all those attached to the hyoid bone normal in every way except the omohyoid, which was reduced to the size of a mere thread; he thought this worth noticing, as the function of the muscle was not satisfactorily known. The interior of the larynx was healthy, all traces of inflammation

having disappeared except the contraction, which had probably followed cicatrisation, leaving the lower aperture of the larynx so narrow as only to admit an ordinary probe.

DR. HENRY PURDON said:—This case has been fully related in the twenty-fourth number of the first series of the Dublin Journal, and was written at the request of the late Mr. Carmichael. The tube through which she breathed may seem dangerously long, and likely to injure the posterior wall of the trachea, but I found the sterno-hyoid and thyroid muscles rendered a shorter one inefficient, and a curved one was worked out by the action of these muscles. Of course the tubes used were double, but this is the inner one of the third or fourth set which have been worn out since the operation was performed. I may mention that I found it necessary in the earlier ones to have a slight collar or rim round the inner extremity of the outer tube to prevent its being worked out.

COMPILER'S NOTE

The following report seems likely to be the one mentioned above although Dr. Purdon was not the operator. It is the fourth case in Mr. Richard Carmichael's paper "Observations on the Use of Tracheotomy in Chronic Diseases of the Larynx, Illustrated by Cases."¹

The next case I shall lay before the public is one of high interest; it is an instance of chronic laryngitis arising from repeated attacks of catarrh in a person probably predisposed to the complaint, as she was all her life subject to hoarseness, whenever she caught cold. The patient, a lady about fifty years of age, resides in Belfast, to which town I was called to see her in the beginning of last May. I found her seated in an arm chair, breathing with great difficulty, and making deep and long sonorous inspirations, of a croupy character; she had not been able to lie in the recumbent position for several weeks, and her legs were swelled and œdematous as high as the knees; on examining her and inquiring into the history of her complaint, I instantly came to the decision that nothing could save her life but tracheotomy, which I accordingly performed the following day, assisted by Mr. M'Cluney and Doctor Henry Purdon, both of Belfast.

For the following history of the case I am indebted to the latter gentleman:—

Belfast, August 10, 1832.

My Dear Sir,

For the last two years our patient, Miss B's breathing has been slightly affected when ascending a hill, and whenever she caught cold her voice was husky; last August, after a slight attack of catarrh, her voice continued weak, which however gave her no uneasiness, as

¹ [Dublin Journal of Medical Science. 1877, v64, p446.]

¹ [Dublin Journal of Medical and Chemical Science, 1833, v2, p159.]

she expected that it would, in a little time, return to its former strength; but, in December, her friends becoming uneasy, the gentleman (Mr. M'Cluney) who attended the family was consulted; her voice then was almost completely gone; she had occasionally a cough; the larynx was rather tender on pressure; the respiration slower than natural: deglutition difficult at times; pulse slow and regular; sleep, appetite, bowels, and strength perfectly natural; leeches were frequently applied to the neighbourhood of the larynx, also blisters and various expectorants.

I saw her about the middle of last February, her voice was then stridulous, or rather a low whisper, and the cough and inspiration were very like what I have heard in the advanced stage of the croup, attended with a sensation of tightness in the larynx.

She went to Dublin in the latter end of the same month, and during the journey her breathing was much easier. After consulting Mr. Colles, she returned towards the middle of March, and immediately commenced using the medicines he had ordered, which were, mercury internally, and a stimulating liniment externally; her mouth became sore in about eight days, and was kept so for twenty-four, and then, as she found herself rather worse, the mercury was omitted, and the mouth allowed to get well; during the time it was sore, small portions of mercurial ointment were rubbed in along the side of the thyroid and cricoid cartilages, with the double view of keeping up the general action of mercury on the system, and at the same time of exciting local counter-irritation; after this a very stimulating gargle was used, which increased the flow of saliva, and caused great irritation, without, however, producing any amendment; lastly, a solution of the nitrate of silver was applied to the lower part of the pharynx, by means of an elastic tube, through which a piece of wire was passed with some lint dipped in the solution (the strength of this was ʒss ad ʒi). Every application caused a severe paroxysm of dyspnœa, and as there was no amelioration, but a gradual increase of dyspnœa, after having been repeated ten or twelve times, it was omitted. We now tried frictions with iodine ointment; but this she was unable to bear, from the severe irritation it caused on the skin.

At night she had paroxysms of orthopnœa lasting for perhaps four or six hours, and for this she took various anti-spasmodics, all of which relieved her for once or twice, and then failed; during the day she was always better, and when the weather permitted, went out in a carriage, and while there was invariably better, the inspirations being much easier and less noisy. Towards the end of April her feet and legs began to swell, and she was unable to lie down at night, but the pulse still continued about seventy-four and good, and the lungs appeared sound, the inspirations twelve in a minute.

You first saw her on May 4th; then the dyspnœa was

very urgent; her pulse seventy-eight, rather weaker than before; lungs sound, both on auscultation and percussion; slight tumefaction on both sides of the larynx. You operated on the 5th, making the first incision with a bistoury; there was a great deal of fat under the integuments; no vessel was divided; that night she slept a little, and was easy next day; on the 7th her breathing became much oppressed, and as the wound and adjoining integuments appeared much swollen and inflamed, you directed a number of leeches to be applied, which caused an oozing of blood during almost the entire night, and was followed by great and decided relief; afterwards, her amendment was steady and progressive; she breathes freely through the wound, which we are obliged to keep open with two concave plates of silver, that form a tube when pressed together, but she is incapable of speaking.

In a note, which I received from her this day, she says: "That my general health is quite good; rest, appetite, and strength, all excellent; but I am dumb, and shall remain so for life."

At present she cannot inspire at all by the natural opening. Should this account not prove satisfactory, it will give me great pleasure to fill up any omissions, or write another if you wish, and believe me, dear Sir,

Your truly obliged,
Henry Purdon.

Now, although I admit it is a great misfortune for a lady to lose her voice, yet it would be much greater to lose her life, which must have been inevitably the case had not the operation been performed. Besides, the loss of voice cannot be altogether laid at the door of the operation, for it was all but lost before that measure was resorted to. For all the other cases of affections of the larynx, either acute or chronic, upon which I performed tracheotomy, the voice was gradually restored as the inflammation and swelling of the larynx subsided; the wound in the trachea, notwithstanding the removal in every instance of a portion of the rings, progressively closing as the obstruction to the passage of air in the larynx diminished.

In the present instance, the same happy result would, no doubt, have ensued, had not the obstruction to the passage of air been owing to a chronic and thickened state of the lining membrane of the larynx, so obdurate as not to yield to the plastic power of the absorbents, even when the artificial opening in the trachea allowed the affected organ to remain in a state of quiescence.

With the view of reducing this thickened state of the mucous membrane, inhalation of iodine was resorted to, but without success.

The patient had been, as was mentioned before, all her life predisposed to chronic laryngitis, as her voice was naturally husky, and whenever she caught cold she was subject to obstinate attacks of hoarseness.

The members present congratulated Dr. Purdon upon the extraordinary success of his operation. No one had heard of a case where the patient survived fifteen years [sic] and continued to require the use of the tube.

Case of Fibrous Tumour.¹

DR. JAMES MOORE exhibited a drawing of a tumour recently removed from a man thirty-six years old. It was firmly fibrous in structure, and weighed 16 ozs.; it extended from behind the ear to the chin, pressed upon the trachea, interfered with deglutition, and disturbed the heart's action. He described the steps of the operation, which several members had witnessed performed with great dexterity. The wound healed rapidly. The tumour was dissected off the facial artery, in a long part of its course.

Dr. Whitla also exhibited a limb removed the same day [by Dr. Newitt] for disease of knee joint.

George F. Wales

Session 1876 77.

Annual Meeting Wednesday November 7th 1877

Present, in the chair Dr. Wheeler, Drs. Dill, John Moore, Dempsey, Core, McConnell, McKee, Coates, Esler and Whitla.

The Secretary read the report of the Council which was adopted and it was agreed it should be printed and appear in the volume of the transactions.

ANNUAL REPORT¹

The Council have much pleasure in submitting to the Members of the Society their Report for the year just terminated.

Ten Ordinary Meetings, in addition to the Annual Meeting, were held, and the average attendance of Members was thirteen.

The Council met seven times, and the following is the attendance of Members:—

Dr. Ross,	6	Dr. Core,	4
Dr. Wheeler,	4	Dr. Fagan,	4
Dr. Wales,	2	Dr. Murney,	3
Dr. Brown,	4	Dr. John Moore,	3
Dr. Coates,	6	Dr. Spedding,	3
Dr. Beck,	3	Dr. Whitla,	7

The Council regret to record the death of one of the most promising Members of the Society, Dr. M'Crea, who had been for many years an active Member, and whose genius and brilliancy had shed much light upon the discussions of the Society. His papers, characterised by great originality and research, show that he has left behind him foot-prints which are fixed and lasting. Upon doubtful and obscure cases brought before the Society, his clear judgment and logical decision were listened to always with marked respect and esteem by the senior Members; and the Society mourns the loss of one cut off at a comparatively early age, who, had he been spared, would have taken the highest place in his profession.

Regarding the work done by the Society during the last year, Council think the results will compare favourably with those of years gone by, as the following will show:—

Thirteen papers were read.

Dr. Coates—"Notes of Cases of Acute Rheumatism treated by Salicylic Acid."

Dr. Beck—"Notes of Cases of Tertiary Syphilis."

Dr. Browne—"Case of Tapping the Bladder in Two Places, per Rectum, and above the Pubes."

„ "Case of Fracture of Lower Jaw treated with Silver-wire Sutures."

Dr. Murney—"Notes of a Case of Successful Ovariectomy."

Dr. Fagan—"Paper on Excision of the Knee-Joint."

„ "Notes of Case of Malignant Cerebral Tumour."

Dr. Spedding—"Notes of Cases of Puerperal Eclampsia."

Dr. Esler—"Oakum as an Antiseptic Dressing."

¹ [Dublin Journal of Medical Science. 1877, v64, p447. To be found immediately after the tracheotomy case but not recorded in the minutes of the Society.]

¹ [Offprint from the Transactions found in the Minute book.]

Dr. Harkin—"Notes of a Case of Recurring Hydatidiform Mole Pregnancy."

Dr. Whitla—"Notes of a Successful Case of Amputation through the Hip-Joint."

Dr. M'Keown read two original papers—one upon "A New Operation for Trichiasis and Entropion," and one upon "A New Operation for Detachment of the Retina."

PATIENTS EXHIBITED TO THE SOCIETY.

Dr. Fagan—A Case of Partial Removal of Tarsus, and Three Successful Cases of Excision of the Knee.

Dr. Browne showed the patient upon whom he had operated for impermeable stricture, by tapping the bladder.

Dr. Whitla showed a patient upon whom an amputation through the hip-joint was performed.

MORBID SPECIMENS EXHIBITED.

Dr. Murney—An ovarian cyst, and a compound fracture through knee-joint.

Dr. Coates—A brain from an apoplectic subject.

Dr. John Moore—A larynx from a suicidal cut-throat.

Dr. James Moore—A fibrous tumour.

Dr. Beck—A vertebra expectorated by a syphilitic subject.

Dr. Whitla—A diseased knee-joint; and a larynx and trachea from a patient who had worn a tracheotomy tube forty-six years.

Dr. Harkin—Hydatids, uterine.

Some of the papers were illustrated by crayon and water sketches and photographs.

The Transactions of the Society have been forwarded to the Dublin Journal of Medical Science, and through the kindness and courtesy of the Editor, Dr. J. W. Moore, have all appeared in its columns without abbreviation.

The Council report, with pleasure, that during the past session no less than nine Members joined the Society. This fact, with the consideration of the amount of work done, leads them to hope that the coming Session will be one crowned with success.

A Microscopic Committee has been formed, consisting of—

Dr. J. W. Browne,
Dr. Fagan,
Dr. Wales,

Dr. Coates,
Dr. Core,
Dr. Whitla,

the latter to act as convenor; and the Council hope that the Members of the Society will avail themselves of this Committee, and that some practical work will be transacted in this very important field.

The Secretary hopes to be able to place in the hands of each Member next month a complete copy of the Transactions of the Society.

The Report was adopted; and, after the usual votes of thanks to out-going office-bearers, a ballot was taken, and the following gentlemen were appointed to act during the Session of 1877-78 ...

Arrangements were made for the Annual Dinner and the following office-bearers elected:

Dr. Wales, **President.**

Aickin and J. W. Browne, **Vice[-Presidents].**

Council: F. E. Beck, W. S. Core, John Moore, A. McConnell, R. Esler, S. B. Coates.

F. Fagan, **Treasurer.**

W. Whitla, **Secretary.**

George F. Wales

Ulster Medical Society
Session 1877-1878
President George Frederick Wales

ULSTER MEDICAL SOCIETY

SESSION 1877-78

OFFICE-BEARERS 1877-78

President:

G. F. WALES, M.D.

Ex-President:

R. ROSS, M.D.

Vice-Presidents:

W. AICKIN, M.D. J. W. BROWNE, B.A., M.D.

Members of Council:

F. E. BECK, M.R.C.P.ED., L.R.C.S.ED
A. M'CONNELL, L.R.C.S.&P.ED
WILLIAM S. CORE, M.D. ROBERT ESLER, M.D.
JOHN MOORE, M.D. S. B. COATES, L.R.C.P.&S.
ED.

Treasurer:

JOHN FAGAN, F.R.C.S.I.

Secretary:

WILLIAM WHITLA, M.D.

LIST OF MEMBERS, 1877-78.

Anderson, R. J., M.A., M.D., M.Ch. (Q.U.I.)
Andrews, Prof. T., M.D.Ed., L.R.C.S.Ed., F.R.S.
Aickin, W., M.D. (Q.U.I.), M.R.C.S.E., L.A.H.D.

Ball, T., L.R.C.P.Edin., L.A.H.D.
Beck, F. E., M.R.C.P.Ed., L.R.C.S.Ed., L.A.H.D.
Beck, J. W., M.D.Glas., M.Ch., L.A.H.D.
Bolton, Reuben, M.D., M.Ch. (Q.U.I.), L.A.H.D.
Browne, J. W., B.A., M.D. (Q.U.I.), M.R.C.S.E.
Browne, S., M.R.C.S.E., L.K.&Q.C.P.I.

Cantrell, T. J., L.A.H.D.
Clements, R., M.D., L.R.C.S.Ed.
Coates, S. B., L.R.C.P.&S.Edin.
Core, W. S., M.D. (Q.U.I.), L.R.C.S.Edin.
Cuming, Prof. J., M.A., M.D. (Q.U.I.), F.K.&Q.C.P.I.

Dempsey, A., M.D. (Q.U.I.), L.R.C.S.I.
Dill, Professor R. F., M.D.Univ. Glas., M.R.C.S.E.
Drennan, J. S., M.D.Univ.Db., L.R.C.S.I.

Esler, R., M.D., M.Ch. (Q.U.I.)

Fagan, J., F.R.C.S.I., L.K.&Q.C.P.I.
Ferguson, H. S., M.R.C.S.E., M.D.Univ. Glas.

Gordon, Professor A., M.D. Univ. Edin., L.R.C.S.Ed.
Graham, J., M.D., M.Ch. (Q.U.I.)
Gribbin, E. D., L.F.P.&S.Glas., L.A.H.D., L.R.C.P.Ed
Harkin, A., M.D. Abdn., M.R.C.S.E., L.A.H.D.

Jefferson, J., L.R.C.P.&S. Ed.
Johnston, D., M.D. (Q.U.I.), M.R.C.S.E.
Lindsay, J., B.A. (Q.U.I.), L.R.C.S.&P.Ed.

Merrick, A. S., M.D. (Q.U.I.), L.R.C.S.Ed., L.A.H.D.
Moore, Jn., M.D. (Q.U.I.), M.R.C.S.E.
Moore, J., M.D. Univ. Ed., M.R.C.S.E.
Mulholland, C., M.R.C.S.E., M.D. Aberd.
Murney, H., M.D. Univ. Ed., M.R.C.S.E.
M'Connell, A., L.R.C.S.&P.Edin.
MacCormac, Henry, M.D. Univ Edin., L.R.C.S.Edin.
M'Kee, S., M.D. (Q.U.I.), M.Ch.
M'Keown, W. A., M.D., M.Ch. (Q.U.I.)
M'Meekin, J., L.R.C.S.&P.Edin.
M'Cleery, J. C., L.R.C.S.I., L.A.H.D.
M'Ivor, R., M.D., M.Ch. (Q.U.I.)

O'Malley, M., M.D., M.Ch. (Q.U.I.)
O'Neill, H., M.D., M.Ch. (Q.U.I.)

Pring, R. W., L.A.H.D.
Purdon, C. D., F.R.C.S.I., M.B. Dub. Univ.

Reid, Prof. J., M.D. Univ. Ed., L.R.C.S.Edin., L.S.A.L.
Ross, R., M.D. Univ. St. And., L.R.C.S.I.

Smith, J. W. T., M.D. (Q.U.I.), L.R.C.S.I.
Smyth, B., M.R.C.S.E., M.B., M.CH. Dub. Univ.
Smyth, J., L.R.C.S.I.
Spedding, B. H., L.R.C.P.&S.Edin.
Speer, W. S., M.D., M.Ch. (Q.U.I.)

Wadsworth, Chas., L.R.S.&P.Ed.
Wales, G. F. L.F.P.&S.Glas., M.D. Abdn.
Wheeler, T. K., M.D. (Q.U.I.), L.R.C.S.Edin., L.A.H.D.
Whitaker, H., M.D. (Q.U.I.), M.R.C.S.Edin., L.A.H.D.
Whitla, W., M.D. (Q.U.I.), L.R.C.S.Edin., L.A.H.D.,
L.R.C.P.Edin.
Workman, Chas., M.D., M.Ch. (Q.U.I.)

Session 1877-78

First Meeting.

The first ordinary meeting of the Society was held in the theatre of the Belfast Royal Hospital on Wednesday evening at 8 p.m. December 5th 1877.

Present, Dr. Wales (President) in the chair, Dr. Browne (J. W.), Dr. J. W. Beck, F. E. Beck, Cuming, Dill, John Moore, Fagan, Wheeler, D. Johnston, Speer, Stra-

han, Spedding, Harkin, O'Malley, Esler, Coates, Dempsey, Whitla, Jefferson, O'Neill, Clements.

A ballot being made, Dr. C. Workman was unanimously elected member of the Society.

The President then read his inaugural address.

Paper:¹ GENTLEMEN—In entering on the presidential duties of the session, let me thank you for the honour you have conferred on me—an honour which was unlooked-for, and which I value the more because of its coming from you so unanimously. It is gratifying to a man after a life's labour to find that he is considered worthy of such a spontaneous tribute of respect, for next in satisfaction to that afforded by the mens conscia recti is that resulting from the approbation of one's professional brethren. I wish I could feel that I really merited such favourable consideration. I can but strive to prove in some degree worthy of your kindness.

I have to acknowledge gratefully the many promises of co-operation in the work of the Society from members generally—from some of my respected predecessors in office, and from my seniors in the profession. With such support, and your indulgence for my shortcomings, I hope, aided more immediately by the staff of the society and its able and indefatigable Secretary, to see its usefulness preserved, and, if possible, extended in the coming session.

It is now more than a quarter of a century since I entered on the duties of my profession and joined the old Medical Society of Belfast. About this time men began to shake themselves out of the old grooves of thought. Physiological, pathological, and chemical research took on more activity, a spirit of inquiry and criticism spread abroad, leading not only to a disposition to break new ground, but also to test the foundations of received opinions and established practices. Amongst the foremost in this town to catch the spirit of the time was the late Dr. Malcolm. He founded the Pathological Society here, not to supplant but to supplement the Medical. I had the honour of acting with him as joint-secretary during the first year of its existence.

It turned out remarkably successful. Its meetings were held weekly, and were well attended by members of the profession old and young, from town and country. Queries were regularly propounded for discussion, and formed a prominent feature in the working of the Society. These always excited interest, the members generally taking part in the discussions, which were published. No man ever did more for the profession in Belfast while he lived than did Dr. Malcolm. Like a little leaven he leavened the whole mass with the spirit which animated himself, but he died too soon, and left a void in our rank which was long felt. After his death the Pathological Society maintained its usefulness for a time, but gradually it waned, and finally merged with

the Old Medical into the "Ulster Medical Society." We thus combine the two, and considering that much of the old matured element is still with us (a consideration which inspires me, in passing, to hope that former presidents will occasionally manifest by their presence and countenance the interest they once felt and promised in our welfare), and considering the superior character of the new element, it will not reflect creditably on either if we have a sluggish and unprofitable session.

In closing this special reference to our Society, it is with unfeigned sorrow I notice, at this our opening meeting, the absence of a once familiar pleasant face. I refer to the late Dr. John McCrea. We will miss him in the work of the Society, in which his ability, attainments, and cultivated experience made him so valuable; and we will miss him otherwise, for the high tone of honour and genial fellowship which characterised him and made him a favourite.

The last quarter of a century has been a period of transition and progress. No similar period in our history has been so eventful, so revolutionary, so humbling to assumption of power, and yet so satisfactory in point of work done. At the commencement of the time referred to we still pursued the vigorous methods of combating disease which belonged to the previous generation, chief of which was blood-letting. In my early years few days passed without my using the lancet, and yet it is now several years since I performed venesection. At first sight it will appear either that we were wrong then or that we are wrong now. I believe the lancet was too much used before, and is unjustifiably neglected now in deference to modern views. I can well recollect the great and permanent relief so frequently given by the lancet in acute serous inflammations, pneumonia, and congestive head affections; and yet it is so forgotten now that I venture to say a great many of our younger brethren have neither bled nor seen bleeding throughout their whole career. Some explanation of the difference in practice at the two periods is afforded by the recollection that formerly it was quite the habit to be bled annually. However such an injurious practice came about I do not know, it begot a plethoric condition which maintained the demand for periodic depletion, owing to the relief that always followed. About the time that bleeding began to be called in question, or rather a little prior to it, very active medication was as much the rule as bleeding, so that patients, I may safely say, were seldom lost by inaction; but with the growth of homœopathy there came a change in our views. Notwithstanding all the irrational assumptions of that system, it secured many adherents amongst the better classes. It fascinated them by the simplicity of its law, by the possibility of their grasping the symptoms, and selecting easily the assumed remedy by a reference to its alleged effects. It satisfied thus that craving for amateur doctoring which so universally

¹ [Dublin Journal of Medical Science, 1878, v65, p65.]

prevails. Then, again, the sugar globules and fanciful dilutions were not unpleasant to taste like our medicines. They did not sicken, and whatever other effect they had or had not was supplied by the imagination. But under homœopathy and hydropathy, another rival system of therapeutics, it was found that patients did very well. Medical men were not slow to discover the truth. They perceived that nature could be safely trusted to manage a good deal of her own business, and that she did manage it in every case treated homœopathically, except so far as the admirable dietetics of that system, and the mental impression contributed to the result. The lesson had its influence. It was found that disease could be dealt with without such active drugging as had been in vogue, and faith and empiricism gave way largely to scepticism and rationalism. The reaction from the excessive use of drugs, like bleeding, led, in the tendency to extremes, to much unjustifiable neglect of therapeutics.

It is right to be as rational as we possibly can in the treatment of disease, but the practice of medicine must always remain largely empirical, and we must not undervalue it on that account. The experience of our fathers should receive our most respectful consideration. If they had not the same light to guide them that we have now, it did not hinder them from doing good work. They certainly were great in powers of observation. They have portrayed disease for us, in nearly all its phases, with singular truth and fulness, and they have given us the great bulk of the medicines we possess, with an accurate description of their effects. That was their work.

Ours is to develop the causation and pathology of the one, so as rationally to utilise the other. In other words, by an improved knowledge of the causes and conditions of disease, to select remedies that will apply to them in preventing or mitigating their operation rather than such as may only influence the symptoms and signs. The more we can succeed in doing this, the more scientific and rational will be our practice. That we are gaining sure footholds in the path of knowledge, and making rapid advances cannot be doubted. True these advances are sometimes made at the sacrifice of much that was considered well established; for example, it is disconcerting to be told that the idea of a limited brain area for each special sense is no longer tenable; that if any such localisation exist, it exists in cells diffused pretty generally through large extent of brain substance.

We can no longer say in a case of aphasia, anæsthesia, or motor paralysis, that the lesion is absolutely so and so, for we know that, apart from any lesion, mere irritation, remote as well as direct, will induce any or all of these; and, further, we know that such conditions may be maintained indefinitely by some inhibitory influence, often slight, the removal of which will again bring into play the functions of the uninjured generat-

ing and conducting nervous structures. In point of practical value I believe that no investigations of late excel those made by Professor Lister. It is a great step in knowledge to know that animal fluids and secretions have not any inherent tendency to putrefy—that they will remain in contact with pure air—i.e., air freed from living germs, without change; that such change when it takes place is a true fermentative process—i.e., a change due to the growth and development of living germs.

I think the Professor has absolutely demonstrated these points by his recent experiments, and that those who have asserted that the ferment (so called) may be a chemical and not a vital agent, have failed in their proofs. Great as have been the advantages resulting to surgery from the application of this knowledge, I believe that greater will be realised in medicine when the various morbid blood conditions come to be better investigated.

Having lightly touched on questions peculiarly our own, there remains one which is of general importance and interest, and which, I think, from the increasing magnitude of the evil, we, as guardians of the public health, have not only a right to speak out on, but I think we are morally bound to do so. I allude to the growing evil of intemperance. I cannot conceive any subject more important or more worthy of our earnest consideration. I am sure I am only speaking your experience when I say from my own that amongst men, and not inconsiderably amongst women of all classes, the use of strong drink as a beverage has produced much of the disease we have had to treat, not to speak of greater evils even than disease.

Speaking for myself, I would say that alcohol in any form is unnecessary in health, and injurious, unless taken in great moderation; that when so taken it should only be in connexion with food, and not before dinner; that those who have not been accustomed to it should not lightly begin it; that youth should take none. It is difficult to see how young persons can be preserved as long as stimulants are habitually used at table. I was much impressed while in the United States recently by observing the general absence of liquor on the tables in the dining halls of the large hotels. Persons who wished for drink had to go to the bar for it.

This was a great protection to youth and weak persons of both sexes, and might be imitated with advantage amongst ourselves. Beyond the class likely to be in any degree influenced by suggestions from us, there are the great classes which will never move to save themselves. They resort to public-houses, not to refresh, but to get wholly or partially drunk. If it is wrong for the respectable man to drink before dinner, why should the poor wretches who have lost self-control in the matter of drink be allowed to drug themselves to ruin and death, either for the profit of the State or individuals? Things are not right.

Let the clergy speak out boldly, and tell their people of the moral degeneracy that drink is producing. Let our legislators and magistrates endeavour, not less to diminish the facilities which they have created and sanctioned, than to punish those who, tempted by such facilities, become victims. Let philanthropists generally who desire to accomplish the greatest good for their fellows and their country, try to save the rising generation from intemperance, protect the weak, and render the irreclaimably inebriate as harmless as possible.

Let us aid the philanthropists and others, by our influence and advice, and by our declaring what we know of the effect of alcohol as a beverage. With its use as a medicine in our hands the public have nothing to do, and would wisely take nothing to do. Our experience will guide us better than theorising and assertion. The whole question is on the paper for discussion. One of greater gravity and importance there cannot well be, and I commend it, gentlemen, to your earnest consideration, with the view to some practical issue in the public interest.

Dr. Wheeler, in proposing a vote of thanks to the President, said that as Dr. Ross, the President for last year, was not present, he took the privilege to move, "That the best thanks of this Society be given to our President for his very interesting and able Address." The subjects he had touched on had been well discussed. He sincerely agreed with him in all that he had said in reference to the views he had enunciated on the subject of intemperance; but as the question came on for discussion, he would say nothing but merely assume the privilege of proposing the resolution.

Dr. Cuming said he had very much pleasure in seconding the motion. The Address had been full of instruction—thoughtful, reflective, and characteristically practical. In the early days of the old Pathological Society, Dr. Malcolm and he were colleagues in the Secretaryship. They had since seen its decline and the rise of the present one. Perhaps they were about to witness the advent of another. He knew the members would be most happy to give every assistance to this Society during the present session, and they knew very well that its proceedings would be presided over with great impartiality.

Dr. Dill, in supporting the motion, wished to refer a little further to what the President had so elegantly spoken of. Inasmuch as he had named Dr. Malcolm as having thrown life and soul into the then Society, he would be disposed to name another gentleman who certainly at a period a little prior to that did give very great life and spirit to the old Medical Society of Belfast—he alluded to Dr. Saunders. His knowledge of the Society at that early period led him (Dr. Dill) to say that he was then what Dr. Malcolm was described to be at a later period. As a matter of historical fact Dr.

Saunders was the first who ever read a paper on any medical or pathological subject before the old Society.¹ He thought it was right this should be placed before them. In speaking of former members, Dr. Saunders was, on the one hand, an eminent surgeon of the hospital, and Dr. Malcolm a physician of it. They were two who gave life to the profession, and entered on their labours with an energy and disposition which he would like to see amongst all their junior professional men.

The motion was carried by acclamation.

Dr. Esler moved Dr. Lindsay as a member of Society. Dr. Wheeler seconded.

Dr. Coates proposed and Dr. Whitla seconded Dr. Jefferson's nomination as member.

Dr. Dill proposed and Dr. Esler seconded Dr. Clements.

Dr. Whitla proposed and Dr. Wheeler seconded Dr. O'Neill.

Dr. Esler gave notice of motion that he begged to propose that the resolution of last session, by which the periodicals were left on the table for a week, be rescinded. He believed that the objects of the mover and seconder of that resolution had not been effected.

Dr. John Moore opened the debate on "Alcohol—Is Its Moderate Use Beneficial or Injurious?"

Paper:² How much hangs on a true answer to that question! That the immoderate use of alcohol is injurious there can be but one opinion; but that men believe in the beneficial effects of the moderate use of alcohol is testified by how much they pay for it—millions of money, oceans of tears, thousands of desolated homesteads, and countless broken hearts are freely flung into its treasury, as the price paid for the beneficial effects supposed to arise from its use when taken in moderation.

I may state at the outset of my remarks that I am not competent to enter upon a discussion of those experiments which have been carried out by practical physiologists and expert chemists on the action of alcohol on the elementary tissues of animal bodies. I may accept the teaching on these points of those fitted to deal with these subjects, and confine myself to the empirical experience gathered over now many years.

The subject presents almost an insurmountable difficulty at the very outset, as we have no "standard of health" to which we can refer—the different amounts of energy or vitality is so varyingly bestowed. One can walk a thousand quarter miles in as many consecutive periods of ten minutes each, and be vigorous at the end, while another would break down under the tenth of the task. On some the climatic state has a powerful effect—bright sunshine, clear frost, brisk breezy days producing a glow and imparting energy, buoyance, and cheer-

¹ [Not correct. See page 4.]

² [Dublin Journal of Medical Science, 1878, v65, p69.]

fulness, whereas dark, gloomy weather sheds the same sombre hue over the spirits, and depresses vitality to the lowest point of health.

The construction of the nervous organism in some is formed on such a high key that every thrill that sweeps across it causes it to vibrate with hyperæsthetic sensations; these know how

Dearly-bought the sudden treasure
Finer feelings can bestow,
Chords that vibrate sweetest pleasure
Thrill the deepest notes of woe.

These are the individuals more susceptible of the influences of alcohol, and more in danger of being drawn into its snares. Others, again, are so anæsthetic that what to the former class would be torture they bear with calm placidity; in these the resisting power is great. The "moderate" use of alcohol presents the same difficulty; it is an elastic measure, not a fixed standard. Where does it begin, and where does it end? Moderation in alcoholic stimulants to one individual is downright drunkenness to another. I know some on whom a single glass of sherry has such an effect as to be quite apparent, and I know others who could carry a bottle, and yet manifest no symptoms of being overburdened. On endeavouring to analyse one's own feelings and sensations on partaking, when the appetite has been sharpened by outdoor exercise, of a tender, well-cooked beefsteak (accompanied with its usual accompaniments, by mealy potatoes with good bread)—these, aided with a bottle of Bass or Allsop's, produce a pleasure in the participation, a feeling of satisfaction afterwards, and an amount of invigoration following as to make one hardly care to call his king a cousin.

The intoxicating effects of the tumblerful of beer is quite perceptible, and lasts for a few minutes; it can be completely dissipated by a mental effort, and can be reinduced by yielding to a relaxation, inducing a dreamy, pleasant mood. That is very evanescent. On substituting a small quantity of claret for the beer, the most careful intra-inspection cannot detect a trace of the psychological action of its alcohol. I know others on whom a single glass of beer has the same effect, or still greater, paralysing not only the vaso-motor nerves, as seen in the flushed face, but also the voluntary nerves, in loss of co-ordinating power over the movements of the tongue, and their speech betrayeth them. Where can be drawn here the line of demarcation? Does the glass of beer cross the limit of moderation, and the glass of claret fall short of it? Again, in order to arrive at an accurate estimate of the injurious or beneficial effects of the moderate use of alcohol, it is necessary to take into account the resisting power of the human system to noxious influence—the amount of toleration of which it is susceptible—the wide range of temperature from the Arctic region to the Tropics which it can bear with impunity; the miasmatic exhalation, so deadly under certain circumstances, yet when an individual becomes

acclimatised, he passes through these as if he possessed a charmed life. The dissection wound that might prove fatal to a young student from blood-poisoning proves harmless to one who has become habituated to the atmosphere of the dissecting-room.

The opium-eater and the laudanum-drinker swallow doses that would be lethal to others; and some of us remember the deadly sickness that crept over us as we were first trying the effects of that wonderful Virginian weed which afterwards came to exert such a soothing influence, when in the silence of twilight's contemplative hour we have mused in a sorrowful mood.

A solution of the problem we are seeking is for this threefold reason rendered impossible—there is no standard of health, there is no measure of moderation, and there is no possibility of correctly estimating the resisting power of the human system to noxious drugs. It is thus placed outside the region of demonstration, and all that we can hope to do is to oscillate and circulate as near the centre of truth on this point without the knowledge of when we have arrived exactly at it.

On the 3rd of July last Dr. Thomas Lauder Brunton, Lecturer on Materia Medica in St. Bartholomew's Hospital, gave evidence before the Committee of the House of Lords, appointed to inquire into the subject of intemperance.

In reply to query 9,249, Dr. Brunton stated that alcohol in small doses, when swallowed, somewhat increases the secretion of the stomach, and thereby aids digestion; it is then absorbed; it increases the heart's action, dilates the vessels, determines the blood to the surface, and gives a feeling of pleasant warmth and comfort.

In answer to 9,529, he says:—If a man eats well and sleeps well he does not require alcohol, he is better without it.

9,527. If a man is perfectly healthy he does not require spirits or wine; but if he is weak they are useful. If a man is working hard all day his stomach is exhausted like the rest of his body, and incapable of digestion; whereas if he takes a glass of wine first it begins to secrete the gastric juice, and his food is digested comfortably, otherwise it lies undigested.

9,356. Do you consider it equally necessary in case of great mental exertion? Yes.

9,357. I think even more so!!

9,365. Spirits taken during exposure to cold are bad, but after the exposure is over they are beneficial.

Dr. John Burdon Sanderson:—9,383. It was generally entertained some years ago that alcohol was not oxidised in the system. This has been completely refuted by very careful experiments.

9,384. An ordinary man may take as much as two ounces in twenty-four hours of alcohol, and the whole of it will be oxidised.

9,385. It is perfectly clear that alcohol does not go to build up any tissue in the body; on the other hand, it is

equally clear that it is used for the purpose of respiration. As long then as alcohol is taken in such quantities that it can be completely burnt, then it is beneficial; but as soon as it begins to accumulate it becomes otherwise than beneficial.

9,386. Alcohol cannot, like fat, be stored up in the system, but the question remains open whether it may not be converted into other kinds of force.

9,398. My belief is that upon the whole the human race would be situated as favourably if the use of alcohol did not exist.

I think so for two reasons. In the first place, because the evils certainly preponderate over the benefits; and the other consideration is simply that all the benefits are dispensable benefits.

9,406. Treating alcohol as a kind of food, there is no other food which deteriorates the organs, almost of necessity, in its use; but perhaps you do not admit that alcohol does so? I quite admit that.

9,435. You would say that the amount of pleasure which is given and the amount of medical aid which is derived from alcohol are overbalanced by the disadvantages? I do not desire to be understood as saying that it is desirable that the human race should do without alcohol even in health, for it is clearly beneficial.

There are two actions of alcohol on the health—that feeling of glow and increased comfort which it produces, which is a most desirable thing; and secondly, its exhilarating effect—its direct effect upon the nervous system.

On the 13th July last Sir William Gull gave the following evidence:—

9,993. I think there are conditions of the system under fatigue and exhaustion where alcohol might be useful, but I very much doubt whether there are not some sorts of food which might very well take its place.

9,996. Take the case of a man of twenty-five, sound in wind, and limb, and health, would you advise him to give up alcohol, if he were to ask you the question?

I think I should consider his calling. If he were a carter, or a man occupied out of doors much, I am not sure that I would not advise him to take some beer, but I am not very positive about it.

10,005. Many people believe that intellectual work cannot be half so well done without wine or alcohol? There I join issue at once.

10,007. Would you hold the very opposite? I should hold the opposite.

10,008. Would you say that a moderately temperate person might be benefited by a slight use of wine or alcohol? I should hold the opposite as regards the intellect.

10,009. The constant use of alcohol, even in a moderate measure, may injure the nervous tissues? Yes, certainly.

10,004. I think that taking it as a whole there is a good deal of injury done to the health by the habitual

use of wine and alcohol, even in so-called moderate quantities.

10,032. I think I have stated that alcohol in its various forms has uses, but I think those uses are very much limited by the age and health of the consumer. I think for the most part good food will supply all the wants up to the middle period of life; in old age and disease you may want some artificial stimulus. I would also say I do not know how alcohol does act upon the body altogether, but in disease it is very much as a sedative.

I have thus endeavoured to give what information the greatest lights, the most brilliant luminaries of British medical science, were able to lay before the highest court of inquiry in this kingdom, and I cannot say they have added very much to our knowledge—indeed their very greatness seems as if it would lead to bewilder, and their very brilliancy but dazzles to blind, and leaves us still wandering in darkness and in gloom groping after truth, if happily we may find it. Let us try and find out, if possible, the secret of the power it exerts over so many millions of mankind; this lies not in its effects upon the stomach in aiding or assisting the process of digestion, nor in any tonic or strengthening influence it may exert upon the system generally. It is the change it produces on the nervous system in which the magic of its power lies, and which renders its potency for good or for evil so enormous.

I remember in my boyhood of a neighbour who, though a little man, had at all times a knowledge of his own importance, but on market-days, on his return home, that sense of his importance had been considerably increased; he would strut up and down, stating that he was cock-of-the-walk, and woe betide any unlucky individual who dared to dispute his statement. I suppose to have a very exalted idea of one's self may be pleasant, and, perhaps, beneficial, but it rendered him very ridiculous in the eyes of all his acquaintances. I knew another who, when struggling with difficulties, and when a bill was falling due which he found it difficult to meet, he would go home, get a bottle of whiskey, and go to bed; he was enabled thus to forget all about his bill, though for the time being he was as rich as Rothschild, built no end of castles in the air, and only awoke from his pleasant hallucination to find the bill protested, his credit gone, and his commercial ruin complete. That it can impart a glow of pleasure and of comfort; that it possesses the power in some temperaments of inducing oblivion of depressing circumstances, and evolving those of a pleasing and exciting character; that it imparts courage and energy, enabling some individuals to do what otherwise they would not, could not, and dare not do, cannot, I think, be disputed. If you can define anything to be beneficial which adds to the pleasure and well-being of an individual, without any counteracting effects, either immediate or remote, then I cannot conceive how any one can deny that thousands are daily enjoying a pleasure, and, con-

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sequently, deriving a benefit from consuming a variety of drinks which contain alcohol. Whence then the terrible effects of drunkenness which lie around us? There are constitutions to which a small dose (how small I am not prepared to say) acts as a spark does to gunpowder, and leads to explosion. They cannot drink without getting drunk. I meet many of this type; they continue perfectly sober for months, perhaps without tasting a drop, but directly they take a glass, it is all up with them, and they never stop till the prison-cell arrest them, or sink into some other pit, till they can sink no lower.

Another class drink moderately daily, but take periodical attacks of drunkenness in which they commit the most disgraceful excesses, causing desolation and ruin if engaged in business, and bringing shame and disgrace and sorrow on their families. They awake with the most dreadful horror and bitter remorse, but only to repeat, after a time, the same sad cycle of events. I have known a few of whom it could not be said they were sober for years. They were constantly drinking, and the system thoroughly saturated with it. Even in such a state a considerable degree of intelligence, and even of commercial sharpness, remained. In these individuals the nervous system seemed to possess a marvellous power of resistance, and the destruction which inevitably comes, comes through the vascular system and secreting glands.

A most important question arises—are we in any way, however, unconsciously or unwillingly contributing to swell the list of drunkards? I have often heard this charge brought against medical men, and have hitherto set it down to that tendency to make excuse and throw the blame on others which has existed ever since the first sin was committed, and the first excuse offered. “The woman she gave me, and I did eat;” but recently cases have come under my notice where I cannot doubt the truth of the assertion, that the medical directions with regard to stimulants were the first step in a downward career to ruin, little dreamt of by those who prescribed them.

I look upon anæsthetics as one of the greatest boons that has ever been conferred upon suffering humanity, enabling us to wrap a patient in a gentle slumber, and carry him through the most terrible moments of existence without disturbing his tranquil sleep. These benefits have been dearly paid for, and many a valuable life has been the forfeit, but the benefits derived have been worth them all. Is it so with the administration of stimulants; do we derive benefits and advantages at all equivalent to the evils which follow, and to the risk and danger in which we place our patients. Have we any means of distinguishing beforehand the peculiar idiosyncrasy of an individual, that lays him at the feet of his passions, when once alcohol has been prescribed for him—or can it only be discovered when the fatal step has been taken, and when the mischief is past recall? I thought it would contribute materially to our know-

ledge on this point to procure, from one of intelligence and education, an account of the steps by which she was led to abandon home, and friends, and comforts, and all that we hold dear in life, for the spell and the charm that circles round the “cup:”—

Dear Sir,—Agreeable to your request, I will try to state how the degrading besetment I am now reaping the reward of first became a habit. I feel recalling these reminiscences rather more painful than I anticipated, and would gladly give it up but that I prayerfully hope it may benefit some, and also help myself to persevere in my determination never again to be the slave of such a vice—but to the point.

Up to the age of forty I had been a Sabbath school teacher, a tract distributor, and, as I thought, a Christian. Then came the testing-point. My dear father was taken from us; we had to leave the house that had been our home in infancy, and, although left in comfortable circumstances, I could not from the heart say, “Thy will be done.” I had a serious illness, reduced almost to a skeleton; the doctor, when I was recovering, ordered me port wine; I took it for a short time, but it produced such an unpleasant hot sensation in the head and face that I was advised to try a tablespoonful of brandy in water. This I soon tired of, as I always associated the taste of brandy with castor oil. Would to God it had ended there; but a dear good old lady, a friend of ours, told me to substitute whiskey—that was the fatal step. At first I thought it nauseous, but imperceptibly I began to wish it was the time to take it. I would not acknowledge this even to myself for a time, but gradually I began to increase the quantity, then to take it oftener, flattering myself that I needed it for some ailment or other. Oh! the sophistries of the human heart, when it wants to cherish any darling sin. After I had given way, and taken the subtle poison to excess, I persuaded myself it was all for the best, for had I not taken it at that time I should certainly have lost my reason, and so things went on growing worse and worse.

Never can I forget the first day I knew it had been noticed on me, and commented on. I tremble now when I recall the feeling of degradation and self-reproach, and how all the meanness and deception I had hitherto used to obtain it rushed to my mind, overwhelming me; but all this, instead of deterring me from ever looking at it again, only urged me on to get more to stifle the bitter anguish. Will you believe me, sir, when I tell you that I loathe the sin of drunkenness more than any other, and did at the time I was taking it? Mine has been one of the worst cases; I could not think I was taking it as a stimulant to elevate, but as a necessary sedative to quiet the irritation of the nerves.

Oh I when I look back, I wonder how I could so blindly deceive myself, and now feel, while writing this, what if it should ever occur again. You who have never known its power can never tell or know what it is to be

its slave—better, far better, a thousand deaths—but oh! I must claim deep, deep sympathy for all its victims.”

I thought the above statement from one sensitive, educated, and refined, would give us a deeper impression of the dangers that may hang around our directions than any words of mine could do. I trust that from this discussion some prophylactic measures may be devised, and some remedial ones suggested for that large and unhappy class who are suffering from one of the most hopeless of maladies.

If there be a gushing wound that calls for staunching—if there is a bitter wail of anguish and of agony that ought to be heard—if there be an imploring prayer for mercy and for pity that should be listened to, it is ascending from those who have loved-ones and dear ones that they would give their heart's blood to redeem from the most degrading of bondages, but they are helpless without your aid. Are they to be told that liberty is too sacred to be interfered with, and freedom an inalienable right? The only reply that can be given to such a statement is—O liberty, freedom, religion, what wrongs are being done in thy name.

It being nine o'clock, the President suggested that Dr. Cuming be not called to address them till next night.

Dr. Whitla proposed that the meeting should be adjourned until the following Tuesday night.

Dr. Dill suggested, seeing the session so well inaugurated, that in place of having the meetings fortnightly, they should be in future held weekly.

Dr. Cuming said this would necessitate a change in the rules, but there could be no objection to adjourning the meeting.

Dr. Browne seconded the motion of Dr. Whitla, which was passed unanimously.

The proceedings were then adjourned accordingly.

George F. Wales

Second Meeting December 11th 1877

Present, Dr. Wales (President), Professor Dill, Cuming, John Moore, MacCormac, Beck snr, McKee, Dempsey, Fagan, Spedding, Strahan, Lindsay, O'Malley, Clements, O'Neill, Coates, Jefferson, David Johnston, Esler, Wadsworth, Whitla, Speer, and about 20 students.

Dr. Esler moved the resolution referring to the journals lying on the table for one week previous to circulation be rescinded. Dr. Spedding seconded.

Dr. MacCormac moved as an amendment that the journals be allowed to remain a few days on the table. Dr. Moore seconded this.

The amendment was put and lost, and the motion of Dr. Esler was carried by a majority of 10 to 7. The original resolution of last session was consequently rescinded.

A ballot was taken and the following gentlemen were

elected members (each unanimously): Dr. Jefferson, Dr. Lindsay, Dr. O'Neill, Dr. Clements.

Dr. Spedding moved and Dr. Dill seconded the nomination of Dr. Wadsworth.

The adjointed debate on alcohol was taken up. Drs. Cuming and Dill took part and the time of the meeting having expired it was resolved to adjourn until this night week.

Paper:¹ Dr. Cuming, in opening the discussion, said:—The first thing he should be obliged to ask them was to restrict the discussion to the terms of the query. The terms had been selected with a great deal of judgment by the Council of the Society. The subject was one on which the members of the Society might be fairly asked to give their opinion, and outside that they ought not to travel. The terms were—“The moderate use of Alcohol—is it injurious or beneficial?” In the first place that clearly excluded altogether the question of intemperance, and left it as a matter perfectly foreign to the essence of the subject, and he was specially anxious that they should leave this out of consideration, because it introduced an element so much debated by the public, involving so many moral considerations, and on which the feelings of many were so strongly excited, that it would be very difficult to prevent their judgment being influenced in one way or other.

He thought that they should devote their investigations mainly, if not exclusively, to what the influence of the moderate use of alcohol was on the average human being in civilised life, and that they ought not to attach too much importance to merely exceptional cases—for instance, those individuals who had such a passion for alcohol that they could not restrain themselves from excess if they once tasted it at all. Nor need they dwell on those exceptional instances in which a small amount of alcohol produced a very great effect on the nervous system. These might be looked on as the idiosyncrasies, and had to be treated as exceptions, such as occurred in the use of morphia or mercury. In dealing with the broad general fact, they should examine it on physiological grounds, as they would examine how castor oil purged or chloral produced sleep.

In addressing an audience such as that before him, one might fairly assume that all the principal experimental evidence was tolerably familiar to them. They need not argue about theoretical considerations. The great question was—what was their own experience, their own observation as medical men? They were all agreed, firstly, that intemperance was a thoroughly bad thing. He was sure they were all agreed that a person might preserve the highest amount of physical health without taking any alcohol at all. That had been demonstrated so very fully by temperance societies, no one could doubt it. Then came the main question—was alcohol in moderate quantities useful? He knew when

¹ [Dublin Journal of Medical Science, 1878, v65, p253.]

he was entering on this subject, and undertook to discuss it at all, that he was touching on dangerous ground, but he felt that it was in a sort of way a duty he owed to the profession not to hide his own views. Now what were the conclusions that his own experience had led him to. He took the average man as he found him in his practice amongst the mercantile and professional classes, whose duties entailed a great deal of wear and tear, a good deal of expenditure of energy, and frequently considerable physical as well as mental exertion. What he believed he had observed in these was, that the use of a small amount of alcohol taken at the evening meal did the following things:—In the first place, it gave a certain amount of appetite to men whose appetite was occasionally doubtful, capricious, and possibly deficient. Again, he thought it sharpened the appetite of men when it was flagging; and, thirdly, he thought that it prevented or diminished the unpleasant sensation of fulness after eating, which was very common in those classes. He was speaking in this matter of averages. He knew there were many exceptions, many men who did very well without alcohol, but he spoke of the general run of men. Persons who were very much opposed to the use of alcohol in any form might meet this by admitting that alcohol can produce these effects, and following it by the statement that the effect passes off soon, and that there ensues a reaction which is equivalent to the primary stimulating effect. It might be said that it was quite true that there was an apparently beneficial effect at the time, but that that effect passed off, and that the patient sunk as far as he had been elevated—

As high as we have mounted in delight,
In our dejection do we sink as low,

This, in his own opinion, was not the fact. He thought that a small amount of alcohol did not lead to any injurious reaction. The question then arose—what was moderation in alcohol; was it possible to lay down a rule for moderation? and Dr. Moore had dwelt on this subject with a great deal of force, and urged that the difficulties in the way were such that it was not possible. It was difficult to lay down any rule, and impossible to lay down a strict rule; but there was no more real difficulty in making an approximation as to what was a quantity of alcohol than there was in ascertaining what was moderation in eating. If a person took such an amount of alcohol as in any way trammelled his mental or physical energy, or produced an uncomfortable effect on his sensations, or if he took an amount, beyond what he found others to use with safety or advantage, then he knew that he had passed the standard of moderation, and, he thought, that that standard should be fixed at a very moderate amount.

He believed alcohol did more than this. He thought a small amount taken by the average human being living in a high state of civilisation had the effect of blunting his susceptibility to petty annoyances. It had something

of an anæsthetic property. He thought it also to be to many a source of harmless gratification, and he did not think the pleasures of life were so very numerous that they should altogether ignore a consideration of this kind. Having gone over this part of the subject he must meet another objection made by total abstainers—that was, they would admit that these beneficial effects might be produced, but then they said the amount that would produce them to-day would not do so to-morrow or months hence; that they were on the edge of an incline; that in a year or so the quantity had to be increased, and so on until it went beyond the limits of moderation, and into the regions of intemperance. Undoubtedly this was a fact in many instances, but these instances he thought also to be exceptional; and, after looking over and very carefully considering this point, he thought from the observations he was enabled to make amongst the men he had known, and with whose history and habits he was familiar, that such a quantity as was taken for a beneficial effect did not require any addition whatever; and he thought that, so far from an increase being necessary in that way, the answer he would be inclined to give was that the experience of humanity was that rather a diminution was the rule than the exception. They saw many instances of this on a large scale on the Continent of Europe, especially amongst the French, Spanish, and Portuguese and Italians.

In these countries the inhabitants were accustomed to take a moderate amount of stimulants all their lives, and they were noted for being generally temperate. Whilst he was quite clear with regard to these views as generally applicable, still it had to be borne in mind that there was a considerable portion of the human race who were gifted with such special nervous organisations that the use of alcohol with them was attended with greater risk than with the generality of the community. Those who were subject to the complex nervous sympathies which were grouped together as hysterical manifestations seemed more liable to the injurious effects of alcohol than their more fortunately circumstanced neighbours, while they were less benefited by it.

He had only to allude finally to the position of the profession with regard to a question of this kind. All of them would recognise what enormous evils had been produced by intemperance, what misery and penury, how fertile a source it was of crime, of vice, and of physical degradation. They must be obliged to admit all this, but did that alter the physiological effect of small quantities. He did not think they should be influenced in arriving at a conclusion by considerations of this kind. They had to hold by scientific truth no matter what was the result. There seemed to be in the minds of many a fear that if they admitted any benefit from the moderate use of alcohol they were opening the door to intemperance and its evils. He was not sure that there was not some element of truth in this, and his sympa-

thies went with those who advocated total abstinence. His judgment and experience were on the opposite side. When they were asked by a patient would a moderate amount of alcohol be beneficial or injurious to him, he thought they should give a candid answer, without taking into consideration what influence his example might have on his neighbours, or what were the evils of intemperance in the world.

PROFESSOR DILL, M.D., after stating that he would not confine himself to the rules laid down by Dr. Cum-
ing, which he thought hampered discussion, said:—In arguing this question, I am disposed to lay it down as a principle—for at least my own guidance—that Science and our first great Authority are never found antagonistic to each other; and starting, as I do, upon this principle, we shall see how it may be brought to bear upon the question at issue, in its social, its moral, and its therapeutical aspects. If what has been stated be admitted, then I go further and assert, that as the use of fermented liquor is sanctioned and recognised for the use of man, we cannot step in to condemn the legitimate and temperate use of it, unless it may be on the ground of expediency. This being so, it must be admitted that it is the abuse and not the use—moderate use—of this agent which is to be discouraged.

I would, moreover, from a social standpoint, be inclined to say that, except where individuals offend against society or against self, or are in any way disposed to so offend, the law should not be put in motion.

I have been at all times an advocate of the very moderate use of alcoholic drinks, and I would still hold by the same opinion. But when I see the daily abuse of it becoming such a plague-spot on our society, then I am forced to the conviction that a reform is urgently needed. On this point I do not enter into details, neither is it necessary that I should here be more specific.

I have said that the question is a vexed one, and it is made more so by the discrepancies and the discordant views entertained by scientific investigators, and amongst medical men themselves. We have Dr. B. Ward Richardson publishing his popular tracts and delivering lectures upon the subject to the general community, sowing broadcast the seeds of his psychological dogmas, and inoculating the untrained mind in science with his fallacious arguments. I shall only take leave to say here, that there is evidence enough in his own statements for a satisfactory reply, and I believe that his whole argument applies to the abuse, and not to the use of alcoholic drinks.

Give me leave to offer you a specimen of Dr. Richardson's reasoning. He says that because the lower animals refuse the use of alcohol, ergo, it is not food; it is not suited to man, and should be rejected by him. As well might I advance as an argument the fact that, because my horse refuses to eat cabbage, ergo, cabbage is not food; it is evident that this animal cannot look upon this article as a favourite cordial. But we have as an

offset to Dr. Richardson's theory on this subject, the opinion of one of the ablest of scientific investigators—I mean Dr. Burdon Sanderson, who maintains that alcohol is a food, and may be used as such in moderation. My own experience leads me to the same conclusion, and that it is to be considered, under certain circumstances, as assisting in promoting recovery from disease. I have now passed through many a phase of life and medical thought, and some very extreme opinions on different subjects have been advanced and practised, and again more moderate views appeared to receive greater favour. I more particularly allude to the extreme views entertained at one time in regard to both the excessive use of stimulants as recommended by the late Dr. Todd, and the very free use of the lancet. These two extreme views are only known to history, and still the question recurs to us, "What of a little wine for the stomach's sake and for our oft infirmities?" to which I would reply, that I have no more right to condemn the general and moderate use of wine, than I have to condemn the proper use of bread and butter and beef.

He went on to say:—I have come to the conclusion that the stimulating plan of treating certain diseases is not so necessary as some would have us to believe. I am also of opinion that the symptoms requiring its use are not watched for with sufficient care, which symptoms are clearly told to us by Dr. Stokes—viz., when the heart's action begins to show signs of failure. The late Dr. Graves has handed down to us an expression of opinion in these words, that "he fed fever;" and, I have no doubt that to many, simple though these words may appear, they are too freely and literally interpreted.

I have in my own person experienced the disadvantage of taking brandy while making a long journey on the top of a coach, on a cold winter night, in the extreme fatigue felt next day. I made the return journey a couple of nights afterwards, on which occasion I took nothing of the kind, and I was comparatively free from fatigue on the next day. I have found that from half a glass to a glass of spirits will arrest the pains of labour as effectually as will two or three grains of opium. I have found that drinking habits are occasionally associated with disease of the womb, but I have not discovered whether it is the disease creates the habit for the drink, or the drink brings on disease.

I am also of opinion that drink creates an increased sexual desire; and do we not know that the poor "unfortunate," by her indulgence in alcoholic drink (as is usually the case), gets into a condition both of obesity and barrenness. I have often been surprised at the very great quantity of drink that some persons will venture to take—a pint, a quart, two quarts of whiskey, are no uncommon allowance over the day.

One would think that the words in the Spectator, by Addison, were applied as a delicate satire on the drinking habits of the age—"I am well, I would be better, and here I am."

Ah ! sir, I have often wished to see some fair hand of genius arise which would restore these matters to their proper level, for when in our highest degrees of enjoyment and happiness, are we not cast down to the lowest depths of depression, as we contemplate the sorrow and the suffering which that demon by his excessive use of drink has entailed, reducing this fair earth of ours to another Pandemonium.

The discussion was then adjourned until Tuesday, December 18th.

George F. Wales

The Third Meeting of the Society (adjourned) was held in the Pathological Museum on Tuesday December 18th 1877.

Present, Dr. Wales (President), Dr. Wheeler, MacCormac, Dill, Cuming, Beck Snr, John Moore, Coates, Spedding, Esler, Core, Dempsey, Strahan, Clements, O'Neill, Jefferson, Speer, D. Johnston, Whitla, and a large attendance of students.

Dr. Wadsworth was elected unanimously a member of the Society.

The adjourned debate on alcohol was for the third time taken up and the following gentleman took part: Dr. MacCormac, Beck Snr, and Dr. Wheeler.

Paper:¹ The debate was re-opened by Dr. Henry MacCormac, Consulting Physician to the Royal Hospital, who said:—The common sense and experience of mankind have long since decided the question as to the moderate use of alcohol. The properties of alcoholic drinks were known from the period—and that is now a long time ago—when the first man or woman laid aside for a little the pressed juice of the grape. Alcoholic drinks, without any reasonable doubt or question, are among the immense gifts of God, and when used with proper restraint and measure, are, or may be, productive of great good. This premised, I must now say that the abuse of alcoholic drinks was, and is, the source of prodigious evil. In fact the community are unaware of the ethics and physiology of fermented drinks, and would require very careful training in regard of both. There are multitudes, we must regret to find, who do not look upon alcoholic drinks as a source of partial sustenance and refreshment, but merely as one of animal enjoyment. The man or the woman who drinks with the express object of intoxicating himself or herself must be considered, in this respect, at least, as little better than a brute.

There are at the present moment some 150,000 public-houses in Great Britain and Ireland—all of them potential, and very often real, arenas of destruction and death. In these houses, men, and even women, spend the proceeds of their industry, robbing their families, debarring themselves of proper food and clothing and lodging, wasting their health and strength and

time, and rendering a provision for age, or illness, or accident, simply impossible. It could not well be otherwise when we find that £147,000,000 sterling are yearly paid across the counter for alcoholic drinks. The present earnings of the United Kingdom amount, it is said, to £1,200,000,000 annually. And were these earnings not so great, it would be impossible for British energy, prodigious as it is, to withstand so immense a drain.

As it is, there are a million or so of paupers—paupers reduced, in too many instances, to pauperism by excess and the almost utter absence of needful forecast. The gaols are filled with criminals, asylums for the insane with mad men and mad women, hospitals and the houses of the poor with preventable disease, more or less springing from the same cause. It is infinitely to be regretted that the fiscal arrangements of the country are such as to render it needful, or seemingly needful to derive a revenue, or at least so great a revenue, from the sale of intoxicating drinks. Would it not be better to tax property, or resort to other means to compass the requisite funds? Instead of holding out virtual boons for intoxication, every possible incentive should be yielded to the cultivation of habits of prudence, sobriety, industry, and forecast.

Compulsory education should be rigidly enforced all over the three kingdoms as well as in the colonies. Primary, intermediate, and technical schools, with lending libraries, should everywhere abound.

The Legislature, if it would, might, so to speak, put down intoxication in a day, for it has the power. Seventy or eighty years ago claret cost some £12 the hogshead—the price at which it may be purchased now. Then a war tax was levied, and the duty on imported wines raised to the monstrous amount of five shillings and upwards per gallon. Then began the introduction of brandied wines, and heady, unwholesome beer. The employment of such beverages, coupled too often with the habitual use of spirits, raw or haply diluted, instead of light wines and mild ales, has proved most disastrous. People unable to afford the one were content to rasp their palates with the other, and all the evils of intoxication followed in their train.

The mild light wines and pleasant beers of France and Germany, so harmless and refreshing, do not contain—the former more than from seven to eight, the latter from thirteen to fourteen per cent, of alcohol; whereas, not to speak of fiery ales and heavy porter, sherry, port, Madeira, and Marsala are so dosed with brandy as to contain thirty, and even upwards, percent, of alcohol. These alcoholic wines and heavy ales are really quite unfit for general safe consumption, since they are calculated, in too many instances, to lead to intoxication and disease—cannot, in fact, be largely partaken of without danger to sobriety and every prudential economic check. The employment of raw spirits, so very much resorted to by masses of the population—I

¹ [Dublin Journal of Medical Science, 1878, v65, p258.]

am sorry to add, of both sexes—is a pernicious, not to say savage, addiction. The natural, unbranded light wines of France, Hungary, and Germany, when unadulterated—say half a pint, a little more or less, at a meal—are absolutely uninjurious. I cannot speak too highly of Bavarian beer, and the light unintoxicating ales, generally, of Germany, Holland, and, indeed, those of France. They may be consumed in moderation by those who like them, with perfect safety, and I could earnestly wish to see them at the home table of the working man, and, as a support, to the nursing mother. In other respects fermented drinks of any kind should commonly be alone employed at mealtime. A prohibitory tax ought to be levied on brandy, whiskey, gin, and rum, whereas the duty on light Continental wines, unbranded, should be lowered from a shilling to a penny or two per gallon, with commensurate abatement in the malt and hop tax.

The half-pint of rum allowed daily, per head, in ships of war, should be changed for a half-pint of claret. The captains and officers do not drink rum, and I do not see why the men should. It only leads to evil habits. The German mode of brewing beer I would everywhere enforce by law. Sophistication of all kinds should be carefully guarded against. Municipalities should keep the public-houses in their own hands, and pay a fixed salary to the salesman, as is done at Gottenberg. These measures, if carried out by the Government in the first instance, and municipalities under them, would go far, I submit, to abate the ravages of intemperance, and render the moderate use of the great good gifts of the Divine Creator innocuous absolutely.

Dr. John W. Beck addressed the meeting as follows:—This question would appear, *prima facie*, a very simple one, and one of very easy solution. That the use, and particularly the moderate use, of anything which all mankind have been in the habit of using, when they could procure it, must have been in some sense beneficial, would appear to be almost self-evident. Indeed, this universal consent would seem to indicate that it was beneficial in all senses, and not at all injurious. But the question is not so simple as this. It is surrounded with difficulties. In starting for a conclusion we meet with so many modifying circumstances and disturbing elements, each of which must be taken into account, and each of which is so difficult to estimate as to its value, that we feel almost inclined to despair of being able to come at anything like a correct answer to the general question.

The answer, in any individual case is not so difficult, as the data for a correct conclusion are not only fewer in number, but much easier to be correctly ascertained. Still it requires great consideration, and will tax the skill of the best of us in any case. The first thing that meets us in this inquiry is the great difference in the opinions which have been formed, with regard to alcohol itself, by persons claiming to be experts. We find

soi-disant very high authorities setting it down as a “deadly poison”—whatever that may mean—compounded in Pandemonium: pronouncing, *ex cathedrâ*, everything connected with it, at all times, in any quantities, and under all circumstances as evil, and only evil.

Others, not so noisy, but I would say, with all due deference, of at least equal authority, have pronounced it to be a food, or at least a condiment, or both. It has been set down both as a stimulant and as a sedative. On the one hand it has been accused of causing degeneration and destruction of the tissues; on the other hand it has been extolled as one of the best means we possess of preventing waste of tissue, such as occurs in fevers and phthisis, or after long and violent exercise; and this, not only by inducing sound sleep, and thus putting the nervous centres into the best condition for recovering their own exhausted energies, restoring tonicity to the muscles, and vigour to the whole system, but also by supplying material for combustion in the lungs, and thus saving some more valuable hydrocarbon. I ask why do we find this wide difference of opinion among men equally in search of truth, and we must suppose equally capable of finding it?

Notwithstanding this—not too charitable supposition—I suspect the solution of the difficulty lies in the fact that alcohol is all these things, and produces all these effects, and a great deal more besides. Hence the difficulty of dealing with its use in health as a general question. To come more immediately to the question before us—the first point to determine is, what is the moderate use of alcohol? Can this question be answered with any degree of accuracy? If we cannot come at the truth, let us endeavour, in the language of my eloquent friend who opened this debate, to vibrate or oscillate as near it as possible. I conceive that in proportion to the correctness of the answer we can give to this question will be the value of any conclusion we may come to in the matter.

It is universally known that what would be a very moderate quantity of alcohol for one individual would be quite an immoderate quantity for another. The glass of punch that might be necessary, of an afternoon, to make an octogenarian feel comfortable, help him to digest his dinner, and procure for him a good night's sleep, may be quite sufficient to make a younger man not only very uncomfortable in the evening, but rise with a very sore head in the morning. I cannot at all agree with Professor Cuming that the quantity of alcohol which the average man—idiosyncrasies apart—may imbibe with safety, or benefit in the twenty-four hours, is anything like as easily to be ascertained as the amount of beefsteak that the average man ought to eat, with good effect, in the same period of time. Any maitre d'hôtel will be able to tell to an ounce how much beefsteak a given number of the average man will consume in a given time; but will at once pronounce the alcohol

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they will imbibe in the same period of time to be an unknown quantity. I told a gentleman a few weeks since to abstain from alcohol altogether while under my treatment. A week or two afterwards he volunteered the remark that he had abided strictly by my orders in everything, and had been particularly abstemious, not having exceeded three or four glasses each day since he had come under my hands. I give you this as a sample of what some people call, not only moderation, but abstemiousness. But, to come nearer our subject. It has been stated, and I believe correctly, that the system of an ordinary healthy adult could digest, use up, dispose of, or eliminate if you like, about two ounces of alcohol in the twenty-four hours without any trace of injury being left behind.

So far, I think, there seems to be no controversy; but, was it beneficial? Well, if it added to the feeling of comfort of body, and contentment of mind, and left no sting behind, I should say it was—even supposing the process was only elimination, pure and simple. But there is something more to be considered than this. Does this daily dose, of two ounces of alcohol, entail no mischief? It is admitted, on all hands, that during its operation it lightens the burdens of life, gives a brightness to the intellect, an elasticity to the step, and paints the whole world *couleur de rose*. This seems a very desirable state to be in, but can it be made to continue indefinitely, or even for any considerable length of time? The experience of us all at once answers that it cannot.

This unusual—I would say this unnatural—strain, action, energy, or whatever else you may choose to call it, cannot be maintained. The system gradually becomes accustomed to the two ounces of alcohol, and the world and its concerns come back, *pari passu*, to their old, common-place jog-trot. You will observe I am supposing the dose has not been increased. Now, the question arises—the question under debate—has this man, in the prime of life and health, gained or lost anything by thus daily dosing himself with two ounces of alcohol? He gained a little pleasure—gratification—for a short time, while the alcohol was new to the system, but that appears to be all. He could have done as well without it. He probably lost nothing, but he risked a temptation to increase the dose. Professor Cuming seems to think that this risk is very small, and that, in the majority of cases, the dose is not increased. It is very difficult to ascertain the truth in this matter; but this is contrary to all my experience. If the alcohol be now dropped altogether for a sufficient length of time, the same process may be repeated again with the same results. Unfortunately, this is very seldom the case. The attempt is generally made to retain and prolong these benefits—and benefits they certainly are, as far as they go—by increasing the dose; but such attempts must necessarily fail. The overexcitement of brain and the surcharge of alcohol which follow this course are sure to bring about a fearful retribution. How few there are comparatively who

having habituated themselves to this daily dose of two ounces of alcohol stop there. I have known several, however, who, having palpably lost any benefits they had obtained from this daily dose, and wisely fearing the temptation drawing them to increase the dose, dropped it altogether. I know several gentlemen who, with the snows of time descending on their heads, abstain altogether from touching alcohol, though for twenty or thirty years of the prime of their lives they indulged in their daily dose without ever exceeding it; and they dropped alcohol for these reasons. Now, this I would call reversing the order of nature. They used—not abused, remark—alcohol when it was little, if any, use to them, and they now abstain from it when it is calculated to be of much value in their declining days; and the more valuable it would be now had they refrained from it in earlier life, but I confess I would be very slow in advising them to touch it again.

And now I will say a word on the abuse of, or rather, on the temptation to abuse, alcohol. It is a long time since the wisest of men said, “Wine is a mocker.” It is a mocker. How many have unwisely increased, and continued to increase the dose, till, taken in an unknown quantity, it not only ceased to be a pleasure, but became an absolute necessity for the very existence of their beastly nature. Nay, none can know better than my present audience of a nature reduced far below the level of the beast that perishes. It is melancholy to reflect how many (some of them the finest specimens of men—aye, and the loveliest of women too) have fallen before this unknown quantity, which, at first, in their judgment, constituted “the moderate use” of alcohol; but, once over the boundary of the really moderate use, the rest is easily told: *facilis descensus*.

Gentlemen, we are the advisers of men. They look to us for guidance in this matter; and they too often look to us merely to sanction a “use” of alcohol, which they are perfectly conscious is a thorough abuse of it. How difficult it is for a medical man, placed in these circumstances, to act conscientiously, we all know. But here we must be, to a great extent, our brothers’ keepers. Let us ask ourselves, *Quis custodiet custodes?* or, should I not rather say, *custodiret?* It becomes a serious question with us, medical men, whether the beneficial effects of alcohol, such as they are, do not sink into utter insignificance when weighed against the injurious effects produced by the temptation—the amazingly strong temptation—to increase the dose up to the unknown quantity that leads to complete destruction.

For my own part, I do not believe alcohol to be either necessary or beneficial in healthy adult life, under ordinary circumstances—say from puberty up to fifty, and, in some cases, sixty years of age; and I am quite convinced, from experience, that females are much more liable to be injured by it than males during this period of life. I need scarcely touch on the use of alcohol in infancy; for, after a practice among infants of more

than forty years, I have no hesitation in saying it can be of no use there, but must in every case and under all circumstances do harm. During youth and up to puberty, we are, perhaps, on more debatable ground; but I hold much the same opinion of alcohol during that period as in infancy—let it alone.

We now come to what I consider the real use of alcohol in health. After fifty or sixty years of age “the moderate use” of alcohol will do no harm, and may do a great amount of good. If judiciously used, its dietetic use in the last decade of life’s years may be very valuable, and it will be found to be much more valuable, as I have before hinted, in declining years, if it has neither been used nor abused in early or mature life. Besides, I hold that the temptation to increase the dose injuriously in any individual who has scarcely touched it at all till after fifty or sixty years of age, is about nil.

This is no mean consideration to anyone entering on life. In proportion as they refrain from alcohol in early or mature years, in like proportion will they not only reap all the benefits its use is capable of conferring on their declining years, but in like proportion will they also escape from its evils. (Dr. Beck then related an instance where he had treated a patient, an old lady of about ninety years of age, who had been a consistent abstainer during life. Some weeks since she had an attack of diarrhoea, and after trying, first, wine, and then whiskey, neither of which had the desired effect, he suggested bitter ale, the use of which soon produced a marked change on her health and appearance. He said he had no doubt the lady owed the prolongation of her days to alcohol, presented to the stomach in the shape most agreeable to it, and most fit to be digested by it under the circumstances.)

In conclusion, he said:—Notwithstanding all that can be said, and truly said against alcohol, I never could see the way clear enough to become so much of a Turk as to eschew alcohol altogether. I have no fault to find either with those who entrench themselves behind the Kara Lom of “Teetotalism,” or of those who fortify themselves in the Plevna of “Good Templarism”—but I altogether dissent from the conduct of those enthusiastic Turks who will persevere in breaking their heads against the impassable Shipka Pass of that craze called “The Bible Wine Question.” Gentlemen, he is a wise man who, in health, can let alcohol alone; but, in my opinion, he is a much wiser man who can touch it moderately, and gently, and carefully, without being seduced by it to injure either his health, or his pocket, or his character.

Dr. Spedding moved and Dr. Cuming seconded the adjournment of the debate till Wednesday 2nd January.

G. F. Wales

Session 1877–78.

The Fourth Meeting of the Society was held in the

Museum on Wednesday evening January 2nd 1878.

The President (Dr. Wales) in the chair. Present Drs. Aickin and J. W. Browne (Vice-Presidents), Dr. Dill, John Moore, Harkin, Dempsey, McKee, Wadsworth, Esler, Jefferson, Strahan, O’Neill, Dr. Wheeler, Dr. Speer, Core, Whitla, and a considerable number of students.

Drs. Esler, Aickin, Whitla, and Speer took part in debate.

Paper:¹ DR. WHEELER gave a history of alcohol and its preparations in every known form, quoting from the Sacred Record, and from Herodotus and Homer, to show its effects on body and mind. He condemned the use of alcoholic fluids as beverages, on the grounds that they were not only unnecessary in health, but positively injurious, and from long experience and patient observation endorsed fully the statement, “that he who drinks will drink again, and that moderation (with many) oils the hinges of the gate leading to excess.”

He quoted from a very able paper of Dr. Wilks, physician to Guy’s Hospital, and also from Dr. Parkes’s paper on the use of a spirit ration in the Ashantee Campaign, which proved that alcohol is not a stimulant, nor a trustworthy aid. He also quoted the opinion of Dr. Parkes and other well-known workers, who agree that the use of alcohol in health is in no way beneficial, but on the contrary, in many instances, decidedly injurious, by exhausting the vital powers and inducing disease. He finished by saying it was needless to dilate upon the dangers which surrounded the use of it as a beverage, and believing that moderation so frequently leads to intemperate habits, thought that they, as medical men, should be very careful that in no way they should encourage the drinking habits of the age.

DR. ESLER said:—Mr. President, the limits put to this discussion by the very terms of the proposition makes it so narrow that one is almost forbidden to touch upon the moral, the social, or the therapeutic aspect of the question.

In thinking this subject over, and in listening to the many speakers who have preceded me, I am driven to the conclusion that the issue arising from the first proposition is too narrow, and for this reason—that you take a standard of health as the condition requiring to be benefited.

Now health—that is, good health, cannot be improved upon, and unless alcohol be proved to be food, and a harmless food, even a desirable food—and until it be shown that an increase of the heart’s action, that is, of the work done by the heart, is not in any degree hurtful to the animal economy—I, for one, fail to see that it is beneficial in health; besides tens of thousands of healthy men with practical experience, and a vast array of the best names in the medical profession, all testify that alcohol in health is unnecessary.

¹ [Dublin Journal of Medical Science, 1878, v65, p360.]

Recently a correspondent of some eminence in *The Lancet* tried to show that in his case a small quantity of alcohol daily was necessary to maintain good health and digestion, detailing three different occasions on which he had given it up, and on each occasion his tongue furred and his appetite failed. My reading of the case was, that this eminent member of the profession had acquired an artificial taste or habit, by which the peptic glands were stimulated to pour out their secretions, and without which they would not act well. Perhaps a little more perseverance would have overcome the difficulty. Against this case I do not think it would be difficult to quote a number where the use, even the moderate use of alcohol, has produced results exactly similar to that produced in this case from abstinence, and the lesson I would draw from it is one for youth—viz., not to acquire the habit, for habit, any habit, and especially the drinking customs of society are too strong to be easily thrown off.

The second aspect of the question is put thus, “Is the moderate use of alcohol injurious?” The answer to which need not turn on the definition of the word moderate. That its immoderate use is injurious no one will question.

Alcohol injurious? Yes. And alcohol in moderation injurious? Yes, and for these reasons:—It fosters an artificial state of appetite, digestion, existence: it is always a dangerous boundary line on which to walk, and immoderate and injurious are moderation’s nearest neighbours; it is a bad example to the young, and to others who have not full self-control. This, to medical men, is an important element in weighing the question, as none of us dare venture to ask, “Am I my brother’s keeper?” That is our trust, whether we answer the question or no.

It is an expensive habit, and this to a great many people is injurious enough. Many a man’s pocket-money spent in beer, and many a woman’s pin-money spent in gin, leaves the fire small on the hearth, the bed-covers thin, cold, and comfortless, and the children’s boots leaking at every point. Remember, too, that its estimated cost to this nation alone is nearly a hundred and fifty million sovereigns in gold.

We have heard a good deal in this discussion about light wines, as if light wines were to bring in a reign of moderation, and it has been affirmed that there is little excess in wine-growing countries. Sir, history and experience have written on the very forefront of wine—DANGEROUS. I am sorry I have not Continental experience, like some of my predecessors on this question, but I have been over a large extent of the wine-growing districts of Victoria, and I can testify to the old experience that it is not uncommon to err through wine, “to err in vision and stumble in judgment.” I have been assured by those who have practical knowledge of the whole question from their residence in grape-growing districts, that the most chronic form of tippling, and

one of the most insidious, is that induced by the constant use of wine; and, leaving out of account the gouty diathesis to which it may lead, I am not inclined, with my present information, to subscribe to the doctrine that light wine is the antidote required to stem the ever-widening torrent which has already devastated, and which threatens yet more extensively to destroy the medical, the social, the industrial, and the moral relations of society. I rather subscribe to the old statement, “Wine is a mocker.”

In conclusion, sir, if I say that, as a therapeutic agent, I consider alcohol almost invaluable—certainly indispensable—but that in health, especially the health of youth, I do not think it is necessary; that it is only exceptionally beneficial, and generally hurtful, and that it is injurious in a degree proportionate to the quantity taken; that its use, when indulged in as a luxury, should be in extreme moderation, only with food, and not habitually, you have pretty much my opinion on this whole subject.

Dr. Speer said:—Mr. President and Gentlemen, I shall briefly state my views on this question thus:—

1. That in my humble opinion the moderate use of alcohol in health is positively injurious.
2. That in cases where its use is decidedly beneficial, the person using it is not in a state of perfect health, in which instance it is fairly entitled to be regarded as a medicine, not a food.
3. That a comparison physically of total abstainers and moderate drinkers would tell immensely in favour of the former; so would a comparison on the question of healthiness.
4. That it is a fact proved to the satisfaction of every honest mind that total abstainers can endure greater cold and more excessive toil than moderate drinkers; and I submit that this fact is a telling argument against the moderate use of, or necessity for, alcohol in health.

Dr. Aickin, Vice-President, said:—Mr. President, the question of alcoholic stimulants being necessary or unnecessary in health, seems to suggest a preliminary inquiry—namely, what do we understand by the term health? It appears to be that nice balance between waste and repair of tissue, which the use of ordinary food produces in our bodies. When this state of fair balance exists, we might say the health of the individual is “at par.” In this we include the healthy action of the nerve-power as kept in the state of natural excitomotor action, by the natural stimulus of healthy blood circulating through the cerebro-spinal system; this cerebro-spinal system in its turn acts upon the whole circulatory system, forcing every separate portion of it to perform its office, whether at the heart or at the ultimate capillaries of each organ or part of the body, giving it that power which removes effete matter, and appropriating from the passing current of blood what is best suited for replenishing the particular tissue

through which it is circulating. This takes place I say when the strength (nerve power) is at par. If this is the state of things in a healthy body, produced by ordinary food, as evidenced by millions of the human race who have never used alcoholic stimulants, then I say alcoholic stimulants are not necessary to maintain a healthy person in health. Contrariwise it will be easy to show, by following the preceding arguments, that their influence on health is generally hurtful. Why? because the nerve-power is overstimulated. When this is done, the immediate effect is to produce—1st, a too rapid action of the heart, sending blood too quickly through the body, preventing the capillaries taking nutriment deliberately and sufficiently. 2ndly, the effete matter is removed too rapidly, congesting the organs that should eliminate this matter, being for the time overtaxed, and not able to act so hurriedly, being over-burdened. 3rdly, this congestive state is further increased, as we know that after excessive stimulation the strength sinks proportionately as far below par as it was stimulated above it.

The effect of this lowered state of capillary circulation is a subsidence of nerve-power below health, producing accumulation of effete matter in capillaries, which means poisoning, requiring a fresh impetus by means of stimulation to get rid of the deposited matter, which if permitted to accumulate will ultimately destroy health, and healthy action of part affected, so that we find that continued stimulation requires, through use and abuse, continued but steady increase to produce the same effect, until ultimately the excitomotor power is so overtaxed that it is impossible for it to respond to the stimulus, and so breaks down through sheer fatigue and want of time for natural resuscitation by nutritious food. This is what takes place when the strength is forced "above par." Now comes the question—when are alcoholic stimulants necessary? Answer, when the strength is "below par." This is constantly the effect when disease has produced that amount of debility which requires stimulation. It then in part raises the functions of the different organs up to par, producing stimulation of nervous system, then increased action of heart and capillary system, giving it power to remove effete accumulations, and by its preservative influence preventing too rapid decay of tissue, as constantly takes place in disease; it also stimulates digestion, directly and indirectly (by nervous influence), and also, by its narcotic property, acts as a soothing agent to the then irritable nervous condition produced by disease. From the foregoing reasoning I consider alcoholic stimulants necessary when strength is below par, or in debility after disease; unnecessary when strength is at par; that their influence is generally hurtful in health, and positively injurious when strength is pushed above par.

Dr. WHITLA (Hon. Sec.) said:—Mr. President and Gentlemen, it never occurred to me to speak upon this subject,

nor should I even now, but for your informing me that it was your intention to call upon me in this meeting. You want an expression of opinion from men who have spent years in the practice of their profession, and the value of the opinion upon a subject like this is certainly in proportion to the donor's experience. Being one of the junior members of the Society, I would consider it wholly unpardonable if I occupied your time at any length. I had not taken alcohol for twenty years, but after hearing and reading much about its beneficial results, I determined to try its effects upon myself. For a period of two years I took small doses of alcohol daily, with more or less regularity, believing now that its use was highly beneficial, and now that it was as lowly pernicious; and it was not till I had repeatedly ceased, and as often resumed it, that I felt at all satisfied with the result.

I found that, in addition to the temporary glow of comfort, dilatation of the superficial capillaries, cutaneous insensibility, cerebral activity, &c., one effect was markedly constant, and as this is the most important of the effects produced by small doses of alcohol in health, and as time is short, I purpose to attentively look into it. I refer to the increase of appetite. Those who opened the debate, and who seemed favourable to moderate doses of alcohol in health, have given prominence to this action. Dr. Cuming, who so ably laid down that the groove in which the discussion should run was that of health, immediately proceeded to say that alcohol in moderate doses will give an appetite to a man who has none.

Now, is a man without an appetite a fit subject to illustrate the physiological effects of alcohol? Here, I believe, lies our most important and vital issue; and without attempting to define "health," I think, sir, in considering these resolutions, if we would keep in our mind's eye a typically healthy man, who is to be just at the time of our experiment in the condition of perfect health of mind as well as of body, much of the difference of opinion on this matter would vanish, and we could hardly conceive any one unable to say that to such a one alcohol is necessary. I found that when in health, the consumption of food was always increased at that meal with which it was taken; this is generally admitted, but in my case I found that the total amount consumed in twenty-four hours was diminished. This is too often overlooked; we order small doses of alcohol with dinner to a patient whose appetite is lagging, and we find he eats more, but there is often no benefit. What are we doing? Compelling a stomach to do an amount of work in an hour and a half which should be spread over twenty-four. In such cases alcohol is manifestly injurious. I believe that all men with vigorous appetites eat much more than is necessary for the maintenance of the organism, and this surplus acts as a direct stimulant to the nerve, vase-motor, muscular, and digestive systems, and produces effects identical

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with small doses of alcohol. During the two years trial of alcohol I was weighed about every eight weeks, and only once was there any marked increase in weight; and I was much surprised, and still am, that this increase followed a period of total abstinence from alcohol, having entirely suspended it from the time of being weighed till next. This is the more remarkable when we consider that the form of alcohol was strong ale.

Well, Mr. President, to sum up my little experimental experience of alcohol, I must say that experience has led me to entirely discard it when in health, which I have done some months ago, and has brought me irresistibly to the conclusions so ably expressed by yourself to the Council, viz.:—

1. That alcoholic stimulants are unnecessary in health.
2. That their influence on health is only exceptionally beneficial.
3. That their influence on health is generally hurtful.
4. In order to lessen the hurtful consequences attending the use of alcoholic stimulants, I believe that, if used, they should be in extreme moderation—only with food, not before dinner, and not habitually.

I cannot sit down without referring to a few statements made by one who so ably spoke at the commencement of this debate. Dr. Cuming no little surprised me when he stated “that in order to daily experience the physiological effects of alcohol, it was not necessary to increase the dose, but if anything to diminish it.” This is not my experience, and if it were true as a rule, I believe there never would have been the necessity for this Society discussing for four nights the sad question of alcohol. To those whose appetites are good, but who wish to be “throned over petty annoyances,” I cannot recommend its use, or call it “an innocent gratification,” knowing by what an awful train of woe this gratification is often followed; and the fact of our being physicians does not release us from the terrible responsibility of being our brothers’ keepers.

The PRESIDENT then read the following resolutions of the Council of the Society:—

“The Society considers,

- “1. That alcoholic stimulants are unnecessary in health.
- “2. That their influence on health is only exceptionally beneficial.
- “3. That their influence on health is generally hurtful.
- “4. In order to lessen the hurtful consequences attending the use of alcoholic stimulants, the Society advises that, if used, they should be in extreme moderation, only with food, not before dinner, and not habitually.”

To the first resolution Dr. Dill moved, and Dr. Dempsey seconded, an amendment, “That the Society considers the use of alcoholic stimulants are not generally necessary in health.” The amendment was put to the meeting and lost.

The resolution “That the Society considers that alcoholic stimulants are unnecessary in health” being put to the meeting, was carried.

The second and fourth resolutions were withdrawn.

The third, “That their influence on health is generally hurtful,” was carried by acclamation.

The President then made the following remarks:—We have now reached the conclusion of the debate on “Alcohol: is its moderate use in health beneficial or injurious?” and, after full and free discussion, we have decided by a majority of votes that it is unnecessary and generally hurtful.

I think we owe much to our senior and leading brethren for coming out and giving us so freely of their valuable experience on this important question, which, I am sure, will be read with interest and profit by all to whom the promotion of temperance is a matter of concern, and I consider it highly satisfactory that members generally, and more particularly my junior brethren, have declared themselves so emphatically on what I regard as the correct side in its scientific aspect, but which, beyond doubt, is the safe side.

I would not have it understood that I condemn the occasional moderate use of alcohol in any form in health, or say that it necessarily does harm, but I do condemn and fear the daily habit of using it even in strict moderation, because a want is thereby created, on the regular supply of which comfortable feeling largely depends; and when a healthy man finds his happiness in any degree involved by his not swallowing a certain amount of alcohol daily, his independence is already largely compromised, and he is liable to be enslaved by the most seductive, tyrannical, and dangerous of all influences; for it must be remembered that it is out of the habitual, and at first moderate, taking of stimulants that excesses grow, and victims are made. How many these are may be assumed by considering the amount of money spent by the people of these kingdoms annually in the purchase of intoxicants—£147,000,000!

Enough in little over five years to pay off the national debt; enough, if spent in supplying food, clothing, domestic requirements, and otherwise beneficially, to develop good trade, the physical, mental, and moral well-being of the people, national greatness, and general prosperity—an average of £23 a year for each family! or nearly £5 for each man, woman, and child! And what do the people get in exchange for all this expenditure? Misery, misfortune, disease, crime!

Your vote this night must have considerable influence in awaking many to a sense of incipient danger. It is a most unselfish vote, for, next to the revenue and the publicans, who benefit so much as we by the intemperance that prevails? It is a vote I look on with great satisfaction, as the first act of the Ulster Medical Society in my year of office, and it is one, gentlemen, which I feel well assured we will never have cause to regret.

Dr. DILL moved, and Dr. Wheeler seconded, a vote of thanks to the President for his conduct in the chair during the debate, which was passed by acclamation, and which brought the meeting to a close.

Dr. McKee proposed and Dr. Whitla seconded the nomination of Dr. Anderson

G. F. Wales

The Fifth Meeting of the Society was held on Tuesday January 15th in the Museum.

Present, Dr. Wales (President), Professors Cuming and Dill, Drs. Wheeler, Esler, Gribbin, Coates, J. Moore, Speer, Lindsay, Clements, Graham, Strahan, and Whitla.

A ballot was taken and Dr. Anderson was unanimously elected a member of the Society.

Dr. Dill in a suitable speech proposed and Dr. Wheeler seconded the following:

“Resolved That it is with feelings of unfeigned sorrow we have heard of and are this day called upon to record the death of Dr. William Stokes of Dublin, Honorary member of this Society, whose great loss will be long and deeply felt not only by every member but by the profession at large and by the whole community as that of a man of whom it may be justly said, and in the truest sense of the words, that he was a perfect gentleman, an accomplished scholar, a great teacher, and an able physician.”

The Secretary was directed to forward a copy of the above to his son.

Dr. Whitla (Honorary Secretary) showed the liver and gallbladder of a patient who died from jaundice by obstruction.

Paper:¹ Dr. Whitla showed the liver and gall bladder of a patient, aged seventy, who had died of jaundice, and gave a brief history of the case. The jaundice had lasted, as far as could be determined, three months and a half; the patient was insane; and, when first coming under observation, a large tumour was detected in the right hypochondriac and epigastric regions. The question of its being an accumulation of fæces or a malignant growth was weighed, and it was determined to try the effects of a series of enemata. To this the patient rigorously objected, and it was found impossible to inject anything into the colon. Laxatives and ol. ricini were ordered, but she refused all medicines; once a little jalap was administered in wine; the patient detected it, and could never be again induced to take it.

Three weeks before death diarrhœa set in—the evacuations resembling fluid tar—and she gradually sank.

On opening the abdomen, the colon was found filled with hard scybalæ—a large accumulation being found at its right bend; its walls were thickened and opaque, a low form of inflammation having extended through its

coats, the gall bladder was full; the cystic duct was almost closed, and near its junction with the hepatic was much narrowed; the lower part of the choledoch duct was normal, a large mass in the colon having by its pressure almost entirely closed the biliary canal near the junction of the cystic and hepatic ducts to form the ductus communis choledochus; a trace of bile was found in the small intestines. The other organs were healthy, except the kidneys, which were congested, but otherwise unaltered.

DR. SPEER remarked that the structure of the liver was apparently natural, and asked had it been examined by the microscope.

DR. GRIBBON had seen several cases where impaction of fæces had produced diarrhœa. He, however, had generally noticed that some scybalæ had come away in the motions, the nature of which he often found resembled those described in the case before them.

Dr. DILL objected to the term diarrhœa being used in a case where there was impaction of the fæces. The word dysentery should be used when describing a case of this sort, especially where it was evident that there were very considerable quantities of blood in the motions. He had himself found ipecacuanha useful, and believed, had it been tried here, good results would have followed.

Dr. WALES thought the specimen very interesting. As regarded the symptoms during life, the presence of jaundice and diarrhœa were especially liable to mislead. He thought that the exhaustive discharge from the bowels in one so advanced in years was quite sufficient of itself to cause death. Probably, as had been said, death was owing to a variety of causes.

He also exhibited the uterus and ovaries removed after death, the uterus being filled with small fibroid tumours and the ovary being cystic.

Paper:¹ DR. WHITLA exhibited the uterus and ovary removed from a patient after death. He thought of showing the specimen, which he obtained the day before, not because there was anything remarkable in the cystic degeneration which was present in the ovary, but he thought it interesting as Dr. Cuming was about to relate to them a case of rupture of the ovary which had caused death in a young patient.

The cyst before them was not larger than a pigeon's egg; it was a purple colour, owing to the flattening out of one or two veins which occupied its surface; the contents were clear and transparent; the walls were of such tenuity that apparently a very slight blow over the abdomen would cause its rupture. It gave rise to no symptoms during life. The uterus to which it was attached presented some very unusual features. It had studded in its walls about a dozen small fibroid

¹ [Dublin Journal of Medical Science, 1878, v65, p450.]

¹ [Dublin Journal of Medical Science, 1878, v65, p451.]

tumours; two near the fundus were sub-peritoneal; this accounted for the shotty feel of the organ. The tumours were hard, about the size of large hemp-seed (one was larger than a cherry-stone), and were distinctly encapsuled, shooting out of their bed upon a slight incision being made over them. From the roof of the uterus hung a small polypus into its cavity. The uterus was removed from an old virgin of seventy-four years.

Dr. WHEELER thought the length of the neck of the uterus was remarkable. The organ would not weigh two ounces, and it seemed to be all made up of cervix. With the tumours, which he thought were fibro-muscular, he would have expected some hypertrophy instead of atrophy.

Dr. DILL thought the uterus, considering its source, was normal in size and weight, and was not more atrophied than the age of the patient would lead him to expect. While recognising the polypoid nature of the small internal tumour, he would be suspicious of the schirrous character of the isolated growths through the uterus; but, not having examined them microscopically, he could not speak positively. He would suggest their being carefully examined, and perhaps cancer cells would be found.

He also exhibited the liver of a patient who had died of hepatic fatty degeneration and Dr. Wheeler gave the history of the case.

Paper:¹ Dr. WHITLA showed a section of a liver, removed the previous day. It presented, in a well-marked degree, all the characters of the fatty degeneration. The cells were broken down, and filled with granules and oil globules, the field being obscured with debris of cells in all stages of transformation, from normal to oil globules. There being some interesting points in the history of the case, he would ask Dr. Wheeler, under whose care the patient had been, to mention them. The entire organ would weigh, he thought, between 6 or 7 pounds.

Dr. WHEELER said the case was to him a very interesting one, especially as regarded the symptoms—viz., violent and agonising attacks resembling angina pectoris; the pain being referred first to the region of the heart, and afterwards over the abdomen in its upper part. These attacks became more and more frequent, and the patient sank in a typhoid condition. The enlarged liver could be felt during life, but it was not clear whether its enlargement was owing to one of the degenerations or to cancer. A large tumour had been ligatured in the rectum about two years previously, the nature of which at the time he believed was hæmorrhoidal or polypoid, though a distinguished surgeon who saw it thought it was malignant. This always threw a doubt in his mind when thinking over the probable nature of the tumour in the hypochondriac

region. In the gall bladder was found a large gall stone, which he thought caused the attacks of pain. The examination was made under difficulties; and he regretted the heart was not examined, the chest being unopened. The patient was never jaundiced. All the abdominal organs were healthy.

Dr. Cuming showed a drawing and gave a complete history of a case where death followed a rupture of the ovary in a young woman.

After a lengthened conversation upon the above specimens, it was agreed as the usual time of the meeting had transpired that Dr. Esler should read his paper next night.

George F. Wales

The Sixth Meeting of the Society was held in the Museum of the Hospital on Tuesday January 29th.

Present, Dr. Wales (President), Professor Dill, Dr. Harkin, McConnell, Lindsay, Graham, Jefferson, Dempsey, Esler, Spedding, Wadsworth.

Dr. Harkin exhibited a patient labouring of chronic psoriasis of many years standing treated by the local application of Chrysophanic acid with beneficial results.

Dr. Whitla also showed a patient upon whom he was trying the acid; on one side of the body.

Combined papers.¹ Dr. HARKIN gave the details of a patient's case who had suffered for nine years from psoriasis. He was a boy aged now about fourteen. He had been so completely covered with the eruption that he was unable to appear in school or be sent to any business. He narrated the various remedies which he had tried—arsenic, phosphorus, iron, &c., as well as nearly every known form of ointment. At the conclusion of each line of treatment he was found to be in much the same state as when he commenced. Hearing of chrysophanic acid, he determined giving it a trial. In three weeks after its use the skin was healthy, and no trace of the eruption was visible. The results were so remarkable that he thought it his duty to produce the patient before the Society.

Dr. Harkin then showed the boy, whom he had not examined for several months—i.e., since the cure by the acid—and it was apparent that there was some slight return of the disease, as a few spots were visible on the back of the chest, the skin elsewhere being entirely healthy.

Dr. WHITLA (Hon. Secretary) showed a patient who had been under his care for three months, and taken large doses of arsenic for a very extensive eruption of psoriasis, some of the patches on the body being as large as the palm of a man's hand. The arsenic had no effect whatever upon the eruption, which continued to increase. Hearing from Dr. Harkin of his success, he

¹ [Dublin Journal of Medical Science, 1878, v65, p452.]

¹ [Dublin Journal of Medical Science, 1878, v65, p453.]

commenced to try the chrysophanic acid, exactly seven days ago; and in order to satisfy himself about the result, the ointment was very carefully applied to one side of the body only. At no place had the application on the trunk extended across the middle line. The patient, a boy aged thirteen, then stripped, and a remarkable difference was observed between the two sides of the body resulting from the seven days' treatment. In no place was the eruption entirely removed, but it was evidently fast disappearing. He could not satisfy himself that mere friction with plain lard could produce any such marked effect, especially as tar ointment had been carefully applied before. He merely produced the patient to show the members the remedy in process of application, by way of illustrating Dr. Harkin's case. Attention was then drawn to the most unusual expression of the patient from the colouration of the skin round the eyes, which gave him the appearance of an owl; and he thought that this effect must be produced by the acid after its absorption. The bed-linen and clothes of the patient were destroyed by its staining properties.

PROFESSOR DILL thought the cases highly interesting to the profession. He had looked upon psoriasis as an opprobrium to the healing art, but the cases which he had seen before the Society encouraged him greatly, and if the cure remained permanent, he would say it was a great triumph. He had formerly believed it was a blood disease, but in those cases the local remedies seemed to have the most effect. Dr. Harkin's case, though after several months showing a tendency to return, he thought, was most remarkable. Did the acid act locally or through the blood? This, which he thought a most interesting point, seemed to be answered by Dr. Whitla's case, where there was a decided change on that side of the body to which it had been applied.

DR. MCCONNELL was not a believer in the chrysophanic acid. As far as he could see, he thought that psoriasis could be temporarily cured by almost any application, but invariably returned. He had produced results quite as satisfactory as in the cases shown, by a simple lotion covered with oil silk. In his own experience he had not met with any successes; in all the disease returned. He had no experience of the acid, but would try it in a case of twenty-five years standing, which he had under his care.

DR. ESLER was disappointed in Dr. Harkin giving no account of the history of the remedy. He detailed some particulars about its early introduction into Belfast. He agreed with Dr. McConnell, that nearly every application could be made to remove the scales, but the disease always returned. Hebra said psoriasis was incurable; if so, there was little use in chrysophanic acid.

DR. SPEDDING had much experience of the disease in the dispensary, but found it always returned. He thought more stress should be laid upon the constitutional treatment, as he believed it occurred generally in

strumous constitutions. He found much benefit from cod liver oil and iron.

DR. DEMPSEY thought the cases, upon the whole, very satisfactory, but thought Dr. Harkin's was showing signs of return.

The President, in reviewing the different theories about the pathology of psoriasis, and the alterations which knowledge of the disease had made in its treatment, was inclined to think most favourably about the success of chrysophanic acid treatment. He commented upon the published cases of Mr. Squire, to whom he thought great credit was owing. He hoped to see the cases brought before the Society again, at the expiration of a few months.

Dr. Esler read a paper upon the disposal of the dead.

MR. PRESIDENT,—The object of this paper is practical. The introduction I desire to make somewhat historical. The intimate connexion and the frequent contact of the medical man with that state called death may be considered a sufficient reason for taking a general survey, and at the same time for looking somewhat critically at this subject—a subject which, I am bound to say, is shunned rather than studied by the great mass of mankind—the only exception perhaps being that of the profession to which it is our privilege to belong. Ever since the patriarchal expression, “bury my dead out of my sight,” it has been the custom of all ages to give effect to the same feeling in some form or other. The ravages of decay and the decomposition of organic matter make it imperative that the dead body be disposed of in such a way as will at once satisfy the respect and affection of friends, and prevent the imperial laws of organic change in its alteration of living into dead matter becoming an offence, or sowing anew the seeds of contagion and death.

In the oldest history to which we have access we learn that the original method of disposal was interment, and it is a somewhat curious circumstance that since the days of Abraham we have not made much improvement, if any; and however for a time other methods have been adopted, civilised peoples, at least, have gone back to the old plan, and bury their dead; and even to the buying of the field and the possession of a freehold in “God's acre,” the Abrahamic spirit and independence is strong amongst us in this nineteenth century.

The method to which we are referring, and with which custom has made us familiar, is repulsive to the natural affection which binds mankind in families, and it is not difficult to conceive of a case in which strong feeling prompted a desire to retain the presence and outward form of some patriarchal father, heroic leader, or tender friend, and called forth the marvellous skill of the Eastern physician who introduced the process of embalming, for which Egypt must ever

stand so famous. But there are other and I believe the true reasons why embalming was adopted by the Egyptians, and that was to preserve the body as a receptacle for the soul, when according to their doctrines it should return to earth after having completed its cycle of *three*, or according to some of *ten* thousand years. The art was practised at least 2000 B.C. The record runs that "Joseph commanded his servants the physicians to embalm his father, and the physicians embalmed Israel."

The method adopted was this:—If a male, the corpse was at once committed to the undertaker's; if a female, it was retained at home till decomposition had set in.

There was an embalming officer of low class, whose premises were situated in the cemeteries. He was called the "Paraschistes," or flank incisor. His duty was to open a line on the left side below the ribs, which had been previously marked by a scribe. This he did with an Ethiopian stone or flint. He was then pelted with stones and pursued with curses. Another embalming officer then proceeded to remove the viscera, with the exception of the heart and kidneys; the brain was extracted by another embalmer by means of a crooked instrument through the nose. In this state the body was ready for future operations, which depended on the sum to be expended on the task.

Three methods prevailed. The first was practised only by the wealthy, and consisted in passing peculiar drugs through the nostrils into the skull. The abdomen was rinsed out with palm wine, filled with costly spices, and the wound stitched up. The mummy was then steeped in natron for seventy days, wrapped up in linen cemented with gum, and set upright in a wooden coffin against the side of the tomb. Herodotus mentions that the Ethiopians placed their mummies in glass coffins, but none of them have ever been discovered.

This process cost a silver talent, or about £725 of our money.

The second process was like the first in removing the brain. The viscera was injected with cedar oil, and the corpse soaked in a solution of natron for seventy days, which brought away the soft portions, and left only the skin and bones. This method cost a mina, value £243 English. The third method was for the poorer classes. The body was washed in myrrh and salted seventy days. The cost was only a trifle. One author states that a common cost of embalming was £108. The body was often kept at home and not sent to the cemeteries, and was produced occasionally at festive entertainments to recall to the guests the transient lot of humanity.

In the fifteenth and sixteenth centuries of the Christian era mummies were used for drugs and other medicinal purposes, as well as nostrums against disease.

In embalming, the Persians employed wax, and the Assyrians used honey. Alexander the Great was preserved in both wax and honey.

During the present century the discovery of the preservative powers of alumina, arsenic, zinc, and corrosive sublimate, enables the student of medicine to cheaply and simply embalm the body for a short period for anatomical purposes. The latest cases of embalming recorded are those of King Victor Emmanuel of Italy and Pope Pius IX.

In addition to burial and embalming, a third method, is *incremation*. This was practised and is still a custom in Eastern lands. It is the universal custom among the Hindoos. Their practice is for those who are rich enough to procure wood to make a funeral pile on the beach or river's bank. On this the corpse is placed. The heir or chief mourner, followed by a procession of relatives, walk round the mound seven times. When the leader applies his torch, all the followers in succession follow his example. Where the people are too poor to purchase wood, they provide cow manure, which is dried in the sun, and serves the purpose admirably. They do not preserve the ashes or put them into urns, but all is allowed to remain until blown away by the first wind, or washed by the rains into the surrounding sand or earth.

The body of Saul and also of his sons were burned, and it is supposed that in their case this method was adopted on account of the advanced state of decomposition of the corpses.

In Greece, in Etruria, and in the north of Europe, this method was practised simultaneously with burial. The tombs of these countries are said to be rich in art, much of it going to the adornment of the urns in which the ashes were deposited, and there can be little doubt that the urn as a decoration of our modern cemeteries is borrowed from this custom. The cineration of the body and the preservation of the ashes in urns is said to have come in with the bronze period, as previous to that the bodies were buried in stone coffins. Among the Jews the custom prevailed of having their sepulchres hewn out of the solid rock, the opening to which was enclosed by a circular stone running in a groove.

There is almost no subject so deeply interesting to the living as the thoughts and associations connected with the dead; and it has been remarked that there is nothing so distinctive of the character of a people as the way in which they dispose of their dead. Heathen or half-civilised people permit the remains of the dead to lie unburied or strewn about on the surface of the earth, and I am enabled to show you a sketch of the method in which the aboriginal tribes of Australia deposit the remains of their friends on a platform of branches out of the reach of the native dogs. They have not the implements of husbandry wherewith to dig a grave, and even if they had, I am inclined to

think they are too lazy to perform the rite. However, that is their mode of disposal.

The Parsees of India have enclosures built, called “towers of silence,” where they lay out their dead naked and exposed to vultures; and I have been told by a resident in India that he has passed by these towers of silence when on the lee side of the enclosure the vultures were congregated and luxuriating in the foul gases which emanated from within.

No civilised nation would allow their friends and scarcely their enemies, to remain unburied, and the greatest contempt with which an enemy can be treated is to meet the fate of Jehoiakim—“He shall be buried with the burial of an ass, drawn and cast forth beyond the gates.”

A notion has prevailed at all times that the dead might require some of those things in which they indulged in life, and so it has been a custom to put into the coffin various articles. The Chinese enclose tapers and slippers as needful helps in the flowery spirit land to which they are committing their dead. Another of their customs is to adorn their cemeteries with a profusion of tapers, which they light up after a funeral. The late notorious Mormon prophet, Brigham Young, was not quite sure of his bodily peace even after death, for he left express instructions in his will to leave him room in his coffin in which to turn.

The disposal of the dead at sea is made a necessity to prevent decomposition, otherwise there is a disposition, where at all practicable, to convey the dead to land; yet a sea burial is one of the least objectionable, and, indeed, in many respects the most desirable of all methods. There seems to be a fitness in committing the body, with its mysteries of resurrection, to the mysterious ocean, with its unfathomed bottom, far-reaching and unexplored shores; and there is no funeral solemnity comparable to that rite of committing earth to water.

A person while living has the power of disposing of the body after death, and I recently read of a case where an American lady left her body to her physician, asking him to honour his sanctum with her bones.

The expenses connected with death have always been very considerable—sometimes, indeed, enormous; and some of the grandest buildings in the world are monuments and tombs, of which the pyramids are a striking example.

Churches became burying places in this way:—If a church was dedicated to a saint, the bones of that saint were, if possible, deposited near the altar, and so great was the desire to be buried near these saints that men of piety or rank or riches obtained a burying-place in the churches. This practice became extended and originated churchyards.

As towns increased in population, the churchyards became overcrowded, and on sanitary principles

many of them have been closed up. The laws regulating burial date so late as 1853 for England and 1855 for Scotland.

In England the parishioners have a common law right to bury in the churchyard, but the body must not be interred in an iron coffin or vault.

To interrupt a clergyman in reading a burial service or to conspire to prevent burial is an indictable offence.

There used to be a popular notion that to permit a funeral to pass over private property constituted it a public right of way. Such an opinion is founded on error, but it is a privilege of persons going to or coming from a funeral to be exempted from toll. Persons found *felo de se* used to be buried at a cross-road corner with a stake through their body, but this barbarous mode was abolished in the reign of George IV., and the law directs that their bodies shall be buried without ignominy, privately in a churchyard, between the hours of nine and twelve o'clock at night.

While on the subject of burial, I cannot pass by burial societies without some notice, and that chiefly in the way of condemnation. The object is to provide money to pay for burial after death, and is confined to the lower classes. It often happens that paupers in the union are being paid for by friends outside who claim them when dead, and obtain the money on which to have a funeral carousal; but a worse feature is the insurance of infants, and in my duties in connexion with one of the charities of this town I am often painfully conscious of the burial money acting as a balm in no small degree to the bereft parents. From the judgments I have formed of the effect of the working of these societies, I am strongly of opinion that they should be discountenanced.

We have seen, in this necessarily brief survey of the practice of disposal of the dead, that *burial* is the custom among those who believe in a resurrection, and at present Christians, Jews, and Mahomedans adopt it. *Embalming* was practised by those whose faith led them to look for a return of the soul to earth, while *burning* and various other methods characterised those who had no definite creed on this important subject.

In coming now to the funeral rites and customs of disposal of the dead in Our own country, we find the forms varying with the faith of the deceased, the locality to which they belonged, and the rank of life in which they have moved.

On the Continent and in England the coffin is generally made of wood, covered with cloth, or sometimes of polished oak. This is borne in a hearse gloomily draped with nodding plumes and unmeaning carvings. This is followed by a number of mourning carriages, all drawn by black horses. In England it is not uncommon to see the hearse preceded by a class of undertaker's men, called “gumpheon men,” who are

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the bearers of a pole with a knot of crape on the top. These are supposed to clear the way. In Scotland the funeral ceremony is simple, and although the Scotch used to give expensive entertainments to the guests, the practice is becoming less observed every year.

Let us now see how things are done in the Emerald Isle. Most of us have seen an Irish wake—I mean a real country wake. When any one dies, the clock is stopped, or at least the striking weight is taken off, and the face covered with a clean white linen cloth, as is also the dresser, the table, and chest of drawers. There is a plentiful supply laid in to provide for several days, eating and drinking, with tobacco, whiskey, and clay pipes in abundance. The neighbours assemble after their work, and often sit the night through. All who smoke help themselves without let or hindrance, but the whiskey is disposed of in a somewhat different fashion. At regular intervals during the night there is a large brew of punch prepared by some one in charge of the hospitalities. This is distributed in doses estimated to be fit for full-grown persons, and in this way a wake extending over two or three nights becomes an expensive affair. On the morning of the funeral the whiskey bottle and biscuits are freely passed among the assembled friends. It is gratifying to know that in many districts these customs are rapidly disappearing, as from such habits scenes often arose which were anything but edifying. The practice pursued among the rich is different, and instead of sitting around the corpse in the fashion of a wake, the body is locked up over night, when the family retire to rest. It was this practice which enabled servants to dispose of the bodies of their late masters in the time of Burke and Hare, when the resurrection men were driven to adopt any device in order to obtain subjects for the dissecting rooms.

Black is the colour which is almost universally recognised as the proper expression of mourning, and crape as the material which most correctly suits the mourner. And at funerals, in some parts, there is a profusion of black crape worn, not only by the relatives but by their hangers-on, dependents, clergymen, and doctors. In the north of Ireland, and, indeed, in Ireland generally, both the colour and the material have been superseded—the colour being white and the material linen. So that white linen for shoulder-scarfs and hat-bands is the prevailing custom among us. This change is said to have been brought about in order to encourage the staple trade of Ulster, which is linen.

A practice has long prevailed among the landed aristocracy of giving perquisites to their dependents on the death of a member of the family. And on the death of a landlord, this sometimes takes the form of a new shirt, or the making of one, to every tenant, which is worn at the funeral as a shoulder-scarf; while all coachmen and cabdrivers are provided with the

making of a shirt-front, which is worn as a weeper round the hat.

Now, let us take one of our modern funerals, and what do we find? Perhaps, on the whole, the proportion of expenditure in connexion with sepulture is in keeping with the means at command; but, often, it is enormously beyond it. In our towns it is rare to find that the old practice of wakes, tobacco and whiskey, is looked upon as a necessary accompaniment of death. And among sensible people the practice of gratuities is disappearing, and we could wish this were entirely abolished, especially as the recipients include clergymen and members of the medical profession. Cabdrivers need not refuse weepers, as, indeed, I find them seldom refuse anything, unless it be their proper fare.

But why clergymen and doctors should be classed with cabmen, and singled out as the objects of gratuity in the material for a new shirt, has been to me somewhat puzzling. That the custom was introduced and has been continued in order to compensate clergymen who have been shamefully underpaid as a class, I do not doubt. And that doctors came in on the same plea, we may easily suppose. And, just lately, I have learned that it is a practice among a certain class of the population to give their clergymen an equivalent for a shoulder-scarf, estimated at three half-crowns, in which event an old scarf is worn at the funeral. And, at least, one medical man in Belfast has been offered, more than once, the money, in case he preferred it to the linen. He, however, declined to receive either. I have known of families being plunged deeply in debt as the result of extravagant funerals. Let the people in their lifetime add something to their pew-rent and give their minister's a fair support; and let them pay their doctors' fees in reasonable time; but let not a custom such as I have been describing be continued in our midst—for this is a custom which, I think, would be more honoured in the breach than in the observance. Because one happens to be the clergyman or the physician to a deceased person is no reason, in my opinion, why he should allow himself to be made a mute, a gumpheon man, or a walking advertisement through the crowded streets of a town, in order to cater to a love of vanity and display.

I have reason to believe that not a few medical men are dissatisfied with the present custom of wearing shoulder-scarfs. Were clergymen only to refuse to receive and hang them on their pulpits, and were this Society to pass a resolution, or even come to an understanding, that none of its members should receive or wear them, this remaining token of feudal times must speedily be banished from our midst, so that our dead might be buried in a decent, becoming, and unostentatious manner.

Thus far I have avoided the advocacy of any particular method of disposal of the dead, so that a concluding

line on this point may close this paper. Our faith will not permit us, in this country, ever to revert to the Egyptian custom of embalming; nor do we think it desirable even by the presence of the preserved body to recall to our own or the notice of others the transient state of humanity. The lesson is written all around us. Cremation will never do for Christendom, which is indoctrinated with the hope of a resurrection. Our faith and our firesides alike rebel at the idea. Heathen customs may do for heathen countries, but must ultimately yield to civilisation. Therefore, burial alone remains to be, as it is, practised in these lands. There is a fitness in committing "earth to earth," nor can we hinder it, if we would. I lately read of the stone coffin of one of the Saxon Kings being opened. His jewels, which were buried with him, were there unaltered and uninjured, but of the King there remained only a handful of dust.

The direction in which I should like to indicate a change would be, not in the better preservation of the body, but rather to dispense with vaults and coffins of stone, lead, or other strong material, and to adopt the method which has been advocated by Mr. Seymour Haden, in *The Times*, of making the shell of light material or wicker-work, ornamented, if you will, and made pleasant to the eye with flowers—fit emblem of man's sojourn here—so that we might not even try to hinder the great and immutable laws of Nature exercising their inalienable right to the legacy: "Dust thou art and unto dust shalt thou return."

After some discussion upon Dr. Esler's paper he gave notice that on following night he would move "That believing the custom of wearing shoulder scarves by medical men at funerals to be objectionable we resolve as far as we can to discountenance the practice".

The Secretary read the following letter which he had received from Mr. Stokes of Dublin:

5 Merrion Square N., Dublin
January 21st 1878

To W. Whitla, Esq. M.D.

Dear Sir, I am in receipt of your kind favour of the 18th inst enclosing a copy of a resolution adopted by the Ulster Medical Society at the last meeting. Will you convey to the members of your Society how deeply I feel their thoughtful kindness in sending me so signal a proof of the esteem in which they held my late father and assure them of my gratitude for their friendly sympathy.

I remain, Dear Sir, faithfully, W. Stokes
PS I have no objection whatever to the resolution being printed with your ordinary transactions.

G. F. Wales

The Seventh Meeting of the Society was held in the Museum of the Hospital on Tuesday February 12th

1878.

Present, Dr. Wales (President), Professor Dill, Drs. Wheeler, Gribbin, Moore, Graham, Coates, Esler, Speer, Core, Spedding, Dempsey, Whitla, Jefferson, McKeown.

Dr. Dill proposed, and Dr. Fagan seconded, the following resolution:—"That this Society, at its first meeting since the decease of Surgeon Henry M. Johnston, one of its oldest members and most esteemed ex-Presidents, desires to put on record its sense of loss by this sad event, and to express its sympathy with his relatives in their bereavement; and further, that the Honorary Secretary be requested to send a copy of this resolution to the Rev. Wm. Johnston, brother of the deceased."

Dr. Esler moved "That believing the custom of wearing shoulder scarves by medical men at funerals to be objectionable we resolve as far as we can to discountenance the practice". Dr. John Moore seconded this but objected to a paragraph being placed in the newspapers embodying the resolution.

Dr. Wheeler, though agreeing with the motion, did not see his way to have the Society move publicly in the matter. He strongly recommended the resolution to be withdrawn.

Professor Dill agreed with Dr. Wheeler.

Dr. McKeown spoke strongly against the habit of wearing shoulder scarves as degrading to the profession as it classed them with case-men and labourers.

Dr. Dill reminded Dr. McKeown that the scarf was always presented to medical men as badges of respect.

Dr. Spedding objected to the matter being taken up by the Society publicly. He thought that no steps should be taken till all the clergy of all the denominations should be asked to meet the Society.

Dr. Core supported the motion, pointing out the fact that these scarves were for display and if abolished would eventually prevent medical men being asked to attend funerals.

Dr. Speer agreed with the spirit of the motion.

Dr. Strahan expressed himself satisfied with the course of the Society interfering in the question.

Dr. Coates agreed with the motion but strongly dislike the idea of publishing.

Dr. Graham agreed with the motion. He thought the scarf was given for display and not through any respect to the profession.

Dr. Gribbin thought that the wearing of the scarf was not a mark of respect to the medical man but an advertisement that the patient had slipped out of his hand. He thought with Drs. Wheeler and Dill that it was hard to refuse the patient's friends. He thought the matter should be let drop. We have no power to interfere.

Dr. Wales' own personal feeling was that he should like to say that he personally objected and that he was

also at liberty to say that if he wore the scarf he did it under protest.

Dr. Spedding moved as an amendment that “We take no public action in the matter without first asking the clergy of the various denominations to confer with us in this matter, and if the conference approve of it that we act conjointly and advertise it in all the local papers”. This was seconded by Dr. Wheeler, put to the meeting and lost.

Dr. Dill after asking Dr. Esler to withdraw his motion proposed as an amendment “the previous question”. This was seconded by Dr. Wheeler, put to the meeting and lost.

Dr. McKeown moved as an amendment that the words “by medical men” should be struck out in Dr. Esler’s motion. This was put and lost.

Dr. Esler’s motion was then put and carried but no authority was given for the matter to be published in our newspapers.

Dr. Wales then open up the 2nd question on the paper, i.e. the retrenchment of expenditure. He regretted the absence of the Treasurer but laid the financial state of the Society before the meeting and urged them to consider the advisability of considering some method to cut down the expenditure.

After a long debate the recommendation of Council was read by the Secretary and Dr. Core moved and Dr. Jefferson seconded the dismissal of the messenger as the only way to cut down the expenditure. This was put to the meeting and carried, 8 for the motion and 3 against. It was decided the messenger should get 3 month’s notice.

Some conversation take place regarding the Library and it was agreed to refer the matter to Council for their report at next meeting.

G. F. Wales

Eighth Meeting February 26th 1878

Present, Dr. Wales (President), Drs. Fagan, Core, Coates, Dempsey, Esler, Jefferson, D. Johnson, and Whitla (Secretary).

The Council report on the Library question was entered upon and Dr. Core was requested to act as librarian which he kindly agreed to do. The question of remuneration to Captain Cox was fully entered into, also the statement of Council, and on the motion of Dr. Coates, seconded by Dr. Whitla, the meeting resolved to give £10 to Captain Cox for his services.

Dr. Core was unable to read his papers.

Dr. Fagan could not produce his patient.

George F. Wales

Ninth Meeting of the Society March 12th ‘78

Present, Dr. Wales, President, Drs. Dill, Esler, Dempsey, Speer, Lindsay, Fagan, Whitla.

Dr. Dill proposed and Dr. Fagan seconded the following resolution: “That this Society at its first meeting

since the death of Surgeon H. M. Johnston, one of the oldest members and most esteemed ex-president, desires to put on record its sense of loss by this sad event, and to express its sympathy with his relatives in their bereavement, and further that the Honorary Secretary be requested to send a copy of this resolution to the Rev. William Johnston, brother of the deceased”.

Dr. Fagan introduced a patient upon whom he performed the operation of sub-periosteal resection of the ulna.

Paper:¹ *Annie Reid, aged three years, was admitted under my care on the 17th November, to the Children’s Hospital. She was affected as follows:—Forearm much swollen—this was most marked at the ulnar border—and ceased abruptly about a quarter of an inch from the head of the ulna, and one inch from the top of the olecranon; the hand was puffy; there was great pain along the region of the ulna. The elbow and wrist-joints were quite free. There was a sinus discharging matter about one inch below the olecranon, and through this a probe passed down along the ulna as far as its head; the periosteum was separated from it in its whole extent.*

The mother stated that about ten days previous to admission she noticed that the arm was very painful when pulled out of the sleeve of the dress. She rubbed it with soap liniment; it became worse. She took her to a medical man who ordered a poultice. After some days an abscess burst over the olecranon, giving relief to the acute pains, and reducing the swelling.

After some days I made a free opening over the lower end of the ulna, so as to favour the discharge of matter and prevent burrowing about the joint. Gradually the swelling and acute inflammatory symptoms subsided, and on the 4th January, six weeks after admission, I removed the necrosed shaft, through an incision about an inch and a half long at the seat of the upper opening. The shaft was apparently quite loose, but, notwithstanding I used a considerable amount of force with a pair of strong sequestrum forceps, I was not able to remove it until I passed an elevator through both the upper and lower openings, and detached several bits of periosteum that remained adherent. I packed the cavity with some carbolised tow, and placed the limb on an angular splint. She made a good recovery. It is now a year and a half since I removed the bone; the ulna is quite restored; there is no deformity; and the only difference observed between the two arms is the presence of two small scars on the one that was affected.

Dr. Whitla showed a specimen [of] the forearm and hand, the seat of large recurrent fibro-nucleated growth; and exhibited under the microscope its structure.

¹ [Dublin Journal of Medical Science, 1878, v66, p262.]

Paper:¹ J. B., aged sixty, a strong, healthy man, sought advice for a small tumour situated below the styloid process of the radius, in the interval between the extensor *primi* and *secundi pollicis*, and extending internal, to this later tendon. It was as large as a hen's egg, and at parts gave the sensation of fluctuation. The skin was movable over the tumour. It looked at first sight like a large ganglion, for which it had been mistaken by two surgeons. It was of upwards of twenty years' growth, and latterly had been very painful, and interfered with the motion of the hand, which had become almost useless.

He willingly consented to its removal, which was accomplished easily in May, 1877—the tumour dissecting out from its connexions without any adhesions; it had dipped down beneath the tendons and lay upon the radial artery and external lateral ligament of the wrist, extending by a tailed end under the flexor tendons on the front of the joint. From this latter situation it was turned out by the handle of the scalpel. The tumour itself had a distinct fibrous capsule, and resembled a very large testicle in appearance. On cutting into it, it was seen to be made up of matter resembling in appearance and consistence foetal brain, with minute extravasations, causing blotches of cherry-red and darker colour through it.

Its microscopic characters were those generally seen in myeloid growths—giant cells enclosing many oval nucleolated nuclei, as well as free nuclei, and many caudate and spindle-shaped nucleated cells, like fibre cells. There were here and there throughout masses of filamentous tissue, resembling imperfectly fibrillated connective tissue in the foetal condition.

The tumour returned in the cicatrix about four months after its removal, and continued to rapidly increase in size. The patient sought the advice of an unqualified practitioner, who applied some local remedy, which caused extensive suppuration. In this state he again consulted me, worn out with pain and anxiety; and, having procured the assistance of Professor Gordon, I amputated the limb at about the middle of the humerus.

The beautiful dissection of the tumour, which I now show to the Society, was kindly made by Professor Redfern. Its attachments are deep, being adherent to the carpal bones; but the unusual and most remarkable point in the case seems to be the manner in which it has behaved towards neighbouring structures. At no spot, for example, could it be seen that the skin was infiltrated with the growth, though the two seemed intimately connected. They readily were separated by dissection. The tendons of the wrist and fingers showed similar anomalous relations. The common extensor of the fingers tunnelled through the centre of the mass unaffected, while one of the deeper tendons was lost in

it. The tendency of the tumour seemed to be to push the tissues aside, and, at the same time, its growth was so rapid as to almost convince one that it buried the surrounding tissues in itself, though at no place could real infiltration be shown; its microscopic characters were less definite. Cells—epitheloid in appearance—with bright nuclei, predominated, and many oval or rod-shaped nuclei were free. Bodies closely resembling the forms described by Dr. Bennett, as seen by him in the “fibro-nucleated tumour,” were present, and throughout were evidences of the same filamentous matrix as was seen in the first tumour. Taking the history and physiology of the tumour into consideration it had, doubtless, many characters of both the innocent and malignant growths, and seemed to belong to the debatable ground between.

Dr. Fagan thought the clinical history of the tumour very peculiar. Its recurrence after the first growth lasting twenty years, he believed, was unique. The naked-eye characters of the tumour would alone lead him to believe it was of malignant nature. He detailed the history of a case bearing on the one before the Society. From what he had seen of tumours, he believed the less we interfered with innocent growths the better, unless their removal was necessary for the proper exercise of the limbs upon which they grew, as in this case.

Dr. F. E. Beck concurred with Dr. Fagan. He thought, in this case, that the second removal was absolutely necessary.

Dr. Dempsey thought the speedy recurrence of the growth, after its first removal, was evidence of its malignant nature.

Dr. Wales thought the tumour a very interesting one. He did not believe that we were justified, in the present state of our knowledge, in denying the existence of an intermediate race of tumours between the malignant and innocent growths. He reviewed the history and characters of the tumours, and thought it did not belong to either class properly speaking. He commented upon the results of the last debate of the London Society upon cancer, and the uncertainty of many of our theories about the origin of carcinomatous growth. He believed there was nothing for this case but operation, and he thought there was a chance of its not returning.

Dr. Dill read a paper upon Version Versus Forceps.

Paper:¹ Professor Dill said—Mr. President, the paper which I have this night the honour of bringing under the notice of the Society is one of much interest, but it may be considered too comprehensive for such an occasion as the present. I shall, however, endeavour to reduce it to as narrow a limit as possible, or as may be consistent in discussing such an extensive subject as indicated by the notice of it in the circular—viz., “Ver-

¹ [Dublin Journal of Medical Science, 1878, v66, p329.]

¹ [Dublin Journal of Medical Science, 1878, v66, p335.]

sion versus Forceps: with notes on other operations suited to the different degrees of pelvic contractions, including Gastro-Elytrotomy and Ablation of the Uterus;" and, indeed, I may say that we should not be unprofitably occupied were we to continue the discussion of this very important and extensive subject over more than one meeting. Obstetric surgery is at all times an anxious department in practice, and it becomes more so when we find ourselves in the presence of a case surrounded with such difficulties and embarrassments as may raise doubts in the mind of the operator as to one operation or another.

It may be here stated that, although there are principles and clearly-defined rules laid down for our guidance by the great masters in obstetric surgery, yet we find them but approximately correct when we come to put them to the test of practice; for we have the scheme of relation of operations to the different degrees of pelvic contractions so carefully reduced to figures that one is tempted to think he has nothing to do but to invariably follow the rule. So, when he has discovered in his patient the first degree of contraction, he has but to introduce the forceps and deliver; or, when he has discovered the second degree of contraction, introduce the hand and turn; or, when in the third degree, perforate; or, in the fourth, perform "Cæsarean section." I need not say here that we cannot pursue this practice either rigidly or uniformly, for by so doing we would be often woefully disappointed. I have no doubt gentlemen present have had charge of a case of labour where the pelvis, although contracted, was not so beyond the first degree of contraction, and yet they have failed in the use of the forceps, even when perhaps they have exerted a greater power than prudence would sometimes dictate. The perforator is the instrument which is usually taken up after having experienced failure with the forceps; but, as this and all instruments associated with it in cases of craniotomy are necessarily not only destructive of the life of the child, but are found, even with the greatest care, to inflict occasionally serious injuries upon the soft parts of the mother, so that one is often inclined to ask himself the question—Is there no alternative? And, without hesitation, I am bound to answer the question in the affirmative; for as the forceps are found, as stated, to be unsuccessful in some of these cases, should we not, before contemplating the destruction of the child, take into consideration—if possible, perform—the operation of podalic version, and by so doing give the child another chance for its life? It is not for a moment to be supposed that I am presuming to advance any new theory, for version under these circumstances was practised by some of the ancients, and latterly it has been revived, the subject elaborately worked out, and the operation confidently recommended, by the late Sir J. Y. Simpson. Since his day, the same has been embodied in the works and teachings of some of our highest authorities.

I know, however, that it is a practice so very rarely adopted either here or elsewhere, and I believe it is of such value and importance, that I am justified in craving for it the careful consideration of the members of the Society.

I have, in not a few cases, successfully performed the operation of turning, after the natural powers of the mother and the forceps had failed, and when, under the usual line of action, no other resource was left but the destruction of the child. I most candidly confess I was very slow and loath in believing, with Sir J. Y. Simpson, that the head could be brought through a narrower pelvis when its base offered at the brim than when the vertex presented. I am now, however, from my own experience, satisfied that an attempt should be made in many cases to deliver by turning, when the child is known to be alive and when other means have failed.

It should, perhaps, be stated here that I believe it is not altogether so much because the base of the child's skull will pass through a pelvis which is found to refuse the admission of the vertex as that we find the narrowing of the pelvis often confined to one side; and if, in turning in such a deformity, we can manage to get the bi-parietal diameter towards that side where there is the largest space, and the bi-temporal into the narrowest space, then the extraction, I have found, becomes greatly facilitated.

The following cases, which have come within my own practice, may be offered here in illustration of the subject under consideration:—

Case I.—Mrs. _ had been in labour for some time, and in the hands of a midwife, when Dr. N. was sent for, who, after a long and cautious trial of the long forceps, found it impossible to advance the head, and was obliged to desist. He asked for my assistance, and after I had made myself acquainted with the character of the case, and although I discovered the difficulty to arise from the promontory of the sacrum projecting forwards and downwards on the right side, so as to diminish at this point of the brim the conjugate diameter to some extent, I was induced, because of more than ordinary anxiety exhibited to have a live-born child, to make another trial of the forceps, but I also failed. After making ourselves sure that the child was alive, we administered chloroform before attempting to turn. I introduced the left hand into the vagina, and with the right hand applied externally, the knees and feet were got towards the os. I seized hold of the latter, brought them down, and when the limbs and buttocks were extracted, we were encouraged to find that the child still showed symptoms of life. After placing the cord in the safest position, and after giving and taking a moment's rest, I proceeded to complete delivery by bringing down one arm, and then the other. When the arms were brought down, very considerable exertion was necessary in the direction of the axis of the brim before the head could

be got away.

I believe about four minutes elapsed from the commencement of the operation of turning till the complete extraction of the infant. It was not long till it breathed, and full respiration established. The infant, a male, was strong, and considerably above the ordinary size. In consequence of being placed under the complete influence of chloroform, the mother was quite unconscious of pain or suffering during the whole process of this otherwise severe operation, and which contributed so largely not only to her ease, but to the safety of her infant. Dr. N. has since told me that she made a good and a rapid recovery, and left her bed, as women of the poorer class in life usually do, in a very few days.

Case II.—Mrs. M'C. had been ill some hours when I saw her at the request of Dr. M. The os was fully dilated, and the pains were strong, but the head showed no disposition to enter the brim. I made an examination of the parts, and found a knuckle on the left side of the promontory of the sacrum.

The long forceps had been applied, and failed. I again made another attempt with them, but did not succeed. I was obliged to withdraw them, as I saw no chance of bringing the head down. Our patient was then placed under the influence of chloroform, the hand introduced, the child turned and brought away alive; respiration was established, as manifested by a strong and vigorous cry. The mother made a good and uninterrupted recovery, dressed and walked into the next room on the tenth day. Without dilating farther, I may just say that the difficulty in this case was increased by the size of the child, which, when weighed, proved to be 14 lbs. 2 ozs.

Case III.—Mrs. M'K., ill in labour for the fourth time. She was delivered of her first child with the forceps; of her second and third by craniotomy. I found her very ill; the os dilated, but making no further progress. Fortunately the liquor amnii was not all away, and I decided at once upon turning. This woman refused to take chloroform, but had great command of herself. I therefore entered upon the operation by introducing the right hand, as I believed the child presented with the posterior-dorsal aspect.

I found the pelvis not very roomy, and the brim somewhat narrowed on the left side of the sacrum. However, I passed the hand with some difficulty up to the limbs, hooked a knee with my finger and brought it down, and extracted the child with more ease than I expected. The child breathed, but died in a very few minutes. The mother made a good recovery. I shall not occupy the time of the Society with the details of other two cases, however interesting—suffice it to say that the pelvis was in each under the normal size. The forceps were tried, but failed, and afterwards turning was successfully accomplished.

Before concluding I should not withhold the fact that I have turned in several cases where I had afterwards to

reduce the size of the head before I was able to get it away. Still I think I have stated enough to satisfy the sceptic that a man is justified in attempting to deliver by turning, where the child was discovered to be alive, when other means had failed.

Dr. Lindsay felt he could not criticise Dr. Dill's paper. He had been an old pupil of his, and he had listened with as much benefit that night as ever he did under his teaching. He was pleased with the statement that a woman should never die undelivered. He wished to state the facts of a case which occurred in his own practice, and then to ask the opinion of the Society, and also that of Professor Dill. The case was that of a patient rapidly sinking from pneumonia. There was no chance of saving the child or prolonging life, and was he right in delivering?

Dr. Beck thought, as far as Dr. Lindsay's question was concerned, he would deliver at once, but if he was certain no good could come of it, he would leave matters alone.

As to Dr. Dill's practice, as laid down in his paper, no second opinion should be offered; the only point was the difficulty of turning. He mentioned some illustrative cases. His difficulty was in the head slipping when very high up, but he always easily delivered by version. All the children lived but one.

Dr. Dempsey's experience was altogether in favour of turning. He thought it was a shocking thing to perforate the head. He met a case in practice where craniotomy had been performed, and the child taken away piecemeal. Afterwards pregnancy supervened, and he delivered a large living child with the forceps.

Dr. Wales, in thanking Dr. Dill for his paper, referred to the experience of a large number of men in support of turning. He believed in the line of action as laid down in the paper, but thought that the difficulties of turning were rather under-estimated, and that it was not an operation to be recklessly undertaken by every young practitioner. Contrasted with the forceps operation, he believed it more difficult, especially for the inexperienced.

Dr. Dill, in reference to Dr. Lindsay's question, said that although he believed it right that a woman should never die undelivered, still, if in a case he had not the shadow of a hope for the child, he would not interfere, because the operation of delivering under such circumstances always caused more or less shock. If it prolonged the mother's life one hour, he would deliver. On the other hand, if she were dying, and must die, and no chance of relief, he would not operate. He said that the remaining portion of the subject, as indicated in the introduction to his paper, would be brought before the Society's next meeting.

George F. Wales

Tenth Meeting of the Society was held on Tuesday March 26th 1878.

Present, Dr. Wales (President), Drs. Murney, Moore, Fagan, Workman, Esler, Browne, Whitla.

Dr. Whitla read a letter from Rev. William Johnston thanking the Society for their kind letter of condolence.

Dr. Murney exhibited a lower extremity removed through upper third of femur for compound comminuted fracture.

Dr. Fagan exhibited a large urethral calculus removed from a patient. Also a knee joint for which he performed the operation of amputation through the thigh.

Paper:¹ Dr. Fagan showed an interesting specimen of “calculous disease” of the urinary organs. The genito-urinary organs were removed entire. The kidneys were enormously enlarged—the right weighed 31 ounces, and the left 14; the capsule was adherent; they were lobulated; the pelvis dilated. The ureters were of the calibre of the small intestine. At the point of entrance of the left into the bladder was lodged a calculus the size of a walnut. On the opposite side was another of similar dimensions, but not in the ureter. Through the base of the bladder, behind the prostate, a sacculus, the size of a small orange, protruded; in this were lodged two calculi. There was another calculus in the prostate. The penis was very large, and the wound into the urethra remained unclosed, through which Dr. Fagan removed a calculus that was situated a couple of inches anterior to the bulbous portion. The history of the case was narrated by Dr. Fagan as follows:—

George Stockford, aged thirty-five, was admitted under my care at the Royal Hospital, on the 16th of March, 1878. He presented a wasted, anxious appearance, showing unmistakable signs of long-continued suffering. He stated he suffered from kidney disease. When I examined him, I found he had incontinence of urine, and a calculus impacted in the urethra about an inch and a half anterior to the bulb. Ten years previous to the date of admission he suffered from severe aching pains in back and over the regions of both kidneys, after which he noticed his urine become darker and tinged with blood. This condition continued for about a year, when he was admitted to the hospital, under Doctor Cuming, for disease of the kidney, and after some time was discharged, improved in every respect.

In about two and a half years after leaving hospital, he again began to experience pain over the kidney and in the region of the bladder. Blood appeared again in the urine, and he suffered from dysuria. Matters continued thus till about two years ago, when he passed two small stones per urethram. He now felt for the first time the presence of a small body in the urethra, which slowly increased in size. He gradually lost control over

the bladder, and was compelled to wear a urinal. The pain produced by the calculus was sometimes of an excruciating character. Before passing the calculi, he suffered frequent attacks of nephritic colic.

Two days after admission I incised the urethra over the site of the calculus; the tissues were very much thickened, and I had some slight difficulty in turning it out. Its long diameter was over an inch, and was placed transversely in the urethra. From before backwards it measured eleven lines, and in thickness five lines. It weighed something over a drachm. It was composed of an uric acid nucleus, coated with copious deposits of phosphates. It was channelled in its upper and lower surfaces by the urine trickling past it.

A few days after the operation he complained of great pain over the region of the right kidney. He suffered from constant vomiting, and died ten days after from exhaustion.

Dr. Browne, who had seen the patient from whom Dr. Fagan's specimen was taken, thought that, though the operation had hastened his death, nevertheless he was right in operating. He detailed a case of his own, where he was consulted by a patient for stricture, though he could only get in a No. 3; urinary fever, with high temperature and rigors, supervened; pulse very high, and pain set in over the right kidney, and death ensued. He found, on making a post-mortem examination, that the capsule of the kidney was very much enlarged, and filled with pus, and that a large calculus was lodged in the bladder, which had caused ulceration and the escape of urine into the peritoneal cavity. Had he got in a lithotrite in time he could have prolonged if not saved his life.

Dr. O'Malley thought the specimen a very rare one, and he believed that Dr. Fagan was right in operating.

Dr. Wales, in thanking Dr. Fagan for the specimen, commented upon the evidences of diseased action, showing how dependent the different parts of the genito-urinary tract were upon the proper and healthy state of the remainder. He thought that the specimen should be brought before the Society again after the kidneys were opened and the calculi examined.

Paper:¹ Mr. Fagan showed a specimen of diseased knee-joint which he removed a few days before by amputation at the lower growth of the femur.

The end of the femur was enormously enlarged, and in the inner condyle a large cavity, containing a sequestrum, existed; this also contained a quantity of pus, and communicated with the joint; the rest of the cancellated portion was expanded, soft, and friable, and infiltrated with degenerated inflammatory products. The head of the tibia was in a somewhat similar condition, and contained a small circumscribed abscess. The articular cartilages and semilunar fibro-cartilages

¹ [Dublin Journal of Medical Science, 1878, v66, p331.]

¹ [Dublin Journal of Medical Science, 1878, v66, p260.]

were nearly all destroyed, and there were attempts at bony ankylosis here and there. Synovial membrane partly destroyed; what remained thickened and pulpy; tissues around joint infiltrated with fatty and gelatinous matter.

The specimen of diseased knee-joint I have just now shown you, I removed by the mixed method of amputation at the junction of middle and lower thirds of thigh, on the 13th of the present month. The history I consider both interesting and instructive. I saw the lad at my own house, just two years ago, at a comparatively early stage of the disease, and the following are the notes I had then taken of the case:—

F. P., aged nine years, was brought to my house on the 14th April, 1876, suffering from an affection of the knee-joint. He had the appearance of an average healthy lad. The limb was encased in a gutta-percha splint, the foot supported by a band passed round the neck, and he was able to get about pretty nimbly on crutches. There was no contraction, nor did he suffer any pain on pressure, although I used a considerable amount; however, the joint, as a whole, was very much enlarged. The condyles of the femur expanded, and there was a good deal of effusion into the joint and the pouch under the quadriceps muscle. The history I got from the mother was that she looked on him as a particularly healthy child up to last September (seven months before I saw him), when he began to complain of pain in the knee, which prevented him sleeping. As there was no alteration in the shape of the knee and no history of traumatism, it was looked on as rheumatic.

In November it began to swell. He was seen by a medical man, who recommended the joint to be strapped and a splint applied. Under this treatment it improved somewhat, when he began again to run about. After a little his condition got worse, when he was confined to his bed, and a starch bandage applied; after some time this was removed, and the joint painted over with iodine. The health began to give way about this time, and the joint had increased to the size it presented when I first saw him.

About February he was seen by another medical man, who put the limb up in the gutta-percha splint, and recommended him to take plenty of open air exercise on crutches. Under this treatment his general health began to improve, and he presented the appearance already described when I first saw him.

As it was solely with the view of getting my opinion on the case that the mother brought the boy to me, I gave it to her very unreservedly. (I may mention here that the opinion I formed as to the condition of the joint was that the disease began in some of the inter-articular tissues, probably from a strain of the crucial ligament; that it had expended itself most on these tissues, which became very much swollen and infiltrated; that the bones had become secondarily involved, but not to any great degree; and that there was a good deal of

inflammatory infiltration into the tissues around the joint.)

My opinion, as given to the mother, was—that although I did not look on the joint as hopelessly diseased, my experience led me to think that unless it speedily showed symptoms of improvement it would soon become so; that there were some encouraging features about the case, such as absence of pain when pressure was made over the ends of bones, his ability to take exercise while the joint was kept at complete rest; that the principles of treatment as laid down by her last medical attendant should be carefully adhered to; that if after this line of treatment had been carried out for some time, and was followed by no improvement, and especially if there was a retrograde tendency, I would unhesitatingly recommend excision of the joint before the disease had extended so far that this operation could not be entertained. As she was going to some friends in Dublin at the time, I recommended her to have the opinion of some eminent surgeon there.

I heard no more of the case till about three weeks ago, when the mother called on me again to say that a local practitioner recommended her to have her son's leg amputated, as the only means of saving his life, and that she wanted my opinion.

She told me that after she last seen me (just two years ago) she took her boy to Dublin, and, on the advice of a surgeon there, continued the expectant method of treatment as already described. Matters gradually got worse, the characteristic changes both in the joint and the constitution slowly but surely taking place; and, after two years of suffering, when I again saw him it was a question whether amputation could be entertained. After examining the condition of the kidneys, I recommended operation, and two days afterwards I removed the limb in the manner described. Since the operation his progress towards recovery has been uninterrupted.

Dr. Murney moved that the Secretary be instructed to procure from the Clerk of the Crown a copy of the charge against, and the punishment inflicted upon, Dr. O'Hare at the Spring Assizes of 1878 (Belfast).

He also gave notice that he would move at next meeting that the said document should be forwarded to the Branch Medical Council for their consideration. The first resolution was carried unanimously (2nd by Dr. John Moore).

The time of the meeting having expired it was agreed that Dr. Dill be requested to postpone his paper till next meeting on the condition that it should be the first business transacted.

John Moore

Eleventh Meeting April 9th Tuesday

Present, Dr. Wales (President), J. W. Browne M.D. Vice-President, Dr. Dill, John Moore, Fagan, O'Malley,

Dempsey, McConnell, Esler, Speer, Workman, Whitla Honorary Secretary.

Dr. Fagan exhibited two patients, one with cervical spinal disease treated by jury-mast apparatus of Sayre's, the other with dorsal spinal disease treated by Sayre's ordinary plaster jacket.

Dr. Dill read a paper upon "Gastro-elytrotomy and ablation of the uterus as substitute for the cæsarean section".

Paper:¹ PROFESSOR DILL said: Mr. President,—Having at a former meeting of the Society submitted for consideration the subject of podalic version, and having recommended its practice when other means had failed—to-night, I beg to offer a few observations on a couple of operations which have been proposed as substitutes for the Cæsarean section. These operations are known by the names of (1) gastro-elytrotomy and (2) ablation of the uterus; and although they have not been attempted here or in these countries, yet, as they have been performed, and that successfully, in the United States of America and in Germany, I think I am justified in claiming for them at least your careful attention. I may here mention that the only mention I find in any of our text-books or English works on midwifery, is by Dr. Playfair, who, in his "Science and Practice of Midwifery," gives but a very brief account of gastro-elytrotomy, whilst extirpation of the womb is never alluded to, so that it is from foreign works and periodicals the fullest information may be obtained regarding both operations.

When we consider the great mortality which is associated with the Cæsarean section, we are only surprised at finding obstetricians not more generally and zealously pursuing inquiries towards devising other operations by which greater confidence might be entertained by the operator, and higher hopes of recovery held out to the mother.

The Cæsarean section may be still admitted to be the most serious operation which the obstetrical surgeon is called upon to perform, and even supposing the patient may recover, she is in danger of becoming again pregnant, of rupture of the old uterine cicatrix, and of escape of the ovum into the cavity of the abdomen, whilst the Cæsarean section must be resorted to again.

The first operation which was suggested and practised as a substitute for the Cæsarean section was symphysiotomy by Sigault, in the year 1763, and from which for a time great hopes were entertained. Very soon, however, this operation got into sad disrepute, and it was given up because of even a higher mortality than was found to follow the Cæsarean section.

In comparison with these two very serious operative procedures, I would beg to draw attention to two other operations (which are considered by those who

have a right to form and express an opinion on the matter) as more hopeful. These are, as already stated, "gastro-elytrotomy" and "ablation or extirpation of the uterus." Gastro-elytrotomy was performed by Jörg, Ritgen, and Buden, and it has been recently revived and practised by Dr. Thomas of New York. I may here be allowed to state the different steps in the operation, and I shall do so as briefly as possible. It is considered necessary, in the first place, or before the operation is entered upon, that the os uteri should be either dilated or dilatable.

The first step in the operation which the surgeon must make is an incision from the anterior superior spinous process of the ilium to the symphysis pubis, and through the abdominal wall until he reaches the peritoneum. The second step is, the peritoneum, in place of being incised, must be disengaged, raised and turned back with the finger or with the handle of the knife, so that a free entrance to the vagina may be made, and the os uteri easily reached. The third step is, the os and cervix uteri should now be made to point toward the wound, which may be done by drawing them into the iliac fossa by means of a blunt hook in one hand, and with the other depressing the fundus uteri, and thus, by these two apparently opposing forces, the os uteri is brought into the open wound. The fourth step in the operation is the introduction of the hand into the uterus, and the child is brought away by turning; or the forceps may be applied when the head presents, and the child extracted by this instrument.

The advantages of this operation over the Cæsarean section are at least theoretically obvious:—1st. The peritoneal cavity is not penetrated, and consequently no blood or other fluid can enter the peritoneum; 2nd. The uterus is not incised, and therefore the danger of peritonitis and metritis is much reduced; 3rd. With our present knowledge of ovariectomy and its results, no one need really say that there is anything in the operation of gastro-elytrotomy to prevent it from being favourably entertained and practised under certain circumstances, and with good hopes of success. And now, as we are to suppose our patient does recover, we must expect that she may become pregnant again, and then, as in the case of the Cæsarean operation, the same difficulties and dread dangers must be encountered a second time. And because of this, Dr. Edward Porro has proposed a measure by which a recurrence of pregnancy is absolutely prevented. He proposed to himself and resolved upon the operation of ablation of the uterus, which he performed with the satisfactory result of the recovery of the mother. So lately as in the year 1876, M. Rein published a paper with the title "Extirpation of the Gravid Uterus as a Substitute for the Cæsarean Section," the result of experiments upon some of the lower animals. M. Rein claims for this operation the following advantages:—1st. Only a very trifling or insignificant amount of hæmorrhage during or

¹ [Dublin Journal of Medical Science, 1878, v66, p422.]

after the operation; 2nd. No important organ capable of lesion is retained in the abdominal cavity; 3rd. The impossibility of a fresh or repeated pregnancy.

Professor Spraeth has reported the case of a patient who had undergone this operation, and he states that the woman made a rapid recovery.

And now, Mr. President, with your permission, I may place the whole matter before the Society by way of a query. Is either gastro-elytrotomy or ablation of the uterus to be accepted as superior to, or are they to be supposed as giving the mother any advantage over, the Cæsarean section?

For my own part, I would answer that, with our very limited knowledge I should not too hastily come to a conclusion, much less reject the proposals as not to be entertained, for experience alone can solve the difficulty; and further, I am disposed to say that obstetricians should not pronounce too severe judgment against gastro-elytrotomy and complete extirpation of the womb, as they have been already performed with some success, and as they are at present our only substitutes or counterpoise to the extreme dangers of the Cæsarean section. Moreover, these operations are yet but upon their trial, and it is to be hoped that further experience will justify the sanguine expectations held out to us by Drs. Skene and Thomas, and Professors Ritgen, Spraeth, and Baudelocque, the expression of whose opinions on any of the great questions springing either from obstetric medicine or surgery should not be lightly esteemed by us.

We are but on the threshold of this inquiry, and if any real advance is to be made it can only be by adopting a persevering attitude, and by a careful observation and study of clinical facts and operative results, without drawing from them too hasty or too positive deductions.

DR. BROWNE said from the paper he learned that the peritoneum was treated in exactly the same way as in ligature of the external iliac artery, and he understood that Dr. Dill advocated the operation on the ground that that membrane was not injured. As for himself, he always saw that the peritoneum was injured. He gave the statistics of Storer of the results of ligaturing this vessel: out of 24 cases, 16 died. His incision was through the rectus muscle, from umbilicus to pubis. As far as the removal of the uterus was concerned, he believed there was as much danger of peritonitis from the operation as in the Cæsarean section. He believed that in all such cases the spray should be used, and showed its results from the success of Spencer Wells, and others.

DR. JOHN MOORE thought he could not throw much light upon the subject, which was an obscure one, and likely to remain so. The operation of the Cæsarean section was of so rare occurrence that only one or two in a generation were called upon to perform it—a state of things preventing any one medical man having any-

thing but a very narrow and limited experience. Many years ago it was the lot of a medical man to operate in Belfast, but no case had turned up here since, except one in hospital, and for various reasons the operation was deferred until too late. To one group of the cases demanding the Cæsarean section—malignant disease of the uterus—the operation recommended by Dr. Dill was inapplicable, the difficulties then being so great that he believed no man was justified in attempting it.

DR. FAGAN felt he was anticipated in his remarks by the previous speaker. He knew little about the subject matter of Dr. Dill's paper, and felt obliged to him for bringing it before him. He thought one should be very careful, indeed, before undertaking any operations like those discussed; but when they were forced to it, the choice lay between two very serious operations, and for his part he would say he was decidedly in favour of a clean cut.

Hole and corner operations he condemned, and thought quite too much was made out of the fact that the peritoneum was not opened. He believed the more freely this was opened the better. As regarded ablation of the uterus, he thought Dr. Dill's suggestions of more value, and should be put in force when a case presented itself.

DR. DEMPSEY thought that, from what he had heard, the operation was a scientific one, and if properly performed he did not see that any vessels of importance would be injured. He thought that the opening of the abdomen and the removal of both ovaries through their respective fossæ would be decidedly more dangerous.

DR. SPEER remarked that abortion or premature labour was not mentioned as a substitute for the more serious and difficult operations proposed. He detailed the case of a woman who had craniotomy performed in a former labour. He induced labour at the end of the seventh month after she had become subsequently pregnant, and she had now a healthy boy growing up.

DR. WHITLA (Honorary Secretary) thought that as regarded the operation of ablation of the uterus as a preventive for pregnancy, there was one operative procedure decidedly less formidable—i.e., removal of both ovaries through the wall of the vagina, as practised by the American surgeons. He gave the results of the operations, and believed that where a cutting operation was demanded as a preventive of pregnancy, it should have the preference.

DR. M'CONNELL thought, from what he had heard of the matter, he would decidedly wait for further light before he made up his mind to give the preference to any substitute for the Cæsarean section.

DR. ESLER agreed with the remarks of a previous speaker, that the operation comes so seldom that it is hard for one man to have much experience. He saw many disadvantages in cutting from the middle line—danger to important vessels and nerves. As regarded the question of ablation, he would rather deal with it in

a more conservative manner, and recommended the use of injections to prevent pregnancy. He narrated a case bearing upon this point.

DR. WALES (President), in thanking Professor Dill personally and also on behalf of the Society, said he hardly felt competent to express an opinion on the nature of the operations. He had watched the mortality of ovariectomy for many years, and saw that even now it was continuing to grow less and less; but he was sorry to say that he failed to see the revolution in obstetric surgery which he had expected would follow the splendid results of Wells, Keith, and other workers. They had it before them in a way unmistakably demonstrated that the dreaded peritoneal cavity could be opened with impunity, the intestines and viscera sponged over, replaced, and uninterrupted recovery ensue; and with this fact before him, he would not think much about whether he reflected or cut the membrane. He could not realise how the operation of gastro-elytomy could be performed without a good deal of stretching of the peritoneum.

PROFESSOR DILL, in replying to the remarks, said that those who spoke on the subject of the peritoneum being injured, seemed to forget that in the Cæsarean section this membrane is twice cut through, and after this you come to the bleeding uterus. If it was a case of only going through one layer, he would hesitate before recommending any substitute; but it was different when he remembered that the layer over the uterus must be incised also.

As regards the question of removal of the ovaries per vaginam, he would have discussed the question raised by one speaker, in his paper, only he thought that the title of his paper confined him to the points about the uterus. On the whole, he said, he must feel that the patient would have a better chance under these operations than in many cases after craniotomy, when the pelvis is very narrow; and gentlemen should remember that these operations were only suggested to meet cases where it was found impossible to extract the *fœtus per vias naturales*.

In reference to Dr. Murney's motion on the paper for the evening the Secretary explained that in accordance with the resolution of last night of meeting he called upon the deputy Clerk of the Crown who advised the Society not to press him for a copy of the charge and verdict against Dr. O'Hare.

He also informed the Secretary that the secretary of the Branch Medical Council had obtained the document and would very likely take action in the matter as he presumed he intended laying it before the Branch M. Council.

This explanation was considered very satisfactory and in the absence of Dr. Murney Dr. John Moore withdrew the motion.

George F. Wales

Twelfth Meeting of the Society was held April 30th Tuesday at 8 p.m. in the Museum of the Belfast Royal Hospital.

Present, Dr. Wales (President), J. W. Browne, Fagan, Dempsey, Whitla, O'Malley, Kirker (visitor) and D. Johnston. Several students.

Dr. Whitla showed specimen of diseased lungs and cancer of liver.

Paper:¹ Dr. WHITLA gave the following notes of a case:—A. G., aged eight and a-half years, an active, healthy girl, had been in her usual health and spirits on the evening of the 4th instant at 7.15 p.m., when she was thoroughly enjoying herself at play. She suddenly complained of a pain in her right side in the mammary region, which was soon observed to interfere with her breathing, and, continuing in severity, she was put to bed, when some shivering was noticed. I was called to see her at 2 a.m., seven hours after the onset. She was suffering intense pain, respirations were very frequent, shallow, and irregular. Any effort at coughing caused great agony. Pulse frequent and weak, and difficult to count; temperature in axilla, 102.8°. Owing to the great dyspnoea it was difficult to get a thorough examination. On inspection there was seen to be diminished movement on the right side; on auscultation the sounds on this side were distinctly fainter.

The signs thus pointed to pleuritis, but I was informed that she had coughed up some little blood expectoration. This settled the diagnosis as pleuro-pneumonia of the right lung. There was no crepitus or evidence of solidification. I gave her 1 grain of opium instantly, and an expectorant, with carbonate of ammonia, &c., and 5 minims of tinct. opii camph. every hour, and applied hot sinapisms. At 10 a.m. she was worse; no material change, but respirations more laboured, lips getting blue, mucous râles over both sides of the chest. The alarming rapidity of the symptoms seemingly increasing every minute in intensity warned me that there was no time to lose. I put on eight leeches and cupped over them, extracting about 5 oz. of blood, with decided, but only very temporary, benefit. Dulness now appeared over the right base, changing with position, and the dyspnoea increased, the lips getting blue and cold, and she sank at 5, 21¾ hours from the time she had been noticed at play in health and glee.

He brought the case before them with the result of the post mortem examination, solely on account of the terribly short duration of the disease. She was conscious up to the moment of death.

On opening the chest about 6 oz. of bloody serum escaped from the right pleural cavity. The base of the lung was partially solid, as they would see. The pleural membrane was deeply injected, at patches showing small ecchymoses or miniature extravasations; it had

¹ [Dublin Journal of Medical Science, 1878, v66, p428.]

lost its polish, and a thin filmy structure could here and there be scraped off it, like a very fine elastic membrane, evidently lymphic; but no shreds of ordinary white lymph were to be seen anywhere.

The left lung, as would be seen, was also partially solidified at its apex, and both lungs were decidedly congested throughout. The heart was normal, and contained no clot.

DR. FAGAN said the question of abstraction of blood from children was a very disputed one. For his part he found that they bore it well.

DR. DEMPSEY said he had not seen much acute pneumonia in children so young. He believed in the extraction of blood to a moderate extent, and would extract it by leeches or cupping. He would give anti-mony, but would hardly give so free a dose of opium.

DR. JOHNSTON had seen much acute pneumonia in children, and they generally did well. He could hardly see from the viscera shown that the cause of the death was in the lungs.

The SECRETARY then cut the lungs exhibited, and placed portions of them in water, when it was found that portions from every part of the right lung sank, and also from the base of left.

DR. WALES, in thanking Dr. Whitla for the specimens, said that the case was one of great interest; it was so also from its extraordinary rapidity. The amount of the disease in the viscera exhibited was astonishing, especially as the case pointed to 21 hours' duration. His experience was altogether in favour of depletion, and was uniformly successful, especially in the first stage. Opium must be given to allay pain, and he believed it might be pushed till pain was subdued. The opium in this case had clearly no effect, though the dose was fair, but the disease was very extensive. If he had a similar case he would adopt the same treatment as had been used in this, but he thought he might likely have bled a little earlier, if he got an opportunity.

Dr. J. W. Browne showed 3 patients upon whom he operated for contracted knee joint successfully.

Paper:¹ Dr. J. Walton Browne exhibited four patients upon whom he had operated for contracted knee-joint; also the photographs of three cases upon which he intended operating.

Dr. Browne said that he had been much pleased with the treatment adopted, a few years since, at Mercer's Hospital, Dublin, by the late Mr. Morgan, which was designated by that surgeon the "immediate treatment," and stated that he intended operating in all suitable cases which should present themselves by the "immediate treatment." He referred to the classification of ankylosis of joints adopted by Morgan—viz.: (1) A firm, true ankylosis; (2) A false ankylosis; (3) Contraction; and pointed out that it was in cases of false and fibrous

ankylosis that the "immediate method" was specially applicable; he also stated that in those cases of fibrous ankylosis where some degree of "spring" is present, most hopeful results could be anticipated.

He drew attention to the difficulty of diagnosis in cases of fibrous ankylosis in which the adhesions were very short—these cases possessing no perceptible degree of motion, and simulating true or bony ankylosis—and referred to Sayers method of diagnosis—i.e., by administering an anæsthetic, and using flexion and extension of the joint; waiting for twenty-four hours—at the expiration of that time, should there be some degree of swelling about the joint, the case is one of fibrous ankylosis. He had found this method of diagnosis of service in a case of ankylosis of the hip-joint.

In three of the four cases exhibited, ankylosis was of traumatic origin; and the fourth case followed an attack of acute rheumatism, the limb being kept in a flexed position for three months. In all the cases the leg was at right angles to the thigh.

In two cases the deformed limb was four inches shorter than its fellow, and in the other two cases the limbs were two inches shorter than the opposite side. In each case the patella was ankylosed to the external condyle of the femur.

In one case the internal condyle of the femur was hypertrophied, so that when the limb was operated upon and extended, the patient appeared as if suffering from genu valgum.

He said that it had been shown by Morgan that most successful and satisfactory results could be obtained in cases of the so-called "white swelling" of the knee-joint, and that the cases he purposed operating upon had suffered for many years from chronic disease of the joint. In performance of the operation, the patients were placed under the influence of chloroform, the flexors of the thigh divided subcutaneously, and the joint forcibly and suddenly extended. The small wounds produced by the tenotomy knife were closed by pieces of lint, saturated with tinct. benzoin co. The limb was then carefully bandaged to a long splint, extending from the tuberosity of the ischium to the heel, and adapted to the contour of the limb. The splint had a foot-piece attached, to which the foot was bandaged, also two cross pieces of wood to prevent the limb rotating. An ice-bag was kept constantly applied to the joint, and was not removed until all heat and tenderness of the joint had subsided; in one of the cases ice was kept applied for four weeks.

In dividing the tendons, the only point of importance was the division of the biceps tendon. In operating, the tenotome should be inserted parallel and close to the side of the tendon, and cut from the inside or popliteal aspect towards the skin. To avoid wounding the peroneal nerve, keep the tenotome close to the inner side of the biceps tendon, and, when passed deeply enough, turn its edge outwards; occasionally it is possible to separate, by your fingers, the nerve from the ten-

¹ [Dublin Journal of Medical Science, 1878, v66, p332.]

don, and roll it inwards. In the four cases the division of all the tendons was found necessary.

After division of the tendons, and when making extension, you should be very careful, as pointed out by Morgan, to place either your own hand or the hand of your assistant in the popliteal space and support the head of the tibia, lest dislocation of the tibia should occur. Two of the cases were under treatment for three months before all pain and heat of joint had subsided; the other two were discharged in six weeks, with stiff but useful limbs. Before leaving, I had boots with thick cork soles made for them, and to-night you are able to see the amount of progression they possess.

G. F. Wales

Thirteenth Meeting May 28th '78

Present, Dr. Wales (President) in the chair, Dr. James Moore, Dr. Dempsey, Dr. Core, Dr. Clarke and Dr. J. W. Browne (Secretary pro tem), McKeown, Dr. John Moore.

Dr. Core brought forward a specimen of cystic disease of the chorion. He supposed pregnancy had been accompanied by profuse bleeding at several periods. The "mole" had extruded at the end of the fourth month.

Paper:¹ Mrs. C. R., who has had six children—the latter three syphilitic—became pregnant in January, 1878, the catamenia having ceased on the 7th of that month. The ordinary early signs of pregnancy were present for two months, when, after having received a severe fright, she fell into ill health, feeling, as she said, quite different to what she had ever done before. Slight watery and sanguineous discharges took place at intervals, up till May, from which time rapid distension, accompanied by considerable hæmorrhage, went on till 20th May, when, pains having set in, I was sent for. I found her considerably blanched, and with quick small pulse. The abdomen, as to size, had the appearance of a seven months' pregnancy. On palpation, however, a doughy, boggy feeling, marked differently from that usually present, caused me to suspect a state of matters which a vaginal examination at once clearly revealed. The uterine pains being feeble, a dose of ergot was followed by the expulsion, in a very short time, of a large hydatidiform mole, part of which I submit to your inspection. No further hæmorrhage occurred, and the lady made a good recovery.

Dr. J. W. Browne brought forward a specimen of un-united fracture of the femur in the lower third in which the union was prevented by a mass of muscular tissue.

Paper:² Dr. Browne exhibited a femur which had been removed from a woman, aged sixty years. She was

admitted into the hospital under his care, suffering from compound comminuted fracture of the left leg, oblique fracture of the right femur, and injuries of the pelvis. The case progressed favourably until the sixth day, when it was deemed necessary to amputate the left leg. At the end of four weeks, when the stump had quite healed, it was found that the fracture of the femur had not united. A few days subsequently, the patient was seized with pyæmia, and died. Upon post-mortem examination it was found that there was an oblique fracture of the lower third of the femur, and some fibres of the vastus externus had become implanted between the fragments, and prevented union taking place.

Dr. Clarke presented for Dr. Fagan a specimen of malignant epulis which he had removed from the upper jaw.

Dr. McKeown related the history of a case in which a set of artificial teeth been lodged in the pharynx and which he removed by the operation of orophagotomy.

Dr. Dempsey read notes of a case of double vagina and uterus where labour was accomplished by Simpson's long forceps.

Paper:¹ DR. DEMPSEY said: Mr. President and Gentlemen,—I was called at one o'clock on the morning of the 18th October, 1877, to attend Mrs. M. in her first confinement. She had been ill from eight o'clock the previous night with sharp pains, but at long intervals. I examined her and found the os uteri to be dilated to the size of a sixpenny piece. To ascertain its dilatability I examined her again during a pain, and this time with great difficulty I discovered the os, and was surprised to find it much less dilated than when I examined before.

It immediately occurred to me that there was some abnormality, and I then found there was a bridge of tissue stretching across the vagina, dividing it into two compartments—an anterior and a posterior. This septum was about one-eighth of an inch in thickness, soft and elastic in structure, and it extended from each labium minus backwards to the uterus. It did not pass straight across the vagina, its attachment on the left side being nearer the fourchette than on the right side. The anterior canal was therefore somewhat larger than the posterior. The os and cervix uteri in each canal had all the characters of normal development.

The head was presenting, and the liquor amnii had escaped. As the labour was likely to be tedious I left her, and returned about six o'clock. The os at this time in the anterior canal was dilated to the size of a crown piece; in the posterior canal to the size of a half-crown piece. I could pass my finger through one os uteri over the septum into the other, so that the uterine cavity was not divided. The pains from this time were quick and strong, until about nine o'clock, when they came at

¹ [Dublin Journal of Medical Science, 1878, v66, p334.]

² [Dublin Journal of Medical Science, 1878, v66, p335.]

¹ [Dublin Journal of Medical Science, 1878, v66, p427.]

longer intervals. At nine o'clock the anterior os was nearly fully dilated; the posterior remained as before—about the size of a half-crown.

At each pain the head of the child was pressed strongly against the bridge of tissue between the duplex os uteri, which completely obstructed its advance.

I endeavoured to keep it aside during the pains, but they came at such long intervals and were so weak, that no advance was made. At 11 o'clock a.m. there was an escape of meconium, and I then determined to deliver at once. I put on Simpson's long forceps, and made gentle traction with one hand during the pains, and with the other tried to push the obstructing septum over the child's head.

Just when I believed I had done so effectually, and that all trouble with it was past, and made stronger traction, there was immediate evidence of laceration, which continued with every pain until I brought the head down on the perineum.

The child was apparently dead, but after some efforts it began to breathe regularly and lived.

The placenta was expelled about fifteen minutes afterwards. There was not much hæmorrhage immediately after confinement, but during the day and throughout the night there was a great deal of a trickling kind, which ceased altogether the following morning—viz., October 19th. A sharp attack of metritis now set in, with high fever and quick pulse. The pulse reached 140 in the minute on the third day after confinement. There was intense tenderness over the uterus, which felt very large, and altogether she was in an alarming state for a few days.

Under treatment of the prescribed kind she recovered, and was able to be up on the 13th day after confinement.

I have never since had an opportunity of examining her, so cannot tell the extent of the laceration, but, from the noise of the rent, I believe it must have been extensive and implicated the cervix of the uterus (at least the part between the ora uteri), as well as the septum. As malformations of this kind are rare, I thought it would be interesting to read the notes of this case to the Society. During a term of four years I find only one such case recorded in *The British Medical Journal*, and that by Dr. Murray, of Durham College, but in his case the uterus was also divided. To understand how this abnormality took place, we must look to the usual mode of development of these parts in the fœtus.

The vagina, the cervix of the uterus, and the lower part of body of the uterus are developed from the genital cord—the genital cord itself being formed by the union below of the two Mullerian ducts. From these ducts above the genital cord are developed the upper part of the uterus and the Fallopian tubes.

In this case the lower portions of the tubes of Muller did not unite into one single tube, but remained as two distinct canals, and the result was a double vagina, os,

and cervix uteri. The development of the rest of the uterus had gone on in the usual way, and there was only a single cavity. I may state Mrs. M. was not aware there was anything unusual in her development.

Dr. Core was appointed Treasurer in place of Dr. Fagan, resigned.

Dr. Browne proposed a vote of thanks to Dr. Fagan, seconded by Dr. John Moore.

Alexander Harkin, President

Annual Meeting Session 1878–79

Present, Dr. Wales in the chair, Dr. Wheeler, Core, Esler, Dempsey, Anderson, Browne, Moore, McKee, Wadsworth, Speer, Graham, McKeown, Workman, Aickin, Browne, Dill, Whitla.

The Annual Meeting was held in the Society's Rooms, Royal Hospital, on Thursday, November 7th, 1878. The Chair being taken by the President, Dr. Wales, [and the minutes of previous annual meeting having been read] the following Report was read by the Hon. Secretary:—

The Council have pleasure in submitting to the Members of the Society their Report for the Session terminated.

Thirteen Meetings were held during the Session, and the average attendance was 14.5—a number which may seem small, but which represents an improvement upon the former year, and is, moreover, the highest average attendance for several years past.

The President's suggestion of opening the Session with a debate proved a decided success, and the discussion upon Alcohol lasted for four nights.

The Council have with regret to mention the death of one of the most respected and beloved Members of the Society, Dr. Henry M. Johnston, an ex-President, whose genial manner and sound common-sense observations will long be missed at our Meetings.

The Council have also to report the loss of Dr. Spence, cut off in the prime of life by sudden disease, and also to mention their sorrow at the national loss of our most renowned and illustrious Honorary Member, Dr. W. Stokes, of Dublin,

Eight new Members joined the Society during the Session, leaving a balance in our favour after deducting those who have left town and a few who have resigned connexion with the Society.

The following papers were read during the Session:—

Drs. Cuming, John Moore, Dill, Beck, senr., MacCormac, Wheeler, Esler, Aickin, Speer, and Whitla, papers on "Alcohol"

Dr. Esler—"The Disposal of the Dead."

Dr. Dill—"Forceps versus Version."

„ "Gastro-Elytrotomy and Ablation of the Uterus as Substitutes for the Cæsarean Section."

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President George Frederick Wales

Dr. Browne—A paper on “Contraction of the Knee-Joint.”

Dr. M’Keown—“Œsophagotomy, with Notes of a Case.”

Dr. Dempsey—“Notes of a Case of Double Vagina.”

Professor Cuming—“Notes of a Case of Rupture of Ovary.”

The following patients were exhibited:—

Dr. Browne—Four cases of contracted knee-joint successfully treated.

Dr. Harkin—A case of psoriasis cured by chryso-phanic acid.

Dr. Whitla—A case exemplifying the action of the acid.

Dr. Fagan—A patient from whom he removed the shaft of the ulna, and two children put up in Sayre’s plaster jackets.

The following specimens were exhibited:—

Dr. Murney—A compound fracture of the knee-joint.

Dr. Fagan—A beautiful specimen of encysted renal and vesical calculi, and a malignant epulis from upper jaw.

Dr. Browne—An ununited fracture of femur.

Dr. Core—An hydatidiform mole.

Dr. Whitla—Diseased lungs, causing death in twenty-one hours; a specimen of fibrous tumour of uterus and disease of the ovaries; an upper extremity the seat of a large recurrent tumour; a liver and gall-bladder from a jaundiced patient; a specimen of fatty degeneration of the liver; also one of diffuse smooth cancer in the same organ.

Important changes have been made in the financial department of the Society. The services of the Messenger have been dispensed with, and his salary to be devoted to the increasing and overhauling of the Library,

Dr. Fagan resigned the Treasurership during the Session, and Dr. Core kindly consented to act.

A Microscopic Committee was appointed last Session, but owing to its size was found impracticable; and the Council, in order to increase the efficiency of this branch, have resolved to appoint a Microscopic or Pathological Secretary to examine all specimens referred to him by Members or by the Society.

A ballot having been taken, the following Members were elected:

Dr. Harkin: **President**

McKeown and Browne: **Vice-Presidents**

Council [votes]: Wheeler (14), Cuming (9), Fagan (8), Smith (7), Moore (7), Anderson (7).

Treasurer: Dr. Esler.

Librarians: Core and O’Neill.

Pathological Secretary: Dr. Workman

Honorary Secretary: W. Whitla.

Drs. Graham and Dempsey: **Auditors.**

Thursday November 21st was fixed as the day. Drs. Dill, Murney, Moore, Wales, Treasurer and Secretary were appointed to act as a Dinner Committee. The Imperial Hotel was arranged to be the place.

A. Harkin, President

ULSTER MEDICAL SOCIETY

SESSION 1878–79

First Meeting of the Session was held in the Royal Hospital on Tuesday 28th November 1878

Present, Dr. Wales (Ex-President), Dr. Harkin (President), Professor Dill, Dr. Aickin, O'Neill, Esler, Core, Dempsey, Whitla.

Dr. Wales after introducing the President, Dr. Harkin, in a suitable speech, vacated the chair which the President occupied.

A ballot was taken and Drs. Clarke and Riddell were elected members.

Dr. Young proposed by Dr. Whitla seconded by Dr. O'Neill was nominated as member.

Dr. McKenzie proposed by Dr. Esler seconded by Dr. Wales, Dr. Withers proposed by Dr. Esler seconded by Dr. Wales, were proposed as members.

Dr. Whitla, the Honorary Secretary, was directed to obtain a copy of the Register and Directory for 1879.

Dr. Harkin then with some preliminary remarks, read his opening address choosing his subject "The milk feeding of infants".

Paper:¹ GENTLEMEN,—In accepting, at your invitation, the honourable position of President of the Ulster Medical Society, my first duty is to thank you most warmly for the high compliment you have conferred upon me, and to express the hope that, with the aid of the Council and the indulgence of the Members of the Society, I shall be enabled to preside at its discussions to the general satisfaction.

I have great hopes that a new era has dawned on our time-honoured Society. Last session afforded evidence of renewed energy and life, and discussions on important topics and valuable monographs contributed to maintain an interest in its proceedings. I have learned, too, that in the coming session there is every prospect of progressive improvement.

I trust that the younger members will not hesitate to bring forward original papers and disquisitions on medical subjects through fear of friendly criticism, and that the seniors will endeavour to overcome the vis inertiae by which they are too liable to be influenced, and that they will cull from the repertory of their note-books some of their important cases and theoretical speculations. Labouring thus in unison, we may have good reason to hope that when the session terminates the retrospect shall be satisfactory to us all. My able and accomplished predecessor in this chair treated in an exhaustive manner, in his opening address, the subject of the great advancement of medical science—its

conquests and its triumphs in modern times. The task which I have imposed on myself will, I fear, be less flattering and agreeable; for it is my purpose to advance opinions adverse to those generally recognised, and to question the propriety of the teaching and practice on a very important subject—"the Milk-feeding of Infants at Nurse."

The proposition which I hope to establish is, that in the unreasonable and excessive dilution of cow's milk practised by mothers and nurses in the feeding of infants, sanctioned and taught by many members of our profession, serious injury is done to the nursing child, its natural development retarded, its growth stunted, and too often the seeds of disease and death implanted in its constitution.

Were every English mother actuated by a sense of her maternal obligations, did she nourish her baby during the early months of its existence with the food specially provided for it by the Author of its existence, defective alimentation could not, with justice, be classed as a potential cause of infant mortality, nor should it be in my power to animadvert on prevalent errors in artificial or hand feeding of children, the main resource of the fashionable dames of modern days. How strange, and how much to be deplored, that the Christian mothers of the 19th century should be as oblivious to duty in this respect as the matrons of Pagan Rome in the age of Tacitus, who, as a proof of the degeneracy of Rome in his days, laments that while in former times "grave matrons attended to their children as their first duty, they now," he complains, "entrust them to the care of some Grecian slave, or other inferior domestic."

But in addition to the class of unwilling mothers, there is another and a numerous one to whom Nature has not been so liberal, and who have not been provided with the maternal nourishment, and who are, therefore, precluded from performing that duty; and a third class who, although secreting freely, are debarred from nursing by the defective quality of their milk through a tuberculous or other taint in their system.

It is in vain that, according to the apostle, "the babe desires the rational milk without guile," for "every nurse and mother," in the words of Sir James Simpson, "thinks that she can improve upon God's food—pure and unadulterated milk." Some nurses from the very first week are in the habit of adding farinaceous food—such as corn-flour and arrowroot—to the posset of milk, in happy ignorance that it is not until the lapse of five or six months that the infant acquires the property of digesting starchy food, and that, in the absence of ptyalin, it passes into the stomach and bowels in an insoluble state, incapable of being assimilated—intestinal trouble being the necessary result of such feeding.

But the greater number—and it is with those that we have now to do—prefer to rear their children on that food alone which most nearly resembles the mother's milk, and therefore the milk of some inferior animal,

¹ [Dublin Journal of Medical Science, 1879, v67, p66.]

when a wet nurse is not provided, is depended upon for their nutrition. The milk of the ass, though suitable for some cases, frequently disagrees, and the milk of the goat is not always available, so that practically cow's milk is the chief reliance of the hand-fed child. Milk as it comes from the cow is a beautiful emulsion—a compound fluid in which sugar, curd, and oil, are mingled with a certain proportion of water— and admirably adapted to the digestive powers of the infant.

While the water and sugar are absorbed, the curd is separated by coagulation, and finally dissolved by the agency of the gastric juice, which is much more powerful in the young than in the adult, and thus greatly contributes to digestion. If then this bland fluid, moderately heated, were given without any of the improvements alluded to, especially the benevolent addition of water in scientific profusion, we should have fewer puny, sickly infants to prescribe for; fewer complaints of colic, of spasms; fewer entreaties for carminatives, for sedatives to still the voice of hunger in the poor starlings whose only requirement is to be found in a cup of genuine unadulterated milk.

But the doctor is consulted—he finds that the infant is not thriving, that it is peevish, languid, restless by night and day, that its evacuations are unhealthy, that it is constantly wetting its napkin, that its countenance is pale and anæmic, its forehead and scalp traversed by large blue veins, that diarrhœa is a frequent visitor, and that if a change do not soon occur, the gravedigger shall soon have his due—every fourth or fifth grave that is dug being for an infant under twelve months; but then—

"Tis not a life—

"Tis but a piece of childhood thrown away!

The doctor soon discovers that there is a great defect in the nutrition of the child, and inquires upon what it is fed. He is gravely answered—"Upon milk and water." He asks, why give water? Because, the nurse replies, cow's milk is too strong for the child, and we add equal parts of water—or, two parts of water to one of milk!! or frequently three parts to one of milk!!! And upon this watery diet you expect the infant to thrive, and you wonder that the water you are incessantly pouring in by the mouth is as constantly passing by urination, that its flesh is not firm, and that its bowels are so relaxed.

On inquiring of trained nurses for an explanation of this practice, I have been answered, "Oh, Drs. A. and B. always do so;" by one that she was taught the science of dilution, 2 parts water 1 milk, in the Rotunda Hospital. My reply was, "Perhaps so." I have no doubt its present masters give different advice. By another, that an eminent gynecologist in Edinburgh told her always to give equal parts. "If so," I answered, "while I have every respect for that gentleman's scientific acquirements, it is evident he has yet some knowledge to gain." But passing from the statements of monthly nurses and mothers, what do our text-books, what do our teachers

say on the subject? I shall quote from but a few, as I am sure the generality of the practice of dilution will not be questioned. Underwood, a great authority in his day, directs a portion of water to be added, leaving the quantity to the discretion of the nurse. Dr. Combe, "On the Management of Children" (p. 234, Chap. XI., on Artificial Nursing), says—"At first two-thirds of pure fresh water should be added to one-third of milk, but goats' or asses' milk does not require more than an equal part of water; after a week or two the quantity of water may be reduced to one-half, and afterwards to one-third, at which proportion it should remain for four or five months."

Some textbooks tell us to give the milk diluted with a proper amount—some two-thirds water to one-third of milk, some with equal parts. The Edinburgh Medical Journal, quoted in Brit. Medical Journal, July 15, 1873, publishes the following, among other rules, for the management of infants, prepared by the medical officers of the New Dispensary, and circulated among the visitors to the charity—further assuring us that they are very similar to those which have been issued for some years at the Middlesex Hospital and the Hospital for Sick Children, London.

After some very useful paragraphs—Paragraph 3, how to bring up by hand:—"If the child must be brought up by hand, it should be fed with milk and water out of a bottle. At first there should be nearly as much water as milk, but when the child is a month old two parts of milk should be mixed with one of water; after this the proportion of milk should gradually be still further increased, till at five or six months it is given plain." The editor of The Edinburgh Medical Journal adds this sensible remark:—"To mix water with milk is needless—too much of that is added before the poor mother gets it, and, even were it not so, the child has need of all the nourishment it can get."

This expression of opinion by the editor formulates in a few terse words my long-cherished idea, the result of my personal observation and experience during the greater part of my professional life, and to enforce its adoption and to induce my professional brethren to reconsider their teaching and practice on this important subject is the aim and object of this paper. I shall trouble you with but one other quotation from a very learned and the latest writer on the Science and Practice of Midwifery, Dr. Playfair. He says, at p. 276, Vol. II.:—"A common mistake is over-dilution, and it is far from rare for nurses to administer one-third cow's milk to two-thirds of water—the necessary dilution will be best obtained by adding to pure, fresh, cow's milk one-third hot water, so as to warm the mixture to about 96°. After the first two or three months the amount of water may be lessened, and pure milk, warmed and sweetened, given instead."

You perceive, gentlemen, dilution is the prevalent idea, with one bright exception, in the hand-rearing of chil-

dren—it is by this potent means that we shall succeed in putting a bone into children when they are young. But you will not fully realise the grandeur of this idea, the complete development of this gospel of nutrition, unless you take the trouble of following the process step by step.

In the first place, according to Letheby, the normal amount of water in good honest milk ranges from 84 to 95 per cent.—a fine foundation for the exercise of the noble act of dilution; to this the dairyman is permitted, by custom, sanctioned by the Society of Public Analysts, to superadd 5 per cent, from the cow with the iron tail; the dealer next appears upon the scene, and he is permitted by the authorities of Somerset House to add 15 per cent, on his own account, as they have declared that milk with 20 per cent. of added water should be passed as genuine.

The purchasers are thus entirely at the mercy of the dealers, who, too often, by dilution and skimming of the milk, rob it of 25 per cent. of its cream and other nutritive qualities.

According to Dr. Cameron, however, while 25 was a usual rate of dilution in Dublin, it frequently rose to 60 per cent. of added water. Let us now follow this sophisticated fluid, this ill-used aliment, to the nursery, and here we shall find that it receives the worst of all bad treatment, for before the passive infant is permitted to take the pellucid fluid it is again doctored by the addition of, not 5 or 10, but of 100, 200, or very frequently, 800 per cent. of water, by the advice or tacit sanction of the physician, and on the plea that the pearly liquid is too strong for the digestive organs of a healthy child! Surely the homœopathic nostrum of the third dilution could not compare in absurdity to this.

To what purpose, may I ask, the interference of the Legislature rendering it a penal offence in a dealer to dilute or adulterate the milk beyond a certain proportion—to what advantage the action of the magistracy who daily, in our courts of law, impose heavy penalties on conviction of the adulteration of milk, assigning as a reason that it deprives the citizens of good and proper nourishment, if heads of families, through ignorance or unsound advice, so often nullify the intentions of Parliament, and mix and destroy the most salubrious of infantile foods?

But where, I ask, in this deluge of water is the poor infant to find the necessary amount of nitrogenous and carbonaceous material? where the saline principles indispensable to the growth and development of the solid textures of the animal frame? But as those matters, so essential to vitality, are not presented to the infant, as a natural consequence defective alimentation leads to individual degeneracy, and ultimately to progressive degeneracy of the race, to wasting disease, and to death.

How sad to mark how soon the flower of human life

Hastes to its fading from its very birth!

Another newly-born ! How near ere they—

The one that's dead, the one that's born to-day!

As a general principle, it cannot be questioned that disease and premature decay are intimately associated with the nature of the food-supply. According to Ancell, milk, poor or defective in its staminal principles, will, no doubt, produce in the nursling all the effects of deficiency of food, and that debility which operates as a predisposing cause of tuberculous and other diseases (vide Ancell, "On Consumption," p. 458); and Donné informs us that he ascertained, "by direct experiment, that an inappropriate nourishment of young animals has a great effect in altering the shape and nature of the corpuscles of the blood" (vide *Microscopical Journal*, 1842, p. 245). It is a long time since Mr. Phillips declared that dilution cannot make cows' milk resemble that of women. Physiology and pathology alike protest against the false principle which I have been arraigning to-day; but my chief reliance shall be upon chemical research to upset the assumption upon which this hypothesis rests—viz., that the milk of the cow is so much stronger than human milk that it requires an amount of water, varying from 25 to 800 per cent., according to the whim of the blender, to assimilate the fluids, and adapt cows' milk to the digestive capacity of a healthy child.

In accordance with ordinary modes of reasoning, if 300, 200, or even 25 per cent. of water were required to reduce a certain liquid to the strength of another, it should only be so because that liquid was composed of elements three times, twice, or one-fourth stronger than the other. Now, is such the case with the two liquids we are comparing? Plainly, is the milk of the cow three times, twice, or even one-fourth stronger in nutritive elements than human milk? Let chemical analysis determine. In the first place, the specific gravity is almost identical, varying in both, according to conditions of health, from 1013 to 1832 (Vernois and Becquerel). According to analysis of Regnault, given in "Neligan," in 100 parts of human and cows' milk there are found—

	Cows' Milk	Human Milk
Water	87.4	88.6
Oil and butter	4.0	2.6
Lactin and soluble salts	5.0	4.9
Casein, albumen, and fixed salts	3.6	3.9
Total solids, cows'	12.6	
" human		11.4
Difference 1.2 (about one-tenth)		

Thus, on the computation that the milk is obtained direct from the cow, about one-tenth is the exact amount of solid nutriment contained in that secretion as contrasted with the milk of the mother; and upon this slender superstructure the edifice of dilution is established!

But to act in every case upon the principle of dilution is simply to become the slave of routine; and, in my somewhat extended experience, I have very seldom found it necessary to add any water to the milk provided for healthy infants, for the mere purpose of dilution. I have occasionally advised the addition of an ounce or two of lime-water to a pint of milk, not as a diluent, but as a corrective of lactic acid, which is frequently found in milk when not absolutely fresh—the normal reaction of good milk being alkaline; and often that corrective is not necessary, for if the milk occasionally disagrees on account of the varying condition of the digestive organs of the child, or from other causes, it is only necessary to boil the milk and carefully skim it before use.

Children nourished with the fresh milk of the cow present a rosy, robust, happy, and contented appearance, in marked contrast with the poor starvings fed upon homœopathic doses of milk administered in floods of water, or mingled with starchy or farinaceous diet. No one can adequately tell the amount of infantile mortality due to inefficient feeding; thousands whose deaths are annually registered as caused by teething, diarrhœa, water in the head, tabes mesenteries, convulsions, thrush, &c., and who perish in the first year of their existence, in reality owe their deaths either directly or remotely to improper feeding. Should not our sympathies, then, be directed

Towards the young souls new clothed in helpless
clay,

Fragile beginners of a mighty end?

And if we could better instruct their mothers in this all-important duty, many lives would be saved to the State, infants would not die as if to make way for others to be born, and some reparation would be made by the present race of medical men for the false teachings of other days, the traditions of which still linger and are painfully evident in many customs of modern life. When a fond mother exposes her child to a cold chilling wind, with the avowed object of hardening its constitution, she is but obeying the dictum of Dr. Underwood, who taught the mothers of the preceding generation to do so, and who testified to “the absolute necessity of inuring very young infants to endure the cold as essential to their health and that of Dr. Armstrong, another great authority, who taught at the same time that infants should be daily plunged into cold water, even the day after their birth, for the purpose of bracing up their nerves, &c. We are also confronted daily with the senseless dogma, believed in by most mothers, that because a child is teething it would be dangerous to stop a diarrhœa, and many an infantile life I have known to be sacrificed to such a vulgar error.

My great object in bringing this subject before the profession is not, I trust, a too ambitious one, if I express the hope that the medical men of the present day—the legitimate advisers of mothers and nurs-

es—will set their faces against this monstrous and wide prevailing abuse; and that, while it may be necessary in some cases for a time or in certain conditions of an infant's health to permit or advise the addition of some diluent to its ordinary pabulum, they will not permit the use of their high authority as sanctioning a process of promiscuous dilution.

(Dr. Wales thanked the President and was about to reply to the subject of the paper when Dr. Wales [sic] proposed that the meeting be adjourned and Dr. Dill seconded this.)

A vote of thanks was proposed by Dr. Wales and seconded by Professor Dill to the President for his able and interesting address. Proposed by Dr. Wales seconded by Dr. Dill that the remarks of the President's paper be postponed till that night week.

A long conversation took place regarding the publishing of the President's address and it was agreed that the President be requested to furnish the manuscript for publication in the Dublin Medical Journal.

**Second Meeting Alexander Harkin president
The adjourned first meeting was held in the
Museum upon Thursday December 5th.**

President Dr. Harkin in the chair, Dr. Wales, Professor Dill, McConnell, Esler, Core, J. W. Browne, Lindsay, Workman, Dempsey, Riddell, Whitla.

Drs. Young, Mackenzie and Withers were elected members of the Society.

Dr. J. W. Browne proposed and Dr. Esler seconded the nomination Dr. John Rea.

Dr. Wales opened the discussion upon the milk feeding of infants, and was followed [by] Professor Dill, Dempsey, McConnell, Riddell, Core, Lindsay, Esler, Workman and J. W. Browne.

Paper:¹ DR. WALES (ex-President) said: In opening the consideration of cow's milk feeding for infants, I will not go outside of the immediate question. With you we will, I am sure, mostly concur that milk as ordinary sold requires no dilution; but doubtless there will be differences in our experiences with regard to pure undiluted milk. Speaking for myself, I have frequently found it necessary to dilute milk both with water and lime-water to diminish the tendency to the formation of an indigestible coagulum even in children seven months of age. I certainly would not venture on ordering undiluted milk for a new born infant with my present ideas and experience. The irritation formed by milk coagulum must be familiar to most of us, and the difficulty of combating its consequences must be felt by all of us, as one of the trials of practice. Knowing that the casein of human milk forms light flocculi, while that of cow's milk coagulates in the infant's stomach into hard gelatinous pieces, often utterly indigestible, occasioning

¹ [Dublin Journal of Medical Science, 1879, v67, p252.]

cholera infantum, I cannot think it wrong to reduce the proportion of casein and salts in the latter to at least the proportion existing in the former by the addition of water, and lime-water also if disposed to acidity. But the difficulty as to milk-feeding is, I think, satisfactorily solved by the introduction of Swiss condensed milk (1-9) which I regard as next to a good breast, and superior to the milk of one cow. I think when its value is generally appreciated it will reduce the mortality amongst bottle-fed infants immensely.

PROFESSOR DILL said that the President, in his opening address, had acknowledged the fact that cow's milk is stronger than that of the human female; and he would therefore dilute it with a little water, at the same time adding a small quantity of sugar, in which it is deficient. He was disposed to say that where the mother fails in nursing her own child we should fall back upon a wet nurse. In cases where bottle-feeding is adopted there is more than quality to be considered—there is quantity. Some members of the profession had taken in hand to weigh a child before and after taking the breast milk, and found that from three to four ounces were taken at a time, amounting in all to about two pounds a day. Another important matter to be attended to is the temperature of the milk; it should have a mean temperature of 95° Fahrenheit. He considered this point quite as important as either quantity or quality, and thought that much injury arose from want of attention to it. He thought that if we could get over our prejudices, ass's milk would probably be the best as it comes nearer the mother's, but as society is constituted, we need not go beyond the cow's milk; but with all the care and attention which can be bestowed, it is a poor substitute for the soothing influence of a mother's lap and a mother's bosom; and no man of any experience could recommend bottle-feeding as compared with the breast. In consulting physiological chemists we find that the mother's milk varies much from first to last, becoming stronger as the child grows older, and is adapted to the child's strength up to that period when the child should be weaned. We should take a leaf from nature's book, and diminish dilution as the child advances. He would not dilute with barley-water, as some advocated, but use simply pure water. The cow's milk requires also a little alkali—depending on the state of the bowels—if loose, chalk or lime-water; if constipated, a little magnesia, and he considers Murray's solution of magnesia the best form.

DR. DEMPSEY said: Mr. President,—For the reasons which Dr. Wales has stated, with reference to the differences between the curd of woman's milk and cow's milk, I believe with him that cow's milk should be given diluted to infants in the early months of life; and it is for this reason that cow's milk is mixed with water when given to infants, and not merely because it is richer in solid constituents than woman's milk. I am in the habit of recommending the milk to be given diluted

with one-third of water, and with the addition of a little sugar. Pavy recommends sugar of milk instead of ordinary sugar. He gives one ounce sugar of milk to three-quarters of a pint of milk, diluted with water in the proportion I have mentioned. I believe many of the cases of dyspepsia and marasmus seen in infants brought up by bottle-feeding to be due more to the carelessness of those who attend them than to the fact of diluting the milk. It is the usual practice of nurses to prepare a bottleful of milk for an infant's meal. Of course, one-half of this is not taken, and what is left is either kept warm or re-heated for the next meal, or probably mixed with fresh milk and re-heated a few times more. This system of re-heating sours and curdles the milk by converting the lactine into lactic acid. Sour milk is neither nutritious nor will it remain on the infant's stomach. Another cause of sickness and wasting in infants is the too early administration of farinaceous foods. Mothers believe that because older children thrive well on them, that, consequently, they cannot be given too soon in life; but young infants, having no salivary secretion, cannot digest starchy food. If any food other than milk food is suitable for early infancy—the only one I can see to be chemically so is on prepared by Liebig. It is made by mixing wheaten flour, barley flour, a few grains bicarbonate of potash, water, and cow's milk, in stated proportions. This is made first by warming it and then boiling. The ferment in the malt, under warmth, converts the starch of both flours into dextrine and grape sugar, the latter of which gives the food a sweet taste. The bicarbonate of potash neutralises the acid reaction of the two kinds of flour and raises the alkalinity of the food to that of woman's milk. This food closely approaches woman's milk in chemical composition. With reference to the condensed milk which Dr. Wales recommends, it is quoted by Pavy that though a child fed on it appears to thrive well, and becomes plump and fat, this appearance is delusive, because under any exhausting disease, such as diarrhœa, it rapidly sinks. I think with care on the part of the nurses in having the bottles thoroughly clean and fresh, and in giving the milk in proper quantities, and at proper times, the mortality of bottle-fed children would be materially reduced. M. Guillot, the authority Dr. Dill referred to, from experiments conducted at the Foundling Hospital, Paris, calculated that a child under one month draws from the mother's breast from two to five ounces of milk at a time, and that two and a quarter pounds of milk is the smallest quantity that will suffice for the nourishment of a healthy child under one month old. I agree with the President that if the milk first taken from the cow be used, it may be given pure, but it contains very little cream, and is not so nutritious—the fatty matter rising in the gland of the cow, as it does out of it—the last of the milking being therefore the richest. For many reasons, when from some unavoidable cause the mother's milk is not available or

suitable, personally, I would prefer, from my experience, hand-feeding, if carried out judiciously and carefully, to wet-nursing. There are so many influences at work—social as well as physiological—when a wet nurse is taken into a family, tending to derange the quality of her milk, and over which there can be little control, that I believe careful hand-feeding, judiciously attended to, is a more satisfactory and preferable way of rearing children.

DR. J. WALTON BROWNE had seen very satisfactory results on bottle-feeding with cow's milk—one-third water and a little sugar of milk added, up to nine months of age. He knew where barley-water was used, mixed with the milk, with the best results. With regard to the temperature of the milk, an American writer advocated giving the milk quite cold, which prevented dyspepsia.

DR. RIDDELL agreed with the President, and would go in for milk, pure and simple. Having practised in a country for three years, where for nine months out of the twelve cow's milk could not be procured, he had seen children fed on Swiss milk, and found that the mortality was much greater than on cow's milk. He considered that the less sugar was added to the milk the better. The cow-keeper was in the habit of giving salines to increase the quantity of milk a cow would give, and this rendered it dilute. One corrective to colicky pains is to provide the child with some additional fat which is destroyed in heating the body. Half a teaspoonful of cod-liver oil, night and morning, makes a child thrive well. His own practice is to give milk in its purity, without warming. He considered wet nurses an abomination, and he very much preferred the bottle. He believed there would be fewer cases of rickets, and fewer little graves, if we confined ourselves to milk as it comes from the cow.

DR. M'CONNELL did not consider bottle-feeding and hand-feeding were at all synonymous. His experience at the union workhouse is that the bottles do not answer, as the nurses left the empty bottles and sour tubes for the child to suck, and he has therefore done away with bottles altogether. The plan he now adopts is to give an orphan child to one nurse's exclusive care, and he has increased the allowance of milk from a pint to a pint and a half, with one ounce flour and eight ounces bread, daily. There should be no fixed rule with regard to quantity, and he deals with each case on its merits, if it is at all peculiar; and with regard to quality there can be no rule, as the milk varies so much at different times and seasons. After the child is six months old he adds no water. The improvement in this system of spoon-feeding, without the use of bottles, has been very marked in the improvement of the children. He had observed that at the time of year when cows were getting large quantities of malt-grains the milk was rendered quite unfit for use, and that the same thing occurred where cows were fed on land which had been

flooded—the milk turned quickly acid and stringy.

DR. CORE remarked that the question for the consideration of the meeting was not whether cow's milk was sufficiently diluted already before it reached the consumer, and therefore should not be further diluted, but whether pure cow's milk required any dilution to make it a suitable aliment for an infant from birth. He quite agreed with a remark made by Dr. Riddell, that a great evil arose from attempts to improve the work of the Creator; but as cow's milk was not the sustenance intended for an infant, he failed to see why the acceptance of that principle should prevent us, when the natural food was not available, making such changes in the cow's milk as would make it approach more nearly in character to the human milk. The fact that not only is the casein in cow's in a larger quantity than in human milk, but that the coagula formed by the former are large, hard, and indigestible, compared with those of the latter, seems to point unmistakably to the necessity for dilution. The amount of this must vary not only with the quality of the milk, but with the age of the infant—the changes known to take place in mother's milk pointing out in this latter respect a line of practice which could not possibly be followed if pure milk were given from the first.

He thought it very difficult, if not almost impossible, in a large town like Belfast, to get milk suitable for an infant, considering the ill-ventilated byres in which so many cows are kept, and the feeding which they get; he therefore agreed with Dr. Wales as to the superior excellence of Swiss condensed milk. He had used it with admirable results. It had one special advantage in that it was not liable to the acid changes which so commonly take place in cow's milk. Dr. Dempsey had quoted a remark of Dr. Pavy, to the effect that children fed on Swiss milk, though thriving well for a time, were liable to succumb to the first attack of serious disease. Now he (Dr. Core) had seen such children come well through serious disease.

One case he remembered, especially from its apparent hopelessness at first, of an infant born prematurely, with whom nothing agreed—it was, in fact, dying. It was tried with Swiss milk, immediately began to thrive, and (though never robust) continued to do so. It afterwards came well through several attacks of exhausting disease. As to wet-nursing, he agreed with Dr. Dempsey in disliking it. The social and moral questions involved, the injustice done in most cases to the nurse's own infant, and the exceeding trouble that, as a rule, wet-nurses gave in a house, made him much prefer bottle-feeding, either with good cow's milk or with Swiss milk. He mentioned, incidentally, that he had seen a child fed on Nestle's milk-food in whom slight rickety symptoms had afterwards occurred, and asked whether any other member had any similar experience.

DR. LINDSAY believed that cases of marasmus occurred simply from the way in which the cattle were often fed,

and considered it the duty of the medical attendant to see to it, in cases where children are bottle-fed, that the milk is pure.

DR. WORKMAN referred to some continental statistics, which proved that in the foundling hospitals the mortality was much greater where children were fed on the bottle than by wet nurses.

DR. ESLER said: Mr. President,—In a manufacturing community like Belfast, where so many thousands of the population are mill-workers, and many of these mill-workers mothers who must leave their children to be nursed by hand, it is alike important to the State—which puts a high value upon infantile life—and to the medical man, who, perhaps, puts upon it a higher estimate, that correct opinions should prevail, and, at the same time, be disseminated on this subject—of laying the foundation of a strong physical development for the next generation of men. In speaking on “the milk-feeding of infants,” I wish to refer first to one or two points in connexion with the natural food—the mother’s milk. A common practice prevails—and prevails extensively amongst the older nurses—that for a few days after birth the infant must be fed in order to keep it alive until the milk comes to the mother’s breast, hence, toast and water, milk and water, or sugar and water is thrust down the infant’s throat ad libitum; and in order to assist young humanity to get rid of this unnatural food, copious doses of castor-oil are administered at uncertain intervals. All this I hold to be wrong. I was very much struck with the practice of the native aboriginal tribes of Victoria, on several occasions, when I had ample opportunity of studying their habits. The pregnant female takes ill, the tribe halt on the march, the child is born, and, almost immediately, put to the breast; by the end of a day the mother, with her young infant swathed in a kangaroo’s skin, is ready to rejoin the tribe. Following the teachings of Nature, I have been insisting on all my patients adopting the same plan—as far as the child is concerned—putting it to the breast at once, preventing the nurse giving it either food or oil. The advantages are double—the child has learned to suck by the time the flow of milk comes to the mammæ, the breast-milk acts as a natural purgative, there is no flatulence, colic, or purging, and the mother is, in almost every case, saved from that stage known as milk-fever. It is sometimes impossible, and in other cases not advisable that the mother should feed her infant. Where such a calamity occurs, the question the medical man has to decide is, whether the infant should have a wet nurse or be fed by the bottle. The selection of a wet nurse in most instances simply means a change of position for the two infants—the mother’s own child is put upon the bottle, and the foster child on her breast. I have no hesitation in expressing my opinion that for the preservation of the life of a valuable child, I would certainly select a wet nurse; but the subject we have to deal with principally in this discussion is that of bottle

feeding by means of cow’s milk or other artificial food. Those of our number who are connected with children’s hospitals have ample opportunity of investigating this matter, and I think they will all agree with me in this statement—that multitudes of our infantile population are starved to death by over-feeding. I cannot better explain what I mean by this seemingly contradictory statement than by instancing a case which came before me only yesterday. One of that possibly (?) useful class of women who may be called baby-farmers, or nursing-mothers, brought a male child, aged four months, to hospital, with this history:—The child had been attended to by another woman until a month ago, when it was put in her charge; it was then rosy and healthy; she understood that it had got a quart of milk in the twenty-four hours. In order possibly to economise, her instructions were to give it a pint of milk daily, with plenty of arrowroot biscuits and sop. The child got diarrhœa, was wasting rapidly, and death stared us in the face. My instructions to the nurse were, to just continue her line of feeding if she wished to see the child in its grave at no distant date; but that if its life was desired she must discontinue all feeding on solids, put the child on a quart of pure milk daily, with just enough boiling water added to make it milk-warm.

There can be no doubt, I think, from all one sees in practice, apart from chemical explanations, that starch as a food is not suited to children before they get their teeth. Cow’s milk, and, if possible, milk from the same cow, with one-third water added to the average of the whole milking, with a little sugar of milk to make up for the natural deficiency in that ingredient, will be found in most oases to give satisfactory results for the first six months of infantile life.

Due attention must be paid to the state of the bottle and tubes. Where vomiting occurs it is generally the result of over-distension of the stomach. A diminution in the quantity given will rectify this, and in cases of acidity an alkali, such as the saccharated solution of lime, or, if indicated, magnesia may be prescribed and added to the milk.

Cases present themselves occasionally where, notwithstanding all care and attention, the child does not thrive on cow’s milk. I have seen nearly all the artificial substitutes for cow’s milk tried with varying success; but the most marked cases of benefit have resulted, in my experience, from prescribing Nestle’s milk food as an addition to the ordinary milk in those obscure cases of wasting which do not come under any distinct heading, and which gives the doctor so much trouble and the parents so much anxiety.

Where you have a good constitution to work upon, bottle-feeding on cow’s milk gives very general satisfaction; but where there is a delicate organism, or unfavourable surroundings, as in the crowded wards of the union workhouse, the best, apparent care and attention is not sufficient to keep a bottle-fed child in

life, especially in cold weather, where the natural heat of the mother's breast and bed are exchanged for the cold cot, and not very warm affection of the attendant nurse.

Our duty as advisers of the public weal, in this matter I hold to be, to acquire right principles for our guidance, and, when opportunity offers, to disseminate these principles among those who can carry them into practice, so that at the same time the nurse may be instructed, the child's life saved, and our wisdom and reputation as preservers of human life placed in such a position, in connexion with the feeding of infants, that we may be recognised to be—what, indeed, medical men as a profession in a most eminent degree are—benefactors to our race.

Upon the motion of the Honorary Secretary the debate was adjourned for a fortnight.

Alexander Harkin, President

Third Meeting held in Hospital December 17th 1878

Present, Dr. Harkin, John Moore, Dempsey, Core, Fagan, Clarke, Wadsworth, Riddell, Workman, Esler, Whitla, Professor Dill.

Dr. John Rea was unanimously elected a member of the Society.

Dr. Whitla opened the discussion upon the milk feeding of infants. Dr. John Moore followed and Dr. Fagan. The President replied.

Paper:¹ DR. WHITLA said: Mr. President and Gentlemen,—My name appears upon the paper this evening as re-opening this discussion, but the announcement is merely a formal one, as it would be unpardonable for me to detain the Society with remarks upon a subject which is simply a matter of experience. In listening to the remarks at last meeting I was struck with their apparent diversity, and I believe this arises simply from the angle at which each one looks at the matter, not from any real difference of opinion.

All are agreed that a healthy mother's milk as food for her offspring cannot be improved upon—all, I believe, will agree that leaving out the moral objections to wet-nursing, and the objections of expense and expediency, that it is the best substitute, and it is only in cases where these two supplies fail us that we have now to consider the best course to pursue. For obvious reasons the milk of the cow is the pabulum nearly universally selected, and the question of dilution of this fluid is one which it is an utter impossibility to settle by any fixed rule. Our President strongly objects to the addition of water on the ground mainly that it has got enough already before it reaches the nursery, and I have no doubt that generally he is correct. My own limited experience in the Children's Hospital has thoroughly satisfied me that children are starved to death

upon milk and water in Belfast. If the question is put to me—would I give milk from the cow to a young infant, I would answer that this would entirely depend upon the feeding of the animal.

Not long since I ordered the pure milk of a fine cow brought from the country by a gentleman in Belfast very anxious to procure pure nourishment for his infant which was four weeks old. The result was near being disastrous, the motions became as firm as cheese, and the child began to sink from starvation of a worse kind than that so eloquently painted by our President. I was then forced to do what should have been my first duty—to inquire and see the cow's food, which I found was the best meal and potatoes, and also to have her daily produce measured, which was only nine quarts. The same cow had a week previously given nearly twenty quarts when fed upon boiled turnips.

This, gentlemen, is no exceptional case—it is the rule, and this fluctuation is what physiology would lead us to expect. Some affirm that though the quantity of milk produced by a cow changes wonderfully on altering her rations, still, they say, the quality remains steady. This I do not at all believe, as I have myself in the country and within the last month in Belfast proved. It is, however, a fact that the character of the milk will also depend upon the cow to an extent totally independent of feeding; and I do not profess to be a cow-fancier, but there is to my mind no cow like a thorough-bred Devonshire for raising strong and vigorous infants. Dr. McConnell stated his experience in the Union, which is of great value, and I believe his position about this question of dilution is the only truly safe one—that is, “to adopt no rule, but judge solely by the quality of the milk when you do not know the food which the animal consumes,” and dilute or not as the case requires.

I believe the practice of diluting the weak milk of cows forced by soft and watery foods, as is the rule in Belfast, has led to many fatal results; and we owe to our President a great debt for bringing the matter so ably and prominently before the Society. One word about the temperature of the milk. This I believe to be of the same importance as the temperature of the air breathed by the infant. Provision is made for variations of nearly 100°, and I think it is a matter of no practical moment whether it be 50° or 100° with a healthy child.

In conclusion, allow me to refer to a class of cases where cow's milk—no matter how pure or well selected—fails to nourish, and we are driven to a further extremity. Every one has met such. It is in these cases that attempts to utilise the teachings of the science of chemistry have resulted, I believe, always in increasing the number of pages in the Registrar-General's Returns; and if there be an example of the truth of Pope's line, “A little learning is a dangerous thing,” surely it is in the feeding of infants upon purely chemical principles.

What are we to do in such a case? My practice has

¹ [Dublin Journal of Medical Science, 1879, v67, p340.]

always been, where I could prevail upon the hearty co-operation of the parent, to resort to beef. Good cow's muscle, under-cooked, sucked to rags by the infant, never fails to sustain life where life is possible, and within these last two years I recommend it to all children. At present I am trying a modification of this practice suggested by Dr. Beck, senior. He recommends strong beef-tea, half a pint, one well-beaten-up egg, and half a pint of milk. As far as I can see it is an invaluable plan where cow's milk fails.

Dr. Core has asked for some information about Nestle's food. It is the only artificial food of which I have any experience, and I have seen splendid results from it. The great objection to its use is its expense. I have seen a strong infant eat twelve shillings worth per week, and this puts it beyond the reach of the poor.

One speaker referred to the infant mortality from a national point of view, and I feel I would not be fulfilling my duty as a physician, and as an humble unit in this vast empire, without seizing this opportunity of stating that the wholesale slaughter-houses in our midst should be under Government supervision. I refer to the system of nursing the children of mill-workers, and the nursing out of illegitimate infants. The Government has started a cumbrous and expensive machinery for watching the exact number of minutes per week each able-bodied operative will be allowed to work, lest the race should deteriorate, while the infants of these men are half-starved, and dwarfed to a degree which hardly anyone could believe without visiting the extern wards of the children's hospitals. And I often feel, while looking at their pinched and weird faces, that their cry for Government protection should be heard before that of lunatics, monomaniacs, and others.

Dr. JOHN MOORE said he should like to know the exact amount of milk considered necessary for an infant. He detailed a case showing the remarkable change which supervened upon the admission into gaol of a woman and her child, after she had given it her undivided attention. He long held that the State should interfere, and agreed with the Secretary that the question was a momentous one. He detailed another case where the child was buried alive, discovered, and taken to prison with the mother, and afterwards left there—as fine a specimen of humanity as he had ever seen. He advocated that women in the last months of pregnancy, and nursing mothers, should be excluded from public work; and he argued that it would be cheaper for the State to support both. He also thought that the food of the cow was of vital importance in the rearing of infants upon the bottle.

DR. HARKIN.—Gentlemen, the discussion evoked by the nature of my Introductory Address has been the source of much satisfaction to me, having called forth an amount of practical statements and observations of a most valuable character, based, as they were, upon the personal experience of the individual speakers.

I cannot regret that the debate should have taken a wider range than I anticipated, or that it should have assumed the form of a general disquisition upon infantile nutrition and the varied aliments and modes of feeding practised and recommended in this country; for, incidentally, much information has been elicited, and further proof has been given, if any were required, that the medical men whom I have the honour of addressing are not obnoxious to the charge of being merely the slaves of routine, then a subject of such vital importance is before them. My friend, Dr. Wales, who initiated the debate, among other sound remarks, stated as his opinion “that milk, as ordinarily sold, requires no dilution; but that he would not venture on ordering undiluted milk to a new-born baby.” In both these propositions he and I agree, for I should not think of recommending milk alone until at least two weeks had passed over, and until the integrity of the infant's digestive organs had been fully established. He says, further, “I cannot think it wrong to reduce the proportion of casein and salts in the cow's milk to those existing in human milk, by the addition of water, and of lime-water also, if disposed to acidity, with the object of preventing the formation of coagula, which often give rise to cholera infantum.” While, however, I accept his endorsement of my proposal, I cannot do so for the reasons assigned by him, as I have had, too often, sad experience of the persistence of infantile diarrhoea, until every, even the smallest, portion of milk was eliminated from the dietary of the suffering child. In this statement the high authority of the late Dr. Graves will sustain me; for in his “Clinical Medicine,” edited by Neligan, Vol. II., page 583, he says:—“It is incredible how small a proportion of milk, even in the most diluted state, will keep up this disease, acting like a species of poison on the intestinal mucous surface. You know that animal poisons, such as the variolous or vaccine virus, will affect the system, even when applied in a state of extreme dilution, and you can, therefore, conceive that a small portion of milk will operate in this manner.” I wish, however, to corroborate, to the fullest extent, all the commendation which Dr. Wales has given to the use of the condensed Swiss milk. I have had, in many instances, the greatest satisfaction from its use. In one remarkable case, wherein the breast milk of as many as seven hired nurses disagreed, and where the child's digestive organs were quite intolerant of cow's milk, from the first dose of the Swiss milk all trouble ceased—the child slept calmly, content spread over its features, the alvine discharges, previously most offensive, became natural—a change which I attributed to the elimination of the casein from the condensed milk, during the process of preparation. I saw this infant some two years after, and she had grown into a healthy, well-proportioned child, and had just passed unharmed through a severe attack of measles. So much for Dr. Pavy's theory. Professor Dill, in a statement replete

with information, among other matters, stated that he would dilute the milk with a little water, and that as the mother's milk grows stronger as the child grows older, he would, following the example of nature, decrease the ratio of dilution as the child advances. He gives the preference to asses' milk. We must remember, however, that, according to Playfair, asses' milk, although containing as much sugar as cows' milk, is too poor in casein and butter for the feeding of infants. Dr. Dill announces his strong preference for wet-nursing in contradistinction to bottle-feeding, and in this sentiment I quite concur.

Dr. Dempsey would dilute with one-third of water, with the addition of a little sugar of milk, and gives very judicious advice as to the care required in bottle-feeding. He attributes the dyspepsia and marasmus of hand-fed children more to the carelessness of those who feed them than to the dilution of the milk itself. I cannot assent to this theory; and Ancell on Tuberculosis, in a chapter on Diet, page 703, is also of a different opinion. He says, referring to children:—"I am practically convinced that habitual excessive dilution is very injurious in tubercular habits. I believe it assists to diminish the vitality of the blood and the number of the red corpuscles, to render the blastema and liquor sanguinis, less nutritive, and to deteriorate the cells and weaken the fibres." He gives also the case of an infant, three months old, in a very advanced stage of marasmus, which completely recovered on goat's milk. "It had nothing but the breast of one and the same goat for five months, and is now a perfectly healthy child." Thus we find that excessive dilution on one hand deteriorates the blood, and that pure unmixed milk is the remedy for marasmus. Dr. Dempsey condemns very strongly the too early administration of farinaceous food, but says that if any other than milk food is suitable for early infancy, the only one he can recommend is that prepared by Liebig. We must not forget, however, that, although Dr. Playfair joins in the recommendation, its use has been condemned by the Academy of Medicine in Paris, after being discussed at several sittings. We cannot, therefore, acquiesce in its suitability until the difference of opinion which exists be settled by an independent examination, by some medical tribunal in this country. Dr. Walton Browne would dilute with barley water one-third, up to the ninth month. Dr. Riddell's experience quite agreed with that of the President. Dr. Lindsay very properly insists that, when children are bottle-fed, the medical man should see that the milk be pure, and given by cattle themselves healthy; and Ancell, page 701, appears of the same opinion. He says:—"I have seen an infant deprived of its mother's milk, because she was of a tuberculous habit, and fed upon the milk of a cow which died of consumption. The child died of tubercles in almost all of the internal organs. The frequency of this disease in cows is a notorious fact. Dr. Workman showed by statistics that the mortality in

foundling Continental hospitals is greater in bottle-fed than in nurse-fed infants. Dr. Core believed that a great evil arose from people trying to improve on the proportion of nutriment given by the Creator. He strongly disapproved of wet-nursing of children. Milk, as sold in Belfast, did not require any further dilution. Dr. Esler disapproved of a practice common among the older nurses of feeding the infant before putting it to the breast, and instanced the case of the aboriginal tribes of Victoria, where the infant is put at once to the mother's breast after the birth is completed. He believed that multitudes of our infant population are starved to death by over-feeding. He would recommend the addition of one-third water till the sixth month of infantile life. He approved of Nestle's food. It is, no doubt, true that, in many instances, children are over-fed before the free secretion of milk appears; but the opposite evil is, in my experience, of more frequent occurrence. Mothers and nurses imagine that the turgescence of the breasts is a proof of the presence of milk, and many an unfortunate baby is compelled to tug and strain at a breast quite innocent of lacteal secretion. The infant starving, sometimes to the very verge of inanition, and often only saved by (I speak of my own experience) the free administration of wine-whey and milk. I do not consider the case of the Indian woman who, as a rule, is able to suckle her child for three or four years, at all analogous to that of the European mother, subject to all the depressing influences of modern civilisation. Dr. Whitla, in a well-reasoned article, among other remarks, states that his experience in the Children's Hospital has thoroughly satisfied him that children are starved to death upon milk and water in Belfast; and if he were asked the question would he give the milk from the cow to a young infant, he would answer—this would entirely depend on the feeding of the animal; and he gives a typical case in which the pure milk of a cow disagreed with a baby, the animal having been fed upon stimulating farinaceous food—food fitted only, in my mind, for a human being, the animal being denied the natural food of a gramivorous creature. I can, however, point to a child, now six months old, fed entirely, for many months past, on the milk of a Kerry cow, whose sole food is to be found in the grass of the field, and no better example of a rosy, thriving child could be found; and besides to many others in town and country, who have not had any other nourishment but the undiluted milk direct from the cow—the nature of the food, as the Doctor suggests, making all the difference possible in the nature and composition of the milk. McConnell diluted, but in regulated proportion to the individual case, not on any preconceived idea, healthy and unhealthy children requiring special provisions. He could not tell the proportion of water in the milk supplied to the workhouse, as he did not believe in the existence of any infallible test, and was guided chiefly by its taste and appearance. It is, however, a matter of

vital importance to look after the composition of the milk delivered to workhouses, as it enters into the diet of children, and old persons, too, in workhouses as a most important element. Mr. Wanklyn found that of fifty-seven samples of workhouse milk only three were up to the terms of the contract. Most of them had been deprived of a large portion of the cream and diluted with water to a serious extent. (See *British Medical Journal* January 27, 1872.) Dr. John Moore, from his experience, placed great dependence upon the undivided attention of the mother, and thought the Legislature should interfere to prevent the too speedy return of a young mother to work in a factory. The President agreed in both statements, and instanced the case of the town of Coventry, where it was feared that in consequence of the mills being closed in which the women worked at ribbon-making, caused by a change in fashion some years since, infant mortality would increase. It was found, on the contrary, that it had a marked decrease, proving that the maternal care given by mothers at home, through necessity, more than compensated for the better fare provided when the mothers were in employment and earning high wages. Dr. Fagan's experience coincided with that of Dr. Esler, and believed judicious starving useful in many cases. The President was of opinion that the children of the poor were not alone injudiciously, but also often overfed—even in their infancy partaking of the farinaceous and animal diet provided for their parents. The children of the well-to-do suffered from the opposite error, that of having to live upon milk diluted and barren of every nutritious material—the child, in many instances, seldom tasting milk except in tea or some other potation.

George F. Wales

Fourth Meeting January 7th 1879

Present, Dr. Wales Ex-President in the chair, Dr. Riddell, Esler, Core, Workman, Anderson, Wadsworth, Whitla, and many students.

Dr. Riddell read a paper upon "Croton Chloral and Amyl Nitrite with notes of several cases treated by these remedies".

Paper:¹ MR. PRESIDENT AND GENTLEMEN,—I thought it desirable to bring before the notice of this Society a few facts and experiences coming under my own notice concerning the medicinal properties of the so-called "Croton Chloral" and "Nitrite of Amyl." The literature of these drugs is not very extensive, but still sufficiently so to enable one to fill up the space of a long paper with notes and cases already reported. I have chosen another course, and prefer being brief and merely relating cases which have been under my own care, and which I have watched attentively. Neither can I enter into any dis-

cussion concerning their chemistry, nor concerning the physiological reasons of their peculiar actions on the diseased frame. I emphasise the word "diseased" for the reason that, as far as I have noticed, their actions in health and disease are quite different.

My first experience of croton chloral, as it is wrongly called, was in the person of a near relative, who for years had suffered from severe attacks of headache—so severe that at the times of attack she was quite prostrated. The constant description she gave to the medical men she consulted was that of feeling as if an iron band were round her head and crushing it. These attacks were recognised by all as neuralgic in origin, and for years it was attacked by all the "great guns" of the Pharmacopœia until its resources were exhausted—the bromides were tried up to so-called "heroic" doses; chloride of ammonium, iron, arsenic, hydrobromic acid, sedatives and stimulants; quinine, in small or large doses, only made it worse—all of no effect for good. I was reading some remarks in *The Practitioner* concerning croton chloral, and it seemed to me that it might do good in this case. I suggested it to her, and she consented to take it, but with no idea or hope of any relief, for she had suffered from these attacks for more than twelve years. I began with 5-grain doses twice daily and 10 grains going to bed, dissolved in spirits of wine and glycerine, with a little acid and syrup of orange to cover the flavour. The good effect of the drug was seen at once; the attacks came at longer intervals, and were less severe, then ceased altogether; and now for upwards of seven months she has had only two attacks—one at a time of great mental distress, and one when she stopped taking the drug, about two months since, when she resumed taking it, and has not had an attack since. She now takes 5 grains per diem (generally at night), is hearty and well, and has a good appetite. Her age, I may say, is sixty-three. The 5-grain doses only caused a slight drowsiness, but the 10 grains at night, by relieving all pain, gave her a good night's rest—in fact, she now enjoys better health than she has done for years.

Since that time I have used it largely—sometimes failing, sometimes relieving—till, by keeping an account of all my cases, it began to dawn on me which were benefited by the drug. Since then the number of cases relieved (some permanently) has increased. These cases are—headache in females arising from mental distress; those cases of headache so frequent at the menopause—in fact, all those called neuralgic, except a few arising from internal mischief, are benefited, and, in many instances, cured. In that distressing species of neuralgia called *tic-douloureux* I have found it in many cases acting like a charm. Of course I do not include any arising from cranial or intercranial causes.

I have tried it in neuralgia of the ovaries, but no good resulted. In insomnia it is not so reliable as the hydrate, but in some cases where the loss of, or inability to, sleep

¹ [*Dublin Journal of Medical Science*, 1879, v67, p346.]

is accompanied by a weak or fatty heart, it is to be preferred, as it has no weakening effect on the central organ of the circulation. In one case of delirium tremens, where the circulation was very feeble, the combination of croton chloral with digitalis had a wonderful effect, and it seemed as if the drugs could be given together in much smaller doses, to produce the same results, than singly. In this I pushed it from 10 to 30 grains every three hours, with drachm and 2-drachm doses of the infusion of digitalis. In pain arising from caries of teeth I have found it useless in most cases, and in all inferior to Richardson's "tr. gelsemini" but in one case of a nervous young lady, by giving her two 10-grain doses I was able to extract a tooth next to painlessly, to her great satisfaction. You will notice in all these cases it is in affections of those parts supplied by the fifth pair of nerves that it is of most use; but, to be of service, you must give the drug in far larger doses than prescribed in the Pharmacopœia—for adults, 5 grains three or four times daily, gradually increasing if required; if stimulants are wanted, dissolve it in rectified spirit; if not, dissolve it in glycerine. In all cases complicated with hæmorrhoids, give glycerine. If anæmia exists, combine it with iron, or, which I believe better, arsenic; then gradually lessen the chloral. In all cases I have found it better to give it in solution than in powder or pill.

Since last meeting, when it was intended that I should have read these notes, some cases of great interest have come under my notice, in conjunction with my observation on the fact that croton chloral exerts most influence on painful affections of the superficial nerves of the face and its adjuncts. On the 18th December I was consulted by J. A., aged twenty, a striker in a smithy, for "something in his eye." I made careful examination, and could find nothing, although there was intense photophobia—tears streaming through the "clenched" eyelids. I dropped in atropia and counter-irritated his temples, which I have often seen doing good, but to no purpose. Another examination discovered a minute abrasion of the conjunctiva. I dropped in oil and atropia again, rubbing the extract of belladonna over the eyebrows; no effect. It struck me to try the chloral, seeing its power over these nerves, and it was most wonderful. I gave him 10 grains at once, and repeated that dose in an hour, when considerable relief was experienced. I repeated the 10 grains in two hours more and the pain was entirely gone, though for precaution's sake I gave him 5 grains every three hours for a day or two.

J. F., brush-maker, consulted me on the 21st for facial carbuncle. You all know the terrible pain suffered in that disease. To control that pain and give sleep I gave opium, Indian hemp, and the hydrate of chloral. Opium gave relief at first, then failed on account of stomach derangement. The other two were useless, or nearly so. Following out the same line of thought as in the former case, I gave the croton in 10-grain doses.

The effect was simply marvellous. Giving 10 grains every three hours, the disease went through its different stages, and very seldom would the patient have known of anything the matter from the sense of feeling.

The last case was a lady who has been under my care a long time, and who for months suffered from neuralgia, coming on at 12 o'clock, noon. In fact, she said (a little bow-stretching, you will say) "I can set my watch by the attack." Considering the periodicity, I gave arsenic, nux vomica, iron, and a whole array of tonics. I then (since last meeting) gave the chloral; and after two days she has had only one attack, and that a mild one.

I do not vaunt croton chloral as a specific—I do not believe in the term except in one instance—I do not compare it with, or fight its battle against, any other drug—no physician should have a "favourite" drug or prescription—but in my hands it has been useful in relieving pain, and I use it as I would any other instrument for good.

I have only one or two facts concerning nitrite of amyl to bring before you. The first case is that of a young married lady with menorrhagia, who, at the times of the catamenia, suffered from terrible headaches—always relieved, however, by hot spirits and water. She herself and her friends were desirous of some other remedial means than spirits. I came to the conclusion that the pain was anæmic in origin; and the nitrite of amyl possessing the dual power of increasing the heart's action and dilating the intercranial vessels, I thought it would do good; so I mixed the amyl with equal parts of eau-de-Cologne, and ordered her to use 5 or 6 drops of the mixture dropped on a handkerchief and inhaled by deep inhalations. It succeeded perfectly, and ever since she has never been without that combination—all other remedies used to put an end to that infliction having failed.

One night I was called out to see a case—a woman aged about fifty-four—"heart disease" the friends called it. When I arrived I saw at once it was a case of asthma. She was in a terrible paroxysm; leaning forward on her elbows, with flushed face and dilating nostrils, she was gasping for breath. I thought of the amyl, and fortunately had some with me. I poured out 5 drops on my hand, rubbing them over the palm, and held my hand to her mouth; when she had inhaled 10 drops she could breathe naturally. A course of arsenic effectually cured her.

J. L., a clog-maker, consulted me the day before Christmas, 1877. He suffered from asthma, and the attacks were so frequent that he was off work more than half time, and the paroxysms were severe. In every case the amyl checked it at once; and now, nearly twelve months having passed, he informed me yesterday that he had only lost one week altogether, and that was through exposure to cold. I may say arsenic was the drug I gave him during the intervals.

I have had abundant opportunities of trying it in

sea-sickness, but only in a few instances it did good. But in that vile sickness one is thankful for small mercies. In one of my voyages one of the passengers had brought some chloroform on board for toothache. I was summoned in haste to her cabin, and found her quite insensible, pulse not perceptible, and evidently dying. Fortunately, though the nitrite was not in the ship's surgery, I had brought some to experiment with. After inhaling a few drops the heart's action was quickened and strengthened. Three or four times we had to repeat the inhalations before she was out of danger. It is so antagonistic to chloroform that I am of the opinion that it should be at hand at every operation in which chloroform is given. I throw out the hint for any of the surgical staff of the hospitals who may be present. In opium-poisoning I have derived no benefit from it—I suppose for the reason that that poison kills by stopping the respiration first. In fainting attacks from weakness of the heart, or brought on by witnessing an operation, or a cut, it is of great service. It has often an equally good effect in spasmodic and cardiac asthma, though its action must be different in the two diseases. In the one it must relieve by lessening the spasm of the air-vessels, in the other by increasing the power of the heart. How it does this I do not know; I am only glad to know that it is a fact.

In conclusion, I have brought before your notice what I believe to be two very valuable medicines, exercising relieving and curative effects on two distressing maladies—neuralgia and asthma, also acting as an antagonist to chloroform. If I can bring out of the more extended experiences of my confrères confirmation of my belief, my object shall have been gained.

DR. CORE said he had not used nitrite of amyl, and would hesitate to employ it while there still existed such grave differences of opinion about its dose and action. Upon the usefulness of croton chloral he would agree with Dr. Riddell if the fifth nerve only was affected.

Dr. ESLER thought with Dr. Core that the croton chloral was most useful and efficacious where the fifth nerve was in question. He had not used the amyl; he knew of so many hair-breadth escapes—and these acted to him as a beacon—he would wait for further light before employing it.

DR. WALES had used croton chloral a good deal; it was a favourite remedy with him in pain-relieving, but he never used it in the doses mentioned by Dr. Riddell. He would not go beyond 15 grains every two hours. He generally gave from 5 to 15 grains every twenty minutes, till three doses were taken, by which time he usually found the suffering diminish rapidly. As for the amyl, he never used it himself. He knew a medical friend who injected 15 minims hypodermically; the patient, however, died, but he did not believe the amyl had been the means; but it was an open question what effect such a large dose would have so quickly introduced into the circulation.

DR. RIDDELL said he mixed the nitrite of amyl with eau-de-Cologne, and allowed it to evaporate upon the palm of the hand while the patient inhaled its vapour. He would recommend that the croton chloral be always tested for starch by iodine, as he often found it so adulterated.

Dr. Whitla exhibited patients and showed microscopic specimens of Trichorexis or the so-called new disease of the hair, illustrating the subject by drawings etc.

Paper:¹ A discussion has been going on for some time in *The Lancet* and other medical journals under the name of "Piedra," and I notice that a lively interest is taken in it in England. Last summer M. Desenne described for the first time a condition of the hair found in the beards of the Columbians, and exhibited specimens before the Academy of Medicine. The diseased or affected hairs were seen to have distinct nodosities at intervals upon their shafts like so many small beads, but which were fixed to the hair, and in some cases only surrounding the shaft partially. The peculiarity of the nodosities, which distinguish them from growths at all approaching them in microscopic or naked-eye characters, is a very remarkable one. They will scratch glass by reason of their stony hardness; and when a bunch of the affected hair is struck against any hard surface a distinct ring is heard. M. Desenne found satisfactory evidence of spores, and concluded that the disease was evidently parasitic. A short account of his paper appeared in *The Lancet* of August 3rd, 1878, under the heading "A New Parasitic Disease of the Hair."

It is not my intention to detain you with any remarks upon this singular and rare disease, which is, as far as I know, peculiar to Columbia, and has only been examined by a fortunate few, who are by no means at one about its pathology. The notice of M. Desenne's paper was the signal for many observers to write—some agreeing, some pointing out differences in their observations; and, upon a careful perusal of the recent literature of the subject, there can be no doubt whatever that the English observers describe a totally different affection which has been for many years recognised in this country by a few. It is of this second condition, called by many names, such as "Trichorexis Nodosa," "Fragilitas Crinium," and "Clastothrix," &c., that the specimens exhibited under the microscope are examples. I noticed it about six years ago, and found its histological characters so beautiful and regular that I have watched for it and examined many such specimens. The first published account of it that I am aware of is from the pen of Erasmus Wilson, in the early edition of his work upon "The Healthy Skin," where, as early as 1849, he described accurately this state of the hair. In 1855, Beigel independently studied the disease,

¹ [Dublin Journal of Medical Science, 1879, v67, p104.]

as he called it, of “bursting of the hair.” In 1857, Dr. Wilks, in his lectures on “Pathological Anatomy,” figured and described the state of the hairs; and later, Tilbury Fox, under the head of “Sycosis,” figured a similar state of matters, plus a graphic drawing of sporules mixed up with the fibres. A few other published references to the subject may be found, but its history and literature are ably and exhaustively recorded in *The Lancet* of December 7th, 1878, by Dr. Thomas Fox, Physician to St. George’s Hospital—who, by the way, quotes Dr. H. S. Purdon as describing an affection which he was not at the time referring to.

Now, as regards the condition or affection, or “disease,” as it has been called, its naked-eye characters vary slightly in differently coloured hairs, and I may say here that it is solely to specimens taken from the hair of the face that my remarks refer. The hairs affected are marked at irregular intervals with white transverse bands, which thus resemble somewhat minute porcupine’s quills. The band is of a pure clear white in the hairs of an amber colour; in the long dry and fine hairs, seen in dark reddish-brown beards, these transverse markings have a dirty white or translucent hue, which often renders them difficult of detection. These bands, or white transverse striæ, have been called nodes by most observers, who describe them as if the swellings of the hair which constitute them were quite perceptible to the naked eye. Such is hardly correct, as in most cases no one could possibly recognise them as swellings till under the microscope—persons with very sharp sight might sometimes.

The hairs breaking off generally at one of these nodes possess thereby another peculiar appearance—their ends seem white and abrupt, just as if they had been burned, and once I was consulted by a gentleman for this state of the hair whose family physician persisted in telling him that his beard was “singd.” There may be only one white mark on a single hair, or there may be twenty. This latter condition is very rare, and the number of nodes seem to depend greatly upon, the coarseness or fineness of the shafts. The strong thick hairs of curly beards and whiskers break off short at these nodal spots, and seldom show more than six upon the stump of the shaft remaining, while the finer sorts of hair, which are straighter, do not give way so readily, and upon one patient’s beard, which I will exhibit to you, you will find hairs eight inches long, with from six to eighteen nodes visible to the naked eye. His case is exceptional, however. As to the situation of these markings on the shaft, I have seen one upon a long hair within one-third of an inch from the follicle, the remaining part quite normal. I have also seen one nearly as close to the free end in a similarly healthy shaft; between these two are all possibly divided conditions. The shaft is frequently bent at the node, the angle formed being always a sharp one—in very curly hairs it may be acute. There is not much bending (sometimes

not any) at the junctions of the nodes in long, straight, fine hairs.

The microscopic characters of the affected hairs are very striking, as you will see by the accompanying diagrams and under the different microscopes upon the table. The fibres of the cortex of the shaft are frayed out in a beautiful manner at the node. The hair seems just ready, as it were, to break into two distinct pieces through the centre of the swellings, as many of the circumferential fibres are entirely separated. The diagram which I draw of the appearance seen under instrument marked No. 1, you will observe, is almost a facsimile of Mr. Wilks’ woodcut in the number of *The Lancet* on the table. The appearance perfectly resembles two blunt camel’s hair pencils placed end to end, and gently pressed against each other so as to cause the hairs at the circumference to bulge out freely. The medulla is seen in No. 2 to be absent entirely, but under the next instrument you will observe a node just in the act of forming. The specimen proves the error of a very eminent observer, who denies that there is any swelling prior to the fraying out of the fibres. Here the diameter of the shaft is unmistakably increased. Only a few small fibres have started out on each side of the node, the soft cells of the pith are much increased in number, and the pigment is scanty. Under another instrument you will see a young node, which, however, is perfectly formed; the small, bright, scale-like particles inside the long frayed-out fibre are, I believe, the pith-cells which have dried up to some extent and are adhering to the inner surfaces of the fibres, possibly showing the reason of the varying quantity of the medulla, as noticed by Dr. Thomas Fox and Kaposi—the drying process probably commencing when the outer fibres burst open. Pigment varies; as a rule you see scarcely any in the outer layers of fibres, and seldom any in the central part, occupied by the medulla, in the node. Air cavities are seen, but only rarely, in the medulla of the shaft at a distance from the break, but sometimes they are found near to it, and, on close examination, you will find this is owing to the consequent drying of the soft cells or the mechanical separation of the harder ones. Some of these hairs are in every other respect normal and perfectly developed, others again are badly formed, stunted, devoid of epithelium, and brittle; at the same time hairs of this latter class are found with all these imperfections, but without any trace of the characteristic nodes. I cannot see any departure from the normal state in the root-sheath. As regards longitudinal splitting, associated with trichorexis nodosa by some observers, I have frequently seen it, but as often in sound hairs as in those affected with the transverse markings. I have never been able to see any evidence of parasitic disease, and the different specimens before the Society are devoid of any resemblance to spores.

The most interesting feature in connexion with this state of the hair is its distribution, and it is to this

point I wish particularly to direct the attention of the Society. I have failed to find it in about half a dozen men whom I have imperfectly examined, and whom I only saw either in a bad light, or rather hurriedly. I am almost certain it is there, but cannot state it is positively. I have failed to find it once when I had every facility and sufficient time, and spared no trouble in searching. If you permit me to make this solitary exception, I say I have seen it in 200 or 300 men whom I have examined, and I believe within certain ages the distribution of these characteristically marked hairs is as universal as the growth of hair itself. The specimens upon the table are each, as you will see, from the office-bearers of the Society, whom I had an opportunity of examining during the last week, beginning with the President. The single exception above referred to was in the case of the Treasurer, who has the most perfectly formed beard to be found, and his case abundantly proves the rule. After a search I came upon a doubtful hair, and placed it under the microscope; it had no characteristic markings, but, what was to me more interesting, a distinct though very small swelling at one portion of the shaft, with two fibres frayed out, as you see in this drawing on the black board, and its owner was convinced that this was the first step in the process of bursting; it was not, however, anything like so evident as the specimen under No. 3. If this be an affected hair, then I have not seen a beard where I have carefully examined and failed. In all doubtful cases the hairs are tested under the microscope. I examined a chemist three times carefully and failed to find a single hair affected, and he was put down as the only exception I had then met with. He had most exuberant growth of beautiful whiskers. I met him a short time ago; he had got his whiskers closely trimmed. He readily consented to re-examination.

The long flowing hairs were not in my way now, and I soon pounced upon two beautiful specimens, one of which is under No. 5; these were the only hairs affected, I believe, upon his entire face. One other case, and we have done with this part of the subject. I sent, some time ago, a few hairs to a celebrated histologist. He examined them, and concluded that the alterations were the result of chemical changes produced by hair-dye. When I next met him I told him I had been finding them in everybody. He seemed much amused, and, when I suggested the possibility of their being in his own beard, he laughed outright. "He had examined it often for other purposes," but upon importuning him I was permitted to look, and found them in thousands. I mention this to show how they may be overlooked unless specially hunted for—the gentleman referred to being the most accurate and gifted observer that it has ever been my good fortune to meet. They will be found studded thinly over the entire beard. This is uncommon. You will often see them in patches as large as a crown. Their most common site is just under the lobule

of the ear. Another very favourite situation is over the region of the depressor anguli oris muscle. They are very seldom found in the much-twisted and incessantly-pulled mustachios of young men. I have only met with them there once or twice. I have seen them in gray-haired men of sixty-six and in boys of twenty. It has never been my lot to find them in the hair of the scalp or on that of any other region of the body.

The rarest class of cases is that where the hairs of the face seem all affected uniformly, and this is the only way in which I can imagine that the matter has been spoken of as being so rare and unusual. Of the last class of patients I have only seen two well-marked cases—one of whom I now show you. He is the owner of an extensive bread-baking concern, and has kindly consented to show himself. You observe the general character of his beard; it is long, straight, red in colour, and surprisingly dry. You feel it and you almost think you are grasping some dry flax, and he tells me he washes himself every morning, beard included, with several lathers of soap, and dries with a coarse towel. He certainly seems to favour the idea that this is a mechanical process operating upon dry hairs. But, upon the other hand, look at these beards round the table shining—some of them even glistening with sebaceous material; they also show the same state of matters to a less extent. Some of these dry hairs are under the last instrument; they in no way, that we can see, differ from those of the chemist's case. I regret to say that I have not yet been able to have an examination of the hairs upon this patient's pubis. A peculiar feature I have noticed in those cases where the affected hairs are found in patches is a sense of burning itchiness, or even smarting, experienced in the patches at times, especially when the face is flushed. This, at one time, led me to think that some irritation might be going on in the hair follicles, and the presence of the entozoon folliculorum suggested itself to me, but I could not satisfy myself that it had any connexion with it, and I have not been able to transplant the animal to the pubic region.

This brings us to the pathology of the subject, and it is possible that we have something still to learn as to the cause of this singular state of the hair. When I first saw it the idea of mechanical twisting being the rationale seemed obvious, and I marked certain hairs close to the affected ones upon my own face, and pulled at them for a few weeks without producing any effect whatever. This, with the fact of their being so rare in the hair upon the lip, satisfied me that torsion had nothing to answer for. One of the specimens upon the table would at first sight lead you to believe that this theory was correct. Here a transverse cleavage has not yet occurred, but the shaft of the hair is bent round like the arch of a bridge; upon the convex surface, where the greatest strain would be, the fibres have sprung out, as if ruptured by the bending. That this is not the beginning of the process, you have only to look at the concave

side, and, though you find no frayed-out fibre-cells, you will see a distinct preliminary bulging, owing to the proliferation of the cells of the medulla. What has occurred is evidently as in No. 3, and if you suppose the specimen there bent at the enlargement you would have this condition precisely repeated, showing that the bending is simply secondary to the swelling and consequent weakening of the shaft at that place.

Beigel states that the breaking is caused by the expansion of air imprisoned in the shaft which, finding no egress, bursts the fibres of the cortex. This could only, however, occur as the result of an explosion, for, suppose one fibre gave way, a chink would be formed and the imprisoned air would escape; and, indeed, I see no reason whatever for supposing air acts in any way inside the cylinder.

I say this without hesitation, though against so distinguished an authority, because the idea presented itself to my own mind long before I had heard of his publication, and I had also discarded it. It has been suggested that altered nutrition, caused by affection of the trophic nerves, as in alopecia areata, would explain this; but it is hardly possible to apply this explanation to cases where only a few isolated hairs are found in a healthy beard. The parasitic theory will not satisfy those who fail to see any evidence whatever of spores; and when you think of the beautiful sieve which the finely reticulating fibres of the cortex make, and consider that this sieve may remain open to every blast of air which blows upon the face, the wonder is that it does not exhibit from time to time quantities of living organisms.

The universal distribution of "trichorexis nodosa" suggests to me that it might, strictly speaking, have no pathology. Can we call a condition which is so general a "disease?" One is led to regard it rather as the result of some physiological action modified or varied perhaps in different individuals. I do not willingly submit another to the many explanations given by writers upon this subject; but the view I would lay before you is one which seems to me the most likely (that is all I can say for it), till some more satisfactory one is presented. It is this—that the outer fibre-cells of the cortex of the shaft of a growing hair, becoming hard and firm as do those of the nails, do not yield to the expansion of the inner quickly-growing soft cells of the medulla, and the result is their gradual separation and the disintegration of the cortex structure.

The specimens exhibited tend to support this. You have unmistakable evidence of a prior enlargement. Abnormal dryness may make these cells more prone to split up; and I found them more abundant in the cleanly, who freely use soap and water, than in those who pay no attention to their personal appearance; but why the cells should split up in a patch upon one side of the face and remain normal on the other, is not easily explained. There is no state of the system which I could

notice that favours their appearance. They do not seem to be at all influenced by the broken-down health consequent upon recovering from typhoid and other fevers or lingering diseases. They will be found in the weak and robust, the young and the old, the vegetarian and the gourmand, the teetotaler and the drunkard.

[The discussion below is not in the minute book.]

Paper:¹ Remarks upon DR. WHITLA'S Specimens of Trichortxis Nodosa, exhibited at last meeting.

Dr. Core had read the discussion, or rather series of letters, in *The Lancet* with interest, and he thought that three different diseases were there referred to—one, the Columbian, then a parasitic, and, thirdly, the one demonstrated by the Hon. Secretary. The subject, he thought, was one of great interest, especially as to its wide distribution. He did not believe the specimens were or could be mistaken for parasitic disease.

Dr. WORKMAN, who had examined very many specimens with Dr. Whitla, could corroborate his statements in every particular. The cause was obscure, but he did not believe in the parasitic theory. Many of the hairs he noticed were split longitudinally, but only at the ends.

Dr. ANDERSON thought that the pathology of the condition was simply a change of nutrition in the root sheath, and he proceeded to support this view by a reference to the growth of the nails, likening the nodes to the white specks seen in these appendages, and to the ridges and irregularities seen in cases of recovery after fevers, &c.

DR. RIDDELL did not see that the subject was one of much interest, or that there was much mystery about it. The hairs seemed broken simply from combing, twisting, and pulling. He had not noticed any hairs like those spoken of in the natives of Australia, and he consequently thought that it must be caused by the use of the comb. He thought that simple bending and brushing might do all that was described—he saw no reason why it should not.

Dr. ESLER thought that Dr. Whitla had clearly demonstrated to him that this was no mere mechanical breakage, and, after examining the specimens upon the table, he thought it impossible to conceive this, nor did he believe it was parasitic.

DR. WALES said the subject was new to him, and he had looked at the microscopic specimens with care and they surprised him. He thought the distribution of the condition a most important point; it proved that it could not be regarded as a disease. He had taken some hairs from the beards of the patients exhibited, and he would examine them with interest.

Dr. WHITLA said he had at first taken every pains to satisfy himself about the mechanical theory. He marked hairs upon the margins of his own face, and found that

¹ [Dublin Journal of Medical Science, 1879, v67, p350.]

twisting, bending, and pulling to an extent far beyond what would be applied ordinarily, produced not the slightest effect. The favourite sites of the affected hairs were not those subjected to friction. He had tried the effects of torsion and bending upon wet hairs, warmed hairs, and very dry ones, without any result. Those who believed in this as the cause always supposed that in order to break, the hairs must be previously diseased—morbidly dry. He was satisfied that three different conditions were described, but was inclined to think that the presence of spores was not the cause in those cases observed in the nodes, for it was clear that the characteristic breaks could be caused independent of them. Several who had written upon the subject—and eminent authorities upon skin affections also—had spoken of seeing one, two, or three cases.

His experience of its almost universal distribution was his apology for bringing the matter before the Society; but he would say, to be always found they must often be most carefully and diligently hunted for in some beards.

Alexander Harkin

Fifth Meeting of the Society was held upon January 21st Tuesday 1879

Present, Dr. Harkin President, Dr. Wales Ex-President, Dr. Browne Vice-President, Dr. John Moore, Dr. Workman, Esler, Clements, Anderson, Dempsey, Mackenzie, Lindsay, D. Johnston, Whitla Honorary Secretary, O'Neill, and Clarke.

Dr. Esler read notes of a case of postpartum hæmorrhage treated by the injection of hot water.

Paper:¹ MR. President,—I bring this subject before the Society—1st, because of its great importance; 2nd, because it is a new method of treating a troublesome complication of labour; and 3rd, because I was amongst the first to try it in this country. The history of its introduction is given in a letter from Dr. Whitwell, of San Francisco, to Dr. Atthill, of Dublin, and is briefly as follows:—

In 1874–5 in the Women's Hospital, State of New York, hot water was injected into the uterus of a patient, from whom a sarcoma had been removed, with good effect. In August, 1875, Dr. Whitwell tried hot water injections in Breslau, and subsequently in Prague, with the best results, always causing quick and firm contraction of the womb.

Dr. Atthill, of Dublin, saw the account of these cases in an American journal; and in *The Lancet* of January 5th, 1878, published his first two cases. I had just read Dr. Atthill's article in the week after publication, when I was sent for to attend Mrs. B., a stout woman of thirty, in her third confinement. Her first child was born two and a-half years before, after which there was extens-

ive flooding. Twelve months after, her second child was born, when I saw her for the first time; there was detained placenta, which had to be removed; flooding supervened, which was treated with cold applications; the loss of blood was so great that recovery was considerably retarded. Her third confinement took place on the 12th January last year; the labour was normal; the pains were regular; but after the expulsion of the child and removal of the placenta, the uterus ceased to contract, the loss of blood was again very great, and was beginning to tell on her pulse; she became faint and blanched.

From her former experience she greatly feared the shock from the application of cold. I immediately procured a Higginson's syringe, passed the vaginal tube well into the uterus, and smartly injected half a basin-full of water at about 112°. Almost instantly the uterus contracted firmly, the hæmorrhage ceased, the pulse improved, and the patient expressed herself as feeling most comfortable, and the anxious countenance gave place to a placid calm. After the expulsion of some clots all went on well. During last Summer I met with two cases demanding more than the usual application of cold—one of them where a midwife thought the patient dying. I need not trouble you with details; the same means used brought about the desired results; and, from what I have seen, I have no doubt that hot water is one of the best agents we possess to cause safe and speedy contraction of the uterus. In each case I have been impressed with the rapidity with which the exhausted patient rallied, and with the expression of a feeling of comfort imparted by hot as compared with cold applications.

DR. WALES had no experience whatever of the injection of hot water, but if a case occurred in his practice he would have no objection to try it. He spoke very favourably of the injection of ergotin subcutaneously.

DR. LINDSAY thought that the case was very graphically painted by Dr. Esler, but he would be very slow to endorse the general use of hæmostatic remedies. In a very large practice of ten years he only met with four cases which he would call cases of post partum hæmorrhage, and he would like to hear Dr. Esler define what he meant by post partum hæmorrhage. He thought that many cases occurring with young practitioners were called cases of post partum hæmorrhage which were not.

Dr. D. JOHNSTONE had no experience of the hot water treatment, but any remedy which fulfilled the indications stated by Dr. Esler would be a welcome one. He would not be inclined to use water at a temperature of 110°; ice at all times responded to his call. He also found that the hand put in cold water and then introduced into the uterus and maintained there for a short time, had a very decidedly beneficial effect. He asked for an explanation of the way in which hot water was supposed to act.

¹ [Dublin Journal of Medical Science, 1879, v67, p352.]

DR. O'MALLEY had a good many cases, but he never had to resort to the hot water or to iron; his cases all yielded to cold water, applied externally, with the hypodermic injection of ether.

DR. BROWNE always used ice in bad cases, and never lost a patient. He commented upon Dr. O'Malley's case of ether as being the first in the North of Ireland.

DR. WORKMAN explained how the hot water caused the stoppage of hæmorrhage, and detailed the effects which he had observed by the application of hot water to frogs; he found it tetanised them by a powerful action upon the entire nervous system.

DR. JOHN MOORE thought that there may be difficulties in wandering away from old paths. One thing which, however, would speak loudly for this new treatment was the universality of the remedy; ice might be difficult to find, but hot water was everywhere; he never used it however. The mortality after delivery was much higher than most men imagined; he had satisfied himself that 1 in 150 was about the true figure. He detailed a case where he saved a life by pressure up on the aorta, and he reviewed other methods of treatment.

DR. CLEMENTS had a large experience as Registrar, and he would state that the mortality was not nearly so high as Dr. Moore stated; he only remembered one case being registered as caused by labour in some six hundred cases.

DR. HARKIN had not tried the hot water—he was perhaps too fond of sticking to the old ways. As regarded other methods of treatment, he reviewed them in detail, and said that when everything failed, “he put a cork in the bottle.” He seized the uterus with one hand firmly, introduced the other into the vagina, and so held it that it was impossible for one drop to escape, and in some cases he had to introduce a sponge in vinegar. If he found after a time that the pulse did not rise, and that on removing his hand a tendency to return occurred, he then injected ergotin, and it always succeeded. He detailed a case where he injected ether two and a-half years ago—the patient, however, died. He would hesitate to use hot water.

Dr. J. W. Browne showed a specimen of extra-capsular fracture of humerus, of fracture of femur, of a femur eroded by an aneurism of popliteal artery, 2 specimens of the os calcis removed for disease.

Paper:¹ DR. WALTON BROWNE exhibited two specimens of diseased os calcis, which he had removed in their entirety by excision. Both specimens had been removed from scrofulous subjects, and had taken on carious action, the exciting cause being an injury. He pointed out the various methods of excision of the bone as practised by Erichsen, Grau, Holmes, Buchanan, Hancock, and Greenshaw, and stated that he preferred Holmes' operation—Holmes' Surgery, Vol. III., p. 828. Dr.

Browne also mentioned Buchanan's idea, that when caries attacks the os calcis, it does not, as a rule, extend to the other bones of the tarsus, so that we are somewhat justified in recommending excision of the bones. He said that he did not approve of the gouging of a diseased os calcis; he had done so five or six times, the results being very unsatisfactory. He did not approve of Allier's subperiosteal excision, but advocated strongly Holmes' method, removing the entire bone, and its periosteum. One of his cases had terminated fatally five months after the operation, the cause of death being phthisis; in the other case, the boy had a fairly useful foot, being able to walk with the aid of a stick. Dr. Browne also mentioned that Mr. Tyrrell, of Dublin, had been the first surgeon in Ireland to excise the entire os calcis. He hoped to publish the case in full shortly.

DR. BROWNE also exhibited an extra-capsular fracture of the femur; also a femur which had become eroded upon its posterior and internal surfaces by the pressure of a popliteal aneurism.

DR. HARKIN thought that the specimens of os calcis were well worthy of recording, but he hardly thought that there was sufficient evidence before the profession to thoroughly establish the operation.

DR. WALES thought that a cast of the foot taken after the operation of excision of the os calcis would be a very interesting study.

DR. ANDERSON asked how long the aneurism had pressed upon the bone.

DR. WORKMAN saw in the Glasgow Infirmary two cases of excision of the os calcis, done by Dr. Buchanan. He believed it was a justifiable operation in suitable cases.

DR. MOORE said the old man who supplied the fracture of the humerus had received the injury upon 24th December last. It showed the effect of an injury to bone in a man so old—eighty-four years. As regarded the excisions about the ankle-joint, he thought too much importance could not be attached to the use of Esmarch's bandage. He detailed the objections to its use, which, he believed, were owing to imperfections in our application. He thought that the fracture of the femur was a complicated one, and that the neck was partly absorbed, he did not think that a fall against the wall would produce this break. It was a question whether the fall in some cases was not the result of the fracture. As regards the popliteal aneurism, he would remark that this form was rare here. He detailed a case where manual compression was used with a success which at first surprised him, but the patient sank from gangrene, he did not believe that the electrolytic method was of any use.

DR. ESLER thought that a lesson might be taken from these dry bones—fractures in old people ending often so fatally, while in the young they seemed to have so little to say to life's duration.

The PRESIDENT, in thanking Dr. Browne for his

¹ [Dublin Journal of Medical Science, 1879, v68, p176.]

interesting specimens, asked about the previous history of some of the patients.

Alexander Harkin

The Sixth Meeting February 11th 1879

Present, Dr. Harkin, Wales, Workman, Anderson, Fagan, McKenzie, Withers, O'Neill, Clements, John Rea, J. Browne, Dempsey, Esler, Dill, and Whitla, and many students.

Dr. Anderson showed the following specimens...

Paper:¹ 1. A beautiful specimen of talipes equinus, and demonstrated the altered directions of the articular surfaces of the bones, and the effects following these. New articular facets were to be seen. He considered the case one of the acquired variety.

He also showed—

2. A very interesting specimen of advanced rheumatoid arthritis of the hip-joint.
3. A case of exostosis of the great trochanter.
4. Rheumatic arthritis of the elbow-joint, showing the porcellaneous formation.
5. A deformed scapula, from mollities ossium.
6. An apparent fracture of the acromium, which has been described as a separation of the epiphyses, the surfaces being rough and irregular.
He spoke of its relation to rheumatic arthritis, and thought this explained the non-union. He supported this view by a study of the centres of ossification. Many of these cases were turning up in the rooms yearly.
7. Ditto. Dried specimen.
8. The bones and ligaments in an old-standing dislocation of the head of femur, associated with atrophy of the muscles, and great thinness of the bones, though the subject from which the specimen was taken was one of very active habits, and lived by spinning.
9. A beautiful specimen from the same subject, the thinned-out calvarium, where the bone was as thin as writing paper.
10. An impacted fracture of the articular surface of the tibia.
11. The calvarium, from a man who died from the effects of the inner table of the skull being broken. The specimen showed the great value which would have resulted from the use of the trephine.

DR. FAGAN thought that he would have had more inversion of the foot in the case of talipes equinus. He explained how the tibialis would have tended to draw in the foot, but, strange to say, there was no inversion. As regards the ununited epiphyses, he thought that these should not be mistaken for fracture. He referred to the opposite shoulder. It generally occurred double. As regarded the fracture of the tibia, he thought the specimen very interesting.

DR. BROWN had two cases of acquired talipes equinus from injury to the leg muscles, ending in diffuse cellulitis. He would have thought that there would have been inversion. He quoted from Dr. Hudson, who trephined all head fractures, and referred to Professor Goslin's authority.

PROFESSOR DILL commented upon the specimen of diseased pelvis, and explained how the disease upon the outside of the pelvis so affected the sacro-iliac joints as to cause difficulty in labour without interfering with the measurements of the pelvis.

Dr. J. W. Browne showed upon a model his method (Spence's) of treating fracture of the patella, and give cases.

He showed upon the model the objections to Maligne's hooks and other methods.

He showed Martin's elastic bandages for the treatment of varicose ulcer of the legs, and commented upon its action and detailed cases.

The Seventh Meeting February 25th 1879

Present, Dr. Harkin President (in the chair), Drs. Wales, Moore, Workman, Dempsey, Withers, Wadsworth, McKeown, Mckenzie, Dill.

Dr. McKeown exhibited a patient from whom he had removed a large nasal tumour through the antrum of Highmore.

Alexander Harkin M.D.

The Eighth Meeting of the Society March 11th 1879

Present, Dr. Harkin, Dr. Dill, Dempsey, O'Malley, Withers, Workman, Whitla.

Dr. Dempsey read a paper upon catarrhal pneumonic phthisis.

Paper:¹ Mr. President and Gentlemen,—Before reading the notes of my cases of catarrhal pneumonic phthisis, with your permission, I will briefly preface them with a general description of the disease.

Catarrhal phthisis is described by Dr. C. Theodore Williams as an affection of the lung, which may be clearly traced to catarrh of the bronchi, induced by cold or damp, creeping down into the alveoli, and thus originating catarrhal pneumonia, followed by implication of the alveolar wall. Niemeyer is of opinion that most cases of pulmonary phthisis have this origin, and he believes that those cases in which tubercles afterwards form have been preceded by catarrhal pneumonia and cheesy degeneration; and Virchow doubts whether there ever occurs an eruption of miliary tubercles without previous cheesy deposits in some part of the body. Pathologists are now pretty generally agreed on the catarrhal origin of a great many of the cases of pulmonary consumption, which hitherto would have been looked upon from the first as of tubercular nature.

¹ [Dublin Journal of Medical Science, 1879, v68, p175.]

¹ [Dublin Journal of Medical Science, 1880, v70, p348.]

The following is a general history of the sequence of events:—A patient who is weakened by some previous disease or privation, or who has a hereditary predisposition to phthisis, or who is scrofulous, or has been scrofulous, gets bronchial catarrh, with cough and expectoration, and after a variable time this becomes localised in some part of the lungs, and at the same time extends from the bronchi into the air cells.

Crepitus becomes mixed up with bronchial râles, expectoration becomes purulent, rusty, or streaked with blood, dulness is elicited on percussion, and with these signs there is an elevation of temperature, and as the disease progresses the symptoms become exactly similar to those usually described as characteristic of pulmonary consumption.

Single lobules only may at first be affected with this alveolar catarrh, but if the disease be not arrested, it may gradually invade the air cells of an entire lung.

In mild cases, and under favourable circumstances, the secretion may be expectorated without undergoing any change, or it may be partially expectorated and partially absorbed—fatty metamorphosis taking place in the cell contents, rendering them fluid, and in a state for absorption. But if the cell elements accumulate in the alveoli to such an extent as to exert pressure on the surrounding tissues and blood-vessels, destruction and death of the alveolar walls occur from want of nutrition. Softening and liquefaction of the degenerated products next occur, and a whole mass may be expectorated, leaving a cavity. In this way a lung may become completely riddled with cavities without tubercle taking any part in the process. But the irritation produced by the presence of the alveolar catarrh and the cheesy degeneration it results in, is supposed to have a local influence in the production of tubercle. Niemeyer suggested that this takes place through the lymphatics, and the researches of Drs. Burdon Sanderson and Klein on the minute lymphatic system of the lungs would seem to confirm his views. Dr. Powell describes a form of tubercle, the result of alveolar catarrh, which differs pathologically from miliary tuberculosis by its primarily attacking one portion of one or both lungs (almost always the apex), and spreading therefrom not by the dissemination of miliary tubercles far beyond the margin of advance, but by a continuous growth involving the destruction and subsequent excavation of the affected lung, and he applies to this affection the name chronic tubercular phthisis.

We should, therefore, look upon all cases of bronchial catarrh with suspicion, especially when it occurs in weakly or scrofulous individuals. By due attention to this catarrh—the “prodromal catarrh” of Niemeyer—we ought to be able to do a great deal in a preventive way to lessen the mortality from phthisis; and even when it has passed on to the advanced stages of the disease, there is still good hope of recovery if there have set in no tubercular complications.

The cases I will now relate were, I believe, of a purely catarrhal nature, and the results of treatment in all was most satisfactory.

CASE I.—Mrs. F., aged twenty-three, fair complexion, gave birth to first baby 29th Dec., 1876. Her convalescence was retarded by a pretty sharp attack of so-called “milk fever.” She nursed her baby, though she suffered severely from fissured nipples. About the middle of February she got a mammary abscess. Whilst attending her for the latter, she complained of a bad cold she had had for some time. I examined her chest, and found it studded over with moist bronchial râles. She was very weak, and had a bad appetite. I opened the abscess, and prescribed quinine and iron.

I next saw her on April 11th, about two months after I had lanced her breast. The cough had never left her; it was getting worse, and there was a great deal of thick expectoration, which some time ago was slightly tinged with blood. She had night sweats, was very weak, and had no appetite; her breathing was short, and she was losing flesh rapidly. There was a hectic flush on her cheeks. Pulse, 118; respirations, 28 in minute. Her father and mother were both living, and there was no family history of consumption. There was percussion dulness under left clavicle, and down to fourth rib, and over this area there was fine crepitation, with scattered subcrepitant râles. The posterior part of the same region revealed the same signs. The base of the lung was healthy; the right lung was also healthy. I painted a blister under the clavicle, and prescribed a mixture of Parrish’s and Easton’s syrups, and directed her to wean the child at once.

20th.—Pulse, 110; appetite better; signs much the same as on last visit. I ordered her cod-liver oil, and directed the affected area to be painted with iodine.

26th.—Pulse, 98; cough very troublesome, and prevents her sleeping at night; night sweats somewhat diminished. Prescribed a morphia and chlorodyne cough mixture. To take Parrish’s syrup alone.

May 3rd.—Pulse, 84; feels stronger; the cough and night sweats very much diminished. The crepitation is now replaced by moist subcrepitant râles, and dulness on percussion is not so marked.

21st.—Pulse, 76; coughs scarcely any; can eat well; percussion note almost as clear as on opposite side. The healthy vesicular murmur is heard all over the apex in ordinary respiration, but on deep breathing some scattered, dry, creaking sounds are heard. Night sweats have entirely ceased. She has gained flesh, and she can walk a good distance without fatigue.

January 19th, 1878.—Nearly two years after attending her, I again examined her chest. There was some hollowing under the clavicle, and the percussion sound was the slightest thing duller than on opposite side. The respiratory sounds were somewhat weaker than in right apex. She has neither cough nor spit, and her general health never was better.

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CASE II.—D. D., aged twenty-three, dark complexion, blind almost from infancy, but, notwithstanding, an accomplished musician and musical composer; naturally thin, and of nervous temperament; father and mother died of phthisis. I saw him on April 26th, 1877. He lived some distance from town. His ordinary medical attendant took ill, and his locum-tenens who visited for him pronounced his disease consumption, and gave such an unfavourable prognosis that he was not again asked to visit him—in fact, he said it was useless for him to come to see him. I learned the following history:—He had had an attack of measles two months before my visit. Immediately after his recovery he got a cold, with cough and slight expectoration; he paid no attention to it, but by degrees it became worse; his appetite failed, and he was losing flesh, and he began to have night sweats.

Then he took a pain in his right side, and he got shortness of breath. The cough, expectoration, and night sweats increased. I found him very low, and much depressed in spirits. Pulse, 130; respirations, 46 in minute; tongue red and glazed. He was much wasted, and there was a large hectic flush on each cheek. The coughing brings up his food. The expectoration is very abundant and mucopurulent. The right lung was dull on percussion anteriorly and posteriorly from apex to base. Auscultation in front gave, superficially, crepitus and deeply bronchial breathing—behind, bronchial breathing. I put him on iodide of potassium, and applied counter-irritation over the lung.

30th.—Pulse, 128; temperature, 102°; perspiration so profuse that bed-linens and night-dress have to be changed twice daily. Prescribed for perspirations, pulv. Doveri, gr. 5, at night.

May 4th.—Pulse, 124; temperature, 102°; cough very troublesome, and expectoration more profuse. Subcrepitant râles and moist clicking sounds heard over lung. Clicking sounds more numerous over the fourth rib in front, and in this region percussion gives the cracked metal sound indicative of a cavity. I now commenced applying small fly-blisters at intervals on different portions of the lung, and ordered cod-liver oil.

6th.—Feels very weak; has had a severe attack of diarrhœa for last few days.

11th.—Pulse, 120; respirations, 36; diarrhœa ceased. Bruit-de-pot-fêlé most distinct; one inch higher, and to the left of right nipple, and over a large area here, there is distinct pectoriloquy and cavernous breathing. I prescribed syr. ferr. phosph. co., and six ounces whisky daily.

14th.—Pulse, 118; night sweats appear to be controlled by the Dover's powder; chest and face to be sponged with tepid vinegar, and liniment of potassium iodide and soap to be rubbed over right lung twice a day.

20th.—Moist râles more scattered posteriorly, and healthy respiration returning; appetite improving, and

night sweats much lessened; scattered creaking sounds and moist râles in front.

27th.—Does not feel so well to-day. The cavity is filled with secretion. Prescribed a stimulating expectorant, and put him on hypophosphite of lime.

June 8th.—Pulse, 108; healthy breathing heard all over posterior part of lung; dry creaking sounds on deep inspiration. He feels much better, and he is quite lively.

26th.—The respiratory sounds are now almost normal; at the apex there are some dry creaking sounds on deep inspiration, and cavernous breathing over cavity. Percussion note is becoming as clear as on opposite side. There is considerable contraction of the side, and the head is drawn over to the right, the apex beat being midway between sternum and left nipple. He has been going about in the garden for the last few days, and he is gaining in weight. From this date his improvement continued uninterruptedly, and he was soon able to resume his usual duties. I have seen him several times since, and his health continues to be pretty good. The side is much contracted, and the breathing is weaker than in opposite lung. The cavity appears to be smaller, and higher up in the lung.

CASE III.—W. M. L., aged nine; father and mother living, but the latter suffers occasionally from hæmoptysis. I first saw him on Feb. 8rd, 1878. He had a cough during the most of the winter, but, as he showed no other symptoms of ill health, no heed was paid to it. On January 27th—exactly a week before the date of my visit—he got shiverings, headache, and general malaise, and his cough became worse. On the following day he complained of pain under right clavicle, which continued until I saw him, but he was not considered so ill as that he should be confined to the house. Pulse, 108; skin hot; respirations, 24 in minute; tongue coated with white fur. On examining the chest I found dulness over right apex, and crepitant and subcrepitant râles. Throughout both lungs there were bronchial râles (scattered). I prescribed liq. ammon. acet. and vin. antimonialis, and ordered poultices and sinapisms to be applied to the chest.

February 5th.—Pulse, 94; temperature, 99°; pain now gone. The expectoration is looser, and starchy-looking. Dulness on percussion is extending downwards.

7th.—Pulse, 102; temperature, 100.5°; percussion dulness and crepitus spreading down the lung; he now suffers from night sweats. A cracked metal sound is heard at the apex, but this is the only evidence of a cavity. I prescribed hypophosphite of lime, and counter-irritation over the lung.

10th.—Pulse, 108; temperature, 101°; dulness and crepitation have now extended almost to the base. To take cod-liver oil.

16th.—Pulse, 106; temperature, 100.5°; expectoration is now purulent; dulness and crepitation extend

over the entire lung. Put him on iodide of potassium.

21st.—Pulse, 100; temperature, 102°; physical signs remain unchanged. Put him on syr. ferr. phosph. co.

March 1st.—The expectoration is now very scanty, and his cough is very much easier. Put him on calcii hypophosph. and calumba.

8th.—The percussion note is clearer from angle of scapula downwards, and crepitus has given place to subcrepitus and moist râles.

18th.—Respiration becoming normal under the scapula, and dulness on percussion disappearing, moist râles are now heard in front, and the cracked metal sound continues at apex. From this date the lung gradually cleared up, and by the end of April—with the exception of weak respiratory sounds and slight percussion dulness—no sign of disease existed in the lung. He gained flesh rapidly, and became much fatter than he had been.

I have examined his chest lately. Percussion over right apex is now more resonant than over left, which I believe is due to emphysematous distension of the weakened air cells.

The cracked metal sound in this case was not due to a cavity. It is elicited in children by percussion over inflated air cells or bronchi, due to bronchial occlusion, with thick tenacious secretion. The chest walls of children are very resilient, and percussion, under the circumstances in question, forces the air out past or through this secretion, and thus causes a sound resembling the cracked metal.

I intended bringing forward some other cases, but as my communication is already too long, I will defer them until a future occasion.

The two first cases are typical examples of catarrhal pneumonic phthisis. The third might be classed as a case of catarrhal pneumonia, but all three had undoubtedly a catarrhal origin. During the progress of a case of catarrhal pneumonic phthisis, and as a result of the inflammation and irritation set up by the diseased products in the air cells, there is an increase of growth of the interlobular fibrous tissue of the lung. In cases that recover, this fibrous tissue contracts the lung, and indirectly the chest wall. The walls of a great many of the air cells in the part of the lung affected are so damaged by the catarrhal inflammation that they become agglutinated together on the removal of their diseased contents, while others not so much injured become distended on the subsidence of the disease. This was the result, I believe, in Case III., because the percussion note was, if anything, more resonant at the apex affected than at the sound one, although the breathing was much weaker. In Cases I. and II., I believe, there was combined with cellular agglutination an increased growth of the interlobular fibrous sheaths, because in both cases, and especially the latter, there was marked contraction of the chest wall, with weak breathing and comparative dulness on percussion. In

all there is limited expansion of the affected lung. With reference to treatment, I am inclined to place greatest reliance on a course of iodide of potassium to begin with, and followed afterwards by the phosphates or alkaline hypophosphites, with cod-liver oil internally, and moderate and repeated counter-irritation by blisters and iodine applications externally. The greatest difficulty one has to contend with in the treatment of these cases is to get patients to persevere and to rigidly adhere to the directions, because once a patient or his friends begin to regard his case as one of consumption, all remedial measures are thrown aside, except the old stereotyped cod-liver oil treatment and change of climate. I would treat all these cases in the early stages as I would any other acute disease, by confinement to bed, or, at all events, to the house.

William Aickin M.D.

Ninth Meeting March 25th 1879

Present, Dr. Aickin, Dr. Wales, Professor Dill, Workman, Dempsey, Fagan, Withers, Rea, Mckenzie, Esler, Whitla, Harkin President, Dr. Young, Speer, and many students.

Dr. Whitla exhibited a patient with a stricture of gullet of 5 years standing following sulphuric acid poisoning.

Paper:¹ The patient was nineteen years old. Five years previously she was admitted under his care into the Royal Hospital in a state of great collapse after swallowing a quantity of strong sulphuric acid. She was then about fourteen years old. The usual remedies were employed. He said that it was needless to remark that the stomach pump was not used. She made an excellent recovery, and left hospital in about three weeks. After six months she was again admitted, suffering from symptoms of obstruction of the gullet. Bougies were employed, and she left considerably relieved. He lost sight of her till about a year ago, when she presented herself in a state of great emaciation, and seemed totally unable to swallow anything, even milk was regurgitated, and there was bleeding from the seat of stricture. A No. 2 catheter refused to pass into the stomach. The stricture was close to the opening through the diaphragm. The catheter caused considerable pain and bleeding. He was at a loss for an instrument sufficiently soft to use without giving pain, and yet firm enough to make way, and he found that sea-tangle, fresh and undried, answered his purpose best; and, after some time, he was able to dilate the stricture, and keep it open whilst healing of the ulceration went on, and now he was able, as the members of the Society would see, to pass the large bougie which he held in his hand, and which was as thick as the middle finger. The patient now was able to swallow anything without pain. He brought the case forward simply to have it

¹ [Dublin Journal of Medical Science, 1879, v68, p175.]

placed upon record. Such cases were rare, and he did not remember a recorded case where so long a period as five years had elapsed with a patient living with a narrow stricture from strong corrosive poison.

Professor Dill showed a specimen of large fibroid tumour removed from the uterus. He detailed the operation and gave the history of the case.

Paper:¹ MR. PRESIDENT AND GENTLEMEN,—Had I reflected for a moment when I at first proposed to bring this case under the notice of the Society, I should have also stated that I would use the opportunity to offer a few remarks on some other cases of fibroid tumours; and, with your permission, Sir, I may do so still. I have not had sufficient time to bring this subject before you in such a way as I should like, or as its importance deserves; but I think it is possessed of sufficient intrinsic interest to make it acceptable.

The subject of the case to which I would first beg to direct your attention is that of an unmarried woman, about thirty-five years of age. On the 10th July, 1878, I was asked to see her in consultation with Dr. Wilson, of Whiteabbey. She had been complaining for seven years, and her illness was principally recognised by the fact that she suffered much from frequent attacks of menorrhagia. At the time of my visit there was a profuse discharge of blood. She suffered much from dysuria, irritation of the rectum, and irregularity of the bowels; she had lost flesh considerably, and was very anæmic. On making a vaginal examination, I discovered a large tumour which engaged nearly the whole of the pelvic brim, the base of which appeared to be embedded in the substance of the wall of the uterus, and extending from a little above the posterior lip of the os to a point very near to the fundus uteri. That part of the tumour which presented was smooth, somewhat globular, very firm, and like a child's head offering at the brim of the pelvis.

Although the patient very much desired it, yet we did not think, from the state she was then in, that we would be justified in operative interference. She was placed upon iron, ergot, sedatives, with a full diet, under which treatment the symptoms, general condition, and her strength became improved after some time. No alteration, however, appeared to take place in the tumour.

On the 18th March, 1879, I was again asked to see her with Dr. Wilson. The tumour had now appeared to have increased a little in size from the time I had first examined it; and, as the patient had become anxious about her state, and desired, if possible, that the tumour should be removed, and as we could not discover any insurmountable difficulty in the way, we consented to enter at once upon the operation for its removal. We placed her upon the left side, near the edge of the bed, or just as in the case for an ordinary confinement. As

she refused taking chloroform, I gave her a 2-grain pill of opium, which I have found useful in protracted operations either with or without chloroform. The bladder and bowels having been previously emptied, the first step in the operation was to get the tumour down and within easy reach, which was attempted by seizing hold of it by means of a vulsellum. This instrument was not found of sufficient strength or power, neither did it keep a good hold of the tumour, and had to give way to the midwifery crotchet with the shield, which answered the purpose uncommonly well, as by this instrument the mass of tumour, which yielded slowly but surely, was safely brought down and outside the vulva. The base, or its attachment to the uterus, which was broad, was then transfixed with a large needle, armed with a double ligature of whipcord. The ligature, being brought half-way through, was divided and tied firmly on each side. Although the operation was a tedious one—lasting altogether more than two hours—yet the patient did not appear to suffer much when it was over, and she slept well the first night, which I ascribe to the timely use of the opiate. The ligatures came away at the usual time. Since that she has menstruated naturally, and she is now—two months since the operation—going about her ordinary business, strong and well. The tumour weighed 9 ozs. 7½ drs. I have given small portions of the tumour which I now exhibit to Dr. Workman, who is prepared to give you his microscopic observations of it. I may conclude this case by stating that, from the first, I was satisfied of it being a fibrous tumour and not at all malignant.

The second case is one which a few words will dispose of. The patient, after being married for five years without any issue, got into bad health, with occasional attacks of menorrhagia. A very large pelvic tumour had existed for a long time. I then saw her with Dr. D. Johnston, when the tumour was so large that it could not pass the brim of the pelvis. We concluded, from its size and from other reasons, that it was not a case for operative interference, and prescribed iron, ergot, &c. We saw her again, in consultation, some short time afterwards, when we thought the tumour had somewhat diminished in size. We prescribed some local application and bromide of potassium inwardly. She was sent to the country, and, again, to the seaside, for change of air. I saw her a third time, at the end of a year, when I found that the tumour had completely disappeared. I could get no exact history as to how it decayed or disappeared, but that she had become quite well and free from the tumour was without doubt.

The third case is one very similar to the second—a patient of about forty years of age. She had been the subject of many attacks of excessive menorrhagia. I saw her on one of those occasions with Dr. M'Crea, when we prescribed for her, and suggested that at some future time she might be fit to undergo an operation. I saw her, back and forward, for some weeks. She was then

¹ [Dublin Journal of Medical Science, 1879, v67, p542.]

sent to the country, and when she returned, at the end of twelve months, the tumour was quite gone, and she appeared to be in tolerably good health.

The fourth case I saw with Dr. H. M. Johnston, who sought my assistance in a complication of labour by a large fibrous tumour. I examined and found a very large, hard tumour of the uterus, low and to the left side. The head of the child could neither be induced in any way to pass the tumour nor could the tumour be induced to pass up beyond the head. After many fruitless efforts to relieve the woman, and being satisfied that now the child was dead, we resolved on reducing its head, and we experienced no difficulty in extracting it. The tumour was such as to invite immediate removal, which was done, and the mother made a good recovery.

The older members of the Society will remember (as I well do) a very interesting case introduced here by the late Dr. Johnston, which occurred in his practice in the Union Workhouse. It was that of a poor woman who took ill in labour in that institution. Dr. Johnston had watched the case with interest for some time. The os was dilating, but the head was making little or no progress. He left her for a short time, and during his absence the pains, which had been strong, suddenly ceased, and, before he could get back to her, the woman was dead. A post mortem examination was made, when a large rupture in the body of the uterus was discovered. A fibrous tumour the size of a cricket ball was found growing at the fundus uteri, towards the right side, and it was also firmly attached to the lower edge of the liver. Evidently the tumour had risen with the increasing size of the pregnant uterus, and in the end it had been pressed against the liver, to which it had become adherent, thereby so bridling the uterus as to prevent it from contracting, descending, and expelling the fetus. The result was rupture of the uterus, and, consequently, the death of the mother and the child. Both might have been saved if the woman's condition could have been diagnosed or clearly anticipated.

My sixth and last case was that of a lady whom I attended for a long time. At first she suffered from severe pain in the lower part of the abdomen and towards the left side. A tumour could soon be discovered in the same region. I was always satisfied, from its position, shape, and size, that it was attached to the uterus, and that it was of a fibroid character. This lady consulted many surgeons and physicians, both here and elsewhere, but it was not satisfactorily diagnosed by any of them, nor the exact nature of the enlargement stated. At the end of more than three years of suffering and doubts regarding the result of the disease, suddenly she was seized with very acute pain and torture, which after a few days became somewhat relieved. I could now feel the tumour freer and rather movable in the abdominal cavity. After some weeks I thought I could feel it becoming fixed, and in the end adhering to the inner and

peritoneal surface of the abdominal walls. The abdominal parietes became inflamed at their point of attachment, and after being poulticed for a time, an abscess formed, gave way, and discharged for a long time. The lady eventually recovered, and she now enjoys good health.

The fifth and sixth cases are full of interest and valuable instruction, because of their varied condition and the somewhat peculiar termination of each. They also verify the fact that such tumours are not confined to the mucous surface, but that they also form upon the peritoneal side of the uterus, and that fibroids may form upon or take as their origin any point of uterine fibre.

These cases may, I trust, though imperfectly stated, be of some interest, and form a small contribution to your "Transactions." The first is of interest in the fact of the woman having been so long ill and in making such a complete recovery after the operation. The second and third cases are possessed of interest from having made—shall I call it?—spontaneous recoveries, by involution, atrophy, and decay. The fourth was one of unusual interest, complicated as it was with pregnancy and labour, and, with all, the woman having made a satisfactory recovery.

Discussion.¹ DR. AIKEN said that Professor Dill had spoken of two cases where the tumours had descended. He explained this as owing to the contraction of the os, and he thought that once the tumour got through the os the removal was easy. He explained how the melting away was accomplished. He believed it was atrophy by the force of uterine pressure. He detailed a case under Dr. Johnston where death occurred from hæmorrhage from a fibroid after birth. He detailed a case of his own where the pressure of the uterus caused the absorption of a large mural fibroid.

DR. FAGAN thought if Professor Dill had used other means than the ligature he would have had less trouble—there would have been less danger of hæmorrhage and pyæmia. He would have used the *écraseur*. He thought that where hæmorrhage declared itself, and the cause was known, operation should be at once decided upon.

DR. ESLER thought that the *écraseur* or thermo-cautery would have been better than ligature. He thought that Dr. Whitla's case of stricture of the gullet was of great interest. He remembered the then child in hospital, and the prognosis was very grave; the most sanguine gave two years as the limit.

DR. HARKIN.—The subject of uterine fibroid tumours which has been presented to us by Dr. Dill must have interest for every one charged with the treatment of the diseases of women. The case seems to have been managed for so far very successfully, and the tumour

¹ [Dublin Journal of Medical Science, 1879, v68, p173.]

removed appears a typical one of that troublesome class. In my own experience I have had some remarkable examples, but shall only refer to two—the first and the latest. I find in my notes of the first, that I was called on February 10, 1842, to visit M. D., a domestic servant, aged fifty, mother of three children, but a widow of thirteen years. She informed me that six years before at the cessation of the menstrual period her health became impaired, two years subsequently she began to suffer from a sanguineous discharge from the vagina, at times taking the character of pure blood, the latter was checked by cold applications and astringent injections; soon afterwards she was attacked by severe pains in the hypogastric region, from which she slowly recovered.

On visiting her at 11 p.m., I found her lying on her back, her legs widely extended, and a large firm globular tumour protruding from the vagina; the bedding was saturated with blood, pulse feeble, and extremities cold. Great difficulty was experienced in making the necessary examination, the os externum being completely plugged by the tumour. After a consultation with Dr. Burden, it was determined to remove the tumour, but on grasping it firmly previous to passing a ligature round its pedicle, the latter gave way, and the whole body of the tumour separated from its attachment without any further hæmorrhage; the patient made a good recovery. On cutting into the substance of the tumour, it appeared fibro-cartilaginous in structure, a layer of a circular form and pearly colour—it weighed 1 lb. oz., measured 11½ inches in smaller, and 15 inches in greater circumference. The tumour was deposited by the late Dr. Burden in the Museum of Queen's College, Belfast, where it may still be seen in a good state of preservation.

The other case was also one of fibroid attached to the os uteri, about the size of a pullet's egg, and occurred in a woman of full habit of body who had not borne any children. I was brought to see her on account of profuse hæmorrhage at the monthly period. On examination the cause was detected and two attempts were made in conjunction with the late Dr. Pirrie to remove it; we only partially succeeded, the patient refusing to submit to any further surgical treatment. The hæmorrhage continuing profuse, after the failure of other remedies, I had recourse to the hypodermic injection of the liquid extract of ergot, with the satisfactory result that there has not been any return of the hæmorrhage after an interval of more than two years, and the patient's health seems quite established.

DR. DILL (in replying to Dr. Aiken's statements about the natural cure from pressure of the uterus) said this cure was not by atrophy but by enucleation and consequent starvation; they were very poorly nourished. It was not the pure fibrous tumours which melted away, but the fibro-cystic, and he explained the supposed process. As regarded the preference to the *écraseur*, he

never fell out with old friends. His reason for using the ligature was the very large size of the base of the tumour. He did not believe with Dr. Fagan that the use of the *écraseur* left no foreign body behind it; the bruised part, or stump, left by it was the worst form of foreign body possible to conceive. He quoted the authority of Simpson and others in support of this.

Dr. Workman, Pathological Secretary, showed microscopic specimens of the above tumour.

In the absence of Dr. Smith, a cancerous stomach was exhibited.

Dr. Fagan showed a specimen of loose cartilage from the knee joint. Also the head of the humerus removed in excision.

Dr. Young showed for Dr. O'Neill a specimen of stenosis of the aorta.

Alexander Harkin, President

Tenth Meeting Wednesday 23rd April 1879

President Dr. Harkin, Professor Dill, present Dr. John Moore, Dr. Aickin, Dr. J. W. Browne, Dr. D. Johnston, Dr. O'Neill, Dr. Esler, William Whitla.

Dr. Dill read a paper upon "Some general considerations on the forceps and a few remarks on the use of this instrument in modern obstetric practice".

Paper:¹ It is altogether unnecessary for me to attempt giving an account of the almost countless varieties of midwifery forceps which have been designed and furnished to the profession since the days of the Chamberlens, now over a period of more than two hundred years. I may be permitted, however, to say that the author of each variety believed there was a superiority and some great advantage in his own design over any other which had appeared before. For a long time, and until within the last forty years, the short forceps was, I may say, the only instrument in common use here as elsewhere. Now, however, it has almost altogether given place to the long forceps; and while I have always given the preference to Simpson's, I believe that Dr. Robert Barnes' long forceps is now received with more general favour. And this is even the case at present in the Dublin Obstetric School, where formerly almost every leading accoucheur had an instrument designed by himself and known by his name.

For so far we, in Belfast, have been satisfied to accept of, and make a choice from among those which have been furnished to us, and which have been recommended by other schools. Still Belfast has not been behind in the increasing but legitimate use of this most necessary and valuable instrument. For I remember well, when it was not much used here, that the late Dr. M'Clurcan, of Belfast, got into high repute in the town and neighbourhood, because of his very extensive and successful use of the midwifery forceps. Dr. M'Clurcan

¹ [Dublin Journal of Medical Science, 1879, v67, p486.]

practised from an early part in the present century until near the middle of it, and from his day to the present time it has been growing in greater and still greater favour.

One incident, and a remarkable one to us now, will strongly mark the difference between the past and the present practice. The late Dr. Samuel Thomson, of Belfast, one of the most eminent physicians of his day, in the north of Ireland, and who held a very large midwifery practice, told me, shortly before his death, that he had never used the forceps in his practice, which had then extended over the long period of forty-five years, and he died in the year 1850. This is a striking contrast to the junior practitioner of the present day, of whom I am safe in saying that he will not be in general practice one year without using the forceps more than a dozen times.

I presume I shall not, with my present audience, be considered as at all overstating the case if I assume that the midwifery forceps, its application and its uses, should be treated as amongst the most important and interesting questions for discussion in the whole range of obstetric practice, involving as it may do, the life or the death of both the mother and the child. Because, if the judicious and skilful use of this instrument be exercised, then safety to the mother and child must be the result. But if, on the contrary, the operation be proceeded with either untimely or by a clumsy and unskilful hand, then is it not more than likely that the consequences shall prove to be most disastrous? We know that in the beginning of and till far on in the present century, delay was practised to a dangerous extent, whilst latterly there has been more than the tendency abroad to an early, if not to the too free, use of the forceps, and especially in the Dublin School of Midwifery, where its introduction has been recently advocated by at least one leading accoucheur before even the os uteri has become fully dilated. I am not at present at all disposed to enter upon a defence of either the one extreme or the other, for in the one case injuries may be allowed to occur from delay and in being too tardy in entering upon the operation, whilst the other may unnecessarily lead to accidents by rashly acting too early. That we may avoid both of these dangerous errors—and which I shall take leave to designate as the Scylla and the Charybdis of obstetric surgery—I am rather inclined to advise here the adoption of a motto borrowed from Ovid's "Metamorphoses"—*Medio tutissimus ibis*.

In the table of statistics of delivery by the forceps, according to Churchill, we find that among British practitioners the forceps was used about once in 450 cases; in France, once in 140 cases; and in Germany, once in 107 cases. And now, when we consider the very frequent use of this instrument in modern practice, we must come to the conclusion, when the time arrives for making a return of the statistics of such cases again, it will be found that they far exceed the largest of the fig-

ures which we have quoted above. It may therefore be accepted as an admitted fact that this instrument is much more frequently used in the present day than it formerly was. And, notwithstanding all that has been stated, if we except those cases in which the forceps has been used before the os uteri was fully dilated, I feel strong in the opinion that at no previous time within the history of obstetric surgery was it ever so successfully used as it is just now.

Amongst the most striking returns on this point are those contributed by Dr. Hamilton, of Falkirk, and which are worthy of some attention. Dr. Hamilton uses the forceps about once in every seventh or eighth case, and he has thus delivered 731 successive children without a single still-birth, which would form a remarkable page in obstetric history, were he able at the same time to record an equal number of successful results on the part of the mother; but, unfortunately, he makes no return, as far as I can discover, on this branch of his subject.

In further discussing this question I would beg to remind you that just as ergot is forbidden during the first stage of labour, so also should we forego the use of the forceps until at least we have reached the second stage of labour.

Dr. Leishman, in discussing this question, gives it as his opinion "that before the application of the forceps it is absolutely an essential condition there should be complete dilatation of the os uteri." And again he says, "An essential condition is, according to all authorities, that complete dilatation of the os should first exist before the introduction of the forceps."

Dr. Playfair has expressed the opinion, in his work on the "Science and Practice of Midwifery," "that the use of the instrument before the os uteri is completely expanded is a very serious matter." And Cazeaux, a very eminent French authority, while discussing this subject, tells us "that before we apply the forceps we should wait, in ordinary cases, till the membranes are ruptured and the os uteri fully dilated."

I could multiply such quotations almost ad infinitum, but I do not wish, by doing so, to tax your patience further upon this point, and the more so as I believe I have already proved to your entire satisfaction the correctness of my position—which is, that in ordinary cases of labour the forceps should not be used before the os uteri is fully dilated. But if more proof were needed, I have only, I hope, to appeal to your own experiences for a complete confirmation of the correctness of my statement.

I find, however, in the number of The Dublin Journal of Medical Science for last January, a "Report" presented to the Dublin Obstetrical Society by Dr. George Johnston, ex-Master of the Rotunda Lying-in Hospital, in which he advocates "delivery by the forceps before the os uteri is fully dilated;" and he has satisfied himself that this practice is not only safe and justifi-

able, but also a great preservative of the lives of both mothers and children. Now, if we were able to satisfy ourselves, as he has done, then it would become a duty with us not only to read and discuss, but also to mark, learn, and practise, according to the rules laid down for our instruction in the "Report" to which reference has been made. But the discussion which follows upon that "Report" throws very important light, and affords some valuable information on the subject; and I think it but due to Dr. G. H. Kidd in particular to say here that in my opinion his statement is a very able, clear, and conclusive answer to Dr. Johnston's important "Report."

Dr. Kidd furnishes us with the statistics of what he is pleased to call "the old school," and he compares them with the information which he gleans from "the new mode of practice," as contained in the "Report," thereby eliciting the fact that the mortality which is found to have existed in the former is but 1.21 per cent., whilst in the latter there did occur a percentage of 2.27, being about double the number of deaths in Dr. Johnston's practice when compared with the practice of the masters who had gone before him in the Rotunda Lying-in Hospital. But when we come to that part of the "Report" which relates more especially to those cases in which the forceps had been used before the os uteri was fully dilated, we find that the result is still worse; for of the 164 cases delivered with the forceps before the os uteri was dilated, and in which cases there cannot be discovered anything beyond the fact that they were ordinary cases of tedious labour, six deaths are recorded, being at the rate of 3.6 per cent., whilst in tables of tedious labour compiled by Churchill the mother's mortality is put down at nil. I might accumulate comparisons of this kind further, but I think I have demonstrated the fact that delivery with the forceps before the os uteri is fully dilated is unsafe, and, consequently, should be considered as unsound in practice.

Under such circumstances as these, and with the facts and the figures before us, is it necessary that I should formally ask the question are we to adopt the teaching, or, as it has been termed, the "new mode of practice," as recommended in Dr. Johnston's "Report;" or shall we adhere to, and pursue, the more moderate means of delivery? For my own part I have no hesitation in stating that I see no reason why I should give up the latter course, as it has been proved to be the safe one; whilst the former I consider not only a dangerous course, but nothing short of an entrance upon a downward if not fatal career—a career to which we might not be far beyond the mark by applying a not inappropriate expression from Virgil's *Æneid*—*Facilis descensus Avernus*.

When I first heard of this "new mode of practice" I was almost tempted to apply to it, in a modified form, the Russian expression, which was used in regard to the light cavalry charge of "the Six Hundred"—that it was une charge magnifique, mais une charge de fous. So of

the "new practice;" it was une opération magnifique mais une opération de fous.

Although I have spoken thus strongly, perhaps too severely, it is only in regard to the use that has been made of the forceps before the os was dilated. At the same time I might be misunderstood if I stopped here without saying that there are certain cases to which the foregoing statements do not apply—such as in the case of a somewhat narrowed pelvis, and in which the os uteri does not become fully dilated because of the forces not being brought to bear upon, or directed towards, its axis, so that in this case, and from a few other causes that demand its use, the period of labour for applying the forceps must necessarily vary.

And now, Mr. President, I have only to say in conclusion (after apologising for trespassing upon your patience with such an imperfect paper) that time would appear in this, as we know it has become in other matters, the absorbing interest of the age. And I think I hear it asked why should we be behind in the race? From my own experience I am much inclined to counsel some prudence and a little more delay. For although we may, by assisting to bring about a hasty termination to a case, win the applause of the moment, we may rest assured that the calm and thoughtful physician, and the skilled and patient accoucheur, will in the long run have a more just and a more abiding reward.

Discussion.¹ AT the conclusion of Professor Dill's Paper he exhibited an interesting diagram of the different sizes of the os uteri.

DR. D. JOHNSTON thought it a question where each should have a fixed principle in his mind about the use of the instrument. He had applied the forceps at every stage. He had no hesitation in saying that in suitable cases the instrument should be applied early, for in the class of cases where the long forceps were indicated seldom does the os fully dilate (the obstruction prevents it), and if we waited for full dilatation we would wait till too late. He laid great stress upon the character of the os as a guide. He had not seen a fistula, and he had delivered 4,000 or 5,000 women, and used the instrument once in every ten cases. He thanked Dr. Dill warmly for his paper.

DR. ESLER commented upon the change in practice in Dublin. He showed the way in which the statistics quoted by Dr. Dill, in reference to Dr. Johnston, might be fallacious. The numbers being too limited, he would side with Dr. Johnston.

DR. AIKEN thought that the character of the os was of great importance. He advocated the "gouging" process, especially in rigid cases; he had practised it scores of times successfully. He found it hasten labour very much. He would not use the long forceps in rigid os, on any account, without a previous dilatation by the fingers. He commented upon the relative merits of

¹ [Dublin Journal of Medical Science, 1879, v68, p170.]

Barnes' and Simpson's instruments, and believed that Simpson's had the advantage. He explained a method of wrapping the handle of the instruments with a handkerchief by which he can alter slightly the axis of the blades.

DR. MOORE thought the question narrowed itself into those cases of unobstructed but tedious labours. Twenty-four hours was the limit to healthy labour; if past this there must be an important cause at work. There was no danger whatever in delay in the first stage of labour; he held this to be of very great importance at the start. With unbroken membranes and undilated os, wait, most decidedly. He was sorry Dr. Dill did not bring prominently forward the character of the os. He detailed instances where a medical man was imperatively called upon to deliver without waiting for full dilatation. If the os is rigid, two things are given us to choose between: either the os will tear, or uterus, child, and all will come with you. With these conditions—a rigid os and unruptured membranes—he would say wait. With these exceptions he would agree with Dr. Dill. He thought the choice of the instrument was more a matter of the attendant's habit. We got great skill with the use of any form after a time. He cautioned the junior members against the habit of tying the handles, which should be allowed to dilate and contract with each pain. He detailed cases where great suffering and damage was caused by the delay in their application.

Dr. WHITLA would not express any opinion upon the advisability of using the instrument in cases of undilated os, as his own experience was not sufficient to lead him to a conclusion; but he was sorry Dr. Dill, in his able paper, did not refer to a method which was now sweepingly advocated in England—i.e., the clandestine use of the instruments, which he thought was a disgrace to the profession.

DR. HARKIN.—I think that the Society should be very grateful to Dr. Dill for the manner in which he has introduced the all-important subject of the use of the forceps in general, and specially in reference to its place in modern obstetric practice. Just now the minds of medical practitioners are agitated by the advocacy of the use of the forceps in the first stage of labour in strange contrast to the timid teaching of the authorities of forty or fifty years ago, and to the practice approved of by the present race of obstetricians. It is then most fitting that Dr. Dill, both as teacher and practitioner, should give us the result of his matured observation, and bear his testimony on one or other side of the debated question. In my experience there has been a well marked ebb and flow upon the subject of instrumental assistance in prolonged or difficult labour. In the first decade of my professional career the use of the forceps was much discouraged, and its application surrounded with such guards and exceptions that it required a certain amount of courage even to mention the subject. Denman's dictum was always acted on, and

it was considered a necessary preliminary that "the ear of the child should be distinctly felt." The short forceps was then perhaps tentatively applied, while at present that instrument is practically discarded, and the long forceps preferred in every case, and by some authorities applied, as a rule, in tedious cases, even before the os uteri is dilated, and the head still above the brim. The tide is now evidently on the flow, and if we have not prudence at the helm we may launch our bark into trouble and discomfiture.

It is quite true that the late Dr. Thompson, in his time the father of the profession in Belfast, frequently stated that in his lengthened experience he had never once had recourse to the forceps; but Dr. Dill must have forgotten to mention that instead of the double blade he had always used the vectis—and this too was my custom in the earlier years of my professional life when engaged in a case of difficult and prolonged labour. I soon, however, learned the superior advantages of the forceps and now only have recourse to the lever in breech presentations when the head is detained in the outlet of the pelvis.

In this predicament the single blade has many advantages over the double-bladed forceps, not alone from its firmer and more unyielding structure, but from the greater curvature of its broader end. The attempt would be idle, from an array of statistics, to formulate a law for our guidance in the use of the forceps. Some men apply them frequently, others very seldom, and each may triumphantly point to results as satisfactory as the other. Each case must eventually be judged upon its own merits; and while, as I have said, an equal degree of success may be claimed by either class when the safety of the mother alone is accounted for, my opinion is that the advocate of more frequent instrumental aid may justly claim greater success in the saving of infantile life, the great end and object of labour, or, as it is properly styled, childbirth. I would then try to impress upon the younger practitioners in midwifery the desirability of attaining early in life a facility in the use of the forceps, for with this acquirement, accompanied with a proper amount of self-reliance, many a parturient woman may be saved from hours of thriftless labour and pain, and the child not seldom from the dreadful alternative of craniotomy. It is awful to contemplate how often this lethal weapon is preferred even by tyros to the bloodless forceps. In my lengthened experience I have known of too many such; and I may, in passing, refer to a statement made at a branch meeting of the British Medical Association in England, when a member, during a discussion on the merits of the forceps, stated unreservedly that while acting as assistant for a number of years to a doctor in a midland county in Ireland, he had never once seen the forceps used in a difficult case, as the perforator was the only instrument chosen to effect delivery. As to the question of applying the long forceps as a rule in

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the first stage of labour, with the head above the brim and the os undilated, I should hold with Dr. Dill, and only interfere in this heroic manner when an insuperable disproportion had arisen between the expulsion power of the mother and the resistance offered by the maternal structures to a head of large size, or in a mal-position.

In cases of difficulty and danger of this sort I have, both alone and in consultation, applied the long forceps in the first stage, and with a happy result both to mother and child, after the perforator had been proposed as the only alternative; but I should always do so with reluctance, and as the safest mode of escape from a painful and dangerous position.

DR. DILL did not enter into the subject with the view of entering upon all the cases where the forceps were applicable, but mainly with the view of testing this new practice. In reference to the figures quoted by him he maintained the fairness of contrasting the two classes of statistics.

He referred to the fact that the head was too often hurried down before the outlet was ready for it, and rupture was sure to follow. No one was more willing to shorten labour than he was, provided the second stage was entered. He would wish them to understand that he excepted the class of case where you would have no dilatation of the os from obstruction high up. He thought the compression should be intermittent. He explained that the sudden dilatation of the os by the head might be brought to a close, and the os might contract round the neck and be a barrier to labour.

Alexander Harkin, President

Eleventh Meeting Tuesday 12th May 1879

Present, Dr. Harkin President in the chair, Dr. John Moore, Professor Dill, Dr. Wales, Dr. Dempsey, Dr. Withers, Mr. Fagan, Dr. Esler, Dr. Workman, Dr. Wadsworth, Dr. Clarke, and a number of students.

Mr. Fagan exhibited an enchondroma he had removed from the shoulder of a patient in Royal Hospital.

Dr. Gilbert-Kirker (visitor) read a paper on his experience in surgery in the Russo-Turkish war.

Annual Meeting November 11 1879

Present, Dr. Harkin President, Dr. Wales, Dr. J. W. Browne, Dr. John Moore, Clements, Core, McConnell, Dempsey, Withers, Workman, Mckenzie, Whitla Honorary Secretary.

Minutes of former meeting having been read, the Secretary read the report of Council and also the report of Honorary Treasurer (who was absent) which showed a balance of £56 in favour of the Library.

Dr. Core reported upon the condition of the Library.

The three reports were then passed.

On the motion of Dr. Whitla seconded by Dr. Wales Professor Dill was unanimously elected President for the ensuing year.

Dr. Whitla was unanimously re-elected Honorary Secretary.

Dr. Esler's resignation was read by the Honorary Secretary but it was the unanimous wish of the Society that he remain in office.

Dr. Core was re-elected Librarian and Dr. Clarke assistant Librarian.

Dr. Workman was re-elected Pathological Secretary.

The following gentlemen (votes) were elected Council:

Dr. Wales (12), Dr. Moore (10), Dr. Dempsey (10), Dr. McConnel (8), Dr. Clements (8), Dr. McKeown (7).

Dr. Moore proposed the usual vote of thanks to the office bearers.

Thursday November 27th was fixed for Annual Dinner.

The Honorary Secretary asked for instructions regarding the gentleman mentioned in the Treasurer's report whether he should notify him to attend meetings etc. and it was resolved as he was not a member of the Society that no notice be taken of him.

R. F. Dill, President

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President Robert Foster Dill

ULSTER MEDICAL SOCIETY

SESSION 1879–80

The First Meeting of the Session 1879–80 November 2nd

Present, Professor Dill M.D. President, Dr. Harkin Ex-President and Dr. J. W. Browne Vice-President, Professor Cuming, Drs. Dempsey, Clements, McKee, Withers, O'Neill, Fagan, Wales, John Moore, McConnell, Workman, Esler, Kevin, Wadsworth, Whitla Honorary Secretary.

Drs. Kevin and Henry Burden were elected members of the Society.

The President delivered his inaugural address.

Paper:¹ GENTLEMEN, We have come here to-night for the purpose of inaugurating another session of the Ulster Medical Society, and I gladly avail myself of this, my first, opportunity to offer my sincere thanks to the Council of the Society for having selected and put forward my name, and to the members, who have done me the honour of electing me—shall I say unanimously electing me—President for the ensuing year.

Then, to be thus called upon by my brethren to fill the presidential chair is, I assure you, to me a source of much gratification and—shall I add—justifiable pride. For when, in the course of a long professional life, after many years spent in very active public and private work, still filling different important appointments, one finds the good opinion of his brethren undiminished, and their voices raised to place him in this elevated position among them, he would be either less or more than human if he did not feel pride in accepting this distinguished mark of approval at their hands.

I have had the honour of being a member of this Society for many years, and longer than many here could remember; and if I did not assist at the birth, I certainly did take part in the operation for its resuscitation. I have watched with interest its development, and I have witnessed its fortunes under many circumstances and at different conjunctures, and I cannot conceal from myself that I never met my friends, the members of the Ulster Medical Society, under circumstances more difficult, more embarrassing, or more trying, than I do on the present occasion.

There may have been a time when I might have been induced to accept of this office with less reluctance—indeed I shall say with more readiness than I do now—but that may have been because I was not then so keenly alive to, or sensible of, the great responsibilities with which it is associated as I am at present.

But why need I dwell on such matters, as formerly no one thought of me for the appointment but myself,

whilst latterly every one thought of me for it but myself. And if this be so, then I can with the more confidence cast myself implicitly upon the kind indulgence of the members, knowing that they will be disposed to throw their friendly mantle over the many deficiencies and numerous shortcomings which must appear with me, from time to time, during my period of office. Indeed at my time of life I should have been seeking rest, in place of taking upon me more work. But loyalty to my profession and respect for friends forbid the idea of rest, or of not obeying their call.

And now, gentlemen, when I look back over the years that have passed between the period I entered the Society and the present, I can—shall I say it—unfortunately see as much to excite feelings of sadness as I can of an opposite character. But why should we look for an exception here of an unalloyed pleasure when we so often see that—

Even mirth is gilded with sadness
Time—inexorable Time—has been busy, sending his swift shafts and plying his sharp and fatal scythe among the members; and I have seen one and another and another cut down, and fall before the fell destroyer. M'Donnell, Thompson, Saunders, Malcolm, Reade, Stephenson, Stewart, Burden, Johnston, besides many other distinguished members I could name, have died since I joined this Society.—No; they still live, and are enthroned in many hearts—they are embalmed in many a memory! But when I look up and around upon this numerous meeting, and when I see these well-recruited ranks again filled by men who have already proved themselves possessed of so much intelligence, ability, and discipline for their work, and when I hear of such favourable accounts from your able and unwearied secretary, Dr. Whitla, as well as when I am told of the very satisfactory results arising from the indefatigable exertions of your worthy treasurer, Dr. Esler, I think I am more than justified in giving expression to the opinion that there is much ground for encouragement, much to inspire confidence, and enough to bespeak a prosperous future for this much-esteemed and very useful Society.

And although, as we have seen, one generation cometh and another generation goeth, yet methinks I hear the whispered sentiment, as it floats upon the breeze—

All men think all men mortal but themselves.”

But men may come and men may go,
But I stay on for ever.

And now, gentlemen, at the risk of wearying your patience, I venture to occupy your attention a little longer with a few observations regarding the nature, the qualifications, and the responsibilities of the medical profession. I hold what I feel persuaded no one, at least here, will deny—viz., that to perform the important functions of the medical profession a medical man

¹ [Dublin Journal of Medical Science, 1880, v69, p67.]

must be possessed of a higher and more varied order of talents, as well as of more extensive learning and acquirements, than are considered necessary for the other professions.

Take, for instance, divinity, law, and physic, which are always spoken of as the three learned professions, and of these there is not one that requires a knowledge of such a wide range of scientific subjects as is demanded by medicine, surgery, and obstetrics.

The student of theology, although admittedly occupied with the highest subject that can engage the attention of man, still is occupied with but a single subject; and law presents to its votaries little or no variety or interest, occupied as they are with the perusal of old, dusty, musty parchments, made venerable, if not by years, by the depth, of dust which gives them weight, and almost seals them to their shelves. And so "law is law."

But what shall I say for medicine. The number of sciences required here are all but endless, and the grandeur of the object which the physician has set before him when he enters on his work is indeed unbounded. He must be intimately acquainted with the body as one great and wonderful machine—with its two hundred and fifty bones; with its four hundred and sixty muscles; with its myriads of vessels and nerves, which are quite beyond my arithmetical powers for calculation; with its heart-pump constantly sending the vital fluid through ten thousand channels, at the rate of more than one hundred thousand strokes a day, for seventy years or more. He must also be acquainted with the way in which these materials are prepared, with the manner in which they find their way into the system, with the mode in which they are purified, and, when they become effete or worn out, with the way in which they are eliminated and again renewed. He must, then, be acquainted with the brain and nervous system, from and by which every part is supplied, and out of which supply come sensation and motion—and, at the same time, do not these threads of nerves convey from head to hand the telegraphic commands of the will?

When this magnificent machine is in active operation we can easily see and recognise results, but we cannot comprehend that most wonderful and mysterious association which exists between it and what is called life, or that still more mysterious association which is found to exist between mind and matter.

In this wonderful structure or contrivance we discover a furnace, combustion, a chemical laboratory, a galvanic battery, a force-pump; and all mechanical appliances and powers may be found at work in this one system, and which would require more than a knowledge of anatomy to give one even the most superficial, the faintest, idea or insight into its workings. To a knowledge of anatomy we must add physiology, histology, pathology, and chemistry. When this great work is completed we must then enter upon a new series of sci-

ences—viz., *materia medica*, botany, zoology, medicine, surgery, obstetrics, and other collateral sciences. And, after all, we are but on the threshold, the border-land, of the field which must be occupied and cultivated by the high-bred, educated, and practical physician.

It were unnecessary before this Society to urge the matter further, or, in establishing my position, to go more minutely into detail; but as students are admitted (and very properly) to our meetings, and as they are to fill our places hereafter and when we are gone, I trust to the kind consideration of the members if, for their sakes, I am drifting into other lines than those which should be kept in an address to a learned Society. Will you, then, allow me to proceed by endeavouring to prove that there are other qualities required by the medical man besides the sciences and the learning of which we have been speaking. By the late Dr. Stokes it was considered necessary (and everything this eminent Dublin physician uttered should be remembered) that the youth when entering upon his professional studies should, in the first place, have a medically constituted mind, or he should exhibit an aptitude for medicine, or, as I believe he termed it, be in possession of the "*mens medica*," before he could expect to attain to any degree of distinction, or even the smallest amount of success in the profession. Indeed, he considered this as a *sine quâ non* for success. Under all the circumstances I would be disposed to say that the case stands thus:—The physician must first have an aptitude for medicine, he must next have a knowledge of the sciences, he must also have not only a large and overflowing measure of the *suaviter in modo*, but he must have, in addition, a proportionate amount of the *fortiter in re*. These qualities harmoniously blended are sure to lead to fortune. Without them the physician must soon discover, before he has travelled far on his journey, that "there is a lion in his path."

That much may be done by training, culture, or by art and education, to overcome natural deficiencies or obstacles to professional success, no one will deny; but that there are marked predispositions in individuals to certain pursuits, which it is always well to seize hold of and cultivate, is a proposition which, I think, most persons must accept. There are one or two very appropriate stories which, although you may have heard before, I think may be happily used here to illustrate the point under consideration. Human life has been compared to a broad table pierced with numerous holes, each of which has a pin made exactly to fit it, but which pins, if stuck into these holes in haste, at random, or without selection, must lead to very awkward errors, and, sometimes, disastrous consequences. And in the same way we may speak of men. If the round man be taken and forced into the three-cornered hole, and the many-sided or square man be driven into the round hole, the misfits must lead to serious blunders and most grievous mistakes. The other is that one which has been recorded

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of Cecco d'Asceli and of Danté, while discussing the subject of natural and acquired genius, and which I shall here advance to further illustrate the matter in hand. Cecco d'Asceli held that nature was more powerful than art, while Danté asserted the contrary. To prove this principle, Danté, the great Italian bard, introduced his cat, which by practice he had taught to hold a candle in its paw while he supped, or sung, or read. Cecco d'Asceli, who before this had expressed a desire to witness the experiment, came prepared for the occasion. While Danté's cat was performing its part, Cecco suddenly lifted the lid of a pot which he had cunningly filled with mice. The creature of art instantly showed the weakness of a talent which had been purely acquired, and, dropping the candle, flew on the mice with its instinctive propensity. Danté was himself much disappointed, and was obliged to admit that nature and the natural gifts or faculties were more to be depended upon or trusted than art. I could, if it were necessary, give other facts by way of illustration, but I think I have said enough to prove the necessity for—first, the natural gifts and dispositions of the mind should be bent on an object, and, second, that when these faculties are properly cultivated that object is more easily reached. To my mind there is no profession more imperiously demands a predisposition than medicine, and this, combined with culture and natural courage, must as a consequence, as I have already sketched, lead to fortune. Moreover, if, in addition to all these great and necessary qualities, the physician be possessed of that identification—that sympathy of feeling with his patient's interests—he must command a confidence, and wake up a responsive echo in the soul which no material means can ever accomplish or make attractive. How could it be otherwise, for what has been spoken of is natural genius—it is a heaven-born gift which, while it may be fostered and cultivated, can never be communicated? This sympathy and identification of feeling would seem to possess a power and penetrate into regions where art, or that cold and icy philosophy of the age, are quite inaccessible.

I would, then, respectfully but confidently submit, that if this complicated machine—this wonderful mechanism—is to be preserved, this remarkable casket, containing as it does such a precious jewel, is to be renewed, I should rather think it would be safer in the hands of him who can with perfect knowledge, disposition, and culture correctly estimate the value of the treasure, than be placed in his hands who is imbued with the chilling philosophy of the times, and who in the end would consign the whole to the maelstrom-whirlpool of destruction, or, as a modern scientist expresses it, “in the end but melts away into the infinite azure of the past.”

But I have to congratulate the Society that its members have no sympathy with such doctrines and sentiments as these. On the contrary, does it not belong to

our profession as a privilege humbly to follow in the footsteps of Him whom we can call our common Master—who, clothed in human form, went about doing good, and delighted in relieving suffering humanity. Like Him, and influenced by such an example, it is our peculiar mission to heal the sick, to give sight to the blind, to make the deaf to hear, and the lame to walk; and from a bed of pain, of suffering, and of anguish, to raise up a first-born, and thereby to make a mother's heart to sing for joy. Allow me further to say, that we are not like those persons in the other professions who use the press, the platform, and occasionally even the pulpit, for their individual aggrandisement and professional promotion or advancement.

Neither is it ever found that the members of the medical profession parade or exhibit themselves before the public as others appear, robed in scarlet and ermine, with mace-bearers and trumpeters before them, and crying “They come! they come!” It has always been the business of this Society and its members to do their work privately and unostentatiously; and whether we be engaged in our common work here or are found in the halls and the chambers of the great and the rich, or in the houses and the garrets of the poor, we are invariably to be found pursuing our professional calling, and making it pre-eminently PRIVATE practice.

In this way we are obliged to throw ourselves, our reputations, and all our professional interests into the hands of those who have no knowledge of what we are engaged in, and no sympathies with us in the difficulties with which we are contending both by night and by day; and how often do we hear our good name and our best intentions assailed and libelled, and that even at the very time when we are engaged on behalf of the dearest interests of our gratuitous and uncharitable defamer, and this without redress. But he that “steals my purse steals trash, but he that filches from me my good name robs me of that which not enriches him, but makes me poor indeed.” Such being the case, we should be oftener found exercising more of the esprit de corps than is found occasionally to exist among us, seeing that we have but one common aim or object—the advancement of science, curing disease, and combating death. But, after all, there is nothing in life “so well becomes a man as a mild demeanour and manly courage,” springing from scholarly attainments and the mens conscia recti which must necessarily follow, and before which the walls of opposition must fall and the citadel be taken possession of. On the contrary, is not that miserable selfishness to be despised which prevents a man coming out and taking part in professional work, except when self-interest is the moving power. And when difficulties of any kind may arise, it is a pity to see the small man pursued before the wind and seeking shelter in his own retirement; to call this success and happiness is a burlesque upon the terms. I should rather take example from a higher, nobler, braver spirit, which,

with fixed purpose and determined will, breasts the storm, and, if needs be, mounts the hurricane; and as we follow him in his onward and his upward progress, we see him rising higher and higher, until at last he enters into that purer, calmer, clearer light above.

He lives too low who lives beneath the sky.

When I commenced to prepare this address I thought it would be my duty to bring before the notice of the Society some of the great achievements, progress, and improvements which have been attained within the last thirty or forty years in my own departments of medicine—viz., Midwifery and Gynæcology. But when I considered that I was to address a Society the members of which are practising in all the departments of medicine, I did not believe that this would be acceptable. Then I thought of reviewing the field of general medicine and the progress we had made in it during the same period; but I felt that the short time I had at my command was not equal to the task, and so I have fallen between these two great subjects, without satisfying myself, and feeling conscious that I have not satisfied my audience. I have, however, made an attempt, by throwing together a few crude and hurriedly-expressed thoughts, to prove that medicine occupies a very high (if not the highest) place among the learned professions. I might have easily done more had time permitted, as it is quite capable of proof that numbers of the medical profession occupy the very foremost ranks in advancing and sustaining the most important, because the most practical sciences, and that we accomplish more good work, in all countries and at all times, by ameliorating and improving man's condition, than is done by all others besides. And, finally, I think I may here claim for you what the public must eventually concede, to use the words of an able and accomplished thinker, that—

We live in deeds—not years; in thoughts—not breaths;

In feeling—not in figures on a dial;

We should count time by heart-throbs. He most lives

Who thinks most, feels the noblest, acts the best;

Life's but a means unto an end—that end

Beginning, mean, and end in all things—GOD.

Upon the motion of Dr. Harkin seconded by Dr. Wales the thanks of the meeting were conveyed to the President. It was resolved that the address be printed with the transactions.

The question of it being published in the local papers was discussed and on being put to the meeting it was decided not to publish in the daily papers.

R. F. Dill, President
16th December 1879

Second Meeting December 16th 1879

Present, Professor Dill President, Dr. J. W. Browne and Dr. Fagan, Core, Esler, Dempsey, McKee, Wales snr.

and jnr., Clements, Mackenzie, Graham.

Dr. Whitla proposed Dr. Frederick Wales, the President seconded his nomination.

Dr. Whitla proposed Dr. Crossle (Newry) and Dr. Clements seconded; Dr. Esler proposed and Dr. Dill seconded Dr. McHarry who were elected unanimously.

Dr. Browne showed an ovarian cyst removed from a patient.

Paper:¹ DR. J. W. BROWNE exhibited a beautiful specimen of ovarian cyst, which he had removed, some days previously, from a patient outside the hospital. He described the nature and supposed mode of origin of the cyst, and briefly related the points of interest in the clinical history of the case, but, as he would bring it up before the Society with other cases of ovariectomy which he had performed, he only asked them to look at the cyst. The patient was progressing very favourably, and he could say the case was decidedly successful.

Dr. McKee a thoracic aneurism.

Paper:² DR. M'KEE exhibited a ruptured aneurism, which was taken from a man who was found in Regent-street, Belfast, lying moaning. The gentleman who found him, believing he was suffering from intoxication sent for a policeman, who said he stooped over him and found a strong smell of drink. He had him removed on a car to the police-office, but on his arrival life was found to be extinct. The aneurism—not a very large one, situate on the ascending part of the arch of the aorta—burst into the pericardium, so that he found that space filled with clots and serum. The opening was about three-quarters of an inch in length. The man's occupation was what is ordinarily known as a plateholder in a shipbuilding yard; he, consequently, would have to lift and sustain heavy weights, which might, to some extent, account for its origin. Owing to the peculiar circumstances under which the man was found, he thought the case would be interesting to the Society—it being mistaken for a case of drunkenness.

DR. DEMPSEY thought it rare to find such a specimen without atheroma. He explained this by a reference to the occupation of the subject from which the specimen was taken.

The PRESIDENT thought it interesting from several points of view. He asked which of the coats had given way, or did all? If this latter, he would say it was a rupture from violence—if the former, he thought it should be put down as an aneurism.

He entered into the surroundings of the case, which were interesting, as it was supposed at first to be a case of drunkenness. Therefore, as coroner, he ordered a post-mortem examination, which revealed the specimen to be an aneurism, and he spoke at length of such a case being brought to the police-office instead of

¹ [Dublin Journal of Medical Science, 1880, v69, p251.]

²]Dublin Journal of Medical Science, 1880, v69, p251.]

directly to the Royal Hospital, where there was every accommodation for treatment, without the delay unavoidable at the police-office.

Dr. Clements showed a patient the subject of an encysted hydrocele of the cord.

Paper:¹ The patient, aged about eighteen, as far back as his recollection served, had observed this scrotal tumour, though he did not consider it anything unusual. His attention had been recently directed to it by the refusal of the regimental surgeon to pass him for the ranks of the army; and, in consequence, he came under his observation at the Belfast Dispensary. He considered the case worth showing to the members of the Society, both as a typical specimen of the encysted hydrocele, and on account of its comparatively large size. The spermatic cord can be distinctly felt passing out of the external inguinal ring, and its course traced for about two inches down to the posterior wall of the cyst, and can be again detected below, passing from the posterior wall of the cyst to the testis. The connexion of the cyst with the cord, both above and below, is definite and distinct, and the cyst is not extended along the cord in the form of a tubular prolongation in either direction. Four weeks ago he removed, through an aspirator needle, about one ounce and a half of hydrocele fluid from the cyst, which exhibited the usual characters of serum albumen, the cyst entirely collapsing. It has again collected, contains now, in his opinion, about two ounces of fluid, and it is his intention to again exhaust the contents of the cyst, and endeavour to excite adhesive inflammation by the injection of a small quantity of diluted tincture of iodine. Before doing so he was glad to have the opportunity of showing the members of the Society what he believed to be so typical a specimen of this affection.

Dr. BROWNE had two cases—one in a man, aged forty-two years, and the other a boy of eleven years. In both he passed a seton soaked in tincture of iodine, and in both there was a cure.

The PRESIDENT thought it was such cases as these that they were glad to see. They were cases which could be treated so well outside, and hence possessed greater interest to the mass of practitioners. He had treated several himself. The seton he used was a common woollen thread.

MR. FAGAN had seen and treated a good number of these cases. Once the diagnosis is clearly made out the path is simple. This was a well-marked case. All his cases were in children. He punctured, and allowed the fluid to get out into the tissues; a slight inflammatory action supervened, and the consequent consolidation caused such pressure as obliterated the cavity. He detailed various methods, and pointed out the importance of first seeing was there any connexion with the abdominal cavity. If this was the case, one should be

careful before using injections.

Dr. Whitla reported a successful case of herniotomy.

Paper:¹ He said:—Upon Oct. 4th I was called by a medical man to see a young muscular man, aged twenty-four years. His friends gave the following history:—In July last he discovered he had a hernia which was reduced by a physician, who fitted him with a truss which was so successful that in two months he threw it aside, the tumour having entirely disappeared. Upon Thursday, Sept. 29th, at 12 p.m., he awoke from an hour's sleep, having gone to bed fairly well, and smart vomiting occurred, with vague abdominal uneasiness, which passed off, leaving him suffering from obstinate and most painful vomiting, which continued in severity till he saw him. He had been attended by a physician whose attention had not been arrested by the suspicion of a hernia, and who treated him with preparations of bismuth and morphia. Upon the following Thursday (the 4th October) another medical man was called in, who discovered the presence of a hernia, and sent me an urgent message to come and see him. I found a tumour in the groin about the size of a small hen's egg, red, painful, and very tender, possessing all the characters of a small inflamed strangulated inguinal hernia. There was complete obstruction of the bowel for six days; there was great tympanites, and constant vomiting of offensive matter, and the patient seemed fast sinking. He had refused to go to hospital, and begged to be relieved by any operation which would give him a chance for life. I rather reluctantly consented to operate, as I feared it would be almost useless. Chloroform was administered by Dr. Quinn; and after a very gentle trial, which convinced me that taxis was unjustifiable, I operated. There was nothing of interest in the operation itself—the sac was very easily exposed, and finally I found it necessary to expose the bowel, which was almost black; the constriction was surprisingly tight, and the margin felt like a little ribbon of steel tied round the knuckle of bowel. One cut of the knife divided this, and I returned the bowel, not into the abdominal cavity, as I had mostly seen it done, but following the advice of my respected teacher, Professor Gordon, I simply left the knuckle of gut about the internal abdominal ring; its condition did not justify its return entirely within the cavity, and I thus hoped I might give my patient the additional chance, if the bowel sloughed, of an artificial anus. After the effects of the chloroform passed off, he passed wind by the anus; there was complete and speedy relief of all his symptoms. Free doses of opium, one grain every four hours for first day, and half this quantity the second. The bowels did not act for five days; then they did so naturally, and in three weeks he had a truss fitted on, and is now at his business—a draper's assistant. I would hardly have considered it

¹ [Dublin Journal of Medical Science, 1880, v69, p252.]

¹ [Dublin Journal of Medical Science, 1880, v69, p253.]

worth bringing under the notice of the Society but for a few points of interest to which I would briefly refer—first, the period of strangulation was very long for a good recovery to follow; and, secondly, it is the fashion to bundle off all such cases to hospital, and I have no hesitation whatever in asserting, had this patient been removed to hospital, he could hardly have survived; the removal and jolting of a hernial subject in his condition must almost necessarily be followed by fatal results. I fully appreciate Dr. Fagan's remarks about the death-roll being increased by the abuse of the taxis. This leads me to look at an entirely new aspect of the hernial question.

Looking at it purely from a “psychological” point of view, one could easily see why the death-roll was so increased. I would not insinuate the least blame to the general outside practitioners; and keeping in mind the complex elements of human nature at play in these cases, no one could blame them. A young man outside hospital will not send in a case of hernia for operation until he has demonstrated fully to himself that it will not go up, for if reduced on admission there will be to his mind some amount of stigma thrown upon him by the ignorant patient and his friends, and the consciousness of this tempts him to try the taxis to the utmost; and though this is but an evidence of weakness from the nature of matters, it must always exist, and should be recognised (though perhaps humiliatingly) in the treatment of the question. I refer chiefly to the hernia cases occurring amongst the poorer classes—hospital cases. If hospital surgeons would agree to visit, before removal, all hernia cases with the ordinary practitioner or poor law medical man, I think hernia would be more satisfactorily dealt with.

Du. FAGAN thought it pleasant to see a success after so long strangulation. There could be no doubt whatever about the wisdom of the procedure. Surgeons now all recognise the advisability—nay, the necessity—of not returning the bowel within the abdominal cavity in cases where the bowel is very much strangulated. He detailed cases illustrative of this. He spoke at some length about the conduct of practitioners outside in using the taxis to so great an extent as they generally did, thus swelling their hospital death-roll.

Dr. J. W. BROWNE said he thought the sac should always be opened in hernia of many days' strangulation. He had operated upon his nineteenth case of hernia three days since.

DR. DILL said taking these two operations, having been performed outside the hospital—the case of hernia and the one of ovariectomy—they supported a view he always held that, without disparaging hospital practice, he could have far better results outside. He quoted, from Savory and others, statements about the antiseptic treatment which illustrated his views, and referred to the condition of the atmosphere in large hospitals in densely populated districts, and contrasted the advan-

tages offered by the patient's home and its surroundings, however humble.

Dr. Browne read an interesting paper upon several cases of unusual hernia.

Paper:¹ SINCE my appointment as surgeon to the Belfast Royal Hospital in 1876, I have operated upon, in private and hospital practice, twenty cases of strangulated hernia—viz., twelve cases inguinal, seven femoral, and one umbilical. Of my twenty cases eleven died. Upon looking over my case-book, I find six cases were almost moribund before being brought under notice.

I may just mention that from the 1st January, 1850, to the 31st December, 1875, ninety-nine cases of strangulated hernia were operated upon at the Belfast Royal Hospital, of which thirty-six died. My patients ranged in age from ten weeks to eighty-four years.

In the after-treatment of all the cases, with the exception of those which were moribund, opium and ice-poultices, or ice-bags, were used.

Immediately after the operation the patient is at once put upon opium, dose being moderated according to the age; and ice-poultices—i.e., ice broken up into small fragments, and mixed with a quantity of sawdust—or ice-bags, which I prefer, are placed over the abdomen, a piece of lint intervening between the bag and skin. At the same time the patient is kept upon spoon diet. The ice and opium are continued as long as any pain or tenderness upon pressure over the abdomen is experienced. I have great faith in the application of ice to the abdomen where symptoms of peritonitis threaten after operations for hernia, and recently I have used ice-bags in all cases of injuries of abdomen in the early stages, at once discontinuing their use should any symptoms of depression occur. A practical paper, “On the Local Use of Cold in Abdominal Inflammations,” appeared in *The Lancet*, February 26, 1876, by Dr. Eade, of Norfolk, in which he advocates the local use of cold in preference to warm applications in nearly all cases of inflammation of the abdomen.

Dr. Eade considers “the modus operandi is to abstract heat, to benumb exalted sensibility, and to contract the dilated and semi-paralysed vessels; and its especial effects have seemed to be to diminish abdominal distension, to control the volvulus writhings of the bowels, and thereby to relieve both pain and tenderness.”

At the end of five days I like to get the patient's bowels to act, and with that view cease the use of opium, provided the pulse and temperature are not much above normal. As a rule, with the cessation of the opium the bowels act spontaneously, and if they do not do so in twelve hours, I order an enema of turpentine and castor-oil, as, no doubt, frequently the safety of the patient depends upon procuring evacuations from the

¹ [Dublin Journal of Medical Science, 1880, v70, p71.]

bowels. To my mind it is very important that we should obtain an evacuation of the contents of the intestines in all cases of hernia after a certain period, but especially in elderly and fat people should we be doubly anxious, as Mr. Jordan, of Birmingham, in *The British Medical Journal*, April 26, 1879, states that the cause of death after hernia operations is frequently due to fatty change and failure of the muscular wall of the gut. Mr. Jordan shows that, upon post mortem examination of some of his fatal cases of hernia, the intestinal canal was singularly and uniformly yellow, and everywhere enormously distended; and the muscular wall, when microscopically examined, was seen to have undergone fatty degeneration.

In some cases where the patient suffered much from flatulent distension about the third day, in addition to using turpentine stupes to the abdomen, a rectal tube has been passed with much benefit. When chloroform has been the anæsthetic used, troublesome symptoms after the operation are nausea and vomiting. I have always prescribed, with much benefit, a cup of very strong tea—a practice advocated by Dr. G. H. B. Macleod, in *The British Medical Journal*, July 8, 1876. In all my cases the sac was opened, with the exception of one case of femoral hernia, to be alluded to further on.

When the strangulation is of several days' duration—and it is in such cases, as a rule, we are called upon to operate in hospital practice—I like to open the sac and see the contents, also where the symptoms of strangulation from the very first have been very acute. Although the stricture is frequently external to the sac, yet the neck of the sac itself may form the stricture. Adventitious bands may remain inside; and as length of time is not an absolute criterion as to the state of the contents of the sac, but rather the tightness with which the bowel has been caught, you cannot tell with certainty when to open the sac, and when to leave it unopened. In all cases of femoral hernia I would be inclined to open the sac, as it is in this form of hernia we so frequently meet with omental sacs, strangulating the bowel.

The late Mr. Maunder, in a clinical lecture at the London Hospital (*Lancet*, January 13, 1877), states that surgeons are pretty well agreed that it is immaterial whether the sac be opened or not in femoral hernia.

In the division of the seat of stricture in all the cases, with the exception of one, where I accidentally wounded the intestine, I used the hernia knife introduced into practice by Dr. Alexander Patterson, Surgeon to the Western Infirmary, Glasgow, and described by him in *The Glasgow Medical Journal*, February, 1873. Dr. Patterson, in describing his knife, says:—"It differs from Sir At Cooper's simply in the blunt, pointed part of the knife having a quarter turn given to it, so that the flattened point passes more readily under the stricture, while its breadth flattens and pushes the gut

aside as the cutting part of the blade follows."

A knife somewhat upon the same principle is the one invented by Dr. B. W. Richardson, of the Adelaide Hospital, Dublin, and described by him in *The Dublin Quarterly Journal*, November, 1869.

I have found Dr. Patterson's knife especially serviceable in operating upon femoral hernia, where the stricture is very tight; the point of the instrument being slightly wedge-shaped, is readily insinuated under the stricture. It will also be found useful in cases of inguinal hernia, where the stricture is deeply seated, and a large mass of intestine is prolapsed, for it is in such cases that we dread wounding the intestine. Here, by placing the forefinger at the point of stricture, the intestines are pushed aside, and the knife can be slipped along the palmar surface of the finger, and the stricture divided; the blade being inserted with the cutting edge upwards, there is no risk of the bowel being wounded. After division of the stricture I invariably pull down into the wound a portion of bowel from the abdomen, in order to see that the intestine is perfectly free, and have a view of the strictured portion. When about to return the bowel into the abdominal cavity, no great pressure should be used; and in three of my cases the hernia knife was re-introduced to enlarge the opening. It is always pleasant to feel the intestine, as it were, glide away. After all the intestine has left the sac, I follow the practice inculcated by my distinguished teacher, Professor Gordon, Belfast—"Never push the finger up into the abdominal cavity; satisfy yourself that the canal is clear, that is quite sufficient."

You will remember that I told you six cases almost moribund had been operated upon. You may reasonably ask me—Why operate in such cases, and thus increase your percentage of deaths? My answer is that I have seen cases operated upon which were deemed quite hopeless, nevertheless they recovered; and I well remember a woman, aged seventy-six, being admitted into the hospital in 1868, when I was House Surgeon, suffering from a strangulated femoral hernia of seven days' duration; she was very weak—in fact, almost pulseless. Mr. MacCormac, now of St. Thomas's Hospital, London, operated, and the patient recovered. This case made such an impression upon my mind that in almost all cases of strangulated hernia, no matter how long the bowel had been constricted, I would be inclined to operate, and give the patient the chance of recovering even with an artificial anus.

Sir A. Cooper, in his *Surgical Lectures*, states that "if the pulse be so small as to be scarcely perceptible, and the countenance anxious and sunken, no time is to be lost; but even under these circumstances, and with hiccough superadded, I have known the operation succeed." And in the next paragraph he says:—"Indeed there is scarcely any period of the symptoms which should forbid the operation."

Sir James Paget, in his *Clinical Lectures and Essays*,

when speaking of strangulated hernia and the various symptoms demanding operation, states at p. 126.:—"A patient must not be allowed to die with a strangulated hernia, if by any means whatever the strangulation can be relieved, and you must not be averted from the operation by any consideration of the number of deaths that follow it." And again, at p. 148, Sir James says:—"I have had to operate on patients already dying; I could not refuse to operate, for I could not be certain that it would be useless."

Having the opinions of two such distinguished men to guide us, I think we are justified in operating in all cases of strangulated hernia, no matter how hopeless the case may appear.

My last eight cases were performed with rigid anti-septic precautions, and I must bear my humble testimony to the great benefits it confers upon the surgeon, and also upon his patients.

I do not intend to give you a detailed history of my twenty cases, but only a short account of seven or eight, which, either differing from the usual condition of matters or from the occurrence of some rare complications, may interest you.

CASE I.—Congenital Strangulated Inguinal Hernia in a boy, aged ten weeks; Operation; Recovery.

M. M., aged ten weeks, a weak, delicate child, was admitted into hospital on 31st August, 1876, suffering from a strangulated inguinal hernia, of three days' duration. Upon examination I found a right inguinal hernia, strangulated; the abdomen was very tympanitic, and tender upon pressure. The little fellow vomited all food, and the bowels had not been opened for three days.

I at once ordered the child a warm bath, and tried the taxis. Following out the practice advocated by some surgeons, especially in strangulated hernia in children, of elevating the pelvis and legs, I was unsuccessful; at once operated; the usual incisions were made in the axis of the hernial tumour; the sac opened; the hernia proved to be of the congenital variety, and contained intestine and omentum.

Owing to the age of the child, I had extreme difficulty in introducing the tip of my little finger into the canal, the stricture being at the internal abdominal ring. When the stricture was divided, as customary, I pulled down a portion of intestine to view the seat of stricture.

The child suddenly made an expiratory effort, and down came two feet of intestine. The mass was so large I had great difficulty in manipulating it through the canal, and before succeeding it was necessary to enlarge the opening, and to wrap the prolapsed intestine in fine cloths wrung out of warm water. After the application of the warm water, the intestine seemed, as it were, to shrink up, and reduction was easily effected. The youngster made an uninterrupted recovery.

Remarks.—At the time I operated (August, 1876) I could

not find recorded a successful operation in a patient so young. Mr. Erichsen (*Lancet*, 1872), I find, operated upon a child six weeks old, but the child died at the end of a month from a low form of peritonitis.

Within the last two months I saw reported in the journals a case of successful operation for strangulated hernia in a child fourteen days old. As regards the elevation of the pelvis in conjunction with the taxis, I once heard a distinguished London surgeon state that he had never found it necessary to operate for strangulated hernia in children—that he was always able to reduce the gut by taxis. However, in my case elevation got a good chance, but failed.

Since the occurrence of this case I have frequently found when a large mass of intestine was down, that by enveloping it in cloths or sponges wrung out of warm water, the volume of the prolapsed portion was almost at once reduced in size, and easily returned by taxis.

CASE II.—Strangulated Femoral Hernia; Omental Sac; Death.

A woman, aged fifty years, was admitted into hospital under my care, suffering from a right strangulated femoral hernia; symptoms of strangulation had continued four days. Upon examination I found a tense femoral hernia in right groin. Administered chloroform; tried taxis unsuccessfully; at once operated. The usual incisions were made, the fascia propria exposed, then the sac. My colleagues requested me to divide the stricture external to the sac; I did so, and by very gentle taxis emptied the sac. After the operation the symptoms of strangulation continued, and in three days the patient died.

Upon post mortem examination we found general peritonitis, and above the femoral opening a small mass of omentum, in the centre of which was concealed a piece of intestine about the size of the tip of the forefinger.

Remarks.—Had I the luck to open the sac in this case, the "omental sac" would have been found, and the intestine easily liberated. It is in cases of femoral hernia, as I previously mentioned, that we most frequently meet with omental sacs, and since the occurrence of this case I always recommend the opening of the sac in femoral hernia.

The seat of stricture, as a rule, in femoral hernia is to be found at the falciform process of the saphenous opening—Hoy's ligament—and not at Gimbernat's ligament. This fact has always been taught by Professor Gordon, and was long since pointed out by Sir A. Cooper. According to Cooper, the stricture may be found both at Hey's ligament and under the crural arch of Poupert's ligament.

A practical point to observe in operating upon cases of femoral hernia is the layer of adipose tissue which lies between the fascia propria, or sheath of the femoral vessels, and the sac. Sir A. Cooper states that he has known the fascia propria to be mistaken for the hernial

sac. In fat subjects divide the strictures until you come upon the “fatty layer,” and you have the sac underneath.

CASE III—Strangulated Inguinal Hernia; Accidental Wound of Intestine; Recovery.

W. R., aged fourteen years, admitted August, 1879, suffering from a right strangulated inguinal hernia. He had been in hospital twelve months previously, suffering from strangulation of the intestine, when the taxis was used successfully. He had not worn a truss, although one was applied before he left hospital.

Upon admission a very tense inguinal hernia, dull upon percussion, was found. An omental hernia was diagnosed, owing to the dulness. The symptoms of strangulation were urgent, and immediate operation, after an unsuccessful trial of taxis, was determined upon. The usual incisions. Opened sac; it contained a large mass of intestine, and no omentum. The seat of stricture, at the internal abdominal ring, was divided with difficulty. When we endeavoured to replace the intestine, the opening was considered too small; and when introducing Sir A. Cooper's knife to enlarge the opening, I wounded the intestine. Almost immediately arterial blood came in a good flow from the wound. Upon examination of the gut an incised wound, half an inch long, but only involving the peritoneal and muscular coats of the intestine, was found; the mucous membrane of the bowel was prolapsed, as it were, to fill up the gap. The vessel was easily secured by Pean's artery forceps, and torsioned; no suture was used. After the operation I at once commenced the use of opium, and applied ice-bags over the abdomen; stopped opium upon sixth day, when bowels acted spontaneously. The boy's temperature and pulse were never above normal, and he made a rapid recovery.

Remarks.—Wound of the intestine, a very serious accident, is not of frequent occurrence. Cases are recorded where the most skilful surgeon has accidentally incised the intestine, and no doubt the gravity of the injury depends upon the fact whether or not the wound penetrates the cavity. Lawrence states:—“A superficial wound—that is, one which does not penetrate the cavity—is of no consequence; the intestine may be returned without the slightest fear of unpleasant results.”

In my case the wound did not penetrate, and I simply restrained the bleeding. In operating upon this case, I used Sir A. Cooper's hernia knife, and I fully believe, had Patterson's or Richardson's knife been used, the accident would not have occurred. You are all aware how it is recommended in works on surgery to introduce Cooper's knife—lying flat upon the forefinger until the seat of stricture is reached, then to turn the cutting edge upwards. You will remember I told you a large mass of intestine protruded, and the stricture being very deep at the internal ring, it was scarcely possible to see what was being cut. The intestine slightly overlapped my finger, and when re-introducing Cooper's

knife in the manner recommended, the gut was wounded.

I think that Patterson's knife is specially of service in cases where a large mass of intestine is in the sac, and where the seat of stricture is deeply situated. The forefinger acts as a guide for it to the point of stricture, and at the same time pushes the intestines aside. The knife is introduced along the finger with cutting edge upwards, and by keeping the blade of the knife upon the centre of the finger, and, just before dividing the stricture, requesting your assistant to make the parts at the neck of the sac tense by gently pulling down the prolapsed bowel, all danger of wounding the gut, in my opinion, is avoided. As regards the diagnosis of this case, you see a mistake was made—from the dulness of the tumour it was thought to be an epiplocele. From my limited experience I consider it almost impossible to accurately ascertain the contents of the sac before operating.

CASE IV.—Strangulated Inguinal Hernia; Intestine abraded of its Peritoneal Coat; Recovery.

J. L., aged thirty-six, admitted to hospital June, 1879, suffering from a large scrotal hernia upon right side. Upon consultation, immediate operative interference was deemed necessary. Chloroform administered, and the usual incisions made. Opened sac; it contained four feet of small intestine of a good colour, with the exception of the portion at seat of stricture, which was very dark. After division of the stricture I endeavoured by gentle taxis to reduce the bowel, but, owing to the large mass, was unsuccessful. Sponges wrung out of warm water were then applied, and the volume of the mass almost immediately became reduced, and at the expiration of ten minutes all the hernia was replaced. Just before the last portion of gut was returned I noticed that it was denuded of its peritoneal coat to the extent of a square inch. The part was washed with a weak solution of carbolic acid, the peritoneum spread out over its former situation, and reduction proceeded with. The patient never had a bad symptom, and left hospital at the expiration of sixteen days.

Remarks.—It is rare to have such a mass of intestine prolapsed as was in this case. The case teaches us to be very careful in the use of the taxis when endeavouring to replace the bowel, and it also shows how much handling the intestine will frequently bear without any ill results.

CASE V.—Strangulated Umbilical Hernia mistaken for a Carbuncle.

Mrs. R., aged fifty-seven, was sent into the hospital, May, 1877, reported to be suffering from a carbuncle of the abdomen. My resident pupil was so confident that the poor woman was labouring under a carbuncle that he had strips of soap plaster ready cut to commence treatment at the hour of my visit. Casually placing my hand over the tumour, which occupied the umbilical region, I felt distinct gurgling when a little pressure

was made. The existence of a hernia was now suspected; and, upon questioning the patient, I ascertained she had been vomiting incessantly for seven days, and that the bowels had not acted for five days. She also told me she had noticed a tumour the size of a walnut occasionally, at the umbilical opening, during the past few years, but that it had increased to the present size (about the size of half an orange) one week since. Certainly the tumour much resembled in appearance and coloration a carbuncle. I now saw we had a case of strangulated umbilical hernia to deal with. Tried the taxis, and immediately the tumour became reduced in size by a half; but there remained a hard mass which could not be replaced. The patient being very weak and evidently sinking, I summoned a consultation, when it was decided to operate at once. Made a longitudinal incision over the hernial tumour, opened the peritoneum, and found a mass of omentum highly congested. Upon gently raising the omentum a portion of intestine was seen to be glued to its lower surface. The adhesions between intestine and omentum were easily broken down. The umbilicus was incised in the median line upwards, and the omentum left in situ. The patient died in twenty-four hours.

Remarks.—This case teaches us to be very careful in diagnosis. We all know how rare it is to find a carbuncle upon the anterior portion of the body—still they do appear there; and a tumour occupying the umbilical region should lead us to inquire into its character. In Lawrence's treatise on "Hernia" (p. 589) you will see recorded cases of fatty tumours on the linea alba which resembled ruptures, and were operated on as such.

CASE VI.—Strangulated Scrotal Hernia diagnosed to be a Hæmatocele, and tapped.

A. R., aged fifty years, was brought to the hospital several months since by a medical man, who informed the House Surgeon that the patient was suffering from a scrotal tumour—probably a hæmatocele—which he had tapped with the ordinary hydrocele trocar and cannula. As very little blood flowed he considered the cavity of the tunica vaginalis to be filled with blood-clots. The patient upon examination presented a rounded tumour of the scrotum the size of a child's head; the skin covering it was very dark, and at a distance it very much resembled a hæmatocele. In addition, the tumour was dull upon percussion, very heavy, and not translucent. The right inguinal canal was occupied by a swelling which could only be felt upon very deep pressure.

At the lower part of right side of scrotum there was a puncture, through which a dark fluid oozed, having a fæcal odour. The patient when seen by me, five hours after admission, was almost pulseless and cold. Before my arrival the House Surgeon had applied warmth and given stimulants. The case was very puzzling at first sight. There was no history of injury to the scrotum. I happened to examine the man's abdomen, and found

that he had been recently blistered and treated for "inflammation of the bowels." He denied ever having a rupture and had not worn a truss, but told me that twelve days since he was suddenly seized with vomiting and pain in the abdomen. At the same time he observed the "lump" in the scrotum. A medical man was called in, who told him he had inflammation of the bowels and stomach.

At the expiration of twelve days, the vomiting and other urgent symptoms continuing, a second medical man was sent for, who now had all his attention directed to the scrotal tumour, which he diagnosed to be a hæmatocele, and punctured it. The same afternoon the patient was sent into hospital.

A consultation being summoned, the diagnosis, strangulated inguinal hernia, was come to, and although no doubt the intestine was gangrenous and the patient very low, we thought an operation might give him a chance.

The usual incisions were made. Opened the sac and found upwards of four feet of intestine in the scrotum. It was quite gangrenous, and ruptured at several points. We saw the opening which had been made by the trocar. The poor fellow only survived the operation eight hours.

Remarks.—At first sight the case much resembled one of hæmatocele, and, in addition, the fulness along the inguinal canal led to the belief that possibly it might be a case of hæmatocele of the tunica vaginalis and diffused hæmatocele of the cord. However, when the history was obtained all doubts regarding the diagnosis were at an end.

As bearing upon this case you will see recorded in Curling's Treatise on "Diseases of the Testis" a case related by Sir A. Cooper, in which a man was brought into St. Bartholomew's Hospital suffering from a scrotal tumour, which was considered a hernia. Owing to some symptoms of strangulation being present an operation was performed. The sac opened, and no intestine found; blood, "partly fluid and partly grumous, burst forth." The case was a hæmatocele of the tunica vaginalis and cord.

CASE VII.—Displaced Inguinal Hernia.

A. J., aged thirty-eight, admitted into hospital 18th September, 1879, suffering from a strangulated hernia. We found that he had suffered for years from a reducible hernia, and had worn a truss. One week since he noticed the hernia had a constant tendency to slip down behind the pad unless carefully watched.

To-day when at work a larger lump than usual suddenly appeared behind the pad. He was at once seized with very urgent symptoms of strangulation, and eight hours afterwards was sent into hospital. Upon looking at the hernial tumour as he lay in bed, I was at once struck by its peculiar shape. Upon examination we found the left inguinal canal and upper part of left scrotum occupied by the hernia, and, in addition, there

was a swelling quite exterior to the internal abdominal ring, situated in the abdominal wall. I now suspected we had a case of displaced hernia to deal with, as a similar case occurred in the hospital when I was House Surgeon.

The patient when visited felt easy—temperature, 98.6°; pulse, 80; no vomiting—in fact, all the urgent symptoms had disappeared since his admission. Ice-bag was applied to the hernial tumour, and opium given. Six hours following admission vomiting recommenced, and, after consultation, I operated. Usual incisions were made; came down to sac, opened it, and introduced my forefinger along the intestine to feel for seat of stricture, but was surprised to find my finger went into a space, which I at first considered to be the abdominal cavity. I now drew down intestine, and as it came outside the scrotum the tumour exterior to the inguinal canal was seen to disappear. It was now quite apparent that my finger had been in a space between the abdominal muscles occupied by the hernia. Now, following the intestine very deeply, a stricture was found at the internal abdominal ring. It was divided and the hernia reduced. The intestine was of a dark claret-colour, and upon its surface several blood-clots were found—the result of efforts at taxis before admission. The patient died upon the fourth day from a low form of peritonitis. Upon post mortem examination I found general peritonitis and a sac between the internal oblique and transversalis muscles, which had been occupied by the hernia.

Remarks.—Cases of displaced hernia are rare. As you are aware they may occur when you have a hernia complicated with an undescended testicle, the testicle occupying the canal and preventing the intestine passing into the scrotum. The intestine, being prevented from entering the canal, then stretches the neck of the vaginal process into a sac placed between the tissues of the abdominal walls, either upwards or downwards, between the skin and muscles, the muscles themselves, or between the muscles and internal abdominal fascia, forming the intra-parietal, intermuscular, or interstitial sac—hernie en bissac of the French, additional sac of Birkett (Bryant).

Although an undescended testicle appears to be the most common cause of this form of hernia, it may also be produced by a badly fitting truss, which, pressing only upon the external abdominal ring, allows the intestine to descend into the inguinal canal. It cannot escape at the external abdominal ring, and, as time proceeds, it gradually stretches the neck of the tunica vaginalis before it, forming an “intra-parietal” rupture.

In my case, no doubt, the poor fellow had worn a badly fitting truss for years, and instead of the pad pressing upon the internal abdominal ring and canal, it had pressed upon the external ring, and permitted of the gradual development of the additional sac.

CASE VIII.—Strangulated Congenital Inguinal Hernia in

a girl; sac contained omentum, intestine, and the Left Ovary.

P. A., aged ten years, was admitted into hospital 12th August, 1879, suffering from a strangulated inguinal hernia, the symptoms of strangulation having existed for thirty-six hours.

Her mother stated that the rupture was noticed shortly after birth, but gave no trouble until the child was three years of age, when it became larger and painful at intervals, but was always easily reduced. When the child was five years of age the hernia became strangulated, and the mother was unable to return it. She was admitted into the Children's Hospital, where it was reduced, and was discharged wearing a properly fitting truss. After a time the truss was left off, and the rupture came down occasionally as before, up to March, 1878, when symptoms of strangulation again occurred. She was admitted into the Royal Hospital under my care, when reduction was easily effected, and she left hospital with a truss applied. The use of the second truss was discontinued, but the hernia did not again come down until the 10th August, 1879.

When admitted into hospital on the 12th August, 1879, I found a tumour at the external abdominal ring as large as a hen's egg, tense to the feel, and painful. Symptoms of strangulation being urgent, the patient was put into a warm bath, had an opiate, and taxis tried unsuccessfully. Chloroform was now administered; taxis a second time being tried without success, the operation was proceeded with. The sac was opened, and instantly a quantity of omentum, very much congested, came into view; behind the omentum lay a small piece of intestine. The stricture, which was very tight, was now divided; the intestine returned. The omentum, measuring four inches long and two inches wide, owing to its congested appearance, was ligatured with a double catgut ligature, and cut off close to the neck of the sac; the pedicle and ligature were then returned into the abdomen. Upon now examining the sac I discovered at its upper part a structure much the size of a small lymphatic gland. When this was carefully examined we found it to be the left ovary and broad ligament. It was some time before an opinion was pronounced, and it was only after the parts had been drawn gently down that we satisfied ourselves regarding the identity of the ovary and broad ligament. The ovary was healthy in appearance, not being in the slightest degree congested, and it was returned into the abdomen. The entire operation was performed antiseptically. Ice-bags were applied to the abdomen after the operation, and opium in small doses administered. The pulse and temperature were never above the normal standard until the twelfth day, when a small abscess formed in the abdominal wall; this was at once incised, and the child was discharged in three weeks' time, wound cicatrised, and wearing a truss.

Remarks.—Cases of hernia in which the ovary has been

found in the sac are rare, no reference being made to it in the surgical works of Holmes, Erichsen, Fergusson, Paget, Bryant, Skey, or Gross. Lawrence mentions cases as having occurred in the practice of Pott.

At a meeting of the Medical and Chirurgical Society in 1864, Mr. Coote mentioned a case which had occurred at St. Bartholomew's Hospital. A woman was admitted into the hospital with a swelling in the left groin, and suffering from the symptoms of a strangulated hernia. An operation was performed. When the sac was opened it was found to contain some thickened omentum and the left ovary. At the same meeting Mr. C. Hawkins stated he had met with two cases in which the ovary was found in the hernial sac.

In the Bellevue Hospital Reports, 1870, twelve cases of ovarian hernia are recorded by Dr. Hamilton, which were operated upon before a diagnosis was made.

In the "Transactions of the London Obstetrical Society" a case is recorded by Dr. Alfred Meadows.

In the American Journal of the Medical Sciences for October, 1877, Dr. Balleray, of New Jersey, reports a case of strangulated hernia which was operated upon, when neither intestine nor omentum was found, but the left ovary was lying near the lower part of the sac. Dr. Balleray also discusses the propriety of leaving the ovary in the sac, or returning it into the abdomen after division of stricture. He says:—"The rule by which the surgeon is governed in the management of strangulated intestine, or omentum, is, I think, applicable to these cases." He considers when the ovary is but slightly congested it should be returned into the abdominal cavity. "But in cases in which, from long continuance of the strangulation, or excessive tightness of the stricture, the tissues of the ovary either are or are likely to become gangrenous, removal of the organ is, in my opinion, the proper course to pursue."

Those of you who have been reading The Lancet must have noticed in the "Transactions of the London Obstetrical Society," published in The Lancet, Oct. 11, 1877, a case of congenital inguino-ovarian hernia, reported by Dr. T. Chambers. The patient had noticed swellings in the groins for many years, and as they were occasionally subject to pain from knocks and injuries, it was determined to remove them, as they could not be returned into the abdomen. After removal they were subjected to microscopical examination, and found to be glandular organs, presenting the structure, not of ovaries, but of imperfectly developed testicles.

In the editorial remarks upon Dr. Chambers' case it is stated:—"Cases of inguinal hernia of the ovaries are rare; cases of congenital inguinal hernia of these organs are much more rare—so-much so, indeed, that any case recorded as such should be looked upon with the gravest suspicion, unless positive anatomical proof of it be brought forward."

There is no doubt but my case was a congenital

inguinal hernia, as the mother had noticed the protrusion almost from the child's birth.

In the examination of the contents of the sac I had the benefit of the experience of two distinguished Scotch medical men, who happened to be present at the operation, and we were all agreed upon the fact that, after the intestine and omentum were returned, there still remained in the hernial sac the left ovary and broad ligament.

Those of you who take an interest in the subject of ovarian hernia will see in the "Biennial Retrospect of Medicine and Surgery" (Sydenham Society) for 1871-72, a very practical paper upon the various varieties of the hernia, its complications and treatment, drawn up by Mr. Waren Tay, of the London Hospital.

John Fagan, Chairman

The Third Meeting was held upon December 30th 1879

Present, Professor Dill M.D., Dr. Fagan, Dr. J. W. Browne, Dr. John Moore, McConnell, Dempsey, McKee, Withers, Mackenzie, Clements, Speer, Esler, Workman, and Whitla. O'Malley, O'Neill.

Dr. Speer withdrew his paper upon "Medico-legal evidence at coroner's inquests".

The Code of Ethics, Table of Fees and Rules of the Society as revised and altered by Council were submitted to the meeting and after discussion some slight alterations were made and it was agreed to have [them] reprinted immediately and bound with the transactions.

A CODE OF MEDICAL ETHICS AS DRAWN UP AND ADOPTED BY THE ULSTER MEDICAL SOCIETY Revised December 30th, 1879

SECTION I.

DUTIES OF PHYSICIANS TO THEIR PATIENTS.

A Physician should ever remember that the health and safety of his patients depend materially upon his assiduity and skill; and should also study to unite kindness with firmness, being courteous while exercising due authority.

1.—Secrecy and delicacy, when required by peculiar circumstances, should be strictly observed; the obligation of the former extends beyond the period of professional services. None of the privacies of personal and domestic life—no infirmity of disposition or flaw of character, observed during professional attendance—should ever be divulged, except when such disclosure is imperatively required.

2.—All unnecessary visits are to be avoided—yet the patient is not to be abandoned because the case is deemed incurable; and, while a Physician should not

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be forward to make gloomy prognostications, he must not esteem any case of too trivial importance; nor should he fail to embrace the opportunity, which he not unfrequently enjoys, of promoting and strengthening the good resolutions of his patients.

SECTION II.

DUTIES FOR THE SUPPORT OF PROFESSIONAL CHARACTER.

There is no profession from the Members of which greater purity of character and a higher standard of moral excellence are required than the Medical; nor can any scientific attainments ever compensate for the want of correct moral principles. It is, therefore, incumbent on its Members that they should be

1.—Temperate in all things—the practice of Physic requiring the unremitting exercise of a clear and vigorous understanding.

2.—Members should avoid, in the presence of non-professional persons, all remarks reflecting on the character of the profession, or those engaged in it.

3.—No Member should resort to public advertisements (except in case of removal), to the issuing of private cards or hand-bills, offering advice and medicine to the poor gratis, nor publish reports of cases or operations in the daily prints, nor suffer such to be made; he should not invite laymen to be present at operations, or boast of cures and remedies. Such is the ordinary practice of Empirics, and highly derogatory to the dignity of the profession.

4.—No Member should give testimonials in favour of any patent or proprietary medicines, or in any way recommend their public use.

5.—No Member should enter into compact with a Druggist or Apothecary to prescribe gratuitously, and, at the same time, share in the profits arising from the sale of the medicines.

SECTION III.

DUTIES OF PHYSICIANS TO EACH OTHER.

In cases of personal affliction, medical men are peculiarly dependent on each other; and kind offices and professional aid should always be cheerfully afforded; therefore,

1.—All Practitioners, with their wives and children, are entitled to the gratuitous services of any one or more of the faculty residing near them; if called to a distance, expenses should be paid.

2.—When, during sickness, affliction, or absence from home (not exceeding one month), one Practitioner has entrusted the care of his practice to a professional friend, the latter should not make any claim on the former, or the patient, for his services; but should, in all things, be the *locum tenens* of the absentee, save in cases of Midwifery, not previously arranged for.

3.—When a medical man has officiated, for another, and the ordinary Practitioner has resumed his exclu-

sive attendance upon the case, the former shall, on no pretext, make friendly calls upon the patient, without the consent of the ordinary medical attendant.

4.—A Physician, being a friend of the family, should avoid visiting when aware that any member of the family is under the care of another medical man.

5.—When a Practitioner is called on an emergency by a family usually attended by another, he should, when the emergency is provided for, meet the ordinary Practitioner, and, after one consultation, resign the case into his hands; but is entitled to charge the family for his services.

6.—When a Practitioner is consulted by a patient whom he has previously attended as the officiating friend of another, he should decline visiting, unless the patient has determined on changing his medical attendant; and if so, he will be justified in taking charge—intimating, in all cases, the same to the former attendant.

7.—When a Practitioner is called to attend at an accouchement for another, he should in all cases, but the one provided for in Rule 2, Section III., be entitled to receive a fair proportion of the fee; and when the delivery is completed, or the arrival of the pre-engaged accoucheur, he should resign the further management of the case, unless with the consent of the ordinary attendant.

SECTION IV.

DUTIES IN REGARD TO CONSULTATION.

A Physician who is called upon to consult should observe the most honourable and scrupulous regard for the character and standing of the Practitioner in attendance. No hints or insinuations are to be thrown out by the Consulting Physician; and he should also refrain from any extraordinary attention or assiduity for the purpose of gaining applause, or ingratiating himself into the favour of families or individuals.

1.—No Member should, on any pretext, meet in consultation persons practising medicine who do not possess a legal qualification.

2.—When two Practitioners attend in consultation, and the period of meeting having been fixed, one of the two neglects punctuality—thus wasting the time of the other—the latter shall be expected to wait ten minutes, and may then visit the patient, provided a note or message be not sent.

3.—In consultations, the attending Physician should introduce the consultant, and, if necessary, be the first to examine the patient; and the ordinary attendant should communicate the directions agreed upon to the patient or his friends, as well as any opinions which it may be thought proper to express. No opinions or prognostications should be delivered which are not the result of previous deliberation or concurrence; and all discussions being held as confidential, neither by words or manner should any of the parties

assert or insinuate that any part of the treatment pursued did not receive his assent; the responsibility must be equally divided, and the consultant should hold no conversation with the patient or his friends with reference to the case, except in the presence of the usual attendant.

4.—When a Practitioner takes charge of a case for his friend, and it appears necessary to change the treatment, it should be done with the most scrupulous care, so as to avoid reflecting on the previous management.

5.—When a Practitioner is called to a patient already under the care of another medical man, he should not interfere, unless in case of decided emergency, but should request a consultation with the latter. Should a consultation be declined by the patient, the Practitioner last called in will be justified in taking charge of the case—a communication to that effect having been made to the former attendant, and his fees paid.

6.—A consultant has no claim to be regarded as a regular attendant on the patient, and his attendance ceases after each consultation, unless otherwise arranged. The patient, therefore, or the Practitioner, is quite at liberty to call in another consultant, without the cognizance of the former, provided no appointment then exist; but in this, as in all other cases, remembering the position in which the consultant is placed, it becomes the duty of the ordinary attendant to see that the *honorarium* be not neglected.

SECTION V.

ON THE ADJUDICATION OF DISPUTES.

Whenever such cases unfortunately occur, and cannot be immediately terminated, they should be referred to the arbitration of the Council, which shall act as a COURT MEDICAL, with the distinct understanding that neither the subject-matter of such differences, nor the adjudication thereupon, shall be made public—as publicity in a case of this nature may be personally injurious to the parties concerned, and can hardly fail to bring discredit on the profession.

MEDICAL FEES

The following Tariff has been adopted by the Ulster Medical Society, and is intended to indicate the minimum of remuneration to which any Practitioner is entitled, whatever be his professional rank, or the extent of his practice. It is expected to be especially valuable for the guidance of junior Practitioners, and as a reference in disputed charges. Those Members of the Profession whose extensive practices make their time specially valuable are not supposed to be guided by these fees. In the following table patients are divided into three Classes, the basis of division being the rent of their residences.

RENTAL.

CLASS I.	£10—£25.
II.	£25—£50.
III.	£50—£100.
IV.	is "Above Class III"

TABLE OF FEES

	CLASS			
	I.	II.	III.	IV.
Single Visit , in ordinary course inside the Borough,	2s. 6d.	5s.	10s. 6d.	21s.
Special Visit , That is, on an urgent message, or when the visit has been requested after the practitioner has commenced his daily rounds.		A visit and half.		
Night Visit , that is, from 11 P.M. till 7 A.M.		Two visits.		
Seaside Visits , according to time and distance,				
Detention of more than half an hour at patient's desire or from urgency of case,	2s. 6d.	5s.	10s.	
Advice at Practitioner's Residence,		Same as visit.		
Letters of Advice ,		Same as visit.		
Attendance on Servants , If employer be responsible,	2s. 6d.	5s.	10s. 6d.	
If Servants pay for themselves,		Charge according to Class I. or II.		
Visit or Advice , of ordinary attendant with a consultant,		Two visits.		
Consultant's Fee ,		Not less than 21s., unless with the consent of the Practitioner previously in attendance.		
More than one Patient in a House, If head of family be responsible,		Half visit for each additional patient.		
If not,		Full charge.		
Simple Certificate ,		One visit.		
Lunacy Certificate ,		10s. 6d-42s.		
Certificate of Death , if Person insured, to be paid by persons interested in policy,		21s.		
Ordinary Midwifery Case (attendance beyond nine days to be charged for extra),	21s.	21s-63s.	42s-105s.	
Below Class I,		10s. 6d.		
Difficult or Protracted Labours,		An extra charge.		
Midwifery Consultant ,		Same for as first attendant.		
Vaccination by regular attendant,		By number of visits.		
Vaccination by other than the regular attendant,		One and a half the visits.		

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LIST OF MEMBERS, JANUARY, 1880

WITH THE DATES OF THEIR JOINING THE SOCIETY.

- 1877—Anderson, R. J., M.A., M.D., M.Ch. (Q.U.I.)
1836—Andrews, Prof. T., M.D. Edin., L.R.C.S.Ed., F.R.S.
1872—Aickin, W., M.D. (Q.U.I.). M.R.C.S.E., L.A.H.D.
- 1868—Ball, T., L.R.C.P.Ed., L.A.H.D.
1868—Beck, F. E., M.R.C.P.Ed., L.R.C.S.Ed., L.A.H.D.
1843—Beck, J. W., M.D. Glas., M.Ch., L.A.H.D.
1868—Browne, J. W., B.A., M.D. (Q.U.I.), M.R.C.S.E.
1842—Browne, S., M.R.C.S.E., L.K.&Q.C.P.I.
- 1866—Cantrell, T. J., L.A.H.D.
1878—Clarke, James, M.D., M.Ch. (Q.U.I.)
1877—Clements, R., M.D., L.R.C.S.Ed.
1875—Coates, S. B., L.R.C.P.&S.Ed.
1856—Cuming, Prof. J., M.A., M.D. (Q.U.I.),
F.K.&Q.C.P.I.
1872—Core, W. S., M.D. (Q.U.I.), L.R.C.S.Ed.
- 1875—Dempsey, A., M.D. (Q.U.I.), L.R.C.S.I.
1841—Dill, Professor R. F., M.D. Glas., M.R.C.S.E.
1846—Drennan, J. S., M.D. Dub., L.R.C.S.I.
1875—Esler, R., M.D., M.Ch. (Q.U.I.)
- 1867—Fagan, J., F.R.C.S.I., L.K.&Q.C.P.I.
1862—Ferguson, H. S., M.R.C.S.E., M.D. Glas.
- 1843—Gordon, Professor A., M.D. Edin., L.R.C.S.Ed.
1877—Graham, J. M.D., M.Ch. (Q.U.I.)
1862—Gribbin, E. D., L.F.P.&S.Glas., L.A.H.D.,
L.R.C.P.Ed.
- 1841—Harkin, A., M.D. Aber., M.R.C.S.E., L.A.H.D.
- 1867—Johnston, D., M.D. (Q.U.I.), M.R.C.S.E.
- 1879—Kevin, Chas.: M.D., M.Ch. (Q.U.I.)
- 1875—Merrick, A. S., M.D. (Q.U.I.), L.R.C.S.Ed., L.A.H.D.
1857—Moore, John, M.D. (Q.U.I.), M.R.C.S.E.
1845—Moore, J., M.D. Ed., M.R.C.S.E.,
1845—Mulholland, C., M.R.C.S.E., M.D. Aber.
1847—Murney, H., M.D. Ed., M.R.C.S.E.
1871—M'Connell, A., L.R.C.S.&P. Ed.
1828—MacCormac, Henry, M.D. Ed., L.R.C.S.Ed.
1874—M'Kee, S., M.D. (Q.U.I.), M.Ch.
1871—M'Keown, W. A., M.D., M.Ch. (Q.U.I.)
1847—M' Cleery, J. C., L.R.C.S.I., L.A.H.D.
1878—M'Kenzie, W., L.R.C.P.&S.Ed.
- 1877—O'Malley, M., M.D., M.Ch. (Q.U.I.)
1877—O'Neill, H., M.D., M.Ch. (Q.U.I.)
- 1859—Pring, R. W., L.A.H.D.

1855—Purdon. C. D., F.R.C.S.I., M.B. Dub.

1878—Rea, John, L.R.C.P.&S.Ed., M.B. St. And.
1839—Reid, Prof. J., M.D. Ed., L.R.C.S.Ed., L.S.A.L.
1858—Ross. R., M.D. St. And., L.R.C.S.I.

1848—Smith, J. W. T., M.D. (Q.U.I.), L.R.C.S.I.
1861—Smyth, B., M.R.C.S.E., M.B., M.Ch. Dub.

1849—Smyth, J., L.R.C.S.I.
1877—Speer, W. S., M.D., M.Ch. (Q.U.I.)

1877—Wadsworth, Chas., L.R.S.&P.Ed.
1866—Wales, G. F., L.F.P.&S.Glas., M.D. Aber.,
F.R.C.S. Ed.

1879—Wales, Fredk., M.D., M.Ch. (Q.U.I.)
1816—Wheeler, T. K., M.D. (Q.U.I.), L.R.C.S.Ed.,
L.A.H.D.

1858—Whitaker, H., M.D. (Q.U.I.), M.R.C.S.Ed., L.A.H.D.
1878—Whitla, W., M.D. (Q.U.I.), L.R.C.S.Ed., L.A.H.D.,
L.R.C.P.Ed.

1878—Withers, Thos. J., M.D., M.Ch. (Q.U.I.)
1877—Workman, Chas., M.D., M.Ch. (Q.U.I.)

**RULES OF THE
ULSTER MEDICAL SOCIETY**

I.—*Name and Objects.* The Society shall be called “The Ulster Medical Society,” whose object shall be to afford its members increased facilities of consulting the best medical works and periodicals by means of the library; of deriving mutual instruction on medical subjects, by means of its discussions and its Pathological Museum; and, as a collective body, protecting the interests of the Medical Profession.

II.—*Members.* The Society shall consist of Ordinary Members, Resident, and Honorary Members.

III.—*Qualifications.* The qualifications of all candidates proposed as members of this Society shall be laid on the table previous to balloting, with the exception of those whose names appear in the “Medical Register.”

IV.—*Election.* A Candidate for membership shall be proposed by two members at one meeting of the Society, and balloted for at the next, one black bean in five to exclude; and prior to ballot, his subscription for the current year shall be paid; if excluded, the money to be returned.

V.—*Life Members.* That when a Resident Member shall have subscribed for a period of 20 years without intermission to the Belfast Medical Society alone, or to the Belfast Medical Society in the first instance, and afterwards to the Ulster Medical Society, or to the Ulster Medical Society alone, he shall become a life member.

VI.—*Subscription.* The subscription shall be One Guinea, and payable in advance. The Society's year shall commence on the 1st November.

VII.—*Honorary Members.* Honorary Members shall be elected only at the stated Annual Meeting; the names of Candidates to be entered on the minutes at least one month previously, and proposed by four members. When elected, they shall be free to all the privileges of membership, except share in the property, without subscription, and in the ballot for Honorary Members one black bean in 10 shall exclude.

VIII.—*Rejected Candidates.* No person who has been rejected shall be proposed again within six months.

IX.—*Inability to Ballot.* That no member can ballot for a person proposed to be a member, if he has not paid his subscription for the current year.

X.—*Officers.* The officers of the Society shall consist of a President, two Vice-Presidents, a Secretary, two Librarians, a Treasurer, and a Pathological Secretary, and a Council of Six Members, all to be elected annually by a majority of votes, and after expiration of office eligible for re-election. The outgoing President to be *ex-officio* Member of Council.

XI.—*Annual Meeting.* The Society shall be specially summoned to meet on the first Tuesday in May, to transact the business of the Annual Meeting, which shall embrace the following subjects:—1. The Report of the Council. 2. The Report of the Auditors. 3. The Election of the New Office-Bearers. 4. The transaction of such other business as may come before the Meeting.

XII.—*Duties of Office-Bearers and Council.* The duties of the Office-Bearers and Council shall be to make all the necessary preparations for the meetings, to examine the contributions of members, and select for reading such as may be eligible; to report, by the aid of Sub-Committees, upon any morbid specimens which may be forwarded by members, or examination of which may be specially requested by a vote of the Society; to conduct the financial and ordinary business of the Society; to make bye-laws and other regulations not provided for in the stated laws of the Society; to report at the Annual Meeting upon all the proceedings of the session, and draw up the Annual Transactions.

XIII.—*Duties of the Secretary.* The Secretary shall keep a record of minutes, enter the cases and notices received, or remarks furnished, in their respective books, and summon and attend all meetings of the Council and Society.

XIV.—*Duties of the treasurer.* The Treasurer shall keep an account of all receipts and disbursements, and furnish his financial statement at the close of the year, and whenever required by a vote of the Society.

XV.—*Meetings.* THE ULSTER MEDICAL SOCIETY shall meet at their rooms on every Tuesday Evening, at Eight p.m., from November till May; then the First Tuesday in every month during the remainder of the Session.

XVI.—*Business of the Meetings.* The ordinary sittings

shall be limited to one hour, but may be extended at the discretion of the President; five members to form a quorum. On the first Tuesday of each month any business may be introduced without notice having been previously given. In the event of a division on any subject, the chairman shall have, in addition to his ordinary vote, a casting one in case of equality. The following shall be the order of proceeding:—

a. The chair to be taken by the President; if he is absent, by one of the Vice-Presidents—if possible, in rotation.

b. Announcements from the Council.

c. The proposal of candidates and election of new members.

d. The following, in such order as the Council may direct:—

1. The Exhibition of or Patients Morbid Specimens.

2. The results of Microscopical and Chemical Examination.

3. The Reading of Cases or Papers on Professional Subjects.

4. Notices of Clinical Facts, and Summaries of Medical Statistics.

5. The Exhibition of New Instruments and Medicines.

6. Papers on New Modes of Treatment.

7. Debates on Doubtful Points in Medical Practice.

XVII.—*Non-Payment of Subscriptions.* A member whose subscription remains due for one year shall be considered as having withdrawn himself from the Society, and forfeited all his privileges and property therein, having been noticed by the Secretaries one month previously. Such persons shall be again eligible by ballot in the ordinary way, on having paid all arrears for the year in default.

XVIII.—*Expulsion of Members.* Members may be expelled for non-professional conduct, by a vote of the Society, provided that such vote be carried by three-fourths of a meeting of at least twelve members, and that due notice of the intention to take such a vote, with grounds of the charge, be given to each member eight clear days before meeting.

XIX.—*The Property of the Society.* The property of the Society shall not be disposed of for the benefit of the Members, nor alienated from the use of the Profession, without the unanimous consent of the Society given at a special meeting summoned for that purpose, and called a month previously.

XX.—*Visitors.* Medical Students shall be admissible as visitors to the meetings of the Society. Any Medical Practitioner may be introduced to the meetings by a member.

XXI.—*Fundamental Law.* That every proposition for the enactment of any new law, or for the repeal or alteration of an old law, must be confirmed at the

meeting subsequent to that at which it was passed, previous to its becoming the law of the Society.

XXII.—*Privileges of Life Members.* That nothing in the foregoing rules shall be construed in any way to interfere with the rights and privileges, heretofore enjoyed, or hereafter to be enjoyed by the Life Members of the BELFAST MEDICAL SOCIETY, or ULSTER MEDICAL SOCIETY.

LIBRARY RULES

I.—That a member of the Society be appointed as Hon. Librarian, who, with an Assistant-Librarian, shall be responsible for the state of the Library.

II.—The Library shall be for the use of the members of the ULSTER MEDICAL SOCIETY only.

III.—No member to have more than two volumes out of the Library at one time, and no book to be kept longer than two weeks without being returned, but a member may borrow the same book for another similar period, provided no application has been made for it in the meantime.

IV.—Any member who loses or injures a book shall be bound to replace the work, or pay such fine as the Council shall think expedient to impose.

V.—The Weekly Journals to be placed on the Library table one week, and the Monthly Journals for one month, during which period they are not to be removed from the Library.

VI.—No Journal, either bound or unbound, to be removed, except through the Librarians.

VII.—Every Work, before admission, must be entered on the proposal book, and the price stated, fourteen days before the meeting at which it is to be proposed.

VIII.—That all Books shall be called in during the first week in October. Any member failing to comply with this rule shall be subject to a fine of five shillings.

IX.—That the Library shall be closed for the month of October annually, and shall then be examined by a Committee of the Council, who shall report to the meeting in November on its condition.

X. That in case any member desires the use of the Library for the purpose of consulting a work, he may do so by arrangement with the Librarian, on giving twenty-four hours' notice.

W. S. Core, M.D.,
Abbotsford Place,
Hon. Librarian.

Session 1879-80

The Fourth Meeting of the society was held upon Tuesday January 13th 1880

Present, Professor Dill President in the chair, Drs. Fagan, Harkin, Clements, Dempsey, Withers, Esler, Kevin, Anderson, McKeown, Workman, Whitla, Wales, Snr., Wales, Jnr., and Mackenzie.

Dr. Esler read a paper upon "Victoria as a health resort".

Paper:¹ Mr. PRESIDENT—There is no fact, I think, better established in the present day in connexion with the practice of medicine than that of the promptitude with which patients act in the matter of change of climate on the advice of their physician. The hand-books on medicine profess to give directions on this topic, and special treatises are published setting forth the claims of various health resorts, and from time to time articles appear in the journals giving the individual experience of members of the profession, and we constantly hear of our merchants and gentry going for a trip down the Mediterranean or up the Rhine, or wintering at Algiers, Cannes, or Mentone, because they have been ordered to do so by their doctor.

It has come within my own knowledge during the few years I have been resident in Belfast that even the Antipodes are not considered too far off for either a trip or a more extended residence for those threatened with pulmonary disease, and I have been consulted frequently, not only on the point of health, but on that of climate, business, profession, and general prospects, regarding that part of the colonies where for eight years I was resident. The information I have given to my patients I purpose in a short paper to now lay before you, and I propose to do so under three heads:—First, the patients who should go; second, the route by which they should go; third, the place to which they are going—and in the treatment of the subject I shall reverse the order, and take the last head first.

I might have made my subject Australasia, which term includes with the Australian colonies the Islands of New Zealand and Tasmania, but as my personal experience is limited to the colony of Victoria I shall ask your attention more particularly to it. Its position on the globe is on the thirty-fourth degree of latitude and between the one hundred and fortieth and one hundred and fiftieth longitude. In extent it measures three hundred miles from its northern boundary to the sea, and five hundred and sixty miles from east to west. Its area is nearly that of Great Britain. Of all the provinces on the island continent it is the most populous, most prosperous, and most wealthy, and yet its entire population is only about three-quarters of a million, the one-third of whom reside in the metropolis, Melbourne, and its suburbs. It is a new country. Its founder landed in 1836, and only for its gold fields it might not for ages have attracted the notice of men in these northern climes. It is of less importance to send a patient to any health resort as a temporary residence than as a place of permanent abode. In the former case they are seldom disappointed, in consequence of the charm of variety, while in the latter there are various considerations to be borne in mind, such as agriculture, commerce, man-

¹ [Dublin Journal of Medical Science, 1880, v69, p255.]

ufactures, educational advantages, and the openings and prospects for the rising generation; but to none of these subjects can we give consideration in this paper. The questions we must discuss are—climate, health, and longevity, and the effects of the climate on consumptive patients or others suffering from chest affections. The climate of Victoria is acknowledged to be one of the finest in the world; the temperature is moderate. It is true the range of temperature is great—between freezing point in winter and a hundred and twelve degrees in summer there is a great contrast, but these are extremes; seldom does the thermometer fall below 45°, and as seldom does it rise above 80°. The mean temperature of the hottest months is 66° and of the coldest 48°; frost and snow may be found on the highest mountain ranges in winter, but through the colony generally when ice forms during the night it melts with the rising sun. Hot winds prevail during the summer months, and this is certainly the most trying time, and the time of most uncomfortable experience to the colonist. “A brickfielder” which transfers some tons of dust or sand from one end of a town to the other end cannot be contemplated with composure, much less with delight. Yet the wheels of commerce do not stand still on this account—the trader bargains, the farmer cuts his crop, the traveller speeds on his way, and the physician on his rounds, much the same as at other times. These hot winds last, as a rule, only about three days at a time, and are followed by a deliciously cooling southern breeze or a refreshing shower, which seems to set nature right again. The seasons are different from home—there is the wet and the dry season; the former—May, June, and July—is more like our April showers than the British idea of a rainy season. Yet there are times of heavy rainfall and blustering, windy weather, when the creeks are flooded and the canvas tents on a digger’s rush are suddenly transferred by a cyclone from the gully in which they stand over the adjoining hill-top. The most usual months for floods, which are occasionally destructive, are September and October, when the rain falls in thunder-plumps. Bush fires are not uncommon in December and January, and occasionally miles of the country may be seen in a blaze of light, carrying destruction in its track. These are some, and, I think, the principal disadvantages of the climate; while, on the other hand, the positive enjoyment of spring and summer is very great. A cloudless sky; a summer heat not too great to interfere with duty or pleasure; the atmosphere light, dry, and genial, imparting comfort to the body and hilarity to the mind; the air scented with the rich aroma of the wattle bush; and the gum-tree tinted with the rich plumage of the noisy paroquet, making the bush one vast aviary, imparts to the traveller a sense of comfort and delight which gives mere existence a charm of which dwellers in humid and colder climates can form no conception. An old colonist says:—“There are days when, with good health,

the surroundings must make one happy—days on which there are brilliant floods of sunlight and warmth—the heat modified and pleasant; the atmosphere pure and dry; the breeze soothing and refreshing; the sky softly blue, or ever changing with thin cloud flocculi; hill and dale clothed with spring verdure; the earth and air teeming with joyous life. On such a day the pulse of life beats joyously, and the soul that is not chained by earthly care or bodily infirmity may enter into Nature’s great calm, and revel in an ecstasy of delight, saying with Longfellow—

It is enough for me
Not to be doing, but to be,
Through every fibre of my brain,
Through every nerve, through every vein,
I feel the electric thrill—the touch
Of life that seems almost too much.

With such a climate we may look for a healthy population, and in this we are not disappointed—there is everywhere the appearance of cheerfulness, cleanliness, activity and health. One exception may be referred to—from the habits of the early settlers in camping out at night and sleeping under no thicker roof than that of calico, one is not surprised to find rheumatic affections of the joints rather prevalent; but with more comfortable edifices and a less exposed life it is not likely that this state of things will be repeated. Epidemics such as visit Europe have been hitherto unknown, and the colonial fever of the first settlers has almost disappeared. The country is yet too young to ascertain the longevity of its inhabitants, but the death-rate presents a very favourable contrast with Britain, being 11 as compared with 23. Accidents and the race for riches, often ending in disappointment and untimely death, have greatly added to the mortality; but in these respects every year is bringing about a better state of things.

Now, coming to the main question—“Is the Australian climate likely to be favourable to the health and well-being of phthisical patients?” I unhesitatingly answer, Yes. There you have the conditions most requisite for a comfortable existence—a dry, warm, mild climate, light, bracing atmosphere, and a range and variety of temperature in the various colonies which will enable one to make choice of every conceivable variety in a few days; for, while I have spoken of Victoria as somewhat medium and typical, there is the more southern territory of South Australia, or the more northern colonies of New South Wales and Queensland; and for colder climes, there is New Zealand, or the Island of Tasmania, which is spoken of as the garden of the earth.

Having decided upon sending our patient to Australia, a not unimportant point will be, secondly, the route by which they should go. For comfort and enjoyment, and where time is no great object, there is no doubt that a first-class sailing ship, such as Wigram’s or Green’s, of London, affords a rest and quietude not to

be realised in a steamer; but, as a set-off, there are the calms of the tropics, and the cold of southern latitudes experienced in bearing down to catch the trade winds, which are anything but pleasant to a delicate chest; and, from personal observation, I should say that the voyage is generally too protracted for an invalid; yet we know that a long sea voyage is one of the conditions made essential by the most experienced medical men. The magnificent ocean steamers now plying by way of the Cape of Good Hope, or through the Suez Canal, afford a pleasant run of some fifty days, while for those who want more variety, and greater change, the route viâ New York, California, and Yokohama is available; but, on the whole, I would recommend either an emigrant or invalid to go by steamer, as being quick, safe, and moderately cheap. The best time of year to arrive there is about February or March, just after the excessive heat of the summer is over, which would necessitate leaving here two months earlier by steamer, and three months by ship.

It is usually young unmarried men who are sent to Melbourne or Sidney for their health, and I am convinced, from experience, that grave mistakes are made in not sending them further. To remain in a city in preference to going up the bush, or on to a station, is leaving more than half the work undone. In Warnambool, Belfast, or the Wimmera districts, or on the Murray River, the life is so different, and, I will say, so suitable to an invalid, that the contrast between Melbourne and a sheep station is nearly as great as between London and Melbourne. For a young man with bad health, bad habits, and a plethora of English sovereigns, a colonial town is about the worst place I know. We must remember that bad habits formed at home are not likely to improve amongst strangers with all restraints removed, and the continual temptation of fast colonial life. Man cannot fly from himself. A change of scene makes no difference in personal character; a colony can work no change in human nature; cannot prevent drunkenness coming to want; cannot inspire the day-dreamer with decision; cannot give force to the heart that quails; cannot force on those whose lives run backward; but I believe it can, and often does, arrest the development of tubercle if the patient puts himself into the conditions favourable to that end.

And now for our last point—the patients who should go. It is no uncommon thing for a passenger in quest of health to die in sight of land, and not a few have only landed to lay their bones on a foreign shore. These were sent months, or it may be years, too late. The only hope is in the early, I would say the very early, stage of tubercle. I have met men doing their full share of this world's work who told me that if they had remained at home they would have been in their graves many years before. If any good is to be accomplished, it is by sending tubercular subjects while the disease is in the incipient stage, and, to my mind, it is cruel in the extremest

degree to separate a patient from friends and home at a time when the Garden of Eden itself could not be expected to afford relief, much less to add to the patient's life. Most of the deaths from phthisis which occur in the colonies are those sent out from England, and yet the death-rate from this disease is 12 in Victoria as against 22 in England, and 14 from other diseases of the respiratory system as against 36 in England. The death-rate is much less comparatively for the country than the towns.

In Melbourne, for instance, with one-third the population of the colony, more than half of all the deaths from phthisis occur. I have been speaking hitherto of individuals, but I think a stronger case might be made out in favour of families emigrating where there is a phthisical taint, and, in place of standing by, and seeing one after another fall under the certain shaft of death's arrow, I consider it the duty of medical men to recommend families with capital, energy, youth, and a love of life to emigrate to a more salubrious clime than that in which their birth has cast their lot, so that they might not only prolong their days, but enjoy life while they do live, and assist in building up that Greater Britain of the South, which is destined yet to play an important part in the councils of the empires or republics of the future.

DR. HARKIN said he was sure if Victoria was nearer to us there would as many take advantage of it as a health resort as now go to Egypt. He contrasted it with the climate of Cannes, and thought the great disadvantage was its difficulty of access.

Dr. WITHERS asked particulars about the dryness of the colonial soil, and was told by Dr. Esler it was very dry—indeed rather too dry for the prosperity of the sheep-breeders.

DR. WALES said the subject had engaged his attention for a long time. While he thought that the sooner the patient was sent away the better, still he could not join in the wholesale condemnation of sending away at a later stage. He could recall very many cases, during his long experience, of men whom he sent away with cavities and full evidence of loss of lung substance. He detailed several cases, in some of which the patients went out almost against his commands, being seemingly too far advanced for a shadow of hope for a cure, and these in many cases turned out strong, healthy men, living still in the colonies, and leading active and laborious lives. He gave the particulars of two telling cases, in both of which there were cavities, and decided cures resulted. From what he had seen he concluded it was a very serious thing to say it was too late to send away a patient.

DR. M'KEOWN would not be disposed to go either as far as Dr. Esler or Dr. Wales. Anyone acquainted with the history of the families of Belfast could recall scores of cases where the sons of the wealthy were sent off at the very earliest period of the disease, and their pro-

gress downwards was as rapid as that of those who stayed at home. He paid a very warm compliment to the labours of Dr. MacCormac upon the fresh-air treatment of phthisis, and expressed himself as doubtful about the climateric treatment of phthisis, except in so far as climate admitted of free exercise in the open air. He thought much depended on the temperament of the patient. If fond of travel, not home-sick, not afraid to die, then the probabilities are that travel and residence at various health resorts would likely be useful. If, on the contrary, despondent, the patient would probably be much better at home.

PROFESSOR DILL, in thanking Dr. Esler for his paper, drew the attention of the Society to the law of fashion in the treatment of disease. He referred to a recent article in Blackwood, and lamented the great difference of opinion upon various medical subjects, and no department showed this more thoroughly than the question of phthisis. He gave a detailed account of the new Alpine resort for consumptives, and contrasted the extraordinary discrepancy of opinions upon the climateric treatment of phthisis. He quoted from Dr. Bennet (Mentone), and, upon the whole, he agreed with the remarks of Dr. M'Keown. His experience absolutely verified what Dr. M'Keown had stated. He detailed cases illustrative of this—cases which beautifully counterpoised those so ably put by Dr. Wales, and he concluded by saying he thought, as in disease so in health, “there was no place like home.”

Dr. Workman thought Dr. Esler had hardly given the Society sufficient information to decide where to send patients. A doctor in Victoria sending a patient to Britain, would like to know something of the differences of climate between the north of Scotland and the south of England, and between those places and Ireland, so Dr. Workman thought there must be great varieties of climate in Victoria. He would like, also, to have heard Victoria compared with the adjacent countries as to climate and its effect upon consumptive patients.

Dr. Fagan read a paper upon the treatment of nævus with cases and showed a patient.

Paper:¹ CASE I.—The child that has been shown to you this evening was the subject of a cellulose-cutaneous nævus of the upper lip, extending nearly its whole length in the vertical direction and about half an inch in its transverse measurement. She was brought to me some time back for treatment.

The first method I tried was the subcutaneous ligature. This did not succeed in destroying the growth. I then tried setons with very little better result; it remained stationary for a time, and seemed as if it were going to shrink. However, it soon began to enlarge again; and the mother being most anxious that it should be removed, I proposed taking it away by the

knife. This I did as follows:—I passed two straight needles, armed with a double-wire suture, under the base of the tumour, at right angles to the long axis, and lying parallel to each other. A hare-lip pin was next passed under its base, in the line of its long axis. They were all made to enter the sound skin about a quarter of an inch outside the margin of the tumour, and were passed deeply, so as to be felt in contact with the mucous lining of the lip. The needles and pin being left in situ, I threw a soft cotton thread round their exposed extremities; and while an assistant pressed the blood out of the tumour, I gradually tightened the encircling ligature, and then tied it, leaving the tumour, that was isolated by the pins, quite bloodless. I next carefully dissected out the tumour, keeping my knife in the sound skin about two lines outside its margin, and deep enough to nearly expose the needles. I next pushed the needles through, and brought the edges of the wound together by the twisted-wire suture. The hare-lip pin was withdrawn, and the encircling ligature dropped off. A pad of dry lint was placed on the wound, and strips of plaster brought over it, from cheek to cheek, to keep it in position.

There was scarcely a drop of blood lost in the operation. For some reason or other the mother did not bring the child back to me for eight or ten days, and during that time the dressing was not removed. I found the parts in a very dirty state—the sutures had ulcerated through, and there was a granulating sore about a line and a half wide in the course of the wound. This healed up in a few days. It is now about six weeks since I operated; there is not a trace of the diseased structure, and the slight scar following the operation will, I believe, be scarcely perceptible in the course of time.

CASE II.—The next case occurred to a child six months old, the tumour being of the same character as the one already described. It was seated on the centre of the cheek, and was nearly the size of a shilling. This I treated as follows:—I passed two hare-lip pins under its base, at right angles to one another, and threw a ligature round them, tying it tightly, thus completely strangulating the tumour.

I did not see the case for six or seven weeks after this, as the child lived some considerable distance in the country. The mother stated that in about a week the strangulated mass dropped off, leaving an ulcerated surface which was healed in about another week. For some short time before she called on me she noticed that when the child cried the place where the sore was became very red and somewhat swollen. When I saw it it had the appearance as if there was going to be a recurrence of muscular growth. Having protected the part around the cicatrix, I freely applied to it with a glass-brush a solution of sodium ethylate in pure alcohol (3ij. of the former to ziiij. of the latter). In a fortnight she called on me again, when I applied the solution a second time, and as I found it very much improved

¹ [Dublin Journal of Medical Science, 1881, v71, p80.]

after the first application, I told her she might not call again if there was no appearance of the redness returning. I have not seen her since, so I suppose it has kept well.

CASE III.—The third case is one in which the tumour involved half the lower lip, the angle of the mouth, and the mucous membrane covering the gums on that side. This I treated by seton as follows:—I got a large darning-needle armed with a very thick woollen thread. I passed this through the tumour, round its margin, a few lines from the healthy skin, after the manner of darning a stocking.

I passed another seton through its centre in the same way. I then passed two or three through the thickness of the lip, and tied all the ends together and cut them off short. The setons were moved every day, and after a little, when free suppuration was established, and the threads became quite loose, I removed them and repeated the same process in fresh parts of the tumour. I may mention that I insisted that the parts should be kept very clean, by constant washing with linen rags saturated with a strong solution of chlorate of potassium. After the removal of the second set of setons the tumour was very much reduced in size, and what was a soft, fluctuating mass had now a feeling of consolidation. I have not seen the child for the past two months, and if it is not already cured, I feel certain a few more similar applications of the seton will make it all right.

There are few subjects in surgery that present a greater variety in their treatment than *nævus*. There are advocates for the knife, the ligature, injections, caustics, cautery, electrolysis, vaccination, seton, and scarification, and the modifications of each of these methods are too numerous to mention. I have given you in a very unfinished way the notes of a few cases that occurred lately in my practice.

A few points in the treatment I may now briefly consider. In the first case I used the subcutaneous ligature ineffectually. I have used the subcutaneous ligature a great many times, and the conclusion I have come to regarding it is this—that it scarcely ever, if ever, accomplishes the end it is meant for—that is, the cutting off of the blood-supply to the tumour and the subsequent strangulation of it. It partakes, to my mind, more of the character of a seton, that for a few hours modifies the vascular supply, and if any good should follow its application, it is due, I believe, more to its action as a seton than a ligature.

The ligature, to be effectual, must occlude all channels by which blood can get to the tumour, and this can only be effectually done by including in it all the surrounding tissue, as I practised in the second case I have described.

The method of removing *nævus* by the knife has been practised by a great many surgeons—the objection to it being the danger likely to arise from hæmorrhage.

The bloodless method I have described is a modification of that practised by Seale and Buchanan and recommended by Davy. It is, to my mind, a very simple and effectual way of getting rid of the deformity with the least amount of suffering and in the shortest time, and one not at all likely to be followed by a return of the disease.

I mentioned in the report of my second case that there was a tendency to return of the disease in the cicatrix, and that it was cured by the application of the “sodium ethylate.” We are indebted to Dr. Richardson for the introduction of this powerful caustic, which will, I believe, take the place of all the others that have been used in the treatment of this affection. It has been found very successful by those who have used it in the treatment of small *nævi*, and many large ones that resisted other modes short of excision. My own experience of it is limited to this particular case, and would not warrant me in drawing any general conclusions.

In large venous *nævi* involving tissue to the amount described in Case III., the seton is, I believe, the safest and best means of treatment. Its use in the manner I have described is, I think, the surest way of obliterating the tumour. It acts in a twofold way—its zigzag course obstructing the circulation to a certain degree, while its presence, causing inflammation and suppuration in the tumour, leads to its consolidation.

DR. HARKIN thought that the operations as performed by Dr. Fagan were successful, but in cases like these he found it impossible to lay down any fixed rule, as every case had to be treated upon its merits.

DR. DEMPSEY pointed out in one of the patients the great resemblance between the scar and that seen in hare-lip, and accounted for this by the direction in which the suture was introduced.

DR. M'KEOWN dissented from Dr. Fagan's practice of sending a patient home until he had seen the final effects of his own operation. He showed many possible ways in which the treatment might be entirely useless for want of a proper adjustment at the proper moment long after the operation. Hence he did not approve of the subcutaneous ligature. He often thought that a surgeon's responsibility commenced after the operation was finished.

Dr. Fagan showed for Dr. John Moore a diseased os calcis.

Paper:¹ MR. FAGAN showed (for Dr. J. Moore) a diseased foot, removed for affection of the os calcis, which he believed was of a malignant nature. It had been gouged out some six months before, and returned with a sprouting, quickly-growing, vascular, myeloid tumour, springing from the os calcis.

R. F. Dill, President

¹ [Dublin Journal of Medical Science, 1880, v69, p260.]

Fifth Meeting January 27th

Present, Professor Dill, Drs. Wheeler, Dempsey, Withers, Mackenzie, O'Neill, Wales Snr., Browne, Esler, Workman, Whitla, Kevin, McKee, Rea, Wales Jr., and several students.

Dr. J. W. Browne exhibited a series of beautiful pathological specimens.

Paper:¹ DR. J. W. BROWNE showed a spongy exostosis which he removed from the unguis phalanx of the great toe of a healthy man who had suffered from it for two years the most distressing agony.

He exhibited a diseased larynx removed after death from a patient upon whom he had performed the operation of tracheotomy. He did not believe that the ulceration was syphilitic or tubercular. There was extensive congestion of one lung and a clot in the pulmonary artery.

He exhibited, also, a bladder from a patient which he tapped per rectum. The case was a very interesting one. The patient was a subject of the hæmorrhagic diathesis. There had been a narrow stricture of the urethra, and before he came under Dr. Browne's care an extensive false passage had been made, tunnelling through the prostate on the right side and entering the bladder; from this opening blood was oozing, but on account of the high pressure within, owing to the distended bladder, the bleeding was prevented, and when he tapped for complete retention this pressure was removed, and the consequence was the bladder filled with large clots of blood. He detailed how he attempted to get rid of these. He injected pepsine and dilute muriatic acid with a view of digesting and breaking up the clots, as recommended by Dr. Foot, of the Meath Hospital. The man sank from uræmic poisoning. A very interesting and unusual point in the case was, as the specimen showed, the remarkable malposition of the ureter—one opened in the middle line at the apex of the trigone. His incision, as they would see, just perforated the bladder in the right spot. He could not say how or by whom the false passage was formed.

He next showed a cyst, semi-solid, which had been removed from a patient; and he gave the following history:—The woman had been tapped twice outside hospital, and the fluid collected rapidly. Finally she consented to have it removed; and he made the usual incision upon Sunday last, and found such universal adhesions and such thorough continuity of tissue as he had never seen before.

He related all the difficulties as they presented themselves, and how he met them. The cyst which he showed was from the interior of the large one. He removed it to gain room, after taking away all the cyst wall possible and the fluid. He concluded the operation, which was performed under the spray, by putting in the usual sutures and a glass drainage tube designed by

Keith; and he here stated that this latter appliance he never would use again, as in removing the dressing next day he found that the glass flange had broken off, though fortunately the glass did not slip inside the abdomen. The patient did well for nearly twenty-four hours, when she suddenly commenced to sink, and died very soon, apparently from shock.

DR. BROWNE next showed a beautiful specimen of compound comminuted fracture of the forearm, extending through the elbow, and showing the T-shaped fracture as described by the late Mr. Adams of Dublin. The limb required instant removal.

DR. WHITLA had examined the specimen of diseased larynx, and he quite agreed with Dr. Browne about its origin; and he was firmly convinced of the fact omitted in nearly all the text books—that true chronic inflammation of the larynx could and does often occur, ending in ulceration, and having neither syphilitic nor tubercular origin.

He described the character of the ulceration met with in ordinary chronic bronchitis of long standing causing death, and he believed it was precisely the same state of matters in the larynx. He could recall, in his short experience, three cases where neither a tubercular nor a syphilitic nor a cancerous origin existed. He had tapped the ovarian patient outside hospital, and seen her tapped in the hospital, and he had examined the inner cyst then, and failed to get from it any fluid by inserting the trocar further in. It was, however, evident what it was through the relaxed abdominal walls.

DR. WHEELER commented upon the interest of the specimens exhibited by Dr. Browne. He thought Dr. Browne could not possibly have done anything else than operate in the ovarian case. If a man only selected such cases as must succeed, and avoided all doubtful ones, his power for good was very limited.

DR. WITHERS detailed a case where two exploratory operations had been made and the patient recovered, the capital operation being abandoned.

DR. KEVIN detailed a very interesting case bearing upon the bladder specimen, where the organ was tapped three times in twenty-four hours.

DR. O'NEILL spoke of the careful and dexterous way in which he witnessed the ovariectomy performed by Dr. Browne. The adhesions could not have been previously foreseen.

PROFESSOR DILL commented upon the care required in the selection of cases of ovarian disease before operation, strongly recommending the exploratory tapping before operating as the best guide to diagnosis. He pointed out the great advantage in operating at the Throne Hospital and not in the Royal.

Dr. Whitla exhibited two specimens of calculi removed by lithotripsy.

¹ [Dublin Journal of Medical Science, 1880, v69, p564.]

Paper:¹ The first was from a girl of six years, who presented herself at the Ulster Hospital for complete incontinence of urine of two years' duration. On an examination under chloroform, he found a large stone; and though his intention at the time was only to make a diagnosis, he was tempted to operate on the spot. The urethra, which just admitted a probe, was dilated by a pair of fine dressing forceps, and the stone easily caught, but extraction was impossible owing to its size and shape, without destruction of the soft parts. It was oblong, and lay with the great diameter across the bladder. A stout pair of necrosis forceps were introduced, the stone caught in the middle of its length and broken in two. Each piece was found to be too large for removal, and a further application of the forceps crushed them into the fragments which they saw in the specimen before the Society. These were removed with some trouble, and by their size an idea of the dilatibility of the urethra might be learned. One was as large as a bean. The passage was dilated during the extraction so much that he easily introduced his little finger and explored the bladder thoroughly. He expected that a good time would be required before the canal would resume its tone again, but he was astonished to find that the little patient was able to keep her urine for two and a half hours after the operation, and continued to improve rapidly, leaving hospital in about a week perfectly well. The stone was phosphatic, and weighed nearly half an ounce, and before removal seemed to entirely fill the bladder, which had contracted round it, the urine as it was carried by the ureters dribbling continually away. More than a year had passed and she was now in perfect health, and had no inconvenience whatever.

The history in connexion with the second specimen was interesting. A stout healthy gentleman, about thirty-eight years of age, had suffered from severe pain of a paroxysmal character in the left hypochondriac region, which was supposed to be of splenic origin by his medical attendant. He lived in England. He had several attacks of this kind, the last being about eighteen months since. About two months ago he received a letter from this patient describing most accurately the symptoms from which he was then suffering—symptoms evidently caused by stone. He wrote to him to that effect, and advised him to travel at once to London and see an hospital surgeon there; but forty-eight hours afterwards the patient walked into his study after crossing the Channel. He passed the small sound, which the members would see was a slight modification of Sir Henry Thompson's curve, and detected a small stone, which the patient affirmed gave an audible note. Upon the second day after this, Dr. Wheeler having administered chloroform, he passed Weiss's smallest size lithotrite, caught the stone and crushed it three times,

the operation lasting about a minute and a half. No irritation of any kind followed.

As Dr. Workman, who watched the case, remarked, there was not a trace of blood to be seen in the urine after this crushing. He bore the chloroform so badly that upon the next operation forty-eight hours afterwards, assisted by Dr. O'Neil, he passed in the lithotrite and only caught two small fragments which he reduced to powder, and washed the bladder out with Clover's apparatus. From thence the convalescence was very rapid. He was put afterwards under ether, and very carefully examined by himself and others, and subsequently by Professor Gordon, and no trace of stone was found.

The fragments, they would observe, were all sharp and angular, and composed of oxalate of lime. The stone was very minute; all that could be collected amounted to not quite 22 grains, which he was certain was at least two-thirds of its entire weight. Though so small, probably not larger than a pea, its presence caused most excruciating agony for more than a year, preventing to some extent the patient, who was the owner of some coal mines, from pursuing his business. From the shape of the fragments they would see that the particles of the stone were united at angles to each other, giving it an almost spinous structure. Pain very much subsided after the first sitting, and entirely disappeared after the second. Upon the eighth day the patient walked several miles with complete freedom, which had not been his experience for more than a year before. Dr. Whitla then referred at some length to Bigelow's operation, which, he thought, marked a new era in the treatment of stone. He was satisfied that a few angular fragments in the bladder were far more dangerous than the prolonged contact of polished steel instruments in careful hands. He showed the great advantages that arise from using a small sound with a sharp curve, and believed that he could not have detected the small stone with the large old-fashioned sound, while he thought he could not pass in the small one without striking it. He exhibited a small metal bougie which he had made for the treatment of fine strictures, its novelty being its peculiar curve, which was hardly perceptible, it being almost straight. Over a year has now elapsed (while going to press), and the patient has never once had a return of his old pain.

DR. WHEELER said he had the opportunity of witnessing the operation which was followed by so successful a wind-up, and he must say that he thought it would have been painless without the chloroform. He was surprised that the patient felt so relieved after the sitting, as he stated to him he felt no inconvenience whatever. He spoke about the difference between the treatment of stone now and what it was in his student days, when lithotripsy was almost unknown.

Dr. J. W. BROWNE said he decidedly was in favour of a clean cut for stone. He detailed several cases upon

¹ [Dublin Journal of Medical Science, 1881, v71, p83.]

which he had operated, and he could recall one in which he was now certain had he performed lithotomy he would have had a very different result. Both the cases before the Society he thought very successful.

DR. O'NEILL described the steps of the operation, as he had seen the patient, and he now understood what he had read in Sir Henry Thompson's book about detecting a stone not bigger than a pea and crushing it at once. The operation was performed without any difficulty, and what convinced him of the great advantage of lithotrity was that he saw that there was not a trace of blood on the instrument or afterwards, and he could not see how in such a case coming before any surgeon again there could be a word spoken in favour of cutting.

PROFESSOR DILL, in thanking Dr. Whitla for his specimens, commented at length about the different operations for stone, and expressing himself confident that every year the cutting operation would become rarer and rarer, as diagnosis became easier, because stones would now be detected when they were small and crushed without danger. Both the cases were to him of great interest. He had not seen Bigelow's operation, but he could see it was based upon rational grounds.

Dr. O'Neill's paper upon Colles' fracture was postponed.

R. F. Dill, President

Session 1879–80

Sixth Meeting of the Society was held upon Tuesday 10th February '80.

Present, Professor Dill, Professor Gordon, Drs. Wales Snr. and Jnr, Dr. Esler, O'Neill, J. W. Browne, Withers, Kevin, McHarry, Workman, Fagan, Whitla, McKee, McConnell, and about 40 students.

Dr. Fagan exhibited a patient with a deformity from Colles' fracture produced 23 years ago.

He also showed a patient upon whom he performed double osteotomy, and a new splint for disease of the wrist joint.

Paper:¹ MR. FAGAN exhibited a splint he contrived for extension of the wrist in acute diseases of that joint, a description and woodcut of which can be seen in the Report of the Transactions of the British Medical Association at the Cork Meeting in 1879.

Dr. O'Neill read a paper upon Colles' fracture and Professor Gordon opened the debate upon it.

Paper:² FRACTURES at the lower end of the radius are of great practical importance, from their frequency and the evil consequences arising from the common methods of treatment still recommended in most surgical works. There are two chief forms.

The first form is usually called Colles' Fracture, so named from having been accurately described by Dr.

Colles, Dublin, in The Edinburgh Medical and Surgical Journal for 1814, Vol X, pp. 182–186, and is usually caused by a fall on the palm of the hand, with a simultaneous forcible extension backwards of the hand.

The second form is produced by a fall on the back of the hand with the wrist flexed. The latter form is very rare, so I shall confine my remarks to the first variety.

Causes.—It is usually caused by falling on the palm of the hand, with the wrist violently extended; the anterior common ligaments and flexor tendons being forcibly stretched, act on the anterior border of the carpal surface of the radius at right angles to its long axis, forcing it backwards so that the radius breaks almost transversely, or with a variable degree of obliquity from before backwards and upwards.

Signs and Symptoms.—1. Swelling over the posterior surface of the wrist, extending upwards on the forearm for about 1½ inches, as the natural hollow over the wrist-joint behind is obliterated, and seems to be transferred to 1 inch or 1½ inches upwards on the forearm. This is caused by the lower end of the lower fragment being displaced backwards with the carpus and metacarpus, and the tonicity of the muscles displaces the lower fragment outwards.

This deformity disappears when moderate extension is made, and returns immediately when the extending force is withdrawn, as formerly described by Dr. Colles himself.

2. Swelling at the lower end of the radius in front, beginning close above the wrist joint and extending upwards from 1 to 2 inches on the anterior surface, the natural concavity of the radius at this part being replaced by a prominence.

3. The lower end of the styloid process of the radius is directed towards the base of the metacarpal bone of the index finger, instead of being in a line with the metacarpal bone of the thumb, as in the normal condition.

4. Acute pain along the seat of fracture in front and behind and over the lower end of the ulna. The pain over the ulna is longest of being recovered from.

5. Inability to pronate or supinate the hand because of the severe pain caused by the attempt to do it; therefore the patient keeps the hand midway between pronation and supination, at the same time supporting the forearm across the chest with the sound hand.

6. By firmly grasping the lower end of the radius close to the carpal border by one hand, and at a point two or three inches upwards on the radius by the other hand, and making moderate extension with backward and forward movement, distinct mobility with occasional crepitus are felt between these points. This sign is conclusive evidence that a fracture exists.

The line of fracture in this accident is described as transverse from before backwards by Smith ("On Fractures in the vicinity of Joints," page 165, Dublin, 1847), Holmes ("Principles and Practice of Surgery," page 247,

¹ [Dublin Journal of Medical Science, 1881, v71, p83.]

² [Dublin Journal of Medical Science, 1880, v69, p566.]

2nd edition), and Packard (*American Journal of Medical Science*, January, 1879, page 124); but Professor Gordon, Belfast, who has carefully studied this subject, states “that of 27 specimens of this fracture in the Belfast Queen’s College Museum 19 are oblique from before backwards and upwards, and 8 are directly transverse” (“On Fractures of lower end of Radius,” page 4; Gordon, 1875).

In the recent forms of this fracture, produced artificially, the line of fracture is oblique from before backwards and upwards, and from within outwards and upwards, extending in front $\frac{1}{4}$ of an inch above the carpal border, and behind from $\frac{3}{8}$ to $1\frac{3}{4}$ of an inch above the carpal border. The lower end of the upper fragment is found to be convex from before backwards and upwards, and from within outwards and upwards, and the upper end of the lower fragment is concave in these directions.

Mons. Voillemier (“Archives Générales de Médecine,” Mars, 1842) maintains that all fractures of the lower end of the radius (that is, within an inch of its carpal surface) are examples of impacted fracture, and considers that impaction of the upper into the lower fragment prevents crepitus from being detected in this form of fracture.

Nélaton agrees with him in this view (“Éléments de Pathologie Chirurgicale,” tome I., page 742). Smith (“On Fractures in the vicinity of Joints,” pages 159, 160) denies that impaction does occur, and remarks that “until the result of the examination of recent specimens can be adduced in support of the theory of impaction I shall be inclined to believe that the impaction is only apparent, and that the compact tissue of the shaft is not found enveloped in bone, from its having penetrated the lower fragment at the time of the occurrence of the injury, but because it becomes subsequently incased in osseous matter during the process by which the bony union of the fracture is accomplished.”

Professor Gordon, in 1875, and his pupils since then, produced this fracture artificially, in the dissecting rooms of the Queen’s College, Belfast, by forcibly extending the hand; and now the more important varieties of this fracture have been represented by artificial ones.

On careful dissection of these fractures produced artificially the line of fracture begins, as a rule, from $\frac{1}{4}$ of an inch above the carpal border of the radius in front, and passes from within outwards and upwards, and from before backwards and upwards, for about an inch; the upper fragment being convex and the lower concave in these directions—viz., from within outwards and upwards, and from before backwards and upwards. In none of these specimens was impaction observed—in fact, it will be easily understood that no impaction can take place in this form of fracture, as its direction is oblique in the directions before mentioned, and because the force which produces this accident acts at right

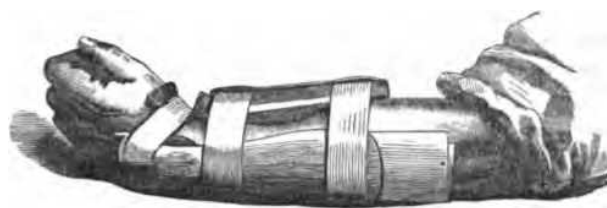
angles to the longitudinal axis of the radius, and rotates the lower fragment upwards and backwards on the lower end of the upper fragment.

Treatment.—Extend the wrist-joint, then apply Gordon’s splint—by placing the bevelled portion of the anterior part of the splint a little above the lower end of the upper fragment—to fix it; now flex the wrist to an angle of 45° , and apply the posterior part of the splint to press forwards, and retain the lower fragment in that position.

The splints must be well padded with spongiopiline, flannel, tow, or other soft material. Place a thick elongated pad of tow (about 1 inch x $\frac{1}{2}$ x $\frac{1}{2}$) against the outer border of the carpus longitudinally, pass a narrow strap through the ulnar part of the splint and over this pad, so as to press the carpus inwards towards the ulna. Fasten the splints by two more straps—one over the splints close to the lower end, and the other over the splints close to the upper end. Secure all by a bandage extending from the fingers to the elbow. Should severe inflammatory swelling of the hand occur during the first twenty-four hours, I remove the posterior part of the splint and readjust the padding. This may be repeated once weekly to watch the progress of the case, and any displacement of the fragments should it arise. In patients under fourteen years of age three weeks will be sufficient time to allow the splints to remain on; above fourteen years four or five weeks will be required. After removing the splints entirely envelope the hand and forearm in cotton wool, and lightly bandage for two or three weeks. See that the fingers are kept frequently moved from the second week after the accident to prevent prolonged stiffness, which may occur if this point is not attended to.

I have treated more than 150 cases in the Belfast Royal Hospital by applying Gordon’s splint in the method above described, and, with few exceptions, have found that the patients soon regained the perfect use of the forearm and hand. Several patients, especially those over fifty years of age, suffered from pain of a rheumatic character along the line of fracture in cold weather, but this was easily remedied by applying cotton wool and a bandage for a longer time after the splint was removed than in younger patients. The accompanying diagram represents Gordon’s splint accurately applied for the treatment of Colles’ fracture.

PROFESSOR GORDON, after the paper was read, made the following observations:—The first thing to be determined is—What is Colles’ fracture? I would define it as



the usual fracture of the lower end of the radius, caused by falling on the palm of the hand, and very rarely extending above an inch from its lower end. In such cases, if the splint be properly applied, the lower end of the radius will be so perfectly restored that it will be difficult to say after five or six weeks which radius was fractured. If the radius be broken from an inch and a quarter to an inch and a half above the lower end, then both fragments are usually displaced inwards, diminishing the interosseous space. In such cases the splint will fail in correcting the displacements inwards, especially of the upper fragments, as it is held in this position by the extensor muscles of the thumb; but I do not know of any more efficient splint for the treatment of this variety of fracture. Indeed the question has often forced itself upon me as to the necessity of limitation of Colles' fracture, so as to give it a precise meaning, and draw the distinction between fractures of the lower end of the shaft of the radius and Colles' fracture. If the fracture be in the lower inch of the radius, and the term Colles' fracture be restricted to that inch, then the treatment of it will be found most satisfactory by my splint; but if the fracture be a little higher up, then a slight diminution of the interosseous space and transverse breadth of the forearm will occur, which neither the radial splint nor any other mode of treatment with which I am acquainted will correct. As to the age at which it occurs, I have seen it in persons from five to twenty-three years of age, and from twenty-five to thirty-five years it becomes very rare; and after fifty years, when senile atrophy begins to manifest itself, it becomes very frequent—so that even the slightest force may produce it. As to the palmar swelling, it is mainly inflammatory, and is caused by the lower end of the upper fragment starting forwards and wounding the soft parts in front. By pressing the upper fragment backwards and the lower forwards, the apposition becomes perfect, all stimulus to inflammatory action is removed, and in many cases there is no swelling of the fingers nor tingling sensation, which was, before the introduction of my splint, considered a necessary accompaniment of Colles' fracture.

And as to the doctrine of impaction in this accident, all I can say on the subject is this—that I have seen and carefully examined several hundreds of the specimens of the artificial fracture, and in none, either produced by myself or by others, was there the slightest appearance of impaction—as the force exerted on the anterior border of the carpal surface, as stated by Dr. O'Neill, drives the lower fragment backwards, whilst the lower end of the upper fragment, being in projectile force by the weight of the body, is forced forwards against and into the flexor muscles, and, therefore, I regard impaction almost as a mechanical impossibility; but as regards that form of fracture produced by falling on the back of the wrist, as referred to in the paper just read, I regard it as a truly impacted fracture, of which I have

two admirable specimens in the Queen's College Museum.

Dr. JOHN WALES did not think that the successful treatment of Colles' fracture was by any means confined to the use of the "Gordon splint."

DR. WALES (senior) thought there could be little doubt as to the great value of the Gordon splint in the treatment of Colles' fracture, as defined by Professor Gordon, if correctly applied. We see, however, even amongst well-informed surgeons, considerable difference in its mode of application. For example, it is frequently applied so as to make lateral pressure on the upper fragment of the radius, near the seat of the fracture, the result of which must be to aid the pronators in diminishing the interosseous space—thus creating a deformity which he had frequently seen as a sequence of this fracture. He thought, therefore, that the principles enunciated by Professor Gordon, rather than his splints, commend themselves most—for attention to the former will enable any intelligent surgeon to construct, out of materials at hand, an appliance which will produce satisfactory results, where such can be produced, by the Gordon splint. But this is not always the case, even with the latter. A suitable pad on the anterior aspect of the upper fragment, immediately above, but not on, the line of fracture; a pad on the end and posterior aspect of the lower fragment and carpus, secured by two plain splints—leaving the hand well flexed and the fingers free, to prevent stiffness from adhesions—would, he believed, meet all requirements in a simple manner.

DR. FAGAN approved of Nélaton's method of treatment instead of Professor Gordon's. He had not much experience of the practical application of the splints, and though he spoke more theoretically than practically, he had given the matter some thought, and he must say he failed entirely to see the intention of the bevelled portion of the splint; nor could he see why the accident could not be as well treated by a piece of straight and flat wood properly padded. While he could see no use in this part of the splint, he thought that its convexity would be sure to produce some lessening of the interosseous space. From an anatomical study of the subject there was no necessity for it. He could not see how it would keep the radius and ulna from approaching each other, as was contended by those who advocated its use.

Dr. A. M'CONNELL said he had considerable experience of Gordon's splint, and used it in all cases to which it was applicable. Its advantages are very evident in cases which have been neglected from two to three weeks. It is easily applied, retains its position without trouble, and effectually corrects any deformity. The splint is a great boon to the practical surgeon, and we owe a deep debt of gratitude to Dr. Gordon for his invention.

Dr. WHITLA said he would refer to a point which was overlooked in the discussion—viz., the latest period

in which one was justified in treating a fracture by the Gordon splint. He had applied it in one case where the accident was of four weeks' standing, in another of three and a half, and in several where the bones had been more than a fortnight fractured—all with great benefit. He thought there could hardly be a limit put to the time, as the splint, properly applied, would restore the natural condition of the parts so perfectly that, even if firm osseous union had taken place, great good would follow its use, as the alteration in the direction of the articular surfaces would be prevented even after a very long time. As regarded the use of the bevelled portion of the splint, he thought that there was hardly room for a difference of opinion when anyone looked at the beautiful natural antero-posterior curve in the perfect bone which he held in his hand. In case of fracture this concavity in the radius was almost always changed into a convexity. The inventor of the splint had early seen and recognised the vast importance of restoring this concavity, and he made the bevelled portion of his splint the keystone of his arch, and with consummate skill succeeded with the simplest contrivance to remedy a deformity that had previously baffled every surgeon. He had used, or seen the splints used in, he believed, over 200 cases, and in no instance where it was applied properly, had he seen any but highly satisfactory results follow; and he believed he was perfectly correct in saying that in nine cases out of ten no proof of fracture could now be detected upon the most critical examination.

Dr. WORKMAN understood Dr. Fagan to speak of the bevelled portion of Dr. Gordon's radial splint as being used to make and keep up a lateral separation between the radius and ulna. Dr. Workman had always been taught by Dr. Gordon that the bevelled portion was not intended for, nor was it capable of performing, such a duty, but was intended to keep the upper fragment of the radius in a plane posterior to that of the ulna; and he knew of no plan of padding which would be at all so effectual as the radial splint. Dr. Workman considered it unnecessary, as a rule, to place the little pad which Dr. O'Neill recommended on the outer side of the carpus, under the carpal strap, but wished to call attention to the advantage of placing a very thick, small pad on the back of the carpus. A pad so placed would keep the carpus with the lower fragment of the radius well forward, and this carpal strap, passing from the back splint to the prominent base of the metacarpal bone of the thumb, would exercise no injurious pressure on the veins. From his experience he had found it better, as a rule, not to keep the splint on for more than about four weeks, for in several cases where the splints had been left on for about six weeks, on removing them he found that, although there was no deformity, the fingers and wrist were very stiff—apparently from the hand being kept in one position for such a length of time—so much so that it was many weeks before the hand had per-

fectly resumed its functions. Dr. Workman thought that spongiopiline or felt was the best substance for padding the splint, but in hospital he was in the habit of using tow, only on account of its cheapness, and had found it to work admirably.

The PRESIDENT said:—I believe I am warranted in the statement, and I think I reflect the minds of the members, when I say that a more important practical and useful paper has not been brought before the Society for a long time than this one, to which we have been listening with so much attention, by Dr. O'Neill, on Colles' fracture and the Gordon splint, and which has been so ably supplemented, and minutely and clearly demonstrated, by Professor Gordon. I have had a lengthened and ample experience in the use of this splint, and I may say that its value cannot be exaggerated, neither can we bestow too much praise upon its admirable adaptation to the wrist and forearm, the great comfort experienced by the patient, and the very satisfactory results which have been found to follow from its proper application. I am free to state that, before this instrument was designed and came into use, I always experienced a want or a deficiency in the treatment of those cases of Colles' fracture which came under my care, as there was a greater or lesser degree of deformity following in each case; but I have invariably found the results to be most satisfactory since I began the use of it. When I first saw and carefully examined for myself the Gordon splint, it at once commended itself to my mind and judgment as a mechanical contrivance which was admirably suited to the object for which it was designed; and I cannot imagine anyone possessed of a mechanical mind or genius but who must see and acknowledge its undoubted merits.

And yet, with all this, I regret to say that, from what I have both seen and heard, there are those in the profession, far and near, who, as has been stated, require still to be educated into the use and proper application of this instrument. To prove this I shall offer you one or two instances. The first is that of a lady who came to me from a little distance. She had her arm in a sling, had on it the Gordon splint, and she was suffering much pain. I found, upon examination, she had received a Colles' fracture, and that the splint was actually applied upside down. No wonder, indeed, that she suffered so much. I need not say I altered the splint, and adjusted it so as to afford her much ease, and the case did well. The next case was told me by one of our young graduates (a Belfast student) who, while visiting a metropolitan school, dropped into a lecture-hall. The subject of clinique was Colles' fracture, and, after exhibiting the Gordon splint, the lecturer proceeded to show how it should be applied. The young graduate could scarcely preserve his countenance when he saw it being applied in the wrong way, or upside down. He took the liberty of introducing himself afterwards to the lecturer, and correcting the error which to a Belfast man

was a palpable blunder. As a few of the members are not agreed upon what constitutes a proper padding between the splint and the wrist and forearm, I may say that I have often applied it without any padding whatever, and when it is made to fit in size and shape, I have seen it to suit the purpose admirably. But before using it in this way I have found it necessary to round off the anterior sharp edge. This I would venture to suggest to Professor Gordon as an improvement under any circumstances. Allow me to conclude by saying that, if, as I assume it to be a test of genius to supply an admittedly great want by producing an original and very appropriate mechanical contrivance, and which has been furnished to us in the invention of this admirable work—then, I submit, to Professor Gordon, the author of this very valuable surgical appliance, the “Gordon splint,” must be accorded the honour of being an inventive genius.

J. W. Browne, Vice-President

Session 1879–80

Seventh Meeting 2nd March 1880

Present, Professor Dill in the chair, Dr. Harkin, Dr. McKeown, Dr. J. W. Browne, John Moore, Dr. McHarry, Dr. Withers, Dr. Esler, Dr. Dempsey, Dr. McKee, Dr. Workman, and Dr. Whitla

Dr. Harkin Ex-President read a paper upon chlorate of potash.

Paper:¹ It is generally known, I believe, to the members of the Ulster Medical Society, that I have for many years been an earnest advocate of the use of chlorate of potassium in the prevention and treatment of disease, and that I have already on two occasions submitted the results of my experience to the consideration of the profession at large. I have written, as it were, two monographs—each one devoted to a special phase in the curative action of the remedy. My first paper, read before the Society, and published in *The Dublin Quarterly Journal of Medical Science* for November, 1861, was entitled “The Use of Chlorate of Potash in the Treatment of Consumption and Scrofula.”² The second, upon “Chlorate of Potash in the Hæmorrhagic Diathesis,” was communicated to the British Medical Association, at its meeting in Cork in August, 1879, and detailed at length my experience of its curative agency in cases of epistaxis, hæmophilia, purpura hæmorrhagica, hæmaturia, menorrhagia, hæmatemesis, hæmoptysis, and hæmorrhage from the rectum.

My intention at present is to demonstrate the beneficial effects of the remedy in another department of medicine. My great difficulty, however, is to make a selection, as there is not, in reality, a single class in the nomenclature of disease that I might not refer to in proof of the salutary influence of this drug. When I

state, as the result of my observation extended over a great many years, that this salt exercises a most potent influence on all maladies dependent upon defective nutrition, secretion, excretion, æration, and molecular metamorphosis—that it possesses the power of developing vital force in weakened constitutions, of retarding the degeneration of the tissues, and of frequently controlling the too rapid advance of senility, due to climacteric conditions—the difficulty of selection will be at once apparent.

Before proceeding further, I may be permitted to refer to its *modus operandi* its dose and mode of administration. My theory is that, being principally composed of two elements indispensable to the formation of healthy blood—viz., oxygen and potassium, its administration, especially where one or other of these substances is deficient, tends to improve and elevate the condition of the circulating fluid, upon which the health of every organ of the body depends. When a solution of chlorate of potassium is taken into the stomach, a portion—as is the rule with iodide and nitrate of potassium—is carried off by the kidneys; another portion passes by diffusion into the liquor sanguinis, the textures, the blood globules, and white corpuscles; a third may be supposed to part with three equivalents of oxygen in the blood, leaving behind chloride of potassium, which may be detected in the urine as well as in the blood, of which it is an important element. After its continued use the patient experiences an increase of appetite—of *nervo-muscular* force; all the bodily functions are performed with greater ease, the colour improves, and the flesh producing power is manifestly augmented, as evidenced by increased weight, the character of the blood itself being altered by an addition to its fibrin and plastic qualities. When required for internal use, I generally order it as a saturated solution, say one ounce of the salt to twenty of water, of which for adults one ounce three times daily either before or after food. Most useful by itself, yet its efficacy in arresting disease, in chlorotic or hæmorrhagic diatheses, may be greatly enhanced by the addition of iron in one of its many forms, the most convenient being the *tr. ferri perchlor.*

With the permanganate of potassium it forms a most excellent gargle and mixture in sore throats with diphtheritic exudation, and for the healing of ulcers; it also forms a good base for many pectoral mixtures. As to the tolerance of the drug, I know not of any remedy so generally well borne. I have prescribed it for patients of all ages and conditions with wonderful success and advantage, and, while I can safely state that thousands have been benefited by its use, I can count upon my fingers the number that it has disagreed with. I have met a few cases in which it produced unpleasant symptoms, and some with peculiar idiosyncrasies, in whom it had to be dispensed with altogether. Like other salts of potassium—the acetate and the nitrate—it occasionally

¹ [*Dublin Journal of Medical Science*, 1880, v69, p398.]

² [See page 255.]

acts, though in a less degree, as a diuretic, but this condition is far removed from nephritis—a disease which Jacobi asserts to be frequently produced by its use. In all my experience I remember but one case that at all approached this condition—it was that of a young German lady, a subject of phthisis, living in Holywood, who, while taking the chlorate, certainly suffered most painfully for a number of hours from strangury, but who recovered by the ordinary means of stupes, hot baths, &c. Dr. Cutter, a very able American physician, told me of a case that occurred to him while crossing in a transatlantic steamer, that recovered with difficulty after taking only ten grains of the salt. As a contrast to this, I may relate the case of a strong young man who, having been supplied with a gargle containing an ounce of the salt, through mistake drank the whole at a draught, and did not experience the least inconvenience in consequence. Whilst, therefore, I do not give any credence to the exaggerated statements which have lately appeared in the medical journals, I do not think that the prescription of this remedy should pass, like cod-liver oil, out of the control of the profession, and become a merely popular medicine, but that it should be given with caution, although without reserve, under medical supervision.

Perhaps among its many valuable qualities none is more remarkable than the rapidity with which its application as a lotion heals up the injuries due to burns and scalds, so often by ordinary treatment both tedious and troublesome to cure. It is quite surprising how soon the healing process commences after the application of the lotion, and the raw surface is covered by the formation of new skin. This rapid improvement takes place not only when vesication is extensive, and the cutis more or less destroyed, but also in the more severe cases, where not alone the cutis but the subcutaneous tissue is destroyed, and even when ulceration is present after the separation of the eschars—the condition which makes the treatment of burns and scalds so troublesome to hospital surgeons, and the wards allocated to their treatment so often foul and offensive.

After a few applications of the lotion a zone of new skin appears proceeding from the circumference, day by day speedily narrowing the denuded surface, till at last the wound is healed. The chlorate of potassium lotion appears to possess the power of favouring the secretion of fibrin in peculiarly plastic condition, and of hastening the formation of new tissues, and thus completing the reparatory process, and the healing of sores. I shall try to illustrate my position by an example. About twelve months since a member of the Royal Irish Constabulary received a scald upon his right hand, producing a painful blister, and he applied to me for advice. My friend, Dr. J. W. Browne, happened to see him at this visit and subsequently. I directed the man to puncture the blister, and remove the cuticle by a poultice, and then to apply a lotion composed of five grains

of chlorate of potassium and one ounce of water, every four hours; twenty-four hours alter its application he returned, already the healing process had commenced, and a border of newly-formed cuticle, one half inch in breadth, presented itself. Next day a further narrowing took place, and so on, till at the end of five days the cure was complete.

Another case, on a larger scale, occurred in the Male Industrial School, then located in Donegall-street, about seven years since—that of a little boy who stumbled when lifting a pot of boiling broth, and received the contents down his back, which blistered him from the neck to the nates. On visiting him I directed the back to be poulticed for twenty-four hours with bread and water, and after the removal of the detached cuticle the surface of the scald to be dressed with lint, and the lotion of the same strength as above to be frequently renewed, and a mixture of the saturated solution to be given in half-ounce doses three times daily. This case comported itself like the former one, the cure was most rapid, and the lad was able in seven days to put on his clothes and resume his ordinary avocations.

CASE III.—I shall only refer to a third case—that of a brewer's man, who was scalded by the overflowing of boiling wort, and blistered on both thighs. In his case the greater part of the blistered surface healed within a week, but some ulcers, with troublesome granulations, required the lotion to be doubled in strength before finally yielding.

An important item is to apply the lotion three or four times daily, to add the permanganate if any offensive discharge arises, and to maintain the strength of the patient by the administration internally of large doses of the salt.

Closely allied to the condition of a scald or burn is that of a sloughing ulcer, due to the application of a blister in enfeebled constitutions. This ailment is usually treated with the *lotio nigra*; the chlorate lotion will be found to be more rapidly successful in giving a healthy cast to the surface of the wound. I shall relate a remarkable case in proof of its power:—

CASE IV.—About ten years ago I was in attendance upon three children of a family living in Murray's-terrace, suffering from scarlatina with diphtheritic exudation and high fever. The two elder patients had required blisters on the throat, which healed without any trouble; not so with the third, a girl of six years, for, twenty-four hours after its removal, the blistered surface assumed an unhealthy appearance; it then began to slough, and soon the healthy surrounding skin became similarly affected, and the slough extended from the chin to the sternum, and from the ears to the collar bones; but the slough took another direction, and after the skin and fascia of the neck it destroyed the *platysma myoides*. And the cellular tissue on the left side, leaving the external jugular quite isolated and the sternocleido-mastoid muscle as well defined as on the

dissecting table. The external jugular being quite occluded I snipped it off with a pair of scissors. The disease still proceeded, and the external carotid was laid bare, and was observed pulsating vigorously at the bottom of the wound. Matters now looked serious, and I thought it right to ask Dr. Murney to give me the benefit of his valuable counsel. He advised the application of my favourite remedy, chlorate of potassium, ten grains to the ounce as a lotion; the result was, that in twenty-four hours one-half of the right side of the neck was healed, and in two days more it was completely cicatrised, the healing process proceeding from the circumference to the centre. The left side, with the deep-seated slough, also healed completely within five days, leaving the child unable to laugh without distortion of the features from the destruction of the skin muscle on one side and the absence of antagonism. However, after about a year, some principle of compensation seemed to be established, and the deformity disappeared altogether.

In the treatment of caries of the vertebra of the neck, by the injection of a solution of the salt I have had on two occasions the greatest advantage; and in cases of strumous abscesses and sinuses treated by injection the cure is generally very rapid—of course in every case the constitutional requirements being attended to by the internal administration of the salt.

Case V.—About twelve years since I was called to see a patient in Lagan village, a married woman, nursing her first child, but in a very delicate, wasted condition, due to a profuse discharge which came from her left shoulder-joint, of a scrofulous nature; there were several openings about the insertion of the deltoid muscle, and the drain was so debilitating that the patient appeared to be in an advanced stage of consumption. I prescribed the internal use of the chlorate of potassium, and injected the sinuses daily, with a weak solution of the salt. Her health immediately began to improve, and in three weeks the discharge had ceased altogether, the arm resuming its ordinary functions. I have seen the patient lately; she carries on the business of a shop in a stirring part of the town.

CASE VI.—Mammary Abscess and Sinuses.—In July, 1868, a lady called on me for advice. She had been suffering from an abscess in the breast for three months. Her baby was five months old, and she had never nursed. She was much exhausted, and in a very nervous condition. On examination I found that the right breast was painful and inflamed, and that there was a purulent discharge proceeding from live openings, the outlets of five sinuses which had subsisted from the date of the original abscess. I prescribed the mixture of the ordinary strength, and injected each of the sinuses with a solution of ten grains to the ounce. When the patient called next day already one of the orifices was closed. I then injected the four remaining; next day another had closed, and by the end of five days the last

sinus was permanently healed. The lady's health was re-established at once, and she has since given birth to three other children.

The effect of chlorate of potassium upon ulcers, simple, irritable, indolent, and rodent, is very remarkable. I might point to several cases at present under my care for ulcers in the leg and on the head, the results of wounds; but would merely state that they heal just as I have described in the case of burns. The hard and elevated edges of old ulcers give way to flattened and healthy ones, and the excavated surface of the sore is altered by the oxygenating power of the lotion and replaced by healthy granulations.

CASE VII.—I shall relate but one case, that of an intelligent, educated man, himself a doctor residing in Kilkenny, who applied to me by letter for advice in 1864, suffering from painful chronic ulcers, that had reduced him so much that he had to get a substitute for his dispensary practice. I have fortunately two of his letters remaining. I shall read them for you; they tell their own tale. In the first letter he says:—"I am now a week using the c. of potash internally as well as externally. There is a great change. The sore is healing, the integuments so unhealthy and breaking away are now pale and healthy looking, and the irritation for which I had to take morphia, as well as add it to the local application, is so much subsided as to enable me to dispense with the morphia locally, and to reduce the internal use from $1\frac{1}{2}$ grains to $\frac{3}{4}$ daily. The elevated and everted glazed edges of the sores are now flattened and dipping into the ulcer. You said it truly when you mentioned that in the chlorate of potash I should find what I'd been long seeking. How can I thank you for the benefit you are doing me? Your remedy stands upon sound therapeutic principles, and is true.—Kilkenny, 5th October, 1864."

He writes again, 30th October:—"I may say I am just healed; the sore is skinning ever so rapidly; I expect it to be entirely closed in a few days." Later on he writes:—"Though not quite healed, and this owing to my being obliged to undertake dispensary duty too soon, yet I have but two ulcers, the size each of a shilling. When I discontinue the chlorate internally I find I am obliged to resume it. It at once improves the aspect of the sore. I have since used it in leucorrhœa and in purpura, in combination with tr. mur. ferri, as you suggested, and with most beneficial results. In a case of the latter disease, a child was under other treatment for months, the first 8 oz. mixture of chlorate with iron astonished its parents, the result was so manifest."

This poor gentleman was finally cured and restored to usefulness and health, and with his case I conclude.

Dr. Meharry congratulated Dr. Harkin upon the success of his cases. In ordinary practice most men combined iron with the chlorate. He did so, but always attributed the good effects to the iron. He would watch it now with interest.

Dr. Withers wished to see its local application more extensively used. He asked for an explanation of its action. Did it act by mild astringency or by stimulation? He had seen it lately tried in the case of a large indolent sore with success after everything had failed.

Dr. Moore thought that Dr. Harkin was too sanguine in his opinion about the efficacy of the chlorate. He detailed his experiences of it in many and different diseases, thought that often it was uncertain and useless; but, upon the whole, there was no doubt that chlorate of potassium had won for itself an honourable place in *Materia Medica*. It was, unfortunately, used so often in combination with iron that there was great difficulty in coming to a conclusion about which agent did the good.

Dr. J. W. Browne said his father had used this medicine so extensively that he was known amongst the students as "Chlorate of Potash." Perhaps he inherited some of the veneration for the drug, and used it often, and more than once with marvellous success. As regards its use in mammary abscess—of which he had four severe cases last year—he injected a solution, and at the same time gave it internally, with most decided benefit. He could say the same of its use in ulcers, only he would remind anyone about to try it that a solution of more than five grains in the ounce would smart considerably.

He then detailed his treatment of burns—first he applied a poultice, and after it came off he had a solution of the salt laid upon the burns, and, in many cases, in twenty-four hours, a new growth of a quarter to a half inch of skin could be seen. He referred to a paper by Mr. Jonathan Hutchinson, and said he could fully corroborate his statements about the very decided benefit of the powdered salt in phagedenic ulceration. He then detailed some important effects which he had observed from chlorate of potassium in various diseased conditions, especially gonorrhœa, in which disease he made a mixture of the salt containing 1 drachm in 2 ozs. Two drachms of this were to be used every second hour for the first twelve hours, and always with great success.

Dr. Whitla had a good deal of experience of the use of chlorate of potassium in the two widely different classes of cases in the Children's Hospital and the Old Charitable Hospital. In the cases of children's disease he must say they simply could not do without it. How it acted he would not pretend to say, still less would he pretend to go into any chemical theory, but he was satisfied it produced very decided change of action in the secretion of most mucous membranes in unhealthy children. He had watched narrowly its action in cases of tonsillitis and pharyngitis, and though he thought it did great good, one thing he was positive about—viz., that if continued beyond the proper time it kept up and increased the congestion. This he had often demonstrated, and the moment its use was stopped the throat got immediately better. He then detailed some cases of

chronic ulcer in the aged where its use was decidedly beneficial.

Professor Dill said at this stage in the history of the profession and in the nineteenth century it was refreshing to hear a paper brought up by a man like Dr. Harkin upon a purely practical subject of such therapeutic interest. He then described the general course pursued by most consultants, nearly all of whom, in his experience, contented themselves by making out the diagnosis of the case. He referred at length to the effect in this direction of the teaching of Laennec and his disciples, many of whom laughed at the idea of treating disease with medicines. He was glad, however, to see that the tendency was now reviving of treating disease with medicines. He expatiated upon the therapeutic action of the drug and the evidences of its decomposition into the chloride and oxygen. He thought as regarded the treatment of burns that the old plan of allowing the blisters to remain without puncture was the best, and he felt he would be slow to follow out the line laid down by Dr. Browne.

Upon the subject of enlarged glands he said we required to know a good deal more than we did about the laws which governed diseased action in these peculiar organisms; how common it was to meet with enlarged glands which resisted all treatment, and which, as far as we were able to tell, differed in no way from those which disappeared as if by magic.

Dr. McKeown read a paper upon a new treatment for relaxed tympanum.

Paper:¹ I have pleasure in bringing before you the results of a somewhat large experience of a new method of treatment of relaxation of the *membrana tympani*, which I have already submitted to the notice of the profession at the meeting of the British Medical Association at Cork in August last. I am happy to say that my faith in it has not waned, that from my first application of it till the present time I have used it almost daily, and that I have the firm conviction it will take its place as one of the most important aids in the treatment of diseases of the ear.

When a claim is advanced for the introduction of a new method and a new principle in the treatment of disease, it is desirable to review the present state of knowledge. On examination of the works of the most eminent authorities in aural science we shall find that—No method of Treatment of any value has been proposed or practised for Relaxed Membrane.—Sir William Wilde, in his classical work on "Aural Surgery," writes:—"This is a cause of deafness most difficult to treat, but unless some other disease coexist with it we may generally assure the patient that his deafness will not increase. When once the membrane has been pressed for any length of time inwards it is very diffi-

¹ [Dublin Journal of Medical Science, 1880, v69, p502.]

cult to restore its position permanently. Many persons inflate the drum by holding the nose and making a forced expiration whenever they wish to hear what is said. In others we can temporarily restore the position by Eustachian catheterism, but in both the membrane returns to its former condition in a short time. I have tried the effect of exhausting the air in the external meatus by means of a syringe accurately adjusted to the outer aperture, but I have not effected any good thereby. On the contrary, I think the congestion produced by the exhaustion is rather detrimental to the organ. I have frequently afforded temporary relief by dropping with a glass tube a little nitrous ether into the meatus, and immediately stopping the external aperture either with the finger or by pressing the tragus over it. Some slight pain is instantaneously felt, followed by a boiling sensation, then a glow of heat, and a feeling, to use the patient's expression, as 'if the drum of the ear was sucked out.' It is difficult to understand how this remedy acts and assists to restore the membrane to its normal position."

Hinton, in his work on the "Questions of Aural Surgery," says:—"In milder degrees of indrawing of the membrane, when, though it can be restored to its place by inflation, and temporary improvement follows, it soon falls back again, Politzer introduced and still speaks highly of the plan of keeping up an air-tight closure of the meatus. Having well inflated the tympanum, he takes some cotton wool rolled up into a small ball with wax or ointment, and with it closes the orifice of the meatus. He thus takes off the pressure of the external air, and even turns to account the absorption of air in the meatus, making it tend to draw the membrane outwards, care being always taken to see that the Eustachian tube is free. The ball may be worn for several consecutive nights, and then omitted for the time. When the membrane is atrophied, however, this plan does not succeed. But then excision of the relaxed part, whether it be a scar or a part otherwise thinned, will sometimes be of use; or if the relaxation has advanced only to a less degree, and the membrane simply lacks the proper tension, simple incisions into the most relaxed part of the membrane help towards a restoration of the normal tension, apparently through the contraction that attends their healing. The incisions may be frequently repeated, and at short intervals; but in this climate, and with the kind of patients we usually see, I should prefer always to let fourteen days elapse." It will be observed how unsatisfactory is the testimony of this conscientious observer regarding the treatment he proposes. It looks as if he thought these means should be useful rather than that they were. He says nothing of his personal experience of Politzer's method. To cut out a piece of the membrane is not an operation easy of execution nor altogether safe, and simple incision is, in my opinion, very unlikely to increase the tension. Certainly he has not

advocated these operative measures in such a way as to lead to their adoption, and we have no data on which to form an independent judgment.

Toynbee deals with the subject, and gives details of cases in which he treated intercurrent inflammatory attacks with success, but we have not a suggestion regarding the treatment of the condition of relaxation.

I need not further quote from authorities. I may briefly state that the works of Von Troeltsch, St. John Roosa, Turnbull, Dalby, Field, and Macnaughton Jones, either pass over the subject altogether or fail to make any valuable suggestion for treatment.

Importance of the proper tension of the Membrane.—There can, I think, be no question that the membrane has at least two functions—viz., to receive vibrations for conveyance through the ossicles to the labyrinth, and to support the handle of the malleus. If the membrane in whole or in part have lost its proper tension, it is, I think, evident that the vibrations will not be conveyed with due regularity, that different vibrations succeeding each other may be confounded, and that a dulness of hearing may result from the confusion necessarily resulting. Further, if the membrane at parts be depressed so as to touch structures within the tympanic cavity, the force of the vibrations may be diverted from its proper channel. It is likewise evident that one part of the membrane may be depressed without materially interfering with the support of the handle. If the membrane be of proper tension in two or three different radial directions, the handle may be well supported, and the hearing consequently will not suffer from this cause. If, on the contrary, the whole of the anterior or posterior segment should be defective in tension, then the handle can have no longer proper support, and is likely in time to assume a faulty position, as a rule, in a direction opposite to that in which the tension is defective. When the whole membrane lacks proper tension, then the handle usually inclines inwards too much, and brings about intra-labyrinthine pressure and nervous disturbance. In some instances the handle as well as the membrane has far too great a range of motion both inwards and outwards—this being no doubt caused by insufflation and forced expiration.

Having now a notion of the functions of the membrane, we may examine with advantage—

The Clinical Characters of Relaxation of the Membrane.—I do not deem it necessary to enter upon a discussion of various diseases which may lead to this diseased condition, but shall simply observe that relaxation is usually brought about either by inflammatory processes in the membrane itself, leading to a loss of resisting power, or by long-continued pressure of the atmosphere on a drum-head exhausted during the course of Eustachian disease. Let us suppose, however, that the original cause has disappeared, and that we have simply to remedy results. The clinical characters are very characteristic, and somewhat varied. As you

would expect from the unsteady condition of the membrane, the hearing power varies quickly and remarkably. At one minute the hearing of the patient may be average, at the next quite dull. The fact is, it could scarcely be otherwise, considering that in many cases the membrane flaps in and out in a most irregular manner on every act of swallowing—indeed almost with every change of position of the head. The patient usually has either been taught, or has found out, that distension of the tympanum by forced expiration—the nose and mouth being closed—improves the hearing for the time, and he therefore resorts to this very frequently for the sake of the temporary improvement induced, but so soon as the membrane collapses he is as bad as before.

Various unpleasant subjective sensations find a ready explanation from the condition of the membrane. For example, the feeling as if the ears were plugged with wax, or some foreign substance is caused by the inward pressure of the collapsed membrane on the ossicles. The confusion of voices, of which many complain, arises, in all probability, from the vibrations not being quickly conveyed and terminated, because of the want of tension of the membrane. The sensations of opening and closing, or of something falling in the ear, are very frequently experienced by the patients, and are clearly produced by an actual physical cause—viz., the movements of the membrane. Some extraordinary noises, of which patients with this disease sometimes complain, may be located in the membrane and cavity of the tympanum, and entirely removed from the objectionable category of nervous disease. It does not require a great stretch of imagination to conceive how rattling, thundering, creaking noises arise from movements of the membrane and ossicles. A patient under my care at present says that he had a feeling as if something were knocking about in his ear when he breathed deeply, blew his nose, or shook his head. Clearly the cause was in the middle ear, and, I have little doubt, was caused by a relaxed membrane, with probably some loosening of the connexions of the ossicula. This view is borne out by the fact that the symptom disappeared on the restoration of proper tension to the membrane.

On inspection of the membrane we find the greatest variety in the appearances. Sometimes the membrane retains its normal transparency; sometimes it is opaque or somewhat thickened, in whole or in part; the membrane may be relaxed, in whole or in part; the depressed part may gradually slope into neighbouring parts, or may be separated from them by a well-defined margin. In some cases the depressed part is involuted, as it were, so as to be in part hidden beneath the surrounding membrane; or may be so pressed down upon the ossicles that the latter are clothed with the membrane.

To complete the examination of the condition of the membrane, it is necessary to inflate the drum by one of

the usual methods. In this way we may determine whether the case is one simply of relaxed membrane, or of relaxed membrane complicated with adhesions. If forcible expiration causes all the depressed parts to bulge, then it is clear the membrane is not adherent; but if by this method no change, or only slight change, is induced, then it will be necessary to use Politzer's method. I have several times remarked that forcible expiration only partially elevated a depressed membrane, and that Politzer's method completed the elevation.

It is especially important to note the relation of the handle of the malleus—viz., whether it is inclined too much inwards or outwards, backwards or forwards; whether it stands out prominently, with membrane depressed before and behind, or has given way entirely to the in-pressing membrane. In the majority of cases deviation in one or other direction will be found.

Prognosis hitherto.—At the best, as Sir William Wilde has remarked, the condition may remain stationary, but too frequently matters take an unfavourable course.

The unsteady condition of the membrane, and the consequent varying degree of in-pushing, are sources of irritation, lead to vascular and nervous disturbance, and often bring about intercurrent congestive attacks. Besides, a non-adherent relaxed membrane may become adherent, and then the case becomes greatly aggravated.

The very treatment recommended by some aurists—and frequently practised by patients to secure temporary relief—only tends to augment the loss of tension; I mean Valsalva and Politzer's methods of inflation. Distensile force frequently applied to a structure already deficient in resistance will generally still further diminish its power of resistance. But insufflation, though clearly injurious in the long run, may be required to prevent the immediate occurrence of a greater evil—viz., adhesions during an inflammatory attack. As regards distension of the tympanum, we may say that its practice may do harm, and that its omission may do still greater.

To restore Lost Tension is the Rational Treatment of Relaxed Membrane.—I trust I have now brought you with me to the point of concluding that to restore tension should be our great aim in the treatment of relaxed membrane. That this can be done now with great ease and safety admits of no doubt. At the meeting of the British Medical Association referred to, I showed that contractile collodion applied on the membrane of the tympanum adhered firmly, contracted the membrane to a greater or less extent, whilst it remained adherent, and also exerted a permanently beneficial influence on the relaxation. I am happy now to report that my anticipations regarding the permanent restoration of tension—that is to say, the cure of the condition of relaxation—have been realised.

History of the first case cured by the application of Collodion.—The patient was an unmarried woman, aged forty-one. She had been under my care from time to time for three years on account of catarrh of the drum and its results, and treated by me according to recognised methods. With the left ear she heard my voice (moderate tone) at a distance of three feet, but the hearing varied much. The noises in her ears were of the most distressing kind. At times the noise was like that of a thunderstorm, again like that of machinery, and sometimes like the blowing of a horn. The sounds of other persons' voices were greatly confused ("entangled," as she put it). Her own voice seemed to her to have a most unnatural tone. She formerly sang in church, but since she became deaf her own voice seemed to her so inharmonious that she was obliged to cease singing. At times she was quite bewildered, and she told me that she believed her noises would have put her mad, had she not been obliged to earn her bread. On examination of the membrane, I found a number of depressions between the upper part of the handle of the malleus and the posterior wall of the meatus. All these depressions became bulgings on inflation of the drum by Valsalva's method. I applied collodion freely. Her hearing was immediately improved, and continued steady. She came to hear my voice (moderate tone) at the distance of eighteen feet, and the noises in the ear ceased. The confusion of voices, and the unnatural character of her own voice, disappeared. She became able to sing as she had formerly done. The depressed part became quite flat. On July 29th (that is, about three months after the application) I thought the layer of collodion loose. I syringed, and found that the loosening was only partial, and that the layer did not come away at all readily. The hearing remained good and the depression had disappeared, probably owing to the long-continued bracing up. The membrane seemed too lax, however, and I put on another coat two days afterwards. At present the hearing is stationary, the relaxed part has its normal tension, there is not the slightest depression at any part, the membrane has become perhaps more than usually transparent, and the patient has not had a single unpleasant noise since my first application. Two applications have sufficed to bring about a permanent cure of the relaxation. No other treatment of any kind has been adopted.

Critical examination of the history of the above case.—But it may be asked was the improvement really owing to the contractile influence of collodion or to some other cause, or to several causes combined? Was the good result a mere coincidence? We know that deaf patients are usually influenced beneficially by a very dry atmosphere, injuriously by a damp one—beneficially by heat, injuriously by cold. The patency of the Eustachian tube improves the hearing, and obstruction diminishes it. Now, I desire to exclude from this case every source of error, and to show that we must con-

clude that the increased tension induced by collodion was the only cause of the improvement. The facts, then, which stand out prominently are—

1st.—That for three years the patient had been subjected to varied treatment by myself, without satisfactory results.

2nd.—That the application of collodion was followed by immediate improvement.

3rd.—That no other treatment was resorted to, either simultaneously with, or subsequently to, the local application of collodion.

4th.—That it is unreasonable to suppose that any chance circumstance of a general character had any influence, as she has been since exposed to varied temperatures, and has continued her ordinary mode of life, but still the improvement has continued throughout.

5th. That only two changes were induced by the collodion, viz.—slight increase of thickness and increase of tension, with steadying of the ossicles. We may dismiss the increase of thickness as the cause of the improvement—indeed, it could easily be excluded by experiment. There only remains, therefore, the increase of tension.

6th. That the permanent cure of the relaxation was owing to the action of the collodion, there being no other cause in operation. Besides, the previous experience of the profession pointed to the permanency of the condition when once established, and this departure from the previous invariable rule was, no doubt, owing to the agent now used for the first time.

This now brings me to the enunciation of what I may call a general law, viz.:—

That the structures of a living body, no matter how resistant they may be, expand or contract, as the case may be, under the influence of purely mechanical forces, and may continue in the new condition of expansion or contraction permanently—in other words, the structures of the body accommodate themselves to new conditions most readily. We are all quite familiar with numerous apt illustrations—as, for example, the lengthening of the ligaments and fibrous structures on distension of joints; the enormous distension of the hydrocephalic head; the increase of the capacity of the fibrous capsules of various organs; the increase in the area of the cornea and sclerotic under increased intra-ocular pressure, and the diminution under diminished intra-ocular pressure; the permanent shortening of ligaments, muscles, and tendons, in prolonged flexion of the limbs; the diminution in area of the capsules of organs on atrophy of the structures of the organ. Likewise, as the membrana tympani permanently increases in area or relaxes under the atmospheric pressure, so it shortens permanently under the long-continued contraction of collodion.

I have, perhaps, in the opinion of some, entered upon this subject too fully. I do not think so, however. I have endeavoured to avoid a mistake too common in

medicine and surgery—of hastily concluding that a certain effect was owing to a particular cause, when it might be really owing to another cause or combination of causes. I am the more particular in dealing with this question in a strictly logical way, as I desire that a method of treatment which has been so successful in my hands should be adopted by my professional brethren, not simply on my representations, but because it is rational.¹

R. F. Dill, President

Eighth Meeting 16th March 1880

Present, Professor Dill in the chair, Dr. Wales, Dr. Anderson, Dr. Workman, Dr. McKee, Dr. Withers, Dr. Esler.

Dr. Anderson read a paper on “Respiratory excitation and depression”.

Paper:² AUTOMATIC respiratory actions have their origin in the medulla and spinal cord. In the former the respiratory bundle is a cord 1 mm. in thickness, which consists of varicose nerve fibres, and is united at its origin with the nucleus of the vagus. This cord receives fibres from the glosso-pharyngeal vagus and spinal accessory, and is connected also with the hypoglossal. In the middle and lower part of the medulla the bundle divides into parallel branches, and these appear to stand in relation with the phrenic nerve. In the dorsal and upper part of the lumbar region the posterior vesicular column, which consists of ganglion cells and nerve fibres, and is most sharply and distinctly limited in the position of the lower dorsal and upper lumbar nerves, establishes a connexion between certain fibres of the posterior roots and other parts of the spinal cord of the same side.

In continuous connexion with this nucleus are scattered masses of cells in the cervical and sacral regions of the spinal cord. In the spinal cord the respiratory bundle is a longitudinal cord of fibres, which may be traced upwards to the medulla oblongata. Nerve fibres pass upwards to the higher nerve centres that establish a connexion between this and the respiratory centre.³ Thus respiratory centres exist in the medulla and spinal cord, capable not only of propagating but of reflecting stimuli. The principal respiratory centre is situated near the *calamus scriptorius*.⁴

Nerve fibres that serve for different respiratory purposes are connected with the medulla oblongata and spinal cord; motor nerves, that act on the muscles of inspiration and respiration; and sensory nerves, that transfer stimuli from distant parts to the respiratory centres, and ultimately to the muscles concerned in the

respiratory acts. The vagi are distributed to the muscular structures found in the trachea (at the extremities of the rings and between the rings),¹ bronchi, and lungs, and the same nerves contain different fibres that are destined for the mucous membrane of the air-passages.

The lung substance and certain respiratory muscles are supplied with ganglia, which confer upon them a certain degree of independent action. Kölliker² found ganglia in the lung substance—a fact that has been confirmed by other observers; and in connexion with the distribution of the right phrenic nerve Luschka³ pointed out the existence of the phrenic ganglion. The experiments of Brown-Séguard with reference to the rhythmical contractions of the diaphragm and other muscles showed that these ganglia are not without their use.⁴ The connexion that exists between the terminations of sensory nerves distributed to the air-passages and to various other parts of the body with the motor apparatus of the chest and abdomen causes the latter to respond to stimuli applied to the former, and section of nerves by which the centres are deprived of existing stimuli produces a change in the character of the respiration.

The effect of cold applied to the external surface in adults and children is an often-mentioned illustration of the effect of a stimulus applied to the peripheral extremities of sensory nerves, and irritation of the peripheral endings of the fifth and other nerves in the air-passages is sufficiently conclusive. The excitation of a sensory nerve was shown by Schiff to produce an increase in the number of respirations, provided such stimulus be moderate. If, however, the stimulus be strong, a diminution takes place, and inspiration tetanus may result.

Division of the vagi increases the depth and diminishes the number of the respirations (Fig. 1), whilst stimulation of the central cut extremity increases the number, and, if strong, will give rise to inspiration tetanus; the rhythmically active agents in expiration in this case become quiescent. The power of a reflex stimulus was found to affect the muscles of inspiration in the same order as increasing dyspnoea—viz., the diaphragm, the external intercostals, the intercartilaginous muscles, *levatores costarum*, *scaleni*, and *serratus posticus* (Traube).⁵ The agents that were rhythmically contractile before became quiescent during the stimulation.

Stimulation of the superior laryngeal nerve, if moderate, diminishes the number of the respirations; if strong, it produces expiration tetanus. Thus, in one of Rosenthal's experiments, with a moderate current (coils 200 mm. distant), the diaphragm was quiescent, the

¹ [See *Dublin Journal of Medical Science*, 1881, v71, p8, for a further paper which was not read before the UMS.]

² [*Dublin Journal of Medical Science*, 1880, v70, p269.]

³ Krause. *Allgemeine und microscopische Anatomie*. Pp. 391, 392, 412.

⁴ Longet. *Traité de Physiologie*.

¹ Ludwig. *Lehrbuch der Physiologie des Menschen*.

² *Microscopische Anatomie*.

³ *Anatomie des Menschen*. I., 2, 218.

⁴ *JrL d. L. Physiologic*. Tome II., p. 115.

⁵ Rosenthal. *Die Athembewegungen u. ihre Beziehungen zum Nervus Vagus*, p. 182.

thorax remained in the position of rest, no muscle contracted, and the thyroid cartilage moved quickly up and down.

With a stronger stimulation (coils 160 mm. distant) there was quiescence of the diaphragm, tetanic contraction of the abdominal muscles, great diminution of the thoracic cavity, and depression of the ribs.¹ The action of the superior laryngeal nerve is thus comparable to the action of the splanchnic on the intestines and the vagus on the heart, with this difference, that the centres on which these nerves act are situated in the organs themselves, whilst in the case of the former nerve the centre is situated in the medulla oblongata. (The researches of Legallois and Flourens showed that the centre for the diaphragm was situated in the medulla.) The fact that stimulation of the superior laryngeal nerve produces inhibition of the diaphragm by its action on the nervous centre in the medulla confirm the opinion of Ludwig and Weber that the two nerves above referred to produce inhibition by acting on nerve cells situated in the organs to which they are distributed.²

The connexion of the respiratory centres with the higher parts of the nervous system ensures a certain amount of controlling power. By the will the number of respirations can be increased or diminished, and the respirations are influenced by the degree of activity of the cerebrum. The effect of close attention upon respiration is an often-mentioned illustration of this fact.

Certain changes in the blood produce very marked effects upon the respiratory actions. The blood so altered may cause these changes by its action upon the respiratory centres or upon the peripheral terminations of nerves connected directly or indirectly with them.

The effect of the introduction of certain substances into the blood is well known. Atropia, for example, when given in small doses, increases the number of the respirations—in large doses it diminishes. Opium retards, and its action is distinct after section of the vagi.³

Strychnia increases the number and depth, and phenic acid causes the respirations to become, first, rapid and regular, and then rapid and feeble.⁴ The effect of morbid poisons has only to be mentioned.

An increase or diminution of oxygen in the blood gives rise to phenomena which are due to an increased or diminished stimulus to the nerve centres, which may take place as the direct effect of an increased or diminished stimulus, or indirectly by the increased or diminished oxidation of certain products in the blood.⁵ An increased amount of carbonic acid acts as a powerful

stimulus to the respiratory centre.

Dyspnœa can be produced in an animal to breathe nitrogen or carbonic acid (700 to 30CO₂). In the former the quantity of oxygen in the blood is greatly diminished, the quantity of carbonic acid being little affected; in the latter the carbonic acid is greatly increased, whilst the oxygen Pflüger found in some experiments increased.¹ Dyspnœa can be produced by opening the thoracic cavity and puncturing the lung over the surface; if oxygen or air be forced into the lung through the trachea the dyspnœa disappears, and will reappear if carbonic acid or nitrogen be substituted for the former gases (Traube). It can also be induced by fitting a stop-cork to a trachea canula and diminishing the aperture.²

The following method, adopted by Dr. von Kries and myself in our experiments in Professor Ludwig's laboratory, has this advantage, that the responses in different experiments can be easily ascertained and compared. A trachea canula was fitted to Müller's bottles;³ the dyspnœa was produced by lowering the tube in the mercury of the inspiration bottle. Some of the results are shown in the following table:—

Time	Number of respirations in five sec.	Temperature	Resistance in mm.	Duration of resistance
H. M. S.				Seconds
4 17 0	0.45	38.2	0	—
4 22 0	0.5	38.6	0	—
4 24 0	1.1	38.6	5	35
4 24 35	0.7	38.6	0	—
4 24 0	1.0	38.6	5	35
4 26 30	1.0	38.6	0	—
4 27 0	0.5	38.6	0	—
4 29 30	0.8	38.6	2	103
4 31 0	1.5	38.6	0	—
4 32 0	4.4	38.6	0	—
4 33 0	1.0	38.4	2	150
4 36 0	1.0	38.4	0	—
4 37 0	0.55	38.4	0	—
4 43 0	0.833	38.4	2	150

In another experiment, with a resistance of 0 mm. of mercury, the number of respirations was 6 per minute; with a resistance of 5 mm. the number was increased to 13.2 per minute; and with a resistance of 2 mm. the number of respirations was 10 per minute. The vagi were cut at the beginning of the experiments. Bert has made numerous experiments with reference to the effects of obstruction. They will be found in his book on Respiration.⁴

Dyspnœa and asphyxia can be produced by supplying

¹ Rosenthal. Op. cit., 229.

² Comptes rendus. 1861. 755.

³ Köller. Handbuch der physiologischen Therapeutik und Materia Medica. Pp. 1004 and 1072.

⁴ Bert. Leçons sur la Physiologie comparée de la respiration. 416.

⁵ Ludwig and Schmidt. Berichte d. Gesell. der Wissenschaften zu Leipzig. 1867.

¹ Pflüger. Archiv. Band I., p. 92, et seq.

² Cyon. Methodik der physiologischen Experimente und Vivisection. P. 253.

³ Annalen der Chemie und Pharmacie. B. 108, p. 257.

⁴ Op. cit., p. 408.

an animal with air or oxygen which contains ozone. The effects of a change in the condition of the oxygen inhaled have been studied by Professor Redfern, Dr. Barlow of Glasgow, Dr. Richardson, and others. Dr. Redfern made use of mice in many of his experiments. The ozone was prepared by electrolysis, and, after being purified, was passed into the chamber containing the animal. A mouse (in Experiment XI.), weighing 60 grains, was placed in the chamber containing oxygen and ozone, at 4 33 p.m.; in half a minute the eyes were closed; in a minute the head was elevated during inspiration. At 4 35 the mouse was removed, and exposed to a current of air, but no improvement took place. At 5 15 the animal is still breathing almost imperceptibly; eyes closed; can walk a few paces when disturbed. At 10 10 the animal, which has remained quiet since last report, and whose respirations have been regular (87 per minute) during the greater part of the time, is attacked now with dyspnœa. The animal died at 10 30 p.m. The right side of the heart was found gorged with blood; the left side was empty.

In order to determine whether the dyspnœa was due to closure of the glottis, an opening was made in the trachea. The animal (in Experiment XIV.) was then introduced into the chamber; in 2½ minutes the mouse fell over on its side, and in 3½ minutes died.

In Experiment VIII. the mouse commenced to inhale the ozone at 12 27; at 12 52 the mouse moved about uneasily, and rubbed its nose; at 12 58 convulsions and death. It will thus be seen that death resulted from asphyxia, the heart in this case also being gorged with venous blood. The experiments of the same observer on rabbits, frogs, insects, and worms, were attended with similar results. These experiments have been confirmed by the observations of Dr. Barlow,¹ who considers the asphyxia to be due to an alteration of the lining of the air-cells by the ozone.

In the experiments recorded above, the amount of ozone present was about the ½₂₄₀th part, the remainder being oxygen; so that oxygen, in the form of ozone, is a very powerful agent in the production of dyspnœa.

Dyspnœa produced by heat is of interest to the physician and physiologist.

If an animal is introduced into a hot-air bath, and the temperature so regulated as to produce an increase in the temperature of the animal (the temperature is determined by means of a thermometer placed in the vagina or rectum), when such an increase is sufficiently great, the respirations increase in number, and diminish in depth.

The respirations can be registered in various ways. The apparatus of Marey² and Bert³ are described in their works; many other methods are given by Cyon.⁴ A

very convenient method is the following:—A small bag connected with a glass tube is introduced into the œsophagus, and passed down to the thorax to within a short distance of the œsophageal opening of the stomach; the other end of the tube is connected with a Marey's tambour; the bag is dilated with water, introduced by means of a syringe after the bag has been passed down to the thorax.

An alteration in the capacity of the thorax causes a movement of the lever of the tambour, so that the respirations can be easily registered. Table II. gives the results of an increased temperature upon the respirations of a dog (Figs. 3 and 4).

Table II. (The temperature and the number of respirations in five seconds are given.)					
Temp.	Resps. in five seconds	Temp.	Resps. in five seconds	Temp.	Resps. in five seconds
o		o		o	
39.8	8.5	40.5	8.0	41.1	11.0
39.9	3.7	40.6	3.7	41.2	6.4
40.0	3.7	40.7	4.9	41.3	5.4
40.1	3.5	40.8	4.8	41.4	7.9
40.2	3.3	40.9	4.5	41.5	8.2
40.3	2.6	41.0	7.4	41.6	7.3

The table confirms the results of Ackermann and Goldstein.¹ A reference to the table and plate will show that two very important changes take place in the respirations—viz., an increase in frequency and a diminution in depth; and whilst the former is generally characteristic of dyspnœa, the latter is present in a different condition, to which I shall hereafter refer.

The dyspnœa so produced is referable to one of the following causes—direct stimulation of the respirations without a corresponding stimulation of the inhibitory centres, or a weakening of the latter without affecting the former. In the former case, the centre itself, the peripheral extremities of afferent nerves, or the cerebrum, are the parts to which the stimulus is applied; in the latter, the respiratory inhibitory agents are the parts affected. If the increase of temperature acts only on the inhibitory centres, then the excitor nerves would either produce apnœa by their own action, or assist artificial respiration in producing it in case complete oxygenation be sufficient for that purpose. Ackermann and Goldstein have shown, however, that apnœa cannot be produced by artificial respiration when an animal suffers from heat dyspnœa, and this although the blood contained in the veins became bright red during the experiment—hence the stimulus must be due, in part at least, to the direct or indirect stimulation of the excitor centres. That heat dyspnœa is not due to the

¹ Journal of Anatomy and Physiology. Vol. XIV., Part I.

² La Méthod Graphique dans les Sciences Expérimentales, p. 541.

³ Bert. Op. cit., p. 209.

⁴ Op. cit., p. 208, et seq.

¹ Ueber Wärmedyspnoe. Inaugural Abhandlung. 1871.

presence of venous blood alone, the experiments of Ackermann and Goldstein show; that it is almost entirely due to the increased temperature, our experiments seem to prove, as artificial respiration altered but little the character of the respirations.

The stimulus may be applied to the respiratory centre directly or indirectly, as already mentioned. Goldstein's experiments show that the dyspnoea is not produced by the action of the heat upon the peripheral extremities of the sensory nerves, on the peripheral extremities of the vagus, or the higher sense organs. Gold applications to the surface, cutting the vagi, and the administration of narcotics, did not affect the results. Heating the carotid in a water bath was found sufficient to produce heat dyspnoea.

The amount of air breathed during this form of dyspnoea seems to be greatly augmented. Several methods may be used in an investigation of this kind. Müller's bottles may be employed with water or mercury, or Czermak's lever¹ applied to the chest, and connected with an electromagnetic arrangement which alternately opens and shuts the inspiratory and expiratory tubes. For the determination of the gases, Regnault and Reiset's modification of Lavoisier's apparatus is the most accurate.²

The respiratory movements of an animal cease under certain circumstances, and this though the heart beats as before, and the actions of the body remain unaltered. This condition was named apnoea by Rosenthal. Hook, in 1667, opened the chest of a dog before the Royal Society, and by means of a bellows forced air into the lung, which escaped by punctures made over their surface. He found that "the eyes were all the time very bright," and the heart beating regularly; there was no respiratory movement³ (Sanderson).

Apnoea can be induced by forcing air into the lung by a series of blasts (60 or more in the minute). The air escapes from the chest after each insufflation, by an aperture in the canula. The duration of the apnoea is influenced by the duration of the artificial respiration that has preceded it.

I have frequently obtained apnoea for 15 seconds in dogs by employing artificial respiration for one minute, and apnoea for 25–30 seconds by artificial respiration of two minutes' duration. By prolonged artificial respiration, however, apnoea may be obtained for two minutes (Cyon,⁴ Pflüger⁵), or even for five minutes (Rosenthal). Ewald, by artificial respiration for half an hour in a dog, obtained apnoea for half a minute to a minute and a half. This was followed by one or two superficial inspiratory actions, which were succeeded

by a pause; after ten minutes normal respiration was established.

In considering the causes of apnoea, it is necessary to take account of the condition of the blood during the cessation of respiration, and the nature and action of the force employed. Ewald found that the oxygen in the blood was slightly increased, and the carbonic acid distinctly diminished.¹ In one of his experiments (Versuch 4, Serie II.) the arterial blood was a brighter red during apnoea than before it. Pflüger found that the amount of oxygen taken up during artificial respiration was sometimes greater and sometimes less than normal—the amount of carbonic acid given out greater. Finkler and Oertmann showed that the amount of oxygen in the blood depends on the force used—anything that diminished rapidly the circulation diminishes the oxygen—and that whilst at the beginning the amount of oxygen taken up is apparently less, and the amount of carbonic acid given out is greater, the reverse held after the cessation of the artificial respiration. They further showed that the colour of the venous blood depends on the character of the artificial respiration and the energy of the heart's action.² The respiratory centres thus lose any stimulus due to the diminution of oxygen or the increase of carbonic acid; quiescence in the active respiratory agents is the result.

It is necessary to take a glance at the effects produced in an animal by breathing pure oxygen. Several observers have directed their attention to this subject. Professor Redfern prepared pure oxygen from peroxide of manganese. The gas was purified by means of lime-water and caustic potash, and passed into a large receiver, placed over lime-water; into this receiver a jet of lime-water kept constantly playing. Two mice were introduced into the atmosphere of oxygen (Experiment XIX.), and were confined in a wire cage, and supplied with food. The receiver was perfectly free from carbonic acid during the whole experiment, and the amount of the latter gas was estimated from time to time, and noted. During the whole time the mice remained remarkably tranquil, and no remarkable difference was observed in the character of the respirations.

The amount of oxygen absorbed when air is breathed is placed by Pflüger at nine-tenths of the amount absorbed when oxygen is breathed. Gréhant³ found, however, the amount very much greater in the latter case, and considers the increase, $\frac{16}{26}$, due to the rapidity of the circulation and activity of the respiratory movements, which cause a frequent renewal. It must be remembered, however, that frequent renewals of the air in artificial respiration is attended with a diminution of the carbonic acid contained in the blood and in the air-cells; and thus the stimulus is diminished. It is well known that if, by the power of the will,

¹ Gesammelte Schriften, p. 820.

² Recherches Chimiques sur la Respiration des Animaux. Annales de Chimie, 3rd Series, 299. T. XXVI. For a description and figure of Lavoisier's apparatus see Jamin, Cours de Physique. T. II., p. 494.

³ Handbook for the Physiological Laboratory. P. 318.

⁴ Op. cit., p. 256.

⁵ Archiv. B. I., p. 256.

¹ Inaugural Dissertation, 1878; and Pflüger's Archir. 1878. P. 57A.

² Pflüger's Archir. 1877.

³ Gréhant. Comptes Rendus. T. LXXV., p. 496.

the number of normal inspirations be increased, the amount of carbonic acid expired is increased. Czermak points to this fact in connexion with Rosenthal's experiments. He says:—"If in tranquil respiration I make 3-4 respirations in 15 seconds, and interrupt the breathing by a final deep inspiration, I succeed in keeping my breath for 30-35 seconds, then, however, the respiratory necessity forces me to continue respiration. If, on the other hand, I make 15-18 complete respirations in 15 seconds, and again interrupt my breathing with a similar deep inspiration, I am enabled to retain my breath for another half minute or minute before I am forced by the same degree of respiratory need to resume my respiration."¹

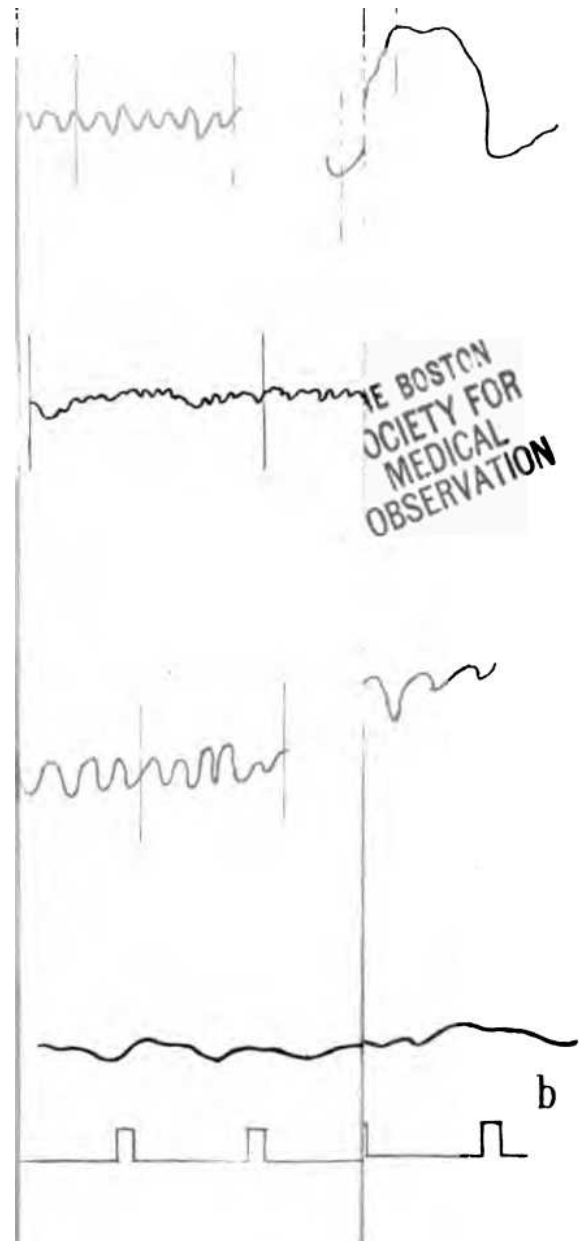
The amount of oxygen absorbed by the blood varies, according to the experiments of M. Gréhant, in different apparently healthy animals of the same species (thus the volume per cent, that could be absorbed he found in one case 18.8, and in another 31.3), and is proportional to the amount of hæmoglobin in the blood.

The experiments of von Lesser, performed in the Leipzig laboratory, show that many circumstances affect the amount of hæmoglobin in the blood. The amount of hæmoglobin in the large arteries and large veins, at the same time and under the same circumstances, is the same. A variation in the rapidity of the flow of blood in the arteries, due to increase in the peripheral resistance or variation in the number of heart heats, produces no change. The amount of hæmoglobin in the blood-current is dependent on such variations in tension in the arterial system as serve to diminish or increase quantitatively the flow of blood to the right heart. This observer has shown that the abstraction of blood, provided that it does not exceed a certain amount, does not diminish the amount of hæmoglobin. Tying an animal in the recumbent position, produces a transitional increase and decrease. The cutting and stimulation of the spinal cord affects the amount of hæmoglobin in so far as it affects the flow of blood to the right heart. Tying the portal vein is attended with a diminution in the amount of hæmoglobin in the arterial system; this diminution takes place with a variable degree of rapidity depending on the vascular connexions of the vena portæ. The diminution is apparently more rapid than the sinking of the arterial pressure. Interruption of the circulation in the lower extremity is attended with somewhat variable results.²

These experiments prove that the number of corpuscles in the arterial and venous system is subject to variation, and that it is dependent upon such a variation in the tension of the vascular system as increases or diminishes the flow of blood to the right heart; and

¹ Centralblatt f. d. Wissenschaft., 1866; and Gesammelte Schriften, p. 767.

² Ueber die Vertheilung der rothen Blutscheiben im Blutstrom. Reichert und Du Bois Reymond's Archiv. Phys. Abth. 1878.



EXPLANATION OF PLATE.
 [Plate is as taken from the original scan]

Fig.

1. Respiration curve after cutting of the vagus.
2. a. Artificial respiration.) Tracing continuous with,
 b. Apnœa.) and subsequent to Fig. 1.
3. Respiration curve, vagus cut, with pulse waves.
4. Same tracing (heat dyspnœa).
5. Respiration curve before resistance.
6. a. During resistance.
 b. After resistance.
7. a.) Respiration curves.
 b.)

N.B.—In Figs. 1 to 6 the vertical lines mark intervals of 5 seconds. In 7 and 8 the tracing of a time-marker indicating seconds is shown.

this tension is, within certain limits, under the control of the nervous system.

In making an estimation, therefore, of the amount of oxygen contained in the blood under different circumstances, it is necessary to take account of the amount of hæmoglobin contained in the blood-stream. Thus, if the number of blood-corpuscles in any part of the system be increased, more oxygen, *cæteris paribus*, will be found in that part of the system, and if less blood-corpuscles, then less oxygen will be present. An alteration in the relation of the blood-corpuscles to the capillary walls is regarded by some as a result of deficient oxygenation.

In this respect their condition is, to some extent, comparable to the relative conditions of the blood and blood-vessels in inflammation. In the latter, in the second stage, a massing of the red blood-discs takes place in the capillaries. This phenomenon, which was regarded by Lister to be of the same nature as the formation of rouleaux in blood that is drawn, has been shown by other observers to depend, in part or altogether, on an alteration in the capillary walls.¹

A change in the distribution of the blood-corpuscles in the state of asphyxia, which would be attended with the withdrawal of an appreciable number of blood-discs from the larger arteries and veins, would necessarily, other things being the same, lead to a diminution in the amount of oxygen in the larger veins and arteries. An estimation of the amount of oxygen in the larger arteries and veins would, in that case, require correction before it could be taken as a sign of the oxygenation of the general mass of blood.

In the condition of apnœa, on the contrary, the diminution in the amount of the carbonic acid in the blood produces necessarily an alteration in the relation of the blood to the capillaries. If such an alteration be attended with a withdrawal of the blood-discs from the capillaries and an increase of these elements in the larger arteries, then the amount of oxygen, as given by an analysis of the blood in the larger vessels, is too high, if it be taken as a sign of the oxygenation of the general mass of the blood.

Pflüger has shown that the colour of the blood depends on the number of corpuscles present, as well as the gas contents.² The venous blood in apnœa is frequently dark in colour—a circumstance attributed by Finkler and Oertmann³ to the character of the artificial respiration and the nature of the heart's action. They showed that if the animal be placed in a warm bath the venous blood becomes red. This may be accounted for in two ways. The effect of the warm bath is to cause dilatation of the capillaries, and the blood that passes into the veins has more oxygen, and the heart's action is at the same time increased by the heat (Finkler and

Oertmann); or the change in the colour of the blood, from dark red to bright red, may be accounted for by supposing the heat to produce such alteration in the walls of the capillaries as leads to a dilatation of these vessels and an accumulation of red blood-corpuscles in them.

In this case the number of blood-discs in the larger vessels would be reduced, and a brightening in the colour would result—so that if such an alteration in the general distribution of the red blood-corpuscles takes place in asphyxia and apnœa, the number of oxygen carriers in the larger vessels in the former case is diminished, and in the latter increased, whilst the total number in the blood may be unaltered.

The velocity of various fluids through capillary tubes must be regarded as an important element in the determination of the general condition of the blood, from an analysis of a portion of blood taken from a large vein or artery during the condition of apnœa or asphyxia.¹

It is necessary to take a glance at the mechanical means used to produce apnœa. Artificial respiration differs from ordinary respiration in this way, that in the former the air is used to force out the lungs and chest walls, and in the latter the expansion of the chest and lungs draws in the air. The force used in drawing air into the lungs, and which acts upon the various tissues in the air passages and chest walls, produces the simple mechanical effects of pressure upon the terminations of nerves in their structures, or by expanding the muscular and elastic tissues of which the lungs and pareties are composed, alters the condition of the nerves supplied to these structures. The state of expansion of the chest walls and lungs acts as a stimulus to the expiratory (inhibitory) nerves of respiration, and the state of contraction acts as a stimulus to the inspiratory nerves² (Hering and Langendorff). The effect of artificial respiration is to stimulate the nerves distributed to chest walls, diaphragm, and air passages, so as to produce an inhibitory action, and in this way the active inspiratory agents become quiescent. The experiments of Brown-Séquard made with a view to determine the cause of the arrest of strychnia tetanus under certain circumstances, support this theory. Brown-Séquard confirmed the observations of Rosenthal and Leube, that insufflation arrests strychnia tetanus, but differs from these observers with regard to the cause. Rosenthal considered the arrest to be due to the increase in the oxygen in the blood. Brown-Séquard found that the mechanical effect of insufflation upon the terminations of the vagi and the nerves of the diaphragm was the cause of the cessation of the tetanic spasms, since insufflation was without effect after division of the vagi and section of the spinal cord above

¹ Dr. Sanderson, in Holmes' Surgery. Vol. V., p. 757.

² Archiv. B. I.

³ Op. cit.

¹ Annales de Chimie. III., XXI., 76.

² Du Bois Reymond's Archiv. 1879.

and below the origin of the phrenic nerves.¹ Thus it is seen that insufflation has a distinct inhibitory effect upon muscular contraction, and this by the stimulation of the terminations of the nerves supplied to the air-passages and diaphragm. The respiratory centres then can be excited in many ways. Oxygen diminishes, carbonic acid excites, respiratory action. As the oxygen is carried to the respiratory centres by the blood-discs, the fewer the number of blood-corpuscles that travel to the medulla, and the less oxygen they contain, the respiratory centre receives the greater stimulus. Increase in the amount of oxygen in the blood-corpuscles and increase their velocity will compensate for a diminished number. An increased velocity can be obtained by an increased action of the heart, and an increase of oxygen by more perfect aëration.

Artificial respiration acts in two ways upon the nerve-centres. The carbonic acid contained in the blood and air-passages is diminished, so that the nerve-centres lose the stimulus due to the action of carbonic acid on the respiratory centres; secondly, the pressure of the air forced into the lungs upon the nerve terminations in the bronchi, &c., produced an inhibitory effect upon certain respiratory structures.

R. F. Dill, President

Ninth Meeting was held upon Tuesday the 27th inst. April 1880.

Present, Professor Dill M.D. President, Drs. J. W. Browne and Fagan Vice-Presidents, Drs. Esler, Withers, Kevin, Dempsey, Wales Jnr., Whitla, Harkin.

Dr. Withers read a paper upon sulpho-carbolates in the treatment of zymotic disease.

Paper:² MR. President and Gentlemen,—I am happy in having the liberty of bringing before you some results obtained from the administration of the sulpho-carbolates in several diseases—as smallpox, scarlatina, and acute tonsillitis. I am the more encouraged to do so as this plan of treatment of zymotic disease has not—at least in this country—been much advocated or known; and, also, since any branch of the therapeutics of germ diseases should be carefully thought of, and well tested.

My attention to these preparations was first directed by Dr. Seaton Reid, to whom I owe much valuable information.

The sulpho-carbolates, as therapeutic agents, were first introduced by Sansome and Crookes in 1867, but their valuable properties have not as yet been generally recognised, and the advantages possessed by them over the sulphites and carbolates call upon an investigation into, and a clinical test of, their merits as members of that great division of therapeutics—the antiseptic system. These advantages are as follow:—They are very stable salts, almost tasteless, soluble to any extent,

easily absorbed by the blood, and at the same time are also antiseptic.

The sulpho-carbolates are formed usually by the union of oxides or carbonates of metals, or alkaline earths or alkalies, with a compound acid named sulpho-carbolic acid. This acid ($C_6H_6SO_4$) is prepared by mixing atomic weights of pure carbolic acid and pure sulphuric acid; however, it is better to add the sulphuric acid slightly in excess, as the compound acid then obtained forms, with the metallic or alkaline base, crystals of a better form. Heat is evolved, and in a short time a dark syrupy fluid is the consequence. After three or four hours, by slow crystallisation, the pure acid may be obtained in long colourless needles, which are readily deliquescent. The sp. gr. of the acid is 1.288, the odour is less intense than that of carbolic acid, and has an acid reaction; the iron test is also more readily manifest than in the carbolic acid alone. It is soluble in water, alcohol, and ether to any extent.

Perhaps it may be well to state the mode of preparation of the salts which I have the honour to place before you.

1st. The zinc sulpho-carbolate— $Zn(C_6H_5)SO_4$. By taking pure sulpho-carbolic acid, and adding oxide of zinc, or pure metallic zinc, until the acid is thoroughly saturated, hydrogen is given off during the process, and by slow evaporation we obtain crystals, in the form of brilliant, colourless, rectangular plates, which are very soluble.

2nd. Iron sulpho-carbolate— $Fe(C_6H_5)SO_4$ —is prepared by acting on the pure iron with sulpho-carbolic acid to neutralisation, and then crystallising. The crystals obtained are in the form of plates of a light green colour, and readily soluble in water.

3rd. Sodium sulpho-carbolate— $Na(C_6H_5)SO_4$ —It is the best known of the series, and is obtained by neutralisation of the acid with carbonate of soda, then evaporating carefully over a water bath. The crystals are brilliant rhombic prisms, soluble in two-thirds their weight of water, slightly soluble in alcohol, but not in ether. The pure salt is tasteless.

The sulpho-carbolates should all yield clear solutions, and have a definite crystalline form. There should not be the least odour of carbolic acid, but on heating carbolic acid is given off. They are also very stable compounds.

In endeavouring to advocate the further and more extensive use of these agents in general practice, I have a few introductory remarks to make before I proceed to state what clinical experience has revealed. You will agree with me that each zymotic disease is the result of a specific poison, which is stated to be in the form of a germ; the action of this poison I believe to be more fermentative than catalytic, so that believers in the germ theory of disease are more clearly recognising the fact that a new era has arisen in the science of therapeutic medicine—that is, if the germ theory be correct, then

¹ Ringer. Therapeutics. P. 561.

² [Dublin Journal of Medical Science, 1880, v70, p354.]

there can be laid down the principle that antiseptics and antiferments will be valuable in the treatment of zymotic disease. To enter into an explanation and defence of the germ theory would be outside the limits of this paper, but I shall merely say that I believe that most of the cases of contagious diseases arise by means of a previous germ—so that if, when this is introduced into the system, it be acted on by a soluble antiseptic, then I am convinced the zymotic poison will be modified in its effects, and its duration shortened.

To obtain a suitable agent, having the above quality, has long been a desideratum; in carbolic acid, however, I think we find what is required, but the difficulty with it is to administer it internally without some unpleasant effects, so that the tissues which have been impregnated with the zymotic poison may absorb the antiseptic. This objection is got over in the combination sulpho-carbolate, which, however, is not a direct antiseptic itself, yet, when it is absorbed, the carbolic acid of the salts is thoroughly projected through the system, and a sulphate excreted by the kidneys and intestine. The sodium salt is the most powerful in arresting saccharine fermentation, and as it is very soluble and tasteless, it has been the most extensively used. I have seen no ill effects from its administration, in scruple doses, every four hours. After being taken for a short time, the odour of carbolic acid can be detected in the breath. I have also noticed a slight looseness of the evacuations occasionally, which I would attribute to the sulphate of sodium after the carbolic acid has been set free.

For some time past scarlatina, smallpox, and acute tonsillitis (which, indeed, in many cases might be classed as the result of a zymotic poison) have been treated in the Union Fever Hospital with the sulpho-carbolate of sodium. Statistics, I am aware, are often not reliable, but as the action of this salt has been so remarkable, I will take the liberty of placing before you some statistical details.

Cases of scarlatina on admission receive a tepid bath, and the treatment adopted is the sulpho-carbolate of soda in solution. No other remedy is prescribed except in cases of hæmorrhage. The diet is milk. The dose of the sulpho-carbolate is 10 grs. every two hours; 5 grs. for children. Since its introduction into the Fever Hospital, 31 cases of scarlatina have been admitted. Of course these were not all of a malignant type, more than one-half being of the simple form of scarlatina, which is said by some to get well without any treatment; however, during the progress of the fever, advantages in the above treatment have been noticed which will place this medicinal agent far in preference to others.

Of these 31 cases there were 3 deaths, which will make a mortality of 9.7 per cent. This I think is a low death-rate, when we consider that about one-quarter of the cases were of an anginous or malignant charac-

ter. The results of this special treatment in these 31 cases have been almost unvaried. The absorption of the sulpho-carbolate of soda into the system is noticed at about the end of twenty-four hours, by the evidence of an almost complete cessation of throat symptoms. The tonsils are of a dirty white colour, as if touched with a mild caustic, and their enlargement is observed to diminish quickly. The temperature and general fever lessen, and the patient proceeds rapidly to convalescence.

Since the commencement of this treatment in no case have I noticed any dropsy, and in the majority there was very slight, if any, desquamation. I have, therefore, every confidence in the substitution of the sulpho-carbolate as an antiseptic antipyretic in the place of the former diaphoretic and expectant treatment of scarlatina. It has been most satisfactory, the recovery of the patients being rapid and complete, and the mortality rate being very low.

The next disease on which we have tried the influence of sulpho-carbolate of soda was smallpox. We were unfortunate during the epidemic of 1878 in not having this preparation in our possession, as then statistics of 156 cases might have been prepared which would have shown more perfectly the reliance that can be placed in it; but, however, in a few cases towards the latter part of the epidemic, and in some recent cases, it has been administered with marked success. These cases were 25 in number, and of them we had 2 deaths, one a young man in whom the disease was confluent and hæmorrhagic, and the other a child of four months old, ill with marasmus, and who received the variolous poison from its wet nurse. You will see we have thus a death-rate of 8 per cent. These cases are taken successively, without any selection, and when we take the last 25 cases of the epidemic of 1878, when it might be expected that the type of the disease would be less severe, it is found that the death-rate was 16 per cent. The rate of mortality for the 156 cases admitted into hospital in 1878 was 19.87 per cent; whilst that for the whole borough was 26 per cent.

Now if we pursue the argument that mortality rates are decisive as to treatment, there can be no doubt as to the proper value of the sulpho-carbolate, but they are often delusive. The internal treatment is similar to that of scarlatina, but occasionally an alcoholic stimulant or a sedative is required. It has been found that when the patient is seen early, and treatment at once commenced, then the primary fever is lessened, the throat symptoms which are so troublesome to a smallpox patient, when the soft palate and fauces are covered with pustules, disappear rapidly—often in twelve hours—and, what is more remarkable, in none of the cases so treated has any secondary fever been observed. I cannot say that the internal administration of the sulpho-carbolate has any effects on the scars of the pustules, and we have not tried the external application

of carbolic acid to the pustules, as has been done in Dublin. The effects of this treatment have been so uniformly successful as to warrant me in adding my testimony in favour of its employment in smallpox.

In acute tonsillitis the administration of sulpho-carbolate of sodium was eminently favourable, the hypertrophy of the tonsils rapidly subsided, rarely is there any suppuration, and power of swallowing is restored in from three to four days. It is in this affection that I think the iron salt will prove most useful, as I have noticed cases where the patient was much prostrated—in fact, in a typhoid condition; and I believe that the administration of the iron preparation will be more satisfactory than the sodium salt, although the latter is very beneficial when combined with quinine.

As for the employment of the sulpho-carbolates in other contagious diseases I have had no experience, but I believe that Ligertwood has administered them in typhoid fever and phthisis with very varying success.

Passing on from the practical to the suggestive, I would ask the attention of the Society to another of these salts—viz., the sulpho-carbolate of calcium. In the treatment of rickets, it has been difficult to find a reliable soluble lime salt. Those generally within our reach are not so, and contain but small quantities of lime, whereas we have in this a salt which is easily soluble in its own weight of water, and containing ninety grains of calcium in the ounce of the sulpho-carbolate. Hence, by this means, we are enabled to introduce lime into the system to any extent, so that I would suggest that this agent should be employed in those diseases of the bones which are marked by a deficiency in the lime salts; for the usual salts employed are deficient in solubility, and allow but of the absorption of the lime in too feeble proportions to be of any practical value.

As for the zinc sulpho-carbolate, I have not seen it employed sufficiently as to warrant any certain conclusion. But Professor Wood recommends its use for ulcers and wounds, in solutions of 5 to 10 grs. to the ounce of water, inasmuch as the fluids of the wound slowly decompose the salt, and set free the carbolic acid, which, acting as a germ destroyer on the surface of the wound, and in the surrounding atmosphere, rids them of all putrefactive particles, whilst at the same time the metallic salt is exerting its own inherent antiseptic and astringent qualities.

In conclusion, gentlemen, whilst we try to avoid, on every hand, by a cautious and prudent abstinence, all extremes, we must have a constant regard for the results of actual experience. These extremes, on the one side, might be a violent advocacy of the germ theory of disease and the attendant therapeutics; or, on the other, quite as violent and total denunciation; yet, whether our position be one or other of these matters little in the consideration of the advantages which arise from the administration of the sulpho-carbolates. In no sense can we be accused of undue influence when there

is but a simply-stated clinical experience. This experience, no doubt, limited so far, will extend and approve of the use of these agents. Experience keeps hand in hand with theory.

The underbasement of the discovery of these preparations was the antiseptic theory, and still keeping in view a knowledge of this, have their qualities been advocated. Any theory which might be advanced to explain their action might, perhaps, be set aside by the exponents of the pro or con, but I venture to submit that it is to the ready solubility of the salts and to the antiseptic character of the carbolic acid that we must attribute their undoubted value. Why these salts seem to act principally on the throat would not be easy to say; but I would suggest, that it is because our attention in the above diseases is directed mainly to the throat, and, hence, here we look for the first improvement, and the patient first expresses his relief in having the throat symptoms subdued. I believe that the medicinal agent induces a total reaction throughout the entire absorbent system, but that owing to the inflammatory action taking so acute a form in the region of the tonsils, it is here we experience the earliest benefit.

The therapeutical action of the sulpho-carbolates I would thus summarise:—The soda salt, so far, has proved a powerful agent in curtailing the natural course of the disease, in subduing the pyrexial condition accompanying zymotic affections, and, lastly, there is an obvious and distinct alleviating influence on the throat symptoms. The iron salt, not yet so much in use, has been beneficial as a tonic antiseptic. Whether its action in those cases of phthisis where there is abundant fetid expectoration will be advantageous, is a point to be determined in the light of future experience.

The zinc and calcium sulpho-carbolates, are still, I may say, in their infancy as surgical remedies, but will, I am sure, be taken up, and fulfil the expectations of those who have brought them forward as therapeutical agents.

Gentlemen, I have no doubt of the usefulness of the sulpho-carbolates, but you will please understand me, that I do not consider them to be infallible in the treatment of zymotic disease. Everyone has met with rapid and deadly cases of infection, where every form of treatment was hopeless. My idea in preparing this paper was to add a tittle of evidence to the growing opinion that the treatment of zymotic diseases must, in the future, be such as to deal with the fever itself, and not with symptoms—or, in other words, expectant treatment must be consigned to oblivion.

Dr. Fagan showed three patients: one with a drainage tube through the os calcis for 18 months; one whose knee joint had been excised; and one whose os calcis been removed; and gave an account of the previous history of the three cases.

R. F. Dill, President

Tenth Meeting was held in the Belfast Royal Hospital upon the 22nd of June 1880.

President Dr. Dill in the chair. Present Drs. Harkin, C. D. Purdon, Wales Snr., Dempsey, McKee, Kevin, Esler, Wadsworth, Whitla.

Dr. Harkin brought up a matter in connection with apothecaries' privileges in compounding but after some remarks he consented to bring it up in another form at a future period.

Dr. C. D. Purdon read a paper upon the infantile death rate of Belfast and suburbs for the 10 years 1864–73 with tabular statements and classifications of the various diseases causing death.

Paper:¹ THE necessity of inquiring into the diseases that cause the great mortality amongst children under 2½ years of age, was forced on my attention by the desire that was expressed in a late meeting of the Medical Officers of Health at one of their annual reunions.

So in examining the register of the Belfast Factory district along with my friend, Dr. Newett, of Ligoniel, for the purpose of ascertaining the relative mortality of the various classes into which the population is divided—viz., the Factory, Artisan, and Labouring, the Professional, Mercantile, and Gentry—I considered it advisable to ascertain the death rate according to the births in each class. As the great mortality among infants is under 2½ years, and as after this period the critical affections of infancy are generally over, I have selected that time as the limitation under this head for my investigation, dividing this period under two general heads—viz., deaths occurring under 1 year and under 2½ years. As the district consists of a town and country division, I have kept the death rates separate, so as to enable the reader to compare the relative mortality in each. In all the tables that I have seen the death rate has been given without specifying the diseases; so, in the first place, I have given the entire death rate in the town and country according to the number of births, without specifying the diseases; and, in the second place, the four diseases in which I have classed the various causes of death in each class, showing the relative percentage of deaths from each disease in each class under one year and the next year and a half.

The tables have been made for 10 years, from 1864 to 1873 inclusive, and are divided into two equal periods. In the first quinquade the number of births in town in the factory class was 2,221; in the artisan, &c., 22,780; in the gentry, 551—total, 25,552. In the second quinquade the births in the factory, 2,737; in the artisan, &c., 28,206; in the professional, middle, &c., 772—total, 31,715; total for 10 years, 57,267.

In the country districts—viz., Ligoniel, Whitehouse, and Carnmoney, in the first quinquade, the births in the factory class were 527; artisan, &c., 1,978; professional and gentry, &c., 107—total, 2,612. In the second

quinquade, in the factory class, the births were 486; in the artisan, &c., 1,804; in the professional, gentry, &c., 68—total, 2,358; total for 10 years, 4,970. This sum added to the number that were born in the town districts, gives a total number of births of 62,237. In the factory district the statistics are calculated according to the births per centum; so taking the deaths from all causes in the town districts among the factory class under 1 year in the first quinquade, we find it amounts to 14.5 per cent.; in the next 1½ years, 6.7 per cent.—total, 21.2. In the second quinquade, under 1 year, 22.8 per cent.; in the next 1½ years, 7.3 per cent.—total, 30.1 per cent.; average death-rate for 10 years amounts to 26.1 per cent. In the artisan and labouring classes the average death-rate amounts, in the first quinquade, under 1 year, to 15.9 per cent.; in the next 1½ years, 7.8—total average, 23.7 per cent. In the second quinquade, average under 1 year, 16.9 per cent.; in the next 1½ years, 8.1—total average, 25.0.

In the mercantile, &c., total average of deaths in the first quinquade, under 1 year, was 5.8; in the next 1½ years, 2.3—total average, 8.1. In the second quinquade, deaths under 1 year, 18.9 per cent.; in the next 1½ years, 4.1—total average, 23.0. I may mention that scarlatina was a complete scourge during this period.

In the country districts the causes of death in the factory class, under 1 year, for the first quinquade, the average amounted to 17.8 per cent.; in the next 1½ years, amounted to 8.2 per cent. In the second quinquade the average was 16.7 per cent. for those under 1 year; in the next 1½ year the average was 7.4 per cent., making, in the first period, a total of 26.0 per cent.; in the second period, 24.1 per cent.

In the artisan and labouring classes the average percentage of deaths, under 1 year, in the first quinquade was 12.3; in the next 1½ years, 4.9 per cent. In the second quinquade the average, under 1 year, was 13.7 per cent.; in the next 1½ years, 5.9 per cent., making a total, in the first period, of 17.2 per cent.; in the second, 19.6 per cent.

In the professional, mercantile, and gentry, the average percentage of deaths, in the first quinquade, under 1 year, was 5.6 per cent.; in the next 1½ years, 2.8 per cent. In the second quinquade the average of deaths, under 1 year, was 14.7 (caused by zymotic diseases); in the next 1½ years, 4.4 per cent., making a total of 8.4 per cent., for the first period, and 19.1 per cent., for the second.

In order to ascertain the relative mortality from various diseases I have divided the causes of death into four general heads—viz., Inflammatory (Surgical), Zymotic, Phthisis and diseases of the respiratory organs, and Neurotic disease, keeping the classes and districts separate as before, also dividing them into two quinquades.

In the town districts, in the factory class, the average death rate from Inflammatory affections in the first

¹ [Dublin Journal of Medical Science, 1880, v70, p530.]

TABLE NO. 1.—Infantile Mortality in Castlereagh District.

Year	FACTORY CLASS						LABOURING, ARTISAN, AND MIDDLE CLASSES						MERCANTILE, PROFESSIONAL, AND GENTRY					
	Born	Died at 1 year	Average	Died at 2½	Average	General Average	Born	Died at 1 year	Average	Died at 2½	Average	General Average	Born	Died at 1 year	Average	Died at 2½	Average	General Average
1864	28	—	—	—	—	—	399	46	11.5	30	7.5	19.0	2	—	—	—	—	—
1865	25	8	12.0	1	4.0	16.0	428	65	15.2	36	8.4	23.6	4	—	—	1	25.0	25.0
1866	39	8	20.5 14.1	4	10.3 7.0	30.8 21.1	516	66	12.8 12.1	35	6.8 6.3	19.6 16.4	10	—	—	—	8.9	8.9
1867	38	6	15.8	4	10.5	26.3	565	47	8.3	23	4.1	12.4	12	—	—	2	16.6	16.6
1868	26	5	19.2	2	7.7	26.9	572	75	13.1	33	5.8	18.9	6	—	—	—	—	—
1869	27	2	7.4	2	7.4	14.8	488	112	23.0	72	14.7	34.7	7	—	—	1	14.3	14.3
1870	15	6	40.0	—	—	40.0	590	78	13.2	24	4.1	17.3	9	—	—	—	—	—
1871	19	2	10.5 24.2	—	— 6.3	10.5 20.5	623	85	13.6 16.3	44	7.0 7.4	20.6 28.0	7	—	—	—	9.5	28.5
1872	11	9	81.8	1	9.1	90.9	632	107	17.2	44	6.9	24.1	8	8	100.0	4	50.0	150.0
1873	23	4	17.4	2	8.7	26.1	613	78	12.7	34	5.5	18.2	11	—	—	—	—	—
	251	45	17.9	16	6.4	24.3	5,426	759	14.0	375	6.9	20.9	76	8	10.5	8	10.5	21.0

quinquade was 3.1 per cent., under 1 year, in the next 1½ years was 1.7 per cent.; in the second quinquade, under 1 year, was 4.6 per cent., in the next 1½ years was 1.5 per cent.

From Zymotic disease, in the first quinquade, the average death rate was 2.8 per cent. under 1 year, in the next 1½ years 2.2 per cent.; in the second quinquade the average death rate, under 1 year, was 4.3 per cent., in the next 1½ years 2.4 per cent.

From Phthisis, &c., the average death rate, in the first quinquade, under 1 year, was 4.5 per cent., in the next years 1.9 per cent.; in the second quinquade, under 1 year, 9.2 per cent., in the next 1½ years 2.6 per cent.

From Neurotic affections the average death rate in the first quinquade, under 1 year, was 4.1 per cent., in the next 1½ years 0.9 per cent.; in the second quinquade, under 1 year, was 4.5 per cent., in the next 1½ years 1.0 per cent.

In the artisan and labouring class the average death rate from Inflammatory affections in the first quinquade was 3.3 per cent., in the next 1½ years 2.1 per cent.; in the second quinquade was 3.7 per cent., in the next 1½ years 1.8 per cent.

From Zymotic diseases the average death rate in the first quinquade, under 1 year, was 2.9 per cent., in the next 1½ year 2.6 per cent.; in the second quinquade, under 1 year, 2.7 per cent., in the next 1½ year 2.7 per cent.

From Phthisis, &c., the average death rate in the first quinquade, under 1 year, was 5.8 per cent., in the next 1½ year 2.2 per cent.; in the second quinquade, under 1 year, the average death rate was 7.2 per cent., in the next 1½ year 2.4 per cent.

From Neurotic diseases the average death rate,

under 1 year, in the first quinquade was 3.7 per cent., in the next 1½ year 1.0 per cent.; in the second quinquade the average death rate, under 1 year, was 3.2 per cent., in the next 1½ year 1.1 per cent.

In the gentry, &c., classes the death rate from Inflammatory affections in the first quinquade, under 1 year, was 1.2 per cent., in the next 1½ year 0.4 per cent.; in the second quinquade, under 1 year, the average death rate was 6.7 per cent., in the next 1½ year 1.5 per cent.

From Zymotic diseases the average death rate in the first quinquade, under 1 year, was 0.5 per cent., in the next 1½ year 1.2 per cent.; in the second quinquade, under 1 year, the death rate was 3.4 per cent., in the next 1½ year 0.6 per cent.

From Phthisis, &c., the average death rate, in the first quinquade, under 1 year, was 1.8 per cent., in the next 1½ years .0; in the second quinquade the average death rate under 1 year was 5.4 per cent., in the next 1½ years 1.5 per cent.

From Neurotic diseases the average death rate, under 1 year, in the first quinquade was 2.4 per cent., in the next 1½ years 1.2 per cent.; in the next quinquade the average death rate under 1 year was 3.2 per cent., in the next 1½ years 0.5 per cent.

In the country districts, in the factory class, the average death rate, under 1 year, from Inflammatory affections, in the first quinquade, was 4.7 per cent., in the next 1½ years 2.8 per cent.; in the second quinquade the death rate under 1 year was 2.9 per cent., in the next 1½ years 1.6.

From Zymotic diseases the average death rate, in the first quinquade, under 1 year, was 2.6 per cent., in the next 1½ years 1.7 per cent.; in the second quin-

TABLE NO. 2.—Infantile Mortality in Belfast.

Districts	Year	FACTORY CLASS					LABOURING, ARTISAN, AND MIDDLE CLASSES						MERCANTILE, PROFESSIONAL, AND GENTRY						
		Born	Died at 1 year	Average	Died at 2½	Average	General Average	Born	Died at 1 year	Average	Died at 2½	Average	General Average	Born	Died at 1 year	Average	Died at 2½	Average	General Average
		District No. 1																	
1864	10	—	—	—	—	—	421	77	18.3	40	9.5	27.8	2	3	150.0	—	—	150.0	
1865	15	4	26.6	2	13.3	39.9	665	59	8.9	42	6.3	15.2	2	1	50.0	—	—	50.0	
1866	12	4	33.3	3	25.0	58.3	530	87	16.4	47	8.9	25.3	6	1	16.6	—	—	16.6	
1867	6	—	—	1	16.6	16.6	593	75	12.6	35	5.9	18.5	7	1	14.3	—	—	14.3	
1868	19	2	10.5	2	10.5	21.0	571	73	12.8	43	7.5	20.3	5	—	—	—	—	—	
1869	12	3	25.0	5	41.6	66.6	546	86	15.7	64	11.7	27.4	5	5	—	—	—	—	
1870	25	7	28.0	2	8.0	36.0	670	104	15.5	58	8.7	24.2	1	1	100.0	—	—	100.0	
1871	24	7	29.1	2	8.3	37.4	664	125	18.8	78	11.7	30.5	4	4	—	—	—	—	
1872	26	12	46.1	1	3.8	49.9	606	145	23.9	66	10.9	34.8	7	7	100.0	—	—	100.0	
1873	25	13	52.0	3	12.0	64.0	562	103	18.3	55	9.8	28.1	2	—	—	—	—	—	
	174	52	29.9	21	12.1	42.0	5,828	934	16.0	528	9.1	25.1	41	14	34.1	—	—	34.1	
District No. 2																			
1864	36	2	5.5	3	8.3	13.8	322	60	18.6	48	14.9	33.5	11	—	—	—	—	—	
1865	36	4	11.1	2	5.5	16.6	446	82	18.4	44	9.8	28.2	9	—	—	—	—	—	
1866	36	3	8.3	1	2.8	5.6	456	73	16.0	49	10.7	26.7	7	—	—	—	—	—	
1867	31	—	—	1	3.2	3.2	461	56	12.1	38	8.2	20.3	7	—	—	—	—	—	
1868	29	4	13.8	3	10.3	24.1	525	86	16.4	50	9.5	25.9	9	—	—	—	—	—	
1869	37	5	13.5	4	10.8	24.3	496	86	17.3	70	14.1	31.4	10	—	—	—	—	—	
1870	36	4	11.1	3	8.3	19.4	563	92	16.3	40	7.1	23.4	20	7	35.0	—	—	35.0	
1871	47	9	19.1	2	4.3	23.4	557	81	14.5	52	9.3	23.8	23	—	—	—	—	—	
1872	48	10	20.8	—	—	20.8	546	111	20.3	37	6.8	27.1	21	9	42.8	—	—	47.6	
1873	46	4	8.7	2	4.3	13.0	549	80	14.6	46	8.4	23.0	17	1	5.9	—	—	5.9	
	382	43	11.3	21	5.5	16.3	4,921	807	16.4	474	9.6	26.0	136	17	12.5	1	0.8	13.8	
District No. 3																			
1864	78	2	2.6	2	2.6	5.2	896	180	14.5	85	9.5	24.0	15	—	—	—	—	—	
1865	114	16	14.0	3	2.6	16.6	1,148	149	13.0	93	8.1	21.1	20	1	5.0	—	—	5.0	
1866	127	11	8.7	2	1.6	10.3	1,229	160	13.0	60	6.5	19.5	16	—	—	—	—	—	
1867	159	9	5.7	7	4.4	8.9	1,233	142	11.5	68	5.5	7.3	22	2	9.1	—	—	13.6	
1868	143	28	19.6	10	7.0	26.6	1,357	165	12.1	102	7.5	19.6	30	—	—	—	—	8.3	
1869	189	19	10.1	12	6.3	16.4	1,443	176	12.2	114	7.9	20.1	30	8	10.0	—	—	10.0	
1870	157	28	16.6	9	5.7	22.3	1,333	178	13.4	90	6.7	20.1	34	4	11.8	—	—	14.7	
1871	197	26	14.2	14	7.1	21.3	1,320	214	16.2	91	6.9	23.1	30	2	6.6	—	—	6.6	
1872	197	26	13.2	8	4.1	17.3	1,236	251	19.5	70	5.4	24.9	34	10	29.4	—	—	35.3	
1873	194	31	16.0	9	4.6	20.6	1,211	204	16.8	73	6.0	22.8	35	1	2.9	—	—	2.9	
	1555	196	12.6	76	4.9	17.5	12,456	1769	14.2	866	7.0	21.2	266	23	8.6	5	1.9	10.5	
District No. 4																			
1864	110	19	17.3	6	5.4	22.7	624	214	34.3	62	9.9	44.2	9	—	—	—	—	—	
1865	138	30	21.7	5	3.6	25.3	833	211	25.3	43	5.2	30.5	15	2	13.3	—	—	13.3	
1866	140	26	18.6	15	10.7	29.3	770	194	25.2	76	9.9	35.1	14	2	14.3	—	—	14.3	
1867	159	17	10.7	11	6.9	17.6	824	167	19.1	65	7.9	27.0	15	1	6.6	—	—	13.2	
1868	134	21	15.7	11	8.2	23.9	958	214	22.3	118	12.3	34.6	15	1	6.6	—	—	6.6	
1869	140	35	25.0	15	10.7	35.7	1,037	199	19.2	125	12.0	31.2	18	1	7.7	—	—	7.7	
1870	107	39	36.4	13	12.1	48.5	850	168	19.8	79	9.3	29.1	15	4	26.6	—	—	33.2	
1871	111	36	32.4	9	8.1	40.5	674	159	23.6	54	8.0	31.6	7	1	14.3	—	—	14.3	
1872	85	27	31.8	7	8.2	40.0	723	157	21.7	57	7.9	29.6	11	13	118.2	—	—	154.5	
1873	98	50	58.8	11	11.8	65.6	856	149	17.4	48	5.6	23.0	14	8	21.4	—	—	21.4	
	1217	300	24.6	103	8.4	33.0	8,149	1822	22.4	727	8.9	31.3	128	28	21.9	9	7.0	28.9	
District No. 5																			
1864	69	9	13.0	9	13.0	26.0	420	65	15.5	36	8.6	24.1	1	—	—	—	—	—	
1865	73	17	23.3	11	15.1	33.4	478	88	18.4	60	12.6	31.0	1	—	—	—	—	—	
1866	103	19	18.4	7	6.8	25.2	564	108	19.1	39	6.9	26.0	—	—	—	—	—	—	
1867	111	22	19.8	6	5.4	25.2	570	78	13.7	39	6.8	20.5	—	—	—	—	—	—	
1868	84	22	26.2	10	11.9	33.1	593	95	16.0	77	13.0	29.0	2	—	—	—	—	—	
1869	121	34	28.1	11	9.1	37.2	664	128	19.3	71	10.7	30.0	—	—	—	—	—	—	
1870	90	35	38.9	10	11.1	50.0	873	140	16.0	75	8.6	24.6	4	—	—	—	—	—	
1871	84	13	15.5	7	8.3	23.8	640	110	17.2	62	9.7	26.9	—	—	—	—	—	—	
1872	59	27	45.8	4	6.8	52.6	596	126	21.1	41	6.9	28.0	2	14	700.0	—	—	800.0	
1873	73	22	30.1	6	8.2	33.3	562	91	16.2	68	12.1	28.3	2	—	—	—	—	—	
	867	220	25.4	81	9.3	34.7	5,960	1029	17.3	568	9.5	26.8	15	14	93.3	2	13.3	106.6	

quade the average death rate under 1 year was 2.5 per cent., in the next 1½ years 2.2 per cent.

From Phthisis, &c., the average death rate, under 1 year, in the first quinquade, was 4.0 per cent., in the next 1½ years 1.9 per cent.; in the second quinquade

the average death rate under 1 year was 8.0 per cent.; in the next 1½ years 2.7 per cent.

From Neurotic affections the average death rate, under 1 year, in the first quinquade, was 6.4 per cent., in the next 1½ years it was 1.7 per cent.; in the next

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TABLE No. 2.—continued.

Districts	Year	FACTORY CLASS				LABOURING, ARTISAN, AND MIDDLE CLASSES						MERCANTILE, PROFESSIONAL, AND GENTRY								
		Born	Died at 1 year	Average	Died at 2½	Average	General Average	Born	Died at 1 year	Average	Died at 2½	Average	General Average	Born	Died at 1 year	Average	Died at 2½	Average	General Average	
District No. 6	1864	15	4	26.6	—	—	26.6	511	94	18.4	32	6.2	24.6	42	2	4.8	1	2.4	7.2	
	1865	18	1	5.5	—	5.5	11.0	611	84	13.7	35	5.7	19.4	66	1	1.5	1	1.5	8.0	
	1866	20	4	20.0	—	—	20.0	367	89	24.2	43	11.8	36.0	54	5	9.3	1	1.9	11.2	
	1867	24	2	8.8	—	—	16.6	642	93	14.5	21	3.3	17.8	51	4	7.8	—	—	7.8	
	1868	16	—	—	—	—	6.2	682	74	10.8	32	4.7	15.6	59	5	8.5	—	—	8.5	
	1869	14	2	14.3	—	—	42.9	654	110	16.8	72	11.0	27.8	54	5	9.3	—	—	9.3	
	1870	12	5	41.7	—	—	41.7	684	75	11.0	37	5.4	16.4	72	6	8.3	—	—	11.1	
	1871	46	2	4.3	—	—	13.0	385	166	18.8	66	7.5	26.3	32	3	3.7	—	—	4.9	
	1872	33	15	45.4	—	—	48.4	1,065	128	12.0	80	7.5	19.5	97	29	29.9	—	—	43.3	
	1873	45	7	15.6	—	—	20.0	1,032	164	15.9	70	6.8	22.7	78	12	16.4	—	—	16.4	
			248	42	17.3	15	6.2	23.5	7,183	1,077	15.1	488	6.8	21.9	650	72	11.1	19	2.9	14.0
	District No. 7	1864	43	11	25.6	7	16.3	41.9	115	20	17.4	5	4.3	21.7	9	—	—	—	—	11.1
		1865	68	11	16.2	10	14.7	30.9	188	23	16.7	12	8.7	25.4	14	2	7.1	—	—	7.1
1866		78	12	15.4	5	6.4	21.8	180	24	18.3	10	5.5	18.8	15	2	13.3	—	—	13.3	
1867		53	6	11.3	3	5.7	17.0	174	23	13.3	11	6.3	19.6	15	1	6.6	—	—	6.6	
1868		68	10	14.7	5	7.3	22.0	168	22	13.9	11	7.0	20.9	14	1	7.1	—	—	7.1	
1869		45	9	20.0	2	4.4	24.4	185	22	11.9	9	4.9	16.8	12	1	8.3	—	—	8.3	
1870		38	5	13.2	2	5.3	18.5	150	16	10.7	6	4.0	14.7	9	1	11.1	—	—	11.1	
1871		46	7	15.2	3	6.5	21.7	78	17	23.3	2	2.7	26.0	5	1	20.0	—	—	20.0	
1872		26	4	15.4	9	34.6	50.0	120	14	11.7	28	23.3	35.0	18	3	23.1	—	—	46.2	
1873		38	8	7.9	4	10.5	18.4	140	19	13.6	4	2.9	16.5	10	—	—	—	—	—	
			508	78	15.5	50	9.9	25.4	1,483	200	13.9	98	6.8	30.7	116	11	9.5	4	3.4	12.9
District No. 8		1864	17	1	5.9	—	—	11.8	89	10	11.2	4	4.5	15.7	2	—	—	—	—	—
		1865	7	4	57.1	—	—	57.1	99	18	13.1	3	3.0	16.1	1	—	—	—	—	—
	1866	8	4	50.0	—	—	50.0	108	12	11.1	3	2.8	13.9	1	—	—	—	—	—	
	1867	7	—	—	—	—	—	128	11	8.6	—	—	8.6	—	—	—	—	—	—	
	1868	7	—	—	—	—	—	106	14	13.2	1	0.9	14.1	2	—	—	—	—	—	
	1869	10	1	10.0	—	—	10.0	119	8	6.6	4	3.3	9.9	2	—	—	—	—	—	
	1870	10	1	10.0	—	—	20.0	102	6	5.9	3	2.9	8.8	1	—	—	—	—	—	
	1871	3	2	66.7	—	—	100.0	102	6	5.9	2	1.9	7.8	—	—	—	—	—	—	
	1872	10	—	—	—	—	—	55	20	36.4	9	16.4	52.3	1	—	—	—	—	—	
	1873	6	2	33.3	—	—	33.3	90	15	16.7	—	—	16.7	—	—	—	—	—	—	
			85	15	17.6	3	3.5	21.1	998	115	11.5	29	2.9	14.4	10	1	—	—	—	—
	District No. 9	1864	34	6	17.6	3	8.8	26.4	114	7	6.1	4	3.5	9.6	8	—	—	—	—	—
		1865	30	5	16.6	3	10.0	26.6	137	14	10.2	4	2.9	13.1	7	—	—	—	—	—
1866		28	8	28.5	2	7.1	35.6	140	17	12.1	14	10.0	22.1	8	—	—	—	—	—	
1867		41	6	14.6	2	4.9	19.5	156	18	8.3	6	3.8	12.1	4	—	—	—	—	—	
1868		38	10	26.3	2	5.3	31.6	136	20	14.7	9	6.6	21.3	7	—	—	—	—	—	
1869		47	8	17.0	3	6.4	23.4	180	20	15.4	12	9.7	25.1	3	—	—	—	—	—	
1870		51	10	19.6	4	7.8	27.4	137	27	19.7	7	5.1	24.8	3	—	—	—	—	—	
1871		49	13	26.5	3	6.1	32.6	124	18	14.5	6	4.8	19.3	1	—	—	—	—	—	
1872		61	7	11.4	1	1.6	13.0	138	21	15.2	11	8.0	23.2	3	—	—	—	—	—	
1873		46	9	19.5	3	6.5	26.0	139	18	13.0	3	2.2	15.2	5	—	—	—	—	—	
			425	82	19.2	26	6.1	25.3	1,351	175	12.9	76	5.6	18.5	49	4	8.2	2	4.1	12.3
District No. 10		1870	80	14	17.5	6	7.5	25.0	240	44	18.3	9	3.7	22.0	3	—	—	—	—	—
		1871	58	16	27.6	2	3.4	31.0	239	53	18.3	11	3.8	22.1	3	—	—	—	—	—
	1872	64	10	15.6	4	6.2	21.3	296	48	16.2	16	5.4	21.6	3	—	—	—	—	—	
	1873	67	9	13.4	4	5.9	19.3	288	53	18.4	27	9.4	27.8	2	—	—	—	—	—	
		269	49	18.2	16	5.9	24.1	1,113	198	17.8	63	5.7	23.5	11	2	18.2	—	—	18.2	

quinquade the average death rate under 1 year was 3.3 per cent., in the next 1½ years 0.8 per cent.

In the artisan and middle classes the average death rate, from Inflammatory diseases, under 1 year, in the first quinquade, was 3.2 per cent., in the next 1½ years 1.6 per cent.; in the second quinquade the average death rate under 1 year was 2.9, in the next 1½ years

2.3 per cent.

From Zymotic diseases the average death rate, under 1 year, in the first quinquade, was 1.4 per cent., in the next 1½ years 1.4 per cent.; in the second quinquade the average death rate under 1 year was 1.1 per cent., in the next 1½ years 1.4 per cent.

From Phthisis, &c., the average death rate, in the

INFANTILE MORTALITY.

TABLE No. 3.—Death-rate from Inflammatory, Zymotic, Phtisic and Diseases of Respiratory Organs, Neurotic Affections.

—	TOWNS DISTRICTS													COUNTRY DISTRICTS													Town Districts		Country Districts										
	No. Born	1864	1865	1866	1867	1868	Total	Average	No. Born	1869	1870	1871	1872	1873	Total	Average	No. Born	1869	1870	1871	1872	1873	Total	Average	No. Born	1869	1870	1871	1872	1873	Total	Average	1st 5 years	2nd 5 years					
INFLAMMATORY.	24 Years	1 Year	Factory .	2,221	12	17	18	18	68	3.1	2,737	19	23	21	35	28	126	4.2	527	5	6	6	3	5	25	4.7	486	2	4	5	1	2	14	2.9	3.1	4.6	4.7	2.9	
			Artisan .	22,780	167	182	154	124	216	843	3.3	28,206	162	179	133	332	180	1036	3.7	1,978	9	10	16	12	17	64	3.2	1,804	10	7	8	17	10	52	2.9	3.3	3.7	3.2	2.9
			Gentry .	551	—	—	2	3	2	7	1.2	772	2	7	4	33	6	53	4.7	107	—	1	1	—	1	3	2.1	68	—	1	—	1	—	2	2.9	1.2	6.7	2.1	2.9
	Factory .	2,221	7	6	7	6	12	38	1.7	2,737	10	6	7	12	6	41	1.5	527	4	7	2	2	—	15	2.8	486	1	2	1	3	1	8	1.6	1.7	1.5	2.8	1.6		
	Artisan .	22,780	95	86	79	100	110	470	2.1	28,206	92	81	109	129	107	518	2.1	1,978	4	10	5	7	5	31	1.6	1,804	9	4	2	24	2	41	2.3	2.1	1.8	1.6	2.3		
	Gentry .	551	—	2	—	—	—	2	0.4	772	—	1	—	11	—	13	1.5	107	—	—	—	—	—	—	—	68	—	—	—	2	—	2	2.9	0.4	1.5	—	2.9		
ZYMOTIC.	24 Years	1 Year	Factory .	2,221	8	17	20	4	13	2.8	2,737	22	21	21	27	28	119	4.2	527	6	2	6	—	—	14	2.6	486	3	3	5	—	1	12	2.5	2.8	4.3	2.6	2.5	
			Artisan .	22,780	158	184	160	86	192	650	2.9	28,206	192	133	160	167	103	775	3.7	1,978	10	6	6	2	4	28	1.4	1,804	6	3	4	3	3	19	1.1	2.9	2.7	1.4	1.1
			Gentry .	551	2	—	1	—	—	3	0.5	772	—	2	1	22	1	26	3.9	107	—	—	—	—	—	—	—	68	—	—	—	—	—	—	—	—	0.5	3.4	—
	Factory .	2,221	9	13	11	2	14	49	2.2	2,737	26	15	9	6	9	65	2.9	527	1	3	4	1	—	9	1.7	486	1	4	1	3	2	11	2.3	2.2	2.4	1.7	2.3		
	Artisan .	22,780	115	120	139	50	180	604	2.6	28,206	305	142	108	93	117	765	3.1	1,978	5	4	13	2	3	27	1.4	1,804	3	7	5	9	2	26	1.4	2.6	2.7	1.4	1.4		
	Gentry .	551	4	—	1	1	1	7	1.2	772	1	2	—	2	—	—	—	107	—	—	—	—	—	—	—	68	—	—	—	—	—	—	—	—	1.2	0.6	—		
PHTHISIS.	24 Years	1 Year	Factory .	2,221	6	23	21	18	32	100	4.5	2,737	30	68	50	60	54	252	4.2	527	2	4	4	3	3	21	4.0	486	10	5	7	10	7	39	8.0	4.5	9.2	4.0	8.0
			Artisan .	22,780	225	272	287	283	245	1312	5.8	28,206	338	366	444	447	438	2033	7.2	1,978	4	14	18	16	23	75	3.8	1,804	23	25	23	27	26	124	6.9	5.6	7.2	3.6	6.9
			Gentry .	551	1	2	3	3	1	10	1.8	772	3	9	—	24	6	42	5.9	107	—	—	2	—	—	2	1.9	68	1	1	—	4	—	6	8.8	1.8	5.4	1.9	8.8
	Factory .	2,221	2	4	8	16	12	42	1.9	2,737	14	15	17	7	17	70	3.4	527	3	2	1	2	2	10	1.9	486	2	—	4	4	3	13	2.7	1.9	2.6	1.9	2.7		
	Artisan .	22,780	77	104	108	95	113	497	2.2	28,206	114	121	168	148	136	687	2.4	1,978	2	3	5	6	11	27	1.4	1,804	9	3	1	15	3	31	1.7	2.2	2.4	1.4	1.7		
	Gentry .	551	—	—	—	—	—	—	—	772	—	2	—	10	—	12	1.5	107	—	—	—	—	—	—	—	68	—	—	—	1	—	1	1.5	—	1.5	—	1.5		
NEUROTIC.	24 Years	1 Year	Factory .	2,221	10	18	19	21	24	92	4.1	2,737	29	29	21	14	30	123	4.5	527	5	8	8	6	7	34	6.4	486	3	4	5	—	4	16	3.3	4.1	4.5	6.4	3.3
			Artisan .	22,780	142	150	186	170	194	842	3.7	28,206	204	205	206	107	201	923	3.3	1,978	14	19	13	18	12	76	3.8	1,804	11	10	6	10	13	50	2.8	3.7	3.2	3.8	2.8
			Gentry .	551	2	3	2	2	4	13	2.4	772	4	3	1	12	5	23	3.2	107	—	—	—	2	—	2	1.9	68	—	1	—	—	—	1	1.5	2.4	3.2	1.9	1.5
	Factory .	2,221	2	2	5	9	3	21	0.9	2,737	2	9	7	1	9	28	1.9	527	3	1	—	—	5	9	1.7	486	1	1	1	—	1	4	0.8	0.9	1.0	1.7	0.8		
	Artisan .	22,780	39	43	45	50	54	231	1.0	28,206	58	67	73	41	59	298	1.1	1,978	2	2	4	2	2	12	0.6	1,804	4	2	2	—	2	10	0.5	1.0	1.1	0.6	0.5		
	Gentry .	551	—	—	—	2	—	2	1.2	772	—	—	1	3	—	4	0.9	107	—	2	—	—	—	—	—	68	1	—	—	—	—	1	1.5	1.2	0.5	1.9	1.5		

first quinquade, under 1 year, was 3.8 per cent., in the next 1½ years 1.4 per cent.; in the second quinquade the average death rate under 1 year was 6.9 per cent., in the next 1½ years it was 1.7 per cent.

From Neurotic affections the average death rate, in the first quinquade, under 1 year, was 3.8 per cent., in the next 1½ years 0.6 per cent.; in the second quinquade the average death rate under 1 year was 2.8 per cent., in the next 1½ years 0.5 per cent.

In the gentry, professional, and mercantile classes the average death rate from Inflammatory affections, in the first quinquade, under 1 year, was 2.1 per cent., in the next 1½ years .0; in the second quinquade the average death rate under 1 year was 2.9 per cent., in the next 1½ years 2.9 per cent.

From Zymotic affections, in the first and second quinquades, there were no deaths in the two periods.

From Phtisis the average death rate, in the first quinquade, under 1 year, was 1.9 per cent., in the next 1½ years .0 per cent.; in the second quinquade the average death rate under 1 year was 8.8 per cent., in the next 1½ years 1.5 per cent.

From Neurotic diseases the average death rate, in the first quinquade, under 1 year, was 1.9 per cent., in the next 1½ years 1.9 per cent.; in the second quinquade the average death rate, under 1 year, was 1.5 per

cent., in the next 1½ years 1.5 per cent.

Such are the results that have appeared from the examination of the registries of the district, which show that the mortality among the infants is so great that special attention should be directed to the exciting causes of those diseases that annually carry off so many of our young to an untimely grave; but though the Legislature has been forced by the representations of medical societies to do a good deal in favour of society, yet more is required at their hands before our infant population is placed in a proper sanitary state. I regret very much that I have not been able to give during this period the state of the barometer, thermometer, wind, and rain—four great factors of our health:—

J. Walton Browne

**Annual Meeting Session '79-'80
6th July 1880.**

Present, Dr. Dill (President), Dr. Harkin, Dr. Moore, Dr. Whitla, Dr. O'Neill, Dr. McKenzie, Dr. Kevin, Dr. Core, Dr. Wadsworth, Dr. Dempsey, Dr. Esler, Dr. Wales Snr., Dr. Workman.

The report of the Council was read and on the motion of Dr. Harkin seconded by Dr. Moore was adopted.

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President Robert Foster Dill

The Treasurer's report was read. Dr. Dempsey moved and Dr. O'Neill seconded its adoption which was carried unanimously.

The Librarian's report was read and on the motion of Dr. Harkin seconded by Dr. Esler was adopted.

Proposed by Dr. O'Neill seconded by Dr. McKenzie that the Librarian and Secretary issue a notice to the members that the Library is now available.

Dr. Harkin moved and Dr. Wales seconded that Dr. J. W. Browne be appointed President carried by acclamation.

Dr. Fagan (10 votes) Dr. McKeown (9 votes) were appointed Vice-Presidents.

Drs. Harkin, Clements, O'Neill, Wales, Moore, and Dempsey were appointed members of Council.

Proposed by Dr. O'Neill and seconded by Dr. Esler that Dr. Workman be appointed Assistant Librarian and carried.

Proposed by Dr. Moore and seconded by Dr. Wales that the thanks of this Society be given to Dr. Whitla and Dr. Esler and that they be appointed Secretary and Treasurer for the ensuing year.

Proposed by Dr. Esler and seconded by Dr. Wales that Dr. McKenzie and Dr. Kevin be appointed Auditors.

Dr. Harkin gave an extract of his paper on "Chlorate of potash—its therapeutic action".

Paper:¹ As chlorate of potassium exerts a salutary influence on all vital phenomena, especially upon the processes of cell growth, nutrition, and secretion, we might naturally expect to find that its administration in an abnormal condition of the conglomerate glands would be followed by evidence of its power; and such is the case, for example, in functional derangement of the salivary and mammary glands.

The first-named may fail in secreting power from congenital defect as in a class recognised by naturalists as dry-mouthed families, or from the effects of wasting diseases, such as diabetes. They may, on the other hand, from various causes, suffer from an excess of secretion, as in the period of dentition, and its opposite, old age; from sialogogues, such as mercury, pellitory of Spain, and tobacco. The sight and smell of savoury viands have the same effect.

In either case—whether that of ptyalism or its opposite condition—chlorate of potassium, taken internally, restores the balance and regulates the condition. Its primary effect in the healthy state is to stimulate and increase the flow of saliva, many persons being inconvenienced by swollen gums while taking it; and, when required and given in the form of lozenge or solution, it restores the absent or failing secretion. We are all conversant with the controlling power of this remedy in cases of mercurial salivation, but mistake its *modus operandi* when we attribute its action to an

antidotal opposition—to mercury, as in the example of opium and belladonna. The salt simply acts as a regulator—in the first instance exalting the physiological power when below par, and in the second by reducing to normal limits the working of the gland when in an excited condition.

This statement may appear, at first sight, contradictory and unreasonable. The exhibition of digitalis in neurotic affections of the heart affords a parallel case—at one time given to restrain excessive energy of the organ, and, again, to increase the effective force of the heart. The mammary gland in the nursing mother is also obnoxious to two opposite conditions—agalacty, or the absence or paucity of secretion, and galactorrhœa, or excessive secretion, and either of these states gives rise to suffering and discontent in the case of the nursing mother; and although no secretion is more readily modified in its physical qualities by the nature of the ingesta, varying as the nature of the food, whether principally animal or vegetable, or more readily affected by purgatives, saline or otherwise, yet there are few remedies which possess the power of increasing the secretion or of controlling its over-production. Chlorate of potassium has the desired efficacy; it will do all that is promised for *jaborandi* and more, for its use in regulated doses will rarely fail either to elevate or reduce the secretion to the desired standard as required. In the nursing mother it seems that the blood is sent to the breast in larger quantities in a given period, while, at the same time, the exhalant properties of the skin and kidneys are diminished. Medicines, which in the ordinary state get into the circulation and pass off by the kidneys, are found less plentifully in the urine, and are carried to the mamma, and thus produce in that organ their tonic and stimulating effects. I have, times without number, prescribed this remedy when the milk was insufficient or totally absent, and have been often entreated, a few days after, to allow the nurse to intermit its use, from the painful and bursting feeling of the teeming breasts. The influence of the remedy as a galactagogue appears limited to the first three months of lactation, and there are some constitutions quite uninfluenced by its use. I believe it shows its power more completely in women of the sanguine temperament, the gland enlarging rapidly and secreting freely under its influence in their cases. A collateral advantage always pertaining to it is, that the nursing improves marvellously, as it shares in the benefit of the salt which it imbibes with its mother's milk—no fact having been better established than that medicinal substances, mineral and vegetable, are discoverable by chemical analysis in the mother's milk, and their physiological influence is demonstrated by their effects on the baby. Out of a number, I shall submit an example of the efficacy of the remedy in the opposite states:—

Case I.—Agalacty.—Some years since, Mrs. J., living in Fleetwood-street, had been attended by me in three

¹ [Dublin Journal of Medical Science, 1880, v70, p403.]

confinements, each time of a daughter. On the first occasion there was not even an attempt made to secrete milk, and in the two succeeding births the secretion was merely nominal. At length a fourth child, a boy, was born, and the mother had a most intense desire to nurse him, but in vain. After a week I prescribed a mixture composed of an ounce of the chlorate to a pint of water, ordering one-half wineglassful to be given three times daily, with the result that before the expiry of three days, and ere the mixture was exhausted, the baby had to be brought to relieve the over-distended breasts. This child was nursed successfully for several months.

Case II.—Galactorrhœa.—Mrs. B., residing in Donegall-street, was confined of twins in her first labour. She had very large breasts, and after the first week the secretion was so profuse that the twins were unable to relieve her; night and day she was in a perpetual bath, and she often found it necessary three times after retiring to rest to change completely her night-dress. I prescribed the remedy in a similar quantity and dose, and in a few days the secretion was controlled to her full satisfaction.

There is a condition well known to the profession in which ladies complain to their medical adviser of debility and wasting, night perspirations, palpitation and pain in the left side under the mamma, due to prolonged lactation; the mother is unwilling, or unable perhaps through delicacy of the child, to consent to ablactation. In this case, so very often occurring, by the administration of the chlorate combined with the *tr. ferri perchlor.*, she may be enabled to prolong her maternal duties through the restoration of her strength, the increase of the secretion and improvement of its character, and the subsidence of the lateral pain. The influence of the medicine is not limited to the living child, but extends even to the period of intra-uterine existence—as medicines administered to the pregnant female affect undoubtedly the unborn baby. We all know that ergot administered freely to the mother three or four hours previous to birth will often result in the birth of a comatose or asphyxiated baby, quite independent altogether of the effects produced by uterine contraction—the poison acting in this case on the brain and nervous system of the foetus; and saline medicines given to the mother have often been found in the secretions of the child after birth. I have often prescribed the chlorate when the movements of the child in utero were becoming feeble, and with the best results; its efficacy, however, is best established in its power of controlling the tendency to give birth to a succession of still-born children at a premature period—cases quite distinct from those caused by a syphilitic taint. Of such I have had many memorable examples. I will adduce a remarkable one in illustration:—

Case III—On 9th January, 1869, I was called to attend Mrs. H. in her first confinement. She was in

labour at the eighth month, and soon a male child was born, without trouble, but without life. There were not any signs of syphilitic taint either in the child or the parents. On 80th March, 1870, I was again sent for, when a girl was born prematurely, caused by an accident in the street from a wild bull. When the third pregnancy was somewhat advanced I put the lady on the chlorate of potassium mixture, and at the end of the ninth month a male child, perfectly healthy, was born alive.

On December 6th, 1872, another child was born alive at full time, the mother having followed the same regime as before. On January 30th, 1874 (the mother still observing my advice), another girl was born at full time alive. On October 29th, 1875, a male child, still-born, came into the world at the eighth month, the mother believing that further medicine was unnecessary, and not having taken any. Two other children were since born alive at full time under the influence of the drug—one at December 18, 1876, and the other December 28, 1878. They are both alive at present.

It results from this, that whilst the mother followed the advice and took the prescribed remedy, a succession of living births at the full period occurred.

I think we may fairly conclude from this case that the medicine has a great efficacy in the puerperal condition, as from the moment that the medicine was taken the bad habit was arrested, that on its intermission another still-birth occurred prematurely, and that on its readoption no more fatal cases appeared. Were it necessary I could adduce many similar cases. Many years since, besides, the late Sir James Simpson also prescribed chlorate of potassium for this very purpose, on the ground that it made the maternal blood more rich in oxygen, and consequently better fitted to protect the foetus from “placental phthisis.” Other eminent gynecologists have also recommended it; and among the rest, Dr. M’Clintock, of Dublin, in an article published in the *Brit. Med. Jour.*, Oct. 13, 1877, upon “Fœtal Therapeutics,” has given a number of striking examples of its controlling power in similar cases.

Young children from the first to the sixth year, particularly those sleeping in overcrowded rooms, are subject to frequent attacks at night of screaming, with insensibility, and semi-convulsions, and somnambulism if not watched, and something approaching to the *petit mal*, due to the protracted inhalation of air deficient in oxygen and laden with carbonic acid and other morbid products—a persistence in this habit often leading to tubercle of the brain or lungs. For this condition I have always found the chlorate of potassium a sovereign remedy; and for the true convulsion and epileptic attacks of children it has proved not only curative, but, more important still, a true preventive. For the adult epileptic, although not so useful as the bromide, I have prescribed with great advantage this salt alone and in combination with the bromide.

In affections of the circulatory system, in palpitation of the heart, and in aneurism of the abdominal aorta and other large vessels, when combined with iron, most salutary results have been experienced, for by increasing the plasticity of the blood it would appear that a deposition of fibrin on the inner coat of the vessel takes place and the walls of the heart and coats of the large vessels appear as if strengthened, while the physical signs of the disease decline, and in some cases absolutely disappear.

If, according to Dr. Levinski, want of energy in the cardiac muscle is often due to the want of oxygen in the blood, we can understand how the chlorate of potassium may supply this desideratum and improve the tone of the organ. In tabes mesenterica the chlorate has a powerful effect, and in the diarrhœa and dysentery of children, when given by the mouth and by enema, the most satisfactory results have been observed in my own practice, and in that of the Vienna faculty, as published in the Rudolph Hospital Reports for 1869. Finally, in diseases of the skin, which generally are characterised by debility and a dyscrasis of the blood, the salt is a most potent remedy. In erysipelas no one is likely to question its value, particularly if combined with iron. It is equally useful in erythema nodosum, in eczema, in impetigo and purpura, in lupus when of scrofulous origin, in boils and carbuncles, in acne rosacea; and in that ailment so intractable and so troublesome to the fair sex, acne punctata, I have prescribed it with unvarying success. The remedy given internally appears to have a controlling power on the sebaceous glands and follicles, and prevents the usual progress towards suppuration. In acne rosacea the salt seems to combat the enlargement of the blood vessels and congestion of the skin, on which the disease depends. In epithelioma and cancrioid affections of the skin and mouth its efficacy as a lotion is generally acknowledged.

Dr. Workman was appointed Pathological Secretary.

J. Walton Browne M.D.

ULSTER MEDICAL SOCIETY

SESSION 1880–81

First Meeting (Session 1880–81)

9th November 1880.

President Dr. Dill outgoing President, Dr. John Walton Browne (President), Drs. Samuel Browne Snr, Wheeler, Wales, Wadsworth, Fagan, Esler, Wales Jnr., Dempsey, John Moore, Mackenzie, Aickin, Rea, Anderson, McHarry, Workman, Harkin.

Dr. Esler proposed Dr. Haslett as a member of the Society.

The outgoing President read a short address on general subjects and especially on obstetrics and gynaecology.

Paper:¹ Gentlemen,—Before retiring from this chair, and from my position as President of the Ulster Medical Society, to which I had the honour of being elected a year ago, allow me to thank you for the honour then conferred, as well as for the uniform kindness which you have so graciously and generously bestowed upon me throughout the session.

To occupy such a position—elevated to it as I was by the unanimous suffrage of the Society—is a dignity which I much appreciate, and an honour of which any member may be justly proud, especially when we consider that it is the highest compliment which the Society has in its power to confer; and I shall ever retain a grateful recollection of the hearty feeling with which your vote was accompanied, which encouraged me much in accepting of the office and of this high trust. At the same time I am free to state that I believe it was not because of any special work done by me for the Society, but it was due to the fact that I am among its oldest members, and that I had been taking an interest in the business and prosperity of the Society.

I may be permitted here to call to mind that this Society was called into existence something more than sixty years ago. Consequently it has survived what may be considered at least as two generations; and now that we are about to enter upon its sixty-second, if not its sixty-third, session, it does so, not in the infirmity or decrepitude of old age, but with as much vigour and vitality and with as much disposition for work as any previous session was ever entered upon. And why, may I not ask, should this not be so, when we have met here to-night for the purpose of installing your President-Elect, from whose young heart and cultivated intellect must flow forth an influence and force which cannot fail to inspire the whole body for work down to the most remote of its members?

At this period in the history of this Society one might feel tempted to compare the state of medical knowledge as it now stands with what it was when it first sprung into existence, but to sketch this thoroughly would require a master-hand and more leisure than I am able to command, so I leave to another the accomplishment of this great and important task. I may, however, be allowed to indicate briefly a few of the points of interest wherein the differences are found to exist between the present and past, and in doing so I think I am correct in stating that obstetric medicine and gynaecology have not been behind in the race.

On the contrary, give me leave to say that these departments have made more progress than either of the sister branches—viz., medicine and surgery. This, it will be admitted, is all the more extraordinary when we find that midwifery, including in that term gynaecology and diseases of children, has always been allowed to occupy the shady side of the profession—indeed we would be safe in asserting that it has been treated as the stepchild of medical science, and even yet it has not had that recognition to which its friends consider it is but justly or fairly entitled.

The other two departments—viz., medicine and surgery, have flourished under the fostering care of men of science and wealthy institutions, and whilst they have been thus out of proportion sustained, midwifery, it must be admitted, was long left to languish and to struggle through a very feeble existence. You will, therefore, scarcely be prepared to hear that, with all these disadvantages, obstetric medicine and surgery have made more progress and have advanced more rapidly than either of the other departments; and if I prove this, I think you will then admit that I am justified in claiming for it more attention, as well as a higher position, than it has been favoured with as a branch of medical study and practice.

Having said so much, you will naturally ask in what does this progress, or in what do these additions and improvements, consist within the last forty years; and while I am advancing a few facts to sustain my assertion, I am fully conscious that most of the gentlemen I address are as familiar with them as I can possibly be. But, even with all this, a rehearsal may, without any disadvantage, be occasionally indulged in.

Whilst I undertake to direct your attention to the great progress which has been made within the period specified, I shall not be unmindful of the value of your time or of your anxiety to hear the address from the President-Elect. I shall, therefore, confine myself to little more than a syllabus—a mere indication of the work which has been done—and first let me say that we have a more accurate knowledge of menstruation, conception, and generation than was possessed forty years ago. We have more correct views at present of the structure of the ovum—its progress, maturation, and process of expulsion—in other words, the mechanism of

¹ [Dublin Journal of Medical Science, 1881, v71, p269.]

labour, otherwise parturition. We have now a tolerably correct knowledge of the spermatozoon influence, the penetration of the ovule, with a more correct knowledge of the use of the fimbriated extremities of the Fallopian tubes, seizing as they do the ovary, receiving the ovule, by which it is conveyed to the uterus, its nine months' resting place, and during which time it undergoes a wonderful development.

We now possess a knowledge of the true changes which take place in the Graafian follicles. The growth of the embryo in utero has received much attention, and is now tolerably well understood. The characters and the conditions of the decidua uteri occupy different positions now, so that our knowledge here is fixed upon a better basis than formerly. There has been much time and careful research bestowed by Goodsir upon the anatomy, the physiology, and the pathology of the placenta, so that now the uses, the mode of circulation, and the diseases of this organ are tolerably well understood, with much practical advantage to the well-being of both the mother and the child, as well as in regard to the causes of the death of the fœtus in utero, which may be now easily diagnosed and accounted for.

The displacements of the uterus, which have of late received such marked attention at the hands of Hodges, Thomas, Graily Hewitt, &c., are now well understood, and by the means which they have suggested and recommended, can be easily and successfully put right.

Vesico-vaginal fistula, which was at one time the opprobrium of the obstetric art, is now not only in many instances prevented by our better management of labour, but, when unfortunately it does occur, it can, thanks to Marion Sims, be subjected to successful treatment.

The mechanism of labour, so interesting indeed, so fascinating a study in itself, has been placed before us in such a clear and intelligible form by the achievements of Baudelocque, Nægele, and Leishman, that we follow it with care, and take advantage from a knowledge of it in the management of labour.

What shall I venture to say of anæsthetics and their marvellous influences for good in labour, and wherever pain is found to exist? And are we not indebted to Simpson, the great accoucheur, in particular for this magnificent additional resource to our art, and inestimable boon to suffering humanity? I need not dwell on what is so well known to you all—viz., the better management of the different stages of labour which has been effected within the time mentioned.

I do well remember that where cases of placenta prævia were, when met with, much dreaded, now they are faced and treated with self-possession, clearness, and precision, and, as I have shown on a former occasion to this Society, with greater success as regards the life of both the mother and the child.

Long within the time of which we speak, has not the after-treatment of labour undergone a complete meta-

morphosis or change as regards nourishment? Formerly it consisted in starvation, now it is quite the opposite; yet, with all this, I still prefer (though not exactly to the same extreme) offering nourishment in a light form and in a sparing manner for a few days after labour; but I would add that each case must be treated in this respect according to circumstances.

Braxton Hicks' improved method of version by internal and external manipulation—in other words, as it has been called, the bipolar and bimanual mode of version, has been favourably received by the profession, and I have practised it in certain cases with ease to myself and greater safety and advantage at least to the mother.

In the presence of such a number of experts I would be slow to dilate upon the use of the midwifery forceps, or to say more than a word in regard to the increased and increasing use of this instrument.

The more frequent use of the forceps has certainly been the means of relieving the mother from the long, indeed the very protracted, labour from which she was allowed to suffer in former times, but with its earlier use there is greater safety to the life of the mother and her offspring.

The cephalotribe is an instrument of modern invention, and is a valuable addition and improvement upon the old crotchet in bringing away the fœtus with more ease and safety to the mother.

The toxæmic condition has received much consideration by Frerichs, Lever, Simpson, and Braun. But perhaps I should, in introducing this subject, have begun by directing attention to Bright's researches regarding the uræmic origin of puerperal convulsions, or true puerperal eclampsia. Through their labours this very formidable complication of labour is tolerably well understood in its chemico-physiological and pathological characteristics, as well as in its therapeutical requirements.

I can now do but little more than mention the names of some other diseases—viz., phlegmasia dolens, thrombosis, embolism, and, more especially, puerperal fever, as having had of late much more light reflected upon them, and, through them, upon the general puerperal condition.

The last-named disease is now recognised as a form of septicæmia—in other words, this disease is believed to originate with blood-poisoning, and that the poison may be absorbed into the system either from within or from without—that is, either auto-genetically or hetero-genetically. With this disease the study and history of the antiseptic plan of treatment have been very intimately associated, so that the decomposition of the coagula in utero has received marked attention and has led to a knowledge of the influences of septic poisoning and of antiseptic injections.

The use of the speculum, uterine sound, uterine dilator, sponge-tents, laminaria, hydrostatic uterine

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dilators—associated as these instruments are with names of the highest standing in medical science, such as Simpson, Priestley, Barnes, Wilson, and Marion Sims—have been well received, and have introduced a new era in the diagnosis and treatment of uterine diseases.

What shall I say of Spencer Wells and Thomas Keith, who occupy such a prominent position before the profession and the world? for do we not stand in perfect amazement and fascination while we contemplate their magnificent achievements in ovarian diseases and their brilliant successes in ovariectomy—creating as they do a halo around their names while they live, and which will embalm their memories into perpetual spring? May I be allowed to speak of such men as the Brobdignags of medical science, at whose feet we, their Lilliputian brethren, should sit, and, looking up, listen and acquire knowledge and intellectual strength, so as to enable us to grow up into the full stature of the perfect man. Time would fail me to speak of many other important improvements and aids to midwifery as they deserve, such as ergotine, perchloride of iron, bromide of potassium, and chloral hydrate.

The alternative operations for craniotomy should be also here mentioned to show you that this department of our art has not been stationary during the last forty years. These operations are—öophorectomy, hysterotomy, and laparo-elytrotomy.

Although foreign, to some extent, to the subjects under consideration, I had intended expressing a few words on the advantages that we in common with the other branches of medicine have derived practically from the use of the thermometer, the microscope, the aspirator, the spectroscope, the ophthalmoscope, the laryngoscope, and the sphygmograph, which are all instruments of precision, and in the hands of scientific men have yielded some most important and extraordinary results in clinical and pathological investigations. Had time permitted I could have adduced a few facts which would be considered as very striking in the accuracy with which we may by the use of some of these instruments not only diagnose disease, but also distinguish one disease from another; I forbear, however, as I ought rather to apologise for taking up already so much time in “telling you that which you yourselves do know.”

In drawing these hastily written remarks to a close, will you allow me to say that, let the astronomers vaunt their Copernicus, the natural philosophers their Galileo, the mathematicians their Pascal, the geographers their Columbus, we will worship at the shrine of a Hunter or a Harvey. From all that has been stated I think I am justified in the conclusion that “the proper study of mankind is woman.”

I beg to introduce to you Dr. J. W. Browne as President for the year, who, I have no doubt, will try to verify the old dogma—viz., that “doctors differ,” and attempt to prove that the correct rendering is that “the proper study of mankind is man.”

Dr. John W. Browne then read his address.

Paper:¹ Mr. Ex-President and Gentlemen,—A few months since, when from home enjoying a short holiday, the announcement reached me that I had been unanimously selected to fill the Presidential Chair of the Ulster Medical Society for the Session 1880–81. I assure you that although a few of my most intimate friends had spoken to me on the subject, I was quite taken by surprise.

I never for a moment dreamt that upon the 14th November I should be occupying the chair of this honourable and distinguished Society.

At first I hesitated to accept the position, knowing as I do the arduous duties and great responsibility of the office, but on learning that my appointment was really desired by a number of my professional brethren, I felt that I would be wanting in a due appreciation of their kindness if I refused so flattering a compliment; and, gentlemen, I cannot permit this opportunity to pass without giving expression, however brief and faint, to the feeling of gratitude and pride which your unexpected, as unmerited, election of me to the honourable position of your President has inspired—gratitude for the courteous kindness of sincere, but, I fear, too partial friends, and pride that even to them I should have appeared not altogether unworthy of so distinguished a mark of confidence. For myself I could have wished that the duties of the Presidential Chair had devolved upon some member—and you have many such among you—more competent and better qualified than its present occupant to perform them efficiently and satisfactorily. Although I may fall far short of what you may consider the essentials of a President, it will be my constant desire to promote the best interests of the Ulster Medical Society—to endeavour by every worthy means in my power to maintain it in a position worthy of our medical brotherhood of Ulster; but when trying to maintain the position of the Society, I hope that it will never be forgotten that for that support and assistance in the performance of my duties, which I feel conscious of needing, I may ever look to your kindness and forbearance; and from what I know of the several members I will never look in vain.

I cannot hope for one moment to be as successful in the management of the Society as my friend and honoured predecessor, Professor Dill, but, I think, with the aid of the hard-working secretary, Dr. Whitla, I will be able to hand over the Affairs of the Society to my successor in a fairly satisfactory condition; and all I can say, if I fail it will not be from want of good intentions.

When looking back upon the past I consider we have much for congratulation, upon the present state

¹ [Taken from *Transactions of the Ulster Medical Society*, 1880–81, p6 (plain text); and *Dublin Journal of Medical Science*, 1881, v71, p451 (italic text).]

of the Society. We have at last a comfortable reading room, and all the medical papers placed upon the table for the convenience of the members; and we have also the nucleus formed of a modern library. Up to a very few years ago we had few, if any, really good consulting authors added to our collection. We have obtained a fair start, and let us hope that nothing will impede the hands of the officials of the Society in their endeavours to extend the usefulness of the library.

During the session which we have entered upon I hope that every member will determine from the outset to work, and embrace every opportunity of presenting to his brother members—thank goodness we have no sister members—any new fact or facts which may come across his path in practice.

I am one of those individuals who believe that one well-observed fact is worth a thousand theories, and I well remember, a few years since, when studying under my distinguished teacher, Professor Gordon, his teaching was “Observe and note facts.”

To observe in Surgery, or in any other art, a genuine, honest, palpable fact, requires, in my opinion, more strength and force of mind than to spin out any amount of fine theory or plausible hypothesis.

Pardon me for one moment referring to a matter which I consider should be deeply studied by each one of us—I refer to professional ethics. It is not pleasant at any time to have a misunderstanding with a professional brother, but when conflicting opinions and views do arise I consider that all differences should be submitted by both parties to the Council of the Society, and not to the medical brethren at large—so acting would frequently tend to again cement former friends and allay petty jealousies and animosities.

In my opinion that is one of the benefits of being a member of a Society such as ours, where brother meets brother on an equality; and thus, whilst the interchange of thought sharpens our intellects and promotes professional knowledge, it tends to develop a kindly feeling one towards another, and helps to extinguish all professional bickerings; and, gentlemen, why should we wrangle and dispute, are we not all striving towards the same end—the cause, prevention, and treatment of disease? Consider we are but mortals, and remember the shortness of our lives.

It has been written—

“ What is Life? A flower that blows,
Nipp'd by the frost, and quickly dead.
What is Life? The full blown rose
That's scorched at noon and withered.

“ Such is Life—a breath, a span,
A moment quickly gone from thee.
What is Death? Oh! mortal man,
Thy entrance to eternity!”

In thinking over a subject which would be appropriate for an introductory I found myself at a full stop; but I suddenly remembered that my distinguished predecessors, Drs. Wales and Harkin, had, at their inaugural addresses, dealt with special subjects—namely, Dr. Wales, “Use of Stimulants;” and Dr. Harkin, “The Artificial Feeding of Infants.” Both of these addresses were followed by excellent debates, and largely developed latent talent; and it is with the hope that we may have a third discussion that I venture this evening to detain you for a short time upon the anæsthetics—Chloroform and Ether, their Advantages and Disadvantages. I hope also to mention some statistics, and draw your attention to a few of the remedies used to prevent poisoning by chloroform and ether.

Nearly every member of the Society, and especially those engaged in surgical and obstetrical practice, must, to a large extent, use anæsthetics; and I trust that every member will be able to give his experience upon the use of the two anæsthetics.

I may commence by saying that I have a firm and unshaken faith in chloroform, having been present at, or taken part in, its administration hundreds and hundreds of times, and will continue to use it until a more satisfactory anæsthetic is introduced to our notice. The prompt action of chloroform and the calm sleep which it induces, its pleasant odour and taste, and the usual absence of subsequent vomiting, if care be taken in dieting the patient, would be alone sufficient to secure its general adoption were it not that so many physicians and surgeons regard it as uncertain and dangerous. With some the conviction is so decided that they advocate its entire disuse as the only radical method of avoiding the attendant risks.

I am quite cognisant of the fact that certain medical journals have denounced the use of chloroform and highly approve of the use of ether. And one recent writer went so far as to say that—“A surgeon who used chloroform in preference to ether, should a death occur in his practice, deserved to be tried for manslaughter.”

The medical journals still continue to report a noticeable number of fatal cases of chloroform poisoning, and these are occasionally referred to by the editors with stringent comments. According to one statement a death occurs in every 2,723 administrations of chloroform, while a more recent writer, Mr. B. Carter, in *The Lancet*, August 7th, 1875, gives the proportion as 1 in 2,500 patients; and Mr. Carter goes on, in the same paper, to state that ether is in all respects as available and as effectual as chloroform, and that it is absolutely safe. He says: “I do not believe that it has ever destroyed life, nor do I believe it has any tendency to destroy life.”

I fear Mr. Carter is a prejudiced writer; other men are as competent to form an opinion as he. Further on I shall show ether is considered unsafe by certain writers, especially so in children. In *The British Medical Journal* 6th November, 1880, you can read a letter

from Mr. Jonathan Hutchinson, advocating the use of ether in preference to chloroform, and calling upon the editor to continue his advocacy until ether is universally used in all suitable cases.

You see Mr. Hutchinson uses the words “suitable cases,” admitting there are some patients who take chloroform better than ether. He prefers to administer chloroform to old people and young children. With all due respect to Mr. Hutchinson’s opinion, were I to give ether at all it would be to old people owing to its recognised stimulating effect upon the heart. In the same journal Mr. Hutchinson’s letter is followed by one from Mr. Jacob, of Leeds, also advocating the use of ether; but admitting that there are certain dangers attendant upon the administration of that anæsthetic. Immediately succeeding Mr. Jacob’s letter is one from the administrator of anæsthetics at the Victoria Hospital for Children.

He considers that in all inquiries relating to the respective merits of the two anæsthetics, chloroform has always been heavily handicapped; and submits that if ether or chloroform were given in cases of similar degree of risk, the mortality of the two would be found to be very much on a par.

Notwithstanding all the adverse opinions and writings, yet physicians and surgeons will rely upon their individual experiences. One has used chloroform in hundreds of cases without any bad results, and considers it safe and reliable; another had almost adopted the same conclusion after a long experience, when alarming symptoms or a fatal issue occurred in his own practice and shook his confidence. Still another has been alarmed by apparently dangerous phenomena resulting from ether, and has returned to chloroform with the idea that its danger has been exaggerated.

It is very odd that the first attack upon chloroform as an anæsthetic was made in America, the birthplace of ether; and all of you must have observed that in the many discussions upon the merits of the two anæsthetics nationality has entered largely into the debate—America v. England; and from the visit of Dr. Joy Jeffries, of Boston, to this country, in 1872, must we date the peculiar ether craze which has sized the minds of some men. It is very remarkable that many of the fatal cases of death from chloroform inhalation have occurred in the practice of dental surgeons, private practice, or in some small institutions—a circumstance which would seem to show that there had been some fault in the mode of administration. A writer in *The British Medical Journal*, January 1st, 1876, claims:—“That by proper care chloroform is a sufficiently manageable and safe agent for use, and that it is not the chloroform which is to blame, but the mode of administration.” With this opinion I fully concur. I always feel safe during an operation when the experienced house-surgeon is looking after the anæsthetic; and I must confess when an inexperienced person is locum-tenens

I always feel uneasy until the operation is finished. I suppose many of you have read of a death from chloroform at one of the London hospitals? Just before the administration the house-surgeon was summoned to a coroner’s court and was consequently absent during the operation; death occurred. Another death from chloroform has also been reported, where the experienced chloroformist was unavoidably absent during the administration. Here you see in the one case the experienced house-surgeon absent, in the other case the chloroformist otherwise employed; the chloroform may or may not have been administered by an experienced person. Comment is unnecessary; still they are deaths from chloroform.

Now let us consider some of the advantages and disadvantages of ether and chloroform.

Advantages of Chloroform.—In most cases its administration is agreeable to the patient; rapid in its action; complete insensibility produced; the entire absence of excitement when the insensibility is complete; little laryngeal or bronchial irritation; the easy maintenance of the anæsthetic influence, and less liability to cause vomiting.

Disadvantage is said to be the risk attending its administration. Death from the inhalation of chloroform may result, and probably does often result, from gradual paralysis of the respiratory muscles from the effects of the chloroform upon the respiratory centres.

There is another form of death from chloroform—cardiac syncope—the heart at one moment beating well, and the next moment stops. So you see chloroform may cause death not only by arresting respiration, also by its depressing action on the heart—this action on the heart being in my opinion, the greatest disadvantage of chloroform, because when the respiratory centres are affected we can watch the change of breathing from its comparatively calm state, gradually becoming more shallow and stertorous; here by following out certain rules danger can be averted. But when death takes place from cardiac syncope, here there is no warning, the time between life and death being almost absent; so that, granting this cardiac syncope to be a serious disadvantage to the use of chloroform, we must take every precaution, before commencing the administration, to limit the risk, by placing the patient in the recumbent posture, and attending to the other well-known details.

Advantages of Ether.—It is said that all records show it to be safer than chloroform—that is a matter of opinion. To my mind the greatest advantage of ether over chloroform which can be presented is, that although ether, like chloroform, may kill by arresting respiration, it does not destroy life by its depressing action on the heart—i.e., it does not kill by cardiac syncope.

Disadvantages of Ether.—It is an unpleasant anæsthetic; it requires a long time to effect complete unconsciousness. The time required to get the full effect of the ether varies to a far greater extent with different people

than in the case of chloroform. As a rule, it is twice as long, the quantity requiring to be inhaled being much greater. Other disadvantages are the restless excitement that often results from its administration, very different to the extreme quiet of chloroform unconsciousness; also the danger of ether vapour catching fire should any light be placed incautiously near the patient's mouth during inhalation. Dr. Neligan mentions, as one of the disadvantages, the persistent taste and odour experienced even for days by those to whom it has been administered; and Mr. Clover has drawn attention to the fact that the flow of saliva is considerably increased during the administration of ether and occasionally gives trouble.

Is Ether really Safer than Chloroform?—If we are to believe all that has been written on the point I believe that we must come to the conclusion that ether is the safer of the two anæsthetics; but, gentlemen, it is to obtain your individual opinions that I have introduced the subject. We still find many medical men very much in favour of chloroform, notwithstanding what has been written in opposition to it. I think we must all come to the conclusion that for operations upon young children and pregnant women chloroform is to be preferred to ether.

A few years since Dr. Tripier, of Paris, read a paper before the French Association for the Advancement of Science, and related cases in which the administration of ether to young children for surgical operations was attended by an arrest of respiration, and alarming symptoms ensued. Dr. Tripier instituted experiments upon young cats with ether, and found, as in young human subjects, an arrest of respiration often occurred. Older animals were less liable to the accident. He, therefore, considers anæsthesia by ether in young subjects as dangerous, and that chloroform for them should be preferred.

My opinion is that ether does not hold so good a position in the scale of safety as it did a very few years ago. I remember some six years since nothing but ether was administered at several English and Irish hospitals I visited, and I was very much surprised to find three weeks since, whilst revisiting these hospitals, either chloroform in use or a mixture of ether and chloroform. I dare say you are aware that up to 1872 Mr. Spencer Wells used ether largely, and that he now either uses chloroform or bichloride of methylene. At the Samaritan Hospital for Women, London, I had the pleasure and advantage of seeing a few ovariectomies performed. Here the anæsthetic used was chloroform administered by Junker's inhaler; and from conversations I had with several medical men just returned from the great medical schools of the Continent, I learned chloroform is the anæsthetic chiefly used.

"In Germany chloroform has a less disputed sway than in any other country, and is now, according to Dr. Kappeler, of Germany, so far as he knows, exclusively

used. In Austria the course pursued by Billroth is an index of the lack of full satisfaction with either ether or chloroform."¹ He is an advocate of, and constantly uses, a mixture consisting of three parts of chloroform, one part of ether, and one part of alcohol. This is the mixture which was so strongly recommended by the Committee of the Medico-Chirurgical Society.

Even in certain parts of America—the birthplace of ether—and notably in the Southern States, chloroform is preferred to ether. A paper bearing out this statement has lately appeared, written by Dr. Chisholm, of Baltimore.² This confidence in chloroform seems to be based upon the experience of surgeons with it in the Confederate Army, and in the Northern States the warmest advocates are surgeons who have had large experience during the American War. According to Sedillot and Malgaigne, ether has never succeeded in supplanting chloroform in France. Gross, of Philadelphia, prefers chloroform.

Why, gentlemen, have such men as Spencer Wells, Bantock, Billroth, Gross, and others, given up the use of ether, and adopted either chloroform or a mixture of chloroform and ether?

In Scotland, as we should naturally expect, chloroform is the anæsthetic in common use, and has a strong advocate in Professor M'Leod, of the Glasgow University. Dr. M'Leod, in *The British Medical Journal*, January 1st, 1876, lays down some excellent rules regarding the administration of chloroform, and goes on to state:—"He believes a good many of the deaths under chloroform have apparently been due to patients, suffering from heart disease, not being completely insensible when the operation was performed, and the shock killing them. Here," he says, "the chloroform is blamed, whereas what was really wrong was that it was not sufficiently pushed." He also states he never measures the amount of chloroform poured on the sponge or towel, simply watching the effects, and considers more deaths are due to too little than to too much chloroform being given. In his paper he alludes to a very important point—namely, always to administer the chloroform in the recumbent posture. With this opinion I think we must all agree, as you are aware a large proportion of the deaths from chloroform have occurred in the practice of dentistry, and chloroform is generally administered by dentists when the patient is in the sitting posture.

Bearing out Dr. McLeod's opinion regarding the shock killing the patient, not the chloroform, a letter has just appeared in *The British Medical Journal* by an Edinburgh professor. When speaking of the sudden arrest of the heart's action from reflex irritation during an operation, he says:—"The treatment of the sudden arrest of the heart's action from reflex irritation should consist in boldly pushing the administration of the

¹ *American Journal of Medical Sciences*. July, 1880.

² *American Journal of Medical Sciences*.

chloroform, in the hope that relaxation of the spasmodic contraction of the heart will speedily occur.” My idea is that chloroform is perfectly safe when administered with the precautions advocated by the Chloroform Committee of the Medico-Chirurgical Society in 1864, and, in addition, carefully adhering to the rule always to administer the anæsthetic in the recumbent posture.

The relative advantages of ether and chloroform were carefully investigated by the Committee on Chloroform appointed by the Medico-Chirurgical Society (Lancet, July, 1868). In their Report they state that ether is slow and uncertain in its action, though it is capable of producing the requisite insensibility, and less dangerous in its action than chloroform. In many respects the action of ether is the same as dilute chloroform. The primary stimulating effect of ether on the heart’s action is greater and of longer duration, and the subsequent depression of the heart’s action is not so great as that produced at the same degree of insensibility by chloroform.

On the whole, however, the Committee concur in the general opinion which in Great Britain has led to the disuse of ether as an inconvenient anæsthetic. The Committee found a mixture of ether and chloroform to be as effective as pure chloroform. This Report was written in 1868, and it was in 1872, subsequent to the visit of Dr. Jeffries to this country, that ether suddenly came into vogue. The Committee suggested for use a mixture composed of chloroform two parts, ether three parts, and alcohol one part, on the ground that ether and chloroform blend uniformly when combined with alcohol, and the constituents escape equally in vapour. The mixture of ether and chloroform I have lately seen used with good effect; the mixture is now used at the London Ophthalmic Hospital—not ether alone.

I now wish to introduce a few words relative to the statistics of the administration of the two anæsthetics. Some deaths have, no doubt, occurred at Guy’s Hospital, London, during the administration of chloroform, but here it was given 12,000 times before any serious accident occurred. In the Crimean War it was given 25,000 times without a death, and during the American War 7 deaths occurred with 120,000 administrations. Professor Andrews, of Chicago, in 1870, collected from the different American and European hospitals the statistics of 117,078 cases in which chloroform was used, with 43 deaths. Of 92,815 cases of etherisation 4 died, and a mixture of chloroform and ether was employed in 11,176 cases with 2 deaths. Professor Gross, of Philadelphia, has given it upwards of 8,000 times without a death. Syme gave it about 6,000 times without any serious occurrence, and Professor Simpson is said to have met with but one death in all his immense experience. Professor Nussbaum, of Bavaria, in upwards of 15,000 administrations, never lost a patient; Billroth has given it successfully upon 12,500 occasions. It is calculated it has been administered in Belfast, includ-

ing hospital and private practice, upwards of 7,000 times; and up to the present, I am happy to say, no death has occurred. Long may we have this story to tell.

It is extremely odd that no writer has made any attempt to present the total number of deaths which have occurred under ether. This death-rate is a very important matter when chloroform is under consideration, but of no consequence in regard to ether. Still, Turnbull in America, Kappeler in Germany, Perrin and Lallemand in France, have reported not a few deaths resulting from the inhalation of ether (see American Journal of Medical Science, July, 1880). Kappeler gives a class of deaths occurring after the administration of the ether is over, and refers to the investigations of Lallemand, Perrin, and Duroy, showing that ether is retained a longer time in the organism, and has therefore a decidedly more prolonged operation. As regards the deaths from ether Dr. Kappeler says:¹—“We are as little prepared to state in figures the dangers of ether as those of chloroform, since neither the number of deaths from it nor the number of administrations are known, and the attempts made to state the proportion of deaths to administrations are mostly the product of the bitter contest—ether versus chloroform.”

From these favourable reports and statistics, which I have just read, I think we may conclude that the time has not yet come when chloroform will be laid aside; and I believe its use will continue so long as there is the existing diversity of opinions regarding its merits. Hence it must be now, as it has been, the earnest wish of surgeons and physicians to diminish the attendant danger; and this leads me to speak of a few of the more prominent remedial measures and preventions to nullify ether and chloroform poisoning.

In threatened death from chloroform the means which we most frequently rely upon are—(1) Drawing forwards the tongue with tongue-forceps; this method was first introduced by Mr. Lister, but it is now considered you gain more by drawing forwards the inferior maxilla; by so doing the muscles which connect the lower jaw with the larynx and os hyoides are drawn upon and open the larynx; it is said you gain a freer opening of the larynx by this method; at the same time as you draw forward the tongue or lower jaw it is recommended to place the patient upon his left side, (2) Nélaton’s plan.²—Inverting the patient so as to lower the head and determine a flow of blood to the brain. (3) Artificial respiration, by Sylvester’s, Marshall Hall’s, or Howard’s methods.—When practising artificial respiration you can place a sponge saturated with hot water over the heart. This is recommended by Dr. M’Leod, of Glasgow.

In threatened collapse from chloroform, and when the heart’s action flags, ether has been injected hypodermi-

¹ American Journal of Medical Science. July, 1880.

² The late Mr. S. M. Bradley, of Manchester, has reported cases treated successfully by this plan.

cally with marked success. Lately Dr. Moinet, of Edinburgh, has spoken highly of the subcutaneous injection of digitaline as a cardiac stimulant in conjunction with artificial respiration. The galvanic battery is also occasionally used to avert impending danger; but those of you who have been reading *The British Medical Journal* lately must have noticed a letter from Professor Schafer, of University College, on the action of the galvanic current when applied to the cardiac region. He says:—"The effect of direct stimulation of the heart is so opposite, according to the part which happens to be brought under the direct influence of the excitation, that it is no exaggeration to say that the treatment is at least as likely to arrest a beating heart as to set an inhibited one in activity." So that, taking into account this celebrated physiologist's experiments, I consider we must not rely too much on galvanism.

In this recent letter you will also observe that Professor Schafer speaks very highly of a hypodermic injection of atropine in all cases in which chloroform is about to be administered. He states that it is well known that atropine paralyses the cardiac inhibitory apparatus, and since it is probable that death in these and similar cases results from a stimulation of this apparatus, either directly by the drug, or it may be, in some instances, in a reflex manner, by the stimulation of abnormally excitable afferent nerves during the actual performance of the operation, there seems good reason for the employment of atropine. He has also performed a number of unpublished experiments to prove the value of atropine as an antidote to the cardio-inhibitory effects of chloroform; and he is of the opinion that atropine should be injected subcutaneously in all cases of anæsthesia by chloroform as a preventive. As regards the previous subcutaneous injection, a letter has just appeared in *The British Medical Journal*, written by Dr. Muro, of Manchester, speaking of the beneficial effects of the atropine injection in chloroform inhalation. He has also performed a number of experiments, which he states he forwarded to the Committee of the British Medical Association, but they did not publish the results of his experiments for reasons best known to themselves.

Dr. Muro is of the opinion that atropine administered previously to the giving of chloroform is a powerful heart protector, making it impossible for the latter to kill, even when administered with that intention.

The modification of the ordinary course of chloroform anæsthesia by the preliminary injection of morphia deserves attention. This is known by the name of the "mixed narcosis," and was first resorted to by Professor Nussbaum, of Bavaria. It is claimed for the "mixed narcosis" that it is especially adapted to prolonged operations, rendering a far less quantity of chloroform necessary—the anæsthesia being continued with far less repetition of inhalation; that the stage of excitement is lessened, and that thereby the dangers of anæ-

sthesia are diminished. It is recommended to make the hypodermic injection of one quarter grain of morphia twenty minutes before administering the anæsthetic, because if made immediately preceding the use of the anæsthetic the stage of excitement is increased.

In *The Lancet* of December, 1877, you can see papers upon the "mixed narcosis method," and details of operations performed by Mr. Marshall and Dr. Sidney Ringer. Mr. friend, Dr. J. F. Wales, informs me that this method is frequently resorted to at the Leeds Infirmary. It appears that none of the advantages of chloroform-morphia attach to ether-morphia narcosis.

Dr. Kappeler¹ gives his experience with twenty-five cases, and states that the combination of these two agents is rather injurious than beneficial.

The medicinal agent which seems to promise most as an antidote to chloroform and ether poisoning is the nitrite of amyl, since physiological experiments have developed an antagonism between the effects of nitrite of amyl and chloroform.

While chloroform impairs reflex excitability and produces contraction of the cerebral vessels, nitrite of amyl restores this excitability and causes their dilatation. Into the enlarged vessels the blood freely enters, and a rapid circulation follows.

Mr. Bader, Ophthalmic Surgeon to Guy's Hospital, in *The Lancet*, May, 1875, gives the results of his experience with the nitrite of amyl. He says:—"In three or four minutes after taking three drops of nitrite on sugar, the blood-vessels of the retina, especially the veins, become enormously dilated and gorged with blood, leaving no doubt as to the simultaneously existing cerebral hyperæmia with increased circulation of blood."

He further says:—"The most striking effects of the nitrite were the quick restoration of breathing, a good colour, and the rapid appearance of sickness."

As to the essential mechanism of this, Dr. Robert Pick (*British Medical Journal*, February 26, 1870) considers that the following conclusions are established by recent experience:—

1. Amyl nitrite produces a direct paralysis of the vascular wall.

2. The effect of the drug must be peripheral; but whether the smooth muscles themselves, or the terminal ends of nerves in these, or, finally, certain hypothetical peripheral ganglionic cells, are the points of attack, is unknown.

Dr. William Dabney, in the "Transactions of the Medical Society of Virginia, America," reports a series of experiments upon cats and dogs, showing the value of nitrite of amyl in cases of threatened death from chloroform and ether.

Dr. M. Schüler has written in *The Berlin Clinical Journal* a series of experiments performed with the

¹ *American Journal of Medical Sciences.*

nitrite upon rabbits. He removed a small portion of the skull, leaving the *dura mater* intact. He found, when chloroform was inhaled for a short time, a diminution of size of the arteries of the *pia mater*, then of the veins, took place. This is accompanied by a corresponding decrease in the pulsations. Soon follows an increasing relaxation of arteries and veins, and at last marked venous stasis. As a result of the venous condition of the blood, the arteries become speedily of a darker hue.

The inhalation of the nitrite of amyl promptly removes the effects of chloroform on the vessels of the *pia mater*. The arteries dilate and become of a bright colour, the veins become of a clearer hue, and the respiration which had been embarrassed grows easier and more frequent. He also states that the reflex excitability which has been destroyed by chloroform narcosis is soon fully re-established under the influence of the nitrite of amyl.

I think these experiments show that in nitrite of amyl we have an agent which will prove of great service when disagreeable symptoms show themselves during the administration of chloroform and ether.

I have thus, gentlemen, in a feeble manner endeavoured to put before you a few practical observations regarding two very important anæsthetics. I had originally intended taking up the subject of anæsthetics in general, and introducing to your notice bichloride of methylene and the two new agents—dichloride of ethidene and bromide of ethyl; but I feared the paper would be too long, and I feel certain your patience is already exhausted.

Annual dinner was decided to be held on the 23rd instant Tuesday on the motion of Dr. Esler. Moved and seconded and passed that the President, Professor Dill, Dr. Harkin, Dr. Moore and Dr. Whitla be appointed Dinner Committee.

James Moore M.D., Chairman
7th December 1880

The Second Meeting Session 1880–1881 was held upon December 7th 1880.

Present, Dr. James Moore (in the chair), Dr. Fagan, Drs. Kevin, McHarry, Anderson, Dempsey, Workman, Whitla, Smyth (Royal Hospital), Professor Dill, Dr. J. W. Browne (who came in late), and several students.

Dr. Haslett was elected a member of the Society.

Dr. Smyth, House Surgeon Royal Hospital, was proposed by Dr. Whitla and seconded by Dr. Fagan as a member of the Society.

Dr. R. J. Anderson read a paper upon the embryology of the lingual muscles.

Upon the motion of Dr. Dempsey seconded by the Secretary the discussion upon the paper was postponed.

Dr. Fagan opened the debate upon ether and chloroform which was freely entered into by most of those

present.

Paper:¹ MR. FAGAN said:—Mr. President,—It is unfortunate that the discussion on the important matter that formed the subject of your Inaugural Address should have been so long deferred. I dare say there are some members of the Society who feel, as I do, that very many important points touched on by you have escaped their memory; while the general impression remains that your exhaustive résumé of the literature of the subject has left one very little virgin ground to work on. As well as I can remember, the drift of your arguments led to the conclusion that chloroform, although not devoid of danger, possessed advantages over ether that would justify you in still adhering to it till a safer and more effectual anæsthetic be discovered.

Granted that I am right in quoting this as the expression of your opinion, I am not astonished at your entertaining it. As you state, I think, in your address, chloroform has been given in Belfast 8,000 times, from its discovery up to the present, without mishap attending it. You have had a large experience, and a pleasant one, of its administration; and it is but right to think that so old, so tried a friend, that has ever proved effectual, and never dangerous in your hands, should not be hastily thrown aside, to be supplanted by another more capricious in its action, less effectual, and acknowledged by many to be not entirely devoid of danger. But, while influenced by the same feelings towards the favourite anæsthetic, I cannot altogether turn a deaf ear to the repeated sounds of warning lately rung out to us through our leading medical journals and by some of our most eminent professional confrères. One of our most influential journals has more than once, in its editorial pages, warned its readers of the serious responsibility that rests on those who continue to employ chloroform in preference to ether; and this sentiment is endorsed by one of the highest authorities in our profession, in the following words, addressed to the editor:—"Will you allow me to express an earnest hope that you will continue that advocacy as long as necessary—that is, until ether is universally employed in all suitable cases." And, again, the same weighty authority says:—"I should consider myself very culpable if I ever permitted the use of chloroform, except in certain cases. I can testify in the strongest possible terms to my own feeling of security with the one and of risk with the other."

Having heard the opinion of such a weighty authority, backed up as it is by numerous correspondents of more or less professional status, are we to consider the case closed, and chloroform condemned either to expulsion from, or to a very obscure corner of, the surgical armamentary? I should be sorry to think so. I believe it will long remain a trustworthy friend both to the anxious surgeon and the suffering patient, and, as the

¹ [Dublin Journal of Medical Science, 1881, v71, p558.]

reserve force in the array of anæsthetics, may be called up with confidence when the more favoured ones have failed. It is by such an address as yours, Mr. President, that the merits and demerits of both ether and chloroform will be clearly exposed, and in this way, tested by the light of facts, its proper position will be assigned to each. Let me here define the limits I intend to go to in treating this subject, which, you will allow, is a vast one. The all-important question for us to decide on is—What anæsthetic is the most potent, and at the same time the most free from danger; and as chloroform and ether are, I may say, universally acknowledged to possess these characters more so than any others, I propose to confine myself to a consideration of their relative advantages and dangers.

It may be fairly asked what light can I throw on the subject whose short experience is based on comparatively few cases. In reply to that I may say, I will add my quota to that of others, while I may be permitted to examine ascertained facts by the light of such accumulated experience, and so will satisfy myself, if not others, as to the relative merits of both anæsthetics, and shape my line of action in accordance with the opinion I form. By each of us acting thus, extreme views may be got to harmonise, conflicting opinions to tone down, and we may be free from such damaging advocates of either form of anæsthetic as the correspondent who lately, in one of the journals, hoped that the general feeling of the profession with regard to the use of chloroform would be like that of a medical friend of his who, when asked to give chloroform, said, “He was leaving town next day, and did not want to be detained by a coroner’s inquest, but would give ether if agreeable.”

Where are we to look for data from which to draw a safe conclusion? We must first look to the recorded experience of the advocates of both ether and chloroform in the old and the new worlds, for in both each has had, and has still, its warm defenders. Let us first take chloroform and see what experience has to say in its defence as regards its safety.

In our own country Syme administered it in 5,000 cases without a death; he expressed his opinion on this subject in a very laconic manner—“A case for operation is a case for chloroform.” Mr. Lister maintains that deaths from chloroform arise from an overdose and from too long-continued administration. In Germany Nussbaum records 15,000 cases, and Billroth 12,500, and no death. Dr. M’Guire, in America, 15,000 cases and one death; and, during the civil war, 11,500 cases and one death.

In the French army, in the Crimea, it was administered in 20,000 cases without a death. In our own hospital chloroform has been administered in 6,000 cases and no death. Then, again, there are other hospitals where there has been one death in 520 administrations. Since 1875, the following list of deaths from chloroform

have been reported to the leading Medical Journals of this country:—

1876, 10 deaths.	1878, 13 deaths.
1877, 12 „	1879, 8 „
And during the first 10 months of 1880, 20 deaths.	

The relative number of deaths to the cases of administration can only serve as indications and approximations, but can never be relied on with any degree of accuracy. Richardson estimates one death in every 2,500 administrations.

Many extenuating circumstances have been brought forward by the advocates of chloroform to lessen the effect of this large mortality—such as self-administration; administration by ignorant and careless persons; cases of death from fright; according to Mr. Lister, an overdose from too long-continued administration; Billroth’s theory of peculiar idiosyncrasy; mechanical causes, as death from collection of mucus in the larynx and air-passages; and impure chloroform. This plausible theory may suit such ardent advocates as those who teach with Sédillot that, “le chloroform pur, et bien employé ne tue jamais.”

If the ratio of deaths from chloroform to administrations is only known approximately, even this is lacking in regard to ether, and as regard to figures, they are no better than guess-work. In a late treatise on anæsthetics a comparison of the two was attempted, and this conclusion was arrived at—that three deaths occurred from ether during the first fifteen years of its use, and 77 from chloroform during the first fourteen years of its use; and during the first year ether was used there was 1 death, and during the first year chloroform was used, 9.

Let us now listen to the statement of Dr. Turnbull:—In the city of Philadelphia alone ether has been used, with but one exception, since its introduction in 1846 up to the year 1878, without a single primary death, and only one recorded secondary death. General testimony of this kind, the record of frequent deaths from chloroform, the tone of the Medical Journals, together with the decided opinions of many leaders in our profession, show that the lesson can be learned from facts quite as well as from figures; and I feel that that lesson teaches us that chloroform is a far more dangerous agent than ether.

Let us now consider what experiment has to add to experience concerning the action of these two anæsthetics on the system. It is conceded, I believe, that the great source of danger in the use of anæsthetics is their influence on both the circulatory and respiratory nervous centres. The most reliable information on this point is to be obtained in the report of the Scientific Grants Committee of the British Medical Association. I will quote one or two sentences from that report that will speak for themselves. Having described the mode by

which the animal was subjected to the experiment, it goes on to say—"It soon became apparent that when chloroform is given in this way there is at once a most serious effect on the heart; the right ventricle almost immediately begins to distend, and the heart presently stops, with the right ventricle engorged with blood. The heart had often, in the case of rabbits, virtually come to a stand-still within a minute of the introduction of chloroform by the method described.

The contrast was most striking when ether was used instead of chloroform. Ether may be given for an indefinite period without interfering with the heart. We kept artificial respiration with ether in the circuit for an hour, not including twenty minutes occupied in producing anæsthesia, and at the end of that time the exposed heart was beating as vigorously as at first."

That chloroform injuriously affects the respiratory centre is also the opinion of this committee, and they account for it in this way—there is failure of the heart in the first instance, and the insufficiency of its subsequent pulsations caused the failure of respiration. In such a state of the circulation the respiratory centres would probably be insufficiently supplied with blood, and be consequently liable to cease acting. Can it be wondered at, that, looking at this subject both by the light of experience and experiment, the advocates of ether should be so loud in its praises and strong in their denunciation of chloroform.

May I be permitted to give my own limited experience of these two agents; and, first, as regards ether, I believe I have been the first to administer it in Belfast in a systematic manner. I have used it in the Children's Hospital for a period of five years, in the cases of children ranging between two and fourteen years of age. It took a very long time to produce anæsthesia, the struggling was sometimes painful to witness, and it was usually accompanied or followed by vomiting, besides being very disagreeable to the administrator. In some cases complete anæsthesia could not be produced, and in rare cases it had scarcely any effect.

As weighing against these disadvantages was the great security I felt as regards the safety of the patient. This was always indicated by the good colour of the face, and steady, full beat of pulse. In one case (a private one) of amputation I gave 8 ozs. ether with scarcely any effect, and had in the end to use chloroform, which at once proved effectual.

My experience of chloroform is greater than that of ether, and although I have never been so unfortunate as to witness a death from it, I have, on many occasions, seen alarming symptoms in my own cases as well as in those of other surgeons.

Before concluding, I will make some general statements, the truth of which, I think, is acknowledged on all sides:—1, that chloroform has never been fatal in cases of parturition; 2, that the deaths from it are almost nil in military surgery; 3, that the large majority

of the fatal cases reported are those where it was administered for minor operations and operations of expediency; and, 4, that there was culpable carelessness and ignorance on the part of those who administered it in many of the fatal cases reported.

As regards ether:—1, it is not devoid of danger to life per se; 2, it is unpleasant, and difficult to administer, and has a great many drawbacks in this way that chloroform has not; and, 3, it is a far less potent anæsthetic.

Dr. Kappeler, in his essay on Billroth's system of surgery says—"The assumption of physiologists that the surgeon is responsible for death from ether, in contradistinction to chloroform, and that death from ether may always be avoided by precaution, stands, in my opinion, without any foundation whatever.

From the experience of the operating table it cannot yet be maintained with absolute positiveness that the administration of ether as an anæsthetic has a considerably less amount of danger than chloroform. We are as little prepared to state in figures the dangers of ether as those of chloroform, since neither the number of deaths from it nor the number of administrations are known, and the few attempts made to state the proportion of deaths to administrations are mostly the product of the bitter contests, 'ether versus chloroform,' and the necessary impartiality is lacking."

The conclusions that I have arrived at from the several considerations of the subject are—

1. That ether, although a less potent, is a safer anæsthetic than chloroform.
2. That ether should be administered in all cases where the circumstances will permit.
3. That chloroform should not be used in minor operations, or operations of expediency.
4. That every precaution should be taken beforehand against the supervention of dangerous symptoms, and that every requisite for combating such symptoms should be in readiness for immediate use.

Third Meeting Session 1880–1881.

Present, Dr. J. W. Browne (President), Dr. Dill Ex-President, Dr. Fagan, Dr. McConnell, Dr. John Moore, Dempsey, Kevin, Workman, Esler, Mackenzie and Whitla.

Dr. J. Smyth, House Surgeon Royal Hospital, was elected member of the Society.

Dr. John Moore showed a large uterine tumour which he removed during labour.

Dr. Whitla exhibited a calculus which he removed from a girl 2 years old.

Dr. J. Browne President exhibited some interesting specimens and read notes of a case requiring recurrent amputation of the thigh.

J. Walton Browne

Fourth Meeting 1880–1881 was held January 4th 1881 Tuesday 8 p.m.

Present, Dr. J. W. Browne President in the chair, Professor Dill, Professor Gordon, Drs. O'Neill, Wadsworth, Haslett, Smyth (H. S. Royal Hospital), McHarry, Esler, Dempsey, Fagan, Kevin, Dr. James Moore, McConnell, Whitla, and a very large attendance of students.

Dr. Whitla proposed and the President seconded the nomination of the following members: Dr. McCaw, Dr. Gilmore, Dr. Stewart.

Mr. Fagan read a paper upon a case of head injury and showed the parts involved.

Professor Gordon submitted a paper on intracapsular [fracture] of the head of the femur and exhibited a large number of specimens.

Paper:¹ *If we carefully compare the statements usually promulgated by surgical writers with those which may be deduced from a good collection of fractures, whether intra- or extra-capsular, it will be at once apparent that much information is still wanting to bring them into perfect accord. The object I have in view in bringing forward the present communication is to show that we have still something to learn regarding these common accidents.*

I shall first take up the Intra-Capsular.

The specimens which I now exhibit clearly demonstrate that we have three forms of this accident, and I might add a fourth, but it might be justly regarded as a variety of the ordinary Intra-Capsular Fracture, in which the compact tissue of the inner surface of the outer fragment has been driven into the inner fragment, forming an impacted intra-capsular fracture.

FIRST SPECIES.

Transverse Fracture of the Neck of the Femur through its junction with the Head, without Laceration of the Periosteum—Osseous Union.—I met with my first specimen of this rare form of accident in 1848, and after careful examination I came to regard it then, as I do now, as an example of a species of fracture hitherto over-looked, or at least not recognised as a special form.

The head is displaced or rotated backwards, and is slightly penetrated by the neck behind, whilst in front the margin or corona of the head and the anterior surface of the neck are on the same plane. In one of the specimens the neck is two or three lines in advance of the head.

The extent to which the head is rotated backwards ranges in the different specimens from 25° to 35°, as is shown by the altered aspect of the depression for the attachment of the ligamentum teres. There is osseous union in all of them.

In 1871 I obtained a similar specimen, in which there was also firm osseous union. During the following session I met with a recent example in the anatomical rooms. In this specimen the head could be moved

slightly in any direction, the sole bond of union between it and the neck being the untorn periosteum. These three specimens are deposited in the Queen's College Museum, and, when carefully considered, show clearly that an aged female, probably bedridden, may sustain fracture of the neck of the femur from some slight motion, which may be unattended by any shortening or other evidence of the accident, except perhaps inability to move the limb, with pain on pressure in the groin below the margin of the acetabulum. When a limb dangles uselessly from the pelvis, owing to any cause, such as paralysis or scrofulous disease of the knee-joint, the neck and head of the femur become more vertical—i.e., the angle between them and the shaft becomes more obtuse, and the head becomes displaced upwards and outwards, so as to project over the upper surface of the neck.

In such a condition the compact tissue is unusually bent as it passes from the upper border of the neck to the head. This form of displacement can be easily recognised by the continuity of the upper surface of the neck with that of the head. The displacement noticed in these cases differs in direction from that which occurs in these fractures, as in the latter the fossa of the ligamentum teres looks unnaturally backwards, in the former upwards.

In point of fact, I do not know of any cause that would produce displacement backwards of the head except fracture, and that this view of the matter is the correct one, a specimen recently produced leaves no room for doubt. The three specimens are similar in size, they are in a state of atrophy, and the deformity in each case is doubtless the result of fracture. In cases of this kind the periosteum is untorn, the fragments, if the patient remains quiet, are held closely in apposition, and an ample supply of blood is afforded by vessels of the periosteum and ligamentum teres, so that the conditions which prevent osseous union in the ordinary intra-capsular fractures do not exist here.

Treatment.—In the treatment of these, as of other fractures of the neck of the femur, I am opposed to the use of splints. If a splint be applied, it loads the limb unnaturally, and compels the patient to maintain the supine position. The back becoming painful, the patient tries to procure relief, but the limb being loaded by the weight of the splints, more than usual exertion is necessary to alter the position, which acts chiefly on the broken surfaces; whereas, if the limb is free, the patient changes the position slowly, without disturbing the fragments or causing them to grate forcibly upon each other. In addition to this may be noticed the injurious effects on aged persons of prolonged maintenance of the supine position. I have no doubt that the mortality is much greater in cases where splints are used than in those where they are not.

SECOND SPECIES.

Transverse Fracture in the Middle of the Neck of the

¹ [Dublin Journal of Medical Science, 1881, v71, p97.]

Femur, with Osseous Union.—There are six specimens of this fracture in the Museum of the Queen's College. They are all so much alike that the description of one would apply equally to all the others. When force is applied from before backwards, the neck being in a state of extreme senile atrophy, it bends and breaks, forming a salient angle in front, and an acute concavity behind. The periosteum being untorn, osseous union takes place, resembling the Greenstick fracture which occurs in young persons, and it might not be inappropriately styled the Greenstick fracture of old age.

The diagnosis in this, as in the former fracture, can only be made out by a careful examination in front of the capsule in the groin. The salient angle of each in front, although detected with difficulty, will be acutely painful on pressure, and if to this we add the history, which is that of the pelvis having fallen backwards, whilst the extremity was fixed, or the extremity being rotated outwards, the pelvis being fixed, or indeed any force which would bend the neck from before backwards. That this is not an uncommon form of accident may be assumed from the fact that in the session 1879–80 I got three specimens of it. In one of these the fracture, instead of passing directly transverse through the whole thickness of the bone, passed obliquely upwards. The compact tissue in front is firmly united, whilst behind there is no union, there being an interspace between the fragments behind.

Diagnosis.—In some cases there will be no shortening; in others it may be to the extent of one-half or three-quarters of an inch, or even more. There will be slight eversion, but this will be so trifling that it could scarcely be regarded as diagnostic. But if we associate the history, the age of the patient, and the pain on pressure over the middle of the neck, with that instinctive dread of movement which usually attends fractures without displacement, a correct diagnosis may be formed.

Treatment.—The treatment is the same as in the former variety. In these, as in all other fractures of the upper end of the femur, all attempts at rotation or forcible extension of the limb should be most carefully avoided. It may be very satisfactory to the surgeon to make out the existence of a fracture by these means, but it is not at all for the advantage of the patient that a fracture which would unite by bone and form a useful limb should be converted into an ununited fracture, and leave the limb a dangling and useless appendage to the body.

THIRD SPECIES.

The Ordinary Intra-capsular Fracture.—In the two forms of intra-capsular fracture just described there is osseous union, whereas in the ordinary intra-capsular fracture osseous union is indeed of extremely rare occurrence. The question may be asked—In what circumstances do they differ? The ordinary intra-capsular fracture is caused by the weight of the body suddenly

falling upon the neck whilst the extremity is more or less abducted. It usually breaks about half an inch from the head, just at the part where it changes from the quadrilateral to the circular form, and is usually oblique from above downwards, with extensive laceration of the periosteum, and this laceration of the periosteum is the main element of the want of union.

In the former specimens the fragments are firmly held in apposition, whereas in the last, owing to the extensive laceration of the periosteum and direction of the fracture, there is a constantly recurring grating of the fragments upon each other whenever the patient makes the slightest movement, and this grating breaks the contiguous compact tissue of both fragments.

If we examine carefully a comparatively recent specimen of the ordinary intra-capsular fracture, we will find portions of the compact tissue of the outer fragment overlying its cancellated tissue, as shown in one of the specimens which I now exhibit. The disappearance of the neck is usually attributed to absorption. No doubt it is absorbed and disappears, but the main agent preparatory to absorption is movement of the fragments upon each other, which produces a constantly recurring breakage of the neck into small fragments until it ultimately disappears, and whilst this is taking place the same movement strips or tears off the periosteum from the neck. In the numerous examples of intra-capsular fracture which I have dissected there were always several bands of the untorn periosteum extending from the head to the base of the neck, and these were the only bonds of union which existed between the two fragments.

J. Walton Browne, President

Fifth Meeting Session 1880–1881 was held upon Tuesday 18th January 1881.

Present, Dr. J. W. Browne President, Professor Dill, Dr. Wales Snr., Dr. Wales Jnr., Dr. McHarry, Dr. Haslett, Dempsey, Dr. Workman, Dr. Anderson, Dr. Whitla, Dr. Smyth (Royal Hospital).

Drs. McCaw, Gilmore and Stewart were elected members of the Society.

Doctor Whitla proposed and Dr. J. W. Browne seconded the nomination of Dr. Nelson.

Dr. Dempsey read a paper upon a case of typhoid fever with unusual complications.

Paper:¹ The history of the following case of typhoid fever presents no unusual feature of interest in its early career, nor, in fact, until the subsidence of the fever. The symptoms and progress of the disease were exactly similar to the average run of cases of typhoid, except that from first to last there was a tendency to constipation rather than to diarrhoea. It was the third case which occurred in the same house, and in the same

¹ [Dublin Journal of Medical Science, 1881, v72, p268.]

RECORD OF TEMPERATURE, PULSE, RESPIRATIONS, &c.

Henry K. ; Age, 33 ; Disease, *Typhoid Fever and Obstruction of Bowels* ; Result, *Death*.

Date of Observations	Nov. 17 1880	18	19	20	21	22	23	24	25	26	27	28	29	30	Dec. 1	2	3	4	5	6	7	8	9	10	11	—	—	—	—			
Day of Disease	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	—	—	—	—			
	M.	E.	M.	E.	M.	E.	M.	F.	M.	E.	M.	E.	M.	E.	M.	E.	M.	E.	M.	F.	M.	E.	M.	E.	M.	E.	M.	E.	M.	E.		
TEMPERATURE—FAHRENHEIT'S SCALE.	106°	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
	105°	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
	104°	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
	103°	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
	102°	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
	101°	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
	100°	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
	99°	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
	98°	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
	97°	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Pulse	{M. E.}	88 —	— —	90 —	— —	90 96	108 —	102 —	102 —	102 —	102 —	95 —	106 —	106 —	106 —	103 —	116 —	102 —	126 —	130 120	114 118	108 108	102 120	120 —	— —	— —	— —	— —	— —	— —		
Resp.	{M. E.}	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —	— —		
Motions		1	0	0	0	2	1	0	1	0	1	0	0	0	1	0	0	1	1	0	0	0	0	0	0	—	—	—	—	—		

family during the past year. The first case occurred at the end of January, and after passing through an uncomplicated attack recovered. The second occurred at the beginning of April, and also terminated in recovery. The third case—the subject of the present paper—was father of the two preceding patients.

He was thirty-three years of age, of dark complexion, tall, thin, and delicate. He suffered occasionally from indigestion and colic pains in the bowels. I saw him on the 17th November, 1880. He was then confined to bed for four days, but he was ailing for some days previous. The onset of his symptoms was of the usual character, and on the 19th. November, or the sixth day after taking his bed, some typhoid spots were noticed on his back. He had a copious eruption of rose spots during the entire fever.

His face presented the pale, earthy hue seen in typhoid; he had tenderness in the right iliac fossa; in short, the diagnosis of typhoid fever was unquestionable. The history up to the time of the first symptoms of intestinal obstruction—the complication which set in in this case—may be seen at a glance from the temperature chart which I hand round.

On December 5th, or the twenty-second day after taking his bed, he was suddenly attacked with a most violent pain on the left side of and below the level of the umbilicus, which shot down into the penis and left testicle and into the hypogastric region over the bladder. I was sent for hurriedly to see him, and found him in great agony. He was doubled up in bed, crying out with

the pain, and his body was covered with a cold, clammy sweat. He had neither vomiting nor purging. There was no pain on pressure over abdomen. Pulse, 126—weak and compressible; temperature, 102.5°. His eyes were glassy and staring. He had one motion a short time before the occurrence of pain, and one on previous day. There was some tympanites previous to this attack of pain, but not to any great extent.

He had been taking plenty of nourishment and 8 oz. of wine in twenty-four hours. I had on two or three occasions previous to this to administer castor oil, because bowels would be unmoved for three or four days. I now ordered turpentine stupes and warm linseed poultices, and a grain of opium every hour until relief of pain. After taking three pills the pain left, and he fell asleep.

6th.—Pulse, 180; temperature, 102°; perspiring freely—but this has been the case for some days; abdomen very much distended with flatus; slight pain on pressure at left of umbilicus; expresses himself as feeling very well. I prescribed an aromatic mixture and ordered turpentine stupes to be repeated. No motion since yesterday.

7th.—Pulse, 114; temperature, 99°; had a bad night; breathing is laboured; he is restless, but quite sensible. Up till yesterday he raved very much. Abdomen is more tympanitic, and the coils of intestines can be seen through the abdominal walls. To-day, besides the pain at left side of umbilicus, there is also pain over a small area to the right side of umbilicus, but it is only felt on

pressure.

He is much annoyed with flatus coming off the stomach, but he has no vomiting. His bowels have not acted since the 5th. I gave an enema of castor-oil, turpentine, soap and water, and prescribed turpentine, ether, and opium draughts, and directed hot poultices to be kept constantly over abdomen, and 1 oz. of whisky every third hour.

8th.—Pulse, 108; temperature, 100°; has vomited several times since; tympanites continues unabated; enema brought away no motion and very little flatus; very little pain on pressure to-day, and only at left of umbilicus. Gave him another enema of assafœtida, soap, and water. It was soon passed down, and only brought some flatus with it.

I saw him again this evening, with Dr. Harkin. Pulse was 108; temperature, 98.5°; vomiting was continuing. We prescribed bimeconate of morphia, solution of bismuth and hydrocyanic acid; gave another enema, and a hypodermic injection of morphia.

9th.—Pulse, 102; temperature, 99°; vomited every half-hour during the night, and the vomited matters are distinctly fœcal in colour, smell, and consistence. I gave another large enema of castor-oil and turpentine, and prescribed pulv. opii gr. i. and ext. belladonna gr. ¼ every second hour, and administered a hypodermic injection of morphia.

10th.—Pulse, 120; temperature subnormal; fœcal vomiting continues; no motion after enema. He is sinking. I gave an enema of brandy, egg, and milk.

He died the following day, December 11th, at 1 30 p.m., having vomited until a few hours previous to death, and on the twenty-eighth day after taking his bed, and on the seventh day from the attack of acute pain.

Now the only two other complications which might be confounded with obstruction in this case are peritonitis from perforation and the vomiting of exhaustion. The symptoms during the time of acute pain did not exactly correspond with those usually attending perforation; they resembled more the passing of a calculus along the left ureter, but there was no retraction of the testicle, and the pain was more severe along the penis and lower part of the abdomen than in the testicle. There was no difference in the appearance of the urine as to quantity or quality following the attack of pain from that preceding it. There was no desire to micturate. The pain did not start from the region of the kidney, but just beside and below the umbilicus.

The acute pain subsided pretty quickly, and there did not appear at any time any symptoms of general peritonitis as far as the patient's feelings were concerned. Though he was quite sensible, pressure over the abdomen only elicited pain at the point from which originated the acute pain on the first day of attack, and pain on pressure remained at this point till the last. Only on one day was pain on pressure felt on the right

side of the umbilicus.

Again, fœcal vomiting is very seldom seen in peritonitis. Murchison, in his book on Fevers, says he observed it only once. The vomiting did not occur until two days after the attack of acute pain, and it was preceded by intestinal distension and frequent eructation of flatus. In perforation vomiting usually occurs at the time of the accident. He was able to turn pretty easily on his side to have the enemata administered, but the enemata, if large in quantity, usually caused him a good deal of pain, and if the tube was introduced too high up, pain was also complained of. His pulse had not the thready feel of peritonitis, and his countenance, though anxious and careworn, had not the pinched appearance seen in peritonitis.

As to vomiting from exhaustion, I am not aware that it becomes fecal in character; but the great argument in favour of obstruction as against peritonitis and vomiting of exhaustion is the fact that no motion was passed from the bowels for seven days, notwithstanding repeated efforts by enemata for that purpose.

Taking the age of the patient, I think the probabilities are it was due to an internal hernia either in the form of a volvulus or from a constricting band, but in the absence of a post mortem examination we can only conjecture. The reason I lay so much stress on the differential diagnosis is because in any works I have consulted on typhoid fever no mention is made of intestinal obstruction as a complication.

Flint relates the case of a child dead from typhoid fever in which were found numerous invaginations, but he believed them to be post mortem. In my case it may have been an accident or a coincidence, but I think when you have intestines distended with more or less flatus, as is usually the case in typhoid fever, the movement of this flatus may very readily push a piece of intestine into a constriction, if such exist, or may cause a volvulus; and in the present case there was a history of occasional attacks of colic which may have been due to localised peritonitis, resulting in adhesions.

DR. DILL commented upon the case. He thought, for a Society like the one assembled, great benefit was found to follow an ordinary case being brought before them. Clinical curiosities were good in their way, but he learned more from a paper like the present.

He went into the diarrhœa of typhoid, and said his experience told him that decidedly constipation was more frequent and troublesome than diarrhœa in typhoid fever. He always directed his attention to the state of the bowels, and pointed out how many evils arose from neglect of enemata and mild purgation. He said he believed the case ended as a case of perforation of the bowel.

DR. WALES felt at a loss to account for the locality of the severe pain unless by supposing that a calculus descended. He did not, however, believe that this had anything to say to his death, which he believed was

owing to perforation.

DR. MCHARRY thought death occurred from simple obstruction owing to impaction, and from it he would take the lesson to always keep the bowels free and use purgation when absolutely required.

DR. J. W. BROWNE found that in all his hernia cases, when perforation occurred, vomiting ceased. He would have thought that abdominal section, as a dernier ressort, should have had a chance.

Dr. Anderson read an able paper upon the homology of the tongue muscles.

J. Walton Browne, President

Sixth Meeting February 8th Tuesday '81.

Present, Dr. J. W. Browne (President), Dr. Harkin, Esler, Dempsey, Core, Haslett, Wadsworth, McKee, John Moore, Mackenzie, J. W. T. Smith, Fagan, Professor Dill, D. Johnson, Whitla.

Dr. Joseph Nelson was unanimously elected member of the Society.

Dr. Fagan read a paper upon a rare injury of the elbow joint.

Dr. Esler read a paper upon the Medical Charities of Belfast, their uses and abuses, and after a full discussion in which most of the members expressed themselves satisfied about the existence of gross abuses, many present giving instances of such, the following committee was appointed to report upon the abuses to the Society at next meeting: Dr. J. Browne, Drs. Harkin, Fagan, Esler, John Moore, Wadsworth, McKeown, Whitla and Dr. Core.

Paper:¹ Mr. PRESIDENT AND GENTLEMEN,—The world is full of charity—a large number of the population of every country live upon charity; but amongst civilised peoples, and in Christian communities, charity has been reduced to a system, and extolled high among the virtues.

There are organisms—developments of brain and heart—that cannot but sympathise with suffering and want, and their natural sympathies find outlet in giving of their alms—some, in accordance with their nature, accompany their giving with blowing of trumpets, while others scarcely let their right hand know what their left hand doeth.

Charity is not confined to or monopolised by any one class of society. The queen, the prince, the noble, give their thousands, the mercantile and middle class their hundreds, while the labourer and artisan's gifts must be measured by the smaller coins of the realm; nor is money always the medium of expression—one may go an errand of mercy, another pass a night in silent watching.

There are marked lines of distinction in this virtue among the various sections and professions in society,

but I think I may safely say that members of the medical profession stand to-day, as they have always stood, in the first rank of benefactors to the suffering and the poor. There is no profession can claim to have done more for humanity in alleviating its suffering, supplying its wants, and mitigating its woes in their individual capacity than that of our own; yet much of the individuality has of late, and especially in the centres of population, been swallowed up by the introduction of a system of hospitals, which, useful and valuable as they are, threaten at no distant day to greatly interfere with the honest income without which even a philanthropic physician or surgeon cannot exist, unless family or fortune has provided a secure and independent living.

My object in bringing this subject before the Society is not so much to give you any information about the details of our charities as to point out the dangers which I think the system fosters, and to stimulate discussion, which may lead to some practical results.

We have been accustomed to hear from time to time at our various gatherings a wholesale and very general denunciation of the abuses arising out of the practices adopted in carrying out the charities of this town. I wish, in examining this subject, to distinguish between the uses and the abuses of our hospital system.

A great many of our so-called charities must of necessity be excluded as they are not properly charities at all. There is the poor law system, which is often classed with the medical charities. The poor law provision for attendance on the poor is in no sense a charity. It is the right of the ratepayers according to our constitution to provide for the wants, medical and otherwise, of the suffering and destitute, and however imperfect the system may be, still medical officers of health are remunerated in such a way as to leave no great room for grumbling. There is, no doubt, a large amount of work done for the amount of money received, but still it is money earned honestly and independently. The so-called charitable or benefit societies have so grown and multiplied that an enormous proportion of the artisan class are included. Many of these people are over-doctored. A man may be a carpenter and a Rechabite and have a different doctor from each society, and if he should happen to be an Orangeman as well, and perchance an Oddfellow, he may have a skilled physician for each of his principal organs; but then he pays for each, and whatever the amount may be, large or small, he has a right to get his bargain, and with him we do not quarrel. There is again the factory class, which by payment of a small weekly sum asserts its independence, keeps away from the dispensary, and on the whole gives fair remuneration to the doctor.

Now, none of these classes come much to the public hospital, and yet these constitute the major portion of our population. Where the hands in a large employ constitute themselves into a society and pay for medical services, and where a medical man undertakes to give

¹ [Dublin Journal of Medical Science, 1881, v72, p272.]

his services for a certain remuneration, I think they are on the right lines to preserve their independence, and are not guilty of medical abuse.

Hospitals are in our midst, have been, and are, increasing amongst us. It is a fair subject of inquiry—What class of patients are they treating? what class of patients ought they to treat? and what is likely to be the outcome of the present practice as far as the public and the profession are concerned?

I will try and confine myself to general statements rather than enter into details, but general statements based upon facts so well known as to make them undeniable. The public hospitals of Belfast are—the Royal Hospital, the Ophthalmic Hospital, the Ulster Eye and Ear Hospital, the Samaritan Hospital, the Skin Hospital, the Belfast Hospital for Sick Children, the Ulster Hospital for Children, the Lying-in Hospital, the old Charitable Institution, with the Dispensary for Chest Diseases, &c., &c.

First comes the Royal Hospital. It is first in importance, in extent, and, I will add, in its usefulness and its abuses. As a school of medicine—equipped with a medical staff of teachers, who devote much time and attention to the students and the patients—the Royal Hospital stands deservedly high; but for its locality and its departmental deficiency it might stand much higher. It is not by any means the fault of the medical staff that it has not kept pace with the progress of the times, and that, as special subjects have been prominently coming to the front, its narrow-minded and blindly conservative managers should have obstinately refused to equip the building with special departments as a school of medicine. Had this spirit not existed I venture to assert that few of the special hospitals now in existence would have yet been built. Is it yet too late to think of adding a wing for diseases of women and children, skin, eye, and ear? The student is thus placed at a great disadvantage in having to go elsewhere to see what should be seen and learned under the same roof of a great hospital. As a useful institution, for the treatment of certain persons and certain classes of cases, no one will find fault with the Royal Hospital—for instance, serious accidents, requiring capital operation and a long time of attendance, with skilled nursing, are admissible. Again, obscure cases, demanding the diagnosis of skilled and experienced hospital physicians and surgeons, should be admitted; a class of poor persons above the pauper has a right to the charity of the subscriber; the poor sailor and similar ill-paid benefactors of mankind should be heartily welcome. But that because the Royal Hospital is a public charity, supported by public contributions, and attended, without fee or reward, by medical men, it should admit all comers—men with incomes which would enable them to pay a moderate, nay, in some cases, a handsome fee—and that they should eat and drink and be treated gratis, is, I maintain, an utter abuse of charity. I venture to make this statement:—

That a large proportion of the cases admitted to the wards of the Royal Hospital free, are such as should be made to pay, and those who do pay, are charged rates much below what their means would warrant. In coming to look into the extern department it must be admitted that a great deal of useful work is done, and, it may be conceded, well done; but it is in this department that the most glaring abuses are met with—abuses which pauperise the community and interfere very greatly with the practice and the income of the general practitioner. It is here that reform ought to commence, and I do not think it is too much to demand for the profession that the committee of management should be called upon to confine their work within the limits of charity, and not in a wholesale, aboveboard, and even ostentatious way, for the sake of gaining public favour and applause, trample upon the sphere and directly interfere with the income of those whose very existence for some years depends upon such practice, and such fees as would arise from the work done in this extern department, for I will venture to affirm that more than half of all the patients treated are quite able to pay a small fee—such a fee as will be accepted at a private surgery. The Report just issued shows the total number treated extern—14,867. Who will say that 10,000 of these could not pay a shilling for advice and medicine, or for surgical dressing? and taking each as being attended to twice, a thousand pounds is thus kept out of the pockets of the general practitioner.

The next Belfast charities we have to notice are the special hospitals known as the Benn Charities, with which may be classed the Ophthalmic Hospital. There can be little doubt but that these charities, situated as they are and under separate management, are the outcome of the dog-in-the-manger policy of the former managers of the General Hospital. Science was progressing; special departments were recognised and being introduced in nearly all the leading hospitals in England and the Continent; young medical men of talent, and with special training, wanted a field for observation and work, but over the portals of the medical school of this town was written large “No admission here.”

But mind, spirit, soul, cannot be fettered even by obstruction chains forged in do-nothing workshops. Hence one man, and another, and another find a platform from which to speak and teach, and the language to-day is unmistakable—“Nothing succeeds like success.” I will not differentiate among these hospitals. They are all worked on the same general principle; they are nearly self-supporting; and while all are not perhaps equally careful to prevent abuse, yet the safeguards are of such a kind that, in the hands of men of high principle and good practical common sense, I am satisfied they will not do anything to abuse the spirit of true charity, nor infringe on the domain of the general practitioner.

Regarding the practice of receiving pay patients, there is, I imagine, as much room for abuse as in the admission of free patients. A class above those who are entitled to receive hospital attendance are induced to come, or excuse their rank and position by coming and paying a fee, however small, for admission or medicine. To prevent this abuse it lies with those at the portal of admission to institute rigid inquiry. I am decidedly of opinion that the public receive more benefit and the profession suffers less injury from the purely special hospitals than from the more general. It is an advantage to the general practitioner to have the opinion of a specialist, when it is known that his terms are such that the patient is not likely to be induced to leave his ordinary attendant.

And now, coming to the two Hospitals for Children, I will not enter upon the questions—Why there are two? Whether there be room for two? Which was first in the field? Which excels in usefulness or abuses?—but deal with both as they affect the public and the profession. In these hospitals there are some 12,000 children seen every year, with twice that number of attendances. That they do a large amount of useful and important work is certain; that a large proportion of that work is a relief to the dispensaries there can be no doubt; and that very many of the miserable mothers who bring their children cannot afford to pay anything I am thoroughly convinced. One of these hospitals has an evening hour three times a week, which is especially useful to mill-workers and others engaged in labour through the day. I think the abuses are less at this particular time than on other occasions, but I am not prepared to say that there are not, on every occasion the doors are opened, some, and on some occasions many, who could, and who should be made to pay at least for medicine; and I do think the time is not far distant when the profession should take a stand and put some check: on the wholesale way in which patients are drawn into the net of so-called charity. For abuse and infringement on the domains of the open surgery I class the Children's Hospitals with the extern of the Royal. In my opinion about half of the patients of both should be sent about their business, and thus the profession would benefit to the amount of £2,000 a year, and the independence of the community would be preserved.

Of the Lying-in-Hospital I may only say that its usefulness I will not question—of its abuses I have never heard. Provident Dispensaries have not succeeded in our midst, and I am doubtful if they ever shall. Where they are established, I am told, they are generally looked upon as the flag of distress of some needy and often half-qualified medical man. The Belfast Charitable Society is, I believe, the oldest hospital in Belfast. It was incorporated in 1774, but, as it is not a public hospital, does not come within our criticism.

I cannot close this paper without glancing at the question of how much individual members of the profession

are benefited from their connexion with an hospital; and, first, that the appointment to the Royal Hospital has been the making of the reputation of some of the staff I think not unlikely. We cannot suppose, and I dare not venture to assert in this Society, that superior talent or attainments are to be found in all the members of an hospital staff, or perhaps in any of them, to that met with in others who have no appointments, but by this means they have a large field for observation, and are brought into contact with the students who in time call in their old teachers as consultants, and in this way members of an hospital staff profit.

There is a great temptation to extern workers to get all the patients they can, and thus extend their observation and connexion. I do not blame them, but as a disinterested member of this Society I must express my opinion that the usefulness to the few must not be allowed to create abuses which extend to and interfere with the many.

As far as I can see the chances for a young man making a practice with the present state of things is one of slow, trying, laborious work. What, between necessity on the one hand, and an over-doctored, pauperised population who are being taught not to pay, on the other, the description of a young beginner is very much like that of the Patriarch regarding Issachar: "A strong ass crouching down between two burdens."

The great advantage of an appointment in a special hospital is to fit a man for that special work, and to extend his reputation in that branch if successful.

In a Children's Hospital one is made familiar with the various phases of children's diseases, and only in this respect is it remunerative. Experience brings confidence, and a consciousness of knowing one's work is both pleasurable and profitable.

The conclusions I would adduce are: That a large public hospital is necessary for the purpose of teaching, and the treatment of urgent and deserving cases, and that it should be fully equipped with special wards, appliances, and every necessary accommodation so as to facilitate the work, and save the time of both teacher and student. That the cases treated in hospital should be from such classes of the community as will at once benefit the suffering, economise the funds placed at the disposal of the managers, and not interfere unduly with the patients of private practitioners. That there are abuses in the working of the out-patient department of all the hospitals, and that the time has now come when this Society should direct the attention of the managers of the various charities to this matter, and request them to put such checks on admission as will prevent a continuance of these abuses.

R. F. Dill, Ex-President

Seventh Meeting February 22nd Tuesday.

Present, Professor Dill Ex-President in the chair, Drs.

Gordon, Wales Snr., Workman, Dempsey, Wadsworth, McCaw, Graham, Haslett, Clements, Kevin, Whitla, Fagan, Speer.

The report from the committee appointed to report upon the abuses of the medical charities was submitted and after a long discussion involving the consideration of many amendments, the following report was agreed to:

REPORT ON THE ABUSES OF THE MEDICAL
CHARITIES OF BELFAST.

A Committee was appointed by the Society on February 8th, 1881, to consider and report upon the abuses of the Medical Charities. Their report as amended and revised by the Society, at a meeting specially summoned for the purpose, upon February 22nd, 1881, is as follows:—

1st.—That provision is made by the Poor Law system for the medical treatment of the poor.

1st.—At the Dispensaries.

2nd.—By visiting at their own homes.

3rd.—By hospital accommodation at the Union Infirmary.

2nd.—That it is necessary in a large town like Belfast to have a General Hospital, with departments for the treatment of Special Diseases, and for the reception of urgent cases, and also for the purposes of clinical instruction.

3rd.—That many persons for whom the Medical Charities of Belfast are not intended, largely avail themselves of the advantages of the various Institutions, owing, chiefly—as we think—to the lax system of admission, and they thus impose upon the Charitable Public and the Medical Profession.

4th.—That injurious results arise to the persons themselves who take advantage of these Charities, as they are thus educated to foster deception and destroy their spirit of independence, whilst amply able to pay for Medical aid.

5th.—That, in consequence of these abuses, the Medical Profession feel aggrieved, as not only is Hospital work greatly augmented, but the interest of the general Practitioner is unjustly interfered with.

6th.—That, although abuses exist both in the Intern and Extern Departments, they predominate to a much greater degree in the treatment of out-patients; and we are of opinion that this department in the several Hospitals should be greatly restricted, and that careful examination into the means of applicants should be instituted.

7th.—That we recommend that a competent person be appointed to exercise close supervision over all those applying for relief at the Extern Departments of the various Hospitals.

8th.—That we disapprove of any member of an Hospital staff receiving fees for services rendered to

any patient whilst under Hospital treatment.

9th.—That a copy of this Report be sent to the Managing Boards of the different Hospital Charities in Belfast.

W. WHITLA, M.D.,
Hon. Secretary.

February 22nd, 1881.

The 8th and 9th resolutions not being embodied in the original report of the committee were proposed and seconded by Drs. Workman and Wales Snr. and passed unanimously.

A deputation consisting of Drs. Dill, Wales, Esler and Whitla was appointed to bring the matter before the board of the Belfast Royal Hospital.

J. Walton Browne M.A. M.D., President

The Eighth Meeting of the Society was held upon Tuesday March 8th 1881.

Present, Dr. J. W. Browne in the chair, Professor Gordon, O'Neill, Kevin, Esler, McCaw, Clements, Anderson, Smith jnr., Mackenzie, Whitla, Haslett, McHarry, James Moore, and many students.

Professor Gordon read a paper upon extra-capsular fracture and showed a large number of beautiful specimens.¹

Paper:² *An extra-capsular fracture is defined as a fracture of the neck of the femur external to the capsule. It would, however, convey a more accurate idea of the nature of the accident to define it as a fracture through the base of the neck. Usually in front the fracture runs along the anterior inter-trochanteric line, above where the neck joins the apex of the trochanter, thence internal to the digital fossa, and downwards along the internal margin of the posterior inter-trochanteric line, till it passes through or above the lesser trochanter. The fracture is thus seen to follow a course which corresponds to the circumference of the base of the neck, which is quadrilateral in form, as described by anatomists, and widens slightly in its antero-posterior diameter as we proceed from above downwards. When a person advanced in life falls upon the outer part of the great trochanter, the limb comes to be at rest; the weight of the body through the pelvis being in projectile force strikes the head, and drives the base of the neck into the trochanter. The direction of the force is nearly parallel to the long axis of the neck, and in the direction in which the neck is mechanically strongest and its base weakest. I have no hesitation in stating that this is the mode in which the extra-capsular fracture is produced.*

If we examine carefully a good collection of these fractures it will be found that no two of them are exactly alike, differing slightly from each other, but generally presenting a remarkable resemblance. In all

¹ [Part one of a two-part lecture. Part two was given on 17 May 1881 (see page 1432).]

² [Dublin Journal of Medical Science, 1881, v71, p499.]

of them the fracture may be said to consist of three fragments—one formed by the head and neck, a second by the apex of the trochanter, the posterior inter-trochanteric ridge, and more or less of the outer and posterior part of the trochanter, and the third by the upper end of the shaft, with a portion of the trochanter attached.

If the reader has before him a femur, and if he draws horizontally a figure, leaving the curve of the outer surface of the trochanter extending, from the anterior to the posterior inter-trochanteric line, this figure will approach closely to a semicircle. Draw across this semicircle a diameter, which may be regarded as the base of the neck. It will be at once seen that the diameter or base of the neck can scarcely penetrate the semicircle without tending to flatten it more or less, a force be applied to the diameter or base of the neck which drives it into the semicircle or trochanter, the effect of such a force will be at once apparent. In the act of breaking, the base of the neck or diameter widens the semicircle, and the broad base of the neck widens the diameter of the trochanter, which then rapidly diminishes. The effect will be a fracture of the trochanter varying in different cases according to circumstances, such as the direction, amount of force, and the fragility of the bone.

Women are much more subject to extra-capsular fractures than men, for several reasons—1. Females generally lead a more sedentary life, and therefore their bones are more atrophied, and are, in consequence, more easily broken. 2. The angle approaches more nearly to a right angle than in males, and therefore a force acting on the trochanter has more power in driving the base of the neck into the trochanter. 3. As we advance in age, the posterior inter-trochanteric ridge becomes widened, and the angle of reflection of the compact tissue becomes more a right angle, and penetration is thereby facilitated. Old age is the main predisposing cause of both extra- and intra-capsular fractures, and the comparative frequency is owing to the manner of falling.

Falls upon the trochanter are the most common causes of this accident. The extra-capsular fracture will be found to be more frequent in extreme old age than the intra-capsular. If the direction of the force be parallel, or nearly so, to the axis of the neck, the fracture will be found to be extra-capsular.

On the other hand, if the force has been at right angles to the axis of the neck, as in forcible abduction of the limb, the fracture will be the ordinary intra-capsular, and from the nature of the force attendant there will be great laceration of the periosteum; and for want of the periosteum there will be upward and downward movements as well as those of rotation, and on this account there will be no osseous union. If a force be applied from before backwards, or at right angles to the neck, there will be a trifling laceration of the perios-

teum and osseous union, if matters have not been aggravated by attempts to elicit crepitus by rotation and extension to enable us to diagnose a fracture. The weakest point of the neck of the femur, to a force applied at right angles to its axis, is at the point where it changes from the quadrilateral to the circular form; this is about one-third of an inch from the head, and is the weakest point of the neck when force is applied with the limb abducted.

In leaping, the extremities are approximated, and the weight of the body at the ilio-femoral articulation is received upon the upper and outer part of the head of the femur, through which it is obliquely transmitted thence to the inner surface of the neck. The chief force of the shock is received by the lower part of the base, between the lesser trochanter and the ridge which forms the boundary between the anterior and internal surfaces of this part. But the upper end of the femur is bent forwards, the effect which is to strengthen this part of the bone in a remarkable manner against shocks, which are thereby diffused over the strong base of the neck internally, and also over the anterior and internal ridge and the compact tissue forming the anterior surface of the upper end of the shaft. The effect of the momentum from leaping or lifting heavy weights is to force the head into the acetabulum and diffuse the shock against that part of the neck and upper end of the shaft to which nature has given it special strength to resist.

If we now direct our attention to the upper and posterior part of the neck it will be at once apparent that this part of the neck suffers very little pressure. I think, when the limbs are approximated, and when force is applied vertically to the upper end of the femur, it is not likely to suffer either dislocation or fracture. I have not met with a single instance of extra-capsular fracture caused in any way but by a fall on the great trochanter. Abduct the femur even to a slight degree, the point of impact becomes more external, and the weight of the body falls upon it almost at a right angle to its axis, and breaks easily—the production of the ordinary intra-capsular fracture being the result. The specimens which I have of extra-capsular fracture resolve themselves into five Forms, each of which presents some character slightly differing from the others, thus affording us an explanation of the various signs which might puzzle us in forming a correct diagnosis if we took only a general view of the accident.

First Form.—In the first form the force is received upon the upper and posterior part of the base of the neck, which gives way, and at the same moment the fracture in front takes place. Above and behind, the line of fracture varies very little, but in front it may pass through the anterior inter-trochanteric line, external to it or even nearly to the outer border of the anterior surface. Below, it passes into or above the lesser trochanter.

The trochanteric fragment is small in comparison to that of the second form. The eversion of the limb is usually well marked, but sometimes to such an extent that the toe looks directly outwards. If we examine a specimen of this form the rotation outwards of the shaft of the femur upon the neck appears so plain as not to admit of doubt. This theory has always appeared unsatisfactory to me. I have taught for many years that the eversion was due to the rotation of the shaft of the femur upon the base of the neck. I always thought that there was more than I had observed. I therefore determined to pursue my inquiries by commencing with the cause of the accident. All my inquiries taught me that it was produced by a fall upon the outer surface of the femur. The extremity is usually extended, and lying with its outer surface upon the ground. The extremity will be fixed, and cannot turn outwards, as the outer margin of the foot lies in contact with the ground. Therefore, so far as inquiry into the history of the accident was concerned, the theory of rotation outwards of the shaft upon the base of the neck was no longer tenable. It is a physical impossibility. I next commenced an examination of the specimens. I took the sound femur, and placed it on its anterior surface, with the aspect of the *linea aspera* looking directly towards the ceiling; then, taking one of the specimens in which there was the greatest amount of rotation outwards, I was surprised to see that the aspects of the head and *linea aspera* were the same, and that, in the specimens the head had undergone a rotation backwards to a little more than a right angle, probably to the extent of 92° or 93° . Other specimens showed similar rotation, varying in amount from 30° and upwards. This examination revealed the true explanation of the eversion in this accident. It is not a rotation of the shaft of the femur upon the neck, but of the base of the neck upon the shaft, whilst it lies with its outer side on the ground, fixed by the weight of the body and in contact with the ground. The theory of eversion of the extremity by rotation of the shaft upon the base of the neck is therefore untenable, as the position of the limb renders such rotation impossible. When the patient falls upon the outer surface of the thigh the extremity comes to be at rest, and the head of the femur looking upwards receives the weight of the pelvis on the inner side of the head, which from its position looks directly upwards; the weight thus received upon the head is transmitted through the neck to its base—that being the weakest part to a force thus applied—gives way, and breaking penetrates the trochanters. The neck being broken, the pelvis losing its support falls backwards, carrying with it the head, causing rotation from before backwards of the base of the neck upon the shaft. This rotation will continue until the posterior surface of the pelvis comes in contact with the ground.

In order to form a true estimate of the views set forth regarding the mode by which the fracture is produced,

and to explain its various forms and their signs, let the femur be placed on its outer surface, the head will look upwards, and it will also be extended, and whatever movement takes place at the ilio-femoral articulation will be that of the pelvis upon the head. The momentum of the pelvis will be received upon the head, and transmitted from it to the neck, and thence to the base of the neck. It must always be borne in mind that the head fits accurately into the acetabulum, and also that the momentum of the pelvis will be transmitted in a line perpendicular to the point of impact. As the head receives a general support from the acetabulum, it is not broken, though it may be in a state of extreme atrophy.

When the pelvis is placed upon the head, with its inlet looking upwards and forwards, the point of impact will fall behind the axis of the neck, and the fracture will be the First Form. If the inlet looks directly forwards, the impact will be in front of the axis of the neck, and the Second Form will be the result. If the ground upon which the patient falls inclines downwards, the upper part of the neck will receive the greatest shock, and deep penetration of the neck above will take place, with an increase in the angle of the neck. This unnatural increase of the angle of the neck is the main ground upon which the Third Form is based. If the impact be upon the lower part of the head, the lower part of the base of the neck will receive the greatest degree of shock, and the base, being dense at this part, splits the shaft, and produces the Fourth Form.

A very slight movement of the pelvis upon the head of the femur, in the various directions above mentioned, suffices to throw the shock upon the back, fore, upper, or under part of the neck respectively, producing fractures having results widely different from each other. I may here remark, that although the various forms of fracture of the base of the neck may be primarily the same, yet the secondary or subsequent lesions and displacements will be very different, according to the direction and amount of force and the fragility of the bone.

In this, the first form, when the patient is placed supine, we see that the injured thigh is in a plane anterior to that of the other side to a greater degree than in any of the other forms, while the limb is shortened and the toes very much everted, and the upper end of the shaft nearer to the anterior superior spine of the ilium, resembling in a remote degree the approximation that occurs in dislocation, upwards and backwards on the *dorsum ilii*, but with the toes remarkably everted. That this accident could be mistaken for a dislocation on the *dorsum ilii* is difficult to understand, as in fracture the outer surface of the femur and external condyle look backwards and outwards, whereas in a dislocation it looks forwards and inwards; and to produce the amount of rotation outwards in the healthy femur would require the head of the bone to have left

the acetabulum and be placed on the pubes. In most instances of this form of fracture the neck forms a right angle with the shaft, but in some the angle is not much altered, but the anterior aspect of the neck, instead of looking directly forwards, looks forwards and upwards, the neck being rotated on its axis as much as 15° or 20°.

The fracture through the base in front is external to the anterior inter-trochanteric line, where it might be easily felt very prominent behind and external to the tendon of the rectus femoris muscle. This prominence with the fulness in the groin is so easily felt, and contrasts so remarkably with that of the opposite side, that the diagnosis might be based upon it alone. As the base of the neck has penetrated behind obliquely outwards and forwards, the trochanteric fragment is usually not large, nor is it displaced much out, but a little backwards and mostly inwards, lying within a short distance of the head and acetabulum; but this inward displacement of the trochanteric fragment is more apparent than real, for were we to deduct the amount of penetration by the neck it will be found very little displaced—therefore prominence of the base of the neck in front, widening and displacement of the trochanteric fragment, would be diagnostic.

Diagnosis.—So the diagnostic signs of this, the most frequent of all the forms of extra-capsular fracture, are as follows:—

1. The history of a fall on the great trochanter.
2. Well-marked shortening.
3. Eversion of the foot.
4. Prominence of the base of the neck easily detected by manual examination, external to, or behind the tendon of the rectus femoris muscle.
5. Increase of the antero-posterior diameter of the upper end of the femur.
6. Pain on pressure at the upper part and front of the shaft.
7. The shaft is approximated to the anterior superior spine of the ilium.
8. The injured femur is on a plane anterior to that of the opposite side.

Although this form scarcely presents a single sign in common with dislocation of the head of the femur on the dorsum ilii, yet, as the latter is the only luxation with which it is possible to confound it, subjoined I give the differential diagnosis:—

Extra-Capsular Fracture.

1. Cause.—A direct fall upon the trochanter.
2. Most common in advanced life.
3. Foot much everted, sometimes pointing directly outwards.
4. Limb shortened.

Dislocation on the Dorsum Ilii

1. Cause.—Forced rotation inwards of the femur.
2. Extremely rare, almost unknown in advanced life.
3. Foot inverted.
4. Limb shortened.

Extra-Capsular Fracture.

Dislocation on the Dorsum Ilii

5. The head may be easily shown to be within the acetabulum by gently flexing and extending the femur by the hand, placed behind the lower end of the femur.
 6. The outer surface of the trochanter looks backwards.
 7. The base of the neck may be felt prominent in front, and there is great increase in the antero-posterior diameter of the trochanter.
 8. Acute pain on pressure along the line of fracture, in front, above and behind.
 9. The displacement of the trochanteric fragment may be easily felt by passing the fingers along the posterior branch of the *linea aspera*.
 10. A groove may often be felt when the trochanteric fragment is separated.
 11. The inter-trochanteric line behind cannot be felt.
 12. In cases of great eversion of the foot in aged persons, from a fall upon the great trochanter, this form may be diagnosed, as in none of the other varieties does the same amount of eversion take place.
5. The head rests on the dorsum ilii behind and above the acetabulum, and the movements are restrained and difficult.
 6. The trochanter is approximated to the anterior superior spine, its outer surface looking forwards.
 8. No pain, or very slight pain, when pressure is made over the posterior part of the trochanter.

Treatment.—I have often asked myself, as well as others, upon what principle can a long splint be serviceable in this form of fracture? The head and neck are firmly fixed in the acetabulum, by the capsular ligament. The base of the neck is deeply driven into the cancellated tissue behind, whilst it is prominent in front. The trochanteric fragment, to which are attached the *glutens minimus*, *pyriformis*, the internal and external obturators, is approximated to the acetabulum behind, and is fixed in this position by these muscles, and the only medium of connexion between it and the shaft is the tendon of the *gluteus medius* and fibrous tissue on the outer surface of the trochanter. The foot being greatly everted, in order to apply the splint we must rotate it so as to make it look forwards. Now in this movement the base of the neck forms the fixed point upon which the shaft must move in this rotation, thereby separating the base of the neck entirely from the trochanter, except in front. The limb being shortened, when extension is made it separates the shaft from the head and neck, which is fixed by the capsule, as already stated. The trochanteric fragment being also fixed by the muscles previously mentioned, would also be separated by extension; indeed the effects of extension would be to draw the three fragments from each other, and render a limb which would otherwise be useful into one that was comparatively useless. I could hardly conceive a more useless or irrational practice,

and one without a particle of sound anatomical knowledge in its favour, not to speak of confining the patient in a recumbent posture, thereby entailing certainly very serious consequences, and often fatal results.

The treatment which I have adopted is that of putting the patient into a comfortable and easy position, and allowing him to move as he may wish. I know of no instance in which the fragments were detached or separated from each other by any rash or imprudent movement on the part of the patient. The accident is usually extremely painful, and any movement made by the patient aggravates that pain, and therefore when they change their position, to relieve the organic suffering from pressure, they do so with the greatest gentleness and caution. Some will experience the greatest relief by lying midway between the side and back positions, the outer and posterior surface of the femur resting on and supported by the bed; others cannot suffer the limb to be extended, but will have it bent at right angles to the pelvis, as affording to them the greatest freedom from pain; others will adopt an intermediate position. The rule which I adopt is to let them select their own position, and support the limb as they find it most comfortable.

Dr. Anderson read a paper upon the homology of the omohyoid.

Paper:¹ THE omohyoid muscle occupies a somewhat isolated position, and, as usually seen in man and many vertebrates, attached by one extremity to the bone of the upper extremity and by the other end to the hyoid bone mediately or immediately, it has given rise to much discussion.

Professor Henle, in his handbook, states that the anterior belly of the omohyoid is a muscle analogous to the sternohyoid, the posterior to a digitation of the serratus magnus, and the tendon uniting the anterior and posterior belly has the significance of a cervical rib. As the lowest cervical rib is not developed the two muscle bellies pass into one another by means of a tendinous inscription.²

Professor Gegenbaur from an examination of the different varieties of the muscle was led to a different result. The varieties which seem to point to the conclusion at which Henle arrived are described by Theile, Gruber, Luschka, and other anatomists. The muscle described by the first anatomist as attached to the upper border of the scapula at the place of origin of the normal omohyoid (which was absent in this case) and by its opposite extremity to the first rib has been regarded by succeeding observers as a variety of the subclavius. The instance given by Professor Gruber³ is named subclavius by him, and the cases mentioned by Luschka, Gegenbaur explains in a similar manner, and shows

that these cannot be regarded as transitional forms of the omohyoid.¹

The same anatomist points out that tendinous inscriptions have not usually the significance of ribs, and adduces the examples of the biventer cervicis, complexus and rectus abdominis, where the tendinous intersections indicate simply the remains of the original separation of the muscle into a number of segments corresponding to the body metamers. The presence of a tendinous intersection at the lower extremity of the sternohyoid serves to strengthen the relation, as it shows the intimate connexion of the sternohyoid and omohyoid.

The tendinous intersection of the omohyoid being generally well marked, and sometimes of considerable length, is explained by the facts that the muscle here makes a bend and it is in relation with the deep cervical vessels. The varieties met with in the animal series and in man show that the omohyoid belongs to a muscle group which is represented in man by the sternohyoid and sternothyroid.

This group is supplied by the cervical nerves coursing in the hypoglossal path. Secondly, in the lower forms the origin of this muscle group extends from the sternum to the clavicle and is continued to the scapula. In crocodiles an episterno-hyoideus is present, which in the saurians becomes an episternocleidohyoideus, and in platyductylus (Sanders) extends to the claviculo-scapular articulation, whilst it passes quite to the scapula in uromastix (Furbinger). By separation of individual portions of this muscle, muscles arise distinguished as the sternohyoid, sternothyroid, cleidohyoid, and omohyoid—a simple absence of muscle substance giving rise to the varieties observed in man and animals. The most frequent variety is the cleidohyoid, which in man, though frequently present, is not usually developed. This variety occurs once in every 15 subjects according to Hallett.² In 373 subjects, 8 on both sides, 4 right side only, 5 left side only, majority in middle third, rarely inner third (Turner³). One in 12 subjects (Gegenbaur⁴).

Finally, the fascia uniting the omohyoid to the clavicle is explained by the retrograde metamorphosis of the cleidohyoid. This is shown by the fact that muscular fibres are to be found in the fascia having the same character and course as those of the cleidohyoid; and the fascia is attached to the muscle, and more firmly to the tendon, with which it is intimately connected. This fascia, which extends from the lower inner border of the omohyoid to the clavicle, is not to be regarded as a portion of the deep cervical fascia.

Albrecht⁵ shows that although the omohyoid is part or

¹ [Dublin Journal of Medical Science, 1881, v72, p171.]

² Handbuch d. Systemat. Anatomie. Muskellehre. P. 128. 2 Aufl.

³ Neue Anomalien. P. 19.

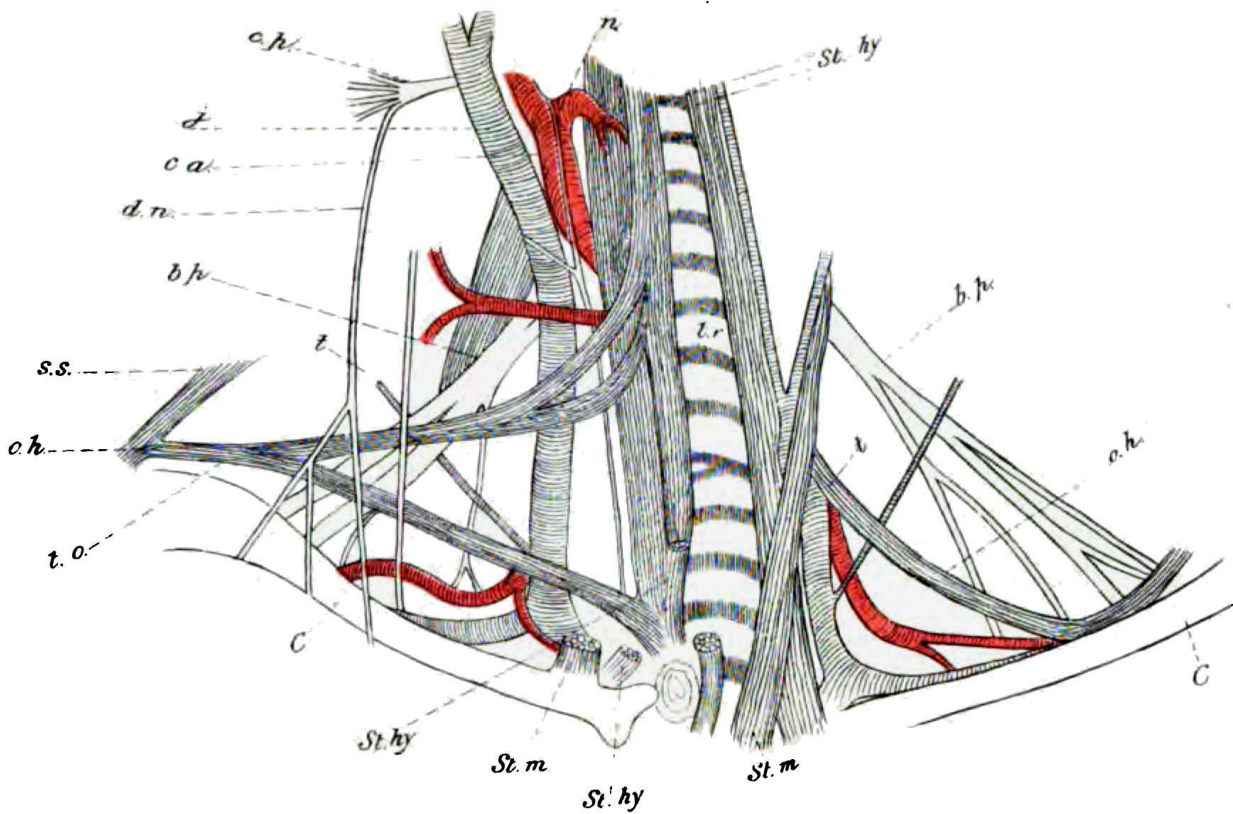
¹ Ueber den Musc. omohyoideus und seine Schlüsselselbein-
verbindung. Morphologisches Handbuch. 1875. P. 243.

² Edinburgh Medical and Surgical Journal. 1849.

³ Edinburgh Medical Journal. 1881. P. 982.

⁴ L. c. P. 247.

⁵ Beitrag zur Morphologie des M. Omohyoideus.



is represented by part of a continuous muscle layer in certain vertebrates, yet in a very considerable number of animals the omohyoid is present as a distinct muscle or is absent altogether, and that it is recognisable in the lower classes.

In mammalia we find it in the lowest forms; in the ornithodelphia it is almost the same as in man. In echidna,¹ according to Mivart, the omohyoid does not much deviate from the condition found in the higher mammals (man). In ornithorhynchus² the omohyoid is present and inserted with the mylohyoid into the hyoid bone; a sternohyoid is present as a distinct muscle. In the marsupials³ the omohyoid presents a scapular origin. The omohyoid is wanting in the edentates (Owen, Humphry,⁴ Macalister,⁵ Galton⁶). The ungulates have an omohyoid. In the ruminant artiodactyla the origin is somewhat variable from the transverse process of the last cervical, in the giraffe from the transverse process of the third cervical. The pachydermatous artiodactyla (Humphry⁷) possess an omohyoid which passes over the anterior edge of the scapula to the upper border to be connected with the radial tubercle of the humerus and the deltoid by fibrous tissue. In the hippopotamus,

according to Professor Humphry, the omohyoid passes from the side of the basihyal and the subhyoidean septum to the under surface of the occipito-humeral part of the trapezius, which it joins at an angle and is united to it by an inscription.¹ In the horse,² of the perissodactyla, the omohyoid arises from the coracoid process. The omohyoid is absent in the carnivora, but some possess it, as meles, hyæna, lutra. Of the pinnipedia, Prof. Humphry⁵ states that this muscle in phoca⁵ is continuous with the sternohyoid, forming a broad muscle which is inserted into the sternum, the ulnar tubercle of the humerus, and a fascial band between the two, similar—as Albrecht remarks—to the arches of the diaphragm or the tendinous arch in connexion with the adductor magnus. In the descoïd placental mammals an omohyoid similar to man has been described in tarsius and cheiromys. Rodents that have a clavicle have an omohyoid. Of the insectivora no erinaceous muscle is present. According to Professor Macalister, in the vespertilionidæ the omohyoid is slender and distinctly biventral. In the phyllostomine bats scarcely a trace of tendinous intersection. In noctulina a band arises from the middle of the clavicle and joins the sternohyoid midway between the origin and insertion; above the point of union is a tendinous intersection.³ In primates

¹ Mivart. Trans. Linnaean Soc. Vol XXV., p.383.

² Owen. Anatomy of Vertebrates. Vol III., p. 5, Fig. 3.

³ Gegenbaur. Op. cit. P. 259.

⁴ Journ. Anatomy. Vol. IV., p. 29.

⁵ Trans. Roy. Irish Academy. Vol XXV., p. 232.

⁶ Trans. Linnaean Soc. 1870. P. 571. Vol XXVI., p. 523.

⁷ Observations in Myology. P. 127.

¹ Humphry. Op. cit. P. 126. The foremost fibres run on to the humerus.

² Owen. Anat. of Vertebrates. Vol. III.

³ Trans. Roy. Soc. Vol. CLXII. 1872. P. 184.

the omohyoid is similar to that muscle in man. In troglodytes aubryi an omocleidohyoid is present (Grateolet).

Albrecht¹ tabulates the varieties of the omohyoid, thus:—

1. Mammals in which a muscle homologous to the omohyoid is absent—
 - (1) Edentates, (2) many Carnivora, (3) Pinnipedia, with the exception of phoca, (4) Rodentia without a clavicle, (5) many of the Insectivora, (6) Cheiroptera, with exception of noctulina (see Macalister).
2. With the omohyoid resembling closely the omohyoid of man—
 - (1) Ormithodelphia, (2) Didelphia, (3) Meles, hyæna, lutra (Carnivora), (3) Prosimiæ, (4) Rodentia with clavicles (5) Insectivora erinaceus, (6) Primates, with the exception of troglodytes aubryi.
3. With a musculus coracohyoideus, Equus.
4. M. cleidohyoideus, Noctulina.
5. M. omocleidohyoideus, A. Troglodytes aubryi.
6. M. omobrachio-hyoideus, Sus.
7. M. trapezio-brachio-hyoideus, Hippopotamus.
8. M. sterno-brachio-hyoideus, Phoca.
9. M. spondylo-hyoideus, Ruminantia.

Of these varieties the first five are known to occur in man, and have been recorded by anatomists; of Nos. 6 and 8 examples must be extremely rare. An example differing slightly from these forms I shall give later on. Instances have, however, been given which approach the conditions given above; thus, Hallett and Schwegel show detached bundles of the posterior belly inserted into the sixth cervical transverse process or into the sterno-mastoid and into the fascia of the scalenus (Hallett). Kelch and Grüber have mentioned a muscle which passes between the outer end of the clavicle and the transverse processes of one or several cervical vertebræ. A cervico-costo-humeralis is described by Prof. Gruber, which was inserted into the smaller tuberosity of the humerus by two tendons into the transverse process of the sixth cervical vertebræ and the anterior end of the first rib cartilage. The other varieties referred to by Prof. Gegenbaur, Albrecht gives, and remarks that the examination has been confined to the mammalian and reptilian type. These varieties are the M. episternohyoideus of crocodiles, the episternocleidohyoideus of saurians, and the episternocleido-omohyoideus superficialis of the mastix. The evidence in favour of the omohyoid belonging to the system of the rectus abdominis, amongst the mammalia, Albrecht points out, is based principally on the presence of a cleidohyoid in a noctulina, an omocleidohyoid in a troglodytes aubryi, and the musculus brachio-ster-nohyoides of phoca. In opposition to this the monotremes present a condition of this muscle resem-

bling closely that of the higher forms. On the other hand, the amphibia, and not the reptilia, are to be looked upon as morphological allies of the mammalia. In the frog an omohyoid is known to exist, and the same muscle has been described in many other amphibia. Humphry has described the muscle in menobranch and cryptobranch. The condition in uromastix may be looked upon as a union of the omohyoid with episternocleidohyoid.

Albrecht shows that in fishes—of which he takes as examples spinax acanthias, raia clavata, acipenser sturio, and gadus morrhua—interbranchial muscles belonging to the internal oblique layer of Humphry are present. Thus, in spinax six interbranchial muscles—the last or (sixth) being the muscle extending from the shoulder girdle to the last branchial arch (omozonio-branchialis), the latter not necessarily the morphological equivalent of one of the others—are present, united with the mesial layer or layer of the rectus (omozonio-hyoides); external interbranchial muscles, belonging to the external oblique layer, are present; in raia the external and internal muscles are present; in acipenser the former are wanting, and the sixth of the latter (omozonio-hyoides) gives evidence of separation into two muscles; in gadus all the external and the first two internal branchial muscles are absent, the sixth being divided into two separate muscles; in amphibia the first four interbranchial muscles present variations—they are absent in tailless batrachians; the fifth and sixth have the following arrangements:—the latter being divided into two, one or other or both being persistent. The sixth dorsal interbranchial is present in siren, proteus, and menopoma—absent in menobranchus, cryptobranchus anoura, and others. The sixth ventral internal interbranchia, with the fifth, is united in one muscle, the omohyoid—the posterior part of which is represented by the sixth, the anterior by the fifth, interbranchial muscle—in proteus, menopoma, and amphiuma, where both muscles join the sternohyoid; in cryptobranchus, where the anterior belly joins the sternohyoid; and in the tailless batrachians, where both bellies are free.

The observations of Albrecht, as will be seen, serve to confirm those made by Humphry, as far as the continuation of the internal oblique layer forwards to the neck is concerned, and as the subject requires a reference to the views of the latter anatomist, I shall here summarise them.¹

The internal oblique stratum represented by that muscle in the abdominal wall is continued to the thorax as the external intercostals, and here the ribs are developed in this stratum as well as the sternum and the limb girdles, and is continued into the neck, where the hyoid bone is developed also in this layer. In the abdomen, the internal oblique, the quadratus lum-

¹ Albrecht Loc. cit P. 11.

¹ Observations in Myology. P. 123.

borum, rectus, and pyramidalis; in the thorax, the external intercostals, levatores costarum, rectus thoracis, rectus thoracis lateralis sternocostalis; in the neck, the scaleni, rectus capitis lateralis, sternohyoid, sternothyroid, hyoglossus, geniohyoglossus, and the middle and inferior constrictors of the pharynx. To the same stratum may be referred the styloglossus, the stylohyoid, the stylopharyngeus, the digastric and the superior constrictors.

The muscles that pass to the shoulder girdle are those which pass above the glenoid cavity belonging to the serratus or costos-capular group, which group is prolonged into the omohyoid and levator anguli scapulæ anteriorly, and those that pass to the girdle below the glenoid cavity, the costo-coracoid group, including the sterno- or costo-scapularis and the subclavius. The nerves to the limb serve to separate the groups in question.

In cryptobranch (p. 11) the internal oblique fibres acquire an anteroposterior direction near the mesial line, and are continued into the deep fibres of the rectus. Anteriorly the omohyoid has a very similar relation to the sternohyoid.

If, then, we trace the middle layer forwards, we have as its representatives, attaching the limb to the trunk, the serratus and levator anguli scapulæ posteriorly, the costo-scapular or costo-coracoid (subclavius) attaching the limb to the trunk anteriorly, the nerves to the upper limb separating the anterior (lower) from the posterior (upper) group. The nerves which separate the subclavius from the serratus separate the omohyoid from the same muscle.

The omohyoid and subclavius present many important points of resemblance, and these will be more readily seen if the varieties of the latter muscle be compared with those of the former.

In emys europæa the subclavius arises from the under part of the first costal plate, and is inserted into the suprascapula and the contiguous part of the scapula.¹ In the crocodile the epicoraco-humeral muscle, which Professor Rolleston regards as the homologue of the subclavius, arises by two heads—the inner from the visceral surface of the scapula, the outer from the precoracoid and from the prescapular portion of the preglenoid expanse. The inner is intimately connected at its insertion with the pectoralis major, and, together with the tendon of the outer head, occupies a position between the deltoid and pectoralis major. The insertion of the omohyoid corresponds with the origin of the preglenoid head, and the fibres of the two muscles are, to some extent, continuous with one another, at least in young specimens.² In the emu, according to the same anatomist, the epicoraco-humeral muscle arises from the mesial part of the sternum or “rostrum” of the bone, from the coraco-clavicular membrane, and from an

irregularly quadrangular preglenoid headland constituted by the scapula and coracoid; it is inserted into the humerus above and internal to the deltoid, and superficial to the coraco-brachialis.

In apteryx, according to Professor Owen, a portion of the pectoralis minor, which he called subclavius, arises from the anterior angle of the sternum, and is inserted into the coracoid.¹

In echidna, according to Mivart,² no pectoralis minor is present; a small muscle arises from the first rib, and is inserted into the coracoid. The subclavius of Owen is inserted into the coracoid in ornithorhynchus. This rectus is inserted into the coracoid at no great distance from the epicoraco-humeral (the homologue of the subclavius of other mammals).

In the wombat of the marsupialia the subclavius arises from the first rib, and is inserted into the outer end of the clavicle, and by means of the fascia covering the supraspinatus into the whole length of the spine of the scapula. It is joined by a fine tendon or thin muscle that arises from the sixth costal cartilage. A fascicle of the rectus abdominis passes into this muscle near its attachment to the rib.³

In dasypus sexcinctus of the edentates the subclavius arises from the first rib, and is inserted into the whole extent of the upper border of the acromion process by a flat tendon, and becomes continuous with the fascia over the supraspinatus and the head of the humerus.

It is split into two portions by the strong coraco-clavicular ligament. In orycteropus capensis the subclavius arises from the manubrium and the first rib, at its junction with the sternum, and in part by a slight prolongation of its fibres from the aponeurosis of the rectus.

It is inserted aponeurotically, along the upper border of the acromial half of the clavicle, into the acromion and supraspinatus fascia.⁴ In chlamydophorus truncatus it arises from the first rib, and is inserted into the coracoid process, acromion, and the acromial end of the clavicle.⁵ In ai it is inserted into the clavicle and coracoid process.⁶ The subclavius is absent in manis, myrmecophaga jubata, and some others. A retro-clavicularis is present in chlamydophorus, and arises from the upper surface of the first rib, near the sternal end, and is inserted into the acromion, process and supra-spinatus fascia and coraco-acromial ligament.⁵

In ruminants a sternoscapular muscle arises from the manubrium, and is inserted into the scapula.³ In the hippopotamus the subclavius is expanded upon the supra-spinatus at its insertion, forming a ster-

¹ Owen. Anatomy of Vertebrates. Vol I.

² Rolleston. Trans. Linnaean Soc. Vol. XXXV., p. 609.

¹ Owen. Op. cit. Vol. II., p. 609.

² Trans. Linnaean Soc. Vol. XXV., p. 382.

³ Rolleston. Trans. Linnaean Soc. Vol. XXVI.

⁴ Galton. Trans. Linnaean Soc. Vol. XXVI.

⁵ Macalister. Trans. Roy. Irish Acad. Vol. XXV.

⁶ Humphry. Jour. of Anat. Vol IV.

nocosto-scapularis. In the pig it reaches the radial tubercle of the humerus.¹

In the porcupine the subclavius arises from the costal portion of the first rib, has a slight attachment to the scapular extremity of the clavicle, and is finally inserted into the spine of the scapula, the supraspinous fascia, and by this to the deltoid, and is extended over the supraspinatus to the humerus.²

In the guinea-pig the subclavius arises from a small surface on the presternal pro-osteon, and from the cartilage of the first rib, exteriorly, to which latter point of origin the epicoracoid has coalesced with the vertebral rib. Some of its fibres are inserted into the coraco-clavicular ligament and some into the clavicle, but it receives fibres also from the clavicle. The muscle is then inserted into the acromion (anterior border), and with the deltoid some fibres become continuous.³

In the cheiroptera the subclavius arises from the first rib, and is inserted into the clavicle.⁴

The following table represents the varieties, with an origin from the first rib, rib and manubrium, and rectus, or precoracoid and scapula. It is inserted into—

- (1) The suprascapula and scapula.
- (2) The humerus.
- (3) The coracoid.
- (4) Outer end of clavicle and spine of scapula.
- (5) Acromion, supraspinatus fascia, and humerus.
- (6) The scapula, with an origin from the sternum.
- (7) Receives fibres from rectus.
- (8) Radial tubercle of humerus.
- (9) Spine of the scapula and humerus.
- (10) Coraco-clavicular ligament, clavicle, and acromion.
- (11) Clavicle only.

Comparing the varieties found in man with these, the subclavius has occasionally an attachment to the clavicle, coraco-clavicular ligament, and coracoid process. It may be inserted into the clavicle, coracoid process, and upper border of the scapula, and may at the latter place be intimately connected with the supraspinatus fascia.

A condition, very similar to that of ruminants, was observed by Mr. Wood, and recorded by him many years ago. The subclavius may be absent; of this I have met with two cases in ninety subjects dissected during the present session. Absence of this muscle was observed by Prof. Gruber.

If the varieties of the omohyoid be placed side by side with those of the subclavius, it will be seen that, first, as far as the origin is concerned, there is evidence of a connexion with the rectus. In the case of the former the anterior belly is inseparably united with the ventral muscle in some lower forms, and occurs as a not infre-

quent variety in man, so that in these the posterior belly must be regarded as a muscle radiating from the rectus, and, in the case of the latter muscle, a variety is presented in the wombat, where the fibres are (in part) continuous with the rectus. An origin of the omohyoid, on the other hand, from the sternum is not, so far as I know, on record; and an example of a sterno-scapular muscle, which, I think, must be regarded as belonging to the sternohyoid set of muscles, I shall give later on. The insertions of the omohyoid and subclavius present, however, many characters which show a definite relationship between these muscles. Each muscle is inserted in some of the animal forms into the clavicle, scapula, coracoid process, and humerus. What in man is a normal attachment of the omohyoid, is an aberrant attachment of the subclavius, and the omohyoid is attached to the under surface of the clavicle in a large percentage of cases. Six cases were recorded in ninety subjects during the present session (1880–81).

I shall now give some varieties of these muscles. Two of the subclavius are recorded with accompanying variation in the attachment of the omohyoid.

The first case is that of a costo-scapular muscle, differing but little from the cases of Theile and Wagner. That it was a true subclavius will be easily seen from the description.

1. In a female subject, aged forty-five, on both sides of the body a muscle arises from the cartilage of the first rib by a tendon one and a half inches in length; this is continued into a round fleshy belly which passes beneath the clavicle, to which it is attached by a firm fascia, over the subclavian and suprascapular arteries and brachial plexus, and is inserted into the upper border of the scapula for one inch, extending forwards from the superior angle. The muscle is supplied by a branch from the fifth and sixth nerves of the brachial plexus.

The omohyoid arises from the under-surface of the clavicle for the extent of one inch at the junction of the middle and outer thirds of the bone; it passes upwards and inwards and unites with the sternohyoid. Below the point of union is situated a tendinous inscription in the omohyoid, from the inner extremity of which a fibrous band passes inwards to the sternohyoid, where it is prolonged into a tendinous inscription less marked than that of the omohyoid. From the arch so formed fleshy fibres pass up to the conjoined sternohyoid and omohyoid, filling up the triangular interval by a thin fleshy stratum. The fibrous band, which was one-tenth of an inch broad, has been referred to by Professor Turner in his paper.

2. The second example occurred in a male subject, aged fifty. The trapezius is inserted into the outer two-thirds of the clavicle on each side; on the right side the external jugular vein passes through a foramen in the muscle close to the clavicle, and the supraclavicular nerves pass forwards through the same foramen. The

¹ Observations on Myology.

² Rolleston. Loc. cit.

³ Galton. Loc. cit.

⁴ Macalister. Trans. Roy. Soc. 1872.

omohyoid is attached to the upper border of the scapula from the superior angle to the notch, to the ligament over the notch, and to the base of the coracoid process; it is further attached to the outer half of the clavicle. The external jugular vein and supraclavicular nerves pass beneath a tendinous arch close to the clavicle, to which some fibres are attached. The muscle is inserted into the hyoid bone superficial to the sternohyoid. A cleidohyoid muscle arises from the inner third of the clavicle for the extent of one inch, is separate from the sternohyoid in all its extent, and is inserted into the hyoid bone above that muscle. On both sides a supraclavicularis is present, arising from the manubrium beneath the sternomastoid; it is inserted into the clavicle between an anterior and a posterior layer of the sternomastoid.

The interest attaching to this case is due to the many irregularities. The individual varieties have been observed by many anatomists. The attachment of the omohyoid superficial to the sternohyoid is the fact which I shall make use of.

3. In a male subject, aged forty-eight, on the left side of the body the omohyoid has the normal origin. Above the middle of the clavicle it divides into two parts; the upper is connected with the anterior belly by means of a tendon, and this belly of the muscle is closely connected with the sternohyoid.

The lower division, half an inch broad, is inserted into a more than usually strong tendinous inscription in the sternohyoid. The place of insertion is on the anterior aspect of the muscle. A muscular fasciculus is given by this muscle to the sternothyroid, the outer border of which it joins.

4. Instances are on record where the omohyoid presented a double belly at the anterior and posterior part. In a male subject (left side) this muscle arises from the scapula at the usual place, and is inserted into the hyoid bone. So far the muscle presents no unusual features, but for an extent of three inches extending on both sides of the tendinous inscription the muscle is double; each part resembles a normal omohyoid.

5. The last variety in this connexion to which I shall refer is the case of absence of the anterior belly. This variety is rare, as Professor Macalister did not meet with it once in 600 subjects. The variety occurred in a female subject, in which the omohyoid of the right side presents an anomaly somewhat similar to that recorded by M'Whinnie. A portion of the outer fibres passes over the sternohyoid near its insertion, over the hyoid bone and beneath the mylohyoid, and then enters the geniohyoid. A portion of the sternohyoid crosses beneath this bundle and is continued into the hyoglossus. On the left side of the head and neck the omohyoid arises from the scapula and terminates in a fibrous band in front of the carotid vessels. This divides into two; both pass upwards; the inner is inserted into the os hyoides, the outer is lost in the cervical fascia, with

which both are in close connexion.

These varieties point to the fact that the anterior belly of the omohyoid, usually distinct in the case of man, lying side by side with the sternohyoid near its insertion, and inserted border to border with it, and so far may be understood as obtaining its substance, not from the rectus, but from the prolongation of the lateral internal oblique layer, as distinguished from the mesial part; yet the variety given under No. 2 shows that the anterior belly may have an intimate connexion with the: superficial part and not the external part. And No. 5 shows, as, indeed, other varieties, that the anterior belly may be connected with the posterior part of the prolonged rectus. Variety No. 4 is another illustration bearing on this point—a portion of the omohyoid is inserted into the anterior part of the tendinous intersection of the sternohyoid. Unless a portion of the anterior belly be considered as absent in this case, we must regard a part of the sternohyoid above the intersection as portion of the omohyoid that has coalesced with the sternohyoid, but a third assumption is possible—namely, that the fibres of continuation are to be sought in the part below the intersection. In case, then, these varieties point to the fact stated by Prof. Henle that the anterior belly corresponds to the sternohyoid, and should be regarded as the analogue, or, to go a step further, as a differentiated part of the sternohyoid mass, this differentiation can be easily accounted for. The separation of the cleidohyoid, as given in No. 2, from the more deeply placed sternohyoid, can be explained on the same principle as the separation of muscles into layers in the limbs and elsewhere, and such an interpretation is rendered almost certain by the fasciculated varieties met with in connexion with the omohyoid.

The division of the muscle given above was as perfect as the ordinary separation that exists between the sternohyoid and the omohyoid; and the muscle shreds that so frequently exist between the omohyoid and the sternohyoid is additional evidence bearing on this point. On the whole, therefore, the varieties met with point to the fact that the anterior belly of the omohyoid should be regarded as a portion of the sternohyoid (at least in man), and that the tendinous intersection of the central mass represents the point at or below which the separation takes place. That the breadth of the tendon of the omohyoid to some extent depends upon the extent of the original connexion of the posterior belly with the mesial mass. Its length is probably due to a variety of circumstances—the extent and firmness of the fascia investing it, the length of the muscle, and the angle of junction. The first and last because they affect its action, and the second, conjoined with either of the former, would serve to increase its length. The absence of an anterior belly is attributable, without doubt, to a solution of the connexion with the mesial mass, or to its

original weakness.¹

So far, then, as the omohyoid can be regarded as composed of a sternohyoid portion and a recto-scapular portion, the posterior belly is similar in its anterior connexions with the portion of the subclavius met with in phascolumys and orycteropus, which in these creatures is connected with the rectus or its expansion; and the similarity in the attachments of the muscles posteriorly I have already mentioned. The nervous supply of the two muscles is different, and is apparently an argument against the homology of the muscles, if there were no other; but the fact that the omohyoid is intimately connected with muscles supplied by the nerves in the tract of the descendens noni, and other instances, such as that of the levator anguli scapulæ, and the serratus where the nervous supply is different, at least frequently—the former muscle, no doubt, sometimes receives a branch from the fifth; but a branch from the third is a very constant nerve to this muscle—furnish reasons for this difference in nervous supply.

The supraclavicularis, originally described by Professor Gruber, has an attachment at the inner and outer end of the clavicle. Tendinous at each extremity and fleshy at the middle, it has been considered by the anatomist who first described it as a tensor of the fascia, and by him regarded as the representative of the fibrous band which one sees occasionally above the clavicle giving attachment to the trapezius. The muscle occurred twice during the present session in the anatomical rooms, and in one case corresponded exactly with the description given by Gruber. This muscle was supplied in the case to which I refer by the descendens noni. A muscle such as this supplied by the descendens noni seems to show that it does not correspond to the fibrous band situated above the clavicle, but must be regarded as a muscle of a deeper layer—namely, of the layer to which the depressors of the hyoid bone belong. It would more appropriately be referred to the fibrous band mentioned in one of the notes given above. Such a muscle, then, might be regarded as a portion of the internal oblique layer which lost its attachment to the sternohyoid band and acquired an external attachment to the clavicle at a place where a cleidohyoid muscle is sometimes found. That the muscle must be regarded in this light is, I think, shown by the following variety, which, as far as I know, is new:—

In a female subject, aged seventy-eight, on the left side of the head and neck the omohyoid is attached to the outer third of the clavicle for one inch, and is prolonged to the upper border of the scapula where it is attached to the ligament over the notch, as also to the bone. Arising in this way the omohyoid passes it up-

wards, and is inserted into the hyoid bone. A faint line which extended transversely across the muscle indicated the line of division of the muscle into two parts. The subclavius on this side has a slight attachment to the clavicle externally (half an inch). It is, however, attached by a slip to the coracoid process, and by a band to the upper border to the scapula beneath the omohyoid. The arrangement resembles that of Böhmer's case, cited by Professor Macalister.

On the right side a sternoscapular muscle arises from the posterior surface of the sternum in this way:—From the anterior surface of the tendon of origin of the sternothyroid tendinous fibres are prolonged upwards and outwards. These are reinforced by fibres arising from the anterior surface of the sternothyroid, and which have a transverse direction above the tendon and below the tendinous intersection of the same muscle. From the band so formed external to the sternothyroid a muscular belly arises, which passes outwards above the clavicle over the subclavian artery and brachial plexus, and terminates in a tendon two inches and a half long, which is inserted into the upper border of the scapula and ligament over the notch for the extent of one inch. A small band passes down to the outer third of the clavicle, and a portion of the fibres is continued into the supraspinatus fascia. The breadth of the tendon of origin is one inch and a quarter; the breadth of the muscle about four lines. The omohyoid has a slight origin from the upper border of the scapula, but is attached to the upper border of the outer tendon of the sternoscapular muscle for its whole length. The muscle passes upwards and inwards to the hyoid bone, and is connected with that muscle so closely, three inches below its insertion, that it cannot be easily separated. Below the point of union a muscular fasciculus from the omohyoid joins the sternohyoid. A tendinous inscription is present above the middle of the omohyoid, oblique in direction, and very faint. The sternoscapular muscle is supplied by a branch of the descendens noni which enters the muscle near its inner tendon. The sternohyoid of the right side has only a clavicular origin, so that, in reality, it is not properly designated by this name. On the left side the muscle has both a clavicular and sternocostal attachment.

This muscle has much in common with the supra-scapularis proprius and the retro-clavicularis, and I think these two muscles may be considered varieties of the foregoing. Dr. Macalister has already stated as his opinion that the muscle described by Mr. Lawson Tait is to be regarded as a variety of the supra-scapularis. To the same set the sterno-humeral muscle of Gruber may with justice be referred. The position of the supraclavicular nerves in this case seems at first sight to show that the sternoclavicular muscle has a significance different from the supraclavicularis, for in Prof. Gruber's example and the two instances referred to, these nerves passed beneath, whilst the same nerves passed in front

¹ Dr. Whitla, of Belfast, has told me of a case where the anterior belly was displaced by a small round tendon on both sides. It occurred in a person who had worn a trachea cannula for forty-three years.

of the sternoscapularis; but this objection loses its importance when we consider that the descending nerves of the cervical plexus sometimes pierce the clavicular origin of the omohyoid or even the clavicle, or may pass under a tendinous arch into which the latter muscle is inserted.¹

The supraclavicular nerves in this example passed over the omohyoid and the sternoscapular muscle. The relations of the origin to the sternothyroid and the insertion of the omohyoid, together with the fact that the muscle has the same nervous supply, show that it belongs to the lateral ventral muscle.

The connexion with the posterior part of the omohyoid seems to show that these muscles are to be regarded as parts of the same lateral muscle band; and the connexion of the sternoscapularis with the sternum internally, the clavicle and scapula externally, shows that it is a serial homologue of the subclavius. The posterior belly of the omohyoid must, I think, be regarded as homologous with the subclavius. The reasons for this conclusion may be briefly stated thus:—

(1) The origin of the subclavius is closely connected with the rectus in some animals. Wombat, *orycteropus*. The posterior belly of the omohyoid passes into the mesial layer prolonged from the rectus, as a permanent condition in *cryptobranch*.

(2) The nerves of the limb separate equally the subclavius and costo-coracoids equally with the omohyoid from the serratus or costo-scapular group.

(3) The aberrant supraclavicular muscles present an origin and insertion similar to the subclavius, and resemble closely the omohyoid in their attachments, relations, and nervous supply.

(4) The extensive clavicular attachment of the omohyoid in certain of the animal series can be explained as a part of the attachment of the recto-clavicular muscle—the inner surface, in some cases, being part of the rectus prolongation.

(5) The omohyoid is bound down to the clavicle so closely in many cases as to completely obliterate the subclavian triangle—in 13 out of 373 subjects (Turner, loc. cit.); and the same arrangement occurs when the subclavius takes origin from the scapula, as in case given above.

J. Walton Browne M.D.

The Ninth Meeting of the Society was held upon Tuesday March 22nd 1881 at eight o'clock p.m.

Present, Dr. J. W. Browne in the chair, Drs. S. Browne, Esler, Smyth, McCaw, Wales snr., Wales jnr., Workman, Fagan.

Dr. Dunn was unanimously elected member of the Society

The President then exhibited a patient in whom the

¹ Krause. Die Nervenvarietäten. During the present session I have recorded three instances where a single branch of the descending nerves perforated the clavicle.

median nerve was divided; and the brachial, ulnar, radial and common inter-osseous arteries were ligatured consequent upon a punctured wound of the arm.

He then exhibited a very interesting specimen of diseased kidney, microscopic sections of which were made by Dr. Workman demonstrating it to be of tuberculosis nature.

He finally showed some casts removed from the urethra, concerning the nature and origin of which differences of opinion were expressed.

Mr. Fagan exhibited a case of wrist joint disease treated by drainage and give details of same.

W. Whitla, M.D., Chairman

April 5th 1887

The Tenth Meeting of the Society was held upon Tuesday 5th April 1881.

Present, Dr. Whitla in the chair, Dr. Harkin, Dr. Fagan, Mackenzie, Kevin, Dunn, Johnston, James Moore, Stewart, J. W. Browne, McKeown.

Dr. Fagan exhibited a specimen of elephantiasis of the labia removed by him. The tumour was very large and had weighed about 30 lbs. Dr. Fagan also gave some particulars of the case.

Dr. Harkin thought that a cast ought to be taken of the tumour as its character would change much in keeping.

Dr. Johnson thought he had seen a tumour almost as large on the neck of a man under the care of Dr. Vesey in the Union Infirmary.

Dr. Moore wished to know if there was any coloured blood in the patient and thought that the tumour should be preserved in a museum.

The chairman (Dr. Whitla) considered that there was much risk throwing all the blood from so large a tumour into the general circulation as it would give too much work to the excretory organs.

Dr. Harkin then read a paper on rheumatism and its cure.

Paper:¹ I think it will be generally admitted that the subject of acute rheumatism, as far as its pathology, ætiology, and treatment are concerned, is still in a very unsettled condition, and that the position assigned to it in the nomenclature of disease is unstable and unsatisfactory. Our early nosologists, *Sauvage* and *Vogel*, gave it a place among the class *Dolores*; *Mason Good* in the class *Hæmatica*, order *Phlogotica*; *Cullen* among the *Pyrexia*, order *Phlegmasia*; *Dr. Farr* some forty years ago believing that acute rheumatism was due to a materies morbi introduced into the body, which, after an indefinite period, leavened the whole mass of the circulating fluid, included it in the list of zymotic diseases in the same category as *scarlatina*, *cholera*, and *erysipelas*; later on the *College of Physicians* classed it

¹ [Dublin Journal of Medical Science, 1881, v72, p296.]

with the constitutional diseases, along with Scrofula and Purpura.

Among our writers on systematic medicine, Sir Thomas Watson says that “rheumatism is a blood disease, that the circulating fluid carries with it a poisonous material, which, by virtue of some mutual or elective affinity, falls upon the fibrous tissues in particular, visiting and quitting them with a variableness that resembles caprice, but is ruled no doubt by definite laws to us as yet unknown;” while Ziemssen, taking into account no pathological relations or affinities whatever, simply from a regional point of view, established a class for itself, grouping with it gout, arthritis, rickets, and mollities ossium, under the heading of “Diseases of the Locomotive Organs.” The importance of a correct nosological and pathological definition of acute rheumatism cannot, in my mind, be overrated, as it is to a great extent on those bases that its ultimate cure must depend. Senator says “its treatment has varied with our theories concerning its pathology, since rational therapeutics (really or apparently in harmony with accepted views on pathology) were substituted for traditional empiricism.”¹ Further on Senator says in forcible language “that no remedy has up to the present time established its claim to universal favour—none has been discovered to possess undoubtedly specific virtues, to be capable of summarily arresting the disease under all circumstances.”

The statement of Fuller is as applicable to-day as when announced a quarter of a century ago—viz., “that each and every plan of treatment which has been hitherto proposed is regarded by the profession as unsatisfactory.” And according to Garrod, “further observation and experiment are required before we can arrive at any satisfactory conclusion with regard to its pathology.”²

Should the existence of this regrettable state of affairs be questioned, one has only to think of the heterogeneous list of remedies so opposite in their nature recommended for the cure of this painful disorder—acids and alkalis; mercury and mint water; venesection and quinine; hot blankets and the cold bath; the hypodermic injection of morphia into the joints and the blistering plan of Davies; subcutaneous injections of cold water and of carbolic acid; cotton wool and icebags to the swollen joints and spine; opium and atropia; tartar emetic and colchicum; aconite and veratrum viride; and, finally, the most fashionable and most disappointing of all—salicin, salicylic acid, and its compounds.

What is most strange is the fact that each of these remedies has for its sponsors most learned and able authorities who can point to apparent cures of this disease, although without being privileged to claim any great numerical advantage over others. We wonder indeed at the toleration of such diverse and heroic rem-

edies, and are reminded of the observations of Dr. Clutterbuck, who said that, “though ligamentous inflammation does not yield so readily as some other inflammations, it bears almost all kinds of treatment with impunity, and at last often subsides spontaneously, the disease seeming to wear itself out.”

Salicin and its compounds deserve more than a passing notice. After being experimented with in Germany, it was introduced to the profession in this country by Dr. Maclagan, of Dundee, who assured us that “it seems to arrest the course of the malady as effectually as quinine cures an ague or ipecacuanha a dysentery; that given sufficiently early and in sufficient doses it prevents cardiac complications, and that its free administration is the best means of staying their progress after they have occurred.” Now, were these promises fulfilled in practice, we might rest on our oars, having been thus provided with the true specific for this intractable disorder. But what does experience testify? Five years have now elapsed (March, 1876) since its advent was so loudly heralded, and what are the fruits? It is certainly entitled to the character of a most potent antipyretic, and, inasmuch, is capable of controlling one of the many distressing symptoms of rheumatic fever, but at what cost to the patient? In my own experience it has proved most deceptive and dangerous. Of salicylic acid and its salts, Senator says that in a considerable proportion of cases “they give rise to vertigo, headache, tinnitus aurium, and deafness, nausea, and vomiting after every dose; profuse sweating, great weakness, with a peculiar eruption on the skin; more rarely the symptoms assume a dangerous complexion, violent delirium, albuminuria, great prostration, with pallid skin and feeble pulse, ushering in fatal collapse, and these results have been observed after the administration of perfectly pure samples of the drug. He thinks highly of salicin, being fundamentally the same as salicylic acid, and that it does not give rise to any of the disagreeable or dangerous accidents common after the salicylic acid and the salicylates.” So far Senator. However, in *The British Medical Journal*, February 12th, 1881, Dr. Charteris, of Glasgow University, gives the result of his experience of 80 cases in which salicin was prescribed. He says—“In uncomplicated cardiac cases it will lower the temperature in forty-eight hours; if the temperature be not lowered in that time, in all probability the heart is affected, and in that case the medicine should be countermanded, for then it will in no way diminish the fever.” And Dr. Curnow, Assistant Physician to King’s College Hospital, in *The Lancet* of Nov. 18, 1876, gives the particulars of a case in which, after having given the salicin in large doses, so much as 800 grains in five days, prior to the appearance of the friction sound, “the result was the absence of any relief whatever, the supervention of a very acute pericarditis, the powerlessness of this remedy against the complication and the attendant fever, the appearance of the

¹ Ziemssen. Vol. XVI., p.59.

² Reynolds. Vol. II., p.904.

friction sound, a tedious recovery and prolonged convalescence.”

Moreover, in two very elaborate papers communicated to the Clinical Society of London by its President, and published in *The British Medical Journal*, 9th May, 1880, Dr. Headlam Greenhow states that in 10 cases of acute rheumatism in which he gave salicin alone, and in 50 cases in which salicylate of soda was administered, similar unhappy and perilous results were developed during their use, often requiring stimulants to restore the heart's action. His conclusion is “that these agents could not be regarded as in any respect specifics in the treatment of rheumatic fever. In all the most acute cases the relief derived from the medicine passed away soon after it was intermitted, and a relapse, sometimes several relapses, took place. Excluding mild cases and deaths, out of 32 remaining there were twenty-one relapses; in 7 one; in 9 two relapses; in 2 three relapses; in 2 four relapses; in 1 five relapses.” Dr. Headlam Greenhow says, in conclusion, “that the complications were not less frequent, the condition of the patient was worse after recovery, and the length of time the patient was disabled was longer than under other modes of treatment. Of those 37 cases they were on an average fifty-seven days in hospital” (forty-two being, as we all know, the normal period, even under the Nihilistic treatment). No stronger condemnation could possibly be pronounced against any vaunted remedy. He concludes that “the pain and distress of the patients were undoubtedly for a time greatly relieved; he feared that the marked weakening of the first sound of the heart present in many when salicylic acid was given indicated the exertion of an influence on the muscular structure which might not pass entirely away when the treatment was suspended. Its prolonged use was likely to prove injurious when the heart was affected.”

That salicin and its compounds act as powerful depressants of the heart's action no one will likely question after the above statements. Salicin never acts therapeutically until its physiological or rather its toxic influence is first induced. Indeed, if we examine closely into the modus operandi of this and the other remedies previously referred to, we shall find that the measure of their beneficial agency in the relief of individual symptoms of acute rheumatism is exactly the extent to which they operate directly or through the medium of the nervous system on the heart itself, thus arriving by different routes at the same goal, just as in olden times all roads were said to lead to Rome.

As my object, however, is purely practical, and not merely to dilate upon the insufficiency of accepted remedies, I shall proceed to relate a number of recent cases, as observed by myself and some of my professional brethren, in which by a simple remedy, and practically without the administration of any medicine, the cure effected in almost every case was at once

rapid, simple, and complete.

Case I.—Acute Rheumatism.—On 24th October, 1879, I visited Sub-constable H., R.I.C., aged thirty, married. He had a rigor three days previously, followed by pains, especially in the left knee and thigh, which were red and swollen.

25th.—Pains had extended to right knee, to both ankles and shoulders.

26th.—Left elbow also engaged; perspiration acid and profuse; urine scanty and loaded with urates.

27th.—State unchanged. Ordered an opiate at bedtime. He had been laid between blankets and his joints wrapped up in flannel and cotton wool.

28th.—Had not slept for a week; at 1 p.m. his temperature was 102°, pulse 108; no improvement; no cardiac affection observable; at that hour I applied a blister 4x3 inches over the region of the heart, ordering its removal in eight hours, and to be replaced by cotton wool.

29th (noon).—Found the patient completely relieved; countenance cheerful; pulse 90, temperature 98°; tongue clean; thirst diminished; perspiration gone; urine copious and clear, and from being on the previous day paralysed in every joint and quite helpless, he was able without pain to flex and extend every joint, and to sit up in bed with ease. He stated that he began to feel relief at 6 p.m. on the previous day, five hours after the application of the blister; that soon after he fell asleep for the first time for many days, and that having occasion to rise during the night he walked unaided across the room, and only remembered his rheumatism after returning to bed. On examining the joints every trace of redness had gone, and the swelling was scarcely perceptible; the joints could be grasped firmly without pain. He then stood up and walked across the floor without any undue effort.

29th and 30th.—Still improving; pulse 90, temperature 98°; swelling and pain absolutely gone from every joint; heart free.

Nov. 1.—Pulse 64, temperature normal; convalescence complete, and my visits ceased. A week after he walked to my residence on a frosty day without any injury, and he soon after returned to duty.

Case II.—Subacute Rheumatism.—On 16th December, 1879, I visited Mrs. B.; she had been confined fourteen days previously; child at nurse; had a shivering on 11th; next day both hands and the left shoulder became painful and swollen; pain increased at night; sleepless for five preceding nights. On examination I found both hands swollen and powerless; all the carpal, metacarpal, and carpo-phalangeal joints were implicated; perspiration profuse; urine scanty and high-coloured. This was her third attack, having been ill for thirteen and sixteen weeks in first and second attack. In this case I did not prescribe a particle of medicine, but applied a blister over the cardiac region.

Calling next day, I found the patient sitting up in bed.

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Despite the pain of the blister she had slept all night. The perspiration had left, *pari passu*, with the pain. The right hand had already regained its power, the fingers were quite free, and in three days after the left hand, which had been most swollen, was quite relieved. I paid her but two other visits, and on the last of which I was gratified to find her down stairs, nursing her baby and perfectly able to take charge of it. My friend, Dr. William Aicken, saw this patient once with me.

Case III.—Acute Rheumatism.—J. F. R., aged fourteen, tall and stout, had a rigor on 6th April, 1880, followed by pains in right and left knee and ankles. I visited him on 9th; found him lying on his back, unable to move from the swollen condition of his joints, his elbows especially. Pulse 88, temperature 101°; urine clear but scanty; perspiration plentiful.

10th.—Condition unchanged.

11th.—Still sleepless, although he had an opiate on previous night; urine now highly acid, with copious deposit; heart pulsating violently, with distinct systolic apex murmur. Dr. Whitla, who examined the patient this day, coincided in the diagnosis. In his presence I applied a blister, *regioni cordis*, to be retained for eight hours.

12th.—Found the patient sitting up and relieved; he had slept soundly all night after the removal of the blister, and had got up unaided to the night chair; urine again clear; pain and swelling reduced in all the joints, which he could flex without trouble. Pulse and temperature unchanged.

13th.—Still progressing; slept well; urine clear; sweating gone; found him again sitting up and anxious for removal into next room. Pulse 68, temperature 99°.

14th.—Temperature 98°, pulse 60.

16th.—Temperature normal, pulse 56; all traces of swelling gone, and convalescence complete; he had taken in all 10 grains of opium. Dr. Whitla watched the progress of this case with me. The pulse and temperature in this case fell so low that I had to order stimulants. Fourteen days after all trace of cardiac symptoms had departed.

Case IV.—Subacute Rheumatism.—Miss L. V., aged ten years, had a rigor on 17th April, 1880, followed by great muscular pains and general malaise, succeeded by urticaria; both ankles then became painful, red, and swollen, and also the right knee.

I saw her upon the 19th; she was then in bed, and unable to move from the severity of the pains; pulse 88, temperature 101°; urine scanty, clear, of acid reaction; bowels confined; perspiration very free; increased palpitation of heart and well-marked apex systolic murmur. Ordered a laxative.

19th.—Fever and thirst increased; had not slept. I applied a small blister over the region of the heart for four hours. The joints had been previously enveloped in cotton wool.

20th.—Pain and swelling of joints much less; had

slept well; perspiration diminished; urine muddy with pink deposit; tongue clean; soft murmur over apex. Pulse 86, temperature 100°.

21st.—Pains all gone; pulse 84, temperature 99°; slept well; appetite restored.

22nd.—Slight recrudescence of pain in right knee, which is stiff.

23rd.—Pain and swelling gone from knee; pulse 80, temperature normal; blister almost healed; much stronger.

24th.—Convalescent; to be removed to another room. The cardiac symptoms did not quite subside for a period of fourteen days.

Case V.—Acute Rheumatism.—I visited A. S., aged thirteen, on 6th November, 1880, and found her suffering from pains in every joint, this being her third attack of acute rheumatism.

She was an inmate of an industrial school, and attributed her illness to a long walk on 1st Nov., a very frosty day. She was removed to a newly-plastered infirmary, on account of overcrowding, where I found her along with L. G., the subject of the next case. Pulse 112, temperature 103°; her heart beating tumultuously, with systolic murmur at apex; 15 minims of *tr. opii* were given at bedtime.

7th.—Next day no improvement.

8th.—Before proceeding to treatment I requested my friend, Dr. Esler, to accompany me. Pulse was then 120, temperature 103°; face flushed, and she was crying loudly for something to cool her. I then applied a blister over the heart for six hours, to be dressed as usual with cotton wool.

9th.—Visited with Dr. Esler; our report was—pulse 118, temperature 102°; painful symptoms much abated; bruit softer; ankles free; shoulder better; can flex knee freely; she walked across the room and returned without difficulty; to-day friction to-and-fro sound first appeared; applied a blister over the sternum.

10th.—Pulse 96, temperature 99°; pain absent everywhere except on left hip; urine clear; slept well.

11th.—Pain of hip gone; pulse 100, temperature 102°; pericardiac trouble subsiding, as well as apex murmur.

12th.—Dr. Whitla joined Esler and myself; his report was—“No affection of any joint whatever, nor is there pain or tenderness anywhere except over the cardiac region; pulse 90, temperature 101.5°; a loud friction murmur over the entire area, masking a feeble endocardial murmur near to the left nipple.”

13th.—Pulse 86, temperature 99.5°; cardiac sounds still loud; no further articular troubles; further signs of effusion, with prominence of left side.

14th.—Area of dulness less; temperature 98°, pulse 72; friction sound less; bruit still perceptible; crepitation at base of lung and left axillary region. A mustard poultice to be applied.

15th.—Pulse 60, temperature 96°; countenance pale;

extremities cold. To have 2 oz. wine in the day and hot water bottles to feet.

16th.—Pulse 72, temperature 97°. 4 oz. wine.

17th.—Found her sitting up at lunch in bed.

18th.—Improved in every respect and proceeding to convalescence, when an inexperienced nurse stripped her at the fireside, exposed her to the cold air of the room, and splashed her over with tepid water, when she immediately took a shivering, and all the cardiac symptoms returned with violence. A fresh blister, however, and a week's rest in bed served to restore her health, and before the end of the month of November she was quite well and free of all cardiac and articular trouble.

Case VI.—Acute Rheumatism.—L. G., aged fourteen; first attack; resembled case No. V. so much that it need not be pursued from day to day. She was exposed to the same chill while walking on 1st November, lay down about the same time, had the same cardiac ailments, and about the same time recovered her strength. She was then maltreated in the same way by exposure and bathing in the newly-plastered room, took a rigor again, was again attacked by the cardiac affection, but was not so fortunate as S., for after getting over all acute symptoms there still remains a persistent murmur at the apex of the heart. My friends, Drs. Esler and Whitla, saw this child along with S., she being in the next bed and same room. She was up and going about on 4th December.

Case VII.—Subacute Rheumatism.—On Nov. 25, 1880, I was called to a religieuse, Sister M., in her convent.

She was anæmic and of hysterical and nervous temperament. She had sore throat, insomnia, general muscular pains, and profuse perspiration. I prescribed for those symptoms, but on 1st December they became more pronounced; pain and swelling of the joints of the upper and lower extremity and acute pain in the præcordial region, increased by respiration, now appeared.

2nd and 3rd Dec.—Was much worse; in addition severe headache, flushed eyes and countenance ensued, and sleeplessness continued. Pulse 98, temperature 100°. I then applied a blister over the heart for six hours.

4th.—Found the patient cheerful and smiling, with clear eyes, face pale as in health, headache quite gone, perspiration had ceased, and all the joints were free from pain and swelling and capable of motion; she could turn in bed without assistance, and had slept soundly; pulse 72, temperature normal; kidney secretion plentiful and clear.

5th.—Improvement proceeding; appetite restored; she rose in three days after, and on 10th December removed into another room, and my visits ceased.

Case VIII.—Subacute Rheumatism.—Sister M. A., in the same convent, while out on visitation on 6th March, 1881, felt fatigued; had a shivering next day, followed

by sore throat, general fever, and muscular pains. On 11th her left knee became red, swollen, and painful; then the right knee and elbow, then right ankle and both wrists became engaged. At this time the heart's action became irregular, with frequent intermissions, and an acute pain was complained of in the interspace between the fifth and sixth ribs, left side. Perspiration very free.

19th and 20th.—Symptoms more pronounced, and on 21st I applied a blister at 3 p.m. over the heart, the temperature being 100° and pulse 84. Next day she declared herself quite well; had found relief at 3 a.m., twelve hours after the application of the blister; she could now flex and extend all her joints freely; swelling and pain almost gone; perspiration much less; kidneys acting freely. Pulse 72, temperature normal.

24th.—Improvement continued; sleep and appetite had returned; was able to rise, and complained of nothing except five or six spots of erythema nodosum, the size of a penny, that had appeared on her limbs; they were very troublesome, but yielded at last to free doses of fluid magnesia.

The next five cases are kindly contributed by my friend, Dr. J. Walton Brown, Royal Hospital, Belfast.

Case IX.—Subacute Rheumatism.—Miss C. B., aged twenty-four, ill since 10th February, 1880, was seen by me on 16th; she took ill with a sore throat and general pains, especially in her knee-joints; she perspired freely on 12th and felt better; her hands and wrists now became swollen and painful, so as to prevent sleep; the pains continued in all the joints, and she became quite helpless. When I visited her both hands and wrists were much swollen, and she could not bear the slightest pressure; had pain in the præcordial region, with slight mitral murmur; pulse 120, temperature 103°; evidently suffering from acute rheumatism. I prescribed no medicine, but following out the treatment suggested to me by my friend, Dr. Harkin, I applied an emplastrum lyttæ, 3x3 inches, over the heart for twelve hours. On my next visit sixteen hours after the application of the blister, I found all pain gone from the hands except when she moved them, and from the other joints; all swelling had entirely subsided; the pulse had fallen to 88 and temperature to 99°. Next day I put her upon a mixture of potass, bicarb. and tr. opii. She was then able to leave her room, and upon 26th February she left for the country. Certainly the effect of the blister in this case was marvellous, the pains ceasing, pulse and temperature coming down, and all swelling subsiding in sixteen hours after the application of the blister.

Case X.—Subacute Rheumatism.—Miss A., from the West of Ireland, was seen on 14th February, 1881. She complained of weak vision and general debility, and was very anæmic. I did not visit her again till 19th March, when I found her labouring under an attack of

subacute rheumatism. The pulse numbered 90 and temperature 99.4°. The wrists, knee, and ankle-joints were very tender to the touch. Ordered a blister, 2x2 inches, to be applied for twelve hours over the cardiac region and cotton wool around the joints; milk diet. Called two days afterwards, and was surprised to find my patient sitting up and all pains gone. She felt very weak, but under treatment was quite well upon 1st April.

Case XI.—Subacute Rheumatism.—Miss M. S., aged four years, was seen by me upon 6th March, 1881. She was suffering from an inflamed throat, with glandular enlargement in the neck. I prescribed the routine treatment, and did not see her again till 11th March. When I visited her I found her ill with acute rheumatism; the wrist and knee-joints were swollen and tender; pulse 120; skin perspiring; she had not slept on previous night on account of the excessive pain. The temperature was not taken.

Applied a blister, 2x2 inches, over the cardiac region, to remain for ten hours; cotton wool to the joints affected. No abnormal cardiac sound could be heard. Next day (12th March) all pain gone from the wrist and knee-joints. The child had slept some hours after the blister was taken off; the pulse was down, the expression of the face calm, and the patient seemed quite easy. On 18th I ordered her an alkaline mixture. On 14th she was out of bed, and in a few days was running about.

Case XII.—Master M. S., aged five years, brother to previous patient, was visited by me on 26th March, 1881. He was suffering from swelling of wrist and knee-joints; pulse 120; thirst excessive; throat congested, and had not slept for two days. His mother knowing the value of the blister in the former case had thought of applying one, but before doing so consulted me. I ordered a blister, 3x8 inches, to be applied for twelve hours over the cardiac region and cotton wool over the inflamed joints.

27th March.—Patient was seen by Dr. Harkin along with me; all tenderness of the joints gone, but some puffing still remained over the wrist-joints; pulse 120. The little patient complained of headache, and the pupils were dilated; he had also on the anterior surface of his abdomen and legs a number of spots very much resembling those of purpura. Ordered him some bromide with the bicarbonate of potassium, also counter-irritation to the nape of the neck.

29th.—All pain and swelling of the joints gone; can move hands and legs freely; pulse 100; taking food; still has an inflamed throat, for which I prescribed.

3rd April.—Patient quite well, with the exception of being a little weak and anæmic.

Case XIII.—D. C., aged twenty-two, was admitted into the Royal Hospital on the 1st March, 1881, suffering from a lacerated wound of little finger of left hand, followed by an attack of diffuse cellulitis of forearm and

arm. After free incisions he became convalescent at the end of three weeks. He had been up but one day when he began to expectorate bloody mucus, and complained of sore throat.

His pharynx was found congested and œdematous; this continued for three days, when his temperature suddenly rose to 102° and pulse to 120. He also complained of pain in the left ankle-joint. Cotton wool was ordered and milk diet.

Next day left knee and elbow-joints were involved; temperature 103.4°, pulse 120. Great pain and acid perspirations were complained of. Dr. Harkin this day visited the patient by request. Upon examination of the heart a mitral whiff was detected.

Emplastrum lyttæ, 3x3 inches, was now applied over the cardiac region for ten hours. Upon its removal the patient declared himself almost free from pain, although the joints were still swollen. The temperature, which, on the application of the blister, stood at 103.4°, gradually came down to 99° in forty-eight hours. The patient made a rapid recovery, and left hospital three weeks from the commencement of the rheumatic attack.

Perhaps the most striking fact in the history of these thirteen cases is the rapidity of the cure and the uniform appearance of delitescence within a few hours after the application of the blister, varied somewhat by the difference in the ages of the patients, their constitutional peculiarities, and other circumstances. In the majority anæmia was present; in six the disease was preceded by an attack of tonsillitis; one had urticaria; another had erythema nodosum as an accompaniment. There is a sort of order observed in the disappearance of the symptoms—the pain in the joints and insomnia are the first to disappear, then swelling and redness and stiffness of the limbs, then perspiration, muddy urine, and rapid pulse, then, among the last, generally about forty-eight hours after the application of the blister, the temperature becomes normal, about the period at which hyperpyrexia yields to powerful doses of salicin.

I have also observed in a few cases an attempt at recrudescence upon the third day, which dies out in twenty-four hours. The immediate removal of the arthritic symptoms leaves us face to face with the cardiac ailments should they assume a troublesome development, to be treated in the ordinary way. It will be observed that there was not any relapse in the correct sense of the word.

In the cases of S. and G., which required my after-attention, there was not a relapse, but a reproduction of the disease by a similar cause as at first—viz., by undue exposure to cold and moisture after almost complete convalescence. According to Latham, “perfect cure does not contemplate that after their removal diseases shall never return; but it does contemplate that before they can begin to return, their actuating cause will have to

begin also.”¹

Having, then, given in detail a record of facts and phenomena, as observed by myself and professional friends, exhibited in thirteen consecutive cases of acute and subacute rheumatism, the question arises—Were these unprecedented results due to fortuitous circumstances, to accidental combinations, or to peculiar constitutional conditions of the respective patients? Or does the unvarying effect of this simple remedy indicate the existence of a hitherto unknown law that dominates and controls the manifestation, course, and termination of this disease? I cannot doubt that an invariable sequence of phenomena must have a common cause, that in the case of acute rheumatism those phenomena spring up from a seminal principle to which all our efforts should be directed; and if it be true that scientific therapeutics often elucidate the nature of disease, then the unailing effect of this simple remedy goes far to prove that the fons et origo of this malady is to be found in the heart itself.

Cullen, in the preface to his “Nosology,” page 16, says—“Remedies cure diseases only in so far as they remove their proximate causes.” If, then, Cullen’s dictum be accepted, and if a blister over the region of the heart cures the disease, and even its articular complications, it surely would not be unsafe to infer that the proximate cause itself is located in the same region—the heart.

According to Dr. Peter Latham, “the treatment of diseases is, in fact, a part of their pathology. What they need and what they can bear, the kind and strength of the remedy, and the changes which follow its application, are among the surest tests of their nature and tendency.”²

I regard acute rheumatism as essentially a cardiac disease, as a specific form of endocarditis, generally allied with myocarditis, which, if not recognised and treated at its onset, speedily modifies the composition of the blood, the innervation and calorification of the body. In its ordinary course it soon gives rise to lesions in the textures, frequently in the pericardium, the pleura, the lungs, muscles, membranes of the brain, the neurilemma, and, in fact, in any organ accessible to arterial and nervous influence. I believe with Cullen, although in a wider sense, that its cause is external and in general known, in opposition to the believers in the humoral pathology, who attribute its origin to a materies morbi, or ζύμη in the blood. I look upon rheumatic fever as an inflammatory disease of local origin, and I agree with Dr. Pollock, “that the tendency of modern thought is to believe less in constitutional and more in local disorders, and to trace every systemic disturbance to some tangible part of the body.”³

The clinical history of endocarditis is both interesting

and instructive. In the early part of this century many English physicians had recognised the intimate relation that subsisted between acute rheumatism and cardiac disease. Dr. Peter Latham was the first to discover the coexistence of abnormal murmur in every case of heart disease arising in rheumatism, but did not recognise its special meaning. Drs. Stokes and Watson further advanced our knowledge by separating the bellows from the friction sound, and by determining the relative value and meaning of each. In 1840, Bouillaud proved by post mortem examination that all those dying with bellows sound died of endocarditis, and he regarded the so-called cardiac complications as the [?] features of the disease; he taught that one-half, other authorities taught that one-third, of the sufferers from acute rheumatism were also affected with endocarditis; but these calculations do not affect the question, as many observers, mistaking the product of inflammation for the symptoms, only recognise those as true cases of endocarditis in which they can detect by the ear the changes worked in the valves and lining membrane of the heart by acute disease. More accurate observers recognise the advent of cardiac inflammation by signs which often precede the endocardial murmur, such as tumultuous action of the heart, a certain length and roughness of the sounds, and other pathognomonic symptoms. Further, Pfeuffer and Hueter, quoted by Senator,¹ look upon cardiac disease as the primary change and the articular disorder as the consequence, the latter stating that “endocarditis may be present without giving rise to either subjective or objective symptoms;” he also suggests “that it may very well precede the inflammation of the joints, even although not recognised till afterwards,” and says “that its presence must be assumed in those cases which appear to run their course without any cardiac complication.” Dr. Stokes, in his work on “Diseases of the Heart and Aorta,” states, “that cardiac inflammation may be developed unattended by any evidence of valvular lesion, and that he has seen cases that could not be explained on any hypothesis except that of the absence of murmur in endocarditis” (page 103). We may then fairly conclude that while the presence of endocardial murmur, along with the other physical signs, will satisfy the most sceptical, its absence does not negative the existence of organic disease. This also explains the difficulty started by Aitken (Vol. I., p. 814), “why the rheumatic inflammation of the joints is frequently preceded by febrile disturbance, and also why sometimes the fever runs so high before any local symptoms have established themselves.”

While, therefore, the cardiac origin of acute rheumatism commends itself strongly to our acceptance, there may be in addition what has been called an overruling neurosis, and doubtless where we have so

¹ Clinical Lectures. Vol. II., p. 417.

² Author’s Preface. P. 38.

³ Harveian Lectures. British Medical Journal. Feb. 5, 1881.

¹ Ziemssen’s Cyclopædia. Vol. XXI., p. 22.

much pain of a flitting character the nervous system must be deeply implicated, but it is difficult to determine whether the neurotic symptoms precede or follow the local phlegmasiæ. The rising school of modern neuro-pathologists, some of whom look upon gout as principally a neuropathy, might tell us that the initiative chill which ushers in the rheumatic attack sets up peripheral irritation, and that the cardiac and articular affections are the result of a disturbance of innervation. Indeed, the experience of late years, which has demonstrated the dependence of certain joint affections (arthritis deformans) upon chronic inflammatory changes in the spinal cord, might justify the idea of an irritation of nervous centres being suddenly propagated to the central origin of nerve supply to distant organs, so as by this means to stir up disease and pain. The special action of nerve influence upon joints has engaged the attention of eminent men, such as Charcot, Ball, Ord, and Buzzard.

The last writer starts the hypothesis that these neuropathic osseous lesions may depend on an invasion of a part of the medulla oblongata closely adjacent to the roots of the vagi. "Is there something," he says, "which we may call provisionally a trophic centre for the osseous and articular system in the immediate neighbourhood of the roots of the vagi? The discovery of such a centre would materially help us to explain the remarkable association of cardiac complications with the joint affections of acute rheumatism, as well as the sweating character of the disease and the occasional hyperpyrexia which occurs in it" Should the pathogeny of rheumatic fever and of gout on further inquiry be found to be identical, it may also be discovered that, owning a common origin, they may also prove to be amenable to similar cure.

As opposed to the theory of the local origin of acute rheumatism, there are two hypotheses which divide the suffrages of the profession—viz., that of a materies morbi poisoning the blood and being the cause of fibrinous deposits on the lining membrane and valves, and of the exudations into the pericardium and joints, and the other based on a chemical idea that the dyscrasis is owing to the presence of lactic acid in the blood, supposed to be generated by some faulty metamorphosis, and although intangible, yet existing—its presence being manifested by pain, and acidity in the sweat and urine. The first of these hypotheses is supposed by such authorities as Holland and Fuller to be demonstrated by the alteration in the composition of the blood, the increase of fibrin, the constancy of premonitory fever, and the frequent occurrence of metastasis—the heart and great vessels being in their view the passive depositories of fibrinous growths. Basham, Garrod, and Fuller incline to the opinion that some morbid matter is generated within the blood, or is not eliminated, and it was with the intent of destroying this virus that the eliminating treatment of Drs. Dechelly and Davies was

introduced. It is remarkable, however, that according to Senator the plan failed to render the urine alkaline, and that if any poison were thereby removed from the system it was not an acid, as the serum produced by vesication was invariably alkaline. This observation replies by anticipation to the assertion that the disease has its origin in an acid state of the blood, as advanced by Dr. Prout. With the intention, then, of destroying the lactic acid assumed to be present many practitioners prescribe alkalies in large quantities. If relief is experienced the argument takes this shape, that as alkalies are in their nature antacid, there must have existed in the circulation of the patient a sensible amount of acid. The fact too of the urine becoming alkaline sometimes during their use gives further countenance to the assumption. The admitted fact, however, that neither uric nor lactic acid has ever yet been discovered in the blood of the rheumatic patient, though plentiful in that of the gouty, should settle this question in the negative.

The lactic acid hypothesis has been recalled to revived consideration by a paper published in *The British Medical Journal* by Balthazar Foster, in December, 1871. Under the heading of "The Synthesis of Acute Rheumatism," he publishes two cases bearing upon the point, and expresses the opinion that "these facts will strengthen the evidence which points to lactic acid as the poison of rheumatic fever." The observations arose incidentally from an inquiry into the effects of certain drugs (among the rest lactic acid) on the sugar excretion in diabetes. It is not my intention to question the correctness of the facts adduced by so accurate an observer. The results are quite consonant with the recognised effects of lactic acid. I must, however, take exception to the conclusions deduced from them, and beg to offer a solution more in accordance with the true clinical significance of the published signs and symptoms.

In the first case, Wright, suffering from diabetes, who had never suffered from rheumatism, is fed on a strictly animal diet, nitrogenous—a diet which in healthy persons predisposes to a certain blood disease, not rheumatic however. Consequent upon the internal administration of the lactic acid, he had six attacks of articular pains fairly attributable to that agent; but, when we come from synthesis to analysis we find that when in place of describing "acute pains in the joints and flying pains about his limbs," as the result of the dose, B. Foster particularises the joints affected.

He says—"The small joints of the fingers of both hands, the wrists, and in a less degree the elbows had become red, swollen, and painful. Moderate perspiration and heart clear. Second attack.—Metacarpo-phalangeal and first phalangeal articulations of the first and second fingers of each hand were red, hot, swollen, and painful. Less pain in the knuckles in the evening. On the evening of April 5th and 6th, after taking the medicine, the pains returned to the knuckles and left

wrist. April 13th—Right wrist. June—Two attacks in hand and wrists. July 8th—Wrists and elbows. July 11th—Right and left wrist and knuckles of right hand; left knee red and swollen.”

In the second case only one attack occurred, and the evidence derived from this case is little worth, since the only joint swollen was the right knee, which was faintly red. How unlike an attack of acute rheumatism, in which we look for a rigor, swelling and pain in the large articulations, excessive sweating, muddy urine, and heart affections. Does it not closely realise our conception of gout, which selects the smaller joints, the fingers, wrists, and knuckles, for its habitat, and what more efficient way could we propose to induce an attack of gout than by introducing into the system lactic acid, generally recognised as the potent factor of the disease, and always present in the blood of the gouty patient? We cannot in this inquiry overlook the fact of the intimate connexion that exists between gout and glycosuria. Garrod states that gout and diabetes occasionally occur in the same individual, and Dr. Dyce Duckworth, in a very suggestive paper which appeared in *The British Medical Journal*, March 26th, 1881, refers to the remarkable relation which exists between gout and glycosuria. “Diabetes mellitus,” he says, “is met with in certain members of gouty families, some having gout alternating with glycosuria, the glucose alternates with uric acid.” Thus it would appear that Dr. Foster’s cases are instances of glycosuria and gout appearing in the same individuals, and one can understand how lactic acid, whether pure or altered in its passage to the blood, would react upon the sugar or glucose in the system, and speedily change the saccharine to the acetous fermentation. Had Foster thought of testing the nature of the disease by a blister, the absence or the presence of lactic acid in the serum effused would have aided in the diagnosis.

But more cogent, in my mind, than critical commentary, more conclusive than any inductive or deductive process of reasoning, more fatal to the hypothesis that acute rheumatism is a disease of zymotic or of constitutional origin, is the fact I have demonstrated that it may be speedily and effectually cured by a topical external remedy, by one which could not possibly modify a diseased condition of the blood or neutralise an acid poison permeating the system.

In presenting these cases and this novel plan of cure, knowing how prone human nature is to self-deception, I have carefully guarded against the personal element by inviting the presence and co-operation of medical men of ability and scientific acquirements and independent judgment. I shall conclude this paper by expressing the hope that this simple plan will commend itself to the consideration of the profession at large, as, while aiming at a truer and simpler pathology, at one fell stroke it puts an end to the pains and perils of polyarthritis, and saves the helpless invalid

from the horrors of meddling polypharmacy.

The President Dr. J. W. Browne came in at 9.5 p.m. and took the chair, Dr. Whitla vacating.

The discussion of Dr. Harkin’s paper was postponed to the next meeting.

J. Walton Browne

Eleventh Meeting of the Society was held upon Tuesday April 26th 1881 in the Royal Hospital.

Present, Dr. J. W. Browne President, Professor Dill, Drs. Harkin, Wales snr., Speer, Dempsey, Esler, Wadsworth, Stewart, F. Wales, Whitla. Drs. McFarland and Byers were visitors introduced by the President. Several students were present.

Dr. Harkin then gave a short resume of his paper upon acute rheumatism in which he advocated the use of a blister over the cardiac region.

The debate following was freely entered into [by] the members present.

J. Walton Browne M.D.

The Twelfth Meeting of the Society was held upon Tuesday May 17th 1881.

Present, Dr. J. W. Browne President, Professor Gordon, Drs. O’Neill, Whitla and Workman and Wadsworth, Esler.

Dr. Gordon read a paper and exhibited some beautiful and interesting specimens of extra-capsular fracture of neck of femur.¹

Paper (cont.):² Second Form.—In the form which I have described as the first, the line of fracture in front may be through the anterior intertrochanteric line, or it may include a large portion of the anterior surface of the upper part of the shaft extending almost to its outer surface. Now in this, the second form, the line of fracture in front is along the inner margin of the anterior intertrochanteric line; above and behind it is at the point of reflection of the compact tissue of the base of the neck, where it changes its direction to form the apex of the trochanter and the posterior intertrochanteric line, above or below the lesser trochanter. Its course is, therefore, more limited to the base of the neck than the first form. From the direction of the force which is applied to the fore and upper part of the head, the base of the neck in front penetrates behind the compact tissue forming the upper part of the shaft; and, as the line of fracture behind is at the junction of the base of the neck with the posterior intertrochanteric line, it follows that the entire base of the neck penetrates the trochanter, and, in consequence of this mode of penetration, the trochanteric fragment is much greater than in any of the other forms. I have applied to this the term penetration en masse. In many instances nearly the

¹ [Part two of a two-part lecture. Part one was given on 8 March 1881 (see page 1413).]

² [*Dublin Journal of Medical Science*, 1881, v72, p3.]

whole of the trochanter is separated from the shaft above. Behind it extends almost, in some instances, to the outer surface of the shaft and below, including the lesser trochanter and part of the shaft below and behind it all in one fragment. In one of the specimens before me at present the depth of the trochanteric fragment is four inches, and its breadth two inches. The angle formed between the neck and the shaft varies but little; it is often a right angle, or sometimes more or even less than a right angle. As the base of the neck is directed more or less backward, there is very little eversion of the limb. Sometimes there is well-marked inversion, and occasionally neither eversion nor inversion. Owing to the depth to which the base has penetrated, there is well-marked shortening of the limb, and a manual examination of the upper end of the shaft renders the diagnosis usually very easy—the great increase in the antero-posterior diameter, from the flattening of the great trochanter, and the great size of the trochanteric fragment, and also often a well-marked trochanteric groove. As nearly the whole of the apex of the trochanter is broken off and carried backwards, measurement of the outer surface of the femur shows a shortening in many instances equal to the depth of the trochanter, or more than an inch. Passing the finger along the outer bifurcation of the *linea aspera* detects at once the prominence of the fragment, contrasting remarkably with the opposite femur. If there is not much swelling, and the limb slightly everted, we may be able to feel the prominence of the anterior intertrochanteric line, which in recent cases would be very painful on pressure. I think that in this case the moment the fracture occurs, instead of the pelvis gravitating backwards as in the first form, it falls forwards; or, in other words, the patient will be found immediately after the accident lying on his back, with the toes remarkably turned out, in the first form, while in this, the second form, the patient will be found prone, with the limb scarcely at all everted or inverted. It is this form which some authors have described as non-impacted extra-capsular fracture—that is to say, where the base of the neck rests upon the large flattened trochanteric fragment and the upper end of the shaft, where penetration has been carried to such an extent that impaction no longer exists.

I have several specimens of the extra-capsular non-impacted fracture. They all occurred in persons of extreme old age, in which there was great fragility of the bone, from senile atrophy, and the force which caused the accident was not of extreme violence, but was by simply falling and alighting on the trochanter.

Treatment.—The treatment of this form is the same as that of the first. Indeed, when I compare two well-marked specimens, I find, in the first form, if the force had been continued it would have placed the base of the neck upon the front of the shaft, with the trochanteric fragment attached to the shaft, whereas, in the second form, the base of the neck would have gone behind the

shaft, with the neck attached to the trochanteric fragment. As regards the impaction of bone, I may here remark that I have never seen any bone whatever, no matter how deeply the fragments were driven into each other, held firmly together. If I take an axe and drive it into a piece of wood, the resiliency of the wood will hold it firmly impacted, but in bone it is the fibrous tissue and not the osseous tissue that holds the fragments firmly together, for if we remove the fibrous tissue the osseous fragments will drop apart from each other.

Third Form.—The basis upon which I found the third form is the deep penetration of the trochanter above and behind, the result of which is a great increase of the angle between the shaft and the neck.

I have only two specimens of this form, and the propriety of considering them as a third form might be questioned, as the mode of penetration above is not exactly the same in each. In one the penetration is deeper above and behind, breaking off a comparatively small part of the upper and posterior part of the trochanter. The increase of the angle is very decided, and the shortening was so slight that it could not be detected by measurement. In other respects it resembles the first form in which the head is carried backwards, the base of the neck forming a salient angle in front.

Diagnosis.—The diagnosis could have been easily made out by the prominence of the base of the neck in front, the increase of the antero-posterior diameter being confined to the apex of the trochanter, without shortening of the limb. In the second specimen the base of the neck has penetrated deeply above, fissuring the trochanter, whilst below it is started forwards, slightly overlapping the shaft in front of the lesser trochanter. The angle is very obtuse. A similar specimen is figured by Mr. (afterwards Sir) Charles Bell in his work on "Fractures of the Thigh Bone."

Fourth Form.—In the fourth form, as in some specimens of the other three varieties, the fracture follows the base of the neck as described by anatomists. The penetration, although slight, is most marked between the lesser trochanter and the anterior internal ridge of the shaft. The compact tissue being thick and strong here, the base of the neck entering as a wedge splits the shaft. In one instance the fracture passes downwards to four inches below the base of the trochanter, in the other it is eight inches in length. In one of these the trochanter is simply fissured above. The patient from whom this specimen was obtained was under my own care in hospital. On making my usual visit I inquired from the house-surgeon the nature of the case. He replied it was a very oblique fracture of the upper third of the femur. On the fourth day afterwards the patient was attacked with traumatic delirium, and as he had displaced the long splint which had been applied, I saw and felt on the outer surface of the thigh four inches below the lesser trochanter the lower end of the upper fragment sharp, thin, and prominent. There was no

shortening or eversion of the limb.

He died on the seventh day. The femur was removed after death, and when given to me by the house-surgeon I thought it was a very oblique fracture proceeding from the base of the neck below, running down across the rough ridge from the attachment of the gluteus maximus. After that it coursed round the outer surface of the femur, and ran up to the capsule at the middle of the base of the neck. On removing the capsule and soft textures I found that the base of the neck moved upon the trochanter, and that this really oblique fracture was caused by the base of the neck penetrating the shaft opposite the lesser trochanter. Had this patient escaped traumatic delirium, there would have been no evidence whatever that he had sustained an extra-capsular fracture. There would have been no eversion, inversion, or shortening of the limb; there would have been no fracture of the trochanter capable of detection. The attachment of the gluteus maximus behind to the linea aspera prevented shortening. In front the upper end of the shaft was firmly attached to and fixed by the capsule. In no part was the penetration greater than half a line.

The second specimen was presented to me by a former pupil of mine, Dr. Chambers. In it the portion of the shaft attached to the trochanter is eight inches in length. It was even sharper and thinner than the first specimen. The amount of penetration of the base of the neck, however, was much greater, but in neither of the two instances was the trochanter broken in the usual way in these fractures. Indeed, in both specimens it may be said to consist of head and neck one fragment, the greater and lesser trochanter to the upper and outer surface of the shaft form the second fragment, whilst the remainder of the shaft forms the third fragment.

Now, this form is exceptional in several respects:— (1) The trochanter will be felt to be normal. (2) There will be no shortening, (3) inversion, (4) or eversion. The obliquity and thinness of the fragment, which is split from the upper and outer part of the shaft of the femur, would be sufficiently diagnostic, and I could hardly conceive any other force excepting the base of the neck forming such an oblique and thin fragment. (5) It is also exceptional in its treatment, as it would require the use of the long splint to hold the split fragments together.

Fifth Form.—In the fifth form the fracture of the base is the usual one, but it acts on the neck by running obliquely upwards towards the head, splitting the neck into two unequal parts. The diameter of the neck being thus diminished, that portion of the neck attached to the head penetrates deeply, and reaches in the two specimens which I have to the inner surface of the upper end of the shaft. Indeed, I have several specimens in which large portions of the neck have been broken off and have disappeared, leaving merely the portion of the neck which was attached to the head. The trochanter is

also fissured, but not widened so much as to enable us to detect any lesion of it.

Diagnosis.—In the diagnosis the signs would be regarded as indicating an intra- rather than an extra-capsular fracture.

J. Walton Browne

Thirteenth Meeting of the Society was held upon Tuesday June 28th 1881 in the Belfast Royal Hospital.

Present, Dr. J. W. Browne in the chair, Professor Dill, Drs. Aickin, Fagan, Esler, Smith jnr., and Whitla and Dr. Wales snr.

Dr. Whitla proposed Dr. W. MacCormac and Dr. J. W. Moore, the former of London, the latter of Dublin, as honorary members of the Society to be balloted for next annual meeting.

Dr. J. W. Browne, Professor Dill and Mr. Fagan seconded the nomination of each candidate.

Dr. McKeown whose name was on the paper could not attend.

Dr. Fagan read an interesting paper upon the treatment of hernia.

Dr. J. W. Browne the President exhibited a child upon whom he operated for cicatrix.

J. Walton Browne M.D. President

Annual Meeting Session 1880–1881 July 5th 1881.

Present, J. W. Browne President in the chair, Professor Dill Ex-President, Drs. Harkin, Wheeler, Wales, O'Malley, Dempsey, O'Neill, Kevin, Smith (house surgeon), Speer, Wadsworth, Graham.

The Honorary Secretary read the report of Council which was adopted.

COUNCIL REPORT

The Council reported "that the Session which has just terminated has been upon the whole most satisfactory. The large number of thirteen meetings took place, and were well attended. This number is in excess of that of the past ten years (with one exception); but the matter which the Council feel most reason to congratulate themselves upon is the nature of the papers submitted during the past Session. About twenty were read at the different meetings, and they mention especially the two able and original monographs of Professor Gordon on Extra-Capsular Fracture of the Neck of the Femur, and one on Intra-Capsular, which may be said to have thrown entirely new light on this hitherto obscure part of the field of surgery. Three very learned papers were read by Dr. Anderson on the Embryology, Homology, and Morphology of the Tongue Muscles, and an original and exhaustive paper by Dr. Harkin on Acute Rheumatism.

The Session will be memorable from the attempt made by the Society to lead to reform in some of the medical charity abuses of Belfast A Committee was

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President John Walton Browne

appointed (after the question had been ably introduced by Dr. Esler) to report upon the matter, and the following were the members of committee : Drs. Browne, Harkin, Fagan, Esler, Jn. Moore, McKeown, Wadsworth, Core, and Whitla, and they drew up a clear and practical report, which has been already placed in the hands of the members.

Many interesting specimens were laid before the Society, and several patients exhibited.

Seven new members were added to the ranks, and we have again the happy memory of being without an obituary column. The transactions of the previous Session have been printed and circulated in a handsome volume of 130 pages, which forms a record of the work done by the Society, and which contrasts favourably with that of past years.

The Treasurer reported a balance in hand of £57 10a 7d. His report was adopted.

Present, Dr. Harkin in the chair, Dr. J. W. Browne, John Moore, Dempsey, Mackenzie, Smith (Royal Hospital), and the Secretary.

Proposed and seconded and passed unanimously that the recommendations of the Council to entertain Sir William MacCormac to the Annual Dinner upon Monday October 3rd 1881 was adopted. Time fixed 7:30 p.m.

It was agreed to have the dinner in the Imperial Hotel and the guests recommended by the Council were agreed to, and the Secretary was instructed to ask them as Society guests.

To The Ulster Medical Society in payment to the Treasurer (Dr. Esler) Co.

1880	To Balance b/d	£ 50 10 11	1880	To Balance b/d	£ 50 10 11
	To Dr. Esler	12 10 0		To Dr. Esler	12 10 0
	To Hospital	1 10 0		To Hospital	1 10 0
	To Dr. J. W. Moore	2 10 0		To Dr. J. W. Moore	2 10 0
	To Dr. Harkin	7 10 0		To Dr. Harkin	7 10 0
	To Dr. Fagan	4 10 0		To Dr. Fagan	4 10 0
	To Dr. Esler	9 8 0		To Dr. Esler	9 8 0
	To Dr. Wadsworth	2 10 0		To Dr. Wadsworth	2 10 0
	To Dr. Beck	1 10 0		To Dr. Beck	1 10 0
	To Dr. Clement	1 0 0		To Dr. Clement	1 0 0
	To Dr. Johnson	1 10 0		To Dr. Johnson	1 10 0
	To Dr. McConnell	1 0 0		To Dr. McConnell	1 0 0
	To Dr. Dill	1 8 0		To Dr. Dill	1 8 0
	To Dr. Whitla	2 10 0		To Dr. Whitla	2 10 0
	To Dr. Esler	4 8 0		To Dr. Esler	4 8 0
	To Dr. Esler	38 6 4		To Dr. Esler	38 6 4
	To Dr. Esler	17 10 0		To Dr. Esler	17 10 0
	To Dr. Esler	£ 57 10 7		To Dr. Esler	£ 57 10 7

*Examined found correct
John Lewis
Auditor
W. J. Browne*

Professor Cuming was elected President.

Drs. Fagan and McKeown were elected Vice-Presidents;

And the following gentleman were elected members of Council: Dr. Wadsworth, Dr. Beck jnr, Dr. Clement, Dr. Johnson (David), Dr. McConnell, Dr. Dill. Drs. Whitla and Esler were unanimously elected Secretary and Treasurer.

A vote of thanks was carried to Drs. Core and Workman for their services as Librarians. Dr. Dempsey was elected Librarian. Dr. Wales, Smith (house surgeon), Core and Speer were elected Library committee. Drs. O'Neill and McKenzie were appointed auditors. Dr. Workman was appointed Pathological Secretary.

Dr. J. W. Moore, Dublin, [and] Dr. William MacCormac, London, were unanimously elected Honorary members.

James Cuming M.D.

Special Meeting Session 1880-81.

ULSTER MEDICAL SOCIETY

SESSION 1881–82

**Session 1881–1882 President Professor Cuming
The Opening Meeting of the Session was held upon
Tuesday evening 8th November 1881.**

There were present Professor Cuming President in the chair, Drs. J. W. Browne, Wales, Dill, Harkin, John Moore, Fagan, Dempsey, Esler, Smith (house surgeon Royal Hospital), Stewart, Clements, Kevin and Whitla.

Professor Cuming opened the session with an able address taking for his subject "Some changes in medical opinion and practice during the last 30 years".

On the motion of Dr. John Moore seconded by Dr. Wales the President was thanked for his eloquent address which he consented to hand over to the Society to appear in the Transactions.¹

Dr. Dill proposed and Dr. Whitla seconded a vote of thanks to Dr. Browne the late President.

Dr. Whitla proposed and Dr. Moore seconded the nomination of Dr. Thompson, Omagh, as a member of the Society.

James Cuming M.D.

Second Meeting of the Session was held upon Tuesday 22nd November 1881.

Present, Professor Cuming in the chair, Professor Dill, Drs. J. W. Browne, Wales, Fagan, D. Johnston, Smith, Jnr., Dempsey, O'Neill, Clements, Whitla.

Dr. Thompson, Omagh, was unanimously elected member of the Society.

Dr. Whitla proposed and Dr. Fagan seconded the nomination of Drs. McFarland and T. K. Wheeler, Jnr.

Dr. J. W. Browne showed several interesting specimens and Dr. O'Neill exhibited a diseased liver.

The hour being late it was decided to postpone the remaining papers on the circular till the next meeting.

James Cuming M.D., President

Third Meeting of the Society was held upon Tuesday 6th December 1881.

Present, Professor Cuming President in the chair, Dr. John Moore, J. W. Browne, Fagan, Core, Clements, Kevin, Wadsworth, Whitla, Professor Dill.

Drs. McFarland and T. K. Wheeler were elected members of the Society unanimously.

Dr. John Moore showed an interesting specimen of rare injury to the eyeball.

Dr. Whitla reported a case of strychnine poisoning in which recovery followed a dose of 6 grains.

Mr. Fagan read notes of cases of blood effusion into the knee joint.

The President proposed and the Secretary seconded the nomination of Dr. Byers.

James Moore M.D.

The Fourth Meeting was held upon January 3rd 1882.

Present, Dr. James Moore in the chair, Professor Dill, Drs. J. W. Browne, McKeown, Dempsey, Anderson, Esler, and Whitla.

Dr. McKeown showed an interesting case of tumour of the eye.

He also read an interesting paper upon pilocarpine and showed the effects of the drug in two patients to whom he administered it before the Society.

Paper:¹ *I purpose bringing before you, as shortly as possible, my experience of the use of pilocarpine; but before doing so, I shall show you its usual effects by injecting subcutaneously the two patients whom I have brought here for the purpose. The preparation I employ is a solution of the nitrate of pilocarpine, and the strength is 1 in 20. The younger of the two, a lad about twelve years of age, has been treated for about a couple of months by the injection almost daily of from four to five minims of the solution, whilst the elder, a young man of twenty years, has been treated for a similar period by the injection of five to six minims daily. You can observe now, immediately after the injection in both cases, great quickening of the heart's action and flushing of the face, followed by copious perspiration over the whole body, and free salivation. If you open the mouth, and place your finger for a few seconds on the opening of the duct of either the sub-maxillary or parotid gland, and afterwards remove it, you will find a regular spout of fluid from the duct. The laryngeal and nasal secretions are also increased to some extent, and likewise it is said the bronchial. The internal muscular apparatus of the eye is affected, a sort of spasm of accommodation being induced—hence patients complain of dimness of vision for distance. It is remarkable also that the genito-urinary organs in both male and female are affected. In these two cases, shortly after the injection there is a desire to pass water, and this, I may remark, is a very constant symptom. It does not arise from an increased flow, but rather from a contraction of the muscular coats of the bladder. The desire exists even when there is little or no urine to be voided—at the same time, often severe pain at the end of the penis is experienced. Special action seems also to be exerted on the vasomotor centre regulating the vascular supply to the penis. In both these cases erection of that organ takes place. I have been told by the elder of the two of another effect, which is rather unusual—viz., the ejection occasionally of a large quantity of pretty clear fluid (about a pint) from the stomach, although he had not taken any fluid for a long time previously, and had not swallowed any saliva. In addition I may mention that*

¹ [Not found.]

¹ [Dublin Journal of Medical Science, 1882, v73, p398.]

in two instances hiccough, continuing for hours, followed the injection. In one case each injection was followed by a bloody discharge from the female genital passages, without pain or other symptom anywhere. In another case the menstrual period was anticipated by a couple of days. Giddiness, with tendency to faintness, also sickness and vomiting, are not unusual.

Putting aside altogether the question of the exact *modus operandi* of the drug, which would lead us too much into vasomotor theories, let us look to the facts which are patent to everyone. The heart, the capillaries of the skin, the sudoriparous glands, the submaxillary and parotid glands, the accommodative apparatus of the eye, the muscular coats of the bladder, the vascular supply of the penis, the female genital organs, the stomachal secretion, the diaphragm, are all affected, some with unvarying regularity, and some occasionally.

Probable Effect on the Circulation in parts not under Observation.—Seeing now the dilatation of vessels of the cutaneous surface, it is now for you to think of what may—indeed what I might say almost certainly does—take place in other extensive vascular areas not under observation. If the whole of the capillaries of the body, with the arteries and veins, were in the same condition of dilatation as those of the cutaneous surface, it is almost a question whether the circulation could be carried on at all.

Now, physiological experiments have shown that, when, by some means or other, dilatation of a large vascular area was established, a balancing diminution of the vessels in some other large area took place simultaneously. We have good grounds for believing that pilocarpine acts in this way. We endeavour to relieve a stagnant internal vascular tract, and promote absorption of effusions by opening up the surface channels, and draining from the blood flowing therein a large quantity of fluid. This is really our object, whether we are dealing with fluid in the peritoneum or in the eye, with a congested kidney, or suppressed eruptive disease. I have remarked that giddiness and faintness are often complained of. Do these symptoms not point to a diminution of the cerebral supply of blood, and have we not an indication for the use of pilocarpine in affections of the brain and its membranes, supposed to be attended with increased vascularity and effusion?

With these general remarks I now pass more particularly to my clinical experience. You must not expect me to deal with the question before us in an exhaustive or very systematic manner, but rather in a suggestive way.

Action in a Case of Painful Menstruation.—From what you have seen of the influence of the drug on the sudoriparous secretion, you would naturally expect that it would have a salutary influence in cases in which that secretion was absent. I had an opportunity of putting this to the test, but with a very different result from what I had anticipated.

Case I.—A lady, apparently about thirty-five years of age, consulted me for an aural affection. I came to the conclusion that it was of a nervous character. She had been a victim to severe neuralgia of the head and face, for which she had consulted several London practitioners skilled in nervous diseases, but without material benefit. She suffered likewise from extremely painful menstruation, for which she had been under the care of several gynecologists, but had obtained no relief. She casually told me that she never perspired, no matter how much exercise she took—that the only effect of the exercise was great flushing and heat of the head and trunk, attended with throbbing in the head. I resolved to try pilocarpine.

I began with a subcutaneous dose of six minims of the solution. It caused great congestion of the head, the chest became also of a rosy tint, there was copious salivation, but no cutaneous secretion whatever. The feet and legs remained cold. Next day she told me her illness came on during the night, and that she had never had so little pain. I continued the pilocarpine for a week in gradually increasing doses till I reached 12 minims, equivalent to $\frac{1}{20}$ ths of a grain of the nitrate of pilocarpine, but without inducing perspiration. The feet and legs always remained cold. Injection of the drug in the leg, which I tried on one occasion, did not at all improve the circulation in the lower extremities. I tried to aid the action of pilocarpine by hot jars to the feet and friction of the legs, but without appreciable effect. The vascular area of the lower extremities was, therefore, stubborn to pilocarpine. The lady afterwards went to India and married, but I have heard nothing of her since.

Discharge of Blood from Vagina after Injection.—I have another case at present under treatment, showing the influence of pilocarpine on the female generative organs.

Case II.—A young woman, aged eighteen years, well developed, and to all appearances healthy, has been under my care for some time for a cloudiness of the vitreous in one eye, quickly appearing and disappearing, probably from some vasomotor disturbance. There is a patch of hemorrhagic effusion in the chorioid. The other eye has been almost blind for a considerable time from dense opacities in the vitreous, probably of hemorrhagic origin, and completely obscuring the fundus. After treatment by pilocarpine for some time, I learned that every injection was followed immediately by a bloody discharge from the genital passage, something like what takes place during her “illness.” This discharge was unattended by any pain anywhere.

I think these two cases show that at least sometimes pilocarpine exerts a great influence on the female generative organs, and it remains for those who have large opportunities of treating diseases of women to ascertain whether this medicine can be used with advantage in certain uterine and ovarian affections.

Action on the Bladder.—I have already mentioned the influence of pilocarpine on the bladder. I would venture to throw out a hint regarding its possible use in atony of that organ. If pilocarpine cause contraction of the bladder, of which I have no doubt, might it not be used with advantage in the cases referred to after the urine has been drawn off? You know that belladonna is the agent, above all others, for incontinence of the bladder in children. As regards the bladder, then, pilocarpine contracts and exerts a sort of irritative action: belladonna, on the contrary, diminishes muscular action and soothes.

Antagonism of Pilocarpine and Belladonna.—This leads me to another point—the very general antagonism between pilocarpine and belladonna. It is rather odd that this should be manifested in precisely the same way on the muscular tissue of two organs with functions so different as the eye and the bladder. Pilocarpine has on the eye a myotic effect, and brings about increased action of the accommodative apparatus; belladonna is a mydriatic, and paralyses the accommodation. Pilocarpine increases salivary secretion; atropine diminishes it. Pilocarpine causes perspiration; atropine prevents it. Pilocarpine diminishes vascular tension, at least in some parts; atropine increases it. They both increase the pulse rate, but from different causes, on which I do not enter here.

Atropine an Antidote for a Dangerous Dose of Pilocarpine.—You will reasonably expect, from what I have said, that atropine is the antidote—and I am glad to say an effective one—should pilocarpine exert its influence to a dangerous extent. One hundredth of a grain of atropine should save a patient from any danger from a moderate dose of pilocarpine. For this reason I look upon pilocarpine as a very safe drug if the physician only take the precaution, when administering the drug on the first occasion, to remain with the patient and observe the effects. From what I have seen I consider the physician should make this an invariable rule at any rate when he uses the drug hypodermically.

Retarding Effect of Instillation of Atropine in the Eye.—An almost infinitesimal quantity of atropine to some extent prevents the full action of pilocarpine, or retards it for a considerable time. For example, in the case of the young man before you, a drop of a solution of atropine (4 grs. to the ounce) was one day applied to each eye to aid ophthalmoscopic examination. On that and the following day the usual dose of pilocarpine fell far short of its usual effects. In the case of a man aged sixty years a drop of atropine solution had been applied three times daily for some time after cataract operation. I injected 3 minims of the solution of pilocarpine to relieve chorioidal congestion. Twenty minutes after injection little effect was observed. It had caused neither perspiration nor salivation. Afterwards, however, free perspiration and salivation, attended with sickness, took place. So you will note that a considerable

difference in different patients is observed. It is, therefore, wise to ascertain exactly the susceptibility of each individual subjected to its influence.

Use of Pilocarpine in Optic Neuritis and Intra-Cranial Disease.

Case III.—A sergeant of the army was brought to me some months since, suffering from almost total blindness, resulting from optic neuritis. He stated that about six years previously, when engaged with some comrades excavating beside the Thames, a bank of earth fell upon them. It was some time before he was extricated. He suffered much from cold and wet. He lost the power of his limbs for a couple of weeks. He had had ever since severe pain in the head. When I saw him he dreaded any sudden movement of the head, or an incautious step. To shake his head caused him much pain, which he referred to the interior of the cranium. His step was quite firm, and he had no paralysis, cramps, numbness, or any other symptoms referred to the extremities. He also complained of pain in the neck on turning his head round, or bending his neck quickly. I inferred from what he told me, and from what I saw, that there was probably some chronic inflammation of the membranes of the brain and spinal cord at some part, with, perhaps, some deposit, and that rapid derivation by pilocarpine might relieve congestion, induce absorption, and perhaps improve vision. No history of syphilis. I injected pilocarpine for some time, with the result of relieving the pains, but without improving the vision. The pains were completely removed, I believe, but, as I chance not to have taken a note at the time, I do not say so absolutely. I have reason to hope that many cases of optic neuritis will, when taken early, be amenable to treatment by pilocarpine.

Case IV.—A healthy-looking lad, now under treatment, aged fourteen years, suffered for a month before he came to me from severe pain in the head and sleepiness, with failure of the right eye. A week before his visit to me his left eye came to be affected also. When I saw him I found optic neuritis of both eyes, not of a very pronounced kind, and indicated only by slight muddiness of the disc and margins, with fulness of the veins and slight exudation along the course of some of the vessels and round the macula of each eye. With the right eye only he had quantitative perception of light; with the left he could count fingers close to the eye. After treatment for a fortnight he came to see to count fingers with each eye at six feet. After the first injection he stated that he felt better, and that his sight was decidedly improved. The case was one of such gravity that although I am an advocate for simplicity of prescriptions, and no needless overlapping of remedies, yet I thought in this case, as pilocarpine is only on its trial, I would only be consulting the interests of the patient in prescribing, in addition to the pilocarpine, remedies in common use in the disease. I prescribed iodide of potassium and mercurial inunction.

Since writing the foregoing the lad has recovered perfect vision of both eyes; the state of the fundus of each eye is satisfactory, and the pain in the head and sleepiness have been entirely removed. I may digress here to state, as the result of my observation, that in children a limited meningitis is much more common than is generally supposed. Practitioners are too much in the habit of regarding meningitis as a disease which either exists in a severe form or not at all. They expect to find the full series of symptoms laid down in books, and if these do not occur in their due order they do not recognise the disease at all. I am satisfied, however, that meningitis often exists, and is only evidenced by a single symptom—viz., pain in the head. This may pass off, leaving no effect behind. Very frequently after a time, however, the vision fails, and the ophthalmic surgeon finds clear evidence of an optic neuritis or atrophy. Now, what more reasonable to suppose than that a limited part of the membranes at the base of the brain may be congested in a passing sort of way, or that this may be followed by a limited effusion affecting some part of the optic tract or central organ of vision.

Use in Scleritis and Sclero-corneitis.—I have used it in a number of cases of scleritis and sclero-corneitis with, I think, more than average success, but as the disease is one so slow, and so variously influenced by heat and cold, season, residence, &c., I really do not feel justified in saying anything positive.

Use in Detachment of the Retina.—I come now, however, to a class of cases in which pilocarpine has, to my mind, been proven superior to everything hitherto tried, and, in fact, to be the only remedy worthy of mention at all.

I refer to detachment of the retina. I am aware of only one case during a rather extensive practice of twelve years having got well. The detachment was small and peripheral, and indeed when what I considered a detachment disappeared, I began almost to doubt the correctness of my diagnosis. In only one case have I seen notable improvement by operation. In that case I removed a circular piece out of the sclerotic; and the patient, who, before operation, only discerned light from darkness, afterwards acquired so much vision that he could go about well in the daytime. For some time I have given up operation altogether, the hits were so few, and the misses so numerous. The experience of ophthalmic surgeons everywhere was just like my own. Medicines were practically useless. This was then a fair class of disease on which to try a new remedy. My attention was first directed to the subject by a paper, by Dr. Danioux, in the Paris Journal d'Ophthalmologie. The results reported by that gentleman seemed so opposed to all previous experience, and altogether so roseate, that I was rather sceptical. However, I tried the remedy, and I am glad to state that a fair proportion of the cases are greatly benefited. Many have improved far more than I could have reasonably anticipated.

Case V.—The lad before you has detachment. His case is rather anomalous. When I saw him first the tension of the left eye was quite glaucomatous. The glaucomatous process had apparently gone on for a long time. For three months, at least, he had had severe pain in and all round the eye, at times so bad as to cause fits. There was no anterior chamber, the lens apparently being quite in contact with the cornea, no iris whatever apparent at the upper part of the cornea, and only a narrow semilunar ring at the lower half of the circumference. I thought the disappearance of the iris was owing partly to atrophy and partly to its being hidden by the pushing forward of the lens. The vitreous was so cloudy that I could not make out by the ophthalmoscope anything of the state of the fundus. The sclerotic was distended and bluish in the ciliary region, with two little round projections below. He had correct perception of direction of light thrown on the eye from a mirror in various directions; could count fingers at six inches. He stated that his vision within the last few days had been better. I questioned the propriety of attempting a sclerotomy or iridectomy. Either could only be done with difficulty, and very imperfectly. I admitted him to hospital. I was surprised to find, a few days after admission, that the tension of the eye had diminished to about the normal, coincidentally with an increase in the size of the sclerotic projections. At the same time the media of the eye had cleared, and I detected easily a detachment of the retina affecting the whole of the lower half of that membrane, and hiding the disc. I could trace the upper retinal vessels close to their entrance in the disc. The sight had cleared somewhat; the detached retina was sensitive. I began to treat him with pilocarpine. There has been continuous improvement. The extent of the detachment has diminished so far that it is now of a narrow triangular form, with apex just at the disc. The disc can be easily seen. He counts fingers at ten feet.

Case VI.—This young man before you has suffered from detachment of the retina of the right eye for five years, and of the left for one year. When I saw him first I found the sensibility of the retina of each eye still well preserved. With right eye he could not count fingers; with left eye he counted fingers at one foot. He has been treated as I have told you, and now he can count fingers with the right eye at two feet, and with the left at ten feet. He can read also $8\frac{1}{2}$ Sn. at six inches. The result, considering the long continuance of the detachment, was quite unexpected. He purposes now working as a carter.

I shall only mention another case of detachment:—

Case VII.—A printer, upwards of sixty years old, always shortsighted, lost sight of right eye in the course of a day. He was a delicate-looking man, and much worn by domestic troubles of various kinds. Detachment of retina below, extending to disc. Began treatment with $\frac{3}{20}$ ths of a grain, but found this produced

giddiness, faintness, and sickness, copious perspiration, and salivation; subsequently injected only $\frac{2}{20}$ ths, and that only occasionally. After the lapse of about two weeks' treatment there was scarcely a trace of detachment, and he could read the smallest type by gaslight. He was then about to return home, but I prevailed on him to remain for further treatment, to make the result more secure. Domestic cares, however, utterly upset his head and health. He was the most despondent man I ever met. The disease relapsed to some extent, and I was obliged to discontinue treatment and send him home.

But, you may ask, are the results obtained in this disease likely to be permanent? I answer, I am not in a position to reply; time alone will test the improvement. At the same time I may remark that it is not improbable that the change in tonicity of the vessels and in the absorptive capacity brought about by this drug, and maintained for a length of time by its steady use, may remain even after the suspension of treatment. I shall, however, report after more extended experience.

Improvement of Function of Skin.—Some writers have noted great improvement in the nutrition of the hair; sometimes even a change of colour has been brought about. I have been treating a young lady for sclero-corneitis of a severe kind. She was troubled with coldness of the extremities and a general feeling of chilliness. She stated that her skin and hair were always dry, and that she never perspired. In this case I have used 5 or 6 minims daily for about three weeks. The drug produced all its usual effects—the chilliness and coldness of the feet have been relieved, her hair is no longer dry, her skin has become moist, and her complexion much improved.

Effect in Tonsillitis.—I have used pilocarpine in a number of cases of severe tonsillitis with results most satisfactory. In the first case the acute disease was of three or four days' duration, grafted on a chronic affection, and the right tonsil so much swollen that I really thought nothing would arrest the suppurative process. A single dose of $\frac{6}{20}$ ths of a grain of pilocarpine completely cut short the disease. Afterwards, with the view of watching its effects in these cases, I admitted such as chanced to come before me (three altogether) as intern patients. They all seemed to me such as would go on to suppuration. The relief was immediate in every instance. I have found that patients who on admission were not able to swallow at all could do so very well shortly after a single injection. I have only had to keep the patients in hospital from one to three days. I cannot too strongly recommend you all to adopt this treatment.

Dose.—Some of you, from what you have read in the journals, may be disposed to think you may use this drug rather freely. Even one grain seems to be regarded by some as not an extra-ordinary dose, and perhaps it may not be in special diseased conditions. For example, in cases of suppressed eruptive diseases, or in case of

great vascular tension, it may be safe to give considerable doses; but, from what I have observed, I advise you strongly to feel your way. I have told you of a case in which $\frac{2}{20}$ ths of a grain in a man of sixty years old produced full effects, and $\frac{1}{20}$ th of a grain more, excessive effect. Young persons of ten years old bear a larger dose often than old persons. For persons in the prime of life you will usually find $\frac{6}{20}$ ths of a grain do all you require. Twelve-twentieths of a grain is the highest dose I have ever administered.

Mode of Administering.—When you wish a decided effect by far the better plan is to use a salt of pilocarpine, and inject it subcutaneously. In two or three minutes the full effect is developed; besides you should remember that half the virtue, perhaps, lies in its instantaneous action. The same dose administered by the mouth will usually not produce diaphoresis, and only acts slowly. You require to give a larger dose. I prefer the salt to the infusion of the leaves, because you can gauge the effects with almost mathematical accuracy.

Lacuna in our knowledge.—We must all regret that in this country there is practically an end of all research into the physiological action of drugs by experiment on animals. We may conjecture that this drug causes contraction of the cerebral vessels, but surely it would be more satisfactory and give a more sure basis for practice if we were assured definitely what effect it had on the brain exposed to view.

What I have said to you raises also the questions: What is its action on the uterus and ovaries? What are its effects on the liver, spleen, and intestinal canal? I do not see how therapeutics is to be elevated into a science without careful experimental research. It used to be that the medical profession was satisfied with extraordinary combinations of drugs, hoping that some one of the many would hit the right nail on the head. Now we require precision.

We look for active principles, and employ them in the expectation of observing definite actions on particular organs or particular nervous or vascular tracts, but how we are to employ with safety the numerous new and powerful agents which are daily brought to the notice of the profession, without some knowledge of their precise action on the lower animals, I fail to comprehend. We can only now endeavour to enlighten the Legislature, and hope for a compliance at no distant date with the reasonable requirements of the profession.

Dr. J. W. Browne showed some cases of osseous tumour.

Dr. J. W. Byers was elected member of the Society.

Fifth Meeting Session 1881–1882. President Professor Cuming M.D. January 17th 1882.

Present, Professor Cuming, J. W. Browne, John Moore,

Fagan, Anderson, Workman, Smith, Jr., Dempsey, McFarland, Whitla.

Dr. Anderson read a paper upon secondary contraction of muscle.

He also read a paper on "Some anatomical notes".

Dr. John Moore moved that a note of condolence be forwarded to the family of the late Dr. Charles Purdon.

Dr. Browne seconded the motion and it was resolved that Dr. John Moore make a draft of a letter and forward it to the secretary.

Sixth Meeting Session 1881–82. January 31st.

Present, the President Dr. Cuming in the chair, also Drs. Kevin, Byers, Esler, Graham, Samuel Browne, Jr., Dempsey, Workman, Dill.

Dr. Esler read his paper on "Whiskey".

Paper:¹ *THE word whisky is a derivation from the Irish Usquebach, the Gaelic Uisage being water, and Featha life. So that literally the word means water of life—Aqua Vitæ. Whisky of late years has become such an important article of manufacture, commerce, and export, so popular as a beverage, and so common as a medicine, that we hope a short paper on the article in its various phases will not be inappropriate to bring before a learned, a scientific, and a practical Society like the Ulster Medical. Our first inquiry shall be—"What is whisky?" The definition given in the dictionary is that "it is a spirit obtained by distillation from barley, wheat, rye, maize, or oats." But we must inquire more minutely into the process by which it is obtained, and this brings before us the subject of distillation. There are two kinds of stills—"the pot still" and the "patent." The patent still produces what is known as silent spirit, so called from being silent as to its origin. You cannot tell from what it is obtained—it is simply alcohol and water without any flavouring matter to give it a distinctive character. This is all left behind, and the alcohol so made may come from grain, potatoes, molasses, or any vegetable matter which will ferment. The spirit so obtained does not undergo as much change with age as pot-still whisky, yet it does improve as you will readily perceive from the samples I am enabled to place before you through the kindness of our local distillers, and also some of our principal merchants. You can here compare whisky only a few days old with other samples of several years of age, and you can thus judge for yourselves of the improvement by age alone. And while referring to the samples on the table I may say that I have here some of the principal whiskies advertised in the London Market—Dunville's (both patent and old still), James Wilson & Son's Bann Whisky, Kinahan's LL., and John Jameson & Son's. These are all labelled and correctly marked as to strength. I have also placed in contrast with these some of the*

stuff bought at public-houses in different parts of the town; and the only comment I can make, after a very careful examination and comparison, is that there is whisky and whiskey. Old still whisky is a spirit distilled from malt, barley, or oats, or a mixture of them, in a pot still, which brings over, together with the spirit, a variety of flavouring and other ingredients from the grain. Its distinctive character is due to the grain products, which are the sources of its flavour, and which, when sufficiently matured by keeping, undergo development into a number of volatile ethers. These ethers are the distinctive characters of good whisky—they are so subtle as to almost elude chemical analysis, but are easily discoverable by the nose and palate, and by their power to produce exhilaration. These ethers are altogether independent of the alcohol which holds them in solution. It is the presence of these ethers which distinguishes old whisky from new. New whisky, from whatever grain extracted, and even when manufactured with the greatest skill and care, contains a proportion of vegetable acids and a crude oil known as fusel oil, which renders it quite unfit for human consumption. The quantity and quality of these products depends largely on the quality of the grain used—good grain producing good whisky, just as good grapes produce good wine, and good hops good beer.

New whisky and new wine are much alike in this—that both improve with age, and neither is fit for use when new. The principal change that silent spirit undergoes by keeping is to lose strength by evaporation; it has no vegetable acid or volatile oil to be acted upon—hence, in its new state, it is most valuable on account of its greater strength; but in the case of pot-still alcohol, which holds these subtle bodies to which we have referred in solution, while the alcohol also diminishes in strength, it acts upon these oils and acids and splits them up into that which gives old spirits value as a medicine, and even as a beverage. It is said that this capacity for improvement is infinite, and that the longer good whisky is kept the better will be its bouquet. When first distilled it is reduced to an uniform strength of twenty-five per cent, over proof before it is filled into casks, because at a greater strength it changes very slowly. And here we might compare its relative strength with that of other stimulants. I quote from Dr. Whitla's recent work on Therapeutics:—"Brandy, whisky, gin, and rum contain 50 to 54 per cent, of alcohol by measure; port wine, 16; sherry, 15; claret, porter, and ale, 5 to 6 per cent."

But the point I want to draw attention to is not so much the quantity of alcohol present as the quality of the stimulant, and the ethereal and exhilarating principle as it has been matured by age. And one has only to think of the wonderful subtlety of the spirit, as seen in ether and chloroform, when alcohol is acted upon by other substances in the laboratory of the chemist, or the powerful soporific effects of chloral hydrate, which is

¹ [Dublin Journal of Medical Science, 1882, v73, p257.]

alcohol treated with chlorine, to understand something of the latent power which our national beverage possesses; and just as the acidity and harshness of unripe fruit are converted into sweetness and flavour during the natural process of ripening, so, I imagine, it is that age imparts mellowness and flavour to distilled grains, by the action of the alcohol on the crude material, which are very much like unripe fruit.

Whisky, in order to be good, must be made from good grain, distilled in a pot still, and then kept for a number of years in casks, and all this means expense, and the older the more expensive; hence it is, rather than wait for whisky to make itself by the natural process of change with age, the manufacture of whisky by the process known as “blending” has become so common. On this subject there is a mass of information given on the authority of certain Dublin distillers, of which the following are the assertions:—

Good whisky and bad are mixed together in order to make a compound acceptable to the taste of the consumer. This is the ostensible object, while really it is to produce a cheap and profitable article. It must be remembered that silent spirit has no distinctive character, is simply alcohol and water, and what serves to differentiate the other alcohols is their source. Spirit, distilled from grape mash is brandy, and has a distinctive character of its own. Spirit distilled from a malt or grain mash is whisky, and has also distinctive characters. Spirit distilled from cane sugar is rum, and could not be mistaken for anything else. But brandy, whisky, and rum may be manufactured from silent spirit.

Irish whisky has of late years become a popular beverage with the English people, and has been much esteemed and recommended by medical men in that country, and this, no doubt, on account of its being really whisky, and from the excellence of the article produced by some of the best distillers; but I have been furnished with the particulars of blends which, I fear, would not add to the reputation of the national drink.

Thus, 3,500 gallons of new provincial whisky were diluted with 2,400 gallons of silent spirit, and to this were added 786 gallons, or thirteen per cent. real Dublin whisky as a finishing touch; and this “blend” was supposed to make the whole bulk good wholesome drink—perhaps it did.

So great is the demand for Irish whisky that a large proportion of our exports are said to have been first brought across the channel to be here blended, in order to be sent abroad with an Irish permit. It is alleged that in one year upwards of 3,000,000 gallons of British spirits were so treated in Belfast alone.

The Dublin distillers say that genuine old still whisky does not require blending, and that the only thing necessary to render it fit for use is to store it up in sherry casks, which gives it a certain colour and vinous flavour, which is much esteemed. The Belfast merchants, on the other hand, maintain that it is

improved by blending, that by a judicious mixture of alcohols you get both smoothness and flavour; and some of it is put twice into sherry casks for this purpose.

In these samples the prices range from 2s. 3d. to 6s. 6d. per gallon in bond; and I believe this difference is not greater than that of the effects produced by their use, which we will investigate presently. On analysis the patent is as good as the pot still, and the new as good as the old. A practical question for the medical man or his patient will be—How and where to obtain really good whisky. Well, you must depend altogether on the dealer for quality; but by going to well-established merchants, and paying a fairly remunerative price, alcohol may be obtained which can be relied upon when prescribed to produce its characteristic therapeutic effects.

I think I have now said enough on the first part of this question, and in coming to deal with the second—what whisky does—I know I am approaching a very wide and difficult subject, and one on which opinions are very diversified.

It is a very curious fact that in nearly all the literature bearing on the action of alcohol, the evils, social and physical, are fully related and set down in the blackest colours imaginable, with scarcely a line or even a reference to its usefulness, or to the good results arising from it. And yet, in the face of all this, the nations of Europe, America, and the Colonies go on drinking it to an enormous extent, and in an increasing degree, disregarding all warnings, believing or acting as if they believed that the use of this thing does them good, and professing to feel the better for taking it.

It is easy to make out a list of charges against this active and popular agent. Our temperance friends charge it with such things as the following:—That it employs a capital in Britain alone of one hundred and seventeen millions of money; that the duties paid on it for a single year are more than thirty millions sterling; that it destroys thousands of lives; that by it multitudes are driven into workhouses, gaols, and lunatic asylums, besides being the direct maker of thousands of widows and tens of thousands of orphans.

Regarding its physical effects, one has only to look into Dr. Richardson’s lectures on alcohol to stand aghast at the frightful havoc it makes on the human frame. A simple enumeration of the diseases attributed to it is as much as we can venture to quote at present—as, for instance, “alcoholic dyspepsia, nervous derangement, alcoholic insomnia, organic deteriorations of the liver, kidneys, and lungs, alcoholic phthisis, alcoholic disease of the heart, cataract, calculi, nervous lesions, mental phenomena, loss of memory and speech, dipsomania, and transmitted disease.” He says it is neither a food nor a drink suitable for man’s natural demands, but that its application as an agent that shall enter the living organisation is properly limited by the learning and skill possessed by the physician.

This Society, on a former occasion, has fully discussed the social aspect of this question, when nearly every member took part in the debate, and the discussion is one of the most interesting in our Transactions.

On this occasion I wish, as briefly as I can, to refer to some of the physical and therapeutic effects resulting from the use of this agent, and first I would remind you of its vast importance in the laboratory. Out of 68 tinctures no less than 64 are prepared with spirits—40 with proof, and 24 with rectified spirit. There are also 16 so-called spirits, which are alcoholic solutions of a volatile oil. In the museum it is the agent in which specimens are preserved; and here we might refer to its great affinity for water—so greedy is strong alcohol for water that it extracts it from the muscle, tumour, or other tissue, while by its antiseptic quality it preserves the specimen from decay or change. The surgeon takes advantage of this quality, and by its rapid evaporating power inflammations and swellings are beneficially acted upon.

Spirit lotion, which means generally whisky and water, is even now among us a somewhat popular remedy. Its uses outside the body are both numerous and well recognised, but in the economy of the human subject its action is not so clearly seen, nor so well understood, yet it produces physical changes and mental phenomena of a very definite character. Most persons who are in the habit of using alcohol are familiar with the different stages of change which it produces in the animal economy.

Dr. Richardson very well describes the four stages thus:—"The first is a stage of excitement, when there exists a state of relaxation and injection of the blood-vessels of the minute circulation. The second is the stage of excitement with some muscular inability and deficient automatic control. The third is a stage of rambling, incoherent, emotional excitement, with loss of voluntary muscular power, and ending in helpless unconsciousness. The fourth and final stage is that in which the heart itself begins to fail, and in which death, in extreme instances of intoxication, closes the scene."

Alcohol enters the blood very readily when freely diluted with water, for which it has great affinity, and almost instantly produces its first characteristic effect of dilating the blood-vessels on the surface of the body by paralysing the nerves.

This stage is a most useful one if we could stop at it; for by this means fever heat is reduced in consequence of the increased quantity of blood exposed to radiation, and there results a marked diminution in the temperature of the body. But not only is the outer surface thus congested, the inner surface also is affected in like manner; and in this way a stimulus is given to a naturally weak or diseased organ to perform its function, for a time at least, under the influence of this spur. But the action does not stop here—it is progressive, and muscular inability quickly follows, unsteadiness of limb, with

incoherence of speech, sopor, and anæsthesia, leading on to the stage of drunkenness.

The primary action of alcohol on the internal organs and the brain is, I think, under the skilful direction of the physician, an important one in medicine; unfortunately, however, a great number of persons do not stop at this stage, but push its use to a degree which becomes injurious; and one of the characteristic effects of its use is, that it creates a craving for itself. They soon get to the brink of a precipice, over which not a few are precipitated. It is this peculiarity and this danger which makes the prescribing of alcohol so dangerous, and which gives rise to so many charges being brought against medical men for sanctioning its use. Now I consider that we have just as much right and liberty to prescribe whisky as arsenic, and that the patient has no more liberty to continue the use of the one than of the other without the knowledge and sanction of his medical adviser; and that if he does so it is purely at his own risk, and for reasons other than its therapeutic effects.

I wish now to state a few of what are supposed to be the good results arising from the moderate and medicinal use of whisky, and I go on the supposition that the alcohol used is the best matured and purest spirit to be obtained; for, during the last fortnight, while I have been experimenting with the samples before you, I have become very fully convinced that while some of the best may be taken with comparative safety, it is not so with other kinds. Even smelling at some of these whiskies will produce an aching pain in the cerebellum of a very depressing and continuous kind.

Another observation I may make—that in no instance are we to suppose that we are dealing with persons in good health. The finding of this Society on the occasion of the debate referred to was:—

"1st. That alcoholic stimulants are unnecessary in health.

"2nd. That their influence on health is only exceptionally beneficial.

"3rd. That their influence on health is generally hurtful.

"4th. That in order to lessen the hurtful consequences attending the use of alcoholic stimulants the Society advises that, if used, they should be in extreme moderation, only with food, not before dinner, and not habitually."

But all this leaves the question of their use in disease untouched. And first I would say, that in some cases of weak digestive powers the addition of an ounce of whisky at the mid-day meal seems to act with good results.

In phthisis I do not know any medicine so relished by the patient, as affording almost immediate relief to the breathing in the first instance, and where prescribed with milk as food it certainly does seem to arrest wasting, and often assists in restoring comparatively robust health; and its use in this form also

applies in most wasting diseases, especially those depending on a tubercular condition in children. In many of the various forms of disease of the heart, especially in the old, the use of alcohol is undoubtedly beneficial. In fevers, and at particular stages in the treatment of the disease, the beneficial effect of alcohol is recognised by most medical men. When dealing with the storm of delirium or the collapse of exhaustion it can be administered so as to act on the one hand as a sedative and on the other as a stimulant, serving as the steam does to the ship, battling with the head-wind of the tempest or propelling through the calm of the tropics, to carry her on only a little way where the trade-winds of a healthy breeze will leave her free to dispense with the auxiliary help. It is in these critical times that one has recourse to such an active agent without any questionings as to either its propriety or its expediency.

One of the common results of alcohol drinking is headache; but this is attributed generally to the impurities it contains, and I am inclined to believe they account for it to a large extent. The most characteristic effect of a moderate dose of alcohol, to me, is that it acts as a sedative to the brain and nervous system, and this effect is most marked on those who are not in the habit of using it constantly. Its stimulating effect on some persons is very evanescent, its sedative effect very prolonged. To such persons there is no work to be got out of alcohol—muscular debility and weariness soon sets in; if walking, they are unable to proceed on their journey, and if engaged in mental work, stupor and ennui supervene, their sensibilities are blunted, and a condition of easy lassitude results. I must now close this study, and I do so with a consciousness of the very imperfect way I have brought it before you, and under a deep impression that the investigation of this subject, from the very nature of it and from the many prejudices and preconceived notions about it, is beset with many difficulties, and the difficulties multiply as we approach a practical conclusion; yet I would venture to submit a few of what I think are plain facts derived from the considerations which have been before us:—

- 1st. That the value of a stimulant depends mainly on the quantity of alcohol it contains.
- 2nd. That where alcohol is prescribed whisky is perhaps the safest form in which to use it.
- 3rd. That the quality of the spirit is an item of importance as regarding its action, old being preferable to new.
- 4th. That in using whisky it should be freely diluted with water.
- 5th. That the habitual use of spirits is injurious to the animal economy.
- 6th. That it is a valuable agent in the hands of the medical profession in certain conditions of disease.
- 7th. That its use should not be continued after the results contemplated are attained any more than that of any other powerful and dangerous medicine.

Dr. Dill made a few remarks general.

Dr. Kevin thought it very questionable if whiskey should be used in phthisis.

Dr. Byers to read his paper the first thing next meeting.

(President) James Cuming

Seventh Meeting Session 1881–1882. February 14th '82.

President Professor Cuming in the chair, Drs. Fagan, Dempsey, Esler, McFarland, Smith (house surgeon), Whitla, Samuel Browne, Jnr. M.D., and several students.

Mr. Fagan exhibited an interesting specimen of osteomyelitis.

Dr. Byers read an interesting paper upon "The patella reflex phenomenon".

Paper:¹ In the year 1875 two celebrated German observers, Westphal and Erb, directed the attention of the profession to the great value, from a medical point of view, of a phenomenon long known as a schoolboy's trick. I refer to the peculiar jerk of the leg which takes place when the patellar tendon is struck. Charcot may have used the patellar-reflex in diagnosis before this period, but undoubtedly the profession at large was first made aware of its importance by the appearance of the papers of Westphal and Erb.

Since then the phenomenon has been studied with extraordinary care in its physiological, pathological, and clinical bearings by Westphal, Erb, Tschirjew, Burckhardt, Fürbinger, Schultze, Berger, Eulenburg, Charcot, Brissaud, and Franck on the Continent, and in this country by Grainger Stewart, Hughlings Jackson, Waller, Buzzard, and Gowers; so that, I think, no one will accuse me of exaggeration when I say that there are few symptoms of greater importance in the diagnosis of diseases of the nervous system than this patellar-reflex phenomenon, especially when it exhibits deviations from its normal condition.

The phenomenon has received many different names; it has been called "the patellar-tendon reflex phenomenon," "the knee-jerk," "the knee-reflex," the "knee phenomenon."

In this paper I shall—First, describe the phenomenon as it exists in a healthy individual, and mention several methods that may be employed to elicit its presence. Secondly, I shall state and examine the different views that have been propounded as to its physiological causation. Thirdly, I shall read the notes of a series of cases in which this phenomenon exhibited deviations from its normal condition, and I shall attempt in each case to account for such alteration.

First. You see in my friend (one of the hospital pupils) who is sitting with his right leg crossed over the left, and bent at an angle slightly greater than a right

¹ [Dublin Journal of Medical Science, 1882, v73, p186.]

angle, that when, with this stethoscope, which has an india-rubber ring round the pectoral piece, I strike the right leg just below the patella, immediately the foot is jerked forwards. Such is the phenomenon, and such is the ordinary method of testing for its presence.

The following plan is suggested by Buzzard if it is desired to ascertain the mere presence of the “patellar-reflex:”—“The patient, who is seated, plants his foot firmly down at such a distance that the leg forms a little more than a right angle with the thigh. Whilst the observer rests the palm of his left hand upon the patient’s thigh, he strikes with some implement held in the right hand several blows upon the ligamentum patellæ at about an eighth of an inch or so below the knee-cap. The quadriceps muscle can be felt, and (if the patient is in masculine garments) can be seen to contract more or less vigorously in response.”

The side of the hand can be employed as a percussor. If no response follows the blow the leg should be bared, and the observer should test most carefully by striking in the usual place, or on the patella, or the tendon above the patella, or the muscle itself, before assuming that the reflex is absent. In children, in whom there is often considerable difficulty in examining for the sign, I usually place them on a table with their legs hanging over the side, and while their attention is occupied in looking at a toy, a light tap on the patellar tendon is usually sufficient to demonstrate the presence of the phenomenon. The patellar-reflex is almost always present in health, although the amount of the contraction of the quadriceps muscle may vary at different times even in the same individual. Berger has examined 1,409 soldiers for this phenomenon, and has found it absent in 22, or 1.56 per cent, of these cases.

Although I have seen the patellar-reflex slight in several individuals, and absent in one—while in none of these when examined was there any evidence of disease—still I think that such cases are exceptional; and I am inclined to believe that the greater the care that is taken in testing for the sign the fewer will be the number of those in whom it is found to be naturally absent. With reference to those cases in which it is stated that the phenomenon is normally absent, it is of little importance, as Westphal thinks, to note in the case of any one that at a given time the patellar-reflex is absent, more especially if we know nothing of his history. The observation would be of much greater value if we could show that the phenomenon had disappeared. In some of these cases the absence of the patellar-reflex may be a premonitory sign of a spinal affection of which other symptoms will appear in the future. Again, in certain individuals the absence of the phenomenon may be owing to mechanical causes, Westphal having shown that it is difficult to develop the patellar-reflex in those in whom the tendon is very short, in those in whom there is a thick pad of fat under the tendon, and in those who are very stout.

Secondly. We shall now consider the physiological causation of the phenomenon. Two views have been suggested to account for it. According to one it is purely reflex—that is to say, that at the point where the observer strikes the leg, impulses are generated which travel up the sensory nerves to the cord, at about the level of the second and third lumbar nerves, and there undergo certain changes, of whose nature we are ignorant—except that as a result efferent impulses descend the anterior crural nerve to the quadriceps muscle, causing it to contract and to jerk forward the foot. According to the other theory the phenomenon is a local one, due to a direct irritation of the quadriceps muscle.

In support of the first view, advanced originally by Erb, and according to which the reaction is of the nature of a spinal reflex, evidence is forthcoming from two sources—(a) the experimental, and (b) the pathological.

(a.) As a result of experiments on animals (Fürbinger, Schultze, Tschirjew, Senator), in many of whom the patellar-reflex exists, it has been found that destruction of the portion of the cord in the lumbar region, with which the anterior crural is connected, or of the anterior or posterior roots of the spinal nerves in the same situation, or of the nerves to the muscle, is followed by a disappearance of the phenomenon.

(b.) In any disease in which the reflex nervous arc, at the situation mentioned, is injured, in either its sensory or motor portion the patellar-reflex is lost. This is exemplified in *tabes dorsalis* (Case I), and in *poliomyelitis anterior acuta* (infantile paralysis) (Case III.)

In favour also of the reflex theory is the fact that drugs which increase the irritability of the cord—i.e., strychnia, cause an exaggeration of the patellar-reflex; thus Eulenburg, in some cases in which the phenomenon seemed entirely abolished on one side, succeeded in making it reappear for some time by the hypodermic injection of strychnia, made in the neighbourhood of the *nervus cruralis*, or into the substance of the extensor muscles. On the other hand, medicines, such as bromide of potassium and opium, which diminish the irritability of the cord, lessen the activity of the phenomenon. Admitting, then, that the contraction of the quadriceps is of reflex origin, the question naturally arises—From what point do the sensory impulses arise when the leg is tapped; is it from the skin, the patellar tendon, or the muscle? That they do not begin in the nerves of the skin is clear from the following facts:—1. A light tap or push over the patellar tendon will not give rise to the knee-jerk. 2. If the skin is lifted up in a fold, so as to be quite separate from the tendon, and is then tapped, no contraction of the muscle follows. But, on the other hand, if the skin is divided and the blow struck on the exposed tendon the leg is immediately jerked forward; this experiment seeming to show that the irritation starts from the tendon—a view that gets additional weight from the circumstance that Sachs has

demonstrated the existence of nerves to the patellar tendon. But this view—viz., that the impulses arise in the nerves of the patellar tendon, is disproved by an experiment of Tschirjew. This observer divided all the nerves to the tendon patellæ in an animal, and, notwithstanding, a blow on it caused the muscle to contract. Further, in all cases in which a blow on the patellar tendon causes the muscle to contract, it must be in a condition of passive tension, and in some cases, as Erb has shown, sudden tension alone, as by quickly pushing down the patella, so as to make the quadriceps tense, will cause the appearance of the knee-jerk. Dr. Gowers has also shown that in certain cases in which the “tendon reflexes” are in excess a tap on the front of the leg will cause a movement of the foot. Here the stimuli do not act on the tendon but on the muscle.

So then we are compelled to believe that the stimuli arise in the muscle. But if this be granted Westphal's view that the contraction of the muscle is a local one may, after all, be the correct explanation of the phenomenon; and this theory is supported by the fact that Burckhardt, Brissaud, Tschirjew, Gowers, and Waller, who have examined the matter with great care, believe, as the result of their investigations, that the time which elapses between the blow on the tendon and the contraction of the muscle is shorter than it should be if the phenomenon was a purely reflex one. At the recent meeting of the International Medical Congress, in a discussion on his paper, Eulenburg gave his adhesion to the view that it might be a peripheral phenomenon. But if we adopt this explanation, how can we account for the absence of the phenomenon in those diseases which cause destruction of the reflex nervous arc?

Is there, then, any hypothesis which will reconcile these two opposing views, which will account equally well for the contraction of the muscle being a local one, and will yet explain the circumstance that any lesion which destroys reflex action causes a disappearance of the knee-jerk? The following explanation is given by Dr. Gowers:—“If,” he says, “we regard the contractions as local we have still to account for the irritability which permits the local stimulus to cause a contraction. This irritability is developed by passive tension. Hence I have suggested that the tension excites, by a reflex influence, a state of extreme irritability to local stimulation—such as that of a tap on the tendon, or such as the vibration from a tap near the muscle, or from a tap on the bone to which the tendon is attached—which thus excites a visible contraction.” I have endeavoured to give a full and fair account of the various views that are held as to the cause of this very remarkable phenomenon. Whatever view will eventually be found to be correct, the fact remains that this patellar-reflex phenomenon is of great value in disease, examples of which I shall now give in this the third part of my paper.

Case I.—*Tabes Dorsalis*; characteristic Ataxic Gait; Argyll-Robertson Pupil; absence of Patellar-reflex in

both Legs; previous history of Pains in the Legs, attacks of Indigestion, and Diplopia.—In Sept., 1881, I was consulted by a gentleman, aged forty-two, who gave the following account of his illness:—He was in perfectly good health until the year 1878, when he suffered from attacks of indigestion, accompanied with flatulence, especially after food. These attacks were not attended with vomiting, but during one of them he was much surprised one day, in looking out of the window, to find that each person passing along the street seemed to him to be double. This double vision was merely a temporary annoyance, but the attacks of indigestion have recurred at intervals up to the present time.

In 1879 he had pains in “the lower part of his back,” of a dull, heavy character, and in the spring of the following year he had also pains in his legs, specially in the back of the right leg, but also, though to a less degree, in the left. These pains have not been of a shooting character, but more like “rheumatic” pains. In the beginning of the year 1881 he first became unsteady in walking, and this unsteadiness was always worse at night. This was noticeable even to his friends at this time, for he states that one evening in coming out of the Turkish baths into the street his walk was so peculiar that a gentleman who was with him said, “You are like a drunken man, or are falling into paralysis.” From this time his heels in walking always touched the ground first. In the mornings, while washing his face (his eyes being then closed), he has a tendency to fall forward. Even before his movements became unsteady he had difficulty in going up and down stairs, and was obliged to keep a firm hold of the baluster. For some time he has had a curious feeling in his feet, “as if there were two or three folds of the sock under the sole of each foot.” He never noticed anything peculiar about his eyelids or eyes, with the exception of the double vision which I have mentioned.

Present Condition.—He is a very intelligent, large, well-developed man. He walks in the most characteristically ataxic manner, lifting his feet high, and bringing his heels down on the ground with a thump. He has great difficulty in starting to walk and in turning, his movements at these times being very unsteady. When he brings his feet together, and closes his eyes, he begins to sway from side to side, and would fall if not supported. In both legs, from the knee downwards, he feels the prick of a pin, and a heated knife when in contact with the skin, merely as tactile sensations. There is no wasting of the muscles of the legs, and when lying on a sofa he moves the legs freely in any direction. That the tabetic incoördination has extended to his upper extremities is shown by the apparent difficulty he has in buttoning his waistcoat. His pupils are very small; they do not respond to light, but act during accommodation (Argyll-Robertson symptom). There is no ptosis or strabismus. He has great difficulty in distinguishing

blue from green wool. There is no visceral mischief of any kind to be detected in the chest or abdomen. Patellar-reflex absent in both legs.

In the above case, when seen by me, the diagnosis was so clear that the absence of the patellar-reflex was of assistance principally in corroborating the other symptoms; but the great value of the symptom is in the early stages of *tabes dorsalis*, before the ataxic gait has become developed, and then it is frequently associated with the lightning pains. Of the very great importance of the absence of the patellar-reflex in *tabes dorsalis*, Dr. Buzzard, one of the most recent writers on that disease, thus speaks:—"Let me say then at once that, in my judgment, we may take it that Westphal's test, the absence of the knee-phenomenon, provided that this is associated with good voluntary power and ideo-muscular contraction of the *vastus internus*—a provision which Dr. Erb has most strongly and justly insisted upon—is a nearly certain sign of *tabes dorsalis*. I am prepared indeed, from something which I lately saw, to meet with the absence of the knee-phenomenon as possibly representing the only symptom of *tabes* in a certain case."

In fifty cases examined by Erb the patellar-reflex was absent in all but one, and he thinks that it is probably always an early symptom. In his experience it is never absent in young or middle-aged people in health, and hence he thinks that its absence may be regarded as almost pathognomonic of *tabes* in its earlier diagnosis.

The lesion in *tabes dorsalis* is sclerosis of the posterior columns, or, to state the matter more correctly, of that portion of these columns known as the "posterior root-zones" (Charcot), involving the posterior roots on their way to the posterior cornua. This lesion causes an interruption of the sensory impulses in their passage to the spinal centre, and so the patellar-reflex is lost. Even without our knowledge of the morbid anatomy of *tabes*, we would almost be warranted in concluding that the motor portion of the reflex arc was intact, from the fact that good voluntary movement of the lower limbs is preserved, and absence of any wasting of the muscles; while, on the other hand, that the sensory portion of the loop is affected, is apparent from the lightning pains and the anæsthesia.

Westphal thinks that there is a particular part of the posterior columns which, when diseased, causes the disappearance of the patellar-reflex; and, as bearing directly on this question, I will give a short resumé of a case, an account of which he brought before the Medical Society of Berlin.

A man, thirty-two years of age, in whose family there were numerous examples of different kinds of nervous affections, was brought in 1877 to the Charité Hospital, Berlin. He had been blind for six months, being merely able to tell, and that only with his left eye, day from night. He was a pronounced hypochondriac,

with all sorts of hallucinations. He had no symptoms of *tabes*, neither irregular movements, nor anæsthesia, nor lightning pains. In October, 1879, the patellar-reflex disappeared on the right side. He gradually got worse, and died in January, 1880. A few days before his death the "patellar-reflex" was gone on the left side—it continued absent on the right.

At the autopsy, in addition to very advanced degeneration of the optic nerves, optic tracts, and corpora quadrigemina, a yellow zone or strip of degeneration was seen in the centre of the posterior columns of the cord distinctly marked off from the neighbouring parts. The situation of this region of degeneration in the posterior columns was altogether peculiar. It attained its maximum on a level with the lumbar part of the cord. The cornua, columns of Goll, and posterior roots, were intact. Westphal infers from this very unique case that the loss of the patellar-reflex in *tabes dorsalis* is due to a lesion involving a definite zone in the centre of the posterior columns of the lumbar part of the cord. This observation of Westphal is particularly interesting as probably representing in some cases of *tabes* the first pathological change in the spinal cord, and as explaining the early absence of the patellar-reflex. Charcot had previously been led to assume that the sclerosed bands in *tabes* are slender and narrow so long as the lightning pains are the only symptoms present; as these areas of degeneration enlarge both outwardly and inwardly, the tabetic incoördination is observed. If there is marked anæsthesia, the posterior roots and posterior gray cornua are involved; while, finally, if the sclerosis extends to the posterior part of the lateral columns, the clinical picture is represented by paralysis (with or without contracture), the advanced stage of the malady. As to those case of *tabes* in which the patellar-reflex is said to be present, Westphal thinks that some of them are not genuine cases of *tabes*, while in the case of others it is possible that the patellar-reflex may disappear late in the course of the disease, indicating that the central portion of the posterior columns has also been involved at a late period.

Case II.—Diphtheritic Paralysis; absence of Patellar-reflex; complete Recovery, and subsequent return of the phenomenon.—On August 24th, 1881, a lad, aged fourteen, was seen by me in the out-patient room of the Children's Hospital. He stated that about six weeks before his legs became weak and unsteady in walking, and at times "seemed to give way under him at the knee-joints." There had been no pains in the legs, but for a time his feet had been "numb and dead," and in walking at first he could not tell whether the ground in contact with his feet was smooth or rough. There had been no symptoms referable to the bladder or rectum. He was now, he said, much better, and had been improving for the last two weeks. The numb feeling, had quite left his legs, and he had no difficulty in walking.

Present Condition.—He can move his legs with perfect freedom; there is no wasting or flabbiness of the muscles, and no anæsthesia. The patellar-reflex is absent in both legs. There is no loss of the power of accommodation, or any other eye symptoms. The condition of the palate is normal, and there is no evidence of any form of paralysis to be detected. On questioning him more closely I learned the following facts, which explained the nature of the case:—Three months before I saw him he had a “very bad sore throat,” and was so ill and weak that he was obliged to remain in bed for a fortnight. Soon after getting up again his mother noticed that his voice had become altered, and “was as if he was speaking through his nose.” At this time he began to have difficulty in swallowing, and he says that frequently, on taking milk, part of it would return through his nose. After having been up for a week he went back to work, but did not remain long, as, owing to a pain in his side—due, he thinks, to exposure to cold—he was obliged to take to his bed a second time. During all this time the difficulty in swallowing continued. While lying in bed the second time he was very much surprised to find that in reading the newspaper he was obliged to hold it at a much greater distance than usual from his eyes, because when he brought it closer “the letters,” as he puts it, “seemed to run into one another and to become indistinct.” He mentioned this circumstance to his friends, but they could see nothing wrong with his eyes. After being in bed for a week he got up, and sometime afterwards his legs began to get weak. His arms have never been affected. I did not see him again until January 26th, 1882, when I found that the patellar-reflex was present in both legs. He said he was quite well, and at work every day as usual.

It is plain that this boy suffered, in the first instance, from a diphtheritic sore throat, which was followed by paralysis of the muscles of the soft palate and pharynx (shown by the nasal tone of voice, the difficulty of swallowing, and regurgitation of milk through the nose); of the eye (in this case the ciliary muscle was involved, as was evident by his inability to read the paper when held close to his eyes, the letters being then indistinct, while he could manage to read it when it was held further off); and of the lower extremities (indicated by the weakness of the legs, the difficulty in walking, the anæsthesia, and the absence of patellar-reflex).

In connexion with this case the following remarks of Buzzard are, I think, very apt, when, in speaking of *tabes dorsalis*, he says:—“There is one pathological condition, however, which may possibly give rise to some doubt—indeed, I have met with an instance in point. In diphtheritic paralysis there is often a tottering gait, accompanied by numbness in the extremities. If there should be, as sometimes happens, no difficulty in deglutition, and no failure of the power of accommodating

the eyes, a strong superficial resemblance to a case of *tabes dorsalis* is presented. In such a case the patellar-tendon reflex will, in all probability, be absent, and the vastus internus muscle may contract as freely as in health to direct percussion. The acuteness of the symptoms, however, the absence of the characteristic lightning-pains, and the history of preceding sore throat should be sufficient to distinguish this condition from *tabes*.”

In this case, when first seen by me, the only symptom present was the absence of the patellar-reflex. The previous history, however, showed that it had been a case of diphtheria with paralytic sequelæ—a diagnosis which was confirmed by the ultimate return of the patellar-reflex phenomenon.

Several observers have noticed, within the last two years, the absence of the patellar-reflex in cases of paralysis following diphtheria. Any explanation, however, of the cause of this strange occurrence would involve, in limine, a discussion of the causation of diphtheritic paralysis itself, which is still, I am afraid, far from being settled.

Some recent pathological researches, however, throw very considerable light on the subject. Thus, Dr. Abercrombie examined very carefully the spinal cord and medulla of seven fatal cases of diphtheritic paralysis. The only pathological changes detected were in the gray matter of the anterior cornua, and they consisted in a swollen condition of the large motor cells. “The margins of these are very ill-defined, and the processes have in most instances entirely disappeared. The contents of the cell have a granular aspect, and the nuclei have disappeared, or, where still visible, are highly granular.” These changes occurred in limited areas.

M. Déjérine has described the changes met with, in three fatal cases of diphtheritic paralysis. They were the same as those described by Abercrombie, but more advanced.

These observations seem to indicate that the paralysis may be due in part to the subacute myelitis. If the cord is affected in the lumbar region the reflex arc would be interrupted, and accordingly the patellar-reflex would be lost. It is very difficult, however, to explain the return of the phenomenon, as one would expect, if the cord was affected by a myelitis, that the patellar-reflex would be permanently absent, as we know it is in poliomyelitis anterior acuta.

Another view as to the cause of the paralysis which follows diphtheria is that which is suggested by Buhl. He found in a case that the spinal nerves were thickened at their roots, and that the sheaths of the nerves were infiltrated with lymphoid nuclei and cells. “His view is that in certain cases these infiltrations lead to thickening of the connective tissue, which in turn contracts, and so compresses the nerves. According to him the nerve symptoms appear when the constricting

effect of the thickening of the connective tissue begins, they remain while it lasts, and disappear finally when the thickening diminishes." This hypothesis of Buhl would account for the disappearance as well as the subsequent return of the patellar-reflex in diphtheritic paralysis.

Case III.—Poliomyelitis Anterior Acuta; Wasting and Paralysis of certain Muscles of Left Leg; absence of Patellar-reflex.—A lad, five years of age, was brought to the Children's Hospital in December, 1880. The relatives said that two years before he had been "hot and sick for a few days." On recovering from this illness they noticed that his left leg was "useless." They had tried various remedies, with little effect.

Present Condition.—The left leg is smaller and colder than the right. There is also wasting of the muscles of the leg, and partly of those in front of the thigh. When he walks the leg is dragged, and there is a tendency to talipes equino-varus. The left knee-joint is very movable, and the bones of the left side seem smaller than the corresponding ones on the opposite leg. The patellar-reflex is present in the right side—absent in the left. Sensibility is retained.

In this case the absence of the patellar-reflex is due to the destruction of the multipolar ganglion cells in the gray matter of the anterior cornua (the essential anatomical lesion in poliomyelitis anterior acuta), interrupting the impulses in the motor portion of the reflex arc. The wasting of the muscles and their paralysis show that it is the motor part of the loop which is involved, especially as the absence of any loss of sensation indicates that the sensory part is intact.

The absence of the patellar-reflex in poliomyelitis anterior acuta is of great diagnostic value, as it distinguishes that disease from paralysis depending on cerebral causes, the patellar-reflex in the latter being either exaggerated or not altered at all.

Case IV.—Right Hemiplegia; Contracture of Right Arm; increased Patellar-reflex of Right Leg, and exaggerated "Supinator-reflex" of Right Arm.—I have at present under my charge, at the Ulster Institution for the Deaf and Dumb and the Blind, a girl, thirteen years of age, who was paralysed at the time she was admitted into the Institution. I have not been able to ascertain the previous history.

Present Condition.—She is deaf and dumb, and is hemiplegic on the right side. There is no rigidity in the leg, but the arm is kept close to the side, the elbow-joint is bent at a right angle, the wrist-joint is flexed, and the fingers are firmly closed. The arm can be extended only after some force is used. The patellar-reflex is very much exaggerated in the right leg. On tapping the tendon of the right supinator longus, the hand is immediately jerked toward the shoulder. There is no paralysis of the face or tongue.

In cases like the above the exaggeration of the patellar-reflex may be due to the withdrawal of the normal

inhibitory action of the brain, owing to rupture of the pyramidal tract, but against this explanation of the phenomenon is the fact that the exaggeration of the patellar-reflex is not, as a rule, noticed immediately after the lesion in the brain, but seems to require some days to elapse before it can be observed. Seeing that the exaggerated patellar-reflex is often associated in these cases with late rigidity (a phenomenon depending on descending degeneration of the pyramidal tracts in the lateral columns), some think that the increased tension of the muscles under such conditions may give rise to a condition of irritability in the terminations of the nerves, which, in turn, increases the excitability of the spinal centre. But this is clearly not the real explanation of the exaggeration of the patellar-reflex in these cases, as the phenomenon appears long before there has been time for the occurrence of degeneration in the cord. No explanation thoroughly satisfactory has yet been given to account for the exaggerated patellar-reflex in these cases.

J. Moore

Eighth Meeting Session 1881–1882 was held upon Tuesday the 28th inst 1882 February.

Present, Professor Cuming in the chair, Dr. John Moore, McConnell, Kevin, Dempsey, Smith, Jnr., Whitla, J. W. Browne, Wadsworth, McKeown, and Workman, Stewart.

Dr. Dempsey read a paper upon the management of pregnancy, labour and puerperal state. He raised the most interesting debate.

Paper:¹ IN this paper I shall only touch upon a very few points in connexion with pregnancy, labour, and the puerperal state: to do more would be to write a system of midwifery. I am aware that even in thus dealing with my subject I must open up an extensive field for discussion, perhaps too much so for any useful purpose. But there are some modes of procedure in obstetric practice which from experience I have adopted, and this communication is more for the purpose of testing their accuracy and eliciting the opinions of the members for my own information than for putting forward any new theories. None of them would individually warrant me in occupying a meeting of the Society in their discussion, so I have placed them under the three heads stated in the title of the paper.

The Vomiting of Pregnancy.—This is, perhaps, one of the most troublesome and unsatisfactory complaints we have to deal with. When it is severe, and incessant the patient's life is placed in great danger from starvation; even in a moderate degree it causes a great deal of inconvenience and discomfort to the patient, and anxiety and trouble to the medical attendant in his endeavour to arrest it. It is pretty generally admitted to be a

¹ [Dublin Journal of Medical Science, 1882, v74, p171.]

reflex act depending upon some altered or diseased condition of the uterus or cervix. Dr. Graily Hewitt regards it as due to flexion or version of the uterus, causing a cramped or tense condition of the uterine fibres at or in the region of the internal os, and consequently his treatment of the complaint is reposition of the uterus. Dr. Henry Bennett and Dr. Clay, of Manchester, say it is due to congestion, inflammation, or erosion of the os or cervix, or both; and they treat it with the local application of nitrate of silver. On the other hand, Dr. Marion Sims and M. O. Jones, of Chicago, hold it is due to some kind of reflex irritation from the cervix, and that its cure will be effected by setting up inflammation by means of caustics at this site, and thus concentrate the nervous phenomenon at the point of irritation, and in that way relieve the stomach. The late Dr. Copeman, of Norwich, had an infallible belief in dilating the os with the finger, and thus relieving the tension of the cervix, which he believed to be the cause of the vomiting.

Professor Tarnier, by the introduction of a vaginal plug, arrested the vomiting of pregnancy, which result he attributed to the steadying action which it had upon the uterus. But, for various reasons, when a patient first consults us regarding vomiting occurring during the pregnant state we are scarcely justified in having recourse to any of these modes of treatment, or in even making a vaginal examination at all, provided, of course, there has not been total failure from the adoption of medicinal remedies. As a general rule, we must first exhaust these before we have recourse to operative remedies. I have never had occasion to dilate the os, or to cauterise it, or to replace the uterus for the cure of vomiting. No doubt in some cases I have had to try a variety of medicinal agents before the desired effect was produced, but latterly in the use of ingluvin in 5-grain doses three times a day I have been pretty successful in the treatment of this complaint. If time permitted I could cite a large number of cases in which bismuth, morphia, hydrocyanic acid, bromide of potassium, oxalate of cerium, and some others were tried without benefit, and in which ingluvin at once arrested the vomiting. Of course I have also had cases in which this remedy appeared to have very little effect, and in which others were more beneficial, but, on the whole, I have had more satisfaction and better results from its use than I have ever had from any other remedy. Inguvin is an American preparation made from the gizzard of the hen. It is therefore a kind of pepsin.

If we might found a post hoc argument upon the good effects of this drug in the treatment of the vomiting of pregnancy we might conclude that the disease is not in all cases of nervous origin depending upon reflex irritation from the uterus, but is in some cases a veritable dyspepsia, probably arising from the altered condition of the circulation and the quality of the blood during pregnancy.

Adherent Placenta.—In 1835 Sir J. Simpson drew attention to inflammation of the placenta. The symptoms, he thought, were not well marked, but pains in the uterus and painful movements of the child created a presumptive evidence of its existence. The most marked symptom is, I believe, a constant aching pain, confined to one point. I think where a pain of this character exists you can almost say with certainty that there is inflammation at the placental site, and you will most likely have a retained placenta. Dr. J. Henry Bennett, in a paper to the British Medical Journal in 1875, casually pointed out this connexion. Even in cases in which the placenta has naturally come away after the existence of pain of this kind, I have always found it hard and fibrous to the feel, and, from its appearance, creating a doubt in my mind whether it had come away entire or had left small patches behind. The frequency with which these cases are followed by offensive lochia and feverish symptoms leads me to think that minute portions of the placenta do remain behind, adherent to the uterine wall. With patients who suffer much from uterine pain during pregnancy I always come prepared to their confinement for retention of the placenta, and a short time before the termination of the labour I give a full dose of infusion of ergot, in the hope that the firm contraction thereby set up may break down adhesions and expel the placenta.

There is no operation that one should be more slow of performing than the removal by the hand of an adherent placenta. The only maternal death I have ever had that I believe depended upon operative interference was after the removal of an adherent placenta. There was very great difficulty in peeling it off, and though I believe I brought it away entire the patient died of septicæmia on the seventh day after labour. I formerly thought nothing of removing an adherent placenta before that occurrence if there was any delay, but now I prefer to wait and to give a good dose of ergot, with the hope of effecting its expulsion.

Forceps.—There is still some difference of opinion as to the application of the forceps, especially in what is called the high operation when the head is at the brim. When the head is low down, the os fully dilated, and labour progressing slowly, authorities are pretty unanimous in recommending its speedy termination by the use of the forceps as a safe and justifiable proceeding for both mother and child.

However, in the high operation when the head is at the brim and the os not fully dilated there is considerable difference of opinion as to the use of the forceps. Some hold the operation should not be performed until the os is fully dilated, others that it may be performed as soon as the os is sufficiently open to permit of the application of the blades, provided, at the same time, that it is soft and dilatable. If the os is hard and rigid all are agreed that the operation should not be performed, at all events, until by the use of hot baths, chloral, chlo-

roform, or some other agents, the rigidity has been overcome.

When other indications for the use of the forceps exist I do not wait, if it is soft and dilatable, until it is fully dilated. The operation, if carefully and slowly performed, will assist the process of dilatation, and I have never known it to do any injury. Recently, in consultation with Dr. M'Harry, I performed the operation with great ease in a case in which the diameter of the os was not more than an inch during the pain, and where there was barely room to introduce the blades. Of course in this case the parts were all soft and lax; the patient was dying comatose of tubercular meningitis; she was in the seventh month of pregnancy; the child was living, but the pulsations were becoming weak; and we thought it was a most justifiable proceeding to make an effort to save the child—and in this we were fortunately successful.

When the bony pelvis is contracted from deformity, but not to such an extent as to preclude all hope of delivering a living child with the forceps, it is usually recommended to leave the case to natural efforts for some hours, even after the rupturing of the membranes. It is said these efforts, if they do not effect delivery, will so mould the head as to make it pass more readily on the application of the forceps.

This is a point upon which I am not satisfied. If the bones of the foetal head are feebly ossified, if the fontanelles are large and open, and the sagittal suture also open, and easily traced from one fontanelle to the other, some moulding of the head and overlapping of the parietal bones will undoubtedly take place, with consequent reduction in its size.

But if the fontanelles are small, and ossification of the bones firm, and very slight possibility of overlapping of the parietal bones, the moulding which such a head will undergo in a slow difficult labour will be more apparent than real, and will be due to the lengthening out of the head from the development of the caput succedaneum.

If any moulding or reduction of the foetal head does take place it is counterbalanced by the dryness and tumefaction of the soft parts which are sure to set in, and which make natural and instrumental delivery much more difficult and dangerous to both mother and child. I was forcibly impressed of the necessity of early operation in a case which I attended in the year 1877. The patient was a small rickety woman, not much over four feet in height. It was her fourth confinement; the three previous ones were instrumental, and the children dead born.

A very large projection of the promontory of the sacrum, which inclined to the left side, was discovered on examination. It was so near to the vulva that on first touching it I thought it was the child's head coming down on the perineum. The head was, however, in front of this, and high up; the membranes were intact; the os

was about three quarters dilated, but soft and dilatable; the soft parts were all moist and in good condition; the head was presenting in the first position.

I stated at once that natural efforts would not effect delivery, that I was afraid I would require a consultant, but that I would first try the use of the instruments myself. I ruptured the membranes, and managed to get the forceps nicely locked over the ears. By forcible traction during the pains, and loosening the blades in the intervals, so as to relieve pressure on the head, I at length brought it through, and she was delivered of a living child.

It was only then I learned that the three previous deliveries were craniotomies; that she was usually two or three days ill; had two medical attendants each time, and that all had expressed their opinion that delivery at term of a living child would be an impossibility; and that for her own safety, if she again became pregnant, premature labour should be brought on at the seventh month. My success in this case, I believe, depended upon early operation, when the parts were moist and afforded every facility for the gliding over them of the head. She was only about three hours ill. I have since attended her in confinement, but found more difficulty; she had been longer in labour before sending for me. I delivered her with the forceps, but the child was dead, or rather died immediately after birth. Since the above was written I have again attended this patient, and by early operation delivered her of a living child.

Dr. Playfair, in speaking of the risk to the mother in labour obstructed by a contracted pelvis, says—"The long-continued and excessive uterine action produced by the vain endeavours to push the child through the contracted pelvic canal, the more or less prolonged contusion and injury to which the maternal soft parts are necessarily subjected (not infrequently ending in inflammation and sloughing, with all its attendant dangers), and the direct injury which may be inflicted by the measures we are compelled to adopt for aiding delivery, all tend to make the prognosis a matter of grave anxiety." Now in the first part of that paragraph there is a general acknowledgement of the evils to the mother attending delay in obstructed labour, and in the second part the injury inflicted on the mother by the means we are compelled to have recourse to when natural efforts fail is only hypothetical—it may or may not take place.

When it is admitted that delay is attended with such injury to the soft parts as inflammation, sloughing, and their consequences, should we not endeavour by timely interference to prevent this injury being done? I think we should, unless there be a greater danger occasioned by interference. But as this interference is needed in the long run in the majority of cases, is it not as likely to produce then the same or, perhaps, greater injury than if it had been undertaken early? Again, in referring to the risk to the child in protracted labours, he says:—

“Even in cases in which the contraction is so slight that the labour is terminated by the natural powers, it has been estimated that one out of every five children is stillborn; and as the deformity increases in amount, so, of course, does the prognosis to the child become more unfavourable.” In the interests of the offspring it is therefore clear that there should not be too much delay in the labour; and the statistics of Dr. Johnston, of the Rotunda Lying-in Hospital, and others, show that the timely application of the forceps lessens very considerably the infantile mortality.

When, therefore, the conjugate diameter is about three inches (and in the case I quote it was not more), and there is scarcely a hope that labour will be terminated by the natural efforts, and if the os is dilated or dilatable, I would wait for no moulding, believing that the compression exercised by the forceps and the moist and lubricated condition of the soft parts will amply compensate for this deficiency, and will give a better chance of a live birth, and do less injury to the mother.

Even when the disproportion between the pelvis and the foetal head is slight, and there is a fair possibility of labour terminating naturally but slowly, I think we are justified in assisting nature by the use of the forceps.

Those cases in which the cavity of the pelvis is deep and the tubera ischii approach close to each other, labour is usually difficult, painful, and slow. Pelves of this kind are often met with in this town among the working classes, and delivery is usually effected in the end by the forceps. Occipito-posterior positions of the child are also usually difficult and slow; and in these two latter cases I do not delay too long, because from experience I know that in the majority of cases the forceps have to be had recourse to in the long run. I have never seen any harm result from the timely use of the forceps, and in the last 500 cases of midwifery of which I have a record I find I used them fifty-five times, or once in about every nine cases.

The Application of the Binder.—The proper application of the binder is a matter, I believe, of very great importance, and yet very little reference is made to it in works on midwifery. The only directions regarding it are to pull it well down over the trochanters and hips, and to put it on comfortably tight.

Very often it is pulled down too low, and this not only prevents the patient from being able to pass water, but it also interferes with the free egress of the lochia, and may thus from retention cause putrefaction and septicæmia. It should be only so low as to give it a sufficient hold to prevent it slipping up around the waist.

Again, I have found that the pad, the use of which most obstetricians recommend, has occasionally an injurious effect. If, as directed, it is placed immediately over the uterus and the binder tightened on it from below, it will either slip over the uterus, or it will push the uterus before it high up in the abdomen.

If anyone takes a small hard pad and places it on the uterus, immediately above the pubis, and firmly tightens the binder upon it, you will find that it will shoot the uterus upwards in the abdomen. I have on several occasions, on my first visit after confinement, found the uterus lying at the margin of the costal cartilages in either hypochondriac region.

In such cases there was always considerable secondary hæmorrhage, and I thought the position depended upon the relaxation of the uterus which generally accompanies hæmorrhage. I afterwards saw that it was the faulty application of the binder and pad which gave rise to both these conditions. The following case is an example:—

I attended Mrs. F. in her first confinement last August. She had an easy labour, and a twin birth. Before applying the binder the uterus was firmly contracted, and there was little loss. I left her in a very satisfactory condition. Five or six hours afterwards a messenger came to say she was very faintish, and had a great loss. On loosening the bandage the uterus was found lying up under the right costal cartilages, and the pad in a position below it. I pressed the uterus down into its place, and the hæmorrhage ceased. Several other cases of a similar kind have come under my notice, and all were attended with secondary hæmorrhage of a trickling kind. I need not mention the evil effects likely to follow upon the enlargement, and the filling up of the interior of the uterus with clots—after-pains, inflammation, and septicæmia are the most immediate, subinvolution and displacements are probable remote effects.

The pad, if used at all, I think should be placed above the uterus, and not upon it, and care should be taken in pinning the bandage not to stretch it too tightly on a line immediately over the uterus, because the uterus not being so likely to go downwards will go upwards, and free itself from the pressure.

Dr. R. Moore proposed [by] Dr. McFarland seconded by the Secretary.

James Cuming, President

Ninth Meeting Session 1881–1882.

Present, Professor Cuming in the chair, Dr. Harkin, Workman, Core, Fagan, Byres, McConnell and Whitla, (Dr. S. Browne, Jnr.).

Dr. R. Moore was unanimously elected a member of the Society.

It was resolved that the books and periodicals recommended by the Council should be got for the Society (vide report of Council 11/3/82).

The Honorary Secretary was directed to procure copies of the two Bills before Parliament (relating to infectious disease) and to submit them to Council.

It was also resolved to ask the Librarian to find out the missing and back numbers of the New Sydenham

Society and to supply the lists to Dr. Byers who kindly consented to order them for the Society.

Dr. Core read a paper on a case of land-scurvy.

Paper:¹ SCURVY, which in past ages was such a human scourge that we find it stated as probable “that it has been more destructive to mankind than any other disorder,” is now so rare, at least in civil practice, that I thought the notes of the following case might not be uninteresting—masked as it was at first, and the diagnosis obscured by an injury.

The ætiology of the disease still being unsettled renders it also desirable that any case which might assist in the determination should be recorded.

On the 16th December, 1879, I was requested to see W. A., a locomotive engine-driver, who, I was informed, had sustained an injury at the Northern Co.’s Railway. On visiting him I learned that some days before he had been standing on the upper step of his engine, the weight of the body resting on the toes of the left foot, he holding on by the handrail. His foot slipped off the step unto another similar one about two feet lower, when he felt as if something had given way in his leg, coupled with a sharp burning pain. He was able, although with difficulty, to remain at his work for a week, when, finding himself getting worse, he sent for me.

On examination I found the injured limb semiflexed, a hard swelling in the popliteal space, and reaching half way down the muscles of the calf, the skin extensively ecchymosed, part of the discoloration being recent and part fading away. There was slight tenderness. He not only made no other complaint, but said his health was as good as usual. His face was of an ashen hue, but as I knew his colour was bad at the best I paid no attention to that.

I was astonished that he had been able to walk about so long after what the signs appeared to prove had been a considerable rupture in the muscles of the calf. My astonishment, however, carried me no further in my investigations, and I prescribed strict rest for the limb, and an evaporating lotion. Under this treatment no improvement took place, fresh effusion occurring from time to time, while the old discoloration faded away. On attempting on one occasion to get out of bed a fainting fit occurred, lasting long enough to cause serious alarm.

So matters were, when at one visit I saw a new ecchymosis situated in the hollow beside the tendo Achillis, quite unconnected with the original seat of injury. Guided by this ray of light, I found enough in a few seconds to establish the diagnosis of a well-marked case of scorbutus, a disease now so rare in this potato-eating country as perhaps to palliate its being for a time overlooked. There were extensive ecchymoses at both ankles, at the gluteal folds, and reaching down the thighs, as well as brawny swellings in both hams, with

contraction of the hamstring muscles. The gums were spongy, rising up so as almost to hide the teeth, and bleeding when touched; the breath foetid; pulse 120 and weak. When asked why he had never complained about his mouth, he replied that he had attributed its condition to having given up smoking when he took to bed, and did not think it worth while to mention it.

A piece of characteristic information now came out—vis., that the patient had for some time thought that his skin must be getting very thin, as he could hardly dry his face with an ordinary towel without drawing blood.

His diet had always been, as he thought, of the most liberal kind, consisting of plenty of beef and mutton, bacon, eggs, bread and tea, oatmeal porridge and milk. For twenty years, however, he had not eaten potatoes, except a few each autumn when they were new, and from the time he had come to Belfast to live, about three years before, he had eaten neither these nor any other fresh vegetable.

The diagnosis being clear, the prognosis was confident and reassuring, and the treatment easy. Plenty of mashed potatoes and other antiscorbutic vegetables, with lemon juice ad libitum, made in a few days a marked improvement.

No further ecchymoses took place, the old ones gradually disappeared, the gums regained their normal condition, and strength returned. The hard swellings behind the knees and the contractions of the hamstring muscles remained longest, but these, too, disappeared, seemingly assisted by occasional faradisation, so that he was able to resume work after having been absent eleven weeks.

In this case, but one of the many, circumstances which at various times have been supposed to be causes of scurvy was in operation. The patient, a well-to-do mechanic, was temperate in habit, always warmly clad, had from the nature of his employment an exceptional amount of fresh air, was accustomed to a good allowance of animal food, was subject, as far as I could make out, to no depressing influences whatever—all these favourable circumstances, however, being inefficient in maintaining health, fresh vegetables being wanting. The latter having been supplied, recovery at once took place.

Mr. Fagan read notes of a case of tumour of the pharynx and showed the patient.

He also showed a patient from whom he removed a large lymphatic gland over the carotid region.

It was resolved to pay the porter £1-1-0 for his serving in connection with the Society room for the present session.

The Secretary read a letter from Professor Dill who was unable to be present, in which he promised a paper on accidental hæmorrhage for next night.

George F. Wales

¹ [Dublin Journal of Medical Science, 1882, v74, p339.]

Tenth Meeting Tuesday 28th March 1882.

Present, Dr. Wales (in the chair), Dr. John Moore, Professor Dill, Drs. Esler, Dempsey, Mackenzie, Workman, Dr. S. Brown, Jr., Dr. McConnell, Dr. Harkin, Stewart, R. Moore, J. W. Browne.

Dr. Murray brought the matter of a petition to Parliament in relation to Medical Officers' Superannuation (Ireland) Bill. This was referred to the Council.

Professor Dill exhibited an abnormal placenta and afterwards read a paper upon "Accidental hæmorrhage and its relation to other uterine hæmorrhage".

Dr. J. W. Browne exhibited a bony plate of the choroid.

James Cuming, President

Eleventh Meeting Tuesday April 18th 1882.

Present, Professor Cuming, Dr. Wheeler, Dr. K. Wheeler, Esler, Workman, S. Browne, McFarland, O'Neill, Dill, and Dr. Whitla.

In the absence of Dr. McKeown the Secretary showed a patient upon whom he operated for a large tumour of the orbit.

Dr. McFarland read a paper upon recruiting.

Paper:¹ *THE subject of Recruiting is not one of much importance to the medical profession in Belfast, as there is a military dépôt here where recruits are at once seen and examined by a military medical officer. I selected the subject for the last meeting of the Ulster Medical Society, as I thought some of our brethren from other towns would be present, who frequently have to examine recruits, and to whom the following hints might be of use, or, at any rate, would be calculated to put them on a good understanding with their military brethren.*

Very frequently recruits are passed in country towns by civilian practitioners, sent up to the dépôt for approval, and there rejected as unfit for the service. Now, when this happens repeatedly, the civil doctor feels his dignity hurt, and sometimes imagines there is an animus on the part of the military surgeon. It is no unusual thing to see him come up to the dépôt to ask the meaning of all these rejections. The truth is that the military surgeon is not actuated by any animus, nor has he any feeling of dignity on the subject, but simply has to protect himself from an official scrape.

The rule of the service is that the approving medical officer must be a military surgeon on full pay. This does not mean that he is more competent than a civil doctor, or than a military surgeon like myself on retired pay; but it is that the authorities can call him to account if he passes bad recruits in a way that cannot be done to us. He may be removed from his appointment, declared to be inefficient, or punished in various ways.

Once a recruit comes before a military medical officer for approval, that officer is solely responsible for

him. Whatever correspondence takes place afterwards is with this military surgeon. If a man is found to be under height or under chest measurement on joining his regiment, the officer commanding is bound to report the fact to the Commander-in-Chief, who then calls upon the officer commanding the dépôt where the recruit was approved for an explanation why the recruit was passed into the service under the regulation size? The officer commanding the dépôt then calls on the approving surgeon, who has then to defend his position as best he can.

If a recruit is declared unfit from other causes—say defective sight, not being able to see the target at the required distance—a medical board is ordered to assemble, and if the board declares the recruit to be unfit for the service, the military surgeon is called upon to explain why he approved of a recruit who was afterwards declared to be unfit for the service by a board of medical officers—a very difficult and unpleasant question to answer.

You will see from these remarks that it is of vital importance to a military surgeon that his recruits are not objected to. Written rules are laid down by Government on the subject; but like an operation in surgery, it is one thing to know how it is done, but another thing to do it practically. By following the rules I will now give there is little chance of recruits being objected to on joining their regiments.

There are two sine quâ non rules which must be observed. One is, the recruit must be examined perfectly naked, and the other that the surgeon make the examination himself. I will illustrate the first rule by one case that occurred to me out of many of the sort. I found a young soldier in the ranks of a regiment I had charge of lame and unable to march. He had bunions and deformed toes. On questioning him as to how he passed the doctor, he told me the doctor was in a hurry, and that he was stripped all to his stockings! No doubt the recruiting sergeant made him keep them on!! It is most essential that a line soldier should have good feet. There is just one pattern boot worn by the infantry; it is called the ammunition; it is the best worn by soldiers of any European army, but a man must have good feet to wear it. They are, of course, made of different sizes, and are used in all climates. A soldier may be served out with them when on active service, and, of course, must be able to wear them at once. The man I speak of could not wear the ammunition boot at all. Secondly. The approving surgeon must examine the recruit himself, as otherwise he may be imposed upon. In any case he must be in a position to say, if the recruit should be objected to, that he examined the man, and found so and so. It will not do to say he saw the man examined, or was present.

In examining a recruit, there are two men the doctor must beware of. One is the recruiting sergeant, and the other the recruit himself. The recruit will make the

¹ [Dublin Journal of Medical Science, 1882, v74, p255.]

most of himself when he wants to enlist—stretch himself up when measured for height, try to swell himself out when measured for chest; but, by-and-by, when he joins his regiment, and begins to repent of the step he has taken, he will make the least of himself. Commanding officers like to have big men in their regiments, and are only too glad to report if recruits are under the standard measurements. Directly the approving military surgeon signs a recruit's attestation paper passing him, the recruiting sergeant gets one pound in cash. These fellows are as wily as foxes; they know that a recruit is taller in the morning than evening, so if he is a little under size they will keep a lad in bed a couple of days, and bring him straight over to be examined, so as to gain perhaps the required half inch. A recruit with varicose veins to any extent is ineligible. A recruiting sergeant will bandage him up to the last minute. Recruits must be eighteen to twenty-five years of age; they will smarten up a man of thirty, make him shave off his whiskers, get his hair cut short, assume a juvenile air, and swear he is only twenty-five. The surgeon is responsible for a recruit's apparent age.

The examination of a recruit and filling up of his attestation paper takes seven or eight minutes, and should be done in the following way:—First, take a good look at him, stripped; if he has inveterate skin disease, marks of scrofula, syphilis, bad varicose veins, rupture, adherent cicatrix, or deformity, reject him. If not measure him for height. This is done by making him stand on the measuring standard; put one end of a tape measure under his heels, keep a steady pull on the other end. If he rises on to his toes the tape will come from under his heels, and you will know it. If he has a great thatch of hair on the top of his head take off a quarter of an inch for it; bring the horizontal beam right down on the top of his head, and read off the measure from the index.

Next take the chest measurements. Make the recruit put his hands over his head, put the measuring tape on the inferior angles of the two scapulæ behind, then make him slowly let down his arms and count ten, and at the same time the surgeon draws the tape together across the chest when the recruit counts ten. This is the Government rule, but I have found from experiments that a man can count ten without any diminution of the chest; but make him count twenty, and, at fifteen or sixteen, he will catch his breath—that is the time to draw the tape together, and you will get his true measurements. The lower edge of the tape should rest on his nipples in front.

Next for the limbs. Make him kick out with both legs alternately, hop up and down the room on either feet, springing lightly on the toes; bend the ankle-joints and toes of each foot alternately, kneel down on one knee, up again, then on the other, then on both, springing up upright; then turn round, separate the legs, stoop and touch the ground with both hands, the knees being

straight. In this position it will be seen if the recruit has piles, or fistula, &c.; rise up, turn round, stretch the arms up with hands over the head, cough forcibly. Examine in this position for hernia or weak inguinal rings, also for varicocele—varicocele to any extent with dependent testicle is a cause for rejection. This completes the examination of lower extremities. Examination of upper extremities is done by making the recruit swing round one arm and then the other, to test shoulder-joints; then strike out both fists, to test elbow-joints; then press elbows to sides, with forearms flexed, and rotate forearms; then bend wrists, twist them round and round, open and shut fingers, to see if any are stiff or deformed; flex thumbs on palms of hands, and extend alternately; there must be perfect use of fingers and thumbs. This completes examination of upper extremities.

The heart and lungs are now to be carefully examined with the stethoscope to ascertain their soundness; any abnormality is cause for rejection. The recruit is to be asked if he has ever had fits of any kind. Mouth is to be carefully examined to ascertain if he has a fair set of teeth, throat free from ulceration, palate sound, &c. The ears are to be carefully examined, also the cranium and the eyes. The test dots, War Office Form 1233, are to be used for examining the sight. The recruit must be able to tell the number of dots at the required distance (15 feet) with each eye, one being covered while the other is being examined. This part of the recruit's examination must be performed with the greatest care and circumspection; it is of the utmost importance.

Of no less importance is the next part of the examination—which is conversation with the recruit. The surgeon having placed the recruit at a distance holds conversation in a low tone of voice, to test his hearing powers by the recruit's answering; the surgeon will observe if there is any hesitation in his speech, and if his intellect is good. The recruit is also to call out in a loud voice "Who comes there?" It is of the utmost importance to ascertain the mental state of the recruit; the only guide, most likely, the surgeon will have will be the appearance of the recruit, and his answers to questions.

This, gentlemen, is the ordeal to which any approving military surgeon will subject a recruit; and civil practitioners may rest assured that unless the recruit can satisfactorily pass through this ordeal he will be declared unfit for the service.

He showed two patients, brother and sister, affected with Duchenne paralysis.

Paper:¹ DR. M'FARLAND at the same time showed two interesting cases of pseudo-hypertrophic muscular paralysis occurring in a brother and sister. Both were very typical cases. The father of the children had been

¹ [Dublin Journal of Medical Science, 1882, v74, p258.]

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confined in an asylum, but was now employed as a porter. He seemed of very inferior intelligence, and very reticent, or else very stupid. This relationship with a father of unsound mind was considered to be a point of great importance in the case.

James Moore M.D. Chairman
2nd May 1882

LIST OF MEMBERS, 1ST MAY, 1882
WITH THE DATES OF THEIR JOINING THE SOCIETY.

HONORARY MEMBERS (elected in 1881).

SIR W. MAC CORMAC, F.R.C.S.E., E.R.C.S.I.
J. W. MOORE, M.D., F.K. & Q.C.P.I.

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L.S.A.L.
1858—ROSS, R., M.D. Univ. St. And., L.R.C.S.I.
1881—SMITH, JAMES C., L.R.C.P. & S.Ed.
1848—SMITH, J. W. T., M.D. (Q.U.I.), L.R.C.S.I.
1861—SMYTH, B., M.R.C.S.E., M.B., M.Ch. Dub. Univ.
1849—SMYTH, J., L.R.C.S.I.
1877—SPEER, W. S., M.D., M.Ch. (Q.U.I.)
1881—STEWART, JOHN, L.R.C.P. & S.Ed.
1881—THOMPSON, ED. C. (Omagh), M.B. Dublin Univ.,
L.R.C.S.I.
1877—WADSWORTH, CHAS., L.R.C.S. & P.Ed,
1866—WALES, G. F., L.F.P. & S. Glas., M.D. Abdn.,
F.R.C.S.Ed.
1846—WHEELER, T. K., M.D. (Q.U.I.), L.R.C.S. Edin.,
L.A.H.D.
1881—WHEELER, T. K., M.D., M.Ch. (Q.U.I.)
1858—WHITAKER, H., M.D. (Q.U.I.), M.R.C.S. Edin.,
L.A.H.D.
1873—WHITLA, W., M.D. (Q.U.I.), L.R.C.S. Edin.,
L.A.H.D., L.R.C.P.Edin.
1877—WORKMAN, CHAS., M.D., M.Ch. (Q.U.I.)

Twelfth Meeting was held upon Tuesday May 2nd 1882.

Present, Dr. James Moore in the chair, Professor Dill, Dr. Wales, Snr., McFarland, Esler, Workman, Core, Mackenzie, Johnston, McKeown, Fagan, John Moore, and Whitla, and Wadsworth, Kevin, Robert Moore.

Dr. McKeown exhibited some specimens of puff-ball and made some remarks about its hæmostatic qualities.

Professor Dill showed a valuable and most interesting series of rare and new midwifery forceps and made an able explanatory statement.

Dr. Core give an account of a case of rupture of the uterus.

Paper:¹ ON the 12th April last I was requested to see R. A. M., a married woman of thirty-six years of age, pregnant for the ninth time and expecting her delivery in about a month. She had that morning a slight "show," some pains, was frightened, and hence the summons.

¹ [Dublin Journal of Medical Science, 1882, v74, p338.]

On examination *per vaginam* I found the os uteri undilated, the cervix hard, thickened, and fissured, and the head presenting. There being at the time neither hæmorrhage nor uterine action, I prescribed rest in bed, and two grains of opium. I left, giving directions that I should be sent for when labour set in. At ten o'clock on the following morning I learned from a messenger that there had been pains and some loss during the night, but that neither had been such as to cause the woman to wish me to be sent for. I arranged to call at eleven o'clock, the messenger having been instructed that there was no urgency. On calling I found from the patient herself that the pains had been pretty constant and pretty severe for about two hours, but that from about ten minutes before my arrival none had occurred. She was restless, but did not make any complaint, and the bed being in a dark and nearly inaccessible recess in a badly lighted room, I did not at first notice anything particular in her appearance, and up to this time neither the patient nor any of those around her had any idea that there was anything in her condition more than ordinary.

On making an examination I found the os two-thirds dilated, and occupied by a soft mass, feeling rather like a placenta, but which further investigation proved to be a clot. Not being able to reach the head, which the previous day had been presenting, I passed my hand over the abdomen, and was easily able to make out that nothing intervened between it and the fœtus but the abdominal wall. That a rupture of the uterus had taken place, with a partial escape of the fœtus into the abdominal cavity, was unfortunately only too apparent; and as collapse was slight I decided, after sending for assistance, to administer a dose of ergot, and deliver as speedily as possible. This was done in a few seconds by turning and without any difficulty, the fœtus being dead and considerably decomposed. In the hope, rather than expectation, of ensuring contraction and thereby stopping hæmorrhage, I introduced my hand into the womb, found that the placenta was lying loose in the abdomen, having passed through a rent in the anterior wall near the fundus, through which also a hernia of the intestines had taken place. There was no contraction, and the placenta was easily removed. Half an hour after delivery was completed death took place. I found, on referring to my obstetric case-book, that on February 29th, 1880, I was asked to see the same woman, who was said to have been for a considerable time in labour, the expulsive efforts having been very forcible and frequent, but quite ineffectual. After examination I caused her to assume a dorsal position, which, by rectifying an extreme anteversion of the womb, allowed the labour to proceed quickly and naturally to its termination.

On making subsequent inquiries I learned that for the last four months of the pregnancy which ended fatally, Mrs. M. had been in bad health, which dated

from a tedious attendance on one of her children who died. During these months she had suffered from a fixed pain, which, from description, appears to have been at the fundus of the womb. The comparative ease, so to speak, with which the rupture in this case took place is noticeable, the actual rent not having been preceded by any violent uterine action, and not being accompanied by pain or by any sensation of anything having given way. Taking the circumstances of the previous confinement into consideration, and remembering the state of health of the patient during the preceding four months, it would seem that ordinary uterine action, rendered ineffectual probably by a want of parallelism between the long axis of the womb and that of the inlet, and to some degree also by a hypertrophied cervix, was too great a strain upon the muscular tissue near the fundus (weakened at that part by a localised metritis) which consequently, to use a graphic phrase, tore like wet brown paper. The exact pathological condition is unknown, no post mortem examination having been allowed.

James Moore M.D. Chairman
14th November 1882

Annual Meeting Session 1882–83 was held upon July 11th 1882.

Present, Professor Cuming President in the chair, Professor Dill, Drs. Wheeler, Snr., Whitaker, Aickin, Mackenzie, McFarland, John Moore, Byers, Workman, O'Neill, Dempsey, Whitla, Wadsworth, Kevin, Esler, J. W. Browne.

The President showed a patient suffering from severe chronic spasm of the neck.

Dr. Dempsey read notes of a case of ascending paralysis.

Paper:¹ Acute ascending paralysis is a disease of such comparative rarity that I believe the details of the following case will be found interesting to the Society.

Rev. A. B., aged thirty-six, of dark complexion and feeble constitution, was seen by me on the 14th of March, 1882.

Previous History.—He had an attack of typhus fever about eleven years ago of a very severe nature, and from which he made a slow recovery. From that time he had shortness of breath and a slight cough, and from my own knowledge he had crepitus at the apex of his left lung for seven years. This appeared to be stationary, and did not give him much trouble. He was able to attend to all his duties, which latterly were of an onerous nature—in fact he was doing the work of a fellow-clergyman as well as his own. Previous to his illness many of his friends remarked that this extra work was telling upon him. About the middle of February he had to attend some cases of small-pox, and, being afraid of

¹ [Dublin Journal of Medical Science, 1882, v74, p341.]

the disease, he asked me to re-vaccinate him, which I did on the 21st of February with calf lymph. It took well, and ran through the usual course—the scab falling off a day or so before my visit to him on the 14th of March.

His present illness commenced on the 5th of March with a cold in the head and in the chest—with cough and expectoration. An eruption of herpes appeared at the same time on his mouth and nose. He felt generally out of sorts, but was not so ill as to necessitate his remaining in bed or even in the house. He attended to his clerical duties, though not so much as usual, but this was more because of the unsightly eruption on his face than of his unfitness for the work. His appetite was not affected. On the morning of the 10th of March, while shaving, he remarked a numbness and want of sensation in his fingers. He could not feel the razor in his hand. This numbness was felt in the thumb and the two first fingers of both hands, and extended as high as the wrists. Numbness was also felt along the backs of the thighs and legs, and in the soles of the feet. On Sunday, the 12th of March, with these symptoms unchanged, he officiated twice, and in the evening preached for nearly an hour. He felt very much exhausted after this effort. The next day he was a little better, and, the day being fine, he went out for a long walk. He attributed the numbness in the legs to bad circulation, and he thought a good walk would make him all right. He walked very fast for about four miles, but did not feel his feet touching the road. The sensation was similar to that of walking on deep snow. He was thoroughly exhausted when he came home, but eat a good dinner. Before going to bed he took a large dose of Eno's fruit salt, which acted several times during the night. He rested very badly—felt hot and uncomfortable, and perspired very freely. However, perspirations had been very profuse for the last two or three nights.

The following day I found him sitting at the window with a newspaper beside him, which he had been trying to read, but the letters after a time became so blurred and indistinct that he was obliged to give it up. This temporary defect of vision was the only one complained of during his entire illness. The conjunctivae were congested, and the pupils moderately contracted. This condition of the pupils remained throughout. The conjunctivae, however, in a day or so became normal. His face was deadly pale, and the expression worn and haggard. From the beginning he had neither dizziness, headache, nor pains in the back or legs. Pressure on the spinous processes did not cause pain. His legs and hands were quite cold, though he felt a burning heat in them. His grasp was moderately firm. The patellar tendon reflex was present. On getting him to walk I noticed slight unsteadiness in his gait. He lifted his feet well off the floor, but let them down in a tremulous clumsy way, somewhat like an ataxic patient. He complained of great weakness in his legs and back. Pulse was 74, and temperature 98°; tongue was coated with a light yellow fur

in the centre, red and moist at the edges and tip. There was no disturbance of the bladder. He passed water freely, which was loaded with lithates, but was free from albumen. Breathing was hurried, and there was dulness and crepitus at the left apex, and moist râles scattered through both lungs. Expectoration was thick, and slightly rusty in colour. The heart's sounds were healthy and regular, but the pulsations were forcible and visible over the front of the chest. His mind was perfectly clear. I prescribed bromide and iodide of potassium, a mustard foot bath, a large mustard blister to the back, and rest in bed.

March 15th.—Pulse 70, temp, normal. Spent a very restless night. Complains of an intolerable burning heat in the legs and up along the spine. This was the most annoying symptom he had, and it continued during the remainder of his illness. He also complained of burning heat in his mouth, but he had no thirst. The weakness in his legs is increasing. He attempted to get out of bed in the morning, but fell on the floor. He can draw his legs fully and quickly up to him in bed, or move them about, and he can raise his arms up or move them in any direction, but his grasp is much more feeble than it was yesterday. I got him out on the floor. He raised himself off the bed with great difficulty, and when up could not stand without support. His legs were very weak and gave way under him, and this was especially the case when he attempted to turn on the floor. This effort to walk quite exhausted him. Patellar reflex is present, but more feeble. Has some difficulty in swallowing today—some tea taken quickly came back through his nose. There is no paralysis of the face, and he protrudes the tongue in a straight line, and there is no difficulty of speech. During the night had a sharp boring pain in the head; it only lasted for a short time, and was the only actual pain which he had anywhere during his entire illness. Sensation was impaired, but not lost. Contact with the skin was delayed in perception, and this was especially the case in the lower parts of the legs. Sensibility was not further disturbed during the disease. The cough was troublesome owing to the accumulation of phlegm, and there was an evident inability to expectorate it though it was quite loose. I had the advantage of Dr. Cuming's assistance in the case today. The bowels not having acted since, we prescribed a brisk purge, and the bromide was reduced in quantity and the iodide increased, while derivatives were applied along the spine.

March 16th.—Pulse 60, temperature normal. Had one hard motion this morning. Has difficulty now in drawing the legs up to him, and there is less power in the arms. Sitting up and turning in bed are becoming impossible without help. No muscular twitchings or spasmodic manifestations in the extremities, nor pain on touch or pressure anywhere. The difficulty of swallowing is increasing; urine is passed freely; perspirations have ceased.

March 17th.—Pulse 60, temp. 98°. During the night was almost suffocated with the secretion which accumulated in his chest, and which he was unable to expectorate. Cannot turn or raise himself in bed. Legs are quite lax, and the greatest efforts only cause the slightest movement in them. They offer no resistance to passive movements, and exhibit no kind of tension or twitchings. If fully flexed upon the abdomen it gives rise to slight pain. The patellar reflex is completely absent in both legs. Arms can still be raised off the bed in a tremulous zigzag way. He is no longer able to grasp the hand. The respiration is still more embarrassed, but the movements of the diaphragm are unimpaired. Deglutition increasing in difficulty. Speech is slightly thickish, but the mind is perfectly clear. At 4 p.m. his pulse was 58 and very weak. Deglutition had become so difficult that he was almost unable to swallow anything.

When then with him I gave him a pill. After a long time he got it down, but was uncertain of the fact, and insisted on me examining his mouth to see if it was not still in it. Respiration was very much embarrassed, and he was making constant but ineffectual efforts to expectorate. There was now complete paralysis of the legs, but he was still able to move the arms a little. The bowels have never acted, though repeated purgatives have been administered. The functions of the bladder are still unimpaired. There is no paralysis of the face, he can shut his eyes, and corrugate his eyebrows. There was no appearance of bed-sores.

He died at 7.30 p.m. He was wanting to get out of bed, and his legs were pulled over the edge for him. He was raised a little up, but immediately expressed a wish to be let down again, and he quietly expired. That was the eighth day after the first symptoms of numbness, the fourth day after the first indication of motor paralysis, and the thirteenth day after catching cold.

Remarks.—We had not the advantage in this case of verifying our diagnosis by a post mortem examination, but the history and symptoms of the disease were so well defined that I think we were justified in founding a positive diagnosis upon them. A post mortem examination, however, in this disease has not revealed in any case yet reported any anatomical changes in either the spinal cord, the medulla oblongata, the brain, the sympathetic nerves, the peripheral nerve trunks, or the muscles.

In the spinal canal, where the symptoms would lead one to expect to find evidence of anatomical change, nothing of an abnormal kind has been discovered.

Neither hyperæmia, myelitis, destruction of ganglion, or of nerve fibres has been found by any of the methods at present available for pathological investigation, so that the disease must be due to some impalpable disturbance of nutrition of so fine a nature as to escape detection.

However, Dr. Ross, of Manchester, in his work on "Diseases of the Nervous System," publishes a case

which was diagnosed as acute ascending paralysis, and in which, on post mortem examination, the central column, the median area, and the central group of ganglion cells, were found to be diseased. "The diseased areas showed granular degeneration of Gerlach's nerve network, complete disappearance of the ganglion cells, increase of nuclei, and dilatation and congestion of blood-vessels." But this patient, who was a female, was not seen by Dr. Ross during life, and the history given of her illness is somewhat imperfect.

The absence of paralysis of the sphincters was one of the strong points which we relied on in distinguishing this disease from acute central myelitis. In the latter disease it is often the first symptom which attracts attention, or if not it generally sets in early in the disease. The functions of the sphincters of the bladder and rectum were perfect until the last; indeed, in the case of the latter, obstinate obstipation was one of our greatest difficulties in the treatment—due, no doubt to paralysis of the abdominal muscles and the muscular coats of the intestines.

Again, the character of the onset of the attack and the gradual progress of the disease were different from the usual course of acute myelitis. Its inception was marked by none of the severe disturbances of sensation or of motion which generally characterise the beginning of the latter disease. There were neither muscular spasms, contractions, fibrillar twitchings, nor even pains, during the entire course of the illness, and the sensation was only very slightly impaired.

The progress of the disease was also characteristic of acute ascending paralysis, as first described by Landry, and more recently by Westphal. It slowly crept over the body, without fever, delirium, loss of intelligence or memory, or the development of decubitus, and finally attacked the functions of the medulla oblongata, producing paralysis of deglutition, asphyxia and death.

The condition of the patellar reflex is a point of importance in the present case. There is only one case reported by Westphal in which it was found lacking. In our patient, with the advance of the disease it gradually became extinct, and on the last day of his illness was entirely absent.

In acute myelitis there is early failure of all reflex actions. In the latter disease there is also a rapid development of acute bedsores—a complication which did not arise in the present case.

From acute myelitis disseminata the distinction is not so easy; however, in it, too, there is generally paralysis of the sphincters and spastic symptoms, but often it is impossible to decide the question positively without the aid of a post mortem examination.

In the causation of the disease, catching cold, mental and physical exertion, and some others, are mentioned. In the present case cold, fatigue, and residence in a damp house, are most likely to have contributed to the production of the disease, but there is a possibility,

perhaps a probability, that the vaccination may have been the exciting cause, or at least that it may have had something to do with its ætiology. The infection of variola is said to exercise a great influence in the production of acute myelitis. May not the vaccine virus, in a constitution already lowered by conditions seriously affecting the nervous system, have a similar effect?

If the vaccination in this case had anything to do with the production of the disease it would strongly favour the theory put forward by Westphal, Landry, and others, that acute ascending paralysis is a disease depending upon some intoxication of the blood—because what more likely channel of entrance for bacteria into the blood than by inoculation with calf lymph from an unhealthy animal.

The present is the first case of this special form of disease which I have ever met with, and I think that—even without the light which a post mortem examination would have thrown upon it—it is deserving of record.

The Honorary Secretary read the report of Council. Its adoption was moved by Dr. Wheeler, Snr., and seconded by Dr. Whitaker and passed.

The Treasurer read the report of the financial state of the Society which showed a balance of £64.11.4 in hand. Moved by Professor Dill and seconded by Dr. Workman and adopted.

Dr. Dempsey read a report of the Library which on the motion of Dr. Moore seconded by Dr. Esler was adopted.

It was moved by Dr. Whitla seconded by Dr. Aickin that a special meeting of the Society be called by the Council after they have considered Dr. Dempsey's report and prepared a scheme for the Library.

The office bearers were then elected.

Dr. McKeown **President**

Drs. David Johnston and Aickin **Vice-Presidents**

Dr. Whitla **Honorary Secretary**

Dr. Esler **Honorary Treasurer**

Dr. Workman **Pathological Secretary**

Dr. Dempsey **Librarian**

Council: Dr. McFarland (13), Byres (9), Dill (9), Fagan (9), Mackenzie (9), Wadsworth (9).

Drs. Kevin and O'Neill appointed **Auditors**.

J. Moore 17th July 1883

ULSTER MEDICAL SOCIETY

SESSION 1882–83

First Meeting was held upon November 14th 1882.

Dr. James Moore occupied the chair, afterwards vacating it for the President Dr. McKeown. There were present Dr. James Moore, John Moore, Wheeler, Snr., Professor Dill, Drs. J. W. Browne, McConnell, Nelson, Wales, Esler, Dempsey, Whitla.

The President delivered an able and eloquent address and on the motion of Professor Dill seconded by Dr. Wheeler the best thanks of the Society were accorded to the President for his eloquent and original address.

Paper:¹ *We have been taught from our earliest days, and with most people it is almost a matter of belief, that though merit and worth, whether of individuals or classes, may be neglected or despised, yet sooner or later they are certain to obtain recognition, and to secure for their possessors all the honours, distinctions, and emoluments to which their character, genius, and usefulness entitle them. The medical profession has, I fear, reason to be sceptical of the general truth of this comforting idea. They have been waiting very long and very patiently. From the earliest times in the history of this country no member of the medical profession has been deemed worthy by the Sovereign to be elevated to the same dignity as the members of the church, the bar, the army, and the navy. The bright days of royal favour have not yet reached us. The majority of our most distinguished men, who have spent their whole lives in the service of humanity, and have done work which will bear fruit as long as the records of civilisation endure, have, as a rule, closed their career without any honorary distinction whatever. I do not think that any honour in the power of the Sovereign to bestow would have added any lustre to the name of a Hunter, a Jenner, or a Harvey; but still, that honours should be lavished on other professions whilst the medical profession is overlooked, is a matter for grave dissatisfaction. Had the late Sir James Simpson been a Frenchman doubtless our neighbours, who love to honour merit, would have conferred upon him senatorial honours. Lister—whose patient and laborious researches have revolutionised surgery, made operations, formerly perilous, now comparatively safe, almost banished from hospital the scourges of the surgical wards, diminished vastly the death-roll after all surgical operations, and gained for himself imperishable laurels—would, long, long ago, in any other monarchical State under the sun, have received the highest distinction. But, I ask seriously, has the profession, in pursuit of its just claims to equality,*

followed the path known to lead to preferment? Has it not shown too little self-assertion, too little professional, and an entire want of public spirit? It has had little political influence, because it never tried to have any—it has had, until quite recently, no organisation—it has never shaken a throne or displaced a minister—it has never been a factor to be taken into account in practical politics.

What reason, therefore, had it to expect aught but the reward usually accorded to those who meekly submit to neglect and injustice? To solve the problems of life and disease, and combat decimating plagues, may earn for the physician undying renown; but, to secure proper recognition by the State, the members of the profession must do as the ambitious of every other profession have hitherto done. I should not at all touch upon this question of honours were it not intimately associated with the question of the greatest possible good to be accomplished by the profession for the community.

I do not doubt that, to the philosophic mind, it will appear that a life spent in the quiet, conscientious performance of professional duties, free from the turmoil and bustle of public life, is the best and happiest of all. Were all men, however, to take this view our Social organisation, the result of ages of experience, would crumble into dust. We must have public men, and I hope to show that, in the interests of the State, we should have public medical men.

You will gather from what I have said my opinion as to the cause of this extraordinary and long-continued neglect. It is not merit alone which counts in the race for royal favour—it is political service, political power. Efficient public service cannot be rendered nor political power secured except by obtaining seats in Parliament. If Harvey, Hunter, Jenner, and others, have been the investigators and discoverers, where, may I ask, are the medical legislators to give prominence in our statutes to the lessons of their teaching, and where the medical administrators to give practical effect to such legislation in every corner of the empire? We want in our ranks legislators and administrators. To have chief administrators we require that medical men should be trained in the great school of public affairs. It is surprising how few members of the profession occupy seats in Parliament. I know that to a provincial practitioner it is practically impossible to pursue successfully his profession and devote a large part of his time to Parliament.

But why do not many of the most eminent metropolitan doctors, who have enormous incomes and large fortunes amassed, seek to obtain positions of public influence out of regard for the welfare of the people? Their advice on all legislative matters touching the general health of the community would be certain to command the attention of Parliament. Continuous attendance would not be at all necessary, and their

¹ [Dublin Journal of Medical Science, 1882, v75, p114.]

professional pursuits would not be interfered with so much as supposed. But, even were some loss incurred, surely many members of the medical profession would be found ready to make some sacrifice, like other members of the community, for the public weal, and to follow the example of the late Sir Dominic Corrigan and of Dr. Lyons, the able representative of the City of Dublin. If the profession only think of adding fee to fee, and do nothing more effective in the interest of the State than tender unsolicited advice, then how can they reasonably expect any honour whatever when ministers are besieged by persons whose votes may either make or unmake a ministry?

How grievously the public interests have suffered from the want of medical members of Parliament, it is impossible to overestimate. Let us take the sanitary laws in operation in Ireland as an example. By an Act of Parliament passed only a few years ago, the dispensary medical officers were forced, under pain of dismissal, to accept the position of sanitary officers at salaries to be fixed by the boards of guardians. They derive a large part of their incomes from private practice, and self-interest, therefore, naturally suggests that they should not take sanitary proceedings which would tend to the rupture of friendly relations with their private patients. Their public duty and their private interests are, therefore, directly antagonistic. How, then, can it be expected that, by sanitary reports and legal proceedings, they should incur both ill-will and loss of income—and this, too, for a mere pittance of £10 to £20 per annum?

Both the salaries paid and the officers selected rather lead to the suspicion that it was never meant that our sanitary laws should be really effective. I wish to do the officers every justice. Perhaps, under the circumstances, no body of men could have been found to have acted with more independence and more in the interests of the public. But the whole system is a blunder; and if we are to have the health of the people really looked after, the sooner it is supplanted by an efficient one the better. Indeed into the mind of man a more absurd idea could not have entered than that of making practising dispensary doctors the sanitary officers of the country.

What immediate advantages might be expected from the presence of twenty to thirty medical members of Parliament? Parliament would then have on the spot, and in a position of influence, men who, speaking generally, would be up to the current knowledge of epidemic and other diseases—their causes, modes of propagation, and the measures necessary to stamp them out; and who would be familiar with the general agencies actively at work undermining the health of the people. Further, medical men know more of the conditions of life of all classes, from the lowest in the social scale to the very highest, than perhaps any other class in the community, and I would confidently expect that

any legislation to which medical men actively contributed would bear the impress of the very widest sympathies. But let me particularise a little the vastness of the interests of the nation in an effective sanitary system, which, be it remembered, can only be brought about by the earnest work of the medical profession. I have not the statistics of the United Kingdom before me, but you all know that hundreds of thousands die annually from preventable diseases. Try to estimate the loss to families and the loss to the State by the untimely death every year of this vast army of persons, who are either bread-winners, or have had large sums expended in their maintenance and education to make them bread-winners.

Our losses in war from the weapons of war in the last half century would not probably equal the preventable mortality in a single year. But sanitary affairs are of importance not only to the civil community, but to our offensive and defensive forces. The great question of the health of the army and navy, on which not only our prestige as a nation but our very existence may sometime or other depend, is one especially for medical men. What is the use of a sick army? It is of more importance to have our men well fed, to protect them from unsanitary conditions—and they are legion—than to provide them with rifles a little more or less accurate in aim, or quick in discharge. The sanitary service should be a distinct service in the army, and should be entrusted to medical officers having nothing else to do—all sanitary orders being subject, of course, to the approval of the superior military officer. Besides these very important matters, there are others in which medical men would be able to give opinions more reliable perhaps than any other members of the community—for example, our poor-law, hospital, and asylum administration, protection of infant life, Contagious Diseases Acts, quarantine laws, the Acts relating to the Infectious and Contagious Diseases of Animals, and our Food and Drugs Acts. Further, medical legislators would be expected to have an influence in promoting scientific research by adequate endowments, and I would not confine that research to any one field. It should embrace not only diseases of man and the lower animals, but of plants. Surely it might well repay the nation to prosecute experiments on an extensive scale to ascertain fully the natural history of the potato disease, to find out a remedy more or less efficient, or to warn the people of all the circumstances of a local or general character which influence it. I do not know of any subject of more direct importance to Ireland. This disease so lessens the food-supply as to lead from time to time to a veritable famine, and is to be charged with no inconsiderable part of our social disorders. The discovery of a remedy for the potato disease would be of more material advantage to the people than many deep-sea dredgings or expeditions to observe the transit of Venus!

Ulster Medical Society
Session 1882–1883
President William Alexander McKeown

But now, leaving the general questions, I revert to sanitary affairs to consider the machinery for carrying out sanitary laws. I would say that with a body of medical members, animated by one spirit, the Government would probably be induced to consider seriously the advisability of creating without delay a great State Department of Health with a Cabinet Minister and a subordinate or two with seats in Parliament. I know of no measure of more importance to the whole community, or one which would give greater satisfaction to the profession. Indeed I note this as a happy omen—that the profession is quite unanimous on the question, and that we only need some activity and the appearance of a number of additional able parliamentary champions to secure attention to our views. I believe that we are on the eve of vast and beneficial changes. We are drifting fast to the era of preventive medicine—then a large proportion of members of the profession will be engaged in the prevention, a more congenial occupation than the cure, of disease.

The chief places in the administration of such a State Health Department, or at least some of them, should be filled by those best suited by previous training to deal with all the questions involved—viz., medical members with good capacity for organisation and general management of affairs. The present sanitary officers should be relieved of duties which they never sought, and which they accepted only through the compulsion of the Act of Parliament. The whole kingdom should be divided into large districts, each district having a chief medical officer with assistants, all to be appointed and removable by Government, so as to secure that independence of local interests without which no sanitary system will ever work satisfactorily. These officers should all be legally qualified practitioners with diplomas in State Medicine, and should be required to devote the whole of their time to sanitary work in its broadest sense. The chief sanitary district officer should have some legal training and should hold the commission of the peace. He should be empowered to hold sworn inquiries when to him it should seem fit in all sanitary matters of importance, such, for example, as the cause, progress, and avenues of dissemination of epidemics. All new houses should be inspected and certified by himself or one of his subordinates as fit for habitation before occupation; the sewerage and water supply arrangements should receive his special attention. To inquire into all matters affecting, immediately or remotely, the health of the whole or any section of the community, should be within the functions of the sanitary officers.

Although I have only spoken of the advantage to the public arising from the accession of a large number of medical men to the parliamentary ranks, and the creation of a great State Department of Health with its officers in every district of the kingdom, we cannot close our eyes to the fact that the profession would

thereby derive much dignity and honour. I doubt not also that, with such a department, the medical profession would furnish more aspirants for parliamentary honours than at any previous time, and that the too well-merited reproach of want of public spirit with which the profession has been so often charged would soon be a thing of the past. Let us hope that we may soon have in our British Parliament representatives of medicine not less distinguished than the late Nélaton in the French and Virchow in the German Chamber.

But now I proceed to the second branch of my subject, and one which, though it may seem to bear directly on the mutual relations of the members of the profession to each other, yet involves the great question of the elevation of the profession in the highest degree. Dr. Thompson, the late President of the North of Ireland Branch of the British Medical Association, delivered some time since an admirable Address. He detailed a scheme for the defining of different grades of the profession and regulating fees. No doubt he had given the matter much attention, and all must concede that he dealt with the question in a very able manner. As you are all quite familiar with his views, I shall not enter upon any explanation. I think his proposals hardly adapted to the circumstances of the time. My chief objection to his scheme was this, that I did not conceive it possible to bring about such a change by any spontaneous action of the medical profession. The profession will, in my opinion, only be reformed and advanced by action from without. The self-interest of the public is the lever I would use. Law has seldom been reformed by the spontaneous action of practising lawyers, and Church reform has been very seldom the work of clergymen. I trust this may not seem a very startling proposition. I believe, however, that all professions are so thoroughly conservative that they would hardly ever budge an inch if not impelled by controlling influences outside.

Now, let us examine the hollowness of our whole system of consultations. A patient under the care of a general practitioner drops into the rooms of a consulting doctor, sometimes with a verbal message or a short letter, and as often without either. He undergoes an examination which, under the circumstances, may be very imperfect, receives verbal advice, and very often an opinion so ambiguous, so undecided, as to be practically valueless. Hurried examinations, an endeavour on the part of consultants to do more than they legitimately can, lead to the cultivation of a talent in too much repute—that of concealing all doubts and difficulties, and of giving opinions which in any event will turn out quite correct. Of this course I would even dispute the worldly wisdom. I affirm without hesitation that if we are to have medicine and surgery raised more and more to the dignity of a science, and the profession advanced in worldly estimation, we should aim at having more precise knowledge, more early and

accurate diagnosis, and more certain prognosis and treatment. This can only be secured by an expenditure of time, by giving to each individual case the most painstaking examination. I do not conceal from myself the complex questions which may render a clear opinion almost out of the question, but this only demonstrates the imperfection of our knowledge and the hopelessness of advancing medicine and surgery, which have already attained such vast dimensions, by the labours of men who pretend to an “all-round” capacity. We require concentrated, not diffuse, light to dispel the mists. We must look for the attainment of truly scientific knowledge to the labours of educated physicians and surgeons who, wisely reckoning the slowness of human progress and the shortness of the span of man’s active life, fix their attention mainly on limited departments, explore fields shrouded with darkness, endeavour to add new territory to the domains of knowledge, and utilise all previous discoveries to guide them on their chosen paths of research. Practically almost all our advances have been made by men who have so concentrated their efforts.

I now intend to suggest a mode of consultation which would, I submit, improve greatly the status of the general practitioner, and raise a class of consulting practitioners of special eminence. Let us take a lesson from the legal profession. A man of means, if touched in pocket or in feeling, consults his solicitor, requires a case to be stated for counsel, a fee to be marked according to the difficulties of the case and the standing of counsel. Money is very often no object, and this even in cases involving a mere trifle or arising from offended vanity. Yet, in matters of health and life we have no trouble taken, often not even a letter from the attending doctor; the consultant receives his one, two, or five guineas, as the case may be, for work which, if thoroughly done, would require the examination of almost every organ of the body, complex urinary tests, frequent microscopic examinations, the use of the stethoscope, laryngoscope, ophthalmoscope, sphygmograph, or hæmatocytometer. How many men, in large practice, for any ordinary fee, could be expected to do this work, and how many men are capable? I fear not one but several physicians and surgeons of eminence in special departments would be required to give reports on these questions. Is it to be supposed that a man of ample wealth would hesitate for a moment in a matter of such extreme importance as a question involving his own life to pay liberally for a complete statement of his case by his family attendant, and suitable fees to consultants for a full opinion on every point? We have too little formality in the profession. We are got at much too easily. To carry out such a system as this—and of course it would be applicable only to persons of considerable means—the men in general practice would require more leisure, and the consultants would be obliged to limit very much their consultations both in number

and scope. Then look at the incentives to care on the part of every member of the profession. The doctor who wrote the case would find his credit involved, and would not, therefore, spare any trouble to show himself conversant with all the bearings of the malady; professional men would be very careful about the preparation of documents which might be kept for future reference amongst the papers of their patients. The consultant would be obliged to be equally careful, as in case of an unfavourable opinion he would perhaps be subjected to the judgment of men more able or more careful than himself. This is precisely what happens from day to day in the profession of the law. In case a barrister gives an opinion which is not so clear as to satisfy the solicitor or his client, the same case is sent to one or more counsel for further advice, and the opinions compared. How much better this than the utterly unsatisfactory, haphazard system which has prevailed up to the present time in medicine. I need not point out to you that the adoption of such a system would lead to the cultivation of special branches by consultants to an extent hitherto unknown.

I need not say that I have been a careful observer of a tone of speech which has been cultivated in many quarters, and which is based on false notions of human capabilities, and of what is best for the interests of the public and of the profession. We have heard of the “all-round” man; but, if you allow me to say so, I think the pretension by any man to be what has been called the “all-round” man, bears with it the evidence of rather too much self-satisfaction. I should like to see the man whose opinion in every branch of medicine and surgery, or even medicine or surgery, would be accepted by the educated public with any confidence. Consultants, no matter how great their attainments, or how wide their education, come to be specialised, not simply by their own natural taste and peculiar capacity, but by the discernment of the public, and the very action of the profession itself. In case of ovarian or uterine tumours in wealthy patients, do you not select Spencer Wells or Keith; and are not these gentlemen, through your very recommendations, and by the influx of patients suffering from special ailments, obliged to become special practitioners, their whole life-work being specialised? In obscure nervous affections do you not consult Brown-Sequard, Charcot, or Hughlings Jackson? I might go over the whole range of medicine and surgery in illustration of the tendency of the profession to move towards specialism, at least as regards consultants and operating surgeons. I anticipate, too, that our future advances will be by special practitioners—in fact, all our progress for a great number of years has, as I have already said in another way, resulted from a concentration of talent on some particular department of medicine or surgery by men of good general knowledge, who have directed their energies in a particular groove.

I can only say for myself that, in my opinion, the questions to be solved in connexion with even one of the departments in which I chance to be actively engaged might occupy, with advantage, the whole lives of many able men—I allude to the department of the ear. No doubt a vast deal has been done in recent years, and the results of the most brilliant character are commonly obtained; but still there are problems, most important problems, waiting solution. I ask what man engaged in the multifarious duties of general practice can afford to give his time for that patient observation, that close study of the individual cases which are essential to make a single step in this difficult department? To a man engaged in the hurry-scurry of general practice from morning till night and night till morning, the thing is wholly impracticable; and if we are to wait for the advance of knowledge of ear-disease for some universal genius, we shall wait, I fear, till the “crack of doom.”

But not only is the tendency to a specialisation of consultants, but there is a steady advance towards more or less of specialism generally. There is a spread of knowledge amongst the general community which will precipitate the change. Families, instead of having one doctor, will soon have several. There will be some re-arrangement; but it will be a positive advantage both to the public and the profession. I have no doubt that it will be soon quite common for families to consult independently and directly the doctor they consider best qualified to give effective aid in any particular ailment, instead of consulting really or formally one for everything. The gynæcologist would have charge of midwifery and diseases of women; the ophthalmic and aural surgeon, of cases of disease of the eye and ear; the general surgeon, of general surgical ailment; and the physician, of the ordinary medical cases. I trust that I have been as plain as I intended to be. I have, no doubt, touched on many knotty points, and I may have run counter to some pet professional notions. At the same time, I would have you bear in mind that, in all human affairs, diversity of opinion and honest but conciliatory maintenance of a position believed to be right, is the best safeguard against that absolute stagnation which is alike the ruin of states and professions.

Dr. Whitla proposed and Dr. John Moore seconded the nomination of Dr. Barron.

Doctor Esler handed in the following notice of motion “That after the present year, the journals now received by the society be discontinued and the state of the library discussed, with the object of making it more useful to the members”

Professor Dill moved and Dr. John Moore seconded that the day for the Annual Dinner be fixed for the 7th December, the day of the meeting of the N. I. Branch of the British Medical Association at 7 p.m. Passed unanimously.

It was decided to have two charges, one for the dinner and one for the wines; and it was agreed to have the dinner at Thompson’s unless the room be unsuitable. The President, Dr. Dill and Browne and Wheeler to act as a dinner committee.

William A. McKeown

Second Meeting Session 1882–83 November 28th ‘82.

President Dr. McKeown in the chair, present Dr. T. K. Wheeler, Snr., Fagan, Esler, Workman, Kevin, Mackenzie, Core, Wadsworth, J. Smith, Jr., McHarry, and Whitla.

Dr. Barron was unanimously elected a member of the Society.

Dr. Whitla showed a patient the subject of Hodgkin’s disease.

Dr. Esler showed some interesting specimens of malignant deposit in abdominal organs.

Dr. Fagan show a patient upon whom he operated on for Dupuytren’s contracture of the fingers. He also showed a cast of the same before operation.

Dr. Esler introduced the motion of which he gave notice last meeting concerning the Library and the journals.

The following resolution was proposed by Dr. Whitla seconded by Dr. McHarry and passed unanimously

“That a committee consisting of Professor Dill, Drs. Core, Esler, McKeown and Dempsey be appointed to get all available information about the town libraries and to draw up a report suggesting, if possible, some means whereby the Library may be placed on a sound basis”, Dr. Core to be convener.

It was also agreed that a circular be addressed to all members of the Society asking them to return any books they may have belonging to the society.

William A. McKeown

Third meeting session 1882/83 December 19th.

President Dr. McKeown in the chair, present Drs. John Moore, J. W. Browne, Dempsey, Core, McConnell, Workman, Wheeler, and the Honorary Secretary. Barron.

Dr. Workman showed microscopical specimens of a sarcomatous tumour of the eye, and Dr. Browne gave a history of the case from which the eye had been excised.

Dr. Browne showed the kidneys and bladder of a patient whom he operated on for stone; also two stones which he removed. The kidneys were dilated and full of pus, the bladder concentrically hypertrophied and the ureters dilated.

He also showed the kidneys and bladder of a patient who had suffered for a long time from stricture of the urethra. Both kidneys were much enlarged and the right pelvis greatly dilated. A small calculus was

removed from the bladder. An interesting feature of the case was that the patient at one time passed what seemed a cast of the urethra. A section of this showed that it was probably a piece of catheter encrusted with phosphate deposits.

Dr. Workman requested the Society to grant him the use of their Pathological Room in the hospital on Wednesdays and Fridays for holding a histological class. Permission was given him to do so.

R. F. Dill, Chairman

Fourth meeting January 9 1883.

Present, Professor Dill in the chair (in the absence of Dr. McKeown President), Drs. J. W. Browne, Dempsey, Esler, Barron, Wheeler, Jnr., Whitla.

Dr. J. Lindsay (Royal Hospital) was proposed as a member of the Society by Dr. Whitla seconded by Dr. J. W. Browne.

Dr. Dempsey reported on behalf of the Library committee that he had seen the Town Clerk and learnt that no steps could be immediately taken in reference to the Public Library as the question was not sufficiently advanced. The matter was referred back to the Library committee.

Dr. Barron showed an interesting specimen of aneurism of the basilar artery.

Dr. Dill read a paper upon puerperal tetanus.

William A. McKeown

Fifth Meeting January 23rd 1883.

Present, Dr. McKeown in the chair, Drs. Harkin, Wheeler, Snr., McFarland, Esler, Dempsey, Barron, Mackenzie, Kevin, Whitla.

Dr. J. Lindsay was unanimously elected a member of the society.

The Honorary Secretary reported that owing to the difficulty of getting any M.S.S.s from the members, that he would recommend the transactions of this and last year were brought out together. This was agreed to.

Dr. McKeown, President, proposed Dr. St George, Lisburn, and Dr. Wheeler seconded his nomination as a member of the Society.

Dr. Esler gave notice that he would move meeting after next meeting that the periodicals for 1883 be no longer left on the table but be kept by the Librarian.

Dr. McKeown showed two interesting cases of sympathetic ophthalmia.

Dr. Harkin read an interesting paper on the pathology and treatment of infantile diarrhoea.

Paper:¹ *The subject of infant mortality, to which diarrhoea is a prime contributor, is not alone of scientific interest, but of national concern. Communities do not increase so much by a preponderance of births as by a diminished death-rate, and to compass this desir-*

able result should be the end and aim of all our sanitary arrangements. Whenever on the evidence of reliable vital statistics we are assured that an exceptionally high rate of mortality prevails at any period of life, at a special season of the year, or in any particular locality, we may reasonably conclude that the laws of health have been disregarded, and that the local controlling influences and surroundings are in an unsound condition.

So long indeed as we must admit with Dr. West that one-half of the children born in these kingdoms perish before attaining their fifth year, or with Sir James Simpson that every fourth or fifth grave is dug for a child under twelve months, we must also own that our social and sanitary customs are defective, and our boasted progress in science and civilisation is without foundation in fact. We have a striking corroboration of these statements, and an indisputable proof of the awful waste of infant life in this country, in the returns of the Registrar-General for England, who tells us that of four millions of deaths registered in England and Wales in one decade (1851 to 1860), nearly two millions were of children under five years of age. The greatest number of deaths occurs in the first year of the quinquennial period, and is chiefly attributable to the influence of diarrhoea—for fatal diarrhoea is essentially a disease of infancy; that it should be so affords matter for most serious consideration. We are the more impelled to the study of this problem by the knowledge that although during the course of the present century great progress has been effected in the reduction of infant mortality from all causes under the first five years—viz., from 70 to 27 or 28 in the 100, and also that during the summers of the early part of this century official returns assure us there was a comparatively small mortality from infantile diarrhoea, yet in recent years the deaths from this disorder have exhibited a marked increase. Moreover, the deaths from diarrhoea under one year, as compared with the deaths at all ages in England and Wales from the same cause, have steadily increased—i.e., from 44 per cent, in 1847 to 64 per cent, in 1873 (British Medical Journal, Nov., 1875).

What causes this increase, with the concurrent decline in the death-rate of typhus and typhoid fevers, it is difficult to determine; it may possibly be accounted for by the fact that while in the last seventy or eighty years the filth accumulations of our large towns have been reduced by the abolition of cesspools, this result has been attained at the expense of the purity of our rivers, from which the water supply of large towns is generally derived.

The drainage of smaller communities is poured into the stream nearer its source, and the residents lower down imbibe with the water supply the germs of zymotic disease—the undue proclivity of children to diarrhoea being possibly owing to their greater depen-

¹ [Dublin Journal of Medical Science, 1883, v75, p307.]

dence upon the use of water for milk dilution, &c., the beverage of adults being generally of a more composite nature.

The prevalence and fatality of summer diarrhœa is generally attributed to the influence of high temperature, subject to some qualification, for Dr. Laycock has long since demonstrated that it is only in the absence of a rainfall sufficient to flood the sewers of a large city that the epidemic rises to its full development, and that its decline and subsidence is sure to follow on the occurrence of this event.

In large manufacturing towns, the great centres of industry, whose increase is so rapid that sanitary arrangements are unable to keep pace with them, infantile diarrhœa is always prevalent—in summer as an epidemic, at other seasons in an endemic or sporadic form.

Besides the remote or predisposing cause referred to, the proximate causes of infantile diarrhœa are of a varied nature, chief of which is defective alimentation, the persistence of the colostrum in the mother's milk, foul air, insufficient clothing, prolonged dentition, hepatic derangement, inattention to cleanliness, defective sewerage and impure water, the absence of maternal care while the mother is from home at work, and the nostrums administered to quiet the baby while away from it.

The prevalence of hand-feeding, which is not limited to the poor, but which is practised among the comfortable classes and the votaries of fashion, is also a pregnant source of infantile diarrhœa. Thus, when a mother, whether from caprice or necessity, withdraws the natural nourishment from her child, the substitute supplied is too often suggested by ignorance or prejudice. Among the poor the evils of over-feeding, among the rich from false theory, and sometimes from a less excusable motive, the evils of a diluted milk supply, prevail to the injury of the nursing. "It would seem incredible," says *The Lancet*, "but that daily experience teaches us the fact, that large numbers of persons occupying decent positions in society systematically starve their children in respect of that article of food which is of all the most essential to their nutrition. Even to very young and fast-growing children they give cocoa with water, and not always even a suspicion of milk, corn flour with water just clouded with milk, tea, oatmeal, baked flour, all sorts of materials indeed as vehicles of milk, but so lightly laden with it that the term is a sham. There are thousands of households in which the children are reared upon this miserably defective dietary—pale, slight, unwholesome-looking, as their parents say, 'always delicate'—households, too, in which wine to the value of four or five shillings is every day consumed in the diningroom. In some there is the excuse of ignorance; in many the stint is a simple meanness, a pitiful economy, which is supposed will not be open to the criticism of observant friends."

But while this discreditable statement is too true, I fear that our profession shares the blame, for many of the body are advocates of this principle of dilution, and this, like many other "vulgar errors," owes its origin in recent or remote times to the dicta of the family doctor. A fallacy very prevalent among nursing mothers is that when diarrhœa arises during protracted dentition, any attempt to arrest its progress would prove fatal to the infant, and for this reason, or rather prejudice, many little patients are allowed to get into collapse before medical aid is asked.

A number of varieties of diarrhœa have been described by various nosologists, dependent principally upon the nature of the evacuations, and a plan of treatment recommended for each. As for those with fœculent, bilious, mucous or serous discharges, it is not my intention to follow them in their sub-divisions, but to refer to the general principles upon which, in my opinion, the treatment should be conducted. In its treatment the dictum of Sydenham, which states that "disease is nothing else than an effort of nature struggling by every means to exterminate the morbid matter, and so restore health," is only applicable in the primary stage of the complaint, where it is often judicious to assist nature by a gentle laxative in getting rid of undigested food or other causes of irritation in the intestinal canal, the eliminant treatment cannot wisely be continued much further, nor would the expectant plan of treatment be permissible. The drain should be stopped at all hazards, and our efforts be directed to the speedy extinction of the disease, and the rapid restoration of the infant's health. But in the cure of this disease, perhaps more than in any other in the medical nomenclature, is its average mortality modified by the plan of treatment adopted; nor is there one in which, by following a mischievous routine and the traditions of the nursery, a mild attack may be so speedily converted into a hopeless one, or vice versâ, by scientific treatment, the sufferer be restored rapidly to health. Among the ideas generally received by mothers and nurses, and unfortunately fostered by the approval or tacit permission of many members of the profession, is the indispensable necessity of the free administration of milk to the child in diarrhœa.

This conviction is so strong as to blind otherwise intelligent people to the immediate laxative results of each dose. They argue, when they reason at all, that whereas the use of milk in health tends to costiveness, therefore in disease it must have a similar tendency, and it is most difficult to prevail with them to make the change; and yet in those cases in which a cure was effected under my care it was almost only when complete ab lactation was resorted to, in the case of both nursing and weanling; and where milk was promiscuously ordered by my medical brethren, with otherwise scientific treatment, I have known too many cases ending fatally.

In every case, then, I enjoin total abstinence from milk—the mother's, or the milk of the cow, as the case may be, and order, as a substitute, arrowroot prepared with water, some sugar and port wine being added; and it is wonderful how much wine given in this way an infant of a few months will consume and require; beef-tea, carefully prepared and freed from fat; and, when available, condensed milk, its use being unobjectionable from its being freed from casein, the irritating element in milk. An equally important requirement is absolute rest in the recumbent position, with sufficient warmth to the extremities and surface of the body, counter-irritation over the abdomen by poultices, a sinapism if required, and, failing other remedies, a small blister over the liver, as we have, in almost every instance, congestion of the hepatic system and functional derangement, and tenderness on pressure—this form of counter-irritation will be found most salutary and rapid in giving relief.

As medicine I have long since dispensed with the old chalk mixture and astringent tinctures, having found them in practice too often acting as irritants to the sensitive mucous membrane of the bowels. My chief reliance is placed upon dilute sulphuric acid, either with or without the addition of laudanum in regulated doses.

It is desirable to give it singly in most cases, as it may then be ordered after even loose motions with safety, whereas when combined with opium it can only be administered after express intervals. This remedy cannot be used, however, with the necessary freedom while the ordinary practice of milk-feeding prevails, as it is almost certain to induce colicky pains by the separation of the curd in an indigestible form, and thus increase the sufferings of the infant.

The indiscriminate administration of milk in diarrhœa produces a result almost analogous. Under ordinary circumstances, when a child imbibes a quantity of milk an immediate change takes place in the stomach—the separation and rapid absorption of the soluble particles, water, oil, and sugar, and the formation of the curd, which is again dissolved by the action of the gastric juice.

But in this case the digestive powers of the stomach are much diminished, and portions of the curd pass unchanged into the intestinal canal, ordinarily producing irritation, griping, and purging, and becoming still more acrid when coming in contact with the acid intestinal secretions always present in diarrhœa. In the chronic mucous diarrhœa and in the diarrhœa of measles I have found great benefit from the administration of chlorate of potassium both by the mouth and by enema.

The treatment of choleraic diarrhœa, as it acknowledges a different pathology, is naturally distinct, being of the same class as cholera infantum, English cholera, and epidemic cholera, which, according to all reliable

authorities, differ but in degree, while similar in nature. They are diseases which affect the whole system, and our best guides in treatment are those who have been most successful in the country where it has its constant habitat.

Dr. Hall, who has seen a large amount of cholera in India, proposed to the Royal Medical and Chirurgical Society in London, on October 13, 1874, a plan of treatment which received the approval of the Society, as well as that of Sir Joseph Fayrer, an experienced Indian medical officer. He recommends dilute sulphuric acid, plenty of cold water in the early stage of cholera, and if they fail to arrest the disease, and the patient get into collapse, then the hypodermic injection of hydrate of chloral diluted with ten parts of water, ten grains at a dose. This, he states, has succeeded in the majority of cases. His statement is confirmed by a large number of Indian medical officers, and his theory is as follows:—

The symptoms of collapse he explains by the result of the experiments of Claude Bernard, who taught that they were due to great irritation and hypertrophy of the sympathetic nervous system. Kolman, too, has demonstrated that the right pneumogastric nerve supplies the whole of the small intestines. This is an inhibitory nerve; and Moreau and Lauder Brunton have shown that the division of all the nerves going to a portion of intestine is followed by the secretion of a fluid just like the rice-water stools of cholera. May not, he continues, the stimulation of the inhibitory vagus be followed by results much the same as if the sympathetic supplying the small intestines were paralysed? At any rate the result is thus given by Mr. Higginson:—Chloral hydrate, being a powerful sedative, soothes the irritated nerves, and so relaxes the contracted vessels; the blood is once more uniformly distributed, the pulse reappears at the wrist, the cramps and burning abdominal pains subside, sleep is induced, respiration becomes regular, discharges lessen, the face fills up, the voice becomes stronger, and the natural secretions are restored. While this plan commends itself to our adoption, I cannot recommend it from personal experience, but I may state that I have repeatedly tested the effect of remedies to the region of the vagus in the neck in cases of dangerous and profuse vomiting in gastritis and bilious attacks, with the most satisfactory results, in the absence of any medication of an ordinary nature.

William Aickin M.D.

Sixth Meeting was held upon Tuesday 20th February 1883.

President Dr. Aickin (Vice-President) in the chair, Dr. Wheeler, Snr., Dr. John Moore, Wales, Fagan, Esler, Dempsey, Wadsworth, Mackenzie, Kevin, Lindsay, Whitla.

Dr. Saint George was unanimously elected member of the Society.

Ulster Medical Society
Session 1882–1883
President William Alexander McKeown

Dr. Whitla showed some specimens of tubercle bacillus.

Dr. Fagan showed a living patient who had suffered from fracture of the pelvis. He also showed a specimen of ruptured urethra from a patient who died from fracture of the pelvis.

Dr. Esler read case in which abortion followed tapping for rapidly increasing effusion of fluid in the abdomen.

William A. McKeown

Seventh Meeting Tuesday March 20th '83.

Present, Dr. McKeown in the chair, Professor Dill, Drs. Nelson, Anderson, Gilmore and Whitla, Dempsey.

Dr. McKeown, President, exhibited a patient upon whom he had operated for a large polypus of the ear which had grown from the middle chamber and penetrated the tympanum. The large perforation left after the removal of the tumour had almost entirely disappeared.

Dr. Anderson read an able paper upon the arrangement of the peritoneum in mammals and in man. He also read notes of various cases of anatomical anomalies.

Dr. Esler's motion was not considered in his absence.

R. F. Dill M.D. Chairman
April 4th '83

Eighth Meeting of the Society was held upon Tuesday 3rd April 1883.

Present, Professor Dill M.D. in the chair, Drs. Wales, Anderson, Lindsay, Wadsworth, Anderson, Mackenzie, Whitla

Dr. Wadsworth showed an interesting case of scleroderma in a male adult.

Dr. Lindsay read a paper upon a case of purpura.

William A. McKeown

Ninth Meeting of the Society was held upon Tuesday 16th April '83.

Present, the President (Dr. W. A. McKeown) in the chair, Professor Dill, Dr. J. W. Browne, Dr. Aicken, Dr. Anderson, Dr. J. C. Smyth, Dr. Dempsey, Dr. John Moore.

Dr. McKeown (President) exhibited a patient suffering from dislocation of the lens into the vitreous in both eyes. He had removed the lens from the left eye by an incision at the lower part of the cornea.

The President also exhibited a portion of bone removed from the posterior part of the right ear which was considered to be the mastoid process of the right temporal bone.

Professor Dill gave a very interesting and instructive discussion of displacement of the uterus.

R. F. Dill, Chairman
29th May 1883

The Tenth Meeting of the Society was held upon Tuesday 9th inst May 1883.

Present, Dr. W. A. McKeown President in the chair, Drs. Dill, St. George, Dempsey, McConnell, Lindsay, Fagan, Barron, Byers, Esler, Browne, Whitla. Dr. Sinclair was present as a visitor.

Dr. Lindsay showed an interesting case of lateral sclerosis in a child. Dr. Lindsay then read a paper upon lateral sclerosis.

Dr. Byers showed a paraplegic patient in whom various reflex phenomenon were well marked.

Dr. Fagan showed a glandular tumour removed from the floor of the mouth.

Dr. Barron showed for Mr. Fagan, who had to leave the meeting, a specimen of diseased knee joint.

Dr. Whitla proposed and Dr. Dill seconded the nomination of Dr. Sinclair, Wellington Park.

J. Moore
17th July 1883

Annual Meeting July 17th 1883.

Present, Dr. John Moore in the chair, Drs. J. W. Browne, Wadsworth, Dempsey, Esler, Barron, Smith (Carlisle Circus), Mackenzie, Wheeler, Snr., Wheeler, Jnr., and Whitla.

The Secretary read report of Council and Dr. Esler made a financial statement; both reports were unanimously carried. The Honorary Secretary, Dr. Whitla, resigned office and Dr. McKenzie was unanimously elected in his stead. Dr. Esler was unanimously elected Treasurer.

Professor Dill on the motion of Dr. Whitla seconded by Dr. Wheeler, Snr., was unanimously elected President.

Dr. Whitla and Dr. McConnell were elected Vice-Presidents. Drs. Dempsey and Barron were elected Honorary Librarians.

Dr. Workman was elected Pathological Secretary.

The following Council was elected: J. W. Browne (10), Charles Wadsworth (9), R. Clement (6), J. C. Smyth (5), John Fagan (5), John Moore (4).

Drs. Wheeler and Barron were appointed Auditors.

Dr. Dempsey moved and Dr. J. C. Smyth seconded and it was unanimously agreed that the Treasurer be directed to invest £50 in 3 percent consols.

Dr. Dempsey give notice that at next meeting he would move "That the reception of the different medical journals of the Society be discontinued at the end of the present year owing to the unsatisfactory condition of the Library".

Dr. Sinclair was unanimously elected member of the Society.

William A. McKeown
November 27th 1883

ULSTER MEDICAL SOCIETY

SESSION 1883–84

The First Meeting of the Society was held upon Tuesday 27th November.

Present, Professor Dill President in the chair, Drs. McKeown, Harkin, Whitla, Esler, McConnell, Dempsey, J. W. Browne, John Moore, Barron, Lindsay, J. C. Smyth, McKenzie Secretary. Dr. McKee was present as a visitor.

The President briefly thanked the members of the Society for the honour conferred upon him by again electing him president of the Society.

The President then proceeded to deliver his most eloquent and interesting address.

Paper:¹ GENTLEMEN, I have to thank you, which I do sincerely, for this renewed expression of your confidence, in electing me so soon again to the Chair as President of "The Ulster Medical Society."

It is rather a peculiar coincidence that, on the former occasion when you were so good as to confer upon me a similar honour, it happened to be on the fiftieth year from the time I had entered upon my medical studies; now it is the fiftieth year since the time at which I became legally qualified to occupy any professional position; but I did not then, nor for some time afterwards, sever my connexion with the University. The fiftieth year has been by certain persons and under certain circumstances called their jubilee year, because, I presume, it was the name given to certain joyous celebrations associated with a release which they had experienced. Be this as it may, or whether there is any analogy between the circumstances in which I stand and those in which those persons stood, I need not here stop to inquire; but, this I know, I have not yet sold my inheritance, neither have I felt my position to be a bondage, and I am not, I assure you, at all anxious to be released from it. Nevertheless, I hope you will allow me the privilege of calling this my jubilee year, because of the many friends I have and whom I see around me, and because of the health and the heart I possess to appreciate their earlier and their later favours, and because I can now look back upon half a century of professional life, with its many varied and its chequered incidents, occurring over that lengthened period and appearing in all the tints of lights and shadows, and yet with all the fresh and fondly-cherished memories of the past.

My first recollection of University life is of what was called "The Blackstone Examinations" in Glasgow, that being the name given to matriculation in that ancient University because of the Blackstone Chair, upon

which the student is seated when undergoing his entrance examinations; and I had occupied it immediately before Archibald Tait, the future Archbishop of Canterbury. At these examinations Archibald Tait scored such high marks that he afterwards obtained the Foundation Scholarship, which eventually carried him up to the Oxford University, and I have always watched with the greatest interest his steady progress and his brilliant career from these Blackstone Examinations, before Sir D. K. Sandford, the accomplished Professor of Greek, until elevated to the Archbishopric of Canterbury, the highest episcopal chair in the empire; and I fancy I can still hear his clear, distinct, and measured readings of those old pentameters and hexameters; and his readings of passages from Sophocles and Euripides were all but equal to an Athenian dramatist.

My second recollection is again incidentally associated with another great name, but of a different order and under different circumstances. The day after I had passed my examination in the Royal College of Surgeons, London, being disengaged for a short time, Dr. Southwood Smith, the popular physiologist of that day, asked me to give him some assistance in dissecting and in making a dried preparation of the body of no less a person than that most celebrated and able political economist—viz., Jeremy Bentham, and yet with all his acknowledged greatness, I could not, I assure you, discover the slightest difference in the dissections of his body from those which were taken from the paupers' burying-ground, Bully's Acre, Dublin. But I did discover a marked difference between it and that which he considered as his Great Grand-father the Oyster.

My third recollection, though not associated with any of the great ones of earth or water, is not on that account of less moment to myself. It was the day after I had been appointed a Dispensary Officer to a district, situated in as beautiful and picturesque a little neighbourhood as could be found in all Ireland again; and the women were as lovely as the scenery was charming—a land flowing with the milk of human kindness and the true sweets of social enjoyment. I remember well that bright May morning riding down that village street, on my way to visit a dispensary patient far into the country, and receiving the congratulations and the salutations, and the smiles from every person, in every door and from every window as I passed along; and I could scarcely suppress the feeling that my fame and my fortune were within "measurable distance."

After reaching the patient's house, examining and prescribing for one whom I found far advanced in consumption, and to whom I could hold out but little hope of relief, and less of recovery, I left saddened at the thought of being able to do so little for that young and anxious seeker after life, but had not gone far when I was stopped and asked (as was the custom to waylay a medical man on his professional rounds) to pay a visit at a very comfortable-looking neighbouring farmhouse.

¹ [Dublin Journal of Medical Science, 1884, v77, p174.]

At the door I met and was asked by the farmer's wife, who stated that she wished me to take a little blood from her daughter's arm, as was her habit at that season of the year, and, as was then our habit, without asking any impertinent professional questions. And although a fine strong and healthy-looking country girl, I pulled out my lancet, most pedantically, tied up her arm and bled her freely and to syncope; she was soon placed in the recumbent position, and the arm immediately adjusted by means of a pad and bandage. When at the door and leaving, the good wife put into my hand a nicely-rolled up little bit of paper, which I graciously accepted; and as I dare not open it in her presence, I mounted and got as quickly as possible round to the other side of the hill. When well out of sight and with patience all but exhausted, with anxiety to realise my first professional fee, I pulled up, unfolded the little bit of paper, and exposed to view my first honorarium, which amounted to—what do you suppose?—just one silver sixpence!

I sighed—but again I thought it might be quite enough for what good was done. However, I rode home an humbler and not a much richer man, and I have often thought since that, let the fame go as it may, from that day till the present the fortune has appeared as a dissolving view; and that, had the blood been less and money more, the balance of power might have been better preserved.

You will not be surprised when I say that I have had some difficulty in determining upon the choice of a subject suited to a scientific and a critical audience; and I have felt that the more because of the numberless addresses to which we have been treated of late. But I feel much relieved because of the valedictory address with which we have been favoured by our out-going President. But however able most of these addresses are proved to be, yet there are to be found in some of them scientific fallacy, in others philosophical fiction, and in not a few you may travel over a great breadth before you come upon a useful fact, or a single grain of truth. Nevertheless, what I have to offer to-night must appear beside them as of little importance, and be looked upon as very small fry; so that I feel I am in the somewhat awkward position of the punctiliously polite Greek gentleman who, while performing the funeral functions of an infant daughter, felt called upon to make his excuses to the spectators for bringing out such a ridiculously small corpse to so large a crowd. But though small and insignificant what I have to offer, I hope you will find it to possess a little more vitality than the Greek gentleman's child; though for size and appearance (our late President and recognised oculist will set me right if I am wrong) much depends upon the medium through which it may be viewed—through one medium it may be very like a whale, through another it appears as a little fish; but no matter if viewed through the spectacles of a Bishop Berkeley.

I hope it may not be considered here out of place if I occupy a few minutes upon some points of interest associated with Medical Education as we now find it, and compare these matters with what we know of the state of education in former times, and, observing the results, draw our conclusions.

Professor Huxley, lecturing the other day, made use of this statement—viz, “that when one of his sons was commencing his medical career he was perfectly astonished when he compared the course of instruction, the requirements, and the kind of examinations which were needed from him, with the very small and perfunctory necessities of his own time.” If the course of instruction, requirements, and the examinations are in his own opinion the sine quâ non of an educated profession, then I submit that this statement of Professor Huxley is rather an unhappy one as coming from him, for with the small and perfunctory necessities of his time, what shall we say or think of his acquirements or of the rank he holds among the learned and scientific men at present. And Professor Huxley is no exception, for although it has been stated that the difference between the past and the present is that the former was the age of literature, the present the age for science; yet I think I am in a position to prove that while there was more profound learning, I believe there were also not a few of the most important scientific discoveries made known, so that education altogether stood as high as we, with all the boasted progress of the present day, do yet enjoy; and the son, I feel persuaded, shall have trouble in rising to the level of the sire; that the men of other days possessed a learning and attainments which many of the present day would pale before.

Medical Education is, I believe, at present passing through a severe crisis—it is passing through very troubled waters. For, have there not of late been too many as well as extravagant changes made in some of our Universities, and too many attempts at medical legislation, and I confess that I, for one, was not sorry that the Medical Bill before the House in the last session did not pass into law. And I know that our students are very much hampered and harassed by these capricious changes as well as by the number and eccentric character of the examinations which they have now to undergo, because of which they are obliged to devote themselves to the advanced departments of science to the neglect of more useful, because more practical knowledge.

I would venture to offer an opinion upon another matter of some interest to us in the present day. I believe it was one of the errors of the age to open our colleges, our schools of medicine, and our universities to women, thereby enabling them to compete with our young men while pursuing their medical studies, and in obtaining degrees and other medical distinctions.

Indeed I should have hoped that the culture and refinement of the age would have forbidden such a con-

summation, as that the two sexes should be found receiving united medical education. Which of us would like to see his sister, his daughter, or other young female friend, in the dissecting room, and at work in common with the youths of the opposite sex. Which of us would willingly join in consultation in certain cases with Dr. Elizabeth—, or be found investigating certain diseases with Dr. Mary—. I believe the properly constituted mind of either sex would revolt at the very thought of such a practice.

But apart from what some would consider the sentimentalism of the subject, woman, from her constitution and her habits, is altogether incapacitated from taking part in the toils, the labours, the responsibilities, the anxieties necessarily associated with medical professional life. When we consider her habits, her functional arrangements, her capricious tendencies, her domestic associations, her bodily weakness if you will, then say is she fit to take upon herself all that is necessary in the work of the profession, both by day and by night. And I believe she is disabled even more by reason of her mental constitution than from her bodily characteristics, which I shall endeavour to show you. It is unnecessary, though, for me here to attempt to prove that it is the brain matter which possesses the power of evolving mind, and which places the beings possessed of this power in the highest rank of creation; but it is necessary, before determining finally the question under consideration, to ascertain what are the essential points of difference between the mind-producing organ of man and that of woman. It is a well-recognised fact that the brain of man is larger than that of woman, the average of the one being forty-nine ounces and that of the other forty-three ounces—the difference in favour of the male brain being six ounces. It is also an accepted fact that the size and weight of an individual's brain are in direct relation to mental capacity; and it is a remarkable fact that whilst in men of high intellectual development, as in Cuvier, the brain has been found to weigh sixty-four ounces, woman's brain has never reached that weight by eleven ounces. We also find that the female brain is not only smaller than that of man, but it is different in structure and in shape, which I would say counts more as regards mental faculties even than does the element of size. Thus we find that the frontal lobes in man are larger than those of woman, and the depth of the convolutions and the density of the cortical or grey substance are greater. The inevitable conclusion we must arrive at is, that as man possesses more brain than woman, he must of necessity possess more mind. But there is not only a difference in quantity, there is also a difference in quality, as in shape and structure, so there must also of necessity be a difference of function; and from this fact I am disposed to argue that the emotional is the first characteristic of a woman's nature, and which holds its ascendancy over her intellectual qualities; and that, no

matter how highly she may be educated, inasmuch as the brain matter is not there either in quantity or in quality, she is incapable of a sustained, an original, an intense degree of thought. But while man's intellectual nature is his chief, his supreme characteristic, and by which he originates, he designs, he discovers, he explores—he, in fact, all but creates, yet who will venture to say that the brain from which will flow a wife's fidelity, a mother's affection, a sister's devotion, and a woman's gentleness, does not mark her out as one who shall rise higher in the scale of a moral and a spiritual life, than the brain from which flows the dry interpretations of the laws of nature.

If it were necessary to pursue this line of argument further, I might show that it is impossible for us, properly, to continue to entertain the novel idea of women occupying the field of medicine, because, if for no other reason, of the excessive strain upon her physical and her mental powers by which permanent injury to both mind and body is often found to follow, and this every physician of experience knows to be the case. I might also show that as woman's brain becomes developed at an earlier age than that of man, it is unfair to place them in competition at this time of life. I assert all this even in face of the statement which I see made at a public meeting and reported the other day—viz., “that women were gradually coming to the front.” In the presence of such advocates and with such advocacy I only wonder that they do not come careering to the front at a gallop. But I am persuaded that this movement must soon come to an end, and that when the novelty, excitement, and sensationalism shall have passed away, this phantom caricature will collapse, and woman will return to her normal sphere.

May I occupy your time a few minutes longer, while I shall endeavour to establish the proposition which I have made in favour of the learning, the attainments of the men of former time. To say that the works of Hippocrates, and Celsus, and Galen, are accepted as amongst our ancient medical classics would be but expressing a truism, as they are to be found in the libraries of our Colleges and Universities. And I do not say more of the earlier Arabian authors, as Razes, Avicenna, Albucasis, than that their works still live and exert a power amongst us. If we consult some of the works of the 13th and the 14th centuries, we shall find that at these early periods, Leonicensus demonstrated that difficult problem which then existed—viz., that of making a correct diagnosis of syphilis, which had been up to that period confounded with leprosy. The treatment of syphilis, however, remained for a short time an unsettled question, as Leonicensus rejected mercury because of so many persons dying from its effects. And amongst these Cardinal of Segorbe, Alonso, &c., whose deaths naturally prejudiced the public mind against this drug; soon, however, it was made manifest by Torello and Theodoric that mercurial unction was the

true remedy (in fact, it was proved to be a specific for this terrible disease, as then experienced) by keeping up the “flux,” as it was called, for three weeks.

And it is to our minds rather an amusing incident to find that such questions in that day were made the subjects of poetry, and that one Fracastorius, in Pope Leo’s time, wrote what was considered an admirable poem, entitled “Syphilis,” in which the chancre, the bubo, the ulcerated throat, the hoarse voice, the mercurial unction, fumigations of cinnabar, the flux, or rivers flowing from the mouth, are set forth and poetically recorded. Whether this poem is to be accepted as sacred or profane poetry you are the judges.

There are other instances, at an early period in the history of medicine, of correct diagnostic powers and successful treatment of disease. Sea-scurvy, which appeared in a most violent form at first, was soon understood and mastered by its true remedy—viz., fruits and vegetable diet.

Mead, in his travels on the Continent, met with the writings of Bonomo, which contained an account of the cutaneous worms which generate the itch. When he returned to London Mead presented an analysis of Bonomo’s researches to the Royal Society, and recommended sulphur as a specific for this very nasty and troublesome disease.

Thus we have in remote times not only a correct diagnosis formed of syphilis but also its specific treatment, in mercury. We find that sea-scurvy was successfully treated with lemon-juice, itch with sulphur, and intermittents by Peruvian bark.

Where, in modern times, do we find anyone who can lay claim to discoveries of more value or of more practical importance than are those I have instanced. But in coming a little further on, where is there to be found, at any period, more scholarly attainments or greater breadth of learning than are enjoyed by Linacre, Letsum, Caius, Sydenham, and Gooch, and a host of others, some of whom Dr. Johnson (no mean authority) pronounces well versed in the writings of antiquity, more particularly in those of the great Roman orator and philosopher, whose luxuriance of style they not only imitated but thoroughly mastered; and we know that the works of these men have not only made their impress upon the age in which they lived, but they have made their mark upon the world’s history.

What, in modern physiology, can at all compare with that grand old discovery, the circulation of the blood; and does not the name of Harvey call up recollections that justly place him in the foremost rank of natural philosophers, and whose services conferred upon anatomy and physiology what Newton rendered to optics and astronomy by his theories of light, and by his discovery of the laws of gravitation.

The name of Hunter cannot be omitted in the “roll call” when genius had become the rank and file of the

age, and when by his great personal labours, and at enormous expense, he designed, completed, and established the Great Windmill-street Anatomical School, and handed down to us his vast treasures, known as the Hunterian Museum, and of which the authorities at the Glasgow University are the trustees and principal custodians. To Hunter also are we not indebted for his great work on the anatomy of the human gravid uterus, which is unrivalled for its splendour and the correctness of its delineations.

Among the names which ought to be held sacred by the undying gratitude of mankind is that of Edward Jenner, who should stand preeminent among discoverers, for it would be impossible to find his equal as a benefactor of the human family by his discovery and the introduction of vaccination, which has proved itself a safeguard—a specific against the ravages of a disease worse than the plague.

And as we travel down the highway of medical science we reach another great landmark, clearly defined, and explicitly directing us on our journey. For has not Laennec put into our hands that most valuable and useful instrument, the stethoscope, which might be suitably termed the key of knowledge, by which we can unlock and lay bare some of the most hidden maladies, and by which are opened up to us mines of diagnostic wealth?

These are old truths which bear to be repeated, and the names of those men who brought them to light, and into use, have a claim upon our gratitude, our sincerest admiration, and our warmest acknowledgments.

I have a lively recollection of many successors to those great men, who taught and practised, and who flourished in the early part of the present century. I have only to mention Sir Charles Bell, whose name is so intimately associated with one of the grandest and most important discoveries in connexion with the nervous system.

I might also make mention of the names of Abernethy, Brody, Lawrence, and Astley Cooper. But to come a little farther down, and nearer home, I would mention Colles, and Carmichael, and Cusack, and Corrigan, but especially Graves, who was one of the most accomplished and distinguished physicians and fascinating lecturers that ever appeared in the wards and lecture hall of Sir P. Dun’s Hospital.

But words do fail me when I attempt to speak of that much-to-be-esteemed and long-to-be-remembered William Stokes, who in the Meath Hospital won not only the confidence and affection of his patients, but also the respect, admiration, and love of his students, by his winning presence, his untiring zeal, but, above all, by his unrivalled powers as a clinical teacher; and from the city of Dublin, which had become the scene of his distinction, and in which he exerted a magnetic influence, he sent forth admiring pupils to all parts of the world, and he really enriched and benefited, by the halo

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which he flung around, the medical school during his brilliant career.

I have heard him relate, in glowing terms, how (in company with our old friend Creery Ferguson and a relation of my own) he mastered the use of the stethoscope under the eye and the teaching of Laennec himself; and William Stokes was the first physician who introduced and who taught the use of this instrument in these countries. These are assuredly the fathers of medical science, whose names and whose deeds have been bequeathed to us as a rich inheritance, and upon whose ashes we shall never allow a foot to trample scornfully. For, although it was not theirs (nor has become the lot of any yet) to crown or complete the great temple of medical science, yet it was theirs, amidst darker times and amidst rougher and harder work, to dig deep, and “well and truly lay” the foundation and not a few chief corner-stones of this great structure.

Talk of titles, talk of decorations, talk of even peerages, for such men as these. You may confer upon them all the honours that a cold, contemptuous, and effete Government can bestow; you may cover them with stars and garters and ribbons—you may; but the stars shall become dim and the garters and the ribbons fade away, yet the names of these princes amongst men shall never be forgotten; their deeds shall form a bright page in the world’s history, and their memories preserved, because embalmed in undying remembrances—for there is no death, no night there; or, as is so exquisitely expressed by our own Immortal Bard—

You may break, you may ruin
The vase if you will,
But the scent of the roses
Will hang round it still!

Dr. John Moore proposed and Dr. McKeown seconded a vote of thanks to Professor Dill for his most admirable and beautiful address.

The President acknowledged the vote of thanks.

Dr. John Moore proposed and Dr. Harkin seconded motion to the effect that the “Secretary be instructed to write a letter of condolence to the widow of the late Dr. James Moore who was so long a member of the Society”.

Drs. O’Connell and Dwyer were proposed by Dr. Harkin seconded by Dr. Dempsey as members of the Society.

Dr. Smith (Shankill Road) was proposed by the Secretary and seconded by Dr. Lindsay.

R. F. Dill, Chairman
18th December 1883

Session 1883–4. The Second Meeting of the Society was held upon Tuesday evening 11th December.

Present, Professor Dill President in the chair, Drs. Esler, O’Neill, Dempsey, Whitla, Wadsworth, Lindsay and McKenzie, Secretary.

Drs. O’Connell, Dwyer and Smith (Shankill Road) were unanimously elected members of the Society.

Dr. Dempsey brought forward the motion of which notice had been given concerning a discontinuance of the medical monthly and weekly journals after this present year. Dr. Esler seconded and Dr. Whitla supported the motion which was passed unanimously.

Dr. Whitla showed sample of “chyle” recovered from the abdomen of boy 13 years old; 13 pints were removed. Dr. Whitla promised to show the patient, if possible, and give the history of the case at a future meeting.

Dr. Lindsay read a most interesting and important paper on the climatic treatment of phthisis.

Paper:¹ My only excuse for bringing so hackneyed a subject under notice is the fact that I have had a more extensive personal acquaintance with foreign sanatoria for phthisis than falls to the common lot. Circumstances have enabled me to travel widely, and amongst other places I have visited Southern France, Switzerland, Italy, Algeria, Cape Colony, Australia, New Zealand, and California—thus including all the most famous health-stations, with the exception of Egypt.

I am far from wishing to exaggerate the importance of the observations and experience of a single traveller, but I feel confident that some practical acquaintance with foreign lands is a very great advantage in selecting a suitable climate for any given case of disease. At the lowest estimate it clears one’s mind of numerous misapprehensions, makes one doubly receptive of genuine information, and enables the traveller to make due deductions from the roseate accounts so often furnished by interested persons. Only personal experience can thoroughly inform us on many points of secondary but still genuine importance regarding any locality—points, I mean, quite apart from considerations of climate. I refer to such questions as the facilities and expenses of travel, the hotel accommodation, the objects of interest to be met with, &c.—points of prime moment to many invalids.

Though the climatic treatment of phthisis has long enjoyed a wide popularity and an acknowledged efficacy, we are still by no means clear regarding the precise conditions of climate which are generally desirable. We know that certain climates are efficacious, but we are not quite certain on what that efficacy depends. The idea that the dryness of a climate is the essential feature is evidently an error, as cases of phthisis do almost equally well in the intensely dry climate of Upper Egypt, and in the intensely moist and humid atmosphere which prevails at sea. Nor can the degree of heat or cold of any climate be looked upon as the really important point, for phthisical patients flourish in the torrid heat of Australia and amid Alpine snow-fields. Then, again, distance from or proximity to the sea

¹ [Dublin Journal of Medical Science, 1884, v77, p110.]

cannot be reckoned an indispensable factor, as phthisical patients do almost equally well at Algiers and at Cairo, at the littoral towns of the Riviera, and on the Darling Downs of New South Wales. Lastly, elevation above the sea level cannot be reckoned essential, since at present it would be difficult to affirm whether better results are attained at Davos or at Algiers, on the highlands of Colorado or on the sea-coast of California. If, then, neither the temperature of a climate, nor its dryness, nor its elevation above the sea level, nor its distance from the ocean, be essential, it becomes of importance to inquire whether any combination of these features is probably indispensable. Here we begin to see light. So far as I am aware no climate which is both damp and cold has proved useful in the treatment of phthisis. Damp climates succeed in some cases, cold climates in others; but climates which are both damp and cold appear to be uniformly injurious. Secondly, the equability of a climate is probably a point of the most vital importance.

Phthisical patients are peculiarly sensitive to sudden variations of temperature—the most frequent cause of intercurrent attacks of bronchial catarrh and pleurisy which such patients have so much reason to dread. Thus the climates of Algiers, Egypt, and Davos, are remarkably equable, while climates where phthisis is particularly prevalent are usually noted for sudden variations. The purity of the air has been much insisted upon by some authorities, and has even been regarded as the one essential condition. A pure atmosphere is no doubt very important; but I venture to think that no case of phthisis could prosper in any atmosphere, however pure, which was subject to sudden variations of temperature. In formulating anything like fixed principles we must not forget the part which individual idiosyncrasy probably plays, nor another fact more frequently overlooked—viz., that certain climates may furnish the desired change from certain other climates. Thus it is possible, and even probable, that two climates may bear such a correlation to each other that a patient removing from one to the other may thus obtain the exact change, climatic and hygienic, which his case demands.

Before deciding where to send his patient the medical practitioner has first to consider whether the patient is in a fit state to go abroad anywhere. This is often a most anxious and difficult problem, and one of the first importance. There may be noticed at the present day some faint signs of reaction against the practice of sending all phthisical cases indiscriminately abroad, and if this reaction merely tends to greater care and caution in the selection of cases, it will be an unmixed boon; but it would be a great misfortune if any prejudice were to arise against the climatic treatment of phthisis in general. In most cases the choice is practically between that and an expectant treatment which ends only too surely in death. By careful nursing and

wise treatment at home, no doubt, the disease may for a time be kept at bay, but recovery is practically out of the question. It is a cruel thing to send a hopeless case abroad to linger out a miserable end, far from home and friends, amid strange faces and uncongenial surroundings, but it is a much more cruel thing to deprive a patient of even one chance in a hundred by dissuading him from a step on which he is bent, and which is to him full of hope.

In deciding the momentous question of sending a patient abroad, let me say, first of all, that the stage of the malady is not necessarily the first or even the chief consideration. This will sound startling only to those who have given little attention and study to the subject. Some of the most striking recoveries on record have been those of patients in whom the malady had progressed to the stage of cavity before a change of climate was sought, while on the other hand there are many cases only in the first stage whom one would never dream of sending abroad; the high range of temperature, the rapid emaciation, and the feeble attempt on the part of nature at reaction—all showing the utter futility of the step. Not the stage, then, so much as the type of the malady, the family and personal history, the amount of reaction present, and the general constitutional conditions, must be our guide.

There are several cases where the climatic treatment is plainly inadmissible.

1. In acute tuberculosis. Here no treatment is of even temporary avail, and the rapid prostration of the patient makes a resort to travel quite out of the question.

2. During acute exacerbations of the chronic malady. Here the wise treatment is to avoid all causes of excitement and irritation, to soothe the patient, and to wait until the disease shall again resume its chronic character.

3. Where the patient's means are insufficient to enable him to travel with reasonable comfort, or where there is an idiosyncrasy which renders travel peculiarly distasteful and irritating.

The chief difficulty in the decision naturally arises with cases which lie upon the borderland. In an ordinary case of moderate severity, what are the leading indications? A distinguished physician of Belfast once told me that he made it a rule never to allow a phthisical patient to go abroad until the pulse and temperature had been for some time under 100. As a rough and ready rule this dictum has its attractions, and in all probability would be found to work fairly well in practice; but we need some more scientific basis for our opinion. I venture to formulate one or two principles:—

1. Let us ask the question—Has the disease been steadily progressive from the first, or has it shown signs of occasional remittance? Are periods of high pyrexia and severe constitutional disturbance succeeded by periods of comparative recovery, leading us to believe

that the disease in the lung is for a time at least quiescent? These cases which approach the remittent type are, I think, peculiarly favourable for climatic treatment.

2. The milder the constitutional symptoms are in proportion to the local pulmonary mischief the more hopeful is the climatic treatment, and vice versâ.

3. It is important to inquire whether resort has ever before been had to travel, and with what results. Patients who are braced and stimulated by change of scene, and who possess much mental elasticity, are more likely to gain advantage than those who are depressed and disheartened by absence from home and the association of friends.

Having determined to send our patient abroad, the next question is the choice of a suitable resort; and the selection is becoming increasingly difficult. Our ancestors went to Torquay, Pau, Egypt, or Madeira, according to their inclination and the state of their finances. Now the whole world is laid under contribution. The Riviera, Davos, Algeria, Egypt, Cape Colony, Australia, Tasmania, New Zealand, California, Colorado, Minnesota, Florida, Bogota, Jamaica, Bermuda—all these have their advocates and their statistics of alleged successes.

To keep my paper within reasonable bounds I shall discuss four types only of sanatoria:—

- A. The ocean climate, met with in perfection on shipboard.
- B. The climate of the seashore—e.g., Algiers, Cannes, &c.
- C. The climate of dry inland localities—e.g., Cairo, inland Australia, &c.
- D. The climate of high altitudes—e.g., Colorado and Davos.

A. The ocean climate, such as prevails on the high seas. This climate, of course, presents infinite varieties, according to latitude, but it has some constant features:—

a. It is remarkably equable. Sudden changes of temperature are rare at sea; and ordinary catarrhs and colds (so injurious to the phthical patient) are practically unknown. It is a matter of common observation that on shipboard one can with impunity risk exposure to cold and wet which on land would entail an inevitable penalty.

β. The air possesses a perfect purity and an excess of ozone not to be enjoyed on land.

γ. The barometric pressure is almost invariably high.

It is obvious that we have here a set of conditions eminently favourable for the treatment of phthisis. When we also recollect that on shipboard, in the warm latitudes, patients can spend from 12 to 15 hours daily in the open air, that the stimulating sea air promotes appetite to such an extent that a rapid increase in weight is almost universal, and that there is an almost complete freedom from all kinds of worry and excite-

ment, it is not surprising that long sea voyages should enjoy a high reputation for the cure of pulmonary disease. Theodore Williams states that in his wide experience of phthisis the best results of all have attended the trial of long sea voyages. My own experience—including four long voyages averaging about 12,000 miles each, and the observation of a very large number of phthical patients—is highly favourable to this line of treatment. With few exceptions, the cases which I observed made progress on shipboard, gaining in strength, weight, and comfort, rarely suffering from sea-sickness, and even in the most advanced cases often making a wonderful temporary rally. The disadvantages of a long voyage are the exhausting heat of the Tropics, the monotony of occupation, society, and diet, the absence of privacy, and the scandalously small and uncomfortable sleeping cabins, which are still found even in the best lines.

As regards the particular class of cases most likely to be benefited by a long voyage, I am disposed to think that most patients who retain a fair amount of vigour are likely to gain by this line of treatment, but that it is peculiarly applicable to cases of hæmorrhagic phthisis. An attack of hæmorrhage is an event of extreme rarity on shipboard, whether the equability of the climate, the quiet mode of life, or the high barometric pressure deserves the credit for this exemption. It is a significant fact that, while patients suffering from hæmorrhagic phthisis enjoy an almost complete immunity from hæmorrhage while at sea, they seem peculiarly prone to an attack on landing after a long voyage. This is a sort of axiom among invalids on shipboard, and I have several times seen it exemplified. As regards the best voyage to choose, the only one which can be confidently recommended is that to Australia—all others being either too short or presenting some serious disadvantages. The advantages of the Australian voyage are—1st, length, the average duration being about 80 days by sail and about 45 days by steam; 2nd, a regular gradation of temperature, from the heat of tropical and subtropical latitudes to the bracing and refreshing coolness of the Southern Ocean.

B. The next type of climate favourable for consumptives is the warm marine climate, of which I shall take Algiers as the type, partly because it is a favourable specimen and partly because I have personal acquaintance with it.

The Algerian climate has been described as the best within the Mediterranean basin, and with that opinion my experience, so far as it goes, decidedly agrees. During the winter months the weather resembles that of a genial English summer. Brilliant sunshine without excessive heat, an almost entire absence of frost and cold winds, great equability combined with pleasant variety—all these mark out Algiers as a delightful resort for consumptives. The mean temperature for the winter months averages from 60° to 64°, sudden changes are

rare, and the diurnal range of temperature is so moderate that patients can go out with safety at all hours. The rainfall is considerable, but it comes in occasional deluges of great violence, and long periods of wet are almost unknown.

That the climate of Algiers is infinitely superior to that of the Riviera cannot, I think, be doubted—free as it is from the morning frosts and the blighting Mistral, which occasionally make visitors to Cannes and Mentone wonder why they ever travelled so far from home to be nipped by unexpected frost and mocked by a brilliant sunshine which seems so strangely at variance with the piercing wind. The traveller who halts on the northern shore of the Mediterranean is still among the cold latitudes, still among the regions of winter cold, of snow and frost and rain. But let him cross the great sea—a passage of about 30 hours—and he feels at once that he has reached the region of eternal summer, where fruits and flowers flourish in subtropical luxuriance, and where the swarthy faces around him serve as a reminder that he has touched the verge of the Dark Continent.

The climate of Algiers is drier than that of most maritime localities—a circumstance which is, no doubt, due to the proximity of the great desert. It is almost quite free from cold winds, and the sirocco (which is such a scourge in summer) is almost unknown in the winter months. While in Algiers I had the novel and not unpleasant experience of being rocked by an earthquake, but this also is an event of great rarity. As illustrating the mildness of the winter climate of Algiers, I may mention that on Christmas Day I enjoyed a swim in the Bay of Algiers, and found the water pleasantly warm.

Apart from considerations of climate, Algiers presents many attractions. The situation of the town is remarkably picturesque, and the invalid need never tire of gazing from the elevation of one of the villas of Mustapha or the village d'Isly over the beautiful bay, studded with the sails of feluccas and backed by the imposing ramparts of the Djur-djura mountains.

Flowers and fruits grow in great luxuriance, and the variety and excellent quality of fresh vegetables (which can be obtained all through the winter months) is a point of real importance to the invalid. One of the recollections which is likely to remain for ever impressed on the mind of the visitor to Algiers is the fact that he was there able to enjoy fresh green peas on Christmas Day.

If the tourist goes into one of the bazaars of Algiers and makes a small purchase he often receives as change an extraordinary medley of coins of different countries. This variety is typical of the remarkable mixture of races which one encounters in Algiers—Arabs, Kabyles, Moors, Negroes, Maltese, Frenchmen, Spaniards, Italians, Turks, Englishmen. I hardly know if even this enumeration exhausts the list. Thus, if the invalid has

any taste for studies of race he has an unrivalled field open to him.

Then again, if antiquarian studies interest him, Algeria has rare attractions. The country has had a stirring history, from the days of Carthage down through the times of the Vandals and Arabian Caliphs to the modern days of French dominion, and the antiquarian remains are numerous and extensive. Only those who have never wintered abroad will think that I am attaching undue importance to these points. Often the greatest trouble of the invalid is the lack of congenial occupation and the consequent ennui, and no wise adviser will send a patient to a health-resort which has only climate to commend it, and which is entirely destitute of objects of interest and attraction.

As regards the particular class of cases benefited by the Algerian climate I regret that I cannot lay down any fixed rules. A large proportion of cases certainly do well, but I am not aware that any marked preponderance of advantage can be claimed for any special type or stage of phthisis.

Australia has long had a great repute as a locality for consumptives, and many remarkable cures have attended the resort thither of patients from these islands. Nevertheless some authorities denounce Australia, and regard it as hurtful to the phthisical patient. The error lies in talking of Australia as a whole. One might as well talk of the climate of Europe as of the climate of Australia. In so vast a country the gradations and variations of climate are necessarily endless; and while some regions, such as the sea-coast especially near Melbourne and Sydney, are decidedly noxious to the consumptive, other regions, such as the Darling Downs of New South Wales and the vast plains in the interior of Queensland, possess an intensely dry, equable, inland climate, like that of Upper Egypt, presenting an assemblage of conditions highly favourable for the successful treatment of phthisis.

The climate of Melbourne and Sydney, especially the former, is decidedly injurious, as the summer heat is there excessive, and sudden changes of temperature—I have myself seen the thermometer fall 40° in thirty minutes—are frequent. Dust-storms are common in the summer season, and are peculiarly distressing to all sufferers from respiratory disease. The consumptive who tries Australia should be recommended to spend as little time as possible in the cities on the coast, but at once to push on to the inland regions, or else to cross Bass' Straits to Tasmania, where he will enjoy one of the mildest, most equable and altogether most charming climates in the world.

D. I have lastly to speak of the effect of residence at high altitudes in the treatment of phthisis, and I shall restrict myself to Davos, in Switzerland. Here I cannot speak from personal experience; but I have had the advantage of frequent intercourse with those who know Davos well, and my information is as good as any sec-

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ond-hand information can be. Davos, as most people are aware, is an elevated valley in the Canton of the Grisons, in the east of Switzerland, and is at an elevation of 5,200 feet above the sea level. A local authority thus describes the chief characteristics of the climate:—"The lightness of the air (one-fifth less than at sea level), its extreme purity and dryness, the remarkable absence of clouds (pleasantly illustrated by long periods of brilliant sunny days), the great amount and comparative uniformity of solar radiation, enabling invalids to spend most of their time out of doors, and even in the depth of winter to sit in the open air for many hours daily, and the bracing, tranquil atmosphere, undisturbed by cold winds—all combine to constitute a sanatorium as nearly perfect as can be found."

The following statistics about the climate of Davos cannot fail to be interesting and instructive. The figures are based upon the average of three years:—

1. Average number of cloudless and sunny days:—October, 11; November, 15; December, 16; January, 19; February, 16; March, 17.

2. Average number of days of alternate cloud and sunshine:—October, 12; November, 7; December, 8; January, 9; February, 8; March, 8.

3. Average number of windless days:—October, 14; November, 22; December, 25; January, 25; February, 17; March, 12.

4. Average number of cloudy days:—October, less than 1; November, 2; December, less than 1; January, less than 1; February, none; March 1.

5. Average number of wet and snowy days:—October, 2; November, 3; December, 1; January, 2; February, 2; March, 2.

6. Average number of days on which some rain or snow fell:—October, 5; November, 4; December, 5; January, 1; February, 2; March, 4.

The average height of the barometer is from 24 to 25 inches.

As the best commentary on the above statistics I shall quote some portions of a letter which I have lately received from Davos, bearing date December 7th, 1883. My correspondent is a medical gentleman who has made a marvellous rally after the disease had rapidly progressed to the third stage, and his information is based not only on personal observation, but on the best medical opinion to be obtained in Davos:—

"As regards the cases which do best here, one cannot honestly draw the line; the reason being, that where there is sufficient vigour in the system to resist the cold, almost all classes of cases do equally well. Where the disease has reduced the vital powers very low the circulation cannot be carried on sufficiently in this climate, and such cases do badly; but I fear for them no suitable climate exists. Hæmorrhage cases in the early stage certainly do well. There are people living here who cannot live in the valleys, or anywhere at the sea level, without rapidly developing hæmorrhage. Chronic

pleurisy and pneumonia cases get on well—in fact, perhaps best of all. The air seems to be almost a specific for causing the absorption of the fibroid material formed in a case of chronic pleurisy. Very many of the cases here are patients with catarrhal pneumonia of both apices, and they usually progress favourably. Cavity cases are perhaps the most interesting, as they form elsewhere the least successful class of all. Here, when the cavity is not very large or the patient hopelessly weak, cicatrization is the rule. In ordinary consolidation the exudatory products are some times absorbed with wonderful rapidity. The great advantage of this climate is its dryness. It is perfectly wonderful how tolerable extreme cold is when the air is dry. Were Davos as damp as London we should all be corpses in a week; but one shivers more in England in the summer than here during the entire winter. It is certain that the cold is invigorating, and that digestion is thereby improved, assimilation increased, and fat accumulated, and, further, that the snow prevents exhalations of decaying substances from the earth. The absence of dust and the bright sunshine are useful adjuncts, but I think the dryness of the air is the chief point. The cold has been alleged to act as a vermicide to the bacilli."

Evidence such as this cannot be gainsaid, and I shall not weaken it by comment. While the exposure to cold of patients suffering from a disease for the cure of which warmth has usually been regarded as an indispensable condition, is a novelty, and as such is sure to excite opposition more or less reasonable, the proofs of the efficacy of the climate of Davos are yearly accumulating, and can no longer be disregarded by the most prejudiced persons. I have not left myself time to sum up my results, but it is hardly necessary to do so. I have already indicated my views with sufficient exactness.

I have no high opinion of the south of France, and am disposed to question if it is much superior to the health-resorts of the south of England. Cannes and Mentone are probably the best of the French stations; and I may here remark that Pau and Montpellier are rightly losing whatever repute they ever possessed. The Italian resorts are not much better, and of these Sorrento is perhaps the favourite. Of Egypt and Madeira I cannot speak, and I think where practicable our choice should lie between the long sea voyage, Algiers, Australia, or Davos. I have already endeavoured to indicate the main indications which must guide our choice in this most vital matter, involving, as it does, both the life of our patient and our own professional reputation.

Since last meeting a most successful dinner was held on 4th inst (Tuesday evening) 7 o'clock at "The Castle Restaurant". 31 members and guests sat down to dinner—10/- and 15/-.

R. F. Dill, President
8th January 1884

1884 Third Meeting was held upon January 8th

(Tuesday).

Professor Dill (President in the chair), present Drs. Wheeler, McFarland, T. Kennedy Wheeler, Dwyer, Dempsey, St. George, Fagan, McConnell, Whitla, Esler, O'Neill, J. W. Browne, McHarry, Lindsay, and Mackenzie, Secretary.

Dr. Kennedy Wheeler exhibited a patient the subject of chronic inflammation of knee joint treated by "Sager's splint".

He also showed patient whose leg was flexed at a right-angle for years. The patient had now a comparatively useful limb.

An interesting discussion followed in which Drs. McFarland, J. W. Browne, Fagan, Esler and the President took part.

Dr. Whitla showed liver with malignant disease and abscess. He gave a clear and detailed account of the symptoms, duration of illness etc. of the patient from whom the liver was taken.

Dr. Dempsey thought it possible that the disease was tubercular.

J. W. Browne showed drawing of large arterial nevus extending over almost the right side of head and face of a child. He described his mode of treatment by the thermal cautery needle.

Dr. Browne also showed an external abdominal ring which he had sutured for radical cure of hernia some years ago.

Dr. St. George read a paper on "Some remarks on bronchitis".

Paper:¹ Bronchitis is a very prevalent complaint, and not only is it of frequent occurrence in different persons, but one of its chief characteristics—and perhaps its most formidable one—is its great tendency to recur again and again in the same person, and often at the same periods of time, the attacks increasing in severity and duration from year to year, until at length the sufferer is scarcely ever entirely free from their effects, and becomes gradually disabled from all active employments.

Moreover, in estimating the importance of a thorough study of this disease, we must not overlook the fact of its peculiarly wide and intimate relations with other diseases both of the lungs and of other organs, and with several of the commonest forms of dyscrasia to which the human frame is liable.

Bronchitis, as we are all well aware, is essentially an inflammatory affection of the bronchial mucous membrane, attended with more or less of flux from the inflamed surfaces. As regards its usual symptoms and physical signs, I shall not now enter into any separate detailed exposition: we are all familiar with them; and it will be more convenient to incorporate any explanations which I may deem it desirable to make on these points with other practical comments on the cases

which I shall quote in illustration of my subject. But though bronchitis is always manifested by somewhat similar symptoms, and is therefore pathologically known by one name, it is by no means of uniform character in different persons, but varies much in extent, intensity, and duration. Thus it may be limited to the larger bronchial tree, or it may extend to the capillary tubes.

It may be a more or less severe, acute attack, running a comparatively rapid course, and ending in perfect recovery; or it may assume a sub-acute or a chronic form, and its duration be indefinitely protracted. In its severer forms it is a very fatal disease, especially to the young, the delicate, and the aged. In its milder forms it is attended by no immediate danger to life; but as a bronchial membrane which has once been inflamed is very prone to a recurrence of inflammation from comparatively slight causes, even a mild attack of bronchitis may, especially in persons whose health is otherwise not perfect, become the starting-point of a chronic bronchial affection, and thus lay the foundation for a life-long delicacy, or for various secondary ailments.

In the next place, although the general symptoms of bronchitis are always very similar, inasmuch as it is always the same structure which is the seat of irritation, this irritation may be produced by various causes—some proceeding from without, and others from within the organism—some accidental, and others constitutional. One cause, above all others, produces, especially in this locality, an immense amount of bronchial disease—I refer to the fine dust and fluff inhaled by the operatives in the large flax spinning mills of this and neighbouring towns. Vicissitudes of weather and exposure to cold or damp are, however, generally regarded as the only exciting causes of bronchitis. Sometimes such exposure is, in fact, the only cause, as when an attack of bronchitis results from remaining for some time wet-shod, getting chilled, or wet through on a journey, or else from passing, without proper precautions, from the hot, dry air of a house to the cold or damp atmosphere out of doors. And again, it is notorious that vicissitudes of weather, such as the setting in of a cold, biting east wind after great heat, often serve as an exciting cause of bronchitis. Nevertheless there can be no doubt that in the majority of cases such causes only excite the disease when a strong predisposition to it already exists, either from some constitutional derangement of health, or else from delicacy of the bronchial membrane consequent on previous attacks of bronchitis or on long-standing local irritation arising from the inhalation of dust, &c. I am, besides, well assured from careful observation that bronchitis is sometimes the direct consequence of some constitutional vice apart from exposure to any external exciting cause. In confirmation of this opinion I may remind you that bronchitis, although certainly far more

¹ [Dublin Journal of Medical Science, 1884, v77, p410.]

prevalent in the colder season of the year, is by no means peculiar to it, and in some cases even has a definite tendency to recur periodically in summer instead of winter, and usually on such periodical recurrence to be associated with some well-marked constitutional disorder. I have already alluded to the intimate relations between bronchitis and various other ailments, local and constitutional. These relations may be either of cause or consequence, as when, on the one hand, bronchitis produces some secondary lesion either of the lungs or heart, or some more remote sequence, such as disease of the liver or kidneys; or when, on the other hand, bronchitis is itself the secondary result of some constitutional vice, such as gouty syphilis, or some local affection, such as cardiac or renal disease. Bronchitis may thus be either a primary or a secondary affection—primary, as when it is the result of exposure, or when the irritation, excited by the inhalation of dust, &c., develops the disease; secondary, as when the bronchial affection arises out of some previously existing ailment, such as any of those I have just mentioned. Again, bronchitis may be associated as a complication with other diseases, as measles or whooping-cough, or with other pulmonary affections, such as pneumonia or phthisis.

The subject indeed is such a wide one that I do not purpose, neither would it be possible for me, to enter into its consideration exhaustively in the compass of a paper like this; but I make these few observations with the hope of drawing attention to the great practical importance of studying a disease, the variety of causes, complications, and consequences of which must obviously render the diagnosis, prognosis, and treatment equally various in different cases.

In order to bring the several relations of bronchitis to which I have alluded more plainly before you, I will, with your permission, read notes of a few cases illustrative of them, which have come under my notice in the County Antrim Infirmary, and in my private practice:—

Case I.—D. L., aged thirty-six, mechanic, was admitted under my care into the Co. Antrim Infirmary, on June 16th, 1880. About six 4 years previously, after a very warm day's work, and while still perspiring freely, he bathed in the River Lagan. He was attacked at that time with a severe cold, and since then has been subject to a cough, from which indeed he is now seldom free. This chronic cough is at any time easily aggravated by exposure; and he has been laid up more or less with it every winter. There is no family history of phthisis, and he has never suffered from gout or rheumatism, nor indeed from any other ailment, except bronchitis. On admission he complained of dyspnoea, and had a frequent hard cough, attended by the expectoration of a thin, transparent, frothy mucus, mixed with opaque yellow masses; skin cool; pulse 72. The chest was well formed, and rose equally and evenly on both sides dur-

ing inspiration, but the breathing was laborious, the sterno-mastoid and scalmi muscles acting powerfully as elevators during inspiration, and the supra-clavicular regions being depressed at the same time. But although the breathing was thus difficult, it was not accelerated in proportion, there being only twenty-four respirations per minute. These symptoms are all characteristic of bronchitis. Both in pneumonia and progressive phthisis the skin is usually pungently hot; whereas, even in the febrile stage of acute bronchitis, when uncomplicated with either pneumonia or tubercle, although the temperature may be raised, the skin seldom conveys to the hand any remarkable sensation of heat; and in cases such as this one, frequently does not exceed the normal warmth. The pulse also in bronchitis never rises as high as in phthisis or pneumonia; and very often, in cases of a chronic character, does not exceed the normal frequency.

Again, though the respiration is generally much quicker in the other pulmonary diseases than it is in bronchitis, yet it is never so laborious. Even, with greatly accelerated respiration, patients suffering from pneumonia are often not conscious of dyspnoea; whereas, in severe bronchitis, laborious breathing is the rule. With respect to the nature of the expectoration, the thin, transparent, frothy expectoration is indicative of recent bronchitis, or rather of a recent attack engrafted on an old chronic affection, as is shown by the frothy expectoration being mixed with the opaque yellow mucus characteristic of chronic bronchitis. In order to complete the history of this case there are two other points to which I must allude. The front of the chest was resonant on percussion from apex to base on both sides; distinct pulmonary resonance being elicited by percussion, even over the cardiac region. The percussion note was also clear posteriorly. The respiration was feebly heard over the left mammary region; in other places it was sometimes harsh, and it was everywhere more or less sibilant. The heart was seen beating immediately below the xiphoid cartilage. The heart sounds were feeble, but free from murmurs. This displacement of the heart was evidently due to emphysema, the presence of which was indicated by the abnormal clearness over the whole front of the chest, with slight enlargement of the right side of the heart. As regards the treatment and progress of this patient, I may say that he improved under a mild antiphlogistic and tonic treatment, consisting of at first the following mixture three times a day:—

R. Tr. scillæ, ℥. xv.
Sp. æther. nitr., ʒj.
Liq. amm. acet., ʒij.
Tr. hyoscyam., ʒss.
Aq. camph., ad ʒj. M.

As soon as the urgent symptoms had subsided, I substituted the following:—

R. Acid. nitro-hydrochl. dil., ℥. x.

Tr. hyoscyam.

Tr. laticis, āā. ʒss.

Inf. gent. c., ad ʒj. M.

To be taken three times a day.

Under this treatment he improved, and was discharged, relieved, in about six weeks.

This case belongs to a class in which great benefit may be derived from medical treatment during exacerbations of the bronchial affection, and in which much may be done by care and proper management to retard the progress of the disease; but in which the disease itself has too firm a hold to give us much hope of being able to effect a permanent cure, especially in persons liable to exposure. I have little doubt that on the first such occasion my patient will suffer a fresh return of his malady, and find his way for relief to me, or some other medical man. I will now draw your attention to a case drawn from a class very common in this part of Ireland; I allude to bronchitis caused by the inhalation of dust mixed with fine particles of flax.

Case II.—R. M., aged forty, hackler, was admitted under my care into the Co. Antrim Infirmary on April 20th, 1883. His work consists in drawing the flax after it has been scutched through a series of iron pins, so as to remove the rougher parts. As the workman stands before these pins, and swings the flax up and down in front of his face, it is evident that a large quantity of the fine particles must be constantly inhaled. Attempts have been made to induce the flax-dressers to wear respirators whilst at their work, but to no purpose.

He had long suffered from cough and tightness of breathing, and latterly also from difficulty of breathing.

At the time of his admission his skin was cool, and pulse quiet, the expectoration scanty, opaque, and of a yellow colour. The chest was resonant on percussion, both in the anterior and scapular regions; but there was a slight degree of dulness over the bases of both lungs posteriorly. The respiration was feeble in the apex of the right lung, and harsh in the apex of the left. The respiration was tubular near the right nipple, and coarse crepitation was heard over a limited space near the left. There was fine crepitation in the base of the right lung, and a large mucous rāle in the corresponding part of the left; urine normal. He was ordered a mixture, containing in each dose, three times a day—

R. Ammon. carb., gr. 5.

Tr. scillæ.

Tr. camph. c. āā, ℥. xv.

Inf. senegæ, ad ʒj. M.

In about a fortnight, as he had improved, I gave him two drachms of cod-liver oil after each meal, and as a tonic before food a mixture containing—

R. Acid. nitro-hydrochl. dil.

Tr. camph. c. āā, ℥. x.

Vin. ipecac., ℥. vi.

Inf. gent. co., ad ʒj. M.

I carefully examined him on the 22nd May, when I

found the cough and dyspnœa greatly decreased. The moist sounds in the base of the left lung had given place to harsh dry respiration. The crepitation near the left nipple had disappeared, and the fine crepitation in the base of the right lung had become coarser, and less extensive. He continued to improve until the end of June, when he considered himself convalescent, and resumed his work.

I had under my care about two years before this a patient who remained longer under my care, and the history of whose case is more conclusive as to the cause of his complaint and the remedy for it

Case III.—J. W., aged twenty-two, a flax-dresser in a mill in Lisburn, consulted me on the 12th June, 1879. His work was much the same as that of the preceding case. He had only followed this employment for eighteen months, and had previously been quite healthy, but had frequently during the year previous suffered from bronchial irritation. For several months before he had consulted me he had been troubled with much difficulty of breathing, and dry cough, attended by an opaque muco-purulent expectoration, which of late had been frequently streaked with blood.

On examination, he had a follicular sore throat, and a husky voice. His chest was well formed and normally resonant on percussion over its whole anterior aspect; posteriorly the resonance was also normal. The respiration was dry and sibilant in front; sonorous rhonchus was audible behind. Over the lower lobes of both lungs, and on the left side as high as the scapula, no moist sounds were anywhere heard. He was put on nearly the same medical treatment as the last patient, and was advised to change his occupation, which, in the meantime, he promised to discontinue. On June 26th the cough and expectoration had decreased. Rhonchus was still audible between the scapulæ, and in the lower lobes of both lungs. The respiration over the front of the chest was still dry and sibilant; expiration prolonged. By July 9th the rhonchus in the back had much diminished; he then went to Newcastle for change of air, and, on his return, reported himself quite well, and resumed his work, which he persevered in for several weeks. On Sept. 11th he returned with much cough, shortness of breath, and wheezing, especially at night.

The expectoration was more copious than before, thin, and frothy. He said his present attack had come on gradually, the first symptoms having been pain, and oppression over the sternum, which had appeared almost as soon he recommenced work. There was no hæmoptysis. His chest was still normally resonant on percussion; but the respiration was harsh and sibilant as before. I warned him again, that if he wished to enjoy good health, he must give up his present employment. On Sept. 25th he reported to me that he was greatly relieved, and on October 16th he informed me that he had obtained work in another part of the factory, where he was free from dust, and there was

already a manifest improvement in his symptoms—the cough and expectoration having much abated. I have had many opportunities of seeing him since, and he has continued in fair health.

We cannot fail to remark the very different degrees of rapidity with which this disease advances, and we perceive that this difference is due in part to more or less frequent occurrence of catarrhal accidents. Other circumstances peculiar to the patient—such as age, habits of life, and constitutional tendencies—are not without great effect on the progress and course of the disease, and of these the last-named especially exercise a most important influence in promoting and modifying its development. We can easily understand that the existence of any constitutional conditions must lessen the power of resistance, in the bronchial membrane, to the mechanical irritation exerted upon it, and thereby not only hasten the development of the disease, but add to its severity.

On the other hand, if there be any tendency to tubercular disease, I can conceive nothing more likely to light it up in the lungs than such bronchitic irritation; and I have, in fact, in a few instances, seen the constitutional tendency and the mechanical existing cause in operation together, and have only been enabled by the history of the case to determine the coexistence of the two factors. The cases I have referred to are drawn from the poorer classes, but I am persuaded that the causes of the bronchial affection in all these patients are, within certain limits, in much commoner operation than might at first sight be supposed. Few private patients are exposed to these noxious influences in sufficient intensity to excite bronchitis directly, but very many unsuspectingly inhale dust or impure air to a degree which gradually produces slight bronchitic irritation, and renders them exceedingly liable to contract bronchitis on being exposed to any exciting cause.

Even the habitual travelling along a dusty road is apt to have this effect, and the constant breathing of hot and dry air in dwelling-rooms, especially if combined, as is too common, with imperfect ventilation, is a fruitful source of the same tendency. The employment of gas in apartments, unless proper appliances be in use for carrying off the products of combustion and for admitting fresh supplies of pure air, produce a dangerous state of the atmosphere. These are things of no small consequence to be borne in mind in private practice.

It is still common for bronchitic patients to shut themselves up in close, hot rooms, and breathe impure air, with the idea that by so doing they are thereby avoiding draughts, although, in fact, they are aggravating their ailments by so doing, and retarding their cure.

No doubt there are cases in which we find it necessary to keep our patients for a time in an artificial temperature, but we should take care that while the air of

the apartment is warm it should never be allowed to become dry. Even the simple device of keeping a kettle of boiling water on the fire, with a tube long enough to throw a constant jet of steam into the room, will suffice to moisten the air, and with proper contrivances ventilation may be always obtained without danger to the most susceptible patient.

By far the greater number of bronchitic patients, however, actually do better when not kept in rooms at too high a temperature, inasmuch as they sustain less injury to their general health, and are able to go about earlier, and with less risk of taking cold from any slight exposure, than those who have been so confined.

It is not so much a warm as a moist atmosphere that is needed by bronchitic patients, with ample protection from chilling of the surface, and this may be secured by suitable clothing. In fact, as a rule, I have found that, all things being equal, bronchitis is slower in its progress, and less speedily affects the general health, in persons whose duties take them much out of doors, than in those who, from their in-door employments, would generally be presumed to be less exposed to causes of taking cold, and less liable to attacks of their complaint.

I will now make a few remarks on the treatment of the class of patients I have brought under notice. When patients come under my care with an acute attack of bronchitis, I find it best to act on the skin, to promote expectoration, and relieve the inflamed mucous membrane. For this purpose, if the pulse be of good volume, and the patient's strength not impaired, I give a mild diaphoretic mixture of Mindererus' spirit, antimonial wine, and tincture of henbane, and occasionally a little ipecacuanha wine.

If, however, the patient be depressed, I give the *vinum ipecacuanhæ* without the antimony. Later on, or in less acute cases, I find the more stimulating expectorants, as squill, the most effectual; but in almost all cases, especially in chronic bronchitis, a time arrives when expectorants cease to be useful. The expectoration indeed continues, but it rather is of the nature of a habitual flux than the result of active irritation.

The treatment now requires to be of a tonic character, and though zinc, iron, or quinine, are all useful, I have found the mineral acids, especially the dilute nitro-hydrochloric acid, in combination with a vegetable bitter, as quassia or gentian, the most advantageous. In chronic cases attended by very copious expectoration, balsamic remedies, as gum ammoniacum, &c., are often of service, but I have found them, as a rule, apt to disagree with the stomach, and as the digestive powers are in such cases often feeble, I have been accustomed to give tincture of larch in mixture, or tar in two-grain pills, which never disagrees, and is equally, if not more serviceable to the bronchial affection.

Its effect is not only to lessen the expectoration, but also

apparently to restore the debilitated membrane to a more healthy tone, and to render patients less liable to attacks of catarrh.

Useful as medicines undoubtedly are in allaying or curing attacks of bronchitis, I need hardly tell you that whenever the bronchial affection is even partially referable to an existing external cause, no permanent good can be effected without the removal of that cause.

Amongst the working classes it is often impossible to accomplish a change of employment, though I have seen cases, such as the one I have related, in which a change of occupation has been effected, and the patients have recovered; but amongst the higher classes much may be accomplished—I say whenever the bronchial affection is even partially referable to an external cause, because, as I have said before, cases of primary bronchitis are comparatively rare. Even amongst hospital patients external causes in a large majority of cases only develop or aggravate constitutional or hereditary tendencies to bronchial disease, and this naturally obtains more among the upper classes, who are exposed to such causes only in slighter degrees.

Time will not permit me to do more than refer to a few cases of gouty bronchitis. I have mentioned before that in a large number of cases bronchitis is a secondary, and not a primary disease—that is to say, a disease arising out of some other previously existing ailment or constitutional dyscrasia.

As in the beginning of this paper I have touched upon examples of primary bronchitis arising solely from exposure to external exciting causes, I now therefore purpose to consider gouty bronchitis. All these cases which I will now refer to have suffered either from gout or chronic rheumatic gout. I am indeed aware that some of our highest authorities consider regular gout and rheumatic gout as entirely different complaints, and no doubt there is a pathological distinction between them, but clinically regarded they are allied ailments affecting the same tissues, and often seeming to occur in members of the same family as manifestations of a common hereditary diathesis.

Case IV.—E. M'K., a carpenter, aged fifty, became a patient in the County Antrim Infirmary, on Dec. 1st, 1882. His father had been a butler, and suffered from gout, and died from asthma, aged sixty-six. One of his brothers suffers from rheumatism, and another from chronic bronchitis.

The patient himself had had several attacks of rheumatism and sciatica. He had also for years been subject to a severe cough in winter, which usually began in October, and lasted till March. The cough was attended with much dyspnoea, and by frequent paroxysms of the same at night.

These generally came on at one or two o'clock in the morning, after he had been asleep, compelling him to sit up in bed for a longer or shorter time. The parox-

ysms of dyspnoea are not, as a rule, common in bronchitis.

Dr. Graves, in his "Clinical Lectures," says that he scarcely ever met with a patient who had been subject to chronic bronchitis who did not also labour under more or less asthmatic dyspnoea, but it is more than probable that Dr. Graves used the term for the dyspnoea, which is commonly attendant on chronic bronchitis, especially when complicated either with pulmonary emphysema or with cardiac disease, and which is only paroxysmal, inasmuch as it is aggravated by every physical exertion, and by every accession of catarrh.

So far as I could learn, it was in this latter sense that my patient applied the term asthmatic to both his parents. At the same time, asthma, like bronchitis, is often connected with a gouty diathesis, and I have no doubt that in this patient this diathesis was the cause of both complaints. At the time of his admission the patient's skin was cool. Pulse, 85; respiration, 86. His cough was troublesome, and his expectoration thin, white, and frothy, but, he said, more generally thick, and of a yellow colour, and had sometimes been streaked with blood.

On examination his chest was found to be broad and deep. The veins of his thorax were turgid, and most markedly on the left side, and respiration was laboured.

He said he was never free from dyspnoea, even in summer, especially in hot weather. The percussion note was clear over the whole front of the chest, especially in the mammary regions, and the clear sound encroached somewhat on the normal cardiac dulness. Posteriorly there was resonance on percussion, excepting over the base of the left lung, where it was slightly deficient. The respiration was harsh, expiration prolonged. Rhonchus was more or less audible over both lungs, and moist sounds were heard with inspiration in the base of the left lung.

The heart's apex was somewhat depressed. His urine was not albuminous. The patient continued under treatment until February, when he was discharged almost well as regards the bronchitis, and without having any return of the symptoms of rheumatism or sciatica.

It is indeed true that the gouty form of dyscrasia is exceedingly common not only amongst private patients, but also the working classes. But, common as it is, gout is found in a very much smaller proportion of the total number of our hospital patients than of the bronchitic class of patients taken by themselves; hence I think I am justified in the conclusion that there is really an intimate relation between a gouty constitution and chronic bronchitis, and that in many cases in which a hereditary tendency to gout has not been developed into the characteristic form of that disease it manifests itself in the form of chronic bronchitis. In further support of these views I may mention that I have fre-

quently known bronchitis and gout or rheumatism habitually to alternate, an obstinate attack of bronchitis sometimes subsiding on the occurrence of a fit of gout, and again at other times a smart fit of gout being relieved by the development of bronchitis.

There was an elderly man for a long time under my care. His ailments were rheumatic gout, eczema, and bronchitis, and he was rarely, if ever, free from some one of them. No two of the three were ever present together; but just as he was congratulating himself on having got rid of the rheumatism, his legs would be attacked with eczema, and this would disappear in a few weeks, to be succeeded by an attack of bronchitis.

I will now mention one or two cases à propos of this form of bronchitis:—

Case V.—H. M'C., a wheelwright, came under my care in 1876. He had then been ailing a year and a half, during which time he had suffered alternately from cough and what he called rheumatic pains in his knees and elbows. At the time of his consulting me he had slight cough and dyspnoea, but he principally complained of gastralgia of some weeks' standing.

The pain came on soon after eating, and was excessively severe. This gastralgia, I may observe, was doubtless but a different manifestation of the same disorder of health which induced the bronchitis and the so-called rheumatic pains. This form of dyspepsia is very common in persons of gouty diathesis, who have never had paroxysms of acute gout, and, like other forms of the disease, may either give place to some new train of gouty symptoms, or be relieved by a fit of gout itself. On this occasion the patient was soon relieved from his ailments by the use of bismuth, &c., in combination with a bitter infusion, and of small doses of blue pill and rhubarb, but he returned to me on May 27th of the same year, with pain and tenderness in the soles of his feet, and with lepra on the arms and knees. He said he had of late suffered but rarely from gastralgia, and only then in very slight degree; neither had he any cough, but he was not free from dyspnoea. I gave him 10 grains of iodide of potassium, with 5 minims of colchicum wine three times a day, to which, as the pains abated, I added small doses of arsenic. On July 22nd the pains had for some time entirely left him, and the eruption was gradually disappearing, but he had again begun to cough and expectorate, and he complained of increased shortness of breath. The chest was normally resonant, but harsh rhonchus was audible throughout both lungs. He was ordered small doses of liq. arsenici hydrochlorici and acid, hydrochlorici dil. with cod-liver oil, and some extract of hemlock at night to allay the cough.

He was soon relieved, and ceased to visit me. Late in October he again consulted me for lumbago and pains in the knees and elbows, having then no cough, but the lepra, which had never altogether left him, was much increased.

As these ailments yielded (after about five weeks' treat-

ment), he once more began to cough, and suffered from bronchitis throughout the winter. On the 20th April, 1877, he was quite free from pain and the lepra, and had only a little cough and expectoration on first rising in the morning. I now put him on a course of dilute nitro-hydrochloric acid and tincture of larch, and he was quite well in June.

I have already said that when bronchitis occurs in persons of gouty diathesis, it frequently happens, on the one hand, that bronchitis makes its appearance on the subsidence of the gouty symptoms; and again, on the other hand, that a fit of gout relieves the bronchitis. The following case illustrates the latter mode of alternation:—

Case VI.—W. J. B., aged sixty, brewer, was admitted into the County Antrim Infirmary, October 22nd, 1880. He stated that he had for many years been subject to cough and expectoration, with great dyspnoea, in summer as well as in winter, as much in hot as in cold weather. A medium temperature suited him best, extremes always increasing his distress. He had had regular gout for the first time twenty years previously, and said he was in the habit of suffering from gouty pains in the hands and feet, but he was free from them when admitted. He was also subject to occasional psoriasis.

On inquiry he admitted that he drank a great deal of beer and porter, as he was brought in contact with it in his business. The patient himself referred his complaint to exposure to cold during his work, but the sudden appearance of the gout having preceded that of the bronchitis, and it having been accompanied or followed by gout in three attacks out of four, we may reasonably assume that these exposures were, at most, only the immediate exciting causes of irritation in a bronchial membrane already predisposed to disease by existing constitutional derangement. When admitted, he was suffering from a pretty severe attack of bronchitis, attended by much dyspnoea and by a copious frothy expectoration; but he said that though he was never altogether free from expectoration any more than free from cough, it consisted, during the intervals between the more acute attacks, of only a small quantity of thick, transparent, bluish mucus. Now, this is the exact counterpart of what we meet with every day in bronchitis, more particularly in those who have also a gouty constitution.

They habitually cough up in the morning, and, it may be, at rare intervals through the day, little pellets of tenacious, bluish, starch-like mucus, sometimes studded with darker specks. This ailment, which may be perhaps almost too slight to attract the patient's notice, is quite compatible with good health in all other respects, but it is nevertheless the proof of an abnormal condition of the bronchial membrane. In the healthy state only just as much fluid is secreted as is necessary to keep the bronchial membrane moist enough for the

due performance of respiration. We may therefore safely assume, as a rule, that wherever there is expectoration, however small in quantity, the membrane is not in a state of perfect health, and therefore is far more liable than a membrane in the normal condition to suffer from any intermediate exciting causes of bronchitis of whatever kind. But to return to my patient. I treated him successively with carbonate and infusion of senega, then with dilute nitro-hydrochloric acid, tincture of gentian, ipecacuanha wine, and tincture of henbane.

On December 11th he was in all respects greatly improved, and passed from under my care on January 16th of the next year.

He came to me again on May 6th of the same year, suffering from gout of the fingers of his left hand, and also from cough, attended by the white, frothy, and mucous expectoration characteristic of recent bronchitis. There was also slight œdema of the ankles, but the urine was free from albumen.

The chest was found on examination to be normally resonant on percussion. Sibilus and rhonchus were more or less audible throughout both lungs. The expiration sound was prolonged, especially in the upper lobes, and mucous crepitation was heard in the base of the right lung. Taking into consideration the mixed character of the illness, showing the actual coexistence of gout and bronchitis, I prescribed a combination of medicines calculated to meet both aspects of the case—that is to say, I gave 4 grains each of potassium iodide and carbonate of ammonia, 10 minims of colchicum wine, and 20 minima each of tinctures of squill and henbane in an ounce of camphor water, three times a day, and 2½ grains each of extract of hemlock and pill of ipecacuanha and squill every night. This is a plan of treatment which, modified according to circumstances, I have found often very serviceable in similar cases, and under it the patient gradually improved; but at the end of a fortnight, his appearance being anæmic, a grain of sulphate of iron was substituted for the ammonia in each dose of his mixture. The gout soon disappeared, but the mucous crepitation in the base of the lung still continuing without change, I ordered him a mixture containing 20 minims each of liquor ferri perchloridi and tincture of henbane, and 10 minims each of vinum ipecacuanha and acidum hydrochloricum dilutum in an ounce of infusion of quassia. He now rapidly recovered, and continued well, and was discharged in August.

He next returned on 5th May following, when he was admitted in an almost similar condition. The finger joints were swollen and painful, and he was suffering from cough and dyspnœa. The bronchitis was, however, in a more advanced state, the expectoration being now thick, opaque, and muco-purulent, instead of glairy and frothy, as on his previous admissions. He was treated in a similar manner, but improved more

slowly than the year before. The cough varied from time to time; but though better on the whole, was by no means gone when, towards the end of June, he was attacked by gout in a more pronounced and regular form, affecting successively the balls of both great toes, the ankles, and fingers. On the appearance of gout in this acute form the cough and expectoration at once abated, and I ordered him as a mixture, three times a day, the following

R. Ferri sulph., granum.

Potass. iodid., gr. 5.

Vin. colchic., ℥. xv.

Glycerin., zj.

Aq. menth. pip., ad ʒj. M.

and a pill at bed-time, consisting of two grains of acetous extract of colchicum and three grains of Dover's powder. This treatment he continued, with some modifications, for a month, when he was discharged cured. But his relief was only temporary, as he returned on December 5th. His cough had returned, with much wheezing and dyspnœa, and with the frothy transparent expectoration I have described as characteristic of bronchitis.

His skin was cool; pulse 90, but quite regular. The sides of his chest rose evenly in respiration, and were equally and normally resonant on percussion. The heart sounds were normal; rhonchus and sibilus were audible over the lower lobes of both lungs posteriorly, intermixed with faint mucous crepitation in the base of the left lung; urine was normal. At this time he was quite free from gouty pains, so I ordered him the squill mixture I gave the first patient, with twenty minims of tincture of henbane every six hours. But bearing in mind his gouty tendencies I added a pill at night of colchicum and Dover's powder as before.

He soon improved greatly as regards the cough, and the expectoration diminished, and became opaque, and of a bluish colour, but the subsidence of the bronchial affection was again simultaneous with the development of gout, though of a less acute character than on the last occasion, this difference being possibly due to the specific treatment the patient had been undergoing before its appearance. In addition to the night pill he again took the iodide of potassium, carbonate of ammonia, and colchicum wine, and soon ceased to be treated, being quite free from both gout and bronchitis.

Time will not allow me, even if I wished, to bring forward cases showing the true relation which I believe to exist between bronchitis, on the one hand, and gout, eczema, or psoriasis or gravel on the other. All these different maladies evidently depend upon a common humoral dyscrasia, which in one case produces gout, in another gravel, in a third psoriasis, or, as in this last case, bronchitis, coexisting or alternating with one or more of these other ailments. These cases are all therefore examples of what I have called secondary bronchitis—that is to say, bronchitis arising out of some

internal condition of the system, that internal condition being, as we have seen, the existence of the humoral dyscrasia, which is known as the cause of gout.

Regarding the treatment of this form of secondary bronchitis, it is clear from the necessarily complicated nature of the subject that I cannot pretend to give any specific directions. The remedies appropriate to the bronchitis and to the other affections must obviously be varied and modified from time to time, in order to meet the constantly varying condition of different patients, and of the same patient at different times. The one essential point towards the successful treatment of all such cases is that we should constantly bear in mind the presence of a constitutional cause for the local affection, and not rest satisfied with directing our efforts towards the removal or alleviation of the bronchitis, but endeavour, as far as possible, to combat the dyscrasia, which is the real source of our patient's ailment.

Dr. Wheeler proposed and Dr. Esler seconded that Dr. J. Strafford Smith and Dr. Dickey be members of the Society

W. Whitla
January 22nd 1884

1884. Fourth Meeting of the Society was held upon Tuesday January 22nd.

Present, Professor Dill President in the chair, Drs. Esler, Whitla, McConnell, Dwyer, J. W. Browne, Kevin, O'Connell, J. C. Smyth and Mackenzie, Secretary.

Drs. J. Strafford Smith and Dickey were balloted for and unanimously elected members of the Society.

Dr. McConnell showed a patient the subject of "Jacksonian epilepsy". He stated that the man received a severe blow on the top of his head with a spade in the year 1879. There were 15 pieces of bone exuded from the wound. He had fits which were confined to one side of the body beginning at the tips of the fingers of the affected side from 1879 until 1882 when the fits ceased [?] and until the present time he has had fair health.

An interesting discussion, in which Drs. Esler, Whitla, J. W. Browne, Kevin and the President took part, followed on the advantage of trephining in this case.

Dr. Browne was of opinion that no harm but good would result from the operation as he thought probably the cicatrix was adherent to the dura mater.

Dr. McConnell also showed a patient with chronic eczema of leg which had been healed repeatedly but which as often broke out afresh.

Dr. Esler give notes of "Cases of scarlet fever traceable to milk supply". This paper opened a discussion in which all the members took part.

The Secretary was instructed to procure a copy of

Churchill's "Medical Registrar".

R. F. Dill, President
5th February 1884

Session 1883–84 Fifth Meeting of the Society was held upon February 5th in the Society Rooms Royal Hospital.

Present, Professor Dill President in the chair, Drs. Whitla, Fagan, J. C. Smyth, Lindsay, Dwyer, Strafford Smith.

Dr. Lindsay read notes of a case of remarkable eruption which followed the administration of two doses of iodide of potassium.

All the members present took part in the discussion upon this case.

Dr. Whitla read notes of the case of "chylous ascites" and showed the patient. An animated discussion followed, all the members present expressing great interest in this very exceptional and unique case.

Mr. Fagan's case was postponed until next meeting where he will take precedence of other business.

R. F. Dill, President
26th February 1884

Session 1883–84. The Sixth Meeting of the Society was held upon 26th February in Royal Hospital.

Professor Dill President in the chair, present Professor Gordon, Drs. O'Neill, Esler, Fagan, Whitla, Moore, Dempsey, Dwyer, St. George, Lindsay, McConnell, J. W. Browne, Barron, and Mackenzie, Honorary Secretary. A number of students were present.

Mr. Fagan showed patient (3 weeks after operation) from whom he had removed an exostosis from lower end of femur. The tumour was the size of an orange and was secured in two pieces. Mr. Fagan give a detailed account of the operation. He did not use "Esmarch's band" and he saturated the wound with chloride of lime.

A discussion followed in which a number joined. Dr. O'Neill did not approve of operating without Esmarch band nor did he approve of the use of chloride of zinc after operation.

Drs. Browne and Murray approved of the non-use of Esmarch band in this case and of the free use of chloride of lime.

Mr. Fagan replied in a spirited manner.

Dr. St. George showed a fibrocystic tumour removed from thigh of woman.

Professor Gordon delivered his instructive, original and highly appreciated paper on fractures of the leg.

Paper:¹ DOES a good collection of specimens of fractures of the leg resolve itself into well-defined species? To this I reply most decidedly in the affirmative. Does

¹ [Dublin Journal of Medical Science, 1884, v77, p289.]

each species demand distinct modifications of treatment? To this I also give the same answer. When I consider the frequency of fractures of the leg, and the deformity and lameness too often dependent upon them, I think these results may be attributed to the practice of viewing them in too narrow and restricted a light, assuming that they require for their successful treatment little variations in position and apparatus.

The following are the species and varieties into which the specimens in Queen's College Museum resolve themselves. I have no doubt as the collection increases other forms shall present themselves—of which the present classification is the beginning—of a more extensive and accurate system than that which now prevails, and without which our practice will be empirical rather than scientific.

1. The Articular Fracture of the Upper End of the Tibia.—The obliquity of the femur from without inwards and downwards, and the perpendicular position of the bones of the leg, cause the shock or impulse of the body, in leaping or falling from a height, to impinge chiefly upon the outer articular facet of the tibia; besides, the sharpness of the outer margin of the external condyle of the femur concentrates the force upon the outer part of the outer articular facet, and sometimes drives it into the cancellated tissue of the head of the tibia beneath it. There are three specimens of this accident in the Museum of the Queen's College. In two of them the tibia and fibula are also broken near their middle, presenting examples of the chisel-shaped fracture of both bones of the leg. In one of the two the compact tissue has been driven nearly half an inch into the cancelli of the head of the tibia. The appearance of the knee in this form of fracture would resemble, in a slight degree, genu valgum.

The third specimen shows less depression than the other two, but equally well marked, and not complicated with any other fracture of either of the bones of the leg. I leave it to future observers to give us a more detailed account of this accident, which I believe to be not uncommon.

Treatment—In the first form, where the compact tissue is driven into the cancelli, I do not see how it can be elevated. But in the second variety, where the condyle is broken with fracture of the fibula, we might, by adduction of the leg, separate, to a slight degree, the articular surfaces from each other; and if at the same time the leg were extended, the biceps flexor cruris would be extended, and more or less elevation of the condyle and broken fibula might be attained.

2. Simple Transverse Fracture of the Upper End of the Tibia.—This fracture traverses the upper expanded extremities of the tibia, a little above, through, or a little below the anterior tuberosity. There is no appreciable displacement. The patient is unable to raise the leg in the extended position, but when we grasp and fix the upper end of the tibia with one hand, and with the

other seize the leg above the ankle and move it from side to side, distinct motion between the fragments, with slight crepitus, will be easily recognised; but all doubts will be removed when we make pressure along the line of fracture, acute pricking pain will be complained of, caused by the very minute spicula wounding the soft parts, especially under the tendons of the gracilis and sartorius muscles.

Treatment.—As there is little or no tendency to displacement, all that is requisite to do is to keep the extremity in the extended position and apply a well-padded splint on each side of the limb, extending from the foot to the middle of the thigh, well secured by straps and buckles.

3. Oblique Fracture of the Tibia from before upwards and backwards.—This fracture is often compound, and is usually caused by great force applied to the crista. When the fracture is high up, the lower end of the upper fragment projects very much forwards, while the upper end of the lower fragment is displaced backwards. The fibula is usually broken opposite the seat of fracture in the tibia. In one instance the fibula was dislocated.

Treatment.—If we place the limb in the extended position, the deformity persists, and the more we extend or pull the worse it becomes. If we place it on its outer side, and attempt to relax the muscles by flexion, muscular spasm supervenes, aggravating very much the deformity. If, on the other hand, the heel splint, suitably padded, be applied to the back of the leg, and the limb slowly and gently raised until the thigh forms nearly a right angle with the pelvis, and the leg a right angle with the thigh, the deformity will generally disappear; then placing a thick pad along the anterior border of the upper fragment and dorsum of the foot, we apply the front splint, and, to prevent rotation or lateral motion, a Cline's splint well padded on each side of the limb.

Sometimes, notwithstanding the relaxation of the muscles consequent upon this position, the lower end of the upper fragment still projects forwards. Now the question will arise: What is the cause of this projection? Is it the quadriceps extensor cruris which pulls the fragments forwards, or the upper end of the lower fragment tilting it forwards? If the projection be from the action of the gastrocnemius and soleus acting on the lower fragment, then the flexion of the leg upon the thigh must be increased, whilst upon the other hand, if it be from the quadriceps extensor, the leg must be more raised, and the angle of the thigh with the pelvis diminished until the extremity assumes the position adopted for fractured patella.

When the seat of fracture is lower, approaching the middle of the bone, the padding applied to the back of the leg must be full, whilst that in front should extend only to the lower end of the upper fragment. A small pad must also be applied to the dorsum of the foot. By

this arrangement of the pads, there is a space between the lower fragment and the back of the anterior splint, and there is therefore no impediment to the lower fragment being pressed forward.

4. Oblique Fracture of the Tibia from before downwards and backwards.—In this fracture, which is generally about the middle of the tibia, the sharp end of the lower fragment often protrudes through the integument, the foot is carried backwards, bringing with it the contiguous part of the lower fragment, and causing its upper end to project very much forwards. The fibula is generally broken at or near the seat of fracture in the tibia.

Treatment—When the upper end of the lower fragment protrudes through the integument the patient is to be placed upon the back, the thigh flexed very much upon the pelvis, and the leg upon the thigh; then an assistant seizes the upper portion of the leg, whilst the surgeon grasps the foot and lower part of the limb, and makes extension downwards and backwards; then, on slowly raising the heel, the deformity will disappear. The heel splint, well padded below, is applied to the back of the leg; then a pad in front, extending over the dorsum of the foot and entire length of the tibia, is laid along the crista, and over this is placed the anterior splint; then a Cline's splint, well padded, is applied to each side of the limb, to prevent lateral displacement, and the whole secured by straps and buckles, or a bandage, and the limb placed upon the "rest," or a MacIntyre's splint, with the leg-piece elevated. Salter's apparatus, as usually made, does not allow of sufficient elevation, and, therefore, does not give us the relaxation of the posterior muscles of the leg requisite to the apposition of the fragments. It is in this form that the sharp angular end of the lower fragment is found to have burst through the skin, which, closing around it, prevents reduction.

The practice to be followed, I think, should depend upon the acuteness of the fracture. If it be narrow and long, we may saw it off, and then, raising the heel, it will slip into its place; or it may be necessary to pass a director into the wound, elevate the integument, so as to draw it over the projecting point. If the projecting end be of considerable thickness, it will be better to enlarge the wound in the skin. After this we cover the wound with a piece of lint, saturated in the compound tincture of benzoin, and apply the splints as before mentioned.

5. Fracture of the Tibia, with displacement of a large central fragment—I saw lately an instance of this form of fracture, the result of a railway accident. The seat opposite to that upon which the patient had been sitting at the time of collision striking the leg, forced from the middle of the tibia backwards a large triangular fragment. It was in the eighth week after the accident when I first saw him. This triangular fragment was quite movable, and displaced considerably back-

wards and slightly inwards. The upper and lower portions of the tibia were approximated, causing considerable shortening of the limb; the latter, at its lower end, was inclined considerably inwards, while its upper end pointed outwards. The impediment to the replacement of the middle fragment was the approximation of the upper and lower pieces of the tibia.

Treatment—The limb had been slightly raised, and two Cline's splints had been applied, with pads on each side. To allow of the return of the displaced fragments, it was necessary to raise the leg much higher, in order to produce greater muscular relaxation. Flexing it upon the thigh, and the thigh upon the pelvis, the heel splint, well padded, was applied posteriorly; a small, soft pad was placed over the triangular or middle fragment, and a thick one along the inner side of the foot and ankle, and a Cline's splint applied to the leg on its outer and inner surfaces. The effect of this change in the position of the limb in a few days became apparent, as the middle fragment had nearly resumed its proper position, and after this the case progressed most favourably; and, considering the serious character of the injury, the patient has recovered with a very useful limb, with scarcely any deformity or lameness.

The case may be regarded as the type of this form of accident, and its treatment cannot be successful unless the muscles are relaxed to their utmost, to enable us to make room for the displaced middle fragment.

6. Simple Transverse Fracture of both Tibia and Fibula at the junction of the Lower Third with the Upper Two-thirds.—Is a comparatively rare accident, and is caused by direct violence, applied transversely, breaking both bones on the same plane. There is no vertical displacement, and the deformity which results is displacement backwards of both fragments. The tibia and fibula are sometimes soldered together; at other times they are not so, but the interosseous space is diminished, with a narrowing of the transverse breadth of the leg at the seat of fracture.

Treatment—In the treatment of this fracture the heel, or posterior splint, must be well padded at the seat of fracture. The front pad should be thick over the lower end of the tibia. The limb may be placed in the straight position, and when the anterior splint is applied and the straps tightened it will act chiefly upon the lower end of the lower fragment, and push it backwards. In this, as in the spiroid fracture, we must be on our guard not to allow the lower fragment to rotate on its vertical axis. For this purpose we must apply a Cline's splint on the outer side of the limb, the foot-piece being well padded to prevent this rotation.

In two well-marked specimens of this accident, in the Queen's College Museum, inclination of the fragments backwards has produced a very great convexity behind, or concavity in front, which becomes remarkably apparent when we stand and look horizontally across the limb; and more than this, as the weight of the

body is thrown on the posterior part of the articular surface of the tibia, and the astragalus, a chronic arthritis and osteitis supervenes. This is a very good example of the mischief which results, unperceived by the surgeon, until too late, by treating the accident with a Cline's splint on each side, or by the use of a starch bandage. By the former there is no support behind, and both fragments gravitate backwards; and by the latter, from the looseness caused by the shrinking of the limb, and the weight upon the heel, a similar deformity results. And, moreover, it presents us with another instance of chronic osteitis, supervening when the natural bearing of the joint surfaces upon each other is altered, and leading to a chronic inflammation which persists, entailing lameness for a long time after the accident.

If the limb be placed on the "double-inclined plane," and steadied by two Cline's splints, the heel will gravitate backwards, carrying with it the lower end of the tibia, and producing an unusual prominence of the upper end of the lower fragment in front. And this remark is applicable not only to this, but to other forms of fracture of the leg, which tend to gravitate backwards from want of adequate support to the heel.

7. The Chisel-shaped Fracture of the Tibia.—This is by far the most common of all the fractures of the leg, equalling in number almost all the other fractures conjoined. It is caused by force being applied from without inwards. The patient in walking sets the outer side of his foot upon a stone. The outer side of the foot being thus elevated, the inner side is depressed, and the weight of the body being suddenly thrown obliquely across the tibia, it breaks obliquely from without inwards and downwards, the fibula, giving way sometimes opposite, but most frequently close to the head. On examination, the lower end of the upper fragment may be felt somewhat rounded, with a little projection in its middle, and the displacement seems slight, but it is always much greater than it appears.

As the upper end of the lower fragment is displaced outwards, the change which the lower or articular end undergoes deserves more consideration than has been accorded to it. The articular surface becomes more oblique with elevation of the internal malleolus, and the foot following the articular surface, its inner border is more raised, and most of the patients who have received this accident walk afterwards more on the outer side of the foot than usual.

Treatment.—Of all the fractures of the leg, the following mode of treatment is that which I found followed by the most satisfactory results:—Observing that the inner malleolus was raised, in order to bring it downwards to its natural position, two conditions were necessary—the first was to relax the muscles; the second was to powerfully abduct the foot; and to enable me to do so I had a splint constructed, to which I have given the name of the "double-bevelled splint." It is

made of a piece of pine, about an inch in thickness, and of the general form of Cline's splint. The foot-piece is cut off obliquely, so as to allow of abduction of the foot. Placing a thick pad on the leg portion of the splint, the limb resting on its outer side is placed upon it, then grasping the upper end of the leg with the one hand, whilst with the other seizing the foot and foot-pieces of the splint, and gently flexing the leg upon the thigh, at the same time abducting the foot, it will almost uniformly be found that in the act of flexion the bones drop accurately into position—so accurately, that it is even difficult to detect where the limb is broken. Then apply the front and back splints, secured by straps and buckles. The patient is to be kept lying upon his side, with the leg flexed upon the thigh, and the thigh flexed upon the pelvis. Some patients dislike the side position, and will complain against it; but if the surgeon be resolute, in a few days they will become reconciled to it.

I have a cast of a fracture of this variety, in which the tibia is broken an inch above the inner malleolus, with fracture of the fibula, two inches from the lower end, with displacement of the malleolus outwards, consequently with great increase of the inter-malleolar space. Where the fibula is broken so low down, and displaced as described, the abduction of the foot would be injurious; it, therefore, must be kept straight, and with this exception treated as previously described.

There is also another specimen of this accident, in which the foot is so much turned inwards that the patient walked on the outer part of its upper surface, as if he had been suffering from talipes varus.

8. Spiroid Fracture of the Tibia.—This fracture occurs in the middle third, or rather in the lower end of the middle third of the tibia, and is usually caused by force applied to the inner surface of the tibia whilst unsupported, except at its extremities. The lower end of the upper fragment presents internally an elongated spire, which, being driven into the upper end of the lower fragment, splits it obliquely downwards, the fissure extending into the articular surface. The upper end of the lower fragment behind presents also an elongated spire, less acute, however, than the internal. The sides of the inner spire are cut vertically to the surface, whilst the spire of the lower fragment is divided obliquely, showing in the clearest manner that the osseous fibres of the compact tissue of the internal surface of the tibia have been broken by compression, whilst those behind, or externally from their obliquity, have given way by elongation.

Diagnosis.—The diagnosis of this accident is easily made. The elongated spire of the upper fragment projects the integument so prominently that it can be easily seen and felt, and the crista of the tibia is also remarkably prominent, notwithstanding the great effusion of blood which takes place immediately after the accident.

Treatment—Those surgeons who have written on this

accident regard it as one which will often require amputation. From the few examples I have seen of it, the treatment will be as successful as any other fracture of the leg, and with as little deformity. Take the heel splint, pad it well, especially opposite the seat of fracture, then raise the limb, supported by the splint, until the thigh forms a right angle with the pelvis, and the leg a right angle with the thigh, and whilst the assistant holds the leg in this position, the surgeon, seizing the foot, makes gentle extension, and at the same time rotates the foot inwards—the fragments then usually drop into their most accurate approximation, all deformity disappearing. Immediately after the accident, from the foot resting upon the heel, and from the action of the tibialis anticus and the extensors of the toes, the lower fragment is rotated outwards.

If extension be made with the outward rotation maintained, it will be of no use; the fragments will not go into position. It is absolutely necessary, then, while we extend to rotate inwards. If we place the limb in the extended position the fragments will not go into their place; and, even should we succeed in the reduction, on the following day the deformity will have reappeared.

The way to treat this accident is to take the heel splint, well padded, raise the limb, flex the thigh upon the pelvis, and the leg upon the thigh, and having corrected the deformity by extension and rotation of the foot inwards, place a Cline's splint on the outer and another on the inner side, with a front splint, all suitably padded, and made firm with straps and buckles. This position must be maintained for four or five weeks by placing the limb upon a box, a "double-inclined plane" with the foot-piece elevated, or a leg—"rest."

Special care must be taken to place a thick pad between the foot-piece of the outer Cline's splint and outer margin of the foot, to maintain the rotation inwards of the foot. The limb may also be placed flexed in the same manner resting on its outer surface, but the leg must be well flexed on the thigh.

The explanation of the great fatality of this accident is mainly due to two causes, viz.:(1). The sharpened end of the upper fragment often bursts through the skin, making the fracture compound, or subsequently making its way through the integument by ulceration. (2). The spire of the lower fragment, which is usually very sharp, wounds the vessels behind, and great effusion of blood takes place, injecting the limb; and if we add to this the inflammatory products and putrefaction of the effused blood, we can then easily see why the accident should be so frequently fatal. Now, however, the antiseptic mode of treatment may have some influence in counteracting such disastrous results.

9. The Bread-cart Fracture.—I have given this name to a not uncommon accident in which a person is thrown down by a bread-cart, jaunting-car, or other vehicle running quickly.

The patient being thrown on his side, the wheel passes

over the inner surface of the leg. If it be at the ankle-joint, both malleoli will be found to be broken off, and the lower end of the tibia crushed and comminuted. If it be higher up, at the junction of the lower with the two upper thirds, the compact tissue of the inner surface will be broken into lozenge-shaped fragments, and driven into the medulla, and also displaced outwards, with fracture of the fibula, at the point where the wheel passes over the limb, the inner malleolus being elevated. If the wheel has passed higher up, the inner surface of the compact tissue will present numerous elongated spicula, whilst the angles, which are the strongest portions of the bone, will be broken off, and present themselves as long detached fragments. A moment's reflection will show us that this is a most serious accident, although there may be no external wound; for the long sharp fragments are driven into the medulla, which will lead to inflammatory action ending in death of many of the loose spicula; therefore, the fact of a wheel passing over the limb as described, although the injury and deformity may seem at first sight trifling, should lead the surgeon to give a very guarded prognosis, as the inflammation, suppuration, and necrosis will sooner or later necessitate amputation.

Treatment.—The limb should be placed resting upon its outer side, with the thigh flexed upon the pelvis, and the leg upon the thigh, with the foot abducted, and the inclination of the fragments either forwards or backwards should be prevented by the anterior and posterior splints.

10. Fracture of both Malleoli on the same plane as the inferior surface of the Tibia.—Both malleoli may be broken off with various forms of severe fractures of the leg, but, in the accident to which I have given this name, the injury is confined to the fracture of the malleoli, and it is caused by (1) forced extension of the foot with the leg more or less fixed, or (2) by forcible extension of the leg with the foot fixed. The accident may be regarded as the first stage of dislocation of both bones of the leg forwards or of the foot backwards.

Diagnosis.—The diagnosis is very easy, as the heel is carried backwards and upwards, whilst in front the lower end of the tibia projects slightly forwards. Both malleoli may be felt movable with slight crepitus; and as the processes follow the foot backwards, a small space in front may be felt between the inner malleolus and the tibia.

Treatment—Apply the heel splint well padded below, then the front splint with a thick pad over the lower end of the tibia, a Cline's splint on each side, thickly padded, over the malleoli, so as to press them firmly against the articular surface of the astragalus. The heel splint pushes the foot forwards, whilst the front splint presses the tibia backwards, and the Cline's splint fixes the foot, preventing any lateral deviation of the fragments, as either abduction or adduction would act injuriously by displacing the fragments. The leg may be

placed in the extended position—if so, it may be requisite to have the straps, which bind the splints together just above the ankle-joint, very tightly buckled, to prevent the heel from going backwards; however, if there be the slightest tendency to projection of the heel backwards, then the leg should be placed upon the “rest” in a semi-flexed position. Dislocation of both bones of the leg forwards is to be treated in precisely the same way, but the semi-flexed position should be adopted from the beginning.

11. Potts' Fracture.—There may be some difference of opinion as to what is meant by Potts' fracture. I, therefore, restrict the term to that not uncommon form of accident in which the inner malleolus is broken off with fracture of the fibula from one and a half to two and a half inches above the lower end of the outer malleolus. In whatever position the patient may be lying when we see this accident, the foot is usually abducted and displaced outwards, with its inner border depressed, and the heel carried usually more or less backwards.

Diagnosis.—The diagnosis is very easy. The inner malleolus may be felt to be movable, and the border of the tibia from which it has been detached may be distinctly felt.

On the outside the outer malleolus will be pressed outwards by the displaced foot, whilst the upper end of the lower fragment will be carried inwards and often forwards, producing a diminished transverse breadth of the leg at this point, with increased lateral diameter lower down, at the point of the malleoli. As this accident is caused by twisting of the foot outwards, or by forcible abduction, we may consider as different degrees of the same accident—(1) Simple Fracture of the Fibula, from one and a half to two and a half inches from its lower end; (2) Potts Fracture; and (3) Dislocation of the Tibia inwards, or the foot outwards—the simple fracture of the fibula being its mildest form, Potts' fracture being the more severe, and the dislocation of the tibia inwards the most severe form. This classification or arrangement of the subject will simplify matters, as the principles of treatment are the same in each. In simple fracture of the fibula the heel is usually displaced backwards, with widening of the inter-malleolar spaces.

Treatment.—Various modes of treatment have from time to time been recommended, but whatever mode be adopted, the heel must be pressed forward and the foot adducted.

By Dupuytren's mode of treatment, or placing a thick pad extending along the inner side of the tibia to the malleolus, with a wooden splint extending beyond the foot, it will maintain the foot sufficiently adducted to correct the deformity caused by abduction; but it does not act sufficiently on the heel to bring it forwards and restore the fibula to its natural position.

The tibio-fibular articulation is the centre of the move-

ments in these accidents—thus, when the heel is carried backwards, the lower end of the lower fragment is carried backwards, while its upper end projects forwards; and in addition to the lower end being displaced outwards by the abducted foot, the inter-malleolar space is increased, with diminution of the transverse breadth of the interosseous space at the seat of fracture. In the treatment of fractures of the fibula no pressure should be made on any part of the shaft of the bone between the points at which it rests against the tibia; hence, in the treatment by Cline's splint along the outer side of the limb, one pad should be applied over the outer malleolus and outer surface of the foot, whilst the upper pad should rest upon the head of the fibula and above it, so that the whole length of the body of the fibula will be free and uncompressed.

If the upper end of the lower fragment projects forwards, then it becomes necessary to use some appliance to push and maintain the heel well forwards. The heel splint will do this. It is necessary to apply an anterior splint to enable us to act upon the posterior splint. Then place the limb on its outer side, with a pad on its outer margin, so that when the limb is placed on its outer side the foot shall be well adducted. Care should also be taken that in Potts' fracture and in dislocation inwards, where the inner malleolus has been broken off, the outer margin of the foot should be well raised; for if the foot be allowed to rotate outwards, the inner malleolus will also be unnaturally rotated.

From the description now given of the treatment of fractures of the leg followed by me, it resolves itself into the use of apparatus of the most simple kind—the heel splint, the front splint, two Cline's splints, and a double-bevelled splint, which permits of the fullest abduction of the foot.

Next, the position in which the limb is to be placed—first, in the straight or extended position, which is applicable only to a few cases, and it may be confined to those cases in which, from their nature, vertical overriding is impossible; secondly, where the patient lies on his back, the thigh flexed almost to a right angle on the pelvis, and the leg upon the thigh; thirdly, those in which the patient lies upon his side, with the leg well flexed upon the thigh, and the foot either abducted or adducted.

I have used the term “rest,” and this name is given to an apparatus which consists of four upright posts made of iron, which support a platform either end of which can be elevated or depressed, and which admits of the leg being placed upon it with very slight extension, or of being at either a right or acute angle with the thigh, giving us all the muscular relaxation necessary to enable us to counteract overriding of the fragments.

I have no faith in the prevention of overriding by forcible extension. Where I have tried it I have failed, but when my attention was directed so as to produce the most perfect muscular relaxation, I do not remem-

ber an instance in which it failed.

All displacements—forwards, inwards, backwards, or outwards—may be easily prevented by the four splints—the front, heel, and two Cline's splints—and then placing the limb in a position in which the muscles are relaxed.

There is another point which, as regards position, must be carefully observed by the surgeon—namely, if the fracture be oblique from before backwards and upwards, or from above downwards and backwards, the patient must lie on his back; for if he be placed on his side lateral deviation of the fragments will take place, and muscular spasm will be the result. If the fracture be oblique from without inwards and downwards, then the limb must be placed on its outer side, with flexion of the leg upon the thigh, and the thigh upon the pelvis.

To make my meaning more easily understood, placing the one hand upon the top of the other, the flat surfaces must look upwards and downwards. That is the position in which the fracture must be treated. Turn the hands so that the edges will be vertical, then it will be seen how easily the ends of the fragments will become displaced.

The President and Dr. Esler congratulated the Society on the honour conferred upon it by Professor Gordon.

Alexander Gordon
March 18th

Session 1883–84. The Seventh Meeting of the Society was held upon Tuesday 18th March in the Royal Hospital.

Present, Dr. Whitla V.P. (occupied the chair), Professor Gordon, Drs. Lindsay, Barron, O'Neill, J. W. Browne, St. George, Wales, and Mackenzie, Honorary Secretary. A number of students were present.

Dr. O'Neill read a paper on "Fractures of the patella" and showed a patient the subject of the accident and illustrated his mode of treatment.

Professor Gordon mentioned cases in which osseous union had taken place in fracture of patella. To ensure this there must be perfect apposition and the failure to secure this accounted for the rarity of true osseous union.

He approved of wiring the fragments and using a back splint to prevent flexion of the knee joint. He thought that in many cases both direct violence and muscular strain were at work in producing the fracture.

Dr. J. W. Browne did not approve of wiring the fragments. He spoke highly of Spence's method of treatment by a modification of Malgaigne's hooks.

He did not approve of any pressure about the joint lest it might interfere with the articular arteries. He thought it well to aspirate the joint if there was evi-

dence that an effusion of blood had taken place.

The chairman concluded the discussion and Dr. O'Neill replied.

Mr. Fagan's case was postponed owing to the advanced hour.

The Chairman read communication from the telephone company. It was agreed to take no action in the matter.

R. F. Dill, President
April 1st 1884

Session 1883–84. Eighth Meeting of the Society was held in the Royal Hospital upon Tuesday 1st April.

Present, Professor Dill, President in the chair, Drs. Moore, Esler, McFarland, O'Connell, McKee (visitor), James Smith, J. C. Smyth, and Mackenzie, Honorary Secretary.

Dr. James Smith read a paper on cephalotripsy and exhibited his own cephalotribe placed on the head of a child which he and Professor Dill had delivered a few days ago.

Paper:¹ THE following are the chief peculiarities of the cephalotribe I show:—

1. It is longer than those in use, being 15 inches, of which the blades are 10 and the handles 5, therefore better adapted for operations at or above the pelvic brim. Each blade and handle is measured from the lock respectively.²

2. In breadth of blade and pelvic curve this cephalotribe is similar to Barnes' long forceps—an instrument I have used upwards of six hundred times in 4,000 deliveries. I have therefore modelled my cephalotribe on the lines of a forceps whose efficiency I have fully proved. Further, as I believe axis-traction depends more on the accoucheur than his tool, I discard all useless encumbrances, such as traction rods with the accompanying belly-band or waist belt.

3. The cephalotribe possesses also a very moderate cephalic curve; this facilitates introduction, and combined with the pelvic curve renders slipping less likely when the head occupies a very anterior position above the pubes. Here straight cephalotribes fail.

4. This cephalotribe is much less formidable and more efficient than those of Hicks, Kidd, &c., and can be applied in the same manner and with as great facility as the ordinary obstetric forceps. The services of an assistant are optional.

5. When the screw is applied to its utmost limit the space occupied by the blades is one inch and a half.

6. The shoulders, in addition to affording greater tractile power, facilitate rotation. They should be of a piece with the handles, and not "dovetailed" therein.

7. The fenestræ yield the following advantages (a.)

¹ [Dublin Journal of Medical Science, 1884, v77, p472.]

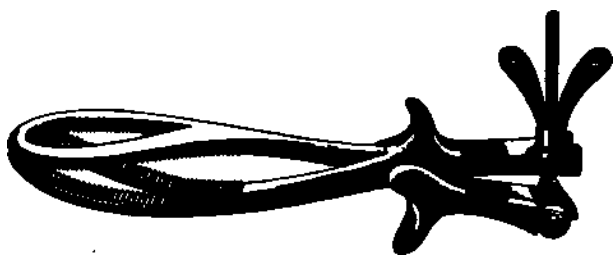
² The free borders of the grooves look towards the lock, and not towards the apices of the blades, which might be inferred from the woodcut.

They add to the lightness of the cephalotribe. (b) As compression goes on the head bulges through (almost to a level with the outer surfaces of the blades), and enables the instrument to hold with much greater tenacity, (c.) For the same reason expansion is obviated to a great extent in one direction, while compression is going on in another.

8. The grooves prevent slipping also, but these might perhaps be dispensed with if the instrument were used only as a cephalotribe; but its employment as a craniotomy forceps in some cases of extreme pelvic distortion, and more especially in those cases where mal-presentation of the foetal head coexists with maternal deformity (e.g., the face with approximation of the tubera ischii), the instrument has proved vastly superior to the craniotomy implements hitherto in use, and has, in the opinion of the leading accoucheurs of the North of Ireland, superseded them entirely. The grooves are, in my opinion, indispensable to the efficiency of the instrument as a combined cephalotribe and craniotomy forceps.

9. The weight of the cephalotribe is about 2½ lbs. The ponderosity of the instrument is considerably augmented by the somewhat heavy but withal neat handles. However, obstetrically speaking, I am a believer in weight—indeed I cherish the conviction that the maternity physician—to be an efficient one—should overbalance twelve stones, while the occupant of the “Master’s Chair” should counterpoise at least sixteen.

10. The practical utility of this cephalotribe is best proved by the fact that it has been successfully used during the past seven years in upwards of thirty instances, some of course being repetitions on the same patient, but the record of one case will illustrate all. Here follow the particulars of a case I narrated to the meeting of the North of Ireland Branch of the British Medical Association, January 17, 1879. On that occasion I not only showed my depopulating tool, but I exhibited its foetal victim. The child weighed at time of birth 8¼ lbs., and was extracted from a woman on whom the operation of craniotomy had been twice performed by Professor Dill and others. On the last occasion the exostosis on the sacral promontory had progressed to such an extent as to preclude the application of Barnes’ long forceps in any diameter. My cephalotribe was applied by Professor Dill and myself, and delivery was accomplished with ease and safety in almost as many minutes as the previous confinements



occupied hours. Recourse was not had to the perforator or other instrument. Let me now apply myself more directly to the business in hand—namely, to show the utility of this cephalotribe as a craniotomy forceps. After more than five years’ rest, during which the pelvic deformity had much increased, this interesting patient again became pregnant, and in the fulness of time sought our professional services.

The facts are briefly as follow:—On the forenoon of Monday, March 24th, of the present year, I was hastily summoned to the parturient couch of this distorted female, and on vaginal examination I detected the right hand presenting through a somewhat rigid os of the size of half-a-crown. Anticipating Professor Dill’s arrival, I introduced per rectum a suppository containing ½ gr. mur. morph. and gr. i. ext. belladonna. This medicament soothed the patient and softened her os. About an hour after the introduction of the suppository Dr. Dill arrived, examined the patient, and found the right hand in the vagina and the os tolerably well dilated and dilatable. We determined on immediate action, and the patient having been chloroformed by Professor Dill, I proceeded to deliver by podalic version. At first I grasped both feet, but on coming to the obstruction I had to relinquish one, the right, but I succeeded in retaining the left in custody until it cleared the vulva.

Traction was now made on the liberated limb, and after the employment of much force the breech appeared, soon followed by the rest of the body, including the arms. At this stage Professor Dill and I conjointly manipulated the body, so as to release the after-coming head, but our efforts were unavailing. The last act of the tragedy consisted in the reduction of the head by the perforator and its extraction by means of the cephalotribe. The administration of chloroform and the accomplishment of delivery occupied only fifteen minutes. The patient made a rapid and complete recovery, resuming her domestic duties within a week after the operation.

Professor Dill stated that in this case the head was tilted forward and resting on the pubes where Kidd’s cephalotribe would not catch hold and this fact suggested the shape of Dr. Smith’s cephalotribe. “I have used it for 5 years and have no hesitation in stating that there is no instrument to be compared to Dr. Smith’s modified cephalotribe from the days of Chamberlain to this date and I have had frequent opportunities of using the cephalotribe of other men such as Lusk’s which I [?] and I emphatically say that it is not to be compared to Smith’s.”

Professor Dill showed a full-grown child which he had a few hours previously delivered by Smith’s cephalotribe. The child was hydrocephalic and had spina bifida.

Drs. McFarland, Esler and Moore congratulated Dr.

Smith on his useful instrument.

Dr. Mackenzie mentioned a case in which he perforated and used Simpson's cephalotribe but he should have preferred using Smith's.

Dr. Smith replied and thanked the members present for their kind criticisms on his paper and cephalotribe.

*Discussion on the New Cephalotribe.*¹

THE PRESIDENT said—Since the invention of the forceps by the Chamberlaynes, now upwards of two hundred years ago, I am of the opinion we have not had furnished to us an instrument equal to Dr. Smith's cephalotribe, suited as it is so well to certain very difficult cases of labour.

I can now exhibit Lusk's modified cephalotribe, so that you can at once have an opportunity of seeing and comparing for yourselves the two instruments, and having done so, I think you will agree with me (who have had considerable experience in the use of each) in deciding in favour of the greater advantages afforded in the use of Dr. Smith's cephalotribe.

I remember well the painful peculiarities of the case which first suggested to Dr. Smith and myself the necessity for such a design as is to be seen here in his instrument.

The case was one in which we found a narrow pelvis, the head above the brim, forward, and somewhat resting upon the pubic bones. After having perforated we made more than one attempt to get Kidd's cephalotribe over the head so as to seize it properly, but without success, for as it was too much forward and outside the line or axis of the instrument the head could not be properly reached. We had, therefore, no alternative but to fall back upon the crotchet and such other means as we had at our disposal, and after nearly three hours of much anxious work we succeeded in bringing away a foetus of more than average size.

The patient made a good and quick recovery, and she became pregnant soon again. In the meantime Dr. Smith had given such instructions to a manufacturer regarding the design and make of his instrument as were suggested by the peculiar characteristics of the case just brought under notice, and the instrument was in our hands before her next confinement.

We met again at the bedside of this difficult, but interesting case of labour. We were, however, somewhat fortified by being in possession of what we believed would meet the emergency, though a little anxious, as the instrument was about to be put upon its trial for the first time; but I am free to say that it more than realised our hopeful expectations, for the perforation, the application of the instrument, and bringing the operation to a successful termination did not occupy much over as many minutes as our first occupied in

hours.

Dr. Smith has just narrated the history of the case, and the operation which he and I performed for the third time upon the same patient with his new and improved cephalotribe, and which served our purpose even better and easier than did his first instrument; and it is now so admirably finished and complete that I think the time is very remote when any material alteration in it may be considered necessary.

Following up the same subject, I may now be allowed to exhibit a large sized foetus, hydrocephalic and with spina bifida, which I (in company with Dr. M'Kee, whom I am glad to see present) brought through the narrow pelvis of a little and a deformed woman, and this even in a very short time and with comparative ease, by means of Dr. Smith's cephalotribe.

I have now used this instrument during the last five years both in town and country in very many cases, and with the greatest satisfaction, and the gentlemen with whom I was in consultation invariably expressed themselves not only pleased but surprised at the wonderful facility with which the work was accomplished, and the short time and ease with which an otherwise laborious case was brought to a successful issue by means of the instrument now under consideration.

Will you allow me, before bringing these very hasty and imperfect remarks to a close, to direct your attention to a case which I see reported by Dr. Atthill, when in the Rotunda Hospital, and in which case I can recognise similar difficulties as were discovered in the case so often under the care of Dr. Smith and myself, and Dr. Atthill experienced equal inability in the application of the cephalotribe as we had done, and like us he also had to call in the aid of the crotchet. Since that time, I believe, Dr. Atthill has put himself in possession of Dr. Smith's cephalotribe, and I believe it is now a favoured instrument with him.

DR. ESLER and DR. M'FARLAND congratulated Dr. Smith on the production of such a useful and complete instrument.

DR. MOORE was much interested in Dr. Smith's paper. He always felt the great responsibility which rested upon the medical man who decided to perform the operation of cephalotripsy. He did not approve of calling Dr. Smith's cephalotribe a depopulating instrument.

DR. MACKENZIE narrated a case in which, after turning, he was obliged to perforate and deliver with Simpson's cephalotribe, but he thought the use of the cephalotribe exhibited by Dr. Smith would have saved time and trouble. The mother in his case made a rapid recovery.

DR. SMITH thanked the Society for the kind reception accorded to his paper, and for the interest taken by the members in his new and improved cephalotribe.

Moved by the Honorary Secretary and seconded by

¹ [Dublin Journal of Medical Science, 1884, v77, p562.]

Dr. J. C. Smyth that Dr. A. P. B. Moore, M.D. be elected member of the Society.

W. Whitla, Chairman
April 29th 1884

Session 1883–84. Ninth Meeting of the Society was held in Royal Hospital upon the 29th April.

Present, Professor Dill President, Drs. J. W. Browne, Moore, Fagan, Dempsey, Nelson, Barron, Esler, Whitla, and Mackenzie, Honorary Secretary.

Dr. A. P. B. Moore M.D. (Q.U.I.) was unanimously elected a member of the Society.

Mr. Fagan read notes of and exhibited patients upon whom he had operated by excision for enlarged cervical glands. He showed a patient from whom he excised several large glands, the cicatrices being scarcely visible and the results being most satisfactory.

Paper:¹ Excision of scrofulous cervical glands has been a recognised mode of treatment for many years among Continental surgeons, notably by the French school. It has been rather sparingly adopted in this country, and other treatment of a less radical nature is usually practised.

I am glad to see, however, that of late there is a growing disposition on the part of physicians to approve of, and surgeons to carry out, this most excellent method in suitable cases.

My medical colleagues, both at the Royal Hospital and the Children's Hospital, have from time to time brought under my notice, with a view to operation, certain forms of obstinate gland swellings that resisted all the recognised modes of treatment. I have up to the present time operated in about twenty-five cases, and the result in each case has been most satisfactory.

I have on more than one occasion, at this and another Society, shown the patients operated on and glands removed, and to-night I have at random secured two children on whom I operated; one sixteen months, the other a year, ago. In each it is with difficulty that you can detect the seat of the operation wound, its only evidence being an indistinct white streak.

As illustrating my mode of operating, as well as the usual progress and termination of such cases, I will briefly record the features of interest in three or four of them; but before doing so I may be allowed to draw your attention in a passing way to the anatomical arrangement of the cervical lymphatics.

Of these there are two sets—a superficial and a deep one. The first lies along the course of the external jugular vein, beneath the platysma, receiving lymphatics from the skin of the neck, part of the face and scalp, and from the auricle of the ear. The deep chain of glands lying in close contact with the large vessels is divided into a lower and an upper set. The first is situated in

the supra-clavicular fossa, and communicates with the axillary and mediastinal glands as well as with those of the upper set. The latter is placed opposite the division of the common carotid, and receives lymphatics from the tonsils, nasal fossæ, lower part of pharynx, tongue, palate, and larynx, from the deep muscles of the head and neck, and from within the cranium. The sub-maxillary set, placed under the cervical fascia, run along the base of the jaw; they communicate with the superficial and deep cervical sets, and receive lymphatics from the mouth and lower lip. The parotid set—placed some in the substance, others on the surface, of the gland—receive lymphatics from the orbit, nasal fossæ and upper jaw, the upper part of the pharynx, and from the frontal and parietal regions of the scalp.

This brief survey of the principal lymphatic chains in the neck may be of service when considering the local causation of morbid changes in them, as also in carrying out any operative measures for their treatment.

Case I.—My first case was a very healthy-looking little girl, aged eleven years, whose family history was exceptionally good. She had an oval swelling the size of a pigeon's egg, situated on the left side of the neck, corresponding to a point a little above the centre and towards the inner side of the sterno-mastoid. It existed for more than a year, and resisted the ordinary modes of treatment. I decided on removing the gland, and proceeded as follows:—I made an incision immediately over the centre of the tumour corresponding with its long axis, and the fibres of the sterno-mastoid. Holding it between my thumb and forefinger it conveyed the feeling of being very superficial, but on dividing the upper layers of fascia instead of the gland, the fibres of the sterno-mastoid appeared in the wound. It then occurred to me that I had to deal with one of the upper set of the deep cervical chain. So I carefully separated the fibres of the muscle, divided the underlying layer of the deep cervical fascia freely, and exposed the gland placed in close contact with the carotid sheath. I now seized the mass with a small double-tumour hook, and, using gentle traction, drew it towards the surface, while with careful strokes of the scalpel I liberated it from its bed of cellular tissue, thus removing it with comparative ease and very little hæmorrhage. Two smaller glands, placed at either extremity of the large one, I removed in the same cautious manner, after twisting a few small arteries and washing out the wound with a solution of chloride of zinc. I bestowed great care in bringing its edges into accurate apposition by numerous points of very fine silver wire suture.

A bit of protective, a pad of antiseptic gauze, and a bandage, constituted the dressing. On the third day I looked at the wound, and found it healed by direct union. There was neither swelling nor redness nor pain. I removed a few of the sutures and dressed the wound as before. On the fifth day I removed the

¹ [Dublin Journal of Medical Science, 1884, v77, p495.]

remaining sutures and put a pad of cotton-wool over the part. On the day following I showed the child to the members of this Society, when the only evidence of the operation was a scarcely perceptible scar, which I expect through time has become still less perceptible.

The large and one of the small glands on section presented in their centres caseous matter, and one or two small circumscribed abscesses.

Case II.—A. M., aged twenty years, was affected for about a year with a chronic hip arthritis, the result of an injury. His health had been considerably impaired, and for three months prior to operation he suffered from an enlarged gland, situated below the angle of the lower jaw. This commenced as a small, hard lump, which soon became painful, and increased till it attained the size of a small hen-egg. It was treated in the usual way, with iodine application, and cod-liver oil, &c., internally.

When I saw him the mass was mobile, hard, and painless. In operating on this case I made the line of my incision in the long axis of the tumour and parallel with the ramus of the lower jaw. The gland was not so easily turned out of its cellular bed as its mobility led me to expect. The surrounding tissue was somewhat closely matted to it, and there was considerable oozing of blood into the cavity that remained; this was checked by the strong chloride of zinc solution. The wound was sutured and dressed as in the former case. On the second day after the operation I removed the dressings, as he had a rigor and high temperature the previous night. The wound was firmly and evenly united, but there was diffuse inflammation extending from it over the side of the face and neck. I removed most of the sutures, opened up with a probe a small part of the wound at its most dependent angle, passed in a small drainage tube, painted all the surrounding parts with the strong iodine liniment, and put him on large doses of quinine and iron. From that time he improved; there was no discharge, except a little serous oozing from the tube. The wound remained firmly united, and a little inflammatory thickening that was about it at first, soon disappeared.

An interesting feature in connexion with this case is that, notwithstanding the very smart inflammatory action, the new plaster material never gave way, nor did any matter form in the cavity from which the gland was removed.

On section the centre or medullary portion was seen converted into a large abscess cavity, and the cortical portion was much thickened from inflammatory infiltration.

Case III.—J. L., aged nine years, a delicate-looking, badly-nourished lad, the subject of purpura, had an enlarged gland, situated a little below and in front of the angle of the jaw. It existed there for two years, occasionally shrinking, but it never totally disappeared. I removed it in the usual manner, the wound healed by

the first intention, the scar was scarcely perceptible.

On section the centre of the gland presented the characteristic patches of caseous matter, with a few pus loculi.

Among my other cases, while there are few points of further interest, the treatment and its result, as well as the pathological condition of the glands, were somewhat similar to what I have already described. In the case of a young lad, where there were two enlarged glands at the angle of the jaw, one of them was partially necrosed and exposed at the bottom of a ragged ulcer, the other joining it was deeply placed. Owing to the matted condition of the surrounding tissue, I had considerable difficulty in removing them, and in doing so wounded the facial artery. I immediately clamped the vessel on either side of the wound with a Pean's forceps, and after dividing it between secured both ends with catgut ligatures. The case did well. In the case of a reformatory lad, who was an exceedingly unhealthy subject and a most incorrigible patient, the removal of the glands was followed by gaping of the wound and rather profuse suppuration. After a somewhat prolonged convalescence the part healed, leaving a very perceptible scar, but not as unsightly as that which follows Nature's process of suppuration and ulceration.

I show you two strings of glands that I removed a short time ago from a lad's neck (four on each side), two of them as large as small hen-eggs. There was some suppuration, but the case has done well.

This is a case I operated on five days ago; the union is perfect. I keep a very small drainage tube in the dependent angle to drain the cavity, from which I removed one very large and three small glands. (The patient was shown to the members.)

There are a few points connected with the operation and its after-treatment to which I think it worth while to direct your attention:—

1. The incision over the gland should not be made too free; but all the underlying structures should be freely divided from angle to angle of the skin wound. When the gland is well exposed it should be seized with a small tumour hook, and steadily but gently drawn through the wound.

In the majority of the cases that are suitable for this mode of treatment this is a simple process, requiring only the occasional use of the knife, a stout director or the handle of the scalpel being sufficient. When all the affected glands are removed, any ragged shreds of cellular tissue that remain should be clipped away with scissors. All bleeding points should be secured, and the wound well swabbed out with a strong solution of chloride of zinc.

2. Regarding drainage of the wound, I have had good results with and without it; still, on the whole, I think it better and safer to drain either with horsehair or very fine tubes. This is especially requisite in cases where the wound is large, and where there has been

oozing of blood and difficulty of enucleating the gland.

3. As regards suturing the wound, the finest silver wire should be used. It should not be passed too deeply through the lips of the wound, which should be most accurately adjusted, and the sutures should be removed not later than the third day, and sooner if the slightest inflammatory blush should appear at their points of exit from the skin. The marks that follow the suppurating tracks of the sutures are far more disfiguring than the scar from the incision.

4. As regards maintaining the parts at rest while union is taking place, this is most essential for obvious reasons. The most effectual way of securing this is, I find, by means of a night-cap with a pair of strings attached to either side; these are brought down and fastened in front to a thoracic binder, and drawn sufficiently tight to bring the head well forward on the chest. Such a form of restraint is especially necessary in the case of children, who will only remain at rest on compulsion.

5. Should inflammation attack the wound the tension should be at once relieved by removing some, if not all, of the sutures; and if there has been no drainage, a probe should be passed into its cavity at the most dependent angle, and a small tube inserted.

I have now explained to you a certain well-defined mode of treatment, as carried out by me in a considerable number of cases, and I have shown you the results of such treatment. To some it may appear very satisfactory, while to others it may seem an unnecessarily heroic method, subjecting, as it does, the patient to a certain amount of deformity no matter how successfully carried out, and not altogether devoid of risk to the life of the patient.

While deferring a reply on this head, I may be allowed to examine cursorily some interesting features in this broad subject that just now occur to me, as in some way bearing on the mode of treatment advocated in this paper.

In the whole range of medicine and surgery I question if there is a subject concerning which there is more diversity of opinion, regarding both its nature and treatment, than there is about what we term scrofula or struma. The various and conflicting views held at different periods by equally eminent inquirers concerning the nature of this condition; the innumerable nostrums displacing one another in rapid succession—their virtue often consisting in their novelty—is a striking proof of the unstable nature of the basis on which the pathology and therapeutics of this disease rest.

From a purely surgical standpoint I would define the term struma or scrofula as an inflammatory process attacking the tissues of a lowly vitalised organism, and manifesting itself by a slow and silent destructive action.

The exciting causes that are likely to give rise to this condition in the lymphatic glands are many and

obscure:—Traumatism, direct or indirect, through the lymphatics; all sources of irritation, internal as well as external—for instance, bad teeth, sore throat, bronchitis, enteritis, skin affections, exposure to cold, &c. That the glands of the neck are more frequently than any other the subject of this condition will appear evident from the fact that there is a very intimate connexion between them and the large amount of lymphoid tissue in the mouth and pharynx, which in most delicate subjects is highly susceptible to the slightest variation in temperature or the contact of septic matter.

While we know that in almost all cases there are two factors—viz., the hereditary and acquired—in producing the strumous condition, you may ask which plays the more important part?

Mr. Savory, in his remarks on the subject of scrofula, answers this question more fully and satisfactorily than any other author. He says the causes of disease are conveniently and naturally divided into predisposing and exciting, and the development of disease depends on the extent to which these causes act in combination. For example, by way of illustration merely, let it be assumed that any given disease cannot be produced unless the sum of the causes reach a certain figure, say 100. Now, so long as this number can be attained by the causes conjointly, it matters not what their relative share in it may be. The predisposing cause may equal 70, the exciting cause 30, or vice versâ. From this it follows, as is well known, that when the predisposition to disease is strongly marked, the most trivial exciting cause may suffice to develop it—it may be 99 to 1. On the other hand, if the exciting cause or causes be sufficiently intense and prolonged, the disease may be produced where there is only the faintest predisposition.

Let us illustrate this by an example:—Take a child of parents in the better class of life, surrounded by all the necessaries for its wellbeing, and although there may be a strong hereditary tendency, the exciting causes being almost nil, the sum total is not sufficient to develop the scrofulous condition; but suppose that child by some misfortune is reduced to the state that we find the wretched children of the poor in our large cities, the victim of bad air, bad food, uncleanness, insufficient clothing, and particularly in this rough, changeable climate of ours, you will soon see the disease manifesting itself in its most severe form.

The hereditary or predisposing causes among the children of the poor may be almost nil, but the exciting are so many and so forcible that of themselves they often give rise to the scrofulous condition.

The general treatment of this affection in its earliest manifestation, more especially when due to hereditary causes, falls within the province of the physician. But there are some conditions of gland enlargement in which timely surgical interference would be of the greatest possible good. In a healthy subject when a gland enlarges and grows painful, if the tension be not

soon relieved the probabilities are that it will go on to suppuration. The timely relief of tension is a principle I strongly adhere to in dealing with all forms of inflammation, especially when the affected tissues are bound down by a dense, resisting medium. If we consider for a moment the anatomical characters of a lymphatic gland, we shall at once see the necessity there is for attention to this point. When its structure becomes inflamed multiple punctures of the dense, fibrous capsule should be made to relieve the congested gland substance and allow the inflammatory products free exit into the surrounding cellular tissue. It can be practised by means of a fine tenotome passed subcutaneously at some distance from the gland.

I find time will not permit me to discuss the merits of many other useful surgical methods of treating strumous gland disease; and while admitting the thermocautery, Volkmann's spoon, and appropriate caustics to be good in certain forms of the disease, I hold strongly to the opinion that when disease is limited within a well-defined area, and the tissue involved is steadily, however slowly, deteriorating, that its total extirpation is the only rational and effectual mode of dealing with it, and this principle is, I maintain, equally applicable whether the structure implicated be gland, bone, or joint, provided anatomical considerations allow of such operative interference. Let it not be understood that, while making this somewhat strong statement, I am an advocate for the wholesale use of the knife for treating diseased structures. Such a practice I believe to be as mischievous as that where its use is never recommended. But the judicious physician or surgeon who, when he sees diseased structure persistently deteriorating, and not alone so, but endangering the vitality of that in its neighbourhood, recommends its timely removal, is a far greater benefactor to his patients than he who temporises in the hope that Nature, with the aid of his nostrums, will bring about a cure.

Anyone who has seen my cases must, I think, admit that the method of treatment I have adopted is the best for those chronic cases that resist all other recognised remedies. Its superiority over the temporising plan will appear strikingly manifest if we compare a patient restored to health after the rapid riddance of the diseased mass, and showing scarcely any mark, with another graphically described by Dr. Clifford Allbutt as "dragging on a chequered and tedious course, drifting, perhaps, from doctor to doctor, consuming volumes of cod-liver oil and medicines, breaking up life and prospects by prolonged exile from home, pestered by filthy discharges, or poisoned by decay which is not discharged, disfigured by sinuses, sluggish streaks and lumps of fibrous increase, seamy scars, and indurated gland-remnants. Such patients, thanks to the marvellous pertinacity of life, do generally fight their way into complete or partial recovery, but at the price of permanent disfigurement; at the price of tell-tale corruga-

tions in the neck; at the price, perhaps, of a deferred pulmonary phthisis, set up by absorption of the partially voided caseous products."

You will admit that this is not an overdrawn picture, and you will agree with me that scrofula, as it now is, is an opprobrium medicinæ.

An interesting discussion followed in which all the members present took part as to the various methods adopted for the treatment of diseased glands.

Mr. Fagan was congratulated upon the excellent results obtained by excision.

Dr. J. W. Browne showed a patient upon whom he operated for genu valgum by McEwan's method 2 years ago, the result being complete success. The boy before operation was unable to walk, has now two useful strong and straight limbs.

Dr. Whitla showed specimens of chyle. He showed the thoracic duct and the point of obstruction. In 8 weeks he removed 120 pints of chyle from the abdominal cavity. The patient died of tuberculosis meningitis.

R. F. Dill, President, 27th May 1884

1883–84. Tenth Meeting was held in the Royal Hospital upon Tuesday 27th May.

Present, Professor Dill President in the chair, Drs. Browne, Dempsey, McFarland, Nelson, J. C. Smyth, Barron, Kevin, Dwyer, Strafford Smith, Whitla, and Mackenzie.

Dr. Browne read a paper on Paget's disease of the breast. He showed the gland recently removed from a patient in the Royal Hospital.

He also gave notes of a few cases of operation by Bassini's method for the radical cure of reducible inguinal hernia.

The President gave a most interesting and detailed account of a case of placenta prævia to which he was called in consultation 30 miles from town. All the members present expressed their gratitude to the President for very lucid and admirable description given of this very dangerous and difficult case and for the minute details of the practice so successfully carried out by him, so carefully as to save the life that was despaired of by the attending physicians.

Paper:¹ Although the attention of the Society has at different times of late been occupied with the consideration of placenta prævia it may not be altogether unprofitable if we should again pursue the inquiry of that important subject a little further.

I do not now intend to enter upon the discussion of that vexed question—viz., the cause, or the causes, of placenta prævia. I merely mean to advance a few practical hints in relation to the management of a case of this kind, which recently came under my observation,

¹ [Dublin Journal of Medical Science, 1884, v78, p454.]

which is not altogether devoid of interest, and which, I hope, may convey some practical information.

On Sunday morning last I was telegraphed for to see a lady in a distant country town. When I reached the house I found that Mrs. A. B. had been ill in labour from the day before, and that she had been attended to by the three physicians of the place. I was met by one of the medical gentlemen, who told me that this was the lady's fourth pregnancy, that she had lost a large quantity of blood, and that as she was in such an extremely exhausted condition it was almost useless for him to return to the room. I, however, was ushered into the lying-in chamber, where I found the two gentlemen hanging over their patient, doing what best they could, anxiously waiting and watching for the end. I made a hasty examination. The face and the lips were deadly pale, the body was covered with cold perspiration. The pulse at times could not be felt, returning at longer and shorter intervals, but with a very feeble pulsation.

I at once lowered the head and shoulders, elevated the hips, and administered a little brandy and milk. As soon as possible I made a careful vaginal examination, and found there was still some loss of blood going on; the os uteri was about the size of a florin piece, and within was distinctly to be felt the placenta all round, but detached and free at its posterior margin, or sacral side. The os and cervix uteri were more rigid than might have been expected, considering the quantity of blood lost and the patient's extremely exhausted condition. And now, although there was in this case more to be feared than to be hoped, yet we agreed upon a definite and a decided course of treatment, and which in the end proved to be effective and successful.

From the first she was sustained with small, and frequently-repeated, quantities of brandy and milk, and added to this she had every hour, or two hours, either zij. , zi. , or zss. of the liquid extract of ergot. The membranes were at once ruptured. One of Barnes' smaller sized bags was inserted within the os, and it was then inflated by means of an air-pump, and the tampon, formed of handkerchiefs, was carefully introduced until the vagina was completely filled up, and until it projected somewhat from the vulva.

The tampon was now firmly supported by means of a pad, the T and abdominal bandage. Within a couple of hours we saw that our patient was beginning to show symptoms of improvement; the uterus was beginning to contract, as was evident from the recurring pains. At the end of the third hour the tampon and the other appliances were removed. The os had dilated a little further, a bag of a larger size was again inserted, the tampon, pad and bandages were all placed as before. This was done five or six times at intervals of two or three hours, until at last, when withdrawn, it was found that the os had dilated sufficiently to allow the head of a seven months' child to fall through and descend into the pelvis. The foetus was then, with the

slightest assistance, easily brought away, the placenta very soon followed, the uterus gradually contracted, and the case gave us no further grounds for anxiety, as far as hæmorrhage was concerned. From this time the patient went on well, and I was informed afterwards that she made a good recovery.

Allow me now to say that, however interesting the relation of a case of unavoidable hæmorrhage may be considered, it is not on that account, neither is it because of the complete success with which our efforts were crowned, that I bring the subject now before you, but that I may direct your attention to the manner in which the tampon in such cases should be used, if we are to expect any good results from it. To act efficiently, the vagina must be well filled, indeed firmly packed, with the material of which the plug is formed, and until it becomes prominent at the vulva; and as already stated, the pad, T, and abdominal bandage should then be so firmly applied as to produce the necessary amount of pressure.

Thus, with the pressure upon the tampon below, by means of the pad and T bandage, and the pressure which is brought to bear upon the contents of the uterus (the foetus), by means of the abdominal bandage above, you have exerted a force and a counterforce which must, operating and co-operating mechanically upon each other, shut up the mouths of the vessels which lie between the opposing forces so efficiently as to prevent them from pouring out any more blood.

Introduce the plug, as I have occasionally seen it, in a perfunctory manner, it does not serve any good purpose, and it had better be dispensed with altogether; but if introduced promptly and efficiently adjusted, as I have endeavoured to describe the operation, it will be the means of saving many a life.

R. F. Dill, President
17th June 1884

1883–84. Eleventh Meeting 17th of June

Present, Professor Dill President in the chair, Drs. Whitla, Barron, McFarland, J. C. Smyth, Dempsey, Dwyer, O'Connell, and Mackenzie.

Dr. McFarland read his paper on "Cholera with special reference to the treatment by permanganate of potash".

The President related his experience of three epidemics in this country.

Dr. Barron read Dr. Smith's paper on rapid dilatation of the os uteri in placenta prævia.

Paper:¹ Mr. President and Gentlemen, permit me, before proceeding to read the few notes I have written out on the subject of "placenta prævia," or "placental presentations," to offer some apology for again obtruding myself so soon on this Society. Indeed I had no

¹ [Dublin Journal of Medical Science, 1884, v78, p83.]

intention of occupying any of your valuable time on the present occasion, had it not been for the importunities of your energetic Secretary, Dr. MacKenzie, who insisted on my hunting up an obstetric case which might add a little variety, and, perhaps, some interest, to his programme for to-night. Moreover, he intimated to me that this would probably be the last meeting of the Session, and used other persuasive arguments which left me no alternative but to comply—hence my presence here as a contributor this evening. I have chosen this subject (*placenta prævia*) for three reasons—viz., 1st. Because my brief observations may serve as an appendix to Professor Dill's remarks on the same subject made here, I understand, on the last night of meeting. 2nd. Because I was assisted in the case by two members of this Society, who will likely have something to say on the merits or demerits of the operation. 3rd. Because the plan of treatment and mode of delivery differ somewhat from the usual methods. I consider it unnecessary to waste your time discussing the various supposed causes of "*placenta prævia*," or "*placental presentations*," and the endless varieties of treatment and operations recommended in our numerous mid-wifery text-books. Suffice it to say that the causes are not yet manifest, and the treatment, so far, has been attended with great mortality. Statistics at present show a death-rate among mothers of 1 in 3, while 65 per cent, of the children are still-born. These facts prove that there is room for improvement in the treatment of "*placenta prævia*." Having said so much by way of preface, let me now indicate the plan of procedure I have adopted on two occasions, and in each instance to the salvation of both mother and child.

To some people it may seem rather "heroic" treatment, but I am satisfied that the results justify the means, which consist in thrusting the hand through the os uteri at an earlier stage than usually recommended. However, this proceeding looks worse than it really is, for rigidity of the os uteri rarely co-exists with *placenta prævia*. On the contrary, the whole uterus is atonic, soft, and flaccid, and the os participates in the general relaxation; and, when the latter has attained the size of half-a-crown, the hand is forced through it with as little difficulty as through an elastic ring. It will be unnecessary for me to describe the two cases I have referred to, inasmuch as the details of treatment and operation are precisely similar, so that I shall content myself with narrating only one, which is unique in that it presented a contracted pelvic brim as well as the *placental presentation*. This abnormality on the sacrum retarded delivery, but it did not necessitate recourse to any kind of instrumental aid. I now proceed to give you some details regarding this interesting case, which are these:—On the 2nd of April, 1888, I was awoke from my slumbers about 6 a.m., and was informed that Mrs. C. (whom I had attended early the previous year in her first confinement) had had a "dreadful flooding," and

was in a faint or swoon. I dressed myself with expedition, and was promptly at her bedside. I found ample corroboration of the messenger's statement to me in the perilous condition of Mrs. C. On inquiry I learned she was past the eighth month of gestation; that she was bothered through the night with trifling pains. These she attributed to having taken oil. During the night there was no hæmorrhage. It came on suddenly and alarmingly, just immediately before I was summoned.

I now busied myself for the safety of the patient, and the first thing I did was to make a vaginal examination. This revealed a *placenta* through an os into which I could insert my index finger. I do not enter here into the various minor details, such as lowering the head, raising the hips, cooling the room, &c.—all these things are implied, if not expressed; but I plugged after the following fashion, which I think an improvement on Schroeder:—I first introduced, through a large-sized speculum, a sponge saturated with tannic acid glycerine. I then filled the vagina in the manner recommended by Schroeder. Before employing the plug I drew off the urine. After plugging I placed a binder round the patient to compress the presenting part against the plug—this is the chief aim of plugging, and it should never be forgotten. A restorative in the shape of egg-flip was administered, and, the patient having been made comparatively safe, I withdrew. I saw her again at 10 a.m. and 2 p.m., but nothing transpired at either of these visits to call for special notice.

About 5 p.m. Dr. J. C. Smyth had paid me a casual visit, and just as I was mentioning the case to him, and asking his help, a messenger hurriedly came and reported matters worse. We both hastened down, and found the patient blanched and almost pulseless. Restoratives were given, the old plug was removed, and as labour had set in and the os was dilated to the size of a two-and-sixpenny piece, we resorted only to the temporary expedient of plugging with a sponge. Meanwhile we informed the husband (who was related to a medical gentleman in town) of the critical state of his wife, laying stress not only on the immediate danger, but also on the gloomy prospects, and enjoined him to tell his relative that we would be glad of his co-operation and assistance. Our advice was taken, and the medical friend sought, but, being unable to get away himself, he despatched to our aid Dr. Kevin, in whom we found an efficient substitute.

All the necessaries being arranged for the operation, and Dr. Kevin having confirmed our diagnosis as to the presentation of the *placenta*, extent of dilatation of the os uteri, and the pelvic deformity, we proceeded to deliver. The operation was performed thus:—Dr. J. C. Smyth gave chloroform, Dr. Kevin steadied the uterus externally, while I thrust my hand through its os (with as little difficulty and resistance, I repeat, as through an elastic ring) into the uterine cavity, and pulled down the right foot. As Dr. Kevin relaxed his grasp of the

uterus while I was turning, he now resumed pressure, and facilitated the expulsion of the body of the fœtus. All we wanted now was the delivery of the head, which was evidently arrested at the pelvic brim. After a slight pause, during which the child kicked vigorously and the cord pulsated strongly, we made another effort, which was crowned with success. The birth of the child was followed by the immediate expulsion of the placenta, and no hæmorrhage ensued, but as a safeguard we gave a full dose of ergot and firmly encircled the patient with a well-adjusted binder. Both mother and child did well.

In conclusion, I beg to express my obligations to Drs. Kevin and Smyth for the able manner in which they discharged their respective duties, for to their competence and skill I attribute, in a great measure, the success of the operation that I have just endeavoured feebly to depict.

A discussion as to the usual condition of the os in these cases took place. The President wound up the discussion in an able manner, making clear any difficulties suggested by the members.

R. F. Dill President 1st July 1884

1883–84, July 1st. Annual Meeting was held in the Royal Hospital.

Present, Dr. Aicken in the chair, Professor Dill, Drs. Smith (Shankill Road), J. C. Smyth, Dempsey, Kevin, Dickey, Barron, Esler, Wadsworth, J. W. Browne, Harkin, Whitla, Lindsay, and Mackenzie, Honorary Secretary.

The President, Professor Dill, read a most interesting paper on the dilatation of the os and cervix uteri. He showed a number of dilators including Hegar's.

Paper:¹ The subject which is on your notice paper for present consideration, but which has stood over from our last meeting, is possessed of much interest; and although we have been favoured by members of the profession with many contributions towards its elucidation, yet, if I may be allowed to indulge in a little facetiousness, I would say that it may, with some advantage, be further dilated upon. And now, although it scarcely comes within the scope of the discussion of our subject—viz., Dilatations of the Os Uteri and Dilators—yet a few observations regarding the condition and the character of the os and cervix uteri may be here introduced with some advantage before we enter upon the more experimental and practical department of our inquiry. We may, in the first place, assume that the os and cervix uteri are formed of circular and longitudinal muscular fibres, but it is not so easily to be assumed, that while the circular fibres exert a large share in the formation of the os, that they consequently represent a true sphincter muscle. So that if the word sphincter is to be here used at all, it must be but theo-

retically, as the idea of sphincter is not supported by the way in which it acts or dilates.

The os yields and expands slowly and gradually, and in this way its dilatation does not resemble the comparatively sudden response or characteristic relaxation made by a sphincter muscle; for if it were such, should we not have quick labours, as far at least as dilatation of the os uteri is concerned? We cannot afford, therefore, to be so dogmatic as to attribute altogether to muscular contraction the resistance given by the os uteri. Is it not probable, therefore, that it is the mixed condition and character of the tissues of which the os and cervix uteri are formed, composed as they are of not only muscular fibre, but of a firmly condensed connective tissue, binding together the whole structure, which, in this compact condition, offer such a powerfully resisting force as to be merely overcome by the perseveringly repeated efforts of the uterus?

I am inclined to advance this explanation as at least the nearest approach to the truth, and because of the fact that the os uteri at first becomes thinner and thinner, and then it slowly opens. As we find, occasionally, that the os uteri takes a much longer time in dilating than is known to be consistent with the safety of the patient, it has been proposed that artificial means should be instituted towards overcoming this difficulty. This branch of the subject has received the best attention from not a few of our ablest obstetricians, with the result that we are now in possession of a large array of uterine dilators, and those are of different kinds, and forms, and sizes.

The forefinger was at one time very much used, and by many persons it is occasionally used still, for the purpose of assisting to dilate an unyielding os uteri.

The late Sir James Simpson, at an early period in his history, contributed to us his admirable spongent; and in the sea-tangle, *laminaria digitata*, or *tupeto*—which was discovered by Dr. Sloan, of Ayr—we possess an agent much and successfully used as a dilator, and which was at once ingenious and original. But, acting upon the recognised fact that the dilatation of the os and cervix uteri is essentially dependent upon the eccentric pressure exerted by the liquor amnii, Barns discovered an equivalent action and corresponding results from his hydrostatic dilators, or as they are now known and used as air-bags.

There is another class of instruments, with two or more branches or limbs, which move by a spring or hinge; when closed they are introduced into the os and cervix uteri, and, when in, these limbs or branches are separated or expanded with less or more force. To this class belong the dilators of Priestley, Braxton Hicks, Marion Sims, Ellenger, and Brusck.

Another class, which we may here designate as graduated dilators, and which originated with Peaslee, Hanks, and Lawson Tait, are conical in shape, are made of vulcanite, and which are from four to ten in number.

¹ [Dublin Journal of Medical Science, 1884, v78, p175.]

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But it is to Hegar's set of graduated dilators that I would now especially direct your attention, though it was not with him that graduated dilators originated, but with Peaslee, Hanks, and Lawson Tait. Hegar's, however, differ from those others both in shape and number, consisting, as his set does, of twenty-six pieces, each piece measuring five inches in length, cylindrical in shape, and having a handle at the end of each, flattened, and an inch and a-half in length. These bougies, as they may be called, are graduated in size, the first being one-eighth of an inch in diameter, and they go on increasing at the rate of about half this size, or one-sixteenth of an inch.

When about to introduce one, the patient should be placed on her left side, and in Marion Sims' position, the under limb brought well toward you and the upper one carried as far forward as possible. The speculum is then introduced, and the cervix should be seized and fixed with a vulsellum, and then one of the dilators is introduced, until it passes through the os and cervix uteri. If it is found to pass freely it may be withdrawn at once and the next larger size introduced. If any difficulty be experienced it may be allowed to remain in ten or fifteen minutes; it may then be withdrawn and the next number can be introduced with ease, and so on, until the parts be dilated sufficiently; and just as we find when the os is opening under natural efforts, so, as the operation proceeds, the dilatation becomes easier and quicker, so that we find it becomes completed in from three to eighteen hours; and as we know the relaxing influence exerted upon the uterus by chloroform, I need scarcely say that if this agent be used the operation is performed with more ease and safety.

If syringing the uterus be the physician's object, he need not go further than the sixth or the seventh piece; if the introduction of nitric acid or other medication be his object, he may require to go as far as the ninth or the tenth; if the finger is to be introduced for exploring purposes, he must go on to the sixteenth or seventeenth; but if his object be the removal of a fibrous or other tumour, he must go on to the higher, probably the highest number. In no cases or conditions do these dilators give more satisfaction or meet the ends more efficiently than in imperfect abortions.

These dilators were introduced to this country from Germany about two years ago by Dr. Macan, of the Rotunda Hospital, Dublin; and from my own experience of them within that time I think I am warranted in saying that they will be found to answer their purpose better than any other instrument or method that has been proposed for the easy and the safe dilatation of the os uteri. However, each instrument possesses certain advantages.

Allow me to add, that smearing over the dilators with carbolic oil will much facilitate their introduction, and by so doing may obviate other grave difficulties. It has been stated that one great advantage in the use of

Hegar's instrument over the sponge-tent, sea-tangle, or those other complex instruments is, that they do not carry with them septic poison. Although, as I have stated, Hegar's set is made of twenty-six pieces, I believe you may with advantage have a higher number; and the set I have the honour of exhibiting to-night consists of thirty-six pieces.

The members were much interested and Professor Dill was thanked for his kindness in showing his various instruments.

The Honorary Secretary submitted the report of Council which was passed.

The Treasurer Dr. Esler brought forward his financial statement for the year which showed a satisfactory balance £106-3-1 in hand.

The hour being advanced the meeting was adjourned for the election of office bearers till the 1st

The Ulster Medical Society in acc ^t with the Treasurer, (Dr. Esler)	
To Income & Expenses 25-17-3.	By Balance 91.13.4
1884.	By Balance 1-10-0
1883.	By Balance 38.17.0
1882.	By Balance 132.0.4
1881.	By Balance 106.3.1
1880.	By Balance 106.3.1

Tuesday in October.

Adjourned Annual Meeting was held in Royal Hospital on Tuesday 7th October.

Present, Professor Dill President in chair, Drs. J. C. Smyth, James Smith (Shankill Road), McFarland, Esler, Wadsworth, Lindsay, Barron, Dempsey, John Moore, McConnell, and Mackenzie, Secretary. Dr. McKee was also present.

Mr. Fagan and Dr. Whitaker were proposed as President for ensuing session. Mr. Fagan was elected by 9 to 2.

Drs. Moore and Wadsworth—Vice Presidents.

Dr. Lindsay (10), J. W. Browne (8), McFarland (9) Dempsey (8), J. C. Smyth (8), James Smith (7)—Council.

Dr. Sinclair was elected Pathological Secretary.

Dr. Barron was elected Librarian.

Dr. Esler was elected Treasurer. (by acclamation)

Dr. McKenzie was elected Secretary. (" ")

Dinner to be on 25th November. Dinner Committee, President, Dr. Esler, Whitla, Professor Dill and Honorary Secretary.

R. F. Dill, President
11th November 1884

ULSTER MEDICAL SOCIETY

SESSION 1884–85

The First Meeting of the U.M. Society was held upon the 11th November in the Royal Hospital.

Present, Professor Dill Ex-President in the chair, Mr. Fagan President-Elect, Drs. Dempsey, J. C. Smith, James Smith, Wadsworth, John Moore, A. P. B. Moore, O'Malley, Lindsay, Sinclair, Whitla, Byers, J. W. Browne, O'Connell, and Mackenzie, Honorary Secretary.

Professor Dill in a graceful manner thanked the members for their kindness to him during his year of office as President and expressed his pleasure at retiring in favour of one for whom he had respect and regard.

Dr. Esler in a neat and feeling speech proposed a vote of thanks to Professor Dill (the retiring President) referring to the cordial and hearty manner in which Dr. Dill entered into everything that was for the interest and welfare of the members.

Dr. Moore seconded and Professor Dill responded to the vote of thanks which had been received and passed by acclamation.

The President-Elect (Mr. Fagan) then proceeded to read his opening address.

Paper:¹ GENTLEMEN,—I feel deeply sensible, I can assure you, of the honour you have done me by electing me as your President for the present year—an honour that is enhanced by the unanimous and hearty manner in which it has been conferred. It will be my earnest wish and endeavour to prove myself worthy of such, by upholding, in every way I can, the dignity that attaches to the honourable post of presiding over such an influential and intelligent body of gentlemen as the members of the Ulster Medical Society. Guided by the bright example of my predecessors, and relying on your kind assistance and forbearance, I hope that when my time arrives to vacate this chair it can be said of me that I have discharged the functions of my office in a not less satisfactory manner than those who have preceded me.

The first difficulty that besets my path is the selection of a suitable topic on which to address you. This wondrous epoch of ours, teeming as it is with startling innovations, is not wanting in the production of societies—religious, scientific, political and social, to promote and protect their various interests. Every profession, every trade has its societies to represent the different shades of thought and interest in each. The profession of medicine is not behindhand as regards the number and importance of its representative bodies. At the annual meetings of our great parent society we are

treated to Presidential addresses, learned orations on some of the absorbing topics engaging professional interest at the time, while the Presidents of Sections and the readers of papers thresh out pretty completely the several subjects of most interest in their departments of medical science. Again, if we look over the country we find numerous smaller societies working on lines similar to their great prototype, and if, together with the work done by those, we consider the addresses annually delivered in our Universities, Colleges, and Hospitals, it is not to be wondered at that there remains scarcely one spot unexplored in the regions of medicine.

It is not my intention to ask you to accompany me into strange regions on speculative inquiries, or to travel over again the well-beaten path that is so familiar to us all as “the review of the progress of medicine and surgery for the past decade.” Neither is it my intention to dwell on, as critic or panegyrist, the great achievements of such men as Pasteur, Koch, Lister, Wells, or Billroth, the great champions of our profession who, by their labours, are daily gaining fresh laurels—one set in the field of preventive medicine, the other by their skill and daring penetrating the most sacred chambers of the organism, and each succeeding year astonishing the world by some novel and bold surgical enterprise; such victories are of frequent occurrence, and our journals duly chronicle those achievements under such headings as hysterectomy, oophorectomy, splenectomy, ovariectomy, nephrotomy, cholecystotomy, and gastrotomy, as well as other exploits in the field of abdominal surgery.

To no such stirring themes do I invite you to listen. Mine will be a less pretentious one, but not less important. It is familiar alike to the pure physician and the pure surgeon, but more especially so to those engaged in general practice. I am sure every thoughtful and observant practitioner who has been some time engaged in professional work, when he looks back over his past labours, must be forcibly reminded of some weak points in the continuity of his practice, such as a wrong diagnosis, an erroneous treatment based on it, a case gone wrong owing to a timid, careless, procrastinating way of dealing with it.

In casting about for a subject, it occurred to me that I might with advantage dwell for a little on some of these points, and by directing our attention more particularly to them we might be able to detect and strengthen those weak links in the chain of our professional labours. To the enthusiast surgeon such an every-day subject will appear dull and uninviting, lacking as it does the glamour of novelty or daring enterprise, but to the thoughtful practical mind it will meet with the reception that its importance and usefulness deserve. As I grow in years and experience the more strongly do I become impressed with this idea, that we allow ourselves to be carried away too much by

¹ [Dublin Journal of Medical Science, 1885, v79, p344.]

speculative theories and novel practices, very often to the neglect of the first simple principles—a true appreciation of which, together with their timely and judicious application, are of infinitely more benefit to the race than the aggregate of the most brilliant discoveries recently made.

The subject-matter of my discourse, to which I will now direct your attention, is—the great importance of, 1st, accurate and early detection of disease and injury; 2nd, the adoption of a timely, judicious, and decided mode of treatment. A higher and more important function still than early detection is the prevention of disease and injury; and it can never be said of our noble profession that, whilst it might appear to be their interest to be indifferent to such, they have not repeatedly and loudly raised their voices, proclaiming with no uncertain sound the importance and necessity there is for observing the common laws of hygiene. In proof of this we have only to look to the labours and teachings and warnings of such men as Jenner, Pasteur, Koch, and Lister, the great apostles of “preventive medicine,” who have preached, and are still preaching, the gospel of sanitation, whereby not only individuals and communities but whole races have been and may still be benefited. Notwithstanding this, ignorance and apathy still prevail, and as the outcome of such, together with the inevitable tendency to degeneration inherent in our nature, the services of the physician and surgeon are still, and, I believe, always will be, in active requisition. If, then, we cannot hope to prevent the occurrence of disease and injury, it behoves us to try and recognise it in its earliest manifestations, for by so doing it can more effectually be arrested or brought to a satisfactory issue.

The first proposition, then, must forcibly commend itself to us, inasmuch as the more accurately the truth is known concerning any subject, the more efficiently can it be dealt with. On the medical attendant devolves the onus of finding out the truth concerning the cases brought under his observation, and on the acuteness of his diagnostic powers often hangs the well-being—nay, even the life of his patient. Ability as a diagnostician is one of the highest attributes of the physician or surgeon, for excellence in it demands that they be possessed not alone of many highly-developed physical qualities, and a large and varied experience, but presupposes as well an accurate knowledge of a wide range of scientific subjects. With all these qualities the highly accomplished consultant makes his mistakes in diagnosis as well as the humblest practitioner, and “Humanum est errare” may, with peculiar appropriateness, serve as a motto for all of us. I have somewhere heard the statement, and often seen it verified, that there is nothing more humiliating to the pride of our profession than the records of the post mortem room.

While there must always be differences in men’s diagnostic powers, there is one important particular in

which all should be equal, and that is the desire to leave nothing undone to enable us to make our diagnosis as accurate as possible. I do not propose to consider what should be the qualities of a good diagnostician, or the best methods to be employed in making a diagnosis, but I will draw your attention to what I consider to be some of the main defects to which not a few are liable:—

1st. A tendency to form a rapid conclusion on very slender data.

2nd. Putting leading questions to a patient.

3rd. Imperfect or ill-conducted physical examination, or no physical examination at all.

The first of these, we will admit, is a common cause of cases of mistaken diagnosis, and I think it can be accounted for in this way. Medical men in large practice would find it physically impossible to get through the amount of work they perform had they to carefully consider in detail each case presenting itself; besides that, they acquire through their large and varied experience a power akin to instinct that, from what I may call the physiognomy of disease, enables them to form, as a general rule, a very accurate diagnosis. That they are sometimes wrong, and evil results follow to doctor and patient, cannot be denied, and there are few of us that do not know or have not heard of cases, painful illustrations of this fact. I, some time ago, heard the following:—A man, who had been some days before in a drunken brawl, consulted his medical attendant for a slight headache and general contusions. A warm bath and some alterative medicine were prescribed, and he was told he would be all right in a few days. After a few days’ time the man, not feeling better, again consulted his doctor, who found his patient’s headache much worse, and also that he had vomited a couple of times. Still looking to the stomach as the cause of his disorder, suitable drugs were again prescribed. A few days after this the headache and vomiting ceased, but the patient began to lapse into a dull state, varied by occasional fits of restlessness and excitement. At this stage another practitioner was asked to see the case, who, after getting an accurate history, made a careful physical examination and found a small contused wound on the man’s head that up to that time had not been detected. The opinion then formed was that the symptoms were due to cerebral mischief, and treatment was accordingly directed to it, but notwithstanding this the man died comatose in a few days. Instead of rushing to the conclusion that the man’s headache depended on disordered stomach following his debauch, had his medical man carefully gone into the history of the case, followed up by a close physical examination, the probabilities are that an accurate diagnosis would have been made, a rational mode of treatment adopted, and, as a result of such, a life perhaps saved.

The second defect to which I wish to draw your attention is, “the habit of putting leading questions to a patient.” This practice very often results in a wrong

opinion being formed, for if the objective symptoms be not sufficiently well marked, the patient is questioned and cross-questioned, not so much with the view to elicit facts as to get confirmatory evidence of some hypothetical diagnosis already formed. Having once formed and expressed an opinion, it is astonishing with what tenacity we hold on to it, and any fresh symptoms arising, and existing ones becoming more marked, are bent and twisted to harmonise with our prejudiced view. Let a fresh mind be brought to bear on the case at this advanced stage; it will at once, by the light of the new and better-marked symptoms, arrive at a true diagnosis; and it will then strike us how strange it was we did not see the case in that light before.

The third defect—and a very grave one in making a diagnosis—is where no physical examination, or a very indifferent one, is made. I need not dwell on the disastrous train of symptoms that often follow in cases where physical examination has been neglected. Some of you have heard, no doubt, of patients treated for colic and dyspepsia, who, on being subjected to careful physical examination, were found to be suffering from a strangulated hernia. I have known cases of incontinence of urine where strychnine and other drugs were assiduously administered, with a view to render the bladder capable of retaining its contents when that viscus was distended to the point of rupture from inability to get rid of, except in drops, the accumulated urine. That such grave mistakes are occasionally made is unfortunately too true; and in well-marked cases, such as those mentioned, where the symptoms point strongly to the more than probable cause, and indicate the necessity for a physical examination, the neglect to do so must be attributed to the culpable carelessness or gross ignorance of the medical attendant. While a perfunctory examination is not so bad as no examination at all, it cannot be too strongly condemned, for while there is an attempt to comply with the form of examination, apart from the mere formality, it serves no useful purpose. It is not an uncommon thing, when a child suffering from a slight pain in a joint or limb is brought for professional advice, for the doctor to feel the parts as it stands beside him, and not detecting anything strikingly wrong, while he prescribes some simple application, gives the consoling opinion that it is nothing worth considering, and will come all right in a little time. The parent, now relieved of all anxiety, accounts for the symptoms as due to the child's nervous disposition, or to what is popularly known as "growing pains." But a condition of well-marked arthritis or osteitis soon after manifesting itself, rouses again the parent's anxiety, and the doctor is a second time consulted. The more decided symptoms now present demand a strict physical examination, followed no doubt by the conscientiousness that had such been done on the first occasion, much mischief might have been averted. I have met with cases where sedatives were assiduously applied

along the course of painful nerves of arm and leg, and hopes held out that with time, change of season or of climate, the pain would disappear, where a careful physical examination afterwards revealed a cancerous nodule in the axilla, or a similar malignant mass in the pelvis, as the true cause of the symptoms present.

There are two affections, of which I see a considerable number occurring with great frequency, and in which an accurate and early diagnosis is of paramount importance—I allude to cases of hip and spinal disease. In their early stages it is often a most difficult matter to make a correct diagnosis; the symptoms in each are obscure and ill-defined, and in the case of hip disease, singly, or even in groups, are not conclusively pathognomonic of this affection. Hence we may have pain in the knee, flattening of the buttock, flexion of the thigh, pain in the groin, stiffness of the joint, each and all of which are usually found in hip disease, and yet their presence is not conclusive of it, as these symptoms may be due to other pathological states. It is for want of making a thorough and complete physical examination that medical men, seeing one or a group of symptoms usually associated with hip disease, jump to the conclusion that it must be present, when they ought to remember that the same symptoms may be equally conclusive of a totally different condition. I knew a very eminent surgeon who, forming his diagnosis on the presence of one or two prominent symptoms, pronounced the case he was called to see to be one of hip disease; accordingly, he gave instructions to have the best room in the house given up to the patient, as her case would be tedious, and likely to confine her to bed for three, six, or perhaps twelve months.

His orders were carried out, but the cure was more rapid than he had anticipated; in a week after he saw her, the child one night passed a large quantity of pus per anum, and in three weeks was up and about. It was a pelvic abscess, not a case of hip disease; the more prominent symptoms present were common to both affections, and his neglect of making a careful and thorough differential diagnosis led him into the mistake he made.

The following case, that occurred in my own practice a few years ago, I think worth recording:—After I had concluded my lectures on hip disease at the Children's Hospital, the students of my class, during my absence, examined a case that was brought for me to see, and pronounced it to be one of hip disease. They detailed as present most of the symptoms common to the affection—viz., lameness, flexion of thigh, flattening of buttock, pain and swelling in the groin. And seeing the child, who was now dressed, walking with the characteristic gait, I coincided with the opinion expressed by them that the case was one of hip disease in its first stage. I told the mother of the child what my opinion was, and that a splint, which I then ordered, would be necessary. A few days afterwards, while the child was

waiting in bed for her splint, I happened to examine her, and finding some important symptoms absent, and others not well marked, my suspicions began to be aroused concerning the correctness of the diagnosis. I got the child out of bed, and noticing that she walked with more freedom than when I first saw her, I asked her if she suffered pain in walking, and, if so, where? She replied she had very little pain now, as her heel was nearly well. On examining the heel I found a little ulcer over the tendo-Achillis; this had existed for two or three months, being very sore at the time of her admission to hospital, and now much improved by the rest obtained. The presence and history of this little ulcer were quite sufficient to account for all the symptoms. To prevent straining of the sore she walked on her toes, with leg and thigh slightly flexed. Owing to the flexed condition of the thigh, the fibres of the gluteus became relaxed, and there was partial obliteration of the fold of the nates, with some flattening of the buttock. The pain and swelling in the groin were due to an enlarged tender gland—produced, no doubt, by the irritation of the lymphatics at the seat of the ulcer. I need scarcely tell you that the order for the splint was immediately countermanded, and the mother duly informed that the rest and other treatment had improved her child so much that a splint would not be required. It was a gratifying communication to her, and she expressed her hearty thanks for saving her child from a cripple's fate. This simple case illustrates very forcibly the liability there is to be led astray by what, *primâ facie*, is strong presumptive evidence of a certain well-defined disease; and the lesson to be drawn from it is that in all cases of the kind the patient should be subjected to a thoroughly searching and complete physical examination before hazarding a diagnosis.

In the first stage of spinal caries the symptoms are also very obscure; pain of an ill-defined character, and referred to regions remote from the spine, is the first warning given of commencing mischief; and I may here mention that at this early stage of spinal disease the case is generally treated by the physician, as the symptoms present point to diseased conditions that come more within his province than that of the surgeon. It is not an uncommon thing to find that cases have been treated for a long period for gastric derangement, and that it was only when actual deformity of the spine was manifest that the true nature of the ailment was discovered. In the same way cases of bronchial and laryngeal irritation have been drugged and sprayed, while the real offender, secretly doing its deadly work in the spinal column, was allowed to go on unnoticed.

A case came under my observation a few years ago of a young man who had been resident in England, and was sent home by his medical adviser, after four months' treatment for a kidney affection, in the hope that his native air would restore him. A careful examination of his case revealed a spinal caries in the dorso-

lumbar region. I was able very clearly to trace the disease to an injury sustained three months before he began to complain. For treatment I recommended rest in the recumbent position. After a little the pains in the loins disappeared; later on jackets, at first of plaster-of-Paris, then of felt, were applied; and I was informed that in some time over a year he was about quite well. For a series of cases illustrating this aspect of the subject I would refer you to Mr. Hilton's classical "Lectures on the Diagnostic Value of Pain."

I have now, in a very desultory and superficial way, brought under your notice some points indicating the necessity for an accurate and early diagnosis in all cases of disease and injury, and we have seen that this can be accomplished only by obtaining a true history of each case, and by a careful consideration of all symptoms, both objective and subjective, after making a thoroughly complete physical examination. We have seen how wide of the truth single symptoms and even groups of such are sometimes apt to lead us; how a flexed thigh, flattened buttock, and a painful swelling in the groin, may exist from other causes than hip disease; how pain in the knee is not conclusive of knee mischief, or even of hip mischief, with which it is mostly associated, but may be due to rectal, sacro-iliac, or other pelvic mischief; how the first warnings of spinal disease manifest themselves, as pains in the regions of the chest, stomach, kidneys, or bladder; and considering all these facts, must we not be forced to the conclusion that it is only by the most careful, thorough, and patient examination and study of each symptom and group of symptoms that we are likely to arrive at an accurate diagnosis.

I will now ask your attention for a moment to what follows as a rational sequence of our first proposition—viz.: "The adoption of a timely, judicious, and decided mode of treatment."

The early and accurate detection of disease and injury is of the first importance, for by the light thus obtained appropriate treatment can be more effectually applied. Up to this point direct benefit to the patient has not been considered, and although we sometimes meet with patients who take an interest in the niceties of diagnosis, and the study of pathological states, the majority come for treatment, which they want carried out quickly and successfully.

By "timely treatment" I mean that which is adopted as soon as the case is brought under the notice of the medical attendant. We know that, owing to the ignorance or carelessness of the patient or friends, cases are not always seen at their commencement—indeed, many not till considerable mischief of a preventable character is done. That, however, is not the fault of the medical man, whose responsibility begins only at the moment he sees his patient for the first time. When a diagnosis is made, treatment judicious and decided should at once be put in practice.

The habit of procrastinating when treatment is required, is a thing that cannot be too strongly censured, especially in cases of great urgency; the number of lives lost, and the amount of suffering entailed, by postponing treatment for even short periods, if it were possible to calculate such, would be appalling to contemplate. In apparently trivial cases, where symptoms are ill-defined, while not playing the part of alarmists, it is wise to give due caution against doing anything that might be injurious, or likely to develop mischief, until every suspicious sign of it had disappeared. One medical man, disdainful of such slight warnings, assures his patients that they need not mind, that they will be all right again after a little. Another practitioner, of a more prudent disposition, advises them to observe caution, avoiding this or doing that, till all suspicious symptoms disappear, and should there be at any time the slightest retrograde tendency, to have their case again inquired into. I think you will agree with me that although in many cases the sanguine expectations of the one are verified, still, on the whole, there is less cause for regret by hearkening to the prudent warnings of the latter, who, anticipating mischief, subjects his patients to a timely and judicious treatment, and, next to the prevention of the disease or injury, does the best thing that can be done for them. In better-marked cases still, we sometimes see this tendency to make light of them, and not infrequently do we hear patients say: "I consulted Dr. A. or Dr. B., but he did not think it would signify, so I paid no further heed to it." And do we not, unfortunately, but too often see painful cases of bone disease, spinal and joint disease, as well as various other affections, both medical and surgical, the outcome of this reprehensible practice of making light of, or ignoring, these primary, though faint, warnings of brewing mischief.

To conduct successfully, through the anxious and tedious stages of disease and convalescence, cases of morbus coxæ or spinal caries, is creditable alike to the patience, judgment, and skill of the surgeon—to save by an amputation a life endangered by a disorganised limb, or to preserve one of the members by a successful excision, are triumphs in which he may take a pardonable pride, but a greater triumph still, and one worthy of a higher meed of praise, is to make an early and accurate diagnosis of disease, and to crush it out in what I may term its embryonic condition.

Unfortunately this, the noblest and most useful quality of our calling, is the least recognised by those who most benefit by it—nay, more, I have known cases where the medical man was not alone not thanked, but strongly censured instead, for what were considered opinions too hastily expressed, and treatment unnecessarily imposed. Instances of this are, I am sure, familiar to all of us. A few years ago I saw, in consultation with a distinguished medical friend, a child who had well-marked symptoms of incipient hip mischief. She was

immediately subjected to a decided line of treatment, which was rigidly carried out for a month or six weeks; by this time the joint was so much improved that the friends, doubting the opinion expressed by us, took her to a metropolitan surgeon, who assured them that there was nothing wrong with the child, that all she required was attending to her general health. While we might indulge in the consoling reflection that we saved that child by timely and decided treatment from the possible fate of a cripple's life, I have reason to know that we incurred the parent's censure for the expression of alarmist views and unnecessary restraint put on the patient. Did time permit, I could quote numerous instances of a like character, but I will only relate this striking one, showing the value of the public opinion on matters purely professional, told by Sir James Paget of a distinguished London surgeon who, while operating on a gentleman for strangulated femoral hernia, with great carelessness cut right into the intestine. Fæces flowed out, and all the miseries of a wounded intestine followed. After much anxious care, at last the patient recovered. His firm conviction was that by this very incision into his bowel he had escaped some dreadful calamity, and that nothing but the most extreme skill could have either made the incision into the bowel, or recovered him after it; and he presented the surgeon who had done this for him with a very handsome gold snuff-box.

For the very reason of this inability on the part of the public to judge rightly, it is all the more incumbent on us, rising above personal considerations, to stand in their place and help them. In obviously well-marked cases, urgently demanding treatment, there can be no excuse for procrastinating; pressure of work, or want of confidence in one's power to deal with the case, is no justification for delay; deferring treatment on such grounds, or in the vague hope that by some lucky chance it will come to a successful issue, is reprehensible in the highest degree. Such cases should not be left uncared for one moment longer than is absolutely unavoidable; and if from any cause the necessary attendance cannot be bestowed on them by the medical man first consulted, he should seek the assistance of another, whose time is less occupied, or who could bring special knowledge and experience to bear on them. Not infrequently do we meet with cases, painful examples of the results of this procrastinating or difficult disposition of the medical attendant.

A short time ago I attended a poor fellow who suffered from urinary fistulas and vesical catarrh; he was reduced to the lowest ebb by prolonged and intense suffering. Some months previously he got a fall on his perinæum, rupturing the urethra; this was followed by urinary extravasation. There were delay and indecision in dealing with the case, and it was only when the mischief was done that a second medical man saw it and adopted the proper treatment of making free incisions

over the infiltrated area. It was too late, however; the whole of the integument covering the lower half of the abdominal wall, as well as the scrotum, sloughed, and the enormous extent of raw surface, with penis and testicles exposed, was, I heard, fearful to witness. I performed a cystotomy for the relief of the intensely painful bladder symptoms, which placed him in comparative ease for some months, and then he died. I give this as an example of the appalling and fatal results that may follow the neglect of a timely, judicious, and decided mode of treatment. Cases of ruptured urethra are common in hospital practice, and when seen soon after the accident, while the swelling and infiltration are confined to the perinæum, are easily and successfully dealt with. The practice I follow is to pass a sound down the urethra as far as the seat of mischief, and make a free deep incision on it, and multiple incisions about the part if its state demands such. I have never seen any of these cases go wrong when dealt with early and in a decided manner, and rarely have I seen constitutional disturbance or suffering of any consequence in connexion with them.

Another form of affection that terminates badly, if not dealt with in a similar way is periostitis. If seen in the very early stage, rest, elevation of the limb, perhaps cold applications, and general antiphlogistic treatment may arrest its further progress; but if not seen till a later stage, when there is great pain, swelling and tension of the part, and it be not dealt with vigorously, the danger to life and limb are very great. I have seen prolonged suffering followed by extensive necrosis, blood-poisoning by which some lives were lost, and others placed in great jeopardy, and all for the want of a timely and proper incision.

Let me explain here what I mean by proper incision. Some men persuade themselves that when they make a puncture and draw blood they have complied with the requirements of the case. If their object is to draw blood and they get sufficient, well and good; but in cases such as periostitis, there can be no more mischievous practice. Owing to the swollen, congested state of the tissues, an incision that appears deep and bleeds freely is frequently useless, for its object is not attained, the periosteum is not reached, and what was meant for good is sometimes only the means of creating further mischief. The motive for interfering is to relieve periosteal tension, which if not accomplished will end in the death of the bone. Hence, to do this effectually it is necessary to pass the knife well down to the bone, and keep the blade in close contact while making the requisite free incision. In this way the tension of all the parts is relieved, and the treatment, so far, is judicious and thorough. The same may be said of cases of diffuse inflammation, when spreading under fascial or aponeurotic structures, so often seen in the extremities following injuries and operations, and it is unfortunately no uncommon thing to see poor creatures who

have survived a protracted period of painful suffering, carry about with them a seamed, scarred neck, a clawed hand, or a crippled, useless limb—monuments of procrastinating habits or timid peddling surgery. Let me not be understood to convey that all such cases are the outcome of indifference or incompetency on the part of the medical attendant. Nothing is further from my mind. They may occur in the hands of the most competent surgeons, for the result may be due in one case to the fact that it was not seen till the mischief was done; in another to the dogged, ignorant obstinacy or fear of the patient to submit to the proper treatment; in others, again, to some defect in the organism, which prevented it responding to treatment, though most judiciously and efficiently applied. The two grand principles of “rest” and “relief of tension,” on which depend the successful treatment of many diseased conditions, especially in surgical practice, cannot be too strongly enforced. It behoves medical men, then, while recognising their value, to see that they are carried out in a thoroughly efficient manner, so as to accomplish the object at which they aim, otherwise they are not alone powerless, but faith in their efficacy being shaken, much mischief may occur for want of their proper application.

Travelling with a professional friend a few weeks ago, I saw him intently and with evident satisfaction observing the back of his hand, on which were visible four linear scars extending the whole length of each metacarpal bone; he next vigorously put his fingers and hand through their various movements, and, finally, seizing mine, he squeezed it with a force that, if it indicated the strength of his regard for me, left no doubt of my being very high in his estimation. He said, “It’s all right again; I can do every thing with it; it is quite as strong and useful as ever.” He was treated by me some time previously for a very bad form of inflammation of the hand, following an injury; it had been poulticed and punctured before he came up from the country to place himself under my care. The scars referred to were the result of the free incisions practised, and after which, with absolute rest and other appropriate treatment, he made an uninterrupted recovery.

This simple case forcibly illustrates the value of the efficient application of the principles already mentioned, and I am sure most of those about me now can record not one but many cases equally successful by the application of timely, judicious, and decided treatment.

In the great and important subject of joint disease and injury, the value of the application of these principles cannot be too strongly impressed on the minds of medical men, and we frequently see that, owing to want of attention to them, injuries, at first trivial, slowly but surely acquire a condition that very often ends in confirmed disease, deformity, or death. While I am prepared to admit that perverseness, gross ignorance, and prejudice on the part of patient or friends, often thwart

the medical attendant in his endeavours to deal efficiently with the early stages of disease in joints, still I am forced to the conclusion that a great deal of mischief of a preventable kind is allowed to take place, owing to the fact that some medical men make light of, or do not appreciate the importance of, early and decided treatment in the first manifestations of disease in these structures.

And now, gentlemen, although many subjects present themselves to my mind in connexion with which the consideration of the propositions first made would be both interesting and instructive, I find that time will not permit it—indeed I feel bound to apologise for the length of time I have already detained you with what will appear to many, I am sure, very commonplace matters, and I hope you will not consider that I have addressed my remarks to you as one who felt he was enunciating views that were not already as familiar to you as to himself. Believe me, I have too keen a perception of my own shortcomings, and too true an estimate of the high professional excellence of my brother practitioners in Belfast, to address them in any such spirit; but you will admit that, owing to the anxiety and hurry entailed by increasing professional labour, we are all of us apt to overlook the little things both of principles and practice that are of the first importance in the every-day work of our profession, and that we can all benefit by repeated and sharp reminders of our backslidings in these matters.

While we are considering some of the important duties we have to perform towards our patients and the public, we are not to forget there are other duties no less strictly demanded of us towards ourselves, our professional brethren, and the honourable calling to which we all belong. The elevation or degradation of the body depends on the aggregate of the acts of its individual members, and in proportion as they are honourable, useful, and enlightened, will it rise in general estimation. Hence, it is incumbent on each of us, by the faithful and conscientious discharge of his duties, by his high moral tone and dignified conduct, to aid in elevating it in its social status, and increase its power for well-doing; and, while acting thus his own part, he is not to be indifferent to his brother who, through carelessness, oversight, mayhap ignorance, fails in his duty to his patients or his profession, but should from mutual interest, as well as in common brotherly charity, hasten to shield him from the hard censure of an unsympathetic public.

Gentlemen, I do not know any means that is more likely to promote such objects more effectually than the Society I have the honour of presiding over this Session. Through it the scientific and social aims of our profession are promoted, interchange of views on the ever-varying questions of the day takes place to our mutual advantage, biased opinions are altered or modified, a spirit of inquiry is fostered, our knowledge and mode of

treating disease are brought more in line with the advanced practice of our time, and our local band is kept well in the forefront of the ranks of our profession.

The promotion of the more intimate social intercourse of its members is not the least important function of this Society. It has not been so fortunate in accomplishing this as one would wish; still we must endeavour, with the facilities at our disposal, to do what we can to encourage it; and I anxiously look forward to the day when a university or college club, in which the medical element will form no insignificant part, will be established amongst us to further still more this desirable object. I believe such an institution will promote the social elevation of our body, smooth any little professional acerbities, and exercise a healthy, restraining influence on erring members by bringing the weight of our united opinion to bear on them.

We have lately seen what the profession in Belfast and the North of Ireland can do when it wishes to put forth its strength. The noble reception it gave to the British Medical Association was the theme of praise and admiration of our numerous visitors, and redounded to the honour not alone of our local profession, but to that of the whole community. We cannot then plead incapacity. As a professional body we are strong enough, and capable of developing our present Society, or forming and fostering a medical club worthy of our body and the important community in which we live. Whether emanating from these modest rooms or more pretentious halls, let the spirit of our Society be ever active in promoting the interests of our body, both as regards our relations to one another as well as to the outside public; and let each member, acting in conformity with that spirit, play his part honourably and well. Let the senior members and those whom the propitious wave of circumstance, aided, perhaps, by ability and honest hard work, has landed into the pleasant places of our profession, sustain the dignity and prestige that are supposed to be attached to the position they occupy. Let remuneration for their services be commensurate with their position and the costly requisites and luxuries of their clients. Let them remember that accompanying such honourable and lucrative positions is also a responsibility towards their less favoured brethren. They should be the standards by which younger members would gauge their professional relationship with the public; and as it is with the learned profession of the law, when a counsel gets silk it debars him from a certain class of practice that becomes the right of the junior brethren, so it should be with us. Those fortunate members who have attained commanding positions should refrain from injuring the prospects of their junior brethren. Should they act in this manner, all interests will be served; the province of the general practitioner will not be encroached on; the labour of the consultant is lessened, while his remuneration is increased; and the patient, often valuing the

services in proportion to the expense and difficulty in securing them, feels satisfied.

As regards the general relationship that should exist between all of us hard workers, whether specialists or general practitioners, let us try and be animated by a spirit of brotherly love and charity; let us bear and forbear with one another; let us, by kindly advice and practical assistance in times of need, lighten the burden that is imposed on us all, pressing with greater force on one than another; let us, by honourable, straightforward dealings in our complicated relationship to our patients and to one another, advance our own and our patients' interests and the honour and interests of our profession. Acting in this manner, our power and efficiency will be strengthened to enable us to carry on with unwearied vigour the great crusade against disease and injury that seem to be the inevitable inheritance of our common humanity.

Dr. J. W. Browne proposed and Dr. Dempsey seconded and Professor Dill supported a vote of thanks to the President for his valuable and practical address.

Dr. Esler proposed and the Secretary seconded that the following gentlemen should be balloted for: Dr. R. Purdon, Dr. Bigger, and Dr. Poole.

John Fagan, President
9th December 1884

Session 1884–85. The Second Meeting of the Society was held in the Royal Hospital upon Tuesday evening 9th of December at 8 o'clock.

Present, Mr. Fagan President in the chair, Drs. Dill, Browne, Dempsey, Whitla, St George, O'Neill, Sinclair, Esler, Kevin, Moore, O'Connell, and Mackenzie, Honorary Secretary.

The President having drawn attention to the death of Dr. Wadsworth, one of the Vice Presidents of the Society, Professor Dill moved and Dr. Browne seconded that the Honorary Secretary be instructed to write a letter of condolence to the relatives of the late Dr. Wadsworth.

A ballot was taken for the following gentlemen who were elected unanimously members of the Society: Drs. R. D. Purdon, Poole, and Bigger.

Dr. Whitla proposed, Dr. St George seconded, and Professor Dill supported a resolution that Dr. Esler be elected Vice President in the place of the late Dr. Wadsworth.

Dr. St. George read a paper on genu valgum illustrated by a case successfully treated by means of "splints" without osteotomy.

The President showed two patients, and Dr. Browne showed two patients, upon whom the operation by McEwan's method had been performed with the most satisfactory results.

An interesting discussion in which almost all the members took part ensued on the various methods of

treatment and modes of operation recommended for the cure of genu valgum.

Dr. Whitla exhibited vertebræ from the Irish Elk showing a rheumatic arthritis as illustrated by specimens of human bones.

He also exhibited a patient suffering from pseudo hypertrophic paralysis.

Dr. Whitla proposed Dr. Ward of Lisburn as a member.

A Council meeting to be summoned soon as possible to discuss place of meeting and any new arrangements which might add to the interests of the meetings. Also the procuring of a new minute book.

Since last meeting a successful and enjoyable dinner of the members and visitors was held in the Royal Avenue Hotel. The members all expressed themselves as being highly pleased with the manner in which the dinner was served.

The following members and guests sat down: the President Mr. Fagan in Chair, Professor Dill Ex-President Vice-Chair, Surgeon Major Thomson A.M.D., Drs. Dunlop, McFarland, Armstrong A.M.D., Browne J. W., Wheeler Senior, St. George, O'Neill, Patrick, Graham, Bigger, Sproule, McConnell, Esler, John Moore, Kidd, Cuming, Harkin, Whitla, Dempsey, O'Connell, J. C. Smyth, James Smith, Gilmore, Poole, Purdon, Lindsay, Barron, and Mackenzie Honorary Secretary. 18/6 and 10/6

John Fagan President 23rd December 1884

1884–85 Third and Special Meeting of the Society was held in the Royal Hospital upon Tuesday 23rd December at 8 p.m.

Present, Mr. Fagan President in the chair, Professor Dill, Drs. Kevin, A. P. B. Moore, John Moore, Whitla, R. D. Purdon, Gilmore, and Mackenzie, Secretary.

The minutes of last meeting were read and confirmed.

The Secretary read a letter from Mrs Wadsworth in reply to the letter of sympathy sent from the Society on the death of Dr. Charles Wadsworth.

The Secretary read the following report from the Council:

"Your council being desirous of increasing the interest of the members in the meeting of the Society and feeling that your place of meeting is very far from being comfortable or attractive, with a view of bringing the members into closer fellowship one with another, recommend (1) That the place of meeting be changed for this session from the Royal Hospital to the Belfast Museum; (2) That the evening of meeting be Thursday instead of Tuesday (on account of the Museum being occupied on Tuesdays) (3) That tea should be served to the members at 7:30 o'clock.

Some of the junior members of the society felt that the meetings were very lukewarm and that there is a want of sympathy displayed one with the other

and in order to bring about a closer acquaintanceship, and cause a firmer bond of union to exist among the members of the Society, your council recommend the 'Social cup of tea'.

Your council express the hope that the members will throw more zeal and energy into the working of the Society by attending the meetings in greater numbers and assisting the secretary in procuring pabulum."

Dr. John Moore proposed and Dr. Esler seconded that the change of meeting place mentioned on the circular and recommended by the Council take place for this session. Passed unanimously.

Professor Dill proposed and Dr. Kevin seconded that the change of evening of meeting mentioned on the circular and recommended by the council from Tuesday till Thursday be adopted. Passed unanimously.

Professor Dill proposed and Dr. R. D. Purdon seconded that tea should be served at 7:30 and business begin at 8, and that the expense should be borne by the funds of the Society. Passed unanimously.

Dr. John Moore proposed and Dr. Kevin seconded that the rules of order of procedure at meetings be adopted and printed with next circular. Passed unanimously.

The Secretary read an interesting proposal from Mr. N. H. Patterson Honorary Secretary of Belfast Natural History and Philosophical Society that the Ulster Medical Society should have the use of the two rooms at the left of entrance hall in the Belfast Museum on alternate Thursdays for 10/- per night (including gas-fire and use of tea equipment). No attendance further than the opening of the door.

Thursday, January 8, 1885.

The PRESIDENT in the chair.

The President, Mr. John Fagan, F.R.C.S.I., made the following remarks at the meeting on 8 January, 1885.¹

On the very threshold of the New Year let me express the wish that it may be a happy, useful, and prosperous one for all of you; and that it may see our Society extending its usefulness, benefiting not alone its own members, but the whole profession within the sphere of its influence, and through them promoting the well-being, health, and happiness of the community in which we live. The year 1885 is a somewhat eventful one for this Society. After a lapse of twenty-three years it has, I hope, in its wisdom thought well of changing its abode. During that lengthened period it has carried on its work within the walls of the Royal Hospital—a congenial place, we must admit, for prosecuting its operations. But the council of your Society has for various reasons recommended the change, and this has been confirmed at a special meeting of the members. I sin-

cerely trust that the change will be a beneficial one, and that the Society under its somewhat altered conditions will carry on its work with renewed and increasing energy.

It is a somewhat strange coincidence that the last meeting of the Society in the place it occupied since its formation should be the last meeting for the year, and that the last minute signed should also terminate the book that holds the records of this Society since its inception. We are not alone turning over a new leaf; we are getting into a new book and a new domicile with the New Year. Let us hope that this marked change will be for the benefit of the Society, and that when the last page of this new book is filled in it will present a record of honest useful work that will redound to the credit of the labourers who took part in it.

It may interest some of you to hear the names of those who attended the first meeting of the "Ulster Medical Society," which was held in the General Hospital on the 4th May, 1862. There were present on that occasion—Professors Ferguson, Gordon, Reid; Drs. Browne, Murney, Mulholland, Corry, Johnston, Magee, Stewart, Patterston, Pirrie J. W. T. Smith, William MacCormac, David Moore, Dill, Brice, Smyth, Bryce, M'Gee Murray, Scott, Halliday, and Whitaker. And of the names I have mentioned the only one appearing at the last meeting of the Society, held in the Royal Hospital on December 23, 1884, is that of our respected and energetic ex-president, Professor Dill. To advocate the advantages to be derived from a Society such as this before such an audience would be a work of supererogation. Its usefulness is patent to all; but, while we admit its usefulness, I am sorry to say that the profession in Belfast does not enter as heartily and thoroughly into the practical work of the Society as the reputation of its members and the size and importance of the community would demand. If we look to the metropolis and provincial towns of the sister country, we find their Medical Societies—not one, but many—in an active and flourishing state, at which the leaders of the profession, both young and old, many at great personal inconvenience, are constant attendants. And if we notice the reports of those Societies in our weekly journals, we constantly meet with the names of such men as Sir James Paget, Sir W. Jenner, Sir Andrew Clark, Sir Jos. Lister, Sir W. Gull, Sir W. MacCormac, Mr. Bryant, Mr. Hutchinson, and other leaders of the profession, as presidents, readers of papers, or members taking part in the discussion. The benefit of the presence and the expression of the matured views of such experienced members cannot be too highly estimated. I entertain the hope that the meetings of this Society will be honoured as well as benefited by a larger representation of its senior members than it has been heretofore. The amount of clinical material available in Belfast is enormous, and this, it is to be hoped, will be turned to useful purposes.

¹ [Dublin Journal of Medical Science, 1885, v79, p156.]

We have, representing the various branches of the profession in this town, men of high culture and vast and varied experience, whose opinions in discussions on the subjects with which they have specially identified themselves would form valuable contributions to medical science. I can well imagine the benefits that would accrue to this Society and to the public by a discussion on such subjects as the present outbreaks of scarlatina and typhus fever, to the latter of which one of our active young members has lately fallen a victim. The diseases of the viscera offer another fruitful field in which we may labour with advantage. Physicians have brought the subject of diagnosis to such a high state of perfection that diseases of the hidden organs, hitherto obscure and ill-defined, can now be demonstrated with astonishing accuracy. Owing to the vast strides that are being daily made in this department of medicine and surgery, and the startling innovations in practice following one another in rapid succession, there will be no lack of interesting and useful subjects for discussion. Through the combined efforts of physicians and surgeons some very creditable work in connexion with abdominal and chest surgery has appeared in the "Transactions" of this Society, and if, up to this, no novel instance in brain surgery—a subject so prominently before the profession at the present time—has been brought under your notice, I hope in a very short time to bring before you a case in which I trephined the skull for a brain affection in a child three years old. The patient has progressed favourably since the operation, now nearly three weeks past; and while not too sanguine as to the child's ultimate recovery, I have every reason to hope that I shall be able to show her to you when I am giving particulars of her case.

With a rich vein of material at its command, and with, as I hope, the active co-operation of all its members, both young and old, I see no reason, gentlemen, why the Ulster Medical Society should not hold a prominent place among similar institutions throughout the kingdom.

COMPILER'S NOTE

As will be seen from the extract above, the meeting of 23rd December 1884 was the last of the year and the last to be held in the Belfast Royal Hospital before moving to the Belfast Museum; the minutes of that meeting were the last to be recorded in the first minute book belonging to the Ulster Medical Society.

It is here that this collection of the records of the Ulster Medical Society and its predecessors will also end. It is to be hoped that the records of the Ulster Medical Society from 1885 onwards will, one day, be similarly collected.

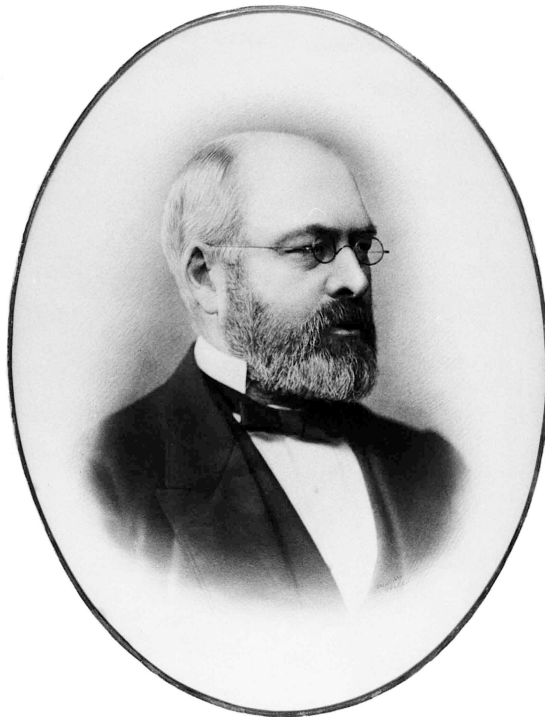
Presidents' Photographs



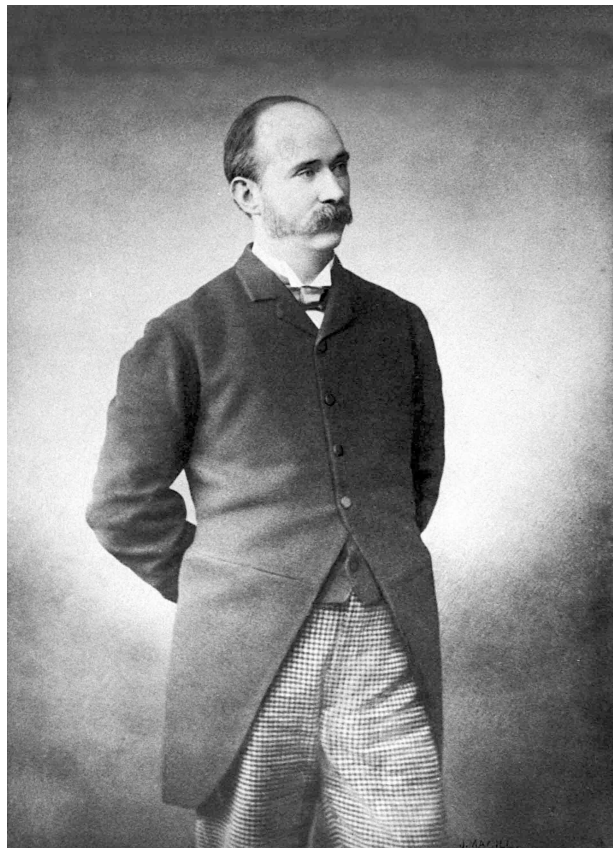
John Walton Browne



Robert Foster Dill



James Cuming



John Fagan

Records of the Medical Societies of Belfast 1822–1884
Presidents' Photographs



Alexander Harkin



William MacCormac



Henry Martyn Johnston



William Alexander McKeown

Presidents' Photographs



Charles Nicholas Delacherois Purdon



James William Thomas Smith



Richard Ross



George Frederick Wales

Appendix

The Nature of the Fevers of Belfast in the early 19th Century¹

by
John Stephens Logan

Almost any account of fever in Ireland must begin with famine. It seldom needed any extraordinary event to bring about famine in Ireland. The small tenant farmer, the subsistence farmer, like his fellows throughout the world had, and has, no certain harvest. It is still true as the poet says that:

He toils and he dare not stop;
His life is a long drawn question
Between a crop and a crop.²

Uncertain weather and plant diseases sufficed to cause famine five times in the 18th century, that is in the 1700s. And, as usual, fever followed famine; that is fever became epidemic, above and beyond its usual endemicity; because of the destitution and social disruption, and the wandering of people that follow famine. But the scarcity and dearth of 1816, 1817 and 1819 were exceptional. An extraordinary event had happened.

In 1815 the volcano of Mount Tambora in the island of Sumbawa in the East Indies erupted. It killed tens of thousands locally by explosion and falls of ash. It was to kill tens upon tens of thousands far across the world by its remote consequences. It is calculated that 150 cubic kilometres of volcanic dust entered the upper atmosphere. This dust spread around the world in the upper atmosphere and lingered there, perhaps for as long as two years. This high atmospheric dust, this dust veil, interrupted the sun's rays, made the weather cold, and spoiled the harvest of 1816, in North America as well as in Europe. 1816 was a year without a summer. The harvests failed, and 1816 and 1817 were famine years. Grain prices doubled in Europe and the United States.

Death rates rose over Europe. There were tens of thousands of deaths in Hungary from starvation. Similar deaths in Eastern Switzerland. In Vermont in New England farm families lived on hedgehogs and boiled nettles.

In Ireland the wheat, oats and potatoes failed. The poor harvest of 1816 was consumed by the end of the year. There can be no carry-over of potatoes and there cannot have been much carry-over of wheat or oats. The subsistence farmers had little, sometimes nothing, to eat, and no money to buy; and if they were bad, how much worse the landless labourers. Consequently in

early 1817 those worst affected abandoned their homes to try to live by begging, and as usual in famine, they made for the towns, including Belfast. In Munich beggars appeared from all directions, as if they had crawled out of the ground. (Let us be thankful nowadays for grain mountains and never complain that we have them. A reserve of grain is a great protection.) In Belfast, as in the rest of the island, fever became epidemic. Doctor S.S. Thomson, physician to the Frederick Street Hospital, now the Royal Victoria Hospital, gave this account of the rise of the epidemic:

I consider the predisposing cause of the present epidemic to have been the great and universal distress occasioned among the poorer classes by the scarcity which followed the bad harvest of 1816, together with the depressed state of trade and manufactures. The deficiency and bad quality of food. The want of cleanliness in the persons and dwelling of the poor. The contagion rapidly spread by the numbers wandering about in the search for subsistence."

McSkimin described the state of affairs in Carrickfergus.

1816. Both summer and autumn of this year were cold and wet: hence the crops were retarded in ripening, far beyond their usual season. On the 16th September the reaping of corn commenced here, but very little was cut before the middle of October, and on the 1st November many had not even begun their harvest. In December, much grain still remained in the fields, and some was even to be seen out in January. Markets of course advanced. On the 15th May, 1817, oatmeal sold at 5s.5d., and wheatmeal at 4s.2d. per peck (2 gallons); both were bad in quality. The ports being now open, a considerable quantity of rye flour was imported into Belfast from America, which was of much service. On the 11th June, oatmeal sold at 6s.4d. per peck, and all other provisions were high in proportion. The calamity occasioned by this dearth, was much heightened by many tradesmen and labourers being destitute of employment, and a typhus fever setting in early in the spring of 1817, reduced many of the working classes to a state of the greatest misery.

In September and October the fever increased to an alarming degree, and a meeting of the most respectable inhabitants of Carrickfergus was held, who entered into a subscription for the relief of the poor, and to establish a Fever hospital. It was opened on the 4th November 1817 and closed on the 3rd June 1818. The hospital was about a mile from the town in the

¹ [Part of an Address to the Belfast Division of the British Medical Association, 1988.]

² [Rudyard Kipling in: The Masque of Plenty, Departmental Ditties and Other Verses.]

Middle Division. The total number admitted was 114, 103 were dismissed cured. Six died. The greatest number of patients at any time was 26. £815.7.5½ had been expended on the hospital and relief of the poor.”

The mortality of 6% is not the mortality usual in untreated typhus or relapsing fever and would be consistent with that of trench fever.

Belfast has had three fever hospitals. The first one had 3 sites—the first site in Berry Street, 1797. The second on the corner of Smithfield and West Street and the third—purpose built—in Frederick Street. Next came the Union Infirmary Fever Hospital, “plain but not inelegant,” and 70 years later Purdysburn Fever Hospital. Belfast’s was the second fever hospital in Ireland. Limerick was first but it began in a shed. Berry Street was a house. In Frederick Street the new hospital was hurriedly completed, opened with the plaster still wet on the 1st August 1817, and was filled immediately. There were sometimes 200 patients and more in the 100 beds. There was no room for ordinary medical and surgical patients at that time, and little for years to come. In the three years 1817, 1818, 1819 it admitted 3527 patients. (Malcolm). How did they manage? There was the nursing staff, and there were three attending physicians, in some years only two; and no one else. No resident staff. No junior staff. There was an apothecary who dispensed 10,000 prescriptions a year and later was supposed to act as clinical clerk to the physicians and to assist at operations. One might wonder how it was done. The truth is I think that it was a nursing hospital. Physical examination was minimal. There were no special examinations. The physicians were really directors of nursing, and drug treatment in the best hands was very restrained, indeed minimal.

We should recall what they meant by fever. The clinical thermometer for practical use had not been invented. There were no temperature charts. The physicians of the time defined Fever much like this. The patient is affected by rigors, by languor, stupor, headache, giddiness, pains in the back and loins, anorexia, thirst, burning heat over the body, a quick pulse, and incapacity for exertion; and all this is not due to any local disease. It was agreed that the fever could not be arrested, it had to run its course. But the mortality could be diminished by nursing. And the risk to others could be lessened by isolation and destroying the contagion in the clothes. Measles, smallpox, scarlatina, tuberculosis or the fever of an abscess are not fever within their definition.

Clinical examination indeed must have been mostly confined to inspection. Percussion was not much practised till the 1820ies. Use of the stethoscope reached the hospital in 1828 (the year James McDonnell retired). One country doctor, when asked about splenic enlargement, said he could not tell, because he had no facilities

for post-mortems. He can never have palpated the abdomen. But they took the sick in, bathed them, gave them clean clothes, put them to bed, and boiled or hot ovened their own clothes “to destroy the contagion”. They seem to have known that that would kill lice but it never occurred to them that the fever, or fevers, were louse borne, though it had been suggested long before. And they observed the course, or courses, of the fever. That will be important later. In those first eleven years in Frederick Street, James McDonnell appears to have ruled the hospital and to have written the annual medical reports. I judge that from his position, from the style, and because when the committee directed that the medical report be signed in future, it was signed by McDonnell. He prided himself in the simplicity of treatment in the hospital. They did not use bleeding (that was contrary to the practice elsewhere) and they did not give mercury. Since 1797 he said, except two or three, no patient in typhus had been bled. Simple laxatives, acidulated drinks, occasional wine, ventilation and cleanliness. A reliance on the effects of nature. Of 370 male fever patients who recovered not one was bled, blistered or mercurialised after admission, and no emetics. Small doses of supertartrate of potash, infusion of roses, infusion of gentian, and wine were used.

McDonnell resisted to the end any attempt to distinguish different kinds of fever. Cases of fever, he said, differ only in degrees of violence, not in kind. Fever he maintained is synonymous with typhus, continued fever, low nervous fever or putrid fever. There was no new fever. Of course he was wrong. The mortality was not that of pure typhus. Moreover elsewhere, and even in Belfast, physicians were observing cases of fever which remitted and relapsed. Such early remissions and relapses could not be typhus. It has long been clear that McDonnell’s fever included not only typhus but relapsing fever. Now louse-borne relapsing fever due to infection with the spirochæte *Borrelia recurrentis* is a serious illness, often with hepatitis and jaundice, with a considerable mortality of its own. Too many patients recovered for all the fever to be louse-borne typhus or louse-borne *Borreliosis*. There is a third louse-borne fever (which also relapses) and it is my contention that many of the fever cases were really louse-borne trench fever due to infection with *Rochalimæa quintana*. Trench fever had been described for a century or more in eastern Europe under various names, but it came to the general knowledge of the profession in the Great War (1914–18). At that time huge epidemics swept both the British and German armies, louse infested as they both were. The disease was epidemic in the trenches of the Western Front, as well as being epidemic in the east on the Russian front. But by that time the louse-borne fevers had so much diminished in the U.K., that memories of what they had been, had faded. Arthur Hurst in 1942 asserted, quite unjustifiably, that trench fever had never occurred in England. He could not possibly know.

He might properly have said never identified, or, if identified, forgotten.

We may presume that among the fevers of those days brucellosis and Q fever were present but not distinguishable, and certainly numerically less important.

Light began to dawn in Belfast when McDonnell retired to the consulting staff in 1828. In the next annual report S. S. Thomson and W. M. Wilson describe relapsing fever. In 1835 Robert Little (recently Sir Peter Froggatt revived his memory) was writing with insight. He could not think that local inflammation was necessary to the existence of contagious fever. He had done 60 post mortems in Frederick Street and found no local focus. He thought that one third of his cases were typhus gravis (probably true typhus), one third synochus (probably Borrelian relapsing fever) and one third typhus mitior (perhaps trench fever). Some, he said, had a typhoid character. This is an early tentative acknowledgement of the work of P. C. A. Louis in Paris, (1829) who distinguished typhoid fever from typhus. Little treated his fevers with tepid sponging, adequate fluids—including 3 to 4 pints a day of infusion of roses—with diaphoretics, “cooling” laxatives, and wine for debility and delirium. He fed them with gruel, panada, and arrowroot with sugar. His mortality was one in 15. Less rationally he used blisters to the neck and turpentine rubs to the chest. Sulphate of quina and aromatic sulphuric acid to hasten convalescence.

Now we come to the best fever physician, J. Seaton Reid. Early in his career he began to distinguish one fever from another. The Union Fever Report 1848 and 49 shows his attempts at classification, and the mortalities. In 1844 he knew, and gave reasons for knowing, that typhus and relapsing fever were different. He observed that an attack of the one did not protect against the other. He observed that the mortality in relapsing fever was less than in typhus, 7% in relapsing fever and 19% in typhus; and relapsing fever he said was more contagious. Many of the hospital staff took it. In 1849 Reid said that there were several separate and distinct species of fever, not counting of course dysentery, small pox, measles and scarlatina. He recognised that the American physicians were ahead of us. They already accepted typhoid as an entity, notably Gerhard in Philadelphia, who had been a pupil of Louis in Paris.

Reid classified fevers so:

Reid 1849.	1987 interpretation.
1. Maculated typhus.	True typhus. Rickettsia prowazekii.
2. The relapsing synocha. A short intense course. Jaundice a fatal complication.	Relapsing fever. Borrelia recurrentis. The yellow fever of Ireland.
3. Synocha or Febricula. The shortest course. Very little risk to life. Begins with a rigor and febrile symptoms. Remits and relapses.	Trench fever. Rochalimæa quintana.
4. Synochus. Often complicated by diarrhœa.	Typhoid fever. Salmonella typhi

Reid's description of synocha or febricula, which I suggest was trench fever, is of the mildest pattern of that infection. But trench fever can run other courses, including a continued fever and a very prolonged relapsing course. Byam, who investigated trench fever in the Great War (1914–1948), thought it possible that “disorderly action of the heart”, an important course of invaliding from the army, might be a sequel of trench fever. The war ended and the question was not settled.

In 1860 Reid said that for the last 9 years he was satisfied that the typhoid fever existed in Belfast. He was certain that he had previously classified many cases of it as synochus. In that year 1860 he said typhoid in Belfast was now more common than typhus. What a revolution in the incidence of disease.

APPENDIX TO MEETING ON 5TH JANUARY, 1867¹

CASE OF OLD STANDING DISLOCATION OF THE HUMERUS.

REDUCTION ELEVEN WEEKS AFTER THE OCCURRENCE OF THE ACCIDENT.

(Read before the Ulster Medical Society.)

By W. MAC CORMAC, M.A., M.D., F.R.C.S.I.;
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The following cases are, I conceive, of sufficient moment to interest the members of the society. I do not, therefore, consider any apology needful in respect of bringing them forward.

The particulars of the first case I have abridged from notes most carefully taken at the time by one of my clinical clerks, Mr. Joseph Smyth, and are as follows:—

George Johnston, 34 years of age, a bricklayer's labourer, was admitted under my care into the General Hospital, Belfast, November 22, 1866.

He gave the following account of how he had met with the accident. Nine weeks since, while "drunk and disorderly," he had fallen into the hands of the police. Considerable violence was required in order to effect his arrest. During the struggle he either fell or was thrown down, and it was then, he believes, that he sustained the injury. His hands were subsequently manacled behind his back, but the pain which this occasioned became so excessive as to necessitate their release.

On the following day, Sunday, as he was suffering very much, his friends thought it expedient to procure medical advice. He was, however, directed merely to stupe the parts with warm water, the nature of the injury, apparently, not having been recognised. Next day the magistrate sentenced him to sixty days' imprisonment. Whilst in gaol, the attention of the surgeon, it appears, was not drawn to the condition of the shoulder. A few days after his time had expired, the man finding himself unable to work, applied to me, and I advised him to go into hospital, which he gladly consented to do.

On examination, the patient was found to be labouring under dislocation of the right humerus, beneath the coracoid process of the scapula, the "infra-coracoid" dislocation of Malgaigne. The acromion process was very prominent, whilst the shoulder had become much flattened, not only from displacement of the head of the bone, but from the atrophy of the deltoid muscles which had ensued. On careful admeasurement, the affected limb was found shortened only one eighth of an inch, while the vertical circumference of the axilla and acromion was increased two inches, a sign first pointed out, and looked upon as a

pathognomonic by Mr. Callender. The fore-arm was in a state of semi-pronation, the arm being directed somewhat backwards, and also slightly abducted. The head of the bone could be felt in the axilla when the arm was raised, but not otherwise. Obscure crepitus, pointed out by Sir Astley Cooper as simulating fracture, could readily be detected by rotating the head of the humerus in its new position.

Although considerable power of motion had been acquired, so much so that the man, whilst in gaol, could pick oakum, and even rake the walks, he could not elevate his injured arm without the assistance of the other arm while the effort occasioned much suffering. He could touch his lips with his fingers, but he could not convey food to his mouth. He had, indeed, to feed himself with the left hand. In short, the limb had become useless to him for the purposes of earning his bread.

On Saturday, the 24th November, precisely ten weeks since the accident had occurred, the man was placed fully under the influence of chloroform, and forcible reduction attempted by means of the pulleys. Extension and counter extension were gradually made, and kept up for a considerable time, with no other effect than breaking down, more or less completely, the new adhesions formed by the head of the bone. The direction of the traction was obliquely downwards and outwards. While the patient was still in an unresisting condition, and the muscles were quite flaccid, before the effects of the chloroform had passed off, White, or La Mothe's plan was tried—the arm being pulled almost directly upwards, the shoulder being depressed by the foot planted firmly against it. The heel was also tried in the axilla. On the 27th, no inflammation or evil effects having followed the previous trial, another effort was made, lasting about half-an-hour, and also under chloroform. Extension was tried in a downward direction, and afterwards manipulation was had recourse to, one hand grasping the head of the bone, whilst the other rotated the arm inwards. The most patient efforts, in this and other ways, obtained no better results than on the previous occasion, and the attempt had, perforce, to be abandoned.

I now almost decided, seeing the risk apt to be incurred from applying so much force, to make no further trial. But an examination of the man's arm, with its almost useless condition, the great and continuous pain which he suffered, especially on trying to raise it, induced me again to make a trial.

Knowing the difficulty of these cases to reside mainly in not employing adequate counter-extension, and sufficiently fixing the scapula, I adopted a suggestion which I owe to Professor Tanner of Cork. It consists in moulding accurately a gutta-percha shield, with a hole in the centre for the arm to protrude, over the back, front, and side of the chest, and round the

¹ [Page 1068. Source: *Medical Press & Circular*, 1867, July 24, p73.]

root of the neck. By this means, the scapula and clavicle were very firmly fixed, and a large surface was available over which to distribute the power employed. The shield was now carefully padded with cotton wool, and re-applied, a sheet passed round it, the arm attached to pulleys above the elbow, and traction so managed as to draw the arm at right angles to the trunk. The fore-arm itself was flexed at a right angle, as well as carefully bandaged. Chloroform having been administered, the pulleys were gradually brought into action for some ten minutes, the humerus at the same time being alternately rotated inwards and outwards. It was then found that the head of the bone had shifted its position externally for fully half-an-inch, and was disengaged from beneath the coracoid, while the adhesions were felt to give way. I now executed the following manœuvre, by means of which I fortunately succeeded in replacing the bone in the glenoid cavity. Firmly depressing the shoulder with my hand, I pulled the neck of the humerus in the opposite direction, by a strap passing round it and over my neck. I requested my colleague, Dr. Murney, who kindly and ably assisted me, to rotate the limb inwards, forcibly, at a given moment. All these preparations having been completed, word was given to let go the pulleys. These were slackened in an instant, when it was found that the head of the bone was in its place. Thus, by means of this combined movement, an old standing dislocation, which had resisted our utmost efforts on two previous occasions, was reduced exactly seventy-seven days after its occurrence.

The shield of gutta-percha was now cut off, while the elbow was kept fixed to the side, and retained there by bandages subsequently sewed together. The skin, which had previously been much abraded by the sheet, was this time unruffled, having been thoroughly protected by the gutta-percha, and that too, notwithstanding the much greater additional force employed. Although the bone was in its place, the prominence of the head, anteriorly, was so marked, as almost to make one fear it could not be so. The muscles around the joint were quite atrophied, causing undue projection of the acromion and spine of the scapula. Nine days after, the bandages were removed, and the patient was allowed to move his arm in a forward direction, as well as to rotate it inwards, but he was enjoined not to exercise it by the reverse movements.

On the 13th I made measurements of the shoulder, and found that the difference of the vertical circumference of the joints had become reduced from two inches to three-quarters of an inch. The transverse diameter of the injured side, taken with calipers, was still one-eighth of an inch greater than the other.

Ten days after, though the man was enjoined to

use his arm, though passive motion was employed daily by myself, I found, on examination, that there was little movement of the arm independent of the scapula, to which it seemed ankylosed. Any attempt forcibly to break down the adhesions, except under chloroform, would have occasioned great pain. The patient, therefore, was put under the influence of the anæsthetic, and having caused my assistants to fix the scapula with their hands, I steadied the head of the bone with my left hand, while I raised the humerus to rather more than a right angle with the other. It was easy both to hear and feel the adhesions giving way, which they did with a peculiar tearing, crackling sound. No inconvenience followed, some temporary soreness excepted, while the additional freedom of action acquired was very considerable.

Before the man had left the Hospital, Jan. 25, 1867, he could readily swing the heavy poker of the ward round his head, stretch both hands equally high against the wall, and perform a number of other feats, which showed that he was rapidly regaining the full power of the extremity. Some months after his discharge, I saw him returning from work carrying a bucket in one hand, and a shovel in the other. He stated that he was always getting more and more command over his arm, and that it was now nearly as useful to him as ever.

Such cases are, in many respects, of great practical importance, and I purposely detained Johnston somewhat longer in hospital than was absolutely necessary, in order that the students might thereby benefit accordingly. In the first place, when the man came under my notice he was quite unaware of the nature of the injury which he had sustained, and his principle complaint was of pain in the neighbourhood of the elbow and fore-arm. He complained of no pain whatever in the shoulder, but only that it was stiff. A short time since, indeed, a carpenter was admitted to hospital with a dislocation of the humerus, which he had believed was a strain, and had treated with liniment conformably; and it was not until nearly a fortnight had elapsed that, finding himself getting no better, he consulted a medical man. Such instances should ensure the exercise of caution in similar circumstances. Great swelling of the soft parts may, and sometimes does, render the symptoms in the event of such injuries obscure; and Hamilton, of New York, mentions two cases in which New York Hospital Surgeons, only a few hours after the receipt of the accident, had failed, from this cause, to ascertain the nature of the injury. In one of these cases reduction was effected by Dr. Hamilton on the seventh, and in the other on the tenth day.

Although, in Johnston's instance, the dislocation was reduced only a week short of the time fixed by Sir Astley Cooper, as the limit beyond which no attempts should be made, many cases are on record where

reduction has been accomplished after much longer periods. It should, however, be remembered that such trials are attended with great risk. Rupture of the axillary artery has but too frequently taken place, and in one instance the nerves of the brachial plexus were actually tom out by the roots. At the same time injurious or fatal results are by no means customarily or uniformly made known.

The force employed on the third trial was simply enormous, and it was all required to pull the bone from beneath the coracoid, and tear up the abnormal adhesions. Its application proved as safe as it was effectual, owing to the equable manner in which the pressure was distributed, and the complete way in which the scapula was fixed by the gutta-percha shield. The principle is the same as that of Sir Astley Cooper's split sheet, but it is vastly more efficient to its employment, indeed, I feel, to a large extent, indebted for the satisfactory issue of the case.

The after progress of the patient was all that could be desired, and the rapid way in which he regained power of motion in the extremity, after such long disuse, was much facilitated by breaking down forcibly the spurious ankylosis between the scapula and humerus, and by the persistent daily employment of passive motion.

In conclusion, I would observe that the forward projection of the head of the bone gradually but not altogether subsided. It is, indeed, important to be aware of this not uncommon occurrence, after reduction of old standing luxations, a circumstance which Hamilton states, has frequently led to charges of malpraxis sometimes successfully, though most unjustly, sustained.

PYÆMIA, WITH EXTENSIVE LESIONS SUPERVENING UPON INJURY OF THE HEAD—DEATH.

The following history serves to show that the body will sometimes be invaded by disease of a most extensive character, and yet the signs of its presence prove very obscure. It presents, as well, some features of medico-legal interest:—

Thomas Gamble, 14 years old, a mill-worker, came under my care in hospital on December 17th. Four days previously, while leaving his work, he was struck on the forehead by another boy with a heavy iron bar some two feet long, inflicting a wound on the forehead, and at the same time knocking him down. The house surgeon dressed the wound, and recommended the lad to remain in hospital, as the pericranium had been stripped off and the bone was laid bare. This, however, the boy at the time refused to do.

When he did seek admission, a vertical wound was found almost in the centre of the forehead, unhealthy looking, and secreting a considerable quantity of pus.

The boy complained of headache, but there was no urgent symptom whatever about the case otherwise.

On the 19th his condition seemed much improved. The wound looked more healthy, and the headache was less.

On the 21st he first complained of his chest. He was annoyed by a short tickling cough, and the sputa were rusty coloured. A stethoscopic examination revealed marked dulness posteriorly over the lower part of the left lung. On the same side in front and above there were great resonance on percussion, and puerile respiration. In the upper part of the right lung well-marked bronchitic râles were heard. He was ordered suitable medicine, and a nourishing diet. Two days after, the 23rd, the chest symptoms became very urgent. The boy's condition was that of a person prostrated with typhoid pneumonia. He was so weak, with a pulse at 125, and hurried, laboured respiration, that it was impossible to make a satisfactory examination. My colleague, Dr. Smith, saw the patient with me on the 25th, and we came to the conclusion that there was evidence of general bronchitis and pneumonia of the lower lobe of the left lung. I need not detail the progress downwards of Gamble's case. He became daily worse and weaker in spite of the most stimulant treatment. He was perfectly sensible and conscious up to his decease. There was no evidence of grave mischief, or any mischief at all, going on within the head, save the headache, which was persistent. He did not even wander in his sleep until the last few nights, and, though very weak, answered any questions put to him in a perfectly collected manner, even when I last saw him alive, on New Year's Eve. He died on the morning of the 1st January, 1867. A post-mortem examination was made fifty-two hours afterwards. The wound was quite unhealed, and its edges blackened from decomposition. On removing the scalp, a groove about an inch and a half in length, involving only the external table, was seen in the frontal bone. It appeared as if made by some blunt instrument. To the right of this groove was a yellow stripe, as if of matter contained in the bone. No fracture or fissure was observed at this time. The calvarium was now removed, whereupon thick yellow pus exuded, through the dura mater, from the anterior part of the right hemisphere, and also lay in contact with the skull. When the membrane was taken off it was found that the entire surface of the right hemisphere was covered with thick greenish-yellow pus, about from two to three ounces in quantity. The anterior convolutions were depressed by it to the extent of quarter of an inch, so as to convey the appearance of loss of substance until the matter had been carefully pressed off with the handle of a scalpel, when they resumed their normal level. There was great congestion of the base of the brain and of the membranes. On section, nothing abnormal was discovered in the interior.

In the left pleural cavity there were found some forty ounces of straw coloured serum. An immense quantity of recent lymph had been poured out. The lower lobe of the lung was solidified, and the upper much congested. On section, a large number of small abscesses were found, perfectly circumscribed, and containing a thick greenish-yellow pus.

In the right lung a similar condition of affairs presented itself. There was not so much serum or lymph, but the abscesses were numerous, and two of them very large.

In the abdomen nothing abnormal could be discovered. On subsequently examining the calvarium, when cleaned, I discovered a minute fissure in the yellow part of the bone, which proved, on section, to contain pus in its diploë. In this way a chain of communication seemed to have been established between the suppurating wound on the head and the other lesions that were found. Purulent absorption had taken place, inducing pyæmia, with purulent depôts or secondary abscesses in the lungs. It is a curious feature in the case, that so little that was indicative of brain disease had attracted attention during the life of the patient. It was remarkable that the brain should submit to so much pressure, that its convolutions should be largely depressed, and that no other symptom should result save headache.

At the trial of the boy who inflicted the injury, the counsel for the defence attempted to prove that the intimate connection between the disorder found in the chest and the injury of the head, as asserted in the medical evidence, was a groundless hypothesis—that the boy had enough of disease in his chest to kill him, independent of the head affection altogether, and that, consequently, no intelligent jury could possibly convict the prisoner of killing my patient. This plea, even had it been sustained, would, however, have been of no legal importance, as, whether the victim of violence be labouring under incurable disease or not, does not affect the legal guilt of the person committing the violence, however it may influence the amount of punishment awarded.

Index

This index concentrates on the presented cases and papers, those presenting, and, if their names were given in full, the patients. Presenters' names sometimes varied from place to place in the text but here they have been standardized.

The aim was to index all cases although it should be noted that some reports are as brief as their index entries. On the other hand, a short entry may sometimes reference a paper several pages long. Generally speaking, no effort has been made to index issues inside papers or arising in the discussions.

Some other activities of the societies have been included but routine day-to-day work has mostly not.

Where possible, indexing in a body system proceeds from proximal to distal, then alphabetically; otherwise alphabetically.

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¹ [Literally 'easy natural death', i.e. not induced.]

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