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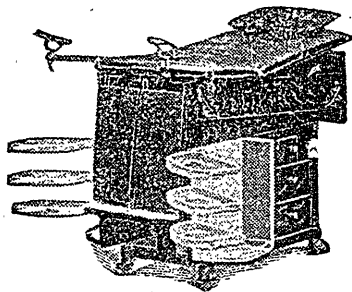
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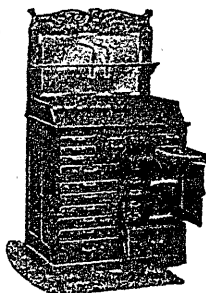
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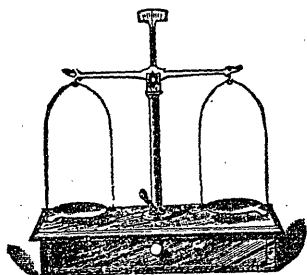


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4TH YEAR.—Surgery, Medicine, Gynaecology and Diseases of Children, Ophthalmology, Clinical Medicine, Clinical Surgery, Practical Obstetrics, Hospital, Vaccination, Applied Anatomy. (Pass Final M. D., C. M. Exam.)

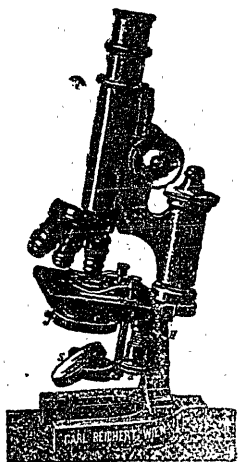
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VOL. XV.

HALIFAX, N. S., MARCH, 1903.

No. 3.

Original Communications.

SOME SURGICAL AFFECTIONS IN CHILDREN.

INTUSSUSCEPTION.

By N. S. FRASER, M. B., M. R. C. S., St. John's, Newfoundland.

October 22nd, 1900, baby H. F., male, aged 8 months, was taken suddenly ill, screaming constantly. A month previously, when at St. John, N. B., he had suffered from summer cholera, at which time he was treated by Dr. G. A. B. Addy, but since then had been in good health—a plump, well nourished baby.

On examination the temperature was normal, tongue very slightly furred, pulse about 130. The baby kicks out and screams, apparently with pain, every few minutes. The abdomen is hard and rigid, but at the left side, corresponding to the descending colon, a tumour can be palpated, rounded and of small size. There is a continual forcing, but only a little blood-stained mucus passes—no free passage since yesterday morning. Vomiting each time he drinks, the milk coming back unaltered. His face is pinched, anxious and so altered that his mother thought him in a dying condition.

The heart and lungs were normal and no discharge from the ears nor any tenderness there.

Intussusception was provisionally diagnosed and the baby anæsthetized for a fuller examination. The tumour was then quite distinct, small, rounded, and movable, in the region of the descending colon.

As the case was so recent, it was decided to try inflation, and by attaching a rubber tube, at one end to a bellows and at the other to a large gum elastic catheter, this was easily effected, the catheter being passed in its full length. After a few minutes inflation, the tumour was felt to move upwards and soon to disappear altogether.

The baby woke up from the chloroform very brightly, laughing and crowing for a few hours, but then all the old symptoms came on again—particularly the vomiting and the collapse. Considering that the intussusception could not have been completely reduced and must now be recurring, I decided this time to try distension with water. The child was again anaesthetized, and, raising the buttocks, having passed in the catheter to its full extent, a large, high injection of salt and water was used, the colon being at the same time massaged. This apparently had the desired effect of undoing the remains of the intussusception. The baby woke up quite brightly again, passed some of the water, but the bulk of it remained about twenty minutes and was followed by a large stool and wind. The vomiting did not return and by the next day he was almost as well as ever, but he was some days in losing the sick look from his face.

This was, I take it, a typical case for treatment by insufflation with air or distension with water. I saw him at the beginning of his sickness. Being my own baby, I could observe him constantly, and so was enabled to interfere while the intussusception was still fresh and easily unfolded, and what was most important of all, the position in the descending colon was such as to be easily reached and affected from the rectum.

G. L., aged two months, seen Sunday, November 19th. The history given was that the child's bowels never seemed just right—undigested food sometimes, or too much straining at other times. Two days ago—Friday—the motions were green and the baby restless. Saturday she had no motion, but on Sunday the bowels moved after an injection of glycerine and water, the motion being brown and soft. The mother noticed that there was not so much wind passed as usual and the baby cries at intervals. But between these attacks she is bright, laughing and looking about in the usual way.

Physical examination showed a fat, healthy-looking baby, nursed from the breast. The temperature in the morning 99.2° F., and in

evening 100.4° F., while the pulse was about 160. The abdomen is plump and rounded, but not distended. On palpation she does not seem to be specially tender, nor is there any spasm of the right rectus muscle, but a small, hard mass can be felt indistinctly in the right iliac region. It is about the size of a walnut, freely movable, but not apparently very tender. Her tongue is perfectly clean, but she has vomited a couple of times. Nothing else can be discovered to account for the crying—the ears especially being examined but with a negative result.

In attempting a diagnosis I considered it must be one of three things:

1. Intussusception.
2. Appendicitis.
3. Volvulus or obstruction from Meckel's diverticulum.

In favour of intussusception there was the tumour in the region of the ileo-cæcal valve; spasms of pain and disorder of the bowels. Against intussusception, were the temperature and absence of blood and mucus from the stools. There was no straining and not any collapse. The latter I considered very important, as the baby appeared perfectly well apart from the short attacks of pain.

In favor of appendicitis were the temperature and the position of the tumour, but the absence of continuous pain, spasm of the rectus muscle and the movable nature of the tumour, so different from the induration around an appendix, excluded appendicitis.

Partial obstruction from some such cause as Meckel's diverticulum seemed probable, because of the history of some irregularity since birth, and because the obstruction was not complete—flatus having distinctly passed more than once, and the bowels moved fairly well with the enema. The paroxysmal nature of the pain and the healthy appearance between the attacks, with the occasional attacks of vomiting, supported this view. The main contra-indication was the temperature.

With a view to operation a consultation was called with Dr. Stabb and the probabilities of diagnosis argued out, with the result that we decided against immediate operation on account of the age (two months), the incompleteness of the obstruction, and the history given by the mother of more or less trouble since birth. It was decided to try high enemata to reduce the tumour. Accordingly high injections

were given on two occasions—the tube passing in thirteen inches and a considerable quantity of saline injected. It was thought that the tumour *did* move somewhat with the injection but it was not reduced.

The next day, Monday, the condition remained the same. Wind passed twice in fair quantity. Not so much pain. The temperature 99.4° F. and the pulse 140. Nor was there any change on Tuesday but the obstruction seemed to be getting more complete—no motion from the bowels and only very little wind passing. But on Wednesday vomiting came on, at first clear and watery, but by the afternoon quite dark. A slight motion also occurred. It was now pretty clear that the case was really one of intussusception and that the invagination was near, if not at the ileo-cæcal valve. It was decided to give the baby the chance—small though it seemed to be—that an operation would afford.

The operation was performed the same night, but it was noticed that a great change had meanwhile occurred. The abdomen was now distended and tight as a drum—the distension having come on since afternoon. The temperature of the room was brought up to 80° F. and a hot-water bottle laid on the table under the baby. The incision was made over the tumour. On opening the peritoneum the bowels protruded from the intra-abdominal tension and a small quantity of ascitic fluid escaped. No effort was made to return the bowels but they were kept covered by towels wrung out of hot saline solution, and drawn out until the tumour appeared. It proved to be an intussusception—the ileum being swallowed by the ascending colon and tightly caught at the ileo-cæcal valve, so that reduction was most difficult. Finding it so tightly caught, no time was spent in attempting reduction, but carefully walling off the part with towels the bowel was opened and reduction effected from within. The bowel was dark but had not lost its glistening appearance, the bowel was therefore returned and the abdomen closed. The operation lasted thirty-five minutes, most of the time being occupied in returning the distended bowels.

The baby appeared to stand the operation fairly well, and a few hours after the operation passed a large motion and flatus, but the shock of the operation was too severe and she died seven hours later.

The symptoms in this case were not the usual symptoms of intussusception, but had the child not been so young the case would have been cleared up the first day of illness by operation and a much better chance of recovery given. It was felt that in a baby of two months while a doubt lasted it would be better to delay operating, hoping that the diagnosis of intussusception was not the correct one. In this way valuable time was lost and the distension of the bowels which came on the last day turned the scale unfavorably and complicated the operation so that nothing but a failure could be expected.

In the list of 115 cases of intussusception treated at St. Thomas's Hospital and published by Bernard Pitts in the British Medical Journal for Sept. 7th, 1901, only one case occurs under 3 months of age, and she succumbed within twenty-four hours of the operation. Of the fifteen cases of four months and under who were operated on, only three survived.

Of the symptoms which were confusing in this case, the absence of collapse in a baby so young I considered as important and confusing as the continued elevation of temperature. Blood and mucus in the stools and tenesmus were also absent. The tumour itself was not the classic "sausage-shaped tumour," but was rounded and about the size of a walnut and very hard. F. Huber (Med. News, Nov. 29, 1902) says: "Colicky pains, repeated vomiting and bloody stools are a sufficiently characteristic symptom complex of the condition. There is prostration or collapse and change of facies."

Holt (Diseases of Infancy and Childhood, page 385) lays stress upon the same symptoms, viz.: "Sudden onset, colicky pains, frequent vomiting, bloody and mucous stools, general prostration or collapse and low temperature." Osler (page 419) says "blood occurs in the stools in at least three-fifths of the cases."

(To be continued)

IMMUNITY.*

By J. M. BARRY, M. D., St. John, N. B.

By the term immunity is meant a non-susceptibility to a given disease or to a given organism, under conditions such as occur naturally or may be produced artificially.

Immunity may be natural or acquired.

Natural Immunity: Certain diseases affect the lower animals but never occur in the human subject, *e. g.*, swine plague; and on the other hand, diseases as typhoid fever and cholera, which are common to the human subject, do not as far as is known, affect the lower animals. Native races in different parts of the world are insusceptible to yellow fever, typhoid fever and malaria. The dog and the goat are rarely affected with tuberculosis. Tetanus is never met with in the fowl. And to come nearer home some individuals are fortunate enough to escape most of the more common infections, others seem to contract disease on every possible occasion, and to suffer from all the ills the flesh is heir to.

A remarkable example of race immunity is that of Algerine sheep against anthrax, a disease which is very fatal to other sheep.

Both man and the lower animals, therefore, respectively enjoy immunity from certain diseases when exposed under ordinary conditions. It must not be inferred, however, that when the organisms of the respective diseases are introduced artificially, pathological effect will not follow. Immunity may be of varying degrees; such a thing as absolute immunity is scarcely known.

In addition to general race immunity or susceptibility, we have individual differences in susceptibility or resistance to pathogenic bacteria. As a rule young animals are more susceptible than older ones. Thus in man the young are especially susceptible to scarlet fever, whooping cough, etc.; and after forty years of age the susceptibility to tuberculosis infection is very much diminished.

With regard to the natural immunity of the native races, this is probably due to natural selection and heredity. It is an illustration of the survival of the fittest. During long periods of time, the

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individuals being all exposed to the same risks, the susceptible ones are weeded out, while the survivors transmit their insusceptibility to their descendants.

The following is a possible explanation of the immunity which carnivorous animals have for anthrax and other forms of septicæmia to which herbivora are very susceptible. From time immemorial the carnivora have been in the habit of fighting over the bodies of dead herbivora some of which may have died from infection from bacterial organisms, and in this fighting they receive wounds and become inoculated with the infectious material which would be fatal to a susceptible animal. If at any time in the past a similar susceptibility existed among carnivora, with individual degrees of resistance, it can readily be seen that there would be a constant tendency for the most susceptible to perish, and for the least susceptible to survive. In this way a high degree of immunity would be established. Sternberg says: "The tendency of continuous or repeated exposure to the same pathogenic agent will evidently be to establish a race tolerance, and there is reason to believe that such has been the effect in the case of some of the infectious diseases of man, *e. g.*, syphilis, smallpox—which have been noticed to prevail with especial severity when first introduced among a virgin population."

Another factor conducive of natural immunity is temperature. Frogs and chickens are immune to anthrax. In the one case the body temperature is low, 18° C., while in the other it is high, 40° to 41° C., and this may influence the growth of the anthrax bacillus preventing the full and rapid development, which may be necessary for the production of the disease. The blood, lymph, and other juices of the body no doubt exert a more or less germicidal action on bacteria. Metschnikoff's theory of phagocytosis is based on the following facts: leucocytes in circulating blood ingest and destroy any foreign particles ingested; secondly, any injury to the tissues is immediately followed by inflammatory reaction with the migration of leucocytes to the injured spot. Similarly in many instances, the leucocytes rapidly congregate at the seat of the bacterial infection and approach and destroy the bacteria.

Metschnikoff explains this migration of leucocytes on the hypothesis that the chemical substances elaborated by the bacteria attract the leucocytes, and exert what he calls a "positive chemotaxis," and the bacteria are in this way removed. In other cases unfortunately, the

bacterial chemical products repel the leucocytes—"negative chemotaxis"—so that the bacteria are free to grow and multiply and a general infection ensues.

With the acceptance of Metschnikoff's theory it was thought that the phagocytes were the only agents in bacterial destruction, but it is now claimed that they play only a secondary part, and that the chief bacteria destroying power is in the blood serum itself. Bucknor, Hankin, Behring and others have shown by numerous experiments that the serum contains a group of proteid substances, to which has been given the name alexins and which have a decidedly germicidal action. It is supposed that these germicidal agents are derived from the leucocytes, so it will thus be seen that the white cells are both directly and indirectly concerned in the destruction of pathogenic organisms.

Acquired Immunity may be induced in any of the following ways:

1. By an attack of the disease, ending in recovery.
2. By vaccination with a modified or less virulent form of the infective agent.
3. By one or more treatments with sterilized cultures, or bacteria-free toxins.
4. By injection of the blood serum from an animal immunized by method 3.

Various explanations have been offered for the production of acquired immunity.

Pasteur suggested that the organism by its growth in the body exhausted some specific pabulum necessary for its development, so that the organism could not again grow in that body,

Chaveau in what is known as the "retention theory" suggested that the bacteria during their growth in the tissues formed substances which ultimately inhibited their growth, and if the animal recovered, prevented a subsequent development of the organism.

Other investigators suggest that each germ produces both toxins and immunizing substances. Ehrlich showed that acquired immunity is of two kinds, one, an active immunity which is of long duration and resulting from an attack of the disease, or from vaccination with a modified virus. This form is not transmissible to the foetus. The other form—passive immunity—results from the inoculation of an animal with the blood serum derived from another animal immunized by the injection of bacterial toxins. This immunity is of short

duration and is transmissible to the foetus. The immunizing agent is known as an antitoxin. The exact manner in which the bacterial toxins are rendered innocuous is not definitely known. It was once thought that the antitoxin directly neutralized the toxin in the same way that an acid neutralizes an alkali. It seems more probable now that the antitoxin acts by rendering the cells and tissues insusceptible to the toxins, though in what manner is not known.

It will thus be seen that while the alexins in producing natural immunity, do so by a distinct germicidal action, the antitoxins exert their influence in an altogether different manner, having in themselves no germicidal power.

That immunity followed recovery from certain diseases has been recognized as long as disease itself. The experimental evidence relative to protective inoculation in infectious diseases dates from the discovery of Jenner (1768) of the protection afforded against smallpox by vaccination; and to Pasteur we must accord the credit of first having shown that animals may be rendered immune against infectious diseases by inoculation with attenuated virus. The next important step was made when it was shown that animals may be rendered immune against certain infectious diseases by inoculating them with filtered cultures containing the toxic agent, but free from bacteria. This was shown by Roux (1888) in rendering susceptible animals immune to anthrax. We are all familiar with the work of Behring and Kitisato in diphtheria and tetanus, and still more recent is the work of the Klempers in proving that susceptible animals may be rendered immune by filtered cultures of the micrococcus of lobar pneumonia.

With the fourth method of producing acquired immunity, *viz*: by injection of blood serum of an animal immunized by treatment with sterilized cultures, I shall have nothing to say as that would lead me into the domain of serum-therapy, a subject too large to be dealt with at a single sitting of the Society.

THE COCAINE HABIT*

By C. RICHARD SHAUGHNESSY, M. D., C. M., St. John, N. B.

In looking over the last edition of the Pharmacopœia, I find that there are drugs there which were known to Hippocrates. There are drugs along the columns of those voluminous works which have been known since pain and disease walked with sinister step into the circumference of human life, and there are others which are the children of the recent yesterdays. Among this latter class is the drug cocaine, the alkaloid, the active principle of the erythroxyton plant, this drug which, together with its first cousin, chloral, was recently called by a prominent German specialist, "crystallized hell." The home of the plant from which cocaine is derived is in South America. The natives there chew its leaves for the purpose of a strong tonic to the entire system. By its aid they will go for days without food, held up by the strong toning power of the coca plant. It is not many years since this drug, the alkaloid of the coca plant, was introduced into medical science under the name of cocaine. Like some of the products of modern chemistry, it was supposed at first that we had found a panacea for many obstinate human ills. It was at first deemed that we had in this alkaloid a remedy and cure for opium disease, and many were the experiments made along in this direction—experiments which resulted too frequently in intensifying and adding a new element to the sufferings of the already burdened opium eater, by introducing him to this border land of pain. As used for such purposes medical science has discarded it, but for the purpose of a local anaesthetic which destroys the sensibility of the cutaneous nerves, which permits of the minor surgical operations without pain, which renders it possible to introduce a knife into the centre of the human eye without producing suffering, it has its place to-day.

Of the pathology of cocaine, of what it does to the nerve cells specifically, comparatively little is known. It seems to spend its power upon the terminal nerves and especially the intellectual and emotional faculties of the brain.

Cocaine somewhat resembles its sister drug, morphia, and in many respects it differs from it. The first touch of the cocaine exhilaration

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is somewhat similar in kind to that of the embrace of morphia. Taken into the system not accustomed to its use its first effect is that of a pleasurable exhilaration, somewhat similar to that produced by three or four glasses of champagne. The life current is somewhat quickened in its movement. A warm pleasurable exhilaration pervades the entire system. The nerves are steadied. The mental activities take on a new rich glow. But of all the dissolving views produced by the earlier stages of these drugs that enslave, that of cocaine dissolves the soonest. Opium in its earlier effects holds the mind of the man into whose system it has gone in a steady equable calm which lasts for hours. With cocaine, however, especially when introduced into the system hypodermically, its presence is felt almost instantly, but it fades away like the shifting pageant of a dream. Twenty to forty minutes is sufficient for the subtle drug to enter the system, produce its results and fade away. It has this further peculiarity in its mode of action, that, while opium leaves the system gradually, so far as its specific influences are perceived, cocaine passes out of the system with almost the suddenness of a lightning stroke. The effect of opium is to produce a tranquility, that, once established, like a fully risen tide, the mark of the waters remain in the same place. Cocaine mounts to the brain almost with the rapidity of the blood circulation itself. The pleasures of alcohol are constantly mounting and tending to a climax. Those of opium are steady, those of cocaine are intense but evanescent. The specific effects of this drug, taken into the system, vary also, very considerably from those of opium. The man who takes opium into his stomach rarely does so more than four or five times per day, the morphia habitue who uses a hypodermic syringe rarely thrusts the injection under the skin more than six or eight times during the twenty four hours; the cocaine habitue in order to know anything about the drug, must repeat his dose at least every hour. Opium takes the nervous system in its grasp and holds it steadily quiet for hours at a time; cocaine puts a mirror before the soul, painted with every bright color, and then no sooner do you look at the beautiful landscape then it is withdrawn. The opium habitue may have a fairly steady hand and a reasonably steady head for years after his addiction, the cocaine user finds a complete and ever increasing lack of power to co-ordinate the muscles of the body, different sets of muscles seem to act independently of each other, the arms moving in different directions and the

head in a different one still. One limb will be distorted with cramp, while the rest of the body seems free from it.

Early in the initiation of the cocaine habitue come other specific influences, which the drug contains. It has the power, more than any other drug of this class, with the exception of *cannabis Indica*, to produce hallucinations. The opium eater lives in a lotus land, and yet he is conscious who he is and what he is; the cocaine habitue lives in the midst of the unreal, of the illusionary. He hears strange voices talking around him, sometimes recognizing that they are the children of the drug, sometimes believing them to be actualities. It is said of the German poet Goethe that "he had the power to project at will a spectre before his vision, that the spectre would assume a chair opposite to that in which he himself was sitting, that with every appearance of being real the great poet was conscious all the while that it was a spectre of the brain."

The appearance of the cocaine user is also different from that of the morphia habitue. The confirmed morphine fiend has the pasty expression, the dull, gray-white look as though his face was cut out of gray, whitish marble. He has the look of helplessness and of despair so characteristic of that form of drug bondage. The appearance of the cocaine habitue is equally significant, but different in kind. The opium eater's wildness of eye, or general look of unreality, is because of a dullness of vision, because of a settled look of sullen indifference which covers his features like a pall. The cocaine habitue is a man whose eye is wild, the pupils dilated instead of contracted, and with a peculiar, haggard blueness of look. The depression of the morphine user is a settled, habitual hopelessness. The cocaine habitue is constantly jumping from the height to the depth only constantly jumping from a lower height and reaching a lower, depth. A drug like this soon tears the mental faculties in tatters. The human brain or nervous system was never made to withstand such shocks, hence his career is far shorter than that of the morphia maniac, whose career often extends through the larger part of a lifetime. Cocaine sends its victims to shipwreck with all the engines in full blast. His life slips away from him as the snow slips away from the earth, when the April wind plays on it. His life is going fast and he knows it, but feels himself powerless to arrest the downward development. The cocaine habitue goes over his Niagara rapidly, and there is hardly a limit to the depth into which he descends. For power to produce concentrated human misery, for power to squeeze out of life everything that makes life miserable, this drug cocaine stands solitary and peerless.

Selected Articles.

THE FUNCTIONAL WEIGHT-BEARING METHOD OF TREATING CONGENITAL DISLOCATION OF THE HIP, AS ORIGINATED AND PRACTISED BY PROFESSOR ADOLF LORENZ.

By DEXTER D. ASHLEY, M. D., New York.

At this moment, when the laity and profession are evincing so much interest in the work of Professor Lorenz, it may be appropriate to add my experience and the lessons learned at his hands to the constantly accumulating material upon this subject.

In this paper I make no comparisons, nor do I attempt to answer the numerous questions and criticisms. I endeavor to give a fair idea of the details of the operation, as I have seen it and performed it. I shall only say, I never saw it performed as herein described until I saw Professor Lorenz operate. I have made notes upon one hundred and twenty-eight operations, seen and participated in, and I hope later to adduce some statistics from the digest of these cases, and at that time endeavor to clear up some unanswered questions.

As our medical journals are frequently consulted by intelligent laymen, I deem it proper to explain our subject briefly. The functional weight-bearing method consists in a series of manipulations by which the head of the dislocated femur is reduced into the acetabulum, the dislocating muscles and ligaments stretched, and the acetabulum deepened. The limb is then encased in plaster of Paris, standing in the position, generally, of abduction 90° and flexion 90° , to so remain for six to nine months, until Nature has deepened the acetabulum and contracted the capsule around the neck, securing the stability of the head in the old acetabulum. This is followed, usually, after the removal of the plaster of Paris, by such exercises and massage as will stimulate the muscles, giving stability, and prevent those muscles from contraction which would tend to produce relaxation.

The younger the patient the more easily the anatomical reposition can be effected, since all deformities become more marked, and some

are produced by the abnormal position and use of the limb. The age most appropriate for this bloodless operation, in clinical cases, is from three to five years, when Professor Lorenz thinks he can get 90 per cent. to 95 per cent. of anatomical repositions. At this age the dressings can be kept clean, the limbs are so developed as to be easily held by the plaster of Paris, and no great shortening or deformity of parts has resulted by long walking. Operations have been performed upon patients from one to thirty-five years of age with anatomical repositions in 50 per cent. of his practice, and functional amelioration in nearly all. The oldest patient in whose case he has produced an anatomical reposition was twenty-three years of age.

An unilateral dislocation can be reduced in a much older patient than if the dislocation be bilateral. A bilateral dislocation in a muscular child of eight years, with a shortening of two inches, should not be attempted without preparatory treatment consisting of extension and active and passive motions tending to stretch the resisting tissues. On the other hand, a unilateral dislocation in a person of the same age and muscular development will not give rise to so much shortening. A unilateral dislocation may be reduced even up to eleven years, without previous treatment; but in every case, we must consider the shortening, the muscular development, and the deformity as revealed by the x-rays.

When operating in ideal cases, no elaborate instruments are required. There should be a good solid table, about 30 inches high, 26 inches wide, and 7 feet long, being rather low in order to permit the operator to stand well over his patient, not working at arm's length, and narrow so that his assistants may be able to hold the pelvis firmly from the opposite side.

Under the pelvis should be placed a firm cushion or sand bag, about $3\frac{1}{2}$ by 6 by 14 inches, and you should have an oak wedge, $3\frac{1}{4}$ inch base, $3\frac{3}{4}$ inches high and 9 inches long, with rounded, leather covered edge, this to be used as a fulcrum for the trochanter major after stretching of shortened muscles and at the time of endeavor to reduce the head through the contraction in the capsule. A pelvic support and back rest should be provided, to facilitate the application of the plaster while the limb is held in the stable position.

The following dressings should be at hand: Seamless stockinet (German trico), under which the rubbing bandage is adjusted, sheet

wadding, common muslin bandages, and plaster of Paris bandages. These plaster of Paris bandages, made of strong, wide-meshed crinoline, should be five inches wide by six yards long. They should be so rolled as not to contain too much plaster of Paris, so that they can be saturated immediately upon submerging in water.

For older children, when extension is necessary, a few other things will be required—a new, strong sheet, a rubber pad $\frac{1}{2}$ by 6 by 8 inches (to be adjusted between the legs), with which to make counterextension, and a soft woolen roll to loop over the foot, by which to make traction.

The five-year-old child having been anaesthetized, her pelvis is held firmly by the assistants, by applying pressure over the symphysis pubis, the anterior superior spine, and the non-deformed limb in flexion or superextension. The operator flexes the limb quite to 80° , and then strongly abducts, with pressure and massage over the origin of the abductors, and with alternate relaxation and application of force in abduction, the limb is forced to 70° to 90° of abduction, and flexion 90° . By this manœuvre the head is forced downward, opposite the contraction in the capsule.

At this point, should the reduction not have taken place before, the wedge is adjusted under the great trochanter, and the operator proceeds to hunt for the contraction and try to introduce the head through it into the acetabulum. In this endeavour, the limb being abducted to 70° to 80° and flexed to 80° , he slowly forces the limb toward superextension and flexion to 110° to 115° . Then slightly abducting from this position, the limb is again brought to flexion 80° and abduction 70° to 80° , applying pressure upon the downward and backward sweep, the limb being rotated inward and downward, according to the deformity of the neck, and again abducted to almost superextension and flexion 115° .

In any of these excursions you may hear the characteristic click of the reduction. Finding it still resistant, the tissues are further stretched by strong flexion, by superextension, and by applying extension. Frequently the limb is grasped at the knee and lifted, flexed and abducted, much as in traumatic hip dislocation, the operator applying pressure upon the great trochanter by wedge or thumb. Again, strong extension has to be applied, as in old cases, with inter-

nal or external rotation and abduction, the operator making strong pressure upon the great trochanter, in which position it may be reduced after the manner of Paci and Schade. Or it may be necessary, after having thus stretched all the shortened muscles, to perform the reduction with the leg in the right angle position to the body, as first tried.

The limb having been reduced, you may find it in flexion 90° , abduction 65° to 75° , the knee bent at right angles, hamstrings standing out like bow cords and adductors tense, with an acetabulum so shallow that a slight attempt to bring the limb by its fellow will produce a relaxation. Too frequently, I fear, has the limb been encased in plaster of Paris in this position—a position that is very unstable and most excruciatingly painful.

It is at this point when the true moulding comes in. The limb being held in reduction, with one hand on the great trochanter, it is further abducted to superextension. Then, by thoroughly stretching the adductors and anterior part of the capsule, the acetabulum is deepened. The leg is extended on the thigh, stretching the hamstring muscles, which again stretches the anterior part of the capsule and deepens the acetabulum. The acetabulum's depth is again tested by gradually bringing down the dislocated limb alongside its fellow. The nearer they can be approximated to each other without luxating, the more stable the position.

Should the position be found unstable, the acetabulum is further deepened by placing the patient on her side and stretching the anterior portion of the capsule by strong superextension and abduction at 90° , and then gradually and forcibly extending the leg, maintaining 60° to 70° of abduction. This manoeuvre also dilates the upper and internal portion of the capsule. This is continued frequently until the head appears anteriorly as a distinct elevation under the skin, and threatening an anterior luxation.

All contracting ligaments and muscles must be stretched, especially those tending to dislocate, as the comfort of the patient, as well as the stability of the reduction, depends very much upon their being put out of action. This is very well illustrated by the histories of the after-effect in earlier and later operations. At first, the operator was satisfied with a reduction and obtaining the right angle position,

without overcoming the contraction of all the muscles. At that time the patients suffered excruciating pain, varying from three days to weeks. At present, after every resistance has been overcome, they frequently make no complaints after the third day.

A bilateral dislocation is reduced by the same manipulations as a unilateral. There being no contrary indications, both limbs are reduced at one sitting.

Now we are ready to apply our dressings. Having selected stockinet of the required size, it is applied to the reduced limb and pelvis. Do not forget your rubbing cloth at this point, since it is a comfort to the patient, to keep the skin clean while resting in the cast.

The patient, still under the anæsthetic, is now placed upon the pelvic rest, the back supported by a cushion or back rest, the previously dislocated thigh being held at right angles to the body or in a position of abduction 90° and flexion 90° , and the knee flexed at a right. In cases of great instability, the limb is further abducted and superextended, so that the knee extends posteriorly to a plane drawn through the transverse section of the pelvis and acetabula.

This is called the "primary position" by Professor Lorenz. This position is maintained by an assistant holding the sound limb in extension and superextension, with his hand upon the thigh, and holding the previously dislocated limb with one hand encircling the calf. The assistant must constantly keep in mind this primary position. This is the Lorenz position *per se*, without rotation inward or outward when the neck is not deformed, and without pressure over the great trochanter.

In a bilateral dislocation both limbs are put up in this primary position, the thighs and perinæum making a straight angle or more, by flexion and abduction.

Frequent mistakes are liable to be made by the surgeon finding a deep, stable acetabulum, and thinking that he is warranted, in this case, in at once placing the limb in the secondary, or comfortable walking position, which is about 45° to 55° abduction and 135° flexion. Experience has proved that the primary position is the best.

Bandages of sheet wadding are now applied about four layers deep, with extra bolsters four to six layers deeper over the inner condyle, anterior, superior, and posterior superior spines. This sheet wadding is then secured by a thin, pliable muslin bandage, drawn smoothly

and tightly over all, bringing out well the anterior superior spines. Over this is applied the plaster-of-Paris.

Commence at the anterior superior spine of the sound side, cross the pelvis at a right angle, cover the opposite anterior spine and the inner and front part of the limb, thence cover the inner condyle, the flexed knee, the outer condyle, the outer surface of the limb, crossing the back of the pelvis, and up to the point of starting. Thus the entire first and part of the second bandage may be applied. Then, commencing at the knee, include these two splintlike portions by a circular application, and continue upon the pelvis by applying the regular figure of eight bandage, making the plaster about $\frac{5}{8}$ to $\frac{3}{4}$ of an inch thick over the symphysis pubis and about $\frac{3}{8}$ of an inch thick over the thigh. This will require fifteen to twenty-five bandages, according to the size of the patient.

In applying plaster in the bilateral case, you proceed as in the unilateral. The first few bandages are applied from flexed knee to flexed knee, crossing the pelvis over the anterior superior spines, and returning over the posterior superior spines, this being secured, as in unilateral cases, by circular and figure of eight applications.

Having applied the plaster to the proper thickness, the edges are trimmed off as shown in the illustrations, leaving a bridge about two inches and a half wide over the symphysis pubis, cutting out well below to prevent soiling at stool, and removing all pressure from the bladder. On the sound side, the plaster is cut off below so that the limb may be flexed to a sitting position. Behind, cut out sufficiently to allow the patient to sit on the stool without soiling the dressing. At the knee, cut off the plaster at the lower end of the inner condyle, sloping backward, leaving the patella free and the outer condyle exposed, giving a free popliteal space. Now trim off your muslin bandage and sheet wadding all round flush with the plaster. Turn all sharp edges outward or cut them off. Turn the stockinet over the plaster of the limb and pelvis, approximating the edges, so that it covers the plaster neatly.

During the first three to five days after the operation, the child will be in considerable discomfort, depending upon the amount of trauma. The little patient should be put to bed, and the pelvis and knee elevated and so supported upon a pillow or cushion as to prevent pressure from the cast. Under the bridge, behind and in front, a large linen handkerchief should be thrust, and brought out above and

below the dressing; this is to prevent the sheet wadding and stockinet from becoming soiled and hard by perspiration. The outside of the cast, behind, should be protected by a folded towel, included under the ends of the handkerchief. When wishing to defecate or urinate the patient should be placed upon a stool. The bed pan can hardly be used without soiling the dressings. The objection to operating upon young children is the utter impossibility of keeping them clean and preserving the dressings intact, holding the leg in the primary position while Nature does her work.

In this position the patient remains in the plaster-of-Paris, wearing a shoe with a cork elevation of $2\frac{1}{2}$ to 3 inches, for six to nine months, the time varying with the stability of the acetabulum at the time of the reduction. As soon as the sensitiveness of the joint has subsided (a time varying from five to fifteen days) she is encouraged to walk, and the leg should be extended daily to prevent contraction at the knee. During this six to nine months Nature contracts the capsule and deepens the acetabulum, which receives the weight of the body at every step.

Upon the functional weight-bearing of the limb depends much of the prognosis. The child that walks for nine months with the limb in a stable position, stimulated by use, will have a much better chance than one who refuses to walk. This is one of the reasons why the double congenital dislocation must be retained longer in the plaster, since the child cannot walk with both limbs in the primary position.

In a bilateral dislocation, the child sits astride a low rolling chair, the height of the seat corresponding to the length of the tibia. In this position the child can push herself around, propelling the chair by means of striking the toes upon the floor. She is thus bringing the limb into activity and transmitting some weight to the acetabula.

After six to nine months, the first plaster cast is removed, and the surgeon must use his judgment as to the requirements of the limb, whether it shall be replaced in the primary position or in the secondary, or walking, position of 45° abduction and flexion 115° to 135° , or left with no diurnal support. This will depend upon the stability of the position then found, taking into consideration the stability at the time of reduction. If the capsule is contracted, the head seemingly well fixed, and you can watch your patient, you can leave off all support except, during the daytime, a strap passing from knee to knee

preventing abduction beyond 45° , and at night a mattress so constructed and worn between the legs as to hold the limb in the primary position while sleeping; commencing your after-treatment at once, seeing the child every day for two to six weeks and giving her active and passive motion and massage.

If not so stable, or the patient cannot be under daily supervision for the first six weeks, it is better to apply a second cast, in the secondary position, to remain for three to four months. Should the capsule be found loose, the knee contracted by neglect of treatment, the head prominent with a tendency to anterior dislocation or in suprapubic luxation, then she should be again placed in approximately the primary position, with such modifications as will correct the dislocating tendency, there to remain for three to six months longer, after which it is probable that the secondary position could be maintained, followed by the after-treatment, as indicated in the first case.

This important after-treatment I hope to fully describe at some future time.—*N. Y. Medical Journal.*



A HANDY METHOD OF STERILIZING INSTRUMENTS.

Dr. Karl Gerson describes in the *Deutsche medicinische Wochenschrift* an efficient and simple mode of sterilizing instruments. Professor Mikulicz brought into use some time ago the method of sterilizing the hands before performing an operation by means of friction with spirits of soap. As a sterilizing agent for the hands the spirits of soap acted well.

Dr. Gerson has recently tested the efficiency of the same method, and has proved to his own satisfaction that instruments rubbed with cotton wool moistened with a solution of spirits of soap are effectually sterilized against the most virulent germs, and that by wrapping them in cotton wool wetted with it they will retain their aseptic condition for a length of time. By applying the spirits of soap thus, the spirit evaporates, leaving a coat of soap on the instruments while the substance adheres to the wool throughout.

Dr. Gerson goes so far as to declare that such are the remarkable antiseptic properties of spirits of soap, that in the case of bougies, catheters, and other large instruments, which it might be difficult to wrap in cotton wool, a rubbing with spirits of soap for three minutes before an operation fully answers the purpose.

The Hospital, December 6, commenting upon this statement, says that it alone is enough to throw doubt upon the whole of Dr. Gerson's conclusions. The writer in the *London Journal* goes on to say: "The septicity of a foul catheter lies within, and it must be quite impossible to sterilize such an instrument with certainty by means of any solution, however germicidal it may be. It is here that heat has the pull, penetrating as it does into the joints and corners of the most complicated apparatus. Still, for solid and smooth instruments there is every reason to believe that the application of spirits of soap will be useful. A somewhat lengthy experience has shown that it does very well for the hands, which are much more septic than any well-cleaned instrument, and there would seem to be no ground for doubting that it will do equally well for any solid instrument to the whole surface of which it can be directly applied. Spirits of soap, it may be added, is merely hard soap dissolved in dilute alcohol. It is essential

to remember, however, that for the removal of the coating of soap left upon the instruments, sterilized water or spirits of wine and sterilized lint, or other form of 'wipe' must be employed, so that, after all, even by this method, one does not get rid entirely of sterilization by heat."

The foregoing remarks are very much to the point, and there can be no doubt that heat by either boiling or steaming is the best sterilizing agent known. Nevertheless, there are times when the facilities for these processes are lacking, and when a more simple method would be very convenient. It is upon such occasions that the method advocated by Dr. Gerson should be extremely useful.

One cannot refrain from moralizing to some extent when one considers how ideas as to the most efficient means of sterilization have become modified. Of course the principle laid down by Lister has remained the same, but the elaborate antiseptic methods which, after his immortal discovery became the vogue, and which, in many places, were carried to absurd lengths, have almost died out, and now the most scrupulous cleanliness, combined with boiling or steaming, is generally recognized as affording after all the soundest defence against infection. The late Lawson Tait who, despite certain eccentricities, was endowed with a very large share of shrewd common sense, was one of the first surgeons of world-wide reputation to laugh at the vagaries of the ultra antiseptic clique, and to assert that extreme cleanliness and boiling water was more effective than the preparations which some operators used to make before commencing their work.—*Medical Record.*



Correspondence.

PROPHYLAXIS OF VENEREAL DISEASES.

NEW YORK, March 4th, 1903.

TO THE EDITOR OF MARITIME MEDICAL NEWS,

HALIFAX, N. S.

DEAR SIR:—

At the last (fifty-third) meeting of the American Medical Association, held at Saratoga Springs, June 10-13, 1902, a joint resolution from the sections of Cutaneous Medicine and Surgery and Hygiene and Sanitary Science, was introduced in the House of Delegates as follows:

"Whereas, There is a burning necessity to check the spread of venereal diseases, and, assuming that the States cannot with impunity ignore the condition, it lies in the province of the medical profession to discuss and recommend to the respective State Legislatures and Municipalities means not regulamentative, but social, economic, educative and sanitary in their character, to diminish the danger from venereal diseases. Resolved, That the Section on Cutaneous Medicine and Surgery of the American Medical Association invite the section on Hygiene and Sanitary Science to co-operate with the section on Cutaneous Medicine and Surgery in bringing about a propaganda in the different States, looking toward a proper recognition of the dangers from venereal diseases, and to arrange for a national meeting under the auspices of the American Medical Association for the prophylaxis of venereal diseases, similar to the International Conference for the Prophylaxis of Venereal Diseases, which meets again this year at Brussels, under the authority of the Belgian Government."

This was later submitted to the House of Delegates, which endorsed the action of Section and adopted the following:

"Resolved, That a joint committee of six from the Sections on Hygiene and Sanitary Science and Cutaneous Medicine and Surgery be appointed by the President, to stimulate study in and uniform knowledge of the subject of the prophylaxis of venereal diseases, and to present to the American Medical Association a plan for a national meeting, similar to the International Conference for the Prophylaxis of Venereal Diseases, which meets again this year in Brussels, under the auspices of the Government of Belgium."

The Committee on Prophylaxis of Venereal Diseases consists of :

Dr. Henry D. Holton, Chairman, Brattleboro, Vt.

Dr. Ludwig Weiss, Secretary, 77 East 91st St., New York.

Dr. George M. Kober, 1600 "T." St. Washington, D. C.

Dr. W. H. Sanders, Montgomery, Ala.

Dr. L. Duncan Bulkley, 531 Madison Avenue, New York City.

Dr. Frank H. Montgomery, 100 State St., Chicago, Ill.

The peculiar social, racial and political conditions of our country are so different from those on the Continent, that they necessitate an expression of solely American ideas on this mooted question, both from a socio-economic and sanitary point of view.

The committee desires the support of the medical profession and the aid and powerful collaboration of the medical press of the country to help them in this work. It takes the liberty of soliciting expressions and views editorially and otherwise, and would be glad of personal correspondence from those supporting the movement, and who will contribute by papers, etc., to make it a success in case the House of Delegates should favor the holding of such a congress.

By giving this a place in your esteemed paper, the committee feel that you will have aided materially in forwarding the work entrusted to them.

I remain with thanks,

Very truly yours,

LUDWIG WEISS, M. D.,

Secretary of Committee.

A TROPICAL INSANE ASYLUM.

DEAR DR. :—

A visit to a tropical insane asylum has many points of interest. The institution here has from 950 to 1000 patients, nearly all colored. (I only saw two or three whites.) Males and females equally divided.

It has a beautiful situation on the harbour, lined with tall coconut trees and large evergreen trees scattered over their very widely extended grounds. The wards are all one story, (at a distance look like sheds) and open on all sides night and day. Brick and concrete with iron roofing are the chief material used in construction ; some of the older buildings are of wood.

The dining rooms are open pavillions, with only a roof to keep off sun and rain. Warming and ventilation, the difficult conditions to be provided for, are here quite eliminated. The airing courts are very large and numerous, but they would be quite useless for such purposes in the north, for our patients would go over the enclosure as readily as they would through the gate. It would not be difficult to scale the ward or building itself. Dr. Williams, resident superintendent, tells me but little attempt is made to go away, for with plenty to eat and *rest* the negro considers he has a good thing and few desire a change.

The most prevalent type of insanity is dementia of varied kinds—congenital and acquired. Of general paralysis of the insane—very little, and but little violent acute mania. Tuberculosis is very common, owing to the unclean habits and crowded way the negroes live, but they are greatly benefitted by the open air residence and sanitary surroundings of the asylum.

The superintendent thinks the chief cause for the large preponderance of dementia is that as a mass theirs is a low type of mental development and there is not much to lose. Only a limited amount of labor is obtained from the patients, their strong point being *rest*.

It only costs about 22 cents a day to keep them, their diet being chiefly vegetable, porridge and soups and codfish. The fish is more used as a flavouring than an article of diet. It adds a piquancy to their soups, which is very much relished; they also have plenty of fresh fish from the harbour.

The death rate is about 6 per cent., not often reaching 8 per cent., and most common cause debility and tubercle. There is but very little surgery. The weather is warm, with a cool breeze from the sea at the asylum. A game of cricket with attendants and patients was very animatedly carried on. Dr. Williams say the negroes take to cricket because it is not work.

Arrangements are all carried out as in other asylums, and the floors being concrete the wards are cleaned out with the hose, as they have abundance of water. Canvas beds in a stout wooden frame is most used and no precaution need be taken to prevent suicide, the negro is not given that way. Tea is the most common beverage (it always means ginger tea) and coffee, but little China tea is used.

A. P. REID.

Kingston, Jamaica, Janurry 30, 1903.

THE MARITIME MEDICAL NEWS.

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

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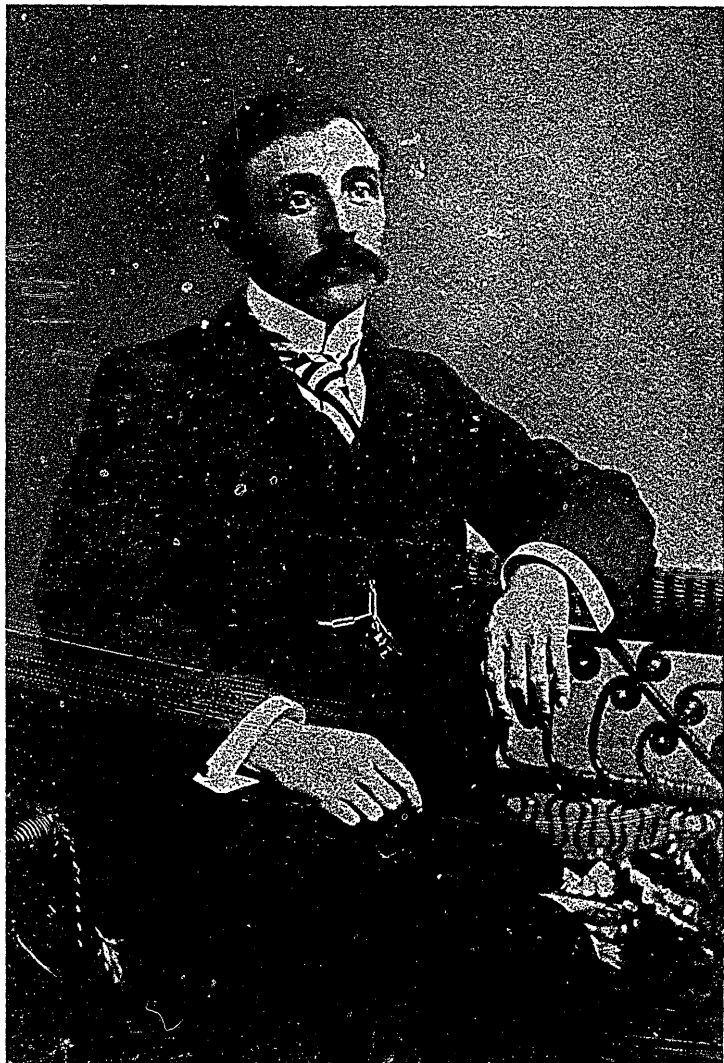
Editorial.

THE LATE DR. HALLIDAY.

It is not often that the death of a young medical man leaves such a blank in professional circles, as was made a few days ago by the loss of Dr. Andrew Halliday.

A busy profession, keen in the struggle for individual advancement, too often looks upon large practice and financial success as the proper criterion of professional merit. It is only on such occasions as the present, that we tardily realize that there may have been one amongst us, neither a busy practitioner, nor a seeker after great emoluments, who filled a larger place and leaves a vacancy more difficult to supply than were possible for the most successful (from the ordinary standpoint) of his colleagues. Sadly too, few have we of medical men in this province, willing to "scorn delights and live laborious days" in the laboratory and class-room, at the inadequate salary available simply for the love of knowledge and for the good of the state.

As the late William Scott Muir, who died exactly a year earlier to the very day, will long be remembered as an example of the great and good physician, sacrificing comfort and even life, in devotion to his work as a busy general practitioner, so Andrew Halliday devoted to the scientific side of medicine, was willing to sacrifice means and health to the arduous work entailed by his services to education and the province. In his more limited sphere he was like Kanthack, of Cambridge, and Wyatt Johnston, of McGill, wrapped up in his work,



The Late Andrew Halliday, M. B., C. M., D. P. H.

indefatigable in his labour and unsparing of himself. His career in Halifax was brief, in fact, after years of preparation he might be said to have just entered upon it, and with the limited means at his disposal, and the increasing public duties he was called upon to perform, he was unable to give much time to original work; but the cultivated mind of the student, the instinct of the investigator, and the capacity of the teacher, were so obvious that no one in frequent contact with him could doubt the future that lay before him.

Little did we think some few months ago, when he was temporarily released from his duties in the Medical College and the Provincial Laboratory, that the end was so near. And his colleagues who so spontaneously presented him with an address and testimonial at that time, must feel a gratification tinged with sadness that they did not miss the opportunity of showing him the esteem in which they held him. He was deeply affected by the evidence of their goodwill, and we have reason to know it was a source of happy recollection to him.

It is good for us as a profession to occasionally pause for a moment in our struggle for existence, wealth or fame, and to inquire if with all our success we can hope to leave a record so clean and free from the stain of common human failings, as either William Muir or Andrew Halliday. Muir was the busy, bustling practitioner, with grand physique, fine health, and full of boisterous life, withal kind and gentle as a woman, a loyal friend, and if perchance a foe, an honourable foe. Halliday, endowed with feebler frame, and less robust health, and an almost diffident manner, was gifted with great natural talent and indomitable industry—the type of the gentle student. Each in his sphere represented what is best in medical life.

With the prospect of employment in the Provincial Laboratory and in the Halifax Medical College, Dr. Halliday had spent a year recently at Glasgow University, giving careful and constant study to subjects relating to the public health. In his classes he was *facile princeps*, and he took his diploma in Public Health at the University of Durham with high distinction.

His capabilities as a bacteriologist and analyst were so quickly recognized by medical men and municipal authorities throughout Nova Scotia, that shortly after his appointment he became overwhelmed with work—samples and specimens to be examined poured in on him from all directions. He was generally accepted as an authority, and his work was proportionately large and responsible,


The strain of such severe work told on his—never too robust—constitution, and with lowered vitality he fell a victim to the great white plague, which has played havoc with so many young lives of great promise.

The necessity for a Provincial Bacteriologist is now established beyond question, and early efforts should be made to secure a successor.

It is not to be expected that anyone as capable as Dr. Halliday can be secured for the small pittance that was given him, but doubtless with the offer of an adequate salary some one will come forward from one of the seats of learning. There are many young men working in the laboratories of the great universities on the *qui vive* for such a position, but to secure one in whom the medical men throughout Nova Scotia shall have confidence, an adequate salary must be offered and unquestionable qualifications and diplomas insisted upon. It is not desirable that the occupant of the position should be engaged in private practice, though he might supplement his income by teaching in the Halifax Medical College and by private laboratory work.

THE LUNENBURG-QUEENS MEDICAL SOCIETY.

We are glad to know that the above society is in a very flourishing state, having recently held a most successful meeting at which some interesting cases were reported. The presidential address of Dr. H. A. March, of Bridgewater, will be published in our next issue. It is the intention of the society to have a special meeting at Chester during the summer tourist season.

 Photogravure, mounted on thick cardboard, of the late Dr. Halliday can be obtained at the office of the NEWS—15 cents each.



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—*The Medical Times and Hospital Gazette.*

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Matters Personal and Impersonal

Dr. W. H. Macdonald, of Antigonish, has just left by the "Beta," on a trip to the West Indies, for the benefit of his health.

Dr. Thomas Verner, of Blandford, had his fine new residence destroyed by fire this month, supposed to be the act of a fire-friend.

Dr. W. S. Woodworth, of Kentville, also had his residence gutted by fire recently.

Drs. Murphy and Weaver have been recent victims of la grippe, the former having been confined to the house for a week.

Dr. T. W. Walsh was unfortunately one of the sufferers by the recent big fire, and has been obliged to take up new quarters a few doors south.

Dr. G. D. Turnbull, of Yarmouth, lately left for New York, where he is doing post-graduate work.

The New York Medical Critic announces that each subscriber to that journal will receive a free copy of the Medical Index this month, (March, 1903). The volume will contain names, place and date of publication, price circulation and names of editor, and publishers of over 600 of the principal medical publications in this country and abroad, and also the titles and authors of each article published during the year 1902, arranged according to subjects and alphabetically. When it is noted that the list is complete up to January, 1903, it should prove especially valuable in bridging over the period which has elapsed since the index medicus was discontinued. Considering the expenditure of time and money in the preparation of this volume, and the liberality of the publishers in presenting it free to the profession, the enterprise marks a new era in medical journalism and merits appreciation and success.

Dr. Laphorn Smith, of Montreal, intends to leave from New York by the White Star steamer Cedric on the 25th March, for a few weeks visit to Kocher's Clinic at Berne, and also to the International Congress at Madrid, before which he has been invited to read a gynecological paper.

Society Meetings.

NOVA SCOTIA BRANCH BRITISH MEDICAL ASSOCIATION.

Feb. 4th, 1903. Meeting held in the Pathological Laboratory of the Halifax Medical College.

Dr. G. M. Campbell first reported a case of pyæmia in a boy of eight that had ended fatally. The kidneys, spleen and liver, which were exhibited, showed multiple abscesses. The mitral valve showed ulcerative endocarditis. Attached to the valve was a septic clot—the cause of the condition. Two areas of degeneration were seen in the brain, the one on the left side being near the posterior cerebral artery, and the one on the right being in the region of the middle cerebral artery. The patient had complained of no special symptoms beyond headache.

The next case referred to was a rapidly recurring ascites. The patient had been tapped a score of times, but always filled up in a few days. The patient was finally operated on and the omentum attached to the parietal peritoneum. The operation was performed on Oct. 25th, and on Nov. 5th it was found necessary to tap her again. The trochar wound became septic and she soon died from septic peritonitis. The autopsy revealed the following conditions: Abdomen attached to parietal peritoneum. The intestines were matted together by adhesions, which were becoming fibrous. Liver friable, adherent above to diaphragm and below to intestines. Through the mass of intestines were pockets of pus. The abdominal cavity was filled with ascitic fluid. Spleen very large, one and three-quarter pounds. Liver small, capsule thickened. The vena cava was widened and baggy, more especially at the entrance of the renal veins. Both pleural cavities and pericardium were filled with ascitic fluid. Left lung collapsed, right emphysematous.

Dr. Campbell then made some interesting remarks on the conditions known as serositis and multiple serositis, and referred to an article on the subject lately published in the *American Journal of the Medical Sciences*.

Dr. L. M. Murray then referred to two recent cases in the hospital, both with enlargement of the prostate. The anatomy of the prostate, the varieties of enlargement, the time of its occurrence and causation were discussed. The obstruction of the lower urinary tract due to enlargement, and the train of events leading to the pathological condition known as surgical kidney were then fully dealt with. The two specimens were then shown to the members.

Drs. Chisholm and Ross gave some further history of the ascites case, The symptoms followed an injury caused by falling from a ladder and producing fracture of two ribs.

Drs. Goodwin and Hare also took part in the discussion.

Feb, 18th, 1903. Meeting held at Halifax Hotel, the Vice-President, Dr. F. W. Goodwin, in the chair.

Dr. J. G. MacDougall, of Amherst, read a most interesting paper on "Cardiac Diseases with Special Reference to Diagnosis and Treatment." He referred to the importance of making a correct diagnosis and thought too much dependence should not be placed on auscultation. The other methods, inspection, palpation, etc., were equally important. In dealing with treatment he referred to endocarditis occurring in rheumatism and urged the importance of prolonged rest in bed. (The paper in full will be published in the NEWS.)

Dr. Chisholm spoke of the use of the lancet in cardiac diseases and thought pulmonary œdema always an indication for its use. He referred to three cases in his own practice in which great benefit followed from venesection.

Dr. Goodwin referred to massage of the precordial region as doing good in cases where exercise could not be taken. He also emphasized the importance of fresh air in these cases.

Dr. C. D. Murray spoke of the unreliability of murmurs in cardiac disease.

Dr. Walsh mentioned the advantage of combining nux vomica with digitalis.

Dr. Mader referred to the difference in strength of digitalis preparations.

Dr. Murphy asked how long it took for digitalis to act.

Dr. Chisholm stated that from experiments with the sphygmograph it acted quickly.

Dr. MacDougall then closed the discussion. With regard to the preparations of digitalis he preferred the infusion made from the

whole leaf. He did not care for digitalin, as it is very variable in its action, though he had seen one case in which it did good.

Dr. Kirkpatrick moved and Dr. Ross seconded a vote of thanks to Dr. MacDougall for his valuable paper. This was put and carried, to which Dr. MacDougall replied in suitable terms.

ST. JOHN MEDICAL SOCIETY.

Nov. 19th, 1902. Dr. Stewart Skinner, President, in the chair.

Clinical case—Dr. Scammell showed a patient with a small piece of iron in the crystalline lens, which was giving rise to a cataract.

Pathological specimens—Dr. T. D. Walker exhibited two vesical calculi having portions of a red rubber catheter as nuclei. They were removed by suprapubic cystotomy.

A paper entitled "Case of Cæsarean Section, followed by Abdominal Hysterectomy," was read by Dr. W. W. Chipman of Montreal.

The patient was 32 years of age and a primipara. Labour came on at seven months. The pelvis was found to be filled with a fibroid tumour and the os uteri was tilted above the pubes.

The abdomen was opened and the uterus transversely incised at the fundus. This opened into the placenta and gave rise to severe hæmorrhage, notwithstanding that the ovarian arteries had been previously ligated. After removal of the foetus, the uterus was removed in the usual manner. On the day following operation, the patient developed broncho-pneumonia, for which oxygen inhalations were found to have excellent effect. The patient made an excellent recovery and left the hospital in one month. The child lived four days.

The history of caesarian section and the various modifications of operation were then fully detailed.

The subject was discussed by Drs. Skinner, Daniel, T. Walker, J. Christie, Wetmore, Burnett, T. D. Walker, who gave particulars of two cases, Lewin, Hetherington, MacLaren, Lunney, McCully and Shaughnessy.

A vote of thanks was tendered Dr. Chipman for his paper, which was a very interesting and valuable one, and which was listened to with much pleasure by all those present.

The President entertained the society after adjournment and a very pleasant evening was enjoyed by a large number of members.

Nov. 29. Dr. J. Christie in the chair.

Dr. J. H. Scammell read a paper on "The Causes and Treatment of Sterility in Women."

The essential conditions for fecundation were considered. The causes rendering coitus difficult or impossible were mentioned, as well as the conditions which are unfavourable to fecundation.

The treatment of the various pathological conditions in the female was then fully considered.

Dec. 3. Dr. Gray, Vice-President, in the chair.

Dr. Lunney reported a case of parovarian cyst, which gave rise to symptoms of hip joint disease. Dr. Gray removed the cyst, which was twisted upon itself and was partly strangulated.

Dec. 3. Dr. Skinner, President, in the chair.

A paper on "Immunity" was read by Dr. Barry. (This paper appears in this issue of the NEWS.)

Dec. 17.—Meeting held at the G. P. Hospital.

Cases were exhibited and described.

Dr. J. R. McIntosh—Two cases of trachoma.

Dr. T. D. Walker—Meningocele. Compound fracture of femur.

Dr. Skinner—Beri-beri. Spastic paraplegia. Hemiplegia.

Dr. W. L. Ellis demonstrated the X-ray apparatus.

THE AMERICAN CONGRESS ON TUBERCULOSIS.

FOR THE PREVENTION OF CONSUMPTION.

The next meeting will be held in St. Louis, Mo., U. S. A., July 18th to 23rd, inclusive, 1904.

The work of organization is being pushed as rapidly as possible. To facilitate this the Congress has been granted a charter, thus making it a legal body and by this means greatly facilitating the work of re-organization on the lines mapped out at the last meeting, when it was decided that a radical re-organization should be completed by the officers elected.

Honorary President, Dr. Henry D. Holton, Brattleboro, Vt.; President. Dr. Daniel Lewis, New York; 1st Vice-Pres., Dr. J. A. Egan Springfield, Ill.; 2nd Vice-Pres., Dr. Frank Paschal, San Antonio, Tex.; 3rd Vice-Pres., Dr. E. J. Barrack, Toronto, Canada; 4th Vice-Pres., Dr. Irving A. Watson, Concord, N. H.; 5th Vice-Pres., Dr. Chas. Wood

Fassett, St. Joseph, Md.; Secretary, Dr. George Brown, Atlanta, Ga.; Treasurer, Dr. P. H. Bryce, Toronto, Canada.

It is earnestly requested that the Secretary be informed of the date of all meetings of medical societies, names of officers of same and other information that would aid him in his work.

Obituary.

DR. ANDREW HALLIDAY.—In the death of Dr. Andrew Halliday, which occurred at Halifax on the tenth of March at the early age of 36, the medical profession of Nova Scotia lost one of its most promising members. Dr. Halliday was born at Hutton, Scotland, and received his preliminary education at Wallace Hall Academy. His professional course was taken at Glasgow University, from which he graduated M. B., C. M., with honours, in 1891. After a year's hospital work, he came to Nova Scotia and began the practice of medicine at Stewiacke, where he was very successful, and soon established an enviable reputation as a physician. His field of labour was a large one, but after a few years at Stewiacke he removed to Shubenacadie, where his situation was more central. While devoted to his profession, he was especially fond of scientific work, and although engaged in a large and exacting country practice, he maintained a small laboratory in which he did a large amount of experimental work. Numerous papers from his pen, of a high order of scientific merit, have appeared from time to time in the Maritime Medical News and in other Canadian medical journals. For a number of years he gave a course of lectures on zoology annually at Dalhousie University.

His special bent was for physiology and pathology, and about four years ago he received an appointment as Lecturer in Pathology at the Halifax Medical College. After lecturing for one session he determined to devote himself altogether to pathology and allied subjects, and resigned his practice. He spent a year abroad in the study of pathology, bacteriology and other subjects relating to sanitation, and won much credit for the character of his work. He was awarded the D. P. H. of Durham. On his return to Nova Scotia he removed to Halifax and was made Associate Professor of Pathology at the Halifax Medical College. He was also appointed Director of the Labora-

tory of the Provincial Board of Health. In both these positions he did excellent work. His enthusiastic and conscientious devotion to his subject won for him the respect and admiration of all with whom he came in contact.

Dr. Halliday never enjoyed very robust health. He suffered intensely from migraine at frequent intervals, and a number of years ago passed through an attack of articular rheumatism, which told greatly upon his strength. Following closely upon this came an attack of pleurisy, the import of which Dr. Halliday fully realized. But neither the ill-health from which he suffered, nor the knowledge of his tubercular condition deterred him from putting forth every effort to acquire information which would assist him in the practice of his profession, or to advance the general fund of knowledge with reference to disease. He was very ambitious to successfully accomplish some research work which he had planned upon the histogenesis of the blood, and upon which he bestowed a great deal of preliminary labour, but increasing ill-health compelled him to abandon the project. Shortly after the beginning of the present college session, he became so ill that all work had to be foregone. He went to the Mu-koka sanatorium, where he remained for several months and received considerable benefit. Only a few weeks ago he contributed a very excellent paper descriptive of this sanatorium to the N. S. Branch of the British Medical Association. On his return to Nova Scotia he endeavoured to continue the principles of sanatorium treatment, and lived in a "shack" which he had erected for the purpose near Shubenacadie. Unfortunately, however, the disease continued to gain headway, and death claimed him on the afternoon of March tenth.

Dr. Halliday was a man of sterling worth. His heroic effort to excel in his chosen work in spite of disease and weakness was little short of pathetic. His death is a very great loss to the public health service of Nova Scotia, and particularly to the Halifax Medical College.

The NEWS extends heartfelt sympathy to Mrs. Halliday in her very sore bereavement.

DR. KENNETH D. MACKENZIE.—The tremendous snowdrifts on the line of railway in Newfoundland delayed particulars as to the death of Dr. Kenneth D. Mackenzie, Medical Health Officer of the city of St. John's, which occurred on the evening of December 24th.

The deceased, who was a native of P. E. Island, graduated from the Halifax Medical College in 1877 and went to Bett's Cove as physician with the mining company then operating there. In the autumn of 1882 he resigned that post and proceeded to Edinburgh, where he took a special course for a year, returning to St. John's and engaging in practice, where he had been domiciled ever since. He was not seriously ill, to all appearances, though complaining somewhat for a week or so, and his demise was a great shock to his friends. He was unmarried; his mother (aged 90) and one brother survive him in P. E. Island. He was well known and liked by a large circle of acquaintances. A man of exceptional ability and rare qualities, genial and warm-hearted, he won many friends.

DR. T. GAILLARD THOMAS.—The noted New York physician, Dr. T. Gaillard Thomas, died on February 28th from disease of the heart at Thomasville, Georgia. He devoted most of his time to obstetrics and gynæcology, his book on "Diseases of Women" being one of the best known on the subject. As a clinical teacher, he was probably unrivaled and as a diagnostician few could equal him.

Notes.

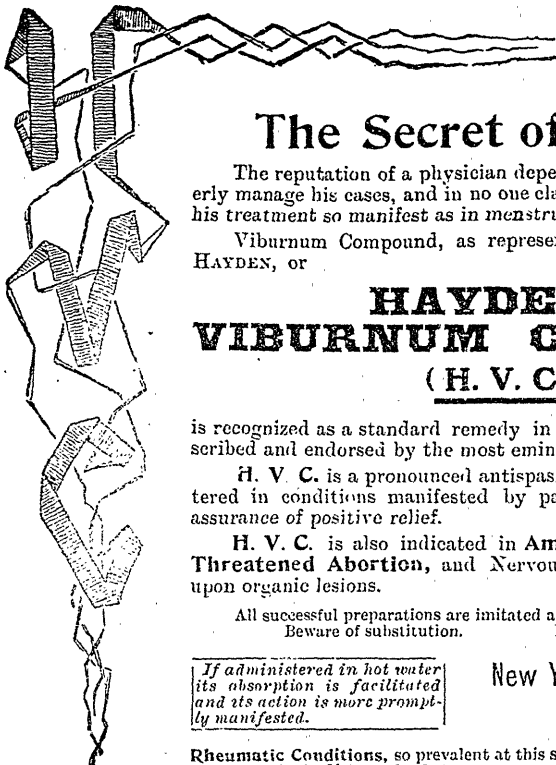
QUICK AND SURE AND TIME TRIED.—No doubt many of our doctor friends will recognize in the following, from Chas. B. Forsyth, M. D., (Bellevue Hospital Medical College, New York City) dated Alexandria Bay, N. Y., Jany. 6th, 1903, an expression which will, in many instances, recall their own experience. He says: "I can say no more than that I have used Antikamnia Tablets since I began practicing medicine. Several times I have switched to other preparations, but I invariably come back to Antikamnia Tablets, when I want quick and sure results."

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