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THE STIMULANTS USED IN COOKING.*

BY DOUGLASS W. MONTGOMERY, M.D.,
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The table as a piece of furniture should be held in great esteem. By turns it is loaded with learned books and succulent meats, which serve for nourishment for mind and body. No one who loves his fellow-man wishes to see the pleasures of the table curtailed, for it is here that some of the most delightful intercourse of human beings takes place. As Rudyard Kipling puts it, we can here praise Allah, who has not terminated the delights nor separated the companions. While conversation is the chief pleasurable feature at table, yet the general surroundings and the manner of preparing and serving the food are all contributory to the charm of a convivial gathering.

But good and evil are born at a whelping, and, while the table brings us much good, it also brings us much evil. Remonstrance is especially needed against the misuse of spices and pepper.

In preparing food, seasoning is important, and when delicately done adds much to our pleasure. Take salt, for instance, of which it is said it is something that, being left out, makes food taste bad. No matter how carefully the cooking is done, if salt is omitted, the dish will taste flat. The ancients considered salt so necessary a seasoning in all cooking, and held it in such favor, that metaphorically they applied the term salt to the witty sayings that give zest to conversation.

Stimulating drugs, such as pepper, are added to food to either

* Read before the Sacramento Society for Medical Improvement, March 17, 1908.

• stir up a jaded appetite or to take away the flat taste, or to vary the monotony of diet.

It would seem impossible in any of our large cities, for a person with a fair digestive system, and moderately well supplied with money, to suffer from monotony of diet. If, after being shown the long list of different good things to eat, one were told that many people live exclusively on bread, meat, potatoes and sugar, with coffee, whiskey, and pepper, one would be surprised. Nevertheless, such is the case. With us this state of affairs would seem especially strange, with a bay and river system that is richer in food than Delaware Bay, and surrounded by the most fertile valleys the world possesses.

The character of our population, too, should prevent sameness in eating. The Southern European, with his liking for garnishes and vegetables, should correct the heavy, monotonous menu of the Anglo-Saxon. The German Israelites are good eaters and bring us many fine dishes. The Italian market gardeners furnish us with a number of vegetables that in the Eastern States are high-priced novelties, and the proprietors of Italian vegetable stalls know many a secret of good cooking, especially in the way of soups and salads. In California, therefore, there is no excuse for the deadly round of bread, meat and potatoes that is the curse of the Middle and Eastern States.

Our very early ancestors, like the other carnivorous animals, ate their food as they killed it, while it still had its warmth, and before the myosine had set. The meat was, therefore, warm and tender. We have learned to keep meat until the myosine again liquefies, and we cook it to restore the volatility of the flavors. In a savage state man's food consists of so few articles, and the cooking is so badly done that the longing for new sensations to the palate must become intense. The demand for strong spices and alcohols becomes a passion that civilized peoples hardly realize, as, for instance, among Indians, who will drink a diarrhoea mixture loaded with cayenne pepper as a beverage. In this view one can get the attitude of the barbarians toward ancient Rome, and can understand why Alaric, on conquering the Eternal City, demanded an annual contribution of pepper. It is said that the Huns, in order to make their meat tender, would ride on it all day. Between the odors acquired from the rider and from the horse such a piece of meat would go down better for a liberal peppering.

The active overland trade between the Orient and Europe was in spices and other drugs that contained great value in small bulk. It was this Oriental trade that made the commercial pre-

dominance of every empire from the Babylonian down through the Assyrian, Greek, Alexandrian, and Roman to the Venetian. It was the spice trade and the desire to reach the Orient by sea to conveniently get at these condiments, that led to the discovery of America and to the rounding of the Cape of Good Hope. Then came the commercial rise of Portugal, Holland and England, and now this Oriental trade has begun to build up the west coast of the United States and San Francisco. The fundamental reason for all this striving is that spices give the human being pleasure, and for pleasure he is willing to go any length, and to endure all hardships, even those of ill-health.

In Nuremberg they keep the old home of Albrecht Durer as a revered monument, and it is furnished as nearly as possible in the way it was in the lifetime of the artist. The kitchen is small and inconvenient. The cooking utensils are few, unhandy and clumsily made, and the stove is a primitive, inconvenient affair. No wonder Albrecht died of intestinal cancer, seeing the kind of food his bowels must have been given to elaborate as nourishment for his august brain. As I looked at the kitchen outfit I saw the material evidence of poor cooking, with its natural consequence of longing for pepper and over-seasoning, necessitating in its turn the long, expensive, risky camel-freight across the Mesopotamian deserts, through a country controlled by the stupid Turk. The obtuseness of the Turk in commercial matters is proverbial, and he barred the way. No wonder America was discovered, and it was particularly fitting that a lady should give her jewelry to have the matter brought about. The whole of Rabelais, that incarnation of the Middle Ages, who lived in the time of Isabella, is one long expression of the desire to relieve the flatness of ill-cooked food by means of vinegar, salt, mustard, pepper, and by the smoking and salting of meats. These foods were to be washed down with great quantities of strong drink, on the principle never to spare liquor to those who are at hot work.

In the memory of those now living, the people of the United States were rural. Even the urban populations were countrified in life and thought. It is only of recent years that commerce has so developed as to change the life of the nation. In a rural population the food is bread, and meat and potatoes, and nothing else, and the castor is always on the table. Pork is about the only meat used, and it is frequently badly cured. We all of us remember the rusty pork of the farmhouses. The bad quality of the meat on the farms led to the consumption of large quantities of starchy foods, as breads, pies, cakes, and heavy pastries. As sugar grew cheaper it also came more into use. This heavy

food, while men were working in the open air on the farm, was usually well assimilated. But as commercial life developed and people got indoor and more sedentary occupations, such concentrated diet acted more and more disastrously on the digestive organs. The combination of heavy feeding with sedentary habits is especially fatal to those that by nature are endowed with a particularly fine digestion. This is one of the most interesting chapters in the hygiene of nutrition, and is best illustrated by a concrete example:

A man past forty-five years of age had a very active occupation before the great fire in San Francisco. He liked good eating, and especially peppery dishes, and also took many drinks of Scotch whiskey throughout the day. His elimination was excellent, and pleasure, not pain, was his portion. After the fire the natural slowing down of elimination at his time of life was accentuated by a more sedentary occupation. Burke has said that there are two things we must guard against as we grow older, the pleasures of the table and a love for accumulating money. This aphorism held true of my man. The quantity of food consumed did not decrease, but the elimination did. The superfluity had to break out somewhere. His face became more full and florid, and its natural wrinkles disappeared, giving him a fictitiously robust appearance. He acquired a catarrhal affection of the bronchial tubes, and a constant cough and clearing of the throat, that is called by the Spanish, "La tos de ricos," the cough of the rich. Rheumatic swelling of some of the finger joints and rheumatic pains arose, and intensely itchy patches of papular eczema appeared. These were the first symptoms of degeneration, which were bound to augment. Is anyone so foolishly optimistic as to suppose that this man will cease whipping up his digestive organs with alcohol and pepper? On the contrary, with the increase of his misery, the use of stimulants will tend to increase. That in the long run such excitation does not ameliorate, but rather tends to drive one farther into trouble, the ordinary man does not know, or knowing, does not heed.

It is the observation of such cases that makes me regard the beginning of the fifties as a particularly critical time of life, the dangers of which may be accentuated by many fortuitous circumstances. For instance, in one of Guy de Maupassant's stories the author depicts a character as a man with a most vigorous digestive system, forced into physical inactivity by having had his feet shot off in the Franco-Prussian War. The author describes him as getting himself into a railway carriage. De Maupassant says: "He was perhaps fifty-three years of age,

but his hair was already nearly white. He had a bristling moustache, and was very fat and heavy bodied, as strong, active people tend to become when forced into inactivity. He mopped his forehead, and, breathing hard, inquired if I should be incommoded by his smoking."

You have here an artistic picture of the aspect of the kind of man I have in mind. He would naturally, from the state of his nutrition, have seborrhea, and consequently his hair would become by fifty not only gray, but white. Being naturally robust, he had stout hair, especially in the moustache. As a cripple he had become fat from inaction, which made him puff and perspire when in motion. There was also a catarrh of the upper respiratory passages, and the discomfort of short breathing was relieved by smoking. We have all of us often seen such people hurriedly fumble for their tobacco.

Anatole France also gives a good description of this class of man: "Notwithstanding his gray hair, he seemed to be in the full strength of his years. He had a smiling mouth and lively eyes, and the folds of his chin descended majestically down over his stock, that, through sympathy, had become as greasy as the neck spread over it."

Such men are not ascetics. They enjoy eating, and are apt to be devoted to highly spiced foods. They suffer from all sorts of ailments incident to their mode of life, such as rheumatism, gout, stone in the bladder, biliary calculi, and many irritating eruptions of the skin. At the same time they often are men of immense physical force, and are among the best positive workers in the world. They have a shorter life than nature intended, and may be said to literally dig their grave with their teeth. These vigorous individuals eat until they get that sense of fullness and repletion that comes from taking in a large bulk of food. They sometimes say that the long-drawn-out dinner of many courses is the only one that gives them entire satisfaction. Their vigorous digestive system enables them to turn this mass of food into nutritious juices that have to be disposed of either as units of work, or as excreta, or as fat. As these men grow fatter their capacity for work is lowered, but their voraciousness in eating continues. It is not infrequent for them to have spells of depression and melancholy, which they try to escape by drinking. While drunk they do not eat, and after such an enforced fast they crawl out as limp as a rag, but feeling infinitely better mentally. Beside going on a spree, they have another natural remedy, an attack of gout, in which their physician puts them on a low diet and a course of purgatives and alkalies. Such

great, fat, pulpy individuals form excellent meat for microbes, and if the bursting of an overfull blood vessel does not kill them pneumonia may, and in any event, when once attacked by one of the great maladies, their exit is apt to be rapid.

The flat taste of food is usually due to over-cooking or bad salting. The flavors of food are the soluble substances that touch the palate, and the odors that please the sense of smell. A good example in this kind was given in the late Spanish War. The army before Santiago was supplied with canned roast beef, which proved meat out of which the soluble, natural flavors had been taken to make beef extracts: the capitalists' idea of killing two birds with one stone. In that warm climate, where meat is not very well tolerated at best, this canned roast beef was nauseating. In such a case a large quantity of pepper would have made it more palatable, but not more wholesome.

One of the secrets of cooking is not to allow the escape of these savors, and if they escape, and if the odor of the cooking is throughout the house, one may expect a tasteless dinner, for *the bouquet of the food is in the atmosphere and not in the viands*. A cauliflower, for instance, that is cooked for ten or fifteen minutes over a quick fire in well-salted water, will be firm and stand up in the dish, and will have a well-defined, agreeable taste, whereas, if longer and more slowly cooked, it will fall into a shapeless, flat-tasting mush, requiring pepper to whip it into line for the table.

Many people take stimulants to increase appetite. This at times is beneficial, and is one of the most frequent therapeutic measures to bring about a balance of health. Sometimes the vital forces seem to slow down, and the individual "fails," as we say, from no ascertainable cause. Under such circumstances a stimulant of any kind may be of service. It may be a course of the mineral acids, it may be travel, it may be a greater variety of food. In whatever form it comes it whips up the vital forces that were insensibly slowing down, and does good. A discreet amount of stimulation is often, therefore, as grateful to the body as a fertilizer is to a plant. Stimulation may, however, like all good things, be carried to excess. Many people so copiously pepper their food that they fall directly into the monotony of diet from which they desire to escape. Their taste becomes so vitiated that the only flavor they appreciate is pepper or something equally strong.

Many diseases are detrimentally affected by the ingestion of pepper. Rosacea is an excellent example of a disease that reacts unfavorably to the ingestion of pepper or alcoholic

stimulants. Many patients will tell you that a glass of wine will set their face in a blaze.

Erythematous eczema of the face is another good example. In this disease the relationship between functional disturbances of the gastro-intestinal tract and the skin affection is often most marked. I refer here to the type depicted in Louis A. Duhring's Atlas of Skin Diseases, where the skin is red and desquamating, and the natural lines of the skin are accentuated. The eyes are sad and tired looking, as if from lack of sleep, and the corners of the mouth drawn down, giving the man the appearance of invincible melancholy. If at all observant, it is likely that this person has found that indulgence in peppers, spices, alcohols, and the strong nerve stimulants such as tea and coffee, are followed by an attack of cutaneous irritation.

Not long ago a young man applied to me for the relief of a tantalizing pruritus. I had long previously treated the father for a severe papular eczema of the face. This was not the sole trouble the father had, for he was highly nervous, had a florid face, and was addicted to drink. The son was of the same tense high-strung type as the father, and his belly had two large scars on it, resulting from an operation for appendicitis. The fact of appendicitis was itself a sign of intestinal irritation, inflammation of the appendix being only the highly dangerous part of a much more extensive catarrhal inflammation of the bowels, just as mastoiditis is the highly dangerous point in a catarrhal affection of the ear. By taking out the appendix, however, the catarrhal trouble in the rest of the intestines is not cured. My hypothesis therefore was that the pruritus was due to intestinal irritation, and that possibly the predisposition to it was inherited, and he was treated accordingly. Among other things he was set on a diet in which pepper was interdicted. Shortly afterwards he returned saying that for some time he had been better, but that the preceding Sunday night he had had a severe attack of itching, which had prevented sleep. On questioning him he admitted eating curry that evening for dinner, and affirmed that he did not know that curry is pepper. It may be that the curry did not cause the attack of itching, but its ingestion occurred at the right time for it to have had this effect. This unperceived enjoyment of pepper and other condiments should always be borne in mind in ascertaining the habits or directing the diet of even amenable patients. In the first place people are not used to thinking along these lines. I remember one time speaking very earnestly to a thoughtful woman on the evil effects of pepper, as particularly emphasized in a member of her own

family. The day following this conversation I lunched in her household, and we had sausages loaded with pepper. Then again many dishes contain pepper so artfully masked as usually to escape detection. An intelligent man suffered exquisitely from neurotic eezema, and I had repeatedly told him in a general way to abstain from pepper. On one of his visits I handed him a list of dishes apt to be highly peppered. On reading it he remarked reflectively that he had just eaten chowder in a restaurant. Patients should also be told to beware of purées or thick soups, as such dishes, that otherwise taste flat, have often pepper added to them to impart a warm full taste, agreeable to the palate. While delightful to the palate, and warm and comforting to the stomach, farther down the alimentary canal they may set every one of the valvulæ conniventes, or winking valves, violently blinking.

I know of no better demonstration of where an eezema patient should not eat, than a good free lunch counter. You there see savory Spanish stews, stuffed peppers, strong cheese, baked beans loaded with pepper, well spiced sausages and pickles. There will also be salt meats, and many foods impregnated with vinegar. The point of view of the proprietor of a free lunch counter is well illustrated by the following story from Rabelais:

A prince wishing to conquer a king in whose country he had landed, sent him a box containing a very hot confection. The king partook of these condiments, and straightway his mouth began to burn. To allay his throat his attendants put a funnel into his mouth and poured down a cask of wine. The courtiers seeing the king with such a magnificent thirst, also partook of the confection, and as a consequence drank copiously, and soon became drunk. The common people seeing their king and nobles all dead drunk, thought it the usual preparation for battle, and got drunk, too. The inebriated town was attacked at the psychological moment, or rather at the unpsychological moment, as the inhabitants were unconscious, and readily fell a prey to the enterprising prince who devised the scheme.

The following is a list of some peppery foods and condiments which should be avoided by those sensitive to the drug:

Black pepper.	Most variety of pickles.	Worcestershire sauce.
White pepper.	Baked beans with tomato sauce.	Welsh rarebit. Purées.
Red pepper.	Salads are apt to be full of pepper.	Chowder eaten in a restaurant.
Ground chili.	All Spanish dishes, as tamales and enchilladas.	Dressing of fowls.
Paprika.	Most Hungarian dishes.	Mustard through all its forms, (mayonnaise for instance) is equivalent to pepper.
Pepper sauce.		
Tabasco sauce.		
Chili sauce.		
Chutney sauce.		

Catsup.	All dishes a la Newburg.	Sausages of all kinds.
Chow chow.	Stews and hashes may	Many escolloped dishes.
Curry.	contain pepper.	Ginger.
Canned tomatoes with	Hashed potatoes are	Cloves.
red peppers.	usually full of pepper.	Oyster cocktails.

Pepper is a favorite method of hiding over-cooking, and is so used by many cooks. If a cook has the "pepper habit," brown some cornstarch, take most of the pepper out of the pepper box, and add the browned cornstarch. These lazy cooks seldom taste their dishes in the preparing, and the ruse escapes detection.

From what I know of human nature, I am of the opinion that the reading of the above list will rather serve as an incentive to eating pepper than as a deterrent.

It should always be borne in mind that pepper is a drug, and a very irritating stimulant one at that. It is a drug that is taken for fun, and one must be always on one's guard about things taken for sport. It is a wise rule not to try to get too much fun out of any drug. Men who try to do so, usually find their path to lead straight to a physician's office, and it is an old saying that "He who dwells with doctors dwells in misery."

INHERITED SYPHILIS,*

BY JOHN FERGUSON, M.A., M.D.

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This subject is of sufficient importance to justify the attention that can be given to it in a short article. It is now admitted that the *spirochæta pallida*, discovered by Schaudinn and Hoffman in 1905, is the cause of the disease. Mr. Jonathan Hutchinson pointed out many years ago, and long before the organism had been discovered, but assumed to exist, that, unless a child brought the germ with it into the world, or got it very soon after birth, it did not inherit nor acquire syphilis. If either of the parents had previously suffered from syphilis, the child might inherit a weakly constitution, though not the disease.

1. THE TERMS EMPLOYED.

Of late there has been a good deal of discussion on the terms, Congenital Syphilis, Hereditary Syphilis, and Inherited Syphilis. The third is the more accurate expression. The term "congenital" is not always true when applied to this disease, as the child may be syphilitic, and yet not congenitally so. The term "hereditary" should be employed for such conditions or states as may descend through a number of generations, which is certainly not the case with syphilis. The term "inherited" means that the child is born with the disease, or acquires it at birth, manifesting the disease while still very young. This is, therefore, the most accurate term.

The cause of syphilis is a special kind of protozoon, of spiral form, with a flagellum at each end. It is very mobile, with three forms of motion—a lashing, spiral, and to-and-fro. With Giemsa's fluid, it stains a pink color, while the *spirochæta refringens* stains a dark purple with the same fluid.

2. MODE OF TRANSMISSION.

It is now established that a syphilitic father cannot impart his disease directly to his offspring. It is not possible for the *spirochæta* to be present in the spermatozoon, grow and multiply in it, and not destroy it. Further, Colles's law has borne the test of time, that a syphilitic child cannot infect its mother, whom it nurses. It would appear as quite clear that inheritance is invariably through the syphilized mother.

If the disease is active in the mother, the infection may pene-

*Abstract of a Post-Graduate Lecture delivered at the Toronto Orthopedic Hospital.

trate into the placenta and infect the fetus, often causing its death. In other instances, where the disease is not very active, either through time or treatment, the spirochæta may not thus reach the placenta and fetus. At the time of labor, however, as the placenta begins to separate, its surface may become infected, and the infection find its way to the fetus through the umbilical vein. In such cases, the exanthematous stage may occur a few weeks to two or three months after the birth of the child. The separation of the placenta corresponds with the chancre in ordinary cases.

It was once held that, in Colles's law, the mother had acquired the disease from her child *in utero*, but it has been shown that this is not possible. The only remaining conclusion is that the mother is first affected, and then gives the disease to her child through the placenta during gestation, or at the time of birth, by the separation of the placenta.

Whether the disease can be transmitted to the third generation or not is still a disputed question. Mr. Hutchinson collected eight instances of persons who had inherited syphilis, but whose children did not show any evidence of the disease. The late Dr. R. W. Taylor recorded three instances of what was regarded as descent to the third generation, and Edmond Fournier has collected 59 instances of what he regards as transmission to the third generation.

It is well known that a person as old as 25 years may show active secondary symptoms from inherited syphilis. This fact would render the transmission to the third generation a possibility on purely scientific grounds. But more evidence is required before a definite conclusion can be arrived at.

3. GENERAL RESULTS.

The mortality among syphilitic children is very high, and the morbidity still higher. It must be remembered that the sores about the child's mouth and anus are highly infecting, as the discharges from these contain the spirochætes. Among the symptoms may be mentioned brown macular spots, pompholyx, stomatitis, snuffles, condyloma, wasting, enlarged spleen and liver, epiphysitis, bone nodes, bent bones. In the earlier years the tibia may become thickened and painful. At and after the sixth year there is marked liability to flattened nose, square forehead, lines from the mouth, short figure, and pallor. During the second dentition, the three signs pointed out by Mr. Hutchinson, namely, notched incisor teeth, interstitial corneitis, and syphilitic deafness, are to be expected. There may be destruc-

tion of the hard or soft palate, ulceration of the skin, caries of bones, and a characteristic form of *daetylitis*.

4. LESIONS OF THE BONES.

In the bones, some very characteristic lesions are found in cases of inherited syphilis. One of these is epiphysitis. This is often an early symptom of the disease, and gives rise to what has been called pseudo-paralysis. It is present in from 10 to 15 per cent. of all cases. It is contended by some that there may be a syphilitic pseudo-paralysis without the presence of epiphysitis, as no tenderness nor swelling can be detected at the ends of the bones in some instances. Such examples of paralysis, whether with or without the epiphyseal bone lesion, usually do well under proper treatment.

The long bones, especially the tibia, may present marked deformity, as irregular enlargements, or a certain degree of curvature, caused by chronic osteo-periostitis. This condition is known as syphilitic osteitis deformans. There may be other stigmata of the disease, but, in some instances, this almost painless deformity of the bones may be the only manifestation present. The enlargement may be quite massive, or confer upon the anterior border of the tibia a sabre-like appearance. These changes in the long bones are frequently associated with mental defect in the children. This form of syphilitic osteitis deformans should be distinguished from Paget's osteitis deformans. This may be done by noting that, in the syphilitic disease, it comes on while the patient is quite young; that it is not painful; that it improves under anti-syphilitic treatment; that the tibia most frequently suffer most; there are often bosses on the bones; there are usually other indications of syphilis; there is no tendency to malignancy. In Paget's osteitis deformans, there are usually severe pains; the femora are often affected; the patients are older; there is a tendency to malignancy, and anti-syphilitic treatment is not effective.

In the bones of the skull there are some important changes found. On the frontal and parietal bones, there may be deposits of vascular, spongy bone. These bosses may also occur in rickets, and are indistinguishable from each other, though anatomically they differ. Craniotabes, or thinning of patches of the cranial bones occurs mainly in syphilis, but may also be met with in rickets. This is also frequently associated with laryngismus stridulus, but this again is common in rickets. The absorption of the cranial bones may be very extensive.

5. CHANGES IN THE TEETH.

In the teeth there are certain deformities in the permanent set that merit consideration. The lower central incisors are notched, and the upper incisors are diminished in size, and usually screwdriver-shaped. These changes are due to an arrest in their development, which was pointed out long ago by Mr. Hutchinson. There is also a lack of development in the sides of the crowns, rounding off the cutting edges. The notching is caused by the arrest of development of the central columella, while the rounding is due to defect in the lateral columellæ, there being three of these for each incisor. Many years ago, Mr. Henry Moon described a deformity in the first molars. These are reduced in size, and dome-shaped, caused by a dwarfing of the central tubercle of each cusp. These changes may appear in the molars, though the incisors are normal. The teeth of children with inherited syphilis are apt to be rather far apart, owing to the lack of development in their lateral columellæ. The characteristic notching has been noted a few times in the temporary incisors, so that the rule that it is found only in the permanent teeth does not always hold good. The notching has also been noticed a few times where there was no taint of syphilis.

6. DISEASES OF THE JOINTS.

Inherited syphilis may cause very serious disease of one or more joints. Synovitis may occur. It sometimes attacks the joints irregularly, and sometimes symmetrically. This affection of the joints has been observed by many, but notably by Dr. George F. Still and Professor Lorenz.

A rather obscure, but very interesting, form of joint affection in syphilis of children is a form of osteo-arthritis, or the osteo-chondritis syphilitica of Wegner. In this complication the joints usually become affected successively; but the disease does not appear to be progressive in character, leading to the destruction of the joints. It generally becomes stationary, even though treatment has not been resorted to. There is some thickening of both the bones and the soft parts. As the result of these changes, there is limitation of movement, which may be permanent, with a certain degree of enlargement. Under the best of hygienic conditions and the most careful treatment, these changes are very chronic and obstinate. When fibrous adhesions are formed, the joint is most likely permanently impaired. There is proliferation of the cartilage cells, ossification at the epiphyses, and thickening of the perichondrium and periosteum.

7. VISCERAL MANIFESTATIONS.

Enlargement of the spleen is one of the most constant of the many visceral lesions. It is met in at least 50 per cent. of all the cases. Some put its occurrence as high as 75 per cent. When this is met with in children too young to be the victims of rickets, it is a valuable aid in forming a diagnosis. The poison of syphilis produces some irritation of the spleen, as distinct inflammatory changes have been found in the organ and its capsule. In later stages there may be the formation of a good deal of fibrous tissue, both in the capsule and throughout the spleen. Gummata are very rare in this organ.

Nephritis has been noticed in connection with inherited syphilis by Drs. Guthrie, Sutherland, Holt, Walker, Massalongo, Stroebe, Carpenter, Sawyer, and others. There seems to be very little doubt now remaining but that syphilis may be a cause of nephritis, both in the child and the adult. The form which the disease assumes is that of the interstitial type, with a certain amount of parenchymatous changes. In recent cases the stroma of the kidney is infiltrated with small cells, in areas. There is also the formation of new connective tissue. The small arteries around the glomeruli tend to thicken. Catarrhal changes may exist in the tubes, which may also contain hyaline casts. There may be also minute hemorrhages into the substance of the kidney. In the advanced cases the organ presents all the appearances of the granular contracted kidney of the adult, with its distorted shape, adherent capsule, dilated pelvis, thin cortex, thickened blood vessels and glomerular capsules, obliterated tubules, atrophied glomeruli, and tubular cysts. Dr. Bradley, of Manchester, in 1871, recognized the condition and successfully treated it. This is the first case on record. The frequency of this complication is not known, but Speirs gives it as 10 in 34 children with inherited syphilis.

The supra-renal glands suffer about once in every eight cases. The changes have been studied by Virchow, Hecker and many others. There may be an increase in size, due to cell infiltration and the formation of connective tissue. This new growth is very liable to undergo fatty degeneration. The organ in time may be changed to a quantity of oily-looking matter and granular debris.

In the liver, similar changes have been found. At first there is a cellular infiltration, and the formation of some new connective tissue. This causes more or less enlargement of the organ, as is the case in the early stage of syphilitic disease of the spleen

and adrenals. Later on these changes give place to atrophies, and there may ensue a genuine fibrosis, or cirrhosis of the liver. This cirrhosis of the liver may be coincident with the enlargement of the spleen.

The heart may suffer in various ways from inherited syphilis. Myocarditis has been observed a number of times. The endocardium may also be affected. New formation of muscle has been met with somewhat in the same way as new formation of bone, as the result of irritation produced by a syphilitic lesion. The small arteries of the heart may be thickened, and there is sometimes found a well-marked cell infiltration into the myocardium.

The peritoneum may become involved in disease. There are a few cases on record of infants suffering from peritonitis which appeared to be due to syphilis. The tenderness and ascitis disappeared under appropriate treatment. Cirrhosis of the liver, with abdominal ascitis, has been met with in the fetus *in utero*, as in the case reported by Dr. Naish, of Sheffield, where the intestines were matted together, the liver showed intercellular cirrhosis, there was ascitis, and the peritoneum presented the appearance of chronic inflammation. West, in his diseases of children, mentions the case of a syphilitic infant, whose abdomen became very tender and distended with fluid, both of which disappeared under treatment.

In the mouth, pharynx, naso-pharynx, and larynx, there may be deep-seated ulceration and necrosis of tissues. The cartilages of the larynx have been known to be destroyed more or less completely. The lumps have been found in a state of splenization. The capillaries were dilated, and the alveolar walls thickened. The alveoli were stuffed with cells. The well-known snuffles require no special explanation. It is caused by a syphilitic catarrh of the mucous membranes, a specific rhinitis, with infiltration and thickening of the tissues. This condition is found in about 70 per cent. of all cases. It may occur in other conditions, such as ordinary coryza, among idiots and Mongols, when adenoids are present among the very young, etc. The snuffles may pass away in a few weeks or months unaided by treatment.

Including the testes and ovaries with the viscera, it may be mentioned here that these organs are occasionally involved. They undergo the usual changes of cell infiltration and new connective tissue formation, to be followed later on by atrophy and cirrhosis, and the development of the condition known as infantilism, if the orchitis or ovaritis is double, at a period

when the sexual characteristics should be pronounced. Syphilitic orchitis happens in about 7 per cent. of all cases of the inherited disease. These organs have also been known to be the seat of gummatus formations. These morbid changes may occur during the early weeks of life. Orchitis in an infant is very indicative of syphilis.

8. ADENITIS.

The victims of inherited syphilis often suffer from enlargement of the lymphatic glands. This condition is not of much value as a diagnostic sign, as many children present enlarged glands who have no taint of syphilis. The condition, however, may put one on his guard, especially if the epitrochlear glands be found enlarged. The enlargement of the glands becomes important corroborative evidence if there be concurrent keratitis, osteitis, arthritis, or skin lesion. When a group of glands enlarge considerably from a syphilitic cause it is usually a late manifestation. This is the opinion held by such authorities as Holt and Hutchinson.

9. SKIN AFFECTIONS.

Some form of skin eruption occurs in 70 per cent. or over of cases of infantile syphilis. The true syphiloderms are frequently accompanied by ordinary skin lesions. There may be a common eczema about the ears, and a true syphilitic psoriasis on the face. If the care of the child is bad, the various syphilitic skin affections, through wet, dirt, and irritation, may come to so resemble ordinary skin inflammations and eruptions as to be quite indistinguishable.

The most usual forms of skin affections caused by inherited syphilis are roseola, psoriasis, erythema, rhagades, pemphigus, hemorrhagic exanthemata, acne, impetigo, ecthyma, and ulcerations. Of the foregoing, it may be said that the psoriasis is very characteristic. "It consists," says Osler, "of bright-red or copper-colored, infiltrated areas on the palms of the hands and the soles of the feet, covered by white, dry scales, which are easily detached, leaving a collarette at the periphery."

The erythema may be accompanied by true ulceration, causing permanent scarring. When the rhagades or ulceration is caused by gummata, the process is usually rapid, a few days may cause great loss of tissue; the edges are sharply cut, irregular and serpiginous; the ulcers are usually deep; the scar is at first brown, becoming white from centre to periphery, and the ulceration is generally a symmetrical one.

Pemphigus neonatorum is a very characteristic lesion. It is

usually on the palms of the hands and soles of the feet. It may be present at birth, or appear soon thereafter. It is at first a bluish-red infiltration, but vesicles and bullæ soon form. The epidermis then becomes white, while the true skin beneath is of a port wine reddish color. The exudate soon becomes purulent.

The other skin affections, the acne, impetigo, ecthyma, or hemorrhages, are not so pathognomonic, but, taken with other conditions, may aid in the diagnosis.

10. THE EYES AND EARS.

The eyes are frequently affected at an early stage of the disease with choroiditis, or choroido-retinitis. The eyes may be seriously damaged as the result of these inflammations. Iritis is much less common, but may appear during the eruptive stage. Keratitis seldom appears under the sixth year; but from this age to that of puberty, or later, it is not uncommon. It is the most characteristic eye disease met with in inherited syphilis. It begins as a diffuse haziness in the centre of one cornea. There is dimness of vision and irritability of the eye. This haziness is made up of a number of minute punctate deposits, and in a few weeks the whole cornea is involved, giving it a cloudy, milky, whitish, or ground-glass appearance. The ciliary region is congested. There is fear of light. The second eye soon passes through the same changes. Eye symptoms appear in some form in about 25 per cent. of all cases.

The ears are subject to certain syphilitic inflammations. Otitis media may result from an extension of disease from the naso-pharynx. Later in life, or during the second dentition, there may come on a steadily progressive deafness of labyrinthine origin, which may end in complete loss of hearing.

11. THE NERVOUS SYSTEM COMPLICATIONS.

In no part of the body does inherited syphilis work such ravages as in the nervous system. The disease attacks this system in several ways, and the consequences are far-reaching and disastrous. Epilepsy, convulsions, tabes dorsalis, paresis, arrested mental development, and meningitis are among the progeny of inherited syphilis.

As pathology becomes clarified by better knowledge of morbid changes and the various infections, it becomes established that syphilis is not often a cause of pia-arachnoid meningitis; but there are cases on record, with attached autopsies, which confirm the belief in the possibility of its occurrence. Thickening and adhesions of the pia have been found that point clearly to men-

ingitis as the cause. Then, also, there are some known cases of hydrocephalus due to syphilis, such cases depending upon a prior meningitis. Sir Thomas Barlow has recorded a typical case of syphilitic meningitis.

The brain may suffer in inherited syphilis in several ways. The cortex may undergo sclerosis; there may be hydrocephalus, or vascular disease, causing hemiplegia. These cerebral manifestations are more frequent than is generally supposed. Dr. G. F. Still states that 10 out of 15 cases of inherited syphilis under his care had some form of cerebral lesion. Dr. G. E. Shuttleworth, formerly of the Royal Albert Asylum, uses the following language: "Degenerative changes due to this cause may, indeed, manifest themselves early in life, and give rise to cranial osteitis, meningeal inflammations and eclampsia, epileptic and paralytic symptoms so often associated with mental defect in children, and frequently assigned as its cause, though more correctly to be regarded as links in the chain of causation."

The most characteristic form of mental disturbance resulting from inherited syphilis is that form described by Dr. Clouston in 1877, under the term, juvenile general paralysis. It is no longer necessary to argue that this form of mental disease is due to syphilis. Such authorities as Mott, Watson, Shuttleworth, Ferrier, and others are all agreed upon this point. Dr. Mott says that it is necessary to look into the family history with very great care. "It is remarkable how often one found absolutely no signs of syphilis on the body of a juvenile paralytic patient suffering from general paralysis, whereas brothers and sisters showed well-marked signs." Dr. Shuttleworth again puts the case thus: "I am inclined to think that inherited syphilis is a more frequent factor in the production of mental defect and abnormality in childhood than can be demonstrated from the institution statistics I have referred to, and to agree with Fournier that many cases of impaired mental development, such as are met with in children relegated to special schools, have their origin in an inherited syphilitic taint, normal brain development having been interfered with by osteitis causing cranial thickening, by meningeal indurations, or by localized cerebral sclerosis."

Juvenile tabes is another disease of the nervous system that owes its origin to inherited syphilis. A man would not be living up to the knowledge of to-day who took any other view of its origin. This disease occurs about once to every ten times we meet with juvenile general paralysis. All the evidence proves that juvenile tabes follows syphilis, inherited, or contracted in

the very early years of life. In the inherited form of syphilis, tabes comes on earlier in life, as a rule, than when the syphilis is acquired shortly after birth. Tabes, following acquired syphilis in the young, is much less frequent than tabes as a sequel to inherited syphilis, perhaps in the ratio of about 1 to 8 or 10. It occurs with about equal frequency among boys and girls. This is accounted for by the fact that, while syphilis is much more common among men than women, the disease is of about equal frequency in the two sexes when it is inherited. This explains why as many girls suffer from juvenile tabes as boys. The symptoms are those well known and classical to tabes. In its clinical features, there is no sign or symptom which occurs in the adult tabes that has not also been described in juvenile tabes. These views might be fortified by quoting from such writers as Ferrier, Nonne, Kutner, Dydynski, Mingazzini, Marburg, Kalischer, Lasarew, Hirtz, Alzheimer, Skala, Raymond, etc. Juvenile tabes must be sharply distinguished from pseudo-tabes caused by multiple neuritis and Friedreich's disease.

12. DIAGNOSIS.

An early diagnosis of inherited syphilis is of prime importance, from the standpoint of treatment. In at least 75 per cent. of all cases, the symptoms, more or less complete, appear within the first three months, and in about one-half within the first four weeks. By being on the alert for the many complications, as already mentioned, there need not be many cases overlooked. The diagnosis is already summed up in what has been said. The serum reaction may soon prove a great aid in diagnosis.

13. TREATMENT.

The treatment of syphilis in the young is simple in theory, but often very difficult in practice. Many of these patients are in an extremely debilitated condition.

The first thing is to secure the best hygienic conditions possible under the circumstances.

The feeding should be looked into. There is no danger to the mother to nurse her own child, even though she show no symptoms herself. Colles's law may be relied upon. If the mother cannot nurse the child, it cannot be nursed by any other on account of the risk of imparting infection.

With regard to drugs, there is but one, namely, mercury. Here, as in the adult, the iodides are useful in the later stages, but mercury alone is curative for all lesions containing infection, or the organism of the disease.

Grey powder in doses of half a grain three times a day may be given to a baby a few weeks old. If any diarrhœa occur, a little aromatic chalk powder may be ordered with it, or minute doses of compound ipecac powder. Some prefer calomel in doses of one-twelfth to one-sixth of a grain, two or three times daily. If this irritate the bowels, small doses of opium may be combined with it. *Liquor hydrargyri perchloridi* may also be employed in doses of 2 to 4 minims thrice daily. This may be combined in various way to lessen the risk of diarrhœa.

When prompt action is required, owing to the severity of the symptoms,unction should be had recourse to. A piece of mercurial ointment of about 15 grains should be gently rubbed into the skin over the abdomen, the inner aspect of the thighs, or the arms, in the evening, and a flannel bandage applied till morning, when it should be carefully washed off with warm water. If used in this way, the results are excellent, and there is but little risk of dermatitis.

The intramuscular injections and the fumigation methods of administering mercury are not very suitable for children, and are not so easily managed as those already mentioned.

The duration of treatment is of much importance. So high an authority as Mr. Hutchinson advises that it be discontinued as soon as the symptoms disappear. But as this might happen in a few weeks, the time must be regarded as too short. It may be laid down as a rule that treatment should be continued for about one year, watching the child with the closest attention, so as to guard it against any untoward effects from the mercury.

The combined treatment with mercury and the iodides is recommended by many. Where it is desired to secure quick results, the combination is often more effectual than mercury alone. It must be borne in mind, however, that the iodides do not cure syphilis.

Atoxyl is now claiming much attention, and may soon take a leading place in the therapeutics of syphilis.

The concurrent marasmus and debility calls for careful feeding, change of air, tonics, cod liver oil, and all means at our command to restore the health of the child.

TORONTO HOSPITALS FOR CONSUMPTIVES.

BY W. J. DOBBIE, M.A., MD., C.M.

That there is, within a few miles of Toronto, a hospital specially devoted to the care and treatment of advanced cases of tuberculosis is, perhaps, a fact that is known to every physician in the Province. It may be doubted, however, if even a small percentage of the members of the medical profession have any adequate idea of the nature of the hospital, either as to its buildings, equipment, maintenance, management, methods of treatment, or results. For, as a matter of fact, it is not at all an uncommon thing for those who visit the institution to admit that they expected to find merely an old farmhouse with a lean-to attached—a sort of makeshift accommodation for possibly a dozen or so dying consumptives. What they actually find, however, is something vastly different. They find in reality two up-to-date hospitals capable of accommodating between eighty and ninety patients, with many comforts and conveniences not to be found in some of the older and more pretentious institutions.

The site on which these two institutions, the Toronto Free Hospital and the King Edward Sanatorium, are built is a naturally beautiful one. Near the banks of the picturesque Humber, about four miles from Toronto, and at a considerable elevation above its bed, it presents at all seasons of the year a very attractive outlook. Being about half a mile from any public highway, the air is comparatively free from dust and the surroundings peaceful and pastoral, and in every way such as to facilitate the enjoyment of a quiet, restful life.

At the Toronto Free Hospital a pre-existing house has been converted into an administrative block and residence for nurses. Ward accommodation for some seventy patients has been added, the initial cost amounting to some \$40,000. The King Edward Sanatorium, on the same site but some distance away, comprises three entirely new buildings, erected at a cost of \$30,000, and provides accommodation for fifteen patients, paying the full cost of maintenance. In these various buildings are provided the following:

Administration Quarters.—Business offices, physicians' offices, lady superintendent's office.

Staff Quarters.—Staff dining room, pantry, doctors' study, nurses' sitting room, nurses' dining room, bedrooms, and bathrooms, the latter being equipped with shower baths.

Medical Quarters.—Examining room, dispensary, two throat rooms, clinical laboratory, clinical microscopy room, crematory room, autopsy room, fumigating room, and morgue.

Nursing Department.—Nurses' offices, diet kitchen, sewing room, supply rooms, linen rooms.

Patients' Quarters.—At the T. F. H. C. accommodation for some seventy patients, including infirmary wards, women's ward, pavilion for men, two shacks, ten cars, and three tents. At the K. E. S. C., fifteen private rooms. At both places all necessary sitting rooms, dining rooms, pantries, bathrooms, etc., are provided.

The lighting throughout is by electricity, there are two steam heating plants, and a complete septic tank system of sewerage. The water is supplied from two spring wells, by windmill, electric motor, and gasoline pump. The latter is a most up-to-date system, the pressure in the pipes being secured by compressed air, while the reservoirs are in the basement. Two Bell telephones, with city connection, as well as a local phone system, facilitate communication.

The staff consists of two resident physicians, a lady superintendent, and a bookkeeper. There is also an honorary consulting staff.

Owing to the fact that graduate nurses are, as a rule, afraid to nurse tuberculosis, and because, as well, it is necessary to give them special instructions in any case, a training school has been established in connection with the hospital, covering a two-year course in general nursing. There are ten nurses on the staff, and the work being done is equal to that in any other institution.

The patients are all under the special care of the physician-in-chief, who regulates, as he may consider necessary, the life of each individual under his charge. He has a general supervision of all their movements, and makes, from time to time, regulations as to exercise, rest, sleep, diet, etc. In all respects patients receive every care and attention, but in no case are patients allowed to deviate from the regulations laid down by the physician in regard to their case. Special attention is paid to diet. Good, plain, wholesome food, carefully prepared, well cooked, and daintily served, with such delicacies as may be advisable, is provided. The menus are written daily, and are kept on file. A record is kept also of what is sent to each bed patient at each meal. In the general dining room a report in writing is made by the patients at each table at each meal. These are also kept on file. All patients able to be up, but requiring special care in diet on account of gastric or other disturbances of digestion, are

placed at a special table, under the supervision of a nurse, with in some cases a special diet list. Written reports in these cases are furnished by the nurses twice a week.

Every facility is afforded for taking the open-air treatment. At the K. E. S. C., the majority of the patients remain outside both day and night, their beds being wheeled in by the orderlies for meals and treatment only. All the standard treatments are used, including the various serums and tuberculins as may be indicated. Complete records are kept on file of all cases.

Lectures are delivered to the patients at regular intervals on various subjects of a practical nature in connection with the disease and its treatment, and in this way an endeavor is made to educate the patients, so that they may inform their friends and the locality in which they live in all matters pertaining to the disease.

As descriptive of the points which may be observed by the casual medical visitor, it may be permissible to quote some sentences from a descriptive article written by the late Sir W. H. Broadbent, M.D., F.R.S., and published in the *British Medical Journal* last year. In it he says, among other things: "The hospital is conducted on open-air principles and is bright and cheerful. Three women slept on a balcony all through last winter. A detail of some interest and importance is that the beds are not close up to the walls. If dust accumulates anywhere in a hospital ward, or ordinary bedroom, it is under the head of the bed, and a clear space here, easily accessible to the moist duster, is an excellent idea. The spittoons are small, square, flat tin boxes with a handle, within which is a close-fitting box of stiff moisture-proof paper. They are all numbered and the paper and tin correspond. The inner paper box is removed at regular intervals and a note is taken of the amount and character of the contents. Perhaps a specimen of sputum is withdrawn for examination, after which the paper box and its contents are burned. The examination of the expectoration is facilitated, and there is no need for an elaborate apparatus for disinfecting the spittoons. The handkerchiefs are made of a soft, thin cotton fabric called, I think, butter cloth, and are cut off from the piece in the institution. They cost less than the washing of an ordinary handkerchief and are burnt. The administration and organization are evidently most efficient. Spray and pulverized liquids and powders for the various parts of the air passages are administered by means of compressed air, operated, as the trans-Atlantic term is, by a minute electric motor situated in the corner of the room. The force of the current of air can be regulated and the spray

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can be given to several patients at once under the supervision of the resident medical officer, which is a great advantage. They sit in a row on a form, each holding his own particular phial of inhalant, into which the compressed air is conveyed. Another interesting detail in the examination and operation room is that a disc of glass is suspended between the physician and the patient during throat examinations. It prevents the disagreeable and dangerous projection of particles of expectoration into the examiner's face, which often gives rise to suspension of the examination or operation, and it does not interfere with manipulation or with a good view of the mirror.

"The value of a hospital like this is not measured by statistical results, but surprising improvement often takes place in the worst cases, and many patients have so far recovered as to be fit to return to their homes without danger to their families."

During the three years since the hospital was opened there have been discharged 421 patients, of whom one was non-tubercular. In these 420 cases the following have been the results:

RESULTS IN PER CENT. FOR THREE YEARS.

	Far Advanced. 218 Cases. Per cent.	Advanced. 159 Cases. Per cent.	Moderately Advanced. 13 Cases. Per cent.	Totals. 420 Cases. Per cent.
Apparently cured....	..	1.6	13.0	1.3
Disease arrested.....	..	5.8	53.8	4.4
Much improvement..	6.9	44.3	30.8	24.5
Stationary.....	7.8	22.2	.	14.1
Failed.....	17.4	7.9	..	12.4
Died.....	67.9	17.9	..	43.3
				100.0

From these figures the value of distinguishing between the advanced and the far advanced cases will readily be seen. As to the permanency of results, it is very difficult to speak with accuracy, because it is almost impossible to keep in touch with those who have been discharged. It is possible to say this much, however, that of those discharged during the last year some twenty are known to be at work regularly and to be enjoying good health. A number, moreover, are in better health at the present time than they were at the time of their discharge, notwithstanding the fact that they have been working and living under ordinary conditions for several months.

In conclusion, it may be said that a visit to these institutions will amply repay any physician, and will, perhaps, make it easier for him to advise patients coming under his care.

Selected Articles.

REPORT OF A CASE OF IMPACTED BREECH PRESENTATION TREATED BY HEBOTOMY.*

BY RALPH H. POMEROY, M.D., BROOKLYN, N.Y.

Quoting from Menge, in the July, 1907, issue of the *Munchener Medicinische Wochenschrift*, on "Indication for Operation for Increasing the Width of the Pelvis": "The after-coming head is often brought down with difficulty, even in pelvis with a conjugate between 7.8 and 8 cm. Hebotomy is indicated in diameters from 7.5 to 8 cm. in breech presentations." This note is quoted in endorsement merely of the following recent case of my own, delivered successfully after hebotomy, as I am ready to stand for the reasonableness of the procedure on the merits of the case alone. The statistics as to mortality in some hundreds of reported cases of hebotomy in Europe appear to run from 5 per cent. to 7 per cent. for the mothers, and from 15 per cent. to 20 per cent. for the children. In America the statistics of twenty cases collected by Fry, in 1907, gave 20 per cent. mortality for the mothers, and 40 per cent. for the children. I have not had opportunity to collate the later operative statistics, in this country, but it is my contention that the proper status of the operation is not determined by statistics covering cases in which the child has been already half killed and the mother's tissues maimed by ill-judged forceps application. Many cases come to the skilled surgical obstetrician too late in the history of the labor for him to do justice to either of the unfortunates. In such cases the effort to save the damaged infant by any means is likely to be to the disadvantage of the mother. It is a curious fact that we are at present at a stage of obstetric philosophy which purports to take an acute interest in the value of the child's life, and yet in practice that interest is spasmodic and erratic. Why should the value of the fetal life loom large in a positive case of contracted pelvis and yet such a life be allowed to fade away unconsidered under the pressure efforts of a dry labor? Why should it be deemed an ordinary and excusable catastrophe for the child to perish in the course of a prolonged second stage due to posterior position of the vertex? These oc-

* Read before the New York Obstetrical Society, Jan. 14, 1908.

currences are common enough, as well as an array of disasters incidental to high forceps operations which are accepted as mere events. The statistics of the causes of still-birth are, to the best of my knowledge, meager and unsatisfactory, but I am convinced that the lowering of fetal mortality in obstetric practice in general deserves more attention from the experts of the profession. Yet, they themselves should be bold enough to sacrifice a damaged infant in the interest of the mother's life and future health. A presumably non-viable child should be craniotomized even before death if the mother's interest positively demands it.

Passing from the consideration of the badly managed cases that come to be extricated from their difficulties, how shall the expert plan for the border-line disproportions? Logically, every relative disproportion case should be subjected to Cesarean section early in labor if we allow maximum value to the child's life. Yet the factors of a spontaneous or slightly assisted safe delivery, *i.e.*, the moulding of the head and the efficiency of the expelling forces, are in many cases so unmeasurable that medical history contains very many stories of prospective and prophesied disasters that have eventuated in easy labors. As long as we hold that the border-line case is entitled to a trial at natural labor, we shall occasionally see cases which have advanced to a point where logically a slight enlargement of the pelvic canal is the proper solution, assuming good surgical skill and surroundings. The "Walcher" posture is lauded as supplying an expedient for many such situations. This is doubtless true, but the amount of gain in the actual area at the obstruction girdle is so slight that this resource does not compare in efficiency with the enlargement of nearly all diameters available by section of the bone or joint.

These observations are made in defence of symphyseotomy, or hebotomy, whichever procedure may win out on its technical safety or efficiency, to be utilized only in certain selected cases of moderate disproportion between the head and the pelvis, where neither mother nor child have been subjected to obvious trauma, but where Cesarean section is contraindicated on account of the advanced stage of the labor or the imminence of infection.

Case Report.—D., married, Catholic, aged seventeen, in labor at term, was brought into the Methodist Episcopal Hospital by the ambulance at 11 a.m. January 4, 1908. Dr. J. E. Hatton, her attending physician, reported an impacted breech presentation with contracted pelvis. The patient had been in labor for twelve hours; the membranes ruptured for nine hours. No meconium had been expelled. She was a slight, small boned woman, already somewhat exhausted; pulse 120, temperature 99 degrees.

Inefficient pains recurred at from ten to fifteen minute intervals. Vaginal examination revealed both feet and the scrotum presenting at the level of the brim—position R. S. P. The diagonal conjugate was 10 cm. (equivalent to about an 8 cm. true conjugate). The cervix was thin and nearly obliterated. The external measurements were: intercrystal, 27 cm.; interspinal, 23 cm.; external conjugate, scant 18 cm., a slightly flattened justo-minor pelvis. Measurements of the fetal head in the upper uterine segment gave a maximum diameter of 13 cm. The liquor amnii had apparently nearly all escaped. The bulk of the fetus was estimated as moderate and proportionate to the size of the mother, but the head probably of average dimensions. Fetal heart regular at 140 to 150. The patient was kept under observation for two hours longer with no definite change in conditions beyond slight further retraction of the thin cervix.

After consultation with the attending physician (who advocated Cesarean section) and with my associate, Dr. O. P. Humpstone, it was deemed reasonable to reject the Cesarean operation on account of the length of time the patient had been in labor with the membranes ruptured and the feet practically in the vagina. It was, of course, accepted that there was a possibility of successful delivery by the ordinary process of extracting the after-coming head. The conjugate, 8 cm., was within the range of many histories of spontaneous or forceps vertex delivery, or of the more advantageous traction and expression expedients available in delivery by podalic extraction. But in a justo-minor pelvis, an 8 cm. conjugate means a much smaller actual passage than a similar conjugate in a flattened pelvis of larger frame. On this reasoning it was voted that the extraction of the unmoulded head would be much facilitated and the child's chances of living would be greatly enhanced by a preliminary enlargement of the pelvic girdle. The recognized exceptional interest of the tenets of the Catholic Church in the life of the child was also given weight in the decision.

Preparations for hebotomy were made, with routine surgical precautions. Under ether anesthesia the vagina and introitus were manually dilated until the closed fist could be extracted. A vertical incision, an inch and a half long, was made over the left pubic bone, separating all structures to the periosteum. With blunt dissection and the finger, the bone was bared posteriorly and an extemporized carrying needle was passed downward and carried out through an incision external to the left labium majus, and the Gigli saw drawn through. There was very little bleeding from the upper incision, and a moderate

venous ooze from the lower. No apparent increase in the hemorrhage was noted on the parting of the bone, which amounted to a finger's breadth at once after the passing through of the saw. The pelvis was well supported by an assistant on either side. On withdrawing the saw the lower incision was packed with gauze. Seizing the feet, successively the lower limbs were extended and the trunk extracted slowly, rotating the occiput to the left anterior position in process of delivering the arms. The head was forced past the brim chiefly by rather severe supra-pubic pressure by the assistants, flexion and guidance into the right oblique diameter being maintained by the operator. The difficulty of passing the brim was severe enough to justify the belief that delivery would have failed if the pelvis had not been severed. The perineum was torn to the second degree in the haste completely to extricate the head. The child was a male, moderately asphyxiated, responding promptly to artificial respiration and flagellation. It weighed 6 pounds 4 ounces. The cranial measurements were : O.M., 13 cm.; O.F., 12 cm.; S.O.B., 10.5 cm.; B. P., 9.5 cm.

The placenta was readily expressed. No post-partum hemorrhage occurred. In the exciting moment of the delivery of the head no accurate note was made of the amount of separation of the divided bone ends. The upper wound was closed with two buried fine chromic and two through-and-through silkworm gut sutures. The injured pelvic floor was also repaired *secundem artem*. Two overlapping broad strips of adhesive plaster, encircling the pelvis, secured against mobility of the severed bone. Removal of the pack in the lower wound showed that oozing was too free to allow safe suture closure; it was, therefore, repacked with gauze.

The patient made an almost uneventful recovery. Catheterization was necessary for several days. The pack in the lower wound was removed on the second day; stitches from the upper wound on the ninth day. The highest temperature was 101.6 degrees, on the third day; thereafter it ranged to 100 degrees in the afternoon until the end of the first week. The pulse continued between 100 and 120 for three days, since which time it has been from 80 to 90. Beyond the adhesive plaster retention no special management of the fracture was arranged for. To facilitate the lochial drainage, the head of the bed was kept elevated about eighteen inches. The usual edema of the left labium was noted. The bowels were kept open by saline laxatives administered by the mouth. One-sixth grain of morphin was given hypodermatically shortly after the operation. There-

after the patient was notably free from pain or discomfort, and successfully nursed her infant. She was allowed to sit up on the twenty-first day, to walk on the twenty-fifth day, and left the hospital on the thirty-first day after operation. Examination on dismissal showed the pelvic measurements unchanged. A slight sulcus could be felt on the anterior surface, and a ridge of callus on the posterior surface of the point of partition of the bone. There was no disability in locomotion.—*American Journal of Obstetrics.*

THE MEDICAL AND SURGICAL TREATMENT OF GALL STONES, THEIR SCOPE AND RELATIONS.

BY JOHN B. DEEVER, M.D., PHILADELPHIA, PA.

The rise of surgery in the last two decades has brought many conditions, formerly left to the internist alone, into the sphere of surgery. Some, such as appendicitis and carcinoma of the gastro-intestinal tract, are by common consent ailments of a purely surgical character. Others are still upon the border-line.

Of the latter class, cholelithiasis is perhaps one of the most conspicuous examples. While the ideal treatment of gall stones is undoubtedly by surgical procedure, it would be folly to assert that all cases should be subjected to such treatment without delay.

Internists and surgeons have indulged in many bitter arguments and discussions on this score, each failing to realize that both have places to fill. The work of the one must supplement and at the same time be guided by that of the other. It is often only by careful observation and discrimination in individual cases that a choice can be made between the two modes of therapy; and an adequate comprehension of the relations of medical and surgical treatment of gall stones lies at the bottom of a sensible use of either.

One of the great strides in an understanding of gall stones brought about by modern surgery has been in the demonstration of the living pathology. While clinicians have been studying the symptomatology, and pathologists have carefully investigated the gross and minute pathology in the cadaver, the surgeon alone is able to show the disease in all the stages of its progress. He sees it in its incipiency in one case—when it has progressed somewhat further in another—and again in a third he sees it

when it has nearly reached a fatal termination. The latter condition, thanks to enlightened medicine and surgery, is daily becoming rarer and rarer, and were operative treatment promptly resorted to, need scarcely exist at all.

Consequently, it is the surgeon first and foremost who is privileged to appreciate what grave lesions and pathological processes may exist with few marked symptoms, and even these may be masked until the time when they will show their effect so quickly that no form of treatment will be of avail. He is able to see more clearly than the physician how the complications of gall stones—adhesions, cholecystitis, pancreatitis, etc.—make difficult the diagnosis and retard the treatment. It is the surgeon again who shows how often gall stones are present and underlie the symptoms when their presence can scarcely be suspected, and he it is who often demonstrates that cases formerly given up in despair of diagnosis, have as foundations of their illness either gall stones or their common accompaniment, adhesions of the upper abdomen.

Such conditions as these would naturally lead us to restrict the field of medicine and enlarge that of surgery in gall-stone disease; yet surgical treatment is by no means to be insisted upon for all patients. It has been well said by Kocher that gall stones do not "belong" to the surgeon. "They belong," he says, "in the first place to the patient, and if he prefers to retain them and to drink Carlsbad waters as well, he is quite within his rights to adopt this method, a line of treatment which, as is well known, is followed even by many surgeons when they themselves have gall stones. In the same way, if a patient prefers to wait in suffering and pain for a stone to work its way down *per vias naturales*, he is but enjoying his personal privileges. But," as Kocher adds, "at the present day the surgeon is certainly justified in telling a patient with gall stones that by an operation he can be quickly and safely cured of his trouble and be saved from eventual danger, more rapidly and more easily than by any other treatment."

There are, in the first place, many cases in which a patient has but one or at most two attacks of gall-stone colic in a lifetime, and in the interval is perfectly well. Medical treatment and hygienic watchfulness meet all demands in this class of cases; but at any moment acute symptoms may arise demanding immediate operation, and then both patient and surgeon will realize, perhaps too late, the greater safety and efficacy of operation in the interval between attacks.

Then again, many patients urgently in need of radical relief

show contra-indications to surgical intervention. Thus, persons who are markedly anemic or cholemic, who are very old, or who have some grave lesion of the heart, lungs or kidneys, should be operated on only as a last resort, if at all.

Many also in whom surgery is indicated refuse for personal or extraneous reasons to consent to operation. Such cases as these are entitled to medical treatment, although the surgeon should not conceal from them the added risk they run in postponing radical cure.

The medical treatment of gall-stone disease I will not discuss at length. It must aim to reduce inflammation of the gastrointestinal tract, to favor elimination of toxins, and to guard against dietary and other indiscretions which cause exacerbation of the symptoms. This is the rationale, or rather what is accomplished in selected cases by the Carlsbad treatment, as carried out at these celebrated Springs. It must not be understood that the Carlsbad waters or the Carlsbad treatment dissolves stones or forces them through the bile passages, for such is not the case. Many people who take the journey to Carlsbad are not suitable subjects for this treatment; the consequence is that much of my time is occupied by operating on patients who have received this treatment with no results. The journey to Carlsbad is expensive and can only be entertained by those whose financial conditions permit it; therefore, he who has to earn his bread by the sweat of his brow must submit to the aseptic scalpel of the surgeon if he would obtain a cure. I have never had any evidence that the medical treatment in these cases is anything but palliative. The cure of gall stones by medication or the relief of their complications by drugs is, for the present at least, an impossibility. Reported cases of cures are generally found to be instances in which the stones have become quiescent, but have not been removed. Dr. A. O. J. Kelley, in studying 216 patients recently operated on by me for infections of the biliary tract, said (*Amer. Jour. Med. Sc.*, Nov., 1906): "We now know that the thousands of gall stones said to have been passed by the bowel after the administration of olive oil are merely masses resembling gall stones in outward appearance, and due to the basely deceptive powers of the olive oil acquired in its passage through the intestinal tract."

There is no doubt that much can be done by medical means to build up the patient, reduce the effects of cholemia and prevent recurrence of attacks of colic, not to mention relief of acute pain. But that gall stones can be broken up, dissolved, removed, or otherwise done away with by drugs, seems to me an idle

statement in view of the modern understanding of their nature and pathology. And especially unaffected by medical treatment must always remain the graver complications of gall stones, such as empyema of the gall bladder, adhesions, fistulae, etc. It must not be lost sight of that gall-stone disease can remain latent until Nature places the patient asleep in the everlasting rest of the grave. Granting then, that surgery is the preferable treatment in most cases, there is still the distinction between those in which the operation is one of immediate necessity, and those in which it is one of choice. In the former group we may include primarily cases in which we have marked infection, with cholangitis, or with empyema of the gall bladder, and those cases of obstruction of the common duct which show no tendency towards amelioration of the symptoms after a reasonable time of treatment—which I consider to be from two to three weeks.

In the latter class are cases of simple hydrops of the gall bladder, and ordinary cases of cholelithiasis in which the attacks are separated by longer or shorter periods of good health.

So also are those doubtful cases in which a diagnosis rests between one of gall-stone disease and a duodenal or gastric lesion. A realization of the number of cases in which prolonged indigestion of a more or less marked type, continued flatulence and vague epigastric distress and pain are due to gall stones or their sequels, has only of late years become more common. First and foremost among these sequels we must count adhesions of the upper abdomen as a result of gall stones. These impinge upon the neighboring viscera, the stomach and duodenum especially, and give rise to symptoms none the less annoying because they are vague and varying in character. Indeed, it is often the pericholecystic adhesions that give rise to the symptoms of which the gall-stone patient most bitterly complains. Bland-Sutton (*Gall Stones and Bile Ducts*, N. Y., 1907, p. 192) narrates that on two occasions where he has removed calculi from gall bladders he was unable to see the liver on account of adhesions.

The prevalence of "indigestion" and "dyspepsia" in gall-stone patients is shown by the fact that in a series of 182 consecutive cases of my own which I have recently analyzed, they were noted in more than forty per cent. of the total number.

When surgical intervention has been decided upon for the relief of one or another of the conditions mentioned, we can undertake it with much better spirit and hope of success than would have been possible fifteen or even ten years ago. In hardly any other branch of abdominal surgery has the recent progress been so rapid, and at the same time of so definite and

lasting a character as in the technic of operations upon the gall bladder and biliary passages.

Needless to say that the patient should be in the best possible condition when the operation is to be performed. Three days of preparation and stimulation where it is needed will often save as many weeks of anxiety after the operation, and will preserve many lives. The circulation should be in the best possible condition, and the excretory organs doing the best work of which they are capable. Anemia should be combated, and delayed coagulation dealt with as far as it can be by the agents which we have at our disposal. In the latter condition the chloride and lactate of calcium have been recommended. I have used them both, but am still very doubtful whether or not they have any real value.

Before the operation itself begins, and during its progress, the anesthetist fully shares the responsibility of the surgeon. Careful anesthesia is of the utmost importance, especially in operations so prolonged as those in complicated gall-stone cases are apt to be.

When the operation itself is considered, there are a number of points to which the surgeon must direct his attention.

1. The incision. In spite of the dictum of so accomplished a surgeon as Terrier, that Mayo Robson's incision is "not sufficient," it is that which I prefer, if any departure from the simple straight incision is demanded. I have never found fuller exposure than it gives, requisite. The use of a sand pillow or some similar support beneath the spine, so as to increase the dorso-lumbar convexity, as first suggested by Eliot, of Boston, is indispensable in most operations on the bile ducts. In very difficult cases the reversed Trendelenburg position may be a further aid in rendering accessible the deeper parts of the common duct or the hepaticus.

2. The field of operation when exposed must be carefully walled off from the abdominal cavity at large, to prevent the distribution of possibly infectious material in the peritoneal cavity. I use for this purpose both gauze pads and marine sponges. The former I introduce first, and the sponges above it. The sponges are of advantage in a two-fold way: (a) They absorb the bile or fluid rapidly and hold it well. (b) By their elasticity they may be made to act as retractors, especially when held by the hand of an assistant. The operation is much accelerated by introducing packs where they are to remain until the close of the operation. Many surgeons will have to remove their packs several times and again reinsert them, before they are

able to obtain sufficient exposure in the depths of the wound. This is usually due to carelessness, and to neglect of the surgical principle of beginning the insertion of the pads from one extremity of the incision. If the first pad be placed in the middle of the incision, the intestines will prolapse on both sides of it, and before a second pad can be placed the first will have become useless.

3. Adhesions must be dealt with and removed when they mask the field of operation, obstruct the biliary passages, or interfere with surrounding organs. They should be left alone when they are doing no damage, as their removal always takes time, and prolongs the operation, and may lead to consequences more grave than those to which their presence gives rise.

4. All the stones present in any one of the bile passages must be removed, unless they are far within the hepatic ducts and cannot be reached. A stone left in the gall bladder becomes a fresh focus of stone formation, while a small fragment in the ampulla or common duct of course invalidates the whole operation.

5. The gall bladder should be left when it is not so much damaged as to be functionally inactive as a bile reservoir, but must be removed when the contrary is the case.

6. After an operation on the gall bladder or bile passages, drainage should always be instituted in the presence of infection, and also in the majority of cases even when no infection is present. This renders the operation much more safe, and lessens the chance of subsequent complications. To me it is incomprehensible that surgeons should regard drainage of the hepatic duct through the common duct into the duodenum as sufficient in cases of infectious cholangitis. To drain one infected organ into another—the duodenum—I consider unsurgical in the extreme. In cases of severe pyelo-nephritis we are not satisfied with the drainage afforded through the ureter, into the bladder, which was probably the original seat of the disease—but we perform nephrotomy, and drain the kidney directly into the loin. So when the liver is infected, and we have a suppurative cholangitis, the only chance of safety lies in direct hepatic drainage through the laparotomy wound. The intra-hepatic pressure must be relieved, and this cannot satisfactorily be done by drainage into the intestinal tract.

7. After removal of the gall bladder in the presence of infection there should always be some chance for the drainage of bile, either by draining the stump of the cysticus, or preferably the hepaticus through the common duct, by means of a rubber

tube. When there is no such infection, and the gall bladder has been removed, a cigarette drain should be introduced to the site of the ligature on the duct, to guard against infection should the ligature slip or be thrown off by the *vis a tergo*.

8. There should be as little disturbance of the peritoncum as possible. If there is much trauma to this delicate membrane adhesions are sure to result. This must be borne in mind especially when introducing gauze drains. These, when used in the conditions under discussion, should always be covered with rubber dam or introduced through a split rubber drainage tube to prevent their sticking and forming adhesions.

This is but a brief outline of some of the cardinal principles underlying gall bladder surgery. Only those who do it can appreciate its difficulties and dangers, and no branch of surgery is less suitable for the tyro. The surgeon who does gall-stone operations must be prepared to do a gastro-enterostomy, or an entero-enterostomy—in fact, must be ready for almost any abdominal operation. Complications are often found to exist which tax the skill of any surgeon, and the avoidance of danger to surrounding organs or spreading infection is no easy matter.

The surgical treatment is by no means ended when the patient leaves the operating table. The after-treatment is in most cases simple. The patient is left alone and recovers. Stimulants may at times be needed, and their nature and indication will be evident. The drainage must be left in an adequate time—until it has fulfilled its function and can be removed easily.

Perhaps the most common post-operative condition that calls for prompt treatment is persistent vomiting. Early and often repeated lavage is its only treatment, and practically never fails to give relief.

The results of surgical treatment of gall-stones are universally acknowledged to be highly satisfactory. In no other branch of abdominal surgery is a final and permanent recovery more sure to follow operation. In a series of 182 cases of gall stones operated upon by me in the last few years, I have had a general mortality of 14.8 per cent. This includes besides simple cases—carcinoma, cholangitis, purulent cholecystitis, perforation of the gall bladder and local peritonitis. In selected cases the mortality is, of course, less. My later cases give a much lower percentage of mortality than the earlier ones, the improvement in the death rate going hand in hand with the improvement in technique and more careful selection of cases.

Much would be gained if the cases came to the surgeon earlier, when gall stones alone had to be dealt with and not their compli-

cations. The complications cause the operative failures and raise the mortality. Sepsis and infection before and at the time of operation have caused nearly half of the deaths in my cases.

It is evident then, that if the cases are sent to the surgeon in due time, and operated upon only when they are in suitable condition, few failures will follow proper surgery.

Medicine and Surgery must go hand in hand in the treatment of gall stones, each treating a separate class of cases, and always bearing in mind the fact that a surgical cure is the only final and definite one.—*Surgery, Gynecology and Obstetrics.*

Progress of Medical Science.

MEDICINE.

IN CHARGE OF W. H. B. AIKINS, F. A. CLARKSON
AND BREFNEY O'REILLY.

Senile Respiratory Disorders.

Powell (*The Hospital*) notes that old age is a health process, not a disease. One of the most common events of this period is the calcification of the costal cartilages accompanied by senile emphysema. But these changes are physiological, not pathological, and are therefore not to be treated. A localized fibrosis is, of course, very common and even in advanced life there sometimes occurs a sudden activity with hemoptysis or other evidence of pulmonary tuberculosis. From an old cavity there may sometimes be a great deal of mucous expectoration and even bacilli in numbers, and yet in the aged, this does not necessarily furnish proof of active tuberculosis.

After an attack of pneumonia or influenza, there is sometimes left behind a basal fibrosis which may be mistaken for an acute process, particularly if accompanied by some bronchitis. The treatment of this condition is directed to the general health, and not to the pulmonary condition.

In the use of strychnine Powell sounds a warning that although undoubtedly of great use it may sometimes be overdone, and the consequent rise of arterial pressure tempts the old man to do more than he has strength for. Any course of this drug, then, should not be too prolonged and small doses only should be ordered, such as two or three minims of the liquor strychninae, or 5-7 of the tincture of nux vomica.

One of the most common "end-diseases" of old people is latent pneumonia, "the old man's friend." The symptoms of onset are fatigue and exhaustion, with a very little cough and expectoration. Cheyne-Stokes breathing, by no means rare in old people, is probably due to an exhaustion of the center which requires a longer rest than it can get in the ordinary way of respiration.

For all these conditions he recommends warm oxygen inhalations, which are more beneficial than alcohol. The gas is passed

through warm water or through a metal tube warmed by a hot water chamber.

The Function of the Optic Thalamus.

Mott, in his lectures on the physiology of the emotions, states that all afferent sensory stimuli meet in the optic thalamus, the principal function of which is that of a sensory relay station to the cortex. Irritative lesions of the thalamus are frequently associated with severe pain in the opposite half of the body. In old cases of cortical hemiplegia, the face on the diseased side can only be imperfectly moved by the will, yet if the patient under the influence of the emotions laughs or cries this side of the face is more strongly contracted than the non-paretic side. In lesions of the thalamus, on the other hand, the opposite is observed. The patient, on the one hand, can voluntarily move the paretic side of the face well in all directions; on the other hand, in emotional expressional movements, this side of the face is immovable.

Physiology and Treatment of the Stomach.

Strasburger reviews what has been learned in late years in regard to the physiology, pathology and treatment of the stomach. Grutzner's research has confirmed the fact that the food as it is taken into the stomach lies in layers and does not become mixed. The food first taken into the stomach lies around the periphery and that taken later lies inside of this and thus does not come in contact with the mucous membrane, even when the food is more or less fluid. These facts show that the Sahli and Mathieu tests of stomach functioning are liable to give misleading findings. They also throw new light on the therapeutic administration of hydrochloric acid. When the hydrochloric acid is given after a meal it lies in the middle of the top layer of the stomach content and thus does not come in contact with the pepsin secreted by the mucosa. The digestion is not improved by its administration unless pepsin is administered with it. Experience has shown, also, that larger amounts can be given to advantage. Leo prescribes for adults from one-half to two teaspoonfuls of a mixture of 5 or 10 parts each of hydrochloric acid and dried pepsin with water to 50 parts, taken in sweetened tea during or after the meal. If the aim is to prepare the stomach mucosa for secretion of gastric juice on ingestion of food, or to stimulate the production of bile and pancreatic juice, the hydrochloric acid should be given alone, just before the meal, without pepsin, and in smaller doses.—*J. A. M. A.*

National Volunteer Emergency Service.

We learn from Dr. F. Elbert Davis, Adjutant-General of the National Emergency Service, that that Service has been reorganized, and will be under the direction of Dr. James Evelyn Pilcher, Director-General. We hope that the reorganization of this Service, which means so much to the public and the profession, will bring forth very satisfactory results.

Toronto Academy of Medicine.

At the annual meeting of the Academy of Medicine, held May 5th, the following officers were elected:—President, Dr. J. F. W. Ross; Vice-President, Dr. A. A. Macdonald; Honorary Secretary, Dr. H. J. Hamilton; Honorary Treasurer, Dr. J. D. Gibb Wishart, and also a Council of 15 members.

At the same meeting the first Honorary members were elected as follows:—Dr. Wm. Osler, of Oxford; Dr. James H. Richardson and Dr. Walter B. Geikie, of Toronto. Dr. Joseph Bascom, of Toronto, was elected a life member.

The Fifth Pan-American Medical Congress will take place in Guatemala, C.A., August 5th-8th, 1908. A pleasant sea voyage, a happy reunion with our Southern confreres in Medicine, and a cordial reception are anticipated. Those interested in Nervous and Mental Diseases are invited to attend and to contribute to the work of the section on Psychiatry and Neurology. For further particulars address C. H. Hughes, M.D., Secretary, Section of Nervous and Mental Diseases, 3872 Washington Avenue, St. Louis, Mo.

The *Southern Medical Journal* made its first appearance in Nashville, Tenn., last month. Its aim will be to advance the interests of the entire Southern medical profession.

OBSTETRICS AND GYNECOLOGY.

IN CHARGE OF ADAM H. WRIGHT, K. C. M'ILWRAITH, FRED. FENTON
AND HELEN MACMURCHY.

A Case of "Fleshy Mole." By J. W. BROWNE, B.A., M.B., B.Ch., Adelaide.

The patient, Mrs. M., was first seen by me on December 26th of last year. The history was as follows: She had been married about a year; was last unwell on October 9th; on Christmas Day she noticed that she was bleeding, and sent for me on the 26th. I found, on examination, that the uterus was enlarged, about the size one would expect at two and a half months, and that there was blood coming away from it. There was no pain. I diagnosed threatened abortion, and prescribed rest in bed, and gave a little opium. The patient stayed in bed altogether nine days, by which time the bleeding had stopped. Only blood was passed during this time. She then got up and went about her work as usual, and I congratulated myself on having prevented a threatened abortion. I may remark in passing that this is a thing I have always tried to do in any case of threatened abortion I have had occasion to treat, but have never yet succeeded in doing, with the possible exception of the present case.

I heard nothing more from the patient until May 6th, when she came to see me. Her complaint was then that she was not feeling altogether well; that she had "no life and felt no interest in anything"; also that she had not noticed that alteration in figure she was entitled to expect. The bleeding had not returned, and there had been no discharge of any kind. I examined again, and was a good deal surprised to find that the uterus had apparently not increased in size since the last examination; it was, so far as I could judge, exactly in the same condition. I told the patient that the child was dead; that it must have died at the time she had that threatened miscarriage, and that it had not come away as it should. I recommended operation, and explained to her that she would not be well until everything left behind had been removed. The family, however, had had a most unfortunate experience of operations in the past, and were strongly disinclined to submit to another, of the necessity of which they were not entirely convinced. They decided to await the healing influences of time and nature. I told the patient to come again in a month. She did, with the same story as before, and I again strongly recommended operation. This time she

consented, asking, however, for four weeks' grace, to give those healing influences another chance.

On July 21st bleeding recommenced, accompanied by severe pain. There had been a slight brownish discharge for two weeks before this date. On the 22nd I found a mass protruding from the os uteri, which I withdrew, and then curetted the uterus. The mass referred to was about the size and shape of a small orange. It contained a cavity, opening to the exterior. The wall of the mass was about an inch thick; the material of medium toughness, and fairly uniform texture. No foetus recognizable. It was, I think, a well-marked specimen of the so-called fleshy mole.

The patient was quite well in a week, and has remained so since. The catamenia returned in four weeks after the expulsion of the mole.

The points of interest in the case seem to me to be the long time, nearly seven months, the mole was retained; the total absence of bleeding during that time; the aseptic condition of the mole; and the comparatively trivial symptoms its presence occasioned. The mole was expelled almost exactly at the time the foetus would have attained to term had it survived.—*Australasian Medical Gazette*.

Monstrosity.

Dr. M. V. Mulcahy, of San Jose, Cal., reports a peculiar case, under date of May 3rd, 1908:

Parents both healthy, no abnormality; they have two children, both girls, one six, the other four, perfectly normal and quite pretty.

The mother gives no untoward history during pregnancy except she had scarlet fever in March last. I attended her; the attack was light, highest temperature 103 degrees, lasted only five days.

I was called at 1 p.m. April 25th, she saying that she was flowing some. I examined; found a breech presentation; os patulous slightly dilated, no pains; ordered her to bed; was called again at 4 p.m., she having hard pains; on examination found os dilating nicely; membranes ruptured. Labor was normal and easy; foetus delivered at 5.30. The placenta, which was expressed without aid five minutes after, was small but normal, cord very small and flaccid. Foetus breathed about once in a minute for half an hour. Monday a.m. mother's temperature 103.6 degrees; lochia scant and very light color, some odor.

Evening temperature, 102; pulse, 120; tympanitis. Tuesday a.m. temperature, 102; evening, 100.4. Wednesday temperature, 98.6, and has been normal since. No cause could be found for rise of temperature, as no part of placenta or membranes were left *in utero*, and thorough asepsis on my part would preclude from that source. I believe cause to have been infection from fluid in foetal nose, or whatever it was.



The foetus was as you see it. There was no nose or prominence between the mouth and eyes. The eyes were, as you see, both evidently in one orbit, and, staring at you, were a very uncanny object. The picture makes them appear white, but the conjunctiva was very much injected. The horn on the forehead had a small opening, central, like a meatus urinarius, and on probing a few drops of a muco-purulent nature were discharged from it. The right arm was like a seal's flipper, jointed back, and terminated in two fingers, middle and little fingers, but they were only about 1 1-2 inches from the elbow; left had thumb located near median line of palm and appearing between middle and ring fingers. Both feet were very marked cases of talipes varus. The ears were of tremendous size for a child, but presented no abnormality. The child was a male and weighed 8 1-2 lbs. It breathed for half an hour with a peculiar noise which was indescribable.

THERAPEUTICS.

Treatment of Angina Pectoris.

Sir Clifford Allbutt, F.R.C.P. (*Folia Therapeutica*, Jan., p. 3) : Too often angina pectoris is regarded as inevitably fatal. On the contrary, of all perilous maladies it is, perhaps, the most curable. The writer thinks that it is usually a painful lesion of the first part of the aorta due to tension. Sometimes it may be produced by stretching of the pericardium, as in aneurysm of the left ventricle, or by inflammation of that part of the tunica which invests the root of the aorta; very rarely it may depend on some extraordinary kind of disturbance in the mitral area. The innervation of all these parts is approximately the same, and the disease even in these rare points scarcely deviates therefore from the common formula. This tenderness may be due to aortitis of any kind, *e.g.*, rheumatic, influenzal, or atheromatous. In the first two the tensile stresses may be about or even below normal; in the third, normal or excessive. Primarily angina pectoris is not a fatal disease; secondarily, by reflex inhibition of a frail heart it frequently proves fatal. Even in the case of an infirm heart complete recovery often comes about. In young subjects recovery is the rule.

In treatment there are three purposes: to mitigate, if possible, the lesion of the aorta; to reduce the stresses; to block the inhibitory influence on the heart. In many cases to reduce the stresses may be our only means of compassing the restoration or quiescence of the vessel. To combat the local affection directly we may use antidotes, as in acute rheumatism for instance, salicylates, and perhaps the iodides. The iodides with or without mercury would be required in syphilis. In aortitis arising from other toxins, such as influenza, antidotal means may be lacking, and we have to trust in the recuperative methods of "Nature." There are, however, intermediate cases, such as gout, in which we may not have antidotes so direct as the salicylates, but tolerably efficacious empirical methods nevertheless, on which we may place no little reliance. Indirectly we may do much by reducing the tension. In many, perhaps in most cases, the tension depends on pressures exceeding the normal. In elderly persons angina pectoris is commonly attended with atheroma and often with increased arterial pressures; but in not a few cases it seemed

to be of infective origin, especially of influenzal origin. In these the arterial pressures were not persistently enhanced, and they ended favorably. It may be difficult to distinguish between means used simply to reduce pressure and similar means for the elimination of gout or goutiness; but the distinction is unimportant. Gentle and frequent mercurials, such especially as calomel, in persons who tolerate it easily, laxative waters, at a spa or otherwise, colchicum, salicylates, iodides, strict diet are some such means. Flatulent or catarrhal states of the stomach must be relieved. In obscure cases of heart disease the morbid element may be syphilis, so in angina pectoris likewise give the patient the benefit of this doubt. To promote normal metabolism exercise is important; but as exertion raises arterial pressures, at any rate at the beginning, we shall have to balance tentatively in the individual one indication against the other. Meals should be restricted in quantity. If appetite be defective, it may be solicited by a draught composed of hydrochloric acid, pepsine, and perhaps a little strychnine or other bitter stomachic of a more carminative kind, not so much to aid in the digestion of the meal as to arouse the languid viscus by its customary excitants. Carbohydrates are the kind of ingestum most concerned in the disengagement of flatus, and must be ordered sparingly and with discretion of form and cooking. Alcohol, strong tea or coffee, and other excitants of the heart must be forbidden.

Rest in bed is essential and is sadly neglected. From the first attack of angina the patient should be sent to bed as if he had an aneurysm, so as to reduce the work of the heart as much as possible. The pressure should be reduced as low as may be consistent with health by vaso-dilators, in co-operation with the measures described. On the other hand, the physician must be cautious in ordering an elderly patient to bed, or bed and couch, even for three months. To send an old man to bed for some weeks may be to consign him to a living grave; his lungs may become œdematous, his energies may flag, and he may never get about again. Or a perishing heart may be kept agoing only by a certain activity of oxidation, and in muscular idleness it may dwindle more and more. In young subjects with sound cardiac muscles and arteries this deterioration is less menacing. Nevertheless the writer constrained a man over 80, wiry, cheerful, with the decreescent form of atheroma, to keep bed and couch for many weeks, and cured an angina pectoris which had lasted a considerable time.

The value of the nitrites in reducing aortic pressure is well known; still we are always learning, even in well-worn subjects.

It may be said that an effect so transient as theirs cannot be of more than passing service. But Dr. Harvey, of Toronto, has proved that compression of the abdominal aorta of rabbits for half an hour daily for two or three weeks rends and destroys the arch of the vessel. We have learned that chloride of barium and digitalis have, by virtue of their pressor effects, an unmistakably evil influence in angina pectoris. To reduce tensions at intervals, even for short periods, seems to give the parts a chance to recover. Moreover, Prof. Osler assures us that we are too chary in the use of the nitrites; and that we drop them too soon. In case of necessity he is not afraid to push the 1 per cent. solution of nitro-glycerine as far as 30 minims thrice daily. Sir William Gowers thinks that the nitrites have more than this virtue of temporary reduction; that by prolonged use they have a "steadying effect on the vaso-motor centre." To this end he administers them for months together, sometimes with a little strychnine. The value of the iodides in arterial diseases, arterio-sclerosis, aneurysm, and angina pectoris, is universally admitted. Unless in the suspicion of syphilis, doses of 3 to 5 grains thrice daily are sufficient. This prescription is to be continued for six months, with, of course, such temporary suspension as any intolerance of the patient may indicate.

Eccentric physical causes, such as irritation in any sympathetic part of the body, as, for example, by a loaded colon, an eczema, and so forth, must be sought with vigilance and promptly removed.

In the palliation of the attacks the nitrites are the chief remedy. The writer urges the need of blocking the reflex by which the heart is inhibited, it may be, fatally. This is best done with atropine, which he orders continuously until the liability to an attack seems to have vanished. As tolerance is established, the dose must be increased accordingly. On the access of an attack he orders a dose to be promptly injected under the skin. Morphia, in the vogue of the nitrites, is not to be forgotten; it likewise probably blocks the dangerous reflex path, besides its great efficacy as a palliative. In a series of attacks, and in their imminence, it is invaluable. It is of little use to inject less than one-quarter grain at once, or, in case of any particular hesitation, one-sixth grain, followed in ten minutes by another sixth.

Reduction of Liquids in the Treatment of Heart Disease.

H. Huchard and Ch. Fiessinger (*Bulletins de l'Academie de Medicine*, Feb. 11, p. 168):

Reduction of the liquids taken has been recommended in the treatment of obesity and the circulatory troubles dependent on it, but after having had considerable vogue the method fell into disuse. Like blood-letting and other methods, it was used too systematically and not according to indications. The writers have found reduction of liquids useful in the treatment of disease of the heart, particularly in that due to arterio-sclerosis. In certain conditions this reduction is urgently necessary in order to save the patient from imminent death. The writers particularly refer to the dilatation of the heart of valvular disease, principally in mitral regurgitation complicated by aortic regurgitation, such as occurs in great drinkers of beer (*Bierherz*). No doubt in the heart disease due to arterio-sclerosis it is necessary to prescribe milk and liquids in abundance to promote diuresis and elimination of toxins. But when cardiac dilatation increases and becomes permanent, when the damming of the blood in the veins is irreducible, diuretic drinks cause little elimination. They surcharge the blood, raising venous tension and immobilising more and more the heart in a state of extreme dilatation. Thus the dyspnoea, oedema, and other symptoms of cardiac failure, against which digitalis and other remedies are powerless, are increased. Hence a latent affection of the heart is sometimes revealed after immoderate imbibition, such as occurs in beer drinkers. The older the patient the greater the danger, for the myocardium loses its tone, the much-altered "peripheral heart" can no longer come to the assistance of the "central heart," and the kidneys are more inadequate. It is then necessary to follow the principle, relieve the heart in order to facilitate its work. Not only the quantity of urine eliminated in the 24 hours, but also the quantity of fluid ingested should be observed. The weight of the patient should also be noted. If that rapidly increases interstitial or visceral oedema, which often precedes peripheral oedema, is indicated. One day the dropsy increases rapidly; the heart becomes still more dilated, the abundance of liquid taken causes diminution in the excretion of urine, and renal and cardiac remedies fail totally. The dyspnoea becomes intense, the insomnia becomes continuous, the oedema invades all the tissues, and life is endangered. Then reduction of the liquid taken is urgently necessary, and, strange to say, is a powerful means of diuresis. After administration of

one or two purgatives the reduction allows elimination of the liquid in the tissues and restores the contractility of the heart. Similarly, in acute hydronephrosis one of the best means of diminishing the tension in the sac and of re-establishing the secretion of urine is almost completely to cut off liquids.

In the cases of acute cardiac dilatation described the writers prescribe for the first day 1,500 gm. of liquid (500 gm. of milk mixed with 1,000 gm. of water), of which a Bordeaux glass full is to be taken every hour. On the second and third day half the quantity is taken; from the fourth day the quantity of solid food taken is also reduced. At the same time small doses of digitalin—one-tenth mgm.—are given for ten successive days, then interrupted for five days, and again repeated for ten days. Thus the danger of a cumulative effect is avoided. Simultaneously 100 egm. of theobromine, which is a dechlorodising agent, are also given. On the first day the diuresis is not always great; the quantity of fluid excreted may be 1,600 or 1,700 gm. On the following days the quantity increases to 2,000, 2,500, and 3,000 gm.; from the fifth day it falls to 1,700 or 1,600 gm., and continues at this level for from 5 to 10 days according to the extent of the œdema. In a few days the dyspnoea and insomnia disappear. In some cases it may be necessary to evacuate pleural or peritoneal effusions or to relieve hard œdema of the legs by scarification. If diuresis does not appear the prognosis is grave. An attempt may then be made to stimulate the heart by injecting one-quarter gm. of caffeine once or twice daily.

Editorials.

HONOR TO ROBERT KOCH.

Dr. Robert Koch, the great German bacteriologist, was entertained at a magnificent banquet in New York, April 11th, 1908. We learn from the *New York Medical Journal* that there were present 450 admirers of the German savant. Mr. Andrew Carnegie sat on the right of the guest of honor.

Dr. Koch was born in 1843, and after graduating, practised medicine in Woolstein from 1872-80. In this little town, removed from all the centres of medical science, he became interested in bacteriological studies, and discovered the anthrax bacillus in 1876. Thus, without a university career, he became soon a prominent figure in the medical profession. In 1880, he was called to Berlin as a member of the Imperial Department of Health. Since that time his work in connection with tuberculosis, cholera, trachoma, rinderpest, plague, malaria, typhoid fever, and sleeping sickness is fairly well known, and highly appreciated.

In his speech given at the dinner we find the following words: "Were I to review everything that has been said to-day in my praise, and also to take into consideration the great distinction conferred by you upon me. I must necessarily ask myself, am I entitled to such homage? I believe that I can accept with a clear conscience many of the laudatory things said about me, but I have done nothing more than you are doing every day. I have worked as hard as I could, and have fulfilled my duty and obligation. If the success was greater than is usually the case, the reason is to be found in the circumstance that I came in my wanderings through the medical field upon roads where the gold was still lying by the wayside. Fortune is necessary to be able to distinguish gold from the base metals, but that is no great merit."

The Chairman, in introducing Dr. Koch, said: "What your achievements in science have been, men who are capable of judging will tell us to-night. It will not be an easy undertaking,

for what you have accomplished will hardly find its equal in medical history. With admiration and deep wonder, we ask ourselves, how can one human brain succeed in creating so much?"

Dr. Welch, of Baltimore, said: "Professor Koch's work is a continuation of discovery for science, and comfort for mankind. He has always shown the stamp of a scientist in his work. He has never allowed his view to wander from what would be most practical for the benefit of men. His work has been a triumph for the experimental method in science."

Dr. Abraham Jacobi said: "The nineteenth century gave to medicine four epoch-making men, viz., Bichat, Virchow, Pasteur and Koch. We have the honor of having with us the only survivor of these great men."

Mr. Carnegie said: "In viewing the progress of the world in its various phases, no profession has made, and is making, greater progress to-day than the art of healing. In the list of the heroes of civilization, Prof. Koch occupies a high position. The world has ever been devoted to hero-worship, ever trained to worship physical force, as displayed in its heroes. These heroes, from the days of Homer, have been men who became celebrated for the number of their fellow-men they had killed. Our true hero of to-day is the man who can count the number of men, women and children he has saved. Jenner, Lister, Pasteur, Reid, Carroll, Lazear, Agramonte and Koch are such heroes."

THE VITAL STATISTICS ACT.

The amended Act, will, it is hoped, facilitate the collection of vital statistics, and be useful to the public in permitting of the registration of, more particularly, deaths; and also enable them to secure more readily than has heretofore been possible, certificates of either births, deaths, or marriages of recent date.

The provisions of the Act have been extended to the Indian districts, they being deemed territories, and the Division-Registrar of the same appointed by Order-in-Council, being paid

for his services in a formal manner, as has heretofore been the custom in the unorganized portions of the province.

Much confusion has existed in the past in reference to definition of a search. This, according to Section (7), sub-section (4)a, refers to one county or district, covering a period of not more than three years; the fee for searching being 25 cents—while for a search for one registration extending beyond one county, or for more than three years, the maximum fee is placed at \$2.00. The fee for a certificate, as issued by the Registrar-General (which is *prima facie* evidence in any court), is 50c, the same as heretofore.

Duties of Division-Registrars.—The officers will now be provided with schedules in duplicate of births, marriages, and deaths, and returns have to be made to the Registrar-General on or before the fifteenth days of January, April, July, and October, and not half-yearly, as heretofore, together with original returns as received from clergymen, physicians, and householders. According to sub-section (6) of Section 11, if a Division-Registrar has reason to believe that any birth, marriage, or death has not been registered, it is now his duty to inform the proper person, and on failure of such person to make the registration, information has to be sent forthwith to the Inspector of Vital Statistics.

For the convenience of the public, the Division-Registrar, upon application and upon payment of a fee of 25 cents, shall give a certificate in the prescribed form, which has not been included in any quarterly return made to the Registrar-General; and the statute distinctly states that the fee is for the personal use of the Division-Registrar issuing the same.

Section 14 provides that every legal medical practitioner who attends at the birth of a child shall forthwith give notice on the prescribed form to the Division-Registrar. And Section 22 provides that the duly qualified medical practitioner last in attendance during the last illness of a person who dies shall, before interment, supply to the Division-Registrar all the particulars required to be registered of such death; and in order that there may be no uncertainty as to these requirements on the part of medical practitioners, when other parties notify of

either a birth or death, sub-section (3) of Section 31 provides that in no case is the doctor relieved of these responsibilities; and it is the intention of the Department to enforce these two important measures.

Re the notification of a birth or death, Section 15 provides as follows:

- (a) The father if living; or
- (b) In case of his inability, or if he is dead by the mother, if living.
- (c) In case of the inability of both parents, or, if neither be living, by the person standing in the place of the parents of the child.
- (d) If neither of these can notify, then by the occupier of the house in which the child was born, if he has knowledge of the birth, and by the nurse or midwife present at the birth.

These notices to be given within thirty days after date of birth. And in the case of a new-born child found exposed, it is the duty of any person finding such child to register such information as is required with the Division-Registrar.

As to the notification of a death, the order is as follows: "Section 22.—The occupier of a house in which a person dies, or if the occupier be the person who has died, then every adult person residing in the house in which the death took place. Where a death does not take place in a house, then every person present at the death or having any knowledge of the circumstances, or the coroner who views the body."

Section 20 provides for the altering or inserting a name after the registration of a birth has been made, up to a period of ten years after the occurrence of the same.

In order to facilitate interment of the dead, sub-section (2) of Section 22 provides that where the death has occurred in a township or territory without municipal organization, the return may be made to the nearest Division-Registrar, who, upon the payment of a fee of 25 cents, *shall register the same and issue a certificate of registration of death.*" The fee in this case being for the personal use of the Division-Registrar. And where the

duly authorized Division-Registrars are remote from any particular section of the Province, the Registrar-General, upon proper presentation of the facts, may appoint sub-registrars for the purpose of issuing certificates of registration of death. The fee being paid by the applicant, and the sub-registrar must make his return direct to the Division-Registrar of the district in which the death occurred, and to the Registrar-General.

A very important amendment is that contained in Section 25. The first part reads as follows: "The removal for burial or the embalming of any body shall not take place, and an undertaker, clergyman, sexton, householder or other person shall not engage in the burial of a body unless a certificate of registration has been previously obtained from the Division-Registrar. The importance of this in criminal cases is quite evident to the medical profession.

Under Section 27, caretakers, owners of cemeteries or burying grounds, are required to transmit to the Division-Registrar of the division in which the cemetery is situated, quarterly returns, and subsequently transmitted by that officer to the Registrar-General.

Toronto, May 12th, 1908.

TORONTO GENERAL HOSPITAL.

It is generally conceded that the site acquired for the proposed New General Hospital is a good one. The block secured is bounded by Elizabeth, College and University Streets on the East, North and West, respectively, and by Hayter and Christopher Streets on the South. The Sick Children's Hospital and the new Nurses' Home for the same institution are east of this block.

It was proposed first (we think, by Mr. John Ross Robertson) that it would be well to close Christopher and Hayter Streets, and purchase the land as far south as Gerrard Street. This would necessitate the continuation of Gerrard Street from Elizabeth Street to University Avenue. The block would then be bounded by College, Elizabeth, Gerrard and University Streets.

It has also been proposed that the new Psychiatric Hospital, the Ontario Government intends to build, should be placed on the southern part of this block.

If the Government and Hospital Trustees carry out their present intentions, it seems probable that, on this magnificent block of 15 or 16 acres, we shall have, in the not distant future, the following buildings, commencing from north to south: Pathological Laboratory, Outdoor Department, General Hospital, Nurses' Home, and Psychiatric Hospital.

THE COUNTRY DOCTOR.

This is a well worn theme, but it puts on fresh attractiveness under the touch of Dr. N. A. Powell, of Toronto, professor of medical jurisprudence and associate professor of clinical surgery in the Medical Department of the University of Toronto. His address on the subject was published in the March number of the *Canadian Journal of Medicine and Surgery*. It was first delivered in 1890 before the students of Trinity Medical College, and it is so good that we do not wonder that it was repeated by request seventeen years later, in 1907, before the Medical Society of the University of Toronto.

Dr. Powell tells us that for ten years he was himself a country doctor, but that it is not his own story that he recounts. He evidently had other country doctors under observation, and the composite photograph which he carries in his mind, and of which his address is an impression, is a well deserved tribute to the country doctor in general. There may be an occasional black sheep in the ranks, but the average country doctor is such as Dr. Powell depicts him. "The glory of optimism pervades his life" "He is the best friend a community can have. He is the confidant of lovers, and helps to make up their quarrels. He brings together again the husband and wife, whom differences have separated. He is father confessor to half the country, and keeps his trust with knightly honor. His sympathy is deep and genuine, and is not worn upon his coat sleeve. No one more

than himself feels contempt for a 'gusher' in or out of his profession."

The address overflows with humor. The author quotes Father Faber as having once said: "There is no greater help to a religious life than a keen sense of the ludicrous." He tells us that "an evangelist at one time got into the habit of calling his audiences 'Dear souls.' Laboring in Ireland, he used to say with effect, 'Dear Belfast souls,' 'Dear Dublin souls,' but when he said 'Dear Cork souls' it did not seem quite so appropriate."

A grand man is the country doctor as portrayed by Dr. Powell, but he is not perfect. "To be perfect," he says, "an ideal doctor, he would need to have the wisdom of Solomon, the patience of Job, the strength of Samson, the bravery of Joshua, the eloquence of Paul, the meekness of Moses, the faithfulness of Abraham, the charity of Dorcas, and the executive ability of Jezebel. He would have to hunt like Nimrod, fish like Peter, climb like Zaccheus, and drive like Jehu. He would have to keep clear of the gout of Asa, the melancholia of Saul, the gastric infelicity of Timothy, and would still fall short of perfection if he had not the tireless perseverance of the devil himself." We have quoted Dr. Powell's own words freely, feeling that any attempt to paraphrase them would detract from their expressiveness. We hope that many of our readers will be fortunate enough to obtain the entire text of the address.—*N. Y. Med. Jour.*

THE ESPERANTO LANGUAGE.

It may be that Esperanto will be used to some extent at the next International Medical Congress, to be held in Budapest, August 29th to September 4th, 1909. If so, it might be well for those physicians of Canada who expect to attend the Congress to learn something of the new language.

We are told by the *Toronto World* that the study of Esperanto is spreading very rapidly in different parts of the world. It has

already taken quite a grip in many parts of Canada. An Esperanto Club was formed in Montreal in 1901, and it is probably not generally known that there is a club in Toronto, and that there are many earnest students of the language in different parts of Canada.

The Jewish Chronicle, of London, England, publishes a very interesting article. The writer says: "Dr. Zamenhof has created a language which, though it may never become universal, is already spoken by hundreds of thousands of enthusiastic disciples in every part of the world."

Dr. Zamenhof was born in Bielostok, on the third day of Chaunkah, 1859, his father and grandfathers before him having been teachers of languages. He was educated at Warsaw, and went to Moscow, and finally commenced practice as an oculist. In his pursuit of a livelihood he for some time underwent terrible hardships on account of prejudices against him as a Jew, and as an idealist. The town in which he practised was a "Babel of languages," and its daily life was poisoned by the bickerings and animosity that arose out of this diversity of tongues. From early boyhood he paid much attention to the following languages: Latin, Greek, French, English and Hebrew, and whilst studying these languages he ever had in view the discovery of some universal medium of communication that would bring forth a better state of things, and, although he met with many discouragements at first, his progress has been uninterrupted and almost phenomenal during the last few years.

The year after his first pamphlet was published the Volapuk Society, at Nuremburg, ceased to exist; but the majority of its members went to form the first Esperanto Club in 1888. Since then societies for its study have been formed in all parts of the world, and there are now many hundreds of them. In Russia there are more people able to speak Esperanto than English. In England there are now sixty groups at work. It is taught in many English and Scotch schools. There is a large Esperanto literature growing up. The grammar has been translated into more than twenty languages and dialects, and there are at least twenty monthly journals devoted to its propaganda.

The Linacre Lectureship at Cambridge.

The Linacre Lectureship is one of the oldest in England, and has been held by many distinguished men. Among them were: Wm. Barrondale, Thos. Gisborne, Sir Thos. Watson, Sir Isaac Pennington, John Haviland, Sir George Paget, Wm. Heberden and Donald MacAllaster. Up to the present time it has generally been held by a single incumbent for a term of years. It is now converted into an annual office, and every year some person of eminence will be asked to deliver one public lecture in the Easter term. The first lecture under the new scheme was delivered May 6th by Dr. Wm. Osler, the Regius Professor of Medicine in Oxford, who took for his subject "Thomas Linacre: His Life and Work."

Heroism among Medical Military Officers.

We sometimes feel sensitive because laymen do not always say pleasant things about physicians. We have to acknowledge, however, that the world at large appreciates the fact that our profession furnishes many military heroes. We are told by the *British Medical Journal* that Col. G. J. Younghusband, C.B., in his "Story of the Guides," says that in many a hard fight the brave and devoted officers who have been surgeons to the corps have displayed the greatest gallantry, but he singles out one of these as specially worth recording. In the expedition of 1853 against the Jowaka Afridis, thirty men of the Guides, under Lieut. Turner, had driven a separate force of the enemy into a stone breastwork at the top of a peak; but night came on and the order to retire was given. Retirement meant practically annihilation for the little force, so, sticking to the rocks, Turner had the bugle sound "Send reinforcements." Hodson, afterwards famous, who was near, but himself faced by great odds, sent all the men he could spare, but these were not strong enough to effect their purpose. Then it was that Dr. R. Lyell, Surgeon of the Guides, took on himself to carry forward the much-needed succour. In reserve, lying near him, was the Gurkha company of the Guides, and also a company of the 66th Gurkhas, under a native officer. Taking these troops, with great dash and personal gallantry he led them to the attack, drove back the already exulting enemy, stormed their position, and extricated Turner and his party from their perilous position. It was a noble deed, nobly and gallantly carried out, and when it had been achieved the brave soldier returned to the tender care of the wounded and to alleviate the pains of the dying.

CANADIAN MEDICAL ASSOCIATION

As announced in our last issue, the Forty-first Annual Meeting of the Canadian Medical Association will be held in Ottawa, June 9-10-11, under the Presidency of Dr. F. Montizambert. It is the first time that the members of the Association have had the opportunity of visiting the capital of our Dominion when Parliament is in session. It will be the first meeting under the new constitution adopted at the meeting in Montreal last year.

The Local Committee of Arrangements makes the following announcements: On the first evening, at 5 o'clock, there will be a reception by local members at the Ottawa Golf Club. On the evening of the first day there will be a civic reception at the Carnegie Library. During the second day there will be an excursion to Caledonia Springs. On the evening of that day there will be a smoking concert. On the third day there will be a visit to the laboratory at the Experimental Farm.

CANADIAN MEDICAL PROTECTIVE ASSOCIATION.

The Annual Meeting of the Canadian Medical Protective Association will be held June 9th at 12 o'clock noon.

Additional information of a local character may be obtained from the Local Secretary, Dr. Wm. Hackney, 376 Somerset Street, Ottawa, and any general information from the General Secretary, Dr. George Elliott, 203 Beverley Street, Toronto.

PROVISIONAL PROGRAMME.

Presidential Address—Dr. F. Montizambert, Ottawa.

Address in Medicine—Dr. Risien Russell, London, England.

Address in Surgery—The Surgical Rights of the Public—Dr. John C. Munro, Boston, Mass.

Treatment of Meningitis with Flexner's Serum—Dr. F. G. Finley and Dr. P. G. White, Montreal.

The Diagnostic Value of Perversion of Gastric Secretion—Dr. Graham Chambers, Toronto.

The X-Ray as a Therapeutic Agent, Its Indications and Untoward Effects, Having Special Reference to Its Action Upon the Generative and Internal Secretory Organs of the Body—Drs. Omar Wilson and J. Harold Alford, Ottawa.

MEDICAL SECTION.

Dr. John T. Fotheringham, Toronto, Chairman; Dr. Alex. J. MacKenzie, Toronto, Secretary.

Our Experience in Broncho-Pneumonia—Dr. C. S. McVicar, Hospital for Sick Children, Toronto.

The Differential Diagnosis of Some Forms of Mental Disease and a Note as to Treatment—Dr. G. J. Fitzgerald, Toronto.
 Out-Patients' Clinics for the Tuberculous Poor—Dr. Harold C. Parsons, Toronto.

On the Choice of a Climate—Dr. Geo. D. Porter, Toronto.
 Hæmoptosis in Pulmonary Consumption—Dr. J. H. Elliott, Toronto.

Spina Bifida Associated with Syringo Myelia—Dr. Colin D. Russel, Montreal.

Meningitis—Dr. A. E. Ranney, North Bay.

Some Interesting Complications of Pulmonary Tuberculosis and their Treatment—Dr. J. K. M. Gordon, Gravenhurst.

Ergot—Drs. E. V. Henderson and W. H. Cronyn, Toronto.

Some Unusual Cases of Rheumatism—Dr. A. McPhedran, Toronto.

What Shall We Say to Our Neurasthenic Patients?—Dr. G. S. Young, Prescott.

Pernicious Anaemia, Report of Cases in Country Practice—Dr. James Baird, Hemmingford, Quebec.

Some Further Observations on Pneumo-Thorax—Dr. W. F. Hamilton, Montreal.

Myo-Cardial Change in Valvular Disease—Dr. H. B. Anderson, Toronto.

SURGICAL SECTION.

Dr. Geo. E. Armstrong, Montreal, Chairman; Dr. Edward W. Archibald, Montreal, Secretary.

Title to be announced—Dr. James Bell, Montreal.

Congenital Pyloric Obstruction—Dr. F. J. Shepherd, Montreal.

Temporary Colostomy as a Curative Agent in Post-Operative Fæcal Fistula of the Colon—Dr. J. M. Elder, Montreal.

The Administration of the General Anesthetic from the Standpoint of the Operator—Dr. H. A. Beatty, Toronto.

Reports of Two Large Abdominal Tumors with Remarks—Dr. A. B. Atherton, Fredericton, N.B.

Diagnosis and Treatment of Ureteral Calculus, accompanied by Case Reports—Dr. A. E. Garrow, Montreal.

Exhibition of Cases to Show Result of Operations Reported at the London Meeting, 1903.

Advanced Hip-Joint without Shortening—Dr. R. P. Robinson, Ottawa.

Calculus of Ureter Removed per Vaginam—Dr. Walter McKeown, Toronto.

The Induction of Premature Labor—Dr. A. H. Wright, Toronto.

COMBINED MEDICAL AND SURGICAL SECTION.

Discussion on: General Peritonitis.

Carcinoma of the Buccal Cavity, Etiology and Treatment—Dr. A. R. Robinson, New York.

Subdural Hæmorrhage and Its Surgical Treatment—Dr. E. W. Archibald, Montreal.

On the Use of the Ortho-Diagraph in Medicine—Dr. Robert Wilson, Montreal.

PUBLIC HEALTH SECTION.

Dr. Chas. A. Hodgetts, Toronto, Chairman; Dr. Robert Law, Ottawa, Secretary.

Address by the Chairman, Dr. Hodgetts.

Title to be announced—Prof. Starkey, Montreal.

Title to be announced—Dr. J. D. Lafferty, Calgary.

Title to be announced—Dr. Seymour, Edmonton.

The Medical Inspection of Schools—Dr. John Hunter, Toronto.

LABORATORY WORKERS.

Dr. W. T. Connell, Kingston, Chairman; Dr. A. R. B. Williamson, Kingston, Secretary.

Anesthesia in Laboratory Work—Dr. V. E. Henderson, Toronto.

Chorion Epithelioma in the Testis—Dr. C. B. Keenan, Montreal.

A Criticism of the Ammonium Nitro—Molybdate Method of Detecting Organic Phosphorus in the Tissues—Geo. G. Nasmith, M.A., Ph.D., and E. Fidler, B.A., M.B., Toronto.

The Bio-Chemical Characteristics of Bacillus Influenzæ—Dr. Handford McKee, Montreal.

Title to be announced—Prof. J. George Adami, Montreal.

Title to be announced—Prof. J. J. MacKenzie, Toronto.

Title to be announced—Dr. C. W. Duval, Montreal.

Contribution to the Pathology of Tumors of the Lung—Three cases of Sarcoma: (1) Primary, (2) Secondary—Dr. E. St. Jacques, Montreal.

On the Technique of the Study of Complement Deviation—Dr. A. H. U. Caulfield, Toronto.

COMBINED PUBLIC HEALTH AND LABORATORY WORKERS.

Water Supplies and Water Analysis—Dr. J. A. Amyot, Toronto; Dr. T. A. Starkey, Montreal; Dr. Gordon Bell, Winnipeg; Dr. W. T. Connell, Kingston, and others will contribute to this discussion.

SECTION ON EYE, EAR, NOSE AND THROAT.

Dr. H. S. Birkett, Montreal, Chairman; Dr. Handford McKee, Montreal, Secretary.

New Therapeutic Notes—Dr. Wilfrid Beaupre, Quebec.

Title to be announced—Dr. G. H. Mathewson, Montreal.

Title to be announced—Dr. Roy, Quebec.

Some Points in the Technique of Sub-Mucous Resection of the Nasal Septum—Dr. C. M. Stewart, Ottawa.

Ulceration of the Cornea, Etiology and Treatment—Dr. Handford McKee, Montreal.—(1) Calcified Fibroma of the Orbit; (2) A Case of Bilateral Lardaceous Infiltration of the Buccal Mucous Membrane, not hitherto classified—Dr. J. N. Roy, Montreal.

SECTION ON MENTAL AND NERVOUS DISEASES.

Dr. W. H. Hattie, Halifax, Chairman; Dr. J. C. Mitchell, Brockville, Secretary.

Some Clinical Consideration of Dementia Præcox—Dr. Elbert M. Somers, Ogdensburg, N.Y.

Hydrotherapeutics when applied to Mental and Nervous Diseases—Dr. A. T. Hobbs, Guelph.

The Differential Diagnosis of some forms of Mental Diseases, with a note as to Treatment—Dr. Gerald Fitzgerald, Toronto.

Title to be announced—Dr. E. W. Archibald, Montreal.

Title to be announced—Dr. Colin Russel, Montreal.

Some Points in the Etiology of Progressive Muscular Atrophy, with Especial Reference to Heredity—Dr. D. A. Campbell, Halifax.

A Study of Thomsen's Disease (Myotomia Congenita)—By a sufferer from it.

Insanity and the General Practitioner—Dr. Moher, Brockville.

Hysterical Manifestations Occurring after the removal of a Brain Tumor—Dr. D. A. Shirres, Montreal.

SECTION ON GYNECOLOGY AND OBSTETRICS.

Dr. F. A. L. Lockhart, Montreal, Chairman; Dr. D. Patrick, Montreal, Secretary.

Title to be announced—Dr. Wm. Gardner, Montreal.

Some Cases of Cæsarian Section—Dr. R. E. Webster, Ottawa.

Pregnancy and Heart Troubles, with Report of Cases—Dr. J. C. Cameron, Montreal.

Title to be announced—Prof. de L. Harwood, Montreal.

Cases of Vicarious Menstruation—Dr. Blakeman.

- Uterine Inversion, with the Report of a Case—Dr. D. Patrick, Montreal.
- The Role of the Gonococcus as a Factor in Infection, following Abortion or Full-Term Delivery—Dr. Fraser G. Gurd, Montreal.
- Report of Second Case of Chorio-Epithelioma—Dr. F. A. L. Lockhart, Montreal.
- Thoroughness in Abdominal Surgery—Dr. A. Laphorn Smith, Montreal.
- Pubiotomy—Edward D. Farrell, Halifax, N.S.
- Title to be announced—Dr. D. J. Evans, Montreal.

MILITARY SURGERY.

- Dr. G. Sterling Ryerson, Toronto, Chairman; Dr. T. H. Leggatt, Ottawa, Secretary.
- Addresses by the President of the Association of Medical Officers of the Militia of Canada, Colonel Ryerson, M.R.D., Toronto.
- On the Advisability of Forming a Canadian Ambulance and Red Cross Association—Lieutenant-Colonel Jones, D.G.M.S., Ottawa.
- Title to be announced—Lieutenant-Colonel Cameron, A.M.C., to V. Field Ambulance.
- The Territorial Army Medical Corps, and the Canadian Medical Services—A Comparison—Lieutenant-Colonel Sponagle, A.M.C.
- Title to be announced—Captain H. A. Kingsmill, 7th Fusiliers.
- Some of the Difficulties Met with in Camp Sanitation—Captain G. M. Campbell, 7th C.A.
- Title to be announced—Lieutenant-Colonel Maclaren, P.M.C., M.D., No. 8.
- The Present Aspect of Military Sanitary Work—Major L. Drum, P.A.M.C.
- Ready and Simple Tests for Water, Milk and the Detection of Disease in Animals—Captain L. M. Murray, A.M.C., No. 1 Field Ambulance.

As announced in our February issue, Edinburgh lost two of her greatest surgeons within a fortnight, during the Christmas holiday times—Mr. Thomas Anandale and Sir Patrick Heron Watson. These men were not only highly respected on account of their great ability, but were very much beloved by all classes, and were commonly known as "Tommy" Anandale and "Pat" Watson.

Personals.

Dr. E. L. Procter, of Port Perry, has removed to Whitby.

Dr. J. D. Berry has purchased the practice of Dr. E. L. Procter, of Port Perry.

Dr. W. H. B. Aikins sailed from New York on the *President Lincoln*, reaching Hamburg May 7th, and from there went to Dresden.

Obituary.

REGINALD HARRISON, F.R.C.S., ENG.

Mr. Reginald Harrison, of London, England, died Feb. 20th of pneumonia, following influenza, aged 70. Mr. Harrison is better known to the profession in Canada through his work done in Liverpool. While working in the Royal Infirmary in that city he published a work on Surgical Disorders of the Urinary Organs, which became very popular in Canada. He removed from Liverpool to London in 1889.

ROBERT B. STRUTHERS, M.D., C.M.

Dr. Struthers died at his home on May 15th. He was a member College of Physicians and Surgeons, Quebec, in 1883. He was engaged in active practice in Sudbury for twenty years. Heart failure is said to be the cause of death. Those who knew Dr. Struthers intimately can appreciate what a great loss his death means to his patients. He was a large man, with broad ideas, high ideals, and anxious to do for others at all times. His profession was a source of pleasure to him, and he enjoyed hard work. He was much beloved by his patients, to whom he was most devoted. The writer and he worked together in '84 and '85 on the north shore of Lake Superior during the construction of the Canadian Pacific Railway, and formed a deep and lasting friendship. That his death was exceedingly sudden and unexpected is evidenced by the receipt of a letter written (the day before he died) in a most cheerful tenor in a light vein and full of quips and jokes. He leaves a widow, two daughters, and a son, who have the heartfelt sympathy of a large circle of friends.

Book Reviews.

SAUNDERS' FORTHCOMING BOOKS.

Messrs. W. B. Saunders Company, medical publishers of Philadelphia and London, announce for publication before June 30th a list of books of unusual interest to the profession. We especially call the attention of our readers to the following:

Bandler's Medical Gynecology—Treating exclusively of the medical side of this subject.

Bonney's Tuberculosis.

Volume II, Kelly and Noble's Gynecology and Abdominal Surgery.

Volume IV, Keen's Surgery.

Gant's Constipation and Intestinal Obstruction.

Schamberg's Diseases of the Skin and the Eruptive Fevers.

John C. DaCosta, Jr.'s Physical Diagnosis.

Todd's Clinical Diagnosis.

Camac's Epoch-Making Contributions in Medicine and Surgery.

All these works will be profusely illustrated with original pictures.

SAUNDERS' POCKET MEDICAL FORMULARY. By William M. Powell, M.D., author of "Essentials of Diseases of Children"; Member of Philadelphia Pathologic Society. Containing 1831 formulas from the best known authorities. With an appendix containing Posologic Tables, Formulas, and Doses for Hypodermic Medication, Poisons and their Antidotes, Diameters of the Female Pelvis and Fetal Head, Obstetric Table, Diet-lists, Materials and Drugs used in Antiseptic Surgery, Treatment of Asphyxia from Drowning, Surgical Remembrancer, Tables of Incompatibles, Eruptive Fevers, etc., etc. Eighth Edition, Adapted to the New (1905) Pharmacopeia. Philadelphia and London: W. B. Saunders Company, 1906. In flexible morocco, with side index, wallet and flap. \$1.75 net.

A very useful work, and we commend it to our readers.

A MANUAL OF PATHOLOGY. By Guthrie McConnell, M.D., Pathologist to the St. Louis Skin and Cancer Hospital and to St. Luke's Hospital, St. Louis, Missouri. 12mo. of 523 pages,

illustrated. Philadelphia and London: W. B. Saunders Company, 1906. Flexible leather, \$2.50 net.

Dr. McConnell discusses the subject with a clearness and precision of style that render the book of great assistance to both student and busy practitioner. The illustrations selected are both useful and artistic. The author's extensive laboratory experience has given to the work a practical character.

ATLAS AND TEXT-BOOK OF HUMAN ANATOMY. Vol. II. By Prof. J. Sobotta, of Wurzburg. Edited, with additions, by J. Playfair McMurrich, A.M., Ph.D. Quarto volume of 194 pages, containing 214 illustrations, mostly all in colors. Philadelphia and London: W. B. Saunders Company, 1906. Cloth, \$6.00 net.

This volume, the direct continuation of Vol. I., treats of the Viscera and the Heart. The selection and reproduction of dissections are identical with the methods employed in the first volume. Topographic anatomy has been especially considered. Practically all the illustrations are original, and especially prepared by most artistic methods, and reproduced in the most satisfactory and careful manner. The text descriptions are particularly clear and lucid and the terminology is made especially distinct by the use of italics and face type. This work should be of very great value to all interested in the subject of anatomy, and particularly, of course, to the medical student.

SURGICAL DIAGNOSIS. By Daniel N. Eisendrath, M.D., Adjunct Professor of Surgery in the Medical Department of the University of Illinois (College of Physicians and Surgeons). Octavo of 775 pages, with 482 original illustrations, 15 in colors. Philadelphia and London: W. B. Saunders Company, 1907. Cloth, \$6.50 net. Half Morocco, \$8.00 net.

Of first importance in every surgical condition is a correct diagnosis, for upon this depends the treatment to be pursued; and the two—diagnosis and treatment—constitute the most practical part of practical surgery. Dr. Eisendrath, in this superb new work, takes up each disease and injury amenable to surgical treatment, and sets forth the means of correct diagnosis in a systematic and comprehensive way. The subject has been presented from a clinical standpoint, and the injuries and diseases grouped in the manner in which the surgeon or general practitioner considers them in examining the patient for the purpose.

of making a diagnosis. The importance of differentiating simulating affections has been constantly borne in mind, and every assistance given along these lines. Special effort, too, has been exerted to furnish the means of making a correct diagnosis in the early stages of the condition. Definite directions as to methods of examination are presented clearly and concisely, providing for all contingencies that might arise in any given case. The chapters on cystoscopy and urethral catheterization are unusually instructive. Dr. Eisendrath, being a strong advocate of the teaching of surgery by the education of the eyes, has had specially made a large number of superb illustrations. These four hundred and eighty-two pictures are not only artistic but practical, for each one gives practical assistance in diagnosing the condition under consideration. The work is beautifully gotten up.

A MANUAL OF PERSONAL HYGIENE: PROPER LIVING UPON A PHYSIOLOGIC BASIS. By Eminent Specialists. Edited by Walter L. Pyle, M.D., Assistant Surgeon to the Wills Eye Hospital, Philadelphia. Third Revised Edition. 12mo of 451 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1907. Cloth, \$1.50 net.

This compilation on Personal Hygiene by several authors and edited by Dr. Pyle, fills a unique place. Its object is to set forth plainly the best means of developing and maintaining physical and mental vigor. Hygiene of the Digestive Apparatus is considered by no less an authority than Dr. Charles G. Stockton, of Buffalo; Hygiene of the Skin, by Dr. Fox, of New York, and other phases by equally competent men. A very valuable appendix is added which gives the relationship of baths, massage, and so forth, together with suggestions in case of accidents and emergencies. It is a very useful little volume, and one which physicians may safely put into the hands of their patients without fear of inculcating false impressions. The new third edition recently issued has been carefully revised and brought right up-to-date.

GALL-STONES AND THEIR SURGICAL TREATMENT. By B. G. A. Moynihán, M.S. (London), F.R.C.S., Senior Assistant Surgeon to Leeds General Infirmary, Leeds, England. Second edition, revised and enlarged. Octavo of 458 pages, beautifully illustrated. Philadelphia and London. W. B. Saun-

ders & Company, 1905. Cloth, \$5.00 net. Half Morocco, \$6.00 net.

The first edition of Mr. Moynihan's work on gall-stones was completely exhausted in eight months. Mr. Moynihan, by his masterly presentation of operative technic and clear, logical discussion of indications and contraindications, has won an enviable place in contemporary abdominal surgery. In this edition, increased in size by some seventy pages, many additional case records have been incorporated and a number of new illustrations added. We note also the addition of a very valuable chapter—Congenital Abnormalities of the Gall-Bladder and Bile-Ducts. It is evident that the whole text has undergone a careful revision and all recent work along the line of gall-stone surgery included. Mr. Moynihan's book still holds first place in its field. The illustrations are very beautiful, especially the nine colored plates.

ESSENTIALS OF MATERIA MEDICA, THERAPEUTICS, AND PRESCRIPTION WRITING. By Henry Morris, M.D., College of Physicians, Philadelphia. Seventh Edition, thoroughly revised. By W. A. Bastedo, Ph.G., M.D., Instructor in Materia Medica and Pharmacology at the Columbia University (College of Physicians and Surgeons), New York City. 12mo, 300 pages. Philadelphia and London: W. B. Saunders & Company, 1905. Cloth, \$1.00 net.

The student cannot find a better or more practical work on Materia Medica, Therapeutics, and Prescription Writing than this little essentials from the press of W. B. Saunders and Company. But then, this work is no exception in this respect to all the other numbers of this excellent series of compends. Dr. Bastedo, in revising the book for this seventh edition, has brought it in accord with the new (1905) Pharmacopeia, introducing all the new remedies and carefully indicating their therapeutic doses and uses. For a work of three hundred pages it contains a mine of information so presented as to be easily grasped. We give it our unqualified endorsement.

The "Medical Era's" Gastro-Intestinal Editions.

The *Medical Era*, St. Louis, Mo., will issue its annual series of Gastro-intestinal editions during July and August. In these two issues will be published between 40 and 50 original papers of the largest practical worth, covering every phase of diseases of the Gastro-intestinal canal. Sample copies will be supplied readers of this journal.