make upon this is that the French surgeon probably did not appreciate the factor on which his success depended—namely, the contractility of the internal cicatrix—nor the importance of the element of time in bringing about the results aimed at.

In conclusion, may we not indulge a hope that the views discussed in this paper may fructify in the minds of others not only in explaining unlooked-for beneficial results of partial operations, even of operations which at the time seemed to fall short of the mark and intention, but also may now and then point out an easier and safer and a less deforming method of remedying overgrowths or deformities?

BLOODLESS AMPUTATION AT THE HIP-JOINT:

WITH A SYNOPSIS OF FORTY-THREE CASES.

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A MAN twenty-five years of age consulted me on Aug. 11th, 1894, on account of a large tumour of the left thigh. From Dr. E. T. Steadman of Hoboken, New Jersey, the following history was obtained. In November, 1893, the patient was found to have a tumour about the size of a goose's egg occupying the middle anterior aspect of the left thigh. Two months before this date, while springing suddenly into a descending car, he felt something snap in the location of the tumour. He says he did not notice any tumour until four weeks later. This tumour was dissected out by Dr. Steadman. It was located beneath the sartorius, not attached anywhere, except at its upper end, where it was adherent to the sheath of the femoral vein. The wound healed nicely. Six months later (May, 1894) there was recurrence; and when I saw him in August a large oblong tumour occupied the left thigh, extending from four inches below Poupart's ligament to the same distance above the knee. It was adherent to the soft structures and surrounded by the femoral vessels. I advised amputation at the hip-joint, which I performed on Aug. 15th at the Polyclinic Hospital after the following method.

1. In the usual position for this amputation the limb was emptied of blood by elevation and application of the Esmarch rubber bandage from the toes to within two inches of the tumour.

2. While the member was still elevated, and before the Esmarch bandage was removed, the rubber tubing constriction was applied. The object of this constriction—and it is the chief point in the method—is the absolute occlusion of every vessel at the level of the hip-joint, safely above the field of operation, permitting the disarticulation to be completed and the vessels secured before the tourniquet is removed. (Fig. 1.) To prevent any possibility of the tourniquet slipping I employed two large mattress needles or skewers, about three-sixteenths of an inch in diameter and ten inches long, one of which was introduced an inch below the anterior superior spine of the ilium and slightly to the inner side of this prominence, and made to traverse superficially the muscles and fascia on the outer side of the hip, emerging on a level with and about three inches from the point of entrance. The point of the second needle was made to enter one inch below the level of the crotch internally to the saphenous opening, and, passing squarely through the adductors, to come out an inch below the tuber ischii. The points were at once shielded by bits of cork, to prevent injury to the hands of the operator. No vessels were endangered by these skewers. A piece of strong white-rubber tube, half an inch

in diameter and long enough when tightened in position to go five or six times round the thigh, was now wound very tightly round and above the needles and tied. The Esmarch bandage was then removed.

3. In forming the flaps in this case, in order to keep as far as was possible from the tumour, a short anterior skin flap was made parallel with Poupart's ligament and one inch and a half below the tourniquet. On the inner and outer aspects of the thigh the line of incision was carried well

FIG. 1.

The needles and constrictor applied. Circular and longitudinal incision for skin flap.

down, forming a long posterior flap. This was dissected up in its entire circumference as high as the constriction, and in it was included the subcutaneous tissue down to the muscles. In order to facilitate the dissection the cuff was split longitudinally over the great trochanter up to the tourniquet. The flap was held well up out of the way and one inch below the constriction, and the muscles, vessels, and nerves were cut squarely across by a circular sweep down to the femur. A second circular sweep was made five inches above the knee; the intervening soft parts were split by a longitudinal cut along the outer aspect of the thigh and by a few strokes of the knife were rapidly stripped from the femur. (See Fig. 2.)

FIG. 2.

Cuff of skin and subcutaneous fat turned back; muscles divided at the level of the small trochanter; bone partly stripped, and large vessels exposed for deligation.

The vessels were now tied (veins as well as arteries) with catgut. This accomplished, the muscles were with scissors or scalpel divided from their insertion into the two trochanters and held away by strong retraction, while the capsule, readily exposed, was divided, the ligamentum teres forcibly ruptured, and the dismemberment completed. The constricting tube, still in position, was now gradually loosened, and every bleeding point, thus safely demonstrated, was at once secured by forceps and ligature. No blood escaped from above, and none was lost, save that necessarily in the thigh between the limits of the Esmarch bandage and the constriction. Satisfied that all sources of bleeding were secured by ligature, except the oozing, which the compression of the dressing would control, the constrictor was again tightened, a twist of sterilised gauze packed into the cavity of the acetabulum and brought out through the outer part of the wound, and the operation completed by silkworm gut sutures and antiseptic dry dressing.

The time consumed was fifty minutes; the antiseptic was ether (only a small quantity was used—in all about ten ounces); the pulse was strong, full, and regular when the patient was put to bed at noon. Two hours later, after consciousness was restored, the pulse suddenly and rapidly increased in frequency, a profuse perspiration was present, and shock supervened, in which condition, without response to hypodermatic stimulation, he sank and died twenty-eight hours after the operation. This was my fifth (and only fatal) hip-joint amputation by this method. In addition to the case herewith reported, the operation by this method has been performed forty-two times with a death-rate of 21.42 per cent. (Six were re-amputations.)

	Cases.	Deaths.	Per cent.
Sarcoma	18	2	11.1
Inflammatory bone disease ...	19	3	15.78
Violence	4	4	100.0
Nerve injury	1	0	—
For disease	37	5	13.51
For injury	4	4	100.0

Ashhurst's table of 633 cases gives a total mortality of 64.1 per cent.

	Cases.	Death-rate per cent.
For disease	276	40.2
For injury	309	82.4

Luning gives:—

	Cases.	Death-rate per cent.
Gunshot wounds	239	98.0
Disease	153	42.0

As the method is yet so little known I hope I may be pardoned for adding the following comments by those who have employed it. Professor W. W. Keen, who employed this operation successfully at the Jefferson Hospital, Philadelphia, in January, 1892, for an enormous sarcoma of the thigh (the patient being five months pregnant at the time), in reviewing all the methods of controlling hæmorrhage, said: ¹ "It was reserved for an American surgeon to devise what is undoubtedly the best method, and in fact what I think we can call now the only method of hæmostasis in amputation at the hip-joint." Professor J. B. Murdoch of Pittsburg, who has four times performed hip-joint amputation, and once by my method, says: ² "I believe this method to be the best, and the one destined to supersede all other methods for the temporary arrest of hæmorrhage." Professor W. F. Fluhrer ³ emphasised "that as little blood had been lost as in an ordinary amputation at the middle of the thigh." Professor McBurney ⁴ expressed the opinion that "no other appliance that had been suggested for the purpose could in any way compare in utility with that of Dr. Wyeth's." Professor Emory Lanphear of Kansas City, who has four times amputated at the hip by this method, says: ⁵ "This operation (Senn's) ⁶ is certainly better than any other yet

¹ The Medical News, March 26th, 1892.

² Annals of Surgery, January, 1893.

³ International Journal of Surgery, 1890. ⁴ Ibid.

⁵ Kansas City Medical Journal, May, 1893.

⁶ This method, devised by Professor N. Senn, requires an incision eight inches in length, commencing three inches above the trochanter; the capsule, trochanter, and upper portion of shaft are exposed, the trochanteric muscular attachments severed, the digital fossa emptied, the capsule divided, and the head of the femur dislocated before any constriction for the control of hæmorrhage is attempted. I do not think that this method will be received with favour by surgeons. The only instance in which it has been applied, to my knowledge, was by Dr. W. D. Foster of Kansas City. "The patient was the subject of chronic coxitis, was much emaciated, and very weak. The operation was tedious, protracted, and bloody, and the patient survived between three and four hours." (Private communication.)

devised, save that which is known as the 'Wyeth bloodless method,' by which method failure to control hæmorrhage seems to me to be impossible." Professor McFadden Gaston of Atlanta says: ⁷ "There was absolutely no trouble from hæmorrhage and I feel satisfied that with this process all bleeding may be prevented in amputation at the hip-joint." Dr. B. Merrill Ricketts of Cincinnati writes me that "the operation was entirely bloodless." Dr. W. B. Johnston of Ellicottville, New York, writes: "There was not one drop of arterial blood, and only a slight venous oozing from the muscular tissue." Professor H. O. Walker: "We have in this a safe and reliable method for controlling hæmorrhage, which, in my judgment, is superior to any yet offered." By personal communication Professors McCosh, Baxter, A. M. Phelps, Hartley, Parham, and Holloway have expressed themselves that the method meets every requirement in the prevention of loss of blood. The question of shock is very important in this major operation. It is strongly brought out by Professor Murdoch, who insists that "the greatest care must be exercised to maintain the vital forces by the moderate use of stimulants before the operation and the protection of the surface of the body from cold and exposure during its performance." To this should be added the minimum of anæsthetic and the maximum of rapidity in technique consistent with thoroughness and the prevention of bleeding. When ether is employed the Ormsby inhaler secures the safest narcosis with the smallest amount of ether.

In regard to the use of the steel skewers, while not absolutely essential, they add an element of security which should not be disregarded. Dr. Lanphear succeeded in holding the constriction in place with only one (the outer) needle. Dr. Deaver was equally successful in holding the tubing well up by two strips of roller bandage, one before and one behind, held by an assistant, and thus dispensing with the needles. As the pressure of the constricting rubber is considerable they should be strong. Dr. A. T. Bristow of Brooklyn informs me that on one occasion a skewer of inferior quality gave way, and hæmorrhage was narrowly averted.

In the formation of flaps the surgeon must be guided by the condition of the parts within the field of operation. When permissible the following method seems ideal. ⁸ About six inches below the tourniquet a circular incision is made, and this is joined by a longitudinal incision commencing at the tourniquet and passing over the trochanter major. A cuff that includes the subcutaneous tissues down to the deep fascia is dissected off as high as the tourniquet. At about the level of the trochanter minor the remaining soft parts, together with the vessels, are divided down to the bone by a circular cut, and, in order to facilitate the search for the vessels, the soft parts are rapidly removed from the femur for several inches below the line of the divided muscles. At this stage of the operation the larger vessels, veins as well as arteries, should be tied with good-sized catgut. ⁹ Before concluding the consideration of the technique I wish to emphasise a point of great importance. When, by reason of severe hæmorrhage before operation, or from any pathological anæmia or condition of weakness, the operation should be rapidly completed and the small amount of blood that will necessarily be lost from capillary oozing should be saved, sutures of silkworm gut should be rapidly introduced, the wound packed with hot, sterilised, plain gauze (not iodoform or bichloride gauze), and the

⁷ Transactions, Alabama State Medical Association, 1892.

⁸ At Bardstown, Ky., in August, 1806, Dr. Walter Brashear amputated at the hip in a negro lad seventeen years old on account of a severe fracture of the femur and laceration of the soft parts. A circular incision was made, the muscles were divided well below the hip-joint, and the vessels secured as the operation progressed. Then a longitudinal incision along the outer side of the limb exposed the remainder of the bone, which, being freed from its muscular attachments, was disarticulated at the socket (Professor D. W. Yandell, in American Practitioner and News, 1890). Dieffenbach's name has been prominently associated with this operation among surgeons, but Dieffenbach did not take his degree in medicine until 1822, sixteen years after the pioneer Kentuckian had performed his operation, which was the first hip-joint amputation in the United States.

⁹ I employ catgut in all cases and have never had a secondary hæmorrhage.

NOTE.—Brashear of Kentucky, in 1806, was undoubtedly the first surgeon to apply a constricting tourniquet near the hip, amputate the thigh, secure the vessels, remove the tourniquet, and then enucleate the remaining portion of the femur. Although unknown to me at the time my first operation was originated, I desire to give him full credit as the pioneer in this method. I employed the rubber tubing and secured it in place beyond all accident by strong steel skewers. It will be seen, however, that, as developed since my first paper in 1890, the operation is considerably modified and improved, and is now not only original but novel, 1894.

TABLE.—BLOODLESS AMPUTATION AT THE HIP-JOINT.

No.	Operator.	Date.	Age.	Sex.	Diagnosis.	Result.	Remarks.
1	John A. Wyeth.	Feb., 1890	39	Male.	Osteo-sarcoma.	Recovered.	At first operation femur was divided at level of lesser trochanter; sixteen days later head of the bone was enucleated.
2	John A. Wyeth.	Feb., 1890	34	Male.	Neuro-sarcoma of internal popliteal nerve.	Recovered.	The tumour of the nerve was extirpated February, 1888; recurred, and limb was amputated at lower third of thigh October, 1888; recurred again, and amputation at hip-joint was performed.
3	John A. Wyeth.	1892	17	Female.	Osteo-sarcoma of lower end of femur; amputation and recurrence in stump.	Recovered.	Amputation through lower third of femur was performed by Dr. Allen, of Cleveland, February 5th, 1892
4	John A. Wyeth.	Nov., 1893	23	Male.	Chronic hip-joint disease.	Recovered.	The femur was so firmly ankylosed to the ilium that force could not break them apart, requiring a chisel and hammer to effect separation.
5	Wm. F. Fluhrer.	May, 1890	18	Female.	Osteo-sarcoma of femur.	Recovered.	Spontaneous fracture at middle of thigh April 26th, 1890.
6	Charles McBurney.	May, 1890	34	Male.	Osteo-sarcoma.	Recovered.	—
7	Frank Hartley.	March, 1892	26	Female.	Osteo-sarcoma.	Recovered.	—
8	Merrill Ricketts.	Feb. 2, 1893	23	Female.	Osteo-sarcoma.	Recovered.	—
9	C. A. White.	May 26, 1891	23	Male.	Osteo-sarcoma.	Recovered.	Patient was up and about after operation, but on twenty-seventh day was seized with pneumonia and died five days later.
10	A. M. Phelps.	1891	55	Male.	Osteo-sarcoma.	Recovered.	—
11	W. W. Keen.	Jan., 1892	30	Female.	Osteo-sarcoma.	Recovered.	Patient was five months pregnant at date of operation.
12	M. J. Ahern.	1892	22	Male.	Osteo-sarcoma.	Recovered.	—
13	J. B. Murdoch.	Feb., 1892	17	Male.	Osteo-sarcoma.	Died.	Death from shock twenty-two hours after operation.
14	Chas. B. Nancrede.	Nov., 1892	32	Male.	Osteo-sarcoma.	Recovered.	—
15	J. McFadden Gaston.	Nov., 1890	—	Male.	Osteo-sarcoma.	Died.	Death on twenty-sixth day, from septicaemia.
16	A. J. McCosh.	1892	27	Male.	Osteo-sarcoma.	Recovered.	—
17	A. M. Phelps.	Dec., 1891	—	Male.	Long-standing destructive osteo-arthritis.	Recovered.	—
18	A. M. Phelps.	1892	—	Male.	Osteo-myelitis of entire femur.	Died.	Death from exhaustion twelve hours after operation. Condition of this patient was so bad that operation was contra-indicated, but was performed at urgent request of parents.
19	Emory Lanphear.	1890	9	Male.	Osteo-myelitis of femur.	Recovered.	—
20	Emory Lanphear.	1892	15	Male.	Osteo-myelitis of femur.	Recovered.	—
21	Emory Lanphear.	1893	28	Male.	Osteo-myelitis of femur.	Recovered.	—
22	Chas. B. Nancrede.	1893	31	Male.	Osteo-myelitis of femur.	Recovered.	—
23	Samuel H. Pinkerton.	1892	17	Male.	Tuberculous osteitis of femur.	Recovered.	—
24	Samuel H. Pinkerton.	1892	10	Male.	Tuberculous osteitis of femur.	Recovered.	—
25	Samuel H. Pinkerton.	1892	42	Male.	Extensive necrosis of femur.	Recovered.	—
26	Samuel H. Pinkerton.	1892	43	Male.	Extensive necrosis of femur.	Died.	Death twelve hours after operation, from shock.
27	Samuel H. Pinkerton.	1892	17	Male.	Osteitis of femur.	Recovered.	—
28	J. Ewing Mears.	1892	10	Male.	Chronic osteo-arthritis of hip.	Recovered.	—
29	Archibald E. Mallock.	1892	30	Male.	Chronic osteo-arthritis of hip.	Recovered.	Operation lasted thirty-five minutes.
30	John B. Deaver.	1890	20	Female.	Chronic osteo-arthritis.	Recovered.	—
31	John B. Deaver.	1893	20	Male.	Osteo-myelitis of femur.	Recovered.	—
32	R. L. Swan.	1892	19	Female.	Chronic osteo-arthritis of hip.	Recovered.	—
33	G. A. Baxter.	1891	17	Male.	Railroad pulpification of right foot, leg, and left lower extremity as high as middle of thigh.	Died.	Patient rallied well; four hours later raised himself in bed to reach a glass of water and instantly expired.
34	W. B. Johnston.	1892	39	Male.	Railroad pulpification of lower extremity, as high as middle of thigh.	Died.	Death ninety hours after operation, from shock and exhaustion.
35	J. D. Thomas.	1891	18	Male.	Femoral vessels divided in Scarpa's triangle by red-hot bar of iron; impending gangrene.	Died.	Great hæmorrhage from the accident. On seventh day after injury, amputation; death thirty-six hours later.
36	Samuel H. Pinkerton.	1892	6	Male.	Compound comminuted gunshot fracture of femur.	Died.	Two hours after operation death from shock.
37	Emory Lanphear.	1892	28	Female.	Osteoma of femur penetrating sciatic nerve.	Recovered.	—
38	H. O. Walker.	1892	14	Male.	Osteo-sarcoma.	Recovered.	—
39	H. O. Walker.	1893	21	Male.	Chronic hip-joint disease.	Recovered.	—
40	H. O. Walker.	1893	—	Young man.	Chronic hip-joint disease.	Died.	Exhaustion in four hours.
41	F. W. Parham.	Oct. 5, 1893	3	Male.	Osteo-sarcoma.	Recovered.	—
42	J. M. Holloway.	Nov., 1892	27	Male.	Osteo-sarcoma.	Recovered.	The patient was discharged from hospital on tenth day and went to his home, a distance of seventy miles, on the twelfth day after operation.

sutures temporarily tightened for snug compression of the wounded surfaces. This packing at once controls all oozing and can be removed in from twenty-four to forty-eight hours after reaction and the sutures finally secured.

WHAT SHOULD BE CLASSED AS DANGEROUS INFECTIOUS DISEASES ?¹

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ALL infectious diseases are dangerous to the public in regard not only to the deaths they cause, but to the suffering and ill-health they give rise to, and ought to be notified, so that, theoretically at least, they may be prevented by subsequent isolation, disinfection, and the other preventive measures with which we are all well acquainted. I repeat that all these infectious diseases can be stamped out and prevented theoretically; but what we have to consider is the practical bearing of the subject—the best results to be obtained practically under present existing conditions and with the present means at our disposal. Such is the subject I intend to deal with. The Notification Act of 1889, Section 6, gives as infectious diseases the following: “Small-pox, cholera, diphtheria, membranous croup, erysipelas, the disease known as scarlatina or scarlet fever, and the fevers known by any of the following names: typhus, typhoid, enteric, relapsing, continued, or puerperal; and includes, as respects any particular district, any infectious disease to which the Act has been applied by the local authority of the district in manner provided by this Act.” The latter half of this section applies to such infectious diseases as measles, whooping-cough, diarrhoea, phthisis, cancer, Influenza (with a capital I), leprosy, &c., and it must be remembered that it is to some of these at present non-notifiable infectious diseases that the high zymotic death-rate is chiefly due. The above-mentioned infectious diseases of the Notification Act become in a later Act—e.g., the Public Health (London) Act, 1891, Sections 58–74—*dangerous* infectious diseases, and of these I will treat in the above order as nearly as possible, pointing out at the same time those that I do not think ought to be so included—at least for the present.

Small-pox &c.—With an unprotected element gradually, but certainly, increasing, small-pox, by virtue of its extremely loathsome character and disfiguring tendencies, is perhaps the most important disease with which we have, or shall have, to deal; but in this connexion I would point out that in semi-protected persons this disease may assume such protean (modified) forms that the differential diagnosis between it and chicken-pox may become extremely difficult, if not at times well-nigh impossible. Such being the case, chicken-pox might with advantage, at least in times of epidemics, be classified as a dangerous infectious disease, and its notification be made consequently compulsory. In the same way and under the same conditions diarrhoea and sore-throat might be so classed in connexion with epidemics of the more serious diseases—cholera or typhoid fever, and diphtheria or membranous croup (this latter disease being an affection of the air passages indistinguishable in my opinion from diphtheria in origin). The difficulty in epidemic periods of drawing a line between diphtheritic and non-diphtheritic throats, between choleraic diarrhoea and true cholera, between chicken-pox and modified small-pox, is well known to us all, but personally I look forward with great hopes to these difficulties in the near future being dispelled by bacteriological diagnosis. The importance of this advance in the matter of children attending school is apparent. Bacteriological examination will be applicable in the same way to cases of cholera or suspected cholera, and will—in the near future, I hope—be applicable to chicken-pox and modified small-pox, now that we are on the point of capturing, if we have not already captured, the germ of small-pox.

So much for small-pox, cholera, diphtheria, or membranous croup, about the dangerous infectious nature of which there is no doubt, and for which notification, isolation, disinfection, and quarantine, or medical inspection, are all-important,

more especially when the first step (notification) is successfully and carefully carried out, and that, too, by the bacteriological methods mentioned above, if required. In this connexion I may mention, as a matter of interest, that in New South Wales there is a Notification Act (restricted to small-pox, however) requiring householders and medical practitioners “forthwith to report every case which may be reasonably supposed to be small-pox,” the responsibility then being removed from the practitioner to the Health Department. Some such wording in our Acts would be useful until such time as diagnosis became more certain or the rising generation of medical men more educated in infectious diseases.

Erysipelas.—As regards this disease, I am bound to confess that I fail to see the use of notification or of including it in the list of those which are dangerously infectious. Does the disease spread from individual to individual? The majority of cases notified in Leicester are trifling in character and have no real bearing upon public health. Further, some of the cases are apt to recur, and so repeated notifications for the same patients are sent in. Erysipelas might in my opinion with advantage be expunged from the list of dangerous infectious diseases. In Leicester the notification of this disease has cost £574 for 4592 certificates during the last fifteen years.

Scarlet fever, typhus fever, typhoid or enteric fever, and relapsing fevers (the last three constituting the group of continued fevers) may all be classed with the first group I have named—viz., small-pox, cholera, diphtheria or membranous croup, as dangerous infectious diseases requiring the stringent preventive measures mentioned above.

Puerperal fever.—Regarding this disease I confess I agree with Drs. Herman and Cullingworth in looking upon it as a wholly preventable disease—a blood poisoning due to the introduction from without of a particulate poison, which gives rise to a severe febrile illness, occurring soon after, and being dependent upon, delivery. The carrying medium may be the hands, instruments, dressings, &c., and the disease is due to want of proper cleanliness and antiseptic precautions. That the disease depends upon a micro-organism is highly probable, but such organism can only be transferred by contact—and this transference can be prevented by cleanliness and the use of antiseptics. Notification is certainly useful, so that inquiries may be made, and preventive measures taken, if necessary, in regard to medical men, nurses, and midwives. The disease, however, ought in my opinion not to exist at all.

So much for the so-called “dangerous” infectious diseases, about which there ought to be practically no difference of opinion; and now I will deal with those about which opinions differ considerably at the present day, foremost among which are measles and whooping-cough, diseases which have high mortalities and widespread epidemic prevalence. In both these respects these two diseases ought to be preventable. But how? Notification is suggested, and would doubtless be useful, but not in the sense that it is useful in the diseases I have already considered. For instance, in measles notification (more especially early notification) would be useful in warning us of an approaching epidemic; in enabling us to close certain schools (elementary or otherwise) if necessary; in bringing together a close relationship between the health departments and the people, thereby enabling precautionary instructions to be given (and of course carried out) as to the dangers of measles, so as especially to prevent exposure to chills; in enabling us to isolate the other children in a household and to keep them away from school; in carrying out disinfection of houses, bedding, clothes, &c.; and, in fact, in generally drawing the attention of parents to the seriousness and dangers of measles, and so disabusing their minds of the extreme folly of looking upon measles as a disease to be “got over,” and doing away with the apathy that unfortunately exists in regard to this particular disease. Insanitary arrangements, again, would be discovered by our inspectors, and it must be remembered that insanitary surroundings *indirectly* increase largely the mortality from this disease. It is true that we must trust to “home” isolation such as it is, for in this disease at present hospital isolation, with its attendant expenses, would be practically impossible, not only on account of numbers and the early age of the patients, but also on account of the intensely infectious early stage (pre-eruptive) of the disease leading to rapid spreading, and its long incubation period. By such means as the above the mortality from measles would be diminished, though I doubt whether its incidence,

¹ A paper read at the Congress of the Sanitary Institute, Liverpool, on Thursday, Sept. 27th, 1894.