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SURGERY AND ALLIED SCIENCES

WINNIPEG, CANADA

VOL. II. MARCH, 1908 NO. 3

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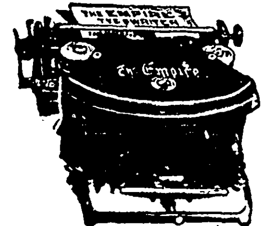

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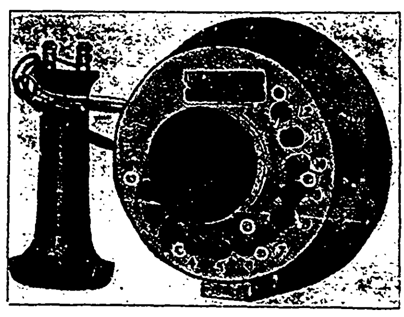

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WESTERN CANADA MEDICAL JOURNAL

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ORIGINAL COMMUNICATIONS.

*APPENDICITIS

(A Plea for Early Operation)

BY W. DUNCAN SMITH, M.D.

EDMONTON, ALTA.

In bringing before your notice the subject of Appendicitis, I feel some excuse or apology is in order, as it is one which has been fully dealt with by the various Medical Journals during the last few years.

To begin with, I have nothing new or original to offer, but as we are all called upon from time to time to treat and attend such cases, which by the way seem to be on the increase, I therefore thought it would be a subject of general interest, and one which would lead to some discussion, and an exchange of ideas.

With a limited experience of 268 operative cases of my own, a large number of which were first seen by other practitioners, I am firmly convinced that many of the men do not grasp the fact, that appendicitis is essentially a surgical disease, and should be treated surgically at a much earlier period than it usually is.

*Read before the Provincial Medical Association of Alberta, Oct. 11th, 1907,

As the subject is a vast one, it is not my intention to enter into all its phases, but merely to touch upon a few points in a more or less rambling manner.

I will classify my cases under three groups as follows:—

1st. *ACUTE CASES*—Including perforating gangrenous, suppurative appendicitis with localized abscess, and more or less localized or diffused peritonitis.	161 Cases 9 deaths a mortality of 5.6%
2nd. *INTERVAL OPERATION*—In chronic recurrent and relapsing cases.	49 Cases 1 death 1 mortality of 2%

This fatal case was referred to me by a confrère 6 years ago.

A young man, ae. 19, with a history of chronic appendicitis of 5 years' standing, his symptoms and complaints were some pain and tenderness in the right Iliac region, especially after any unusual muscular exertion, and a feeling of weakness and insecurity in that side, symptoms of indigestion, constipation and occasional attacks of diarrhoea. He had never been confined to bed, until three weeks before the operation, when he had an acute attack lasting three days. He insisted on having the "grid iron" incision which was made in a vertical line, one inch to the inner side of the Ant. Sup. Spine. In this case the appendix was constricted, 6½ inches long and its tip adherent to the ant. abdominal wall, to the left of the median line, several adhesions were present.

There was tenderness on deep pressure over McBurney's point, but at no other place. The incision was enlarged, but even then, in a comparatively limited space and the unusual position of the appendix, it involved too much handling of the bowel, and he died in three days from Peritonitis.

I have always felt, that, with the ordinary simple incision, this appendix would have been readily removed, and I would have had no mortality in this group.

3rd Group. *ADVANCED AND FULMINATING CASES*—With general septic peritonitis, or extensive plastic peritonitis extending upwards along the course of the ascending colon with numerous small pockets of pus. Many of these were practically moribund when seen with an illness lasting from 3 days to 2 weeks or more. A large percentage of these cases had had the opium treatment.	58 Cases 54 deaths a mortality of 93%

This gives us in the three groups of 268 cases, 64 deaths or a mortality of 24%.—Leaving out the hopeless cases of group 3, we have 210 cases with 10 deaths or a mortality of 4¾%, which is altogether too high. I believe that if the cases of appendicitis were operated upon within the first 24 hours of the attack, by competent surgeons, the mortality would be less than 2%, possibly not more than 1%.

The ages of the patients varied from 2½ to 60 years, the majority of cases occurred in young adults.—175 were males and 93 females.

The length of the appendix varied from 1 to 6½ inches long, and it was found radiating from its attachment to the coecum, to all points of the compass.

In the majority of cases no difficulty was found in locating the appendix. Two of the cases however were unusual, in each of these, the peritoneum was reflected from a point on the coecum, above the junction of its longtitudinal bands to the wall of the iliac fossa and neighboring viscera. There were no signs of adhesions or inflammatory products. The peritoneum was incised below the coecum and by careful dissections the appendix in each case was found post coecal, containing pus, but no perforation.

Of the appendices removed, a few presented comparatively few lesions, although the symptoms were pronounced. I attribute this to the faulty positions they occupied. In the other cases all degrees of inflammation existed, from a simple catarrhal one to a gangrenous mass.

The vermiform appendix in man is the rudimentary representation of the long coecum, which exists in many of the lower animals, and being a rudimentary organ, its powers of resistance are diminished.

The normal appendix varies from 2 to 3½ inches long, usually covered with peritoneum, and possesses a mesentery containing nerves, lymph, vessels, veins, and a single artery which supplies the appendix but does not anastamose with other vessels, except possibly in the female, where the appendix receives an additional blood supply through the appendiculo ovarian ligament. The mesentery varies in length, in many of the cases it is too short causing the appen-

dix to be curled upon itself, or bent at various angles, thus partially constricting it in one or more places.

One can easily understand the various positions in which this organ is found, when we consider its attachment to the end of the coecum, which of itself does not occupy a fixed position in the abdomen.

The wall of the appendix is similar to that of the colon, and its mucous membrane is richly supplied with glands. A fold of the mucous membrane forms a more or less imperfect valve, between itself. and the coecum.

In this small tube, which is about the size of a goose quill ending in a blind extremity, we find in the normal appendix some mucous, and a great many bacteria, amongst them, pus cocci and bacterium coli. To my mind this is an ideal culture tube closed at one end, moist with an even and regular temperature, and the presence of bacteria.

What is going on in this blind sack? Faecal matter more or less liquid, finds its way into this narrow channel, which has to be returned through this common orifice of entrance and exit by peristaltic action of the appendix, working against pressure from within the coecum.

As this passage is frequently tortuous, curved, or constricted from various causes, such as kinks or twists due to too short a mesentery—narrowing due to involution going on in the mucous membrane which may reduce the organ in time to a fibrous cord—ciccatrization from within, or adhesions about the appendix the result of previous attacks. All or any of these conditions when present or a pendant position of the appendix will interefere with peristaltic action, and the organ will be unable to empty itself.

Minute solid particles of faecal matter lodged in the appendix lead to the formation of one or more concretions, some of which may reach the size of a hazel nut. These also by narrowing the lumen interfere with peristalsis. It is much easier for anything to get in than to escape from this blind passage, especially when its lumen is narrowed at one or more points, or when it is bound down by adhesions.

The various conditions mentioned tend to increase the pressure within the appendix, and it is well known that bac-

teria are taken up readily by the tissues, wherever they exist under pressure.

It is a pretty well recognized fact that the cause of inflammation of the appendix is always due to bacterial invasion, and all the above mentioned conditions are predisposing causes, besides these there are several others, which play a more or less active part, viz.:

Acute Indigestion, Exposure to Cold, Traumatism, Typhoid Fever, Influenza, etc.

Faecal concretions, while not a direct cause, are one of the frequent exciting causes of acute appendicitis, as the concreiton becomes sufficiently large, and especially if roughened it becomes harmful and irritating to the mucous membrane, keeping it in a hyperaemic state, and the germs which are always present, set up inflammation followed by pressure necrosis,. perforation or gangrene.

Any condition whereby the lumen is narrowed, either acting from within or external to the appendix, plus some inflammation, may, by obstructing the circulation result in acute gangrene within a few hours.

In two of my cases operated upon within 24 hours of the symptoms complained of,—a gangrenous appendix was found, and yet there was nothing in the symptoms or the condition of these patients to lead me to expect to find such a grave pathological condition.

It is not my intention to take up your time with the symptoms of acute appendicitis, as we are all familiar with them, in fact the layman of average intelligence can usually detect these acute cases.

It would be impossible for me to attempt to classify the symptoms met with in my cases, to conform with the pathological conditions found. Some of the grave cases with perforation or gangrene operated upon within 48 hours of the attack did not present as marked or urgent symptoms, as did some where there was simply a catarrhal inflammation.

My experience is that the temperature is not much of a guide to the severity of the case. In some cases with high temperature the appendix was found to be simply inflamed, on the other hand some of the perforative and gangrenous

ones presented scarcely any elevation from the beginning of the attack.

I consider the pulse, together with the local symptoms our most reliable guide. A pulse steadily or suddenly increasing in frequency invariably means serious pathological changes going on, viz.: the formation of pus—perforation—gangrene—peritonitis or other serious complications.

While it is true that the symptoms usually become more marked with pus formation or when perforation, gangrene or peritonitis supervenes, it is also a fact that remission of all symptoms, except local tenderness, may occur and the disease may be progressing to a fatal termination.

I do not think sufficient attention is paid to cases of chronic appendicitis. Many of these cases lead a miserable life, drifting from one physician to another without a proper diagnosis having been made—suffering more or less from pains and aches referred to different parts of the abdomen, especially after some unusual exercise or exertion or after some indiscretions in diet. They frequently suffer from constipation, attacks of diarrhoea, bilious attacks, dyspepsia and indigestion.

Some become emaciated and are frequently ailing with vague symptoms. Many such cases are looked upon as neurasthenics.

These cases require a thorough and careful examination, when some tenderness will be found in the region of the appendix, which can be palpated in many cases if the abdominal walls are thin and not offer too much resistance.

As to treatment, to my mind this is easily disposed of. Acute cases of appendicitis should be operated upon as soon as diagnosed. This would be within the first 24 hours of the illness, as I consider it one of the easiest diseases to detect, and I think I am safe in saying that in almost every case a diagnosis should be made at the first visit.

During my first few years in practice, on more than one occasion I have regretted in not insisting upon an operation in the beginning, but I have no cause to lament operating too early.

I have been called to attend some cases lately, by men who realized the importance of early operation and the seriousness of delay and the complications liable to arise. Their treatment had been rest in bed, restricted diet, bowels evacuated usually with oil or divided doses of calomel and salines, when the stomach would retain any of these, and locally an ice bag, or hot applications, of these two I prefer the ice bag.

When possible a thorough evacuation of the bowels in the beginning, not only diminishes pain but also aids the peritoneum and intestinal tract in disposing of effete and poisonous matter. This is good routine treatment in the beginning of any illness.

Beyond this preliminary treatment I cannot see what medicine has to offer, or can do for an inflamed appendix which is liable to be converted into a pus tube, perforate, become gangrenous or result in acute septic peritonitis, all of which may occur in a very few hours.

I may have been unusually unfortunate in meeting more cases, however, where delay had been the rule and the patient had received a full dose of the expectant treatment, frequently combined with opium.

If the patient recovers, many of these practitioners flatter themselves that they have cured the case.

But what is the condition of the appendix? Is it not in a worse pathological state than before the attack?

Does this not explain the cause of the successive attacks these patients unvariably have? Each attack, if the patient is fortunate enough to worry through, increases the morbid condition and adds to his future danger.

Severe pains being one of the pronounced symptoms of this disease, opium in some form is given by many, which soothes the poor victim and he is kept under its influence, with what result? The bowels are paralysed and distended, the peritoneum is less active and everything is in a more favorable state for sepsis to thrive and extend.

All symptoms are masked, the patient is comfortable and apparently doing well and the attending physician is blindfolded. more or less suddenly the patient's true condition

asserts itself, and the surgeon is called to find some of the following conditions.

A patient dangerously ill, lying with his knees drawn up, anxious expression, marked prostration or restlessness, dry coated tongue, unable to retain anything on his stomach, vomiting, possibly stericoraceous matter, constipated and a weak pulse running anywhere from 120 to 140, and a leaky skin.

On examining the abdomen he may find a tumor in the right lower abdomen, more or less painful and tender on pressure, dull on precussion with rigidity of the abdomen, especially in the right half. The abdominal distension and tenderness may be general, while in other cases with diffuse peritonitis the abdomen may be flat with hard rigid walls.

If septic absorption has progressed so far that paralysis of the nerve filaments has been caused, we find the tenderness has almost disappeared without a corresponding diminution in the progress of the disease. The abrupt cessation of pain previously located in the region of the appendix, followed by a fall of temperature, increased pulse rate, and an anxious expression are symptoms which indicate the occurrence of gangrene.

The prognosis is bad and yet the surgeon is expected to take charge of such cases. Is it any wonder that some hesitate in operating, which is the only possible means of saving such a case. The mortality is high and when the patient dies the surgeon is too often unjustly blamed.

Even in these neglected and hopeless cases I consider it the surgeon's duty to operate.

In one of my cases, a young man aged 22, ill over two weeks, practically moribund, pulse 140. Septic temperature and leaky skin, tumor in lower right side of abdomen and symptoms of general peritonitis, and an abscess in the right parotid gland.

I had him removed to the hospital and operated immediately, when a gangrenous appendix with a large stinking abscess about the caecum and filling the pelvis was found, this was thoroughly wiped out and a considerable portion of the omentum which was becoming gangrenous, removed, exposing the intestines which were distended, having scalded appearance and covered with lymph.

The parotid abscess was opened and bare bone found about the tempero maxillary articulation and the external auditory meatus. The patient's condition was critical. Two days after operation he developed a large faecal fistula and on the 14th day he was taken with a severe pain in the right

side, rapid breathing, with dullness on percussion over the base of the right lung, he was slightly jaundiced, under local anaesthesia I resected a portion of a rib and evacuated some 8 or 10 ounces of pus. He left the hospital in 14 weeks, cured.

A physician, when called to attend a case of acute appendicitis, should frankly explain the seriousness of such cases, the dangers and complications liable to arise and advise early operation, pointing out that it is a safe operation when undertaken early, a shorter confinement to bed, a wound closed without drainage and the less likelyhood of hernia following.

By fulfilling this duty to his patient he protects himself at the same time from adverse criticism.

CONCLUSIONS

1. Appendicitis is a surgical disease.
2. We have no medical treatment that will reach an inflamed or diseased appendix.
3. Recovery from one or more attacks does not mean a cure, but usually the reverse.
4. It is impossible to definitely diagnose the pathological condition existing, from the symptoms present.
5. Acute cases should be operated upon if possible within 24 hours of the onset.
6. More attention should be paid to chronic appendicitis.
7. Advanced and neglected cases which are apparently hopeless, should be given the benefit of the doubt and operated upon.
8. The public is becoming educated to the necessity of operation in these cases. This should be encouraged.
9. The physician who delays and does not advise early operations is coming in for a fair amount of criticism from the public.
10. The operator should be experienced and be prepared to meet and deal immediately and rapidly with any complication met with at the operation.
11. The dressings, after treatment and care of the patient, in many cases demand more surgical knowledge and skill than the operation itself. A surgeon must have a knowledge of the complications liable to arise after operations, detect them early and know when and how to deal successfully with them.

*PERFORATION IN TYPHOID

BY J. O. TODD, M.D.

Surgeon to the Winnipeg General and St. Boniface Hospitals.

The frequency with which rupture of the intestine occurs in typhoid fever together with the progressively favorable results obtained by surgical measures adopted for the relief of the condition, is my reason for asking your consideration of this important subject. Though known to exist as a lesion for many years following the recognition of the individuality of typhoid fever, there would seem to be no recorded advice or attempt to surgically repair the intestined rent until 1884, four years subsequent to Mikulicz bold if unsuccessful suturing of a gastric perforation; and it is fitting that the same dexterous fingers, acting upon the advice of professor Leyden, should be again first to dare the dangers of an angered peritoneum in a successful closure of one of these typhoidal ruptures; for the name of Mikulicz canopies the first recorded performance of this operation. Close in the running for priority in this work are the names of John C. Wilson and T. G. Morton, both of Philadelphia; Wilson being the Mentor to Morton that Leyden was to Mikulicz. From that day to this the brains of Philadelphians have been active in investigating of this lesion. From combined clinical and post-mortem data the frequency of perforation in typhoid would seem to be about 2 to 3% of all cases, but the mortality percentage has a greater variation running from the 5.7 to 30%. Osler's figures of one death in eight as due to perforation, give the alarming total of 4,422 out of a U. S. census report of 35,379 deaths from typhoid in one year.

In our own records at the Winnipeg and St. Boniface General Hospitals I have taken a period in which the complications of typhoid have been noted; for through many years both institutions had a death as being due simply to

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*Read before the Winnipeg Medical Society, February, 1908.

typhoid without specifying further. In a total of 4,896 cases of typhoid fever there are recorded 44 perforations or .9%—of these 44 perforations 43 died or .8%.—In the 4,896 cases there were 482 deaths from all causes—of the 482 deaths 43 were due to perforation or a mortality percentage of 8.9%, or nearly one in eleven.

Briefly the pathological course of a case ending in intestinal rupture is a proliferation of the endothelial cells of the lymphatics and blood vessels primorarily of the lymphoid areas of Peyer's Patches and the solitary glands but extending therefrom, to the subjacent intestinal layers. This cellular blockade of the blood vessels impoverishes the tissues of the intestinal wall and lends intensity to the action of the typhoid, or mixed toxines till there is cut out of the intestinal wall a block of necrosed tissue, varying in shape mainly according to that of the originally infected lymphoid node though to a great extent also influenced by the area of tissue blockaded by the ischaemic process. This necrosed patch, unable to bear the intestinal pressure or movements, ruptures, and there is communication established between the intra- and extra-intestinal areas. The disturbed peritoneum in the immediate vicinity following its rule, throws out a plastic barrier which more or less surrounds the necrosing spot and may in favorable cases effectually limit the intestinal extravasation to such point that there is formed an adhesion to some firm, neighboring support or there collects a circumscribed quantity of matter which spreads in the line of least resistance and may ultimately point in various directions. Perforations are usually single and are found to be located most commonly in the two feet of the ileum proximal to the caecum upon the wall of the small intestine opposite to the mesenteric attachment; a choice of situation that anatomical features would favor; for it is in the upper ileum that the patches of Peyer and the solitary glands are most numerous and it is upon the portion of wall distal to the line of the mesentery that these are more closely clustered as well as most poorly supplied with blood vessels.

The microbic flora associated with the peritonitis ensuing upon a perforation is composed of Eberth's Bacillus, in com-

pany with streptococci, staphylococci, pneumococci, and Bac. coli. communis and much graver prognosis attaches to that case in which streptococci are dominant over Eberth's Bacillus.

The causative factors in perforation as yet can be but uncertainly cited and we must wait further investigation before attaching too great value to the statistical ascendency of such factors as race, sex, age, season and geographical locality. The stage of the disease and severity of the attack would appear to be important factors and it is generally accepted now by authorities that perforations may be looked for, more frequently by far, in the third week of the disease than at other periods, though cases are reported in the first and as late as the sixteenth week. Although Allbutt and others report it as occurring in mild and even apyrexiol typhoid, still there can, I think, be little doubt of its greater frequency in association with severe symptoms. In the list of exciting causes of perforation may be noted such conditions as undigested portions of food—tympanites, vomiting, active purging, large or too forcibly administered enemata, muscular action, as in turning quickly in bed, straining at stool, walking; and Armstrong, of Montreal, has reported intestinal worms as being present in two of his series of cases. Occurring as this lesion usually does in the midst of an established symptomatic display it is not to be wondered that its own peculiar colons are apt to be lost in the general blending and it needs all our attention to detect in the pathological color scheme before us, the addition of the shadings characteristic of it. Fortunately, however, for our diagnostic purposes, its incidence into the symptomatic complex of typhoid fever is usually marked by one or more dominating effects and it is upon the true reading of these that our diagnosis will stand.

Foremost among the symptoms of perforation should be placed pain. As in appendicitis so in perforation pain may be referred to the peri-umbilical region or to the end of the penis, but it is more commonly located in the right lower quadrant than elsewhere. From a personal study of five perforations as well as from an analysis of a series of cases from

our hospital records it would seem to me that in cases of typhoid exhibiting intermittent pains throughout the attack a special watch ought to be kept for perforative symptoms. The temperature will often drop suddenly through three, four or more degrees and rigidity of the right-sided abdominal muscles commonly asserts itself. The pulse rate is accelerated as a rule. Loss of liver dullness when it is present is a most valuable sign, almost, I should say, pathognomonic. Osler values a leucocytic count taken very frequently, as often as every half hour, but the difficulty of carrying out such a programme weakens its usefulness. A most valuable and fairly constant index of perforation is the pinched expression about the nose and mouth.

The treatment of typhoidal rents is essentially surgical and the dictum "operate on diagnosis" is to me nowhere more applicable than here. The anaesthetic may be general or local with the preference, in my opinion, to the general. The abdomen is opened by a median or right-rectus incision below the umbilicus. The caecum appendix and ileo-caecal junction are to be located and the small intestine traced downward from here. The tear having been found it is to be sutured or excised and a judicious search made for other perforations or impending ones. Now comes the question of peritoneal toilet. Shall we flush or mop? I believe that the choice ought to depend upon the extent of peritoneal involvement present. If the peritonitis is circumscribed great care ought to be taken to avoid distribution of infection and such a case had better be treated by mopping, but if there is already wide peritoneal involvement I would favor free irrigation with lumbar counter openings and drainage either by tube or gauze with the patient in the Fowler position.

In the analysis I have made of twenty cases of perforation I shall only now refer to some of the leading points.

The age incidence runs from 16 to 38. In the twenty cases only two are females. The nationality is varied, English, Canadian, Russian, Polish, Austrian, Dane, are found. In one case two perforations were found at autopsy and in one case a second perforation occurred three days after the

suturing of the first. In all the others the perforation was single.

The sight of the perforation was within two feet from the ileo-caecal valve in nearly all the cases, only one being placed three and a half feet from valve.

In seventeen of the series an acute onset of pain is noted and in six, intermittent pains throughout the attack are recorded. The time from the onset of pain to death runs from seven hours to twenty days. In this latter case no operation was performed and unfortunately no autopsy either, but the clinical evidence is very strong for perforation.

Diarrhoea is a clinical feature in eleven cases, Haemorrhage occurs in only two of the series. Tympanites is present in six.

Liver dullness was lessoned in four cases; normal in three and lost in only one, in the others it is not referred to.

Leucocytosis was was observed in three cases. Rigidity is definitely mentioned in six—is present only slightly in three and is absent entirely in one.

High temperature features seven of the cases and moderate temperature eight.

The temperature drop, so much discussed, is present in six of the series, the drop in one case ranging from 104 1-5° to 96°—in another from 104 to 97⅕. In seven of the number no temperature drop whatever is found.

The pulse rate is noted as being unaffected in two cases, slightly affected in six and pronouncedly disturbed in five.

Chills are features of two cases.

My own direct experience has been in five cases upon four of which I operated with one recovery.

Case 1, Reg. No. 2366, W.G.H.—On entrance July 21st 1905 complained of pain in left inguinal region—these pains continue through attack. Widal is positive. On August 17th, 1905, about 2 P.M. he gave evidence of severe abdominal pain—at 4 P.M. had chill—at 5 P.M. I saw him and found abdomen very rigid—tender—distended—liver dullness diminished—pulse 140 and bad quality—leucocytic count 10,400 —no drop in temperature. The patient's condition was so

bad that I could not advise an operation and he died four hours after.

Case 2, Reg. No. 2917, W.G.H.—On entrance August 16th, 1906, was admitted to surgical side for pain in left abdomen and chest—he was examined by me and transferred to medical side as suspected typhoid. Two days after Widal is positive and Roseola present—still complains of pain in side. August 28th at 3.30 A.M. turned from right to left side and in doing so made outcry and complained of pain like cramp. Temperature 102—at 6 A.M. temperature 98⅗, pulse 100—had cramp and a large movement of bowels followed by relief—at 6.45 vomited and had another movement. He was easy all this morning until 4 P.M. when he had a severe attack of pain—was referred to me at 8 P.M. that evening and operated upon at once—there was general peritonitis—faeces in cavity—flakes of lymph and a small round perforation two feet from caecum—this was sutured with silk Lembert and cavity freely flushed and drained. He died a few hours after.

Case 3, Reg. No. 3168, W.G.H.—At 11.30 A.M. of August 19th, 1906, complained of severe abdominal pain—acute drop in temperature 104⅕ to 100⅗. Pulse rate markedly affected —at 12 P.M. that night he was transferred to my section and operated on at once—there was marked distention—general peritonitis—intestines could be handled only after several punctures to let off gas—perforation size of pea found twelve inches from valve—free irrigation—median and lateral drainage—death 1.35 on the 21st, seventy-two hours after.

Case 4, Mrs. K., W.G.H.—Presented features similar to case three and was treated the same—death occurred four days after.

Case 5, Reez Keenerz, Galician, St. Boniface Hospital.—Entered Hospital August 23rd, 1907, having been ill for over a week—had been in railroad consrtuction camp—ran a moderate typhoid course only characterized by occasional abdominal pains which were noted on his entrance and subsequently. On September 1st, at 10 A.M., at about the third week of the disease, he cried out with a severe abdominal pain in right side. Temperature dropped in the succeeding

few hours from 102 to normal and subnormal and then was succeeded by a rise. Pulse rate was never markedly affected —I saw the case at 8 P.M., ten hours after the first outcry, and found him in severe pain, moaning and crying out—the abdomen was very tender—not distended—rigidity over lower abdomen and especially right side—liver dullness normal—fluctuation wave. Temperature 100, pulse 98, respiration 30. Operation performed at once—Median incision. Right side of abdomen filled with fluid containing quite large curds of milk several of which chunks were picked out and thrown on floor—perforation readily found about one foot from caecum —the opening being about the size of a lead pencil end and surrounded by masses of lymph and deeply congested intestine—opening stitched by Lembert silk—abdominal cavity widely mopped without irrigation—cavity drained through 1½ inch rubber tube dipping into pelvis. Patient placed in extreme Fowler position. The course of this case was uninterruptedly progressive to complete recovery. Temperature kept steadily to the normal and subnormal lines—the tube was removed on the sixth day—he sat up on the 27th of September and was discharged on October 23rd.

From this data I would submit:

1. That operation to close intestinal perforation in typhoid is justifiable in all but moribund cases.

2. That the sooner the operation is undertaken after diagnosis the better.

3. That value of general abdominal flushing is questionable.

—

4. That mopping with patient in Fowler position and subsequent drainage with Fowler position maintained gives most favorable results.

THE PROFESSION IN WINNIPEG

BY DR. EGERTON POPE,

WINNIPEG, MAN.

To the newcomer, whose name is legion, the conditions obtaining in the medical profession of Winnipeg are of the greatest interest. The very first impression that one receives is that of a want of unity in our guild. After a few weeks' residence, one has only to feel the pulse of the profession to find that it is perceptibly dicrotic.

For many years medical men have been crying out for greater unity. Even in England, where everything has been almost as highly systemized as time can make it, there is to be heard an occasional wail about the lack of unity and organization in the profession of medicine. In Winnipeg, however, there is something akin to disruption in our ranks and scarcely a voice is raised to protest, little thought is given to a remedy.

Now what are the causes underlying this deplorable state of affairs? First, there is the rapid growth of the community. Secondly, there is the taint of the ubiquitous spirit of commercialism. Thirdly, Chauvinism. It is quite possible that the latter two are largely dependent upon the first. Nevertheless, there they are, all three, and we are face to face with problems that are of the greatest concern to the future welfare of the profession, individually and collectively.

The rapid growth of a community encourages the immigration of medical men from divers schools and places. Some are attracted because they have failed elsewhere. Some come from the country, hoping to enlarge their scope of professional attainment and to increase their personal comfort. Some come fresh from the medical schools of various countries, thinking that the "bread and butter" stage of practice will here pass earlier into the stage of "cakes and ale." Some men come because of the atmosphere of speculation in which fees may be turned into land and land into gold. Some men

come well equipped in the technique of Higher Medicine, prepared to work and wait as they would do in any other community. Some men come from the local School of Medicine. These having been educated here and having made social and professional associations of value, feel that their future is bound up with the place. In all cases there is the fundamental idea of making a living and up to this point everything is praiseworthy and good. The more medical men there are, the more surely will the public get the best medical service, because in an educated community the weaklings of the profession must needs go to the wall. The cosmopolitan talent brought from the various schools, with their diversity of training, should go to make up a great School of Medicine in the Central Canadian metropolis. The advantages of influx are, however, often lost sight of in the shadow of the disadvantages, and they are not fully grasped or appreciated by the profession because the profession is too busy to attend to its own interests. Its unity and its strength do not grow in proportion to its numerical expansion. The individual interest supplants the collective interest almost to the point of total neglect of the latter and as a result the individual interest suffers in the long run.

The taint of the ubiquitous spirit of commercialism is incidental to the rapid growth of a community. It sprouts up like a noxious weed from the land and its pollen is scattered through every field of municipal life. The Hippocratic Art does not escape. What do we mean by the spirit of commercialism? It is the slavish devotion of one's daily energies to the process of converting one's physical and mental capacities into dollars and cents without taking proper heed of the still small voice of Humanity. The desire for gain is a laudable thing up to the point of an enlightened self-interest. We need not sell our wares cheaply. But when the desire for gain becomes an undiluted self-interest or incarnate selfishness, then the motive which is by nature laudable and natural becomes a vice and a curse. The profession of Medicine is intrinsically the noblest of professions. With the expansion of human intellect it is thought that the Doctor of Medicine will tend to supplant the Doctor of Divinity; that

Medicine is really as much concerned in the mental or spiritual as it is in the physical part of humanity. Surely then it is the duty of every one who follows this profession to be large minded in matters of pecuniary interest. In is in this connection that the subject of professional ethics arises. We must be aware by observation of other communities that where professional ethics are most studied and best practiced, the profession individually and collectively is most prosperous and most happy while the public gets the best service for its expenditure. Where these ethics are lax, nothing but misunderstanding and discord can prevail both in the ranks of the profession itself and in the relationship of the public and the profession.

Thirdly, there is the element of Chauvinism. This term is defined by Dr. Osler as "a narrow, illiberal spirit in matters national, provincial, collegiate or personal." No calling or profession is quite so likely to be infected by this spirit as is the profession of Medicine. The London man is prone to believe that his school surpasses all others. The Edinburgh man is prone to look upon Edinburgh as the heart of the medical world. The McGill man, reeking of the prestige attributed to him by a flattering public, comes to us singing, "What's the matter with old McGill?" The Toronto man believes in his own heart that the methods he learned as a student are the best methods. The Queen's man comes with his soul full of melody of "The Royal am a moverin' a moverin' along." The American comes with his alert mind, his aggressive methods, and his heart full of the Fourth of July. The Manitoba man will vow by the Heavens that for width of training, no school under the sun compares with his. He is fairly tatooed with Manitoba. Then, in addition to all these school marks, there are the stamps of the Provinces, and there are the stamps of Nations. This diversity of origin does not tend to harmonize the whole rank and file unless each man takes heed unto himself that he offend not in his tongue.

Again, there unfortunately exists a certain definite antipathy, mostly under the rose but none the less definite, between local graduates as a body and outside graduates as a

body. The local man is disposed to think that he has the first claim upon the public by right of priority of interest. The outside graduate believes that he has the first claim because he comes from an older and better known School of Medicine in the far away East. Unhappily, this feeling is only too apt to lead to a parting of the ways. Lastly, the scramble in a new community is liable to engender a tendency to personal aggrandizement in the practitioner. He is likely to feel that even apart from school or province or nation, he is the man of the hour, his is the intellect, the other man cannot rise to his level.

As a result of it all, the stranger within our gates does not find himself over-welcome. He is isolated, lonesome, a stranger in a strange land. He cannot understand why, after years of study as an undergraduate in the best school on earth and possibly after two or three years of post-graduate work in two or three countries in Europe, he is not heralded by the older and leading practitioners with a brass band in attendance, and why he does not have thrust upon him offers of partnerships, staff appointments in the hospitals, and professorships in the schools. He takes his cool reception and casual greeting as a menace. He interprets indifference as antagonism and mutual antagonism results. It is all vary deplorable.

So much then for a statement and analysis of the conditions. These were of little avail could one not formulate an attempt to remedy the conditions, to promote unity and harmony. The remedy is to be applied in three ways:—

(1) through the outside graduates or "Outlanders"
(2) through the local graduates
(3) through the individual practitioner.

Let the gentlemen who immigrate from the East or the South or the West remember that for some time after their arrival they only hold the footing of guests at a public reception; welcome, not specially invited, not specially privileged. No invitation is essential; far from it. Every new-comer is, however, more or less on approbation, not only in relation to the public but in relation to the profession that has preceded him. He must therefore prove himself worthy of respect

without preaching his worthiness from the house-tops. He will not gain the respect of his tolerant host if he immediately proceeds to eat the latter out of house and home. In a throng of genteel folk it is necessary to tread carefully lest one trample on some on'es corns. To the newcomer, a thorough devotion to professional ethics will be a better advertisement than half a column or even a "professional card" in the daily papers. He must respect the powers that be even though he sees weakness in their tradition and tyrrany in their authority. The College of Physicians and Surgeons, the Manitoba Medical College, the Medico-Chirurgical Society, the governing boards of the Hospitals, all have a proud tradition and all are by necessity vested with authority. If to the newcomer the traditions appear to be worn out and the authority tyrranical, then it remains for him as a liberal scientist to ally himself in so far as he can with these corporate interests and exert his influence for their betterment from the inside rather than from the outside. If his voice be strong enough, it will be heard as of one crying in the wilderness, "Saul, Saul, why persecutest thou me?" If he is not of the calibre to enter into practice, gain the respect of the public and the profession, and score a success by ethical methods, then it were better that he should seek a community more in keeping with his own size. If success cannot be secured under the patronage of professional ethics, then the aspirant had better look for other worlds to conquer. It is true that many a good man may be excluded by the waiting process and the pinch of dire necessity. If no one has faith enough in his future to finance him, then he had better go to the village or the town. Whatever he does, let him live up to the accepted standard of professional ethics or give up the game.

Secondly, the remedy is to be applied through the local graduates. The great strength and at the same time the great weakness of the Manitoba graduates is their undying devotion to the Manitoba Medical School and its environment. It is a great source of strength because one knows that a strong esprit de corps makes for unity and therefore strength. At the same time it is a source of weakness because exclusiveness is foreign to the best interests of the profession and be-

cause the "outside element" will continue to grow stronger as the community grows larger. Medicine recognizes no favorites. With the growth of this city, the profession is bound to increase numerically and it is likely that the increase in outside graduates will be out of proportion to the increase in local graduates. Increase in numbers means increase in power if there be unity. There is now a union of a portion of the outside body in the form of the Winnipeg Clinical Society, which is the embodiment of a feeling of revolt against an alleged combine amongst the leading spirits of the Winnipeg Medico- Chirurgical Society. It does not seem possible that such a short-minded policy could exist in the latter body. It would be contrary to the whole spirit of the profession. Even if it did exist, it could very easily be overcome by forces from within and the result would be more harmonious for all concerned. As a matter of fact the Winnipeg Clinical Society is a going concern and it is well endowed with that important fund called Energy. If the Winnipeg Medico-Chirurgical Society wishes to remain the representative medical body of Winnipeg, there are two or three things to be done. First and foremost, it should eliminate the cold-shoulder tendency which brought about the revolt, and it should adopt the policy of Absorption. Secondly, it should purchase a copy of Bourinot's Constitutional Procedure and conduct its meetings according to recognized rules. There is much need of a big stick for the President's use.

The future of medical teaching in this city is a thing to be reckoned with and carefully studied. Shall we allow the thing to be split up in political factions and establish a basis for a second Chicago where there is a medical school for every day of the month making it the laughing-stock of the profession, or shall we sink our differences and build up a United School, a School of Central Canada, a School united in the aims of Science, devoid of politics, free from Chauvinism, commanding the respect and admiration of the greatest and most representative Schools of the East and of the most representative men of the profession? How shall the local graduates help to apply the remedy? The answer is in the one word, University. In that one word lies the essence of

the remedy. In it there is no taint of combines or monopolies, no malodorous politics. The key-note of University is Absorption. It is true that the local graduates often have much to contend with as it is not impossible that newcomers sometimes have patronizing airs and affectations of superiority. Let even such be absorbed in the University idea and let them be taught in the School of Modesty, which is one of the great teaching branches of the true University.

Lastly, let the individual practitioner come to a true knowledge of himself, take down and burnish up his halo, and sink his alma mater, his province, his nationality, and himself in the great pool of Humanity. Let him preserve his personality as a citizen of the world and a member of society, let him engender a feeling of enlightened self-interest, but let him realize and act up to the realization that the profession of medicine knows no favorites. The man with fourteen letters after his name may learn something from a final or even a first year Manitoba student. Let us study our professional ethics and practice them with no less srupulousness than the golfer practises the etiquette of golf. Let us believe that Two Dollars lost by extending professional courtesy to a brother practitioner in good standing will mean a Hundred Dollars gain in friendship and mutual understanding. Let the old practitioner extend to the new practitioner some such courtesy as he himself at one time desired. Let the young practitioner, no matter how highly qualified, remember that he owes great respect to the old practitioner for his experience even though his methods are not in keeping with the latest German literature on the subject. Let the older man condescend to probe the younger man for new things, new ideas, and thereby keep himself from becoming prematurely moss-grown. Let the young man not shrink from picking up the crumbs from the older man's table and being thankful therefor. Let the older man give the young man a blood count or urinalysis and not forget to pay him for it. Let the young man not scorn to call the older man into consultation. Let the young man and the old man realize that the means of legitimate advertisement in Medicine are few and that the daily press is not one of them. Legitimate advertisement

is gained through one's patients and through the profession. All these things are the things that go to make men happy, with peace and good-will driving out malice and envy. Let us try to find out the best in every fellow practitioner and if there is a difference let us discuss and settle it in solemn conclave. Let us not be dogmatic and illiberal but docile and tolerant.

Outlanders, be patient and forbearing. Local graduates be tolerant. Let us all unite in the cause of Medical Science and Knowledge and let us try to preserve the good of the profession as a whole and therefore the good of its component parts, rather than attempt to aggrandize a section of it. Thus shall we fulfil the social contract and thus serve the higher interests. The proper study of mankind is man, and our guiding principle is Humanity.

WESTERN CANADA MEDICAL JOURNAL

GEORGE OSBORNE HUGHES, M.D. *Editor*

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EDITORIAL

We are publishing the paper on "The Profession in Winnipeg"—not because we can agree with many of the views held but because an independent Medical journal should be in touch with every element which may contribute to professional success, even to the airing of the views of the new-comers and malcontents. Free discussion never hinders, but can often assist progress. Muzzling is no good. Perfect satisfaction can never be and there will always be complaints. When such are made, the thing to do is to ask are they true and, if so, set about getting a remedy. Probably each in his way is aiming at what he thinks best for the profession. Let us hope so. So the more we hear all sides, the sooner we shall become one progressive whole (not a number of cliques, each with grievances, unknown, perhaps, to those in authority), and then we shall get that *collective* action which is imperatively necessary for real advancement.

Regarding the lack of unity said to be observable after a few week's residence, one can only say that a few week's residence can only give a most *superficial* view of the conditions in anything.

The more one travels and visits different countries, the more cautious one becomes in passing opinions, regarding peoples and conditions. A few gifted mortals may see into the "hearts of things" right away, but it is very doubtful whether any experienced man would place any reliance on the views of any but those of a fairly long residence. The newcomer at least is more apt to hear the voice of the superficial element and the malcontent than that of the steady, satisfied worker. Is not this the case in every line of life ? The writer speaks of lack of unity. There are those who say that never did the members of the profession take a more active interest in matters medical and never where they nearer UNITY.

The members of the profession in Winnipeg are charged, with the commercial rather than the professional spirit (that spirit which makes a man place first *the value of the thing he is doing to the world,* and second, the profit he makes on it. Were that so matters would indeed be hopeless, for no profession can ever do anything worth whose members are men with small spirits, especially so in the medical, for has it not been said "Charity should be written in letters of gold on the brow of every doctor." Regarding how the Winnipeg men stand in this respect, a few enquiries of members of the general public (those who should know best) would probably reveal the fact that in spite of the many temptations to the contrary, many physicians have escaped the taint of Commercialism. The great amount of gratuitous work done in the various missions and in private practice should alone disprove this.

Among reasons given for men coming to Winnipeg to practice, the writer speaks of those who have failed elsewhere. A deeper knowledge would prove that the biggest city in the West where there is the greatest competition and where only two things can make success, viz., solid good work or political "pull"—is the last place for the poor "stickit doctor." He has omitted to mention the man who, after a number of years hard general practice—the taking of several good post-graduate

courses (not of weeks, but of years in some cases) in Europe and the States or both—resulting in higher degrees—comes here to engage in his special branch, very wisely considering that there is a field for him in a rapidly developing country. Regarding the profession being too busy here to attend to professional matters, is it not always the busy man—curious, but true—who takes the most interest in the welfare of his calling whatever it be !

Mention is made of some model communities where professional ethics are zealously carried out resulting in peace and prosperity to the public and profession. Where is that Happy Land ? One's mind wanders to Austria, Germany, France, Britain. One looks at their journals—not there. Then where? We agree when the writer says "where Ethic are lax misunderstandings occur." Very true. In our profess sion as in others, let us have laws—a *few good* ones, clearly defined and let us see that they are enforced. Then the newcomer can easily know what is expected of him. Ours is said to be the noblest profession--yet we are charged with being infected by the most ignoble spirit of Chauvinism. Very much to be questioned. The spirit that makes the young medical student think *his* school the best in the world because he *knows no other so well* is natural and right But if that same ardent young student after having the privilege of visiting a number of other medical schools, watching their work and methods and results is not able to take a rational view and judge a school by its standards and results and not by associations, then indeed is he a narrow-minded individual. Sentiment will make him think well of his own school, but sense will guide him to judge rightly.

As to the antipathy mentioned between "outside" and local men. It certainly is not observable. Antipathy between individuals there always will be as long as this old world lasts, but "Outside"—"Inside" are wrong terms. Many so-called "Outsiders" (if one must use the language of the few) have received posts, etc., while one can think of so-called "Insiders" after work in their native town and post-graduates abroad, who have been passed over. However, it is only fair that the local man, other things being equal, should have first claim. Local

talent is always most appreciated—other must work its way to appreciation. Still an older man, with years of experience and high qualifications, has every right to feel aggrieved if passed over for a younger man with inferior qualifications and plenty of "pull" or finances. The public, too, have right of complaint in such a case, because they do not get the best man.

Now for remedies proposed. If "not invited" then the newcomer is not "a guest." Let us take the practical point—that of a professional card in some of the papers. Some years ago the opinion of the B.M.A. was asked regarding this matter. The reply was that in the Colonies the card in papers is a question for each Colony or Province and the newcomer can only be governed by what he finds the custom. If he finds men on hospital staffs and school teachers with cards in the papers, he has every right to place his own in if he wishes. Certainly there seems no definite ruling on this point and it is simply for the individual physician to decide himself as to whether he prefers *direct* advertising by card; or *indirect* by social functions. lectures. clubs and other well-known ways. The newcomer with "pull" has no need for either, but every man starting adopts one method or another. The word "Ethics" can convey so many meanings. To some it means conforming to laws which help science and humanity; to others, conforming to laws which help a few men at the expense of the many, humanity and science suffering thereby. Ethics, too, alter with time and place. The spirit of progress affects the medical as other callings. Opinion is at present divided on this point. The conditions under which we live now necessitate corresponding changes in our theories and aims in education and ethics. If the man with few dollars and no influence and thus unable to play the "waiting game" throws up the result of many years' work and a career mapped out with ideals and enters business life,—he may profit materially but humanity would certainly lose. Such men are rarely materialistic. Their heart is in their science and they are the very ones who should be encouraged to stay in the profession. The very fact that they have arrived so far on the road without much finance shows the character of their work.

Regarding the formation of the Clinical Society. The

reason was the need for greater clinical experience than was obtainable. The members of the clinical are in most cases members of the Medical Society. The more of such gatherings, the better, as from the constant hints and suggestions, etc., from the experienced men the others learn and all are benefited. The progressive physician is ever a student and welcomes such opportunities without any thought of rivalry. The only question to be asked in forming a society are (1) Will it add to the knowledge of the profession; (2) to the advancement of science; (3) to the welfare of mankind. If the answer is in the affirmative, then it is *in order and good*. The tendencies of earnest work in societies is to really unite the different workers. Science unites nations. We all desire the advance of knowledge, so as societies have for their object the furtherance of science, hence they should lead to unity, not dissension. Petty jealousies are unknown to true pursurers of knowledge.

Matthew Arnold said, "*The hope of the English people lay* in their patient and good-humored endurance of fault-finding and criticism by their own writers." Possibly the hope of the medical profession in the West will be their patient endurance of criticisms by their own members.

> "Do not neglect to rectify an evil because it may seem small, for though small at first, it may continue to grow until it overwhelms you." *Confucius.*

CORRESPONDENCE

The Editor,

Dear Sir,—With deep regret and profound humility do I acknowledge that The Alberta Medical Council was wrong in refusing to register Dr. James Donald, whose letter was published in your January issue, and to whose aid Dr. Arthur so valiantly comes in the February number.

The latter must be patient with us. We cannot all be legal experts. Intelligence is a quality of the mind, and if he will allow me to say so, Dr. Arthur betrays a remarkable poverty of that same quality when he brands the whole profession of Alberta as unintelligent because of the very pardonable mistake of one man. Besides, it is unkind of the good doctor, and hurts us deeply.

Here are the facts: Dr. Donald accepted a contract from a coal miners' union and jumped into a small town of two or three hundred people, where there was already one qualified practitioner, and where if both remained, one was bound to go hungry. He did not register, did not make any attempt to register until he had been there two or three months and his attention had been called to the irregularity. He then applied for registration on his British degree, and our registrar refused to enrol him, explaining that the requirements for registration in Alberta involved the passing of an examination as well as the possession of a degree, British, foreign or domestic. In this it now appears that the registrar was wrong, and that a British graduate of a date prior to June 1st, 1887, is entitled to registration in any province. As I said, our registrar did not kno this. Mallory's case in 1879 was an unknown quantity to him. It was very unintelligent not to know of a 29 year old legal case, but he didn't. I fear that his lack of intelligence was shared too by ninety-nine hundredths of the practitioners in Canada, as well as the great bulk of the legal profession.

However, he refused to register Doctor Donald unless he went up for examination and passed. The Doctor did not present himself for examination but quietly continued to practice. He was warned of the consequences, but with true British pertinacity kept on in the even tenor of his way. The case was then turned over to me, and I turned it over to our solicitors. The Doctor was taken before a magistrate and fined $25 for practicing without a license of the C. of P. & S. of Alberta. He did not deny the facts, but I believe pleaded the sufficiency of his degree. I am afraid he was guilty of practicing without a license, and the magistrate had no option in the matter. The doctor had undoubtedly put himself in the wrong. He should not have started practicing without registering; he knew that, at any rate. Then, when he was refused registration, he should have applied for a mandamus, as the famous Mallory did, to compel the Registrar to enrol him. Having preferred to break the law in which he did not believe, he has only himself to thank for the consequences of his ill-advised course.

I may add tha n reading Dr. Donald's letter, I referred the matter to our solicitors, and on the day on which your February number reached here I had just got their opinion that a British gradute registered in England prior to June 1st, 1887, was entitled to practice in any province in Canada. The Council of the College of Physicians and Sur-

geons of Alberta therefore realizes that Doctor Donald is entitled to register, and he will be registered if he chooses to apply for it again.

I will go further, and say—although not authorized to do so—that the council sincerely regrets that Dr. Donald was refused registration on his first application. For his subsequent prosecution, it has no regrets. It only did its duty and protected the qualified practitioner.

I cannot close a letter already too long, I fear, without expressing our appreciation of the courteous manner in which Dr. Arthur called attention to our little lapse. We are all—almost all—liable to err, and it is so nice to have a dear brother at hand who knows it all and so cheerfully puts us right.

Yours Truly,

G. A. KENNEDY,

Macleod, February 29, 1908.

NOTE—Dr. Kennedy deserves the thanks of the profession for at once looking into this matter and rectifying the error.—EDITOR.

BOOK REVIEWS

The Crain Case Book which we have received, is a loose-leafed system for keeping a record of every department of a medical man's work. It should be it would be of great assistance to any busy practitioner.

PROCEEDINGS OF THE WINNIPEG CLINICAL SOCIETY.

The Winnipeg Clinical Society met at the Medical Library on Tuesday, February 4th, the president, Dr. Milroy, being in the chair.

Dr. Munroe showed a specimen of a tape worm, the host being a child of sixteen months. He pointed out that the difficulties of expulsion were considerably greater in a child, because of the small doses that had to be used. He first tried a tannate cellieterine in half grain dose, but was not successful. He tried etherial ext. felix mass ½ drachm in divided doses, followed by a purgative of castor oil, which had the desired result. He found out that the child had been eating uncooked meat. He thought it was rather unusual to find a tape worm in a child of that age.

Dr. McKenty presented a male patient, 54 years old, showing carcinoma of the mouth. He first noticed it last April. It began about the median line of the hard palate. There was no glandular involvement. The place was cauterized. At the time of showing, the ulcerated area was looking more angry than at any previous time. The diagnosis was made by Dr. Bell, pathologist.

Dr. Milroy remarked that he supposed an early operation was more likely to be successful in such a case. Dr. McKenty concurred in this.

Dr. McDonald said that there appeared to be a white discoloration on the hard palate. He wondered if it was caused by smoking. Dr. Hughes asked which—lymphatic glands were likely to be affected in the case. Dr. McKenty replied that the superficial lymphatic gland would be the first involved. He did not think there was any discoloration. If there was, it was probably due to the fact that the man had been a smoker. It was about six weeks since the operation. Dr. McDonald remarked that if the operation had been the means of stimulating the growth it would probably be rather manifest by that time.

Dr. McKenty said that his opinion in regard to prognosis was rather unfavorable. The operation to be successful, would necessitate the removal of the hard palate and probably of a large portion of the soft palate. You could get along without the removal of the superior maxilla but he did not know what a dentist could do with such a buttess to build an artificial hard palate on.

Dr. Milroy—"What is your experience with X-ray treatment in those cases in the early stages?"

Dr. McKenty—"It has been very unfavorable. The only effect is simply to promote the dissemination of the carcinomatous growth; but my personal experience has been very limited. I don't think the X-ray for work of that kind is nearly as popular as it was."

Dr. Milroy—"What about the serum treatment. It has been known that in cases of erysipelas it seemed to obliterate cancerous growth. Do you think it would be worth trying in a case of that nature, where there was no glandular involvement?"

Dr. McKenty—"I believe its action is more favorable in skin cancer. My impression is that Colley does advise its use in cases of this kind."

Dr. Dorman presented a male patient, Swede, aged 31, and had been a sailor until about 1906. He had gonorrhoea about seven years ago. The discharge ceased in about three months, after which a

swelling developed in the right groin. This was incised and healed in about five weeks. About sixteen months ago he contracted what he called a soft chancre, which he treated himself and effected a cure in about three weeks. A bubo developed shortly after, in the right groin, and for this he went into the hospital, where it was opened. About three weeks later, he noticed a swelling in the right testicle. This was fomented and remedies were applied which reduced the swelling, and he was well for five weeks and then he went into the hospital again at Kenora, and the testicle was incised. He was told that it was diseased and should be removed. He did not agree to this and came away. Two months after he came under the doctor's care for relief of the swelling. A considerable quantity of fluid was drawn off and he remained much the same for about four months when he noticed the left testicle also swelling. About a week ago he fell astride a log, striking the part and afterwards noticed that the swelling which was previously hard, now seemed smooth and he could now feel hard lumps in the part. The next day swelling and pain occurred and had continued since.

Referring to Dr. Dorman's case, Dr. Donald said, "I think I can recollect a somewhat similar case when employed as a civil surgeon during the South African war. In the case of soldiers in the navy, one meets with a large number of venereal cases. This man had had a very similar turmor to that in the testicle of this patient, and it was diagnosed, and I am inclined to think this case is also one of syphilitic tumor of the testes. There are the hard, indurated glands in the groin and, in addition to that, the fact of testicles being affected, being symmetrical, and the fact of tumor appearing within two or three months after the primary venereal sore. There are, of course, no definite symptoms of syphilis in this case, but I would certainly try the effect of inunction of Mercurial ointment or proto. iodide of mercury. In connection with the difficulty in diagnosing a primary venereal sore. it is thought, among army surgeons in the British army at any rate. that there is so much difficulty in diagnosing between a soft chancre and a hard chancre, that in every case of a sore appearing on the penis, it is to be put down as primary venereal sore, and in the medical history sheet (every soldier has one) it is marked down "primary venereal sore" in pencil, and his movements are watched for the next three months. If no symptoms of syphilis appear within the next three months, the case is marked down definitely in ink, "soft chancre," but until the three months passes, the medical history sheet contains P. M. S."

Dr. Lehmann—"I would strongly suggest the use of pot. iodide, although it is quite well known that syphilitic tumors of the testes do not re-act as well as other syphilitic manifestations."

Dr. Kenny—"I would like to draw attention to the fact that the man has an active discharge. As far as the involvement of the glands goes, a man with a history of two attacks of bubos is very liable to get indurated glands. I think the only way to deal with the case would be to put him on a therapeutic test, i.e., pot. iodide, and see if the tumors disappear. He is evidently suffering from some form of gonorrhoea as well. The absence of tenderness, of course, in both epididymi would tend to exclude gonorrhoea and would point to syphilitic infection."

Dr. Hughes—"What relation, Dr. Kenny, has hydrocele to syphilis?"

Dr. Kenny—"I would like to ask Dr. Hughes first if he could demonstrate hydrocele in the man."

Dr. Hughes—"There was translucency present and Dr. Dorman said that fluid had been let out of it."

Dr. Hunter—"What is Dr. Hughes' diagnosis in this case? Is it a double hydrocele then?"

Dr. Hughes—"I think it is a very much more complicated condition than appears primarily. I think there is both a specific history to be reckoned with—I mean by specific, syphilis—and I also think gonorrhoea has to be considered. I think the two affections are intermixed. The thing that struck me was the difference between the two sides. On one side I found both the epididymis and the testicle affected, and on the other side only the epididymis."

Dr. Kenny—"Which side was the epididymis alone affected?"

Dr. Hughes—"It was on the left side, I think."

Dr. Hunter thought he could feel a distinct enlargement behind the epididymis on the left side. He thought that possibly there was some fluid on the right side and also some enlargement of the testes. The trauma in the last few days might possibly account for the enlargement on the right hand.

Dr. Monroe remarked that on the previous Saturday he had seen the case with Dr. Dorman and they had diligently applied the light test and found it absolutely opaque. The test that night would lead him to form the same conclusion. The fact of the withdrawal of the fluid would not of necessity rule out a syphilitic condition, because he believed authorities stated that with a syphilitic involvement of the testes there was sometimes an effusion of fluid. He agreed with Dr. Donald that the condition was likely to be syphilitic. He thought the specific treatment was the one to take.

Dr. Dorman stated that when he first saw the patient he had an undoubted hydrocele and quite a quantity of fluid was removed but the whole swelling did not subside at the time. He did not think there was any translucency on the right side. There was probably a hydrocele on the left side. When he first saw him he was on antisyphilitic treatment and the tumor subsided and did not increase, but the patient went on to a homestead and it had been increasing. He could get no previous history of syphilis.

Dr. Sharpe remarked that he had noticed scars on the neck. Patient had stated he had had five operations for enlarged glands in the neck. Dr. Dorman could not say as to these.

Dr. Milroy remarked that the case was very interesting and presented certain complicated features. There was primarily a hydrocele which had now disappeared. There seemed to be a concensus of opinion that it was syphilitic and that there was gonorrhoea present. There had never been any systematic prolonged treatment. He hoped Dr. Dorman would be able to report future developments from a therapeutic standpoint and from diagnostic reasons.

Dr. Lehman again brought forward a case which he had presented at the last meeting. He had also a second patient present who had damaged his ulnar nerve in almost exactly the same place and he presented them both for the purpose of comparison. Both injuries were in the right hands. The second case presented practically the same features. There was the wasting of the thenar and hypothenar eminence, inability to spread his fingers, anaesthesia and contraction of the ring finger. The small finger had been amputated nine months after the injury due to trophic changes. No anesthetic being needed. The ring finger, of course, was never quite so much contracted as the little finger.

Both were cases of typical ulnar nerve paralysis, especially the second, barring the necrosis of the little finger, which was distinctly rare. He now claimed that his sensation was coming back and the atrophy of the small muscles was not nearly so great. The sensation was never very typical, that was, from an anatomical standpoint, because the sensory nerves interlaced.

Commenting on Dr. Lehmann's case, Dr. Richardson said that the point that impressed him was the way in which the median nerve reacted on the muscles of the extended hand.

Dr. McKenty said there should be no difficulty in accounting for that. The injury to the ulnar nerve was below the point where it gave off its muscular branches. The only muscles not enervated were those of the thenar eminence and hypothenar eminence, consequently he should have perfect command of his fingers.

Dr. Sharpe questioned the reason for the reaction within a few hours after the operation. He was able to extend his index and middle finger and previous to the operation they were contracted right into the palm.

It was suggested that the condition was due to a spasm of the flexors and that the spasm might possibly be brought about by the injury to the nerves.

Dr. Lehmann replied that at the time of the operation the long muscles supplied by the ulnar nerve and median were in a state of spastic contraction and as soon as the diseased portion of the nerves was removed, that contraction was immediately removed.

Dr. Milroy thought that feature had been previously explained from the standpoint that it was an irritative lesion.

Dr. Lehmann stated that that was the only explanation of the condition as it then existed.

Dr. D. S. Mackay referring to the first case, asked why if it was an ritation of the ulnar nerve did one get the condition so rapidly recovering afterwards. Was it due to the lesion sometimes described where an irritation to one nerve may cause an irritative lesion in another nerve?

Dr. McKenty said that he was not convinced that there was an irritation of the median nerve from the position of the hand indicated by Dr. Lehmann. One might get the fingers drawn up by an irritative lesion of the ulnar nerve only.

Dr. Lehmann replied that he could not see the connection between the ulnar nerve and the index finger.

Dr. McKenty rejoined that the ulnar nerve supplied the ulnar sides of flexor profundus digitorum and that the outer half of that was intimately connected with the inner half.

Dr. Lehmann—"Taken for granted, which I am not prepared at all to do, that the median nerve was not affected, how would Dr. McKenty explain the contraction of the long muscles supplied by the ulnar nerve when the ulnar nerve was served considerably below the branches which supplied those muscles?"

Dr. McKenty—"I cannot explain, except on the theory that it was not an irritative lesion."

Dr. Lehmann thought that theory of the lesion of the median nerve could be positively excluded.

Dr. Hunter asked whether such lesions were common and if they were in line with irritative lesions with upper motor segments.

Dr. Milroy—"They knew irritative lesions would cause changes in the motor area and produce tonic spasm but doubted very much if

those lesions produced spasms such as described. If the nerve was severed you might get degenerative changes upwards in the nerve and it might possibly affect an adjoining nerve.

Dr. Lehmann said that it was not frequent to get a speedy recurrence of sensation after a nerve had been severed.

Dr. Mackay disputed this point. He had seen a case at the Royal Infirmary, Liverpool, where in the process of making plate glass, a man had a piece of glass driven into the median nerve, taken to the hospital and the wound was simply sutured. They did not know the nerve was cut. Six months after he came under the care of Mr. Hamilton at the Infirmary and a piece of glass was taken out of the nerve. They could not get an electrical reaction but inside of 36 hours there was a return of sensation and electrical re-action.

Dr. Lehmann had been unable to find a similar case described in literature on the subject. His only explanation was that it was an irritative lesion which had probably extended up to the motar area and from there down the median nerve, as well as along the ulnar nerve.

A paper on pernicious anemia with sclerosis of the cord was then read by Dr. Meindl.

On concluding, he added that Dr. Bell had stated that there was degeneration in the lateral half of the spinal cord.

Dr. Milroy remarked that it was a typical case of combined sclerosis but he failed to see just wherein the case of pernicious anemia was made out.

Dr. Hunter had seen the case and said as to the diagnosis of pernicious anemia there was the extreme paleness of the patient, and associated with that there was the condition of the heart, there was no enlargement and no anemic murmurs. There were a million and a quarter red blood cells and 40 to 50 p.c. of hemaglobin; a considerably bigger proportion than would be expected from the amount of red blood cells. There were extraordinary variations in size and shape. The poikilocytosis was very well marked. The old idea that the presence of megaloblasts was necessary to the diagnosis of pernicious anemia was now given up, because they were frequently present in other conditions, i.e., chlorosis and certain anemic cases they were absent. He did not see any other condition associated with the fact of the post mortem. The condition was similar to cases he had seen inLondon. shown by Dr. Risen Russell. The conditions in the cases presented by them showed perhaps more clearly the three stages. First there was the slight ataxia. Secondly the ataxia became more marked as did the paralysis, and the sensation was rather more affected. Thirdly. the increase in reflexes gave place to a complete flaccid paralysis. He also saw a case in Hull of a man about forty years of age who had well marked ataxic paraplegia, then the originally present jerky movements of the knee, first one and then the other. There was a fairly rapid ending.

Dr. Milroy wished to know whether any of those were cases of anemia.

Dr. Hunter replied the last case he saw there were very marked signs of pernicious anemia. He had also seen a case in Winnipeg in which he had little doubt that this condition was present, associated with cancer of the stomach.

Dr. Kenny who saw the P. M. said there could be no doubt as to this.

Dr. Munroe wished to know in what relation the two conditions

stood towards each other. Was pernicious anemia the cause of the sclerosis or vice versa?

Dr. Meindl replied that as a rule pernicious anemia was followed by symptoms of spinal cord. Dr. Dana had cited the case of a patient in the Medical Record which he said might be called a family form of pernicious anemia and combined sclerosis.

Dr. Milroy stated that Osler claimed that in cases of pernicious anemia you got very marked symptoms of tabes and especially ataxic and sensory symptoms.

Dr. Hunter said cases were definitely recorded in which the blood. when examined, was practically normal and yet a condition of subacute combined sclerosis occurred. He did not think the vascular theory would account for other cases. It was generally assumed that both were simply the common effects of some toxic condition.

Dr. Milroy cited a case which he saw at the General Hospital. A man was admitted to the wards and a very careful history was taken by Dr. Andrew. The early symptoms were those of ataxia. There was no particular anemia and the family history was good. He had a personal syphilitic history. There was exaggerated reflex and the ataxia was very marked. He walked in the usual characteristic way.. The Romberg symptoms were very prominent. Whenever he closed his eyes, he would fall. Ataxic symptoms were present in the arms. When his eyes were closed and he was told to touch the tip of his nose, he would touch the top of his head. Spastic symptoms were also extremely prominent. There were no particular sensory symptoms. He had also girdle symptoms, which were referable to the abdomen, being a feeling of stricture around the waist. There were no eye symptoms but he presented all the features of ataxic paraplegia. An ophthalmoscopic examination elicited no results, the cause thereof being referred to the history of syphilis. He was put on anti-syphili treatment and in two months he was practically well. He had to strain a little before he could void his urine. On one occasion 14 or 15 ounces were withdrawn with a catheter after he had voided all the urine he could. He thought the spastic features were primarily the features of combined sclerosis. There was no evidence of local paralysis.

February 18th, 1908.

Dr. Nichols, V.P., in the chair. The minutes of the last meeting read and adopted.

Case presented by Dr. Sharpe: Male, aged 21, height 5 feet 9½ inches, weight on February 11th, 240 pounds; no previous sickness. At twelve years of age went to Cape Town; at 18 came to Winnipeg—had dysentry one day; worked on the street railway for the last 2½ years: recently he had noticed himself falling asleep while at his work, and found it impossible to prevent himself losing consciousness for a short time. His arterial tension was 160, pulse 90. No headache; appetite good, but slight constipation. Dr. Bell suggested an examination of the urine might disclose the cause of the trouble. The urinalysis is as follows:

February 10: Clear, 10.19; acid, alb, fair quantity; Hyaline cast: urea 1 1-5 p.c.; arterial tension, 150.

February 12: Dark color, 10.30; acid, alb. ½ 1 mille; Hyaline cast. February 15, arterial tension, 130.

February 17: Dark color, 10.30; acid, alb. ½ 1 mille; no sugar; Hyaline casts.

The treatment consisted of diuretics and ordinary dietetic treatment, and on account of the arterial tension, practically the same method had been followed that was advocated by Sir Lauder Brunton when he was in Winnipeg. The patient had been given hot nitrate and sodium nitrite in the morning, and calomel twice a week, followed by a saline in the morning. Last two days patient had been put on another diuretic. No arterial sclerosis. Dr. Sharpe presented case because he had seen no mention in literature of similar cases. Dr. Bell said he had seen 4 or 5 cases. One of which was that of an engineer on the C. P. R. He would go to sleep at his work frequently while running on the line, and at other times the same man would go to sleep Sunday and wake up on Wednesday."

Dr. Hunter—"How long do the effects last?"

Dr. Sharpe—"For a short time until he strikes something on the track. He is not on duty now; he resigned immediately that he became aware of this condition."

Dr. Hunter—"How long may it last? Does it occur at any other time than on duty?"

The patient—"Only while I am on duty."

In reply to various questions, the patient gave the following answers:

Never had any biting of the tongue or wetting of his garments; was not aware whether he changed color or not during the attacks; be in full possession of his faculties and then suddenly fall asleep; longest period of unconsciousness, 4 or 5 minutes. Condition occurred daily during his work; sometimes once, sometimes twice; never lost his faculties when walking around; never fallen; knees would give way slightly and then he would wake up; did not drink or smoke; no epilepsy; feet did not swell; always been stout.

Dr. Nichols—"I have not seen the condition before. It is apparently a most important matter for the public welfare. One can quite understand what disasters might come to the public through a man like that being placed in charge, either as a motorman as as an engineer."

Dr. Hunter was of the opinion that the hyaline casts did not count for much, being what one could find practically in any condition and in a more or less normal kidney. The tension, as far as he could judge. was certainly high, and he thought that the heart was a little enlarged, but he questioned whether in a man with no other symptoms. one could bring the kidney condition into the causation. He was aware of a man residing in Winnipeg, aged 40 and weight 230 pounds who frequently fell asleep at meal times. He also cited the case of a commercial traveller, as a stout man, middle aged, without any special signs of disease, who would suddenly fall asleep during conversation with his companions. Exact cause never ascertained. At one time septemia considered. He thought it was not invariable for the patient at some time or other to fall, but that was not at all an essential part of petit mal. The lack of sudden and complete loss of consciousness and the absence of a history of fits in this case, was against that theory and he did not care to offer a definite opinion in regard to prognosis.

Dr. Carscallen also cited the case of a traveller who would fall asleep whilst riding on the cars, during conversation, or when sitting down in a chair. That condition had been present for years, but a year ago he had been found dead in bed. He was not aware whether there was any condition of the kidneys in that case.

Dr. Lehmann—"Regarding this man's case being petit mal. I think we can exclude that, because he feels the condition coming on, fights

against it, and is quite conscious some time before that he is going to falling asleep."

Dr. Hutchinson—"A man's rotundity and the size of his appetite has a great deal to do with the condition. Men who are very stout usually have enormous appetites and consequently there may be some absorption of poison, causing dulling of the brain, a reason for the man falling asleep."

Dr. Hunter—"There is another condition allied to it. I have seen three cases in 18 months. One of them is a teacher, who had an attack over a year ago. He was a nervous man, not very stout, aged about 40; otherwise his health was good. On two occasions after a fairly heavy meal, he lost consciousness. First he fell to the floor and the second time his head dropped. There was no recurrence. In another case, the patient, a real estate man, aged about 45. He had a similar attack a year ago. An examination of the organs revealed nothing and he has had no further trouble. The third case was a very stout man of about 50, with a rather irregular heart. He has had at least one attack, also soon after a fairy heavy meal. In all of these cases they would lose consciousness for perhaps a few seconds, up to apparently a minute or so. I do not know the explanation."

Dr. Donald—"This can can be discussed under four headings. First. the Tropical condition that we read about, due to some parasitic affection. I think we can exclude that in this man's case. He lived in Cape Town but that is not a tropic. It is not sleeping sickness, which is principally characterized more by anemia, and when the blood is examined, different miscroscopic organisms are found.

"Secondly symptoms of disease of the kidneys. He has albumen in the urine. He does not look like a man who suffers from Bright's disease; there is no swelling under the eyes. I do not think it could be included under any of the chronic forms of Bright's disease of the kidneys.

"Thirdly, the dietetic cause. He is a big eater. He is not intemperate but would probably take a good meal. In order to digest that meal blood has to descend into the stomach, and I think that to some extent the third cause is the one in this man's case. The food lies in his stomach, the blood descends from his brain to digest it, and consequently he falls asleep.

"The fourth cause is the epileptic petit mal or nervous cause. He does not look like an epileptic subject. I am inclined to think that the condition is due to the dietetic cause and my treatment therefore would be a careful regulation of diet."

Dr. Sharpe—"There is one matter which Dr. Hunter brought up which I am sure the insurance companies would like to be the case. the one regarding the hyaline casts. I have had some experience in examining requests for insurance, and we could get rid of the albumen. but we could not get the hyaline casts to disappear. I believe there is a consensus of opinion that hyaline casts have an important pathological significance and all the prominent men in the insurance companies to support that.

Regarding the case that Dr. Carscallen spoke of, Mr. C.—— a man about forty, more fleshy than the patient present, weighing about 250 pounds. The diagnosis in his case was adenoids and nasal obstruction, blocking the air passages. I have known the patient for 15 years. He will be talking at the table, and immediately cease, and begin to snore. Dr. Gordon Bell expressed his opinion that the patient had Bright's disease as soon as he saw him. As to the epilepsy, there is

no foundation, for an argument on that ground. He has no family history. One diagnosis suggested was that as his fiancee was living in the same house, he might be keeping late hours. That the dietetic feature is very important in this case, I am sure, and hope to have an expression of opinion as to the method of treatment that should be followed. We must recognize the fact of the chronic Bright's disease. The man has been under observation for some considerable time and is not improving. In fact, the only change has been in the Sp. Gr. It was 10.19 and is now 10.30 The specimen in this case has been collected in the evening between the hours of four and six. The difficulty lies in the dietetic treatment. To reduce his weight would be contraindicted by the condition of the kidneys. What would you think of putting a man in his condition to bed, and putting him on a milk diet or a buttermilk diet for a week or so? His urine is normal. and passes seven or eight times a day.

Considering his employment and the possible dietetic feature causing the anemic condition of the brain owing to the carrying on of the digestive process. The man is very corpulent, his muscles are fairly strong and are not really flabby, and he has a great deal of blood. It struck me that if he were cold (he is standing as a rule in an unheated vestibule of the car), and there was contraction of the vessels of the epidermis; would you not get sufficient blood to carry on the dietetic functions without arguing the necessity of an anemic condition of the brain? Would we be right in ignoring the condition of Bright's; put this man on a restricted lean meat diet and endeavor to reduce the weight in that way, or would it be advisable to put him to bed and put him on a milk diet or let him go around on a milk diet?"

Dr. Bond—"Considering the amount of adipose tissue, one of the chief indications of treatment would be to get rid of it and save the amount of blood that circulates in that for the rest of the body. The best way would be light baths treatment, which could be followed out without any interference of the general tone of the system."

Dr. Sharpe—"Would not vapor baths have the same effect?"

Dr. Bond—"No."

Dr. Sharpe—"What is the theory of the loss of adipose tissue? Does it not produce an increase in the amount of perspiration?"

Dr. Bond—"It would produce a large amount of decrease in the perspiration. Steam baths only act upon the surface. With the light baths, elimination is produced by the internal organs and also by the skin. A man sitting in a chair in a light bath is soon sitting in a pool of water. At the same time, the amount of carbonic acid in the lungs is increased and the bowels are stimulated."

Dr. Sharpe—"What reduction in weight would you anticipate in two weeks?"

Dr. Bond—"Not much as only one or two baths a week could be given."

Dr. Hutchinson—"I do not consider that the condition has much to do with anemia of the brain through the stomach being active. Perhaps the elimination from the bowels and kidneys is not sufficient to carry off all the waste products. There may be more or less absorption into the blood which would have a narcotic effect on the brain. As the patient is very stout and his blood is not in the best condition owing to that absorption, I am of the opinion that to take a good pint of blood away every two or three months would have a good effect, in addition to reducing his weight."

Dr. Donald—"I would suggest the administration, to begin with, of

large quantities of skim milk; nothing but milk for some long-continued period, to flush out the kidneys. Afterwards to be followed by peptonised foods and the exclusion of flesh for a considerable period."

Dr. Sharpe—"Would you allow him his liberty?"

Dr. Donald—"No, because if allowed to go about, he would be inclined to take solid food. To keep him under observation he should be kept in bed for at least a week. I have seen a case of acute Bright's disease which the late Dr. McKenzie Stewart, of Edinburgh, was treating, on the skim milk principle. He kept a big, strong Irishmen absolutely on skim milk. The instructions were that a jugful was to be placed beside his bed for a fortnight and he got as much of it as he wanted. The man, however, complained so violently that the treatment had to be stopped. Within three or four days, it had had a most beneficial effect. I would begin with the skim milk treatment and proceed to farinaceous foods."

Dr. McKenty—"I had a case of a boy twelve years of age. He was under my observation for eight years and during all that time he frequently had similar spells. He was a farmer's boy, and would go to sleep while driving his team, during meal time and during his prayers in church. He was otherwise healthy and there was no pathological condition. I tried thyroid extracts. There is no doubt that he was a masturbator. He recovered when he reached the age of twenty-one. Dr. Good said that possibly he had hypertrophied turbinates."

A paper on "Spinal Anesthesia" was then read by Dr. Lachance.

Commenting on the paper, Dr. McKenty said: "I used it in one case in amputation of the hip joint. I did not use Stovain, but used a five per cent solution of tropococain. The anesthesia was complete seven minutes after the injection and lasted sufficient for the operation. The patient was not a subject for a general anesthetic, as he was very septic. I thought it less dangerous than the general anesthetic. I used tropococain in preference to Stovain for reasons given in an article by Barker, of University College, London. One of his reasons was that the action of the drug was supposed to be less paralysing to the motor fibres and less dangerous to the respiratory functions. He also lays importance upon the Sp. Gr. of the solution. The Sp. Gr. of the spinal fluid is about 10.7, and Barker in order to have control of the solution after it is placed in the arachnoid sack, uses a solution of Stovain that has a Sp. Gr. of 10.20. Barker in a recent article in the British Medical Journal gives his experience in 200 cases quoted as confirmatory evidence on the value of having the Sp. Gr. of your solution slightly greater than the Sp. Gr. of the spinal fluid.

Its extension upwards is a dangerous feature about spinal anesthesia. It is necessary to be able to limit that. A heavy fluid sinks with the patient in an upright or a sitting position. You must place your patient in such a position that he controls the movement of this fluid. German authorities previously held that this was impossible. However, Barker has shown positively that he can regulate the extent of the anesthesia from the pelvic regions up to as high as the nipple now adopting this view The dangers of spinal anesthesia are ' those adopting this view. The danger of spinal anesthesia is in the danger to the respiratory functions. In the case I operated upon it was very satisfactory. There was much less danger from it in that particular case than there would be from a general anesthetic."

Dr. Meindl—"I have never used Stovain. I have used cocain in sixteen cases. The results as far as the anesthesia was concerned. were very good. In one case, the line of anesthesia went practically to

the middle of the neck; from there down, it went from the lower part of the body. In three cases of fracture of the femur, in one case I had complete anesthesia on the sound leg and practically none at all on the other leg. The fracture of the femur was complete and the muscles were fairly relaxed. In 8 cases the after effects went on very nicely; in 8 others, we almost lost our patients. They suffered from headache, vomiting, and severely from shock. One patient was almost pulseless for three days. The patients felt pressure before we made the incisions, but they did not observe any sensations of pain, the only sensation being pressure when the incision was made. Our cocain was Sterlised in a salt solution. In eight cases we made a 25 m. of 1 p.c. solution and in the other eight we used the salt directly. After punching the arachnoid and letting a drop or two of the spinal fluid escape, we made the solution in the spinal fluid itself. In the cases where the anesthisia was so high up. I think the injection was made at the fourth lumbar space and injected very rapidly. If we injected slowly, we did not have the same amount of anesthesia that we did when we injected rapidly."

Dr. White—"I recall an operation for hernia in which it acted well. Also a case of obstruction of the bowels, but the obstruction let up immediately on using the injection and so the operation was not performed. We used Stovain.

Dr. Mackay—"I have seen some cases by Armstrong in Montreal. where a solution of cocain was used. I also saw Caird in Edinburgh do several. There is no doubt from the literature that men of ability have tried it successfully."

Dr. Lehmann—"There is an opening for it but I don't see that it is superior to anesthesia as a general rule. In a condition of gangrene where anesthesia is extremely dangerous there is no doubt that spinal anesthesia is a distinct advantage, although I must say that all I have seen had considerable after effects, but did quite well."

Dr. McKenty—"What is the Sp. Gr.

Dr. Lachance—"I will give a more complete report later on, showing the way in which the different injections should be administered. As to the Sp. Cr. I used a 10 p.c. Stovain saline solution. The solution of Stovain used is very likely the same as the spinal liquid, for the anesthesia does not seem to go higher than the point injected, even if the pelvis is elevated. Regarding Dr. Lehmann's remarks I think general anesthesia will always remain but local anesthesia is useful. I have seen patients that would very willingly be operated on under it, especially women, when they would not take chloroform. I intend to perform a double hernia operation with spinal anesthesia."

Dr. Nichols—"No doubt the field for its use is restricted. If, however, we can arrive at some definite ideas as to the exact conditions under which it should be used, it will be a great benefit to the profession and the public.

Dr. D. S. Mackay then read a paper upon "Hydatiform Mole of the Uterus in a Woman," published shortly.

GENERAL MEDICAL NEWS

MEDICAL SOCIETIES

The College of Physicians and Surgeons of Manitoba met at the Winnipeg Medical Library on February 19th—Dr. Rogers presiding. There were present: Drs. Rogers, O'Brien, Patterson, Gray, Thornton, Hutchinson, Moody, McFadden, Harrington, Milroy, Ross and McCharles.

The resolution presented by Dr. Thornton, M.P.P. (Deloraine) and seconded by Dr. O'Brien that was published in our November issue was passed with only two dissenting votes. The following points were brought out in the discussion. (1) That the colleges had no legal right to choose their examiners. (2) That they had no control of the standard of examination for candidates for licence; (3) and that the Board of Studies of the University was the only body which has the power to allow any graduate to take the examination for a license.

The Legislative Committee was delegated to place the resolution before the University Commission now sitting.

Dr. Pattenson presented the first three volumes of the Lancet (England) to the Medical Library as a gift from Dr. Pennefather. A vote of thanks was given for this addition to the Library.

The Winnipeg Medical Society met March 6th, Dr. Davidson presiding.

Dr. Galloway presented a case of Coxa Vara and read a paper on the subject. Dr. Hunter read a paper on "Some Points on the Nervous Element in Disease."

VITAL STATISTICS

WINNIPEG

Diseases.	Cases.	Deaths.
Typhoid Fever	12	1
Scarlet Fever	21	—
Diphtheria	28	2
Measles	13	—

Tuberculosis	1	—
Mumps	15	—
Erysipelas	1	—
Whooping Cough	3	—
Chickenpox	5	—
Smallpox	7	—

Vaccinations 569; all successful.

Saskatchewan, January 31, 1908—Report of Infectious and Contagious Diseases for month of January:

	Smallpox	Chickenpox	Scarlatina	Measles	Diphtheria	Typhoid Fever	Tubercolosis
Carnduff					1		
Hanley						1	
Langham				1			
Milestone					1		
Moose Jaw		3	1				
Prince Albert		4					
Regina	1	1			1		1
Rosthern				3	1		1
S Qu'Appelle			1				
Swift Current			2				
Wapella				2			
Whitewood				10			
Yorkton				2			

The following towns did not report: Arcola, Alameda, Balgonie, Battleford, N. Battleford, Broadview, Carlyle, Caron, Davidson, Estevan, Fleming, Francis, Humbolt, Indian Head, Lloydminster, Lumsden, Melfort, Maple Creek, Moosomin, Oxbow, Rouleau, Sintaluta, Strassburg, Vonda, Weyburn, Wolesley and Yellowgrass.

HOSPITAL NEWS

The Chemainus General Hospital is to have a Maternity Ward built.

In the report of the Provincial Board of Health, B.C., the past year is said to have been a very healthy one. Attention was called to the necessity of continuing the campaign against rats. Recommendation was made that quarantine

officials report to the Provincial Board of Health all cases of disease arriving in port. 38 cases of smallpox during the year, most of which were imported from the United States. Also recommended that law compelling vaccination be enforced, and further that all school children be required to produce certificates of vaccination. 14 deaths from Diphtheria out of 98 since introduction of anti-toxin, death rate from diphtheria has been reduced from 55% to 14%. Suggestion made that the manufacture of anti-toxin should be carried on by the Government and supplied at cost to the public on direction of physicians. Recommended the Dominion Government be petitioned to establish a laboratory for the supply of Sera especially Diphtheria anti-toxin. Recommended also that means be adopted to qualify school teachers to impart instruction in Sanitary Science.

Dr. Doherty, Superintendent of the B.C. Provincial Asylum, recommends an entirely new building to accommodate 1500 patients. First to erect two buildings for chronic cases. Dr. Wm. Workman, who resigned on account of ill health, was replaced by Dr. J. G. McKay. The per capita cost of maintenance was $178.59. There are 14 Departments, each with separate heads. The most urgent need is a well-equipped laboratory to conduct pathological and other investigations. This would cost about $1200.

A by-law was passed to provide for the sum of $5000 to supplement the sums of $15,000 and $10,000 authorized for the erection and equipment of a municipal isolation hospital at Edmonton.

A free grant of land in the National Park is to be given Alberta by the Dominion Government for the purpose of building a hospital for consumptives.

Dr. Stewart, of Calgary, has been visiting Vancouver and Victoria to look at their hospitals and get practical suggestions for Calgary's new $150,000 hospital.

Ninette has been decided upon as site for the Manitoba Sanitarium.

MEDICAL NEWS

Montreal has just inaugurated a system whereby nurses are to visit the city schools and give medical treatment to the scholars suffering from mild form of contagious diseases, as scabies, etc. The nurses will also visit the homes of poorer scholars and give advise to the mothers. In cases where the children are suffering from serious contagious diseases, the Medical School Inspector will attend to them.

March 3rd Sir Wilfrid Laurier and Mr. Fisher were waited upon by members of Parliament and representatives of the Canadian Medical Association, who urged the establishment of a Dominion Bureau of Public Health.

Feb 5th Dr. Black (M.P. for Hants) moved, "That in the opinion of this House, the time has arrived when the government of Canada should perfect organization whereby present scientific knowledge should be made practically available for the suppression of the causes of preventable diseases." This was seconded by Dr. Chisholm (East Huron). Dr. Wilfrid McIntyre (M.P., Strathcona) spoke most ably in support of the motion. He said that in suggesting a Dominion Bureau of Health there was no intentions to interfere with the work now being done by the Provincial Boards of Health, but rather that it should supplement and amplify the work of these boards. The suggestion was that there be an advisory board known as the Dominion Bureau of Health The debate was adjourned.

The following is the recently elected Medical Council of British Columbia:

Vancouver—Drs. McKechnie, Tunstall, Proctor; Victoria—Drs. Jones and Fagan; New Westminster—Dr. Walker; Revelstoke—Dr. Sutherland. Dr. Jones is chairman and Dr. Fagan the secretary.

We congratulate the members of the interior on having secured representation.

The Public Health Department of Saskatchewan has issued a circular on "Smallpox, its Cause and Prevention." The circular is prepared and published under the direction of the Commissioner of Agriculture, by Dr. Seymour, Provincial Health Officer.

The Winnipeg School Management Committee dealt with the question of medical inspection of schols in their report at the closing meeting, 1907, but so far nothing has been decided.

In the **Dominion Medical Monthly** the question of fees is discussed and the suggestion made that it would be better to drop the per visit charge and charge according to gravity of case.

The Bill to prohibit medical practice by companies which passed the House of Lords last year is again in charge of Sir John Tuke.

The University Court of Glasgow University has founded a lectureship in psychology.

PERSONALS

Dr. P. H. Bryce, of the Dominion Government Health Department, Ottawa, is visiting B.C. and the West.

Dr. and Mrs. Condell are visiting Winnipeg.

Dr. Holt, of Lashburn, has been visiting Lloydminster.

Dr. C. T. Hilton has started practice in Alberni, B. C.

Dr. and Mrs. O'Brien, Dominion City, paid a short visit to Winnipeg recently, Dr. O'Brien attending the meeting of the Council of Physicians and Surgeons.

Dr. C. Wrench, of Hazelton, B.C., has been appointed Health Officer.

Dr. Dyer, who formerly practiced in North Vancouver, has returned from a visit to the Old Country.

Dr. Elwood McDonald Blakely, of Elm Creek, has been appointed Coroner.

Dr. Culton has taken over the late Dr. Tierney's practice at St. Albert.

Dr. and Mrs. Lafferty, Calgary, have gone on a visit to the East.

Dr. Pierce has been appointed resident pathologist at the Winnipeg General Hospital. This work was formerly done by Dr. Webster, who has taken up anesthetics as a specialty and intends devoting his whole time to it.

Dr. F. C. Norman, of Skagway, Alaska, is visiting Vancouver.

Dr. H. R. Ross, of Brantford, Ont., has started in practice at Langdon, Alta.

Dr. Speechly, Pilot Mound, is visiting Winnipeg.

Dr. Bechtel, of Calgary, has settled in Nanton, Alta.

Dr. J. E. Schon, of Princetown, B.C., has been appointed Coroner, and Dr. F. T. Stanier, Victoria, B.C., Deputy-Coroner.

Dr. Sandeman, Pine Lake, has been visiting Edmonton.

Drs. Knight, Moose Jaw, and Cooper, Asquith, have been appointed Coroners.

Dr. McLeod, Winnipeg, we regret to say, is at present seriously ill.

Dr. R. G Montgomery, Winnipeg, is now convalescent.

Drs. Thornton (Deloraine), McConnell (Morden), Grain (Selkirk), Armstrong (Gladstone), have returned home, the session being ended.

Dr. G. H. Manchester, formerly medical superintendent of the Public Hospital for Insane at New Westminster, B.C., who has spent some time looking into the possibilities of the Maple Ridge District of B.C., as a sight for the Weir Mitchell sanitarium, has decided to look more in the direction of the environs of Vancouver. To this end he has upon his recent return from post-graduate work in the East removed his office from Hammond to New Westminster from which point he hopes to be able to develope his plans a little more expeditiously.

BORN

David—The wife of Dr. A. David, of Prince Albert, Sask., of a son.

Hutchinson—The wife of Dr. H. H. Hutchinson, Winnipeg, of a son.

OBITUARY

We regret to report the death of Dr. J. K. Tierney, of St. Albert, Alta., at the early age of 24. Dr. Tierney was born at Ottawa and educated at Ottawa University, afterwards taking his medical course at McGill. He took his degree in Medicine with honors at 24, and for 10 years has been practising his profession in the West. Dr. Tierney leaves a widow and two children.

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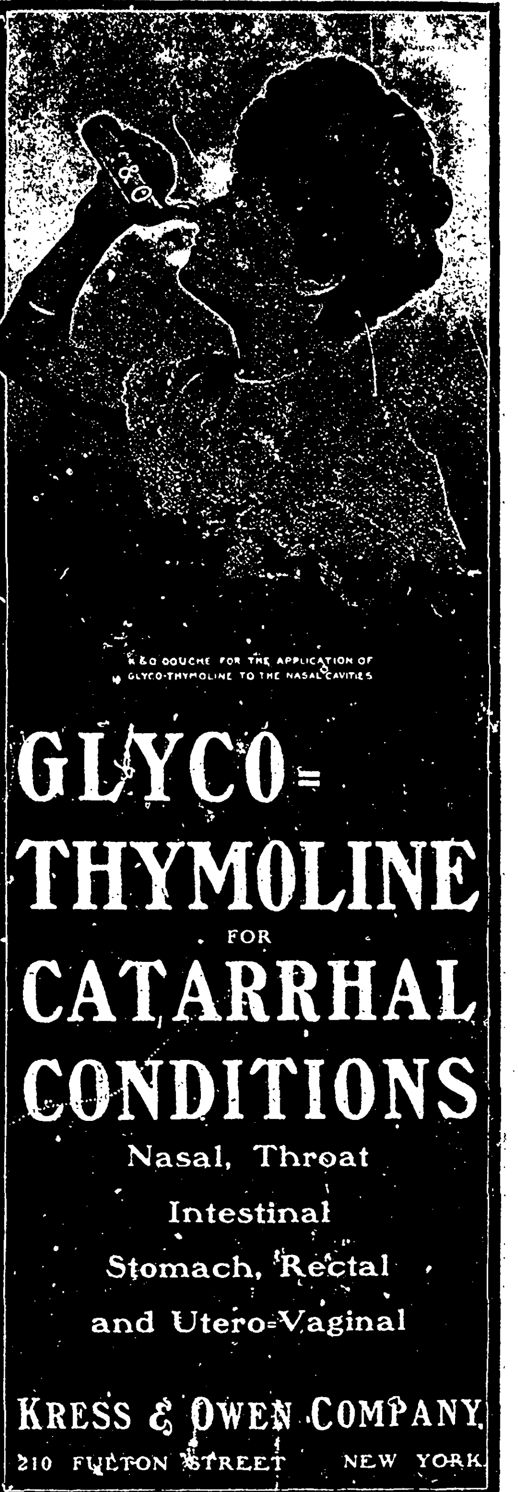

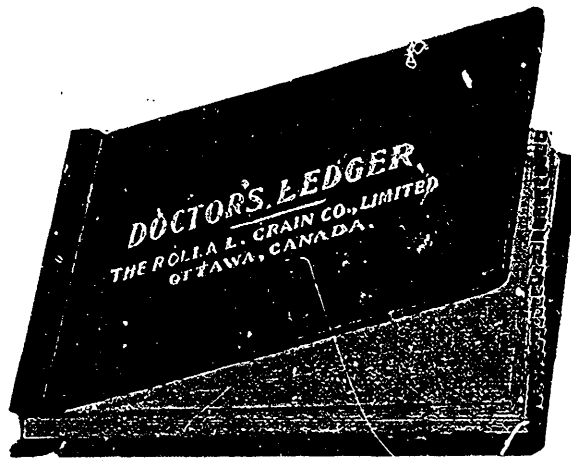

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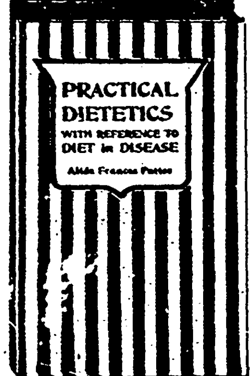

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Synopsis of Canadian North-West Homestead Regulations

Any even numbered section of Dominion lands in Manitoba, Saskatchewan and Alberta, excepting 8 and 26, not reserved, may be homesteaded by any person who is the sole head of a family, or any male over 18 years of age, to the extent of one-quarter section of 160 acres more or less.

Application for entry must be made in person by the applicant at a Dominion Lands Agency or Sub-Agency for the district in which the land is situate. Entry by proxy, may, however, be made at an Agency on certain conditions by the father, mother, son, daughter, brother or sister of an intending homesteader.

The homesteader is required to perform the homestead duties under one of the following plans:

(1) At least six months' residence upon and cultivation of the land in each year for three years.

(2) A homesteader may, if he so desires, perform the required residence duties by living on farming land owned solely by him, not less than eighty (80) acres in extent, in the vicinity of his homestead. Joint ownership in land will not meet this requirement.

(3) If the father (or mother if the father is deceased) of a homesteader has permanent residence on farming land owned solely by him, not less than eighty (80) acres in extent, in the vicinity of the homestead, or upon a homestead entered for him in the vicinity, such homesteader may perform his own residence duties by living with the father (or mother).

(4) The term "vicinity" in the two preceding paragraphs is defined as meaning not more than nine miles in a direct line, exclusive of the width of road allowances crossed in the measurement.

(5) A homesteader intending to perform his residence duties in accordance with the above while living with parents or on farming land owned by himself must notify the Agent for the district of such intention.

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