

## Technical and Bibliographic Notes / Notes techniques et bibliographiques

The Institute has attempted to obtain the best original copy available for scanning. Features of this copy which may be bibliographically unique, which may alter any of the images in the reproduction, or which may significantly change the usual method of scanning are checked below.

L'Institut a numérisé le meilleur exemplaire qu'il lui a été possible de se procurer. Les détails de cet exemplaire qui sont peut-être uniques du point de vue bibliographique, qui peuvent modifier une image reproduite, ou qui peuvent exiger une modification dans la méthode normale de numérisation sont indiqués ci-dessous.

- |                                     |   |                                     |   |
|-------------------------------------|---|-------------------------------------|---|
| <input type="checkbox"/>            | Coloured covers /<br>Couverture de couleur  | <input type="checkbox"/>            | Coloured pages / Pages de couleur   |
| <input type="checkbox"/>            | Covers damaged /<br>Couverture endommagée   | <input type="checkbox"/>            | Pages damaged / Pages endommagées   |
| <input type="checkbox"/>            | Covers restored and/or laminated /<br>Couverture restaurée et/ou pelliculée   | <input type="checkbox"/>            | Pages restored and/or laminated /<br>Pages restaurées et/ou pelliculées   |
| <input type="checkbox"/>            | Cover title missing /<br>Le titre de couverture manque  | <input checked="" type="checkbox"/> | Pages discoloured, stained or foxed/<br>Pages décolorées, tachetées ou piquées  |
| <input type="checkbox"/>            | Coloured maps /<br>Cartes géographiques en couleur  | <input type="checkbox"/>            | Pages detached / Pages détachées  |
| <input type="checkbox"/>            | Coloured ink (i.e. other than blue or black) /<br>Encre de couleur (i.e. autre que bleue ou noire)  | <input checked="" type="checkbox"/> | Showthrough / Transparence  |
| <input type="checkbox"/>            | Coloured plates and/or illustrations /<br>Planches et/ou illustrations en couleur   | <input checked="" type="checkbox"/> | Quality of print varies /<br>Qualité inégale de l'impression  |
| <input type="checkbox"/>            | Bound with other material /<br>Relié avec d'autres documents  | <input type="checkbox"/>            | Includes supplementary materials /<br>Comprend du matériel supplémentaire   |
| <input type="checkbox"/>            | Only edition available /<br>Seule édition disponible  | <input type="checkbox"/>            | Blank leaves added during restorations may<br>appear within the text. Whenever possible, these<br>have been omitted from scanning / Il se peut que<br>certaines pages blanches ajoutées lors d'une<br>restauration apparaissent dans le texte, mais,<br>lorsque cela était possible, ces pages n'ont pas<br>été numérisées. |
| <input type="checkbox"/>            | Tight binding may cause shadows or distortion<br>along interior margin / La reliure serrée peut<br>causer de l'ombre ou de la distorsion le long de la<br>marge intérieure. |                                     |   |
| <input checked="" type="checkbox"/> | Additional comments /<br>Commentaires supplémentaires:  |                                     | Continuous pagination.  |

THE  
CANADIAN PRACTITIONER

FORMERLY "THE CANADIAN JOURNAL OF MEDICAL SCIENCE."

EDITOR:

A. H. WRIGHT, B.A., M.D. Tor., M.R.C.S. England.

Business Management,

THE J. E. BRYANT COMPANY (Limited), 58 Bay Street.

TORONTO, MAY 1, 1891.

Original Communications.

INFANT DIETARY, WITH SPECIAL  
REFERENCE TO STERILIZA-  
TION AND EXHIBITION  
OF APPARATUS.

BY W. J. GREIG, B.A., M.B., L.R.C.P. LONDON.

It is not the object of the writer to discuss the subject of Infant Dietary in a general way, or to refer to the merits of the different articles of infants' food, except incidentally, but to bring before you a comparatively new method of preparing food, known as sterilization. Sterilization means the killing of germs. The remarks and conclusions of this paper are especially applicable to infants whom it has been necessary to deprive of their mothers' milk.

The subject is by no means a new one, Dr. Jacobi, of New York, having years ago laid before the profession the necessity of boiling milk for bottle-fed children. It is only during the last few years, however, that the matter has been prominently brought forward. To my knowledge, neither by any medical journals nor by any paper read at a medical society in Ontario has sterilization been dealt with; and aside from its importance and the deep interest which the writer feels in it, this is my reason for bringing it before you. There is an immense literature on the subject of infant dietary, and by all authorities it is acknowledged that the mother's milk is the proper food for an infant. But many circumstances may arise to

interfere with the nutrition of the child in the natural way, and it is then that the question of a substitute food becomes all important, and the relative merits of ass's, goat's and cow's milk, and of the various infant foods, are discussed. Comparing the constituents of these articles of diet with mother's milk, it is found that ass's milk bears the closest resemblance, goat's next, and then cow's. But owing to the accessibility of the latter, it is the food generally used. When cow's milk is altered in various ways, it can be made almost exactly similar in constituents to mother's milk. Nevertheless in practice, in warm weather, cow's milk does not agree as a rule with infants. Indigestion, diarrhoea, and inflammatory troubles are too often set up. These occur more commonly in cities and towns, so that for years it was thought that the heat and bad hygiene were the causes. But why infants under six months of age should be exempt while other children in the same family should suffer could not be explained. Of late years, since the common acceptance of the germ theory of disease, other ideas of causation have crept in, and while we still believe that heat and bad hygiene are the causes, acting as they do by lowering vitality and hence interfering with the functional activity of the alimentary canal, yet they have another and more important effect *on the food*.

A few years ago Dr. Siebert, of New York city, investigated the relation of heat to the summer troubles in children. His investigations extended over a number of years, and he

found that in very hot summers the infant mortality was no greater than in summers of medium heat. He noticed the fact that as soon as the outdoor thermometer registered 60° and remained at that for some days the trouble began. Now, milk begins to turn at 60° F., and as milk was and still is the chief article of infant dietary, the conclusion was natural that the food had a good deal to do with the trouble. He also noticed that breast-fed children, as a rule, were exempt. His conclusions have been verified by other researches.

Weinert claims that of 602 fatal cases recorded by him only 24 were breast-fed, cow's milk being the food of the balance.

Holt states that of 431 cases only twelve per cent. had been breast-fed. Hope, of Liverpool, states that of one thousand fatal cases only thirty had the breast exclusively. Ballard states that of three hundred and forty-one fatal cases only seven had the breast. That is, out of one thousand nine hundred and forty-three cases only ninety-nine, or about four per cent., had been fed on the breast alone.

These statistics bear out the statements of Dr. Siebert, because mother's milk is not affected by the heat in the same way as cow's milk, and hence the low mortality in breast-fed children; moreover, children fed during cold weather on cow's milk generally do well. Hence our conclusion that the action of heat on the cow's milk is the chief cause. Vaughan, of Ann Arbor, was the first on this continent (to my knowledge) to draw attention to the presence of a chemical prism in milk, which was being fed to a child suffering from cholera infantum. He has published a number of similar cases since. From this milk he was able to separate a substance which crystallized, and which when fed to rabbits produced diarrhoea and vomiting. He named it tyrotoxin, and was able to group it in the diazo-benzol series. He has been able to produce this poison artificially, but has not yet ascertained definitely the exact germ on which the development of tyrotoxin depends. His contention was that this poison was one of the pathogenic organisms of cholera infantum, but only one of a class which were cathartic in nature and all of which were liable to develop in milk.

This brings us to the central point of the

paper, viz., the view that the presence of bacteria in the intestinal canal is the cause of the different kinds of diarrhoea, and these bacteria produce this result by a toxic ptomaine which is thrown out by them in the process of digestion. Certain antecedent conditions may be necessary to produce these symptoms—such as a vitality depressed by heat and bad hygiene, or a functional indigestion produced by too frequent feeding, improper food, or failure of the digestive powers for any reason. Result the same always—a partially digested mass of food, which at the body temperature rapidly ferments, and thus a fitting soil is furnished for bacterial growth.

Let us review briefly the evidence in favor of this contention:—

1. Diarrhoeas begin when the temperature rises to 60° F., at which temperature milk begins to ferment.

2. Children in the country are comparatively free, because they can always have fresh cow's milk. Breast-fed children have been shown to be very free.

3. Cow's milk agrees fairly well, in cities and towns, with children in cold weather; but in milk carted long distances and thus placed under conditions favorable to bacterial growth, and in warm weather, these diarrhoeas begin.

4. Actual discovery of a toxic poison known to result from the activity of germ life, which was being fed to a child suffering from cholera infantum, and which ptomaine, when fed to animals, produced the symptoms of cholera infantum.

5. There is undoubted evidence that impure milk, in which germ life is always active, will produce these summer diarrhoeas.

6. Several varieties of these summer diarrhoeas are infectious.

7. Bacteria can produce intestinal disturbance, e.g., the typhoid bacillus, the tubercle bacilli, and the comma bacillus of Asiatic cholera.

All these facts point very strongly, in fact positively, to the bacterial causation of these summer diarrhoeas, but we are not able yet to specify the particular type of bacillus which causes any particular form of diarrhoea. In the faeces of a healthy suckling child two bacterial forms are found, viz., the bacterium lactis

aerogenes, which is suffered to inhabit the upper bowel and assist in the breaking up of the milk sugar, and the bacteria coli commune, which is found in the lower bowel.

In the fæces of diarrhoea enormous numbers of bacteria are found, and notably certain forms are found to predominate in certain forms of diarrhoea. None of these bacteria grow in ordinary hydrant water, but all flourish in milk. I might say that one variety predominated and was found almost constantly in enteritis and cholera infantum. In the latter a liquefying bacillus was found which, when cultivated and injected into the veins of rats, caused death by purging and vomiting.

It is well known that certain diseases are communicated to others by milk, viz., typhoid, diphtheria, scarlet fever, etc., but a pre-existing case has always been supposed. Late investigations would seem to indicate that animals themselves may have these diseases. There appears to be no doubt that cow-pox in cattle is a similar disease to small-pox in man.

Lately epidemics of scarlet fever have occurred in which the suspicion existed that the contagion came from the cows themselves, who were suffering from a disease resembling scarlet fever. These outbreaks were at Hendon and Wimbledon in England. Prof. Klein reported to the local government board that the cows were suffering from a disease similar to scarlet fever. This was afterwards denied by another expert. The matter is still *sub-judice*, and whatever the result, it teaches us to be careful of our milk supply. Again, Louis Park states that a disease resembling diphtheria has been found in calves. He also states that diphtheria has been transmitted from farms and dairies in good sanitary condition and carefully kept, where there was no pre-existing diphtheria. In such cases it was natural to look to the cows themselves as the source of the disease.

An extensive literature has sprung up lately in regard to tuberculosis in milch cows. It is claimed that ten per cent. of all cows suffer from tubercle, and twenty-five per cent. of cows kept in towns. To impart the tubercle bacillus to their milk, the udders must be affected, and this is very likely to be in some cases. Hence the evident danger, especially in milk from town or city fed cows, to infants whose organs are

still in an undeveloped condition and therefore very susceptible to disease. Park states that five per cent. of the mortality of children under five years of age, whose diet presumably is chiefly milk, die of tuberculosis of the abdominal cavity. He adds:—"The present amount of knowledge on the subject of animal diseases is so limited and unsatisfactory that until dairy cows are under sanitary control, or until these diseases are better understood, more care must be taken with milk as an article of infant dietary."

I would like to sketch rapidly the course of milk from the time it leaves the cow until it reaches the consumer, to give an additional motive for sterilization. Dirty milking methods, diluting the milk with water from the barnyard pump, cans not too scrupulously clean, put into the cans while still warm—thus having a suitable temperature for bacterial growth, and then a rapid and rough ride on a wagon to the train or through the town, and lastly, the delivery through the city by dirty milk boys. The driver stops before a house, takes off the can lid and fills his measure. During this time the wind is carrying mud from a neighboring waste heap, or from the street, and deposits it, loaded as it is with dangerous bacterial life, in and around the milk can. Ask Dr. Prudden, of New York, or Louis Park, what this street dust chiefly consists of, and they will answer, organic debris from powdered horse droppings. After the milk is taken into the house, it is allowed to stand in open vessels and it very rapidly absorbs gases of different kinds.

We will now consider briefly the changes that sterilization produces in milk:

1. It kills all germs.
2. Sterilized milk forms in the stomach fine flaky curds, which are easily digested. Cow's milk, taken pure, curdles into a putty-like mass. This has always been a difficulty in feeding infants with cow's milk, even in winter time, and various means have been adopted to prevent the formation of this indigestible curd. Sterilization effectually answers the purpose. Escherich claims that there is no practical difference between sterilized cow's milk diluted in proper proportions, and human milk, the chief change being made in the curd.
3. A recent article in the *Medical News*,

based on a careful analysis, states that the following chemical changes take place in sterilized milk :

(a) Coagulations of albumin, which may render the milk more difficult of digestion.

(b) Interference with the coagulability of milk by rennet, and presumably, therefore, with its digestibility by the gastric juice.

(c) Globules of fat in milk are enclosed in a pellicle of albumen. Sterilization has the effect either of freeing the fat from its albuminous coating, or coagulating the albumen and thus enclosing the fat globule in a less easily destructible envelope. In the former case, the free fat is not easily assimilated; in the latter, the fat is slow of digestion and probably not fully absorbed.

All these difficulties are easily overcome by a partial predigestion of the milk before sterilization with pancreatine and sod. b'carb., or with the peptogenic milk powder, which latter is the method adopted in the New York Infant Asylum.

The success attending the use of sterilized food has been very good. True, it is not a perfect substitute for mother's milk, but it is the greatest advance which has yet been made in infant dietary. The majority of children do very well on it, especially if it has been partially predigested, and it is in use to-day in all the leading American children's institutions.

When fermentation is in progress in the intestinal tract, sterilized milk is not curative. Milk in any form is seized on by the bacteria of the disease, and forms a suitable culture-ground for them. But if you can prevent the entrance of bacteria by passing at once from mother's milk, the infant may be tided over the trying season of infantile existence. Or if the child has been fed for some time on non-sterilized food, before beginning the use of the new method, clear the alimentary canal of all its impurities. Milk thus prepared will keep for weeks, and, if starting for a sea voyage, a stock prepared beforehand will last the whole trip.

*Method of Preparation.*—The proper way is to have bottles of different sizes according to the age of the child, each bottle holding milk enough for one feeding. Bottles should be of such a shape as to be easily cleaned. The top should be of such a shape as would allow a rubber

teat to be used on it, thus obviating the necessity of changing the milk into other bottles and thus undoing the sterilizing process. Great care should be taken to keep the rubber teat antiseptic, and to prevent sour milk from collecting around the folds. After putting in the necessary amount of milk, the neck of the bottle should be closed with antiseptic cotton. If it is intended to keep the milk for some time, a rubber cork is better, with a slit out of the lower half of one side. And after sterilization this cork can be forced tightly into the bottle and thus prevent the entrance of all germs.

The bottles, thus prepared, are put into the sterilizer, exposed to the steam of boiling water for twenty or thirty minutes in winter time, and forty-five minutes in hot weather. They are then put away for use, and allowed to stand preferably on a wooden shelf in a cool room—not in a refrigerator.

Now as to apparatus. Arnold's sterilizer is the best. Siebert has one which is simply a tray which holds the bottles and which is set in a covered iron pot with water at the bottom. It does not do to set the bottles on the bottom of the pot in the water, as they will crack instantly. The old-fashioned steamer, found in all kitchens, will answer well, if high enough when covered to allow the bottles to stand. Dr. Rotch, of Boston, uses a tin vessel set on legs ten or fourteen inches high, with an apparatus in the lid to allow the steam to escape. Four inches from the bottom a perforated tin diaphragm is inserted, on which the bottles stand. The bottom of this vessel is covered with water to the depth of one inch and heat applied.

#### REPORT OF CASES OF TUBERCULAR PERITONITIS AND ACUTE SEPTIC PERITONITIS: LAPAROTOMY.

Notes read before Toronto Medical Society,

BY J. F. W. ROSS, M.D., C.M.

*Tubercular Peritonitis.*—A case kindly referred to me by Dr. Shaw, of Orillia; Mrs. J., æt. 36. Menses first came on at fifteen years of age, lasted usually six days, no pain, not profuse. Been married for fourteen years; menses now same as before. Has had three children, and no miscarriages; labors were severe. Previous

history: About the beginning of February, 1891, she noticed that she was enlarged; suffered but little pain, no diarrhoea. Complained chiefly of fullness and "bloating," as she called it, of the abdomen, derangement of digestion, flatulence, loss of appetite, general weakness, and fever of a somewhat periodical character, worse at night. She thought the enlargement seemed lessened in the mornings. She gradually increased in size until I saw her. State at first visit: Thin, and looks like a patient in about the second or third week of typhoid fever; tongue angry, red at edges and tip; palpillae swelled, and coating in the centre; teeth dry and covered with sordes; ascitic fluid in abdomen; irregular tympanites; a small area of hardness to be felt indistinctly; abdomen flattened laterally on making rectitense. I found that the temperature was  $103^{\circ}$ , and pulse running from 100 to 120. The temperature had been elevated for two or three weeks, and seemed to have been elevated from the first onset of symptoms. In spite of treatment faithfully carried out by Dr. Shaw, she had grown gradually worse. Attacks of profuse perspiration came on; enlarged veins were present over surface of abdomen.

Diagnosis: This lay between malignant disease of the peritoneum and tubercular peritonitis. The symptoms, to my mind, pointed to the latter, and I advised opening and washing out.

The operation was done at the Red Cross Hospital near Orillia. Dr. Corbett gave chloroform. On coming down to the peritoneum it was found thickened and studded with miliary tubercles, and as rough on its external as on its internal surface, and about one-eighth inch thick. A coil of bowel narrowly escaped injury. Intestines studded with tubercle omentum fastened in a conglomerate mass, producing the hard lump to be felt before operation, and all looking angry, red and inflamed. Bowels pressed back and irregularly matted together. Could not reach pelvis as incision was made high up and the patient had an unusually long loin. Washed out, but did not drain; wound closed, interrupted sutures. Dressed iodoform gauze and Gamgees pads. Temperature ran from  $103$  on day of operation down to  $100$ , and remained at that for three or four days, when it began to rise again. There was usually a morning fall, but never to normal, and an evening rise. On the eleventh day the

morning temperature, according to the chart, stood at  $99\frac{1}{3}$ , and evening temperature at normal, and for three days the evening temperature remained lower than the morning. On the fourteenth day the morning temperature was  $97\frac{1}{3}$ , and evening  $100\frac{2}{3}$ . From this on the temperature took an irregular course. The patient developed symptoms of general miliary tuberculosis, and died on March 26th, just one month after operation. This is the most rapidly fatal case of tubercular peritonitis I have seen. Dr. Shaw carried out the after-treatment.

*Septic Peritonitis: Laparotomy.*—Case of young woman, married four months. Miscarriage a week before I saw her, with her attendant physician, Dr. Verner. Agreeing with him that she was suffering from acute septic peritonitis, I opened the abdomen at once. On opening the peritoneum, thin milky fluid, sero-pus, gushed out. Uterus found enlarged; bowels covered with lymph and glued together in places by recent and easily broken adhesions. Temperature before operation  $102-103$ ; pulse, 152. Mentally, very bright. Ascending, descending, and transverse colon distended; rest of intestinal canal not much distended. Washed out thoroughly with several quarts of water from a douche pail, held high to give force to the stream. A large drainage-tube put to the bottom of Douglas' pouch. Stopped opiates, and gave calomel 8 grains, followed by two or three seidlitz powders and copious enemata. Dr. Verner remained all night and tried to get the lower bowel to act, but without avail. The bowel had become paralysed. A flatus tube gave no relief. Patient was in pain all night, but pain was not intense. In the morning I found colon enormously distended, pulse increased in rapidity, a coolness of arms commencing, breathing labored, and hiccough. Died eighteen hours after operation.

Two or three thoughts crowd into one's mind: 1st, Were the indications sufficient twenty-four or forty-eight hours before operation to justify such a procedure? 2nd, Would operation twenty-four or forty-eight hours earlier have saved the case? 3rd, Are not many of the cases of high temperature and rapid pulse, after miscarriage, really cases of purulent masked peritonitis, not showing any tympanitic symptoms? We all know that the cases of localized or circumscribed or so-called pelvic peritonitis

following miscarriage frequently recover. The same septic focus, the septic uterus, is present in each; then why the difference? The difference does not lie in the septic uterus but in the pus-laden lymph cavity, the peritoneal cavity. When the whole cavity is affected nature cannot throw off the poison, and we should then help her by two methods; drainage back and front, or, in other words, abdominal section and purgation. In this case the sero-pus soon changed to straw-colored serum, but we could not produce peristaltic action of the intestines. These cases will die. Exploration does no harm. One physician who gave the anæsthetic remarked when he saw the sero-purulent fluid gush out, "Surely this is the rational treatment." Such cases are not deaths to be put at the door of surgery, but are simply surgical attempts to save life after medical treatment by poultices and opiates have failed. I am convinced that the treatment of every case of general peritonitis should be surgical. Peritonitis is not, as is often stated, a disease analogous to pleuritis. Pleuritis is nearly always due to cold or tubercle. Peritonitis is either septic or traumatic, from without or from within. Idiopathic peritonitis is a mere supposition at best. The peritoneum protects itself better during drainage than the pleura. The walls of the chest are rigid and are expanded during each inspiration. Air has a tendency to enter and serum becomes readily purulent. In the peritoneum the bowels crowd around a drainage-tube and form a track for subsequent drainage, and the discharge has not such a tendency to become purulent. I have seen the belly filled with sero-sanguinolent fluid after the onset of peritonitis following operation, and have seen the fluid become clear and serous in a few hours after reopening and draining. I wish to show you this specimen from a dog operated on two weeks ago. In applying the bone plates to do an intestinal anastomosis for artificially produced obstruction, one of the four threads broke. I supplemented this loss of strength by Halstead's superficial sutures, but felt uneasy as to the result. The dog was well two days after operation at 8 o'clock, and dead one hour later. *Post mortem* showed that the part that depended on the broken thread had given way, and loaded the abdomen with fœcal matter, killing the animal

by shock. Such work to be successful must be thorough.

*Case of Gonorrhœal Peritonitis—Laparotomy—Death twenty-four hours after.*—Mrs. P., æt. 25 years. Attended in her third confinement in October, 1888, by Dr. Carveth. She made an early and good recovery. During the following February she contracted gonorrhœa from her husband. For this no special medical care was received. After some time she recovered, and required no attendance till her fourth confinement, which took place on March 4th of this year. On the ninth day she was up and around, having had an easy labor, and made a good recovery. On April 6th she was suddenly seized with a pain in the region of the umbilicus after a chill. This was followed by vomiting and diarrhœa. At noon on April 7th her expression was anxious, tongue dry and brown; temperature, 102½; pulse, 100; abdomen very tender all over, but no special tenderness in the pelvic region. At noon, on April 8th, her temperature was 103; pulse, 120; and abdomen very much swollen and tympanitic; bowels constipated. Dr. Machell saw her in consultation with Dr. Carveth on the evening of the 8th, and advised abdominal section. At 9 a.m. of the 10th her condition had not improved, and at 11 she was taken to the General Hospital, and put under Dr. Ross' care.

Dr. A. H. Wright saw her with Dr. Carveth and Dr. Ross. It was decided to open and wash out the peritoneum and find the cause of the disease. Dr. Wright assisted at the operation. On opening abdomen, sero-pus flowed out; bowels looked red, and were covered with lymph flakes mixed with pus; adhesions not yet formed; bowels so distended that it was difficult to keep them in the abdomen; found appendix quite healthy; followed up bowel loop by loop to duodenum, and found no obstruction. The bowels were never allowed outside except as the loop was drawn out. No bile color was found in fluid, and thus was excluded perforation by gall-stone. No urinous smell, and no symptoms pointing to perforation of renal calculus, or perforation or rupture of bladder. No fœcal extravasation. Tubes and ovaries elt normal in size; they were not drawn up because the manipulations were hurried and difficult, owing to patient's condition, and because they

were not enlarged. After washing out, a large glass drainage-tube was passed into bottom of Douglas' pouch, and closed the wound as rapidly as possible. The patient lived twenty-four hours. We seemed to have excluded the following by operation:—Perforation of gall-stone (Dr. Barker examined the fluid from the cavity for bile subsequently, and found none), perforation of renal calculus, perforation of gastric or intestinal ulcer, perforation of urinary bladder, appendicitis; so that the only parts not excluded were the genitals. We had history of previous attack of gonorrhœa, of the infection by the husband on a previous occasion, of the recent pregnancy and confinement requiring abstinence from intercourse until about the time that the woman fell ill, namely, one month after confinement, all pointing to the tubes as the starting point of the inflammation. *Post mortem*: the wound was re-opened; nothing could be found to account for the inflammation until the ovaries and tubes were drawn up. The tubes were almost purple in color, and the ovaries looked grayish on the surface, and were covered with ecchymosed spots. They had every appearance of acute inflammation. We proceeded at once to examine for gonococci, Drs. Barker, Hillary, and Cullen, assisting in the search. None could be found, but pus cells were obtained from the interior of the tubes. Many observers have been unable to find gonococci even in cases of undoubted gonorrhœal pyosalpinx. Staphylococci were found in abundance. The bowels were in places almost gangrenous, either from the severity of the inflammation, or from the pressure produced by the distention with pus.

Such cases have a frightful mortality by any method of treatment. Incision can do no harm and evacuates a fluid loaded with poisonous products. If only one life is saved by such a procedure out of 100 cases, the operator is repaid for his work.

## GYNÆCOLOGY IN THE JOHNS HOPKINS HOSPITAL, BALTIMORE.

BY ALBERT A. MACDONALD, M.D.,

Physician to the Toronto General Hospital, etc.

During a recent trip to Baltimore, Dr. J. E. Graham and I enjoyed the hospitality of our old

friend, Professor Wm. Osler, and were also entertained by others of the leading medical men of Baltimore, whose cordial manner cannot help but foster warm and friendly feelings. Johns Hopkins Hospital is unique and must be seen to be appreciated. Though it is situated near a densely populated part of the city, where clinical material is abundant, it is so elevated that it commands a view of the city and suburbs. The hospital buildings are so constructed that they give the most perfect sanitary results. The grounds are spacious and well kept. Everything seems so ordered that both the convenience of the medical men and the best interests of the patients may be served. Post-graduate work is only done. The teaching is thorough, and such a scientific atmosphere pervades the place that it cannot help leaving a favorable mark upon all who are fortunate enough to be able to avail themselves of its manifold advantages.

In the hospital my time was chiefly occupied with work in the gynæcological department, under Professor Howard Kelly and Dr. H. Robb.

One is particularly impressed with the great amount and thoroughness of the work. From the out-patient clinic suitable cases are chosen, and the wards are filled with many patients demanding operative measures for their relief.

The wards are well lighted, suitably ventilated, scrupulously clean, and supplied with every convenience. The appearance of the operating room is unique, with its tiled floor, clean walls, brass table with glass top, instrument cases with glass shelves, wash basins, trays, vessels of glass of different color for different solutions, sterilizers, and glass bottles for cotton, bandages, etc., and in fact every appliance for convenience and perfect cleanliness.

Professor Kelly believes that the greatest difficulty is encountered in freeing the hands from infectious germs—the most harmful of which he takes to be the streptococcus aureus. In order to be sure of avoiding the baneful effects of these germs, he goes through and causes his assistants to adopt a most rigorous course. First, they dress in white duck for the operation. The hands and arms are bared, and after scrubbing for ten minutes with soap and hot water, they are rinsed with pure water and



soaked in a saturated solution of pot. permanganate, which is again rinsed off in distilled water, and then the brown color is removed by a saturated solution of oxalic acid, which in its turn is rinsed off in tepid distilled water. The instruments are wrapped in a towel, sterilized by steam, and placed in a glass tray under distilled water ready for use.

I saw some "hand cultures." After an assistant had washed his hands and soaked them in perchloride of mercury solution, some scrapings from under the nails were placed in culture media. In due time germs were produced, some of which, when injected into a rabbit, caused death. Dr. Kelly believes that perchloride of mercury solutions retard but do not absolutely prevent the production of poisonous germs, whilst saturated solution of permanganate of potash absolutely destroys the germs. The patients are prepared with as great care as the instruments and the hands of the operator. Ether seems to be used oftener than chloroform. I saw a good many cases of vaginal hysterectomy, all doing well. One was notable, as the operation was done for prolapse of the uterus, which was of such a marked character that no other plan of treatment seemed to offer a chance of relief from her distressing symptoms. Some of the hysterectomies were done for myomata, and Dr. Kelly believes that when the life of the patient is rendered unbearable by pain or disease caused by pressure from myomata, and when other treatment is unavailing, hysterectomy is justifiable. One case of cystic ovary was operated upon by Dr. Kelly in which the adhesions were so dense and general and the bleeding was so free that the cyst could not be removed without seriously threatening the life of the patient. He broke quickly through the adhesions at the pedicle, ligated it, emptied the clots out of the sack and washed it out with warm water, drained and packed with iodoform gauze, with good result. In a case of subperitoneal myoma removed by Dr. Robb the omentum was attached, and its vessels so enlarged that, instead of separating adhesions, he tied off omentum, tied the pedicle and removed the tumor, after which he tied the pedicle again by cross stitches.

There were very many other operations of great interest to me. In dilating the cervix

uteri, Professor Kelly uses the dilators with repeated quick movements, changing the position so as to dilate evenly. In repairing lacerations of cervix, he cuts the scar tissue away very freely, and uses silk-worm gut with catgut for the superficial stitches. In lacerations of the perineum he does a very neat operation, using Emmet's curved scissors, and denuding higher up on the vulva than many advise. Catgut for the lesser and silk-worm gut for the deeper stitches are used. Glass catheters are preferred, as they are so easily cleaned.

## Selections.

### THE PRESENT POSITION OF ANTI-SEPTIC SURGERY.

(Correspondence in *The British Medical Journal*.)

SIR,—The allusion that I made to Professor White's unnecessary readiness to take Sir Joseph Lister's place in an argument upon this subject will be found to bear an altogether different meaning from that forcedly put upon it by Professor White. My article was the criticism of Sir Joseph's address in Berlin, where my own arguments were not only not ignored, but were pointedly alluded to and by name. That, however, is a matter of no consequence. Professor White's unnecessary and inconsequent intervention was due to what he calls "an abiding faith"—a singular corroboration of the criticism I advanced against the whole antiseptic doctrine fifteen years ago. Its analogy can be found only in theological metaphysics. It is like the doctrine of "innate ideas"—it requires "an abiding faith," and, when that has been acquired, its recipient is wholly beyond the province of ordinary reason. I accept—I have often used as one of my strongest arguments—"the every-day facts of the surgical ward." It is precisely because I see the cut of the morning shave heal without suppuration in a healthy man, because I know that simple fractures heal without it, as do contusions without loss of continuity, and because of a hundred other daily facts of surgical experience which are ignored by the "peculiar people" of the "abiding faith," that I laugh at the whole thing.

The facts of the "beef and pickle" argument, and those of the "henwife and the housewife"

are quite familiar to everybody in this country, and, taken together with those of the every-day practice of surgery, they prove three things: (1) that the germs of putrefaction exist, with restrained potentiality, in all living tissue; (2) that the restraining influence is what we call, for want of a better name, vital force; (3) that when the restraining influence has its balance upset by what we call disease, lowered vitality, accident, etc., the germs are let loose to work their evil wills. This is the fundamental pathology which I was taught as a youth, and my mature experience confirms it every day in every particular.

One matter aside. Professor White complains of my attack on the deadly and dangerous character of the double cyanide dressing. I have had no experience of it, and my objection certainly was *a priori*. But with the awful experience we have had of the poisonous effects of carbolic, have we not reasonable grounds for fearing in a "double cyanide" something far worse? The part of the whole business of the antiseptic processes, where ridicule becomes the most potent, indeed the only argument, is that when we have seen every few months an infallible nostrum introduced, adopted by those of the "abiding faith," sworn to as the perfection of the system, and then, *incredibile dictu*, dropped into oblivion without a word of explanation or apology. Ordinary, plain-sailing, every-day folk, like myself, were charmed with the idea of the spray. It seemed so complete, so logical, that the confession on the part of Sir Joseph that he was ashamed of it put the final stone on the cairn of antisepticism.

I am, etc.,

Birmingham.

LAWSON TAIT.

SIR,—Mr. Tait reiterates but does not add to his previous argument. His interesting observation of the innocuous effect of the "cut of the morning shave" is merely confirmatory from the masculine standpoint of the great truths already made clear to him by the experience of the opposite sex as embodied in the "facts of the henwife and the housewife." On this broad basis of generalization he erects a "fundamental pathology" which he condenses into three propositions embracing views as to "restrained potentiality," "vital force," and the "evil wills" of the germs of putrefaction—a

sort of pathological metaphysics at least as irrational as the theological variety to which he objects.

The fact that he practically ignores the evidence I ventured to bring forward and the authorities I referred to renders further argument useless.

Something has been gained by his confession that he described the double cyanide dressing as "deadly and dangerous" on *a priori* grounds solely, and without having had the very least experience with it.

By the side light which this ingenuous admission throws on Mr. Tait's mental processes I would be led, were I truly a metaphysical theologian, to conclude this final contribution to my side of the discussion by preaching him a short sermon, taking as my text the saying of Confucius: "To know that we know what we know and that we do not know what we do not know is the sum of all human knowledge."

I am, etc.,

Philadelphia.

J. WILLIAM WHITE.

ON THE DIFFICULTY EXPERIENCED IN THE DIAGNOSIS OF WHOOPING-COUGH FROM THE PRESENCE OF A TUBE IN THE TRACHEA.—A boy, six years old, was admitted to the Royal Hospital for Sick Children, Glasgow, on November 6th, 1888. He was in such distress from urgent dyspnoea, due obviously to laryngeal obstruction, that in about an hour after his admission tracheotomy was performed by Dr. Hector C. Cameron. The breathing was at once relieved. The case was at first suspected to be of diphtheritic nature, although no membrane was seen either before, or during, or after the operation. The boy was reported to have had a cough for a fortnight before his admission, and he was said to have vomited with his attacks of coughing. After the operation the boy seemed to do well enough, but he continued to have a very troublesome cough, which was supposed to be connected, in part at least, with the irritation of the tube, etc. On the eighteenth day the tube was removed, and he did well enough without it. The cough still continued. After the removal of the tube the peculiar character of the cough began to excite my suspicions, and in three days the resemblance to whooping-cough became so great that his removal to the

isolation ward was ordered; another three days the diagnosis was complete, and he was removed to the whooping-cough wards of the Fever Hospital, at Belvidere, on November 30. The report from there was that the case proved to be a mild one; the tracheotomy wound healed in a few days, and he was dismissed well on January 12. Inquiry of the parents elicited the fact that others in the family, as well as this boy, were affected with a cough, which, after the patient's admission, had developed the character of whooping-cough in them also. The case was, no doubt, one of whooping-cough, complicated by laryngitis, suddenly presenting a grave form of obstruction. The idea of whooping-cough never entered my mind till after the tube was removed from the trachea, although the irritating sound of the coughing, with the air rushing through the tube, was heard repeatedly, and its cause could not be ascertained on physical examination of the chest. Of course the presence of a tracheotomy-tube necessarily interfered with any manifestation of the spasm of the glottis, on which we rely for the most characteristic sign of this disease. The effect of the tube completely misled the diagnosis. So far as we ascertained, no children in the ward were infected by his three weeks' residence here. A complication like this is rare, so far as I know, and it may have some value in discussing certain theories relating to whooping-cough.—By *James Finlayson, M.D., Physician to Glasgow Western Infirmary, and to the Royal Hospital for Sick Children, Glasgow, in the Archives of Pediatrics.*

ON THE USE OF ACONITE.—I have for many years been in the habit of prescribing aconite in doses which my medical friends assure me are very dangerous; yet I have never had any accident or an approach to one. My favorite preparation is the tincture (not Fleming's), and the dose ten minims three times a day. For rheumatic iritis I invariably order this, in combination usually with iodide of potassium and alkalis. On one occasion I had a remarkable illustration of its value. I had treated the same patient repeatedly for annually recurring and severe attacks of iritis. On one occasion he insisted that the medicine did not relieve him as it had formerly done. I compared my prescription with those of former years, and found

that though very similar in other respects, I had omitted the aconite. It was added, and relief soon followed. Since that I have never forgotten it. In almost all cases of rheumatic affections attended by pain, aconite seems to suit, and I have used it also much in inflammatory states of the skin, eczema, etc., especially when they are pruriginous. For the pain of cancer it is also, I think, decidedly useful. I recently saw a lady who had for this object continued my prescription of ten minims three times a day for a whole year. It had never disagreed in the least, and she believed that it had to some extent controlled her pain. From statements made to me by many professional friends, I am inclined to believe that there is far more danger in smaller doses at short intervals than in those which I use. I may repeat that I have never witnessed ill effects. My patients are always forewarned that they are using a powerful remedy, must be careful to measure the dose, and must leave it off if the tongue tingles. For acute inflammations of important viscera I have seldom used aconite, preferring tartar emetic. I can well understand that if it be given every half-hour or every ten minutes, as some recommend, that however small the dose it will need most careful watching, and may easily prove dangerous. I can also easily believe that such administration may be very efficacious, for it is undoubtedly a very powerful remedy. My chief reason for penning this note is, however, to bear testimony to the harmlessness of ten-minim doses not oftener than three times a day, but continued indefinitely, and to their efficiency in a variety of inflammatory, pruriginous, and painful affections.—*Hutchinson's Archives of Surgery.*

CANCER OF THE STOMACH WITHOUT SYMPTOMS.—At the Société Médicale des Hopitaux, Nov. 7th, M. Siredey exhibited pathological specimens taken from a woman who died of cancer of the stomach. When she was admitted into L'Hopital Laënnec under M. Strauss in September last, the woman showed no symptoms of cancer of the stomach, nor even dyspepsia. Her general health was excellent, and she had a rosy complexion. There were some signs of ethylism. Examination of the epigastric region, however, revealed the presence of two large tumors, one above the other, the one

appearing to belong to the omentum, the other to the stomach. Her general condition remained excellent until the month of October. At this time obstinate vomiting began, which soon produced emaciation. The patient, however, did not lose her appetite. The characteristic yellow tint was never present. The glands were not enlarged. Death occurred on the 28th of October. At the autopsy two cancerous tumors were found, one in the omentum, the other in the stomach; the latter extended over two-thirds of the great curvature, and from thence to the pylorus, which had become almost impassable. There were some granulations on the peritoneum. In the discussion which followed M. Hayem stated that in cancer of the stomach the chemical action which goes on in the stomach is usually much altered, but that sometimes the glands of a large portion of the mucous membrane remained normal, and consequently digestion and nutrition was not interfered with, the chemical action going on normally. This, he thought, was the case in M. Siredey's patient. He remarked that it was well to remember, however, that chemical action in the stomach might be completely abolished without there being any signs to show it, and that intestinal digestion could supply the want of stomach digestion. In responding, M. Siredey pointed out that the mucous membrane of a large part of the fundus of the stomach in the present specimen was healthy. In addition, the liver and the pancreas of the patient were quite sound; and consequently digestion might be carried on as indicated by M. Hayem.—*L'Union Médicale*.—G. A. F.

THE THERAPEUTIC EFFECT OF STRYCHNINE IN CARDIAC AFFECTIONS.—The *Medicinisch-chirurgische Rundschau* for February 1st has an extended notice of a recent paper by Professor Baldo Zaniboni, of Padua, on this subject. Zaniboni's article is based on a large number of clinical observations, with sphygmographic tracings, and appeared originally in the *Revista Veneta*, Nos. 2 and 3, 1890. The following are his most important conclusions:—Strychnine is without question a very efficient exciter of cardiac activity. By its use the systolic impulse is strengthened, the diastole is prolonged, and at

tacks of arrhythmia are cut short; subsequently the arterial tension is increased and the pulse-rate, if rapid, is slowed; if retarded, is accelerated. Acute dilatation and the dangers of heart failure, especially of the right side, are removed. Respiration becomes freer, and attacks of dyspnoea are completely relieved. Only in cases in which the nervous and muscular elements of the heart are no longer susceptible of stimulation does strychnine remain without effect. Œdema, even when it has resisted treatment with digitalis, disappears quickly, and there is free diuresis without the occurrence of albuminuria, such as follows the use of strophanthus. The bodily temperature is not noticeably affected. The appetite improves and the action of the bowels is regulated in consequence of increased peristalsis. The contractility of the arteries is heightened by the vaso-motor action of the drug. The hypodermic injection of strychnine is well borne, and with careful antisepsis causes no local reaction. Beginning with one sixty-fifth of a grain, the dose may be increased to one-third of a grain three or four times a day, without producing either subjective or objective disturbances. The treatment may be stopped abruptly, even when the largest doses are being given, without causing any unpleasant symptoms. The effect of the salt is seen very quickly (in about ten minutes) after the injection, and lasts for several hours. Even after the long-continued use of strychnine no symptoms were noted that pointed to any cumulative action of the drug.—*New York Medical Journal*.

TREATMENT OF EFFUSION IN THE KNEE-JOINT.—In the London *Practitioner* for February, 1891, Owen describes his treatment for effusion into the knee-joint. He says:—In some instances the aspirator was employed, but in others the distended joint was dealt with by a hydrocele canula of about the gauge of a No. 1 English catheter. In the use of either instrument the surgeon must take care that it is aseptic, and that the skin through which it is to be introduced is not only "cleansed" but clean. Moreover, he must not operate with "unwashed hands." Another point to be attended to, when using the canula is that just as the fluid is

ceasing to flow the surgeon should block the end of the instrument with his finger, and so withdraw it that he does not introduce air into the joint. A canula thus used is as safe as an aspirator, and it has this recommendation, that it is sure to be in working order. If an ordinary canula and trocar cannot be used with security, peritoneal cavities, ovarian cysts, and vaginal tunics should have been in the habit of suppurating. This we know is not the case. It is very much the fashion now, however, to drop the simple word "tapping," or its equivalent "paracentesis," and, with a homage to euphemism, to employ the term "aspiration." To the practitioner it matters not whether the fluid is blood or sero-synovia. He has merely to obey the indication. If the joint has begun to swell up directly after the injury, the distending fluid must be blood; but if a day or more have intervened between the hurt and the swelling, the fluid has been poured out by the inflamed synovial membrane. Such fluid is a mixture of synovia with serum; often it is stained with blood. Dr. Owen has never known any trouble to follow the tapping of a joint; he adopts it as a routine treatment in the case of fracture of the patella as well as in the more simple variety of distension. As a rule, the puncture is made to one side of the patella. When withdrawing the canula the track is obliterated by firm pressure with the finger. The skin puncture is covered with a scrap of lint dipped in collodion, or by a little pad of dry wool. The knee, together with the upper half of the leg and the lower half of the thigh, is then enclosed in lateral splints of house-flannel and plaster-of-Paris. The limb is fixed in the extended position, the foot being slightly raised. The firm pressure which is made around the joint is comforting, and it effectually prevents further effusion into the synovial membrane. Having watched the effect of this method of treatment, Dr. Owen can honestly say that, should he have the bad luck to be the subject of acute traumatic hæmarthrosis or sero-synovial effusion of the knee, he would most certainly have the joint treated in the manner described. And he should ask that the site of puncture might be first numbed by the application of a piece of ice and some salt.—*Medical News*.

AMATEUR PRESCRIBING AND ITS RESULTS.— Acid nitrate of mercury is, doubtless, a useful external application in certain cutaneous disorders, but it is hardly the thing to smear over one's body as a cure for scabies. Acting on the advice of an unlearned fellow-laborer, however, three country yokels last week purchased some quicksilver and some nitric acid, and, having mixed the two, anointed their itching skins, with the result that the coroner has had to inquire into the cause of death of two of them, while the third is simply "hanging fire." The chemist who sold the materials came in for some censorious observations, but he does not seem to have infringed even the spirit of the law. Nitric acid is an article in common use in the arts, and quicksilver is not in itself poisonous. Another time, however, perhaps he will take the trouble to inquire what such things are wanted for. Had he done so in this case he would have saved two, if not three, unhappy men from an agonizing death.—*Hospital Gazette*.

---

THE  
Canadian Practitioner

A SEMI-MONTHLY REVIEW OF THE PROGRESS  
OF THE MEDICAL SCIENCES.

---

*Contributions of various descriptions are invited. We shall be glad to receive from our friends everywhere current medical news of general interest.*

*When a change of address occurs please promptly notify the Publishers, THE J. E. BRYANT COMPANY (Limited), 58 Bay Street.*

---

TORONTO, MAY 1, 1891.

---

LICENSING BOARDS IN THE UNITED STATES.

Recent legislation in many of the States is likely to exert great influence in medical education in the near future. It is certainly remarkable that the standard in the United States should so long have remained so low as compared with that of all other civilized countries. A few years ago there was practically no entrance examinations for the great majority of medical students. As the medical schools were the masters of the situation in those times, the

standard was purposely kept low, because it meant a larger attendance and greater profits.

There is a medical school in the State of New York which furnishes a good example of an institution conducted on business principles. It is in the neighborhood of twenty years since the writer, attracted by the great reputation of this big concern, attended its lectures for a few weeks. He met, as fellow students, the queerest motley crowd of uncouth, uncultured, and ignorant creatures it was ever his misfortune to be associated with. To matriculate there meant to pay five dollars. The student was supposed to be able to read and write, but not to spell; this latter was an accomplishment so rare as to be considered rather a vulgar one.

This was one of the two-year mills, so common in those days, scarcely forgotten yet. It was run on a plan as simple as it was easy. Some hundreds of students listened to two courses of didactic lectures; they were never allowed inside a hospital ward; they were not asked to do laboratory work; they were ordered to do some dissecting, and in this their celerity was unexcelled, as they frequently completed the dissection of an extremity in one evening.

The legislation before referred to is, however, bringing about a new order of things. Licensing boards are being formed with a rapidity that is very satisfactory. Most of our profession will probably be surprised to learn that such boards now control medical practice in twenty-one States in the Union, as we learn from the *Medical News*. We are pleased to learn that that indomitable fighter against quackery, humbug, and ignorance, Dr. Rauch, of the Illinois Board of Health, has called a meeting of representatives from the various licensing boards, to be held at Washington on May 6th. Concerted action on the part of these bodies will do much for higher medical education in the United States.

#### INTERNATIONAL AMERICAN MEDICAL CONGRESS.

A formal notice has been given of a very important motion to be introduced by Dr. Chas. A. L. Reed, of Cincinnati, at the coming meeting of the American Medical Association in Washington. We understand the proposed resolutions will be as follows:

"1. That the American Medical Association extend an invitation to the profession of the republics and colonies of the western continent to assemble in this country in an International American Medical Congress.

"2. That the Committee on Nominations be instructed to nominate one member for each State and Territory, and one each for the Army, Navy and Marine Hospital Service, to constitute a committee with power to act, to which will be referred time, place and permanent organization of the proposed Congress."

A Congress such as this, organized in the manner indicated, ought to prove a success in the highest sense of the word. The American Medical Association, which passed through serious trials from internal dissensions a few years ago, is now becoming very strong. Its prospects were never so bright as at the present time. It will probably soon become for the United States all that the British Medical Association is for Great Britain. Some have thought this could never be on account of the magnificent distances between the different sections of the Union. The comforts and conveniences of modern travelling have, however, almost annihilated such difficulties, as the large attendance at recent meetings proves beyond doubt.

We think Dr. Reed's idea is a very happy one, and hope it will be well received by the Association.

#### ANTISEPTIC SURGERY.

The discussion arising out of Dr. White's address in the Post-Graduate Course of the University of Toronto has not yet ceased. We publish in this issue another letter on the subject from Mr. Lawson Tait, which appeared in the *British Medical Journal*. Mr. Tait dislikes to be ignored by the London lights, and is too fond of controversy himself to ignore any one who criticises adversely his opinions or methods.

NOTE—Since the above was put in type we have received from Dr. White a copy of the reply he has sent to the *British Medical Journal*. It will be found in this issue.

#### THE CLOSE SHAVE.

Our barbers, so skilled in surgery in former times, have not yet lost their cunning. One of

their greatest triumphs in modern times is what is called "a close shave." Their dexterous finger tips, moistened and spread slightly apart, press the skin in such a way as to make the lower part of the hair-shaft unduly project beyond the follicle. Dr. Shoemaker tells us the follicle itself is partially forced outwards. The razor then removes not only the visible hairs but also a thin layer of the cuticle, lacerates the tiny blood-vessels at the orifices of the follicles, exposes the delicate endings of nerves, and thus renders the skin tender and unhealthy.

#### SPRING EXAMINATIONS.

The dreaded examinations are once more completed, and the results have proved unsatisfactory to many aching hearts. We have not yet the returns from the Ontario Medical Council, but report says the candidates did fairly well at the oral examinations. In the University of Toronto about thirty-three per cent. failed to reach the required standard, and were either rejected entirely or required to take a supplemental in one or more subjects. While we may extend our sympathy to the unfortunates, we must commend the action of the examiners in placing a high value on the examinations held by the Provincial University.

#### ONTARIO MEDICAL ASSOCIATION.

We would direct the attention of our readers to the list of papers already promised for the annual meeting of the Ontario Medical Association. The excellence of the programme should ensure an attendance even greater than that of last year. Dr. Senn, of Milwaukee, will read a paper on "The Surgical Treatment of Intussusception"; Dr. Howard Kelly, of Baltimore, will deal with "Gynæcology for the General Practitioner." The well-known reputation of the other contributors guarantees that their papers will be not one whit less interesting or valuable than those of our visitors.

**BURLINGTON AND HOME DIVISION.**—Owing to the resignation of Dr. James Russell, of Hamilton, representative of the above Division in the Ontario Medical Council, an election to fill the vacancy will be held in May, 1891. See the Registrar's advertisement in another column.

## Meeting of Medical Societies.

### THE TORONTO MEDICAL SOCIETY.

April 9th, 1891.

The President, Dr. Spencer, in the chair.

Dr. J. F. W. Ross narrated the history of a case of tubercular peritonitis, and two cases of septic peritonitis, submitted to operation. These are published in detail at page 200 of THE CANADIAN PRACTITIONER.

Dr. B. E. Mackenzie showed a boy one year and ten months old, who presented a

#### DISPARITY IN THE LENGTH OF THE FEMORA.

The following history was given: Two days after birth the nurse noticed that the left leg was shorter than the right. The labor was normal, and at the time of birth nothing unusual was noticed. The left leg is seen to be shorter and smaller than the right (left is about two-thirds length of right leg), the shortening is confined to the femur. Motion at the hip joint is normal; the trochanter is normal, so also are the head and neck of the bone. There is a depression on the surface, a dimple over the outer part of the upper portion of the femoral shaft; there is apparently some cicatricial tissue at this spot. The foot is held in a position of equinus.

Dr. Peters thinks the dimple furnishes a clue to the cause of the condition. An intra-uterine injury affecting the bone at the point of commencement of ossification might cause it. There is no dislocation of the head of the femur, and the trochanter is in proper position. It is probably of congenital origin, and likely due to some affection of the ossific centre of the shaft of the femur. The disproportion in the length of the two limbs will probably not be greater, in after life than it is now.

Dr. Mackenzie has little doubt as to its being congenital. He regards the condition as possibly due to the result of an intra-uterine fracture of the femoral shaft.

Dr. Price Brown gave the history of a case of

#### LARYNGEAL FIBROID TUMOR

removed by galvano-cautery in a patient suffering from aortic aneurism.

A farmer, æt. 45, presented himself with a large laryngeal growth, causing almost complete stenosis. On examination a fleshy growth was

observed below the arytenoid cartilages, covering almost the whole of the right vocal cord and part of the left. In the upper portion of the chest was a swelling, with dullness over it; no bruit. The patient first came to Toronto in December, 1890, when the growth was cauterized, with relief of the dyspnoea. January 3rd, 1891, he returned worse. Dr. Reeve saw him in consultation. It was thought that tracheotomy was indicated, and Dr. Cameron was also called. After consultation, Dr. Brown performed intubation, and the rales, heard on auscultation before operation, disappeared after intubating. The tube was only kept in position about ten minutes, and was then removed. The following day a lower growth, below the cords, was cauterized. He returned home to the country better. March 13th, 1891, he came back worse. On examining the chest, strong pulsation was observed over the swelling, but no bruit; aneurism was diagnosed, and he was advised to go home. A few days after, Dr. Brown was hurriedly called, but he died shortly after Dr. Brown reached him. The man was a hæmophilic. *Post mortem*: the superior left corner of the thyroid cartilage was absent; there was a small ridge representing the site of the upper growth, and a cicatrix at the former seat of the lower growth, with two minute nodules, and a depression between them at the same situation. A large aneurism was found on the aortic arch, formed just before the innominate artery is given off. The innominate artery was pressed to one side beyond the middle line, and an artery, which was observed during life to ascend up in front of the trachea, proved to be the right common carotid. The absence of bruit was probably due to the fact that it was an old aneurism with thick walls, and the blood stream flowed pretty well through the centre of it. There was perforation of the sternum, due to pressure of the aneurism.

Dr. W. Beattie Nesbitt gave a demonstration of

#### MICRO-ORGANISMS IN KOCH'S LYMPH.

Koch mentions that dead tubercle bacilli are present, but other forms of living bacilli have been found by Dr. Nesbitt. All solutions for experimental purposes were made in sterilized test tubes. A series of cultures from a fresh bottle of lymph was made. Some of the forms

of bacteria present were peculiar, and have not previously been recognized by Dr. Nesbitt. Any special virulence which the organisms possess has, as yet, not been ascertained, but investigations will be carried out by inoculation on animals. The facts stated illustrate the necessity for thoroughly sterilizing the lymph before using it.

Dr. Ross showed two dogs on whom he had performed an operation for

#### INTESTINAL ANASTOMOSIS.

The first dog Dr. Ross had operated on died on the second day; this was attributed to the fact that during the operation one of the threads broke, and although its loss of strength was supplemented by Halstead's superficial sutures, yet at the *post mortem* it was found to have given way and leakage occurred, proving fatal. Dr. Ross killed a dog on whom he had operated eight days previously, and performed a *post mortem* examination before the society. The anastomosis was sound, but was closing, in consequence of the fact that a silk ligature, which was passed around a loop of gut, to cause obstruction, had cut its way through the gut, healing taking place behind its track; the suture was found on the inner surface of the intestine, and the old lumen of the gut re-established. The anastomosis was no longer necessary, and hence was closing. There was some evidence of digestion of the bone plates which had been used.

April 26th, 1891.

The President, Dr. Spencer, in the chair.

Dr. B. E. Mackenzie showed a girl, two years and three months old, with the

#### LEFT HUMERUS ONE INCH SHORTER THAN THE RIGHT.

When six or seven months old the child was very ill and so much emaciated that recovery seemed doubtful; it was thought at that time that she was suffering from acute epiphysitis; suppuration occurred in the region of the shoulder. Fixation of the joint was secured by bandaging the arm to the chest wall; cod liver oil and malt were administered, and the child recovered. There is now the shortening as described.

Dr. Sweetnam presented a specimen of





immediately in ice freezers has been found efficacious in preventing the development of bacilli. This seems better and produces a more digestible article than the sterilized milk.

Dr. Machell thinks the simple sterilization alone is not sufficient to make cow's milk fit for the infant.

Dr. Rotch's formula is :

Cow's milk . . . . .	℥ii.
Cream . . . . .	℥iij.
Water (previously boiled)	℥x.

To each pint two measures of sugar of milk sterilized for twenty to forty minutes, then add one ounce limewater at time of feeding. This produces a milk almost identical with mother's milk.

Dr. B. E. Mackenzie thinks it important that the child should be fed at regular intervals. The great difficulty arises from the large size of the coagulum of cow's milk. The milk should be allowed to stand two or three hours and then pour off the top of the milk. This increases the amount of fat material.

Dr. Greig, in reply, claims that milk is altered in its chemical composition by being kept too cold. If the artificial digestion be not carried out too long, the milk will not become bitter.

## GYNECOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE.

February meeting.

The President, Dr. Henry M. Wilson, in the chair.

Dr. Neale reported a case of occlusion of the os uteri during four days parturition.

Dr. J. Whitridge Williams read a paper on  
THE INDUCTION OF PREMATURE LABOR IN  
CONTRACTED Pelves.

He pointed out that the comparative neglect of the operation in this country was due to two causes—the absence of large lying-in institutions, and the consequent lack of large amounts of clinical material, and the almost total neglect of pelvic measurement. By the term premature induction of labor one understands the artificial interruption of pregnancy at such a period that a viable child may be born; that is any period from the twenty-eighth to thirtieth week to the end of pregnancy.

Dr. Williams then went into the history of the operation, and showed that it was first rationally employed for this indication in England, as the result of a conference of the eminent physicians of London in the year 1756. Within fifty years it was quite generally employed on the continent and soon enjoyed a popularity which caused it to be resorted to on the most trifling pretexts, and which in 1869 called forth Spiegelberg's forcible denunciation of the operation, by which he showed that the mortality both of the mothers and children was nearly three times greater after the operation than if the woman went on to term. This was soon followed by articles by Litzmann and Dohrn, who showed that Spiegelberg had painted the picture in colors far too dark.

Litzmann showed that in moderate degrees of contraction, 8.25 to 7.5 cm. ( $3\frac{1}{4}$  to 3 in.), the operation was indicated in the interests of the mother, as shown by a mortality of 7.4 per cent. after the operation compared with one of 18.7 per cent. when the woman was allowed to go on to term.

Dohrn stated that the proper method of appreciating what the operation accomplished was not to compare so many cases of induced labor with so many cases of labor at term, but to compare the results of premature and spontaneous labors in the same woman; by this method he found that twice as many children were saved by inducing labor as by allowing the woman to go on to term. Consequently they proved that the operation was indicated in properly selected cases both in the interests of the mother and child.

The introduction of antiseptic methods into midwifery almost completely robbed the operation of danger for the mother, as will be readily seen from the following statistics. Thus, Haidlen reports forty-four cases from the Stuttgart clinic, with no maternal deaths and 72 per cent. of the children saved.

In 1889 Korn stated that Leopold lost one woman in forty-five cases, and saved 66 per cent. of the children. And last July Ahlfeld stated that he had induced labor 118 times with the loss of only one mother, and had saved 62 per cent. of the children. At the Berlin Congress, Tehling stated that in sixty cases he had save all the mothers, and 80 per cent. of the children.

From the above sketch we will readily see that the maternal mortality in properly selected cases is very slight; 401 cases collected by Korn showing a maternal mortality of only 2.9 per cent., or just a trifle more than normal labor in a normal pelvis, while the fetal mortality ranges from 20 to 70 per cent., the average being about  $33\frac{1}{3}$  per cent. So in this operation we have a means of saving about two-thirds of the children without any risk to the mother. On reckoning by Dohrn's method, we save at least twice as many children as if we allowed the woman to go on to term and then resorted to some conservative operation. These are the prospects of the operation, but unfortunately the degree of contraction within which the operation is justifiable is very limited, and one can only think of it in moderate degrees of contraction, according to Litzmann in flattened pelvis with a conjugata vera of 7.5 to 8.25 cm. (3 to 3.25 in.), and to Schreder, 6.5 to 9.5 cm. (2.5 to 3.75 in.). As pelvis with a conjugata vera above 8 cm. ( $3\frac{3}{8}$  in.) offer a reasonable chance to both child and mother at term, and those below 7 cm. ( $2\frac{3}{4}$  in.) offer no chance to the child, I think that the operation should be restricted to these limits; that is, between 7 and  $8\frac{1}{2}$  cm. ( $2\frac{3}{4}$  to  $3\frac{3}{8}$  in.) in simple flattened pelvis. In the justo-minor pelvis a conjugata of  $9\frac{1}{2}$  cm. ( $3\frac{3}{4}$  in.) or less will usually be an indication for the operation. In the rare forms of obliquely narrowed pelvis, whatever its cause, we must be guided almost entirely by the history of the previous labor. We thus have the operation restricted to a very small range,  $1\frac{1}{2}$  cm. ( $\frac{5}{8}$  in.), which should only be exceeded when the previous history tells us that the previous labors have all ended disastrously. We should not think of inducing labor in a flattened pelvis with a conjugata below 7 cm. ( $2\frac{3}{4}$  in.), for in that case the prospects for the child are almost *nihil*, and the dangers to the mother greatly increased. Here we come to the relative indication for Cæsarean section, when it is best to allow the woman to go on to term, and attempt to save both mother and child by that operation.

With these contracted indications we readily see that an accurate idea as to the exact size and form of the pelvis is an absolute pre-requisite for the performance of the operation; and the only means by which we can accurately

obtain this information is by carefully measuring the pelvis. We should not content ourselves with simply measuring the conjugata vera, but should also take the external measurements, and thereby attempt to determine with what form of pelvis we have to deal. After doing that, we must carefully examine the interior of the pelvis to determine its height; to see if it is generally contracted; and if contracted, if the contraction increases as we approach the outlet. We must look for exostoses of the pelvic bones, and carefully examine the promontory to see if it is double or not. If we think the pelvis contracted laterally, we should measure the distance between the tubera ischiorum on each side, as Breisky recommended. We should also attempt to estimate the transverse diameter of the pelvis, which is most difficult to do, and the most that can be expected is to examine alternately with each hand and try to stroke the linea innominata, and so relatively to get some idea as to the transverse diameter.

Having decided that an operation is necessary, the next question is, when shall it be done? Of course the younger the fœtus, the smaller will be its size, and consequently the easier its delivery. But, unfortunately, the smaller the fœtus, the less chance will it have of living, even if it survive the operation. Generally speaking, we say a child is viable after the twenty-eighth week, but its chances of living are almost *nihil*; indeed, children thirty to thirty-two weeks old have next to no chances of living. The later the operation, the more chance has the fœtus of living after it, but unfortunately its size and consequently the difficulty of its delivery increase with its age. If possible the operation should be done about the thirty-fourth to thirty-sixth week, our object being to operate at the latest possible period consistent with safe delivery. To fulfil this object, we must attempt to gain an accurate knowledge as to the size of the child's head. Unfortunately we are unable to determine its size with mathematical precision, or even with the relative precision of pelvimetry; so we are obliged to take advantage of every possible hint on the subject. Some of the following points may be of assistance in different cases. We must consider the mother's account as to the duration of the pregnancy; notice the size of

the parents, large parents usually having large children. Inquire about the previous labors, particularly as to the size of the head. Endeavor to estimate the size of the head by abdominal and combined abdominal and vaginal palpation; and note the consistency and amount of resistance to compression that the bones of the head offer. Try to measure the head with the pelvimeter through the abdominal walls, and deduct the estimated thickness of the abdominal walls from the result. Notice the size of the large anterior fontanelle, average width 2 cm.; the width of the sutures; and the distance from the anterior to the posterior fontanelle; for as they are larger or smaller, it indicates a larger or smaller head. Measure the length of the fœtus as it lies in utero, from breech to vertex, double the measurement, and it gives, according to Ahlfeld, the length of the fetus. If a foot is prolapsed, measure it, for Goenner stated that there is a difference of nearly one centimeter between the length of the foot of a child at term and one at thirty-two to thirty-four weeks.

One of the most important methods is that of Mueller, who attempts to force the head down into the pelvis by pressure from above. As long as he is able to force the head down, he knows that labor will readily take place; but when he can no longer force the head down, and when it bulges out over the symphysis, then he considers that the time for operation has arrived. As the great danger to the mother is from sepsis, one cannot be too careful in one's efforts to guard against it, and consequently one should be most particular in one's preparation for the operation.

For several days previous to operating, the woman should have a warm bath daily, and several times a day be douched with warm water, 95 to 98 per cent., containing salt or borax, by which the cervix is softened and dilated. Just before operating, the genitals should be most carefully washed with hot water and soap, followed by a 1-1000 bichloride solution; the vagina should also be most carefully cleaned. The hands of the operator should be washed for at least ten minutes in hot water, and the hairbrush vigorously used, after which they should be placed for several minutes in a 1-5000 bichloride solution. All instruments should be sterilized by steam or placed in a 5 per cent.

solution of carbolic acid for at least thirty minutes.

The most generally approved method is that of Krause, or the introduction of a disinfected flexible bougie between the membranes and the uterine wall. If properly conducted it is almost entirely devoid of danger for the mother, and will bring about the birth of the child in a period varying from 8 to 24 hours, averaging about 80 hours or about three days. To insert the bougie the woman is placed on her back or side, as may be most convenient, and the cervix brought down by a pair of bullet forceps, and the cervical canal carefully cleansed with bichloride on a pledget of cotton; the bougie is then carefully inserted, so that its lower end is within the vagina, care being taken not to wound the membranes or the placenta. Then the vagina is packed with iodoform gauze, care being taken not to wound the membrane which serves to hold the bougie in place. If at the end of twenty-four hours no labor pains have been produced, the bougie should be removed and another introduced at another point, under the same precautions as the first.

If this method fail, we may resort to Kiwisch's method of allowing a current of hot water, 100-110 F., to flow through the vagina several times a day, for a period of five to fifteen minutes. Or we may puncture the membranes; as accessory to these we may loosen the membranes about their lower pole, dampen the vagina with iodoform gauze, or employ Barnes' bags.

If the pains are weak, Tehling recommends version by Hick's method and bringing down one leg, whereby increased contraction is produced, and one is afforded a ready means of ending the labor, if one deems it expedient in the interests of the mother or child.

Dr. Neale: I regard the chief point in this very able paper to be the endeavor to definitely fix the limits for the induction of premature labor in contracted pelvis, not as opposed to Cæsarean section, but as applicable to a distinct and separate class of cases. This endeavor I strongly advocate, but at the same time must confess that I do not believe the plan is always practicable at the bedside. There are so many factors entering into the determination of this question, as I stated in my paper, that I can now only

repeat what I there quoted, viz.: "A given pelvic measurement is useful as an indication of what has been the experience of others under similar circumstances, but is not a final ground for decision."

After the evidence adduced, which doubtless represents the opinion of the best medical authorities, I am sure I only voice the concurrence of this society in accepting the limits for this operation as stated by Dr. Williams.

This is practically in accordance with the teachings of Lusk—probably our strongest American authority—who places the range for the induction of premature labor in contracted pelves at a conjugata vera of from  $2\frac{3}{4}$  inches (7 cm.) to  $3\frac{1}{2}$  inches (8.75 cm.).

As stated in the paper, I believe the most reliable statistics of this operation are those of Dohrn, who compares the results of induction of premature labor with those of labor of term in the same case, showing a very decided advantage in premature labor. It must be remembered, however, as Litzmann has clearly shown, that children born alive by this operation are far more likely to die early than matured children. The risk to the child does not cease with the delivery.

I can not recall any reference in the paper to pelves contracted from hip-joint disease, and yet I have met with two obstetrical cases of this character during the past two years in this city, both were in private practice, and both were primiparæ.

The first case I saw in consultation during a very severe labor at term, and delivered her of a still-born child by a difficult high (Tarnier) forceps operation.

Premature laor was induced on the second case at the eighth month. In this case the bougie was retained under antiseptic precautions (2 p.c. creoline, cervical and vaginal douche, and iodoform gauze over os), between the membranes and uterine walls, for forty-eight hours without effect. It was then withdrawn, the douche again administered, and bougie reintroduced in a different position and retained for twenty-four hours again without effect. The sac was then punctured high up by the probe, and labor began in about fifteen hours. Thus we see the method of Krause, although the best, may fail where puncture of the sac will not.

As this lady was poisoned to death by an unclean servant, who dressed and picked carious bones from her foot and then attended my patient, and handled all her linen, napkins, etc., without my knowledge, it shows the importance of extending our antiseptic precautions to everything coming in personal contact with the case. As regards the method of delivery, the experiments of Budin and others speak strongly in favor of version and extraction as opposed to forceps.

Dr. Kelly: The subject is too large to be discussed formally. I will merely refer to one or two points of interest. A serious complaint is to be entered against the records of foreigners in regard to the statistics of infant mortality after premature labor. Many observers only state whether the child was born living or dead; some few state whether or not it was living when discharged from the hospital. What we want to know for practical purposes is whether the children live any time after they get home. My own experience is but few live. If they are sent out simply to die soon after at home, the induction of premature labor among the poorer classes simply becomes a species of uterine gymnastics. A method of my own which I have found most successful in inducing premature labor is taking a flexible whale-bone bougie, introducing it between the membranes and the uterine wall, high up into the uterus, and sweeping it gently around for one or two inches in either direction. This has not failed me in any instance in bringing on labor.

---

## Hospital Reports.

---

### REMOVAL OF THE RECTUM FOR CARCINOMA.

UNDER THE CARE OF L. M'FARLANE, M.B., SURGEON TO TORONTO GENERAL HOSPITAL.

[Case reported by J. E. McCarty, M.D., House Surgeon.]

C. V., at. 55 years; born in Canada. Admitted to Toronto General Hospital, February 27th, 1891; hotel-keeper; has lived moderately. Only serious illness was an attack of peritonitis in 1875. His grandfather died from epithelioma of the lip; the remainder of his family history is unimportant. Five or six years ago he first noticed pains in the back and

general weakness. After having the bowels freely opened by means of cathartics, he would feel fairly well for a couple of weeks and then there would be a recurrence of the pains. About two years ago there commenced a slight discharge of a bloody consistence, when at stool. Defecation not particularly painful. This discharge has gradually increased since, and has the peculiar cancerous odor. He was told that he had internal hæmorrhoids, and for such was treated by quacks, who prescribed numerous ointments. He received no beneficial effect from these and came to the Hospital. On admission, cancerous cachexia well marked; has lost weight, is anæmic, has no appetite, and looks older than he should. Bowels are usually constipated; other organs are normal. Digital examination of the rectum revealed an annular tumor about three inches from the anal margin, and extending higher on the right than on the left side. It was nodular to the feel and bleeds some. No enlarged glands could be felt in the vicinity. Examination per speculum showed a warty cauliflower mass.

*Diagnosis*.—Carcinoma of the rectum, requiring excision.

*Operation*.—The bowels having been thoroughly cleared out by calomel and enemata, he was operated upon by Dr. L. McFarlane on March 2nd, 1891. He was anæsthetized and placed in the lithotomy position, Clover's crutch being used. A large antiseptic syringe with tape attached was passed up the rectum above the tumor. The rectum was then thoroughly irrigated with a solution of hydrarg. perchloride (1 in 4000). An incision was made at the junction of skin and rectal mucosa. The dissection was continued upwards from the anus to almost an inch above the tumor, the rectum being fully separated from the surrounding tissues, going a little higher on the right than on the left side. The tumor was now drawn down by means of a polypus forceps, the portion of rectum above the tumor being secured by means of a large Spencer-Well's cyst forceps. The mass was removed by long, curved, blunt-pointed scissors. Hemorrhage being profuse, the wound was irrigated with water at 120° F. All accessible bleeding points were secured and ligatured. The intestinal wall was next drawn down and stitched to the skin. A large tube

*en chemise* was passed up the bowel, packed with iodoform gauze. A pad of bichloride gauze, with an opening in the centre for the tube, was placed over the wound, and over all a pad of antiseptic wound wool. The dressings were held in position by a T-bandage. Patient's pulse was weak after operation, and he was slow in recovering from the effects of the  $\text{CHCl}_3$ . Spts. vini. gallici. m. xxx. was given hypodermically; later, when pulse had improved, morph. sulph. gr.  $\frac{1}{4}$  was administered subcutaneously.

March 3rd: Urine per catheter every six hours; temperature 98 $\frac{1}{2}$ ; respiration 20; pulse 102; dressing changed; no hemorrhage.

March 4th: Temperature, 99 $\frac{1}{3}$ ; respiration, 22; pulse, 97. Morph. sulph. gr.  $\frac{1}{4}$  p.r.n. to relieve pain. Dressing changed: slight mucus discharge. Bowel irrigated with a warm saturated solution of boric acid. The tube was discarded and a rectal bougie one inch in diameter, well carbolized, was used instead.

March 7th: Temperature, pulse and respiration normal. Dressing done every second day.

March 9th: Pulv. glycyrrhiza co. ʒj was given internally. Bowels moved freely.

March 25th: Patient's appetite good. Bowels move every three or four days. Says he never felt better in his life.

April 2nd: Patient discharged.

Dr. John Caven examined specimen microscopically and reported it a malignant adenoma, or as it is commonly called, a columnar-celled epithelioma. It was of very rapid growth. Adenomata found in the large and small intestines and rectum are as malignant as the malignant carcinomata. They invade the surrounding tissues and form metastases.

*Remarks*: The successful issue of the above case is particularly encouraging. Although the disease was far advanced, the whole lumen of the tube being involved, the patient was very much improved by operation; and while it is quite probable there will be a recurrence of the affection sooner or later, yet the freedom from pain and marked benefit to the patient's general health resulting from operation prove that it was justifiable.

DR. KILBORN, of Kingston, will shortly go to China as a medical missionary.

## Reviews.

*Heredity, Health, and Personal Beauty.* By John V. Shoemaker, A.M., M.D., Professor of Materia Medica and Therapeutics and Clinical Medicine, and Clinical Professor of Diseases of the Skin in the Medico-Chirurgical College of Philadelphia, etc. Philadelphia and London: F. A. Davis, Publisher.

This is an exceedingly interesting book, both scientific and practical in character, intended for both professional and lay readers. In showing the influence of heredity the author discusses freely Darwin's theory of evolution, particularly with reference to acquired as well as congenital characters. He contends that the physical, moral, and mental worlds are, all alike, controlled by the law of evolution. In speaking of health and personal beauty, he discusses the effects of environment, exercise of various kinds, the treatment of the skin, and the various parts and organs of the body. Many and useful are the hints given as to bathing, clothing, food, ventilation, etc. The book is well written and presented in admirable form by the publisher.

*The Year-Book of Treatment for 1891.* A critical review for practitioners of medicine and surgery. Contributors: Drs. Baron, Mitchell Bruce, Garrod, Berry Hart, Herman, Maguire, Owen, Phillips, Power, Ralfe, Reynolds, Ross, Skerritt; Messrs. Cooper, Reginald Harrison, Malcolm Morris, and Walsham.

The object of this year-book is to supply a concise epitome of the chief articles by the year, with a short criticism of the more important subjects, together with full references. It is not intended to be either a dictionary or text-book of medicine, but a ready help to practitioners. The names of the contributors will afford a guarantee as to the excellent character of the work. It is published by the well-known firm of Lea Brothers & Co., of Philadelphia.

*The International Medical Annual and Practitioner's Index for 1891.* Edited by P. W. Williams, M.D., Secretary of Staff, assisted by a corps of thirty-eight collaborators—European and American—specialists in their several departments. 600 Svo. pages. Illustrated. \$2.75. E. B. Treat, publisher, 5 Cooper Union, New York.

The ninth yearly issue of this valuable reference work is to hand. Part I. comprises the new remedies, together with a review of the therapeutic progress of the year. Part II. is devoted to special articles on diagnosis. Part III., comprising the major portion of the book, is given to the consideration of new treatment. Part IV. is made up of miscellaneous articles, such as improvements in pharmacy, books of the year, etc. In short, the *Annual* is a recapitulation of the year's progress in medicine, serving to keep the practitioner abreast of the times with reference to the medical literature of the world. Price, \$2.75.

## Personal.

DR. LAFFERTY, of Hamilton, who was seriously ill for over three months from pneumonia and its sequela, has recovered.

DR. A. B. ATHERTON, of Toronto, sailed for England on the *Etruria*, April 18.

LATEST reports show that Dr. A. T. Carson, of Toronto, is in Rome. He had a slight attack of bronchitis, from which he is recovering.

DR. E. P. GORDON, of Toronto, is surgeon on one of the C.P.R. steamers, which left Liverpool } April 11, on its voyage round the world.

MR. THOS. BRYANT was elected a representative of the Royal College of Surgeons in the place of the late Mr. John Marshall.

DR. EDWARD A. AYERS has been elected to the Professorship of Obstetrics in the New York Polyclinic.

DR. L. S. McMURTRY, of Louisville, Kentucky, President of the Southern Surgical and Gynecological Association, delivered two lectures before the Alumni Association of the College of Physicians and Surgeons, Baltimore, April 11th and 13th, on "The Pathology, Diagnosis, and Treatment of Ectopic Gestation."

DR. J. D. TURRY, formerly of Dunville, Ontario, died in Chicago, April 21st, on his way home from the Sandwich Islands, where he had gone for his health. He attended two sessions in the Toronto School of Medicine in 1880 and 1881, and completed his course in Buffalo, after which he practised in Peoria, Ill.

### Obituary.

DR. JAMES N. MCCREA died in Warkworth, April 27th, at the age of seventy-two. He graduated in the University of Victoria College in 1859. He practised many years in Warkworth, and for a time in Campbellford.

KARL BRAUN VON FERNWALD, M.D., Professor of Midwifery in the University of Vienna, whose name has long been familiar to gynecologists throughout the world as that of one of the foremost among practitioners and teachers of the obstetrical art, passed away on March 28th, after a short illness, in the 70th year of his age. He was born at Vienna, and took his M.D. degree in the University of that city in 1847. He became *Privat-docent* in 1853, and not long after was appointed Professor in the School for Midwives at Trenn. He was called to the Chair of Midwifery in the University of Vienna in 1857, and was elected Dean of the Medical Faculty in 1867 and again in 1871, and filled the office of Rector of the University in 1869.—*British Medical Journal*.

### Births, Marriages, and Deaths.

#### BIRTHS.

GALLOWAY.—At 200 Euclid Avenue, on Saturday, April 18th, the wife of Dr. Herbert P. H. Galloway, of a son.

#### MARRIAGES.

FRANCIS—READ.—On April 15th, at Toronto, Richard P. Francis, M.D., of Montclair, New Jersey, to Jessie, eldest daughter of the late John B. Read, barrister-at-law, Toronto.

GAMBLE—MCINTOSH.—At Toronto, on the 16th of April, Joseph B. Gamble, B.A., M.B., of Jarvis, Ont., to Lizzie J. McIntosh.

#### DEATHS.

BRAY.—At Toronto, April 11th, Mary F., wife of James Bray, M.D.

### Therapeutic Notes.

PRESCRIPTION FOR WHOOPING-COUGH.—Von Genser is said to use the following prescription in the treatment of whooping-cough:

R.—Carbolic acid	1 ½ grains.
Rectified spirit	2 drops.
Tincture of iodine	5 "
Tincture of belladonna	10 "
Peppermint water	2 ounces.
Simple syrup	1 drachm.

To a child of two years a teaspoonful of this mixture may be given every two hours.—*Medical News*.

POWDERS FOR INDIGESTION.—*L'Union Médicale* states that Dujardin-Beaumez uses the following powder in the treatment of dyspepsia:

R.—Subnitrate of bismuth	} of each, 2 ½ drms.
Carbonate of magnesium	
Prepared chalk	
Phosphate of sodium	

This is to be divided into forty powders, and one powder taken after each meal.—*Medical News*.

CREOLIN IN ERYSIPELAS AND ECZEMA.—Dr. Rothe has used in the treatment of erysipelas a creolin ointment containing—

Creolin	1 ½ parts.
Creta præp., axung. porc.	aa 15 "
Ol. menth. pip.	gtt. 5 "

This is spread in the thickness of the blade of a knife over the diseased parts twice or three times a day, a thin layer of cotton-wool being applied as a covering. In from twelve to twenty-four hours improvement was always apparent, and the disease was cured in three or four days. The same ointment also did good service in a case of weeping eczema of the face, as also in several cases of eczema in children. A patient suffering from scabies was treated with a thorough washing with soft soap, and inunction of this ointment, with such a decided effect that Dr. Rothe considers creolin to be undoubtedly a specific for the disease.—*British and Colonial Druggist*.

THE British Gynecological Society will hold a provincial meeting on June 18th and 19th at Newcastle-on-Tyne. Dr. Robert Barnes, Honorary President of the Society, will take the chair at the meeting, which will be held in the College of Medicine.



## Miscellaneous.

### PROGRAMME OF ANNUAL MEETING OF THE ONTARIO MEDICAL ASSOCIATION.

*Medicine.*—“The Cardiac Phenomena of Rheumatism,” by Dr. A. McPhedran, Toronto, assisted by Drs. Mullin, Hamilton; Henderson, Kingston; Gillies, Teeswater.

*Surgery.*—“The Causes and Treatment of Carcinoma,” by Dr. J. L. Teskey, Toronto, assisted by Drs. J. Wishart, London; Groves, Fergus; I. H. Cameron, Toronto.

*Obstetrics and Gynecology.*—“The Treatment of Fibroid Tumors of the Uterus,” by Dr. Eccles, London, assisted by Drs. A. A. Macdonald, Toronto; Fenwick, Kingston; Mathieson, St. Marys.

*Ophthalmology and Otolaryngology.*—“Points of General Interest in Otolaryngology,” by Dr. R. A. Reeve, Toronto, assisted by Drs. A. B. Osborne, Hamilton; Hodge, London.

*Therapeutics.*—“Modern Antiseptic Measures,” by Dr. Saunders, Kingston, assisted by Dr. McKay, Ingersoll, and others.

*Papers by Guests of the Association.*—“The Surgical Treatment of Intussusception,” by Dr. N. Senn, Milwaukee. “Gynecology for the General Practitioner,” by Dr. Howard Kelly, Baltimore.

*Papers.*—“Pathological Weeping,” by Dr. A. B. Osborne, Hamilton. “The Surgery of Tuberculosis,” by Dr. G. A. Bingham, Toronto. “Pelvic Cellulitis,” by Dr. Gardiner, London. “Deviations of the Nasal Septum,” by Dr. Price Brown, Toronto. “The Diagnosis of Typhoid Fever,” by Dr. J. E. Graham, Toronto. “Hæmaturia,” by Dr. Wm. Britton, Toronto. “Is Alcohol a Stimulant?” by Dr. Arnot, London. “Epilepsy—The Results of Asylum Treatment,” by Dr. T. Millman, Toronto. “Short Notes on Injuries of the Skull and Epithelioma of the Larynx,” by Dr. Burt, Paris. “The Use of Fluorescin and Pyoktanin in Ophthalmic Medicine,” by Dr. G. S. Ryerson, Toronto. Reports of Cases (Medical) by Dr. Campbell, Seaforth: “Acute Osteo-myelitis.” Report of Cases, and exhibition of Cultures, by Dr. G. A. Peters, Toronto. “The Symptoms and Cause of Eye-Strain, and its Diagnosis by

the General Practitioner,” by Dr. Caldwell, Peterborough. “Injuries from the too long use of Pessaries,” by Dr. Hamilton, Atwood. “Hydrocele,” by Dr. E. E. King, Toronto. “Senn’s Decalcified Bone-filling,” illustrated by presentation of patient and specimens, by Dr. Wm. Oldright, Toronto. “Exploration of the Female Bladder,” by Dr. James F. W. Ross, Toronto. “Phlegmasia Dolens,” by Dr. A. H. Wright, Toronto. Papers will also be contributed by Drs. Wilson, Richmond Hill; Irving, Kirkton; Grasett, Toronto; Primrose, Toronto; Buchan, Toronto.

W. R. WARNER & Co. are evidently determined to keep in the van of therapeutic remedies. Antalgic Saline appeals to us to-day for recognition as a remedy for the relief of headache, also for influenza and neuralgia; and as an antidote of la grippe they issue the Pil. Chalybeate Compound:

Composition carb. protoxide of iron, grs., 2½.

Ext. nuc. vom., - - - - - gr., ⅛.

Sig.: One pill every four hours and increase to two pills three times a day.

Antalgic Saline, one dessertspoonful every four or five hours till relieved for headache. The same mode of administration precedes that of the chalybeate pills for la grippe.—*Weekly Medical Review.*

P. BLAKISTON, SON & Co., the medical publishers of Philadelphia, announce for early publication, “A Handbook of Local Therapeutics,” being a practical description of all those agents used in the local treatment of disease, such as ointments, plasters, powders, lotions, inhalations, suppositories, bougies, tampons, etc., and the proper methods of preparing and applying them.

MEDICAL BOOKS.—In 1889 about 133 new medical and surgical works emanated from the press, and 49 new editions of old or standard works. In 1890 the number ran up to 143 new works, and there were 50 new editions. On the other hand, theological, fictional, and historical literature show a marked decrease in the number of new volumes published.—*Med. Age.*