

TWENTY-FIRST ANNUAL MEETING

— OF THE —

On 3 vol 20 Oregon State Medical Society,

— HELD IN —

PORTLAND, OREGON,

May 31 and June 1-2, 1894.

FIRST DAY.

10.6 IMPERIAL HOTEL, PORTLAND, ORE. }  
May 31, 1894, 10 A. M. }

Dr. H. R. Holmes, President, in the chair. The "Address of Welcome" was first read by Dr. F. B. Eaton.

The applications for membership of Drs. G. W. Cox, Brownsville; W. H. Davis, Albany; L. J. Lemieux and D. B. Channel, of Portland, read and referred to executive committee.

Case of Dr. Stanley referred to committee composed of Drs. Cauthorn, Haines and Eaton.

The privileges of the society were extended to visitors.

Dr. D. H. Rand's paper, "A Brief Report of Treatment, Especially of Syphilis, at the Genito-Urinary Clinic," was then read.

Discussion was entered into by Drs. Fulton, Binswanger and Littlefield; discussion closed by Dr. Rand.

Application of Dr. W. H. Boyd was read and referred to executive committee.

Paper of Dr. Thomas Parker, "Chronic Urethritis," was then read.

Drs. Giesy, Darling and Moore entered into the discussion of it.

#### AFTERNOON SESSION.

Meeting called to order at 2 P. M. by the Secretary.

Both the President and Vice President being absent, Dr. Mackenzie was elected temporary chairman.

Paper by Dr. William Jones, "Thiersch's Skin Grafting," was then read.

Discussed by Drs. Coe, Wilson, Fulton, Mackenzie, Bell, Maston, Fried, Cauthorn, Saylor, and closed by Dr. Jones.

Paper by Dr. George F. Wilson, "The Modern Treatment of Hernia in the Male," was then read, and the discussion was entered into by Drs. A. C. Smith, William Jones, Mackenzie, Cauthorn, and closed by Dr. Wilson.

Dr. G. W. Maston's "Report of Case of Appendicitis," was next read, and discussed by Drs. Cauthorn, Mackenzie, Fulton and Moore.

Applications of Drs. J. L. Shorey, P. H. Fitzgerald, W. F. Amos and W. S. Cattel were read and referred to executive committee.

Adjourned to June 1, at 10:30 A. M.

#### SECOND DAY.—MORNING SESSION.

Meeting was called to order by the President.

Dr. J. P. Tamiesie then read his paper, "What I Do Not Know About the Cervix Uteri."

The paper was discussed by Dr. Strong.

It was then moved by Dr. Coe, that the discussions be limited to ten minutes in opening, and five to general discussions; carried.

Motion made and carried that election of officers take place at 4:30 P. M. to-day.

Dr. J. A. Fulton's paper, "Tubal Pregnancy; Rupture; Operation After Twenty-one Years," was then read.

The report of the special committee appointed to investigate the charges of irregularity against Dr. H. B. Stanley was read and adopted. The report was as follows:

We, your committee, having fully investigated the charges against Dr. H. B. Stanley, and having heard the doctor in person in his own behalf, would recommend that the doctor be allowed to retain his membership in the society. Believing, however, that, notwithstanding the extenuating circumstances, detailed to the committee, the doctor was not quite so careful of his professional relations as he might have been, we would recommend that the doctor be admonished to conform in the future strictly to the Code of Ethics.

F. CAUTHORN,  
F. B. EATON,  
J. W. HAINES, Committee.

Meeting adjourned to 1:30 P. M.

#### SECOND DAY.—AFTERNOON SESSION.

The meeting was called to order at 2 P. M., with Vice President A. C. Smith in the chair.

The Secretary being absent, Dr. C. C. Strong was elected temporary secretary.

Dr. H. C. Wilson then read his paper, "Tubercular Peritonitis," which was discussed by Drs. G. M. Wells and G. F. Wilson.

Dr. M. Fried then read a paper upon "Treatment of Gall-Stones; Harley's Method."

Drs. W. H. Davis, S. J. Lemieux, D. B. Channel, J. L. Shorey, P. H. Fitzgerald, George W. Cox and W. F. Amos were then elected members of the society.

A paper by Dr. L. M. Robinson, "Obstetrics From Standpoint of Gynecologist," was then read and discussed by Drs. Strong, Fulton, Kelly, Wells and Linklater.

Paper by Dr. R. Nunn, "Ophthalmia Neonatorum," was then read. The paper was discussed by Dr. Eaton.



Dr. Eaton introduced the following preamble and resolution:

Whereas, Statistics compiled in this country and in Europe demonstrate that fully 25 per cent. of our blind owe their affliction to an inflammation of the eyes appearing a few days after birth; and

Whereas, Experience has proved that the inflammation can be cured and the eyesight saved in the majority of cases if treatment is instituted at an early stage of the disease; and

Whereas, The destruction of the eye and blindness are usually the result of delay, in treatment; be it

Resolved, That we heartily recommend that the people of the State of Oregon, represented in senate and house of representatives, do enact as follows:

Section 1. Should one or both eyes of an infant become reddened or inflamed at any time after birth, it shall be the duty of the midwife, nurse or person having charge of said infant, to report the condition of the eyes at once to some legally authorized practitioner of medicine of the city, town or district in which the parents of the infant reside.

Sec. 2. Any failure to comply with the provisions of this act shall be punishable by a fine not to exceed \$200 or imprisonment not to exceed six months.

Sec. 3. This act shall take effect on the first day of June, 1895.

Referred to a committee composed of Drs. Eaton, Wood and Bird.

Dr. Coe addressed the convention upon the subject of better medical laws for Oregon, asking for a discussion by the society of the subject, which was accordingly done.

Dr. Coe offered a resolution, which was adopted, authorizing the chair to appoint a committee of three upon medical legislation, which committee should counsel with the executive committee of the society and formulate and present a medical act to the coming session of the Oregon legislature.

The President appointed on such committee Drs. Coe, Mackenzie and Saylor.

The time having arrived for the election of officers, Dr. J. A. Fulton was placed in nomination for President by Dr. Eaton, seconded by Drs. Mackenzie and Strong.

Dr. Wheeler placed in nomination Dr. A. C. Smith, seconded by Drs. Saylor and Amos.

Moved that a committee be appointed to draft suitable resolutions relative to deceased members; carried.

Drs. Cauthorn, Robinson and Linklater were appointed as such committee.

Ballot being spread, Dr. Fulton was declared elected—28 to 19.

Dr. William Jones was elected Vice President by ballot cast by the Secretary.

Dr. Cauthorn was elected Secretary by ballot cast by the President.

Dr. Mae H. Whitney was elected Treasurer by ballot cast by the Secretary.

Dr. G. M. Wells was elected member of the executive committee.

Portland was selected as the next place of meeting.

Upon motion, Dr. Smith was requested to perform his operation at the Oregon State Medical College Building.

Meeting adjourned to said place.

#### SECOND DAY.—EVENING SESSION.

Meeting called to order in the Hall of Oregon State Medical College at 8 P. M.

Dr. Smith demonstrated the use of the Murphy button on a dog very admirably, and read his paper on "Intestinal Anastomosis."

Discussed by Drs. Cauthorn, Jones and Fulton.

Drs. W. H. Boyd, Joseph E. Hall and N. Molliter were elected members.

The following were elected delegates to the American Medical Association: Drs. J. S. Stott, Gervais; A. W. Moore, J. M. Quigley, Henry W. Coe, H. R. Holmes, Mae H. Whitney, D. H. Rand, Andrew C. Smith, J. D. Gaff, Portland; S. T. Linklater, J. P. Tamiesie, Hillsboro.

Dr. Coe's paper "Gastric Neurasthenia," was read by title and referred to the executive committee.



Paper by Dr. C. H. Hall, "Heredity," read by title and referred to executive committee.

Paper by Dr. Linklater, "A Bicephalous Monstrosity," was then read.

Paper by Dr. Cliff, "Puerperal Eclampsia," read by title and referred.

Paper by Dr. Humphrey, on "Diphtheria," referred.

Dr. Koehler's paper, "The Antiseptic Treatment of Disease and Antiseptic Surgery," was referred.

Dr. Stanley's paper on "Club-Foot" was referred.

The following resolution, by Dr. Wells was adopted:

Resolved, That we condemn the action of all medical journals whose columns are devoted to the discussion of political subjects or who recommend candidates of any political party for election.

Resolved further, That as long as the MEDICAL SENTINEL is the official organ of this society that the editor of the same be hereby requested to refrain from publishing in its columns anything of a political character, and also refrain from putting forward any candidates, recommending them as his choice.

The following resolution, proposed by Dr. Cauthorn and seconded by Dr. Strong, was unanimously adopted:

Resolved, That the Oregon State Medical Society believe that the recognition of irregular practitioners of medicine, of whatever school, by consultation with them, is derogatory to the best interests of scientific medicine and that we heartily oppose any change in the Code of Ethics whereby such recognition may be sanctioned; further, be it

Resolved. That the delegates from this society to the American Medical Association be instructed to use their best efforts to prevent any change in the Code of Ethics as now adopted by that association.

A vote of thanks was extended to Mr. Guinean, of the Imperial Hotel.

A vote of thanks was extended to Dr. Smith and the retiring officers.

## ORIGINAL PAPERS.

### ADDRESS OF WELCOME.

F. B. EATON, M. D., PORTLAND, ORE.

The pleasant duty has been allotted to me, on behalf of my colleagues, of welcoming to our city and to the twenty-first annual meeting of the Oregon State Medical Society, our non-resident members.

Upon you, gentlemen, who come from every part of the State of Oregon, the success of the present meeting will largely depend.

It is not only a pleasure to see you among us, but we anticipate the profit to ourselves of hearing your experiences and heeding your opinions. Many of you are so situated that of necessity you must often, in most desperate and critical cases, rely solely upon yourselves, with no fellow practitioner with whom to counsel, or to share with you your responsibilities. The experiences so gained are often of the greatest value. Let us hear them.

In attendance upon the meetings of this Society, and in active participation in every measure toward the advancement of professional standing in this state, lies the strength of this organization and its standing in our national organization, the American Medical Association which meets next week in San Francisco. Never before, it is said, has medical organization advanced as it is doing at this time; but never has it needed more wisdom and professional honor to retain among medical men a high standard of professional conduct, individually and collectively. I trust, therefore, that not one of



you, our visiting colleagues, will hesitate to express boldly your views on the important questions which will come before us at this meeting, the decision of which, will notably effect our powers of usefulness to the community and our personal welfare. Unlike political organizations, we are working for one common end, and in the accomplishment of that end, gentlemen, the physicians of Portland in welcoming you, ask your hearty co-operation.

BRIEF REPORT OF TREATMENT, ESPECIALLY OF SYPHILIS,  
AT THE GENITO-URINARY CLINIC.

By DAVID H. RAND, M. D. Portland, Ore.

Professor of Genito-Urinary Diseases and Clinical Surgery, Willamette Medical College; Surgeon in Charge, Genito-Urinary Department of Portland Free Dispensary; Surgeon Portland Hospital; Surgeon Hospital Aid Association, St. Vincent's Hospital; Secretary of Section on Dermatology and Syphilography, American Medical Association, Etc.

In my report of 155 cases treated at the dispensary this last year, 25 of them were syphilis, 17 were gonorrhœa acute, 20 were latent gonorrhœa or gleet, 8 were chancroidal ulcers and 27 cases were treated for strictures.

You will see that a large majority of the cases which presented at this clinic were from the three venereal diseases, gonorrhœa, chancroid and syphilis, and stricture.

Our treatment for gonorrhœa is chiefly local injections, in the form of mild astringents and antiseptic continuous irrigation in connection with alkaline diuretics, and strict attention to hygiene and diet. Latent gonorrhœa and gleet are treated with the steel sound and by thorough and continuous irrigation of the urethra with sol. potas. permang. gr. i. to ij. in water ℥ vi. to ℥ viii., and by the application, at first, of sol. argent. nit. gr. i. to water ℥ i.; then, in two days, grs. ij. to the ℥i., with an increasing strength of one grain every other day up to 5 to 10 grs. to the ℥ i., this injected into the deep urethra, or upon any granulated spot. Good results are obtained by this method.

Quite recently I have been using a solution of sennine, a few grains to the ounce, for irrigation in acute as well as gleet urethral disease, and must say that the results have



been remarkably fine. The solution should be of just sufficient strength to be noticeable to the patient.

Chancroid or chancroidal ulcer, being a strictly acute, contagious and local disease is treated by local means only, except in some cases where the patient's constitution is depleted, when restorative tonics are given to build up the system, but in most cases such supplementary care is not necessary and the treatment is strictly and wholly local. We endeavor, first, to destroy the specific character of the ulcer; secondly to keep the parts free from the secretions, and thirdly, to protect such parts from irritation. To destroy the specific character of the ulcer, caustic applications should be made. Not with fused nitrate of silver, as that makes a cover under which the ulcer continues its ravages, but with a solution of bromine, 5 per cent, in alcohol, or acid nitrate of mercury, or the old reliable fuming nitric acid. Another application for "phagedena" is the solution ferri et pot. tart., grs. xv. to water  $\bar{3}$  i.

The first burning must be thorough, deep into the tissues, with a pin pencil point, destroying every portion of the poison. After the caustic applications we keep the parts free from the secretions, and protected from irritation by dry dressings, using surgeons' absorbent cotton or lint, changed often, with any one of the following powders: aristol, sennine, iodol, bismuth subnit., euophen, iodoform and acetanilid. Acetanilid has been used by me with marked success this last winter.

Peroxide of hydrogen (Marchand), as an application, has also been used many times by me, the best results being when it was used under atmospherical pressure.

Syphilis is classified into four periods. (a) Incubation; (b) primary lesion or chancre; (c) secondary eruptions, (d) and, finally, the tertiary form of syphilis.

The primary lesion is the presence of a simple, unique modification of the tissues at the point of deposition of the contagious matter, and presents itself in three distinct ways.

First, a dry papule, which is probably the rarest seen.

Second, an eroded coppery-red spot, scarcely raised above the surface, which is more or less papular and quite dry, covered with a crust of thin scales, which exfoliates and leaves the spot raw, with a shiny surface; this is probably the most frequent form found.

Third, the hard chancre, a cup-shaped, scooped out, indolent ulcer, with raised, rounded, glossy edges, and grayish base, containing a watery, serous-like fluid, which is not auto-inoculable, usually healing after about six weeks. This form is the most readily recognized.

Knowing that a hard chancre is only a local manifestation, of an already existing constitutional disease, by getting a complete history of the case, as to period of incubation, etc., and watching the primary sore "for a few days only," we are able to predict, with almost absolute certainty, at an early period of its development, whether the patient will or will not be subject to secondary symptoms. Therefore, the early employment of constitutional treatment is advised, thereby curing the local manifestations by its influence in fourteen to eighteen days, and saving the patient the annoyance and humiliation of the appearance of the secondary eruption.

The tendency of syphilis, in its early, if not in its advanced stages, is toward the production of a plastic albuminoid material in the tissues, and we have in mercury an agent, the action of which is to retard such deposition, and to promote its absorption. Hence, the earlier this agent is administered the better, but in no case should mercury be given until a thorough and well established diagnosis has been made of true syphilis.

It not infrequently happens that a soft chancre is followed by constitutional disease, but this is an accidental complication, for here we have two diseases, two poisons, syphilitic and chancroidal, mixed, just as we could have gonorrhœa and syphilis in the same person, but each disease running its own course. The chancroidal ulcer may be on the decline, it be-



ing shorter lived, or the two sores may progress together, having more or less of the distinctive characteristics of each, induration and stony hardness of one, with the sharp cut, ragged edges, worm-eaten base and auto-inoculability of the other. The occurrence of the eruption and character of the swelling of the nearest lymphatics should, of course, establish the diagnosis with certainty.

If the diagnosis is thoroughly established, then the early employment of mercury should be persistently continued, for years, if necessary, until all tendency toward plastic formations shall cease. The plan of giving mercury irregularly, I believe to be worse than useless, for during the interval the disease gains renewed strength, and so-called relapses occur again and again. In fact, there is no relapse. The disease is merely following its natural, but temporarily interrupted, course. Mercury should be given continuously, and persistently, while the disease is sleeping, as well as when it is clearly manifested.

Not until we realize that syphilis is a chronic constitutional disease, and treat it accordingly, can we hope to obtain satisfactory results in its management. A disappearance of the local lesion, or, perchance, of the eruption, is frequently followed by the discharge of the patient, when, in truth, his organism is still charged with the virus of syphilis, which, multiplying itself during its forced latency, only awaits a favorable opportunity to renew its manifestations.

The discharge of fluids from so-called secondary lesions, such as from mucous patches, or any mucous surface yielding a discharge, and from condylomata, as well as the blood of a syphilitic person, will produce a specific chancre upon the denuded surface of a previously non-specific person, followed in due course of time by general syphilis; hence, care should be exercised to prevent contagion by the use, in common, of towels, linen, glasses, etc., and from the surgeon's promiscuous use of instruments.

Dr. L. Duncan Buckley, of the New York Post-Graduate

School, has written a very interesting article on "Chancre of the Tonsil," wherein he shows many cases where the patients have contracted syphilis innocently from extra-genital sources.

I have seen and treated in my experience here in Portland but three cases of chancre of the lip. Of these a woman aged 32, called me to see a sore on her lip, which I treated locally for a short time, suspecting it to be a hard chancre, and so stated to the patient. She left shortly afterward for the springs in California, but I heard from the case a few months later, at which time she was suffering from secondary symptoms. The other two cases were under my care for a long time, presenting the usual symptoms of constitutional syphilis.

I advocate the use of mercury in the primary and early secondary stages of syphilis. The forms of mercury used are the tannate, gr. ss. to gr. i. at a dose, three times a day; or the protiodide, gr.  $\frac{1}{4}$  to  $\frac{1}{2}$ , three times daily, or the bichloride, gr.  $\frac{1}{8}$  to  $\frac{1}{2}$ , three times daily. Mercury with chalk also, may be used if the stomach is irritable. Blue mass is also well borne by the stomach.

The early and intelligent administration of small doses of mercury, together with hygienic measures, and, as the disease progresses, tonics and generous diet, will be rewarded by the disappearance of the disease. Mercury should never be pushed to salivation, nor is it necessary to "touch the gums;" in fact, better results are obtained when only a gentle influence of the drug is manifested.

When ulcerative degeneration of tissues exist, or cachexia is established, mercury is believed to be contra-indicated. The mixed treatment of hydrarg, bichlor. and pot. iod. is recommended where mercury is not well borne, and in the later secondary periods, and, finally, large doses of pot. iod., gradually increased, in the tertiary stage.

The local treatment should invariably consist only in the application of cleansing, soothing, healing preparations, and not caustic. Nothing is gained by burning such a sore.



Sennine in my hands has produced many favorable results. It may be dusted on the sore as a powder.

Strictures are treated by me on the following plan: The size and location of each stricture is determined by the bulbous sound and Otis' urethrometer, and I cut strictures of small caliber, when in the pendulous portion of the urethra, with Otis' urethrotome, and deep strictures in the membranous and prostatic regions with Arthurs' urethrotome.

The steel sound is introduced every day for the first five or six days, then every two or three days for eight or ten weeks, generally giving most happy results. Many of the cases of stricture are only stricture of large caliber, and I treat them by the gradual and persistent dilation with the steel sound over a period of three to five months, which, as a rule, gives favorable results.

Many cases we meet with have both gleet and stricture, and we endeavor to cure both by first injecting into the deep urethra, or even into the bladder, a solution of potas. permang., gr. i. to grs. iii. in distilled water ℥ viii., and allow the patient to pass it off by micturition.

This washes out the bladder and also makes the urethra aseptic. We then anæsthetize the urethra with a 2 per cent solution of cocaine, injecting it into the deep urethra with a long nozzled urethral syringe. Waiting about four to six minutes, the Tuttle urethral dilator is introduced, with rubber cap over it to get even pressure, or, in absence of Tuttle's dilator, a piece of rubber tubing is adjusted over the whole length of Otis' urethrotome and inserted up the neck of the bladder, and the constricted portion and the granulating surfaces which may be present, are stretched gradually. The urethra is stretched as much as we think it will stand, and then the bladder and urethra are washed out again with sol. potas. permang. gr. j. to grs. iii. to ℥ viii. Treatment like this is given every three to four days, which will be rewarded by the drying up of the discharge and disappearance of the stricture, so that a moderately good-sized sound can be used

thereafter for a little while, and then this be discontinued altogether, the patient then being cured.

Cases of impotence and allied disorders of the male sexual organs have presented themselves at the clinic from time to time, but we classify them for treatment, so far as possible with some appreciable pathological disorder. We study impotence and classify it upon the same plan as Samuel W. Gross, into four classes, atonic, psychical, symptomatic and organic. In all cases the deep urethra is examined with an exploratory bulbous bougie, and in more than 90 per cent of the cases the cause of the trouble is found to be in the stricture of the urethra, hyperæsthesia or inflammation of the prostatic urethra. Our treatment of impotency being the treatment of the stricture by dilatation or cutting, and the use of measures looking to the relief of the hyperæsthetic prostatic urethra, which generally restores to the patient his normal sexual powers.



THE LOCAL TREATMENT OF CHRONIC URETHRITIS OF THE  
MALE.

BY THOMAS PARKER, A. B., M. D., PORTLAND, ORE.

Strange idiosyncrasies are continuously playing their fantastic tricks in these days as well as of yore. Some are and have always been allowed more license in this respect than others; for instance, our worthy President and Secretary, otherwise men of good judgment, by some unfortunate eccentricity, have me appear before your honorable body with a paper entitled "The Local Treatment of Chronic Urethritis of the Male."

Gentlemen, for some time past, my local plan of treating chronic urethritis has rested upon a very simple induction of the following premises:

That chronic urethritis is amenable to local treatment in proportion as the urethra be made an unfit soil for the various germs which, as a rule, find in that canal a local home and habitation for their existence and the propagation of their species.

The natural induction follows, that, the proper remedies having been selected, their contact with the diseased mucous membrane should be as little subjected to interruption as the case will permit.

This indication is secured, *par excellence* by insufflation of the proper remedies selected in their powdered form by means of a De Villibus powder-blower passed through an Otis urethroscope, which, well oiled, having first, with all gentleness, been passed into the deep urethra, and, while the operator slowly withdraws the urethroscope with the one hand, he, with the other, insufflates the necessary amount of the powder.

Iodoform will answer in most cases, but where objectionable, on account of its odor, aristol, although a feebler remedy, still may be used with confidence and be relied upon to promote a cure. In very obstinate cases, and those of long standing, a first charge of powdered cubebis prepares the way for the iodoform and materially hastens a cure. In a tubercular case, where a peculiar symptom (described by the patient as an irritable sensation), producing uneasiness, which was relieved upon urination but augmented by sexual desire, calomel answered the purpose and promoted a cure in six weeks.

A cure in the average case of chronicity is usually obtained in from one to two weeks, in stubborn cases and in those of long standing as many months may be consumed.

Mr. President and Secretary, my thanks to you for the honor as well as pleasure you have conferred upon me in presenting me before this learned body.

Fellow members, my thanks to you for the patient bearing and attention you have so generously vouchsafed me. For you are not more sensitive than I to the shortcomings of this paper, either respecting its adornments or perspicuity.

These few simple thoughts—stumbled upon in my weary plodding along—overlooked by abler minds in their search for grander things; these few glimmerings, brought before you in every day attire, cannot possibly soothe your fancy or gratify your cravings in bringing to light new springs of action—new ideas, thoughts and generalizations—in your field of labor; and while my discourse, though dry, lacking in the profundities of scientific research, void of elegance and beauty, unadorned by a single flower to smile on your toiling path; still, should any one here feel himself better equipped to battle with disease for the contribution of this mite; nay, should any one feel spurred on with more zeal for further investigation, I shall feel amply repaid and know my endeavors were not entirely in vain.



## THIERSCH'S SKIN GRAFTING.

BY WILLIAM JONES, M. D., PORTLAND, ORE.

*Professor of Clinical Surgery in the Medical Dept. of the State University.*

I have taken this subject for a paper, for the reason that familiarity with this valuable surgical operation is not as general in this section of the country as its importance merits.

There is not, in any surgery that I have seen, a description of it, nor is mention made of it. From this I judge that it has not been crystallized into the general surgical knowledge of this country.

Skin-grafting, like most other important inventions, has been of slow development, and it has taken a long time to bring it to its present state of perfection.

It had its beginning a century ago when John Winter transplanted the spur of a young rooster from its leg to its comb, and from its comb to the comb of another cock, and succeeded in making it grow in both situations.

The next step was not taken till 1869, when Reverdin of Paris succeeded in transplanting small pieces of skin from one part of a man's body to a large granulating sore; under this treatment, healing was accelerated and the resulting cicatrix was superior to that obtained by ordinary healing by granulation. This was a great step in advance; by means of it much time was saved in the healing process and surfaces too large to heal by granulation were quite rapidly got to cicatrize, with only moderate contraction.

A few years after Reverdin published his method, Thiersch brought forward the method that bears his name. The essentials of it are the following:

Given, an aseptic raw surface covered with shavings of healthy aseptic skin, and kept moist with a weak, aseptic salt solution beneath a protective covering. Previous to the operation, the part from which the grafts are to be taken should be shaved, scrubbed with hot water, green soap and a scrubbing brush; the soap rinsed away with clean boiled water; then sponged with ether; then washed with bi-chloride solution 1 to 2000 and finally washed with a sterilized salt solution. This salt solution is six parts of common salt to 1000 parts of water, and sterilized by boiling. The granulating surface to be grafted and its neighborhood should be cleansed in the same way as the surface from which the grafts are to be taken. From this time all antiseptics should disappear from the operation and the salt solution should be the only solution used. No antiseptics should come in contact with the grafts nor with the surface to be grafted, as they lower the vitality of the tissues and cover the surfaces with a thin coating of coagulated albuminoid substances and greatly endanger or entirely prevent the success of the operation.

With a sharp scalpel, the edge of the ulcer is completely cut away so as to remove the dense cicatricial tissue from the whole circumference. Within this area the granulations are shaved off leaving a smooth bleeding surface. This surface is irrigated with the warm salt solution, and aseptic gauze pads wet in the same solution are pressed upon it to stanch the bleeding. The oozing must be completely stopped before the grafts are applied; a thin layer of blood between them and the grafted surface will prevent their taking. The bleeding may be very tedious and take a long time before it can be controlled, so much so as to tax the strength of the patient through the prolonged anesthesia. By means of Esmark's bandage, applied above the field of operation—when it is on an extremity—this bleeding may be almost entirely obviated and much time saved. The bandage can be left on for an hour or two after the operation



is completed. It should be applied just sufficiently tight to control the bleeding and no tighter. If there is a spurting bloodvessel it should be controlled by twisting if possible. If a ligature is applied, it prevents the graft taking at that place and for a little distance around. The surface of the ulcer and the surface from which the grafts are taken should be kept wet with the salt solution during the whole operation.

The outside of the thigh is the best locality from which to take the grafts, and a sharp, broad razor is the best instrument for removing them. An assistant should stand beside the thigh and face the foot. He should grasp the thigh with the broad surfaces of his palms rendering the skin tense in a lateral direction. The surgeon should face the assistant and with his left hand grasp the thigh below stretching the skin downward and thus it is rendered tense and hard. With the razor wet in the salt solution in his right hand, the surgeon applies its edge to the skin at the more distant part, and with a slight sawing motion cuts towards him, taking off a thin shaving of skin as long and as broad as possible. It should be sufficiently thick to cause slight oozing of blood but should not go down to the subcutaneous fat. The shaving as it is cut, folds itself upon the broad surface of the razor and is transferred directly to the surface of the ulcer, and applied evenly from one edge to the other. One strip is applied beside another, touching but not overlapping, until the whole surface is covered. The edges of the grafts should be carefully straightened out, for they have a tendency to roll under and if they are left so there will be recrosses of the infolded part and all that overlies it. After the whole surface is covered, the grafts are shingled over with strips of protective, laid side by side and overlapping each other. The protective should be rendered perfectly aseptic before it is applied. It should be scrubbed with green soap, rinsed in sterilized water, soaked in strong bichloride solution, and finally washed in the salt solution. It should be cut into

strips an inch wide for use. Over this protective covering several layers of aseptic gauze are applied and held securely in place by appropriate bandaging. The dressings are moistened and kept moist with the salt solution. The dressings should be changed every two days and the grafts cleansed by gentle irrigation, care being taken not to infect them. The strictest asepsis is imperative at the time of the operation and at all the after dressings. No antiseptics however should be allowed to come in contact with the grafts. The grafting solution only should be used for cleansing purposes and for moistening the dressings. The moist dressings should be continued from 10 to 14 days. If a dry dressing is applied too soon, the grafts may become desiccated and die. If the whole surface is not healed at the end of this time a stimulating dressing like balsam of Peru should be used. Healing is usually complete at the end of two weeks even when a large surface has been grafted.

The denuded surface, left by the removal of the grafts, should be dressed and treated the same as the grafted surface and heals in the same length of time. There is no permanent scarring. It is much like a surface that has been blistered. I have used this method to cover extensive granulating surfaces, the result of burning or violence to the integument, in chronic ulcer of the leg, in amputation of the breast for cancer when such an extensive removal was made as to make it impossible to completely close the wound and in malignant disease of the skin where extensive removal was necessary.

In the cases of excision for malignant disease I have placed the grafts on the fresh cut surface as soon as the bleeding was stanchd. In the cases on which I have operated, I had complete failure in one only, an ulcer of the leg. It was a very old ulcer and complicated with eczema. The grafts did well for a week, when the patient left the hospital and the result was a complete failure. I repeated the operation two years later under more favorable conditions and



with complete success. My first case was a partial failure. The patient was a man who had met with a crushing injury to the foot; a partial amputation was made and a large denuded surface left on the top of the foot to heal by granulation. I was unable to completely sterilize this granulated surface on account of some deep-seated necrosis. The grafts became infected and more than half of them died. The healing process, however, was much hastened.

The method has a large field of usefulness in malignant disease where extensive removal of integument is necessary in going wide of the disease. Surgeons have been deterred from operating in such cases, or have made only partial operations on account of the extensive granulating surfaces left and their inability to heal them rapidly. These surfaces may be healed in from two to three weeks, no difference how large they may be.

The grafts are said to take on any aseptic raw surface, on muscle, fascia, tendons, bone, cartilage and on healthy granulations. They should not be placed on granulations, however, as their sterilization is uncertain and contraction in the cicatrix is said to be greater than when they are shaved off.

To illustrate the results of this operation I will exhibit a patient on whom I performed it 15 days ago. He entered St. Vincent's Hospital about six weeks ago with a deeply ulcerated surface on the side of his face. It was about two inches in diameter, had thick, everted, infiltrated edges and was covered with an offensive secretion. It had commenced three years ago and was attributed by the patient to a heavy blow with a sledge hammer received twenty years ago. It had all the clinical features of malignancy and I diagnosed it to be rodent ulcer. A day or two after his admission Dr. Kane of the house staff, by my direction, curetted the whole surface with a sharp spoon, cut away with scissors the overhanging edge of skin left by the undermining of the curette, and then with the Paquelin cautery at a red heat cauterized

the whole surface deeply. When the eschar had separated there was left a healthy granulating surface having no appearance of malignancy except at some points about the edge where there was thickening and infiltration. On May 15th I excised a liberal margin of skin about the whole ulcer, sawed away the granulations and grafted with the result as you see. The wet dressing was replaced on the 10th day by balsam of Peru, and healing was complete on the 13th day.



THE MODERN TREATMENT OF INGUINAL HERNIA IN  
THE MALE.

BY G. F. WILSON, M. D., PORTLAND, ORE.

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On account of the great frequency with which hernia is encountered, especially in the male sex, it has been, from the earliest times, a subject of great interest to surgeons. This interest too has been stimulated not only on account of the many deaths directly traceable to it as a cause, but also on account of the failure of conscientious workers in the field to offer to the sufferers a safe method of relief from the slavery of a truss.

To show how earnest the work has been you need only to consult any work on surgery, published prior to the last decade, to see the various methods which have been devised: all of which, without exception, have failed to stand the test of time.

By comparison of such works with those issued at a more recent date, it is also observed that the nature of the experimental work has materially changed; while the older investigators busied themselves with devices applied to a field often-times remote from the seat of the trouble, on account of their dread of encroaching on the peritoneum, modern workers have, as it were, entered the very lair of this monster, and attained success by utilizing a portion of its stronghold in the erection of their fortification.

It does not seem strange then that the modern workers should have met with a degree of success, but how humiliating it would be to an older surgeon if he knew that his failure was due to the fact that he was not clean. Nevertheless,

such is the case, for an appreciation of the necessity of absolute cleanliness has alone brought to successful termination the endeavors of men striving in this line as well as any other branch of surgical experiment.

Cleanliness is not only the ground work of your barrier, but the guarantee of the immunity from danger to the life of the sufferer, and as such, in this work alone, adds renewed lustre to the immortal crown of Lister, the father of aseptic surgery.

The presence of the spermatic cord in the inguinal canal has been and is the most potent factor against the success of every remedial measure, a fact which was not fully appreciated by investigators even after the fear of the peritoneum had been overcome. As a consequence, most of the late operations have not proved satisfactory, and relapses have occurred with such frequency that many surgeons began to refuse to operate, except in the presence of strangulation or other complication.

Dr. Bull, of New York, as Halstead says, dealt the most telling blows against the radical cure operations by the publication of the results of his own efforts and the study of the relapses occurring in patients who presented themselves for relief at The Hospital for Ruptured and Crippled of New York. Since that time, however, he has adopted other methods, and in the hands of his assistant, up to 1893, only one failure was observed in a series of about forty cases in children, and in this case it was due to suppuration, and not the fault of the method. Though a sufficient length of time has not elapsed to justify pronouncing these cases cured, yet the outlook is very flattering, and surgeons have already begun to look again with favor on the procedure. While it would prove entertaining to consider all the modern methods which have been devised, I must content myself with a short description of those only which have been most popular, especially in this country, reserving for more minute des-



cription the method which, at present, is most in vogue among surgeons.

In all but the latest operations, the treatment of the sac was the essence of the whole matter, as Dawbarn says, but now the strengthening of the posterior wall of the canal with a proper disposition of the spermatic cord, is considered the keynote of success.

The methods of Czerny, Banks, Nussbaum and Sewell consist of a careful separation of the sac and its ligation and removal as close to the internal ring as possible. Then a narrowing of the inguinal canal is produced by passing sutures of silk, catgut or silver wire through the aponeurosis of the external oblique muscle, conjoined tendon and Poupart's ligament and finally through the two pillars of the external ring.

The methods of Riesel and Barker do not differ materially from the above except that the fundus of the sac is left in situ, or drawn up by threads, and the suturing of the canal begun at a higher point.

In Bulls method, the separated sac is grasped in the jaws of forceps and twisted on itself until further torsion would result in rupture. A portion of the fundus is removed, and the twisted stump secured to the approximated pillars of the external ring by sutures.

MacEwen's method consists of a careful separation of the sac up to the internal ring, though adherent connective tissue and fat are purposely left to make it more bulky. The peritoneum about the internal ring is also separated for about half an inch. A thread is now fastened to the distal end of the sac and passed several times backwards and forwards through it, so that when drawn upon, the whole sac becomes puckered. By means of a slightly curved needle this same thread is carried up the canal and brought out through the muscles of the internal ring and there fastened. Pulling on it draws up the puckered sac thus forming a bulwark. The operation is completed by closing the canal, the conjoined

tendon being drawn out as near to the anterior superior spine of the ilium as possible.

The "open method" of McBurney consists of a ligation of the sac as high up as possible and an inversion of the edges of the wound, iodoform gauze being packed to the bottom so as to insure healing by granulation, thus making a dense and broad scar.

Of these methods, that of MacEwen was the most popular, but it is not adapted to all cases and is being superseded by that of Bassini, which I will endeavor to describe in detail:

After preparing the patient by a cathartic and careful cleansing and shaving of the field of operation, the skin is retracted downwards so that the section of the deeper tissues will occupy a different plane. An incision is begun at the spine of the pubes and extended upwards and outwards to within about two inches of the anterior, superior spine of the ilium. The aponeurosis of the external oblique muscle is next divided on a director to a point a little beyond the internal ring. The upper flap is then reflected upwards until the conjoined tendon is well exposed, while the lower flap is separated in an opposite direction, bringing the edge of Poupart's ligament into view.

The structures overlying the sac are now cautiously divided and the sac isolated from the cord and its surroundings by a careful dissection, began within the internal ring, as here the adhesions are less dense and the cord not so much flattened out. After this the sac is opened. Any firm adhesions of the contents are tied with fine catgut; bowel is returned into the abdominal cavity, while omentum is tied off with catgut and removed.

Next the sac is twisted, transfixed at the neck and ligated with catgut. If the neck is large a glovers stitch should be applied. The isolated cord is now held out of the way and the conjoined tendon with the transversalis fascia brought into close opposition with the edge of Poupart's ligament by means of interrupted sutures of chromicized catgut or silk.



The outer edge of the rectus muscle being included in the sutures nearest the pubes. A continuous suture of catgut unites the recently divided external oblique aponeurosis and the skin incision is closed by interrupted sutures of silk.

No drainage is ordinarily employed. The usual gauze and cotton dressing is used for the wound, a narrow strip of rubber tissue being applied directly to the closed incision and a large piece, perforated for the penis, added externally. This should extend well beyond the edges of the dressing as a further safeguard against outside contamination. Strips of rubber plaster or a plaster of Paris bandage makes the ordinary bandage more effective in keeping the entire dressing in place.

Halstead modifies this operation by extending the incision beyond the internal ring to a point in the abdominal wall where the muscles are not thinned and brings the cord out at this site. He also reduces the size of the cord by excising all the veins except two. The neck of the sac is thus practically done away with and the peritoneal incision is closed by a continuous catgut suture, as in an ordinary abdominal section. All tissues between the peritoneum and skin are united by an uninterrupted mattress suture, care being taken not to constrict the cord by beginning too near its new site. The skin incision is closed by a continuous buried suture of fine silk by which infection through the medium of the sebaceous follicles is avoided. In this operation the spermatic cord lies immediately beneath the skin, while in Bassini's it is placed beneath the external oblique aponeurosis. Bassini permits his patients to leave the bed in ten days, but Halstead does not consider the union firm until about three weeks have elapsed.

As the majority of operators will first undertake this line of work through the necessity imposed upon them by the presence of strangulation, the subject would not be complete without a few general remarks on the management of bowel, the vitality of which has been impaired.

If the natural lustre returns, even though the color remains dark, the bowel may be safely returned to the abdominal cavity. If on the other hand gangrene is present, the surgeon has the alternative of resection or the establishment of an artificial anus. Frequently the condition of the patient will not warrant an immediate resection, even by the most expeditious methods, consequently the formation of an artificial anus becomes imperative.

Even under these circumstances the restoration of the continuity of the bowel should be attempted within two or three days rather than within as many weeks, as the operation, difficult under any circumstances, is made more so by the greater firmness of the adhesions.

I regret that my own cases are too few and too recent to be of any statistical value, yet all have presented interesting features.

In one a silk suture was discharged from a persistent sinus six months after operation; in another, which might rightly be designated "reckless surgery" the return to the abdominal cavity of a suspicious knuckle of bowel did not interfere materially with the convalescence.

One of Halstead's cases is quoted as very instructive in which suppuration followed the leakage of urine from a punctured bladder. A case of mine, similar in many respects might be considered especially instructive as the leakage unfortunately took place into the general peritoneal cavity, a circumstance which was fully demonstrated at the autopsy.

To fairly represent the present opinion of surgeons as regards this subject, I believe that it can be truthfully said that no conscientious surgeon, familiar with the technique of the Bassini method, will wait for stercoraceous vomiting to make a diagnosis of strangulation.

He will, on the other hand say: You must submit to an operation, if gentle taxis, extending over the short period of one hour, aided by the administration of a small dose of



morphine, the application of cold and elevation of the extremities does not effect reduction.

To the patient with a hernia which cannot be controlled by a truss he can say: You ought to take advantage of the certain relief afforded by an operation, and to the patient who may be both safe and comfortable with such report, he can say: It is possible to relieve you without danger to your life, from the irksomeness of that apparatus.

Such I believe to express the views of the least enthusiastic.

#### WHAT I DO NOT KNOW ABOUT THE CERVIX UTERI.

BY J. P. TAMIESIE, M. D., HILLSBORO, ORE.

After selecting my subject for this paper and mailing the same to our worthy secretary, I began to think that if I should write *all* that I did not know upon this subject I would not observe the caution to "make your papers brief." Hence, will confine myself to but one condition or affection, namely, *cervical endo-metritis*.

1st—I do not know what is the natural course of this affection; whether it has a tendency to self-limitation or cure when not treated.

2nd—I do not know whether treatment *cures* this trouble, or whether cases get well in spite of all we do for them therapeutically.

3rd—And last, I do not know if we are right in the present theories of etiology.

I quote from recent authority the following: "Intimately connected with the subject of *cervical endo-metritis* is that of ulceration and degeneration of the cervix. So much disputation and misunderstanding having occurred concerning the true pathology of the affections of the cervix called ulcerations, that it seems proper to give a more full and distinct account of them.

"Within recent years new views of their pathogenesis, based upon microscopical investigations, have been advanced, which seem to revolutionize our previous ideas"

Permit me to say that we have far too many "new views" now, and what we wish are views ripened into facts by the use of what I shall term *personal statistics*.



It is the duty of every true physician to keep a record of all cases, and especially of those cases whose etiology and pathology are obscure, and I shall always be interested in any physician's *case book*.

It is very different to convince a patient suffering from cervical endo-metritis for three months, and who has been under treatment during the whole time—I say it is very difficult to convince such patient that she is better, when you do not believe it yourself.

But you do it, and send to Europe or New York City for recent authority and at the end of three months, repeat the whole proceeding or lose your case.

I said that "I do not know if we are right in our present theories of etiology," but I hope that every member of this society will assist—by *personal statistics*, to prove or disprove, that, *apart from lacerations of the cervix, all cases of cervical endo-metritis are due to:*

1st—*Prevention of conception.*

2nd—*Interruption of pregnancy.*

Of these two causes the first is the more fruitful of *cervical endo-metritis*; and the most baneful as a subdivision of the first cause is the very prevalent practice of *onanism*. Of 33 recorded cases, I find it in 23 (and six more used other means to prevent conception). And for this information I was obliged to have an interview with the husband, as the woman may know nothing about it.

Now as to treatment, that is obvious. My cases are doing better under *absolute sexual rest*, which I insist upon and consider most important. I do not decry pessaries when they are needed; neither do I object to a few antiseptic hot water douches or the removal of foreign matter from the uterus; but I do believe there is a great waste of *absorbent cotton* and *absorbent wool*.

TUBAL PREGNANCY WITH REPORT OF CASES AND OPERATION FOR REMOVAL OF SKELETON OF FIVE MONTHS FŒTUS, TWENTY-ONE YEARS AFTER DEATH OF FŒTUS. RECOVERY.

BY J. A. FULTON, M. D., ASTORIA, ORE.

Before proceeding to the consideration of the case which I have to report, it may be well to run over briefly the different varieties of extra-uterine pregnancy or rather the different results which are liable to follow tubal pregnancy. Extra-uterine pregnancy is, I believe from all I can learn from the different writers on this subject, as well as my own knowledge of the anatomy and physiology of the pelvic organs of the female, always tubal in its inception. That impregnation may be possible at some other point outside of the uterus and tubes may be possible, I will not deny, but I have my doubts about it, and that a placenta will become attached to and grow from a peritoneal surface, I cannot believe.

Thus starting from the tube as the original location of an extra-uterine pregnancy, we find that after a few weeks or months of growth of the foetus the expansion can go no further and there is a rupture; from this rupture and the position the foetus takes after it, arise all the different varieties of extra-uterine pregnancy.

Which way is the foetus going when the tube ruptures? If the rupture takes place into the broad ligament we then have an extra *peritoneal* gestation, and if it takes place into the peritoneal cavity it becomes an intra-peritoneal gestation. But in each case impregnation has taken place in the tube, and the placenta in either case will be the same, and attached to the inner surface of the ruptured tube, which would



naturally become everted in case of intra-peritoneal gestation. This no doubt gave rise to the theory that a placenta could become attached and grow from a peritoneal surface. Therefore if it be true that extra-uterine pregnancy is always tubal to start with, we can see that the half dozen and more varieties of the French writers, are nothing more than the different positions in which the foetus has at different times been discovered, after the rupture of the tube; such rupture being overlooked. If the sac ruptures into the peritoneal cavity death from hemorrhage or peritonitis is apt to follow rapidly, but if the rupture takes place into the broad ligament, the chances are not so much against the patient's recovery. In either case a prompt diagnosis, and if indicated a prompt operation offer oftentimes the only chance for recovery. If the rupture of the sac is not followed by the death of the woman in a few hours or days, from hemorrhage or peritonitis, the final termination will be one of uncertainty and doubt. If rupture is in the broad ligament, absorption of the blood and products of conception may take place, or suppuration, with opening and discharge into the rectum or vagina may follow, and recovery may take place this way. Consequently a rupture in this direction is not nearly so serious as one into the peritoneal cavity. Here the conditions are different entirely. Death from hemorrhage being very liable to, and frequently does follow very soon after the rupture. If inflammation ensues, suppuration with all its attendant evils, is apt soon to destroy the life of the woman.

At times (rare it is true) the ovum may go on developing in either location up to near the ordinary period of normal gestation. When the foetus dies and becomes encysted (which must be rare), or what is more common inflammation and suppuration (unless the surgeon steps in and operates), the death of the woman soon follows.

If the foetus becomes encysted or if there are adhesions thrown around it, it may remain there for years without

causing any particular inconvenience, although while in the abdomen it is always a menace to a woman's life.

Extra-uterine pregnancy being one of those strange and extraordinary freaks of nature which the physician and surgeon is liable to meet and be called on to treat at any time, it is necessary to be prepared at all times to diagnose and treat such cases with intelligence. That the diagnosis of this condition before rupture of the sac has occurred (and I might well say afterwards also) is one surrounded with doubt and uncertainty, everyone will admit, and just how to diagnose such a condition with certainty and without delay, remains to be told in the future, although a knowledge of the pathology and ordinary symptoms of the disease must be our guide to-day.

Unfortunately we are rarely able to diagnose ectopic pregnancy with absolute certainty without an operation, and are rarely called upon to diagnose this condition until after rupture of the sac and death of the foetus has taken place. Therefore the proper treatment of such cases comes to be of prime importance. Fortunately for these so afflicted abdominal surgery is so far advanced to-day that the treatment of such cases is better understood. It being pretty well agreed among surgeons that the opening of the abdomen with the removal of the sac with its contents where possible, is proper at all times, after a diagnosis is made; and in case it is impossible to remove the entire sac, and there is great danger from hemorrhage in removing the placenta, the sac is to be stitched to the edge of the abdominal incision and the cavity packed with iodoform gauze, when in a short time the placenta may be removed with safety and the sac allowed to contract and heal by granulation, this in brief is I believe in accordance with the modern idea and practice to-day.

On account of the comparative rarity of such cases and the importance to the patient of a prompt diagnosis and especially prompt treatment, every case of this character



should be reported, no matter how ordinary, and if possible put in such shape as to be of use to us in the future.

The case I have to report is one wherein a woman for want of proper treatment carried the skeleton of a five or six months old foetus, the product of an extra-uterine pregnancy, in her abdomen for over twenty-one years. The history of this case although very incomplete is nevertheless instructive so far as it goes. I was requested to prescribe for a lady, Mrs. P——, who was at that time living in the state of Washington, for what was supposed to be an inflammation of the bowels. The lady was living up in the woods several miles away from any settlement, and for this reason had had no physician. It was reported to me that she was suffering intense pain, vomiting, had high fever; and that the abdomen was largely swollen, "tight as a drum" was the expression used to describe the last condition. She, as well as her friends, had given up all hopes for her recovery and only expected to receive something which would give her relief from pain and allow her to die easily.

While writing the prescription for her it was remarked that she had passed from her bowels a few small bones. The gentleman reporting the case being a man of good intelligence, I became much interested in the case and urged him very strongly to put her upon a litter and bring her to the hospital in Astoria, agreeing to operate upon her if I found the history of the case to be as reported to me. Although they had decided to allow her to die as she had requested at home, instead of in a hospital among strangers, they were finally induced to bring her to St. Mary's Hospital in Astoria. She was admitted to hospital some time early in the month of September, 1893. On her arrival I found that she could not speak English, and the history of the case I obtained from a relation of the patient whose command of the English language was not all that could be desired.

However, the history I did obtain is clear so far as it goes, and it enabled me to give the necessary treatment for relief.

The patient was a Russian Finn, who had been married twenty-five years; had never had a miscarriage and had never been sick until about five years after her marriage. At that time she became pregnant and during the first five months of this condition nothing out of the ordinary was observed. Between the fifth and sixth month of her gestation she was thrown from a boat and narrowly escaped drowning. Following this accident the distention of the abdomen due to the pregnancy disappeared almost entirely and although she gave no history of shock or collapse, still for three years, she was an invalid, she declares she could always feel the bones of the foetus in her abdomen and that for three years the soft tissues of the decaying foetus passed continually away through the vagina. During the first three months of this condition she was confined to her bed, but after that she was up and around although far from being well. She consulted several physicians, but failed to obtain relief. After three years she regained her health and aside from an occasional twinge of pain in her side she was a well woman. Menstruation became regular and natural and there was no trouble whatever that would or did indicate uterine disease. She passed the climacteric at the age of forty-five, with no more than the ordinary disagreeable feelings which accompanies such a change usually, and until one month before I saw her she was a well woman. One month before I saw her she was taken ill, had intense pain, high fever, chills, sweating, vomiting and excessive distention of the abdomen. Once during this time she passed several small bones, after she had taken a cathartic. That is the history of the case up to the time she was admitted to the hospital.

On examination I found her very weak and much exhausted, abdomen distended, pulse 120 weak and rapid, temperature 102°, sweating at times profuse, could detect on left side midway between crest of ilium and umbilicus what I thought was the bones of the foetal skeleton. Diagnosis, Tubal pregnancy, with rupture of the sac at fifth or sixth



month, skeleton encysted for twenty-one years. Finally suppuration of sac occurred, resulting in general peritonitis, and an opening into the bowel, which, however failed to relieve the patient. I operated the next day. Made an incision three inches in length, midway between crest of ilium and umbilicus. Found tumor adherent to wall of abdomen, but in opening into the sac, I had to open into the peritoneal cavity. On opening into the sac I found the bones of a five or six months old foetal skeleton covered with fecal matter, these were removed without trouble and then I found the sac opened into the sigmoid flexure. I attempted to examine uterus and ovaries, and found uterus and right ovary normal in location and size; left ovary and tube were bound down to uterus in such a way as to be almost indistinguishable. I had no trouble in stitching the sac to the abdominal incision and thus the cavity was packed with iodoform gauze. Relief to patient was immediate, and she felt better the day after the operation than she had the day before.

After the operation, for some time the bowels moved through the opening in the abdomen and I feared the formation of a permanent artificial anus or fecal fistula. At the end of two months I attempted to close this opening and partially succeeded. After that, the opening closed rapidly and is today entirely closed, and the patient is a strong healthy woman.

It is interesting to note in this case that this woman failed to become pregnant during the first four years of her married life, although she took no precautions against it. That when she did become pregnant impregnation was extra uterine. That she never became pregnant a second time although uterus and right ovary were apparently normal. These are interesting points which refer to the pathology of tubal pregnancy.

The case is interesting also on account of its rarity. From the way nature had attempted to save and might possibly finally have succeeded in saving this woman's life.

From the fact that those bones should have been carried in this woman's abdomen for twenty-one years, in this day of advanced surgery, and escape so long a surgeon's notice, and finally to see how simple and easy it is for the surgeon to assist nature in a case of this nature, and do in a few minutes with greater safety to the patient, that which nature had been working at without assistance for over twenty years, and even then came near losing her patient.



## CASE OF TUBERCULAR PERITONITIS WITH ASCITES.

BY HOLT C. WILSON, M. D.

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Mrs. Burgoyne, native of Maine of French Canadian parentage, aged 45 years, mother of ten children, consulted me about January 1st, 1892, for general debilitated feelings and incidentally for distention of the abdomen. Patient on examination presented sallow cachectic appearance, muddy complexion and weighed about 290 pounds. Physical examination of the abdomen revealed an enormous accumulation of fat, pendulous in lower part and overhanging pubis to some extent. In addition however, it was not difficult to perceive that a very large tumor was present, showing evidence of thin fluid. Tumor conical and projecting as in an ovarian cyst and remaining so in recumbent position—only doubtful symptom being fact of sagging of fluid on sides, pressing loins outward. This symptom I have also seen in simple ovarian cyst of large proportions. The early history was obscure. Patient probably did not notice enlargement owing to adipose deposit. I was disposed to think the case to be one of simple ovarian cyst and advised operation. Patient entered hospital and operation was performed January 9th. Anaesthetic was well taken. The enormous bulk of patient made it seem like handling a hippopotamus calf. Abdomen was carefully incised and there appeared to be no muscular tissue, came down upon peritoneum after incising enormous layer of fat. Peritoneum was friable and tore like wet paper. No cyst wall was found, many gallons of watery fluid almost clear gushed out. Peritoneum of abdomen and intestines was covered with miliary tubercular deposit.

Thin adhesions prevailed everywhere but no attempt was made to break them up. Cavity was emptied as carefully as possible and wound closed. Peritoneum stitched first with continuous catgut and then silk through skin and fat; no drainage. Previous to and at the time of operation patient had fever 100 to 101 or 102. Made an uninterrupted recovery. Wound healed as a fine line and has ever since appeared to be the strongest part of abdominal wall.

The condition of Mrs. B. improved steadily. Her complexion cleared up, lost some flesh, appetite good, strength returned and fever disappeared before leaving the bed. As expected however, there occurred a gradual re-accumulation of fluid beginning several months after operation. The abdominal wall became thinned in places on both sides of the cut, giving the appearance of hernia. Two or three such places appeared. The cicatrix as mentioned above remained firm and fibrous. This condition increasing and fluid becoming gradually great in quantity, though not nearly so much as before, I advised a second operation with a view to draining the cavity.

Without any particular preparation, under an anaesthetic, an incision was again made Feb. 20th, 1893, thirteen and one-half months after previous operation in lower part of old incision but not more than half as long. The fluid was run off and abdominal wall was found to be in spots degenerated by caseous breaking down so that sinuses were formed. These were scraped carefully and one or two near line of incision were slit up and a drain of iodoform gauze stuffed into them. A large glass drainage tube packed around with iodoform gauze was placed in angle of incision and remainder of cut stitched up as before. Again an uninterrupted recovery. Drain left for perhaps four days or until pushed out. Openings then packed daily with iodoform gauze until all discharge ceased.

I should also state that adhesions were firmer and more organized. Patient was soon able to work and be about.



General appearance quite normal except bulkiness. No fluid seemed to accumulate for many months, then a moderate accumulation in right side. To the left of incision parts firm, hard and apparently normal. About January 1894 drew off perhaps a pint of fluid with a trocar. Soon reaccumulated and as such good results had been had before by operation patient was willing to be incised again. Accordingly, February 12, 1894 made small cut over point of projection in right side but there was not very much fluid. The appearance of the tissues had changed very much; no degeneration, no tubercles, no roughness or congestion. Intestines and walls looked healthy. A large rubber tube was left in but drainage only took place for forty-eight hours and tube was pushed out and wound healed.

Patient left the hospital seven days from date of operation. Ordinarily this would have been improper but I rather wished that a sinus would form and drainage continue but the cut healed as did the others, firmly and strongly. The diseased process has evidently been disappearing and the patient has suffered no particular inconvenience or pain. Has a dread of a full recurrence, which is not likely to take place.

You observe that the patient improved immensely after the first operation, after which there was no drainage or washing out as recommended by authorities. In the two later operations a thorough washing out was done with Thiersch's solution and drainage was carried out. Am unable to say whether the washing out was of any particular benefit. A few days ago there being evidence of pressure of small amount of fluid in the right side, I tapped with a very large trocar and injected experimentally a 10 per cent. emulsion of iodoform in glycerine which caused some griping, and patient is still sensitive and tender over abdomen in consequence; in fact quite a reaction has been caused, which however I think will subside without untoward results.

I selected this case from a number of surgical cases as perhaps presenting, at least to some of the gentlemen, points of more than ordinary interest. The size of the individual, the readiness with which such diseased tissues healed each time and the beneficial effect of emptying the cavity and exposure to the air and light. Authorities claim, perhaps properly, that therein lies the cause of the disappearance of the tubercular process.

Tubercular Peritonitis occurs in three forms. With Ascites, second Fibrino-Plastic and third Adhesive. The first form only is benefitted by operation, a point to be borne in mind. Infection probably takes place through the blood as in joints, possibly through the Fallopian tubes. The large majority of cases occur in women, seldom in men. In the Fibrino-Plastic variety there is a matting together of everything. In the adhesive variety same condition with a firmer adhesion, often ulceration and inter-intestinal fistulæ. No fluid in either of above forms. General Tubercular infection is apt to take place. Such cases are usually hopeless. I believe in our present state of knowledge it is not known what causes the different forms. I am inclined to think that probably there is, (except in the variety with ascites) an involvement first of the inside of the intestine and later of the peritoneal covering.

My patient has kindly consented to present herself and I will be pleased to have such members as wish, examine the abdominal wall. You will observe that the incisions have each time made the wall stronger instead of weaker as might be expected to happen. Also that all appears normal in the left side and weak on the right where there is still some disease.



## TREATMENT OF GALL STONES; HARLEY'S METHOD.

BY M. FRIED, M. D., PORTLAND, ORE.

The object of this paper is to call attention to a treatment, which although not original with me, may yet be of interest to you.

It is not a succedaneum in all cases yet adaptable to many. It is the removal of gall stones by digital pressure, as recommended by Harley. In suitable cases it will obviate the use of the scalpel, and in others it will curtail many months of suffering. Most patients only accept as a last alternative an operation which has its risks. This procedure will not interfere with operative action, if required, but with due care is almost devoid of danger. It will be aided by most remedies that are used in the treatment of gall stones, especially the antispasmodics. Ziensen and Loomis merely recommend such drugs as allay pain, act as solvents of biliary calculi or increase the amount and fluidity of the bile, while Strumpell in addition also mentions the present popular American remedy Sweet Oil, in these words: "Cases not infrequently come under observation in which the patient either of his own notion or following ignorant advice has taken large doses of olive oil, most of the oil is passed in lumps which have a superficial resemblance to gall stones and are some times called such." Theoretically the action of these remedies is what is practically desired yet unfortunately rarely attained, unless months elapse when perchance the offending mass slips back into its former bed from which it originally stirred, or passes onward in its march to the intestine. I do not desire to criticise these remedies, but feel that unaided, their action must be markedly restricted

by the size and density of the obstructing mass, if they have a solvent action. These remedies will also be restricted by the location of the stone, if it is within the cystic, hepatic or the common duct it is most apt to become impacted at its entrance into the duodenum. If within the common duct it is most apt to become impacted at its smallest portion which is next to the bowel, and here the solvents should act most vigorously. I believe their action will be markedly enhanced by position. Place the patient for a time after taking the medicine, on the right side inclined backward with the buttocks somewhat elevated, so if possible to bring the medicine in contact with the stone. I would in addition to the drugs add the method recommended by Harley as described in his monograph in the Medical Science of 1890, with such modifications as may present themselves. I quote freely from this article. I believe his method is the most practical one for the removal of gall stones outside the domain of surgery, although as he says, its limit of usefulness is for stones the side of hazelnuts.

Posture: put in reclining position with buttocks elevated and somewhat inclined to left side to get the benefit of gravitation. Although one cannot grasp the gall bladder through the intact abdominal walls, yet when it is distended with bile its fundus presses directly against them, sometimes even to such an extent as to slightly elevate them. There is no difficulty whatever in applying pressure to the fundus of the gall bladder by the tips of the fingers pressed against the integument directly over it. And just as in the case of an india rubber syringe it is as easy to make it expel dirt from its nozzle when water is suddenly jerked out of it by manual pressure, digital pressure applied to the fundus of a distended gall bladder is equally successful in making it expel its contents along the ducts into the intestines in all cases where the obstructing body, be it inspissated bile or stone, is sufficiently small to be able to be propelled by the bile along the ducts into the intestine. Moreover the ducts being dilatible, even



impacted concretions as large as hazelnuts may be forced along them by daily, judiciously applied, slow and graduated pressure. There is always one point in favor of the operator namely, that in cases where an obstruction to the flow of bile is caused by a biliary concretion, the gall bladder is more or less distended with fluid and this has a double advantage for firstly it renders the situation of the organ more easily detected and secondly there is plenty of bile in it for the operator to push against the obstruction and thus induce its forcible extrusion from the duct.

The pressure is to be applied with care, using the tips of the fingers over the bulging part of the abdominal walls caused by the distention of the gall bladder, and pressure made backwards and toward the median line. If percussion and palpitation indicate the enlarged bladder, apply like treatment. If the gall bladder is not sufficiently distended or for unknown reasons is not discernable below the lower border of ribs as it was in my case, apply pressure from below upwards and backwards and somewhat toward the median line, for in my case the first time I had occasion to try this method, on the third endeavor the stone was extended into the bowel, followed with a sensation imparted to my fingers, as though a fluid was escaping through a small aperture under a high pressure, or as described by the patient, who was highly intelligent "like water escaping from a syphon." Harley mentions several interesting cases where stones have been passed after one or more manipulations; one where the stone was supposed to have lodged in the duct for nine months.

I will give a brief history of my case during the different attacks which cover a period of five years. It well illustrates the usefulness of this method of treatment even for diagnostic purposes, for here jaundice had been almost completely absent all the time, and the doctors who were all able diagnosticians differed in the diagnoses, yet the smallest number

were inclined to call it gall stones until the passage of three stones during the fourth attack.

Patient, female, age 49, weight first attack 200 pounds, last attack 128, but has gained 39 pounds within the past year and three-quarters on a rather abstemious diet.

First attack in 1888; resided then in Washington; lasted two weeks; diarrhoea preceding and following attack, which became chronic, severe vomiting; no jaundice; stools normal color; severe pains in epigastric region repeated about six times; diagnosed gastritis.

Second attack 1889, vomiting and pain, and lasted but a few days, now diagnosed gall stones.

Third attack, now resident of this city began April 1891, severe pain and vomiting lasting during a week. Bowels obstructed for three days, but when convalescent bowels moved again; diagnosed, obstruction of bowels.

Fourth attack, and longest lasted three months, jaundiced a few days at beginning of attack and just before its termination. Constipation rather marked all this time. Stools natural clay color. Pain severe. Diagnoses both of cancer and gall stone, until eventually three stones passed.

Fifth and last, began on October 8, 1892, seven months after previous attack. I first saw the case, Oct. 15, on which occasion there was no jaundice, no distended bladder noticeable by sight, palpitation or percussion; pain severe. First I tried olive oil for a few days according to methods recommended by exponents of this treatment but results negative. I changed treatment in a few days, to a compound spirit of amyl valerianate, and external manipulation as described, with the happiest results on the third manipulation; a purgative was given, when the stone was passed 26 hours later.

I was enabled to state at the time that I felt positive from the sensation imparted to my fingers that no more stones were in the duct, and now over a year and a half has elapsed



with no indications of error in my assertion. Patient has for the first time gained in weight since first attack and this is the longest intermission that has elapsed between previous attacks. This is the stone, which is about half the size of a hazel nut. There was no pain caused by the movement of stone, which also inclines me to the belief that the pain in gallstones is primarily due to the presence of the stone and not to its movement, as stated in text books, or rather due to spasmodic action of the muscular wall of bladder in its endeavor to empty itself of its over distension, than the irritability due to the movement of the stone.

Summarizing things necessary to observe; position of patient; medicines that aid in relaxation of parts; care in the manipulation.

Things that tend to successful results: size of stone; earlier the treatment the better; patient not too corpulent so as to locate bladder; considerable distension of gall bladder.

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OBSTETRICS AS VIEWED FROM THE STANDPOINT OF THE  
GYNECOLOGIST.

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BY F. M. ROBINSON, M. D., BEAVERTON, ORE.

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The great importance of the obstetrical art to the general practitioner, and through him to mankind in general is my apology to the Society for bringing this subject before it at this time.

In the proper hygienic management of the puerperal woman and the termination of her pregnancy in successful delivery, and a speedy return to normal health, is found a field of no mean importance and one in which no man can excel except after years of study and painstaking labor.

Primarily there are a number of accidents and many difficulties connected with the safe delivery of a pregnant woman that the general practitioner should keep in mind and always be prepared to meet and overcome with the very best means at his command because with all the skill and means best adapted to promote his art, accidents will happen and difficulties of the gravest kind will beset his path. He will often be called upon to act promptly on the spur of the moment with the lives of two human beings hanging in the balance, and to blunder or hesitate would be to lose both. Decision, courage and skill are sure to be put to the test in the obstetrician sooner or later.

Undue haste during the latter part of the second stage of labor endangers the perineum, yet we are told retardation of the first part of same stage may cause cystocele or vesicovaginal fistula through prolonged distention and pressure, injury to the rectum and posterior vaginal wall, sagging of the



pelvic floor from over distention and straining of the levatorani muscle.

Laceration of the cervix, rupture of the uterus, or uterine inertia may come on before dilatation takes place, necessitating forcible dilatation and instrumental delivery. These accidents are in the main preventable, and when unavoidable can usually be successfully repaired by a primary operation. Secondary or preventable forms the etiological factor of which is sepsis, as colpitis, endo-metritis, metritis, salpingitis, pyosalpinx, and peritonitis, all of which leave their blighting effects to continue very often during the life of the unfortunate victim.

These women are constantly annoyed by ovaritis, dragging, weight, and pelvic pains, brought on by a subinvolved uterus; a loathsome acrid discharge from a lacerated eroded cervix or diseased endometrium attended by the usual train of reflex symptoms. These poor women after bearing from three to ten children have sunk so low in the physical scale that life has become a burden almost too grievous to be longer borne. At this point an experienced gynecologist is consulted and a diagnosis made and the etiological factors in the case are made out to be lack of skill in the two or three different obstetricians who had attended her during her several confinements.

The woman is perhaps a typical case of the class usually met with in the consulting room of the gynecologist. Partially lacerated perineum, sagging pelvic floor, uterus in the hollow of the sacrum, vesical catarrh, haemorrhoids, ovaritis at each menstrual period and most of the time between, the uterus is more or less fixed, the result of peritonitis. Loss of proper vermicular action in the motion of the intestines has resulted in chronic constipation with its train of gastric symptoms.

How far the present status of the obstetrical art is responsible for this condition among the female portion of our patrons is the very important point upon which we wish to

get information. I am fully convinced by my own experience in gynecology that some members of our honored profession are guilty of great negligence in treating their obstetrical cases especially as to torn perineums or lacerated cervixes. But the physician is not to blame at all in many cases, as they will often refuse any further treatment at his hands, and I have often heard a patient say: the Dr. said my womb was torn at my last confinement; but she would not say the physician wanted to stitch it, and I refused, until forced to do so by a cross examination.

How many of these accidents that are laid at the door of the obstetrician by the gynecologist, can be prevented by care and skill, and how shall we establish rules of procedure and methods by which the general practitioner may attain the proper proficiency, and the great army of living witnesses which testify against him by their broken lives be materially reduced.

To this end let us review some of the positions taken by men in high repute as gynecologists to some woman's hospital, or as obstetrician to some maternity home. Robt. A. Murray, M. D., said in a paper read before the County Medical Society of New York, Jan. 24, 1894, as follows: "Through the results as evidenced in gynecological examinations of patients, I am convinced that a large body of obstetricians do not believe in or do not practice thoroughly aseptic midwifery."—(*American Medical Surgical Bulletin, May 1, 1894.*) As to the question whether antiseptics are necessary, or would not mere cleanliness do, the writer takes the ground that there is no cleanliness without antiseptics. And then follows a dissertation on the kinds and the strength of antiseptic solutions to be used, the principal part of which is of no use to the general practitioner in midwifery because they cannot be used without skilled persons to handle them.

In answer to Dr. Murray, I will refer to an article on the Fetichism of Antiseptics by Dr. Wm. A. Hammond, Surg. Gen. U. S. A., in *American Medical Surgical Bulletin*, Jan.



15, '94, and read at the Pan American Congress in which he thoroughly scouts the idea that there can be no cleanliness without antiseptics. The great Surgeon General puts himself on record before the world in the following emphatic language: "I wish to add my influence based upon no small experience, towards the abolition of what I am more than satisfied is nothing more than a gross superstition." And with the great Surgeon General I am fully agreed. For the past five years I have used no solution or so-called antiseptics to prevent sepsis, but believe in and practice the abundant use of clean boiled water and soap for the sake of personal cleanliness of hands, arms and face hot as can be borne and also for cleansing the patient when necessary, and have not had one case of septic poisoning in my practice, where I have had the case from the beginning.

In what light do our most noted specialists view the general practitioner who does any work in the domain of gynecology; let the following attest, which so far as I know is about what we have from all sources of specialism. Dr. R. M. Cunningham of Birmingham, Ala., in a paper read at the meeting of the Southern Surgical and Gynecological Association, Nov. 15, 1892, (vide *American Journal of Obstet*, February, '93, p. 310) said that the general practitioner should never attempt any work that could be better done by a specialist unless where one could not be procured. And among these he enumerated secondary or plastic operations upon the perineum, vagina and cervix and as they required more than average skill to obtain good results they therefore belong to the domain of the specialist.

How shall we manage our accidental cases, shall we condemn the obstetrician who does not do a primary perineorrhaphy, colporrhaphy, or approximate the torn and bleeding lips, of the cervix uteri. I think you will all say yes with one accord. As to the secondary operations they are merely elective, not coming within the scope of this paper, the object being only to prevent the usual sequellæ by closer attention

to primary accidents, and may be left as a matter of choice to the surgeon. But the primary operation is imperative in order to do justice to our patients.

When I have used all the means at my command and cannot reduce a rigid perineum or a hard, swollen and oedematous os uteri, I make an anterior and posterior incision into the cervix, and one in the median line of the perineum sufficiently deep to prevent laceration, and all cases so treated have united by first intention. When called to a case and I find that the cervix or perineum have been torn I do an immediate primary operation, repairing a laceration if any exist.

These notes have been taken principally from the field of gynecology and applied to my obstetrical practice with the hope of getting better results along the lines where we have been so bitterly complained of by our brother specialists in the field of gynecology.

There is certainly much to be gleaned from the gynecologist that will be of great lasting and practical benefit in midwifery; and I feel that I have very materially lessened the ground of complaint within the scope of my practice and therefore think that I have been well repaid for my labor.



✓ PRESIDENT'S ADDRESS.

BY H. R. HOLMES, M. D., PORTLAND, ORE.

*Professor of Gynecology and Clinical Gynecology, Medical Department  
of Willamette University.*

Members of the Oregon State Medical Society: I desire that what I shall have to say at present shall possess the merit of brevity, and I promise you candor of speech. It would be a pleasure, could one honestly do so, to praise the society in all its actions, but this cannot be done. True, our society has made great progress and is annually advancing, but certain objectionable features have and do embarrass its prospects as a scientific, liberal organization. I will endeavor later to point some of them out. \* \* \*

✓ This society was organized just twenty years ago with Dr. Alfred Kinney as president. Dr. Kinney was known, even then, as a surgeon of wonderful skill. One secret of his success was his unwillingness to attempt an operation, which he was not sure of being thoroughly qualified to perform. I remember Dr. Kinney declining, about ten years ago, to do an ovariectomy, and bringing to Portland from San Francisco an ovariectomist for the purpose, which showed his regard for specialism, his belief in the eternal fitness of things, and more, it proved him a conscientious man, although his thorough knowledge of anatomy, and of the principles of surgery, with his exceptional manual dexterity, would have made him certain to do ovariectomy more properly than the large majority of those who are now doing such work occasionally in this part of the country. He rather would, and persistently did, leave to others those particular operations which he believed they had studied

more, and consequently, were more specially fitted to perform. Dr. Kinney, although not yet quite a middle-aged man, has filled many positions of trust and occupies a prominent and very responsible one at present. No wonder the Oregon State Medical Society should succeed with such a man as Kinney to give it a start.

[The writer then complimented succeeding presidents.]

✓ Drs. Watkins and Glisan attained distinction and enviable reputations as teachers and authors.

✓ Dr. L. L. Rowland was a nervous, active man; an enthusiastic physician; a popular minister; an able orator; a great scholar. He had traveled in many countries and was familiar with many languages. The diversity of knowledge which he had attained was manifested by the many degrees which he possessed—doctor of law, doctor of divinity and doctor of medicine. He was one of those rare men whose boundless general knowledge seemed not to dilute his knowledge of particular things. He studied medicine in its Greek and Latin and believed that there was no medicine but regular medicine. He despised every kind of pathy. \* \* \*

✓ Dr. Carpenter was one of the pioneers of scientific medicine and surgery in Oregon. Like all pronounced men, he had his enemies, but his friends were legion. \* \* \*

✓ Dr. Rice commanded the respect of all who knew him.

✓ Dr. F. A. Baily, twenty years ago, was considered one of the best educated physicians on the coast. A reputation like his as a diagnostician was seldom attained. Dr. Baily has sustained his good reputation through all his years of practice. He is regarded as thoroughly modern, having kept abreast of the profession's progress up to date.

✓ Dr. C. H. Merrick was a man of an unusually analytical mind. He suggested to the society the adoption of the metric system, and wrote a pamphlet explaining its advantages. I am somehow impressed that Dr. Merrick became discouraged by the unsystematic work and slow progress of



the society and lost interest in it and probably withdrew. It was a rebuke to the earlier days of the society, that its energy and enthusiasm were not sufficient to encourage the companionship of Dr. Merrick and other valuable progressive men, who similarly withdrew about the same time and later. \* \* \*

It would afford me great pleasure to note just a few of the excellent qualities of Drs. Strong, Saylor, Josephi, Wade, Givens, Mackenzie, Page, Giesey, Wells, Cauthorn and Rinehart, but time forbids me doing them anything like justice, and I must content myself in saying that their names, collectively and individually, stand for all that is progressive in medicine in this part of the country.

Did I not desire to give you a short address, I would be glad to compliment some other of our members extensively, of whom we may so well feel proud. I would particularly mention Dr. Henry Jones for his pioneering, his energy and success in gynecology; Dr. Eaton for what he is well known to have done as a pioneer for the specialty of the eye and ear, and Dr. Andrew C. Smith for the impulse he has given the profession in Oregon, in regard to operations for the radical cure of hernia, and the various uses of the Murphy button.

I would compliment Dr. Coe for his good work, and congratulate him on his success in medical journalism, as well as in the practice of his profession. He is doing more to elevate the standard of medical education in this state than all other agencies combined. He has put our leading men, in this and neighboring states, in touch with each other, giving one a chance to know the methods of practice and the results of others. He is making a history of medicine and surgery for this part of the country, and letting the world know that on this North Pacific coast are as learned and progressive physicians as are found anywhere. To have started the *Medical Sentinel* in the face of many past futile efforts required faith, to firmly establish a medical journal here required indomitable energy. His journal is now so

much of a success, that we have already almost forgotten that, when it was started, many of its best friends wondered whether or not it could possibly continue. Dr. Coe is establishing for himself a national reputation and one that will live in history.

I feel it now my painful duty to attempt the neglected task of pointing out just a few of the obstacles which have been and are yet in the path of this organization. Our state, like our local societies, has for its leaders mainly those whose knowledge of medical societies is limited largely to the Oregon State and Portland Medical Societies.

Those who have sometimes attended medical societies outside of our fair state observe a striking contrast on attending ours. This I confess in shame, for we do often act without precept or precedent. The president in a Portland Medical Society, less than twenty months ago, called a meeting to order, and then told an uninteresting joke (?) about having bought some butter that was just on the turning point. Is not the case unparalleled? Later, when a member had expressed his disapproval of Tait's perineorrhaphy, which was respectfully discussed, the president elucidated his knowledge of the anatomy of the female pelvic floor by saying he was "sorry for Tait." Such terseness may be becoming on the sheep ranch, it may be excusable in the Indian camp; such withering sarcasm may find an appropriate pulpit, but should never find a place in the medical society. To thus snappishly attack a member from the chair, with such argument (?), is unprofessional, impolite, ignorant and cowardly.

The same member, on delivering what purported to be an address of welcome, at a meeting of the State Society held at Portland a few years ago, said to the visitors from towns smaller than Portland, "We are glad to see you, and are sorry we cannot give you more attention; but, not like you, we are busy men; we cannot take our knives out of our pockets and sit down on the edge of the sidewalk and whittle, and have a good time entertaining our friends, as



you can, but we hope you will go home feeling that you have enjoyed yourselves." He, with other members of a meeting of a medical society held in Portland not more than twenty months ago, objected to passing resolutions of respect when one of the greatest surgeons that America has ever known, had died.

It is well known that quite a number of Portland's prominent physicians, members of this society (I submit this as bearing upon and influencing our state society, for I will indicate later that our state society is regarded by many of Oregon's physicians as a Portland medical society), until recently, have time and again consulted with irregulars. \* \* \*

Members have voted to exclude a member from our society and have, soon after, met, in consultation, he whom they voted to exclude. Let it be understood that I regard all species of fault-finding as an unpleasant task, but I am willing to invite attention to these, and the following facts, with a hope that they will be adjusted properly and to the credit of the society.

A physician living in the capital city once said to me, "I should like to attend the State Medical Society at Portland were it not a fact that at every meeting a few officers and members, residing in Portland, always assume an air of proprietorship in the society." A physician living in Washington said to me: "I have sometimes thought I should like to locate in Portland, but I realize that if a physician were to do so, he would meet annoyances if he were to get any business, and a man must, if practicing medicine in Portland, either be satisfied to do very little or he will excite the jealous ill-will of those who feel that newcomers are intruders." A physician of The Dalles last year said, when some professional irregularities were being discussed, "You Portlanders must correct these errors at home, for there they are nursed and protected." A physician of Idaho said recently, that he "never knew physicians, belonging to the same societies, to speak so disrespectfully of each other as they do in Portland."

A Montana physician said, "I wish all the Portland physicians could know how respectful and friendly to each other the physicians of our state are." Another physician from Washington said, "I know of no other place on the coast, where the profession of medicine is so like 'a house divided against itself' as it is in Portland. Why, they even cultivate cliques in medical societies there." These remarks emanated from high-toned, honorable gentlemen, with whose names I am willing to supply any inquirer.

It may be, if our annual meetings are always held in Portland, that they will have a larger attendance, but if ours is a state medical society it should not always be at a place to accommodate Portland physicians. It has been falsely said that the society was a failure at Salem in 1877. My observations lead me to believe that the physicians around and about us are quite as busy as we of Portland, and can no better spare the time to come to our town than we can to go to theirs. I am afraid that the regularly repeated election of Portland as an annual meeting place looks selfish to our neighbors. I fear that it has caused the organization of the Southern Oregon Medical Society, and may yet cause the organization of an Eastern Oregon medical society, and another one somewhere about the capital city, all of which will prove more or less antagonistic to this society.

I know that these statements will sound unpleasant, but I hope that, the truth being unhidden, good may come of it.

It may be truthfully said that we have a fair attendance of members at our meetings, but how much could this be improved if the society was conducted on a different plan. I now candidly suggest, as this is a state society, that it should have no special relation to Portland, and, wherever its meetings are held, all its members should feel it their duty and their pleasure to attend them and cheerfully contribute to the support of their own Oregon State Medical Society.



## ✓ PUERPERAL ECLAMPSIA.

(Read by Title.)

✓ BY H. R. CLIFF, M. D., ST. HELENS, ORE.

By puerperal eclampsia we mean a peculiar epileptiform convulsion which may occur in the later months of gestation during parturition, or after delivery, causing danger to the lives of both mother and child.

Considerable difficulty arises in describing eclampsia correctly. One text book will call it epileptiform, another hysterical and still another apoplectic. This is confounding different diseases. True eclampsia differs in clinical history from any of these diseases, Caseau says, "by puerperal clampsia, I understand a series of fits in which nearly all muscles of relative and frequently those of organic life are convulsively contracted, accompanied by a more or less complete suspension of sensational and intellectual faculties for a variable time. It is unusual in early months of gestation, and is not affected by season, those occurring before labor most serious during sessions, after, seldom fatal."

Predisposing causes: kidney, presence of albumen in urine accompanied by other evidences of kidney lesion. The mere presence of albumen does not constitute the disease, some have albumen and no eclampsia; others only after eclampsia, albumen is at least a predisposing cause. Kidney at fault, an acute or chronic nephritis, often of long standing, as from scarlatina in childhood, uterus the distension pressing on internal organs may repeatedly produce eclampsia, or intestine accumulation in the bowels.

## SYMPTOMS.

Excitability, impatience, irritability, unlike self, drowsiness, headache; a few have more marked symptoms, giddiness, nausea, dimness of sight, etc.

## CLINICAL HISTORY.

For some weeks patient has not passed usual quantity of urine; by examination may find albumen casts, urea, in the morning eyelids puffy, œdema, stiffness, tightness of rings, etc., later in the day œdema of legs, patient not herself, feels chilly, some are nervous and hysterical. After symptoms have continued some days then attack of convulsions.

## STAGES.

First, initiative, patient suddenly seized with quick winking of eyes, also of nose dilated, mouth partly open, risus sardonicus, inclination of the head to one side, hand quickly turned to one side, sometimes fingers straighten out, soon all muscles of the body seized with rapid contraction.

## SECOND TIME.

Suddenly movements stop, body is immovable, tongue protruded, frequently bitten, arms stiff, breathing suspended.

## THIRD CLINIC STAGE.

Ridgity subsides, succeeded by clonic spasm, invading every muscle of the body. Head twists, mouth moves, respiration quick, shallow, imperfect, noisy, due to contraction of the laryngeal muscle. At the commencement of fit, pulse full and hard, at the end almost imperceptible, skin inactive, during fit patient is insensible more or less profound. Prognosis, one, three, four, die.

## DIAGNOSES.

Hysteria, not unconscious, general condition, young, nervous women are most likely to have it, commences in legs, family history, presence of albumen. It is hard to diagnose in some cases.



## PATHOLOGY.

A disease of toxæmia is probably dependent on acetine in the blood which may set up the nephritis, albumen decomposed to urea, these are not uræmic convulsions, and the albumen hypothesis would necessarily involve a large kidney lesion, another theory, anæmic condition of the brain depending on several causes, watery condition of the blood, arterial tension.

## TREATMENT.

Advisability of producing labor, if albumen is present and no convulsion. It is not advisable for many reasons to bring on labor, diet milk, out door exercise, free purgatives, to improve general condition. Ferri, digitalis, convulsion, advisability of bringing on labor, some authors state increased irritation of dilating the os may prove fatal. Waiting 2 or 3 hours is sometimes better than forcing labor if possible; if necessary first puncture the membranes, immediately the head is within reach apply forceps, keep patient under chloroform, hypodermic injections of morphine and atropine are beneficial, chloral and pot. brom. are also useful, copious enemata, application of ice to head and leeches to neck, if patient is young and full blooded, attack severe, intervals short, kidney impaired, urine scanty and cloudy, bleeding is good. It is also necessary to put a gag in the mouth to prevent patient from injuring herself by biting the tongue. Before closing I would like to mention a case that came under my observation about twelve months ago. I was called in to see a Mrs. L., age 21 years, never been sick before; at the time she was about 7½ months along, she complained of head-ache and dizziness of sight, and constant pain in the lumbar region, on examination found oedema of legs, had not passed usual quantity of urine for almost 7 days. I gave the pot. brom. gr. xx and left saying I would call again in a few hours. Two hours afterwards her husband came for me in great haste saying his wife was having convulsions. I went immediately and found such to be the case, eyes twitch-

ing, head firm and rigid to left side, I gave a hypodermic injection of atropine and morphine, then commenced administering chloroform, keeping the patient partially under the influence for the next twelve hours, at the end of which time there was no abatement of convulsions, I then called in Dr. F. Cauthorn, thinking it advisable to produce labor and needing assistance. After consulting together we decided to wait a few hours as there were signs of labor pains and thinking nature would do the work, but at the end of that time the symptoms were worse and no dilation of the os. We then introduced a medium sized silk and rubber catheter and ruptured the membranes; dilatation was very slow. The patient was then put under the influence of chloroform and Dr. Cauthorn introduced the forceps under difficulties as there was only room for the end of the blade, in fact I might say he partly dilated with the blade and in a short time the fœtus was delivered and lived about 6 hours, after which the patient seemed to improve slightly. She was treated as follows: mist. ferri et acetati ʒss. t., i. d. and elaterium as a purgative. Two days afterward the convulsions returned and the temperature ran as high as 106. I then used chloral, hypodermic injection of morphine and applied leeches to the neck when they diminished and in 10 days the patient was able to sit up, but did not regain her right mind for 2 months. Afterwards, at the present time she is in perfect health.



## ✓ NEURASTHENIA.

(Read by Title.)

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Our neurasthenic patients tell much the same story. While the detail symptoms are as varied as are the winds of heaven, there is generally that sensation of cerebral pressure, that "dreadful feeling" of indescribable helplessness coming upon the sufferer suddenly, and at times in the midst of strength; that sensation that now all work must stop; that inability to do certain things or to go to certain places, together with dizziness, pain in the head and through the body; pains through the limbs and a myriad of strange and unaccountable feelings and impulses which at times course through the body. There may be derangement of the nerves of special sense, nausea, *muscæ volitantes*, photophobia, undue dryness or undue moisture of the skin, flushing, cold hands and feet, hyperæsthesia, podalgia, and many other indications that the nervous centers are suffering irritation.

Rockwell classes the cases ordinarily called neurasthenia into neurasthenia proper, lithæmia and neurasthenic lithæmia.

Scientifically speaking, such a division is incorrect, for lithæmia is not a condition of a nerve exhaustion, but of nerve poisoning. But from a practical standpoint, permitting the term neurasthenia to stand for a certain train of similar nervous symptoms, forgetting the derivation of the word itself, the classification is a rational and practical one. Cases of lithæmia, to be sure fall within the province of auto-infection, the subject of which has been so ably treated by

Dr. Ch. Bouchard, in his work, entitled "Auto-intoxication in Disease," just issued by The F. A. Davis Co., of Philadelphia. This subject has also been handled from its bacteriological standpoint by Dr. J. W. Hickman, of Tacoma, in a paper recently read before the Washington State Medical Society, in which the author handles the subject according to the latest theories upon the question.

When a well-fed, phlegmatic, lazy individual presents himself, with a description of neurasthenic symptoms, we have no difficulty, in most cases, in correctly diagnosing the disease as one of auto-intoxication, but even some of these cases may be truly neurasthenic in character. With some, the tendency to accumulate adipose prevails in the midst of serious nervous difficulties, while some "lean and hungry Cassius" may be suffering from the most acute and distressing phases of self-poisoning, the result of absorption, which is taking place from an over-loaded and bacteria-charged intestinal tract.

The fact that in so many cases, lithæmia and true neurasthenia are interchangeable conditions, makes it easier, and it seems to me that every interest is better served, by treating all such cases under one general head of neurasthenia.

Taking this broad view of the subject, I wish to refer to but one phase of the disorder, by narrating some specially marked cases which have recently come under my observation in Portland.

CASE 1. A salesman, aged 23; father and mother living and comparatively healthy, although mother was "nervous and had to be careful what she ate." Patient was fairly well nourished, and had been of good health until a few years ago, when he began to suffer from nervous symptoms of various kinds. He had been under the treatment of a number of physicians for varying periods of time, but with his irritable disposition and the annoyance which he gave to any one treating him, he would not long remain with any practitioner. He came into my hands after being under the treatment of a



neurologist of considerable skill, who, tiring of the man's exertions, had summarily dismissed him.

He complained of a sense of impending disaster; he feared that he was going insane; he was irritable and morose, and made life miserable for his neighbors and friends, with whom he had frequent quarrels, although he was reputed to have been a few years before of an amiable disposition. He suffered from insomnia and feared evil results from some slight sexual irregularities in younger days. He would often in the midst of some work, suddenly have to cease it from a feeling of weakness which would overcome him. One peculiarity affecting this man was that at certain times he would be unable to pass a chair, but must take a seat therein, if but for a moment. No matter where he might be, if he suddenly came upon a chair, he would have an impulse to take a seat, which in many instances he could not resist. On one occasion he came to my office with a look of abashment on his face, as he related that he had been recently passing up the street, in front of the jail, seeing a chair could not resist the temptation to sit down. "Sitting in front of the jail, doctor! What will my friends think of me? Can't you do something else for me?" says he, with much mortification and excitement.

He had a voracious appetite and did not complain of digestive troubles, his nervous symptoms so completely overshadowing everything else. His tongue, however, was characteristic of his disease. It was not the bright-red tongue of one form of gastric disturbance, which we find so often accompanied by nervous symptoms, but the flabby tongue with the creamy coat. This man was now a "border liner," and one of those cases which, under confinement in an insane asylum and a restricted diet, is soon discharged as cured.

This patient, like nearly every one who has long suffered from neurasthenia, had gone from doctor to doctor, and from the care of one form of medical faith to another. He was, in fact, what Beard says most of these cases are, "a

rounder." Among other methods of treatment employed, had been tonics and reconstructives, sedatives and narcotics, massage and electricity, and other means looking to the relief of his mental troubles, but no special treatment had been directed to his digestive tract, so far as I could ascertain. At least, he had never remained with any physician who had treated him on this line for a sufficient length of time to attain the relief he desired, and so he had gone on to other and newer doctors.

Under the treatment now instituted, the narcotics and sedatives which he had been taking were withdrawn, and a treatment commenced directed to his gastric disturbances alone. A milk diet was instituted and maintained for two or three weeks, and later, a more liberal but carefully selected diet insisted upon for a long period of time. As to remedies, small doses of *nux vomica* and *hydrastis canadensis* were administered, together with such remedies as were indicated for any temporary minor deflections from health. The case was an interesting one throughout and much could be written about it if space at command would permit. The important point is that the man soon began to improve. The appetite was difficult to control, but in time it came fairly under subjection, and after some months' care, I had the satisfaction of seeing the patient restored to health. He once more regained his wonted energy and spirits, and could do as much work as he had done before his sickness, and his nervous symptoms had passed away. There is no doubt but that with care in his diet, he is permanently relieved from a condition where death almost would have been preferable, and in which "central" nervous disease would probably in time have developed.

CASE 2. A real estate dealer, a gentleman 64 years of age, for many years had been troubled with various obscure nervous symptoms of vague character. He was afflicted with insomnia and had aching pains across the loins and hips.



He would, in the midst of some work, physical or mental, suddenly be obliged to give it up. He had queer passing sensations, indescribable in character, in his head, and was generally miserable in body and mind. He often felt as though his brain was too large for its cavity. He was in a despondent mood and was only restrained by high moral principles and affection for family from taking his life. He had much headache and often complained of a sense of stiffness in the back of his neck over the cervical spine. Business matters, which in health would not have disturbed him, seemed to threaten his ruin and caused him unnecessary anxiety.

The closest examination of nervous system disclosed no organic trouble. The stomach digestion seemed normal. The heart and lungs were in prime condition, and not until the rectum was examined was any cause of the disease discovered. The rectum presented two large ulcers, and, apparently, the scars of others, although the patient did not complain of any local rectal distress, either present or past, commensurate with the disorder now discovered. The discharges from the rectal ulcers seem often to have an anæsthetizing property which do not permit to the rectum the impetus which is given it when normally fæcesfull, and by which a desire is imparted to void such organ. Therefore, the condition so often found in the rectal ulcers, constipation, was present in this case.

The rational treatment was employed in the local care of the ulcers, by usual methods. Paralysis of the sphincter and local applications of an alterative and disinfecting nature were systematically used. The recovery was, as in most cases, prompt and decisive. The nervous symptoms entirely subsided and new life seemed to have come into the man, and he frequently remarked that his muscles had taken on qualities of "tempered steel." He frequently, in the latter part of his treatment, walked up the seven flights of stairs to my office, in preference to taking the elevator, to demonstrate

to himself, and to the satisfaction of his physician, that he was as sound and strong as any man could be.

CASE 3. This was somewhat similar to No. 2, and the results reached were quite satisfactory. This gentleman had changed climates on two occasions for relief from his nervous symptoms, but never became entirely recovered until a somewhat serious rectal disease, of which he had thought but little, had been relieved. This man was affected with hemorrhoids, and a former operation had improved his health somewhat, although not entirely curing him, and it is likely that some ulcerative condition had persisted after the first operation.

CASE 4. This case is now under my treatment, in which, besides some of the ordinary symptoms, is present an inability to wait with patience or ease when ready to go anywhere. For instance, this gentleman lives up the river and comes to Portland by boat, having been sent to me by another gastric neurasthene, who was relieved by me three years ago. If, when he gets to the landing, the boat is not there he becomes almost uncontrollably nervous. He suffers severely in his attempt to remain in an apparently passive state, and, if the detention continues for any considerable length of time, he has an attack of diarrhoea. He does not become nervous if he is hurrying to catch a train or boat and fearful that he will lose it, but when he has to wait, then his neurotic symptoms show themselves. This man's trouble is entirely gastric, and in this case the patient fully understands it, for his stomach gives him much annoyance. He is just beginning treatment and it is too early to see much change, but I have no doubt but that he will recover.

CASE 5. A married lady, the mother of several children, and a woman of much business ability; had for some years past been treated for various nervous disease, but had not experienced the recovery which she had hoped for. Several months previous to the time she came to me, she had been



operated upon by an able gynecologist, for severe pelvic trouble, and had been much improved in health. Many of her neurasthenic symptoms however, had continued. Although the patient stoutly asserted that her digestion was not at fault, she was referred to me by her physician, who diagnosed digestive disorder. She was subject to constipation, and had a bright-red, sharply pointed tongue.

She had a good appetite, and nothing which she ate seemed to disagree with her. She slept well. She was poorly nourished and complained of many nervous symptoms. She had prickling sensations up and down her arms and legs, and at times could not go out on account of the pain which she experienced in her feet and toes when attempting to walk. Especially was this true when walking upon stone pavement.

One special feature in this case was that she did not feel that she could go into a public place where many people were congregated. She could not post a letter if a number of people were in the postoffice. She could not go into a store to trade, if there should be a considerable number of people present, without being overcome with that indescribable feeling of impending disaster, which would impel her to rush out as soon as she could do so. She could attend to her shopping if alone in the store, but as this was hardly ever possible, she had to leave to others this important duty of the feminine sex.

I am reminded, *en passant*, of a friend of the writer, a physician, who has since recovered, who for years carried about in his pocket a four-ounce vial of whiskey, to have at hand whenever he should be seized, as he occasionally would be, and sometimes in a trying position, with one of those seasons of death-like depressions so characteristic of neurasthenia. Case No. 5 was placed upon a strictly anti-dyspeptic treatment. I like in all these cases to begin with an absolute milk diet, or, at least, a fluid diet. As the withdrawal of meats and all stimulating foods sometimes exerts a decidedly depressing effect, I have found the liquid peptonoids an excellent preparation for these, and, in fact, in all cases where

forced nutrition is urgently indicated and easy digestibility a necessity.

This patient is just passing from under treatment. She feels like quite another woman. The medicines used have been few, anti-dyspeptic in character, but the regimen has been systematic and thorough. After a careful course of dieting, she has herself found that the stomach has much to do with her trouble, and that while one form of diet will leave her in a comfortable condition, another will bring on the nervous symptoms.

This case is illustrative of another fact, which is, that to be completely well, one needs to be well in all parts. While this lady made marked improvement after the surgical relief from pelvic disorders, the neurasthenia had been so long seated, no doubt the result of both the pelvic and gastric diseases, that the removal of one of the causes, whether it had been pelvic or gastric, would not have completely relieved the nervous state. After years of nervous irritation, she needed to have every exciting agency removed to afford complete relief to her nervous system. She is now nearly well. She is able to go about town every day and to attend to considerable business, and she is proud of her ability to again go into a crowded store and do her own shopping in comfort.

From one who has never worked out the problem of neurasthenia, the patient who is troubled with this condition often finds little relief. The existence of the disorder to such is not at all apparent. The fact is that the majority of these cases at first conceal from the physician the very features which specially mark them as neurasthenic in character. They begin to complain of their strange feelings at home, to friends and family. They receive no encouragement whatever. So unreasonable seem many of their symptoms that their disease is soon looked upon as either entirely assumed, or worse; the complainers are looked upon as "cranks." As their symptoms are either present or foreboding all the time, they soon tire out all about them with their vague de-



scription of strange symptoms. When a neurasthenic, therefore goes first to a physician, he has a reticence in referring to the peculiar features of his case, which have perhaps brought only ridicule elsewhere, and he is often under treatment for many months before he finally discloses the important pathognomonic features in his case, or perhaps he never does report them. It requires patience, therefore, and tact, to clear up the diagnosis in many of these cases.

The walk in life of our patient may sometimes help us diagnose the condition, for those in the better classes of society are the ones usually affected. Upon this subject I cannot do better than to refer to what Dr. I. N. Love, of St. Louis, has recently said thereon:

While by no means maintaining that leisure and wealth are the only conditions favorable to neurasthenia, so-called, I still urge, with Beard, that it is seldom found among those who live below the upper crust of the social world; that its habitat is rather in Fifth Avenue than the Five Points. The manual laborers of the world, however little they may know, generally know enough to rest when they are tired, and they have the advantage of fewer superheated and poorly ventilated homes, besides their muscular development holds down their emotional centers to a safe level. Neither are they, as a rule, disturbed by the trinity of A's which confront a large proportion of those in the higher walks of life, viz: Ambition, Avarice and Anxiety, and the trio of L's which environ the rest, viz: Laziness, Luxury and Lust.

From my inclusion of the foregoing cases under a title, neurasthenia, it becomes evident that my own opinion is, that gastric and intestinal disturbances can have much to do with so-called neurasthenia. Not only so, but for many years I have possessed the belief that, in a vast majority of cases, the cause could, by care and diligent research, be demonstrated to have a peripheral origin, and, in most of such cases, the origin to lie in the gastro-intestinal tract. That neurasthenia may be central in its origin, and that gastric and other reflex disturbances occur, is a well proven fact, but in very many cases, the history of which we see reported by ultra-neurologists, my opinion is, that the real disease should be properly located in organs other than the cerebro-spinal center. Neu-

rological symptoms may present from inherent or acquired defect existing in the cerebral cells themselves; or from a lack of tone from insufficient nutrition; a condition not only named but described by the term, neuropathia, a term which was, a dozen years ago, aptly coined by Dr. C. H. Hughes, editor of the *Alienist and Neurologist*, of St. Louis.

But while neuropathia or neurasthenia proper is a condition deserving a local habitation and a name, we must acknowledge that the greater portion of nerve symptoms are but reflex in nature, and that quite often the cause is produced by self-poisoning.

Bouchard says, when referring to such cause, in his work already referred to:

The (human) organism in its normal, as in its pathological, state, is a receptacle and laboratory of poisons. Amongst these some are formed by the organism itself, others by microbes—low forms of vegetables—which either are the guest—the normal inhabitants of the intestinal tube, or are parasites at second-hand, and disease-producing. Man is in this way constantly living under the chance of being poisoned; he is always working toward his own destruction; he makes continual attempts at suicide by intoxication. And yet this intoxication is not realized, for the organism possesses numerous resources which enable him to escape the intoxication which is always threatening. He throws off these toxic substances into a special reservoir, from which they afterward pass outward; and, besides, the blood subtracts from the organs the poisons as soon as they are formed.

This being true, is there any wonder, through imperfect operation of the great system which must largely discharge these poisons, with gastric and intestinal putrefactive toxins at work, that the nervous system is so frequently oppressed by many strange and distressing manifestations? When we think that the blood itself, in its normal state is loaded with toxic material, so that while it makes up one-thirteenth of the weight of the body, if, by venous injection, the so-called vital fluid be increased to one-tenth of the body weight, the increased toxic effect would cause marked nervous symptoms with early death of the individual, as pointed out by Bouchard, we are impressed with the fact that the intestinal emunctory must be ever active to permit a fair degree of



health. Bouchard not only demonstrates that this result would have to occur by mathematically comparing the body weight, amount of urine, urea and other poisons eliminated, amount of blood and number of complete blood revolutions per twenty-four hours, but he conclusively demonstrates the truthfulness of his theories by experimentations upon the lower animals. He also demonstrated that the intestinal blood is most poisonous of all. Thus, while he found that twenty-five cubic centimeters of blood per kilogramme of animal undoubtedly produced death, if, instead of drawing the blood from the general circulation, it should be taken from the portal vein, charged with biliary and putrid intestinal poison, it would require but fourteen cubic centimeters to cause death, per kilogramme of animal. As death itself will ensue if the blood contains two and one-half times the amount of poison normally found therein, what wonder is there then that the nervous centers are so often toxically impressed?

Under neurological treatment of these cases, mental and physical rest, medicine and diet, the patient recovers; while under gastro-intestinal treatment, without special mental and physical rest, most of them will also recover. A neurological treatment without care of the gastro-intestinal tract, on the other hand, gives in most of these cases negative results.

Beard says that neurasthenia is an American disease, in that it exists nowhere else as in this country. It is a strange coincidence that, the world over, dyspepsia is known as *the* American disease.

Sir Andrew Clark, who was an invalid from his childhood, whose parents both died of consumption so young that he never remembered them, was appointed upon a hospital staff during time of trouble between rival applicants, who thought that he was sure to die and leave again a vacancy within a year because he worked hard and ate little, remarked as he referred to the fact that all his first friends had passed away, that hard work, mental and physical, never kills;

might have gone further and said that one great cause which does unfit men for the best work, is their inordinate appetites and the fact that they never arrange time for their digestive system to take care of the food they are crowding into their stomachs. With a sufficiency of good, plain, clean, digestible food, and a season devoted to digestion, with plenty of sleep, we should not hear so much about these "American diseases."

If, by any chance, the case presenting for treatment should be neurasthenia of central origin, we must carefully differentiate cerebraesthesia from myelasthenia, moderate brain activity does good. In cerebraesthesia, bodily exercise is almost essential, while in myelasthenia, the patient must often be put to bed to enforce bodily rest.

A gastric neurasthenic must not expect that he can longer abuse his digestive tract. After recovery he must, by care, protect the organ which has made him his trouble. He must ever be on his guard. Fortunately, he generally has early warning of approaching danger and can, if he be wise, avert the threatening nervous storm.



✓ THE ANTISEPTIC TREATMENT OF DISEASE AND ANTI-SEPTIC SURGERY.

(Read by Title.)

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*Mr. President and Members of the Oregon State Medical Society. Ladies and Gentlemen:*

By the kind invitation of your executive body, I have been invited to read before this meeting a paper on some voluntary subject. The above subject I have selected believing it may interest you, and principally for two reasons, first, because at the present time the practical value of internal antiseptics is being commented upon and secondly, because union without suppuration is certainly the grandest triumph of modern surgery. In the whole domain of therapeutics there is no more simple or attractive theory, than the one which tends to advance the intrinsic value of antiseptic medication. Medical journals and pamphlets all over the country teem with the remarkable merits of the so-called anti-parasitic drugs. Notwithstanding all that may be said in their favor we cannot, however, place too much reliance upon their practical utility in the treatment of disease. The rapid strides of modern pharmacology are becoming alarmingly productive and nowhere, perhaps, is the spirit of experimentation and investigation so conspicuous as in the direction of general sepsis. Anti-parasitic, anti-microbic and antiseptic remedies are the popular therapeutical gems of the day. Asepsis, however, in the treatment of all parts of the human body

does not seem so plausible a theory as experimental pharmacology would have us believe. The purifying and sterilizing of wounds impregnated with bacterial poison is at once suggestive and practical. A method, however, of destroying bacteria or neutralizing their effects within the organs and tissues of the body has many obstacles to overcome. The anti-microbic elements of a drug, however successful they may be in proving themselves qualified germ destroyers in the laboratory test tube, may encounter in the test tube of the human body conditions of so totally a different character that their workings may be retarded or even entirely destroyed. The various acid or alkaline media through which the anti-parasitic remedy must pass, a possible conflict with the principles of osmosis, the influence of mucous or purulent fluids, all operate more or less antagonistically against any definite result. And moreover, it is not difficult to understand that many organisms to which are attributed some of the more common forms of disease, are inaccessible to the action of the so-called germicides when we consider that long before the main lesions have become manifest, or the disease is organized, these organisms have passed into the lymphatics into the interstices of the lungs, the liver and the spleen. Other things being equal, therefore to be of practical value as a germ destroyer, a remedy must be capable of pursuing the microbes of disease into the very furthest recesses of the body and there destroying them. Out of the long list of antiseptic remedies, including naphthaline, salicylate of soda, subnitrate of bismuth, salol, thymol, eucalyptol and creosote, we have not a perfectly trustworthy and efficient germicide, for none of these are capable of pursuing the microbes of disease into their innermost lairs, and there destroying them without risk or injury. It is gratifying to note that at this time the medical profession is undergoing a most interesting transition from the extreme views formally held in regard to the employment of germicides. Not more than a very few years ago, it was deemed to be scientific and progressive to use



antiseptic measures of the most energetic kind in all operations whether there was a septic element to combat or not. Modern investigation tends to prove the harmful effects of germicides upon normal structures and bacteriologists even go so far as to teach that the so-called antiseptic agents are capable of setting up septic processes in healthy tissue, so the surgeon is urged to eliminate germicides from his surgical procedures in ordinary cases and confine the cleansing of recent wounds to simple sterilized water. And it would properly seem that it is about time for bacteriologists to halt a while in their restless search after the microscopical accompaniments of certain diseases, and pause to consider what they are accomplishing for the good of therapy. It has been ascertained almost to a certainty that the tubercular process for example, is associated with a certain form of microscopic growth which is not found as an accompaniment of other diseases, and it is therefore assumed, and correctly no doubt, that this micro-parasite is the cause, either directly or indirectly, of tuberculosis. This is all very well, it is a plausible theory and one that offers great inducement of advance in the therapy of certain diseases. But is it not also apt to blind us to the actual necessity of treatment, and cause us to neglect the plain and indicated medication while enchanted in the play of running after some specific microbicide. It is natural to suppose that since the so-called germ theory of disease has become an established fact of the utmost importance to mankind, ranking one may say, as one of the grandest scientific discoveries of the present century, that the study of the various so-called antiseptics and their action upon microbes, has become an indispensable branch of knowledge to the physician. Through the researches of experimenters, it has gradually come to be recognized that microbes are more easily affected by one kind of antiseptic than by another, according to the particular species of germ or virus under consideration. This fact, coupled with the presumably antagonistic circumstances already quoted, open up new grounds for discussion so that at

the present time, the whole question of antiseptic medication is in a state of uncertainty and confusion. During the last twenty years the employment of antiseptics as a means of prophylaxis has formed a most important adjunct to hygiene and will end, combined with careful attention to the laws of hygiene, in diminishing the extent of the ravages caused by zymotic diseases, and it is to be hoped that the time will come when the true theory will flash out, when the rampage of cholera, small pox and yellow fever will be forever stamped out. Medical men, are, I believe, as a rule, apt to ride a hobby to death, a little harder, perhaps, than men of any other profession and especially do we find hobby riders in the germ theory field; and you will find many not satisfied in accepting what has already been proven, but they must assume what remains to be and which possibly never will be. You will find them looking for bacilli in every departure of the human organism from health. As a curious illustration of this the following is but one of many: Not long since a Russian investigator examined the water obtained from melted hailstones and found it to contain several varieties of bacteria. There was nothing very remarkable about this discovery for it would have been indeed strange had no bacteria been found, but what was remarkable were the conclusions which the man drew. He thought it very probable since rain, snow and hail had been found to contain micro-organisms, that there was a specific microbe in the hitherto undiscovered disease to which only those were liable who had been exposed to a storm, and had been wet to the skin by water containing these peculiar bacilli. In these days when sanitation is happily so well to the front, when preventive medicine and hygiene are advancing so rapidly, it does not seem strange that the study of the common causes of contagion should receive so much attention. And I believe that in the education of public opinion in relation to the dangers that foster the spread of disease, lies one of the noblest works of the scientist, and as the masses become more and more acquainted



with the elements of contagion and the laws of sanitation, will the dread diseases of our time which leave in their wake cries of anguish and tears of desolation, become less and less frequent. One sees everywhere sources of common contagion on every hand, media through which the evil is promulgated, the dust of the street, the insects that infest the atmosphere, the habit of kissing, and some people make a business of kissing everything, kissing animals, birds, dogs and cats and the habit of putting money into the mouth is very suggestive of the transmission of disease. Children and even grown people will put silver pieces and pennies into their mouths and I have wondered that the habit has not been more productive of disease than we have observed. A common source of contagion lurks in all barber shops from the poorest to the best. It is notorious that cleanliness so far as utensils are concerned, is an attribute sadly lacking in even the best barber shops. Impetigo contagiosa, syphilis, sycosis, various forms of dermatitis, alopecia areata and ringworm, cases of all these dermatoses have been reported as having their origin in all probability in the barber shop. The agents of contagion being the dirty finger nails of the barber, the head rest of the chair, the razor, the powder puff and the hair clipper. These are some of the common sources of danger and it is plain to be seen how much more intelligently asepsis can be applied in their prevention rather than their cure.

The apostle of English sanitation has said: "Let me build the houses and I can determine the ages at which the people will die." This is perhaps an extreme statement for there are many elements outside the home which go to determine the length of our lives, but in our beneficent land with its mild climate, if the house is what it should be and men and women exercise common sense and judgment in reference to matters of health there is no reason why in this land at least people should not live to a very old age. In summing up this subject it may be said that in the future preventive medicine will take just pride in its advancement.

Cholera, consumption, typhoid fever and a host of other diseases will cease to be the scourge they now are. In reviewing the dangers of antiseptics, I find that Emil Senger in a paper read before the Berlin Medical Society pointed out the liability of danger to the kidneys and other organs from antiseptics. Senger therefore recommends surgeons to avoid antiseptics in operations over the thorax and abdomen, urges them to employ either sterilized water as practiced by Lawson Tait, or a solution of salt. He proved first that this kills the streptococcus pyogenes aureus in 28 minutes and its effect is independent of the strength or degree of concentration for a 5 per cent solution is just as effectual as a 20 per cent. He claims that chloride of sodium does not in any way injure the organs that no dose is strong enough to kill any animal. Even in this great field of asepsis, seemingly there is nothing new under the sun, and we are going back to the practices of the ancients and a few interesting facts in reference to the employment of antiseptic measures among the ancient Greeks would here be in place. Hippocrates and Galen were aware that an unclean condition of wounds retarded healing. They were also well acquainted with the fact that by the employment of antiseptic measures infection might be prevented. Hippocrates warned his disciples against the use of moist dressings on account of the danger of suppuration and forbade the employment of drugs before the wound was dry; says Galen avoid dirt as it prevents healing. The ancient Greeks boiled their water before applying it to wounds; sponges were avoided and sharpil recommended in their stead, which was to be destroyed after use. One of the principal antiseptics substances then in use was wine, which was usually heated before using and with which according to Hippocrates, all wounds were to be washed. Salt was in very general use either in solution or in the form of sea water. The solutions were rendered aseptic by boiling; sulphate of copper was relied upon as an antiseptic for foul wounds. Galen was acquainted with catgut and advised the use of non-putrefying



substances for suture. These surgical procedures practiced so long ago by the ancients, were founded upon some knowledge of the principals governing the healing of wounds and it is interesting to note that we at the present time are impressed with their simplicity and their efficacy. It is claimed that the antiseptic action of a very weak solution of corrosive sublimate is increased by heat and that so used they are as good as strong solutions. This has a very important meaning. Mr. Richet, Prof. of Physiology at the Paris faculty of medicine demonstrated some years ago that 5 centigrams of mercuric chloride in 100 grams of urine would prevent putrefication, if it were heated up to 43° centigrade, but if allowed to remain at 30° centigrade it would rapidly spoil. A solution of 3 per cent of carbolic acid will allow the virus of gangrenous septicaemia to grow, but it will destroy it if the solution is heated up to 36° centigrade. Many surgeons are now using very weak solutions of the stronger antiseptics and find them sufficiently strong when properly heated. This method certainly presents an advantage that all see at once, that is, that there is but little danger of poisoning; toxemia that is so much talked about at the present time especially after obstetrical operations may thus be avoided by using simply hot and weak solutions. Dr. Ruppert of Dresden, who performs a great many operations, says that for years he has never had a case of carbolic poisoning as long as he used a 3 per cent gauze, for children a 1 per cent especially prepared. He makes the statement that at one time his supply of 3 per cent gauze became exhausted and he was obliged to use for several days a much stronger gauze, with the result of having upon his hands three cases of well marked carbolic poisoning and he draws the following conclusions:

1. A 3 percent gauze; for children a 1 per cent which is amply strong to insure an aseptic condition of wounds.
2. A 6 per cent gauze employed in larger dressings may produce death by absorption.

3. Manufacturers of carbolized gauze would do well to state upon labels the per centage of carbolic acid contained in the product.

I propose now to leave the subject for your discussion at this rather cut short ending, believing that your personal experience with the various antiseptic agents both in medicine and surgery, and your methods of treating disease and handling surgical operations aseptically will prove both interesting and instructive.



SOME NEW THOUGHTS ON THE TREATMENT OF TALIPES,  
OR CLUB FOOT.

BY H. B. STANLEY, M. D., DALLAS, ORE.

In the treatment of a subject like this, it is very difficult for any writer to confine his remarks strictly to the text of the subject; because frequently in any essay many of the *new* thoughts are not good, and vice versa many of the *good* thoughts are, strictly speaking, not new.

The word "Talipes" is derived from two latin words, talis, ankle, and pedis or pes, foot. The word is most appropriate, because the apparent deformity is in the foot; while the real lesion, or lack of development is in the ankle and the ligaments, tendons, and other structures contiguous thereto. In the correction of all orthopædic deformities, after the parts have been brought into their normal relations, it is only necessary to observe four points in the after treatment to effect a perfect cure. Those four points are pressure, counter-pressure, extension and counter-extension. After the necessary operation has been performed to free the parts from their abnormal restraint, by keeping up extension and counter-extension with proper pressure, and counter-pressure, the limb will assume the appearance of health and perform correctly all the functions required by nature.

The great difficulty orthopædic surgeons have had to contend with in the past in all forms of talipes, has been to obtain an appliance by which they could get a proper counter-pressure and counter-extension.

Some years since, I devised a simple little splint which in my hands has met all the requirements in any form of

clubfoot, and has entirely superceded the complicated appliances which have been in use for so many years. The appliance which I here present to you for your criticism, is simplicity itself. It consists, as you see, of a tree such as shoemakers use in stretching the point of boots, with a thin piece of board nailed on the back, and another piece nailed on the bottom for the soles of the feet to rest against. The part applied to the legs should be just long enough to reach from the heels to the center of the popliteal space. The footpiece should be a little longer than the soles of the feet of the patient to whom it is applied. The splint thus made with a good heavy roller bandage furnishes all the pressure, counter-pressure, extension, and counter-extension required to keep any case of talipes in proper relations until nature effects a cure.

The usefulness and application of the splint can be better illustrated and explained by giving a very brief history of the last case treated by me on this plan. On the second day of March, 1894, Henry Haynes (the full name is given by consent of the parents) was brought to my office. He was suffering from equino varus in a marked degree in both feet. There was a noted lack of development both in the feet as well as the upper lip and palatal arch, he having had a very bad hare-lip and cleft palate. Some eight or nine months previous our worthy Secretary, Dr. Cauthorn had operated for the last named deformities with good success. Nine days after the first examination, the patient was thoroughly anesthetized and the tendons of the tibialis anticus and tibialis posticus of both feet divided. After wrenching and twisting the distorted feet into proper shape, they were placed in the splints and a roller bandage applied, tightly and firmly, with instructions to leave it on for twenty-four hours unless evidence of strangulation of the circulation should appear. At the end of twenty-four hours the dressings were removed and the feet bathed in hot water, when the splints were again applied with instructions to remove them twice a



day, and after bathing them in hot water, massage was to be performed over both feet and legs, but especially over the muscles opposing the tibialis anticus and posticus muscles; that is peroneii, tertius, brevis and longus as well as the exterior muscles of the toes. At the end of one month, the patient was again anesthetized and the tendo Achilles of both heels divided. The feet were again put into splints of the same pattern. After dividing the last-named tendons, I found it an easy matter to bring the feet into their normal position with but little force. At the end of three weeks from the date of the last operation, the splints were laid aside, and the feet were encased in plaster of Paris bandages. Every week since that time, the plaster of Paris has been removed, and the feet thoroughly bathed in hot water. For the last two weeks, no splints or supports of any kind have been used except at night. Each night at bed-time, the first kind of splint used is applied and allowed to remain until morning, when his shoes or stockings are put on and allowed to remain all day. At this time the feet, as you will see by the accompanying photograph, are almost perfectly straight.

The little fellow is beginning to walk, and gives every evidence of making a useful member of society instead of a hopeless cripple. To aid the retarded development, he has had nutritious food consisting largely of meat and milk, and three times a day he has taken ten drops of a mixture consisting of three parts of the syrup of the hypophosphite of calcium and one part of the syrup of the iodide of iron.

✓ OPTHALMIA NEONATORUM.

✓ BY RICHARD NUNN, M. D., POTTLAND, ORE.

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If there be a disease to which the epithet preventable may be applied it is purulent ophthalmia, occurring in the new born child a few days after birth.

When this statement is taken with the fact that many eminent authorities attribute to this disease the cause of at least eighteen per cent of cases of blindness in the large blind asylums of the country, it would seem that the laity, were they aware of this fact, might rightly ask of the profession why is this so.

Estimated only from a commercial point of view, what must be the loss to the country in dollars alone when all these numbers (amounting in the year 1890 to 50,411) of totally preventable cases of blindness are not only prevented from aiding to the countries' wealth, but must from the nature of their cases entail enormous cost for their support. It is not my intention to describe such a well known disease as ophthalmia neonatorum. The etiology, symptoms, treatment and disastrous sequelæ are only too well-known generally, though of course there may be some differences of opinion on this, like every other professional subject.

I will only say here that once the disease has been allowed to occur and has been recognized, a far more vigorous line of treatment must be taken than is usually the case. The time has gone by for using mild astringents and weak germicides. I do not recommend any particular drug, believing that there is more virtue in the method of treatment



than in this or that application. Perhaps I might suggest peroxide of hydrogen as a clean, strong and not painful application, but the efficacy of treatment consists in frequent cleansing by day and night and frequent and careful examination of the corners. This, by means of retractors properly used, can be done without any danger of rupturing even a macerated cornea; once the cornea shows any signs of being implicated atropine should be used; if the pressure from the resulting chemosis is very great the external canthus may be slit up or even a vertical incision may be made through the upper and lower lids and the cut ends be turned back.

But what I do wish to urge and to bring before this meeting, now that the specialists in this line of practice have shown whence the evil comes (I presume that no one present will deny that the cause, in by far the majority of cases, is due to direct infection of the conjunctiva from discharges from the genito-urinary canal of the mother, not necessarily gonorrhoeal), and that it can be almost entirely prevented, is that this meeting pass a resolution condemning the doctor or midwife who allows a child to lose the sight of even one eye from this cause.

What would be the opinion held of a confrere, who still refused to practice asepsis, and persisted in using the old water dressings or poultices in wounds made in operations. The cases are similar, in each we have the knowledge, the sure relations of cause and effect; when all this unnecessary misery, not to speak of pecuniary loss, can be prevented by each accoucheur disinfecting the eyes of each child with a few drops of a one per cent solution of silver nitrate or any other equally effective disinfectant. It is really high time that professional societies should condemn those who are guilty of what amounts almost to a crime. Fox and Gould in their little work on diseases of the eye write:

"A large part of the blindness of the world is caused by ophthalmia neonatorum, which is both preventable and curable if some one were not at fault;" and again; "The obstet-

rician who fails to drop a solution of nitrate of silver (or other germicide) in the eyes of every new born infant, should be deprived of his diploma."

The states of New York, Maine and Rhode Island have passed laws which have for their object the preventive treatment of this disease, and you will be asked to-day to use your influence to obtain similar action by the legislature of this state.

The law in New York, known as Chapter forty-one of the laws of 1890, is as follows:

✓ AN ACT FOR THE PREVENTION OF BLINDNESS.

"SECTION 1. Should any midwife or nurse having charge of an infant in this state, notice that one or both eyes of such infant are inflamed or reddened at any time within two weeks after its birth, it shall be the duty of such midwife or nurse so having charge of such infant, to report the fact in writing, within six hours, to the health officer or some legally qualified practitioner of medicine, of the city, town or district, in which the parents of the infant reside.

SEC. 2. Any failure to comply with the provisions of this Act, shall be punishable by a fine not to exceed one hundred dollars, or imprisonment not to exceed six months, or both.

SEC. 3. This Act shall take effect on the first of September, eighteen hundred and ninety."

Whether this is a proper matter for the legislature to take hold of or not, opinions may differ. Those holding socialistic opinions will differ from those holding individualism, and the latter may raise a cry of paternalism. This is for each man to settle with himself, and I would not attempt to dictate on so broad a question. But we, as professional men, knowing the ease by which this disease can be prevented and cured, and also knowing its disastrous effects, ought to condemn those of our profession who allow helpless children to be thus blinded for life.



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 INTESTINAL ANASTOMOSIS.
 

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Since intestinal surgery is so prominent a topic among the surgical controversies of the day, and more especially that portion of it which relates to anastomosis, I trust you will join me in a brief discussion of the subject.

The term "intestinal anastomosis" is now broadly applied to all forms of establishment of fistulous communication between different parts of the digestive tract. Thus gastro-intestinal, choledocho-intestinal and entero-intestinal communications whether end to end, lateral or by implantation, are known as anastomosis. To realize how rapid its process of evolution, as a surgical procedure, one needs but to recall that only a decade ago these operations were attended with appalling mortality.

Since Rahmsdohr, in 1780, first restored the continuity of the divided intestine by suture, invention has run riot, till now, the different forms and methods of suture, and complexity of mechanical contrivances which are extolled as especially applicable to the bowel, are legion.

Of these, many are imperfect, a few are ridiculous, some ingenious, most of them complicated, while but one is, in my opinion, at once expeditious, safe, and practicable.

Of the many sutures, Lembert's only has stood the test of time, and is today unequaled by any with which we are acquainted. The straight common sewing needle is the best in general intestinal surgery, and for suture material, the pure purple silk, red or black, should be selected. Although

the operation of restoring obstructed or interrupted intestinal circulation, was resuscitated from many years of obscurity and placed on a practical basis by Senn. His ingenious decalcified bone plates though given to the world as late as '87 are already nearly consigned to oblivion, inasmuch as better methods now obtain. The same may be said of the catgut rings, vegetable plates, segmented rubber tubes, and other similar contrivances which are in general, inferior to Senn's plates. All of them have been found to be followed by too rapid cicatricial contraction, and occasionally by leakage, suppuration, or hemorrhage, or similar complications.

I fully realize that some of you will, in the discussion to follow, bring me to task for relegating to the past the Senn plates, but I will not only repeat, but reiterate the statement, and submit for your consideration the proposition that there are but two methods by which intestinal anastomosis should be resorted to, and that in a great majority of cases the one to be adopted should be that without suture, which I am about to demonstrate, viz: the "anastomosis button" of that brilliant American surgeon, Dr. J. B. Murphy, of Chicago. This ingenious, time-saving device has so many advantages over any form of suture-method, that I know of hardly any circumstances under which it should not be preferred. In my estimation there are no such circumstances, except an emergency where the button can not be procured. The other method to which I refer, and which I will designate as an emergency resource, is the long, four inch incision, with lateral approximation by double rows of continuous Lembert-suture, as modified by Abbe.

But perfect as appears to be the result in this method of "free-hand" anastomosis, when successfully accomplished, it like the other suture methods is open to grave objections. In it life depends upon the exactness of application of each loop of the entire double row of sutures. Verily, indeed, then under these conditions does "life hang upon a thread," for, if any single portion is too tight, sloughing, leakage and



fatal peritonitis will result. If not tight enough, the same accident will happen minus the slough. If this long serpentine suture is too superficially applied, its light peritoneal support will at some treacherous point yield to the intermittent struggles of peristalsis, and that fatal leakage again asserts itself. But if caution in this direction prompts us to embrace enough of sub-serous tissue to insure against such an accident, we cannot be assured that a single small fraction of a loop of this 18 to 20 inches of suture has not entered the lumen, or nearly enough to become septic, and by capillary absorption reached the peritoneal domain!

Alas! results have demonstrated that this fear too, is well grounded. But the greatest objection of all is the usually dreadful, and often fatal shock which so frequently follow the application of the tedious suture method.

Should we not then embrace with delight that *gem* of intestinal surgical devices—the anastomosis button of Dr. Murphy. Its application is safe, simple and rapid. It *sustains* exact contact of the opposed peritoneal surfaces, absolutely preventing leakage, while it furnishes no source for sepsis or hemorrhage and while it steadily and without irritation produces pressure, necrosis and liberation of itself within a few days, if firmly locked; in the meantime, it permits of the uninterrupted circulation of intestinal contents through the opening in its cylinder. It can be placed in four or five minutes with mathematical precision. I will not occupy your time in describing its mechanism and technique of application as I exhibit the set to you, and will demonstrate its insertion into the intestine of the living animal.

I am not usually in favor of adopting new surgical procedures, before mature judgment and ample time have demonstrated their value, but in my opinion, the Murphy button has given such uniform results, both experimentally and clinically, that its general adoption should be recommended. It is *widely* applicable to intestinal surgery, rendering much less formidable all abdominal sections for restoration of the

intestinal circulation, as from obstruction, volvulus, multiple gun-shot, or other serious wounds, gangrenous hernia, or any of the many traumatic or idiopathic conditions, which demand an immediate enterorrhaphy. For the re-establishment of gastro-intestinal communication in pyloric stenosis, it is invaluable, for in this class of cases time-saving is a great desideratum, because of the usually debilitated condition of the patient. The button also meets this urgent demand for rapidity of operation and avoidance of shock by prolonged exposure of the abdominal contents, in serious wounds of the bowel, where without we could not resort to immediate enterorrhaphy, but would have to be content with an artificial anus. To briefly recapitulate, then, the Murphy button establishes a lateral anastomosis, as well as any other method, with much greater rapidity and safety and no greater degree of contraction.

For end-to-end anastomosis it is the ideal method, with which none can compare, and it is the *ne plus ultra* of cholecystenterostomy.

I will not occupy your time with a further enumeration of the advantages of this device, but will leave it to you in discussion to enlarge upon—you can not well detract from—its good qualities.