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THE

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A MONTHLY JOURNAL DEVOTED TO MEDICINE & SURGERY

VOL. XIX. HALIFAX, NOVA SCOTIA, NOVEMBER, 1907. NO. 11

Maritime Medical News

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THE
MARITIME MEDICAL NEWS
VOL. XIX., *NOVEMBER, 1907*, No. 11

The Blood After Splenectomy. A paper written by Edwin Matthew and Alexander Miles, entitled "Observations on the Blood Changes Subsequent to Excision of the Spleen for Traumatic Rupture," appears in the *Edinburgh Medical Journal* for October. A case of rupture of the spleen is cited, occurring in an alcoholic subject as the result of comparatively trivial violence. The symptoms were slow in appearing, and, apart from the history of injury, suggested a septic condition rather than one resulting from loss of blood. According to the authors, the clinical changes after extirpation of the spleen are found mainly in the blood and lymphatic tissues, and may be stated as follows: (1.) An enlargement of various groups of lymphatic glands occurs. The increase in size sets in early after the operation, is not of any great degree, is probably general, and is not permanent. (2.) Corresponding to the lymphatic hyperplasia there appears in the blood an absolute increase in the number of lymphocytes. This increase persists in man for years after the removal of the spleen. (3.) Appearing along with the lymphocyte increase, a moderate eosinophilia is present for some weeks. During this time the blood plates are very numerous. (4.) After recovery from the loss of blood, the red cells and hæmoglobin follow a normal course. (5.) After excision of the spleen, individuals who recover suffer from no inconvenience. The spleen is consequently not indispensable.

Treatment of Cholelithiasis. In an article contributed to the *Journal of the American Medical Association* for October 26, on "The Medical Treatment of Cholelithiasis," G. Dock says that two things have contributed to put the treatment of cholelithiasis on a certain basis: First, Naunyn's demonstration that gallstones are chiefly due to infection and stagnation of bile, supplemented by Kramer's experiments showing that the colon and typhoid bacilli precipitate bile in the test tube, and, second, the revelations of the actual conditions by surgeons. Prevention must be limited practically to those who have a known tendency as shown by previous infection of the biliary tract. The measures required are generally well known. They consist in regular healthful habits as to diet, regulation of the bowels, moderate exercise, avoidance of tight clothing and anything that can cause congestion of the portal circulation. Systematic deep breathing is perhaps useful in overcoming such congestions. Among drugs, salicylates are probably of definite value as disinfectants and cholagogues, but they should be watched and stopped if undesirable effects appear. The presence of the stone is less important than the existence of the infection, and the therapeutic problem is not to lessen pain so much as to lessen inflammation and the attendant risks. The majority of the cases, in the attack, are not surgical, but they should be viewed with a surgical eye, and if the physician is unable to do this, he should have a surgeon's

coöperation. For the attack, anodynes to relieve pain, but not entirely becloud the clinical picture, are advised. Dock does not use chloroform in these cases. Local hot applications and the hot full bath are useful, but he prefers copious washing of the stomach with hot water or hot Carlsbad water, which theoretically, should lessen congestion and act as a general sedative to the affected tissues. Rest so far as possible and movements of the bowels should be encouraged. The after-treatment depends on the suspected conditions in the biliary tract, and after the acute symptoms have passed especial attention should be given to the occurrence of bile in the urine or stools, leucocytosis, etc. Dock thinks the passage of gallstones out through the common duct a comparatively rare event and that in many cases in which this is supposed to have been the case perforation has actually occurred. Perforation can easily happen in the severer attacks of bilious colic, but he is also convinced that it sometimes occurs with symptoms so mild as to be overlooked at the time and only discovered by operation or autopsy. In conclusion, Dock expresses the opinion that olive oil may possibly be of some service in reducing gastric hyperacidity and hypermotility, thus improving intestinal digestion and relieving some of the symptoms.

*

Bier's Hyperæmia in Infections. In a paper entitled "The Treatment of Microbic Invasions by Bier's Hyperæmia," appearing in October's *Practitioner*, A MacLennan accepts Bier's teaching that disease is dependent on microbes and that inflammation indicates the struggle of the tissues against it. He approves of the treatment suggested by Bier, applying the elastic bandage with moderate pressure so as to induce little discomfort. He associates with it other methods of combatting inflammation, using antiseptics in the intervals. Dry dressings, lightly applied, should be used when hyperæmia is being produced. Time should be allowed for the œdema to disappear, and parts distant from the inflamed area may be massaged. The points in favour of the treatment are as follows: (1.) It is agreeable to the patient. (2.) It relieves pain and obviates painful procedures, like packing an abscess cavity. (3.) It is beneficial before infection is established, and in all mild inflammations. (4.) It aids recovery, repair going on in the face of infection. (5.) It permits small incisions and diminishes scarring. (6.) It diminishes the number of operations and is helpful in many cases for which there is no other treatment.

*

Acute Anterior Poliomyelitis. Joseph Collins, in the *Medical Record* of November 2, reviews the history of recent epidemics of this disease and discusses its clinical manifestations, particularly as observed during the present epidemic in New York city and its environs. He estimates that already there have been more than one thousand cases, but as yet nothing definite has been learned in regard to the etiology of the disease. A noteworthy feature of the epidemic has been the number of cases in which a fairly good recovery has resulted; that is, in which there has been little or no muscular atrophy. The explanation of this is that the inflammation in the anterior horns is not so intense as to destroy the cell bodies and nutritive processes of the peripheral motor neurons. In order to secure data to aid in in-

vestigating the etiology of the disease, Collins urges physicians who see the patients early to send lumbar-puncture fluid, urine, and fæces to those who are equipped to study them adequately. Later on in the disease there is less hope of discovering facts of importance.

*

The Venous Pulse

A. R. Cushny, and L. C. Grosh, (*Journal of the American Medical Association,* October 12), report investigations both experimental and clinical, on the venous pulse. In their experiments on dogs, they registered the jugular pulse, as in their clinical observations, by means of a funnel receiver connected by an air tube to a very sensitive tambour, the writing end of the lever being in contact with the smoked paper of the kymograph. The carotid pulse was registered by means of a cannula in the carotid connected with a Hurthle's sphygmomanometer, and movements of the auricle and ventricle were registered by threads attached to them and to the membrane of the tambour which connected with another writing on the kymograph. In the jugular tracings, as a rule, a series of elevations separated by deep depressions is seen. The elevations are composed of three minor waves, which are marked *a, c, v* in their figures, after Mackenzie's method. The wave (*a*) has been ascribed by Mackenzie to the auricular contraction, and Cushny and Grosh find in their tracing that on projecting the auricular tracing on the jugular the middle wave corresponds exactly with the auricular contraction in its commencement and fall. The succeeding wave (*c*) was considered by Mackenzie to be communicated impulse from the carotid, and others have supposed it communicated from the systolic stiffening of the aorta and the large arteries of the thorax. Morrow has lately revived Potain's view that this wave is produced in the heart during the ventricular systole and transmitted along the course of the vein. The authors' results indicate that this wave is not of local origin in the neck, but they are unable to say whether it arises in the heart or in its immediate neighbourhood. They consider the question, however, as hardly of great importance as regards the clinical use of the method of recording the jugular pulse. The (*v*) wave appears to be dependent on the ventricular systole, and can not be due to stasis as some have held, but their experiments do not suggest a perfectly satisfactory explanation of its mechanism. It may possibly be, as Francois-Franck has suggested, an indication of increased intra-auricular pressure associated with ventricular relaxation. A number of other points of interest are noticed, and the clinical observations in four patients suffering with cardiac disorders are detailed, with special reference to the alterations of the venous pulse. The authors think that more attention might be given "to the form of the auricular wave in the jugular pulse, and that as much information as to the state of the heart may perhaps be derived from this source as has occurred from the study of its time relations."

*

Movable Kidney.

C. M. H. Howell and H. W. Wilson contribute a paper under this caption to the *Practitioner* for October, in which they review briefly the history of the condition. The signs which indicate movable kidney may be classed as follows: (1.) Excessive descent with respiration, so that

the anterior surface may be palpated with deep inspiration. (2.) Abnormal mobility communicable to the organ from without. The organ is then no longer influenced by respiratory movements. (3.) Possible rotation of the kidney, alone or in combination with descent. The following classification is therefore suggested: (1.) Kidneys which have merely prolapsed. (2.) Kidneys which have prolapsed and the lower pole has rotated inward. The kidney returns to its normal position when the patient is recumbent. (3.) Kidneys which have prolapsed, the lower pole rotated inward, and have undergone anterior displacement. There is no tendency to return to the natural position. (4.) Kidneys which have undergone rotation only. There is no prolapse, and the organs are usually impalpable without an anæsthetic.

Ptosis of Abdominal Viscera. Charles Greene Cumston, writing in the *Medical Record* of October 19, regards ptosis of the abdominal viscera as a condition occurring in individuals predisposed to relaxation of the muscular and fibrous tissues by heredity. Disturbed nutrition shows itself by a distensible condition of fibrous tissue. In the male this results in hernia, in the female in eventration, in both in varices. The stretching of labour with its muscular effort, aided by improper treatment after labour, and getting up too soon, may be an important factor in the production of ptosis. Tumours may have a similar effect. The use of corsets that compress and push down the liver is also causative of this relaxation. This temperament may show itself at birth, but it is most manifest between the ages of twenty and forty. In elderly females its worst forms are shown. The author's method of surgical treatment includes the union of the recti with kangaroo tendon sutures so as to overlap, resection of the anterior aponeurosis and its union, and the removal of all the redundant skin.

*

Opsonins and Vaccine Therapy. G. W. Ross, Toronto, (*Journal of the American Medical Association*, October 12), defines opsonins as substances not yet isolated but existing in the blood, by means of which the phagocytes are enabled or induced to destroy bacteria. Their existence was one of Wright's discoveries, another was the technic by which we are able to measure the quantity of opsonins in a given blood, or the opsonic index. The application of these discoveries to the treatment and diagnosis of disease by means of the therapeutic inoculation of devitalized bacteria, or bacterial vaccines, he also credits to Wright. He offers the following classification of bacterial diseases in their relations to vaccine therapy: Class 1. This class comprises mostly chronic infections with persistent low opsonic index, due, it is supposed, to the absence of autoinoculation. The bacteria do not escape into the blood and increase the opsonins, hence the infection persists. In this class are included many tuberculous infections of glands, bones, joints and early pulmonary tuberculosis. Here also we find acne, boils, felons, etc., and many persistent suppurative conditions. Class 2. In this class autoinoculation is the characteristic feature, and severe pulmonary tuberculosis is the type. The opsonic index fluctuates from high to low, and *vice versa*. Class 3. This class comprises the pure septicæmias with probable general lowered opsonic

index, such as ulcerative endocarditis and puerperal septicæmia. It is in the first class of localized infections that vaccine treatment has been most successful, and Ross reports an illustrative case showing the method of treatment. He also gives his experience wi h the treatment of boils, carbuncles and other staphylococcic infections by this method and also in the treatment of localized tuberculous conditions with new tuberculin. Lupus he finds rather more refractory than most other forms of localized tuberculosis, since we fail with it as often as we succeed. In early pulmonary tuberculosis, he considers tuberculin a powerful agent for good, but in advanced cases it will be of little benefit. Streptococcic, pneumococcic, gonococcic and other bacterial affections have been treated with success, and cases of cystitis, sinuses, etc., due to infection with bacillus coli communis, have yielded to colon vaccine. He also reports a representative case of the third class of diseases, the septicæmias, and a case of ulcerative endocarditis, successfully controlled by streptococcus vaccine after antistreptococcus serum had failed. In conclusion, Ross states his opinion that inoculation with proper vaccines is a powerful aid in the treatment of many bacterial diseases. There is considerable difference of opinion concerning the relation of the opsonic theory to inoculation, but it is his opinion that while estimation of the opsonic index is often unnecessary, such investigation has been and still is of great service in enabling us to determine the proper dosage and time for inoculation and reinoculation when we are in doubt.

Indications for Prostatectomy. John Pardoe concludes a paper on "The Indications for Prostatectomy," read before the section of surgery at the recent meeting of the British Medical Association, and published in the *British Medical Journal* of October 5, as follows: (1.) Except in very early cases, it is not permissable to operate upon carcinoma of the prostate, except with a view to permanent drainage. (2.) In the case of fibrous enlargement interfering with micturition, piecemeal enucleation or a prostatectomy should be done. The mortality of the latter operation is practically nil, and the results are satisfactory, both immediately and permanently. (3.) In very aged men with a marked tolerance of catheter life prostatectomy should not be urged. (4.) Unfortunately catheter life has serious discomforts and dangers for the majority of sufferers, and for these enucleation is by far the best treatment. It should be done at the period of election—namely, before septic infection has taken place. I have tried both perineal and suprapubic complete enucleation and much prefer the latter. (5.) The surgeon should not refuse operation to cases seriously infected and very ill. Their lives are sure to be painful and seldom prolonged if operation is refused, and although the mortality is higher than in selected cases, it is not unduly high, especially if the operation is done in two stages.

*

The Hepatic Functions. Writing in the *Medical Record* of September 21, under the heading "The Hepatic Functions, Their Pathology and Treatment," H. Richardson enumerates the liver functions, and then considers especially the antitoxic function. The liver

eliminates urea; it undertakes the sulphoconjugation of the phenols; it transforms alkaloids and renders them non-poisonous; it has a depuratory rôle, eliminating metallic poisons and colouring matters, it removes toxins and insoluble substances; and its cells have greater phagocytic powers than the leucocytes. The treatment of autointoxication is one of the modern problems First comes flushing out of the intestines by calomel and magnesium sulphate. The biliary secretion must then be stimulated and the best stimulant is sodium glycocholate mass. Diet should be as small as possible, milk being the best antiseptic. Small amounts of proteids and larger ones of well cooked carbohydrates are the best. Brewer's yeast in the form of cheese or weissbier is a good antiseptic.

*

Hæmoptysis Due to Tuberculosis. J. M. Anders, Philadelphia, (*Journal of the American Medical Association*, September 28), discusses the symptoms, etc, of tuberculous hæmoptysis, first calling attention to its pathologic etiology. We are apt to ascribe any early pulmonary bleeding in consumptives to congestion of the bronchial mucosa, and Anders shows that it is probable, rather, that minute areas of necrosis already exist when these bleedings occur. That a high grade of congestion, however, is a factor, is shown by the influence of physical strain, and the heart's condition must be also considered. Patients with chronic valvulitis undoubtedly have more frequent hæmorrhages. Hæmorrhages from eroded vessels and miliary aneurisms are the more frequent causes of fatal results, and less frequent occurrence of pulmonary hæmorrhage in advanced cases of consumption is ascribable to endarteritis, causing gradual thickening and greater resistance of the vessel walls. Undoubtedly there is in many cases an existing hæmorrhagic tendency and hereditary taint is often obvious. Aggravation of the cough and muscular exertion are frequent exciting cases. Anders points out that the frequency of the symptom is very marked, and he agrees with Os'er that it is a feature in from 60 to 80 per cent of all cases. His own experience does not show greater frequency in females than in males, and he says that sexual differences are not as great in this regard as has been claimed. Season has a decided influence as shown by his table. More cases occur in the spring and summer months than in the winter. We must regard hæmoptysis, he says, as the result of existing tuberculosis although other signs and symptoms are lacking. The attack does not seem to have any marked effect in reducing temperature in the majority of cases, and sometimes there may be a notable rise, which he is inclined to ascribe, sometimes, at least, to exacerbations of tuberculous inflammation from the setting free of toxins, etc. The majority of bleedings occur after secondary infection with the streptococcus. There is a form of periodic hæmorrhage, though it is not common. In his summary of treatment, Anders remarks that the prophylactic measures are unduly neglected. The importance of rest and avoidance of stimulants are hardly duly appreciated. A residence away from the sea coast and a cold dry aseptic air are beneficial, as pointed out by Curtin. Among drugs, he relies mainly upon opium, discontinuing it, if abundant moist bubbling rales are heard over the uninvolved portion of the lung—

a rare event, except in case of rupture of a miliary aneurism. In case there should be ruptured aneurism with profuse hæmorrhage and danger of inundation of the uninvolved lung, cough should be encouraged rather than suppressed, and opium is contraindicated.

*

Canadian Society of Nurses. The Canadian Society of Superintendents of Nurses' Training Schools met in Montreal, on September 11th and 12th. The officers selected for the ensuing year are as follows: President, Miss Snively, Toronto; 1st Vice-President, Miss Chesley, Ottawa; 2nd Vice-President, Miss Livingston, Montreal; Secretary, Miss Bent, Toronto; Treasurer, Miss Meiklejohn, Ottawa; Councillors, Miss MacDougald, Halifax, Miss Wilson, Winnipeg, Miss Chesley, Ottawa, Miss Patton, Toronto, Miss Greene, Belleville, Miss Scott, Kingston.

*

Canadian Militia Medical Officers Association. This Association, which was first organized in 1892, has been revived and reorganized. All medical officers of the militia, A.M.C. and regimental, are *de facto* members without election. The objects of the Association are the development of departmental *esprit de corps,* the discussion of military medical subjects, the reading of papers and discussions thereon on military medicine and surgery, hygiene and equipment. The following officers and committees were elected: Hon. President, Hon. Sir Frederick Borden, K.C.M.G., M.D., Minister of Militia and Defence; Hon. Vice-Presidents, Col. E. Fiset, D.S.O., Deputy Minister of Militia and Defence; Lt.-Col. G. Carleton Jones, D.G.M.S.,; President, Colonel G. Sterling Ryerson, M.R.O., Toronto; Secretary-Treasurer, Lieut. T. H. Leggatt, A.M.C., Ottawa; Vice-Presidents for Military Districts—No. 1, Capt. D. H. Hogg; No. 2, Lt.-Col. Hillary, 12th York Regiment; No. 3, Lt.-Col. Duff, P.A.M.C.; No. 4, Major J. D. Courtney, M.R.O.; No. 5, Major McTaggart, 1st Regiment, Prince of Wales' Fusiliers; No. 6, Lt.-Col. A. N. Worthington, A.M.C.; No. 7, Lt.-Col. Grondin, 87th Regiment; No. 8, Lt.-Col. McLaren, A.M.C.; No. 9, Lt.-Col. Sponagle, A.M.C.; No. 10, Major DeVine, P.A.M.C.; No. 11, Lt.-Col. J. A. Grant, P.A.M.C. No. 12, Lt.-Col. Johnson, A.M.C.; No. 13, Capt. W. S. Hewetson, A.M.C. Executive Committee—Capt. H. A. Kingsmill, 7th Regiment; Major G. A. Rennie, A.M.C.; Lt.-Col. K. Cameron, A.M.C.; Capt. M. Lauterman, Duke of Connaught's Hussars; Capt. E. A. Lebel, 9th Regiment; Major G. N. McNally, 71st Regiment; Capt. G. M. Campbell, Nova Scotia Regiment; Lt. J. W. Manchester, 90th Regiment; Capt. F. C. McTavish, 6th Regiment; Lt.-Col Warburton, 82nd Regiment; Lt. T. A. Hislop, Headquarters Staff. The next meeting of the Association will be held at Ottawa on February 26th, 1908.

*

Halifax Medical College.

Commenting upon some recent letters in the Halifax press, relative to a change in the teaching staff of the Halifax Medical College, from which some quotations are made, the *Montreal Medical Journal* says: "Leaving out of account all local and personal circumstances, the experience of the Halifax Medical College is not unusual. The medical school without ample endowment, large scientific equipment and extensive hospital facilities, has fallen

on evil times. In the old days the possession of a lecture room and a few bodies were considered sufficient warrant for carrying on the teaching of medicine, and many excellent practitioners issued from that system with profit to themselves and to their teachers. To-day the teaching of medicine is impossible without a large subvention from the state or from private munificence. It costs McGill University $1,650 to graduate a student in Medicine, and it receives from the student only $575 in return. Bishop's College was astute enough to foresee the changing condition of affairs, and entered into an arrangement with McGill by whch it was relieved from a burden which in time would have grown intolerable.

"The only hope for the smaller medical schools is that McGill has raised its requirements to five years, and Toronto will follow next session. No one contends that this is too much, but there are always students who will be content with the second best. These will seek the smaller schools and give to them a renewed though temporary lease of life. Halifax may take courage from what has happened in Kingston, where, in a city of 17,000 inhabitants, with corresponding hospital facilities, there are registered this year 230 medical students."

We can hardly believe that the writer of the above would intentionally do injustice to the smaller medical schools. Yet the quotations from the correspondence which appeared in the lay press relative to the Halifax Medcal College represents but one side of the case, and so might appeal to a fair critic as being not unbiased. And the blunt statement that those students who are "content with the second best" will seek the smaller schools, is one which the editor of the *Montreal Medical Journal* must surely regret having allowed to appear in print. Other statements are quite as lacking in justification, and we are compelled to conclude that the article was either written hurriedly and without careful consideration, or else that it was inspired by interests inimical to the smaller medical schools, and particularly to the Halifax Medical College.

We frankly concede that the Halifax Medical College lacks the equipment in which the larger schools glory. It has never benefited by "large subvention from the state or from private munificence." But, thanks to the devotion of the men comprising its teaching staff, it has, through many discouragements, continued to do the "impossible," and *has* taught medicine to a body of men who not only do their alma mater credit, but whose professional career compares very favourably with that of those who have graduated from the large and richly endowed colleges. Those who teach at the Halifax Medical College know that they cannot depend upon an elaborate array of mystifying paraphernalia to impress their students, and consequently they content themselves with a plain and practical presentation of fundamentals, aiming always to equip the students with that knowledge which will ensure their success in practice. The teaching may be deficient in the spectacular, but it is honestly given, and given at a real sacrifice on the part of every teacher, for no one would argue that the ridiculously small return from students' fees can be regarded as in any way a recompense for the expenditure of time and labour which the teaching demands. The best indication of the value of that teaching is the record of the men who have passed through

the college. The testimony of the examiners of the Provincial Medical Board, fully one half of whom have no connection with the college, is to the effect that the students of the Halifax College compare very favourably, in the examinations for license, with those from other colleges. Throughout the Maritime Provinces is a large sprinkling of Halifax College men, who have proved to be thoroughly capable practitioners, and who rank well with their confreres who have received their medical education elsewhere. And when Halifax College men go abroad to pursue post-graduate work, they almost invariably establish a record which is most creditable to their alma mater.

The hospital facilities at Halifax must be considered in view of the fact that the Victoria General hospital is a provincial institution, maintained by the government of Nova Scotia, and attracting patients from every portion of the province. In its wards the students have perhaps greater freedom than in any other hospital, being allowed every opportunity for study at the bedside. The comparatively small classes make it possible for the teachers to consider the individual needs of the students, and the per capita allowance of clinical material is unusually large.

To set right the editor of the *Montreal Medical Journal*, we may further say that in making appointments to the teaching staff of the Halifax Medical College, the merits of the various candidates are always considered, and the one selected is the one adjudged to be best fitted for the work. There is no ring-system at this college. While it is true that last year's senior class numbered but four, the graduating class this year numbers thirteen, the freshman class is one of the largest in the history of the college, and the other classes are a good average in point of numbers. And it is well known that the faculty is now arranging to at once extend the course to include a fifth year.

HYPERTROPHY OF THE PROSTATE.

SUPRAPUBIC PROSTATECTOMY, WITH REPORT OF A CASE.

By N. E. MacKAY, M.D., C.M., M.B., M.R.C.S.

Senior Surgeon, Victoria General Hospital.

Read before the Hants-Colchester Counties Medical Society, Windsor, August 20th, 1907.

IN order to appreciate the details of an operation for the removal of an hypertrophied prostate by enucleation, it is necessary to be familiar with the anatomical structures immediately concerned in it, and their relations. You will therefore pardon me if I briefly review these before taking up the subject proper of my paper.

The prostatic gland is situated at the neck of the bladder. It has above it the symphysis, and it rests on the rectum in front of the second and third segments of that viscus. In front of it is the triangular ligament against which its apex rests; its base is directed upwards and backwards towards the bladder. In shape it resembles a horse-chestnut and measures one and a half inches across its widest part, one and a quarter inches from before backwards, and three-quarters of an inch in thickness. Text books on anatomy teach us that it is a single organ with the urethra traversing it from behind forwards. Embryologists tell us that until the fourth month of fœtal life the gland is formed of two distinct organs, and that at this period the two separate masses become agglutinated, except in the region of the urethra which it embraces; and that these two sections, although welded together, remain functionally separate and distinct in after life. Each mass has its gland ducts—12 or 20 in number—which discharge into the urethra on either side of the veru montanum. In function the two sections are as separate and distinct as are the two testicles. In operating by the suprapubic route, advantage is taken of these anatomical conditions by removing each section separately, so as to preserve the prostatic urethra uninjured and avoid subsequent stricture. It is very desirable that this part of the canal should be maintained intact if at all possible, although Moynihan, of Leeds, and Freyer, of London, remove the prostatic urethra without hesitation and no serious results follow.

The ejaculatory ducts should receive attention. Their destruction may lead to impotence. They enter the two lateral masses from behind in their course to the urethra, where they end. These ducts should be preserved uninjured if at all possible, and so lessen the likelihood of the production of impotence.

The gland itself is formed histologically of glandular substance and a stroma of muscular (unstriped) and fibrous tissues. The glandular element is composed of follicular pouches and ducts.

The enlarged prostate has two distinct capsules, viz.: (1) An inner or true capsule, (2) An outer or external capsule or sheath. The inner capsule or sheath is composed of unstriped muscular tissues intermingled with some fibrous tissues. This sheath sends numerous processes into the substance of the gland which connect

with a central collection of unstriped muscle which surrounds the urethra. The inner sheath is therefore firmly adherent to the substance proper of the gland. The external capsule is formed of the recto-vesical fascia. It does not cover the gland above. These two capsules are held together loosely by a few bands of fibrous connective tissue. Imbedded in this loose tissue is the vesico prostatic plexus of veins which sometimes gives rise to troublesome bleeding. There is therefore a line of cleavage between these two sheaths, and advantage is taken of this anatomical condition in the operation for complete enucleation of the gland.

An orange forms a rough illustration of the structure of the prostate, if we are to suppose that the edible part of the orange is formed of two vertical sections joined together in the middle line. The strong fibrous tissue which joins or holds the two segments of the orange together, and which is closely connected with the pulp, represents the true capsule of the hypertrophied prostate, the two segments of the orange being represented by the two lobes. The rind of the orange represents the outer capsule, known as the recto-vesical fascia.

In enlargement of the gland confined to the lateral lobes, it is plain from these anatomical conditions that each lobe may be removed separately without inflicting any serious injury on the prostatic urethra. The enucleating finger may be inserted on either side of the urethra and shell

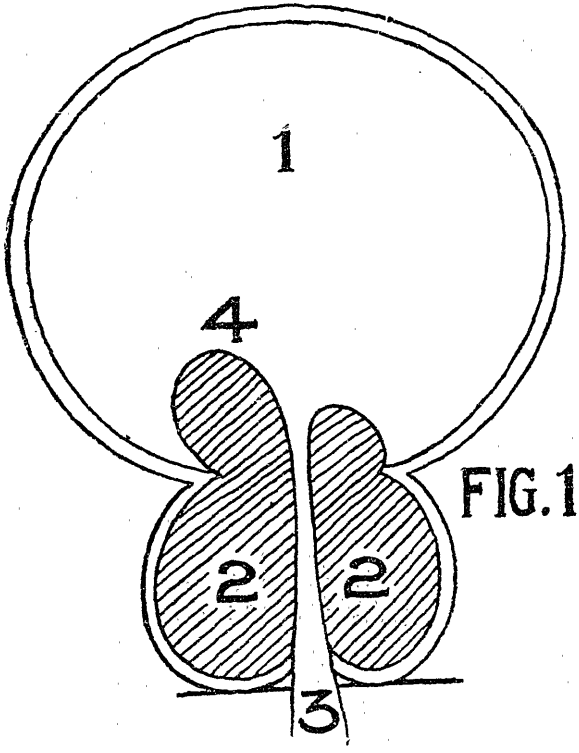

FIG. 1

1. Bladder.
2. Prostate (R. & L.)
3. Urethra.
4. Enucleation begins.

the hypertrophied lobes out of their beds. (Fig. 1.) When the outgrowth is in the centre of the organ the urethra is likely to be torn in the operation.

The condition known as "hypertrophy of the prostate" is incidental to old age. It is rarely met with under the age of 55, and it is said that 33 per cent. of the men who arrive at that age suffer from it, although in only 5 per cent of cases does it give rise to any serious inconvenience. The gland increases in size in the direction of least resistance, and that is upwards and backwards into the bladder. The external capsule is absent here. The tumour does not grow downwards and forwards to any appreciable extent because of the resistance offered by the outer capsule and the triangular ligament. The effect of this upward tendency of the growth is to raise the internal meatus of the urethra on a level above the base of the bladder, and form a sac or pouch in that viscus behind the prostate in which "residual urine" is retained. The amount of "residual urine" will depend on the size of the pouch. The prostatic urethra is at the same time greatly elongated and rendered very tortuous.

TYPE OF TUMOURS.—There are three types of tumours recognizable, viz.: (1) The large soft prostate, (2) The small hard prostate, and (3) mixed variety. The type present depends upon which tissue is in excess. When the glandular elements predominate, the growth is of the large soft variety, and when fibrous tissues are largely in excess it is of the small hard type. The enlarged soft prostate is the one most favourable for prostatectomy, and the small hard one the least. The reason of this is, the line of cleavage between the two capsules is well defined in the former, and hence the growth is easily shelled out from its bed, while in the latter the cleavage line is ill-formed and the two capsules are glued tightly together so that enucleation is both dangerous and difficult.

SHAPE OF TUMOUR.—The gland may enlarge uniformly, or the growth may be limited to one of the lateral lobes, or the lateral lobes may be affected but very little, the enlargement being confined chiefly to the so-called middle lobe, which is merely an outgrowth from the centre of the prostate. Then again there may be irregular outgrowths from the lobes.

The external capsule (the recto-vesical fascia) does not meet above the gland, and hence the tumour grows upwards in the space left between the reflections of this fascia, and insinuates itself between the vesical sphincter and the internal meatus of the urethra (Fig. 2.) and pushes aside the muscular fibres of the bladder and produces a certain amount of atrophy of them, so that nothing is left to cover the outgrowth at this point except the mucous membrane of the bladder. In removing a prostatic tumour by the suprapubic route, advantage is taken of these pathological conditions, as will be seen by the description of the operation.

CAUSATION.—This is unknown as in the case of other tumours. French surgeons hold that this condition is a local manifestation of a general or constitutional affection which begins with a general arterial sclerosis in which all the genito-urinary organs share. The result is a fibroid degeneration of the prostate (Guyon). This is very improbable.

Other eminent surgeons claim that it is inflammatory in origin and is al-

ways secondary to and results from posterior urethritis (Hunter and Virchow). It may be urged against this theory that the disease develops when the sexual function is on the wane and at a period when posterior urethritis is less likely to be present.

Then again some surgeons maintain that these tumours are similar to uterine fibroids, and that both occur when sexual activity is on the wane, (Virchow, Thomson, White.) It is urged in support of this view that the utricle of the prostate is the analogue of the uterus; that in structure the prostate and uterus are alike; that there is a great similarity in structure, position and mode of growth between the fibro-myomata of the uterus and the hypertrophied prostate; and that the disease occurs in both cases when sexual function is on the wane.

In opposition to these views it is contended that the utricle, which is the analogue of the uterus, does not take any part in the prostatic growth and that uterine tumours begin as fibro-myomata whereas prostatic tumours originate as adenomata.

It is now generally admitted that the so-called "senile hypertrophy of the prostate" is chiefly, if not wholly, adenomatous in character.

The effect of enlargement of the prostate is obstructive dysuria. The amount of impediment to the flow of urine depends to some extent on the part of the gland involved, but it chiefly depends on the size of the tumour. In an outgrowth from the centre of the gland the amount of obstruction may be very serious even when the lateral lobes are not markedly enlarged and when no very serious enlargement of the gland can be determined per rectum. The symptoms due to hypertrophy of the prostate are familiar to you all, and the

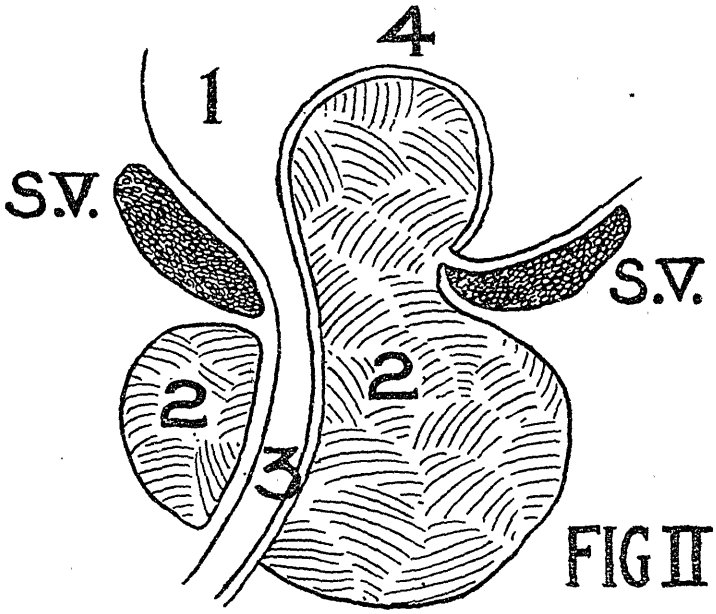

FIG II

1. Bladder. 2. Prostate.
3. Urethra. 4. Intra-Vesecal, part of prostate.
S. V. Sphincter Vesicæ.

pathological changes to which it gives rise in the bladder, ureters and kidneys are similar to those resulting from organic stricture of the urethra. They are cystitis, hypertrophy of the bladder, distention of the bladder with atony, ureteritis with hypertrophy and distention of this canal, hydronephrosis, pyonephrosis and pyelonephritis.

The complications to be feared after prostatectomy apart from septic infection are stricture, epididymitis and orchitis, impotence, incontinence, and fistulæ—suprapubic, perineal and recto-urethral.

STRICTURE.—In the operation of prostatectomy a portion of the prostatic urethra is generally torn away and a scar forms in healing, and this scar may subsequently contract and give rise to an organic stricture. However, a stricture rarely follows if due care is exercised in the performance of the operation, and in conducting the after-treatment of the case. It is not a very common complication. This has been the experience of Moynihan, of Leeds, and Freyer, of London.

EPIDIDYMITIS AND ORCHITIS.—This sometimes occurs from infection transmitted from the prostatic site. The passing of a sound after removal of the drainage tube may bring on an attack. It is usually slight in degree although in a few instances it has ended in the formation of abscess.

FISTULÆ.—These are not of frequent occurrence, especially the perineal and suprapubic varieties. Usually they arise from contraction of the anterior portion of the urethra, (stricture). To guard against their occurrence the urethra must be kept well dilated in the after-treatment of the case. The recto-urethral fistula may result from a tear made in the rectal wall during the operation, or from subsequent sloughing of the parts from the

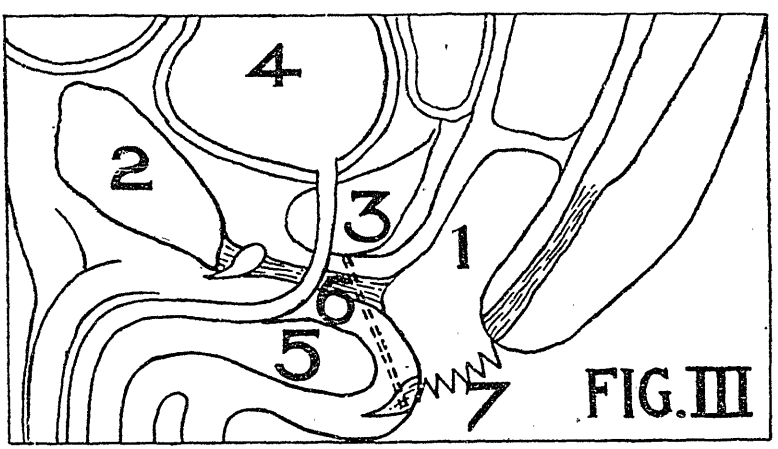

FIG. III

1. Rectum.
2. Pubes.
3. Prostate.
4. Bladder.
5. Bulb.
6. Recto-Urethralis muscular fibers drawing anterior wall of rectum towards urethra and pubes.
7. Track of perineal operation.

presence of a drainage tube or a tampon. It is met with most frequently after perineal prostatectomy, (Fig. 3) and especially if inflammatory or fibrotic changes have taken place in the perineal structures.

IMPOTENCE.—This is a rare complication. It is supposed to be due to laceration and subsequent stricture of the ejaculatory ducts. It is more apt to follow operations for outgrowths from the centre of the gland because the danger of wounding these ducts is much greater than in operations upon the lateral lobes. Then again it is more likely to result from operations on the small hard prostate than on any of the other varieties of tumours. To guard against this complication precautions should be used in performing a suprapubic prostatectomy, to preserve intact the ejaculatory ducts and the segment of the prostatic urethra in which they enter. This is not always easily done when the tumour is situated in the middle of the gland, or in the small hard prostate. Horwitz says that impotence may occur in cases in which these ducts are not injured, that it often arises from injury to the nerves supplying the parts. This complication is more likely to ensue in persons whose sexual vigor is on the wane or in abeyance. In such cases an operation may bring about sexual exhaustion. In operating on individuals whose sexual function is fairly vigorous, the surgeon should exercise care not to damage these ducts.

URINARY INCONTINENCE.—An examination of 530 cases showed that incontinence occurred in 3½ p. c. of cases. It may be present for two or three months after the operation in a very few cases, and continue until the structures about the neck of the bladder regain their normal tone and vigor, after which the patient has complete control over urination. Incontinence may arise from various causes, e. g. (1) hardened cicatrix of the urethral wall leaving a patent tube, (2) damage to vesical neck and sphincter, (3) laceration of prostatic urethra and defective healing of the same, (4) injury to external sphincter or compressor urethræ muscle, (5) damage to nerves supplying the parts.

In a small proportion of cases some leakage persists indefinitely. It is, however, an infirmity of very little moment in comparison with the disease for which it has been substituted.

TREATMENT.—The treatment of enlargement of the prostate has heretofore been very unsatisfactory. As an evidence of this I need only mention the various make-shifts that have been resorted to in the vain hope of overcoming the obstruction to the free flow of urine incidental to this disease. They were all operative in nature and were intended to reduce the size of the organ and so lessen the impediment to free micturition. In some instances the gland was attacked directly, e.g. Bottini's method This consisted in dividing the obstructure at the neck of the bladder by a concealed galvano-caustic knife, or snaring it when pedunculated. Such proceedings were uncertain and not free from serious risks, and happily are not often resorted to to-day. In other instances the gland was attacked indirectly, e.g., castration and vasectomy. These abominations need but to be mentioned, only to be condemned. They fortunately are not often resorted to now-a-days.

At the present moment the treatment of enlargement of the prostate,

is practically reduced to the use of the catheter and prostatectomy, which means enucleation of the whole organ.

Prostatectomy may be performed by one or two routes, viz., (*a*) The suprapubic route; (*b*) the perineal route. Then again the perineal operation may be performed by either "a limited longitudinal median incision carried down to the capsule of the prostate, or through a free transversely curved incision through which the organ is fully exposed. The advantages claimed for the transverse incision is that enucleation is done largely under the guidance of the eye. Whereas in the other two methods, enucleation is effected by finger dissection unaided by the eye. I am not so sure that enucleation can be better effected under the guidance of the eye in these cases, than by the finger dissection aided by the sense of touch only. Each route has its advocates. The selection of methods and routes should not be a matter of indifference, or chance, or prejudice. That method should be selected which in the opinion of the operator is most likely to re-establish the ability of the individual to readily, fully and painlessly empty his bladder, and which at the same time is least dangerous to life.

In these operations we must expect a death rate of from 5 to 10 per cent. Permanent cure is obtained in 68 per cent., and in a large proportion of the remaining cases marked improvement has resulted to the obstructive symptoms; the residual urine is lessened, the cystitis improves, the frequency of catheterization diminishes and the passing of the catheter is much easier.

Prostatic dysuria once declared, the question of contraindications to an operation of this magnitude has next to be considered. Under certain circumstances, age contraindicates the operation, but age is a relative term. One person at eighty may stand an operation better than another at seventy. Septuagenarians and octogenarians often stand operations well. Advanced kidney disease and profound general prostration from prolonged suffering and loss of sleep are the chief contraindications to the operation. In these cases the surgeon should be satisfied with palliative measures, such as the use of the catheter, drainage (perineal or suprapubic), bladder irrigation, urinary antiseptics, the removal of a stone if one is present, and sedatives and general hygiene.

Prostatectomy is not an operation of emergency. This being the case, measures should first be used to ensure the best state of bodily vigor. Sleep should be secured by sedatives if necessary; the bowels should be regulated by suitable aperients and diet; the kidneys should be flushed by copious draughts of water; the skin should be acted upon by hot baths; the urine should be made antiseptic by prescribing urotropin grs. x, or salol grs. x, four times a day; and the mucous membrane of the bladder should be rendered aseptic by irrigation with mild antiseptics.

SUPRAPUBIC PROSTATECTOMY.—I perform the operation in the following manner: The patient is prepared in the usual way, and the parts in the neighborhood of the field of operation are sterilized thoroughly. The bladder is washed by a warm boracic lotion at a temperature of 103°F until the return fluid is clean and clear, and then ten or twelve oz. of the lotion is allowed to remain in.

An incision is now made in the median line immediately above the pubes, from 2½ to 3¼ inches in

length—in a thin subject 2¼ inches, in a stout person 3½ inches. The incision is at once carried down between the recti and pyramidales muscles (linea alba), and through the transversalis fascia into the prevesical space, known as Retzius's space, which is filled up with fat. Care must here be exercised not to wound the fold of peritoneum which extends above from the fundus of the bladder to the parietal wall in front. This fold is seen in the upper angle of the wound. On inserting the finger in the lower angle of the wound the tense disturbed bladder is easily felt. The prevesical fat is now removed from the anterior surface of the bladder with the finger-nail and it and the peritoneal reflexion already referred to are drawn upwards out of the field of operation. This is easily done, as the connection between the bladder and peritoneum is fairly loose. In doing this, however, care should be taken not to wound the plexus of veins which cover the anterior surface of the bladder in this region, and so avoid troublesome hæmorrhage. The distended viscus will now be seen at the bottom of the wound glistening and pale-white in colour. Two traction cords of silk are then inserted into the bladder wall, one on each side of the wound, to hold the organ forward against the abdominal wall and steady it, and a vertical incision is made into it an inch in length, between these two traction cords. If necessary, this wound may be enlarged by inserting two fingers into it and tearing it apart, or by a knife or a pair of forceps. As the solution is flowing out of this wound the index finger of the left hand is quickly inserted into it, and the bladder is explored, and if stones are present they are removed by forceps or scoop.

At this stage a rubber catheter is introduced into the bladder per urethram so as to determine the position of the internal urethral meatus, and is left in situ. This forms a land mark for the position of the prostatic urethra, which should not, if possible, be torn in the operation. The gloved index and middle fingers of the left hand are now inserted into the rectum so as to steady the tumour and push it upwards and forwards against the index finger of the right hand which does the enucleation. With the finger-nail, the mucous membrane, covering the most prominent part of the hypertrophied prostate, is scratched through until the internal capsule is reached, (Fig. 1-4), and the tip of the finger is then gently insinuated in the cleavage line between the internal and external prostatic capsules already referred to, and the organ is thus shelled out of its bed. In conducting this part of the operation, the pulp of the finger should be kept closely against the gland in every position of the enucleating finger—in front, behind, underneath, and to the sides of the gland. By attending to these precautions, the finger rarely leaves the cleavage line during the entire procedure, and the danger of injuring adjacent structures—the external capsule, rectum and urethra—and of subsequent extravasation of the urine, cellulitis and other complications is reduced to a minimum.

Normally, the sphincter is situated between the prostate and the vesical mucosa. Sometimes this relation continues undisturbed, in which case the tumour is extra-vesical. More frequently, however, the gland as it enlarges insinuates itself between the sphincter and the internal meatus of the urethra and pro-

jects into the bladder, constituting an intra-vesical enlargement. (Fig. 2.) This latter condition is especially suitable for the suprapubic operation. The prostatic tumour is removed in this operation through the space at the neck of the bladder, which is uncovered by the recto-vesical fascia, and situated between the internal meatus of the urethra on the one hand, and the sphincter vesicæ and the muscular fibres of the bladder pushed aside and atrophied by the growth on the other. The muscular fibres of the bladder and the sphincter grasp the finger tightly during the procedure. The enucleation being completed, the prostatic tumour is lifted up from its sac and removed from the bladder by a pair of forceps. The bladder is now irrigated with hot saline solution at a temperature of 110°F., to rid it of blood clots and at the same time check bleeding which is sometimes quite free. However, irrigation should not be continued longer than one or two minutes, as any longer time tends to encourage rather than arrest hæmorrhage, by distending the prostatic sac and reopening the sealed mouths of the vessels.

The bladder having been freed of blood clots, a drainage tube is inserted in the suprapubic wound, extending about an inch inside the cavity of the viscus, but no further. The tube should not rest on the base of the bladder because if it does it gives rise to pain and vesical tenesmus, and neither should the end of it enter the prostatic sac as it would prevent it from contracting, and so encourage free bleeding and give rise to other complications, e.g., recto vesical and perineal fistulæ and pelvic cellulitis. The lumen of the drainage tube should measure 5/8 of an inch in diameter, and have two openings in the vesical end of it, one on each side, and these openings should be entirely intra-vesical when the tube is in position . The reason the tube should be so large is to provide ample room for the escape of blood clots.

Under proper treament the prostatic cavity disappears very rapidly. This is largely due to the inherent elasticity of the recto-vesical fascia and to the contractility of the surrounding muscles and also to the pressure exerted by the pelvic structures generally. Its obliteration may be aided by gently manipulating the two opposing surfaces between the fingers in the bladder and rectum. For similar reasons extravasation of the urine rarely occurs.

A few stitches of cat-gut may now be inserted in the angles of the vesical wound, but these are not always necessary, as the bladder often closes upon the tube without them. It is desirable that all the urine should escape through the tube. To prevent blood and urine from accumulating in the prevesical space, a strip of iodoform gauze should be packed loosely into it for 24 or 48 hours. This packing ought to be changed two or three times in the 24 hours. These precautions are necessary in order to prevent extravasation of urine and cellutitis. In my experience urine does not infiltrate into the tissues to any serious extent unless it is held under pressure. A few stitches of silk worm gut, deep enough to embrace the recti muscles, are then put in the upper and lower angles of the skin wound, which is afterwards covered with a dressing of double cyanide of zinc and plain sterilized gauze, and the patient, to keep him dry, is enveloped—front, sides and back—in a deep dressing of absorbent material, e. g. cotton-

wool or wood wool or cellulose. However, before withdrawing the catheter and applying the dressing, the bladder should be once more irrigated, in order to remove all blood clots and to see that drainage is free. The whole dressing is held in place by a many-tailed bandage loosely applied.

The dressing should be changed when saturated with urine, every 4 or 5 hours, according to the amount of urine secreted. During the first twenty-four hours after the operation clots of blood usually form in the tube; these should be removed by a pair of long forceps at each dressing, and thus secure free drainage and prevent over-distension of the bladder from backward pressure. That drainage should be free the first few days is very important, because the prostatic sac must be kept at rest and the blood clots which seal the mouths of the vessels must be left undisturbed and thus obviate bleeding and facilitate healing.

In irrigating the bladder the lotion should flow into it and out again without any force, and so guard against increasing intra-vesical pressure and its evil effects on the progress of the case. To accomplish this, the irrigating pan should be held or placed on a table on a level a little above the patient's abdomen, and the lotion runs in and out of the bladder without force. Irrigation should be done only once a day unless the urine is foul, when it must be done twice a day. The surgeon himself should attend to this the first few days after the operation, as it is too important a matter to be entrusted to a nurse, or even a house surgeon. Irrigation may be effected either through the abdominal wound or through a catheter in the urethra. When done through the abdominal wound the nozzle of the syringe is inserted into the wound and the lotion returns on either side of the nozzle, and no increase in the intra-vesical pressure shall ensue. But when the opening is so small that the water cannot return in this way, the nozzle is withdrawn and the lotion is allowed to escape before any serious increase in the intra-vesical pressure occurs. Patients should not be allowed to void urine by the urethra under 10 or 12 days, as those who are not permitted to do so generally do better. They have better control over the act of micturition, and are less liable to be troubled with incontinence.

The drainage tube is left in for from 3 to 5 days. In thin subjects it may be removed in 3 days, but in stout persons it had better be left in for 5 days. By this time the track along the tube is usually covered with granulation tissue which prevents extravasation of urine and subsequent cellulitis occurring in the prevesical space. The suprapubic wound is now allowed to heal as fast as nature can do it by granulation, which will usually be in two or three weeks.

In connection with the after-treatment of prostatectomy, this important question arises, Should a catheter be retained in the bladder to maintain continuous drainage and prevent the formation of the urethral stricture? This is one of the complications to be feared. Some surgeons favour the retention of a catheter. Its retention is not necessary or desirable even in cases in which the prostatic urethra has been badly lacerated, much less in those whose urethræ have not been much damaged. The catheter does not drain well, and it has been found not

to be necessary to prevent stricture formation.

Moynihan, of Leeds, and Freyer, of London, found no serious complications to follow cases of severe laceration of this canal when treated without a catheter. For my own part I see no objections to the passing of a catheter occasionally, under proper precautions, and to ascertain the condition of the urethra, whether or not it is threatened with a stricture.

The following case I had in my practice in the autumn of 1906:

R. D. F., age 67, was admitted to the Victoria General hospital on the 25th of September, 1906, for hæmorrhoids. He always enjoyed good health until his presnt illness began, and looked fairly well when he was admitted; appetite good; bowels inclined to be loose. He has suffered from bleeding piles off and on for ten years. His water bothered him for the last two or three years. He had to get up four or five times in the night to void urine, and had to strain a good deal during the act, and then he was able to void only a small quantity each time; he was unable to empty his bladder completely. In the mornings he was not able to urinate till he moved about and he felt a swelling in the mesial line above the pubes, which disappeared when he urinated, and then the urine came away suddenly and he was unable to control it. He had to strain hard at stool and when voiding urine; this brought down the piles. He came to the hospital to be treated for hæmorrhoids, and not for prostatic affection. Removed the hæmorrhoids on 9th of October, with the ligature. While he was confined to his bed after the operation, he suffered intensely with his water. He had to be catheterized all the time, and the urine became foul, despite precautions, which necessitated irrigation of the bladder.

The prostate was quite large and soft, and I recommended an operation, to which he agreed. Prostatectomy was accordingly performed on the 23rd October, 1906, by the suprapubic route. The operation was done and the after-treatment carried out as already detailed. Bleeding did not amount to much during the operation, but there was a good deal of oozing from the bladder wound on the afternoon and night immediately following the operation. The bladder filled up with blood clots which were removed by irrigation, and to stop the oozing the prostatic sac was packed for twelve hours with a strip of gauze saturated with adrenalin. The after progress of the case was uneventful, and he was discharged well on the 29th day of November, five weeks after the operation.

He is now well and has complete control over his bladder, and can void urine without any discomfort, and he does not have to get up at night to urinate.

Prostatic surgery has not been developed to any very great extent in this province. It is safe to state that its cultivation has heretofore been practically a dead letter. Up to the time of writing, only two prostatectomies were performed in Nova Scotia, and both recovered, but whether they were both successful, I do not know. This depends on the operator's idea of success. My own case was the second one.

Since my return from London, in August, 1904, I have been watching in hospital and private practice, for cases suitable for operation, and strange to say I have met with only three or four, and of these, only one

submitted to an operation. In one case the attending physician warned the patient, who was a clergyman, not to submit to an operation (prostatectomy) under any circumstances. It is needless to say he took his physician's advice. It was an excellent case for operation. I removed an outgrowth from the centre of the gland, suprapubically, with a pair of forceps. It helped his condition a good deal. This was all he would agree to have done.

From what I have witnessed in prostatic surgery in the London hospitals, I am in favour of the suprapubic route, especially in the large soft tumour which its always intravesical. And the case I had myself seems to confirm the soundness of this opinion.

The perineal operation may be performed with advantage in the small hard tumour which is situated generally extra-vesical, and the whole proceedings may therefore be conducted extra-vesically. Operations by this route are more apt to be followed by fistulæ—rectal and urethral—because of the close proximity of the rectum and urethra to the track of the operation. (Fig. 3.)

What symptoms call for operation? This is a large question which I do not intend to answer in this paper, which is far too long already. However, it seems to me that operation is impracticable on the first serious interference with the passage of urine. First because the patient will not submit to it, and secondly, he has no time to lay up. This is the case, especially if catheterization does not give rise to any special discomfort. However, the dangers of delay and of the use of the catheter—cystitis, ureteritis and nephritis—should always be impressed upon him. In my opinion, an operation is indicated and should be recommended whenever obstruction is present to a degree which materially interferes with the comforts of the individual, or entails marked disability.

PROVERBS XXV., 18.

By G. W. T. FARISH,

Yarmouth, N. S.

(Read at meeting of Maritime Medical Association, St. John, N. B., July, 1907.)

IN the 25th chapter of Proverbs, and the 16th verse, you will find these words: "Hast thou found honey? eat so much as is sufficient for thee, else thou be filled therewith, and vomit it." Having taken this mode of beginning these my feeble efforts, I do not wish you to think that I have left you all, and gone into theology, although there are occasions which present themselves, when that would be an excellent adjunct to the medical profession, as is shown by the good work done by the medical missionaries in the East. But in this country it is as much as one can do to attend to and exist with one of them at a time. Also, I do not think that, until that time when the universal church is established, it would be conducive to the well-being of the general practitioner to combine theology with his general work, as he would be compelled at times at least, to divulge his "ism." And this would in turn lead to discussions and it is well known that it is next to impossible to convince a man but what his "ism" is the one paramount above all others.

However, having been invited to read a paper before the Society this year, and having refused so many times that I feel ashamed to do so again, partly for fear that I might not be invited to have that opportunity when it offered itself to my convenience, I began to look about for a subject with which I might fill in the allotted fifteen minutes to advantage.

I know that we are all here for the purpose of mutual fraternization, and interchange of any and all ideas which might emanate from the gray matter of many of the collossal brains of my medical colleagues of the Maritime Provinces, and to that end I felt it was my bounden duty this time to look over my case book, as a person does his barrel, and see what I could find which would be of sufficient interest to place before you. I did find some, and I think quite interesting cases at that, but is it absolutely necessary, I thought, that all papers should be: —

Mrs. A. B., age 52, married, housewife, 25 children and no miscarriages?

After some thought, I came to he conclusion that I would omit the stereotyped "case report," and speak of something which rather appealed to me, but whether or not it will do the same to you remains to be proven. Whether or not it is instructive matters not this time. On some other occasion I hope to be able to give you something more in that line, so if you will bear with me, Mr. President and brethren, for the few minutes which are at my disposal, I will proceed. And first I will just relate how it was this paper was evolved.

Last summer there was sojourning at Yarmouth a dear aunt of mine.

During her stay she was seized with an attack of so-called biliary colic, arising from a condition of cholelithiasis from which she had been suffering for a period.

As convalescence was becoming established my better half invited her to dine with us one evening, and during the course of the meal, I was re-

ferred to frequently, as to the dietetic possibilities.

In a jocular way I appealed to her not to be seized with a pain during the night and at 2 a. m. disturb my peaceful slumbers. So she and her husband returned home at an early hour, she apparently none the worse for her meal.

At 2 a. m. precisely the door bell pealed forth, and to my surprise the husband stood before me to acquaint me with the fact that my patient had had a return of the pain in her stomach.

I naturally felt very guilty, and my wife ditto, for it is not a pleasant feeling to have a person go from your hospitality and then be compelled to send for you at a sufficient length of time after which would unmistakably identify the meal with the pain or vice-versa. It savours of graft. However, fortunately, a few days sufficed for her to recover her equilibrium. And then she, feeling that we were sensitive on the matter, wished me to tell my wife that it was not her dinner which caused the pain, but to quote to her this proverb: "Hast thou found honey? Eat so much as is sufficient for thee, else thou be filled therewith, and vomit it."

This appealed to me as being so apropos, that I asked her to repeat it until I could carry it home with me, and when I returned I took up my Bible and began to peruse the book of Proverbs in search of this particular one. In so doing, I encountered so many which applied so directly to one's every day life and especially, I thought, to that of a practitioner of medicine, that it struck me they seemed to be applicable to that more especially and hence what follows:

Let us, for instance for a few minutes, run through some of the features of a physician's life, and see how many of the proverbs of Solomon, in the short while at my disposal, can be made to dove-tail into it in one way or another.

He begins his career at college where he is supposed to get "wisdom and understanding, and to receive the instruction of justice, wisdom and equity;" "to the young man knowledge and understanding;" "wisdom is the principal thing, therefore get wisdom, and with all thy getting, get understanding."

He graduates, and enters upon the practice of his profession, and frames his course according to his liking, and naturally he feels ambitious to acquire practice and fame.

Now he meets with opposition, and it behooves him to know how to act, so that he will always hold the respect of his fellows and colleagues.

He must bear in mind that he must not be two "greedy for gain," lest this should be conducive to his failing to be courteous to his brother practitioners, and here Solomon admonishes that "so are the ways of every one who is greedy of gain."

As he progresses he will probably feel that he has a particular fitness for some one or other of the different specialities; it may be surgery, or medicine or any one of the numerous ones which are now rampant amongst the profession, one of the latest of these to come under my observation being that of a back specialist.

However, suppose he takes up that of surgery for instance, he may become over-zealous, as Elbert Hubbard in the *Philistine* in speaking of trusts mentions that of the medical trust in which he remarks:

"If the medical trust has committed murder, as possibly it has, its

victims have been the crippled and diseased. If it has killed, it has been thus: indiscretion, inadvertence and an excess of scientific zeal, and so is entitled to leniency." So in this position he should be careful not to be so over zealous as to get to that point of removing healthy organs such as appendices, ovaries, etc., which might as well be sacrificed when the opportunity offers for fear that they might become diseased and become sources of trouble hereafter, for from the book of Proverbs he will find that Solomon cautions such to beware, in that he says "If they say, come with us, let us lay wait for blood, let us lurk privily for the innocent without a cause," then shall such and such happen, and at the end he remarks: "So is the way of every one who is greedy of gain."

The physician to be successful should be a reader and a student, and not only acquire a general knowledge of the things of the world, but rather those relative to the advancement of his own profession, for only by these can we attain knowledge and wisdom, "and when wisdom entereth into thine heart, and knowledge is pleasant unto thy soul, discretion shall preserve thee and understanding shall keep thee."

Honesty and uprightness are two great essentials to the good physician. "For the upright shall dwell in the land and the perfect shall remain in it."

If we peruse further through this wonderful book and apply these wise sayings to other characteristics which are so essential to the well-being of a general practitioner, we will find that he speaks very strongly in the matter of diligence and method in our doings. It is essential that a practitioner to be successful should bear in mind that "he becometh poor who dealeth with a slack hand; but the hand of the diligent maketh rich." "He that gathereth in summer is a wise son; but he that sleepeth in harvest is a son that causeth shame." "The soul of the sluggard desireth and hath nothing; but the soul of the diligent shall be made fat."

Should a doctor marry? Here is a point where I know the majority of you will hold up both hands in yeas! And to those I have nothing to say, for they have already found out yea or nay. But to the younger men of the medical profession who are still occupying their virtuous couches, I will say that Solomon, who evidently knew a great deal about women, seems to have a wonderful admiration for a virtuous one, but for her whom he terms contentious or brawling, woe unto him who takes her unto himself, for says he "It is better to dwell in the corner of the housetop than with a brawling woman in a wide house." And "For three things the earth is disquieted, and for four which it cannot bear, for a servant when he reigneth, for a fool when he is filled with meat, *for an odious woman when she is married,* and an handmaid when she is heir to her mistress." Also, "it is better to dwell in the wilderness than with a contentious and angry woman."

But listen young unmarried medicos, who are contemplating, and be guided thereby, what Solomon has to say of her who is a good woman:

"Who can find a virtuous woman, for her price is far above rubies. The heart of her husband doth safely trust in her, so that he shall have no need of spoil. She will do him good and not evil all the days of her life. She riseth also while it is yet night and giveth meat to her houshold. She looketh well to the ways of her household and eateth not of the

bread of idleness." Again he saith, "A virtuous woman is a crown to her husband" and last but not least, "Whoso findeth a wife, findeth a good thing and obtaineth favour of the Lord."

So should it be a yea or a nay, without doubt the affirmative, but should she not only be virtuous but able to fill this saying "Whoso keepeth his mouth and tongue keepeth his soul from trouble." But why should I expatiate on the *kind* of a wife a physician should have? Love is blind, and will remain so for a time, but after its eyes are opened and sight restored, then, should she not know the necessary qualities to ensure her being the ideal wife, she should be instructed to read this section of the Proverbs of Solomon before mingling with the throng.

Now that we have the proper wife for the doctor his success ought to be assured; but still there are a great many obstacles in his path through life. He is the observed of all observers.

He must walk a straight and narrow way, else should he swerve there is always some busybody who is ready to notice it. Of such persons Solomon says "Frowardness is in their heart, he devises mischief continually; he soweth discord.'

Such people as these, in a community, and they are universal, are to be feared. So that it behooves the doctor to do the best he is able, and although under the most favourable circumstances, he will be censured, still "ponder the path of thy feet, and let all thy ways be established," and he will minimize the dangers arising from this source.

For the young doctor starting out in life I would like to say a word or two on a subject on which he will often be called upon to play a very important part. There are those of our female patients (God bless them), who seem to object to the furtherance of the population of the community in which they dwell. These cases may occur in otherwise respectable people, the other class occurring in the unmarried but not always uninitiated. Young physician, when you are appealed to, make a barrier between me and thee which cannot be broken down, for if not "a wound and dishonor shall he get; and his reproach shall not be wiped away." Another very important point which I would like to touch upon, viz., for the physician to keep his own counsel: not to go from house to house eulogizing himself to the apparent success of himself and to the detriment of his colleague, for "let another man praise thee and not thine own mouth, a stranger and not thine own lips;" "for by their works shall ye know them."

As he goes through the world he has many and varied natures to deal with, the rich and the poor, the meek and the lowly, the true and deceitful, and he that has a "proud look and high stomach."

One of these, the poor, we have always with us, and of three sorts: God's poor, the devil's poor and the poor devils. The first and last deserve his kind and honest treatment, the middle class I will leave to his own discretion.

I cannot resist, at this stage, in paying a tribute to one of my colleagues, since passed to the great beyond, who by his unerring and faithful attendance on all and every one alike, laid down his life for the good of mankind. It seemed that none were too poor for his most careful care and attention, and one could hardly imagine how, even in his last

days, when it must have been so irksome for him to concentrate his mind on his work, he was able to do so. Still he felt that it was his duty, and while he lived he had the respect of all, and now that he is dead is honoured by all with whom he came in contact in life. I refer to my late lamented colleague, Dr. G. D. Turnbull, of Yarmouth.

Solomon admonishes in respect to the poor that "he that oppresseth the poor reproacheth his Maker, but he that honoreth him hath mercy on the poor." He that hath mercy on the poor lendeth unto the Lord, and that which he hath given will he pay to him again."

"Withold not thine hand from them to whom it is due when it is in the power of thine hand to do it." "Whoso stoppeth his ears at the cry of the poor, he also shall cry himself, but shall not be heard."

This, say you, sounds well theoretically, but I will leave it to each one of you to see that you are not imposed on by this individual.

Who has ever heard that "a merry heart doeth good like medicine," or that "a merry heart maketh a cheerful countenance"? Who has ever heard of what cheer from the physician can accomplish in the sick chamber?

You will note the wisdom of Solomon when he says that it doeth good *like* medicine, and as they are both of such inestimable value individually, what must they be in combination? Surely they are not incompatibles, and of what aid they can be in the uplifting of those who are stricken down by the different diseases which flesh is heir to!

There is still one very important question to be seriously thought of relating to a physician's career, viz.: Should he use intoxicating beverages? I think the concensus of opinion is no! He gains nothing and loses woefully. It will ensnare him sooner or later. "Be not among wine bibbers; for the drunkard and glutton shall come to poverty."

"Look not upon the wine when it is red, when it giveth his color in the cup, for at the last it biteth like a serpent and stingeth like an adder."

"Wine is a mocker, strong drink is raging, and whoso is deceived thereby is not wise."

The doctor who has lived up to all this is revered and honored, and justly so, by his colleagues, and by the community at large, as one who has practiced faithfully, honourably and diligently the noblest profession barring none.

Then comes the time when after over half a century of hard and unremitting toil there is "a little sleep, a little slumber, a little folding of the hands to sleep," and all is over, and "the hoary head is a crown of glory, if it be found in the way of righteousness."

But his estate pans out next to nothing, and the people who worked him day and night open their eyes in wonderment to find out for a surety that the poor doctor was eking out an existence only, and his family was not provided for. And where lies the fault? I am afraid in a great many cases in the doctor himself. He has laid down his life for his fellows, but has failed woefully to lay up any treasure for those who follow him. So although sentiment is good and noble, still there are other things to be thought of, viz., strict and close business relationship between doctor and patient, for "Short payments make long friends." And then he

will not be compelled to occupy the place of our friend who dreamed the following, taken from the pen of Dr. Moore, of Missouri:

Last evening I was talking
With a doctor aged and gray,
Who told me of a dream he had,
I think 'twas Christmas day.

While snoozing in his office,
The vision came to view,
For he saw an Angel enter,
Dressed in garments white and new.

Said the Angel "I'm from heaven;
The Lord just sent me down
To bring you up to glory,
To wear your golden crown.

"You've been a friend to everyone,
And worked hard night and day,
You have doctored many thousands,
And from few received your pay,

"So we want you up in Glory,
For you have laboured hard,
And the good Lord is preparing
Your eternal just reward."

Then the Angel and the Doctor,
Started up toward Glory's gate,
But when passing close to Hades,
The Angel murmured: "Wait!
I have here a place to show you;
It's the hottest place in hell,
Where those who never paid you
In torment always dwell."

And behold, the doctor saw there
His old patients by the score,
And taking up a chair and fan
He wished for nothing more,

But was bound to sit and watch them,
As they sizzle, singe and burn,
And his eyes would rest on debtors
Whichever way they'd turn.

Said the angel "Come on doctor,
There are pearly gates to see:"
But the doctor only murmured:
"This is good enough for me!"

He refused to go on further,
But preferred to sit and gaze
At the crowd of rank old dead heads,
As they lay there in the blaze.

But just then the Doctor's office clock
Cuckooed the hour of seven,
And he awoke to find himself
In neither Hell nor Heaven.

STRANGULATED FEMORAL HERNIA.

By J. A CASWELL, M. D.,

Gagetown, N. B.

ONE of the most common blemishes that befall the human race is hernia, and judging from the number of cases under my observation it is increasing. There are many cases that seem to give little or no trouble, at any rate the physician is not consulted; while others continually cause distress owing to an inability to keep the protruding abdominal contents in place; or again others become strangulated. In this last condition an operation more or less s rious, according to conditions, has to be undertaken at once. I regret to say a great many of us country practitioners are not well prepared to cope with such conditions.

Femoral hernia I believe to be one of the most difficult varieties to reduce, owing to the depth of the femoral ring, the course taken, and early damage to gut or omentum. When the hernia is recent and stricture is at the saphenous opening, it is not a difficult matter to reduce it. A simple stricture without adhesions, at the saphenous opening, only requires a parting of a few fibres of the falciform process or that part of the fascia lata forming the upper boundary of the saphenous opening. After doing this and returning the gut, the sac should be ligatured high up, a horse shoe shaped piece of pectineus fascia and muscle reflected up and stitched across the femoral opening, or Bassini's operation.

The stitching of Hey's and Cooper's ligament is a much more difficult task owing to the depth of Cooper's ligament, and very often the absence of an herniotomy needle.

After the hernia has been down some time and adhesions formed and perhaps gut injured, the stricture being at the femoral ring, it is much more difficult to separate adhesions and relieve stricture. If the hernia has recently come down and Gimbernat's ligament easily felt, this ligament can be nicked, gut returned, and the sac and other parts dealt with as above. If from changes due to hernia being down for some time and a tight stricture, adhesions are formed or gut becomes damaged, it is nearly impossible to nick Gimbernat's ligament without further injury to the bowel. In such cases it is better to leave that ligament and nick or divide Poupart's and, if needed, that part of the fascia lata from the femoral ring to the saphenous opening, being careful not to damage the deep epigastric artery, spermatic cord, or round ligament above Poupart's. This can be done with very little risk of injuring parts beneath. If an abnormal obturator or other artery is cut, it can be easily tied, adhesions can be separated more easily and gut, if damaged, dealt with. If the gut is sound it should be returned to abdomen, sac dealt with, Poupart's and fascia lata mended and the horseshoe shaped piece, apex downwards and inwards, reflected up. If the gut is gangrenous it can be more easily dealt with here than if at an opening bound down by Poupart's.

CASE:—Mrs. McC——— age 26.

On June the 3rd, 1907, while lifting a tub of clothes, she was taken with a severe pain in the right groin, followed soon by vomiting. Pain and vomiting continued until I saw her on June the 4th, when I found her

condition as follows:—Pain radiating up from below Poupart's. Vomiting constantly. Bowels tender over lower part of right abdomen. Thigh slightly flexed. A small flat lump, not very tense, about the size of a walnut in the groin. Temp. 102° F. Pulse, 140.

She had complained of a pain in the right groin at intervals for 15 months. Last March she was taken with a severe pain radiating upwards from the groin, with vomiting. This continued for 24 or 30 hours. One of her neighbors gave her a morphine tablet, which she took, applied heat and got relief.

The case being one of strangulated femoral hernia, I was not prepared to operate at once. I applied ice and gave an injection of a quarter grain of morphia. Being 20 miles from home it took some time to send a messenger for help. As soon as possible, assisted by Drs. H. M. MacDonald and Kirby, the patient was anæstetized and reduction was attempted by gentle taxis. Failing this I operated. I found the glands enlarged around the saphenous opening, accounting for the soft feeling of the tumour, and beneath this a small knuckle of intestine, tightly constricted at the femoral ring. On account of many firm adhesions and gut not being in a very satisfactory condition, I could not reach Gimbernat's ligament without running a great risk of damaging the gut. Having been previously told that one of Montreal's surgeons was dividing Poupart's in place of Gimbernat's in certain cases I decided that this was a suitable step for that case. I then liberated stricture by dividing Poupart's from without inwards (not wishing to injure gut by dividing from within outwards), also fascia from Poupart's to saphenous opening. Next separated adhesions, returned gut, ligatured sac and cut it off, then mended Poupart's and fascia, stitched Poupart's to pectineal fascia. Here it would have been better to have reflected up the fascia and a piece of muscle as there would have been less tension on Poupart's. Placed a small drain in lower angle and closed incision.

After the operation, vomiting and severe pain ceased. Bowels moved without help the third day. Temperature and pulse became normal. Sutures were removed the ninth day and everything went well until the eleventh day, when there was a little suppuration around some of the deep sutures. By June 22nd parts were all healed except a small sinus at the lower and upper angles of incision. The lower closed July 1st and the upper a few days later.

In summing up, I would ask is it better, in certain cases of strangulated femoral hernia, for instance where a small knuckle has been constricted at the femoral opening for some time, adhesions having formed and gut more or less damaged, to try and liberate adhesions and pass a director between gut or omentum and Gimbernat's and liberate stricture there, or do a more open operation by severing part or whole of Poupart's and fascia between Poupart's and saphenous opening?

This latter certainly is the simpler method for relieving the stricture. As regards a radical cure by this operation we cannot at present demonstrate it by actual results, but such may be in the future.

COMPLIMENTARY BANQUET TO DR. FORD.

DR. F. S. L. Ford, of New Germany, was tendered a complimentary banquet by his brother members, of the Lunenburg-Queens Medical Society. Dr. Ford, who for twelve years has practised his profession at New Germany, has been compelled through ill-health to give up his work for a time, and seek rest and resumed health in a warmer climate. As a physician and as a man the genial and popular doctor has won the esteem and respect of his many patients, and of all who have had the pleasure of his friendship or acquaintance. The banquet, which was a most enjoyable function, afforded an opportunity for his medical friends to give expression to the high regard and affection in which they held their guest. Dr. Marshall presided, and proposed the toast to Dr. Ford in a very bright and complimentary speech. Dr. Ford in reply expressed his gratitude for the kind words and good wishes, and his regret at having for a time to leave his work and his friends. This was followed by appreciative speeches from all present. Dr. James Ross, of Halifax, and Dr. A. McD. Morton, of Bedford, were among those present, having gone especially to join with their brethren in doing honor to the guest. Dr. March, the poet of the society, had prepared a poem for the occasion. This was received with great applause. The dinner was given at "The Fairview" and Mr. Awalt proved himself a competent and obliging caterer.

The following verses were read at this meeting in honor of the guest of the evening:

Now you'll pardon I know if I put into rhyme,
The few little thoughts in my mind at this time.
And should I get funny, please tell me to halt,
Or should stale be my verses then pass me the salt.

Should you find them insipid and, tasteless alas!
There's mustard at hand, and good, strong Worcester sauce.
Whatever the treatment you wish to accord,
Just mete out the dose, and I'll blame it on *Ford*.

'Tis an age of unreason you know very well,
When Doctors go eating and drinking pell mell!
They try to extract from their cerebral pit
Jibes, jokes, heavy humour and wittiest wit.

Gastronomics is not a bad theme to discuss,
When chickens and turkeys are staring at us;
When salads and jellies are spread on the board,
And all the good things that the earth can afford
In the eatable line, as we have them to-night.
We're told that a barking dog never does bite:
The converse has just as much right to be true,
But we *bite* and then *bark*, which a dog wouldn't do.

Yes, we up fill our gasters with partridge and goose,
Then whilst we're exuding the dear gastric juice
From regions congested, we search for our brains;
Small wonder we just have our work for our pains.

Medicoes are the queerest illogical sort,
That ever to knowledge and science paid court.
They know what is right, and they sell it for gold,
And themselves give away ere the banquet is cold.

Post prandial speeches are pleasant to hear,
But doesn't it always appear to you queer
That you seldom retain their gist or their point
As long as it takes you to digest that joint

Of roast ox or baked porker? The reason is plain—
When you've feasted to surfeit you're resting your brain.
The wines may be good and the Scotches be strong,
Of wit quite a bit may be passing along,

But who ever yet got much wit from a goose?
In the breast of a chicken found wisdom or use?
Drew from "lobster la Newburg" inspiration to please?
Or borrowed choice stories from Limburger cheese?

Physicians well know 'tis a practice accurst
To feast hard and talk after. It should be reversed.
And if they just had the least bit of guile
Like the other professions, it might be worth while

To look for a clue to this terrible strife
Between knowing and doing—but not on your life!
For I feel 'twould be fruitless and even if not,
Who would give up the game when full is the pot

And he holds a good hand, a straight or a flush!
With prime wine in the bottle? Let other folks rush
At their eating and talking, but we'll take our time,
Knowing precepts unpracticed are never sublime.

We have met here to-night to do honour to one
Well loved and respected by each loyal son
Of the medical craft, whose good fortune has been
To meet with and know him and on him to lean

His six feet four inches (not one whit too much;
There's nothing like having full plenty of such),
Tho' oft filled with envy, we were forced to admire,
And high as he was, sometimes wished he were higher.

We never felt jealous to observe that his mind
Left the most of us full head and shoulders behind.
How we warmed at his smile! and were well pleased to grasp
That hand, that just knew how another's to clasp.

We shall miss him, yet hope that it may not be long
Till he join us again both in story and song.
At our medical meets, round the bright festive board,
We shall miss the advice and the laughter of Ford.

Like Ruth to Naomi we fain would declare:
"Wheresoever thou goest we too will go there."
But that were unwisdom, for each one may trace
New regions of duty in filling his place.

So fare thee well, brother! We wish you God speed:
We would much like to keep you, you're just the right breed.
Come back to us soon with health fully restored—
We'll hang out the latch string—Just pull on it, Ford.

H. A. MARCH, M.D.

CHOOSING A PHYSICIAN.

HERE is an Oriental story of a certain prince who had received from a fairy the faculty of not only assuming whatever appearance he thought proper, but of discerning the wandering spirits of the departed. He had long labored under a painful, chronic disease, that none of the court physicians, ordinary or extraordinary, could relieve; and he resolved to wander about the streets of his capital until he could find someone, regular or irregular, who could alleviate his sufferings. For this purpose he donned the garb and appearance of a dervish. As he was passing through one of the principal streets he was surprised to find it so thronged with ghosts that, had they been still inhabitants of their former earthly tenements, they must have obstructed the thoroughfare. But how amazed and dismayed he was when he saw that they were grouped with anxious looks round the door of his royal father's physician, haunting, no doubt, the man to whom they attributed their untimely doom!

Shocked with the sight, the prince hurried to another part of the city, where resided another physician of the court, holding the second rank in fashionable estimation. Alas! his gateway was also surrounded with reproachful departed patients. Thunder-struck at such a discovery, and returning thanks to the prophet that he was still alive, despite the practice of these great men, he resolved to submit all the other renowned practitioners to a similar visit, and he was grieved to find that the number of ghosts kept pace with the scale of their medical rank.

Heartbroken, and despairing of a cure, the prince was slowly sauntering back to the palace, when, in an obscure street, and on the door of an humble dwelling, he read a doctor's name. One single, poor, solitary ghost, leaning his despondent cheek upon his fleshless hand, was seated on the doctor's steps.

"Alas!" exclaimed the prince, "it is then, too true, that humble merit withers in the shade, while ostentatious ignorance inhabits golden mansions. This poor, neglected doctor, who has but one unlucky case to lament, is then, the only man in whom I can place my confidence."

He rapped; and the door was opened by the doctor himself, a venerable old man, not rich enough perhaps to keep a domestic to answer his infrequent calls. His white locks and flowing beard added to the confidence which his situation had inspired. The eated young man related at full length all his complicated ailments, and the still more complicated treatment to which he had in vain submitted. The sapient physician was not illiberal enough to say that the prince's attendants had all been in error, since all mankind may err; but his sarcastic smile, the curl of his lips, and the dubious shake of his hoary head most eloquently told the anxious patient that he considered his former physicians as an ignorant homicidal set of upstarts, only fit to depopulate a community. With a triumphant look he promised a cure, and gave his overjoyed patient a much valued prescription, which he carefully confided to his bosom; after which he expressed his gratitude by giving the doctor a purse of golden sequins, which made the old man's blinking eyes shine as bright as the coin he beheld in wondrous delight. His joy gave suppleness to

his spine, and after bowing the prince out in the most polite manner, he ventured to ask him one simple question—"By what good luck, by what kind planet, have you been recommended to seek my advice?"

The prince naturally asked for the reason of so strange a question; to which the worthy doctor replied, with eyes brimful with tears of gratitude: "Oh, sir, because I considered myself the most unfortunate man in Bagdad until this happy moment; for I have been settled in this wealthy city for the last fifteen years, and have only been able to obtain one single patient."

"Ah," cried the prince in despair, "then it must be that poor, solitary, unhappy-looking ghost that is now sitting on your steps."

PERSONALS.

Dr. P. A. MacDonald has opened an office at 207 Pleasant Street, in the house formerly occupied by Doctor Dickey.

Dr. H. L. Dickey and family have taken rooms at the Halifax Hotel for the winter.

Dr. F. W. Goodwin, of this city, and Dr. G. E. DeWitt, of Wolfville, are both seriously ill, but we hope to hear of their speedy recovery.

The NEWS extends its deep sympathy to Dr. Rindress, of North Sydney, in his sore bereavement.

Dr. R. E. Mathers was the only Halifax physician who attended the Canadian Medical Association meeting at Montreal, in September.

Dr. E. D. Farrell has started for Vienna, to take a surgical course. He will probably not return until next May.

CURRENT MEDICAL LITERATURE.

ANÆSTHETICS AND THEIR ADMINISTRATION: A Text-book for Medical and Dental Practitioners and Students. By Frederic W. Hewitt, M.V.O., M.A., M.D., Anæsthetist to His Majesty the King, Physician Anæsthetist to St. George's Hospital, etc., etc. Third Edition, 1907, with Illustrations. PUBLISHED BY MACMILLAN & CO.

In the preface to the third edition, the author states he has done his best to make this book as complete as possible, and it may be considered that he has largely succeeded in his aim.

It is a book of 611 pages, well printed on good paper and with excellent type. The general arrangement consists of:—

PART I.—The history, pharmacology and experimental physiology of general surgical anæsthesia.

PART II.—Preliminary consideration before anæsthetization.

PART III.—The administration.

PART IV.—The management and treatment of the difficulties, accidents and dangers of general surgical anæsthesia; and,

PART V.—The condition of the patient after administration.

The table of contents is carefully and fully drawn up, and is of much service as a reference.

The book gives a full description of the properties of the chief anæsthetics, and of the theoretical and experimental physiology of anæsthesia.

There is an interesting chapter on the selection of anæsthetics, sequences and methods in ordinary and routine cases.

In it the author states that the practice of employing one anæsthetic for all cases must be regarded as belonging to a bygone time. To insure success in inducing and maintaining general anæsthesia, we must vary our anæsthetic and our methods of using it, according to the exigencies of the case with which we have to deal. This is followed by two excellent chapters, also on the selection of anæsthetics, sequences and methods in particular and exceptional cases, and contains a large amount of valuable information; anæsthesia being discussed in relation to numerous diseases. This is of much value both to the administrator and operator.

The author points out "that it is often erroneously supposed that the possession of a vigorous vascular system affords a guarantee of safety, whilst the existence of organic cardiac disease, or of a so-called weak heart, almost contraindicates surgical anæsthesia. As a matter of fact, a precisely opposite view would more nearly approach the truth."

The author prefers the use of the C. E. mixture in many cases, that is two parts of chloroform to three of ether without alcohol.

He considers, speaking generally, that the C. E. mixture is an excellent anæsthetic for patients with advanced morbus cordis.

A reference is made to the production of acetonuria, more especially by chloroform.

The subject of posture in anæsthetics is fully dealt with, and the dorsal position with the head turned to one side is strongly recommended, while in some cases the lateral position is preferred.

The selection of an anæsthetic in various operations, and special reference to anæsthetics in these different operations is well set forth.

In dental operations, Hewitt considers the anæsthesia produced by nitrous oxide with a small percentage of oxygen, is the best. He also says he considers the C. E. mixture of great value in abdominal operations, and it more frequently meets the requirements of the anæsthetist than any other agent. It may be administered after any of the induction sequences, the best of which he considers is the nitrous oxide-ether sequence, or it may be used throughout.

He states that great caution must be used in changing from ether to chloroform, particularly when the patient is deeply anæsthetized.

The manner of the method of administering the various anæsthetics is fully detailed. He states that as a general rule it is impossible to produce deep anæsthesia by the open system of etherization, that is where a plentiful supply of atmospheric air gains access to the lungs throughout the administration. This statement, however, cannot be substantiated, for the open system is used by some well known operators of the present day almost entirely.

The management and treatment of the difficulties, accidents and dangers of general anæsthesia is well considered.

The last chapter of the book deals with the after-condition of the patient.

The volume is written in a clear and interesting style, and after reading it, one is impressed with the great importance of the subject and the amount of careful attention which should be bestowed on it.

The book contains a large amount of useful and valuable information, and will be found of much service to the practitioner.

HUMAN ANATOMY: A new work on Human Anatomy recently published by the J. B. LIPPINCOTT COMPANY. **It is a large volume of 2,088 pages written by four Anatomists, George A. Piersol (the editor) Professor of Anatomy, University of Penusylvania, Thomas Dwight, Professor of Anatomy, Harvard University, J. P. McMurrich, Professor of Anatomy, University of Michigan and Carl H. Hamann, Professor of Anatomy, Western Reserve University.**

This book deals with the subject fully and completely.

It gives an excellent account of development, the structure of the various tissues and organs are describ d minutely, while the more purely anatomical portion is admirably dealt with.

It is copiously illustrated, there being over seventeen hundred illustrations of which over fifteen hundred are original. Many of these illustrations are coloured, and depict in an excellent manner in various structures described in the text. Indeed the illustrations may be considered one of the prominent features of the book. They aid greatly in following different descriptions. This, for instance, is very noticeable in the account of general development and in the anatomy of the arteries and the veins. The pictures of the bones are are hardly as successful.

A further special feature of the volume is "The Practical Considerations," written by J. William White, Professor of Surgery, University of Pennsylvania, which are added throughout as a commentary to practically the whole anatomy, and are written from a practical and largely surgical standpoint. They form a useful and interesting addition to the anatomical facts, and as they have been fully followed out, will be found useful for medical and surgical reference.

There has evidently been great effort and care expended in writing a complete modern work.

It must be readily admitted that the writers have succeeded in producing a well written, clearly printed and nicely illustrated work which gives a full, well-rounded account of Human Anatomy.

*

MANUAL OF DISEASES OF THE EYE By Charles H. May, M.D., Chief of Clinic and Instructor in Ophthalmology, College of Physicians and Surgeons, Medical Department, Columbia University, of New York.—1890-1903; Ophthalmic Surgeon to the City Hospitals, Randall's Island, New York; Consulting Ophthalmologist to the French Hospital, to the Gouverneur Hospital, and to the Red Cross Hospital, New York; Adjunct Ophthalmic Surgeon to Mt. Sinai Hospital, New York, etc. Fifth Edition Revised with 362 original illustrations, including 22 plates, and 63 colored figures 1907. Price $2.00 net. PUBLISHED BY WM. WOOD & CO., NEW YORK.

We have had occasion before to express our high appreciation of this manual when it came out as the fourth edition. The volume at hand is the fifth edition, and is up-to-date. Some illustrations have been replaced by superior ones and some new ones added, but the book has not been enlarged, still remaining a good size for the student and general practitioner. We desire to congratulate Dr May on the popularity his work has attained.

SOCIETY MEETINGS.

ST. JOHN MEDICAL SOCIETY.

Oct. 2nd, 1907.

THE President, Dr. T. H. Lunney, in the chair.

The opening meeting of the year took place on the above mentioned date amid cheerful and pleasant surroundings, for during the summer months, the Society's room had been renovated and decorated very successfully, and much to the satisfaction of the members.

The President delivered his address, which will appear in the MARITIME MEDICAL NEWS. It dealt with the history of the Society, the desirability of making greater scientific use of the General Public and other hospitals, and of the future of St. John as a medical educational centre.

The address was referred to a committee for consideration and report.

OCTOBER 9. A paper on appetite was read by Vice-President, Dr. Pratt. The nature of appetite was first considered, and then the normal and various forms of abnormal appetite were discussed. Loss of appetite is characteristic of numerous diseases.

The Secretary, Dr. J. S. Bentley, read a paper on vomiting, in which

were considered the nature of the process, the differential forms in Gastric diseases, and vomiting as it occurs in many diseases such as central tumour, movable kidneys, pregnancy, etc. Finally, vomiting due to anæsthetics was discussed.

OCTOBER 23. Dr. Corbet read a paper entitled "Liberty." He advocated throwing open hospital private wards to all registered practitioners, and suggested various changes in the manner of making hospital appointments.

NOVEMBER 6. "Another Point of View" was the title of a paper read by Dr. Rowley. He dealt with hospital work and the relation of the profession to hospitals.

Dr. Warwick gave a paper on "The Laboratory and the General Practitioner." The great assistance obtained by laboratory work in the diagnosis, prognosis and treatment of disease was fully pointed out.

LUNENBURG-QUEENS MEDICAL SOCIETY.

The Lunenburg-Queens Medical Society met in Liverpool on Wednesday, Oct. 30th, last.

The afternoon session was devoted to general business of the socity and reports of cases and discussion by various members.

The evening session was spent in discussing the formation of an Anti-tuberculosis League and other matters pertaining to general health. It was decided to advertise a Public Meeting to be held in Bridgewater, Nov. 21st, at 8 p. m., to organize an Anti-tuberculosis League for Lunenburg and Queens. This is a matter in which it is hoped that the laity will be as deeply interested as the medical profession. No greater plague afflicts our land at the present time than consumption, or tuberculosis, and of late years in this province where one individual dies of the much dreaded disease, smallpox, one hundred succumb to this "Great White Plague," consumption.

The Lunenburg-Queens Medical Society was organized August 7th, 1902, and included every medical practitioner in the county of Lunenburg. At this present session every physician in South Queens, with the exception of Dr. Farish, who could not be present, but was made an honorary member, joined the society and signed the constitution, by-laws and scale of fees of the society.—*Liverpool Advance.*

NEWFOUNDLAND MEDICAL COUNCIL.

The Newfoundland Medical Council held its first examination for registration on 3rd September last. Dr. S. G. Kean, of Queen's University, Kingston, and Dr. H. A. Giovannetti, of Boston College of Physicians and Surgeons, successfully passed the examination and have been entered upon the register.

Dr. Herbert Rendell is now Registrar of the Newfoundland Medical Board, vice Dr. Tait, resigned.

OBITUARY.

HON. DANIEL MCNEIL PARKER, M. D., L. R. C. S., (EDIN.)

BY the recent demise of Hon. Dr. Parker, the profession in this city and province has lost its most distinguished member—distinguished alike for his professional knowledge and skill, his high reputation, and the unusually long period of his beneficent public services.

Of English descent on his father's side, and of Scottish Loyalist descent on that of his mother (nee McNeil), Daniel McNeil Parker was born at Windsor, Nova Scotia, on April 28, 1822, and was therefore in his eighty-sixth year at the time of his death in Dartmouth on the 4th of November, 1907.

THE LATE DR. PARKER.

Part of young Parker's academic training was received at the Collegiate School, Windsor, and subsequently at the Academy in Horton, where he first met Charles (now Sir Charles) Tupper, and a warm and lasting friendship sprang up between these two young men, both destined to distinguished careers.

In the late thirties, young Parker became, according to the practice of that time, an indentured student in medicine to Dr. William Bruce Almon, then one of the leading practitioners in Halifax. Having during several years of such apprenticeship obtained considerable knowledge of general practice, and a special training in pharmacy, he proceeded to the medical school of Edinburgh University in 1841. His career at the university was highly successful, even brilliant, and he graduated in 1845, as M. D. from the University and also as L. R. C. S. (Edin.), and winning the Gold Medal in Surgery. The title of his thesis was: "The Mechanism and Management of Parturition."

Returning to Nova Scotia, he settled down in Halifax to the practice of his profession, and here he soon acquired a large and lucrative practice, and won a good reputation, both of which steadily increased during his twenty-five years of general practice as a physician and surgeon. At this time he stood in the very front rank of his profession, was engaged in most of the more serious cases, was held in high esteem by his professional brethren, and was regarded with unbounded confidence by the public. Indeed, so great was Dr. Parker's professional success during the first twenty-five years of his practice, that the second quarter-century's practice can hardly be said to have added much or anything to it, though it continued and confirmed it, and rounded out a half century of practice in a manner than has been very rarely equalled.

Lister, (now Lord Lister), having for several years carried on ex-

periments in his new method of Antiseptic Surgery, first at Glasgow and afterwards at Edinburgh, the Listerian system, in its earlier developments, was in full use in Edinburgh by 1870, and this new learning Dr. Parker was determined to obtain at first hand. He accordingly gave up his practice in Halifax in 1871, and for the next two years pursued courses of study and investigation in medicine and surgery in Europe, but mainly at his *alma mater* in Edinburgh.

Such a proceeding on Dr. Parker's part was eminently characteristic. He never suffered himself to fall behind the rest of the world in the knowledge of his profession. He was ever determined to keep up-to-date, and he did so; notwithstanding his fifty years' of practice, he was fully possessed to the last of the latest advances in medical and surgical science.

Upon his returned to Halifax in 1873, he did not again enter into general practice, but limited his practice to that of a consultant in medicine and surgery. In this he was highly successful. He enjoyed the esteem and confidence of his professional brethren as well as of the public, and his fine professional judgment, great knowledge, and ripe experience found a wide field of public usefulness.

In 1895, after half a century of faithful, skilful, successful work, he retired from practice, with a record rarely equalled and a name to be honored.

That a man who had spent so much of his life in attendance on the sick and suffering, should not contribute much to the literature of the profession, was rather to be expected. Yet Dr. Parker was the author of many addresses on professional subjects, and also of some special papers. A few of the latter may be mentioned: "Three Cases of Ruptured Perineum and Sphincter Ani Cured by Operation," (*Edin. Med. Jour., 1857, p. 448*) "Fatal Cases Resulting from the Habit of Arsenic Eating," (*Edin. Med. Jour., 1864, p. 116*); "Notes of Some Unusual Cases of Disease Involving Primarily the Skin Covering the Mammary Gland," (MARITIME MEDICAL NEWS, Vol. I, p. 131).

Throughout Dr. Parker's career, his professional brethren testified their esteem in many ways. In 1857 he was elected President of the Medical Society of Nova Scotia, and again in 1877. In 1870, he was made the second President of the Canadian Medical Association, the first President having been Dr. (now Sir) Charles Tupper. From 1872 to 1888 he was a member of the Provincial Medical Board, and during the last three years of that period was its President.

On his departure for Edinburgh in 1871, he was tendered a complimentary banquet and presented with a signed address by the Members of the profession throughout the Province, and upon his retirement from practice in 1895 he was presented with an address by his professional brethern in Halifax and Dartmouth, to which he made a lengthy reply, full of reminiscences of considerable historical interest. This reply is published in the MARITIME MEDICAL NEWS, Vol. vii, p. 205.

As Consulting Surgeon at the Provincial and City Hospital, and, later, the Victoria General Hospital; as Commissioner of the Provincial and City Hospital (now the Victoria General) and of the Poors' Asylum, (now called the City Home), and in connection with the Asylum for the Insane, the Halifax Dispensary, and other institutions more or less allied to the profession, Dr. Parker rendered throughout his whole career most zealous and valuable services.

Dr. Parker was also a man of many activities beyond the professional field, and in all respects a public-spirited citizen, taking a great interest in educational, religious and philanthrophic work. He was a Governor of Acadia College, in which he took much interest as the college of the Church of which he was a valuable member. He was also a Director, and for a time the President, of the Institution for the Deaf and Dumb, and rendered that Institution zealous services. With the Y. M. C. A., the Inebriates' Home, the School for the Blind, the Industrial School and the Home for the Aged, he was also identified, and even in the old days when Mechanics' Institutes were among the educational forces of the Province, he was a leader and helper, and delivered before these Institutes many addresses on such subjects as "Respiration," "Vitality," "Instinct and Mind," "The Circulation," etc. Indeed, it would not be easy to mention any philanthropic institution in this city or vicinity with which this man of overflowing sympathy and good-will and of many activities was not connected as a willing helper and conscientious worker.

Nor were purely business concerns neglected. He was interested in the Halifax and Dartmouth Steamship Company, the Halifax Gas Company, and the Nova Scotia Benefit and Building Society.

Dr. Parker was also a valued member of the Legislative Council from 1867 to 1901, when he resigned; and both in his place in the Council and elsewhere he always took a great and helpful interest in all legislation relating to the profession, to the public health, and to humane institutions.

If there is one lesson more than another that Dr. Parker's whole life and beneficent career must impress upon his professional brethren and his fellow-citizens, it is that afforded by his example of unremitting and conscientious devotion to duty. He looked upon his profession as imposing upon him a duty to his very utmost for his fellow-man, and this, combined with his goodness of heart and great kindliness of disposition, made him an untiring worker in the relief of suffering and for the benefit of mankind. Whatever Dr. Parker did, he did with all his might, not for hire, but as the faithful and hearty performance of a duty; and it is quite certain that the case of the poor man who could not pay a dollar for advice, got from him the same conscientious consideration and careful treatment as the case of the richest among his many patients. As a physician, and as a man, Dr. Parker leaves behind him a memory that is an inspiration to faithful work and rectitude of life.

Dr. Parker was twice married. His first wife was Elizabeth Ritchie Johnston, daughter of the Hon. J. W. Johnston, Attorney-General and afterwards Judge in Equity. Their only child, James J. Parker, died in Edinbugh while pursuing his medical studies. His second wife was Fanny Holmes Black, daughter of the Hon. W. A. Black, of Halifax. He leaves a widow and four children—Mary Ann, wife of Rev. Dr. Keirstead, a professor in McMaster University; W. F. Parker, barrister; Laura McNeil, wife of McCallum Grant, merchant, of this city, and Fanny A. Parker, living at home.

THE PAGES OF THE "MARITIME MEDICAL NEWS."

Within the 40 pages of text every issue (nearly 500 pages a year) not a single line of advertising is ever printed. There are no advertising inserts; no commercial notes of any description whatsoever. We regard each subscription as a contract with the physician to furnish him monthly with 40 pages of reliable information upon the different subjects relating to medicine and surgery.

Guarding your rights along these lines as carefully as we do, we beg of you to read the announcements of our advertisers, and favor them with inquiries and requests for samples: and when so doing, please be so kind as to mention having seen the advertisement in the MARITIME MEDICAL NEWS.

To the notes below and on the following pages, also in future issues, we respectfully direct your attention.

Yours very truly,

MARITIME MEDICAL NEWS.

NOTES ON SPECIALTIES

The Value of Codeine.

The *Cleveland Medical Journal*, quoting from the *Denver Medical Times* concerning codeine, states that, according to Butler, "it is less depressing and more stimulating than morphine, does not constipate, cause headache or nausea, and rarely leads to the formation of a habit. Codeine seems to exert a special, selective, sedative power over the pneumogastric nerve, hence its value in irritative laryngeal, pharyngeal and phthisical coughs with scanty secretion. Like morphine, it has proved of value in checking the progress of saccharine diabetes, and it has been used for long periods, without the formation of the drug habit, inasmuch as when glycosuria was brought to a termination by dietary and other measures, the cessation of the use of codeine was not followed by any special distress. The effects of codeine on the alimentary canal are remarkable, in that it assuages pain as well or better than morphine, and nevertheless does not check the secretions or peristalsis notably, unless the latter is excessive, as in dysentry." In view of these facts it would seem that Antikamnia and Codeine Tablets are a remedy which should find a wide field. Prof. Schwarze (Therapeutische Monatshefte) in writing upon the treatment of the different forms of dysmenorrhœa, and the different forms of congenital deformity of the uterus, states that the coal-tar analgesics are of much use, as well as the preparations of iron and sodium salicylate. In many cases it is necessary to administer codeine in small doses, and the tablets of "Antikamnia and Codeine" would seem to have been especially prepared in their proportions, for just these indications.

Useful Prescriptions.

WHOOPING COUGH.

Wester (*Medical Summary*) has found the following to be very effi-

cacious in the treatment of whooping cough.

℞ Resorcin, ... gr. xv
Quiniæ tannate, ... gr. x
Pulvis acaciæ, ... ℥ j.

M. Sig: Make impalpable powder and use in an insufflator, freely blowing it into the nose every three hours.

RELIEF FOR TOOTHACHE.

A small piece of absorbent cotton may be introduced into the cavity of a tooth, having been first moistened with the following solution:

℞ Cocainæ hydrochloridi, .. gr. iv. gr. vii
Mentholis, ... gr. xxx
Camphoræ, ... gr. xv

M. Triturate until liquified.

Sig. Apply to the cavity of the tooth and renew every half hour until the pain is relieved.

Robin in *Journal de Medicine de Bordeaux*, 5, 1907.

SCIATICA.

℞ Aspirin, ... gr. vi
Phenacetine .... gr. v
Quiniæ salicylate, ... gr. ii
Codeinæ sulphatis .... gr. ¼ to ½

Having first cleansed out the bowels with calomel and salines, this in capsule should be repeated very two or three hours.—*Buffalo Medical Journal.*

*

To Check the Flow of Milk.

When the mother is not to raise her child upon the breast, control of the flow of milk becomes a serious problem sometimes. If the breasts be bound tightly by a bandage extending from three or four inches below the mammæ to the clavicle and the pressure be continued firmly and evenly for several days, the flow will be prevented in some and greatly diminished in others. If milk forms abundantly, some of it must be drawn off with a breast-pump. Equal parts of tincture of belladonna and tincture of camphor should be rubbed into the

skin over each breast twice daily (at the time when the milk is taken) and the pressure resumed. If this be done before the breasts become "caked" they soon are found to be soft, painless and free from secretion. But often an acute inflammation (mastitis) arises; the breasts are found hard and knotty, the skin red, shiny and terribly tender, the patient has much pain and a temperature of 99½° or 100° F. In such cases equal parts of unguentum balladonnæ and of lanolin may be mixed together and rubed over the areola and skin; with a kaolin-glycerin poultice over all. Abscess may very often be thus prevented.—*American Journal of Clinical Medicine.*

*

The Three Ages of Women—Third Stage

With the climacteric, the sexual life of woman is brought to a close, and is considered by some authorities as the most critical era of her existence.

Various disturbances of the circulatory, nervous and digestive systems as well as of the pelvic organs are usually characteristic of this period, and are manifested many times by hot flashes, headache, melancholia, vertigo, neuralgia, etc.

For its carminative and sedative action upon the nervous system as well as for normalizing effect upon the vasomotor system, Hayden's Viburnum Compound seems to have proven, as a result of twenty-six years of clinical investigation, to be a most satisfactory remedy from a therapeutic standpoint for administration just preceding, at the time of, and following the menopause.

Sal Hepatica has been found specially serviceable as a safe laxative and

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THERE ARE, IN ADDITION TO THE ABOVE, A STAFF OF FORTY-THREE DEMONSTRATORS AND ASSISTANT DEMONSTRATORS.

The Collegiate Course of the Faculty of Medicine of McGill University begins on Septempter 18th, 1907. Notwithstanding the fire of April 16th, 1906, which destroyed a part of the Medical Building, arrangements have been made for the carrying on of the work of the College without interruption and as efficiently as formerly.

MATRICULATION.—The matriculation examinations for Entrance to Arts and Medicine are held in June and September of each year. The entrance examinations of the various Canadian Medical Boards are accepted.

COURSES.—Beginning with the session 1907-08 the Regular Course for the Degree of M. D. C. M. will consist of five sessions of about eight months each.

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A POST-GRADUATE COURSE is given for Practitioners during June of each year. The course consists of daily clinics, ward classes, and demonstrations in general medicine and surgery, and also in the various special branches. Laboratory course in Bacteriology, Clinical Chemistry and Microscopy are also offered.

DIPLOMAS OF PUBLIC HEALTH.—A course open to graduates in Medicine and Public Health Officers of from six to twelve months' duration. The course is entirely practical, and includes in addition to Bacteriology and Sanitary Chemistry, a course on Practical Sanitation.

HOSPITALS.—The Royal Victoria, the Montreal General, the Alexandra Hospital for Contagious Diseases, and the Montreal Maternity Hospitals are utilized for the purposes of Clinical instruction. The physicians and surgeons connected with these are the clinical professors of the University. The Montreal General and Royal Victoria Hospitals have a capacity of 250 beds each.

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"Is the room disinfected?"

"Yes, mother; and I have sterilized the curtains, deodorized the furniture, septicized all the fixtures, vaporized the air, washed my lips in an antiseptic solution, and ——"

"Have you septicized the mistletoe?"

"Thoroughly, mother; everything is done. Arthur is waiting now in the hydrogen room."

"Then you may go in and let him kiss you dear."—*December Lippincott's.*

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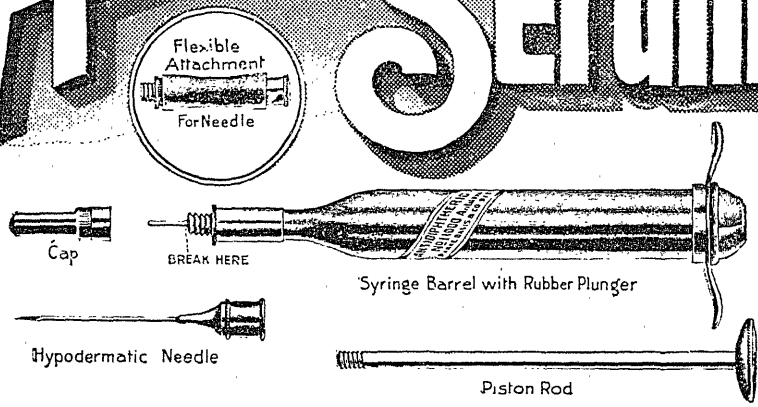

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