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Saskatchewan Medical Journal

VOL. I. JANUARY, 1909 No. 1

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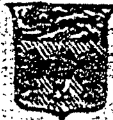

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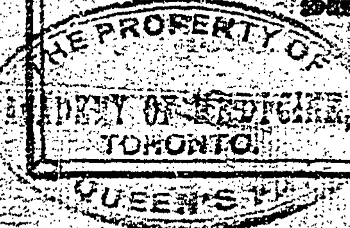

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All communications, books for review, and matters relating to this publication should be addressed to Dr. Harry Morell, Box 209, Regina, Saskatchewan, Canada.

All matters relating to questions regarding the Saskatchewan Medical Association should be addressed to Dr. G. A. Charlton, Regina, Saskatchewan, Canada.

THE SASKATCHEWAN MEDICAL JOURNAL

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Orginal Memoirs

ACUTE SEPTIC PERITONITIS

BY GEO. A. BINGHAM, M.D., Tor.; M.D., C.M. (Trin.)
Assoc. Professor Clin. Surgery, University of Toronto.

Mr. President and Gentlemen:—

Permit me, first of all, to thank you for the undoubted compliment you have paid me in asking me to be present with you to-day at the meeting of the Saskatchewan Medical Association. I want to assure you that the honor is thoroughly appreciated and although I felt obliged to decline the first invitation, when I found that you had postponed your meeting for a month, I knew that such an honor seldom knocked at one's door twice in a lifetime and I felt constrained to change my entire plans for the summer in order to be with you to-day and I wish to emphasize the fact that I am glad that I did so.

The exhiliration of our great Western Continent, of which I have seen nothing heretofore, but of which I hope to see much before returning to my eastern home, has somehow impressed me with the fact that this is the greatest and most valuable holiday I have ever known and I know that I shall carry home with me many a straight object- lesson of which I have never dreamed before.

I think your committee did wisely when they selected Acute Septic Peritonitis as the subject for discussion to-day. There is probably no subject of greater interest to the general practitioner no one that comes more closely home to him in his dealings with his patients.

There has been, in the past, too much difference of opinion as to the proper treatment of these cases and indeed too much haziness in the mind of the surgeon as to the proper interpretation of the pathological conditions found in a given case. But now, thanks largely to the laboratory work of the bacteriologist, certain data have been evolved which afford us fairly constant working rules in the treatment of these cases.

Before taking up the all-important question of the treatment of this dreaded condition, it will be profitable for us to discuss briefly the physiology of the peritoneum., as well as the varieties, etiology and pathology of acute septic peritonitis.

The layer of endothelial cells lining the peritoneum is, of course, the protection against the entrance of colon bacilli or other septic organisms. So long as this layer is intact and the peritoneum well supplied with blood, the patient is safe. But should these cells be injured or destroyed or removed from any cause—as for example by the meddlesome surgeon—there is no longer a barrier against the entrance septic material. The first line of defence, in other words, is destroyed and the issue must now be decided between the phagocytic army defending the citadel and the invading hordes of bacilli. Surely if we carefully consider these facts we must find a highly important lesson to apply to the treatment of the disease.

Mascatello and others have abundantly proven that the absorbing powers of the peritoneum increase as we ascend from the floor of the pelvis to the diaphragm and this would appear to be a fortunate thing because my own experience, at least, has taught me that the virulence of infection increases as we descend from a perforated gastric or duodenal ulcer to a gangrenous appendix or diseased fallopian tube.

Now if we realize as thoroughly as we should that in acute septic peritonitis the dangerous area, as far as absorption is concerned, is the diphragmatic zone, and next to that the peritoneum covering the small intestines, certainly this fact will be of infinite importance to us in our treatment of these cases.

As to the *causation of* acute septic peritonitis I would place first, gangrene of some hollow viscus, with or without perforation, notably the appendix. Septic infection may occur quite readily without perforation. All that is necessary is that such a change shall take place in the wall of the intestine as shall permit of the passage through it of septic organisms. Such a condition is present in gangrene and also in cases of distension of the bowel with haemostasis. Hence, as a second cause, one may designate injury to a viscus with distension and haemostasis, as in intussusception, volvulus, internal hernia or post-operative ileus due to paresis. A third caue is ulceration and perforation of some hollow viscus with exudnoiation of its contents; a fourth cause is traumatic rupture of some hollow organ, and lastly, rupture of a local abscess as, for example, in a case of neglected appendicitis.

Now a word in regard to the pathological processes which take when the peritoneum is invaded by septic organisms. Sargent has pointed out that the entrance of streptococci or colon bacilli is usually preceded by the comparatively harmless staphylococci. This is an important factor in the case because the staphylococcus is just enough of an irritant to lead to reaction on the part of the peritoneum and hence to the pouring out of an army of phagocytes which will be already in the field when the real enemy appears. So that the question of priority on the field of battle is a most important one.

If, by any means, we can delay the invading army even for a few hours until nature has an opportunity to furnish the leucocytes so necessary for the defence we shall probably win, because, after all, the surgeon in the case is only a very humble assistant to the natural resources of the patient's organism.

Later on, in discussing the question of treatment, I shall hope to show that there is a way by which the septic invasion may be delayed and many a life saved that otherwise must be lost. Then that wonderful organ, the omentum, reaches out to the point of threatened invasion and by inflammatory adhesions rapidly surrounds it and the worst that may occur may be a localized abscess, to be opened almost at our leisure.

Should the disease, however, get beyond the point of invasion either owing to defective or delayed phagocytosis, or to excessive virulence of the invading bacilli, nature quickly covers the endothelium with a layer of lymph which appears to fulfil three functions. It acts as a protection to the endothulim, thus preventing the entrance of further germs from the underlying viscus; it causes agglutination between adjacent coils of intestines, thus limiting peristalsis and to that extent retarding the progress of the infection; and lastly, it acts as a carrier of innumerable laucocytes upon which we must now depend for the protection of the patient's life. And yet, gentlemen, it is not so long ago that were taught and eminent surgeons carried into practice the lesson that the proper thing to do in such cases was to eviscerate the patient and then go over the coils of intestines inch by inch and carefully remove this deposit and incidentally the adherent endothelium beneath it. In such a procedure of course the lymph spaces and blood channels were at once opened for entrance of toxins and fatal toxaemia was the result.

If the phagocytes win in the struggle the dead bodies of the invaders and defenders accumulate upon the battle-fields which are rapidly surrounded by walls of inflammatory adhesions; in other words, circumscribed pools of pus are found which may be opened and drained by the surgeon. On the other hand, if the invading bacilli win the fight, toxins gradusually enter the lymphatics and blood vessels, the central nervous system is poisoned, intestinal dilatation with haemostasis and finally paresis occurs and as a result there is a great increase

in the septic invasion from the intestinal tract and the patient ultimately succumbs.

Every operating surgeon however must have met with a class of cases in which the pathological process differed materially from that just described. In certain cases, for example, of sudden gangrene or perforation of the appendix, the invasion is so sudden and the virulence of the colon bacillus and streptococcus is so great that there appears to be no time for reaction on the part of the peritoneum and therefore no phagocytosis. In such a case the patient dies from septic absorption within 36 or 48 hours of the onset of the attack. Of this class of cases I hope to have something more to say under the head of treatment.

In discussing the treatment of acute septic peritonitis I have thought it useful to recognize clinically three varieties of the disease, viz: (1) circumscribed, (2) general, (3) diffuse. An example of the circumscribed variety is seen in an ordinary attack of appendictis where there has been good reaction by the peritoneum and where the appendicular region has been well walled off by inflammatory adhesions. In other words, the invader has not yet got beyond the first line of defence. Here there is not much difference of opinion as to treatment. The abdomen is opened over the seat of trouble (which in the vast majority of cases is the appendix) and if the parietal peritoneum be adherent to the underlying structures the localized abscess is at once evacuated by carefully separating adhesions with the fingers until the pus is reached. If the parietes be not adherent to the seat of inflammation, before proceeding to evacuate the pus, an artificial coffer-dam of gauze is built around the seat of the abscess so that not a drop of pus will escape into the general peritoneal cavity. After the pus has been reached and the cavity carefully wiped out, the appendix may or may not be removed. If it form a part of the inflammatory wall confining the pus. I prefer not to disturb it, fearing general infection. The cavity is drained with gauze and treated as an

abscess cavity elsewhere. After healing has taken place, the appendix may be removed with practically no danger to the patient.

In general septic peritonitis we have a very different proposition to deal with. Here the enemy has succeeded in passing the first line of defence, either by breaking down the inflamatory barricade or by the suddenness and virulence of its onset it has taken the phagocytes by surprise so to speak before the defenders could be organized and now the fight must be waged over the whole peritoneal field. Now, before deciding on our line of action, let us frankly recognize the fact that the person's own organism must be largely responsible for success or failure. Then in the light of our knowledge of physiology and pathology let us carefully consider in what way we can best assist nature, remembering always that there is quite as much danger in doing too much as in not doing enough.

Realizing the fact that the invading army is entering at one given point, the wise surgeon sees that it is his first duty to check that invasion by quickly removing the diseased appendix or gangrenous gall-bladder or by closing the perforation in the stomach or intestine. After the opening is closed or the offending organ removed, a cigarette or gauze drain down to the point of invasion will, by removing the diseased exudate, stimulate a flooding of the part by healthy serum loaded with leucocytes.

Then one must recognize the tremendous importance of maintaining the integrity of the endothelium. Hence there must be no unncessary handling of the intestines. As Murphy has tersely put it "get it quick and get out quicker."

In this connection, the question of *irrigation* must be decided. Personally I prefer not to irrigate unless foreign matter, such as the contents of the stomach or bowel, is present in the peritoneal cavity. Some objections to irrigation are that it injures the delicate endothelium, thus allowing the direct absorption of toxins; it is impossible to wash away all the pus

and merely disseminates it still further; and besides it forces out friend as well as foe, washing away the healthy leucocytes upon which we depend, and especially those life-saving fibrinous deposits which protect the visceral peritoneum. When, however, as in perofrated gastric ulcer, foreign matter is found in the peritoneal cavity, one may irrigate with normal saline at a temperature of about 110 degrees as follows:—After the opening in the stomach has been inverted and closed with mattress sutures, a second incision is made above the pubes or in Douglas' pouch and a large drainage-tube is inserted to the floor of the pelvis. Then the stream of saline is directed downwards through the upper wound and washes out the foreign matter by way of the pelvis.

Again, the wise surgeon never forgets that the diaphragmatic zone is the dangerous area of the peritoneum and should not be interfered with in general septic peritonitis unless it is itself the seat of primary infection, as in the case of a perforated gastrc ulcer on the lesser curvature of the stomach. It would seem that here is another argument against lavage, for taking a case of general septic peritonitis produced by that most common of all causes viz., appendicitis—the irrigating stream would be almost certain to carry the colon bacilli up to the daphragmatic peritoneum where they would be most productive of danger.

The question of *drainage* should now be considered. Drainage, in these cases, to be of value, should be low down, from the flanks or the floor of the pelvis or both and should be used in connection with Fowler's position. My practice, of late years. has been to pass a gauze drain down to the seat of primary infection and then to introduce a large rubber tube down to the floor of the pelvis through an incision either above the pubes or in Douglas' pouch. The small intestines (the second most dangerous area) are prevented from descending into the pelvis by bringing down the omentum and tucking it around them and by filling up the pelvis by dragging into it any adjacent

coils of large intestines. Then by placing the patient in the semi-sitting position, the exudates are induced to gravitate from the highly dangerous upper zone to the comparatively harmless pelvic region. It has been argued as against drainage in these cases (1) that it is impossible to drain all the natural pouches of the peritoneal cavity; (2) that the drain is isolated by inflammatory adhesions in a comparatively few hours and then ceases to act, and (3) that the pressure of a drainage tube on the small intestines tends to produce obstruction.

In answer to these objections it may be stated that the whole peritoneal cavity may be more or less effectually drained by placing the patient in the semi-sitting position when all exudates necessarily gravitate to the lowest point, whence they are removed by the tube. As for the second objecton, it is true that the drain is shut off from surrounding localities after a comparatively short time but it is just that short time which appears to be all-important. As the exudate is being carried away it is as rapidly replaced by healthy serum bringing to the scene a great body of phagocytes urgently needed to surround and destroy the enemy. In this way a localized encapsuled abscess is formed which does not endanger the life of the patient. In answer to the third objection, if the precautions, already mentioned, have been taken, the drainage tube will never come in contact with the small intestines at all.

The patient having returned to bed, is placed in the Fowler position and a *continuous stream of normal saline* is administered, per rectum. By this means the functional activity of the kidneys is stimulated and the elimination of toxic material greatly increased; and what is perhaps more important, the lymphatic current in the intestinal wall is reversed. That is, instead of the lymphatics carrying more and more bacilli from the infected contents of the bowel to reinforce the invading host in the peritoneal cavity, in obedience to a simple law of physics, there is a reversal of the current in the intestinal lymphatics which are thus made to act as

innumuerable drainage tubes carrying away the diseased products from the peritoneum to the intestinal canal.

The method of using the continuous saline is vitally important. At first, one is prone to use a stream which is too large for the absorbing powers of the patient with the result of intestinal irritation and expulsion. The reservoir should not be more than 18 inches above the level of the anus. Attached to the distal end of the rubber tube should be a small nozzle with *several* perforations. This nozzle is placed just within the spincter and may be kept in position by adhesive strapping over the buttocks. Then the rubber tube should be clipped by a pair of forceps until the stream is so small (perhaps even drop by drop) that it is absorbed as quickly as it enters. By this method irritation and expulsion are avoided.

One of the greatest dangers now threatening the patient is intestinal dilatation and paresis, because in that condition the colon bacillus can pass freely from the bowel to the peritoneal cavity. Recognizing this danger an early duty is to see to the evacuation of the intestines. I like to wash out the bowels by a high enema shortly after the operation and 24 hours later to administer a saline pugative by the mouth. Strychnine is given to induce contraction and for the same reason morphia is studiously avoided. Morphia is objectionable because it masks symptoms, it encourages paresis and above all, it has been shown that it limits leucocytosis and would thus appear to be a dangerous drug to use in these cases, either before or after operation.

If I have not already exhausted your patience, I should like to say a few words regarding the third class of acute septic peritonitis, which is neither circumscribed nor general and which I have called *diffuse*. Every operating surgeon has met with these cases more particularly in connection with a gangrenous or perforated appendix. The onset has been so rapid that there has been no time for reaction and no effort has as yet been made to wall off the pus or to localize the dis-

eased process. The whole abdomen is more or less rigid, but the area of tenderness is as yet limited. The temperature is usually high but may be subnormal. The respirations are rapid and shallow, the pulse small and fast, nausea or vomiting is present as well as meteorism and pain. If the abdomen is opened at once the appendix and adjacent coils of bowels are found bathed in pus and though the general peritoneal cavity is not as yet involved it very soon would be and, principally owing to the constant peristaltic movements of the small intestines, the only freely moveable structure in the neighborhood of the disease.

One may illustrate this progress of a septic process by the well-known example of the dissecting-room finger. After infection, the student continues to work throughout the day and in the evening finds more or less pain in the finger. After a night's rest the pain has disappeared and he works during the second day only to find that the pain is still more severe in the evening. After a second night's rest there is little or no pain and again he resumes his work only to find evidences of lymphangitis on the evening of the third day. Now he is obilged to give up work and pay some attention to his hand and arm and he soon learns the lesson that absolute rest to the part relieves the pain and checks the progress of the infection. After a time, one or more localized abscesses will form and may be opened at one's leisure. In the old days such a case would have been treated heroically. At the seat of infection an early free incision would have been made, a tendon sheath probably opened resulting in teno-synovitis and a permanently maimed finger. Now-a-days the infected limb is put in a position of absolute rest with proper antiseptic precautions. Indeed, if one were restricted to one single measure in the treatment of spreading sepsis it would appear that *rest* would be the paramount remedy

To return to our case of diffuse septic peritonitis. Such a case I formerly operated upon at once only to find that, too often the disease advanced in spite of the operation and the

patient succumbed. As Richardson said such a case was "too late for the early and too early for the late operation."

After reading a paper by Ochsner, in 1901, I was lead to believe that perhaps many of these cases might be saved by waiting and assisting nature to combat and perhaps localize the disease. As pointed out in that paper, if the small intestines are kept in a condition of absolute rest, the spread of the infection is retarded, if not arrested, giving time for peritoneal reaction and allowing the omentum to exercise its well known function of crowding around the diseased area, thus forming a barrier to the progress of the infection, in other words, localizing it. Now the cause of peristalsis and meteorism in the small intestine being the presence of food or the administration of cathartics or large high enemata, obviously one's first duty was to eliminate these factors. Since that time I have treated many of these cases by first washing out the stomach, then by absolutely abstaining from the giving of food or cathartics by the mouth. Not even sips of water are allowed to enter the stomach and the results have been most satisfactory. The pain, tenderness and rigidity disappear, the temperature becomes normal in about 48 hours, the pulse becomes slow and the respirations normal and at the end of 3 or 4 days the patient is apparently well. What has happened has been that nature's forces have had a chance to work and have localized what was rapidly becoming a general septic condition. In the meantime, the patient's strength has been maintained by judicious rectal feeding as follows:—The lower bowel is washed out by a small soap enema every 24 hours and a nutrient enema is thrown into the rectum. In quantity this enema consists of four ounces every four hours or six ounces every six hours according to conditions. The enema contains three to five ounces of normal saline with one or more ounces of panopepton or predigested beef-juice or peptonized milk or any other of the many excellent prepared foods now manufactured. It is only fair, however, to acknowledge that the extremes of life do not take kindly to rectal feeding.

PRAIRIE CONJUNCTIVITIS

BY JAMES McLEOD, M.D., C.M. (McGill)
REGINA, SASK.

Mr. President and Gentlemen:—

The wise man in the Good Book tells us that there is no new thing under the sun, and if I were to blurt out the statement that I purpose describing a new disease of the eye the effect might be somewhat startling. Now, I do not wish to be sensational. What I purpose doing is, to describe a disease or condition of the eye, several cases of which I have seen in this province, but never anywhere else.

During a prolonged experience at Moorfield's Eye Hospital, London, England, where I had an opportunity of seeing the rare cases of an out-door department of six hundred eye patients a day, I never saw a case such as I am about to describe. There is nothing in the text books like it. Even in such an exhaustive work on ophthalmology as that of Fuchs of Vienna there is no disease mentioned that even approximately resembles the one under consideration.

For convenience of reference in this paper I have named the condition "Prairie Conjunctivitis." It is a form of conjunctivitis and of a very chronic character. It is characterised by the presence of small white spots or dots situated on the palpabral conjunctiva and most commonly on the lower lid. The places of predilection are the reddish patches on the tarsal conjunctiva near the inner and outer canthi. The most typical dots are pin-point in size and of paper whiteness. They appear to project from the surface and look like specks of chalk stuck on a red cushion. There are other spots that are a little larger, not so intensely white, and more deeply situated in the tissues. The conjunctiva around them is invariably inflamed.

The worst cases I have seen were in young ladies from 17 to 21. They had all lived in this country for several years. One of them was born here. Another case was a body of fifty who had lived in this province for 20 years. I have seen a number of cases in males ranging in age from 20 to 55.

During the last last four months I have examined about ten cases in which these specks were present. They varied in number from one to a dozen and usually the severity of the symptoms was in direct proportion to the number of specks present.

I have not yet seen this condition in a recent arrival in this country. Though I have never seen a case outside of this province I am not prepared to say positively that Saskatchewan has a monopoly.

The diseases and conditions of the lids in which we find white, yellowish, or greyish spots or patches are the following:

1. Trachoma.
2. Follicular conjunctivitis.
3. Henle's glands.
4. Infarcts and calcareous deposits in the meibomian glands.

1. Trachoma. There is no more resemblance between the white dots of Prairie Conjunctivitis and the yellowish spots characteristic of beginning Trachoma than there is between a snowflake and an omelet. The diagnosis is made by the color, size, depth and location. The dots of Prairie Conjunctives are quite white, very small, superficial and generally seen on the red patches towards the inner and outer canthi. The spots of Trachoma are yellowish in color, larger in size, more deeply seated and situated along the attached border of the tarsus.

No experienced eye could mistake Follicular conjuctivitis for the prairie variety. They have little in common. The follicles of Follicular conjunctivitis are of a greyish or pearly translucency, and are arranged in rows like beads on a string. They

are larger and deeper in the tissues and are most commonly seen in the retro-tarsal fold of the lower lid.

A collection of inspissated secretion in Henle's glands somewhat resembles beginning Trachoma. They are most frequently found in the upper lid near the attached border. They are more deeply seated and of a yellowish color.

Infarcts in the meibomian glands are easily recognized. The several glands frequently show distinctly through the conjunctiva as parallel whitish lines beneath the surface. An enlargement of the lumen of one of these glands could scarcely be mistaken for anything else. The deposit of lime salts in the glandular secretion makes them easier of recognition.

Symptoms--Patients complain of the eye feeling weak, of irritation in it and of watering. It looks red and tearful. There is some photophobia. Blepharitis is frequently associated with it, and is sometimes localized to the part of the margin of the lid opposite where the dots are found. The symptoms resemble those produced by a foreign body, but are generally of less severity. We can readily conceive of one or two small smooth foreign bodies causing precisely similar symptoms.

On looking at a typical case one cannot help getting the impression that these little white "flakes" are "stuck on." There are other spots that are not so purely white, are a little larger and more deeply seated. They give the impression of having become imbedded and covered over with epithelium. This led me to inquire as to a probable cause. Could it be possible that a small foreign body such as the pollen of some plant, getting into the eye and becoming adherent to the conjunctiva could produce this condition? The minuteness of the "flakes," their superficial nature and the appearance of being "stuck on" all lend weight to this theory. The subsequent history is also favorable. They become covered over with epithelium, lie deeper in the tissues and are not so distinctly white.

Or are they of bacterial origin?

I sent some cultures from the conjunctivae of eyes affected for bacteriological examination but only the staphylococcus albus was found. I also sent a section from the conjunctiva containing three dots for microscopic examination but satisfactory mountings were not obtained. I hope at a later date to be able to give a complete pathological report.

The first case that came under my observation was that of a young lady of 20. She was born and brought up in Manitoba and has lived in this province for three years. I treated her for conjunctivitis and a chronic form of blepharitis. I used astringents, painted the lids with a two per cent. silver nitrate solution and applied a simple ointment to the margins. I also used zinc sulphate, one or two grains to the ounce. The condition improved but her eyes were not cured. After about five weeks' treatment she left. I had not seen her again for two years. Meeting her one day and wondering what had become of the "flakes" I requested her to come to my office. On examining her eyes I found the condition somewhat better than when she had discontinued treatment. Three spots still persisted and one of them had become larger. There was, however, no ulceration or discharge. The blepharitis was also better. If this had been a case of Trachoma and she had gone two years without treatment the vision would probably have been lost.

Treatment—The ordinary treatment for conjunctivitis has little effect. Neither silver nitrate, zinc sulphate nor copper sulphate produces any material improvement. Still the treatment is very simple. It is mainly that for a foreign body. Remove the "flakes." If they are superficial they can be picked off with a spud, if deep, we have to dig them out with a spud or other suitable instrument. This can easily be done under cocaine. Then use a simple boracic lotion and results are brilliant.

I fully realize, gentlemen, the imperfections and incompleteness of this paper, but it is a beginning; and if my pretty

little theories are upset by subsequent investigations and completer knowledge I shall have no regrets. I shall continue my observations and I trust to have more exact information to present when we meet again.

PELVIC ABSCESS

BY H. E. MUNRO
SASKATOON, SASK.

I was called in consultation to see Mrs. B., a married lady of 35 and the mother of five children. At the time I saw her she weighed 98 pounds, having lost 18 pounds during the two preceding months.

Family history: good. Previous history: two years prior to this time she had an attack of pneumonia, otherwise her history contains nothing of importance.

Menstrual history: five normal births, and one miscarriage. Six weeks prior to this time at about the third month of pregnancy, the vaginal discharge existed at intervals of about two weeks.

Present illness: dates from the miscarriage, being attended at that time by an untrained nurse. A small amount of hemorrhage from the uterus continued for a few days, which, however, soon became more copious and lasted for four weeks. During this time she felt comparatively well until about the end of the fourth week when she complained of pelvic pain, which continued for two days, extending down the left leg. She had a severe chill, and when her physician was called in he found her with a temperature of 102 degrees F., pulse 120, respiration 24.

Physical Examination: Patient somewhat emaciated; cheeks presented a well marked hectic flush; heart and lungs normal; abdomen rigid in the left lower quadrant; an indurated mass was palpable extending down along the crest of the ileum, from the anterior superior spine forward along Pouparts ligament and backward to the lumbar muscles. This area was dull on percussion. Upon trying to define the illiac fossae by pressing

the fingers well in, it was found to be obliterated, which, however, owing to the thin condition of the patient, was easily done on the right side. A hemorrhagic discharge was present from the vagina. The urethra and perienum were normal. The cervix was easily palpable two inches from the vulva. The enlarged fixed uterus was drawn to the left. A solid exudate was felt to the left and continuous with the cervix about one inch in diameter.

Extremities: Right, normal; left, flexed at an angle of about 90 degrees, could not be extended wthout pain. Urine normal. No blood examination was made.

Diagnosis: Pelvic abscess resulting from puerperal infection. Differentiated from hip joints by mobility of leg without pain while in the flexed position.

Operation: The patient being prepared and anesthetized, incision about two inches long was made over the dull area about one inch internal to the left anterior superior illiac spine. When the abdominal wall was opened, instead of opening into the abscess I found my fingers in the free abdominal cavity. On exploring the lower part of the abdomen accessable I found an indurated mass involving the psoas muscle, extending into the iliac fossa to the left, following below the course of the femoral vessels, and also going down into the true pelvis, to which part the left tube and ovary was firmly adherent. I then stripped the peritoneum of the anterior and lateral abdominal walls to the left and adjacent to the incision, continuing the reflection along the posterior surface of the abdomen exposing the illio-psoas muscle. I then sutured the opening in the peritoneum and opened the abscess cavity which allowed the escape of about six ounces of pus. Inserting my finger I explored the cavity, breaking down all laculi. The cavity was then flushed out with a lysol solution and two tubes placed in the abscess cavity, one down into the true pelvis, the other leading upwards along the anterior surface of the psoas muscle.

Pathology: In addition to what has already been described I might mention a smear from the pus showed staphylococci and streptococci in abundance.

The followng day her temperature went down from 102° to 100°. Her leg, with assistance, became gradually straight. She was given a few ten C.C. strptolytic serum. The wound was dressed daily and she made a complete recovery in four weeks.

Note.—The point of importance in connection with this operation is that a retro peritoneal abscess was removed through an anterior abdominal incision.

SARCOMA OF LUNG

BY C. M. HENRY, M.D.

YORKTON, SASK.

Mr. N., age thirty-three, male, born in Canada, of Irish parentage, occupation farmer, living at Yorkton, Sask., married, with two living children.

Complaints: Patient first complained of a sharp pain on left side, shortness of breath and weakness.

Present Illness: One year ago, the patient was plowing in a field when he was struck by the plow handle on the left side, knocking him unconscious. A few months later he was seized with a sharp pain on that side, causing him to faint. In April last, two months previous to present condition, he was again seized with sharp pains on the left side with symptoms of dry pleurisy. This condition progressed favorably and disappeared in three weeks.

Family History: Father died of some malignant disease; from description of his death likely carsinoma of stomach, at the age of sixty-five.

Present Condition: The condition of patient one month after pleuritic attack (May, 1908) was that of a man of about thirty years of age, tall and emaciated, face thin and skin flushed; malar bones prominent, intelligence average and mental condition good. Patient was lying in bed in the half-sitting position. Respirations 30, T. 100, P. 120, W. 135.

Locomoter System: Negative.

Lymphatic System: Negative.

Circulatory System: Pulse 120 of low tension, small volume, irregular. Heart—a bulging of the precordial area which outlined the precordial sac. was distinctly visible. The

outline of same extending from the second interspace above to the seventh below anteriorly and from the left margin of the sterum to the left anterior auxillary line. Pulsation of chest wall was visible over entire area, but more especially in second costal interspace. On percussion area was dull and on auscultation cordiac sounds were faint and weak, but no murmurs were discovered.

Respiratory System: Patient is short of breath and has to change his position in bed to help relieve the dispnoea. Pain over heart and left lung. Respirations are fast, short and shallow, followed by an occasional sigh, voice normal, cough rather dry and irritating, patient expectorating nasty brown sputu. T.B.C. test negative. On examination of lungs, expansion was less on left side, vocal fremitis diminished and expansion lessened, the entire area was dull on percussion, but more especially anteriorly and in the anterior axillary line. Coarse moist rales were present throughout lung.

Alimentary System: Negative.

Genito-Urinary System: Negative.

Nervous System: Patient could not sleep without an opiate on account of pain and dispnoea.

Diagnosis: Pericordial effusion, a localized pleuritic abscess, and possibly malignancy.

Treatment: In support of the diagnosis of effusion into the pericardial sac. an aspiration was made in the fifth costal interspace and about an ounce of straw colored serous fluid was collected. This relieved the dispnoea and pain for a couple of days, then the symptoms returned with greater severity. The chest wall bulged more and a prominent tumor presented in the second interspace. An aspiration with a large aspirating needle was performed in this space to ascertain the contents but could only get a few drops of a thick, brownish jelly-like material which was sent to the Saskatchewan Pathological Laboratory for examination. But as the symptoms became more severe, more

pain and dispnoea an exploratory incision was made in the second interspace two days following the aspiration. From this incision, as soon as the parietal pleura, which was very thick, was punctured a quantity of thick, reddish brown jelly-like material poured out. On examination of the pleura which was not adherent it felt smooth but thickened. The lung tissue was smooth but of a stony hardness. A second incision into the pleural cavity was made in the seventh costal interspace post axillary from which several ounces of straw colored serous fluid escaped. Here the pleura and lung felt like that in first incision.

Patient's breathing was easier for a day or so following the openings but death followed in ten days from first aspiration.

The pathological findings were sarcoma of the lungs. As no P.M. was allowed further pathological information was wanting. The point of interest in this case to us was the history of injury dating a year previous, the probability of the condition being primory sarcoma of the lung, a rare condition. The difficulty of diagnosis from pleurisy and the great prominence of the pericardium simulating a pericardial effusion.

TETANUS

BY G. R. PETERSON, M.D.
SASKATOON, SASK

Mr. President and Gentlemen:—

To the following case report I wish to direct your attention for a few moments, not so much because of the intricate surgery connected therewith, nor yet the diagnosis of the case; both of which were simple in the extreme; but on account of the favorable termination of what is, as a rule, a most trying affliction, ending in a fearful death, the percentage being variously given as 50 per cent. to 70 per cent. in such cases.

This was a young man, W. A., of about 28 years of age, who, at the time of the onset of his illness, was bartender in one of the hotels in Saskatoon. On the evening of December 20th I was called in consultation with with Dr. Weaver, through whose kindness I am allowed to report this case, and found the patient suffering from violent spasms coming on irregularly every 30 seconds or oftener. These spasms, which were general convulsions, he called "fits," as he could not understand them, they coming on without, to him, any apparent cause, and the only suffering he was having was the excessively powerful contractions of the muscles, he being quite conscious and feeling no sickness. In fact the whole thing looked to him like a joke. He also, when asked about it, mentioned a sore spot on the thenar eminence of the left hand, and one upon the elbow of the left arm.

Up to six days previously he had been in perfect health. On December 14th, 1906, being a day upon which the bars were closed, he went to one of the slaughter houses in the city to work. These institutions, at that time, by the way, in this city were more of the nature of disease breeding pest spots than slaughter

houses. While slaughtering one of the animals there he accidentally struck his elbow on one of its horns and bruised the tissue between the external condyle and olecranon process, and during the same day he was unfortunate enough to cut the skin on the thenar eminence of the left hand. The cut on the hand I believe was dressed in the ordinary way and cauterized. The elbow was not touched as the skin was not broken. However, they gave considerable trouble in healing, and did not seem to do well at all; at all times remaining quite tender, even after being completely covered wth healthy skin. They therefore constantly annoyed him. During the last few days of the interim before the onset of the spasms, or "fits," he developed considerable pain along the course of the muscular spiral nerve, towards the axilla. It will be remembered that the cutaneous branches of the latter nerve supply the skin in the region of the elbow at the seat of the infection. He did not complain at all of the radial, and unfortunately, we did not take the time to question him closely regarding it. He felt perfectly well and continued to work right up to the moment of the onset of the "fits" which began about 7 o'clock in the evening.

Such was his condition then when we saw him in the evening of December 20th about 8 o'clock, except that on the left hand, as mentioned above, there was an area of swelling about one inch long and half and inch broad, very tender in the centre and very red. There was no evidence of pus formation. The same condition was to be seen at the old site of the abrasion on the elbow also, but somewhat larger.

There was very marked tenderness to pressure over both the spots. The temperature was normal and pulse accelerated somewhat on account of, probably the exertion induced by the spasms, and the respiration was changed from the same cause. The patient had always been a sturdy, robust man with no history of illness except what is unfortunately allowed to fall to the lot of children, and had seen active service against the Boers in the late South African war.

His habits, however, were not of the best, and tobacco in any form, especially cigarettes, was used to excess, in fact, the worse the spasms the more he smoked cigarettes, thinking it was some form of nervousness and the cigarettes would relieve him.

He also used alcohol constantly but no drugs. His sexual habits were those common, more or less, to military men. His family history was negative. He was a man about five feet eight inches tall, weighing 175 pounds, in perfect health, judging from the state of his nutrition. The color of his skin was normal except during these very powerful spasms when his face would become flushed and his conjunctivae injected. At such times he tended to assume the opisthotonus position and rolled to one side with his arms flexed. At such times he made a very striking impression on one's mind, he being an exceedingly well developed man and very powerful. During all this time he remained perfectly bright and perfectly conscious.

There was no glandular enlargement noticed. The respiratory system was normal except somewhat hurried after the spasms and during the spasms there was a cessation of respiration due to all the muscles of the body being in a condition of tetanic spasm. The circulatory system was likewise normal except that the heart-beat was somewhat increased. There was no nausea or vomiting, the digestive system being normal as was also his genito-urinary system.

Taking into consideration the history and source of the injuries dating back about six days, the refractory healing, the spasms, the general condition of the patient, and the two inflamed spots, it pointed pretty clearly to Tetanus, and recognizing the seriousness of his condition, I advised immediate operation. He was given a small dose of chloroform, the elbow and hand scrubbed, and two eliptical incisions were made around the seat of the trouble, keeping wide of the central area as well as deep enough to evade any likely infected tissue. The surfaces exposed were very thoroughly cauterized with pure carbolic acid, the wounds dressed with moist antiseptic dressing and he

was allowed to recover consciousness, and to my utter amazement he had but one slight convulsion thereafter. There being no serum in stock at the local drug stores, some was wired for. It arrived two days later and was administered subcutaneously, more to use it up than for any other reason at that stage.

He made a perfect recovery, the wounds granulated up and were covered with a healthy skin in a short time. Having escaped from the miseries of Tetanus, the following winter he succumbed to the "Captain of the Men of Death."

The tissue that was removed I examined and found the Drumstick Bacilli of Tetanus. I likewise forwarded some tissue to Dr .Charlton of Regina who confirmed my findings.

CHRONIC GLANDERS IN MAN

BY J. C. BLACK, M.D.
REGINA, SASK.

The patient is a young man aged twenty-five years; of English parentage. He is a farm laborer by occupation. His family history is negative except that one aunt died of bronchitis which lasted two years, so was probably of tuberculous origin.

His previous history is of no special interest, except as relates to his present illness. His only illness previous to this was measles when a child. In the summer of 1907 there were horses killed on the farm on which he worked because of glanders. These horses were thrown out and the pigs were allowed to eat them. In due course of time the pigs were also killed and in turn were eaten by the farm hands. As far as we know the patient is the only one who suffered from this and this can probably be explained by the unhealthy condition of his mouth. Since he came down here we have have had four roots and four decayed teeth removed. In October of 1907 the patient got a severe cold in head, accompanied by considerable cough, which he says lasted for about six weeks. During the latter part of this illness a large swelling appeared under the right side of the jaw. This lump, he says, disappeared after about a month and a lump came on the left shoulder which opened and discharged. About three weeks after this the lump appeared again under the right side of the jaw and extended from the back of the right ear to the chin. This also opened and discharged.

On April 1 he was admitted to the hospital with a large swelling on the right side of the neck extending from the mastoid process to the anterior part of neck. Pus was discharging from an opening behind the ear and from another opening under the chin. The neck was swollen and tender and was of livid red

color. At the angle of the jaw there was a fluctuating mass which was opened and a thin bloody pus escaped.

Over the left clavicle there was another bluish red swelling. It extended over the middle third of the clavicle and was discharging a thin pus from the upper angle. The skin surrounding this area was spotted with little pustules as was the skin on the right side of the neck.

On entering the hospital the patient was put on large doses of pot. iodidi as actinomycosis was suspected but examination failed to show any of the fungi, it was then thought that syphilis might be the cause and mercurial inunctions were added to the former treatment, but this failed to cause much improvement. A specimen of the pus was again examined by Dr. Charlton and this time a bacillus resembling that of glanders was found.

Third Annual Meeting of the Saskatchewan Medical Association

The third annual meeting of the Saskatchewan Medical Association was held at Regina on Monday evening the 20th of July, 1908. In the absence the President, the Second Vice-President (Dr. H. E. Munroe of Saskatoon) took the chair.

The meeting having been called t order, Dr. G. A. Charlton (secretary-treasurer) read the minutes of a special meeing held at Indian Head.—Confirmed.

The following programme was announced.

MONDAY NIGHT, JULY 20

At 8.30 p.m., in the Police Court Chambers, City Hall

1. Meeting called to order.
2. Secretary's report of the last annual meeting.
3. Reports of Committees.

(*a*) Committee of Arrangements—Dr. M. M. Seymour, Chairman ,Regina.

(*b*) Committee of Papers and Business—Dr. G. R. Peterson, Chairman, Saskatoon.

Committee of Papers and Business, Local—Dr. Harry Morell, Chairman Regina.

(*c*) Committee of Social Entertainment—Dr. A. S. Gorrell, Chairman, Regina.

(*d*) Committee of Credentials—Dr. W. McKay, Chairman, Saskatoon.

Case Reports:

4. Dr. G. R. Peterson, Saskatoon—"Tetanus."
5. Dr. J. C. Black, Regina—"Chronic Glanders in Man."

TUESDAY MORNING, JULY 21

At 9.30 a.m., in the I.O.O.F. Hall, Smith and Fergusson Block, Rose Street

1. Civic Welcome by His Worship Mayor Smith.

2. Introduction of Delegates.

3. Report of Nominating Committee and Business.

4. Address on Surgery by Professor G. A. Bingham, Toronto, Associate Professor of Clinical Surgery in Toronto University.

5. Paper—Duodenal Ulcer, by Dr. J. W. Kemp, Indian Head, Sask.

6. Case Reports.

"Pelvic Abscess"—Dr. H. E. Munro, Saskatoon, Sask.

"Spastic Paraplegia"—Dr. J. R. Matheson, Prince Albert, Sask.

"Amœbic Abscess"—Dr. G. R. Peterson, Saskatoon.

TUESDAY AFTERNOON, JULY 21

At 2 o'clock, at Smith and Fergusson Block

1. Election of Officers and Business.

2. Address in Medicine by Professor A. D. Blackader, Montreal, Professor of Pharmacology, Therapeutics and Lecturer in Children's Diseases, McGill University, Montreal.

3. Paper and Demonstration, "The Importance of a Knowledge of the Protozoa to the General Practitioner." Illustrated by lantern views and microscopic preparations. By John L. Todd, M.D., Professor of Parisitology, McDonald College, Ste. Anne de Bellevue, Quebec.

4. Medical Clinic.

Dr. R. J. McLeod, Regina, Prairie Conjunctivitis.

Dr. A. C. McKean, Rouleau, Diabetes Insipidus.

Dr. W. A. Thomson, Regina, Leukemia.

TUESDAY NIGHT, JULY 21

At 8.30 p.m., Public Meeting in City Hall Auditorium, under the Distinguished Patronage of His Honor and Madam Forget

1. Dr. P. H. Bryce, Dominion Health Officer, Ottawa. Address on Public Health.

2. Dr. M. M. Seymour, Provincial Health Officer, Regina. Address on Tuberculosis.

3. Dr. John L. Todd, Quebec. Experiences in South Africa in relation to "Sleeping Sickness."

Musical Numbers:

Solo—Mr. Hayes—"Good Bye"......................Tosti
Violin Solo—Miss Munro—"The Legend".......Wieniawski
Piano Solo—Miss Evans—"Hungarian Rhopsody No. 2" Lizzt

WEDNESDAY MORNING, JULY 22

At 9.30 a.m., in the I.O.O.F Hall, Smith and Fergusson Block, Rose Street

1 Election of Officers and Business.

2. Paper—"Manifestations of Syphilis Commonly overlooked by Physicians." By Dr. Victor Boujou, Sintaluta, Sask.

3. Paper—Advances in the Surgical Treatment of Syphilis. By Dr. Arnold Simmers, Saltcoats, Sask.

4. Case Reports.

Sarcoma of Lung—Dr. C. M. Henry, Yorkton, Sask.
Locomotor Ataxia—Dr. W. Dow, Regina, Sask.

WEDNESDAY AFTERNOON, JULY 22

At 1.30 p.m., Smith and Fergusson Block

1. Address of President.
2. Introduction of President-Elect.
3. Unfinished Business.

WEDNESDAY AFTERNOON, JULY 22

3 to 4 p.m.

1: Reception at Government House by His Honour the Lieutenant Governor and Madam Forget.

Wednesday evening from 5 to 7—Doctor and Mrs. Seymour will entertain the members at their residence, Scarth Street, at a garden party.

Wednesday night, 9 p.m., King's Hotel—Banquet given by His Worship and City Council.

This programme was adhered to as closely as possible, a few unavoidable changes had to be made, for instance, Dr. G. R. Peterson being absent, his paper on "Tetanus" was read by Dr. Charlton, and owing to illness in the family of Dr. Seymour the garden party had to be given up.

The papers presented at this meeting were of high order and of scientific interest and ably discussed, and the Association was fortunate in having three prominent medical men from the east, Prof. G. A. Bingham, Toronto; Dr. P. H. Bryce, Dominion Health Officer, Ottawa, and Dr. John L. Todd, Quebec.

Dr. Bingham gave an address on Acute Septic Peritonitis which was of special interest and invited a large discussion. The esteem and love in which the doctor is held was shown at the close by the members singing "For He's a Jolly Good Fellow," with great enthusiasm.

The public meeting given in the City Hall on Tuesday evening was largely attended not only by members of the association and their wives, but members of the other learned professions were present along with the general public. Dr. P. H. Bryce's address on public health was extremely interesting and instructive, and Dr. Todd's experiences, in South Africa in relation to Sleeping Sickness, were received with marked attention. The musical numbers rendered made a pleasing diversion. This gathering was unique in character and a decided success.

On the afternoon of Wednesday, July 22, carriages were at the King's Hotel for the memebrs and their wives, who proceeded to Government House, where one of the most pleasant features of the meeting occurred, the reception of the members of the Association and their friends by His Honour the Lieutenant Governor and Madam Forget, who entertaained in their usual

charming manner. At the termination of this pleasing affair the return drive was made via the Provincial Exhibition.

The banquet given at the King's Hotel in the evening by His Worship and the City Council was rather marred by the sudden illness of Dr. Harry Morell, upon whom Dr. Bingham operated for a strangulated hernia, however this being in the "day's work" the banquet proceeded merrily. The repast was excellent, the toasts bright and humorous, and thus the third annual meeting of the Saskatchewan Medical Association was brought to a close.

ELECTION OF OFFICERS AND BUSINESS

The time for the election of officers having arrived, the Nominating Committee was appointed as follows:—

Dr. Munro, Dr. Morell, Dr. Gorrell, Dr. Low and Dr. Henry. The following officers were duly elected for the ensuing year:—

Honorary President—Dr. W. A. Thomson, Regina.

President—Dr. H. E. Munro, Saskatoon.

First Vice-President—Dr. C. M. Henry, Yorkton.

Second Vice-President—Dr. D. Low, Regina.

Secretary-Treasurer—Dr. G. A. Charlton, Regina.

Executive Committee—Dr. H. M. Stevens, Regina; Dr. J. R. Matheson, Prince Albert; Dr. G. R. Peterson, Saskatoon.

Dr. Munro: I beg herewith to give notice that I will bring in a motion at the next annual meeting to amend subsection (a) of section 7, and other faulty clauses in the bylaws and constitution

Dr. Meek moved, Dr. Munro seconded, "That this third annual meeting of The Saskatchewan Medical Association hereby expresses its appreciation of the sacrifice of time, etc., which our eastern medical friends have made to assist us at this gathering and we hope that at succeeding meeting of this association the precedent now set will be followed. Motion carried.

The question re the formation of a Western Canada Medical Association was taken up, and discussed and disposed of as follows: "That at this time nothing definite was known of the objects or advantages of such an organization and the matter be dropped."

The President (Dr. Thomson): I am pleased to see this third annual meeting of our association such a success. I think everyone interested has made his best effort to be here, and in that way has helped to make it a success. Our organization was commenced three years ago by a preliminary meeting at Regina, Dr. Seymour being the president. At that meeting Dr. Henderson was elected as president of the association which held its next meeting at Saskatoon in 1906. In 1907 we went to Prince Albert when I was elected president. We had a special meeting at Indian Head the same year. Each of those meetings seemed to me to be a little better than the one which preceded it, and it was necessary that the present meeting should go one better, and I think it has done so. Through the kindness of the College of Physicians and Surgeons we were able to get men from the east, and in that way a great deal of interest has been added to the gathering. We have appreciated their presence very much. Some people at times think we are not a unit., but upon the present occasion we have demonstrated that we are a unit to a man. I have to acknowledge our indebtedness to Dr. Charlton, our secretary-treasurer, who has been a host in himself. I wish now to refer to our next place of meeting, Saskatoon. Saskatoon has a record of its own for entertaining. I believe that at our next meeting there we shall have one of the best of times.

On motion of Dr. Meek it was decided that the transactions of this society be edited and incorporated with the minutes of our proceedings and published if the state of finance will warrant.

The President: I have pleasure in introducing our new President, Dr. Munro, of Saskatoon.

Dr. Munro: Mr. President and gentlemen, I assure you I consider it an honor indeed to be elected to this position. I was interested in what the retiring president has said in connection with the history of the association, to the effect that each meeting was an improvement upon the preceding one. I hope that may be said regarding the next meeting. I think it will. There are in Saskatoon many good fellows upon whom I shall depend to make the meeting there a success. So far as the local entertainment goes we shall strive to give a good time socially, and I am sure that the committee that will have charge of the arrangements will try to have a good programme to present, and bring some interesting clinical material with them, or read a paper on some interesting subject. I again thank you for the great honor you have done me in electing me to this high position.

Dr. Low: This year we have inaugurated a precedent in asking the assistance of the College of Physicians and Surgeons to defray the expenses of our meeting, but it is not quite fair that every member of the profession in the province gets the advantage of the association without contributing to its funds. I think this association ought to strive to be self-sustaining. I think if each of the members will bear this in mind and assist in increasing the membership it will not be long before this comes to pass.

Dr. Charlton: If every practitioner was a member of the association the question of finances would be solved. We should have funds in the treasury to have an A1 meeting every year and to publish a journal. There are over 300 men resident and practising in the province. At two dollars a head there would approximately be a revenue of $600 a year.

Dr. Low suggested that towards the end of the year a notice be sent out to every medical practitioner in the province asking them to join the association.

Dr. Seymour: It affords me a great deal of pleasure to support the movement towards getting increased membership and consequently more money in the treasury. I think the accept-

ance of this money has done as much good towards the larger number of members of the profession in Saskatchewan as in any other way that the money could be spent. We had on hand at the division,—when a sort of temporary division was made,—we would have somewhere in the neighborhood of $20,000 on hand. It was my intention to introduce a motion at this meeting to ask your opinion as to the advisability of diverting some more of this money along the lines, if possible, of publishing the reports of our meetings. If we are short of funds I think no better means could be taken than making use of some of this money to properly finance this society. But as it is somewhat late I will leave this matter over until next meeting.

Dr. Murray moved, Dr. Peterson seconded, "That a vote of thanks be paid to the retiring officers."

Motion carried.

This ended the business.

THE SASKATCHEWAN MEDICAL JOURNAL

HARRY MORELL, M.D., C.M.
Chairman of Publication Committee

G. A. CHARLTON, M.D., C.M.
Secretary-Treasurer

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Regina, Canada.
Box 209.

All communications relating to this publication should be sent to Dr. Harry Morell, Box 209, Regina, Saskatchewan, Canada.

Editorial Notes

The primary object, in the publication of this journal, is to gratify the desire, expressed by so many members of the Association, to have the transactions of its annual meetings permanently recorded.

* * *

After reading some of the scientific material herein contained, which shows merit and great care in preparation (and which represents only part of the papers presented at the last meeting) it must be admitted that it would be wrong to allow such work to be destroyed.

* * *

All of the papers published in this number were prepared for, and read at the last meeting; and if the compilation of this work done by the Saskatchewan Medical Association will further stimulate the efforts of the individual members the Committee of Publication will be amply rewarded by any extra work expended in the production of this the first number of "The Saskatchewan Medical Journal."

It is the intention of the Committee that every active practitioner in the Province receive a copy of this publication, also the committee wishes to remind the members of the Association to send their annual dues to the Secretary-Treasurer, because the success of an undertaking such as this depends, not only upon the moral and intellectual, but also upon the financial support of the members.

* * *

The Chairman of the Publication Committee would be thankful to receive from the members of the Association their views on the continuation of this Journal, whether a monthly, quarterly or the annual transactions. The general result and concenses of opinion will determine the fate of this publication.

* * *

All communications relating to this journal should be addressed to Dr. Harry Morell, Box 209, Regina.

News Items

The Maritime Medical Association will hold its annual meeting at Charlottetown, P.E.I., on the 7th and 8th of July next. Contributions of papers are invited, and notice sent as to the title, etc., to the secretary not later than the 15th of Aprl. Address the secretary, Dr. Geo. G. Melvin, St. John, N.B.

The next annual meeting of the Saskatchewan Medical Association will be held in Saskatoon. The definite dates are not yet given out.

Mr. E. L. Day, Saskatchewan representative for Chandler & Fisher, Ltd., Winnipeg, has opened a branch office and permanent sample room in Regina. Mr. Day is well known to the doctors of Saskatchewan, and we bespeak for him and the house he represents a large increase in business during the year.

At the last meeting of the Academy of Medicine, held November, 1908, a portrait of the late Dr. John Fulton, Professor of Surgery in Trinity Medical College, was presented to the Academy of Medicine by his daughters. Miss Fulton unveiled the portrait and Dr. G. A. Bingham made the presentation speech.

The forty-second annual meeting of the Canadian Medical Assocation will be held in Winnipeg, Man., on the 23rd, 24th and 25th of August, 1909. The chairman of the Local Committee of Arrangements is Dr. H. H. Chown, Winnipeg, and the secretary Dr. Harvey Smith, Canada Life building, Winnipeg. President, Dr. R. J. Blanchard, Winnipeg. General Secretary, Dr. George Ellott, 203 Beverly Street, Toronto. We are requested to state that those desiring accommodation in the hotels of the city at that time should write early for hotel accommodation ,because the British Association for the Advancement of Science will meet in Winnipeg at or about the same time.

Book Reviews

Operative Surgery, Including Surgical Anatomy—McGrath.

By John J. McGrath, M.D., Professor of Surgical Anatomy and Operative Surgery at the New York Post-Graduate Medical School, Visiting Surgeon to the Harlem Hospital, etc. *Second Edition, Revised and Enlarged.* Royal Octavo. Nearly 650 pages. 265 Illustrations, including many Full-page Plates in Colors and Half-tones. Extra Cloth, $4.50, net; Half-Morocco, $6.00, net. *Sold only by Subscription.* Philadelphia —F. A. Davis Company: "We are glad to voice the following review which appeared lately regarding this work:

"There is always room for a new work on Surgery if it is a good one and this volume is an excellent work on operative surgery. Dr. McGrath has combined in a practical manner surgical anatomy and operative surgery. The subject is covered thoroughly and yet the work is not too voluminous for the general practitioner and student. The various operations are described so clearly that a clear idea may be obtained of each operative procedure. The book is up to the times in all respects and the latest operative measures are given.

The subjects of gastro-enterostomy and the surgical treatment of diseases of the stomach and intestines are treated in detail. The operative surgery of the pancreas and spleen is described at length and recent advances in the surgery of the prostrate gland given.

The author rightly regards illustrations an important part of such a book and and colored and half-tone plates and drawings are freely used to elucidate the text. Many of the drawings are diagrammatic, as the author considers them very satisfactory for teaching. We commend the book to every physician needing a modern work on operative surgery."

The "Doctor's Factotum" issued by the New York Pharmacal Association, Arlington Chemical Co. and Palisade Manufacturing Co., conjointly, November, 1908. This little booklet issued as above, gratis, is up to the usual standard, and contains some very interesting information, especially on the Chemistry of Milk and milk free diet in typhoid fever. Part II contains cleanings "In Lighter Vein," all of which is good.

Obituary

ROBERTSON—The death of Douglas Argyll Robertson is announced by the "New York Medical Journal" as follows: "Dr. Robertson, an opthalmologist of world-wide fame, died on Sunday, January the 3rd, in the 72nd year of his age. After his retirement from practice in 1904 he made his home on the island of Jersey, and it was there where he died. The phenomenon known as the Argyll Robertson pupil was discovered by him about forty years ago.

DRYDEN—In Guelph, Ont., on Dec. 2, Dr. James Robert Dryden, M.B., aged 53.

GILLESPIE—In Cannington, Ont., on Dec. 22, Donald Gillespie, M.D., aged 70.

LEESON—In Brandon, Man., on Nov. 25, M. Leeson, M.D., C.M., was killed accidentally.

With Our Advertisers

We congratulate Huston Brothers Company of Chicago, but still more the medical profession upon the new combination of Buggy Heater and Lantern that this Chicago Physicians' Supply House has put on the market. By means of this new device the doctor can defy the elements, for no matter how far below zero the mercury may be, and no matter how dark and disagreeable the night, the doctor can take his long drive in comfort, giving his thoughts on the way to his patient's condition rather than to that of the weather. We are informed that there is no doubt at all about it—Huston's New Combined Buggy Heater and Lantern can be placed under the seat or underneath the robes (the doctor's feet resting upon it) and the temperature maintained at about the same degree as the doctor's comfortable office. Not only does it throw out a warm glow of heat, but illuminates as brightly as the conductor's railway lantern. The advantage of this feature alone is so self-evident to every physician that further comment is unnecessary and we have no hesitation in advising you to make the immediate investment of the small amount of $2.00 required for the entire outfit.

The price of this apparatus has always been $3.50 and Huston Brothers reserve the right to restore the price at an early date. We refer the reader to their advertisement.

Phenolphthalein has rapidly grown in favor as a general purpose cathartic and hepatic stimulant.

Phenolax Wafers (Upjohn) offer an attractive form for the administration of Phenolphthalein and have proven a most efficient product for the treatment of all forms of constipation, hepatic torpor and intestinal atony. The palatable and attractive features of tihs preparation present a striking contrast to the old-time cathartics and have given rise to merited popularity with physicians and their patients.

The Upjohn Company, of Kalamazoo, Mich., will send literature and samples to the medical profession on request.

We advise our readers to write Messrs. Van Valkenburg, Limited., Regina, when they are in need of anything in the camera line, or anything that has to do with the production of photographs. This firm carries a very large stock of all kinds of photo materials. Messrs. Van Valkenburg fill mail and express orders promptly.

Messrs. Farewell & Rhines advertise in these columns their special make of "Cr[illegible] Flour." They also make a variety of special makes of flours, including "Special Dietic Food." Those interested will do well to write to them at their "Crescent Hungarian Roller Mills," Watertown, New York, for circulars relating to these, which they will gladly send on request.

McGill University, Montreal, have an announcement in the columns of this Journal, and prospective students should write to the Secretary of the faculty for the annual announcement. Practi-

tioners should not forget that the Post-Graduate courses are second to none on this continent.

For any kind of an Auto or Motor of any description or make, prospective buyers will do well to write for catalogues to the Saskatchewan Automobile Co., who advertise in this issue.

Messrs. Charles E. Frosst & Co. of Montreal, one of the old and reliable chemical and pharmaceutical establishments of Canada, have announced some of the latest formulae they have put on the market. Physicians should not overlook their advertisement which appears.

Anything in the way of optical goods or repairs, manufacturing, etc., the filling of prescriptions for glasses, etc., can be supplied by the Regina Optical Co.

Messrs. Macnab & Roberts of Winnipeg are experts in replating in all finishes, and those who have work on hand of this description should remember that we recommend this house. Surgical instruments are also replated by this firm, who make a specialty of this kind of work.

Jolly, "The Druggist," has three stores in Regina and makes a specialty of having on hand for emergency any serum made. Physicians may wire or phone and the order will receive prompt attention day or night.

"Antikamnia" is still one of the safest of the coal-tar products. It has been and still has an enormous sale both by prescription and by the doctor from his grip.

"The Regina Pharmacy" stores have been aptly named "The Quality Stores." Their stock speaks for itself. Their stores are stocked with the latest product of the manufacturers, and one can be accommodated by personal inspection or by mail.

Swineheart Endless Motor—Buggy Tire. Resilent, Durable, Increases traction, easily applied. It is unexcelled for Cabs, Ambulances, Delivery Wagons, Heavy and Light Carriage work. Write to The Swinehart Clincher Tire & Rubber Co., Akron, Ohio, for circulars.

For a good sign write or call on Messrs. Soucisse & Co., Regina. They will make any sort of a sign for a doctor. This firm is fortunate in having Victor Soucisse with them. It is conceded that Mr. Soucisse is one of the most artistic sign writers in the Canadian West.

Messrs. Chandler & Fisher, Winnipeg, Regina and Vancouver. This house carries possibly the largest stocks of surgical instruments, hospital appliances, physicians' supplies, etc., in Canada. Mr. Day, one of their representatives, is well and favorably known to the physicians of Saskatchewan, and has been made the firm's manager at Regina. So in future Mr. Day will make his commercial trips from here.

Duncan's Pharmacy, Regina, have lately restocked and at this time carry a full line of all the latest pharmaceuticals, chemicals, etc., and prescriptions are filled carefully by competent men. Mail letters are given attention.

We are glad to have represented in our advertising columns Messrs. Parke, Davis & Co., as this house is without doubt the largest, best and most reliable manufacturing pharmaceutical firm

in the world. The products of "P. D. & Co." are known in all corners of the globe, and what they make, as hypodermic tablets, pills, tinctures, fluid extracts, serum, etc., are accepted as the standard by practitioners everywhere.

There is one point which is not touched upon in the advertisement of the Southern Alberta Coal Co., Ltd., and that is that this is a "working mine"; it might influence one to invest in some stock. We know that many in Regina use their coal. They say that "Climax" is all that is claimed for it.

We direct our readers to R. N. Kelly's card. Mr. Kelly will be glad to fill orders for serums, hypodermics, chloroform, etc., in answer to phone or wire messages to any part of the Province.

The "King's Hotel," Regina, is admitted to be the best and most elaborately furnished hotel from Winnipeg to the Coast. When physicians pay a visit to the Capital City they need have no hesitation in checking their baggage for the "King's."

"Sal Hepatica" is being constantly and increasingly prescribed, as it meets the conditions intended. Its main therapeutic value lies in the fact that it contains all the elements which form the Salts of the bitter waters of some of the celebrated springs of Europe and is very useful in rheumatic conditions especially.

The Canada Book and Drug Co. of Regina carry one of the largest stocks of drugs, books and stationery in Western Canada. This firm is the oldest and one of the best known houses. Orders are attended to by a special mail order department and we recommend any one of our friends to write there for anything they want.

"The "Wascana Hotel," Regina, is a first class and very popular house for professional men and their wives when they visit Regina. It is noted especially for its table and general attention extended to its guests.

Mr. E. W. Roberts, who carries an advertisement in this issue, has lately taken over the Broad Street Pharmacy and at this time has a full stock of drugs, chemicals and pharmaceuticals. The prescription department of this establishment pays particular attention to the filling of mail or express orders, which are promptly and faithfully carried out.