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THE

Canadian Medical Review.

EDITORIAL STAFF:

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Physician to Toronto General Hospital.

A. B. ATHERTON, M.D.,
Surgeon to St. John's Hospital for Women.

J. H. BURNS, M.D.,
Consulting Obstetrician, Toronto General Hospital.

J. FERGUSON, M.D.,
Physician to Western Dispensary.

ALBERT A. MACDONALD, M.D.,
Gynecologist to Toronto General Hospital.

G. STERLING RYERSON, M.D.,
Oculist and Aurist to Toronto General Hospital.

ALLEN BAINES, M.D.,
Physician to Hospital for Sick Children.

VOL. I.] TORONTO, APRIL, 1895. No. 4

Original Communications.

The Treatment of Dysmenorrhœa.*

BY ALBERT A. MACDONALD, M.D.

IN a normal condition women should menstruate without pain every twenty-eighth day, but whether on account of their mode of life or hereditary defect they are subject to a considerable degree of irregularity.

The flow may last from one to seven days, and still be normal; an amount of irregularity may exist, and still the woman may be healthy. But if the amount of pain suffered with menstruation is considerable, the woman is not healthy, and we are called upon to give her relief from her sufferings.

We are apt to think that women are specially prone to disease, and that disorders of the reproductive organs belong to this age; but the more we consult the older books, the more clearly we see that such troubles had a very early recognition, and that some of the means employed for their alleviation were not only of the same class, but were very much the same that are in vogue to-day.

* Read at meeting of Toronto Medical Association.

Writers upon diseases of women have for the past thirty or forty years followed a similar classification of the varieties of dysmenorrhœa. Thus Sir James Y. Simpson, in 1863, gave:

1. Neuralgic dysmenorrhœa. This form occurs in patients who are subject to neuralgia elsewhere; it becomes localized and intensified in the region of the uterus and ovaries at the menstrual period, lasting as a rule during the whole period.

2. Congestive dysmenorrhœa. An exaggeration of the ordinary amount of congestion which goes on at the menstrual period.

3. Inflammatory dysmenorrhœa. Due to acute or chronic inflammation in or around the cervix uteri or an ulcerated condition of that part.

4. Gouty or rheumatic dysmenorrhœa. Due to gout or rheumatism in the system.

5. Dysmenorrhœa due to organic disease or displacements.

6. Membranous dysmenorrhœa, where there is an exfoliation of the uterine mucous membrane occurring at the menstrual period.

7. Obstructive dysmenorrhœa. Due to stricture of the calibre of the cervix uteri.

If we compare this classification with that of one of our recent authors in the American text-book of Gynæcology, we find that obstructive and mechanical dysmenorrhœa are merged into one class, and are made to include dysmenorrhœa due to organic disease and displacements. The gouty and inflammatory forms are omitted, and ovarian dysmenorrhœa is added as a separate class where the pain is due to ovaritis and peritonitis (I would not add post-operative, etc.). We see, then, that, though we may have to wade through oceans of printers' ink, we do not arrive at anything very new with regard to classification. Such, however, is not altogether the case where treatment is involved, for though there is good evidence to show that the so-called Hegar's dilators of to-day were made of lead in the days of Hippocrates, and that Cook, of Warwick, in the seventeenth century, made use of sponge tents and hollow stem pessaries in cases of mechanical narrowing of the cervix, and that many other men devised various instruments in olden days for use in these troublesome affections, it has remained for those of later years to give us instruments of accuracy and finish which, with aseptic methods and a more perfect technique, may be used with comparative safety, and with regard to medication some of the more recent drugs are of special value.

Though no single plan of treatment can be laid down for all classes of this trouble, it must be borne in mind that the mere correction of general ill health will, in some cases, be sufficient to promote a cure.

It seems almost as if I should apologize for mentioning what is so self-evident and is well known to all of you, but still we do find cases in which so much attention is directed towards the organ chiefly at fault that the general body is somewhat neglected. But, to be more exact, what shall we do for the neuralgic form of dysmenorrhœa during the attack? This form of the trouble may not be associated with any pelvic disease, but may and usually does attack one who suffers from neuralgia in some other portion of the body. There is hyperæsthesia of the lower abdomen, undulatory pain, and pain on pressure in the ovarian region. Rest and warmth, with local heat in the form of fomentations, poultices or the hot-water can, if the latter is made in such a way that it arches over the abdomen without making much pressure. A hot flannel cloth may be applied underneath the can, and a long-continued, comforting heat may be secured. Chloral hydrate and bromide of potash, with hyoscyamus, are often very efficient. Phenacetin, antipyrine, and such remedies, are prompt in many cases. Cannabis indica, in sufficient doses, is very suitable at times, though there are some who cannot stand it. There are many other remedies, but these are the chief ones which have found favor with me. Morphine and whiskey, though prompt, are too dangerous, and anyone who has witnessed, as I have, the painful sequences of their too free use in such cases, would hesitate before prescribing such remedies, as potent for evil as for good. It is in cases of this kind that great good may be done by careful treatment during the intermenstrual period. Constipation, which is usual in this form of dysmenorrhœa, must be removed. The tone of the system at large must be elevated by tonics, fresh air, exercise, and relief from overwork or anxiety, if such exist. The skin and all the secretions of the body must be stimulated to healthy action. As the menstrual period approaches, apiol 5 ♏ in capsules, three times a day, or pulsatilla gtt. v., in the same way, are advised. But I have seen benefit follow the use of valerianate of zinc three times a day for ten days before the flow, and chloral in fifteen-grain doses when the pain appears. Electricity must not be forgotten, for some cases yield to a constant current of 30 to 40 milliamperes applied for ten or fifteen minutes a day for two or three days before the flow, one electrode being placed in the vagina near the painful ovary, and the other, a large flat one, over the abdomen in the ovarian region.

In the congestive form of dysmenorrhœa, where it is ushered in with a sudden onset of pain in the pelvis, scanty flow, irritable bladder, with such general symptoms as headache, fever, delirium and scanty urine, the treatment must be active—warmth, both local

and general, salines, diaphoretics, hot hip bath and douche. Phenacetin is most useful, both to relieve headache, promote perspiration and to allay nervous irritation. Bromide and chloral are also most useful.

In some such cases I used to practise scarification of the cervix and abstraction of blood by means of the artificial leech, but of late years I have found other ways less objectionable, and perhaps just as efficacious.

In the ovarian form, where the ovaries are enlarged, tender and prolapsed, the treatment is often extremely difficult and unsatisfactory. Over and over again I have been tempted to remove the ovaries in such cases where but temporary relief has been afforded by regulating the general system, tamponning with glycerine and belladonna, giving bromides, etc., and rest with warmth, but have resisted the temptation, and in some cases where there has been no ovarian organic lesion complete recovery has followed pregnancy. This has confirmed me in the view that oöphorectomy should only be done to relieve the condition, if organic ovarian disease exists, and even then *the pain sometimes persists.*

In the membranous form of dysmenorrhœa, we have the labor-like pains, and relief after the extension of a membrane which may be distinguished from that of pregnancy by the absence of the chorionic villi. In my cases there has been almost invariable headache at the onset and sickness of the stomach.

Temporizing by medical treatment alone is of little use. Dilatation of the cervix, thorough curetting and the application of Churchill's tincture of iodine have been the means most useful in my hands. In such cases, if pregnancy follows the treatment, relief of the condition follows parturition at full term.

The constant electric current by the electro-chemical action of the negative pole in the uterine cavity, and about 50 to 75 milliamperes passed through from aluminum or platinum intrauterine electrode to the large abdominal electrode, gives good results in this form of trouble, though I doubt if the results are any better than when the treatment is by mechanical dilatation and curetting. The only advantage of the electricity is that it is done without chloroform, and, if the application is aseptic, it is also without danger.

Mechanical dysmenorrhœa, caused either by a flexion or by a narrowing of the passage from inflammatory changes, is most common. Though the average amount of menstrual fluid secreted rarely exceeds two-thirds of a drop a minute, and that one would hardly think so small an amount capable of producing much pain, we have

sufficient clinical evidence to convince me that even in many cases where the average-sized sound can be passed without much force we have pain as the result of obstructed or tardy flow. I am astonished at the number of young women, in all classes of life, who suffer severely from pain during menstruation, which, to my mind, is due to mechanical obstruction. In many instances it is difficult to arrive at satisfactory treatment. One hesitates to advise local measures in the case of the young and over-sensitive maiden, and still other remedies often prove futile. In these cases the pain is somewhat characteristic, being more of the nature of uterine colic. It increases until a clot is expelled, when a measure of relief follows. In this variety of the trouble medical treatment carried out with care is capable of affording an indefinite amount of relief, but where there is a narrowing of the canal of the cervix, due either to flexion or other cause, such undue narrowing should be removed, and with its removal the troublesome symptoms will disappear. Dilatation and straightening of the cervix may be brought about in more than one way. Sponge and other tents which were used in the earlier days are now superseded by more rapid and less dangerous means.

Electricity by the negative intrauterine electrode, and a moderate constant current applied twice, or, in some instances, three times a week, is productive of favorable results, and the number of reported cases cured, and of pregnancy following such a course of treatment, is truly encouraging. Gradual dilatation by means of instruments that are worked by a screw for their enlargement are useful where the patient cannot spare the time to lay up or where an anæsthetic is objectionable. Treatment twice a week will overcome the difficulty in about six or eight weeks, and with care only a very moderate amount of pain need be given.

Rapid dilatation under an anæsthetic, with strict antiseptic precautions, is, however, the ideal method in these cases. The time chosen for the initiative in this operation should be immediately following a menstrual period, for then the cervix is softened and yields more readily than at any other part of the intermenstrual period.

If the dilatation is done with Hegar's or other solid dilators, the vagina and cervix having been made thoroughly aseptic, the patient being in the dorsal position and a suitable speculum in place, the anterior lip of the cervix is grasped by forceps or hook and the dilators are passed in succession; if there is much resistance, each one is allowed to remain a few moments in place in order to overcome it. Dilatation up to No. 15 or 18 may readily be secured in this way. With the hinged dilators, such as Ellinger's or Goodell's, a consider-

able amount of force is sometimes used, and care must be taken lest we rupture many fibres of the organ and lay the patient open to the chance of inflammatory or infective processes.

Too much stress cannot be laid upon the necessity for the most rigid antiseptic precautions, as well as for a due amount of gentleness in these most important manœuvres. We must not lose sight of the fact that serious results have followed in some cases. After rapid dilatation the patient should remain a day or more in bed. A glass stem may be inserted, and may be kept in place by loosely packing the vagina with antiseptic gauze or wool.

The chief advantages of the slower methods are that anæsthetics may be dispensed with, and that there is not the same loss of time to the patient, but even with gradual dilatation we cannot forget either the necessity for antiseptics or for rest.

Cases of cellulitis are recorded as following undue exercise and exposure to inclement weather soon after gradual dilatation by careful men. By keeping the causes of the trouble in view, and by bearing in mind that in all cases both general and local measures are required, we can bring our patients to such a condition of health that the menstrual period will no longer be approached with dread.

Clinical Notes.

Foreign Body in Œsophagus.*

BY CHARLES TROW, M.D., C.M., L.R.C.P.,

Ophthalmologist and Otologist Toronto General Hospital; Clinical Ophthalmologist and Otologist Trinity Medical College.

THE patient, B. F. W., aged 24, was sent to me by Dr. E. E. King a short time ago, with the history that he had swallowed a hard piece of biscuit about thirty-six hours previous. He complained of severe cutting pain, locating the position by putting his hand on the vertebræ halfway down his back. On questioning him, found he had been eating oysters with his cracker, which led me to think it was a piece of oyster shell.

He said the pain for the first day was in the throat, but with repeated efforts at swallowing and by taking food he had got it farther down, but the pain had become more severe.

On laryngoscopic examination, found an abrasion on the left arytænoid. With probes or œsophageal forceps of different kinds

* Read at Meeting of the Toronto Clinical Society.

could not feel anything as far as I could reach, which was probably two or three inches down the œsophagus. I then introduced the horse-hair probang nearly the whole length before the end passed the offending body. Expanding the umbrella part and withdrawing, brought up this piece of oyster shell, which measured 1¼ x ¾ inches. You will notice most of the edges are quite sharp and the ends pointed. The patient expressed relief at once. He was cautioned to use only fluid diet for a few days, and report, which he did some three or four days after, saying he was all right.

Piece of oyster shell—actual size.

I don't think producing emesis would have been a fruitful or yet wise measure, as the movements might have caused perforation. A skein of thread swallowed might have entangled the body in its loops, but would not protect the walls on withdrawal. The coin extractor would likely have allowed the edges to cut the œsophagus, as its walls would not have been expanded as with the horse hair. Œsophagotomy, I think, should only be done as a last resort. If left in, it would soon likely have caused ulceration, perhaps perforation, pus formation or severe hæmorrhage.

If he has any symptoms of cicatricial stricture, dilating probangs will be required from time to time; but I don't anticipate this, as there was not any dysphagia or any complaint after extraction.

Would this body have become dissolved if it had gone into the stomach?

SPORADIC CRETINISM.—Dr. Wm. Osler, of Baltimore (*Archives of Pediatrics*, February), gives the notes of a case of sporadic cretinism. It was a very well-marked case. The child was placed on the thyroid treatment in March, 1893. In April, 1894, the improvement was very marked. The cretinoid aspect had entirely disappeared. In the next place she had begun to develop rapidly. She had grown four inches in fourteen months. She was also acquiring the power of speech. One seeing the child for the first time would not notice anything peculiar about her. In October, 1894, the improvement had continued. She was then very bright and active. The only apparent defect was that she did not talk as plainly as she should for a child at her age.

Society Reports.

Toronto Medical Society.

(JANUARY 24TH, 1895.)

President, DR. PETERS, in the chair.

Hæmoglobin.—Dr. A. B. MACALLUM gave an historical sketch of the comparative views which have been held in regard to the physiological and therapeutic use of iron in the past. Although it was used, he said, as early as the time of Paracelsus, yet it was only within the past fifty years that any explanation of its use was advanced. At this later period hæmatin was isolated from the blood, which was found to contain iron; and it was hinted that the respiratory power of the blood was in some way or other associated with iron. In 1861 and 1862 hæmoglobin was isolated, and it was proven that the oxygen-carrying capacity of the blood was directly associated with it. Previous to this it had been found that iron salts increased the number of corpuscles, and under its influence anæmia disappeared. The speaker related the experiments which were made with the object of ascertaining whether the iron administered really formed an organic compound or not.

About ten years ago this was answered. From experiment on the organic iron compounds in egg-yoke, Bungé discovered that the hæmoglobin of the body was formed out of these, the iron-holding nucleins present in the food, which are derived primarily from the vegetable cell. Bungé stated that the action of the iron-salts was due to the part they played in shielding the organic compounds of the body from destruction, they, the salts, not being absorbed at all. Dr. Macallum stated that from experiments he had made, he had found that iron salts were absorbed in the intestine, and he had traced their presence from the blood vessels to the liver. He also found that the organic salts were absorbed, too. The speaker then discussed the question as to whether all organic iron compounds are alike efficient in anæmia. He decided not, as he had produced siderosis in animals by the administration of hæmoglobin. He detailed the history of a case in which he had seen at the *post-mortem*, a similar condition, where he believed that death was hastened by the administration of defibrinated blood.

Six Cases of Vomiting of Pregnancy.—Dr. POWELL reported the history in brief of six cases of vomiting of pregnancy. In Case I. serious symptoms did not occur until the seventh month. Abstinence

of food per mouth, and the administration of food per rectum tided the woman to term, when recovery followed. Case II. resisted all the classical treatment. Nutrient enemata were tried for five weeks, but despite all treatment premature labor came on and the patient died from exhaustion. Case III. occurred in a young woman during her first pregnancy; had suffered six weeks; a miscarriage relieved the condition. In Case IV. improvement followed the administration of mercury, although 10 per cent. silver nitrate locally and dilatation of the cervix had been previously tried with little effect. In the fifth patient, who had suffered from dyspepsia, there was no improvement from any of the above mentioned methods of treatment. Hypodermics of morphia daily gave relief. In the last case, a marked one, Dr. Powell had tried several full dilatations of the cervix, with benefit following each dilatation.

Gall-stones.—Dr. Ross presented several small gall-stones about the size of a pea, which he had recently removed. He outlined the history of the case, all the typical symptoms being present.

of the Aorta.—Dr. POWELL presented a *post-mortem* specimen of a ruptured aneurism of the ascending portion of the arch of the aorta from a young man aged 30, who had suffered from pulmonary tuberculosis. The tubercular condition had been arrested. The lungs were shown which confirmed this diagnosis. The pericardium contained about a pint of clot.

Dr. CAMERON reported a case of a man, aged 55, in whom death occurred from rupture into the œsophagus.

Dr. BRITTON reported a case in which death took place from the same cause, in a patient with tuberculosis of the lungs.

Dr. WILLIAMS asked the opinion of the members for an explanation of the statement that aneurismal dilatation of the aorta relieved pulmonary tuberculosis.

Cerebellar Abscess.—Dr. MACMAHON read the history of a case in which the patient had died from cerebellar abscess. The patient was a gardener, aged 43. Illness began in October, with pain in the head and right ear, lasting with a greater or less degree of intensity for three months. A specialist saw him at Christmas. Result, negative. The patient vomited once on December 1st, two nights preceding the date on which the essayist saw him. Delirium and incontinence of fæces and urine were also features of the case for a short time. There was no evidence of paralysis or loss of sensation. If not supported he would fall backward. Temperature, subnormal. Knee-jerk was exaggerated on both sides, and there was marked ankle-clonus. He was sent to the Toronto General Hospital. Albumen

was found in the urine. The patient became comatose. Eyes, negative. For some weeks past the right hand was cold. A small swelling appeared on the neck behind and below the right mastoid process. Pressure caused pain. Hypodermic needle was introduced, but no pus withdrawn. *Post-mortem* showed pus in the lower mastoid cells, and an abscess in the right lobe of the cerebellum. There was also some evidence of inflammation of the middle ear. In the lateral sinus just within the cerebellum there was a bare piece of bone.

(MARCH 14TH, 1895.)

President, DR. PETERS, in the chair.

Empyema.—Dr. WILLIAMS, of West Toronto Junction, presented a patient upon whom he had operated for empyema. The child was aged eighteen months, who suffered from an attack of pneumonia in July last. It terminated in an empyema. During this attack the temperature ranged from 99° to 102°. There was dulness from the clavicle down to the base of the lung. The heart was displaced, the collection being in the left pleura. Aspiration revealed the nature of the contents. The incision was made in the ninth interspace, below the scapular angle. The pus was sweet. There was no washing out nor special antiseptic precautions, as the surroundings were exceedingly unsanitary. A perfect recovery took place in two weeks.

Dr. POWELL thought such a good result so soon was exceptional. He thought there would be some danger in operating so low down. The patency of the opening might be difficult to maintain, and the diaphragm might be in danger of injury in case of aspiration. He spoke highly of the use of creolin as a washing-out fluid in cases where the pus was non-laudable and irrigation was resorted to.

Dr. PETERS pointed out that the diaphragm would likely be out of reach of the needle if the fluid were sufficient to press it down.

Extra-Capsular Fracture.—Dr. SCADDING reported the history of a case of extra-capsular fracture in an old woman aged 92. No treatment was adopted but rest in bed. The old woman, being restless and mentally deficient, threw herself out of bed twice soon after the fall that occasioned the fracture, falling on the affected hip. However, after lying eight weeks, union took place.

Dr. WINNETT, who did the *post-mortem*, presented the head of the femur, showing how union had taken place. The impaction was well shown. In most cases of this kind the great trochanter is fractured, but in this case it was not. There was also an absence of large processes of bone which are invariably thrown out along the intertrochanteric lines.

Dr. WILLIAMS said that the woman must have had a great deal of vitality, for at that age, with such a fracture and the necessity of keeping the recumbent position so long, there was a danger of her dying before union took place.

A Pedunculated Tumor was presented by Dr. POWELL, which he had removed from the gluteal region of a woman aged 65. It was superficial, pedunculated, and appeared like a fungating sarcomatous mass before removal, but on gross examination it appeared more of a fibrous character. He would present microscopic specimens at a later meeting, when the nature of the growth could more positively be ascertained.

Mitral Stenosis.—Dr. GARRATT presented a heart showing mitral stenosis. He related briefly the history of the case. The woman suffered extremely from pre-cardial pain and dyspnœa, despite everything he administered to relieve her. He had aspirated the peritoneum and the œdematous legs, withdrawing a large quantity of fluid. There was no history of rheumatism in the case.

Dr. CARVETH said he had seen it stated that these cases do not die after exertion, as is commonly supposed, but after lying quietly in bed.

Dr. ADAMS said that, after following the history of a number of these cases, he had come to the conclusion that it was a wise thing to warn patients with heart disease to be careful as regards exercise; that their lives would be prolonged by so doing. He outlined the history of two or three cases he had observed.

Dr. GARRATT said that he considered exercise a very necessary element in the treatment of such cases. The fresh air was very helpful to the respiratory functions.

Dr. DWYER presented a heart showing a condition of mitral stenosis, with dilated and hypertrophied left auricle. Unlike Dr. Garratt's case, it caused absolutely no symptoms. The woman died from nephritis of the chronic interstitial variety, from which she had been suffering for eight years. He also showed the kidneys, which were large and red in color. The capsule was adherent. He outlined the symptoms. Another kidney was shown by Dr. Dwyer, showing the condition of parenchymatous nephritis. He also related the clinical history of this case.

(MARCH 21ST, 1895.)

President, DR. PETERS, in the chair.

Fracture of the Ulna.—Dr. WINNETT presented a patient who while sparring had fallen forward on the palm of his hand, fracturing the ulna at the junction of its upper and middle thirds and dislocating

the radius head forward and upward. A right-angled splint was applied and the dressing taken down at the end of twelve days. The dislocation had not improved. Under chloroform it was reduced and the arm was put up in the straight position. It was now five weeks since the accident. The radius appeared to be dislocated forward at its head, as only partial flexion of the elbow could be made. There was also paralysis of the muscles supplied by the posterior interosseous nerve.

Dr. MacKenzie advised that these cases should be put up with the elbow flexed at an acute angle, the wrist being tied close to the neck. Authorities were generally agreed that this gave the best result. It had worked well where he had tried it. He was not in favor of any sort of splint that would restrict the circulation around the joint, such as plaster of Paris cases.

Dr. Primrose advocated the use of absorbent cotton splints after dislocations of the head of the radius, and firmly bandaged. The pressure would promote the absorption of the inflammatory material about the joint. The elbow could be perfectly flexed in this way.

An Analysis of 6,777 Cases of Midwifery.—Dr. J. F. W. Ross gave an analysis of 6,777 cases of midwifery which his father had conducted. He referred to many interesting features connected with the cases. Although a busy practitioner, the late Dr. Ross kept a full account of all the important items connected with each case. The mortality of mothers was 39, the largest losses being from two epidemics of puerperal fever. The reader traced the disease in its course through each epidemic, and showed how careful his father was in regard to cleanliness and change of apparel in those pre-antiseptic days. He had made two runs of 650 cases without a death. There were 15 deaths from placenta prævia. There were 19 cases of version. There were 5,409 head presentations, 148 breach, 58 foot, 5 breach and foot, 25 face, 7 brow, and 34 arm and shoulder. Forceps were used 491 times. Latterly he had used them oftener, with a lessened mortality rate and a less number of lacerations of the perineum. He believed the forceps properly used were conservative to the perineal body. Chloroform was used in 458 cases. There were 48 cases of retained placenta, and 27 perinea were torn.

Dr. A. H. Wright pointed out that in very many respects this was a phenomenal record. There were many lessons to be learned. One was that of cleanliness. Dr. Wright also spoke of the success that had attended Dr. Ross in his management of occipito-posterior positions of the head, and the ease with which he manipulated them into the anterior position. Another good lesson was the infrequent use of

forceps. He believed in these latter days these were too often used. Another good example he set was in using chloroform so seldom.

Dr. MACHELL pointed out the excellent results as regards the mortality of mothers. That there were only 11 cases of eclampsia was also an astonishing part of the record.

Dr. ROSS closed the discussion. He went carefully into his father's management of the cases in many points, showing how his good results had been attained.

It was moved that the Society petition the Provincial Legislature to reject Bill No. 96, the Patrons' Medical Bill, which was aimed at hurting the profession. Carried.

Toronto Clinical Society.

(MARCH 12TH, 1895.)

DR. MACFARLANE in the chair.

Case of Pericarditis.—Dr. N. A. POWELL gave the following history of a case: Woman, aged 50. Always healthy till a year ago, when she suffered from an attack of la grippe, from which he understood she had made but an imperfect recovery. She was sick about a week before he saw her with grippal symptoms, some of the features of which were headache, cough and general malaise. She recovered partly from this, went downstairs, sat in a draft, and returned to bed with increased bronchial symptoms and sub-sternal pain. This was her condition when first visit was made. Fearing the supervention of pneumonic or pleuritic trouble, he went over the chest pretty carefully. He did not think he would have missed a pericarditis if it had been present at that time. But it developed subsequently, while he was treating her. These cases were likely to be overlooked. It was related of a medical man who apologized to a celebrated consultant in London for having overlooked a case of pericarditis, that the reply was, "Don't let that trouble you; if you had discovered it you might have treated it." The speaker did not think the condition in the present case was due to the treatment. The patient had a normal temperature and pulse of eighty-five or ninety for two or three visits, and was doing apparently very well. Suddenly she was attacked with a pain in the left side. Going carefully over the side he heard a to-and-fro friction rub limited to the costal cartilage of the fourth rib on the left side of the sternum. This was heard close to the ear, and was heard when breathing was suspended. The pain was intense, and the action of the heart was tumultuous and rapid, reaching 120 or 125.

The temperature rose to 102. He saw her twice a day after that till the time of death. After two or three days the pain was measurably relieved, but the action of the heart increased in rapidity to 140 or 150, and the dyspnœa became very marked. The heart became very irregular. There was not at any time, as far as he could recognize, any pericardial effusion. The diagnostic point of such effusion in limited amount, as Roach and others had emphasized, is the occurrence of dulness in the fifth interspace in the right side of the sternum, the normal heart projecting to the extent of half an inch to the right of the sternum in the space. There was no increase of dulness there whatever. Being a spare woman, this could be marked out with reasonable accuracy. The pulse, after reaching its maximum rapidity, came down to 120—even less. It was very irregular from minute to minute, and intermittent. The bronchial trouble increased, but the cough was not accompanied by any mucous expectoration. The cough was progressive. The patient died from prostration with signs of heart failure. The interesting features of the case were :

1. The causation of the trouble. It was well known that traumatism and Bright's Disease were factors in its causation, and that the purulent forms often accompany Bright's; but pre-eminently it was met with in connection with rheumatic attacks. There were none of these causes present in this case. A sample of urine gave negative results. The only toxic element he could think of in connection wtth the case was the grippal poison, whatever that might be.

2. The absence of effusion. There were cases of pericarditis undoubtedly with formation of fibrin upon the surfaces, and it was notable in these cases that the friction sound was heard where the heart was closely hugged by the pericardial sac, not in its lower part where the motion was at its maximum. There were cases of dry pericarditis, just as there were cases of dry pleurisy. There were cases with fibrin thrown out and cases with serous effusion and with purulent degeneration or purulency of that fluid, *ab anitio;* and a fourth form, the tubercular. This case, of course, was limited to the first.

3. Why did the woman die? Was it the pericarditis that killed her or something else? It was to be remembered that she was a weakly woman and there was an associated bronchitis. The best explanation that has been given in such cases of the cause of death is given by Bland Sutton. The cases where he (the speaker) had opportunity to examine the bodies after death bore out the statement. Where pericarditis does cause death it was not from the pericarditis but from the associated myocarditis not made out during life by physical examination so much as by the presence of dyspnœa. In the case

the breathing did not fall below fifty; it even exceeded that number even after the temperature and the pulse were hardly above normal. The marked dyspnœa was due to the extension of the inflammation along the fibrous tissue extending from the pericardium itself into the structure of the heart. The inflammation extends along the fibrous structures of the left heart, and in this way the nutrition of the heart is interfered with. In every case where death has followed pericarditis the left heart has been found to be soft and flabby. Heart failure followed as a direct result, not from an inflammation of the covering but of the walls. He did not know that it was necessary to speak of the treatment. The anti-rheumatic treatment was often resorted to as rheumatism was so often an associated condition. Statistics proved that the least perturbating treatment produced the best results. He had had one other case in which the diagnosis was very difficult. It belonged to that class of cases with which there is associated a limited amount of pleurisy, in which there is present at the time, or subsequently developed a dry pleuritic friction sound limited to about the area where the pericardial friction sound would be heard. He did not think anyone, no matter how expert, could make a diagnosis from physical examination alone. A study of subsequent events was necessary to clear up the uncertainty that might be present.

Dr. C. A. TEMPLE—I would like to ask Dr. Powell if there was any lessening in the quantity of the urine.

Dr. ANDERSON—I would like to ask Dr. Powell about what time the dyspnœa appeared. The pericarditis might have been due to some toxic element in the blood, and that same toxic element might have affected the heart muscle which would be the cause of the dyspnœa. But from the acuteness of the symptoms I would be of the opinion that the inflammation of the heart muscle was rather due to an extension of the pericardial inflammation.

Dr. POWELL—In answer to Dr. Temple, I might say there was a notable diminution in the quantity of the urine, particularly in the latter days of life. Coincident with the development of the inflammation there was increased rapidity in the breathing and accompanying pain. But after the pain was relieved and the temperature had fallen, and the pulse rate decreased, the dyspnœa still continued. The rapidity of the breathing was noticeable even when the patient was resting quietly and sleeping.

Dr. MACFARLANE asked Dr. Anderson what form of toxic agent he considered the affection of the heart might be due to.

Dr. ANDERSON said that it might be due secondary to Bright's Disease, or as Dr. Powell had said, due to the poison of la grippe.

The dyspnœa might be accounted for by the action of the poison on the nerve mechanism of the heart.

A Case of Pericarditis.—Dr. C. A. TEMPLE then read a paper, "The History of a Case of Pericarditis."

Dr. GREIG—There are one or two points in Dr. Temple's paper that call for remark. I could not help noticing the high temperature present; I think it was unusually high—104°. Under such circumstances one would expect to find pus. However, I suppose that can be ruled out, because in children, if the nervous element is present, the temperature rises from slight causes. But in older persons, with a temperature of 104°, I would strongly suspect pus. I had a case of pericarditis with effusion two years ago which was secondary to an attack of sub-acute rheumatism, which was very well marked. The diagnosis of pericarditis was not difficult. There was a to-and-fro friction rub on the left side of the sternum. The effusion was excessive, causing dulness on the left side. If I had not heard the friction rub I would have suspected pleurisy. The case did well and finally recovered. The treatment I followed was the administration of the salicylate of soda, but I found that it inclined to depress the patient. The salicylates have a well-known tendency to deteriorate the blood. The patient was losing ground. As soon as I noticed this I put the patient on iron, arsenic, and cod liver oil, and stimulants. As soon as the effect of these began to show itself recovery was rapid. During convalescence the girl was indiscrete, going out and getting her feet wet. A relapse followed. She was sent to the hospital. I heard no more about the case.

Dr. POWELL asked Dr. Greig a question—If, at the base of the heart, the friction rub having been heard in the early stage, and the effusion subsequently becoming very large, he found it to be the case that the friction sound persisted throughout the existence of the effusion? Dr. Powell said that he had noticed in the last edition of "Quain's Dictionary" the statement that when once heard in this location it did not disappear, no matter how much the effusion. He did not know of any other author who made the statement so positively. With regard to the iron used in these cases it seemed to him that there were two forms especially useful. One was used largely by Loomis. He (Loomis) said it was nonsense, qualifying it with an expletive that he (the speaker) would not reproduce, but which was very emphatic, to give the syrup of the iodide of iron in any less quantity than a dram every three hours. Thus kept up it produced rapid absorption. It should be given largely diluted. The other form was the ferri-salicylic acid mixture, advised

by Cohen, of Philadelphia. This combination was rather hard to make. But it was the only combination of these two drugs according to Rice, one of the revisers of the Pharmacopœia, that could be given together.

Dr. GREIG said that the friction rub did disappear during the effusion. It reappeared during the process of absorption. It was heard during the latter stages as distinctly as at first.

Dr. FOTHERINGHAM said in the last case he had the double rub was heard until the patient had almost recovered. It was heard about half-wa between the base and apex, at the left of the sternum.

Dr. TEMPLE said in his case he was a little puzzled about the diagnosis at first, as the patient had slept with the one that had died from diphtheria four or five days previously. He was not sure whether the pericarditis was due to the diphtheria or the rheumatism. He gave salicylate of soda to relieve the pain, and when this was relieved, administered the iodide of iron.

Dr. MACFARLANE asked Dr. Temple if there were symptoms of rheumatic trouble.

Dr. TEMPLE replied that the only symptom was pain in the knee-joint, but there was no swelling or local heat.

Cystitis or Stone in the Bladder.—Dr. GREIG then detailed the history of a peculiar bladder case in a boy. He said: "I have not a paper for you, but I think I can give you the points in the case as well without as with one. The case to me is rather interesting, and a little out of the usual line of such cases. About a month ago, a lady brought to my office a boy, complaining that there was a large amount of deposit in his urine on standing for some time. He passed a sample for me, and it was very muddy in color, thick, and very suggestive of pus. The reaction was intensely alkaline. The specific gravity was 1012. On filtering and making the reaction acid, I could not detect any albumen, nor did it give the chemical reaction for pus by the liquor potassa test. However, I could see pus cells under the microscope. There were no casts. The boy was aged 12, not very robust, but appeared to be in good health. He went to school regularly, and was always ready for his meals. There was no constitutional diathesis as far as I could make out. There was no tubercular history on either side. The peculiar feature of the case was that there was no frequency of micturition nor increase in the quantity of urine passed; nor was there any pain. He passed urine four or five times a day. Four years ago, when they were living in Winnipeg, he had symptoms of gravel. He was taken to a surgeon, who sounded him for stone. No stone was discovered. I might say

that on examining the urine under the microscope, there was to be seen a profuse precipitation of triple phosphates, the most extensive display I have ever seen. I sounded for stone three times, but I could not detect any. I have been treating him by washing out the bladder and administering internal remedies. Internally I have given boracic acid and salol, combined with tonics. The effect from this was not very satisfactory. I changed to the benzoates, giving first the benzoate of soda, and afterward the benzoate of ammonia combined with buchu. The effect not being satisfactory, I have been giving a preparation containing benzoic acid, buchu, uva ursa and several other drugs. The drugs I have used for washing out the bladder were, first, boracic acid, 10 grs. to the oz. The effects of that appeared to be nil. It produced no pain. I found that a very large quantity could be injected with no discomfort—as much as twenty ounces—and the bladder was not full then. It appeared to be a very large amount to pass into the bladder, especially in a boy aged 12. I next tried bichloride 1-10000; the result was beneficial in one way. The next visit, the urine was perfectly clear, and the reaction was not so intensely alkaline, but it caused him much pain: he could not sleep that night. I reduced the strength until he could bear it, but when it was diluted this much it seemed to lose its effect. I am now using permanganate of potash 1 gr. to 1 oz. But this, again, produced a great deal of pain. I next used ½ gr. to 1 oz., but this also produced pain. Last night I used ¼ gr. to 1 oz., and while the pain was not so great as before, yet it was considerable. The 1 gr. and the ½ gr. solutions caused a spasmodic action of the bladder. Its force was so great as to raise the fluid almost to the top of the funnel when nearly empty. A spasmodic contraction of the rectum also took place. This was so violent that I was obliged to cease the washing while the boy went to the closet. This case is interesting in a good many ways. You would expect to find stone; and yet stone in children is easily diagnosed. You generally strike the stone immediately on introducing the sound. In this case I have manipulated most carefully, and can get no indication of stone. Nothing can be felt per rectum. The liver is normal. A fair-sized catheter can be passed without difficulty. If the permanganate is not successful in curing the case, I am going to try silver nitrate. However, it is so powerful I am a little afraid to use it.

Dr. MACFARLANE (to Dr. Greig)—What did they consult you about first?

Dr. GREIG—The deposit in the urine. The boy was suffering no pain. There was no irritation, no frequency of micturition: simply a deposit of phosphates and pus.

Dr. POWELL—I would like to ask a question and get Dr. O'Reilly to answer it. I know he has had a good deal of experience. Has anyone any knowledge of the use of creoline as an irrigating fluid for the bladder? I have had some experience with it that makes me think it better than other remedies we have been using for this purpose. For example, in two recent cases of empyema I have used it after using saturated solutions of boracic acid. The pus discharged was extremely offensive, and continued so, notwithstanding the use of boracic acid. The first injection of creoline, 1-120, wiped away the odor completely, and it did not return. The case went on to recovery sooner than any I had seen before. Eight ounces of creoline by mistake have been swallowed, and recovery followed. I suppose we have all used it in intra-uterine irrigation. Prof. Shuttleworth has made experiment with regard to its efficiency as a germicide and antiseptic. He finds it one and a half times stronger than carbolic acid in similar strengths—(quoting from memory). If its efficacy be greater than that of carbolic acid, and it be non-poisonous, it should be a proper fluid for irrigating the bladder. I have used for bladder irrigation silver nitrate solutions. I am not surprised at 1-500 permanganate solution causing pain. My experience is that 1-1000 or 2000 solutions are sufficiently strong, and should then be increased gradually.

Dr. O'REILLY being called on, said that he did not hear the paper, but was interested in the subject, as very many cases came under his observation at the hospital.

Dr. MACDONALD said the case was one in which a person would naturally look for stone as the cause of the trouble. The urine was apparently the urine of irritation, but it appeared on careful sounding that no stone was present. Even that did not exclude the possibility of stone being present. It might be there and be sacculated. It might be lodged in a pouch that was partly pervious and yet miss sound. There was one point that he had heard Dr. Greig refer to, and that was there was an amount of residual urine. It had likely disappeared since the washing had been carried out. If there was a want of tone in the bladder and residual urine was present, the case would resemble one of advanced prostatic disease. The question, however, was practically one of treatment, and Dr. Greig had certainly treated the case in a way that he (the speaker) would approve—by washing out the bladder with antiseptics. He had not yet tried turpentine. As this had the effect of changing the odor to that of violets, he thought it was worth trying. He did not know the manner Dr. Greig had followed, but some were in the habit of injecting small injections slowly. His plan was to allow large amounts to flow in freely. He

used the ordinary fountain syringe, with "Y" in the main tube leading to two branches, the one being clamped while the bladder was filled, then released, and the other one clamped while the bladder was emptying. (Dr. Macdonald here produced the apparatus for inspection.) At the end was an ordinary soft catheter. For women he used a glass catheter, and found it very satisfactory. He commonly used much weaker solution of the permanganate and the bichloride than Dr. Greig had used. The bichloride was apt to produce considerable pain. A large injection would wash out the folds better than a small one. As to frequency he would wash out two or three times a day at least. If this treatment did not effect a cure the best thing would be cystotomy and drainage. It was easy to cut a hole in the bladder and drain; but such cases were not invariably successful, so he considered it wise to persevere with the washing out and the general systemic treatment for a considerable time before resorting to operation.

Dr. MACFARLANE said that he had listened with a great deal of interest to the report of the case. From what had been said, he could not see that the symptoms were those of cystitis, as there were no subjective symptoms. There was no frequency of micturition, no increase in the quantity of urine, and no constitutional effects of the disease. In his experience, cystitis acted entirely differently, whether from stone, tubercle, or from whatever cause. Frequency of micturition was invariable. There was also a certain amount of restlessness on the part of the patient, especially at night; and then there were constitutional disturbances. The washing-out with strong escharotics would do more harm than good, whether permanganate, bichloride, or silver nitrate. He did not think it wise to throw them into the bladder where there were no other symptoms than the presence of pus.

Dr. O'REILLY asked if Dr. Greig had used Skene's mixture, containing benzoic acid and carbonate of potash, internally.

Dr. GREIG said that he had used benzoic acid and buchu. He had found a number of drugs that would purify the urine, but when he ceased using them the urine would again become foul.

Dr. COOK suggested that there might be some trouble in the pelvis of the kidney. He asked if there were any symptoms referable to the kidneys. He spoke of administering the turpentine by inhalation. This was useful in the case of children. Half an ounce to two ounces might be used in this way during twenty-four hours.

Dr. FOTHERINGHAM asked if any of the Fellows had tried oxalic acid in small doses for these bladder cases. He had seen it act promptly in one or two cases. He had seen no rational explanation of its use.

Dr. MACFARLANE asked if there was any phimosis present.

Dr. GREIG replied that there was some adherence of the prepuce, but not enough to account for symptoms. The authorities stated that stone in children was easily recognized. There was one peculiar point, and that was, on the sound entering the bladder it always had a tendency to fall to the left side. He was not able to bring it to the right side at all. He did not know if that indicated any malformation of the bladder, but it suggested it. He had not tried oxalic acid. He had thought of trying creoline, but as he had never heard of its being used he did not like to initiate the treatment. In regard to Dr. Macdonald's plan, he thought there was danger of too much force being brought to bear on the walls of the bladder.

Dr. MACDONALD said that by raising or lowering the bag any degree of force could be obtained.

Dr. GREIG continuing said that he followed Skene's method of washing out the bladder. He stated that in this case he could not use a large catheter, so that irrigation was necessarily slow. He pointed out that the amount of residual urine amounted to about two ounces, which he withdrew with the catheter. He had asked the patient to pass his water while on the hands and knees so that the bladder would be more completely emptied. As the urine was alkaline he thought there was no kidney trouble, unless the acidity of the pyelitis was hidden by the alkalinity caused by the cystitis.

Dr. TROW then read the report of a case of a foreign body in the œsophagus. (See page 124.)

Dr. POWELL related the history of a case of which he heard, in which a fish-hook had been swallowed. A boy upon his return home from a fishing expedition found his grandmother asleep with her mouth open. The temptation being great he dropped his baited hook into the old lady's mouth. Awaking with a start and a swallow, down went the hook with the line attached. A young physician who had just settled in the place was hastily summoned. He asked the boy for another of his hooks, took a bullet from his pocket, made a hole throught it so that it would fit over the hook. Then he threaded it on the line and with a catheter pushed it down, so that it slid over the hook in the stomach, which was then withdrawn without injury to the walls of the stomach or œsophagus. [We have not yet received a statutory declaration under the Canada Evidence Act of '93 bearing upon this case.—ED.]

Dr. BINGHAM presented a double-headed monster which he had recently delivered.

Editorials.

The Patrons and Medical Education.

THE REVIEW extends its congratulations to the College of Physicians on the overwhelming defeat of the iniquitous Patron Medical Bill. Of course there are wiseacres who say, "I told you so" We happen, however, to be in a position to know that had not a vigorous course been pursued, which this journal inaugurated with the assistance of Dr. Ryerson, amendments of a more or less objectionable character would have been enacted, and the precedent established that every Tom, Dick or Harry can amend the Act at any time, if he has a sufficient political pull. To Sir Oliver Mowat's eternal credit, be it said that he stood up manfully for our rights, and delivered a most effective and able speech in favor of the medical profession. He was ably seconded by Mr. Whitney, of the Opposition. The latter was particularly facetious, alluding to the "squad of adventurers" who had invaded the House, and who proposed to reorganize the medical, legal and clerical professions. The end is not yet. In spite of the tremendous majority against the bill—71 to 15—these bucolic buccaneers have given notice of another bill. The object of this new attack is said to be political. It is intended to reduce the registration fee to $50. The remote object of this move is to capture the medical student vote in the Province. It is hoped that this bill may meet the same fate as its predecessor. The profession, through the Council, is quite able to determine what shall be the fee for examination.

The Honorable Dr. Baxter's Re-election.

CONGRATULATIONS are the order of the day, and in each instance the subject of congratulation is the defeat of the Patrons. In the late general elections, the members of our profession were especially singled out for vindictive and venomous attacks, chiefly of a personal character, and relating to charges for professional services rendered. Drs. Willoughby, McKay (Oxford), McKay (Victoria), and Preston succeeded in defeating their opponent Patrons, but Drs. Barr and Baxter were not so fortunate. Patron Senn, who opposed Dr. Baxter, was unseated by the Courts, and on the bye-election Dr. Baxter was returned by a triumphant majority, who took this very effective way of testifying to his worth and to their detestation of the tactics of his opponent and his friends. Dr. Baxter is especially held

in esteem in the House on account of his kindly and genial nature, and because he is the "father of the House," being the only member who is now in the House who was elected at Confederation. He has been Speaker of the Assembly. The honorable and worthy doctor has our hearty congratulations.

The Ludicrous Excess of Physicians.

It is an easy matter for a young man to say to himself, "I am going to study medicine." Having formed this resolve, it becomes a more difficult question to find the means needed for a long and expensive sojourn at college. What with loss of time, clothes, books, board, etc., the expense may safely be set down at $3,000 as the price of the piece of parchment on which a few Latin words are printed and a large red seal stamped. But the question, "Where am I going to practise?" is the hardest of all. Every city is full to overflowing; the towns have two doctors for one that is really needed. Some time ago Dr. Lauder Brunton stated that the average income of medical men in Great Britain had greatly decreased. It is certainly so in this country and in the United States. In some American journals it has been shown that the incomes of medical men have decreased at least fifty per cent. The London *Lancet* pointed this fact out very forcibly, and drew attention that many who graduated in medicine disappeared from practice, showing that their professional work had been a failure. It is an actual fact that in many cities in Europe and the United States, the incomes of the majority of the doctors are not better than those of the ordinary mechanic. When the profession of medicine ceases to bring in a fair income, it will soon cease to bring dignity to its members. When the competition becomes excessive the fees will be cut down, in the hope that cheap attendance may bring some patients to the office. Doctors will be forced—as in many large cities they are now forced—to do other things to increase their incomes. From all sources the same cry comes forth that the profession is fearfully overcrowded. The notion that there is plenty of room at the top is too visionary for everyday life. Of the thousands who graduate every spring, only a few, a very odd one, attains to eminence or affluence, and then only after a life of the most arduous devotion to his duties. What a writer in the *Medical News* says of the United States is, we believe, equally applicable to Canada. We have a perfectly ludicrous excess of physicians half starving and competing with others all over the land. While France finds one

doctor enough to two thousand of the people, Germany, the home of scientific medicine, finds the proper proportion one to three thousand, and Sweden one to seven thousand, we, in our suicidal intoxication, run the proportion up to one to six hundred.

Syphilis and the Nervous System.

It is well known that this disease is the cause of some very important affections of the nervous system. These affections do not often happen before six months have elapsed, and are not at all so likely when the disease has been well treated in its early period.

Syphilis must, according to Gowers, be regarded as an organismal disease. Some of the effects of this disease on the nervous system must be regarded as the result of a chemical agent produced by the organism of the disease. This poison acts on nerve elements in same way as the poison of the diphtheria organism. This poison appears to possess the power of causing degeneration.

Then syphilis may give rise to inflammatory troubles, such as meningitis, neuritis and myelitis.

Another form of disease in the nervous system from syphilis is the gumma. This peculiar tissue is the result of syphilitic action.

When syphilis affects the arteries, it is almost always the larger cerebral ones that are involved.

In many cases the iodides cease to exert a beneficial influence, and mercury controls the disease, causing many of the nervous symptoms to disappear.

Ontario Medical Association.

The meeting of the above Association is announced for June 5th and 6th. The programme of papers will contain the names of distinguished visitors as well as those of eminent men from our own province. It is hoped that much valuable work will be done, and that the papers presented may be full of scientific interest. This is expected from men whose medical training has been so thorough.

We would suggest that every man who has a case in practice of interest—and who has not?—should report it at the meeting. To many men this society is the only one to which they can belong, and its privileges should be taken advantage of.

The profession in Toronto have borne a name for hospitality and cordiality, and we can assure our outside confreres that a visit to the

Queen City in the balmy month of June will prove a delightful holiday as well as a season of practical helpfulness. Let the membership of eight hundred swell to a thousand.

Re Patent Medicines.

A BILL has been introduced into the New York State Legislature, giving the Board of Health power to regulate the sale of patent medicines. Such measures are to be commended. If our Patron friends in Ontario would turn some of their energies in a similar direction, much good might result.

If our people were made aware that many of the nostrums sold as patent medicines are made up of inexpensive and sometimes harmful compounds, they would not feel like paying large prices.

If the formulæ were printed clearly upon the labels, it would go a long way in the direction of educating the people towards self-protection. It is true that the manufacturers might not make such large profits, but the people would be the gainers.

Militia Medical Service.

WE desire to extend our congratulations to Dr. Ryerson on his promotion to be Assistant Surgeon-General, and while doing so we express the opinion of the majority of the profession, that the evidence thus given of a desire to reconstruct the Militia Medical Service meets with approval. Appointments of a similar character will, it is believed, be made in other provinces. The principle of selection—not in the strict line of seniority—is one which has of late been in vogue in the British army. It has also been the rule in the Canadian Militia. No more common example can be found than the appointment of gentlemen as medical and combatant officers of superior grade without previous service. We trust that the struggle for a better militia medical service has now passed its crisis, and that better times have come.

Alcohol in the Manufacture of Drugs.

SOME time ago the well-known house of Parke, Davis & Co. applied to the Excise Department for the privilege of importing alcohol in bond for the manufacture of pharmaceutical preparations. They claim that they can buy and import in bond a pure alcohol cheaper than they can obtain the same grade in Canada. This was taken

by some to mean that the firm wished to import a "low grade" alcohol for their house. This is entirely false. All that was sought by this firm was the right to import in bond the best quality of alcohol, as they can do so to the advantage of all concerned. The firm has been fully vindicated in this matter. What was sought was a legitimate business transaction, and it was granted. This house has no proprietary interest in any patent medicine, nor does it advertise or sell any of its products to the public. It confines its operations entirely to the medical profession, which it reaches through the usual channels of the wholesale drug trade and retail pharmacists.

Immunity Conferred by an Attack of Infectious Disease.

To no one class of men does this weighty subject more strictly demand attention than the general practitioner. How many physicians in general practice have had their diagnoses questioned, and have felt that possibly they are mistaken when told that scarlet fever, or diphtheria, or typhoid fever is impossible as the patient has had it before?

Should one look back but a few years he will find in fact that such an idêa was not only prevalent, but the mass of authority claimed it to be incontrovertible. Mr. John Simon wrote as late as 1882 ("Quain's Dictionary of Medicine") on contagion: "There is the extremely suggestive fact with regard to our best known febrilizing contagia, that they run a course of definite duration, and that in this course, provided the patient do not die, all present, perhaps all future, susceptibility to the particular contagium is utterly exhausted from the patient, so that reintroduction of the same contagium will no more renew that patient's disease than yeast will excite a new alcoholic fermentation in any previously well-fermented bread or wine."

Again, in looking over the hand-books on pediatrics we find no mention of a secondary attack, or simply mentioned in the most casual matter, "Keating's Cyclopædia" being an exception. In the articles on the various contagious diseases, attention is more markedly called to second or third attacks.

How long the immunity from a second attack lasts is not at all clear, it simply at the present time being a matter of speculation. This question will possibly be answered when the effects of the various antitoxines in use are clinically better understood and data more reliably tabulated.

Nearly every practitioner of some years' experience has had cases of, say, scarlet fever, typhoid, etc., recurring in the same individual. Small-pox also has in our own experience attacked two patients twice. A case of syphilis has come under our care in which the true Hunterian chancre developed with the regular phenomena of secondary and tertiary symptoms, exactly as had occurred in this patient ten years previously.

The following extremely interesting abstract from the *Boston Medical and Surgical Journal*, commends itself as forcibly illustrative of this important question:

"Maiselis has published important statistics bearing on the subject of the length of the periods of immunity conferred by attacks of infectious disease. This well-known principle, which is the basis principle of the work of Jenner, Pasteur, Koch, Behring, and of all the workers in the field of serum therapeutics, has been misstated by various writers on medicine, some of whom affirm that the survival from one attack of an infectious disease confers life-long immunity. Gregory, for instance, says: 'The immunity against a second attack of an infectious disease is one of the most universal and important principles in pathology. It is applicable not only to variola, measles, etc., but to all diseases which are due to a poisonous influence or miasm.' Samuel says: 'By the survival of a single attack of an infectious disease, immunity is generally conferred for the remainder of life.' The same opinion has been expressed by Hebra, Henoch, Thomas, with regard to the acute exanthemata; by Griesinger, Murchinson, Zuelzer, as to typhoid fever; Audouard, as to Asiatic cholera.

"On account of the great theoretical and practical interest of the question, Maiselis has collected from literature the following authenticated cases of repeated attacks of infectious diseases in the same patient:

"SMALL-POX.—Two attacks, 526 cases; three attacks, 9; seven attacks, 1; total, 536.

"SCARLET FEVER.—Two attacks, 144 cases; three attacks, 7; four attacks, 1; eight attacks, 1; seventeen attacks, 1; total, 154.

"MEASLES.—Two attacks, 103; three attacks, 3; total, 106.

"TYPHOID FEVER.—Two attacks, 203 cases; three attacks, 5; four attacks, 1; total, 209.

"ASIATIC CHOLERA.—Two attacks, 29 cases; three attacks, 3; four attacks, 2; total, 34.

"In order to avoid the danger of including cases in which relapse might have been mistaken for a second attack, only those cases have been included in the preceding tables where the interval between the

attacks was sufficiently long to preclude the possibility of the second and third attacks being relapses.

"Considering the fact that all cases of second attacks of infectious disease are not recognized, and that the deeply-rooted belief in immunity among the laity, as well as among physicians, often renders the diagnosis of a second attack difficult to establish, one is led to believe that repeated attacks of infectious diseases may not belong to the rarities in medicine. This consideration also tends to establish the analogy between the immunity conferred by natural and artificial processes. The quantitative principle of immunity suggested by Erlich and systematically elaborated by Behring applies also to the natural processes of immunization.

"It seems probable that so many difficulties would surround an exact determination of the period of immunity conferred by a given attack of infectious disease, that no exact statement of the safety period could be applied to particular cases. If a child is taken with scarlet fever, we have no means of estimating the amount of toxine absorbed, or the length of time the so-called natural antitoxine of the disease is present in effective quantity. The period of immunity conferred by the injection of given quantities of the artificial antitoxine of approximately known strength is a matter of doubt and study; and the estimated length of the period of immunity, as defined by Behring himself, has lately been changed. If the period of immunity is so difficult to compute in a case where we can approximately calculate the amount of antitoxine injected, how much more difficult will it be to calculate that conferred by the absorption of an unknown amount of toxine, and consequent antitoxine production?"

PHENACETINE BAYER.—Dr. J. E. Clausen, of Philadelphia (*Times and Register*, March 9th, 1895), claims that this drug is specially valuable in the following conditions: 1. In scarlet fever he finds phenacetine very useful, especially when there is much rheumatism. It acts promptly and effectively in relieving the acute pains, while at the same time it reduces the fever. 2. In the treatment of rheumatism both acute and chronic, it is very valuable in relieving the pains. It will succeed in many cases where the salicylates and iodides had failed. 3. In spinal meningitis it is of marked use in relieving the severe pains and controlling the fever. It acts as an excellent sedative to the nervous system, and guards the patient against some of the worst and most distressing symptoms. Of all the drugs that reduce fever and relieve pain the author thinks that phenacetine is the least depressant on the heart.

CANCER OF STOMACH.—In an article on the physiological treatment of cancer of the stomach in the *New York Medical Journal*, March 9, Dr. Keefe holds, in view of the rule that the circulation of a viscus is in direct ratio to the work it does, recommends rest to the stomach by administering foods in liquid form digested in other parts of the alimentary tract. The neoplasm thus will share with the stomach a minimum supply of blood and a consequent slowness of growth.

"REPORT of a case of septic poisoning, following the use of antitoxine," by Dr. Edward J. Ware, *Medical Record*, March 30th, 1895, is worthy of perusal. The chief points of interest are that there was a peculiar rash thirteen days after injection, and that there was a continuously subnormal temperature for eight days, commencing on the fifteenth day after injection. The child's mother had a deposit on the left tonsil—was injected, the rash appeared in five days, was evanescent, and was unaccompanied by constitutional disturbance.

DIETARY IN PHTHISIS.—In consideration of the great importance of sufficiently nourishing the phthisical patient with food of the proper quality, Dr. Loomis, in the *Practitioner*, gives the following dietary: On awakening, eight ounces of equal parts of milk and seltzer, sipped slowly. Breakfast of oatmeal and cracked wheat with a little sugar and abundance of cream, rare steak or loin chop with fat, soft boiled or poached egg, cream toast, half pint of milk, and a small cup of coffee. Early lunch, half pint milk or small tea-cup of squeezed beef juice with stale bread. Mid-day meal, fish, broiled or stewed chicken, scraped meat-ball. stale bread and plenty of butter, baked apples and cream, and two glasses of milk. Afternoon lunch, bottle of koumyss, raw scraped beef sandwich or goblet of milk. Dinner, substantial meat or fish soup, rare roast beef or mutton, game, slice of stale bread, spinach, cauliflower, fresh vegetables in season (sparingly).

BLOOD CHANGES IN ETHER ANÆSTHESIA.—Dr. John Chalmers Da Costa (*Med. News*, 2nd March) concludes that the following changes take place in the blood in ether anæsthesia: 1. There is a diminution in the hæmoglobin of the blood. 2. The red corpuscles and hæmoglobin are especially affected in anæmic cases. 3. The white corpuscles show irregular changes which are not characteristic. 4. Age does not affect the results. 5. Ether pneumonia may be due to the intense cold upon the lungs arising from the ether vapor. 6.

Œdema of the lungs may be due to the ether vapor causing contraction of the capillaries and thus producing venous engorgement. 7. The chilling of the blood stream may be the cause of the nephritis that occurs in some cases of ether inhalation. 8 Prolonged anæsthesia damages the blood seriously, and greatly retards recovery.

CASTRATION FOR HYPERTROPHY OF THE PROSTATE.—In the *Western Reserve Medical Journal* for March, there appears an editorial on the above caption. It refers to the connection of Dr. J. William White, of Philadelphia, with the introduction of this operation. Experiments on the lower animals show that after castration the prostate gland undergoes rapid degeneration and atrophy. White's first operation was performed in January, 1894. Prior to this, however, the operation had been performed a few times. It has now been done by Ramm, Fremont Smith, Finney, Powell, Mayer, Moullin, Thomas, Ricketts, Swain, Bereskin and others. In some cases where the urine had to be removed for years, and the patients were regarded as hopeless, a speedy improvement took place. The prostate rapidly decreases in size and the urine becomes healthy. Where the use of the catheter has still to be continued, it becomes easy and painless. Those who have done the operation regard it as very successful.

EPIPHORA.—Dr. G. E. DeSchweinitz (*Philadelphia Polyclinic*, March 2nd) classifies epiphora as follows: 1. When it is caused by refractive error. It is common in persons nearing the presbyopic age. It is also found in astigmatism. In exophoria there is often extreme epiphora. In some of these cases, as soon as near work is begun the eyes fill with tears. In other cases there is a sudden rush of tears, with a sense of relief of pain. The treatment is, correct the error in refraction. 2. The epiphora of intranasal origin. When the nasal mucous membrane is irritated there is often a free flow of tears. This is markedly the case in hay fever and irritable rhinitis. Again, the anterior end of the middle turbinated bone and adjacent mucous membrane may be hypertrophied or displaced, causing obstruction to the nasal duct. Such cases must be treated by relieving the irritability of the mucous membrane and correcting the pressure. 3. There is a form of epiphora of nervous origin. In neurasthenic and hysterical patients this condition of lachrymation is frequent. It is found also in connection with some central nervous disorders, as in locomotor ataxia. 4. The cases of epiphora due to obstruction in the ducts from chronic inflammation.

INFANTILE VACCINATION.—Ernest Hart, in the *British Medical Journal*, refers to the great falling-off in infantile vaccination, and says it is due largely to the absence of a small-pox epidemic and the opposition of the anti-vaccinators. In his advocacy of the efficiency of vaccination he quotes many statistics to show the enormous lessening of the occurrence of this dread disease, and the lessened mortality rates. From the tabular result of the outbreak in '87 and '88 in Sheffield, as regards children under ten, we quote:

Per 1,000 of the number of children in each class:

The attack rate of the vaccinated was	5.00
The attack rate of the unvaccinated was	101.00
The death rate of the vaccinated was	0.09
The death rate of the unvaccinated was	44.00

THE TREATMENT OF INFLUENZA.—Dr. A. F. Plicque (*Med. Presse*, February 6th, 1895) gives the following as the main features in the treatment of this disease: 1. In the majority of cases good hygiene is sufficient. Hot drinks should be employed, and milk is among the best as it is nutritive and diuretic. 2. As to drugs, antipyretics relieve the pains and restlessness, but often increase the bronchial irritation. Tincture of aconite in frequent doses relieves the fever and the larynx, trachea, bronchial catarrh, but has the disadvantage of rendering the patient restless. Quinine is the favorite remedy with the author. A gentle purgative should be given, and, when there are thoracic complications, manna or castor oil is to be preferred. 3. The nasal and oral congestion may be greatly relieved by the use of some lotion or gargle as boracic acid. 4. For the thoracic catarrh a mixture containing tincture belladonna, tincture of aconite, tincture of drosera, and tincture of myrrh is one of the very best. Daily dry cupping is of much service in these chest complications. Blisters do more harm than good. Tea, coffee and brandy should be employed. When there is much bronchial catarrh an emetic does good, particularly in children. 5. For restlessness and delirium there is no drug so useful as potassium bromide. Chloral may be added to the bromide mixture when there is marked insomnia. Cool compresses to the forehead aid these measures. 6. In adynamia the greatest attention should be paid to the hygiene. Stimulants are of the utmost value. Kola and caffeine are very helpful. Strychnia is useful as a heart tonic. Subcutaneous injections of ether and caffeine may be tried. 7. The gastro-intestinal form should be treated in children from the first with emetics, and in adults with saline purgatives. For diarrhœa,

salol, bismuth salicylate, and naphthol should be used rather than opium. 8. In the convalescence, arsenic, cinchona, coca, kola, and iron are useful.

INSOMNIA IN SURGERY.—Dr. George VanSchaick (*New York Medical Journal*) has an article on the above subject. He divides insomnia in surgery into the following classes: 1. The insomnia due to fear of the operation. In some cases the announcement that an operation is necessary causes great excitement. The patients do not sleep. Some hypnotic should be given, and one that does not depress ought to be selected. 2. Insomnia due to some exhausting diseases and long suffering. Before operating it is well to improve the patient's health. This requires a fair amount of sleep. Chloral is a good hypnotic, but too depressing. Trional is the one recommended by the writer. 3. Then there is insomnia due to pain. For this form of sleeplessness there is no remedy to take the place of morphine. It relieves the pain, and sleep results. 4. There is a form of insomnia with restlessness, jactitation, and nervousness following such operations as passing sounds, urethrotomies, etc. For this form trional is very safe and reliable. 5. In alcoholism and *delirium tremens* as a complication of surgical cases, trional is of special value. The dose is from 15 to 30 grs. The lesser dose may be given and repeated in an hour if necessary. It acts promptly. This of course is a great advantage over sulphonal. It does not cause depression, and is not followed by headache. The sleep obtained by trional is very nearly the same as that without the aid of a hypnotic. It does not inhibit the secretions. It is readily absorbed from the stomach or rectum.

LEAD POISONING.—Prof. Wannebroucq (*Med. and Surg. Reporter*, February 23rd), on lead poisoning, states that in the making of white-lead by the Dutch process there is much dust, which contains carbonate of lead. Lead, when introduced into the system, acts especially on the nervous system in its central as well as peripheric portions. But in *post-mortems* it is found in other portions of the body, as liver, spleen and kidneys. When a person begins working with the lead salts, and is of careless, dirty habits, he notices that his health begins to fail, as shown by loss of appetite, disgust of food, nausea, vomiting, constipation, general weakness and, later, colic. The teeth come to be covered with much tartar, and at the gums there is a blue line, caused by the action of sulphur on the lead. This sulphate penetrates into the mucous membrane and becomes fixed, as a sort of tattooing. A tattooed line is often seen on the lip. With regard to the abdominal

pains, it should be noted that these pains are not found all through the abdomen. Pressure on one part will cause pain, while in another there may be no pain at all. It is also noteworthy that in some cases the pain is in the abdominal muscles, and especially in the recti. The pain, often called colic, is often only a myalgia. The application of mustard or tr. iodi. to the abdomen often relieves the pain, and then the vomiting. The abdomen becomes soft, and usually the bowels move. If they do not move. give a purgative. Two or three sulphur baths will remove the lead in the skin. Sulphurous mineral waters will precipitate the lead in the intestinal canal. For the lead that may be stored in the tissues, good hygiene is the best treatment. The author is inclined to think that iodide of potash does more harm than good. Hypodermics of chloroform are sometimes of greatest value in treating the abdominal myalgia of lead poisoning. The three main points, then, are: 1. Tincture of iodine for the abdominal dermalgia, or pain in the skin. 2. Sinapisms for the myalgia. 3. Sulphur baths and sulphurous water for the removal of the lead from the system.

Items.

SIR WM. SAVORY, the well-known surgeon to St. Bartholomew's Hospital, died on March 4th, aged 69 years.

PROFESSOR DUJARDIN-BEAUMETZ, the distinguished French physician, died at his home in Paris on the 16th of February.

WITH the March issue of the *American Lancet*, Dr. Leartus Connor ends his editorial work on that paper, and with his retirement its publication is discontinued. The *Lancet* will be greatly missed from our exchange list.

DR. ALFRED LOOMIS left an estate of $1,000,000. To the Loomis Laboratory he left $25,000, and $10,000 to the New York Academy of Medicine. The hope is expressed that some of our millionaire physicians in Toronto may remember the Ontario Medical Library when making their last will and testament.

DR. EDWARD D. WORTHINGTON, of Sherbrooke, Que., died on Monday, the 25th of February, in his 75th year. For over fifty years he had been engaged in active practice, and was respected and beloved by the members of the profession in the Eastern townships, where he was best known. It is stated that he was the first surgeon in Canada to perform a capital operation under an anæsthetic.

MR. J. W. HULKE, F.R.S., the skilled and learned President of the Royal College of Surgeons, died on the 19th of February, as the result of pneumonia, following a cold which he contracted during a night visit to the hospital in response to a call to operate for hernia.

A RECENT visit to Bellevue House shows that under the auspices of Drs. Temple and Macdonald it has lost nothing of its popularity. During the past month, not only has the work there been heavy, but applications have been received in excess of the power of accommodation.

DR. D. HACK TUKE, the eminent alienist, died last month in England. Some of the alienists of this country have reason to remember him, for he visited Canada in 1884, and the following year published a work entitled, "The Insane in the United States and Canada." "He had in truth, a loving and gentle spirit, zealous ever for the good of his afflicted brethren; zealous always for the honor of the profession."

DR. GEO. WRIGHT died at Redlands, Cal., last month. For many years he was a resident of Toronto, and when here enjoyed a large practice and held many positions of trust—chairman of the Public School Board, member of the Public Library Board, physician to Toronto General Hospital, member of the teaching staff of Toronto School of Medicine, etc. Owing to failing health he removed to California in 1888, but unfortunately the change did not materially improve his physical condition, and he died at the age of 57 on the 10th of March.

Book Notices.

A Manual of Bandaging: Adapted for Self-Instruction. By C. HENRI LEONARD, A.M., M.D., Professor of the Medical and Surgical Diseases of Women, and Clinical Gynæcology in the Detroit College of Medicine. Sixth edition, with 139 engravings. Cloth, octavo, 189 pages. Price, $1.50. The Illustrated Medical Journal Co., Publishers, Detroit, Mich.

This volume is profusely illustrated with cuts, showing bandages applied to all parts of the body. The turns are numbered, and the direction shown by arrows, so that a student can acquire the art without a teacher. It is a book of much interest to the medical student and young practitioner, and even the older medical man will find many new features.

Dose-Book and Manual of Prescription Writing. By E. I. THORNTON, M.D., Ph.G. Philadelphia: W. B. Saunders. Price $1.25.

This is an interesting little work for students, although the Canadian student may not relish the section devoted to the Latin declensions and conjugations after his long pre-matriculation drill in that subject. It is based on the U.S.P. for 1890, and, as a book of reference by the busy practitioner to the later official and officinal preparations and the best methods of their administration, it will be useful and convenient. The typographical portion of the work will commend itself to the eye of the reader.

Suggestive Therapeutics in Psychopathia Sexualis; with Especial Reference to Contrary Sexual Instinct. By Dr. A. VON SCHRENCK-NOTZING (Munich, Germany). Authorized translation from the German by CHARLES GILBERT CHADDOCK, M.D., Professor of Diseases of the Nervous System, Marion-Sims College of Medicine, St. Louis; member of the American Medico-Psychological Association; Attending Neurologist to the Rebekah Hospital, St. Louis, Mo., etc., etc. One volume, royal octavo, 325 pages. Extra cloth, $2.50 net; sheep, $3.50 net. Sold only by subscription to the medical profession exclusively. Philadelphia: The F. A. Davis Co., Publishers, 1914 and 1916 Cherry Street.

This work, as Cæsar said of Gaul, *divisa est in tres partes.* The first part deals with sexual hyperæsthesia, the second with sexual impotence and anæsthesia, and the third with sexual paræsthesia. Under each of these headings there is much useful information. Some of the historical portions are particularly good, such as those treating of boy love, satyriasis, nymphomania, etc. The treatment employed in sexual perversions by the author is suggestive. To those who cannot make use of suggestive therapeutics, the book loses much of its interest. Apart from treatment, however, there is much in the book to interest the reader on pathology, history, habits, etc., of these cases. The publishers have certainly made a handsome book.

THE Buffalo *Medical and Surgical Journal*, which was founded by the late Dr. Austin Flint, will be fifty years old in a few weeks. Its semi-centennial anniversary will be signalized by increasing its reading pages from 64 to 80. There are very few medical journals that have reached this age, but this journal will never grow old or out-of-date with Dr. W. W. Potter in the editorial chair. We extend our congratulations and best wishes for its continued prosperity.

Correspondence

The Editors are not responsible for any views expressed by correspondents.

To the Editor of the CANADIAN MEDICAL REVIEW.

SIR,—With respect to the alleged animus of our attack and bitterness of our letters, allow me to say that our critics, perhaps, wilfully or otherwise, mistake mere vigor and earnestness for violence and rancor. Personally, I am not conscious of having, throughout the controversy, penned anything in a spirit of bitterness or with malicious intent, and I am quite sure the same can be said of my associates. Once it became patent that an attack on the late Council was inevitable, it necessarily had to be made a strong attack. Determined men do not attempt to remove a mountain by blowing thistle-down at it, or to break up a long-established system of legalized injustice, by being mealy-mouthed, or carefully young-ladyish, in the choice of the language they employ in its exposure. Whether we should have made our strychnine more palatable, or increased its tonicity, by administering it in syrup is open to question. We can look back with great satisfaction on the fact that our modes of warfare, if ungentle, were in no case dishonorable. If there was hard hitting, on the part of the Defence Association, it was, at all events, hitting straight from the shoulder. There was, on our part, at least, no striking below the belt, no stabbing beneath the fifth rib, no descent into the regions of epistolary blackguardism, no resort to the coward's chosen methods of innuendo, anonymity, moral attenuations, and personal vilification. We neither invoked nor accepted the assistance of professional outcasts. We, in no case, forgot the amenities of public debate, or violated the decencies of reputable journalism, or subjected any newspaper or periodical that published our letters, to the stinging suggestion that, before being issued, it ought to be thoroughly disinfected and deodorized by the Board of Health, or, failing this, should be carefully lifted with a pair of tongs out of the post-office into the stove. We severely left to our opponents a rigid monopoly of these and all kindred methods of being *strong*. We confined our criticism to the public acts of public men, carefully avoided misrepresentation and vituperation, and kept to established facts and hard-fisted arguments. That our articles were vigorous and forceful, we are glad to believe, especially in view of the fact that those of our adversaries were strong only in the sense already referred to. When, as now and then chanced, we found an official editor or an ex-president flaunting his nakedness in our face and, shamelessly,

rioting, *sans culotte*, in trickery, double-dealing and untruthfulness, we did not hesitate to give him the cobbing he seemed to invite, and, to make it more effective, we occasionally, I confess, dipped the shingle, before applying it, in a weak decoction of sarcasm. But even then, sir, we only mildly satirized offenders who richly deserved to have been severely lampooned—we did but gently fret the cuticle which we ought, in strict justice, to have excoriated or scorched. And yet, so violently do even an honest man's sympathies and associations warp his judgment and bias his sense of fair play, that, notwithstanding our careful avoidance of all that is low and reprehensible in controversy, the able and ordinarily just editor of one of our best medical periodicals ventures, in a recent article, to class us with our opponents, and professes to regard our methods as being no very great improvement on the questionable tactics pursued by them! From such a partial judgment we confidently appeal to the intelligence of the great body of our unprejudiced fellow-practitioners, who have probably perused the literature on both sides with a less jaundiced eye.

My own letters have especially offended our critics by their number and their length, and by their faults of style. My position as secretary of our association has naturally, in a large measure, imposed upon me the onus of correspondence, and I have not grudgingly devoted myself to it. I would gladly have made my published letters fewer and shorter had my opponents left me any option in the matter. In all serious public controversy, charges that are explicitly made, and facts and arguments that are distinctly set forth, are either frankly admitted or categorically refuted. Our adversaries, however, in this dispute, did neither the one thing nor the other. They adopted the unusual and somewhat fatuous course of pooh-poohing our whole indictment, and then trying to pose, before the medical electorate, as having triumphantly disproved every count thereof. This unworthy procedure compelled us, more than once, to repeat the entire arraignment, and to insist that our charges should be squarely met, or judgment suffered to go by default. Hence our long letters and a good deal of iteration and repetition. But, while freely admitting that my letters were long and frequent—necessarily so from my point of view, and that my style is by no means free from serious blemishes, I claim that it must be a matter of opinion whether it is justly open to the charge of verbosity. I may be permitted to point out that even a very short letter may be prolix to tediousness, while, on the other hand, a very long one may be sententious almost to laconism. I greatly admire a nervous, pithy and racy style of composition, and I have, in my humble way, earnestly striven to attain to it. If, as charged, I have been diffuse where I

sought to be terse, it is my misfortune, and would seem to indicate that my long-unused pen hath lost whatever of cunning it may have been once thought to possess. If such be the deliberate verdict of my confreres, I might plead in extenuation, the very unfavorable conditions in which these letters of mine were penned. A private correspondence with the medical electorate involving, during the last three years, written replies to nearly three thousand letters and post-cards, and an official connection which led to some twenty-five visits to Toronto, each causing one or two days' absence from home, super-added to the professional claims of a country practice, have left, at my disposal, but little time to devote to the mere graces of epistolary composition, and may be held to excuse the shortcomings and faults to be found in my press correspondence. My whole claim is that I have written with honest intent, without malice, and with the single desire to elevate the status and to advance the best interests of the medical profession in Ontario.

Yours, etc.,

JOHN H. SANGSTER.

Port Perry, March 11th, 1895.

To Blow or Wash.

To the Editor of the CANADIAN MEDICAL REVIEW.

SIR,—Having been afflicted with the pervading epidemic la grippe in the form of a persistent influenza for four weeks, using all kinds of sprays locally and medicaments of all sorts internally; feeling as miserable as a man could feel; taste gone, even had I appetite to eat, which I had not; one ear entirely deaf from inflammation of Eustachian tube; stock of handkerchiefs nearly used up from constant use; nose very sore from constant blowing, the supply seemingly as inexhaustible as the widow's cruse, a lucky hit brought to my notice the enclosed short article from the *British Medical Journal.* I did not use plain water, but very hot, in which I put sufficient boracic acid to make the strength 1 to 40. The relief experienced was almost immediate, hearing returned in the deaf ear inside three hours. The widow's cruse began to give signs of bankruptcy in about four hours, and the sense of smell and taste returned next day. I used this method every hour for six hours, and next day every two hours. This is, of course, but an isolated case and, there-

fore, not at all positive, but the article itself is well worth everyone's perusal and digestion, and I think the simple remedy deserves a trial.

MEDICO.

"TO BLOW OR WASH?

"In these days of warfare against dirt, why don't we wash our noses? Surely they get quite as dirty as our teeth, which we brush so laboriously every day. The civilized nose is, in fact, one of the dirtiest organs of the body; for, so long as civilization, which mostly means crowding, involves the breathing of dirty air, the nose, which is the organ by which the air receives its first preliminary purification, must become loaded with all sorts of nastiness. The man with a cold, who is always sneezing and slobbering with a handkerchief, is not a pleasant companion; but, for all that, by dint of much "running," his nose at least is washed, and is cleaner within than that of the fine lady who has trained herself never to use the highly-decorated little bit of lace which she carries about and calls a handkerchief; for in that nose condense and accumulate the soot, the dust and microbes of our far from cleanly cities. People who suffer from nose diseases have, of course, to apply various lotions, the efficacious part of many of which is the water they contain, and this they commonly do either by placing the fluid in the palm of the hand and snuffing it up—a process which only draws it through the more open lower passages of the nose; or by means of a nasal douche or syringe, a process somewhat more effectual, but also more irksome. The simple plan is to plunge the face into a basin of clean water, cold or tepid, and take slight snuffs, in and out, while under water. By practice it will be found that before the face has to be withdrawn for breath, water can be drawn in and out of the nose several times, filling and emptying the nasal cavities every time, without using any force, and without drawing the water into the throat or causing any choking. The state of the water after the performance indicates the necessity for this little operation."—*British Medical Journal.*

Miscellaneous.

THERE are many preparations offered the profession for treatment of dyspepsia—some good, and some of little benefit. Of the former variety, Lactopeptine admittedly stands at the head, and we have recently made trial, with most satisfactory results, of this preparation in its new form—Lactopeptine tablets. The formula, as is well known to the profession, comprises a perfect simulation of all the ferments necessary to perfect assimilation, and in the tablet form preparation, can be carried in the pocket of the patient, and used at such intervals as his physician may direct. They are very neatly put up, and can be secured through any druggist.

ANTISEPTIC LAVAGE OF THE STOMACH.—

℞.	Sodæ biboratæ	ʒij.
	Creolini	gr. iv.
	Acid. salicylici	gr. xviij.
	Thymolis	gr. iv.

M. Use with a syphon tube after clear water lavage once a day.—*Rosenheim.*

Dr. ROBERT H. BABCOCK, of Chicago, has been using Maltine with Coca Wine, and says he is convinced of its great service when it is desirable to check undue tissue waste, or to enable a patient for a time to endure unusual demands upon his strength. He recently prescribed it for a female patient with tubercular induration of one apex. The tendency was to fibroid transformation rather than caseation, but for some reason she had come to a standstill, and his efforts to improve her condition seemed futile. Her chief complaint was a feeling of weakness. After using Maltine with Coca Wine for a week, she reported herself as feeling better and certainly appeared stronger and more cheerful. She continued the preparation for a month, and the decided improvement in her condition dates from that time. Malto-Yerbine is, in his opinion, a good stimulating expectorant, and in one case of broncho-pneumonia contributed much to the patient's recovery. He says it seems to be a good vehicle for the administration of other expectorants in the case of children, and it has been occasionally so employed by him.—*Maryland Medical Journal.*