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NO. I.

Original Contributions.

PRESIDENT'S ADDRESS.*

BY W. BURT, M. D., PARIS, ONTARIO.

Ladies and Gentlemen,—I cannot fully express myself for the honor I received at your hands at our last annual meeting. My voice is not strong enough to express my appreciation of your good-will towards me and my confreres from the West. I feel my inability to do justice to the position to which I have been exalted, and I will crave your patience and sympathies for a brief space of your time.

I cannot vie with those who have preceded me in this honored chair. I can only strive to emulate them. We have already an honored list of past-presidents, and, while the time now is short when I will be with them, I feel that my interest in this Association will ever increase as the years roll by, and I never for a moment believe that our Association will ever wane, but that its usefulness and power will increase from year to year, and that it will be a standing authority on Provincial matters concerning our profession.

I am sure we may well feel proud to-day to celebrate the 25th anniversary of our existence. We have arrived at the quarter-century mark in a very healthy and prosperous condition, and I do not fear—I feel I can be prophetic—that those who will celebrate the fiftieth anniversary of this Association will, when it arrives at the half-century mark, find that medicine has made even greater strides during the second quarter than during the first, and that our Association will be credited with promoting in no small degree the welfare of the people. I feel that we here in Ontario would be unworthy of our noble calling if we had not brought into existence the Ontario Medical Association, and given it our encourage-

*Delivered before the Ontario Medical Association, June, 1905.

ment and support. Among our neighbors to the South, the people of the United States—I came near saying Americans, but, as is well known, we as Canadians claim that title ourselves—the State Association is a great factor in the building up and ennobling of all the higher ideals of life, and is considered one of the best authorities on all matters pertaining to the control of the profession and the health of the people. In this, I feel we should vie with our neighbors, and not be behind in any matter pertaining to the health of the Province. There is no reason why Ontario should not be to the fore in the fight against the enemies of life. There is much that is of a provincial nature—the work of the Provincial Board of Health, the care of the insane, the public hospitals, the relief of inebriety, medical legislation including medical education. A matter of no little importance, too, is it brings the members of our profession into closer touch with each other. It is to the benefit of the individual member. He cannot fail to have his mental horizon extended. In union there is strength.

It has been said that surgery has about reached its limit, and that there is little left for us to do in the way of improvement. Surgery is in as active a stage as ever. While much of the work that is being done now appears marvellous compared with the work of a quarter of a century ago, there is no doubt, and many of our surgeons recognize it, that there is still in sight a great field for improvement, and that we may be looked upon as lilliputians compared with those who will do the work at the end of the next quarter or half century. While our knowledge is actually great, it seems little after all when we consider the possibilities of the future. When the tubercle bacillus was made known to us we were congratulating ourselves that the white plague would disappear forever. Although we are wondrous wise we have no reason as yet to boast of any great wisdom. No matter how much we quarantine the microbes they still produce—I say this advisedly—such diseases as the white plague, enteric fever, the infectious diseases and many others, and by their flank movements get in their deadly work. On the part of the physician it will always be a fight to the finish—the French proverb, “Après la mort le Médecin,” expresses it aptly—on the part of the microbe a fight to the death. The discoveries that have already been made impress us only too strongly that research work must be pursued on a larger scale than ever, and our multi-millionaires benevolently, philanthropically inclined in their later days at least could not do better than aid in the great work of research. While we can felicitate ourselves for much that has been done in the matter of serum treatment, especially in diphtheria and rabies, we may look forward to even greater things. Great as these advances seem, the possibilities seem greater. The surgeon, as is well known, is too often the victim of so-called blood poisoning. It has claimed as its victims many of the most skilful and cultured of our profession, besides placing many others near the brink of the great beyond. It is

needless to mention names, they are well known to us all. There are many living to-day who feel that they have narrowly escaped the jaws of death—I might say the jaws of the microbe—and only a vigorous constitution, or a rather attenuated attack of the microbe, has spared them a few years more. I appeal again to the philanthropist to assist us in our work of research. There is no fight on now of greater import than the battle against the disease-producing microbes. As it is, I rather think the microbes have a little the best of it, perhaps a good deal the best, but I hope ere long through the work of research, aided and abetted by the lovers of humanity, that the microbe will suffer defeat, in fact be annihilated, or at least rendered harmless. And, while I am on the matter of research work, let me pursue it a little farther. It is not through ignorance of the habits of the microbes that many diseases are prevalent. Take, for example, the somewhat common disease of diabetes mellitus—how little is known concerning its origin, its prevention, and successful treatment. And again, take the epileptic—their number is legion. There are being, very properly, sanatoriums established for their care and maintenance. We are well aware that the great majority of epileptics are epileptics to the end. These are simply examples to show what a great field there is for research work other than what the microbes give us. It would be well if many of our clever gold kings would study medicine and pursue with their surplus wealth the great field of research. I think it would be better if they would use it for the establishment of schools for research work, wherein those who are known in our profession for their abilities may pursue their work. We are well aware that a school of this kind has been established in Washington by the King of the Iron Industries. While I am not jealous of our neighbors—I am indebted very much to them—I would like to see in this fair province of ours a school for research work in medicine that would be untrammelled, unfettered, by the want of financial support. This is not unreasonable. It was through the air of Ontario that the telephone wire first came into use—not in one of our large centres—but from a country residence, Tutela Heights, to the now city of Brantford. I can recall how I was thrilled when listening in the first Brantford office to music produced at the country residence of Prof. Bell.

Canadians have already done considerable research work. While it may be that research work can be carried on in our larger cities to greater advantage, it has been well shown that in preparing the student for research work many of the smaller schools do as efficient work, if not more so, than the larger ones. Personal supervision of the teacher is one of the greatest helps in preparation, and this as a rule is better carried out in the smaller schools. However, our larger schools by increasing the staff are giving recognition to the fact that individual attention is one of the greatest helps to the student life. Many of the improvements and advances in our profession have not been due to the labor-

tories of our universities, but have been thought out during the daily rounds, let me say, of the country physician. I ask you to recall Ephraim McDowell.

Not to be behind our smaller cities in Ontario, Toronto, every one will be glad to know, is about to make a great effort to be up-to-date in the matter of hospital extension and library work. There is no doubt that if successful in their undertaking research work will receive a great impetus. While it may seem a matter of great renown for him who succeeds in the field of research and gives to the world something new, it is no less praiseworthy for him whose lifework consists in administering all that is latest and best for the relief of human suffering. There may be a scintillation of truth in the fact that if a man has little desire to enter the field of research before middle life he is not likely to do much after, but it is an incontrovertible fact so far as the application of what is already known to be beneficial, to be helpful for the relief of suffering humanity, the powers of the physician, his experience, his judgment, his power of discernment, increase as the years roll on, and do not cease until disease or a ripe old age superannuates him. The author of "Bonnie Brier Bush" tells us that it created a scandal in his country for any citizen to "slip awa'" before sixty, and that persons above ninety were understood to be acquitting themselves with credit, and brushed aside the opinion of seventy as immature.

You will agree with me, I am sure, that the sum of human happiness could be materially increased by the stamping out of some preventable diseases—diseases that may be totally avoided, diseases that are under the control of the individual and society. The gynecologist, the genito-urinary surgeon, the neurologist, will tell you that a great deal of their work is due to the gonococcus and syphilis. What diseases are more loathsome? You will admit I am sure, that these are preventable diseases. What diseases are more contagious? What diseases leave their dire results in the human system more than these do, to be handed down to the third and fourth generations? And yet they are preventable, wholly preventable. It is not for me to discuss the phases of social life that produce these, but in many instances useful innocent lives should be protected. It is true in the practice of our profession, in operations on the syphilitic, numbers have been inoculated and lives of usefulness marred. What more noxious than a syphilitic with mucous patches or an epithelioma on his lips or a specific sore throat offering his pipe to a comrade or participating in the communion in any of the Christian churches where the individual cup is not used. I feel sure if the laity could understand the disastrous results of oral aspsis, there would be no dissenting voice in the use of the individual communion cup. The physician can evidently curtail much misery, but he needs the help of the public to stamp it out altogether. It needs a greater concern on the part of everyone in social and moral reform, a cultivation of

higher ideals. You may attribute it to ignorance or want of education. These are but scapegoats. If it is due to want of education, then let me say that the people of our large centres are lamentably ignorant; and just here I beg to state, in my opinion the ends of justice would be as well secured by taking the oath with the hand uplifted as that impure method of kissing the Bible—a Bible that has done untold service. What more impure? To return again to the disease-producing germs, a well-known characteristic of the microbe is that it is cowardly. It will attack many subjects unless their systems become weakened, as is the case of many young people, from want of proper nourishment, from living in closely crowded, ill-ventilated, tenement houses, or from working longer hours than is consistent with a healthy system. It is acknowledged that these are factors that go to swell the victims of the white plague. If people were to fall in love with fresh air, sunlight, wholesome food and cleanliness in their youthful days, and regulate their hours of work as many do after contracting the disease, the demand for sanatoriums would be much less. A great interest is being taken in the erection of sanatoriums for pulmonary phthisis, and, while I hope that it may continue, I feel that the work in this direction should grow less and less from year to year as the death rate becomes reduced. The great arteries which keep up the supply of consumptives pulsate stronger and stronger in many places. If ever we can boast ourselves a great people, and vie with other nations, if ever we can sustain the reputation of our country for prowess, for culture and refinement, it will be by so altering, so modifying the strenuous life that we live that we shall not permit any feeding grounds, any culture grounds, for the microbe, that we shall be able to remove all sources of the dread malady. It does seem that while great efforts are being made for the cure of the afflicted, our thoughts, our energies, are not sufficiently concentrated and aimed at the faults of our national life in many respects.

You are all familiar with the harrowing details of the lives of the children in the coal regions of our neighbors to the South during the great strike of the miners three winters ago. I need not repeat here that these mines were veritable hot-beds for the spread of the white plague. The coal mines are not the only culture grounds for the cure disease. I may refer you also to the culture beds of the cotton mills of the North and the South, where child labor has been and is much in evidence. But why, you may say, am I talking about my neighbors? Are we as a province free from the culture beds? As you are aware, I belong to a town which is noted for its woolen industries. It possesses the largest wooler mills in our fair Dominion. I would like to say that our civilization, our Christianity, was of that type that we could boast that we are abreast of other people, other nations, that we are living in a land where there are no culture-beds—no culture grounds—for the white plague, in a land where child labor is

unknown and where our neighbors cannot point at us the finger of scorn. My fervent prayer to-day is, would it were so. After all the churches that we see towering above us, the magnificent works of the architect, after all the efforts of our various leagues with their Christian influences, after all the sermons that are preached and prayers offered up, to say that we are living in a land where child labor exists is to say that a most lamentable condition of affairs exists, and that our neighbors can point at us the finger of scorn, and that we, too, lack much that might strengthen and support the props and bulwarks of a great country. We are much indebted to some of our noted women for some of the greatest reforms the world has ever seen. What was it, I ask, moved the world to the abolition of slavery more than anything else, and made Lincoln free the slaves, if only as a matter of military expediency, if not the writings of the author of "Uncle Tom's Cabin"? No one has written more strongly or more pathetically on behalf of growing childhood than Mrs. Browning in "The Cry of the Children." I will give you but two lines:

"And they look up with their pale and sunken faces
And their looks are dread to see."

And yet there are those who cannot see that the factory labor of children is slavery. In Greater New York, we are told, some sixty thousand school children go hungry every morning to school. It is needless to say they are unfit for their work. In Great London, we are told, the number is vastly greater. In Toronto—well the latest report has not been handed to me. In regard to this matter a prominent weekly paper, published in Toronto, states: "Of the many terrible things in some of our great cities this is one of the most awful to contemplate." I need not enlarge on this subject. The result is self-evident. Is it any wonder that many systems are vulnerable to attacks of the white plague and other diseases? The work of prevention seems almost insuperable, but it should not be so. If we could but eliminate from the make-up of the individual and our nation's representatives the words "grasp," "graft," and "greed," and we possessed more of the altruistic spirit, our national life would be in a more healthy condition and the gaols and the tombs would have fewer occupants. If our children starve, our nation cannot be well developed. We must build up a nation by building up the individual. We must have a sound body for the in-dwelling of a sound mind. Inasmuch as a nation is made up of individuals, as matter is composed of molecules, the perfection to which we bring each individual goes far to establish on a firm basis the bulwarks of a nation. Any nation that will permit or encourage child labor is bankrupt morally, socially and politically. With the lamentations of the mother and daughter ringing in our ears, may Canada show forth to the world her greatness, her godliness and emancipate this fair province of

ours from the disastrous consequences of the white plague, and may we be first and foremost in this respect among the nations of the earth. It would go a long way to strengthen the bulwarks of our nationality and help to produce a healthy, happy and contented people.

I would not like to admit that in the early history of the world physicians were a much better class than exists to-day, but it is indisputable that in olden times people lived as many hundred years as they now do tens. How is it? I would not like to say that they had better Boards of Health. I can only answer that there is a Divinity who is the Author of natural laws, that natural laws are Divine laws, that there may be an alteration in our well-known laws governing youth and old age by the Divine will, and that the cycle of life of the present time as compared with that of the olden times is a vivid illustration of the fact. Natural laws are God's laws, and if the Almighty sees fit to change the laws of the properties of matter, it will be done, as it was done, in the shortening of the natural period of our lives.

I feel that I would not be doing my duty if I did not call your attention to a most pressing matter, that of the indigent and wealthy inebriates. This subject should not be disregarded or passed over lightly. The Ontario Society for the Reformation of Inebriates should receive our strongest support, and I sincerely hope that the Government of to-day will see its way clear to aid this Society and help to carry on the work which it is endeavoring to accomplish. While here again the prevention of inebriety should not be lost sight of, a great advance would be made in the citizenship of our Province if we were to put in force the measures adopted by Great Britain and the United States. It is well recognized that what many an inebriate needs is to be placed where he cannot have the source of his trouble and be treated with that sympathetic kindness that he needs, and he will be grateful for the help given him. No one can help feel, if the wishes of the Society could be carried out, another strong prop would be placed in our nation's manhood. But I would go farther—I believe that the wealthy inebriate would be very grateful if taken care of. The inebriate in many cases only requires to have the proper restrictions enforced. The inebriate himself frequently desires the restrictions, and there are cases where it may be said that the inebriate has lost his self-control, has not sufficient moral force left to impose the restrictions himself, and what is needed is that he shall be taken charge of by his friends and the restrictions carried out for him. This cannot as a rule be done without adopting some one or all of the measures the Society has proposed. I hope that the indefatigable worker of the Society, Dr. Rosebrugh, and the other members will soon have the satisfaction of knowing that their efforts in this direction will be crowned with success.

Another matter that should not be lightly passed over is lodge practice. In regard to lodge work I have long since expressed

my views. Some may say that I should not express myself because I have never taken up lodge practice—it is not necessary to practice an evil to know the evil. The so-called free attendance is no doubt a drawing card on the one hand, and the prospect of an immediate clientele of patients an alluring bait to the young practitioner on the other. My own opinion is that lodge practice has no redeeming features. Not many years ago the Supreme Chief Ranger of one of the fraternal societies in one of his addresses stated that the free medical attendance—I do not use the term “free” absolutely—saved his order some millions of dollars. I only wish to state that this would have been a nice fund for the fatherless and the widows of the deceased members of our profession. It is only too well known that many in our profession, faithful workers during their lifetime, have left but a pittance to their loved ones. I do not hesitate to say that both the fraternal societies and the physicians would be on a more enduring basis, on a more solid foundation, if the societies had their benevolent funds with the lodge physician left out. It is so in many, if not all, of the United States; and from them we might well take a lesson. And just here I would wish to state, what will commend itself, I am sure to everyone, that in many cases a trained nurse should be engaged by the order instead of drafting members who have been at work all day to do more work at night. The interest of the patient demands it, and just here let me state that a great deal of the success of the physician is due to the trained nurse. The trained nurse has come to stay. If anyone wishes to pursue this subject further I will ask those of you who have not read the last chapter of Dr. John Beattie Crozier's work on “My Inner Life,” to do so. There you will find a better statement than I can give you, and in the language of a well-known writer, of the disastrous results of lodge work or club practice as it affected him in his home in England. Dr. Crozier is a graduate of Toronto University of '72, of the same year as our lamented Zimmerman. Our Osler was of the same year, but left us for McGill at the end of his second year. Dr. Crozier, as many of you are aware, was an old Galt boy, and is now receiving an annuity from the British Government for his work as a philosopher. Crozier's work at the G. G. S. helped to stimulate many a less apt student. He has done much research work, but it was hunting for an ideal. Had he turned his attention to medical research I have no doubt no microbes would have kept out of his way. I think, however, you will find his writings in regard to lodge work solid. Crozier is one of Canada's famous sons, of whom we have great reason to be proud.

A short reference to another subject, and I am done. You are well aware that there could not be a more important subject than public hygiene, and especially that part of it which comes under school hygiene. It needs a great deal more attention than has been paid to it. The hygiene of the schools is in a somewhat crude state, and a little more attention would bring the sanitation of our

schools up-to-date. Our knowledge of what is required is not deficient. It seems a matter of neglect pure and simple. A Minister of Health, which we have not yet, would be one of the most important portfolios that any Government could have. Good health is one of the greatest assets that an individual or a Government can possess.

Many subjects I must leave untouched. It is well understood that in the medical profession there must be a division of labor, but whatever department we pursue we must do so with "prudence, promptness and patience." These are the graces of the soldier, so well described by Miss Harris. They may well be the graces of the physician, for the practitioner of medicine in its widest sense is a soldier always, a combatant, fighting the enemies of life, striving to keep death as far off as possible. Even on the battlefield he never shrinks from danger; he is doubly, thricefold, a combatant. A parting word to doubting ones. The thought that the cycle of life, changed as it is to a short period, is manifestly due not from any want of skill on the part of the medical profession but to a Divinity, to God alone, does not need a very strong faith to believe. It is proof itself, and if we believe in this great change of the cycle of life, why can anyone take exception to the Immaculate Conception, the Resurrection and the Ascension? Contrary to much that has been said of the physician's belief, he has certainly been one of the strongest supporters and exponents of Biblical history. We have been placed here to work out many problems, and if we make use of the means of research that have been given us, the mist and the clouds which hang over us may be cleared up, and it will be given us to know much of what is seemingly mysterious. We have no conception of such phrases as *boundless space* or *in the beginning*. It may be given us to explain much that is now mysterious, but it will only be done by honest, faithful work, not by the methods of so-called Christian Scientists, but by the labors of those who will enter the great field of research work in Nature's laboratories and the special laboratories for research.

THE AMERICAN DISEASE: AN INTERPRETATION.*

BY WILLIAM BROADDUS PRITCHARD, M.D., NEW YORK.

MEDICAL nomenclature, certainly as regards names for many diseases, stands to-day the most neglected, the most incongruous, the least rational and the least progressive of all the minor divisions of the subject. Many of those most familiar justify a continued existence solely through the fallacious law of traditional custom. In some instances, both name and disease being inelastic—typhoid fever or epilepsy, for example—no special harm is done. In others, as hysteria and chorea, we continue to insult intelligence apparently without either consciousness of shame or hope or desire for reform. There is something of promise in the tuberculosis of to-day rather than the consumption of our fathers, but much remains to be done, the work having scarcely begun. The field of neurology, perhaps more than any other, needs the scythe and pruning hook. The latter instrument could, in my judgment, be used with particularly beneficial effect if employed vigorously and with discriminating judgment in neurological nosology. Its first work, if in my hands, would be to clip and trim and shape into at least some semblance of definite form and substance that phantom, once a tree, now a forest and rapidly becoming a wilderness, so rank and riotous is its growth, neurasthenia. No shorter road to nervous prostration exists than along the route of present interpretation and mental comprehension of the term as generally understood or misunderstood. I confess to an antipathy—I think rational though amounting almost to an obsession—for the word. Originally intended to possess a definite significance, its field of application has been so elaborated and broadened and abused that to-day it means almost anything and with equal truth almost nothing. The inspiration which gave it birth marked the genius, but the child has grown a monster, fattening upon the flesh of hundreds of brothers and sisters, and even its cousins. It is still from custom classed among the neuroses or psycho-neuroses and thus the special property of the neurologist, but like its twin sister—the only sister left, by the way—hysteria, it has wandered afar with an omniverous appetite and is known to-day and claimed in some one of its hydra-headed forms in every field of medicine. To the stomach specialists belong the gastric and lithemic types, to the surgeon the post-operative and some of the traumatic cases. The sexual neurasthenic is the property of the genito-urinary specialists, the reflex cases are almost equally distributed to those who know the eye, the ear, the nose and throat, while the neurologists divide the remainder with the gynecologists, or play battledore or shuttlecock with all. The general practitioner alone is counted an

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invader in this field, and he, wise man that he is, with appreciative philosophy rarely feels himself aggrieved.

My criticism is not of the term etymologically. On the contrary, properly restricted in interpretation, it is an excellent example of word-making. It should stand, however, for either fish, flesh or fowl—for a definite entity or syndrome—if retained in our nosology. If discarded in this field, by all means keep it, but restrict it to the broad, descriptive significance of a generic term alone. I am not yet willing to accept the dictum embodied in the recent paper of an eminent American writer who, with a stroke of the pen, announces the passing of neurasthenia, for which he would substitute a group of pure psychoses, if for no other reason than that he leaves us none the better off for such a begging of the question; and yet one is almost tempted to let it pass away into final oblivion and without a protest on reading a serious thesis by another recent writer upon neurasthenia in babes. If it is to continue a neurological and general medical waste-basket into which we are to dump all forms and degrees of illness associated with irritable, nervous weakness to which we cannot attach a standard label, then it cannot be lost too quickly. It means to-day to the student mind mystery, confusion, chaos and correlated aversion, curiously mixed with a contradictory fascination; to the patient it has become a term full of suspicion; to the medical teacher it is a term of reproach. No observation or experience during my fifteen years of post-graduate teaching has been more emphasized than this attitude or mind of the student body. Year after year and many times a year, the cry has been the same from all my classes: "What is neurasthenia?" I think you will agree with me that something should be done. The solution of the problem to me seems relatively simple. Let us stop running after strange gods and the making of false idols and return to the worship of our fathers and to one faith. There is a nervous affection—the very same which originally inspired Dr. Beard to coin the word, with a broadly constant symptom picture, a more constant etiology, a conjectural pathology, a fairly certain prognosis and a definite plan, in principles at least, of treatment, the chief and essential symptomatic manifestation of which is an irritable, quick exhaustion of nervous function in many or all directions. It has become almost lost, it has suffered degradation, it has fallen from the genus to the species in the literature of the subject, not so much through intrinsic conditions, but because of the confusion and chaos of interpretation. The dignity and importance of this subtype, its rapid and progressive increase, the charm and fascination of its study and of its remedial and curative treatment are such as justify and, indeed, demand that it be taken from this chaotic mass and be given a distant identity. Let *this* be neurasthenia. We shall simply give back to Cæsar what was his, lost property to the original owner. It is but the restoration of the birthright. How the thief will cover his nakedness is his problem, not ours.

I have but borrowed for a purpose my title, and having explained my motive, I discard it. And yet it is not altogether bad. That it has the ring of cheap sensationalism is a just criticism, though nothing was further from my mind, a disavowal which I hope has been anticipated and is accepted. In much that the condition that I have in mind represents, in much that is peculiar to this affection—to neurasthenia—the term, the American disease, is both accurate and appropriate. As I conceive it, it is an American disease indigenous to this soil and essentially a product of causative conditions peculiar to this country. That it now exists elsewhere, and probably always did in sporadic form I do not doubt, but this is its home, this its soil, this the atmosphere in which it luxuriates. What is this disease? What are its symptoms? How differentiate it? What is its etiology and prognosis, and how is it to be treated? My limit of time will permit me to create the scheme of the picture only, but if the viewpoint be the proper one and the perspective liberal in breadth, any one of my audience will, I am sure, be able to do the filling in. I would count my work well done and a good end accomplished if I did no more than infect you with the enthusiastic interest with which the subject inspires me. In the effort to do so I shall create part of the perspective referred to. First as to your material: Neurasthenia never occurs in fools. The idea constitutes a paradox. Neurasthenia may make a fool, but you cannot make a fool a neurasthenic. It is a disease of bright intellects, its victims are leaders and masters of men, each one a captain of industry. Each case is unique as a study if you are to study helpfully. There are no arbitrary limits to the horizon of studious effort. The political history of the world has been made largely by paranoiacs. Mahomet, Peter the Hermit and Oliver Cromwell are examples in point, to go back no farther. In each there was an imperative and an impelling monomania. The world of literature, of art and of science, of fruitful endeavor in all higher fields, is indebted in an analogous degree to the neurasthenic, analogously endowed with an imperative and an impelling energy. Dr. Gould's list includes such names as Carlyle, Wagner, Huxley, Spencer and many others. The confidence, the faith of patients of this type, is to be classed as an inspiring stimulus in itself and is well worth the struggle to grasp understandingly this subject. That yours is the helping hand depended upon by such men—such giants—whom you may lead as little children; the knowledge that you, and sometimes you alone, may bring back into the world's arena of action and into the old supremacy, such factors in the world's work, represents to my mind an objective, a purpose, a sphere of usefulness second to none of the many laudable ambitions along the highest planes of medicine.

In painting the clinical picture it would mar my scheme to paint an individual likeness. I shall give you first the basis for a composite photograph, made up of the case histories of fifty selected patients from private practice. Forty-two of these were American

born, the remainder, 8, with two exceptions, had been residents more than fifteen years; 22 were from New York City, 4 from Connecticut, 3 from Massachusetts, 5 from Pennsylvania, 2 from New Jersey, 5 from as many different Southern States, 1 from Canada, and the remaining 8 from as many different sections. Forty-three were from cities of more than 100,000 inhabitants, although only 21 were city born. The average age was 37, the oldest 62, the youngest 26. Without a single exception all were brain workers. Sixteen of these fifty had been makers of history in different spheres, some large, some small; mercantile, literary, religious, scientific, political or economic. Two of the number were among the hundred captains of industry assembled in a list made to commemorate a national function celebrated a few years ago. By occupation 13 were financiers, in multiple mercantile lines, really better described as promoters; 6 were lawyers, 3 clergymen, 2 merchants, 5 physicians, 5 brokers, 4 school teachers. Of the remaining twelve, 2 were professional politicians, 2 corporation officials, and 4 managers of large industrial plants. Four of the fifty were men of independent, self-acquired means, who described themselves as having no occupation at the time of record. They have been included in the groups mentioned according to previous occupation. Four of this series were women, 1 a journalist, 1 an actress, and 2 of them teachers. Fourteen of the fifty were unmarried, the age average of this series of fourteen being relatively high, forty-four. The four females were all childless, though two of them were married.

Instead of an analytical elaboration of individual symptoms, let me give you a standard clinical history selected from the series of fifty as a type portrait.

M., aged 33, male, born of healthy good stock, American parentage, the only handicap being parental poverty. Driven by necessity and by that subtle factor, temperament, to early effort in extraordinary degree, he acquired the strenuous, ambitious, high tension, keenly sensitive habit. He could not afford a liberal or broadening education because his own dollars paid for it. At 19 he was in business as apprentice in a large establishment manufacturing mechanical engineering appliances. At 26, with a capital of \$500, he organized a company, had it incorporated, was president, secretary, treasurer, superintendent, salesman and chief stockholder, entering into competition with established and lavishly capitalized rival corporations. Awake at 7, he hurried through breakfast a few minutes later, mixing an omelet with an order or a countermand, assimilable sometimes with the former, always incompatible with the latter, taking in with his coffee the London market or the Paris bourse, dividing the steam supply between brain and-stomach when it should have been all turned on at the point of physiological demand. A hurried walk to the train, possibly a delusional constitutional in this very walk, the steam being still turned on to the top floor. In the office a pile of mail,

interviews with clerks, orders, directions, instructions, detail work in every department. Just here *en passant* is laid the immediate foundation of the breakdown. It is the man of detail, the man great in everything except the qualities which make the general, who becomes the neurasthenic. It is the crime of attending to minutiae which makes the nervous derelict. The general is never a neurasthenic. It is the one flaw in the statue of true greatness. That quality, the highest, which helps us to select our lieutenants, is always lacking. The neurasthenic is the archetype of the pooh-bah. He is not only general, but also colonel, major, captain and private. The penalty is inevitable. No man can do the work of four along higher lines without paying for it.

After four hours in the office this man goes to lunch, tired, nervous and with preoccupied mind. He takes his secretary or manager, and again the attempt is made to mix a steak or an omelet with a business problem. The steam is still turned on at the top, our patient eats fast and drinks a lot of water or other fluid, prematurely flushing the contents of the stomach into the intestine. Already by nervous inhibition he has interfered with biliary and other secretions. The intestine, the duodenum, cannot take care of the albumenoids—the proteids—properly. It cannot take care of its own. The alkaline reaction of duodenal secretion has been upset by the flushed overflow of acid gastric juice, the secretion of bile has been inhibited by the state of mental tension and the diversion of energising agencies from digestive viscera to brain. Fermentative decomposition with resulting ptomaine and toxine formation follows, deficient nutritional assimilation plus chemical irritation are added to cell fatigue along a routine line without rotation. Notices of protest begin to come into first subconscious recognition, but are disregarded. They may come from any one or many sources. Headache of the cincture or helmet type, vertigo, a sense of irritable weakness, mental and physical follows; vague, mysterious messages in a strange language, never heard before, are received but not understood. This patient has always been well and has had no training along the lines of familiarity with symptoms. These messages at first ignored, sometimes hushed with a cocktail or a highball, or many of both, become more and more continuous and imperative. The habit of almost mechanical activity of mind projects itself into the hours for sleep. Insomnia develops, at first as dreamful, anxious sleep, then with fitful, broken sleep, and later with an allowance cut by more than half from the normal. He wakes tired, irritable. The pneumogastric is one of the first and often the most emphatic of the aggrieved protestants. Palpitations, overaction, an irregularity partly toxic, lay the foundation for what later has become an obsession of fear of sudden death—heart anguish. He fears to be alone, to walk alone, to sleep alone. To this other fears have been added. A perfectly legitimate dizziness has laid the foundation for an almost hallucinatory persistence of this impression. Rapid

motion, as in the cars or a carriage, high places, sudden changes in the visual perspective, originate as many phobias. Every nerve gets on edge and this hyperesthesia of auditory, or visual, or olfactory, or gustatory, or pneumogastric nerve, varying, as it necessarily does, in degree, gives explanation for the protean system picture. It is the mystery of it all which leads to introspection in attempts at explanation, and finally to an exquisite exaltation of subject consciousness, a veritable delirium of anguish.

Neurasthenia is essentially a recoverable affection. In a majority the recovery is complete and final. In a few, usually neglected or mismanaged cases, the recovery is imperfect, relapses are common and the neurasthenic habit becomes almost a part of the individual. Even in these cases a steadily progressive tendency to recovery and to a normal poise as the final fixed habit may be established by persistent effort based upon an intelligent understanding of the general principles of treatment plus an appropriate application of such principles to the personal equation of the particular patient. Neurasthenia carries with it no penalty to succeeding generations. This statement is contrary to *a priori* reasoning, and also contrary to routine teaching and unthinking or ignorant belief. It is a statement based, however, upon careful observations in an extended experience, and I believe it to be absolutely true. The victim pays the whole penalty; the disease is free from the law of entail. The high average standard of good health and nervous poise in the children of neurasthenic fathers has been a frequent personal observation.

I do not believe that any individual case of neurasthenia ever originated in a single cause. The very essence of the affection makes such an hypothesis a paradox. Equally true is it that no single agency is sufficient to explain the prolonged maintenance of this condition. Any one of many causes may appear to dominate in a given case and for a given time, but the carefully studied etiology will prove a complex one in every instance. The list of stereotyped and empirically accepted causes is a long one and undergoes a progressive expansion from year to year. Overwork, worry, prolonged mental tension and anxiety, malnutrition from deprivation of food, sleep and rest, toxemia of autogenous and heterogenous sources, shock, trauma, reflex irritation, and as many more are on the list. Most of these are contributory factors only, and some are effects which are essentially secondary, being part of a vicious cycle, vicious in fact and even more so in interpretation. The insufficiency alone of any of these factors is tacitly admitted in the usual statement that an hereditary predisposition is fundamentally necessary, a proposition not sustained in my own experience, though carefully investigated always. Neurasthenia is, I believe, essentially an acquired state and heredity, except of temperament, and a high grade cortex is an almost negligible equation. My chief criticism of the ordinary etiology as outlined is the narrow viewpoint with resulting technical limitation in treatment.

What is the cause of these causes? *The factor in neurasthenia in the American disease—the factor common to all cases—is, broadly, that of atmosphere—the atmosphere peculiar to this country, the atmosphere of limitless possibilities, not in one field, but in all; in commerce, in art, in literature, in every field of intellectual accomplishment. It is this ether of limitless possibilities which stimulates the individual to a degree of effort, of tension, of strain, of superstrenuous endeavor, impossible and unknown, except by the infectiousness of example elsewhere. There is no limit to the game, and anybody may sit in. America is the only country in which you can go in with one white chip and have a chance to quit the biggest winner. It is this atmosphere which is the incentive to overwork. It is the anxiety, the tension, the strain of the game, which brings worry, loss of sleep and all the rest; and even here the penalty comes indirectly. The intoxication of endeavor, the delirium of effort, is at the expense of all conservatism. The laws of nature—inexorable as fate—fate itself in fact, are violated not daily, but every hour. The hygiene of life is set aside. All kinds and degrees of insult are offered to brain, stomach, heart and every other organ. Day after day the steam is kept turned on and at full pressure to the one floor, and, worse still, often to the one room. Is it any wonder that all the rest of the house grows cold, or that, the power being insufficient, the machinery of the lower floors works poorly and makes poor goods? Every function suffers sooner or later. One after another, and sometimes several together, they protest, then openly rebel and finally go on strike. Indigestion, toxin and ptomaine formation, torpor of sewerage function and resultant, defective elimination add the element of chemical irritation, or autoxemia, or lithemia, to the situation. The tired brain cell gives way under this added handicap and goes out on sympathetic strike.*

The accident of dominating symptoms in a given case is but rarely of any value in determining the etiology. Gastric and lithemic and other types may be recognized and distinguished symptomatically with some minor advantage, but no more serious error of interpretation exists than to conceive of them as primary etiological types with a correlated therapeutics. Anti-lithemic drugging will not cure a lithemic neurasthenia nor will lavage make well your so-called gastric cases.

I have again and again noted a urine with specific gravity above 1,030 with 14, 16, 18 and even 20 grains of urea per ounce, with lime oxalate and urates in abundance, all these conditions giving way to the normal under direct treatment, the neurasthenia remaining essentially unchanged. I never knew a sexual neurasthenic, so called, to be cured by any plan of direct genito-urinary treatment, and this statement applies with equal truth and force to all efforts (and I have seen many) to cure the reflex cases by removal of a supposed cause in any peripheral irritant.

I know of no condition in medicine which demands more ex-

actively of the physician all the diagnostic resources of the profession, and yet mistakes in diagnosis should be rare. The symptomatic semblance of neurasthenia—the pseudo forms—which may sometimes present much of the picture, but will always show a radical omission or addition somewhere, should always be in mind and should be excluded carefully seriatim. More than one patient referred to me as a neurasthenic has been found to be the real victim of tuberculosis, of malaria, of Bright's disease, of gastric ulcer or some other similar affection. Anomalous forms of Basedow's disease in women and various toxic states among men have represented especially common mistakes in diagnosis. Paretic dementia in its incipient stages and some forms of melancholia, particularly the affective types, demand special mention. A guarantee of escape from the opprobrium of error as to the pseudo types is possible only through an exhaustive recourse to all measures and methods of accurate information. Elaborate urinalysis, blood examinations and often examinations of the sputum is a routine procedure with me. In any case in which the dominant symptoms are referable to a particular function or organ persistently, I am proportionately suspicious of a local disease at least complicating the general state. It should not be forgotten that a neurasthenic may have a coexistent Bright's. In Basedow's disease which, as we know, may utterly lack the spectacular symptoms, the absence of goitre and of exophthalmos may easily lead us to interpret the nervous irritability, the quick exhaustion, the fear, the digestive and other functional disturbances, the loss of sleep and the widespread vasomotor symptoms as due to a neurasthenia, but the habitual quick pulse, the shallow respiratory action, the diarrhea and the *tout ensemble* of constancy in the picture will always give rise to doubts which will be converted into negative certainty when the etiology is considered. From paretic dementia we can distinguish neurasthenia by the presence in the former and the absence in the latter of organic signs. No matter what the degree of incipency, if the disease has advanced to the point of inducing symptoms, we shall find in paresis somewhere some of the physical signs. Special care should be observed in the melancholic (by the way, the majority type) forms of paresis. In melancholia we have, no matter what the subtype, a constant syndrome; a characteristic facies, a post-cervical ache, a shortened sleep, an irrational melancholy and a tendency to suicide. In neurasthenia this facies is absent and the tendency to suicide is rare. Melancholiacs get to sleep as a rule with but little difficulty, but wake too soon, at 2, or 3, or 4, and sleep no more. In neurasthenia they sleep lightly, dream much and wake often. The post-cervical ache may belong to both, but in neurasthenia it is often a cincture or helmet headache, quickly dissipated by mental diversion. The neurasthenic can laugh, the melancholiac cannot. For a melancholiac to laugh is to refute the diagnosis. From myasthenia gravis it is to be distinguished chiefly by the absence of dominant bulbar symptoms.

What is the pathology of neurasthenia? The answer is almost anyone's guess, and yet to know the lines of experimental research and investigation already established is a long step in the direction of what will finally prove the correct guess. The work of Hodge, familiar to you all, was a far call in the right direction, and while it has given us no final solution, it probably paved the way to the yet to be demonstrated pathological explanation of these cases. The effects of fatigue, of worry, of irritation, upon the brain cell structure was proven to be actual and demonstrably so, by his work. Barrows has added observations which demonstrate with equal positiveness, the structural and sometimes actually organic changes and results which follow to the cell from malnutrition. All neurasthenics, it should be remembered, are examples of malnutrition from faulty assimilation and metabolism, usually secondary. The work along chemical lines with a final explanation in states of auto-intoxication promises much, but that which appeals most strongly, even though as yet it offers least in a tangible, material way, is a combination of the others with an imaginative elaboration of the ion theory. The analogy of the highest governing nervous system with a telephone service in a large city has occurred to many, appeals to most of us and is familiar to you all. We have all been able to grasp mentally some conception of the power plant, the conducting wires, the receiving and transmitting station of the subscriber and a central, but the plan of a central switchboard is where we stop. The hello girl of the central station will not do. She is too unreliable; she goes to sleep on post; she talks distracting gossip; she has no sense of duty at times. Her sole stimulus to duty well done is often the approval of the inspector only and the \$10 per week. Neurasthenics don't gossip, they don't go to sleep—more's the pity—and yet the switch gets out of gear and you cannot get a connection, or if you do there is a buzz and you can't understand which stands for the weakness; to which we might add in carrying out the analogy, the usual profanity, to represent the irritability. Mendelssohn, Frankhouser and others in attempts to give a tangible, graspable explanation of electrical action upon nervous function, have advanced and elaborated what might be called the theory of wandering ions. You will recall that, when first announced, the neuron theory, in addition to facts proven, claimed, but did *not* prove a distinct individuality for each neuron, with no anastomosis anatomically with our neurons. This undemonstrated claim was unaccepted for the reason that it left less explained than before the observed and familiar facts of concert of action and synergistic relationship of nervous function which seemed to demand some anatomical connection. Imagine bodies endowed with autogenous mobile life, which stretch an arm from 1 to 5, or A to G, wandering about with a restless usefulness, connecting two separate souls who want to get in touch in the same way but with infinitely more of reliability, as the central hello girl connects you up with the number you send in from the transmit-

ting phone. Imagine these little bodies goaded day after day to extraordinary effort, allowed no rest, no sleep, whipped by alcohol, or tobacco, or coffee, suffering from deprivation and irritation in every way, rations served foul, working for a thoughtless, selfish, utterly inconsiderate master. Do you wonder that they get discouraged, tired, exhausted and confused, taking messages wrong, turning in a fire alarm here, calling in the police there, doing many things which they should not do and leaving undone those things which they should do? Very pretty, you will say, but fanciful. I admit it, but I deny any more of fact in any other theory.

The first step—the essential foundation of any plan of successful treatment in neurasthenia—is the establishment of a proper relation between physician and patient. The status of the physician should be firmly established before the question of treatment is considered at all. He will have laid the foundation of any plan of successful treatment well in a direct ratio with the thoroughness, the exhaustiveness of his diagnostic examination of the patient. Nothing should be taken for granted—no second-hand information should be accepted. At the risk of being tedious, examine for yourself. Five minutes or less is often more than sufficient time for a final diagnosis in paresis or tabes—two hours is often time well spent in the first examination of a neurasthenic, and this is true even in the instances in which as many minutes only have been necessary to convince you of the nature of the case. Remember there are two parties to the transaction. Your own enlightenment is not the only requisite. The neurasthenic always takes himself and, at least, some of his symptoms seriously. To tell him abruptly that this or that means nothing is not convincing to him, however true to you. No obvious foundation has been laid for so positive a statement in so short and superficial an examination. To you many of the symptoms are distorted by exaggeration, to him they are real. Do not forget the axiomatic fact that neurasthenia does not develop in a fool, and as corollary to this fact make your appeal to the intelligence of your patient. Explain things; give the patient something tangible to grasp, some explanation which appeals to reason. He will leave the ether of imagination and come down to the terra firma of fact gladly. The effect at first may be upon the subconscious ego only, but the leaven of action will later rise into controlling consciousness. The physician, by the way, should never think, or believe, or guess; he should know. Therefore, he should lay at least a plausible foundation for such knowledge in a patient examination at the first interview. It is just as important that a reverse attitude should be the rule thereafter. Discuss with your patient in subsequent interviews every topic conceivable except his ills. At stated intervals go over the case objectively, taking an account of stock. Where favorable progress is noted, not only mention it—prove it; if still *in statu quo*, explain the delay in results. Silence is rarely golden in such situations. Equally important with this factor or proper relation-

ship between doctor and subject is the control of the patient's environment. Just which is proper varies with different cases, but once settled, it should rarely vary with the case. Compromises and concessions are always dangerous. The patient's hand should never touch the tiller, once you have taken charge of the ship. First, place him so as to minimize the influence of all adverse factors, domestic, financial or otherwise. Break up, as far as possible, all subtle or obvious factors which contribute to a morbid introspection by conscious or subconscious association. Encourage objective consciousness by a change in the physical and mental atmosphere. Sometimes this must be done radically, and the patient cut out from the family or from his business. Never leave him alone, and never leave him idle. Put with him a tactful, resourceful, sensible, attendant—train your own nurse, by the way—train him over again, if a hospital graduate. Don't call him a nurse in any event—neurasthenics resent trained nurses. Give all your instructions to this nurse-companion—never to the patient, who should have nothing whatever to do with his case. Arrange all details of diet, of exercise, medicines, baths, diversion, etc., with the nurse. Give your patient a chance to escape from a knowledge every hour of the day that he is a patient. Keep him busy, fill in every minute of the day. A salt rub in the morning, the patient standing in eighteen or twenty inches of hot water, three minutes of practice in deep breathing exercises, after which comes breakfast. All meals should gradually be made as full and as nutritious as possible. I observe idiosyncrasies, but no other law of special diet. After each meal from twenty to thirty minutes of recumbent rest is insisted upon—a habit observed by nearly every carnivorous animal, except man. Next comes the daily visit to my office, with treatment by the galvanic current, one electrode back of the neck, the other over the forehead, both as large as possible, in order to get the utmost diffusion at the point of contact and thus a maximum of electricity with a minimum of discomfort from local action. A steady battery, a rheostat, a meter, and proper electrodes are absolutely essential. Part of the benefit is undoubtedly due to suggestion. This is a small part, however, by comparison with what I am firmly convinced by years of careful observation to be an intrinsically dynamic effect of sometimes striking benefit from electricity thus administered in these cases. I never exceed five milliamperes in amount, or half an hour for the seance. Usually I begin with one milliampere and a five-minute seance. On leaving my office, my patient goes direct, riding or walking, according to circumstances, to a gymnasium, the director of which, Dr. Watson L. Savage, is a medical graduate, whose life-work has been given with enthusiasm to the co-operation, elaboration and perfection of a plan, which we both believe will, when perfected, prove a specific, curative treatment for these cases, a proper environment and control being the only other essentials. By this plan of psycho-

physical, educational control, we secure, by the indirect method, what is always difficult, and often impossible, by any direct plan—a lowering of tension, a mental relaxation, a return to rational inhibition, to order from chaos. These patients are taught the lesson of physical, muscular relaxation—how to lie down, how to go through the mattress to the bottom, how to turn loose physically. That the muscular system is energized and overkeyed into states of hypertension through sympathy with states of mento-nervous exaltation is familiar to us all in the tense mouth, the corrugated brow, the clenched hand, the restless walk. We simply start at the other end, and re-educate the higher through the lower. The quickest, the surest, the most rational way to key-down a man mentally, is first to key him down motorially. I have waited for ten years of results to accumulate before announcing publically, except in the lecture room, the value of this procedure. I give you no experimental theory. My unqualified endorsement is based not only upon a rational conception but many confirmations in experience. I count this part of the plan of treatment in neurasthenia one of the most positively helpful and essential of all the major details. The afternoon, following lunch and another half-hour of rest, is spent out of doors—a drive, a horse-back ride, golf, tennis, a walk, a visit to some museum or place of public interest: a shifting from one to another of these various diversions, largely based upon the personal equation of temperament and aptitude in your patient, fills up the afternoons. In suitable cases part of the evening must be filled, and occasionally the theatre or a concert can be utilized, but never at the expense of sleep, if insomnia be present. A half-hour of massage at bedtime closes the day's work.

This one symptom, insomnia, must be controlled always. Make your patient sleep—count a dreamful night insomnia. Veronal, trional, sulfonal, in 5, 10 and 15-grain doses are effective and satisfactory. I often shift them. All should be given in some hot menstruum. No nervous patient should ever know his drugs—send the prescription yourself, and always mark it, "No copy. Do not repeat." Fifteen years ago a few neurasthenics under my care came back to health and nervous poise in spite of the drugs which I employed in treating them. For five years past, using less than half the drugs, my percentage of recoveries has increased fourfold. Drugs play a varying part—sometimes no role at all, again a vital one. Some patients demand them, others are indifferent, and still others need them neither mentally nor physically. Sleep must be secured and maintained, elimination and prompt sewage function regulated and complicating accidents combated. For temporary use, until the regime outlined becomes effective in lessening it, the mental state of unrest and hyper-psychical esthesia should be controlled, and the drug which most effectively accomplishes this purpose is opium in the form of the denarcotized, aqueous extract in doses from one-tenth to quarter-grain three or four times daily. Free water drinking between meals is a desir-

able habit to encourage and a positive water, always symptomatically remedial in cases in which lithemia is an aggravating factor, is the Royal Fachingen. I do not believe in the sanatorium treatment of these cases as I know sanatoria. If the ideal sanatorium existed, the sanatorium plan would be ideal. I add nothing to your personal knowledge, when I tell you that such an ideal does not exist. I can conceive of no more fitting nor important statement in conclusion than one of condemnatory criticism of the misapplication of the Weir-Mitchell plan of rest and isolation in these cases. It is to be condemned first, as involving the conception of a *routine system or plan* of treatment; second, as encouraging introspection; and third, as violating in principle all intelligent interpretation of the whole subject. For women and feminine males it will do no harm; for men and masculine women it is an insult to intelligence.

Pharmacology and Therapeutics.

IN CHARGE OF
A. J. HARRINGTON, M.D., M.R.C.S.(Eng.)

TREATMENT OF UTERINE BLEEDING.

DR. H. J. BOLDT, of New York, read a paper before the Southern Surgical and Gynecological Association, supplementing his former report on the use of cotarnine hydrochlorate—which is called stypticin by its introducer, Dr. Martin Freund—in various cases of uterine hemorrhage, his opinion of the therapeutic value of this medicament being based on seven years' experience with it. He first briefly describes the remedy, which is a base obtained from narcotine by oxidation. It occurs as a microcrystalline yellow powder, is soluble in water, and has an intensely bitter taste. A *résumé* of its physiological action follows.

The author then cites a number of cases in which he used cotarnine hydrochlorate with marked effect, and also those in which it was ineffective. In thirty-five cases of fibromyomata, eleven were more or less benefited, while twenty-four were not. In one case of excessive menstruation, due to an interstitial fibroid, the relief was very marked.

In nine cases, where hemorrhage was due to cancer of the uterus, the result was negative.

Complete cure followed in from two to six days in five cases of post-puerperal bleeding, after removal of retained placental particles.

In conjunction with curetting, this remedy was found effective in hyperplastic endometritis, but in the glandular form results were negative. In one case out of five of retroversio-flexio with endometritis, the menorrhagia was relieved without resort to surgical intervention. In chronic metro-endometritis, five of nine cases were more or less benefited.

In various forms of non-suppurative pelvic inflammation, only three out of twenty-three patients were not relieved by cotarnine hydrochlorate.

In irregular bleeding during pregnancy it has been found very beneficial, and no unfavorable symptoms have been noted.

In profuse menstruation in virgins, without changes being

found in pelvic organs, only five of seventeen patients were not benefited.

In atypical bleeding during the climacteric period, if no pathological cause were found, cotarnine hydrochlorate usually gave a satisfactory result.

The author remarks that while this remedy is not a panacea for all cases of uterine bleeding, he has found it better than any other remedy. In some instances it has practically served as a specific. If no effect at all is produced after three large doses have been given (from $2\frac{1}{2}$ to 5 grn.), it is useless to continue with the drug. Likewise, in fibroid, it is not recommended to continue its use if two hypodermic injections of 5 grn. each, at intervals of four to twelve hours, do not cause a diminution of the hemorrhage.

An important fact is that the author has never noted any harmful results from cotarnine hydrochlorate, even when administered in such large doses as 5 grn. every three hours. In some instances it also relieved the patients of pain associated with the profuse bleeding.

In instances of too profuse menstruation, the author found the best plan was to begin with 1 grn. doses three times daily about one week before the expected flow, and as soon as the flow began to let the patient take $2\frac{1}{2}$ grn. every three hours, to be continued during the entire period. In instances of metrorrhagia, from $2\frac{1}{2}$ to 5 grn. may be given at intervals of from two to three hours until the bleeding is lessened; then the dose may be decreased to from 1 to $2\frac{1}{2}$ grn. at intervals of three to four hours. If a quick result is important, it is best to give 3 to 5 grn. in a 10 per cent. solution subcutaneously into the buttocks, using the customary antiseptic precautions.

Because of the disagreeable taste of the medicine, it is best administered in the form of capsules, the pharmacist being ordered to put the powder dry into the capsules. It may, however, also be given in tablet form.

A J H.

Treatment of Multiple Warts.—Arthur Hall (*British Journal of Dermatology*, July, 1904) says: It is a well-known fact, although some are highly incredulous, that the magnesium salts, through internal administration, have a direct and specific influence in some way upon multiple warts. After the report of a case thus beneficially influenced, the author believes that a possible explanation may be that, granted the disease is due to a micro-organism, it is one of poor resistance and may be destroyed by a very slight alteration of the soil, thus an increase

of magnesium salts in the tissue juices, a small quantity of arsenic, thyro-iodine, etc., may be sufficient to retard the further growth of the organism, with consequent shrinking of its new formation and disappearance of the disease. Such a view is consistent with what we observe in other parasitic diseases.

Ivy Poisoning.—Death from ivy poisoning is extremely rare, especially among adults; but a man forty-two years old died in the St. Joseph's Hospital on the 21st, after two months of intense suffering from this affliction. A striking peculiarity of the poison ivy is the varying degree of susceptibility to its effects—some persons are affected by merely passing the plant, without coming in contact at all, while others can handle it with impunity. A case is related of a child, six years old, who died from the effects of severe ivy poisoning produced by having his skin rubbed while wet by the hands of a boy who had been rooting up plants of the poison ivy. This case is rendered still more remarkable by the fact that the boy had previously washed his hands thoroughly, under supervision, first with soap and hot water, and afterward with vinegar. The boy who had been working with the plants had a full and apparently permanent immunity to the poison.—*Bulletin Health Department, Chicago.*

Experimental Decapsulation of the Kidneys.—Following the decapsulation of kidneys in rabbits, in normal dogs, in dogs with induced nephritis, in dogs with infarcted kidneys, and in dogs with normal kidneys but with additional work thrown upon them. Gifford (*Boston Medical and Surgical Journal, July 14th, 1904*) finds the following conditions: (1) In all my cases of two days and under and in my controls the entire thickness of the capsule had been removed over two-thirds of the surface by the operation of decapsulation. (2) There is a certain amount of intracapsular tension in unencapsulated kidneys, normal or with nephritis, as shown on removal of capsule. (3) There is an immediate increase in size of decapsulated kidneys persisting up to one month at least; afterwards, a decrease to approximately normal size complete at end of six months. (4) There is congestion, moderate in degree, most marked in the intertubular blood vessels in cortex, lasting three to five days after the operation. (5) No histological change in the renal epithelium follows the operation of decapsulation of kidneys. (6) A new capsule, very vascular, at first, two to four times thickness of old, is well marked at end of eight days. At the end of six months it returns to approximately the normal thickness and vascularity. The new capsule arises chiefly from the connective tissue cells of the intertubular connective tissue, but in part from the retroperitoneal connective tissue which is present in the new

bed of the kidney. (7) No new vessels are formed which anastomose with those of the kidney. (8) The increase in size is due primarily to the increase in blood supply, possibly resulting from the removal of the capsule.

How the General Practitioner Should Treat Gonorrhoea.—

At the recent meeting of the American Medical Association, F. C. Valentine read a paper with this title. He offered the following conclusions: (1) Every general practitioner is practically competent to treat successfully uncomplicated anterior gonorrhoea, if he will devote as much attention to this as he does to any other disease. (2) Every patient with gonorrhoea is entitled to the services of his family physician, just as much as though he had acquired some other disease in consequence of drunkenness or other violation of morals. (3) The general practitioner who declines to treat uncomplicated anterior gonorrhoea avoids one of his most sacred duties to the profession and to humanity. (4) The patient who, because he has gonorrhoea, refuses the services of his family physician, is likely to become an opponent of scientific medicine, to the detriment of his health, that of his family, and that of the community. (5) The scientific treatment of this form of gonorrhoea is perfectly within the power of the general practitioner. (6) The irrigation treatment is as yet the most effective method, and is most in accord with the modern scientific understanding of the disease.

Treatment of Fresh Perineal Tears.—Dr. J. Eversmann believes thoroughly in the immediate repair of perineal tears. They may heal, it is true, without any stitch; but since the firmness of the perineum depends upon a perfect union of the muscles, and it is the nature of muscles when severed to retract, unless this tendency is overcome by suture, there will not be a close and firm union, but rather a more or less wide separation of the edges of the wound. Of 132 cases of sutured fresh perineal tears, only two, or 1.5 per cent., failed to heal properly. In no case was there much pain, and in only 45 per cent. a slight rise in temperature—*American Medicine*, June 4th, 1904. [That these views are without contradiction I am thoroughly satisfied, as I have made it a routine practice to examine the integrity of the perineal triangle in every case, even without evidence of external tear. It is remarkable how often one will find a tear in the posterior vaginal wall without external evidence, and it is remarkable what an influence a deep single suture will have on the healing of these injuries. I usually use ten-day catgut for these internal tears and silkworm gut for external ones.]

A. J. H.

Proceedings of Societies.

CLINICAL SOCIETY OF THE NEW YORK POLYCLINIC MEDICAL SCHOOL AND HOSPITAL.

A STATED meeting of the above society was held on March 6th, 1905, the President, Dr. D. S. Dougherty, in the chair.

Specimen of Myomatous Uterus.—This specimen was exhibited by Dr. L. J. Ladinski, who said he had removed it from a patient twenty-eight years of age, with the following history: Married; began to menstruate when thirteen years old. Had two children, both living and healthy, and had had no abortions. Menstruation of late was very profuse, lasting from ten to fourteen days, and so much blood had been lost that the patient had become very pale and anemic. About a year ago she noticed a lump in her right side, which seemed to diminish during the menstrual period and to increase between these periods. Lately the bowels have not moved freely, and cathartics have been resorted to. For the past three months the tumor increased in size very rapidly, until it reached the umbilicus. There was constipation and constant and painful urination.

Bimanual examination revealed a large tumor filling the pelvic and abdominal cavities and reaching to umbilicus; it was immovable, owing to its fixed position on the right side and in front of the pubes, and appeared to compress the bladder. The tumor involved the entire uterus, and was very soft and boggy to the touch, so much so that it could readily be mistaken for a uterus pregnant between the fifth and sixth month.

A diagnosis of soft myoma was made and operation advised.

Abdominal hysterectomy was done under ether anesthesia two days ago. The ovary and tube of the left side were not removed.

On incising the tumor, it was found to contain a large quantity of calloid material, surrounding several small fibro-myomata, showing in all probability a myxomatous degeneration.

The case is interesting because of the calloid or myxomatous degeneration of the fibroid, a condition which, though not rare, is sufficiently infrequent to warrant reporting, and especially from a diagnostic standpoint.

Soft myomata of the uterus are extremely difficult to differentiate from pregnancy, especially when there is amenorrhœa, as

frequently happens in these cases. In myomata the uterus is uniformly enlarged and pre-ents an palpation a soft, boggy feeling, simulated very closely by that of pregnancy, and when there are a number of small fibroids imbedded in the tumor, as is sometimes the case, they may be mistaken for fetal parts. Careful palpation will show, however, that in pregnancy the uterus is more uniform in contour and that there is also the characteristic feeling of elasticity and fluctuation to distinguish pregnancy from the soft, boggy, almost mushy feeling of a myoma. The speaker knew of no condition which simulated pregnancy so closely, and which was at times so difficult to distinguish from it. The specimen was to be submitted to microscopical examination to determine the exact nature of the tumor and the character of the degenerative changes.

The patient has run a perfectly normal course up to date, and there is every reason to believe that she will have an uninterrupted convalescence.

Dr. F. M. Jeffries said that the colloid degeneration never took place in any tissue other than epithelial, and as the specimen under discussion was a fibroma, he thought the colloid degeneration could be excluded. He also could not recall having heard of a single instance of myxomatous degeneration in a fibroma. From the microscopical picture presented, he was inclined to think that the change was probably edematous. There are two types of fluctuating fibroma, one in which there is merely a necrosis or breaking-down of the cellular structure, and the other simple edema, where the interstices are filled with fluid, which may even be partly viscous in character. Of course, to make a positive diagnosis, a microscopical examination would be necessary, but the speaker's diagnosis, from the gross, was an edematous, rather than a colloid or a myxomatous degeneration.

A Case for Diagnosis.—Dr. D. A. Sinclair presented a case for diagnosis of pyoarthrits of a chronic nature. Mr. H., twenty-three years of age, railroad employe by occupation. Mother and father living. Ten or eleven brothers and sisters died in infancy—cause unknown. Family history negative to tuberculosis. Six years ago had an attack of gonorrhœa, for which he was treated, and he says was apparently cured. About a year later there was a recurrence of the discharge, lasting about three weeks, there being no apparent cause for this attack. Attacks have been frequent since that time, without the patient having exposed himself to them, all showing an uncured condition since 1899. Fifteen months ago he developed a swelling of the left elbow. He then noticed a pain in the right knee, and then in the left hip; three months later this left elbow opened spontaneously and pus escaped. He stated that during all the

time the left elbow was swelling he felt absolutely no pain. At about this time the left index finger, second joint, and the middle finger, at the third or distal joint swelled, and later the same condition of swelling obtained in the joints of the great and second toes, all rupturing and discharging pus.

The patient entered the hospital January 5th, with an acute epididymitis on the left side. This inflammation was accompanied by pain. Hot flaxseed poultices were applied every hour until fluctuation was felt. The abscess was opened under ether and a foul, cheeselike substance was taken away, which had destroyed the epididymis completely.

When he entered the hospital, the patient had a large abscess on the right side, extending from just below the margin of the nipple downward six or seven inches, and about three and a half inches wide, burrowing posteriorly to the ribs. This was punctured with a hypodermic needle, and the material evacuated was examined by Prof. Jeffries, together with the discharge from the urethra and prostate gland, but no evidences of the gonococcus or tubercle bacillus were found. About ten days ago another fluctuating tumor began to develop on the right hand, about one-half an inch posterior to the first joint of the little finger. The patient has suffered no pain from any of these lesions. The treatment has been oil of gaultheria locally applied and given internally, without benefit; iodide of potash has also been given internally, without, however, reducing any of the swellings. The joint lesions are still swollen and discharge a greenish material; the abscess on the chest wall has not yet closed, and the chronic urethritis is still present.

Dr. F. C. Keller said that from the history and general appearance of the patient, he was inclined to think the lesions of tubercular origin. He had seen several cases of tubercular arthritis, and this case had many features in common with them.

Dr. V. C. Pedersen said he had seen two or three cases of gonorrhoeal arthritis, but the patients all suffered severe pain, and there was no destruction of bone, but some destruction of the joint tissue. He had read of one case of gonorrhoeal infection where the patient died, and pure gonococci were recovered from the fluid in the pericardium and in the pleura after death. The patient under discussion presented some general appearance of gonorrhoeal arthritis, but the slow onset of the joint symptoms, their comparative mildness, their wide distribution and the tuberculous temperature and sinus formation, and the difficulty in obtaining any pathological findings from the fluid in the joints all seemed, in the speaker's opinion, to point to tuberculosis.

Dr. A. Lyle said he thought the condition tuberculous. The destructive process in the joints, together with the lack of gono-

cocci in the discharge, seemed to prove rather conclusively that it was of a tuberculous nature.

Dr. Jeffries said he had examined the fluid on two occasions, and, finally, the fluid from the cavity of the chest, and had been unable to find gonococci of any sort, by examination or culture. He could only assume that the condition was tubercular, because, in the absence of any demonstrable form of germ in pus we can only come to this conclusion, although the pus does not necessarily contain tubercle bacilli. If the walls of the abscess were scraped, some tubercle bacilli might be obtained, or the histological structures of tuberculosis may be demonstrated. The bacilli, by the time they have become part of the pus, have so far undergone disintegral changes that they fail to accept the dyes, and thus there is pus without any demonstrable bacilli.

Dr. M. Franklin said he had examined the patient with the fluoroscope, and the appearance of the bones was unquestionably tubercular. The fluoroscope, however, unaided by the X-ray photograph, was far from reliable.

Dr. James Pedersen said that possibly the patient had had a more or less pure gonococcal arthritis of the elbow-joint; but that in his opinion the sinus formation about the finger-joints and in the testicle was significant of a tuberculous process there. He had never seen a gonococcal infection of joints behave just as these finger-joints were behaving, and the history of the case, together with the clinical picture, and the pathologic findings, together with the fluoroscope picture, as already stated, seemed to him conclusive.

Dr. M. Packard said the joints of the patient's fingers reminded him of the picture of spinoventosa, which occurs in specific and tubercular patients. A positive diagnosis might be made by injecting some of the fluid from the patient's abscess into a guinea-pig.

Dr. L. L. Roos said that the apex of the right lung showed some fine rales and a slight dulness, which was indicative of tuberculosis.

Patient Suffering from Facial Paralysis.—Dr. G. B. McAuliffe presented a patient who, during the course of an acute otitis media, developed facial paralysis. When this occurs as the result of the otitis, it is due to the pressure of an exudate on the nerve exposed by reason of a bony dehiscence, or due to a neuritis established by inflammatory extension through the small foramina in the facial canal. The case was referred to Dr. Franklin with electrical treatment.

Fibroma of Inside Cheek.—He also showed a patient with a small fibroma inside of the cheek, which had existed for twenty years, and which got so continually between the teeth that the

woman had developed the habit of speaking with the jaws almost set. The wonder is that she endured it so long.

Epithelioma of the Lower Lip.—Dr. J. A. Bodine showed a case of epithelioma of the lower lip on which he had operated. The patient had been treated for three months under the X-rays, with a resultant increase in size of the growth. He first appeared at the clinic with a foul, fungous mass, which involved the lower lip from the angle to within a third of an inch of the other angle, and extended downward over the chin. The raw surface was closed by plastic flaps.

The speaker said he never put a dressing on a face wound. He had removed upper and lower jaws, and lower lips and closed hare lips, and had never applied any gauze dressing, and yet never had any suppuration. The reason for not applying a dressing is that if it be under the eye, the dressing becomes saturated with tears; and if below the nostrils, the nasal secretion will infect the wound, or below the mouth the saliva will be retained and decomposed in the gauze, thus infecting a wound that would otherwise heal. In the operation under discussion, every single gland and every bit of loose alveolar tissue was dissected down to the clavicle and both submaxillary glands were removed, care being taken not to sever the facial artery, as the life of the flaps depends upon the integrity of this artery.

Dr. Franklin said that he had never known of an epithelioma of the lower lip being cured by exposure to X-rays, and did not believe that it could be done. He thought that now, however, was the time to subject this patient to X-ray treatment, and thought that about fifteen radiations would materially lessen the chances of recurrence.

Dr. D. S. Dougherty said that he would like to send his mastoid patients around with a very light dressing, and was much impressed with Dr. Bodine's idea of getting patients with face wounds out of bed in a short time. He always got his mastoid patients up, if possible, on the second day, and even allowed them to leave the hospital two or three days after operation.

Pott's Disease of the Dorsal Spine.—Dr. V. C. Pedersen presented this patient, three months after operation, in order to illustrate the importance of stripping a patient for physical examination. The abscess in the case had pointed at the tip of the left twelfth rib, where a small incision had been made before the case came into Dr. Pedersen's hands. No examination of the back had been made, so that the kyphosis present in the mid dorsal region escaped attention. At first the cavity drained freely, but under the persistent use of ten per cent. iodoform in glycerine emulsion, all discharge had ceased. With the aid

of orthopedic corsets, prescribed by Dr. Homer Gibney, further progress of the disease appeared to have been arrested. The usual systemic treatment for tuberculosis was also being followed. Dr. Pedersen stated that he hoped to have the boy leave the city, and take up farming as his life's work.

Periurethral Abscess.—Dr. Pedersen also presented two cases of periurethral abscess. The first patient developed complications before any treatment of the disease was had, in the mid-penile region. The speaker adopted the plan of treatment which he thinks is best in these cases—not only opening the abscess throughout its entire length in the long axis of the penis, but also of slitting the skin somewhat in addition, thus producing a large cone-shaped cavity, with its apex at the urethra, and its base in the skin sheath of the penis, thus facilitating packing from the bottom. In this case the entire cavity was closed in three weeks. At no time previous to or subsequent to the operation was there a communication between the abscess and the urethra. The expectant method of treating the gonorrhoea had resulted in a perfectly healed urethra in the course of twelve weeks' treatment, which included the surgical care of the abscess.

The second case was one of periurethral abscess in the glans penis, which appeared during the course of a gonorrhoea, but without material symptoms. When first seen by Dr. Pedersen, the gonorrhoea was well, with the exception of a few shreds in the first urine passed. The abscess was about the size of a pea, and entirely without subjective symptoms. Pressure did not show any connection with the cavity of the urethra. A hypodermatic needle was passed into the abscess and withdrew a few drops of mucopus, which, unfortunately, were lost in the dispensary before examination for gonococci could be made. Since that time the hypodermatic needle hole in the wall of the abscess has remained open, but no material discharge which the patient noticed was coming away, and no urine escaped. As to treatment, the speaker thought that the proper method was to open the region about the abscess as far as the floor of the urethra, and tie off the neck of the abscess at this point, and then dissect out the wall, allowing the wound to heal by granulation. He thought this method would result in complete and steady cure. The case was presented as showing how an abscess in the fossa navicularis could develop with few symptoms, subjective or objective.

Dr. James Pedersen opened the discussion of these cases. He had never seen an exact duplicate of the second case presented, that of abscess in the glans near the frenum. Abscesses in that locality were much more frequent on one side or the other of the frenum. If the abscess in question were opened too freely,

he thought there was risk of a sinus through which urine would leak, and which would be difficult to close because of the scant amount of tissue with which to do a plastic operation. The glans penis does not lend itself well to plastic work. He thought the abscess might be punctured with a very slender bistoury, from within the meatus.

The second case, that of the periurethral abscess near the peno-scrotal angle, he thought had been very skilfully treated. A manoeuvre he had seen practised in these cases consisted in making the usual free incision in the skin, over the prominence of the tumor, but in incising the abscess cavity either above or below the centre, so that, in case the floor of the urethra sloughed at the site of the abscess, the resulting sinus would have an oblique direction, and could, therefore, be the more easily closed, with or without a plastic operation.

Dr. D. A. Sinclair said that in cases of periurethral abscess, he always tried to have the discharge through the urethra, rather than external, even though the skin was slightly yellowish, showing that the abscess wall was about to burst, because by incising into the urethra danger of fistula is removed. The incision is made by passing an endoscopic tube into the urethra, making a free incision into the abscess, and then using a twenty-five per cent. solution of peroxide of hydrogen once a day, through the urethral opening. When the abscess bursts externally, and a fistulous tract results, the sinus is closed by dissecting around it, from the skin surface to the urethra, and tying a ligature around it, just below the mucous membrane, with the result of nearly always closing it.

Dr. Lyle said he did not think anything was being accomplished by the iodoform drain. He had been using recently a solution of iodine, and irrigating with it from below the sinus, and in one case, particularly, had obtained very good results after five irrigations of five per cent. iodine. A tuberculous abscess was opened at the clinic, and three pints of pus removed, and it was curetted and washed out with iodine once a week for five weeks, with excellent results.

Dr. Bodine said that he would have known Dr. Pedersen was a general surgeon by the scar of the periurethral abscess case. He advocated draining these abscesses externally, rather than into the urethra, as the latter process does not follow the rule of general surgery of dependent drainage.

Dr. V. C. Pedersen said, in answer to a query from Dr. J. Pedersen, that the little pocket of pus is situated well in front of the frenum in the glans penis proper. This came during an attack of gonorrhoea, but without symptoms of pain, and he thought it some congenital condition, which had developed later. He

thought a rather free opening and tying off the same at the floor of the urethra the correct one, and also agreed with Dr. Bodine that an abscess containing pus, whether prostatic or urethral, should be dealt with on surgical principles. An ischio-rectal abscess is not drained from the canal of the rectum, but from a skin opening liberal enough to guarantee drainage from the very bottom. After opening the abscess to its utmost limitations, extra cuts should be put in the skin, so that the skin will not heal first. He had tried the iodine irrigations on other patients, with very good results. Lugol's solution of iodine, he thought, was better than the simple solution, as the former prevented the precipitation of the iodine and enabled it to work its way through the sinuses.

Dr. Frederick E. Beal read the paper of the evening, which was entitled, "The Recognition and Differentiation of Rales." He said, in part:

"In my opinion, the rales heard in the lung should be divided into but two main divisions, dry and moist; and that it is as easily possible to differentiate between a dry and a moist rale as it is to tell the difference between the sound of a piano and that of a violin. It is true that a dry rale may vary in its size from that produced by the largest bronchus to one having its origin in the tiniest bronchial; while the size of the moist rale may be that of the finest air-vesicle to that of the largest cavity; and the number of rales, each of different size, that could possibly exist between these extremes is almost without limit. Why, then, should we confuse ourselves by picking out two or three of each kind, and giving these the dignity of a name. It is enough to know, and it is of the greatest importance, from a diagnostic and prognostic standpoint, that a rale is moist or dry; and this can with certainty be known, while its size, though important, can be told with a moderate degree of accuracy, by its pitch.

"The greatest point of differentiation is that a dry rale has always some duration to it, while a moist rale is always instantaneous. A dry rale is caused by air going at a given rate of speed through a smaller-sized tube than it normally should do, thereby raising the pitch of the sound this passage of air produces. The commoner causes of dry rales are mucus stuck so tenaciously on the side of the bronchus that breathing does not move it; this will lessen the calibre of that bronchus. Any pressure from without, or any foreign body or growth within, that would encroach upon the size of the air-passage, and, finally, any nervous phenomenon that would spasmodically cause the bronchi to lessen their calibre, would all give rise to the same condition.

"The moist rale is caused either by the pulling apart of moist

adhered surfaces, or by air passing through an accumulation of fluid that is sufficiently liquid to allow it to bubble through. This size may be caused by the breaking apart of the stuck-together surfaces of the finest air-vesicle, or that of pulling apart of the walls of a collapsible cavity, or the air may break through a collection of thin mucus filling a bronchus; or, again, a cavity may be more or less filled with fluid, and entered below the surface of that fluid by a bronchus. The air entering through the bronchus will bubble up through the liquid, but the sound produced will always be instantaneous.

“The moist rales are of far graver significance than the dry. The dry rales are the whistlings heard, perhaps, in their greatest profusion and purity in bronchitis, emphyza and asthma, while the moist rales are most typical in pneumonia and tubercular pulmonalis.”

Dr. V. C. Pedersen asked where the reader placed the friction rale of pleurisy.

Dr. Beal said that the dry rale, or the rale with duration, always sounds a little at a distance when listening to it, and the moist rale always sounds closer to the ear. The difference between these and the friction rale of pleurisy is that, while the friction rale has duration, it always sounds close to the ear. It is sometimes confounded with the dry rale.

WILLS' HOSPITAL OPHTHALMIC SOCIETY.

STATED meeting of the Wills' Hospital Ophthalmic Society was held at the hospital on the 23rd of January, 1905, Dr. Charles A. Oliver in the chair.

Dr. James A. Kearney showed a most interesting case of hypopyon keratitis from traumatism in the left eye of a middle-aged man, a house patient of Dr. Conrad Berens. The conditions and various methods of treatment were fully and informally discussed, Drs. George C. Harlan and Oliver expressing their preference in favor of Sæmisch operation, while Dr. S. Lewis Ziegler tending towards the employment of paracentesis. The various methods of cauterization of the infected corneal area were alluded to, Dr. Ziegler stating that he had most frequently secured good results in desperate cases with careful touching of the part with a one per cent. solution of formalin, and in selected cases by careful application of equal parts of camphor, chloral and carbolic acid.

In the absence of Dr. W. W. McClure, the Senior House Surgeon exhibited a case of corneal staphyloma which had been

operated upon by excision of the staphylomatous portion of the cornea and bringing the two lips of the wound together by two interrupted sutures. The corneal scar was fully healed and the anterior face of the membrane was properly curved. In the discussion Drs. Cliver, Ziegler and Harlan compared the relative values of the different methods of procedure and cited instances that had occurred in their public and private practices.

Dr. Kearney showed for Dr. P. N. K. Schwenk several most excellent results from the operation of abscission of the cornea. The indications for the procedure, the modification of technique, and the comparative results of the operation were fully discussed by Drs. Dewey, Harlan and Kearney. The methods that had been in vogue in the hospital and those which were employed at the present time, were given in the fullest detail, eliciting much regarding why some of the plans had been supplanted by others and giving reasons for the substitution of other procedures.

ASSOCIATION OF CLINICAL ASSISTANTS OF WILLS' HOSPITAL, PHILADELPHIA.

THE first regular meeting of the Association of Clinical Assistants of Wills' Hospital was held at the hospital on the 18th of January, 1905, at 8.30 p.m., Dr. J. Hiland Dewey in the chair.

Dr. Stanley S. Smith read a report of a most interesting case of gumma of the iris and ciliary body occurring in the clinic of Dr. Charles A. Oliver. The case presented all of the characteristic symptoms of the condition, and was fast becoming well. Dr. Smith stated that it was very instructive to note the secondary rapid diminution of vision produced by haze in the media, which had been probably caused by a deposition of the gummy infiltrates into the chambers of the eye. In the discussion, Dr. John T. Krall commented upon the comparative painlessness of specific cyclitis and the character of the infiltration into the aqueous and vitreous, which was chiefly composed of round cell exudates. In support of the belief of others that gummata of the ciliary body usually occur on the upper border of the cornea, he had seen but one in which the swelling was situated to the lower side.

The various methods of administering mercury were informally discussed, the consensus of opinion being in favor of the use of mercurial ointment by inunctions.

Dr. Josephine W. Hildrup read a paper upon ten cases of interstitial keratitis, nine of which had been studied in the clinic of Dr. Oliver, and the remaining one in her own clinic at the

Woman's Hospital. The ages of the cases varied from six years to fifty-eight years. The dyscrasia had been very carefully studied in all. Females had been preponderant in the series. With but one or two exceptions, all of the cases had passed on to resolution.

The discussion, which was quite informal, embraced the forms of treatment which were the most prevalent among the surgeons in the institution. Dr. James A. Kearney stated that he had seen much good from the use of inunctions of protiodide of mercury. Dr. Dewey spoke favorably of the use of dionin, claiming that it had hastened resolution in a number of cases which he had seen. He had not had much experience with subconjunctival injections and had seen some unfortunate results, such as conjunctival ulceration, giving rise to disfigurement from their use. Dr. Kearney exhibited a case in which the right eye was being treated by the ordinary routine methods, supplementing these by subconjunctival injections of common salt solution in the left eye; the latter organ (although the first involved) seeming to grow well much more rapidly than its fellow. Dr. Krall stated that he had learned to share the opinion of others that if injections were made under the conjunctiva, their effects would be to produce a number of adhesions between the bulbar conjunctiva and Tenon's capsule; and stated that even though the injections were made into the capsule, their good results were but transitory, as adhesions were sure to occur. In other words, he, with many authorities, believed that such injections did more harm than good.

Dr. Kearney presented a case of double pterygium from Dr. William Zentmayer's clinic, in which one eye had been operated on by the von Arlt method and the other by the McReynold's. He exhibited a case of entropion of the upper lid, taken from the same clinic, in which a Hotz operation had been performed with little or no improvement, followed by a Jaesche-Arlt operation, which afforded a very satisfactory result. He also showed a case of entropion from the clinic of Dr. Frank Fisher, in which the cilia had been transplanted and the tarsus removed, giving most excellent results. In the discussion, Dr. Krall was of the opinion that the McReynold's operation had no advantage over the von Arlt. He believed that every case should be treated on its own merits, one method of operation not being applicable to all. Drs. Dewey, Milton A. Robison, and Smith cited several cases in which different plans of treatment had been most successfully applied.

Selections, Abstracts, Etc.

OBSERVATIONS ON THE USE OF STOVAINE IN SPINAL ANESTHESIA.

PROF. DR. CHAPUT, surgeon of the Boucicault Hospital, Paris, in a paper read before the Société de Chirurgie of Paris, refers to the use of Stovaine, the new synthetic local anesthetic, in a series of operations numbering over one hundred and fifty. Dr. Chaput used a method based upon the teachings of Guinard, Ravang and Auburg and employed a 10 per cent. solution, making the injection with a Pravaz syringe. The doses varied from .3 to $1\frac{1}{4}$ grains, an analysis of the last one hundred operations being as follows: Region of the lower limbs, 45; region of the perineum, 26; region of the abdomen, 29, and the opinion is advanced that there is not an operation of the region of the perineum and lower limbs, but which can be performed with this local anesthetic. With its aid an outward dislocation of the foot and one of the hip was very easily reduced. Complicated fractures can be operated upon with Stovaine without fear of seeing the reduction compromised by muscular tonicity.

Insensibility was reached in 90 per cent. of the cases in less than ten minutes, while in 75 per cent. of the cases it reached the umbilicus in less than ten minutes.

During the anesthesia the pulse gradually increases, while during the operation it decreases. Nausea and vomiting are very rare, the general condition is good, the patient can take nourishment immediately. Headache and backache are rare and when present are slight and of short duration. Increase of temperature is not great. Finally, Stovaine does not cause retention of urine in the operations on the anal region. From this comparison it can be seen that Stovaine presents considerable advantages over cocaine and deserves to be substituted for it everywhere and always.

Technique of the Operation.—"The solution used was contained in 1 c.c. tubes sterilized at 115° Centigrade. The needle used is the Tanon modification of the Tuffier form, being closed at the point, and with a .3 mill. hole on the side, so placed as to prevent it becoming clogged with adipose tissues. One-half the syringe is filled; it is then held vertically, the regulator adjusted on the piston-rod, corresponding to the number of drops which I wish to inject, generally about eight, this number being necessary for a radical cure of inguinal hernia and about double that quantity for a sub-umbilical laparotomy. The piston is then pushed forward so as to expel the excess of the liquid; the needle is taken off the

syringe which is held vertically by an assistant. The patient is then placed in proper position, and the needle is directed obliquely forward, upwards and inwards; when it has been driven a few centimetres, the operator has the sensation of puncturing a parchment-like tissue, and if the needle is driven a few millimetres further the cephalo-rachidian liquid is soon seen issuing. The syringe is then fitted to the needle; the liquid is drawn into the syringe to dilute the solution contained in it; the lateral hole of the needle is turned upwards and the contents of the syringe are injected without jerking, after which it is immediately withdrawn and the patient made to lie down.

"Cleansing of the region to be operated upon is then done, and after a few minutes the operation may be commenced."

In conclusion, Dr. Chaput states that the local analgesic action of Stovaine in solution is identical to that of cocaine while it is less toxic than the latter. Syncope is not present and patients can be operated upon while seated, being able to arise immediately thereafter. All laparotomical operations may be performed, even the most difficult.

ABSTRACTS.

Typhoid vs. Tuberculosis.—J. A. Wyeth, New York (*Journal A. M. A.*, May 6), gives notes of two cases of tuberculosis in which the disease appears to have been arrested or cured by the occurrence of typhoid fever. In both cases there was a marked increase of body weight, together with the disappearance of the symptoms of the tuberculous disease. Both have remained well for about four years since the typhoid attack. Dr. Wyeth is indebted for the notes of these cases to Dr. Francis W. Gallagher, of El Paso, Texas, to whom he refers inquirers for further information. He asks, however, whether there might not have been in these cases an antagonism between the typhoid and the other pathogenic germs, and hence a suggestion of another possibility of immunity from the dreaded scourge of tuberculosis.

Human and Bovine Tuberculosis.—S. von Ruck, Asheville, N. C. (*Journal A. M. A.*, April 29), reviews the literature on the inter-transmissibility of human and bovine tuberculosis, and from analysis of the evidence considers Koch's statement that cattle are insusceptible to human tuberculosis as still unrefuted. The experiments, moreover, have not shown that the danger to man from the tuberculosis of cattle is a paramount one compared with that of human tuberculosis. He criticises Behring's opinion regarding this and reviews the evidence from other sources. His final conclusion is that with all the circumstantial evidence available, the question of the susceptibility of mankind to bovine tuberculosis can not be considered as satisfactorily settled. Only experiments on human

beings can clear up this point, and these are impossible. The inoculation of cancerous cases with tuberculosis in one hospital as a therapeutic measure, based on the theory of the antagonism of the two infections, did not produce the disease in a single case. So long, however, as we can not show beyond all doubt that the disease is not thus transmissible, measures against bovine tuberculosis must remain imperative. Although, as Koch shows, thorough cooking and boiling will destroy all danger from tuberculous meat and milk, the use of these products of diseased animals is still objectionable.

Smokeless Powders.—C. F. Kieffer, Fort D. A. Russel, Wyoming (*Journal A. M. A.*, April 29), reports an investigation on the pathologic effects of the fumes of the high explosive now so generally in use. A number of different powders were tested regarding the gases given out and the effects on the human system. The latter series was carried out in a room. Dr. Kieffer experimented on himself and on several members of the hospital corps by exploding a carefully measured quantity of the powder in a sealed room containing about twelve hundred feet of air space and observing the effects. The chief symptom was the well-known "dynamite headache," and the fumes seemed to have marked effects on the circulation and heart, with secondary effects on the nervous system. In some cases there was incoördination and diminution of hearing and of vision. Low temperature seemed to aggravate the conditions, and at least one person was found who appeared to be immune. In most cases a certain amount of tolerance is gradually established. Kieffer also mentions a patient seen in Da Costa's clinic who could take six hundred and fifty drops of *spiritus glonoini* without serious effects. According to his findings the gases to which the effects are attributable are carbonic oxid and nitrogen peroxid, especially the latter, though the symptoms are due to the combination of both. To meet the nitrate poisoning endeavor should be made to restore the vasomotor tonus, and strychnia is indicated in full doses. The carbonic oxid will be eliminated rapidly in moderate cases, but in severe intoxications oxygen inhalations and artificial respiration may be required. For the headache, coal-tar anodynes are not only useless, but dangerous. The best remedies are strong coffee and a linseed poultice to the nape, as advised by Key. The danger from these fumes is a real one, as numerous fatal cases testify.

Sterile Water Anesthesia.—F. W. Stevens, Bridgeport, Conn. (*Journal A. M. A.*, April 29), has employed Dr. Samuel G. Gant's technic with sterile water for the production of local anesthesia in a number of operations for hemorrhoids, in other minor surgical procedures and in one exploratory laparotomy, with the best results. In the latter case, as haste was required, the operation was finished under ether. By this method he anesthetizes the skin over the

line of incision by repeated small injections, followed by deeper ones for the underlying tissue. The advantages he claims for the method are rapidity or effective local anesthesia; absence of need of elaborate preparations; absence of toxic effects—nausea, vomiting or straining; no fear from lung, kidney or heart complications; no after pain; and its value in emergencies in which other methods are not available. Operations for hemorrhoids can be performed in the office or at the patient's home, and need not cause loss of time or interruption of business. He recommends that the method be given a thorough trial, and thinks that when it has become more familiar its advantages will be apparent and its employment general.

Apparatus for Applying Hot Air to the Ear.—Albert J. Heath, St. Paul, Minn. (*Journal A. M. A.*, April 29), describes an electrical apparatus that can be used with any cautery battery for applying heat to the ear. He claims for it the advantage of proper graduation of the temperature by means of the rheostat; the possibility of definite application by means of the otoscope simultaneously employed; lack of danger of burning; simplicity of construction and management, etc. The air is heated by the cautery apparatus and forced through a rubber tube into the ear. By this means he claims the application of heat to the ear is made a definite therapeutic procedure, the amount being controlled and the application directly observed.

Immunity.—In this the fourteenth chapter of the special article on Immunity (*The Journal A. M. A.*, April 29), discusses the simplicity of hemolytic experiments and the rapidity with which they may be performed and terminated. The corpuscles for such experiments are obtained by the defibrination of freshly drawn blood and the removal of the fibrin. Usually they are made in a 5 per cent. suspension by dilution with isotonic salt solution. The 5 per cent. emulsion of the undiluted blood is centrifugated, the overlying fluid drawn off by means of a pipette and substituted by fresh salt solution. The corpuscles are then thoroughly mixed with the new solution and the process of centrifugation repeated. The experiments of Bordet showing the analogy between bactericidal and hemolytic serums are considered, and the studies of Metchnikoff, Ehrlich and Morgenroth are also referred to. The absorption of amboceptors by cells is fully discussed and the experiments are described in detail. It is stated that when micro-organisms gain entrance to the body they are killed and dissolved into considerable masses, and, that as a result of this certain bacterial constituents reach the circulation, and among them are molecules or receptors which possess haptophores capable of uniting with a particular type of amboceptor, the latter being an integral part of some tissue cells. This union having taken place, an affinity for circulating complement may be created as in the test-tube experiments. This chapter concludes by stating that inasmuch as the

heat-resistant body alone is increased during immunization or infection, the greater part of the specificity would seem to depend on the nature of the amboceptor rather than that of complement. No theory except that of Ehrlich offers at present a tangible explanation of this feature.

Autopsy Findings in Epilepsy.—B. Onuf, Sonyea, N.Y. (*Journal A. M. A.*, April 29), reports the results of careful autopsies on sixteen epileptics at the New York State Institution for Epileptics. In twelve cases there were valvular changes of the heart, most frequently of the mitral valve (80 per cent.), less so of the aortic and still less frequently of the tricuspid valves. These he considers generally as secondary results of the special strain due to the major epileptic attacks. Capillary changes, tortuosity and aneurismal dilatations, were observed in several cases, and were attributed to the same cause. In eight of the cases where the lungs were examined, there was acute pneumonia as a contributory cause of death. The cerebral changes were very striking. In ten cases there was a marked thickening of the pia chiefly over the frontoparietal lobe. In other cases there were vascular lesions, circumscribed atrophy of one frontal lobe, subdural hemorrhage (one case), internal hydrocephalus (one case), cerebellar cyst (one case), and shrinkage of convolutions of vermis and adjoining cortex (three cases). The most striking changes, however, were noted in the thalamic region. These were in the nature of atrophy, sometimes the pulvinar, sometimes the other portions being most markedly affected. There was also an apparent discrepancy in the proportions of the geniculate bodies. Onuf discusses the possible relations of these thalamic changes to the epilepsy, but does not venture to express an opinion as to whether they are directly connected with the seizures or are only part of a general pathologic condition of the brain. He suggests that there was probably an optic atrophy in some of these cases, and hence the importance of fundal examination in epileptics. The importance of good clinical histories in these cases is also emphasized.

Cerebrospinal Fever.—J. C. Wilson, Philadelphia (*Journal A. M. A.*, April 29), reviews the history, causes, symptoms, treatment, etc., of epidemic cerebrospinal meningitis, a disease which has at present a special interest on account of the lately occurring epidemic in New England and in New Ycrk. While it has been recognized for about a century, most of our knowledge of the disorder has been acquired of late years, and largely through the work of our countrymen, Councilman, Mallory and Wright. Councilman's recent paper (*Journal A. M. A.*, April 1, 1905) is referred to by Wilson. Formerly the communicability of cerebrospinal meningitis was doubted, but it is now admitted that if the nose, ears, or lungs are affected, it may readily be conveyed from one person to another. Second attacks are very rare: it is prob-

able that one attack confers a persistent immunity. The germs are found only in connection with the lesions of the disease, but mixed infections are not uncommon. The symptoms are most diverse, there are no prodromes, and the period of incubation is unknown. In the malignant cases, the symptoms of inflammatory lesions of the brain and cord, and those of a general malignant infection are both overwhelming. The author goes at some length into the description of the general symptoms and those of the anomalous types, the fulminant form, the abortive, the intermittent and the chronic types. Few diseases vary more in their severity and mortality, or are followed by more complications. The diagnosis may be difficult, but if meningitis be present, it is not usually embarrassing during an epidemic. In doubtful cases, lumbar puncture should be resorted to, and the presence of the meningococcus in the cerebrospinal fluid ascertained. The differential diagnosis between this form and tuberculosis meningitis may, in some cases, be far from easy without this. The mortality of different epidemics varies between 20 and 75 per cent., the average is estimated by Wilson as near 40 per cent. In the mildest cases no treatment is required; in the malignant ones, none is effective. Quiet, nutritious diet, cold applications to the head and spine, laxative doses of calomel in the beginning of the attack and opium are recommended, the last named drug being regarded as indispensable. For prophylaxis, cleanliness and avoidance of overcrowding in times of epidemics, isolation and sterilization measures, and in cases of successive attacks in the same family, abandonment of the dwelling and thorough disinfection are advised.

Syphiloma of the Kidney.—R. R. Campbell, Chicago (*Journal A. M. A.*, April 29), points out that gumma of the kidney is to be considered as a possibility when dealing with "surgical kidneys." In case the gummata are of large size, palpation may reveal a tumor, which must be differentiated from a malignant growth. In individuals who have had syphilis, ill treated or untreated, syphiloma of the kidneys must always be thought of in differentiating obscure kidney disease. One kidney only is usually involved, a fact which must not be forgotten, and we should eliminate in the diagnosis, all symptoms that may be caused by co-existing nephritis. The gumma involved portion of the kidney is inactive; therefore, typical urine findings are wanting. If, however, there are single or periodic discharges indicating the rupture or breaking down of a gumma or a tumor presumably syphilitic is found, nephrectomy should not be performed until the possibility of syphilis has been excluded.

Reaction of Colon Bacillus Toxin.—The action of the intracellular poison of the colin bacillus, the extraction and characteristics of which were described by Dr. Wheeler, has been studied by V.

C. Vaughan, jr., of Ann Arbor, Mich. (*Journal A. M. A.*, April 29). His conclusions are in substance as follows: 1. The colon bacillus produces a powerful poison when grown on artificial media. 2. It is intracellular in character and contained in both the living and the dead bacterial cells. 3. It can be separated from the other constituents of the cell only by chemically breaking up the latter. 4. The peritonitis occurring after intraperitoneal inoculation with the colon bacillus is due to the presence of the poison in a combined and not in a free state. 5. This intracellular poison causes a marked fall in body temperature. 6. The poison of the colon bacillus apparently causes death by paralysis of respiration. 7. The intracellular poison is an essential group of the bacillus, and can be built up synthetically on proteid free media. 8. It is the poison causing death in animals inoculated with cultures of the living colon bacillus.

Gout.—E. Schmoll, San Francisco (*Journal A. M. A.*, April 29), offers the following as his conception of gout: In gout the uric acid is produced not only by oxidation of purin bases, but by synthesis; this synthesized uric acid therefore, has not at its disposal the thymic acid necessary for its solution in the blood. This is why we can detect uric acid in the serum. If the formation of the synthetic uric acid increases for any reason, the serum becomes saturated, and as no thymic acid prevents its precipitation it is deposited as tophi in the joints. He explains some difficulties of this theory and gives the results of his experiments with the thymic acid treatment. The excretion of uric acid is constantly increased during the medication and gouty attacks cease to appear, the swelling goes down, and, in some cases, entirely disappears. The dose is about one-quarter of a grain, three or four times a day, and is given after meals to avoid gastric disturbance. Larger doses, three or four grains in twenty-four hours, may cause local inflammatory reaction. He does not claim to cure gout in this way, but simply to neutralize the primary metabolic disturbance revealing itself by the synthetic formation of uric acid.

Protection from Roentgen-Ray Injuries.—C. L. Leonard, Philadelphia (*Journal A. M. A.*, May 6), calls attention to the serious risk that X-ray operators undergo, especially if they follow the practice advised of testing the qualities of the rays on their hands with the fluorescent screen. The only practical method is to limit their radiated field by covering the Crookes tube. For this purpose he uses a pasteboard box a little wider than the diameter of the tube and covered with X-ray lead foil a little heavier than the ordinary tea lead. This extends two inches below the bottom of the box, and can be adjusted so as to limit the field to any extent required. It is not necessary to cover the anode end, and the box is held on a bracket over the portion of the body to be treated; if a very small field is required, a local shield may also be employed. He thinks possibly some effects are due to the strong induction field surrounding the coil which, especially in large hospitals, should

be kept in another room, but with the controlling apparatus within the operator's reach. For the dermatitis of the operator's hands, he advises twice daily soaking in very warm water and scrubbing with Eichhoff's superfatted resorcin soap, followed by inunction of lanolin containing half an ounce of boric acid and a dram of resorcin to the ounce. For the acute erythema of X-ray treatment, he employs a stearate of zinc powder with 10 per cent. ichthyol, which he thinks acts as a prophylactic against severe burns. This should not be confused with stearate of zinc ointment, which may do harm.

The Cause of Cerebrospinal Meningitis.—S. J. Maher describes cultural and animal experiments undertaken with pus from the spinal canal of an adult sick with cerebrospinal meningitis. The results lead the author to say that his findings seem to show that the diplococcus of Weichselbaum is only one phase in the life cycle of an organism, which at times is larger and rod shaped, at others small and of the shape of the pneumonia diplococcus, and probably at others of yeast shape.—*Medical Record*, May 6th, 1905.

System and Expedition in Office Practice. Office Plans and Details.—R. L. Dickinson discusses numerous methods by means of which it is possible for the physician to economize time in office work and so increase his capacity for work. Expedition may be effected in several ways, such as by well-planned quarters, by completeness of outfit, by appointments and by selection among waiting patients, in history taking, and by proper assistance. All of these topics are discussed at length, especial attention being devoted to a consideration of the manner in which the available space of an ordinary city house may best be utilized for office purposes. A large number of plans are reproduced, showing what may be done under different conditions, and many practical hints in regard to methods of securing sound proof doors and partitions, economizing space, arranging sterilizers, etc., are given. The most convenient methods of illumination and numerous details facilitating office treatment are also described, for all of which reference must be made to the original.—*Medical Record*, May 6th, 1905.

The Present Status of Rontgen Ray Therapy.—R. H. Boggs says that much experience is necessary in applying the X-rays in order to get the therapeutic effect, as the various mechanical guides to the dosage are not always reliable. The use of the fluoroscope involves a good deal of risk to the operator even if but infrequently employed, while it is really practically useless except for the purpose of testing tubes and making minor examinations and gives such untrustworthy results that it should be discarded. Sufficient evidence has accumulated to give the X-rays a place in the treatment of all forms of tuberculosis. While a large number of skin diseases are benefited by the application of the rays it is advisable to treat only the most obstinate in this manner, as trivial affections can be relieved by other measures with less expense to the patient. The author concludes by saying: (1) That the wide difference of

opinion as to the value of the rays is largely due to the manner in which they are applied. (2) That if the best interests of our patients are to be considered the rays must be given a place as a therapeutic agent. (3) That injury to the operators from the rays during the past two years has been due to thoughtlessness or lack of familiarity with what is going on in the X-ray world. (4) That in applying the rays it is essential to know the quality as well as the quantity of the rays absorbed, and that this must be varied to suit each individual case. (5) That unless the operator has had a wide experience in the treatment of carcinoma, he should always consult a surgeon in each case, as it is certainly by the combination of surgery and X-ray that the best results are to be obtained.—*Medical Record*, May 6th, 1905.

An Emergency Poisoning Case.—J. W. Wainwright describes and illustrates a compact case containing practically all the essential means for treating emergency cases of poisoning.—*Medical Record*, May 6th, 1905.

Primary Epithelioma of the Epiglottis.—D. B. Delavan describes this case which came under observation so early that a circular area of hyperemia one-quarter of an inch in diameter on the laryngeal surface of the epiglottis was the sole evidence of disease. Six months later a positive diagnosis could be made and one-third of the epiglottis, including the diseased area was removed. Nearly two years have elapsed since the operation, but there is no evidence of recurrence.—*Medical Record*, May 6th, 1905.

The Present Limitations of Serum Therapy in the Treatment of the Infectious Diseases.—H. W. Berg reviews the principles underlying the production of antitoxic and antibacterial sera and their therapeutic application. The bacteria concerned in the production of the specific infectious disease fall into three classes. First, those which, like the bacilli of diphtheria and of tetanus, produce a virulent, real toxin which is set free in the culture media. Second, those bacteria which secrete but little or no free toxin but do contain a powerful endotoxin which is partly liberated only on the death and disorganization of the bacterial cells; good examples of this class are the pneumococcus, typhoid bacillus, the streptococci, etc. Third, those bacteria that produce no free toxins nor have in the bacterial cells endotoxins of any power, but in which the cell plasma contains other poisons in addition to the protein poisons common to all bacterial cells. The most important member of this group is the tubercle bacillus. Against the first group the antitoxic sera are available, but their success depends largely on the interval of time that has elapsed since the infection began, for the antitoxin can bind only such toxin as has not yet had time to enter into combination with the body cells. In tetanus the poison becomes fixed in the central

nervous system so rapidly that the serum has little chance for effect. The difficulty with the anti-bacterial sera is that the body's supply of alexin is very small, so that theoretically the injection of the serum should be accompanied by an additional dose of fresh normal animal serum to supply this deficiency; an impracticable procedure. The attempts to treat one disease by means of the antiserum of another, as has been attempted by injecting diphtheria antitoxin in pneumonia and cerebrospinal meningitis is repugnant to the principles of scientific serum therapy and tends to discredit its principles. The use of Moser's antistreptococcus serum in scarlet fever in the Vienna hospitals has not given results equal to those obtained by the author in the Riverside Hospital, following the classical lines of treatment. The introduction into the body of a child of the large amounts of serum required by Moser's plan is also objectionable owing to a possible hemolytic action.—*Medical Record*, May 6th, 1905.

Scissors for Cutting Secondary Membranous Cataracts.—

E. L. Oatman has designed special scissors to be used for cutting the membranous bands sometimes forming after cataract extraction. One point is blunt and the other, which is sharp, is ground to a knife edge on its back, so that after introduction into the anterior chamber it may easily perforate and pass below the membrane.—*Medical Record*, May 6th, 1905.

Pneumatocele of the Cranium.—L. L. McArthur, Chicago (*Journal A. M. A.*, May 6), reports an operation for this condition, and discusses the diagnosis and treatment. The etiologic factors are chiefly two—traumatism and sudden increased pressure within the buccal and oral cavities. Fifty per cent. of the reported cases have occurred spontaneously, so far as history of injury of inflammatory conditions are concerned. During the growth of the tumor, sneezing or blowing the nose may cause an appreciable increase of the size of the tumor or external pressure may cause escape of air into the oral cavity. Because of the separation of the periosteum from the bone osteophytes may be produced, and this accounts for the irregularities felt when the tumor is collapsed. With modern antiseptic methods the treatment has become more simple and successful. In nearly every case a perfect cure can be effected if a free opening is made with due care so to dispose the incision as to make the point of final healing immediately opposite the bony perforation through which the air entered the tumor. McArthur quotes the conclusions of Costes, of Bordeaux, as follows: 1. Pneumatoceles are very rare. 2. They always depend on perforations of the bony walls. 3. They are always tympanitic. 4. They are more or less reducible by pressure. 5. They can take their origin only from the mastoid or the frontal sinuses. 6. They are of very slow and indolent formation. 7. They are never dangerous except from complications (infections). A bibliography is appended.



WILLIAM BURT, M.D., PARIS, ONT.

Under whose presidency last month's meeting of the Ontario Medical Association was so successful

The Canadian Journal of Medicine and Surgery

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NO. I.

Editorials.

THE TWENTY-FIFTH ANNUAL MEETING OF THE ONTARIO MEDICAL ASSOCIATION.

THE twenty-fifth annual meeting of the Ontario Medical Association was held on the 6th, 7th, and 8th of June, in the Medical Faculty Building of the University of Toronto. Over two hundred and twenty members registered. Thirty-six papers were read.

Among the papers of special interest was one on "The Surgery of the Stomach, from the Standpoint of the Clinician," by Dr. A. J. Ochsner, of Chicago; and one on Neurasthenia, by Dr. W. B. Pritchard, of New York.

In the afternoon of June 6th, Dr. Wm. Burt, of Paris, delivered a resourceful address on the war against the microbe, expressing the strong conviction that philanthropists should assist in this great work of research. He denied that surgery had reached its limit, in fact it was decidedly in the active stage. The spread and omnipresence of the microbe were patent proofs of the existing room for research work on a larger scale than ever. The microbe had still the best of the conflict. Only through the establishment of schools for research work by gold kings could the study be untrammelled and unfettered.

Canadians had already done considerable research work. Although this study could be carried on in our larger cities to greater advantage, the smaller schools had amply proven the advantage of personal supervision on the part of the teacher. Many of the improvements and advances in the profession had been due to the observation of the circumscribed country physician. The source of human happiness could be materially increased by the stamping out of some preventable diseases. If the laity could understand the disastrous effect of oral sepsis there would be no dissenting voice in the use of the individual communion cup.

The microbe was a cowardly enemy, inasmuch as it attacked systems weakened from the lack of proper nourishment, from living in closely-crowded, ill-ventilated tenement houses, or from working longer hours than were consistent with a healthy system. In Greater New York 60,000 children went every-morning to school hungry. It was upon the children that the future of the country depended, and every country that depended on child labor was bankrupt, morally, socially and politically.

Touching on work among inebriates, Dr. Burt strongly endorsed the Ontario Society for the Reformation of Inebriates as worthy of strong support.

Dr. Burt also referred to the advisability of the appointment of a Minister of Health. There was no more important subject than public hygiene, which warranted more attention than had yet been paid to it, he said. A Minister of Health would be one of the most important portfolios any Government could have.

In a paper, entitled "A Plea for a Minister of Health," Dr.

Lodgetts, Secretary of the Ontario Health Board, dealt with the functions which would devolve on a Minister of Health, if such a portfolio were established as part of the Provincial Cabinet. The members of the Association were delighted with the new idea, and a strong deputation was appointed to bring it to the notice of the Premier of Ontario and urge its adoption.

General approval met Dr. D. Campbell Meyers' advocacy of the establishment of wards in general hospitals for acute nervous and mental diseases, and a committee was appointed to memorialize and wait upon the Premier and Provincial Secretary to ask for the establishment of such wards.

The Committee on Public Health advised the Association to lend its assistance to further the demand for an institution for the housing and treatment of inebriates to be maintained by the State. They declared they were influenced by the fact that wealthy drunkards might be treated in private inebriate asylums, while no provision was available for the poorer victims of the habit.

This committee also advocated the offer of aid towards the establishment of municipal hospitals for tubercular patients under the provisions of the Stratton Act. Lastly, it considered the time opportune for a campaign in favor of county medical health officers.

Festivity did not form a large feature of the meeting. The President, Dr. Wm. Bur', entertained the Committees of the Association at dinner, on the evening of the 7th. An automobile trip had to be cancelled owing to wet weather. A general invitation was given to the members to attend Ben Greet's Pastoral Play at the University.

The Nominating Committee having recommended the following list of officers, a resolution was passed declaring them elected: President, Dr. Geo. A. Bingham, Toronto; First Vice-President, Dr. Ingersoll Olmsted, Hamilton; Second Vice-President, Dr. E. B. Echlin, London; Third Vice-President, Dr. A. Gillespie; Fourth Vice-President, Dr. Hadley Williams, London; General Secretary, Dr. Charles P. Lusk, Toronto; Assistant Secretary, Dr. Samuel Johnston, Toronto; Treasurer, Dr. Frederick Fenton, Toronto. The installation of the officers concluded the business of the meeting.

J. J. C.

A NEW HOSPITAL FOR TORONTO.

THE Ontario Government, as part of the scheme of aid to the University of Toronto, propose to establish a new hospital in this city, and the site is to be chosen near the Medical Faculty Building of the University of Toronto. The estimated cost of the site and buildings is put at a million dollars. Of this sum, \$250,000 is to be contributed by the Provincial Government. It is hoped that \$200,000 will be voted by the city of Toronto, to aid in purchasing a site for the new hospital. It is said that a part of the remaining \$550,000 will be paid out of a fund accruing from the sale of the present Toronto General Hospital site and buildings. It is also expected that gifts of money in aid of the new venture will be offered by wealthy and public-spirited persons, \$100,000 having already been given by one benefactor, and \$100,000 having been promised by another.

The money given by the Ontario Government is not in reality granted for an hospital, but as a gift to the University. The hospital is merely the *locus in quo*, where work for specific purposes, constituting clinics' facilities for the medical faculty and students is to be done. It will be a Provincial institution, with public and semi-private wards. It will be the clinical hospital of the Medical Faculty of the University of Toronto. It seems probable, therefore, that, for clinical purposes at least, all pauper patients admitted to the new hospital will be handed over to its regular staff, which will consist of clinicians belonging to the University Medical Faculty. Semi-private patients would, of course, be allowed to select their own physicians, the Government grant being given only to such hospitals as permit all qualified practitioners to treat cases inside their walls.

The principal consideration for placing the new hospital near the University of Toronto is to facilitate the work of clinical instruction in this city. The present General Hospital is situated at a considerable distance from the Medical School, and the giving of clinical instruction necessitates a good deal of journeying between the General Hospital, where most of the work is done, and the Medical School.

The modern craving for hospital treatment is shared in by the rich as well as the poor. The latter go to hospitals from necessity, the former from choice. Thirty years ago the rich almost never went

to hospitals for treatment; to-day hospital managers are perplexed to find accommodation for them. We do not stigmatize this condition of affairs; we merely chronicle it. All the same, the poor should have first choice. Hospitals supported by Provincial and municipal funds should be chiefly for the use of the needy—hospitals for the rich ought to be built and maintained by the rich, out of their own resources. The "Thirty-fifth Annual Report upon the Hospitals and Charities, etc., of Ontario, for the year ending 30th September, 1904," shows that the General Hospital, Grace Homeopathic Hospital, the Hospital for Sick Children, St. Michael's Hospital and the Western Hospital, received, during that year, \$34,040.50 from the city of Toronto, in payment of patients' maintenance. The daily municipal grant to an hospital, being 50 cents per capita, would be \$182.50 for a year. This sum, divided into the total city grant, shows that the daily average of city order patients in Toronto during last year was 187. Now, as these are the only patients the city is bound to find accommodation for, the actual hospital provision made in this city for the sick poor must be sufficient. Should well-to-do citizens or people from other municipalities resort to the hospitals of Toronto, they do so for their own convenience; but that is no reason why Toronto ratepayers should vote a large sum of money to further the increase of hospitals in this city. The general hospital requirements of Toronto are well served by the General Hospital in the east, St. Michael's in the centre and south, the Western Hospital in the west, and Grace Homeopathic Hospital in the north. The eastern part of the city would be left rather bare of hospital provision if all the buildings of the present General Hospital were converted to other uses; but when the new hospital is built a small hospital could be maintained at the old stand, which would probably suffice for the hospital requirements of the east end of Toronto.

Then, again, there is an excellent reason why the older institutions should continue to receive clients, even from the poor. The new hospital may be used principally for clinical purposes. Now, patients entering an hospital are not animated by a single desire to serve as object lessons for the clinical instruction of students. In fact, if allowed to choose, and this right could not be denied them by the city, municipal order patients might prefer to enter an hospital in which the treatment of diseases would be the sole professional object of the medical staff. Hence, we think

it is quite possible that Toronto may not vote \$200,000 to purchase a site for an hospital of the kind contemplated.

As a further indication of the wide-reaching influence of this new hospital venture, we notice that the Medical Faculty of Queen's University, Kingston, request "a proportionate grant for the development and improvement of medical education in Eastern Ontario." "What is sauce for the goose is sauce for a gander," and Queen's University believes that if the Provincial Government is going to depart from the educational policy of the past by grants of public money, the work done for charity and medical education by the Kingston medical faculty should also be recognized. It is quite possible that a similar request may be made by the Western University of London.

Before forming an opinion on the outcome of the request made by Queen's University, it may be well to remember that Michigan has for many years maintained by most liberal grants a university hospital at Ann Arbor, in connection with the State University. Michigan has several other medical institutions; but its grant for medical education is given to but one institution—the State University. The University of Toronto, which is a Provincial institution, has received financial aid from the Province and will continue to receive it. Queen's University, not being of the same class, has no real claim for receiving Provincial support.

J. J. C.

EDITORIAL NOTES.

Dover's Powder.—Dover's powder, which has been used in medical practice for over two centuries in England and has been introduced into the American, German and French pharmacopœias, was invented by Thomas Dover, M.B., an English physician (1660-1742). The inventor's directions for the preparation of Dover's remedy are:

Take Opium one ounce, Saltpetre and Tartar vitriolated, each four ounces; Ipocacuana one ounce, Liguorish one ounce. Put the Saltpetre and Tartar into a red-hot mortar, stirring them with a spoon till they have done flaming. Then powder them very fine; after that slice in your Opium, grind these to a powder and then mix the other powders with these. Dose from forty to sixty or seventy grains in a glass of White Wine Posset going to bed. Covering up warm and drinking a quart or three pints of the Posset, drink while sweating. And the prognosis of the case after the adoption of the author's advice is thus stated in his own words: "In two or three hours, at furthest, the patient will be perfectly free from pain; and though before not able to put one foot to the ground, 'tis very much if he cannot walk the next day. When it is taken keep

year bed till next day noon. This remedy may be taken once a week, or once a month." Anticipating doubts which practitioners might naturally feel about the dosage, he says: "Some apothecaries have desired their patients to make their wills, and settle their affairs before they venture upon so large a dose as I have recommended, which is from forty to seventy grains. As monstrous as they may represent this, I can produce undeniable proofs where a patient of mine has taken no less a quantity than a hundred grains and yet has appeared abroad the next day. This notion of theirs proceeds entirely from their ignorance and from the want of knowing the nature of those ingredients that are mixed up with it, for they naturally weaken the power of the opium."

The Dover's powder of the French Codex, *Poudre de Dover*, is nearly the same as that originally used by Dr. Dover, the chief difference being the substitution of dry extract of opium for opium; it is composed of sulphate and nitrate of potassium, each forty parts, and dry extract of opium, ipecacuanha, and liquorice root, each ten parts, the whole to be made into a homogeneous powder. The formula, according to the British Pharmacopœia is: "Ipecacuanha Root in powder $\frac{1}{2}$ ounce, Opium in powder $\frac{1}{2}$ ounce, Potassium Sulphate in powder four ounces." Dover's powder, as now prepared, contains in every ten grains one grain each of opium and ipecacuanha, and eight grains of sulphate of potassium. The last-named ingredient is supposed to be entirely negative in producing the physiological effects, which are sleep and diaphoresis. The latter is perhaps favored by the ipecacuanha, but is essentially produced by the opium. Needless to say, this valuable remedy has been used by many generations of physicians in treating the forming stages of muscular rheumatism, and the commencement of attacks of coryza, sore throat, laryngitis, bronchitis, pleurisy, pneumonia, enteritis, etc. When full diaphoresis is desired the dose may be fifteen or twenty grains, and its operation may be promoted by hot drinks, thick bed-clothes, etc.

Japanese Hospital Nurses.—That Japanese nurses are as skillful as the best nurses of America is the opinion of Mrs. Anita Newcombe McGee, M.D., who recently returned from Japan to the United States. This lady took with her to Japan nine American nurses who were appointed by the Japanese authorities to serve in the hospital ships running to Dalny and the Yalu River, as well as at the great base hospital of Hiroshima. Mrs. McGee says: "All the nursing in the field and part of that on the hospital ships and in Japan is done by men. Some are soldiers who have learned only to carry stretchers, while even the most skilled are inferior to the women nurses of the Red Cross Society in the length and completeness of their training. The training school of the Red

Cross Hospital at Tokio requires three months of probation, during which twelve hours daily are spent in cleaning and other manual work about the hospital. For the next year and a half alternate days are spent in the same way, and the others in attending lectures and studying from notes. At the end of this time the pupils receive printed text-books for reference, and are sent into the wards for eighteen months of practical nursing before graduation. The Red Cross nurses' training is military throughout, and a large proportion of women take it primarily as an act of patriotism. These marry or take up other occupations after finishing their hospital course. All nurses trained by the Red Cross Society must engage to serve in the army, if physically able, at any time within fifteen years after graduation. By the beginning of autumn, 1904, the Society had supplied for military service all available graduates and pupil nurses as well—a total of 2,200 women, besides 594 men. One of the most remarkable things about these Japanese women was their extraordinary strength and endurance. At the Hiroshima Hospital they were on duty for twenty-eight hours upright with only such sleep as they could get in the ward ante-room where they were within call. Like all Japanese they drank hot tea at any hour, but they took scarcely fifteen minutes to eat their light, cold meals. They thought nothing of carrying a man on their backs. They were cheerful, generous and always willing and uncomplaining. The work of the Japanese nurses in the operating room is the same as that of nurses elsewhere. In the wards they pay great attention to the wishes of the individual patient. If he is asleep, the taking of his temperature is postponed; if he feels hungry, if he wants one of his eggs boiled, or if he needs water after drinking his medicine from its bottle, a nurse waits on him. The Japanese patient's ideal of a trained nurse is one as kindly attentive as are his own female relatives."

Local Anesthesia by Injections of Sterile Water.—In an article published in the *Journal of the American Medical Association*, April 29th, 1905, by Dr. Stevens, Bridgeport, Conn, allusion is made to the practice of Dr. Samuel G. Gant, New York, who produces local anesthesia in his patients by injections of sterile water. Dr. Gant began experimenting in 1901, and showed that local anesthesia could be quickly obtained by injecting into the skin, mucosa and deeper structures sufficient water to produce a

glassy appearance of these tissues, the anesthesia being due apparently to the pressure on the terminal nerve filaments. His results were so satisfactory that he now employs this method to the exclusion of general and medicinal local anesthesia in most of his rectal operations. The method of producing water anesthesia is very simple. The only requirements are warm sterile water and a hypodermic syringe fitted with a long fine needle. The temperature of the water is unimportant in producing anesthesia; but warm water causes less discomfort than hot or cold water. After thoroughly sterilizing the syringe, needle and skin, the skin along the line of incision is first anesthetized by introducing a fine needle into it almost parallel to the surface. A few drops of water are slowly injected, causing a wheal to appear which is absolutely without sensation. The point of the needle is pushed further into the skin. Through this area of insensibility a few drops of water are again injected. Another wheal arises close to the first and by extending those injections farther the whole line of incision is distended and rendered anesthetic. When the syringe is empty it is withdrawn, refilled and the needle reintroduced within the anesthetized area, and the injections are repeated as before. After the skin has been anesthetized the needle is pushed through this distended line into the subcutaneous tissue, and injections are made until a firm, whitish, ridge-like swelling, about as wide and thick as the index finger, is produced. If the procedure has been well carried out, the skin and underlying tissue can be incised and, in almost every instance, without pain. In operations for external, thrombotic hemorrhoids it is only necessary to anesthetize the skin over the clot, which can be turned out after the incision is made. For external, cutaneous hemorrhoids both the skin and tumor should be tightly distended to produce anesthesia. In operating on internal, venous hemorrhoids the injection is made into the centre of the tumor until it is distended and turns white, when it can be removed painlessly by the ligature method. In operations for fistula in ano the skin and subcutaneous tissue, up to the anal margin, should be distended and, in some cases, the mucosa, submucosa and external and internal sphincters have to be infiltrated. In operating for sebaceous cysts, the skin overlying the cyst is first anesthetized, and then the needle is plunged between the skin and the cyst wall; as the water is injected it separates the skin from the cyst wall and allows the adhesions, if present, to be cut without injuring the sac. In operating for varicose veins the skin and subcutaneous

tissues are distended and the veins ligated. Dr. Stevens feels sure that this method will become general when surgeons have become familiar with it.

De Renzi's Views on the Prevention and Treatment of Heart Affections.—E. De Renzi, in *Berliner Klinische Wochenschrift*, urges that greater attention should be paid to warding off and to treating diseases which are known to favor the development of cardiopathy. Acute articular rheumatism stands in the front rank in this respect and demands vigorous treatment. Daily doses of 90 to 120 grains of salicylate of sodium are none too large. These doses may produce symptoms of salicylic acid poisoning; but this inconvenience is slight compared with the danger arising from the installation of an incurable heart affection. The delay of a day or even of a few hours may allow the inception of a fatal cardiac defect which might have been avoided. Gout and obesity should be promptly and effectually treated for the same reason. De Renzi protests against Huchard's advocacy of repose as beneficial to patients who have heart lesions. His own opinion is quite the opposite. He believes that exercise trains and strengthens the heart and is the sovereign remedy for all cardiopathies. As the heart becomes hypertrophied cardiac defects are benefited, and the heart muscle develops as it is exercised.

J. J. C.

Errata in the June Issue.—(1) In the leading editorial article, entitled "Divergent Opinions on Matters Relating to Small-pox Infection," the words "aerial conversion," 10th line from the bottom of page 405, should be "aerial convection." The same error appears at two other places in the same editorial. (2) In a book review of "The Vermiform Appendix and its Diseases," by Howard A. Kelly, A.B., M.D., page 432, for "appendectomy" read "appendectomy."

PERSONALS.

DR. FREEMAN has resigned as Medical Superintendent of the Hamilton Hospital.

DR. J. W. MARSHALL, of Owen Sound, was recently in town, visiting his brother, Dr. J. P. Marshall, 577 Spadina Avenue.

DR. GRAHAM CHAMBERS has retired from general practice and will devote his time from now on to Internal Medicine and Cutaneous Diseases.

DR. GEORGE A. PETERS, we are glad to say, is recovering nicely from his recent illness and hopes to resume practice about October 1st. He is at present enjoying a vacation near London, Ont.

Obituary

DEATH OF DR. JAMES THORBURN.

DR. JAMES THORBURN, one of Toronto's oldest and most esteemed medical practitioners, died on May 26th, at his residence, corner of Spadina Road and Bloor Street.

Dr. Thorburn's death was rather sudden. The previous day, though he had not been well for three years, he was down at his office, at the North American Life Assurance Company, and attended a meeting of directors. The same evening he was taken ill, but he was not considered to be in a serious condition. His family were with him when he expired. Dr. John Caven, Dr. William Caven, and Mr. Irving Cameron were his medical attendants.

Dr. Thorburn was in his seventy-fifth year. He had practiced in Toronto ever since he completed his medical education in 1855. His standing in the profession and professionally was amply attested by the number of important posts he was selected by brother physicians and business men of the city to fill. By a peculiar co-incidence interment took place upon the birthday of Dr. Thorburn's elder daughter, Mrs. Bruce Riordan.

Dr. Thorburn was a son of the late David Thorburn, member for Lincoln in the old Canada Assembly. He was born in Queenston, on November 21st, 1830. His early education was under the late Dr. Russell, of Stamford. He entered Toronto University in his teens, and obtained his medical education at the Toronto School of Medicine.

He took a post-graduate course in Edinburgh, and for some years filled the chair of Pharmacology and Therapeutics in the medical faculty of the Toronto University. He was physician to Upper Canada College and consulting physician to the General Hospital, and held several similar appointments for other institutions. He was for some years surgeon to the Queen's Own Rifles, and was with that corps at Ridgeway in 1866. He retired as surgeon-major in 1879, and became examiner of the College of Physicians and Surgeons in the same year. In 1896 he became vice-president of that body. In 1895 he was president of the Canadian Medical Association, and in 1897 became the president of the Ontario Medical College.

He was a brilliant writer to the medical press, and in addition published a "Manual of Life Insurance Examinations." He was the medical director and vice-president of the North American Life Assurance Company. For some years he was president of the Imperial Loan and Investment Company.

On June 8th, 1858, he married Miss Jane McTavish, daughter of Mr. Donald McTavish, of Grafton, Ont. The family consists of one son and two daughters. The son is Dr. James D. Thorburn. Mrs. Bruce Riordan, the wife of Dr. Bruce Riordan, is the elder daughter. The other is Miss Georgina Thorburn.

Dr. Thorburn was a member of St. Andrew's Church. He was a staunch Liberal of the old school.

The funeral took place on the following Monday to Mount Pleasant Cemetery. There were present a large number of medical men, both local and from the country.

DEATH OF DR. A. R. BOYLE.

DR. A. R. BOYLE died on May 27th, in Grace Hospital. Dr. Boyle had been living at Wychwood Farm, in York township. There he had a room and boarded himself. He became to ill to be left alone, and through the influence of the reeve of the township and Dr. Warren he was removed to the hospital, where he died the following day. Dr. Boyle was 70 years of age. In 1859 he graduated from Queen's, and for many years had a good practice in Wychwood Park. In 1895 he removed to Toronto, where he continued his medical profession at 172 Dovercourt Road, till a short time ago, when he went back to live at Wychwood Park.

IN MEMORY OF ALAN S. BURRITT.

<p style="text-align: center;">IN MEMORY</p> <p style="text-align: center;">Private Alan Schofield Burritt 12th Lancers</p> <p style="text-align: center;">Who gave his life for his Country In South Africa</p> <p style="text-align: center;">On April 4th, 1901</p> <p style="text-align: center;">Erected by 12th Lancers, past and present</p>

SURMOUNTED by the coat of arms of the 12th Lancers, thus reads the inscription on a very handsome brass tablet, received from the regiment by Dr. H. C. Burritt, of Wellesley Street, in honor of his soldier-son, who died at Kimberley of enteric fever during the South African War. It is the first time that the memory of a Canadian has been honored by an Imperial regiment in this way.

The family were deeply touched by the gift of the tablet, which has been erected in the family home, and forms one of their proudest possessions.

Alan Burritt was well and popularly known in Toronto. He was thoroughly imbued with the military spirit, and had served for five years in the North-West Mounted Police. Subsequently he took a course at Stanley Barracks, and was afterwards a lieutenant in the Prince of Wales Dragoons of Peterboro'. He was promised a Canadian Commission for South Africa, but as it failed to come in time he went to Aldershot, England, and enlisted as a private with the 12th Lancers, in the expectation of winning his laurels at the front, and obtaining a commission, as many spirited young men had done. He served in several engagements, and was of the relieving party when the siege of Kimberley was raised. It was shortly after the latter event that his career was cut short at the untimely age of 28 years.

Similar tablets have been erected by the 12th Lancers in memory of the other members of the regiment who fell in South Africa.

News of the Month.

CANADIAN MEDICAL ASSOCIATION.

As we have already announced, the thirty-eighth annual meeting of the Canadian Medical Association will take place this year in Halifax, under the presidency of Dr. John Stewart, of that city, who, along with his Executive Committee and Programme Committee of Arrangements, are ardently working for the complete success of this meeting, the first which has been held in Halifax since 1881, when the number present just numbered fifty-three. If a united effort be put forth by the vice-presidents and local secretaries in the different provinces, especially in Nova Scotia, Prince Edward Island, New Brunswick, Quebec and Ontario, there should be a largely attended meeting. There are indications that Montreal and Toronto are both going to send down good contingents. Daily there are additions to the list of contributors, whose names we will publish in a later issue. This year all delegates will travel on the usual standard convention certificate plan, which means that every delegate when purchasing single first-class fare to Halifax, must get from ticket agent a standard convention certificate for himself, his wife or daughters if they accompany him. Delegates will kindly bear in mind that they do not have to get any special certificate from the General Secretary. If fifty are present holding standard convention certificates, all will be returned free to Montreal. Montrealers will, as well as delegates from Quebec, be returned for single fare. If there are three hundred present holding standard convention certificates, all will be returned free to their original starting point. This applies to all parts of Ontario, Manitoba, the Northwest Territories and British Columbia. Delegates from points west of Port Arthur, will not be allowed to use the upper lake routes when travelling by this certificate plan, in either direction. In all cases return transportation must be arranged for at Halifax. The usual time limit for conventions will be allowed for points east of Port Arthur, namely, three days before and three days after the meeting. Our readers will kindly extend this information as much as possible; and those who intend contributing papers and being present, are requested to notify the General Secretary, Dr. George Elliot, 203 Beverley Street, Toronto, without delay. No arrangement can be secured for return *via* Boston or New York after the meeting; and those desiring to be routed thus should ask for tourists' tickets. Arrangements have been completed for boat trip, Toronto or Kingston to Montreal or Quebec *via* the Richelieu and Ontario Navigation Company's line.

FINAL EXAMINATIONS AT TORONTO AND TRINITY UNIVERSITIES.

THE following results of the Fourth Year Examinations in the Faculties of Arts and Medicine at the University of Toronto and Trinity College were handed out after the meeting of the Senate last month :

FACULTY OF MEDICINE.

Final Examination—The following received degrees with honors: (1) W. S. Lemon, (2) G. Ford, (3) R. H. Bonnycastle, (4) S. R. Dalrymple and G. G. Little, (6) Miss McAlpine, (7) M. E. Gowland, (8) A. G. McPhedran, (9) W. Roberts, (10) C. Schlichter, (11) Miss M. E. Reid.

Medicine, Clinical Medicine, Pathology and Therapeutics—(1) W. S. Lemon, (2) S. R. Dalrymple and G. G. Little, (4) F. J. Snelgrove, (5) J. H. McPhedran, (6) A. G. McPhedran, (7) G. Ford, (8) Miss M. E. Reid, (9) M. E. Gowland, (10) R. H. Bonnycastle, (11) W. Merritt, (12) W. Roberts, (13) F. J. Fuller.

Surgery, Clinical Surgery, Surgical Anatomy and Pathology—(1) W. S. Lemon, (2) G. Ford, (3) G. G. Little, (4) S. R. Dalrymple (5) W. Merritt, (6) C. Schlichter and F. J. Snelgrove, (7) W. C. Toll, (9) J. H. Soady, (10) W. Roberts, (11) M. E. Gowland, (12) C. E. Spence and R. H. Bonnycastle, (14) S. J. Boyd and A. M. Rolls.

Obstetrics, Gynecology and Pathology—(1) W. S. Lemon, (2) S. R. Dalrymple, (3) J. H. Soady, (4) G. Ford, (5) C. Schlichter, (6) M. E. Gowland, (7) A. G. McPhedran, (8) W. Merritt and W. C. Toll, (10) G. G. Little, (11) W. Roberts, (12) Miss M. E. Reid, (13) F. J. Fuller, (14) J. H. McPhedran, (15) F. J. Snelgrove, (16) G. I. Black.

Medical Jurisprudence, Toxicology, Hygiene and Medical Psychology—(1) W. S. Lemon, (2) W. Roberts, (3) Miss M. McAlpine, (4) G. Ford, (5) W. Merritt, (6) Miss M. E. Reid, (7) J. H. Soady, (8) A. G. McPhedran, (9) M. H. V. Cameron and M. E. Gowland.

UNIVERSITY OF TRINITY COLLEGE.

Final M. D. C. M. Examination—Certificates of Honor—W. J. Dobbie (gold medalist), R. R. B. Fitzgerald (silver medalist), E. F. Atkinson. Class I.—R. D. Orok, C. A. F. Caviller, W. J. Corrigan, J. A. Kinnear, W. Dales, H. C. Kindred, C. W. Field. Class II.—A. R. Curtis, H. W. Burgess, G. E. Seldon, T. C. Brereton, J. R. Serson, J. S. Springer; R. J. Carson, B. T. Davey (equal); E. C. A. Reynolds, W. H. Godfrey; G. H. Carlisle, F. W. Rolph (equal); J. A. Gallagher; Miss M. E. Donglan, G. W. Hall (equal); M. J. C. Naftel, H. M. East, J. A. Collins, W. B. Cassels, J. S. Pritchard, J. Boyce, J. P. Campbell, A. J. Weart, R. M. Cumberland, E. J. Hagan. Class III.—H. Glendenning, T. H. Argue, F. W. McKee, S. J.

Staples, G. S. Strathy, A. E. Murphy, J. G. Middlemas, C. A. McKay, Miss G. L. Urquhart, A. W. Keane, C. Howson; S. Blumberger, W. J. J. Brawley (equal); D. C. Lochead, W. A. Peart, H. A. Abraham, J. M. Dale, D. H. Gesner, B. E. Tughen, G. D. R. Black.

BANQUET OF THE UNIVERSITY OF TORONTO ALUMNI ASSOCIATION.

"WE meet to-night under happy auspices. I see before me a noble assemblage of graduates, all zealous for the interests and objects of the university. The last turn of fortune's political wheel of fortune has been not unfavorable to this institution. I believe that Mr. Whitney will do what he says he will do for the university. I went once to hear him speak on a question trying to a politician of candor and integrity, and on my return I was asked how he had impressed me. 'His is the eloquence,' I replied, 'that to me is of most value. He spoke like an honest man.' Mr. Whitney's policy toward the university is a wise and liberal one. In earlier days the university was the final training place for culture, but now it has extended itself into an emporium of all branches of knowledge, and not least of those sciences which are the master key to our national prosperity and wealth. Once a few bookcases and a small staff were all that a university required, but to make a great scientific institution requires a combination of resources. The aiding of the university is a wise policy from even the commercial standpoint, but this does not mean the abandoning of culture, and the turning out of money-makers instead of good and wise men."

With these words did Dr. Goldwin Smith begin his address in responding to the toast of "Alma Mater" at the sixth annual banquet of the University of Toronto Alumni Association, held on the 9th ult., in the university gymnasium. The banquet was a complete success, the attendance being even larger than that of last year. Nearly one-fourth of the number present were ladies. The speakers of the evening included Dr. Smith, Vice-Chancellor Moss, Rev. Canon Welch, Hon. Dr. Pyne, Minister of Education; Dr. L. F. Barker, of Johns Hopkins, and Judge Dean, of Lindsay. An interesting feature was the first appearance of a representative of the faculty of Trinity College as a federated institution.

The chair was occupied by Dr. Reeve, President of the Alumni. The following gentlemen sent regrets at their enforced absence: Hon. J. P. Whitney, Hon. G. W. Ross, Dr. Hoskin, K.C., Dr. Temple, J. Ross Robertson, Prof. Scrimger, of Montreal; J. W. Flavelle, Christopher Robinson, K.C., Frederic Nicholls, W. K. George, Principal Sheraton, T. Eaton, D. D. Mann and William Mackenzie.

President Loudon proposed the health of "The King" in a graceful little speech. King Edward had earned by his conciliatory,

tact the title of "Edward the Peacemaker." Even when he visited turbulent Ireland, rollicking peasants formed his loyal body-guard. When he went abroad, he carried not "the big stick," but the pipe of peace.

In the absence of Provost Macklem, through illness, Rev. Canon Welch, as the official representative of Trinity College, was called upon to propose the toast of "Alma Mater." Only the bold man, he said, would have prophesied ten years ago that a provost or ex-provost of Trinity would be proposing the toast in hand. Though his own alma mater was on the banks of the reedy Cam, he looked upon Toronto as his alterna mater. The association should work to emphasize the college spirit; it might also do a great deal to maintain and uplift the ideals of university education. The object of all education was to train for life and not for a special occupation. Living encyclopedias were not wanted, but men and women filled with good citizenship.

The reception given Dr. Goldwin Smith on his rising to respond to the toast was a repetition of that which greeted him on his entry, the entire assemblage rising and cheering him heartily. After uttering the words quoted above, Dr. Smith went on to speak of the federation spirit in the air. Trinity had come in; McMaster was coy, but would come in, too. Trinity College at Cambridge and Christ Church College at Oxford had many famous graduates, but each college was proud to be a part of a greater university. Hon. Mr. Whitney had promised to revise the constitution of the university. All the works of man in time required revision. It would be well to simplify the administration, and vest more power in one head, and have a less unwieldy senate. The public should be lenient in their judgment of the faculty, for it was rare to find men in whom great knowledge of a subject was combined with the highest powers of exposition. Dr. Smith referred to the recent investigation as lowering the honor and dignity of the university. It was inevitable that in every limited circle envy and jealousy should arise which would breed tattle and newspaper copy. By cleaving to the higher ideals of university life these abuses would be overcome, and Toronto University would continue to flourish and prosper.

Col. W. N. Ponton, of Belleville, who followed, opened by saying that he could not better sum up the alumni's estimate of Dr. Goldwin Smith than by quoting Dr. Smith's description of Lord Rosebery as "a man of infinite talent, attractiveness, and grace." In his own day at the university, there were no lady graduates, and present-day students must appreciate the raising of the standard of chivalry because of the presence of the ladies. Col. Ponton deprecated the proposal to take a part of the campus as a site for convocation. To the old graduates such an action would seem almost a desecration, for the campus was hallowed by many pleasant memories, and when they crossed it they felt a thrill of conscious pride and filial affection.

Judge Dean, of Lindsay, who graduated from Victoria 51 years

ago as a member of a class of two, gave a witty and pithy address. Since the federation of Victoria and Toronto, he said, he felt like the boy whose father had married his deceased wife's sister. The boy did not know whether to call her mother or aunt, but he did know she was a mighty fine old lady. He was further puzzled by the addition of Trinity. The judge said he had first opposed the federation of Victoria and Toronto, for he feared Victoria would degenerate into a mere theological school, and he believed colleges, like men, should keep all their faculties about them. Chancellor Burwash's logic converted him, and now he honored his Alma Mater:—"Three in one, one in three, God bless her!"

Vice-Chancellor Moss proposed "Our Guests," coupling with it the names of Hon. Dr. Pyne, Dr. John Seath, and Dr. Lewellys F. Barker, of Johns Hopkins.

Hon. Dr. Pyne said that, now that the university was provided for, the Government would have time to think of other educational interests of the province which also needed adjustment. It must be remembered that 95 per cent. of the people of the province got their whole education in the Public and High schools, and if these could be improved the Government would be happy indeed to bring it about. He would deem it his privilege to confer with the authorities of the university and with High and Public school inspectors and teachers with a view to formulating a policy which would meet all the province's educational needs.

Dr. Seath, Inspector of High Schools, said that the Government, in recognizing the university's needs, had taken the logical course. It could now afford to take steps to meet the wants of the High and Public schools. One question which should be looked into was the decreasing number of graduates going into the teaching profession.

Dr. Barker's address was an admirable mingling of wit and wisdom. After a reference to Dr. Osler's chloroform joke, and the concern manifested by the Chicago papers in his own opinions on the subjects, Dr. Barker spoke eloquently and enthusiastically of the future of medicine. Beginning in myth, and passing through the stage of dogma, it was rapidly taking rank as an exact science. It was still largely empirical, but it was struggling to become national. The doctor of the future would get more out of his patient and less out of his own head. Dr. Barker said he was not willing to place a limit at to what medical science would be in the future, but the outlook was a hopeful one. The time might be near when a national aggressive therapy would go into the body and compel the organs to resume their normal functions. In this great work of medical advancement, the faculty and graduates of Toronto University would play an important part.

Dr. Bell, President of the New York branch of the Alumni, spoke briefly on the necessity for fostering the university spirit. W. D. McDonald and W. S. Lemon responded to the toast of "The Graduating Classes," the former speaking for the arts men, and the latter for the 157 medicos, the largest class in the history of the university.

ANNUAL COMMENCEMENT EXERCISES OF THE UNIVERSITY OF TORONTO.

OVER two thousand people crowded into the gymnasium of Toronto University on the afternoon of Friday, June 9th, to attend the annual commencement exercises and witness the conferring of degrees upon six distinguished Canadians and on five hundred graduates. The promised completion of the new convocation hall in time for use next June is a consummation devoutly to be wished, for to the majority of those in attendance at this function, the afternoon was one of discomfort. Many stood throughout the exercises, which lasted nearly three hours, while even those holding seats were uncomfortably crowded. The heat in the building added to the general discomfort.

During the ceremony of conferring the honorary degrees quiet was maintained, but once this period of restraint was over the light-hearted students surrendered themselves to the spirit of the occasion. They yelled their college yells and sang their college songs. As the graduates appeared on the platform to receive degrees, the usual good-natured chaff and badinage was showered upon them by their fellows, who in turn became targets for railery during the brief moments when they were the centre of attention. These interludes contributed to the enjoyment of the crowds present, while they provoked only indulgent smiles from the Chancellor, Sir William R. Meredith, the Vice-Chancellor, Hon. Chief Justice Moss, and the other grave and reverend signors upon the platform.

Of the six honorary degrees conferred at the commencement exercises of Toronto University the greatest interest centred about the personalities of Dr. Lewellys Franklin Barker, who received the degree of M.D. (*honoris causa*), and Capt. Edouard Gaston Deville, F.R.C.S., Surveyor-General of the Dominion of Canada, who was made an LL.D. Dr. Barker, who was graduated from Toronto Medical College in 1890, with the reputation of being the ablest student ever turned out by the school, is now considered the leading anatomist on the continent of America. When Dr. William Osler, Toronto's distinguished son, resigned his chair at Johns Hopkins University to become regius professor of medicine at Oxford, it was to Canada that the great Baltimore university looked for a successor, and Dr. Barker was selected to take Dr. Osler's chair of medicine. It is confidently expected that Dr. Barker will in his new post score fresh triumphs as an investigator and teacher of medical science.

Dean Reeve, in presenting Dr. Barker for his degree, said that when he left Toronto in 1890 with his degree of M.B. and a few gold medals, a brilliant future had been predicted for him, and this prediction had been more than verified. Attracted by the fame of Dr. William Osler, Dr. Barker had gone to the Mecca of Canadian

students, Johns Hopkins University. He soon published a work on the anatomy of the nervous system, which was immediately accepted as an authority on the subject, and it was not long before Chicago University claimed his services. When Dr. Osler left Baltimore there were a host of applicants for the vacant chair, but Dr. Barker was unhesitatingly chosen for the most enviable position open to a medical man in America. Genial, scholarly and erudite, he was an ornament to his profession and an honor to Toronto University.

The Chancellor, Sir William Ralph Meredith, then conferred the degree upon Dr. Barker, and the latter signed the roll. In his brief address of acknowledgment Dr. Barker spoke of his great pleasure at the fact that his first honorary degree should come from the university where he had received his medical education. If he had done anything worth while in his profession it was because of the thoroughness of the training he had received from his instructors. He congratulated the graduates in medicine on the improved conditions under which they had received their education, consequent upon the union of the two schools and the centralization of energies. Canada and the United States offered unlimited opportunities for young physicians. Dr. Barker concluded by saying that he regarded his degree not so much a personal honor as a recognition of a certain branch of the medical profession.

Dr. Barker received an ovation of cheers from the assembly at the conclusion of his address.

The duty of presenting Capt. Deville was well performed by Prof. Alfred Baker. Capt. Deville, said Prof. Baker, was born in France and educated at the Naval College at Brest. After doing good work in the hydrographic service he came to Canada, and was appointed by the Government as scientific explorer and inspector of surveys. In 1885 Capt. Deville was made Surveyor-General of Canada, and since then he had filled that post with distinction. There was no citizen of Canada who was not interested in or benefited by Capt. Deville's work. He was a member of the Royal Society of Canada and the Royal Astronomical Society of England. In conferring a degree upon Capt. Deville the university was honoring his mother country, France, which had contributed so much to the advancement of art, science and literature.

Capt. Deville's reply was a brief and modest one. He thanked the university for the honor it had done him, and which he appreciated highly.

As Capt. Deville took his seat the enthusiastic students broke into cheers, a compliment which the gallant captain blushingly acknowledged.

Hon. R. A. Pyne, M.D., Minister of Education, was presented by Rev. Chancellor Burwash in an apt address. Chancellor Burwash referred to Dr. Pyne's personal worth and services to the university as a member of a Government which had dealt so generously with the institution.

Dr. Pyne's reply was couched in a humorous vein. It was not the lot of every politician, he said, to occupy such a distinguished position, nor could he promise the graduates that they would all some day occupy the position he held in the Government. His predecessors had held the office for a long time, and if he followed their example the graduates of to-day would be too old to enjoy it. The visionary politician was not generally highly esteemed, but Dr. Pyne said he had always found the visionary man a man of ideas. Had anyone predicted six months ago that the financial needs of the university would be so amply met by the new Premier he would have been called a visionary. The Government which gave \$30,000 a year to 'Varsity could give twice as much if it were needed, and as the province prospered so would the university.

Vice-Chancellor Moss, in presenting Æmilius Irving, K.C., for his degree, referred to him as the Nestor of the Ontario bar, he having been admitted to practice more than half a century ago. The Law Society of Upper Canada, of which Mr. Irving was treasurer, had numbered in its ranks many distinguished lawyers, jurists and statesmen, and such a society would choose only a man of the highest character for the position which Mr. Irving held.

Mr. Irving made a grateful address of acknowledgment, in which he spoke of his long acquaintance with the Vice-Chancellor. Mr. Irving spoke briefly of John Beverley Robinson, Hilliard Cameron, Blake, and other great names associated with the Law Society of Upper Canada.

Mr. Irving Heward Cameron, in presenting Dr. James Algernon Temple, spoke of his high standing in his profession and of his good service during his term as dean of Trinity Medical School.

Dr. Temple, in his reply, spoke particularly of the great work being done by the medical faculty of the university in turning out efficient graduates to minister to the needs of Canada's ever-increasing population.

Mr. John Seath, Inspector of High Schools and Collegiate Institutes for Ontario, was presented by President Loudon, who referred to Mr. Seath's services to the cause of secondary education. Mr. Seath, in replying, spoke approvingly of the senate's proposal to establish a department of education for the teaching of scientific pedagogy, psychology and other subjects. He congratulated the university on the financial aid given it by the Government.

The honorary degrees having been conferred the 500 or more graduates were called to the platform to receive their degrees, after which the medals and scholarships were presented. This ended the proceedings of the afternoon.

One hundred guests sat down at the luncheon given at noon by the Chancellor at the university. The luncheon was purely informal, the only toast proposed being that of "The King."

ITEMS OF INTEREST.

The American Orthopedic Association held its annual meeting for the current year at Boston, Mass., a few weeks ago. The 1905 Convention was the most successful in the history of the Association. The meeting for 1906 will be held in Toronto, and Canada has been honored by having its President chosen in the person of Dr. B. E. McKenzie. The Vice-Presidents are Drs. H. P. H. Galloway, of Toronto, and Charles Wilson, of Montreal.

Hotel Accommodation at Halifax next Month.—Medical men who will attend the annual meeting of the Canadian Medical Association at Halifax, N.S., August 22nd to 25th, are requested to communicate, as soon as possible, with C. Decker Murray, M.B., Chairman of the Information and Lodgings Bureau, 66 Queen St., Halifax, with a view to securing hotel accommodation in advance. The hotel rates vary from \$1.50 to \$3.00 per day.

Vice-Royalty at Victorian Order of Nurses' Home.— Her Excellency Countess Grey made a visit of inspection to the Victorian Order of Nurses' Home on Spadina Avenue, on May 26th, and presented a medal to one of the graduates, Miss Mary McBride Muir, who is to accept a post at St. John, N.B. Her Excellency was accompanied by Lady Evelyn Grey and Captain Trotter, and bouquets of flowers were presented by Miss Walls, the head nurse, as the party entered the building. The Countess expressed satisfaction with the management of the institution. Her Excellency afterwards visited the Sick Children's Hospital and presented flowers to some of the patients.

Earl Grey Visits the University.— His Excellency Earl Grey, accompanied by Lord Bury and conducted by Mr. J. C. Eaton in his motor car, visited the University of Toronto, on May 20th. He was received at the main entrance by Premier Whitney, Chancellor Meredith, President Loudon, Dr. Wm. Hoskin, Dean Reeve of the Medical Faculty, and Professor A. B. Macallum. The buildings inspected were the main building, the School of Science, and the Library. Earl Grey expressed himself as delighted with the equipment of the University. He was particularly interested in the Paul Kane exhibition of paintings presented by Mr. E. B. Osler. His Excellency consented to open the new Convocation Hall on its completion in June of next year. He will then receive the honorary degree of LL.D. instead of at the commencement next month.

The Physician's Library.

Operative Surgery. By JOSEPH D. BRYANT, M.D., Professor of the Principles and Practice of Surgery, Operative and Clinical Surgery, University and Bellevue Hospital Medical College; Visiting Surgeon to Bellevue and St. Vincent's Hospitals; Consulting Surgeon to the Hospital for Ruptured and Crippled, Woman's Hospital, and Manhattan State Hospital for the Insane; former Surgeon-General of the N.G.N.Y.; Fellow of the American Surgical Association; Member of the International Society of Surgeons, and of the American Medical Association; former President of the New York Academy of Medicine and of the New York State Medical Association; President of the New York State Medical Society, etc. Volume I.: General Principles, Anesthetics, Antiseptics, Control of Hemorrhage and Shock, Treatment of Operation-wounds, Ligature of Arteries, Operations on Veins, Capillaries, Nervous System, Tendons, Ligaments, Fasciæ, Muscles, Bursæ and Bones, Amputations, Deformities, Plastic Surgery, Operations on Mouth, Pharynx, Nose, Esophagus and Neck. This volume contains eight hundred and ninety-eight illustrations, sixty-one of which are colored. Volume II.: Operations on the Viscera connected with the Peritoneum, the Scrotum and Penis, and miscellaneous operations, including those for some deformities of the External Ear. This volume contains eight hundred and ninety-five illustrations, thirty-nine of which are colored. Fourth edition. Printed from new plates, entirely revised and largely rewritten. New York and London: D. Appleton and Company. 1905.

As the title implies, this is a work dealing with operative surgery. The surgery of fractures and dislocations is not included, except in connection with some reparative operations, *e.g.*, the suturing of fractured patella. The author is an operating surgeon and he speaks with the authority of experience; he is a teacher and he explains surgical questions as a clinical teacher would do in instructing a class. Much space in the volumes is taken up with illustrations, but none too much, as they serve a good purpose in helping to elucidate the text. The instruments required in doing any operation, *e.g.*, in the operation for hernia, in that for intestinal repair, etc., are represented in half-tone illustrations, serving, no doubt, as useful reminders to refresh the memory of the surgeon.

Dr. Bryant does not limit himself to the expression of his own particular views, but gives fully the operations of other surgeons. This, no doubt, adds to the bulk of the volumes but cannot be

considered a fault. A surgeon of experience, who has familiarized himself with a particular method of doing an operation, and who has obtained good results from it, is not likely to change his method. A beginner is not in the same position and, before selecting a method of doing an operation, he should familiarize himself with the work of different operators.

The illustrations have been done in good style and the letterpress is excellent. Altogether, the book does credit to the author, artist and publisher.

J. J. C.

Studies in the Psychology of Sex—Sexual Selection in Man.

I. Touch. II. Smell. III. Hearing. IV. Vision. By HAVELOCK ELLIS. $6\frac{3}{8} \times 8\frac{7}{8}$ inches. Pages xii.-270. Extra cloth, \$2.00, net. Sold only by subscription to physicians, lawyers and scientists. Philadelphia: F. A. Davis Company, publishers, 1914-16 Cherry Street.

This is quite an interesting book, and deals with a subject not dealt with, for obvious reasons, by many authors. Its four parts deal with the sexual selection in man in relation to: 1. Touch. 2. Smell. 3. Hearing. 4. Vision. The author does not anticipate or attempt to, as yet, give any definite scientific results as to the subject chosen, but contents himself, and that wisely, with something more preliminary. He bases his theory on views as laid down by Darwin in his "Descent of Man," and shows that more recent investigations have placed on a still firmer basis the doctrine known as sexual selection. The book is worth reading, and the author one who is in a position to speak authoritatively on the subject.

Surgical Diagnosis. A Manual for Practitioners of Medicine and Surgery. By ORTO G. T. KILIANI, M.D., Surgeon to the German Hospital, Member of the New York Surgical Society, of the Surgical Society of Berlin, Germany, etc. Illustrated by fifty-nine full-page plates and by engravings in the text. New York: William Wood & Company. 1905.

The author remarks very aptly that the decision as to when surgical interference becomes advisable rests frequently with the physician who necessarily must lack, to a certain extent, the experience as a diagnostician acquired by the surgeon in his daily work.

It would be too much to say of this work that it is sufficiently full and explicit to satisfy the specialist. The aurist or oculist will scarcely come to a work of this kind for the detailed information which he requires and with which he has become familiar in the performance of his ordinary daily task. The same, probably, is true of the specialist in other lines. The general practitioner,

however, will find the great salient facts, which are the important ones in making a surgical diagnosis, very clearly set forth.

The arrangement of the book is also very helpful in these particulars, and essential distinctions being brought out by differences in type. The introductory chapter explains many terms that are necessarily employed in making careful examinations, but which frequently are not understood. It would have been advantageous if more comparative tables had been arranged to make clear the differential diagnosis between conditions that present features of marked similarity. These, however, are not by any means wanting in the work and such as are employed add greatly to the conciseness and effectiveness of the work.

It may be said that both in its mechanical execution and in the work done by its author that this is a most valuable addition to surgical literature and of special importance to those who have the whole field of medicine under their purview, but have had less opportunity to make themselves acquainted with the less frequent surgical diseases which they may be required to distinguish from others that are somewhat similar.

B. E. M.

International Clinics. A quarterly of illustrated clinical lectures and especially prepared original articles on treatment, medicine, surveying, neurology, pediatrics, obstetrics, gynecology, orthopedics, pathology, dermatology, ophthalmology, otology, rhinology, laryngology, hygiene and other topics of interest to students and practitioners by leading members of the medical profession throughout the world. Edited by A. O. J. KELLY, A.M., M.D., Philadelphia, U.S.A.; with the collaboration of Wm. Osler, M.D., Baltimore; John H. Mussen, M.D., Philadelphia; James Stuart, M.D., Montreal; J. B. Murphy, M.D., Chicago; A. McPhedran, M.D., Toronto; Thomas M. Rotch, M.D., Boston; J. G. Clark, M.D., Philadelphia; Jas. J. Walsh, M.D., New York; J. W. Ballantyne, M.D., Edinburgh; John Harold, M.D., London; Edmund Landolt, M.D., Paris; Richard Kretz, M.D., Vienna; with regular correspondents in Montreal, Paris, Berlin, Vienna, Leirsic, Brussels and Carlsbad. Vol. I., fifteenth series, 1905. Philadelphia and London: J. B. Lipincott Co. 1905.

The contributions to Vol. I of the fifteenth series are 21 in number, and include such names as Dr. J. Walter Carr, of the Royal Free Hospital, London; Dr. J. C. Bloodgood, of Johns Hopkins University; Dr. A. L. Benedict, of Buffalo, N.Y.; Dr. A. E. Gallant, of the New York School of Clinic Medicine; Dr. Carstairs Douglas, of Glasgow, and others.

The book is divided into six chapters in all, viz., treatment, medicine, surgery, neurology and obstetrics, and last and most important, about 125 pages by Drs. A. A. Stevens, D. L. Edsall and J. C. Bloodgood, entitled "Progress of Medicine During 1904."

That section of the volume is certainly worth the price charged for the book. Dr. Stevens takes up all the advances made and new theories brought forward in the treatment of most of the infectious diseases, viz., typhoid, scarlet, diphtheria, small-pox, pneumonia, whooping-cough, tetanus, plague, syphilis, tuberculosis, rheumatism, etc. It also goes into treatment on diseases of the blood and of the ductless glands, of the circulatory system, kidneys, respiratory tract, digestive tract and nervous system. Dr. D. L. Edsall and W. B. Stanton treat of medicine and advances made in that department, whereas, Dr. J. C. Bloodgood, adheres to that of surgery. Vol. I is an auspicious opening for the fifteenth series of Clinics, which has become so deservedly popular.

An Introduction to Pharmacognosy. By SMITH ELY JELLIFFE, PH.D., M.D., Professor of Pharmacognosy and Instructor in Materia Medica and Therapeutics in the Columbia University (College of Physicians and Surgeons), New York. Octavo volume of 265 pages, fully illustrated. Philadelphia, New York, London: W. B. Saunders & Company. Canadian Agents: J. A. Carveth & Co., Limited, 434 Yonge Street, Toronto. 1904. Cloth, \$2.50 net.

This introduction to Pharmacognosy is the first work published in this country dealing with the special individual anatomic characters of the different drugs, and it will be found of great service in enabling the student to recognize any drug in its crude condition. Dr. Jelliffe has laid special emphasis on the microscopic characteristics of drugs, not, however, neglecting the macroscopic appearances. He has also given considerable attention to the description of drug powders.

In the selection of the drugs studied in detail the author has shown great care, taking those which are most typical of the general drug structures, amply equipping the student of pharmacy to pursue individual research of a practical nature. The source of each drug is given, then the microscopic and macroscopic appearances, the chemistry, and the adulterations—an all-important factor in practical pharmacy.

The Sanitary Journal of the Provincial Board of Health of Ontario (Canada). Being the twenty-third annual report for the year 1904. Printed by order of the Legislative Assembly for Ontario.

The Provincial Board of Health announces that hereafter it will publish its annual report in four numbers, which will appear, as far as possible, in the months of March, June, September and December. These reports, bound in one volume, will constitute the annual report, of which the above mentioned report is the first exemplar.

In future the Monthly Bulletin will be discontinued, also the Report of the Executive Health Officers' Association, both being

printed in the *Sanitary Journal*, the papers read before the Association appearing as appendices, and continued throughout the year.

The laboratory reports will be prepared by Dr. J. A. Amyot, Bacteriologist of the Board. The editing and publication of the *Sanitary Journal* have been placed in the hands of the Chairman and Secretary.

Science and Immortality. By WILLIAM OSLER, M.D., F.R.S., Prof. Medicine, Johns Hopkins University. Boston and New York: Houghton, Mifflin & Company.

"The physician's work lies on the confines of the shadow-land, and it might be expected that, if to any, to him would come glimpses that might make us less forlorn, when in the bitterness of loss we cry,—

"Ah, Christ!, that it were possible
For one short hour to see
The souls we loved, that they might tell us
What and where they be!"

Dr. Osler's lecture is of absorbing interest. He uses beautifully clear English in which to clothe his thoughts and dovetails in the opinions and expressions of stoics, materialists and poets in such a way as to add to the interest of his solution of the problem of the ages. He certainly confesses much; he denies nothing. Does he prove all things? Read and learn. W. A. Y.

A Manual of Practical Hygiene for Students, Physicians and Medical Officers. By CHARLES HARRINGTON, M.D., Assistant Professor of Hygiene in the Medical School of Harvard University. Third Edition, Revised and Enlarged. Illustrated with twelve plates in colors and monochrome, and one hundred and eighteen engravings. Philadelphia and New York: Lea Brothers & Co. 1905.

A handsome octavo volume of 798 pages, giving in a clear, succinct form and in a pleasing, readable style the observations of a teacher of hygiene on Practical Hygiene. It deserves wide popularity among non-professional, as well as professional, readers. Dr Harrington evidently believes in presenting the newest and latest views on the subject to his readers, for it is but a short time since the second edition of his work was noticed in the medical press, and now we have the third edition.

It deals with Foods, Air, Soil, Water, Habitations, Disposal of Sewage, Garbage, Disinfectants and Disinfection, Military Hygiene, Tropical Hygiene, the Relations of Insects to Human Diseases, Hygiene of Occupation, Vital Statistics, Personal Hygiene, Infection, Susceptibility, Immunity, Vaccination and Small-pox, Quarantine and Disposal of the Dead.

J. J. C.

A Text-Book of Legal Medicine. By FRANK WINTHROP DRAPER, A.M., M.D., Professor of Legal Medicine in Harvard University; Medical Examiner for the County of Suffolk, Massachusetts. Octavo volume of 573 pages, fully illustrated. Philadelphia, New York, London: W. B. Saunders & Co. 1905. Cloth, \$4.00 net. Canadian agents: J. A. Carver & Co., Limited, 434 Yonge St., Toronto.

Dr. Draper's "Text-Book of Legal Medicine" is undoubtedly modern, and contains most of the latest advances made in this subject. We cannot, however, think that there is much in it that is not contained in the books already on the market, though its handy size and simple style will attract many readers who find the average System too cumbersome and unwieldy.

The Thyroid and Parathyroid Glands. By HUBERT RICHARDSON, M.D., late Pathologist to Mount Hope Retreat; Pathologist to Maryland Asylum and Training School for Feeble-Minded Children; Demonstrator of Physiologic Chemistry, University of Maryland. With seventy-seven half-tone illustrations made from special drawings by F. P. Wightman. Pp. 261. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut Street. 1905.

The author presents an extremely interesting and instructive monograph on this subject, and at present there is hardly any field which requires more careful attention from the profession than that of the diseases of the thyroid and parathyroids and their appropriate treatment.

At the outset the author deals with the historical facts regarding the development of our knowledge of the functional value of the ductless glands of the body and particularly with the suggestions which have been made from time to time to use different animal organs of this category as therapeutic agents for administration in disease. The anatomy of the thyroid and of the parathyroids and the physiology of these organs are discussed and a special chapter is devoted to the Chemistry of the Thyroid Gland. The succeeding chapters include a consideration of the subject under the following heads: Goitre; Surgery of the Thyroid Gland, the Thyroid in Infectious Disease, Acute Thyroiditis, Syphilis of the Thyroid, Cretinism, Myxedematous Infantilism, Myxedema, Basedow's Disease, Thyroid Feeding in General Therapeutics, finally a bibliography and index.

The author's conclusions regarding the treatment of exophthalmic goitre (Basedow's Disease) are that "the medicinal treatment of Basedow's Disease has not so far proved very satisfactory, and the opinion of to-day is in favor of surgical interference." He adds that "many cases can, however, be improved and even cured by careful attention to details and by the intelligent use of drugs."

There are some excellent illustrations in the book, more particularly those illustrating myxedematous infantilism and cretinism. These pictures are themselves very instructive. In the treatment and clinical phenomena presented in these diseases the author has not given us a great deal of original matter, but he has compiled, in a most effective and thorough manner, an interesting summary of the whole subject, and we are indebted to him for a work which is of value as a most reliable guide to a knowledge of the subject as far as recent scientific investigation has developed it.

A. P.

"*Modern Clinical Medicine.*"—D. Appleton & Company expect to publish at short intervals a translation of "Die Deutsche Klinik," a publication which is being brought out in parts in the German language. The articles upon the various diseases have been written by the most eminent men in Germany. Professors Leyden and Klemperer are the editors of the German work, and the articles are written by such well-known authorities as Leube, Ewald, Boas, Baginsky, Liebermeister, Eichhorst, Strumpell, Jurgenes, Ehrlich, Grawitz, Binz, Nothnagel, Gerhardt, Loeffler, Kraft-Ebing, Hoffa, Ortner, Kaposi, and many others whose names are as familiar to you as the above-mentioned. It is the plan to publish this work in several volumes, the entire work to be translated and edited under the general supervision of Dr. Julius L. Salinger, of Philadelphia, Pa. Each volume in the series will have a special editor. The first volume of "Modern Clinical Medicine," "Infectious Diseases," will be published at once. This volume will be edited, with annotations, by Dr. J. C. Wilson, Professor of Medicine at the Jefferson Medical College, Philadelphia, Pa. The second volume, which will appear shortly after the first, will consist of "Constitutional Diseases and Diseases of the Blood."

"*Gray's Anatomy.*"—Messrs. Lea Brothers & Co. have pleasure in announcing a new edition of "Gray's Anatomy," to be published about midsummer, and embodying nearly two years of labor on the part of the editor, J. Chalmers DaCosta, M.D., of Philadelphia, and a corps of special assistants. Commensurately with the importance of the largest selling medical work ever published, this new edition will present a revision so thorough and searching that the entire book has been reset in new type. In addition to the changes necessary to bring it abreast of the most modern knowledge of its subject, several important alterations have been made with the view of adapting it still more closely to present-day teaching methods, and in fact to anticipate the trend of anatomical work and study. Thus, while the older nomenclature is used, the new names (B.N.A.) follow in brackets; the section on Embryology and Histology at the back of the present "Gray" has been distributed throughout the new edition in the shape of embryological,

histological and biological references and paragraphs bearing directly on the part under consideration, thus contributing to a better and easier understanding. The illustrations have come in for their full share of the general revision, so that at this writing more than 400 new and elaborate engravings in black and colors have been prepared. "Gray" has always been noted for its richness of illustration, but the new edition far exceeds anything that has hitherto been attempted. No medical text-book has ever approached "Gray" in sturdy longevity and accumulating strength. Notwithstanding the many would-be competitors who during nearly fifty years have periodically appeared and endeavored to share its ever-increasing popularity, this wonderful creation of a genius who lived barely long enough to realize that his work was done—how well he never knew—goes on and on, each succeeding year bringing new friends and strengthening the fealty of the old. The editor and publishers have spared neither labor nor expense to keep "Gray" at the forefront of anatomical knowledge, and there seems to be no reason to doubt that its next fifty years will pass as smoothly and as successfully as have those past.

BOOKS AND PAMPHLETS RECEIVED.

Laboratory of the Inland Revenue Department, Ottawa, Canada. Bulletin No. 101, Standard Fertilizers, 1905.

Reprint of original article, "Neurology and the Prevention of Insanity in the Poor." By D. Campbell Meyers, M.D., M.R.C.S. (Eng.), L.R.C.P. (Lond.), Neurologist to St. Michael's Hospital, Toronto.

Reprint of original article, "Neurasthenia in Some of its Relations to Insanity." By D. Campbell Meyers, M.D., M.R.C.S. (Eng.), L.R.C.P. (Lond.), Neurologist to St. Michael's Hospital. Reprinted from the *CANADIAN JOURNAL OF MEDICINE AND SURGERY*, Toronto, August, 1904.

"Thirty-fifth Annual Report of the Inspector of Prisons and Public Charities upon the Hospitals and Charities, etc. of the Province of Ontario." Being for the year ending 30th September, 1904. Printed by order of the Legislative Assembly of Ontario, Toronto: Printed and published by L. K. Cameron, Printer to the King's Most Excellent Majesty. 1905.