

HEALTH OF SCOTCH TOWNS.

The annual rate of mortality in the eight Scotch towns, which had rapidly increased from 22.3 to 31.8 per 1000 in the preceding four weeks, declined again to 28.3 in the week ending the 13th inst., but exceeded the mean rate during the same week in the twenty-eight large English towns by 5.7. The rates in the Scotch towns last week ranged from 17.9 and 19.5 in Greenock and Leith, to 32.6 in Glasgow and 36.6 in Paisley. The 684 deaths in the eight towns included 30 which were referred to whooping-cough, 27 to measles, 23 to diphtheria, 17 to diarrhoeal diseases, 8 to "fever," and 4 to scarlet fever; in all, 109 deaths resulted from these principal zymotic diseases, against 101 and 140 in the preceding two weeks. These 109 deaths were equal to an annual rate of 4.5 per 1000, which was more than double the mean rate (2.2) from the same diseases last week in the twenty-eight English towns. The 30 deaths from whooping-cough included 11 in Glasgow and 4 in Greenock. Of the 27 fatal cases of measles 13 occurred in Glasgow and 10 in Dundee. The 23 deaths from diphtheria included 11 in Glasgow and 3 in Dundee. Five of the deaths from "fever," and all the 4 from scarlet fever, were returned in Glasgow. The deaths referred to acute diseases of the respiratory organs in the eight towns, which had been 181 and 231 in the two previous weeks, declined to 190 last week, but exceeded by 83 the number returned in the corresponding week of last year. The causes of 92, or more than 13 per cent., of the deaths in the eight towns last week were not certified.

HEALTH OF DUBLIN.

The rate of mortality in Dublin, which had been equal to 35.4 and 33.2 per 1000 in the preceding two weeks, further declined to 28.7 in the week ending the 13th inst. During the first eleven weeks of the current quarter the death-rate in the city averaged 29.3 per 1000; whereas the rate during the same period did not exceed 20.0 in London and 19.6 in Edinburgh. The 193 deaths in Dublin last week showed a further decline of 30 from the high numbers in recent weeks, and included 24 which were referred to the principal zymotic diseases, against 39, 23, and 25 in the preceding three weeks; 9 resulted from scarlet fever, 8 from whooping-cough, 3 from measles, 2 from "fever" (typhus, enteric, or simple), 2 from diarrhoea, and not one either from small-pox or diphtheria. These 24 deaths were equal to an annual rate of 3.6 per 1000, the rate from the same diseases being but 2.2 in London and 1.5 in Edinburgh. The 9 deaths from scarlet fever corresponded with the number in the previous week, while the 8 from whooping-cough exceeded the number in any recent week. The fatal cases of measles, "fever," and diarrhoea showed a decline. No inquest case or death from violence was registered, while the 51 recorded in public institutions showed a further decline from recent weekly numbers. The deaths both of infants and of elderly persons also showed a decline. The causes of 26, or more than 13 per cent., of the deaths registered during the week were not certified.

MORTALITY IN THE PUNJAB.

Two recently received weekly returns, issued by the Sanitary Commissioner of the Punjab, afford most unsatisfactory evidence of the insanitary condition of that Indian province. It appears that during the fortnight ending Oct. 18th the annual death-rate in the province was equal to 73.7 per 1000. This terribly high death-rate was mainly due to mortality from "fever," to which no fewer than 39,755 of the 48,882 deaths from all causes were attributed. The deaths included 151 from small-pox, and but 3 from cholera. It is noteworthy that the death-rate in the forty-two large municipal towns of the province was 72.0 per 1000, and slightly below the rate for the entire province. It is evident, therefore, that the mortality in the rural parts of the province exceeds that in the largest towns. The "fever" fatality in some of the smaller towns is, however, sufficiently startling. In the week ending October 11th 175 deaths occurred in the town of Karnal, with a population of 23,133, giving an annual rate of 393 per 1000, 147 of the deaths being attributed to "fever"; the same number of deaths from "fever" occurred during the same week out of 185 deaths from all causes in the town of Umballa, with a population of 26,777 persons. Such death-rates from "fever" are almost beyond comprehension, and it would be well if we could believe them to be impossible.

Correspondence.

"Audi alteram partem."

THE REVIVAL OF OVARIOTOMY.

To the Editor of THE LANCET.

SIR,—The address on the revival of ovariectomy, which you did me the honour to insert, having been reprinted in pamphlet form, I have sent (and intend to send more) copies to some of my friends. In reply Mr. Nunn, Consulting-Surgeon to the Middlesex Hospital, has sent me a very interesting letter, with the suggestion that if I think it of sufficient importance I shall send it on to you for publication. I trust you will consider that it may be of such interest to your readers as to merit a place in your columns.

I am, Sir, yours truly,

T. SPENCER WELLS.

Upper Grosvenor-street, December 8th, 1884.

"DEAR SIR SPENCER WELLS,—I have to thank you for the copy of the 'address delivered at Birmingham.' It is of the greatest interest to all who have been engaged in ovariectomy as a history of your special work commenced at the Samaritan Hospital, and continued, one may say, over Europe; work which has resulted in giving a *rational and scientific basis* to the operation of ovariectomy. There was, however, a pre-Samaritan era of ovariectomy in London, of which I happen to have directly or indirectly some personal knowledge, and I write to you on this. The operation was then more or less an empirical proceeding, the propriety of which was warmly disputed. If you will refer to THE LANCET of 1847, vol. ii., p. 467, you will find a report of the meeting of the Westminster Medical Society, October 23rd. At that meeting Dr. F. Bird related a case of 'extirpation of both ovaries with recovery.' A discussion on ovariectomy followed. Mr. Francis Hird said that he 'doubted whether the operation was justified by the general result of cases of ovarian disease.' Dr. Murphy, on the other hand, 'thought the fault was with the operator, and not with the operation.' Mr. Hancock made reference to the alleged suppression of the truth about fatal cases of ovariectomy. The following year I became the colleague of Dr. Frederick Bird at the Western Dispensary, Westminster, and I also made the acquaintance of Baker Brown, who at that time was with Samuel Lane, Alexander Ure, and others, working to establish St. Mary's Hospital, then in embryo. In THE LANCET of 1848, vol. i., p. 201, there is a report of a paper by Baker Brown (December 15th, 1847) giving the details of a case where, after much treatment by mercury and pressure, he came ultimately to suggest that Mr. Lane should perform ovariectomy.

"In a series of most able papers in THE LANCET, Dr. E. J. Tilt dealt with the question of ovarian disease. At page 420, vol. ii. (Oct. 14th, 1848), Dr. Tilt says:—'There are now 150 cases recorded, though insufficient for the final decision of the question of ovariectomy;' and at page 526 (Nov. 11th), he gives an analysis of the results of the operations of Lane, Bird, Walne, Jeaffreson, and Clay. It was just about this time that I joined the Westminster Medical Society, and became aware that the excitement of the somewhat acrimonious discussions on ovarian disease had not subsided. Baker Brown had vehemently assailed Dr. F. Bird, and advocated tapping and pressure. At the meeting of January 27th, 1847, Baker Brown exhibited bandages 'applicable in the treatment of ovarian dropsy'; one bandage 'applicable where pressure is required for a long time after tapping.' Now, Sir Charles Locock was a staunch friend of Baker Brown's, and sent to him cases of ovarian disease. Brown was kind enough to ask me to assist him in tapping such cases. I cannot tell you accurately the number of these, but at any rate they were sufficient to prove in many that tapping and pressure and mercury could be of no avail; that is to say, where sebaceous matter, hair, bone, and teeth (the, as it were, sweepings of a pathological dustbin) constituted the contents of the sac, to say nothing of a multilocular or semi-solid condition of the tumour. Thus it became obvious to Brown that his favourite plan had to be thrown overboard, and hence he began his career as an ovariectomist. I assisted him in his operations of ovariectomy, as I had done in his cases of tapping, until St. Mary's Hospital came into full blossom, when I almost lost sight of Brown, he obtaining assist-

ance (as was quite natural) from his colleagues at St. Mary's, and thus the matter went on for a time. However, Brown's operations for ovarian disease at St. Mary's Hospital were attended by results so unfortunate (I use the word advisedly as proper to the *empirical* stage of ovariectomy) that his colleagues objected to the further practice by him of ovariectomy at the hospital. I was told that he was even threatened with a coroner's inquest if he again operated with a fatal result. This was in the year before the *annus mirabilis* of ovariectomy, 1858, to wit. At this juncture Baker-Brown again came to me, and appealing to my past experience of ovariectomy, and to my conviction that it was a justifiable operation, proposed that we should establish a small hospital where it could be carried out. The upshot of this interview was the opening of the *London Home* in 1858, and we commenced operations there, *but practically on the old lines*. Although certain improvements of detail had been introduced, we were still groping in the dark; it was bewildering to see that whilst the most unpromising cases frequently did well, those apparently favourable died. Nélaton paid a visit to the *London Home*, and he did not conceal his astonishment when he was shown three or four cases recently operated on satisfactorily convalescent. The great French surgeon took care to inspect the cicatrix of the abdominal incision in each case. You will most probably remember the date of Nélaton's visit to London to study ovariectomy. I believe your first communication to the Medico-Chirurgical Society was on five cases of ovariectomy (1859), your second on fifty cases (1863), and then on five hundred, and soon increasingly distancing your competitors. This vast labour and your example, as I have said, have afforded a *rational and scientific basis* for an operation which formerly was a dread proceeding, and only attempted by a surgeon at the risk of being stigmatised as rash or unscrupulous. I cannot refrain from telling you that three years after you commenced to operate and the *London Home* was established, I (on Oct. 25th, 1861) read a paper at the Medical Society of the Middlesex Hospital on the subject of ovariectomy. At that date you had then operated (as you informed me) twenty-nine times, and Baker Brown had operated in the *London Home* nine times. I said in that paper that 'having during the past ten or twelve years assisted at some thirty cases of ovariectomy, I do not hesitate to say that I believe ovariectomy will take rank with the most approved surgical operations. I am quite sure that much of the mortality has been due to causes now preventable, and that by an increase of experience many former errors will be avoided, not only in the operation itself, but in the after-treatment.'

"Now, I say that I feel grateful to you, that by your unrivalled experience and *rational and scientific study* of the operation my prophecy has been more than fulfilled.

"I am, Sir, yours faithfully,

"Dec. 6th, 1884."

"T. W. NUNN.

COCAINE.

To the Editor of THE LANCET.

SIR,—I have much pleasure in supporting the opinions of your many correspondents regarding the great value of cocaine, and in expressing the results of my experience of this most important drug as a local anæsthetic in ophthalmic surgery. Such is the high opinion I have formed of the value of cocaine, that I believe ophthalmic surgeons are as deeply indebted to Dr. Carl Koller for his discovery as the surgical world is to the late Sir James Simpson. I consider it specially valuable in ophthalmic surgery for the following reasons: its ease of application, its rapidity of action, its local effect only, its duration, and, lastly, its leaving no bad results. My experience leads me, however, to differ somewhat from those writers who are of opinion that it causes complete anæsthesia of the deeper structures of the orbit, so as to allow of enucleation. I am very sceptical regarding cocaine being sufficiently powerful to allow of this operation being performed without pain, and I would certainly hesitate to enucleate an eye by its use alone. I have been using it freely during the past month, and beg leave to report some of the more painful operations in which I employed it.

A foreman engineer, had his right eye severely burned from an explosion of boiling metal, which resulted in symblepharon and destruction of a portion of the ocular

conjunctiva at the inner angle of his right eye, laying bare the sclerotic, and thinning that membrane to such an extent that by focal illumination the retina could be seen. Preparatory to operating upon this case, for transplantation of conjunctiva from the rabbit, in company with Dr. Philip of this town and Dr. Crawford of Port Glasgow, a 4 per cent. solution of the muriate of cocaine was dropped into the eye. Eight minutes after the cornea and conjunctiva were as completely anæsthetised as they would have been under the influence of chloroform. Knowing the operation would last at least thirty minutes, the solution was dropped into the eye four times, at intervals of five minutes. The patient made no complaint of pain during the introduction of the eye-speculum, or while seizing the ocular conjunctiva with forceps, or in stitching the foreign conjunctiva to the newly raw surface. But while dissecting and separating the cicatricial conjunctival bands he complained of pain, and asked for more drops to be put into his eye. After a further instillation of the solution the operation was finished, but not without some slight suffering. It was necessary during the operation to exercise care while applying the solution to avoid injuring the newly transplanted conjunctiva.

The next operation was on a young man aged twenty-six, who had a congenital malformation of both eyelids. There was in each eye a double eyelid with eyelashes. The inner eyelid of each eye was partly adhering to the cornea at its lower border. In the right eye there was a convergent strabismus. As in the former case, a 4 per cent. solution of cocaine was freely instilled into the cul-de-sac, and after an interval of thirty minutes the operation for strabismus was completed, without any complaint of pain. The solution was again applied, and we proceeded to remove the eyelid. During dissection there was no complaint of pain until the deeper tissues were reached, when the patient seemed to feel as much pain as if no anæsthetic had been used.

I may further mention that I have used it in the removal of cataract, and in such cases it is specially valuable during the removal of the lens, the cornea and conjunctiva being insensible to pain; spasm of the ocular muscles is prevented, and there is thus less risk of escape of vitreous.

In operations for iridectomy the iris does not become so completely anæsthetised as the cornea and conjunctiva. In strabismus operations pain is experienced during the hooking up and snipping through the tendon. Its value as a sedative in all painful eye affections is very great.

I remain, Sir, yours very truly,

N. GORDON CLUCKIE,

Greenock, Dec. 8th, 1884. Surgeon to the Eye Infirmary, Greenock.

To the Editor of THE LANCET.

SIR,—Perhaps during the present discussion on the merits of cocaine as an anæsthetic a brief series of experiments with a 10 per cent. and 20 per cent. solution of the hydrochlorate of cocaine may not be uninteresting, even to others than those engaged in my specialty in surgery. With the 10 per cent. solution I met with but very limited success, its highest merit being as a very partial obtunder of pain. In one instance it gave some temporary relief in a case of chronic periostitis, whilst in the extraction of a tooth for a near relative, in whose case I had the opportunity of exhibiting the drug to the best advantage, the effects in preventing pain from the operation were almost *nil*. Without troubling you with similar examples, it may be said that the 10 per cent. solution is of but little use in odontalgia or neuralgia. The 20 per cent. solution gives much more promising results. I have instantaneously destroyed an exposed pulp—one of the most painful operations in surgery—almost without pain, the carious cavity having been so sensitive previous to the use of the cocaine that it could not bear the slightest touch; whilst I have extracted two permanent teeth without anything like the usual amount of pain, though in a third and severer case the relief was not so manifest, though sufficiently appreciable. Its action in a case of earache which incidentally came under my notice to-day was most striking. The severe pain seemed entirely relieved in a few minutes. My limited experience leads me to hope that with a stronger preparation, say 30 per cent., success will be greater, whilst it is not too much to say that extraction in children may be relieved of many of its horrors, though too much must not be