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**G**ENTLEMEN,—There are pinnacles to which we reach, only to be hurled down from the dizzy height into the valley below to be hidden from the rude storms of the world, and where peace and quiet and easy-going hum-drum pervades the spot, while the green grass grows under the feet. This is the well known valley of the "have beens." Hills have only two sides, one going up and the other going down, and when one has reached such honor as you have conferred upon me he has climbed the up-side and must begin the descent. One is elated with the honor, but grieved with a retrospect of all that led up to it; one is pleased with the evidence of the good-will of his fellows—and a better lot of fellows never lived in any profession—but subdued with that soul-shading feeling that youth is fleeting and age approaching. Each man naturally looks forward to the day upon which he may occupy the presidential chair, but when the day comes he would give much to be able to postpone the honor for another ten years. And now it is time for the past presidents to move up and make room for me; but I do not intend to be placed upon the shelf, if health and strength remain. We all like to mingle with youth, but, unfortunately, youth and age were never meant to mix, as Charles Kingsley has aptly put it:—

“When all the world is old, lad,  
And all the trees are brown,  
And all the sport is stale, lad,  
And all the wheels run down,  
Creep home and take your place there  
The spent and maimed among,  
God grant you find a face there  
You loved, when all was young.”

It is a satisfaction, in dealing with the awful miseries of life, to know that others suffer, that suffering and death are the accompaniments of life, and from this springs much of the beautiful sympathy that is witnessed by our profession. We have a grand work to do.

Charles Dickens has put it in the words of the doctor's wife where she says, "We are not rich in the bank, but we have always prospered and we have quite enough. I never walk with my husband but I hear the people bless him. I never go into a house of any degree but I hear his praises or see them in grateful eyes. I never lie down at night but I know that in the course of that day he has alleviated pain and soothed some fellow-creature in the time of need. I know that from the beds of those who were past recovery thanks have often gone up in the last hour for his patient ministrations. Is not this to be rich?"

The young doctor must have as his main master faculty, sense, common sense, and he must have a real turn for the profession. A great divine has said: "The grace of God can do much, but it cannot give a man common sense." The danger of the present day is that the mind gets too much of too many things. A young medical student may have, as one author puts it, zeal, knowledge, ingenuity, attention, a good eye, a steady hand, he may be an accomplished anatomist, histologist, analyst, and yet with all the lectures and all the books and other helps of his teachers he may be beaten in treating a whitlow or a colic by the nurse in the wards, or the Old Country doctor, who was present at his birth. The prime qualifications for a doctor have been given by Dr. Brown in the words, *Capax*, *Perspicax*, *Sagax*, *Efficax*. *Capax*, room, for the reception and proper arrangement of knowledge; *Perspicax*, a keen and accurate perception; *Sagax*, the power of judging, ability to choose and reject; *Efficax*, the will to do, and a knowledge of the way to do it, the power to use the other three qualities.

The doctor must have a discerning spirit. There is a nick of time, or in other words, a presence of mind, and this he must have on, as Dr. Chalmers has said, "Power and promptitude." "Has he wecht, he has promptitude, has he power? He has power, has he promptitude, and, moreover, has he a discerning spirit?" The doctor must be as a general in the field or the pilot in the storm. I often think he belongs to no one in particular, but is a public property. His time is never his own. His children see little of him, and he leads a sort of Bohemian life, restless, active, thoughtful, worried, much beloved and occasionally cordially hated. He should be Bohemian in his tastes if he wishes for refinement to soften his manners and make him less of a wild beast. Art and literature, however, help to make noble only what is already noble, but such hobbies elevate and improve the mind and lift it above the rut of everyday life. A good education is a first essential. It is not necessary that everybody should know everything, but it is more to the purpose that every man, when his turn comes, should be able to do some one thing.

"The boy who teaches himself natural history by actual bird nesting is healthier and happier, better equipped in body and mind for the battle of life than the nervous, interesting, feverish boy with the big head and thin legs—the wonder of his class." It is well to have a pursuit as well as a study.

The doctor should marry, but his wife should be kept out of his work. Goldsmith said, "I was ever of opinion that the honest man who married and brought up a large family did more service than he who continued single and only talked of population." By marriage a man's sympathies are extended and his views of life are broadened. A touching picture of the refining influence of sorrow has been given us by Dr. Brown, the author of "Rab and his Friends," in speaking of his father. He says, "a child, the image of himself, lovely, pensive, and yet ready for any fun, with a keenness of affection that perilled everything on being loved, who must cling to someone and be clasped, made for a garden not for the rough world, the child of his old age. This peculiar meeting of opposites was very marked. She was stricken with sudden illness. Her mother was gone, and so she was to her father the flower he had the sole keeping of, and his joy in her wild mirth, watching her childish moods of sadness, as if a shadow came over her young heaven, were themselves something to watch. She sunk at once and without much pain, her soul quick and unclouded and her little forefinger playing to the last with her father's curls, her eyes trying in vain to brighten his. The anguish, the distress was intense, in its essence permanent. He went mourning and looking for her all his days." But the affection, we learn, softened and refined him, and made him better fitted for his work. His son tells us further that "his affectionate ways with his students were often very curious. He contrived to get at their hearts and find out all their family and local specialities in a sort of shorthand way, and he never forgot them in after life."

And such attentions are valued throughout life, and the clay is moulded and figured and ornamented and enriched and burned in the fire, and fitted for the battle of life. And the defective articles must be rejected and the broken articles may, perhaps, be mended, but they are never the same again, and, perhaps, we would be better without them. Our ranks must be kept clean. We must have a good, healthy professional growth, and in Ontario I am glad to say that such exists. The regular who adopts the methods of a quack is a much more dangerous individual than the quack himself. But we have others who are by no means quacks, who unfortunately lack discernment, and who do not

mean to do the harm that they certainly occasion. Our duty is to relieve and not to cause suffering. Some surgical procedures of the present day require severe criticism. Surgeons may be too conservative or not conservative enough. A few years ago we had an epidemic of the former, and now we are suffering from a plague of the latter. We are able to do so much that we are apt to do more than we should. I hope that the few dangerous individuals will soon be quarantined, so that the death rate and the cripple rate may diminish and the epidemic be checked. The epidemic has been spreading, and has assumed large proportions, and seems to affect chiefly young and middle-aged nervous women. Men with exposed organs appear to be fairly free from its ravages.

But, as a profession in general, we have been making great strides. The State is being saved from the enormous losses incident to great epidemics, and the medical profession is out of pocket as a consequence. It does not appear that proper efforts have been made to reimburse the doctors. We are asked to do what our friends, the lawyers, would take good care not to do without a proper arrangement for the payment of a proper fee. We are asked to register births, to register deaths, to notify regarding infectious diseases, and to attend the poor without remuneration. These are not charities. We are assisting and defending the commonwealth, and the commonwealth should pay us, and we should organize and agitate with this end in view. Unless such matters are attended to and a new method of payment of members of the profession is adopted, the numbers entering must be considerably reduced. In China the doctor is paid for keeping the family in good health. In Canada we, as a profession, protect the people from dangerous diseases, but the services are not paid for and are scarcely recognized. A few officials take all the fees. Our real charity is not among the really needy but among the apparently well to do. A proper revision of the relations of medical and surgical fees to one another is much needed, and a ruling of the Association on the ethics of commissions is required. A special committee of this Association should be appointed to investigate these matters and submit a report at our next meeting. It has been said that knowledge is no barren cold essence, but it is alive with the colors of the earth and sky, and is radiat with light and stars. If we endeavor to follow along the lines of experimental investigation of natural phenomena, we must obtain a fondness for the impartiality and truth which such a study incites. Says Draper, "we will thus dedicate our days to the good of the human race, so that in the fading light of

life's evening we may not, on looking back, be forced to acknowledge how insignificant and useless are the objects that we have pursued."

A paragraph that has greatly interested me by way of a retrospect, is the following: "In olden times, the surface of the continent of Europe was for the most part covered with pathless forests; here and there it was dotted with monasteries and towns. There were low-lying districts, sometimes hundreds of miles in extent, that spread agues far and wide. In Paris and in London, the two largest cities, the houses were built of wood, and daubed with clay and the roofs were thatched with straw or reeds. There were no windows and very few had wooden floors, until after the introduction of the saw-mill and such a thing as a carpet was unknown. A little straw scattered here and there in the room was the covering used for the floor. As there were no chimneys, the smoke of the ill-fed, cheerless fire, escaped Indian wigwam-wise, through a hole in the roof. It is needless to say that in such habitations, there was but little protection from the weather. No attempt was made at drainage and the putrefying garbage and rubbish were thrown out of the doors. Men, women and children slept in the same apartment and not unfrequently with domestic animals as companions, and as a consequence, neither modesty nor morality could be maintained. The bed was usually a bag of straw, and a wooden log for a pillow. Personal cleanliness was unknown and great officers of the state, even dignitaries so high as the Archbishop of Canterbury, swarmed with vermin. Perfumes were largely used to conceal personal impurity. Many of the citizens clothed themselves in leather, a garment that with its ever-accumulating impurity lasted for many years. If a man could procure fresh meat once a week for his dinner, he was considered to be in easy circumstances. Not only was there no house drainage but there was no street sewerage. There were no pavements or street lamps. After nightfall, the shutters were thrown open and the slops were unceremoniously emptied down, to the discomfiture of the wayfarer, tracking his path through the narrow streets, with his lantern in his hand." What a picture for us to criticize in the present day! And yet we scarcely realize all the hard work, ignorance, bigotry, persecution and glorious self-denial that have given us what we have to-day in our Western civilization.

Much progress has been due to the work of societies, such as that grand old society, the Royal Society of London. As university men and as educationalists knowing as we do that our present day conditions are due to the dissemination of knowledge, we should organize and promote similar societies and see to it that they hold as

prominent a place in the community as the churches. It was by the Royal Society that Harvey's discovery of the circulation of the blood, was first accepted. The same society gave so much encouragement to vaccination that Queen Caroline submitted her own children to the operation. All scientific observers are satisfied that Queen Caroline was right and the Royal Society was right. Then it was demonstrated that scurvy, the curse of long sea voyages, could be cured by the use of vegetable substances. We follow along and find jails and buildings ventilated and illuminated with gas. Cities were lit up, and made much more habitable. If we expect to have progress, we must rally around our educational institutions and see to it that they are well provided with the means required to carry on efficiently and well the work of scientific investigation, and that they are untrammelled by the views of either church or state, remembering always, that the slogan of the twentieth century is, "Knowledge is power." If this is done, man cannot lapse again into the dark days of the dismal centuries, when pestilences were looked upon as the visitation of God and not as we know them to be, the consequences of filth and wretchedness, easily prevented by personal and municipal cleanliness. In the twelfth century it was found necessary to pave the streets of Paris, as the stench from them was unbearable. Dysenteries and spotted fever, that had been prevalent, diminished and a sanitary condition was soon established, that approached to that of the Moorish cities of Spain, that had been paved for centuries. But alas for backsliding. Many of the Spanish cities have been allowed to lapse into an insanitary condition and the evidences of Spanish sanitation, as I saw it in Cuba, were not calculated to excite enthusiasm. Under the control of Western civilization and the proper application of knowledge matters have been changed. When it was decided that plagues were not a visitation of God, quarantine was established. Nothing has protected the human race to a greater extent than the establishment of proper quarantine.

When anaesthetics were first introduced their use in labor was discouraged as it was believed that women should not escape the curse denounced against them in Genesis. Now anaesthetics are, I hope, very universally used, to prevent the awful agonies of labor, by an enlightened, educated, scientific and humane profession. The very best evidence that can be brought forward to emphasize the benefits to mankind of improved methods of living has been obtained from the British Government reports of life insurance transactions, carried out in the 17th and again a hundred years later in the 18th century. In 1693, the British Government borrowed money by selling annuities on lives from infancy



upward, on the basis of the average longevity. The contract was profitable. *Ninety-seven years later, another tontine of scaled annuities on the basis of the same expectation of life as in the previous century, was issued. These latter annuitants, however, lived so much longer than their predecessors, that it proved to be a very costly loan for the government. It was found that while ten thousand of each sex in the first tontine died under the age of twenty-eight, only five thousand seven hundred and seventy-two males and six thousand four hundred and sixteen females in the second tontine died at the same age, one hundred years later, or in other words, 20,000 died in the first period and only 12,188 in the second period of one hundred years later, a very greatly diminished mortality, all conditions being identical except the improvements wrought by advanced sanitation.*

Once fairly introduced, discovery and invention have unceasingly advanced at an accelerated pace. Each continually reacted on the other, continually they sapped supernaturalism. The diffusion of knowledge by the newspapers and reviews has immensely increased the power of the press. Where ignorance reigns, crime is prevalent. In such cities as Naples, where the education laws, such as we have in Ontario, either do not exist or are not enforced, the streets are filled with street arabs, who are a nuisance and a menace to society, growing up in squalor, ignorance and filth. In our Western civilization such a condition of affairs cannot exist and I trust never will exist. The intellectual enlightenment, surrounding scientific activity, has imparted innumerable and invaluable blessings to the human race. Science is not confined to any one nation, but is cosmopolitan. We are living in an age of electric progress. The marvels of electric force have been studied and utilized for the great benefit of mankind. To-day the mummified remains of an Egyptian King Amenophis, who lived thousands of years ago, are viewed in the original tomb, with the aid of the rays of the electric light. The telegraph and telephone are to be found in the very heart of darkest Africa. The discovery of the achromatic microscope has rendered us great assistance in studying the nature of disease and the x-ray has enabled us to pierce what was before impenetrable gloom. The harvest is ready but not riper than it has been for centuries, but there are more enlightened and better educated and better equipped workers in the field. There is very much to be done and we must be constantly up and doing. I say this particularly to the young and enthusiastic. The foundation of our knowledge as modern doctors is science and the superstructure must be built upon scientific lines. Hospitals are needed, not such as those that were first established,

but modern, properly equipped and up-to-date institutions, with modern up-to-date methods.

Many hospitals have been erected through the munificence of individuals in the towns, throughout our country. Every town of any size should have its hospital. Such institutions are not intended to do the work of the larger ones in sixteen larger centres; but there is a certain amount of work that can never reach the larger centres that can be done very satisfactorily in small hospitals properly equipped and served by a properly educated profession. Assistance from the larger fields of observation can be obtained when required and under improved conditions such aid will be of greater service. The almost universal use of the electric light aids our work very materially.

Our prisons have been improved. Our younger criminals have been cared for. Our insane have been kept off the streets. Our poor are being looked after and now health and comfort go hand in hand. The true function of our study and deliberation is to prevent rather than to cure disease and we are fulfilling our functions. But yet death reigns everywhere and at all times, and in all places and we know it. But he is not the stalking giant that he was. He has been marvelously reduced in stature. Our medical press requires considerable regeneration. The articles published are not censored as rigidly as they should be. Much that is written and published is incomplete, speculative and inaccurate and hence misleading. Our journals should be purely scientific publications and not the hot beds for the propagation of unstable theories. Looking back is not always a pleasant pastime but there is a definite certainty about it, that does not belong to the future. All that has been printed is liable at any time to be reviewed.

And now in closing, let me say that during the year that has passed, a much desired amalgamation has been effected between two of our greatest educational institutions, Trinity and Toronto University. At first the task looked like a hopeless one, but owing to the good feeling existing between the rival faculties, it was finally achieved. Our province stands high in the banking world, in the musical world and in the educational world. I was gratified to hear our provincial University so well spoken of in the mother land and even in Egypt. The Medical Faculty of the University of Toronto, as now constituted with its ever increasing facilities, stands second to none in Canada at least, and the work accomplished, as evidenced by the standing obtained by our students abroad, is of a very high order.

Fathered by this Association, is an institution intended to be a guardian and repository of our archives. We must be prepared to pre-

serve our records for the use and assistance of those who come after us. A calamity befell the world when the Alexandrian library was burned, and a calamity would befall the profession of this province if the books, collected under the name of the Ontario Medical library, should meet with a similar fate. We are about to occupy new premises, but we need more money to carry on the good work. This is not a municipal matter but a provincial and professional need and I hope that many of the out of town members of this Association, will assist us. Such an institution to do the work well must be liberally endowed.

Three trustees have been appointed and through the generosity of the members of the profession of Toronto, of our good friend, Prof. Wm. Osler, of Mr. Geo. Gooderham, of Mr. E. B. Osler, Mr. Timothy Eaton and the executors of the Estate of the late H. A. Massey, ten thousand dollars are already in sight.

I desire to thank this Association for the great honor it has conferred upon me and to thank those who have organized and arranged this meeting.

I feel sure that the hope and desire of every member of this vigorous twenty-four year old Association is that it may long be spared to write, to teach and to guide the medical profession of this our great Province.

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### THOUGHTS ON CANCER.\*

By the Hon. Sir WM. HINGSTON, F.R.C.S.  
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**W**HATEVER may be the state of our knowledge in other departments of the healing art, we must admit we know little of the etiology of tumor formation generally, and especially of these forms we are accustomed to call "malignant." These are still, as Kelynack, observes, "shrouded in darkness and mystery." Yet at no time in the history of surgery has cancer occupied a greater share of thought than at the present time. France and Germany have long been pursuing most diligent investigations to unravel its hiddenness. In Great Britain a Cancer Research Fund has been recently established and the function of general superintendent of cancer investigation has been created: To supervise workers; to collect statistical, dietetic, topographical and other information; to organize a system of correspondence with Home, Colonial, Indian and Foreign Laboratories: to invite the Colonial Offices to assist in obtaining information as to the relative prevalence of cancer in the

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\* Read at the Ontario Medical Association, June, 15.

various Colonies of the British Empire; and to trace, if possible, any connection with the mode of life, food, habits, environment, and so forth, of the inhabitants. How much will be accomplished by organized investigation of this character and how much by the unobtrusive individual worker in the quiet of the hospital and the laboratory—time alone will determine.

A couple of months ago the Cancer Research Fund of the Royal College of Physicians and Surgeons made its first report. It consists of three papers: The first—the Zoological Distribution of Cancer, showing the disease to exist in most of the domesticated animals; in many of the wild; and in several of the fish tribe. The second—dealing with the Transmissibility of Cancer, establishing beyond a doubt—at least in the case of mice—that carcinoma can be transmitted from animal to animal. A third—taking exception to the view that cancer consists in a change from normal tissue to malignant—or as stated by Campbell, “that cancerous growth is caused by the degenerative reversion of epithelial cell to a germinal type, in association with a local irritant; and in the presence of an abundant blood supply.

In other parts of Great Britain private charity comes to the aid of a local research fund. Thus in Liverpool, for instance, one person leads off with a subscription of \$50,000. The Liverpool Royal Infirmary furnishes a ward for facility of observation and experiment, and its University has placed five large rooms at the disposal of the research fund for the same purpose.

It is quite beyond the scope of this paper to discuss the *nature* of cancer. That aspect of the question is as yet incomplete. One writer expresses the view that the disease is due to a pathogenic organism belonging to the numerous yeast family; another, that it is an animal organism; a third, that it is in any case a parasite; a fourth, that it arises from some, not always recognizable, disturbed action of the natural competent parts of the body. At the present time the tendency of thought is towards the theory that the origin of cancer is extrinsic—that there is, as Meyer observes, an extrinsic cause, and that it remains only to discover it.

If cancer has a parasitic origin, has it a micro-organism of its own? If it has, so soon as the nature of that organism is understood we may indulge the belief that a specific cure of cancer may ultimately be found. So far, however, there has not been successful cultivation, outside the body, of those micro-organisms which have been supposed to be of malignant growth. And this notwithstanding what the French style “Cancer a deux,”—an accident so extremely rare as scarcely to deserve

mention. But where attempts have been deliberately made, as by Alibert upon himself, his medical friends and students, the result has been invariably negative.

So far, therefore, it may be said, the origin of cancer remains an enigmatic secret. For my part the conviction is forced in upon me from bedside observation, that the cause of cancer is perverted action, possibly inflammatory, without, at first, the usual evidences of inflammation; or, in other words, that it is perverted nutrition. This is the view I have held for many years.

But while every diligence is being exerted to unravel the *causes* and *nature* of cancer, something less problematical, something less doubtful, is forced upon our notice—its *increase*. Cancer is greatly on the increase, and reliable statistical information is at hand in support of that opinion. "After all the necessary corrections," says the British Medical Council, "there is an enormous increase in the registered mortality from malignant disease in all civilized countries having a complete register of causes of death."

"In London alone," says Dr. Caldwell Smith, "the cancer death rate has increased from 65 per 100,000 to 95 per 100,000 in five years: in fifty years it more than doubled. Observers have remarked that the increase is chiefly from visceral cancer.

The cancer death rate in England and Wales increased between four and five times in fifty years. On this side of the Atlantic the question of the increase of cancer has been carefully gone into by Warren, of Boston, and Roswell Park, of Buffalo—and no men in America, you will admit, are more competent to conduct an investigation of this nature—and the conclusion arrived at by both, independently of each other, is in favour of increase. The State Board of Health of Massachusetts says: "Every year there is an increase in the reports to the State and the number of deaths from cancer, even when allowance is made for age and greater population." And Professor Roswell Park, speaking of his native State, says: "If, for the next ten years the relative death rates are maintained, we shall find that ten years from now there will be more deaths in New York State from cancer, than from consumption, small-pox and typhoid fever combined."

Statistics in Canada are as yet too incomplete to be of much value, but the experience of hospital physicians and surgeons is to the effect that cancer in Canada is *greatly* on the increase. It has been said by those who do not share this view that "a surgeon's personal experience is often misleading, as cases in which he is specially interested are constantly being sent to him by friends and former pupils, and one case

brings another from among the public." That view I have taken carefully into consideration, but I am the more impressed as to the greater frequency of cancer than formerly, and as to its steady increase, from observation outside of my own special field of labour.

And while the disease is on the increase, medicine has effected little save by co-operating with surgery, to enable the knife, with all the safeguards asepticism can secure, to penetrate parts of the body hitherto regarded as beyond its reach.

The internal specific treatment of cancer, either local or general, has rarely been without claimants to the possession of some special knowledge of a remedy claimed to have been acquired, inherited or revealed. I should not be disposed to treat, at all seriously, the claims of those who pretend to cure cancer by the internal administration of remedies; for, notwithstanding the certificates of cure which are daily appearing in the public press and elsewhere, it may be safely stated that hitherto, internal remedies have been found to be without any value whatever.

And what can be said of the claims for excellence put forth on behalf of those *external* applications which are imposed upon a credulous and easily deceived public? *Pari passu* with the admittedly occult nature of the disease, the treatment, it is contended, is not within the usual bounds of ordinary medical knowledge, and thus the cancer curers, by plasters and unguents of mysterious action have increased in numbers and in presumption. The ordeal to which patients sometimes subject themselves at the hands of ignorant but pretentious quacks, for the removal of supposed cancer, and the suffering and disfigurement which sometimes result, are conditions we occasionally witness from the use of plasters long since discarded by the profession as unsafe, unscientific, unsurgical and uncertain. I once saw a woman who had had a wart on the back of her hand. It was a harmless excrescence on the skin, but a cancer curer assured her it was malignant. Contrary to the advice of her family physician she permitted a plaster to be bound upon the part. On her arrival at the hospital a few weeks later, not a vestige remained of the dorsal aspect of the hand; neither tendon, ligament, nerve nor blood vessel. The metacarpals, from carpus to phalanges, were black as charcoal and dead. The cutaneous palmar surface, however, still retained vitality, and after a while the patient returned home carrying with her, a limp, flexible hand, without the usual bony support, but bound up with the assurance that while her hand had been lost her life had been saved. If the Charlatan knew nothing of surgery, he could form some fair notion of the patient's credulity and supply her with a text which suited her case exactly: "if thy right hand offend the" and so forth. And was it

not her right hand which had offended. Verily the text had been written in anticipation of her case.

I turn from isotericism and occultism to something more intelligible, where deduction from certain manifest qualities are the result of experimentation.

#### ITS TREATMENT.

The treatment of malignant disease by *Electrical methods* has for some time attracted notice. Although success has not generally followed these attempts, yet patience and energy have sometimes been rewarded by improvement. The healing of an ulcerated, cancerous surface says Lewis Jones, has been observed in a certain proportion of cases; relief of pain in cancerous parts is a fairly common experience, and superficial nodules, undoubtedly cancerous in nature, will sometimes decrease notably in size under electric treatment.

The science of electricity, however, is yet in its infancy, and the *technique* of its application is imperfectly understood, while the reluctance of the surgeon to counsel treatment involving delay are, and will be for some time, hindrances to the more general use of electricity, save in those cases which cannot be easily reached by the knife. It is yet too early to speculate on the results of the electric treatment; some are of the opinion that they can bring about the painless removal of the slow-growing epitheliomas. I shall content myself with stating, that the treatment which is said to be successful in causing diminution of hyperæmia, inflammation, infiltration and serous exudation, may, ultimately, be found to be of permanent value.

A new, a powerful, and as yet not thoroughly understood, and not always easily controlled therapeutic agent, has been added to our armamentarium in the treatment of cancer and other diseases. By one or other of those wonderful deductions from light and heat and from certain modifications of the electric waves, or from their analysis and separation, whether as the X or Roentgen Ray, the N-Ray or Cathode Ray, the Rays of Blondlot or the Alpha, Beta, Gamma Rays, the Finsen Rays, or the Rays of Charpentier, or that mysterious phosphorescent ray, likened to that which is developed during muscular action or mental effort. Whatever name they bear and whatever the source of their potency, a power has been created to be utilized to our advantage. Have these rays or any of them the therapeutic value claimed for them? The illustrations we find in medical journals on both sides of the Atlantic would seem to speak encouragingly of this painless form of therapeutics. The latest at hand is from the London Middlesex Hospital Cancer Research, where after trying various remedies with generally

unsatisfactory results it says: "In x-rays we have an agent capable of doing more for superficial cancer than any other hitherto known. The work already done in Canada is evidence of intelligent and persevering effort. Dr. Girdwood has effectually cured intractable rodent ulcer and benefitted recurring epithelioma, and Dr. Leforest has effected the extensive destruction of hair follicles in bearded women without producing even an erythematous blush.

With the assumption—and it is so far only an assumption—that cancer is a micro-organism, the therapeutic value of some of those forms of electric force most amenable to control, may yet be found capable of bringing a hitherto distressingly frequent and cheerless malady under subjection. But it must not be forgotten that improvement occasionally noticed in the more superficial forms of cancer, as epithelioma for instance, must not be allowed to lull the sufferer into dangerous security. I have many times, by the application of an escharotic, kept under subjection, for many years, epitheliomata of the eyelid, face and lip, and have obtained their final disappearance without the use of the knife. But of the deeper form of cancer it may still be said with MacIntyre of Glasgow, "that the serious, deep-seated affections which, in the public mind at least, may be considered synonymous with the word cancer, have so far baffled us. The problem remains to-day as great as ever." Perhaps in the future the penetrative ray may be isolated from its surroundings and be sent on its errand of mercy deep through the normal tissues without affecting them, and attack the hidden morbid growth at greater length or less depth, as in our northern lakes and rivers, the sun rays sometimes pass through the thickest ice without melting its surface, and establish centres of liquefaction in many places in the interior of the frozen mass.

So far the various forms of the x-ray, whatever name they bear, act as stimulants and excitants, producing, at first, tingling; then as irritants and caustics producing pigmentation as in sun burns, erythema and other evidences of dermatitis; then if continued, vesiculation or desquamation; then deeper congestion and stasis, leading to all the changes we may notice in burns. But these severer effects are legotten, in some measure, of inexperience in adjustment, on the one hand, or of accommodation on the other, and are becoming less frequent as the new power can be more intelligently measured and the tolerance or power of re-istance of the individual better understood.

I can only allude *en passant* to artificial fluorescence of living tissue, and wish for it more than has hitherto been vouchsafed to other methods.



The still more modern treatment by Radium, it is claimed, has given promise of success. But reports, so far, as to its value as a therapeutic agent are not encouraging.

Notwithstanding the advantages sometimes resulting from the employment of the Roentgen or other rays, Symes' dictum of upwards of half a century ago remains as true as it was then; that in the treatment of cancer when the disease can be wholly removed reliance must still continue to be on the knife.

But why the knife? Is cancer curable by operation? To this I unhesitatingly reply in the affirmative, provided the operation is done sufficiently early, permitting the entire removal of the disease *and that it is removed.*

I now proceed, but most hurriedly, to deal with some of those forms of cancer to be met with and first of the digestive system. As to the tongue. Although sharing the opinion that its partial removal is wrong in principal, there are cases arising from local irritation where partial excision affords excellent, and in some cases, permanent results. In total extirpation it is marvellous what recuperative power is sometimes met with. I once removed a cancerous tongue down to the hyoid bone, separating it close to the epiglottis, pharynx and soft palate, and with the tongue I removed the whole of the lower jaw, as well as the sublingual and submaxillary glands on one side; yet the patient—an old man—made an uninterrupted recovery.

Concerning Cancer of the throat. One might read Sir Morell Mackenzie's book on the late Emperor of Germany's fatal illness; and then the comments of the German surgeons and of the German and British Medical press, and decide as to what is and what is not cancer in those regions, and act or not act accordingly.

As to the operations of the stomach for cancer, it may be said: they will be satisfactory or otherwise in direct ratio to the care and prudence with which cases are selected for the knife and the cases are few. The delay sometimes caused by medical treatment; the difficulty, often, of diagnosis when seen, and of deciding as to the extent of the disease, will always make operations on the stomach anxious, and too often uncertain. It is only when the disease is confined to the stomach itself—where it has not gone beyond that organ, nor infiltrated into neighboring glands or organs that any hope of success need be entertained.

Gastrotomy is yet on its trial, and the time afforded has not been sufficient to enable one to decide whether the operation introduced by Billroth, some years ago, possesses all the advantages claimed for it. Let me guard you against an error which is too prevalent—the belief

that disease of the pyloric end of the stomach from ulcer, passes, after a time into cancer of that organ. Ulceration, often with resultant stenosis, continues as such, and rarely, very rarely, becomes cancerous. Treatment should be based on this assumption, and should not be influenced by a dread lest the painful, but non-malignant gastric ulcer might eventually become the more formidable malignant affection.

I pass over *gastro-intestinal operations* hurriedly, as each case of malignant disease of the stomach and bowel has a law unto itself. But the cases are comparatively few where surgical interference is warrantable. When malignant disease is limited to the pyloric end of the stomach, and when its constricted condition interferes seriously with the passage onwards of the contents of the stomach, relief is often obtained from the junction of that viscus with the duodenum or jejunum. But, while relief is sometimes marked, it is often unhappily but for a time, when, as Maylard observes, "vague but suggestive symptoms insidiously reappear," prompting one to ask, "is it for the real benefit of our patient to rescue him from death, simply to die over again." I should have been disposed to answer in the negative; but the recent address in Surgery by that brilliant writer and operator, Mayo Robson, leads to the conclusion that, not only as a palliative, but as a curative measure gastro-enterostomy must take its place among the regular operations in surgery.

Cancer of the large intestines—whether of the caecum, ascending or descending colon, or of its hepatic, splenic or sigmoid flexures—may in some few cases demand surgical interference. But while contemplating operation on the lower bowel, it is well to bear in mind Jonathan Hutchinson's recognition of exaggeration in two directions: "The danger of the operation he says is put much lower than it really is while the probable duration of life without it, and the possible freedom from pain are much underrated."

Although the diagnosis of cancer of the head of the pancreas may, with the aid of Courvoisier's law, often be made out "deep, painless jaundice and enlarged gall bladder;" the recognition of these conditions is sometimes insufficient as a safe prelude to surgical interference. In a case mentioned by Stewart of Leeds, where cancer of the head of the pancreas was found at the autopsy, a prolonged search of over half an hour was made for the gall bladder but none was present.

A considerable number of cases of cancer of the *rectum* having come under my notice, I may, perhaps, be in a position to express an opinion as to the best means of dealing with them. In general terms I may say: in the early stages, when the disease can be circumscribed,

and its base well defined with the finger, Langenbeck's operation, called the *low* operation offers many advantages. When the disease is not so limited colotomy may be resorted to, or it may with advantage precede proctotomy. When, however, the disease is more advanced, Kraske's operation presents itself as a last and almost forbidding alternative. I have performed the operation with Bardenheuer's modification several times, and I am not enamoured of it. As the lower excision of the rectum is practicable in but a small percentage of cases, Kraske's operation is advisable in a still fewer number. There may be comfort, however, in knowing that cancer of the lower bowel, being usually a columnar carcinoma, as Rose and Carliss observe, is not so malignant as cancer elsewhere. Most of you will recall, no doubt, cases where well marked carcinoma of the bowel existed for years without producing any great disturbance.

In suspected cancer of the womb the early diagnosis of malignancy is of the first importance. The diagnosis clearly made—even sometimes by microscopical examination of scrapings by the curette—what operation should be performed?

Some surgeons give preference to the vaginal, others to the abdominal method. We should not be prejudiced adherents of either, although I have practised both. When the disease is clearly limited to the os and cervix, the vaginal method, it appears to me, is preferable, as being less hazardous to life. When disease is in the body of the uterus with possible involvement of the appendages, the abdominal route, methinks, offers superior advantages. The extent to which the disease has spread when within the uterus should not deter from operating. In other parts of the body the lymphatic system is generally involved at an early period, whereas, in cancer of the womb the lymphatics are not affected until the disease has advanced, by direct extension, into the adjoining parts. This circumstance seems to have led the editor of the British Medical Journal to state: "If cancer of the womb is only recognized early enough, it can be removed with small risk, and with a good prospect of years of freedom from recurrence."

In those *inoperable cases* where closing the vagina, draining through the rectum, ligaturing the arteries, etc., have been proposed as methods, I am free to confess I do not endorse. Curetting offers, methinks, a much better result, especially when followed by application of a proper caustic, or, perhaps, by one of the forms of x-rays.

Concerning cancer of the uterus and ovaries, the observations as to surgical interference are almost identical, for the risk of operating upon either is about equal. As early operation in cancer of the appendages,

as of the uterus, is, when successful, usually attended by relief of the more distressing symptoms. Moreover, the differential diagnosis is comparatively easy, and the limits of the disease may be somewhat correctly defined.

What has been said of the ovary may be applied to cancer of the *Fallopian tube*. The difficulty, nay, the impossibility sometimes, of disuniting affections of these two organs, and the unwisdom of attempting, even were it possible of accomplishment, to remove the one and retain the other, renders it usually necessary to excise both or neither.

Perhaps I should notice, *en passant*, the operation of oophorectomy, not for disease of the ovary, but for recurrent or re-appearing disease of the breast. It is not easy to explain how the removal of a healthy organ at a distance, can destroy cancer germs in the organ involved, however intimate sympathy may be between the two. Besides, oophorectomy is not always the harmless operation it is claimed to be by those who regard it as a cure, or even as a palliative, for cancer of the breast. The operation has been performed many times, and we have yet to learn a result which might be called satisfactory. Williams of Clifton goes so far as to say, "not a single definite cure can be instanced unless one of Herman's cases may be so regarded." But even if a score or so of "cures" could be cited, the sources of fallacy are so numerous that little weight would attach to them in the face of the overwhelming preponderance of negative results. In fact, every new specific for cancer says Williams has had no difficulty in justifying itself by far more convincing crops of "cures" than any that has been adduced on behalf of castration.

I should not have alluded at such length to this mischievous meddlingness had it not been that the mutilation undergone for that and other purposes has been somewhat too frequently resorted to on this side of the Atlantic, where ovaries bid fair to be considered, ere long, useless and troublesome appendages to be got out of the way.

While I am speaking of cancer in different parts of the body, I am sure the minds of many of you travel, not to those more formidable affections of organs hidden in the interior of our economy which can be visited only by a limited and expert few, but to that more tangible form of the disease which so often afflicts the female breast. As it concerns the well-being of the mothers of our race, I shall deal with it at some length.

And first as to diagnosis.—It is at the earliest moment that an examination of the breast is most valuable, and it is then it should be most thorough. As inspection sometimes conveys the earliest and sometimes the only information, the whole chest should be freely uncovered, so that

both breasts may be readily compared. The patient should stand or sit on a stool or chair without a back, so that the examiner may stand behind her permitting the educated palmar surfaces of the fingers, not their extremities, to impinge upon the parts to be examined. Both hands should be used in the examination, one to support the breast if necessary. But the examination is not complete until the patient is afterwards examined in a recumbent position, the examiner being, at will, at the patient's head or at either side. These are elementary suggestions but they are too often neglected.

A few words as to the mode of operating, the manner of which, as generally practised, has always appeared to me to be, in many respects, faulty. I am free to confess that for the first twenty-five years of my professional life, although I followed always the most recent text-book, I was not satisfied with my own way of operating nor with that of others. Having before my mind the instructions of surgical writers to cut and dissect parallel with the muscular fibres, the knife was used too freely—almost exclusively—and a doubt often remained with me as to the sufficiency of my dissection on the one hand, and as to the needlessly extensive mutilation on the other. Gradually I learned to do less with the knife and more with the finger in the work of separation—and with greater satisfaction. Although sanctioned by very eminent authority, I could not regard the early separation of the skin from the subjacent mammary gland as a wise procedure. And here let me observe that an error has long been indulged in as to the form and attachments of the mammary gland. Anatomical works often describe the female breast much in this fashion: "Two hemispherical eminences, nearly circular, flattened, or slightly concave, on the posterior surface, convex on the anterior aspect." The female breast is not like an inverted saucer, nor a shell bounded by the surface of a sphere. It sometimes sends off cusps above, below, and to the axillary region; sometimes to and across the sternum; sometimes even to its fellow on the opposite side. The breast gland, aptly called by Dennis a cutaneous subaceous gland, is sometimes connected most closely with the skin, through fatty tissues of varying thickness.

To ascertain the form and extent of the mammary gland my first incision—usually at the most dependent part of the breast—is down to, and below the gland. I must see, and feel, the outer margin of the gland and then separate it from the subjacent pectoral with my finger not with my knife and thus throughout. If the separation takes place easily I am satisfied the disease has not extended to the muscle beneath and do not remove it.

But when there is the slightest suspicion of adhesion and the large pectoral is to be removed, how should this be accomplished? Not by separating it at the wide circumference of its broad, fleshy basal attachments to ribs, sternum and clavicle, but at its narrower tendinous attachment to the humerus. By turning forward the now liberated muscle, its freedom from or adhesion to the pectoralis minor may be established, and the preservation or removal of the latter follow.

When large quantities of skin and muscle are removed leaving the ribs with the breast glands to a large extent uncovered, skin grafting may be sometimes resorted to with advantage, but when? I share the opinion of Læ Dentu that it is better to wait till the wound had begun to granulate and had contracted somewhat, and to have recourse to Thiersch's method at a later period than is often practised.

It is not advisable to go beyond the mammary gland when there is no evidence of the disease outside of it. My practice, notwithstanding weighty opinion to the contrary, is invariably to confine myself to the mammary gland, when it alone is diseased, and to the elliptoid integument to be removed. I am confirmed in that practice by having noticed that when the disease reappears it is usually in the cicatrix, and rarely in the axilla. The supply of lymphatics leading to the axilla is doubtless abundant, but the lymphatics above and beneath one mammary gland anastomose freely across the sternum with those of the opposite side—yet it does not usually occur to the surgeon to remove both breasts when one only is affected. Besides, removal of the axillary glands adds greatly to the patient's discomfort and to her risks, and is, I contend, in the vast majority of cases of early cancer of the breast unnecessary.

To my mind there is no more reason to remove the axillary glands when not diseased, than there is to remove the network of lymphatic glands which encircle the chest in all directions and directly find their way even to the thoracic duct. I ventured to so express myself in Washington several years ago, and I have not since found it necessary to modify the views I then gave utterance to.

But should the disease again show itself, what then? As I am firmly of the opinion that it is a reappearance of the disease, a returning or coming again into view of what has been removed merely from sight and apprehension but not thoroughly and entirely, I repeat the excision as thoroughly as possible, once, twice, thrice or oftener—as often indeed, as any appearance of the disease is visible, or as the anatomical relations of the parts will continue to permit. In this way I have had the satisfaction of being able to obtain final success after many efforts. But this success it must be admitted is only occasional; it is sufficient, however,

to encourage the surgeon to repeat his efforts even if frequent failure almost forces him to look at any effort on his part as to that of which there is but little hope.

In conclusion, Mr. President and Gentlemen, it may appear to many of you that I have stated nothing which could not have been said by any of my listeners, but when I was honoured with the invitation to address you to-day, it occurred to me that it might possibly interest you to view a few creatures in a disease which is attracting an unprecedentedly large share of attention through the optics of one, who, during years not a few, has had exceptional facilities for clinical observation.

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### ADDRESS AT THE CLOSING MEETING OF THE MEDICO-CHIRURGICAL SOCIETY, OTTAWA.

By SIR JAMES GRANT, M.D., K.C.M.G., Honorary President.

**I**N the first place I congratulate you on the widely diversified work which has been accomplished during the winter session of this Society. At the closing exercises, I desire to thank you for the opportunity of reviewing some lines of action, at home and abroad with reference to the Science of Medicine,

*Registration of Nurses.* A move in this direction is being made by the Royal British Nurses Association, and the Irish Nurses Association, together with several independent leagues of nurses warmly supporting the registration movement. As the public have not the knowledge to discriminate the value of certificates, it is well their interests should be guarded as far as possible. Under such circumstances it would be a step in the right direction, to have the system of registration carried into operation in Canada. The whole question, however, is now under the consideration of the Medico-Political Committee of the British Medical Association, which will be an object lesson on this side of the Atlantic. In the training and work of our Canadian nurses, we see much of hope and promise. The field of labor is now widening and the quality of thoroughness will always command respect and support.

*School Hygiene.* The International Congress of School Hygiene recently held at Nuremberg was represented by nearly every European Country. Buildings, Furniture, the Hygiene of the Boarding School, the Physiology and Psychology of Education, the training in Hygiene for Teachers and Scholars, Physical Education, Contagious Diseases, Home and School Life. These various subjects were of great importance, and the time has nearly arrived when schools and their inmates should be

systematically inspected by medical men which would contribute greatly to the comfort of the parents and the prolongation of life.

*Cancer Research in America.* For fully four years the worker's in the laboratory of Dr. Roswell Park, Buffalo, have been engaged in cancer research, pathological, chemical and bacteriological investigations are in progress, in correlation with each other. Dr. Park, makes the broad statement that there is not a practising physician in the United States, who has more than a rudimentary knowledge of the subject. Professor Calkins of Columbia University, consulting biologist, is of opinion that the cell inclusions in carcinoma, are phases of an organism, after the most careful investigation, he favors the idea, that the cell inclusions are not secretions, but phases of an organism belonging to the group protozoa.

In London, Henry Morris and Dr. Bashford, Director Cancer Research Fund are doing able work, in the line of investigation, and we look forward to good and practical results.

*The Pancreas.* This gland has recently come into considerable prominence as to its morbid conditions and clinical symptoms, through experiments on animals, and the surgery of the abdomen. Much credit is due to Dr. Mayo Robson, as to the distinctive features of the various pathological affections of the Pancreas. Pawlow has also noted most carefully the conditions under which the pancreas secretes the ferments, which perform so important a part in the digestive process. Starling and Bayliss have also ably defined the fact, that "secretion," obtained by them from the intestinal mucous membrane, stimulates the pancreatic juice, when introduced into the circulation. The diagnosis of pancreatic diseases, is extremely difficult, owing to the fact, pointed out by Mayo Robson, that the vicarious power possessed by other organs, to perform the functions of the pancreas, cloaks symptoms, which otherwise might be of great diagnostic value. Much interest has been attracted to the "Pancreatic reaction," discovered by Dr. Cambridge, depending upon the presence of *Glycerine in the urine*, defined as in close association with, the fat necrosis, characteristic of pancreatic disease. Mayo Robson in the many cases under observation, has only found a few, in which glycosuria was present, and he has pointed out, that it is only when the entire gland is destroyed, as in malignant disease, that diabetes supervenes. Until recently this department of pathology has been a comparative blank.

*The Laryngoscope.* Senor Manuel Gracia the discover of the laryngoscopes, entered his hundredth year, March 17th, 1904. Born at Madrid, Spain, 1805. For a time he was engaged on the stage, which he was obliged to abandon as his physique proved inadequate to the strain of



the stage, his first appearance being in New York. For a time he was engaged in teaching singing in Paris, where he gained quite a reputation and was appointed Professor in the Conservatory. Since 1850, he has resided in London, England, where he trained many of the world renowned singers. In 1854 the idea of the reflection of two mirrors struck him, by which he saw the glottis for the first time, wide open, before him, and trachea fully exposed. In 1855 Gracia presented a paper to The Royal Society of London, entitled "Physiological observations on the Human Voice." Bobington devised an apparatus, somewhat like that of Gracia twenty years previous, but he never examined his own larynx, as Gracia did. The working out in extenso, the physiological and practical application of the instrument, is due to Czeomeek of Buda-Pesth, and now world wide in its application.

The next centenarian to whom I shall refer briefly is Senator David Wark, who, in February last, passed the hundredth milestone of his life's journey, and has always enjoyed excellent health, never a day in bed from illness, since infancy. Had a farm at Richibucto, Kent, N. B., two miles from his place of business, to and from which he generally walked daily. Has not tasted spirits for seventy-five years, and previous to that date, only a little wine, which he abandoned. Never used tobacco. Irish descent and his grandparents brought the system of eating oatmeal from Ireland. Senator Wark makes the following statement:—

"For breakfast, I take porridge, which is a great luxury, one cup of tea and a small piece of bread. For dinner, I take a small piece of fowl or fish, a potato or two, and a small cup of tea. For supper, I take a cup of tea, and a piece of bread." "I sponge the body regularly and keep the bowels free." "I usually sleep soundly five hours each night, and generally have a short nap after each meal. I have been sixty-one years in political life, and have lived in the reign of George the 3rd, George the 4th, William the 4th, Queen Victoria, and King Edward the VII. My entire life, has led me to the following conclusions; that people eat too much; smoke too much and use too many beverages, which should be carefully guarded against, in order to enjoy a good old age."

Dr. R. A. Rudolph, of the Toronto Light Horse, met with a serious accident. He was riding a spirited horse, and, colliding with a trooper of the R. C. D., was thrown, sustaining a concussion similar to Col. Otter's recent experience. He was cared for in a private house by Dr. McPherson. He is doing well and will soon be around again.

DR. OLIVER WENDELL HOLMES, PHYSICIAN AND  
MAN OF LETTERS.\*

By F. R. ECCLES, M.B., F.R.C.S.,  
Professor of Gynaecology in the Western University, London.

I had thought it would be interesting to some of you at least and I hope to all, to deviate from the old beaten path, of taking up some pathological condition, and select some subject allied to medicine or embracing it, or some life associated with medicine, which might with profit be introduced at one or two meetings during the year. We read of Gregory's powder, Busham's mixture, Dover's powder, Pott's disease, Dupuytren's splint, Chopart's operation. Then we know, or read of medical men who have achieved some prominence in the arts, in poetry and literature—such as the author of "Rab and his friends," John Keats, Weir Mitchell, the late Sir Henry Thompson, and our own Dr. Drummond. A history (minus the living) of either of those personages would perhaps embrace something historic in medicine. To some this may appear as an innovation, and a tendency to the conversion of our time honored association into an historic club.

Some time ago, I was much interested in reading some of Dr. Oliver Wendell Holmes, medical essays and noted the strong vigorous manner in which he asserted his opinion in reference to any medical question, and especially, on the contagiousness of puerperal fever. A generation ago, he would be remembered as a lecturer on anatomy, physiology, microscopy and other medical subjects. By this generation he is remembered more by his literary ability. But in his early days he was a practitioner and teacher of medicine first, and exercised these literary gifts, which have made his name famous, as second to his great calling. In his early days, as a practitioner and teacher, he supplemented his income by frequent lectures, at night, often going many miles in the country and returning in the small hours of the morning. This he told me robbed him of his sleep and it grew tiresome, so he took to writing which was much more pleasant and agreeable and paid him better.

He continued to lecture on anatomy from his appointment till 1882, when owing to advancing years, and health more or less broken up by asthma (his old *bête noir*) and bronchitis, he resigned his chair. Besides anatomy he lectured on physiology, microscopy and histology, and when once questioned as to what chair he occupied in the medical college he humorously replied, he occupied a settee.

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\* An Address delivered May 9th, before the London Medical Association at its rooms, in the Y.M.C.A. Building.

He was, as every reader of his works would expect, an entertaining lecturer. As England's great Chancellor of the Exchequer could take the dry details and figures of his budget speech and present them in such a manner as to entertain and interest his auditors for hours, so Oliver W. Holmes, presented to the anatomy class the driest of subjects, anatomy, in such a manner as not only to make it instructive and entertaining, but, added to this, a facility of remembrance.

Of Puritan stock—of strong moral character, as well as strong convictions, it is not surprising he broke away to a certain extent from the religious influences and the dogmatic teaching of the old Puritans. His mind was cast in a more liberal mould. In all matters of conscientious convictions in reference to his professional duties and professional responsibilities, he brought all the faculties of a well trained mind to defend his position. The profession, yea the world, is indebted to him for the strong and ever combative way in which he assailed the leading medical lights, who sought to put the hands of the clock backwards and to belittle the investigations, researches and opinions of Dr. Holmes on the contagiousness of puerperal fever. I refer to Dr. Meigs and Dr. Hodge two of the greatest obstetricians of the day and professors in the great schools of Philadelphia, Dr Hodge, Professor of Obstetrics in the University of Pennsylvania and Dr. Meigs of Obstetrics and diseases of women and children, in Jefferson Medical College; men known to the present generation by their writings and works. Being professors in these great schools, they spoke with authority, and took ground against the doctrine of the contagiousness of puerperal fever maintained by Holmes, in an able paper in 1834. This paper had its origin in a discussion that arose in a medical association like our own, concerning the death of a medical man, who made a postmortem examination, of the body of a patient who died of puerperal fever and who himself became infected and died within a week, but who had in the meantime attended several women in confinement, all of whom were attacked by puerperal fever. At a subsequent meeting the paper appeared, but not until Dr. Holmes had collected a large amount of information, by looking up records, and by enquiries from leading practitioners at home and abroad, as evidence concerning the view he held on the contagiousness of puerperal fever.

The introductory lecture of Dr. Hodge, in October 1852 was on the noncontagious character of puerperal fever. Let me give you a quotation from it, "The result of the whole discussion will, I trust, serve not only to exalt your views of the value and dignity of our profession, but to divest your minds of the overpowering dread that you can ever

become especially to women, under the extremely interesting circumstances of gestation and parturition, the minister of evil; that you can ever convey, in any possible manner, a horrible virus, so destructive in its effects, and so mysterious in its operations as that attributed to puerperal fever." *Prof. Hodge, 1852.*

Professor Meigs in the same year 1852 said "I prefer to attribute them to accident or Providence, of which I can form a conception, rather than a contagion of which I cannot form any clear idea, at least as to this particular malady." And then in 1854 reasserting the same opinion and belief, sowing the seed to a large class of students of what we now know would be highly criminal in any great teacher in medicine.

In Dr. Ramsbotham's *Obstetric Medicine and Surgery*, 2nd. edition 1844 in reference to this subject he says "The best paper in any language with which I am acquainted written to prove the highly contagious nature of puerperal peritonitis is by Dr. Oliver Holmes, and published in the *New England quarterly Journal of Medicine and Surgery*. Boston, April 1842. It is a masterly performance and well worth perusal by any sceptics on the subject.

An expression of opinion like this from one of the leading Obstetricians of England at that day, ought to furnish food for the two leading teachers of the art, in the great medical schools of Philadelphia, Drs. Meigs and Hodge. Personally affable and courteous, Dr. Holmes would not bring his great power of satire and invective into action except where great principles were involved, and doctrines were to be defended. He had no use for negative evidence, where human life was at stake. "Children that walk in calico, before open fires are not always burned to death; the instance to the contrary may be worth recording; but by no means, if they are to be used as arguments against woollen frocks and high fenders." The smooth satire of that sentence, is more powerful than pages of argument.

Then listen to his pleading on behalf of the poor woman exposed to the hidden danger." "The woman about to become a mother, or with her new born infant upon her bosom should be the subject of trembling care and sympathy wherever she bears her tender burden, or stretches her aching limbs. The very outcast of the street has pity on her sister in degradation when the seal of promised maternity is impressed upon her. The remorseless vengeance of the law, brought down upon its victim, by a machinery as sure as destiny, is arrested in its fall at a word which reveals her transient claim for mercy. The solemn prayer of the liturgy singles out her sorrows from the multiplied trials of life to

plead for her in the hour of peril. God forbid that any member of the profession to which she trusts her life, doubly precious at that eventful period, should hazard it negligently, unadvisedly, or selfishly."

When Dr. Meigs, however used disparaging language, and sought thus to dispose of Dr. Holmes claim to be listened to; he spoke of "the very young gentleman" "the jejune and fizenless dreaming of sophomore writers" etc. If Dr. Holmes had chosen to use his weapons of invective and irony Dr. Meigs would have gone down before his spear and lance. He however replied with gentle satire. "One unpalatable expression" he says "I suppose the laws of construction oblige me to appropriate to myself, as many rewards for a certain amount of labor bestowed on the investigation of a very important question of evidence and a statement of my own practical conclusions. I take no offence, and attempt no retort. No man makes a quarrel with me over the counterpane, that covers a mother with her new born infant at her breast. There is no epithet in the vocabulary of slight and sarcasum that can reach my personal sensibilities in such a controversy. Only just so far as a disrespectful phrase may turn the student aside from the examination of the evidence, by discrediting or dishonoring the witness, does it call for any word of notice"

Then referring to the many testimonials of his essay at home and abroad, and the compendious eulogy of Ramsbotham "as being all that self love could ask," he says, "These testimonies half forgotten, until this circumstance recalled them, are dragged into the light, not in a paroxysm of vanity, but to show there may be food for thought in the small pamphlet, which the Philadelphia Teacher treats so lightly." "They were at least unsought for, and would never have been proclaimed but for the sake of securing the privilege of a decent and unprejudiced hearing," and "if there is any appetite for facts so craving as to be yet unappeased. more can be obtained." "Why a grand jury should not bring in a bill against a physician, who switches off a score of women one after another along the private track, when he knows there is a black gulf at the end of it, down which they are to plunge, while the great highway is clear, is more than I can answer."

A few of these extracts reveal the smoothness and vigor of his pen in his young days, which was more or less characteristic of his writings down to the last. Crossing the ocean in 1833 an obscure medical student to pursue his studies abroad, was somewhat different from his second crossing in 1886. Then 77 years of age the Autocrat of the Breakfast Table was known by name and reputation wherever the English language was spoken. What a contrast and change in the

world's history and progress spanned by these 53 years. The only railroad in England was from Manchester to Liverpool. The locomotion was entirely by stage coach, with this compensation, that one could better take in the charms of English scenery from the top of the coach in those days travelling 10 or 12 miles an hour, than from the window of a railway train travelling 50 or 60 miles an hour as at the present time. In his reminiscences of the journey made in 1886, he gave expression to the intense pleasure produced by the revisiting of the scenes of his early manhood; he dilates on the fascination of Edinburgh, the singular beauties of that modern Athens, the home, for a time, of Scott and the oft repeated visits of Burns. Here he was the guest of Professor Brown, a near relative of Dr. John Brown, whose son dined with him and the hand of whose sister he had the pleasure of grasping. To one of Oliver Wendell Holmes' lovable nature this was the next best thing, now that he has gone, to greeting the author of "Rab and his friends," himself.

Everywhere Dr. Holmes was received with unbounded enthusiasm. The two great English universities, Oxford and Cambridge bestowed the honorary degree of LL D. on him and the great Scotch University of Edinburgh the degree of D. C. L. The convocations were noisy, like some of ours; some voices cried "speech, speech." "Did he come in the "One Horse Shay?" At Cambridge in combination-room, St. John's College, where Dr. Holmes breakfasted with about 50 gentlemen, one of the gentlemen read a poem, a few verses of greeting to Dr. Holmes, the last verse of which was:

"On us, O son of England's greatest daughter,  
A kindly word from heart and tongue bestow,  
Then chase the sunsets o'er the western water,  
And bear our blessings with you as you go."

Honors fell thick and fast on our professional brother, and such as come to few in a life time. One perpetual round of entertainment and social engagements, from the time he landed until he bade adieu to Old England; breakfasts, luncheons, dinners, teas, receptions, etc. As he quaintly puts it, our arrival pulled the strings of the social shower bath. Before he quite recovered from the fatigue of the voyage, he received his "baptism of fire" in that long conflict of social functions, at Lady Harcourt's where he dined with 20 celebrities, following which was a grand reception. At some social function or other he met the celebrities of England. Royal personages, poets, philosophers, scientists, statesmen, dramatists, artists, church dignitaries, and the celebrated members of our own profession; all delighted to do honor to the author of the "Breakfast Table" series.

Sir Henry Thomson, just lately passed away, great artist, more than amateur astronomer, but greatest as a genito-urinary surgeon entertained him at dinner, where he met Gladstone and Browning. He spent about a week in that charming part of England, the Stratford-on-Avon district, visiting Great Malvern and from the top of which, about 1000 feet in height, you get a great view of English scenery, tracing the windings of the Avon. Here he met the late Lawson Tait, and it was shortly after he had 139 consecutive cases of abdominal section without a death. In the land of Shakespeare and in the immediate neighborhood of his youthful wanderings, this thought came to Dr. Holmes: "Which would give the most satisfaction to a thoroughly humane and unselfish being of cultivated intelligence and lively sensibilities; to have written all the plays which Shakespeare has left as an inheritance for mankind, or to have snatched from the jaws of death, more than a hundred fellow creatures." Such a self-proposed question unfolds to us the altruistic nature of the man, and the exalted views he had of the sacredness of human life and creates a great admiration of his impassionate appeal on behalf of woman approaching maternity.

Dr. Holmes belonged to a famous coterie of New England writers of whom he was "the last leaf" on the old tree. In reference to that poem He says, "When, in my exulting immaturity, I wrote the lines not unknown to the reading public under the name of "The last leaf" I spoke of the possibility that I myself might linger on the old bough, until the buds and blossoms, of a new spring were opening and spreading all around me" Let me quote one verse :

"And if I should live to be,  
The last leaf upon the tree.  
In the spring,  
Let them smile as I do now,  
At the old forsaken bough,  
Where I cling."

Emerson, Lowell, Longfellow, Whittier, Holmes—what a quintette! always, as far as I know, warm friends. Whilst the lives of the other four were largely if not wholly devoted to literature, or closely connected with literary pursuits, Holmes practiced, for a time, a laborious profession, taught anatomy, physiology, and allied subjects, for nearly 35 years in Harvard Medical School, at the same time he accomplished the larger part of his literary work. His was a strong personality and so carried one along with him in his writings as to make one feel a personal loss in his death. His writings strengthen the moral fibre of man's being; are perhaps optimistic, but wholesome and eminently character-

istic of a high ideal of manhood. His medical papers were few, full of vigor and indicative of great research and careful preparation. His paper on puerperal fever, should give him a place among the immortals of our profession.

On the 29th of March, 1893, the year before Dr. Holmes died, a medical friend (a namesake of his) and I called on him at his house on Beacon Street. We were guests at the Palmer House, and sent a messenger with a note to Dr. Oliver W. Holmes expressing our desire to call upon him at his convenience. The messenger returned in a short time with a note stating that he would be glad to see us any day after three. We went that day. It was a murky afternoon, with heavy, almost foggy, atmosphere. We gave our cards to the maid, when we were ushered into a small reception room furnished in white. It might be taken for a library (not a working one); table, chairs, wainscotting, little bookcase here and there, all in white, the books within also bound in white, the whole so suggestive and emblematical, on this occasion, of the white flower of a blameless life. The fortunate engagement of the autocrat with a previous caller gave us the opportunity of an observant seat in the cosy *recherche* little reception room. We saw coming down the stairs the caller, a portly dignified gentleman, whom the autocrat afterwards spoke of as the friend of many years.

As the visitor descended the stone steps to the street, the maid closed the door after him and asked us to walk up stairs, at the top of which we were greeted by Dr. Holmes in the most cordial manner, and were taken into his working library. A bright cheerful fire in a large old-fashioned fireplace, with a large easy chair on each side of it, was very inviting that chilly, murky afternoon. The room was in great part filled with books from the floor to the ceiling. On the wall directly opposite to the large bay window a large instantaneous photograph of Dr. Holmes, John Bright and others marching in procession to receive the degree of D.C.L., which Dr. Holmes showed us with no little pride. On each side of the photograph were the two horses that he saw win the Derby—"Plenipotentiary," in 1834, painted by Herring, the celebrated painter of hunting scenes, on the right, and a coloured portrait of "Ormonde," with Archer on his back, 1886, on the left. It was thus just 52 years between his first and second Derby Day. From the intensity and vivacity of his conversation about the Derby, I should judge he was a lover of horse-flesh, but not by any means a sport.

He interrogated my friend, Dr. Holmes, of Chatham, as regards his ancestry and the origin of his name, and gave him some archaeological information about his name that interested us both. The original Saxon



word was Holme, which meant "a meadow surrounded with brooks," the final letter "s," he said, was often added to the English names. He talked much about both journeys to England, especially of the latter, and of the whole-hearted and unbounded hospitality of so many dear English friends, not confined to his *confreres* in the profession of medicine and literature.

He gave us an account of his visit to Lord Tennyson at Farringford, Isle of Wight. He walked about with the poet over his small estate, admired the green sward, rested under overshadowing trees—Lord Tennyson's just pride. Dr. Holmes said with trees, flowers and lawns, as well as the beautiful sleek cattle, I was quite familiar and at home in any conversation about these, so I talked about trees, about cattle and about flowers; but I made a mistake, I should have asked him to recite one of his poems.

I told Dr. Holmes that I had just purchased from Houghton, Mifflin & Co. the library edition of his work, just published. Hoping to secure his autograph I took one of the volumes with me, and left it down in the little white reception room. He had not seen this edition and was anxious to do so, and requested me to bring the book up. I brought up the only volume I took with me, and he seemed disappointed that I had not brought them all, and said it would have given him pleasure to have written in every one. But when I saw that his eyes were somewhat weak and shaded by the green cover it would have been an imposition on kindness to ask his autograph in thirteen volumes. He spent some time in selecting his pen; the one selected had a large natural feather handle.

"You tell your friends that I wrote with my favourite pen mounted in what?" he said. There was silence for a few seconds, the painfulness of which I broke by saying, "in our country we would say that was a turkey cock's feather." "Not so ignoble a bird," with a sort of explosive energy, was the prompt and incisive reply, and indicated the loving patriotism of the man, as well as his exalted appreciation of the emblem of his country. Sitting at his large flat-topped writing table, with his back to the bay window, he wrote in the book. My friend and I, at Dr. Holmes' request drew back the curtains so as to let in as much light as possible, and at the same time we looked out and over the Charles River at the back. It was this outlook that suggested the poem, "My Aviary."

We had discussed our time limit before arriving at the house, and now found we had far exceeded that limit, and got up to leave, but we were so cordially asked to remain longer, and in such a manner as to

make one feel that the four score and four years was not wearied, and that our stay was by no means an intrusion. At every turn of the conversation he manifested quick and lively interest, with now and then a vein of unconscious humor, and at no time manifesting any indications of senility; but rather of vigorous mind, and active non-treacherous memory. He spoke about his asthma and bronchitis; his regular and careful habits. The temperature of the room was always brought up to the same point every day before he rose. He watched the weather vane: if the wind was in the west, he walked east and rode back; if in the east, he walked west and rode back. But the bane of his life at this time was the number that wanted to talk to him either in the cars or on the street. Shaking the warm slight hand we bade him goodbye at the top of the stairs, where he greeted us as we ascended. The memory of that afternoon is still fresh, and lingers with this author of sweet memories as I write this.

Dr. Holmes was born in 1809, in the same year as Gladstone, Tennyson, Lord Houghton, Darwin, Lincoln and Cardinal Newman. He said, "It seems like an honour to have come into the world in such company. Men born in the same year seem to watch each other, especially as the sands of life begin to run low, as we can imagine so many damaged hour glasses to keep an eye on each other. Women, of course, never know who are their contemporaries."

Let us learn a practical lesson, how possible it is by the exercise of due care to prolong our lives. The regulation of habits, the systematic arrangement of work and recreation, and the early and complete discipline of the mind in relation to worry ought to have its reward in the longevity of the members of our profession. Dr. Holmes gave his last lecture on Nov. 28th, 1882, reviewing his 35 years' connection with Harvard Medical School. It "was the occasion of an affecting leave-taking." "It was a delightful address, full of happy sketches of the luminaries of medicine whom he had known," and reminds one somewhat of the late Dr. Watson's leave-taking of his class at King's College, Old London.

He died in his working library where I had the interview with him. "He was sitting in a chair, with his head braced on the arm of another chair and it was thought he would be more comfortable if he could be moved into his favorite arm chair, an old fashioned piece of furniture, with a winged back. Accordingly his son supported him to the big chair, and as the poet sank into it he leaned his head on one of the side rests and said "That is better, thank you." This was his last utterance.

A writer of his obituary said " He continued writing to the end and neither age, nor infirmity, nor bereavement, could dim the brightness of his spiritual outlook, or stiffen his joints." " He retained his cheery optimism to the last, and obeyed the summons for which he had long held himself in readiness, writing *Finis* in his book of life, probably with a sign of relief." " To few men can it have been given to lead a life so completely in accordance with his tastes, as was the life of Dr. Oliver Wendell Holmes. He never felt the bitterness of the struggle for bread ; he was most happy in his family relations ; he had troops of friends among the most distinguished of their times ; he was beloved by thousands, who had never seen his face or heard his voice. To him more perhaps than to any other writer, the fairy god mother of literature, of Macaulay's exquisite lines might have said ; " And if for some I keep a nobler place, I keep for none a happier than for thee."

Ellwood Place, London.

### HISTORY OF A CASE OF INTESTINAL PERFORATION IN TYPHOID. OPERATION, AND DEATH THIRTY-ONE DAYS AFTER OPERATION FROM ABSCESS OF THE PELVIS.\*

By NEIL J. MACLEAN, M. D., Winnipeg, Man.

MR. PRESIDENT AND GENTLEMEN,—The case that I have been asked to report to this society is one of perforation of the bowel during an attack of typhoid fever and which presents several points of interest.

The patient was a school boy, nine years old, whom I first saw on September 17th, presenting the usual symptoms of the onset of an attack of enteric fever. The disease ran a favorable course, the temperature ranging between 100 and 102.5 degrees F., the only complication being a slight tympanites. At 5 a.m. on the morning of October 5th, the nurse reported that the patient had been suddenly seized with a severe pain in the abdomen and that he cried out to her that he was dying. A sudden and serious change had come over the patient in a very short space of time. He was restless, and the face had an anxious, pinched expression. The pulse, which previously had not exceeded 100 beats per minute, was now 120. The abdominal wall was extremely rigid. I diagnosed intestinal perforation and called Dr. Blanchard in consultation. Operation was decided upon and performed at 12 a.m., seven hours after the perforation had occurred.

The operation lasted one hour and was performed as follows : An oblique incision four inches long was made external to the right semi-lunar line. Free gas and dirty fluid was found on opening the peritoneal

\* Read before the Manitoba Medical Society, December, 1903.

cavity. The Ilio-caecal junction was found and drawn out of the abdomen. Immediately a perforation was found two or three lines in diameter and about two inches from the caecum. This was inverted and closed with three or four Lambert sutures. A second perforation was found a few inches from the first and treated similarly. Two other thin and discolored spots were found, apparently in the preperforative stage and these were buried in the wall of the intestine by a few Lambert stitches. The ilium having been explored for several feet from the caecum for further perforation and none being observed the remaining bowel was drawn outside the abdomen and washed by a constant stream of warm normal saline solution and wrapped in warm towels. The abdominal and pelvic cavities were next flushed and sponged with the saline solution, the bowel returned within the abdomen a glass drainage tube inserted into the bottom of the pelvis and out of the lower angle of the wound and the upper part of the wound closed.

The case progressed favorably, but developed a parotiditis which suppurated and was drained on October 18th. The temperature, however, continued between 99 and 100 degrees and patient died November 5th.

*Post mortem.*—A small collection of pus, partly walled off by a slight exudate, was found in the pelvis. The sutured ulcers were well healed. No fresh perforations found.

*Three points of interest.*—1. The development of a suppurating parotiditis after the operation. 2. Pus in the pelvis. This may have developed slowly from the original infection of the peritoneum or from a secondary infection. 3. The absence of exudate, only the slightest amount being found about the abscess. This is said to be peculiar in typhoid.

#### NOTES FROM THE LITERATURE.

*Senn's Practical Surgery.*—Kussmaul was the first to perform laparotomy, excise, and suture a perforating typhoid ulcer. The operation was performed October, 1885. Lucke reports a case in which he performed laparotomy for the same indication October 22nd, 1885. A large perforation was found excised and the edges sutured. The patient died in seven hours. In the following three years the operation was performed by Bontecou, Bartlett, and T. G. Morton with no recoveries. The first successful result was obtained by Van Hook. J. Price has recently reported three consecutive operations with as many recoveries, a surgical feat which it will be difficult to duplicate.

Treatment of the perforation would be in the following order according to the condition of the patient and the condition of the bowel.

First, suture; second, excision; third, artificial anus (Greig Smith Abdominal Surgery). The last of these indications would now apparently become first according to recent reports from the Johns Hopkins Hospital and reports from the Vienna Clinic recommend leaving the perforation open as a natural drain.

The Year Book of Medicine and Surgery for 1903 records two cases. One of suture, lavage and closure of the abdomen without drainage, recovery; and one with suture of the perforation and drainage of the abdomen during the course of a severe attack of typhoid with recovery.

Keen (Surgical Complications and Sequela of Typhoid Fever) gives the following interesting statistics, tabulated by Fitz:—

*Frequency of Perforation.* In 4,680 cases, 6.58 per cent.

*Age at which Perforation Occurs.* The largest number in 192 cases occurred between the ages of 20 and 30 years, 77, or 39.8 per cent., and less as you ascend or descend the scale of life.

As this is nearly in direct ratio to the number of cases afflicted with typhoid at this age we cannot infer from this that a patient would be more predisposed to perforation at one age than at another.

*Date of Occurrence of Perforation.* The largest percentage (24.8 per cent. in 193 cases) occurred during the third week. Four occurred during the first week and one as late as the 16th week.

*Seat of Perforation.* (167 cases, Fitz).

Ilium, 81.4 per cent.

Large intestine, 12.9 per cent.

The Appendix Vermiformis, Meckel's Diverticulum, and the Jejunum were also found perforated.

*Number of Perforations.* One hundred and sixty-seven cases

Usually one, but 25 to 30 were found in two cases.

Perforation does not bear any direct ratio to the gravity of the attack. "In about one fourth of 2,000 cases the course of the disease was distinctly stated to be mild." (Fitz).

One point of interest in the diagnosis of perforation, but which may be present from other complications, viz., a leucocytosis. According to Thayer there is no increase in the proportion of W. B. cells during typhoid, but rather a slight diminution. Cabot, however, found a leucocytosis in four uncomplicated cases. A leucocytosis may be present from complications, other than perforation, as phlebitis, otitis media and abscess.

# CURRENT MEDICAL LITERATURE

## MEDICINE.

Under the charge of A. J. MACKENZIE, B.A., M.B., Toronto.

### EXODIN, A NEW PURGATIVE.

**I**n the *New England Medical Monthly*, there is a report taken from the Gottingen Medical Clinic by Ebstein on 'Exodin' the diacetyl rufigallic—acid—tetramethyl ether, a yellow powder melting at 180° to 190° C, odorless, tasteless, insoluble in water and with difficulty dissolved in alcohol.

It forms a useful and agreeable evacuant in doses of 7½ grains, active in 8 to 12 hours, without nausea or eructations, causing two to four movements which are unattended by straining. From an extended experience Ebstein recommends it strongly as being free from any of the objections which attach to many of the newer as well as of the older purgatives.

### THE OATS CURE IN SEVERE CASES OF DIABETES MELLITUS.

The *Postgraduate* for May, reproduces an article from the *Berliner Klinische Wochenschrift*, by Von Noorden on a new dietetic treatment of Diabetes Mellitus. It is pretty well conceded that a diet freed entirely from carbo-hydrates is unsuitable in most cases of this disease, but the writer found in the 100 cases treated, that there were very marked individual variations, which made it difficult to formulate laws for treatment, and which perhaps accounts for the fact that many forms of diet have been rewarded by success in one case though it could never be repeated in others.

The oats are prepared by boiling in water for a considerable length of time with a little salt and while boiling some egg-albumin is added; an average daily dose at the beginning would be 250 gm. oats, 100 gm. albumin, 300 gm. butter in the form of a soup, given every two hours, and the diet was completed by a little brandy, wine or strong coffee.

Case reports are given—one in which the sugar secretion in spite of ordinary diet precautions reached 50 gm. per day, with acetone values between 1½ and 2 gm. In this case by the third day of the oats diet

sugar was diminished and disappeared, return to ordinary diet showed temporary reappearance of sugar, but it disappeared permanently in a month. The patient was dismissed upon the following diet, which may be useful:—

Breakfast: Tea or coffee, 50 cc. of cream, 2 eggs in various forms.

Second breakfast: A cup of oatmeal, 20 gm. of the material prepared with 30 gm. of butter, 50 gm. of bacon and two yolks of egg.

Mid-day meal: No soup, 120 gm. prepared meats, plenty of green vegetables and salad, 50 gm. of potatoes, 25 gm. of cheese, coffee with two tablespoonfuls of cream.

Afternoon luncheon: Tea with two tablespoonfuls of cream, two yolks of egg.

At night: 80 gm. of prepared meat, plenty of green vegetables and salad dressed with oil, 50 gm. of potatoes, 25 gm. of cheese, butter

Every day Bodemann's acated bread (gluten free from carbo-hydrates) and 100 gm. of "desaccharated fruit."

Every five days of this diet is to be followed by a "vegetable day." A daily ration of three-quarters of a bottle of light wine is permissible.

Ten cases out of the 100 are as favorable as this, which report from such a famous dietician makes the treatment well worth a trial.

Other cases are given in which the results were not so successful, one which was improved by occasional 'vegetable' days when as much as 150 gm. of starch were given. No reason is adduced for the results obtained, but it is noted that in all cases taking the oats cure the nitrogen values of the urine decreased very markedly, proving a notable ingestion of albumen and explaining the increase in weight and strength that accompanied the treatment.

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#### GERMS IN DRINKING WATER.

In the *Journal of the American Medical Association*, April 9th, 1904, there is an article by Dr. Vaughan, of Ann Arbor, which summarizes researches in this subject since 1888, as follows:—

(1) Of 709 samples of drinking water sent by health officers and other physicians to the hygienic laboratory of the University of Michigan between Oct. 1, 1888, and Dec. 31, 1903, 213, or 30 per cent. contained toxicogenic germs.

(2) Ten samples, or 1.4 per cent., contained no bacteria capable of growth at 38 C. Of these 10 samples, 4 were from deep springs, and 6 from the great lakes—4 from Lake Superior and 2 from Lake Huron.

(3) Waters that contain no germs capable of growth at 38 C. or higher could not cause disease.

(4) Waters that contain no toxicogenic germs are not condemned.

(5) Waters that contain as their only toxicogenic organism a typical colon bacillus are not condemned. By a typical colon bacillus we mean one which is non-motile, produces indol abundantly, produces acid in milk, coagulates milk within twenty-four hours, and evolves more or less gas from glucose and lactose cultures.

(6) Waters which contain as their only toxicogenic organism a typical proteus bacillus are not condemned. It must be remembered that other germs can not be excluded until after repeated plating of the cultures made from the heart's blood fails to show their presence.

(7) Waters that contain any member of the venenosus group or any such germ as we have marked doubtful in the table given are condemned.

(8) I have never found in drinking water a germ that responded to the Widal test.

(9) Sixteen years of experience with the bacteriological method of water analysis convinces me that the results given by it are in the majority of instances trustworthy.

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#### ON A BACILLUS ISOLATED FROM WATER AND AGGLUTINATED BY HIGH DILUTIONS OF TYPHOID SERUM.

In the May issue of the *Journal of Medical Research* there is a contribution by Oskar Klotz, McGill University, describing a bacillus isolated from tap-water obtained in the township of St. Henri, and also from the region of a supposed pollution in the St. Lawrence. An examination showed that this bacillus, which he named as *B. perturbans*, bears a very marked resemblance to *B. typhosus* in size, morphology, staining reaction, growth on gelatine, agar and blood-serum, non-liquefaction of gelatine, etc., but differing in motility, growth on potato, formation of gas, etc. The agglutinating tests (*i.e.*, by human typhoid serum) showed an agglutination in dilution of 1 in 1550.

Tests with serum from rabbits, immunized with *B. perturbans*, showed differences from *B. typhosus* in the time of reaction.

On the whole, one would conclude that even where a positive result is obtained with relatively high dilutions of typhoid serum, it is unwise, not to say mistaken, to regard the reaction as absolutely specific.

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#### PHYSICAL SIGNS OF PLEURAL EFFUSION.

In the *Journal of the American Medical Association*, May 28th, Professor Bridges discusses this subject, and calls attention to some of the more important ones, as follows:—



On inspecting the normal chest in others than the obese, it will be noticed that when the persons observed speak short words or syllables there is a distinct elevation of the intercostal spaces, seen most distinctly in the lower and wider spaces. If there is effusion bulging the spaces, this sign should be more plain, whereas in a solid tumor or consolidation of the lung it would not be so.

Litten's test is made by having the patient lie down with feet toward the light, sidelight being excluded, when it may be noticed that with each deep act of inspiration a narrow shadow, starting at the anterior axillary and seventh rib, descends obliquely forward to cross the seventh, eighth, and ninth ribs, and to recede with less distinctness during expiration, caused by the receding of the diaphragm from the chest wall. This is obliterated in case of effusion.

Heart displacement away from the affected side, vocal fremitus, percussion, and auscultation are also mentioned.

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## SURGERY.

Under the charge of H. A. BEATTY, M.D., M.R.C.S., Eng.  
Chief Surgeon Canadian Pacific Railway, Ontario Division; Surgeon Toronto Western Hospital.

### THE TREATMENT OF APPENDICITIS.

At the last meeting of the American Medical Association, at New Orleans, Ochsner, of Chicago, gave twelve rules for the treatment of appendicitis. These rules have received much praise, and are well worthy of careful consideration. They are as follows:—

1. The mortality in appendicitis results from the extension of infection from the appendix to the peritoneum or from metastatic infection from the same source.

2. This extension can be prevented by removing the appendix while the infectious material is still confined to this organ.

3. The distribution or extension of the infection is accomplished by the peristaltic action of the small intestines.

4. It is also accomplished by operation after the infectious material has extended beyond the appendix and before it has become circumscribed.

5. Peristalsis of the small intestine can be inhibited by prohibiting the use of every form of nourishment and cathartics by mouth and by employing gastric lavage in order to remove any substances of food or mucus from the stomach.

6. The patient can safely be nourished during the necessary period of time by means of nutrient enemata. Large enemata should never be

given, for they may cause the rupture of an abscess into the peritoneal cavity.

7. In case neither food nor cathartics are given from the beginning of the attack of acute appendicitis, and gastric lavage is employed, the mortality is reduced to an extremely low percentage.

8. In cases which have received some form of food and cathartics during the early portion of the attack, and are consequently suffering from a beginning diffuse peritonitis when they come under treatment, the mortality will be less than 4 per cent. if peristalsis is inhibited by the use of gastric lavage and the absolute prohibition of all forms of nourishment and cathartics by mouth.

9. In this manner very dangerous cases of acute appendicitis may be changed into relatively harmless cases of chronic appendicitis.

10. In my personal experience no case of acute appendicitis has died in which absolutely no food of any kind and no cathartics were given by mouth from the beginning of the attack.

11. The mortality following operations for chronic appendicitis is exceedingly low.

12. Were peristalsis inhibited in every case of acute appendicitis by the methods described above, absolute prohibition of food and cathartics by mouth and use of gastric lavage, appendectomy during any portion of the attack could be accomplished with much greater ease to the operator and correspondingly greater safety to the patient.

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#### SURGICAL OBSERVATIONS IN THE PHILIPPINES.

In the *Journal of the American Medical Association*, April, Surgeon-Major Bannister, U. S. Army, gives a review of the past year's work at the First Reserve Hospital, Manila. From the statistics of operations, the work accomplished seems to have been of a very creditable character. Bannister gives the following conclusions:—

(1) Aseptic results will just as surely follow aseptic methods in the Philippines as in America or Europe.

(2) Should septic infection occur in any clean case subjected to operation in the Philippines, the technic, not the climate, must be blamed.

(3) Successful attainment of the object for which operation has been undertaken will follow careful and skillful surgery in the Philippines with the same regularity as in America.

(4) Convalescence after surgical operations in the Philippines is rapid and satisfactory when such operations have been carefully and skillfully performed.

(5) The danger of mortality after a skillfully performed surgical operation, in which case all the details of a rigid aseptic technic have been carried out, is not increased by the influences of the Philippines unless the patient is, at the same time, the victim of some other serious disease.

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## GYNAECOLOGY

Under the charge of S. M. HAY, M.D., C.M., Gynaecologist, Toronto Western Hospital; Consulting Surgeon Toronto Orthopedic Hospital.

### UNSETTLED QUESTIONS IN ABDOMINAL SURGERY.

The above subject is very ably dealt with in the May Number of the *American Journal of Obstetrics and Diseases of Women and Children*, by Dr. John G. Clark, of Philadelphia.

Operative Gynaecology has been developed in the last twenty-five years from a very narrow field to one of the most perfect of specialties, when reviewed from the general standards of accuracy of diagnosis, perfection of operative technic, and splendid curative results.

When the abdominal cavity has been opened—for example for the removal of a diseased ovary—a systematic examination of the contents of the abdomen should be made. In this examination of the abdomen, a topographical cycle, having as its center the umbilicus, may be described which will touch the organs of the abdomen most frequently the seat of surgical diseases. Beginning with the uterus and sweeping outwards, the tube and ovary and the pelvic portion of the ureter are examined, then the appendix, the cecum, the ascending colon, the right kidney, the gall-bladder, the liver, then towards the center, the stomach, the pancreas, then sweeping over to the left, the spleen, kidney, and thence downward to the ureter, the descending colon, sigmoid flexure, and back to the left ovary and tube. Within this circle very few surgical conditions are encountered compared with its periphery.

*The Appendix.*—The appendix may quite as easily be removed in the larger majority of cases through the central as through an incision directly over it. In acute appendicitis, especially where drainage may be necessary, it is wiser to make the incision at McBurney's point.

*Gall-Bladder.*—In several cases which have occurred within the last two years this routine examination has yielded positive results, for a considerable number of stones have been removed coincident with other abdominal operations.

*Mobility of Kidney.*—While Dr. Clark's studies have led him to decide in favor of the removal of the appendix as a coincident part of an-

other abdominal operation, and, likewise, in the event of gall-stones being found that they should be removed, he is quite as positive that the mere finding of an undue mobility of the kidney is never an indication for operation, unless unquestionable symptoms point directly to it. In other words, vague neurasthenic or dyspeptic symptoms are never indications for nephrorrhaphy.

*Gastroptosis.*—Without doubt many of the cases which hitherto have been ascribed to reflex causes or, of later time, to movable kidneys, are directly the results of ptosis of the abdominal viscera. In exaggerated ptosis of the transverse colon it may be attached by means of the gastro colonic omentum to a point on the anterior abdominal wall above the umbilicus. If the sigmoid flexure is so greatly prolapsed that it forms an exaggerated malposition in the pelvis, it should be drawn up to more nearly a normal position and fixed to the inner surface of the abdominal wall.

There are certain contra-indications to the employment of the so-called cyclical examination. For example, when the operation in the pelvis has been attended with the evacuation of pus, which, if generally distributed in the peritoneal cavity, might give rise to a peritonitis, this exploration should be omitted. In cases which are in a critical condition at the termination of the operation it should not be made. In cases which are operated upon for a simple condition when the clinical symptoms are clear cut and point definitely to but one condition, it should again be omitted. Good surgical judgment must be our general guide.

First—Should the normal appendix be removed as a coincident part of all pelvic operations? Intelligent patients should be left to decide. In other cases the surgeon will, Dr. Clark believes, consider the patient's best interests by removing the appendix.

Second—Should gall-stones, if discovered in the course of another operation, be removed? In every case, unless the patient's condition is a contra-indication to any further operation, gall-stones, even though they have not produced symptoms, should be removed.

Third—In mobility of the kidney, what set of symptoms are sufficiently pathognomonic of a pathological mobility to indicate nephrorrhaphy? Only in instances when the symptoms very directly point to pathological mobility of the kidney should this organ be suspended as a coincident part of another operation. In his experience the percentage of these cases is not more than one in one hundred and fifty cases.

Fourth—What degree of descensus of the stomach and transverse colon require operative measures for their restoration? If the transverse

colon is situated at the brim of the pelvis and the lower curvature of the stomach is below the umbilicus, this organ should be replaced and held in position by stitching the gastro-colonic omentum in a transverse line across the upper portion of the abdomen.

Fifth—Is there a group of symptoms significant of sigmoiditis? Dr. Clark is, as yet, in some doubt, but believes that the cases of fixed aching pain at the brim of the pelvis associated with obstinate constipation in the absence of pelvic lesion, are strongly significant of this condition.

Sixth—In these cases should sigmoidopexy be performed? Although, as yet, a novel procedure, sigmoidopexy if only performed in the more exaggerated cases, may offer a hope of correcting this dislocation and relieving symptoms.

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### THE IMMEDIATE REPAIR OF LACERATIONS AFTER LABOR

The April number of *Gaillard's Medical Journal* contains an article on the above subject written by Dr. Stricker Coles, of Philadelphia. He says the frequency of lacerations of the pelvic floor and perineum is variously estimated by different authorities, from 5 to 10 per cent. in primiparæ. He thinks this estimate too low. "In each case I deliver, the patient is brought to the edge of the bed and the parts are thoroughly inspected by placing the middle finger in the rectum and bringing forward the posterior vaginal wall. I always go prepared to repair any laceration that may occur."

The time for closing lacerations is immediately after labor, and the author of the paper does this in every case. He does not agree with those who advise waiting for involution, etc., but firmly believes that immediate repair is best. Often, in neglected cases after prolonged labor, the tissue will be swollen and oedematous, and the results will not be good, and a secondary operation may be necessary. The result will be better after immediate closure and a secondary operation than after waiting for involution and allowing the muscles to retract and the parts to lose their normal relationship. The cardinal point in closing lacerations is to have the tissue in direct opposition, bringing muscle to muscle, and fascia to fascia, and mucous membrane to mucous membrane, and skin to skin, and this can only be done, if the muscle is torn across and has retracted, by catching the ends and bringing them together, and when the tissue has not retracted, by passing the needle in a circular direction around the tear so that the needle will not come into view until it comes out on the opposite side, remembering that when the liga-

ture is tied it will form an ovoid, and there will be a pulling in of the tissue and not direct opposition unless the needle is passed circularly.

In closing lacerations of the cervix, always remember that immediately after labor the cervix is much longer than it will be forty-eight hours afterwards, so that the stitches should not be too close together nor too close to the lower edge of the cervix. You should use interrupted chromicized cat-gut sutures.

Lacerations of the anterior vaginal wall often bleed profusely. To close these and stop the hemorrhage, take in a large amount of tissue and be sure not to include or injure the urethra. Slight lacerations on the posterior vaginal wall should be closed by introducing the middle finger into the rectum while the ring and index fingers separate the vulva. The skin part of the tear should be closed with silkworm gut, starting at the anus and coming upward. The results are not perfectly satisfactory in repair of lacerations of the cervix,

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## OPHTHALMOLOGY AND OTOTOLOGY.

Under the charge of G. STERLING RYERSON, M.D., C.M., Professor of Ophthalmology and Otolaryngology, Medical Faculty, University of Toronto.

### THE VITAL IMPORTANCE OF THE DETECTION AND RELIEF OF EYE STRAIN.

Dr. Ambrose L. Ranney, of New York in the *New England Medical Monthly*, deals fully with this important subject. He says in part, the recognition of eye strain as a cause of nervous derangements unquestionably marks one of the most important epochs in medical progress. "I am personally more strongly convinced every year, after a larger experience in the investigation of the eye-factors which exist among neurotic subjects, that a large proportion of the inmates of asylums and epileptic colonies would be at large to-day provided the modern methods of scientific investigation of the eyes of such sufferers were practised upon them by capable ophthalmologists." At least 90 per cent of all typical cases of sick headache, if unassociated with organic disease, owe their attacks to some form of eye defect. In 1897 Ranney published some completely tabulated statistics relating to a series of cases of headache, chorea and epilepsy that were subjected to eye treatment alone. He showed that in twenty-six cases of chronic epilepsy, better results were obtained by eye treatment alone than have ever been reported by any other method of treatment. The results were, absolute cure, seven cases; practical cure, three cases. These patients were cured without recourse to drugs of any kind or any form

of treatment but eye-treatment. The main factor is defective equilibrium of eye muscles called heterophoria. Many cases of nervous prostration, epilepsy, vertigo, etc. are unquestionably due to the incessant struggle on the part of the brain to overcome the embarrassments and perplexities entailed by being improperly balanced. It is always wise to correct any existing refractive errors very accurately with proper glasses. Some of Dr. Ranney's conclusions are eye strain can be a potent factor in disturbing the normal development of both mind and body. Near sightedness causes little or no eye strain. Far sightedness and astigmatism causes an unnatural expenditure of nerve force. Mal adjustment of the eye muscles is a prolific cause of physical and mental ills. A large proportion of eye defects is congenital. No examination without the use of a mydriatic can be considered as final. Without a thorough investigation of refractive anomalies in any patient, all muscular tests are open to suspicion and doubt. The modern methods of testing for anomalies of adjustment by means of instruments of precision are the only reliable ones. The cure of disease to-day is intelligently based on the search for the cause rather than on the indiscriminate administration of drugs

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#### THE USE OF ATROPINE IN OPHTHALMIC PRACTICE.

Aaron Bray, M.D., in the *Therapeutic Gazette*, of 15th April, 1904 has an article on the above subject.

It was in 1833 that Geiger Moin and Hess announced that the action of belladonna on the pupil and accommodation is due to an alkaloid which they named atropium. Atropine is the alkaloid of *atropa belladonna*, a member of the family Solanaceae. It is a yellowish-white, silky, prismatic crystal without smell, having a bitter, acrid taste. It is soluble in 300 parts of water and 25 parts of ether. The salts of atropine are easily soluble in water and are therefore suitable for ophthalmic use. The sulphate is the one most commonly used, 1, as a mydriatic; 2, antiphlogistic; 3, analgesic; 4, iridoplegic, and 5, cycloplegic. A drop of a half per cent. solution dilates the pupil in 20 minutes by paralyzing the terminal filaments of the motor nerves and it has also a stimulating effect upon the sympathetic fibres. Atropine is absorbed and appears in the aqueous humor. One drop of a half per cent. solution is sufficient for mydriatic purposes. Mydriasis is used chiefly for diagnostic purposes. Its antiphlogistic power depends upon the fact that it forces the blood out of the iris vessels into the ciliary vessels and again by contracting the iris and paralyzing its motor function, giving it absolute rest. It is also analgesic, diminishing or abolishing pain.

Total paralysis of accommodation is the cycloplegic effect of atropine. This is accomplished by its action on the ciliary nerves, requiring about two hours for the purpose. Its effect does not wholly wear off in less than twelve days. In the estimation of errors of refraction atropine is of great value, also in deep seated diseases of the eye.

The effect of atropine on intraocular pressure is a subject still under dispute. By some it is claimed that it increases intraocular tension, and by others that it has little or no effect.

Indications for the use of atropine.—In correcting errors of refraction in persons under forty years of age unless there is a contra-indication for its use, such as glaucoma, lactation or pregnancy, atropine is a useful agent. Homatropine is to be preferred as it does not incapacitate the patient for so long a time. In the spasm of myopia, in diagnosing posterior synechia, in various inflammatory conditions, keratitis, iritis, in ulcers of the cornea, in diseases of the choroid and retina, in diseases of the sclera, uveal tract, atropine is of inestimable value.

Contra-indications to the use of atropine.—1. Glaucoma and in all conditions in which there is increased intra-ocular tension. 2. In people over forty years of age for correction of errors of refraction. 3. In cyclitis it will increase the pain. 4. In ulcers of the cornea with impending perforation, atropine should be used with the greatest care. In the employment of atropine in children care should be used as many of them show a marked toxic idiosyncrasy. While using atropine the following points should be borne in mind: The preparation should not be contaminated nor too strong; the lacrymal punctum should be compressed; the solution should be aseptized by the addition of a fraction of bi-chloride; not more than three drops should be instilled at a time.

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## LARYNGOLOGY AND RHINOLOGY.

Under the charge of PERRY G. GOLDSMITH, M.D., Belleville. Fellow of the British Laryngological, Rhinological and Otolological Society.

### NATURE, CAUSES AND TREATMENT OF NASAL POLYPI.

P. Jacques, *Revue. hebdomadaire de Laryngologie*, after an extensive discussion of the pathological histology, draws the following conclusions: Nasal polypi are not of the myxomatous type of tumors. They must be considered as localized œdematous hypertrophies, inflammatory or not of the pituitary membrane. They are not neoplasms of foetal connective tissue type, but the production of irritation of hypertrophied nature with a tendency to œdematous infiltration.



Predisposing causes: Age, sex, profession, manner of life, climate. Polypi have been repeatedly seen before the age of seven (they are very rare in children). There undoubtedly exists a hereditary transmissibility of the tendency to nasal polypi.

Actual causes: (a) Anatomical—(1) Abnormal narrowness of the nasal fossae, forcing the patient to repeated physiological efforts. (2) Abrupt bending of the vessels of the ethmoidal membrane at the level of the bone, predisposing to stasis and œdema.

(b) (1) Foreign bodies, local traumatism attacking primarily the bone, necrosing ethmoiditis and rarefying ethmoiditis attacking primarily the membrane (1) Simple chronic catarrh, (2) local specific infection, (3) neighboring suppurations.

Nervous causes: (1) Spasmodic rhinitis-hydrorrhœa. (2) Hysteria

#### ADENOIDS: THEIR SYMPTOMS, RELATIONS THEY SUSTAIN TO ACQUIRED DEAFMUTISM AND TREATMENT.

B. L. Floyd *Cin. Lan. Clin.* In considering the bad effects of adenoids in children the author expresses his belief that this condition is the most frequent cause of deaf-mutism. He thinks a special board of otologists should examine all deaf-mutes and when required the condition producing the deaf-mutism should be removed.

#### REFLEX APNŒA AND CARDIAC INHIBITION IN OPERATIONS ON THE RESPIRATORY TRACT.

William Harmar Good and W. G. B. Harland (Philadelphia). Based especially on observations during adenoid operations and during intubation, in which cases of instant death are now on record, they conclude that the origin of reflex apnœa and cardiac inhibition is through the medulla by irritation of trifacial and sensory branches of the vagus; that inhibition may be caused by irritation of the mucosa of the nose, rhinopharynx, and lungs; that obstruction to respiration is indicated by cyanosis and full pulse, while reflex inhibition produces pallor and slow, weak pulse. Reflex inhibition differs from syncope in not causing distention of blood vessels. Carbon dioxid starts respiration, and the consequent inflation of the lungs removes cardiac inhibition. In the prevention of inhibition care must be directed to the proper use of anaesthetics, both local and general; atropin may be employed effectively.

When the condition occurs, stop operation and use with vigor and persistence the usual methods for resuscitation, particularly tongue traction, lung inflation, and position of patient.—From *American Medicine*.

### TONSILLECTOMY BY FORCEPS AND SNARE, THOROUGH, PAINLESS AND SAFE.

E. Fletcher Ingals (Chicago) states that the operation here proposed although practised for years and justifying the above title, is not generally familiar to physicians. In addition to an exhibition and description of instruments with a clear demonstration as to the manner of employment, he dealt at some length on indications and contraindications for tonsillectomy, emphasizing the point that the pathologic condition of the tonsil structure and not its size must be the guide. In most cases the tonsil, not larger than an almond, does not need removal; but even when much smaller, if frequently inflamed, it should be extirpated. Points of advantage claimed for the snare method of removal are: 1. Abnormal distribution of arteries sometimes renders the ordinary tonsillotome dangerous. 2. After freeing adhesions—by an instrument which he devised for that purpose, the clamp forceps holds the tonsil in such position that the snare can be drawn around base, thus insuring complete removal—otherwise the operation would be futile. 3. Bleeding is not so profuse after removal with snare. 4. The snare may be gradually tightened so that the pain is very slight. For children he prefers general anæsthesia. 5. The method is especially recommended for buried tonsils. The paper was freely discussed and generally approved for certain selective cases, by Casselberry, Stucky, Richards, Wood, Donnellan, Pynchon and Freer. Freer exhibited a snare guard he had devised to prevent the wire loop from catching in the forceps.—From *American Medicine*.

### THE SIGNIFICANCE OF TUBERCULOUS DEPOSITS IN THE TONSILS.

George B. Wood (Philadelphia). In an exhaustive study involving much original research, Wood deduced the following points of interest: Tuberculosis of the tonsils occur secondarily in almost every case of advanced pulmonary involvement. It occurs as a primary infection in about 5 per cent. of all hyperplastic, faucial, and pharyngeal tonsils. Tubercle bacilli can probably pass through the tonsillar tissues into the lymphatics without causing any local disease in the tonsil itself, which goes to show how important may be the tonsillar structures as an etiologic factor in the production of tuberculous adenitis of the neck.

While tuberculous adenitis in most cases is not followed by pulmonary tuberculosis, it must be remembered that experimentally the tubercle bacilli, when placed in small doses in any portion of the body, show a predilection for the apices of the lungs. A series of experiments was carried out on pigs, the tonsils of some of which were exhibited.

In the discussion which followed, by Swain, Myles, Pyncheon, Mayer, and others, the author was highly commended for the thorough and painstaking line which he had followed in carrying out this most interesting research.—From *American Medicine*.

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### OPERATIVE TREATMENT OF THE FAUCIAL TONSILS, WITH A VIEW TO PREVENTION OF CERVICAL ADENITIS AND GENERAL INFECTION.

Robert C. Myles (New York) states that while it is generally believed that the faucial tonsils are the usual portals of acute infection of the cervical glands, a point which is either entirely overlooked or at most given scant consideration by the average author, is that there is frequently a hidden chronic septic condition in the bottom of the cysts of the submerged or basic tonsils, which often escape what is considered a complete extirpation. He advises not only the removal of all cryptic tonsils, but further states that approximately complete extirpation of these basic lymphoid masses should be performed in all suspicious cases and the earlier in child-life, the better.

*Discussion.*—Stucky stated that he believed in the radical operation, but not to the extent of removing every particle of tonsillar tissue, since small remnants will atrophy in many cases after the bulk of the tonsil is removed. Pyncheon emphasizes importance of after-treatment in cases where small points or remnants of tonsil may be reduced and depressions developed by "massage," which may help in the development of a smoothly-healed surface. Tidings expressed approval of the plan of tearing loose the adhesions instead of cutting.—From *American Medicine*.

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### HEADACHE AND NASAL DISEASE.

In the *Journal of the American Medical Association* for March 5th, 1904, Robertson calls attention to headache from disturbances of air pressure in the nasal accessory sinuses. Any closure of a natural sinus outlet leads to a diminished intra-sinusal pressure owing to the absorption of oxygen by the blood-vessels of the mucous lining, and as a result the latter swells. Later there may result a serious outpouring into the sinus and an engorgement of its lymph channels.—*The Medical Times and Hospital Gazette*.

## PROVINCE OF QUEBEC NEWS .

Conducted by MALCOLM MacKAY, B.A., M.D., Montreal.

The medical staff for the General Hospital for the season of 1904-5 was announced June 9th, and of the present staff only two, Drs. F. S. Patch and C. W. Anderson, will remain for another year.

Dr. R. P. Campbell, who was formerly attached to the house staff of the hospital, and who is at present in Germany, will succeed Dr. W. G. Turner as medical superintendent. Dr. Turner has left on a visit to England and Germany, and until the arrival of Dr. Campbell, who is expected here next month, Dr. R. C. Patterson, who has been acting medical superintendent of the hospital, will continue in that office.

The new members of the house staff who will commence their duties in September are as follows:—Drs. R. D. Forbes, anaesthetist; J. L. Robinson, J. C. Fyshe, W. G. Ricker, J. A. Nutter, L. L. Reford, H. H. Kerr, H. G. Wood, physicians; Drs. A. C. Rankin and W. E. Ainley, locum tenens.

The Governors of the Royal Victoria Hospital have made the following appointments to the resident medical staff for the year ending August, 1905:—

Admitting officer—Dr. R. King.

Physicians—Drs. R. Hardisty, D. McKechnie, J. C. Meakins, W. A. Lincoln.

Surgeons—Drs. H. Church, F. McKenty, J. Coffin, J. A. Faulkner, D. C. McLachlan: eye and ear, Dr. L. C. Launchland; nose and throat Dr. H. O. Howitt; gynaecologist, Dr. J. Foster; anaesthetist, Dr. F. D. Charman; locum tenens in medicine, Dr. J. E. Gillis; locum tenens in surgery, Dr. J. W. Hutchinson; externe in medicine, Dr. J. R. Rogers.

At the last meeting of the Board of Governors of McGill University, the following appointments were made:—

In the Faculty of Medicine: Dr. R. Tait Mackenzie to be Lecturer in Anatomy; Dr. A. A. Robertson, to be Lecturer in Physiology; Dr. W. G. M. Rogers, to be Lecturer in Ophthalmology; Dr. W. G. Scane, to be Lecturer in Pharmacology and Therapeutics; Mr. J. R. Roebuck, to be Lecturer in Chemistry; Dr. W. S. Morrow, to be Associate Professor of Physiology; Dr. A. G. Nicholls, to be Associate Professor of Pathology and Bacteriology.

In the Faculty of Arts and Science: A. S. Eve, M.A. (Cantab), to be Lecturer in Mathematics.

In the Faculty of Science : Dr. Coker, to be Associate Professor of Engineering.

In the Faculty of Arts : Mr. S. B. Slack, to be Associate Professor of Classics.

At the Montreal Medico-Chirurgical Society, Dr. Birkett presented a case of melanotic sarcoma of the hard and soft palate. Sections from the growth showed the typical formation of a spindle-celled melanotic sarcoma, but nevertheless the growth had been very slow. The case has been under treatment with the x-rays for a short time and showed slight improvement.

Dr. Starkey read a paper on the etiology of infantile diarrhœa. Areas in the city had been mapped out by the professor in which the mortality was abnormally high ; these areas were noticed to have some relation to cesspools and to low-lying districts. An interesting discussion followed, in which Drs. Adams, Evans and Girdwood took part.

Dr. Klotz read a paper on several cases of carcinoma of the bile papilla. In discussing the cases he stated that no record had yet been made of the growth starting in brunner's glands but the sections which he had in his possession undoubtedly showed that these tumours might have this origin.

Dr. Mackay reported a family in which eighteen members had been affected with hereditary chorea in four generations.

At the convention of the American Medico-Psychological Association, recently in session at St. Louis, Dr. T. J. W. Burgess, medical superintendent of the Protestant Hospital for the Insane, Verdun, Que., received the honour of being elected president of the Association for the year 1904-5. The Association held its annual convention in Montreal in 1902, when some two hundred members received the hospitality of the city and the Verdun authorities.

Dr. F. W. Campbell, Dean of Bishop's Medical College, Montreal was recently awarded \$2,500 damages against the Montreal Street Railway Company, for the injuries he sustained last August.

Dr. McKenzie Forbes will be unable to fill the position of resident English doctor at Little Metis this summer, owing to the demands made on his time in connection with the Children's Hospital. The committee have selected in his stead Dr. J. Appleton Nutter, who has just finished his college course with great distinction, to fill the vacancy. Dr. Nutter will remain at the Metis till the middle of September.

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## MANITOBA MEDICAL MATTERS

Conducted by R. H. RICHARDS, M.D., C.M., Winnipeg.

At a recent meeting of the Winnipeg Medical Association, Dr. Amelia Yeomans presented a case of six years morphinism in whom the very strong desire for the drug, after the failure of all the usual methods, gave way to some religious experience, the patient having been cured some six years.

The subject of hospital appointments is a very live one with the profession in Winnipeg as there is only one public hospital in the city, the St. Boniface Hospital having no staff. The Winnipeg General Hospital is the only hospital in Western Canada with any pretense to clinical teaching, and it is to it that we look for the advancement of clinical medicine and surgery. Of the nearly 100 practitioners in Winnipeg, only 17 are on the attending staff of the hospital and, unfortunately, there is an opinion prevalent among the profession that the board of management of the hospital has for some time past allowed social, financial, and political reasons of expediency to rule in their choice rather than the professional enthusiasm and ability of the appointee.

Of course a hospital appointment carries with it a certain amount of prestige, when it is the only hospital in the city it is felt that a position on it is, or most certainly ought to be, the opportunity of professional education and attainment.

Some time ago, a meeting of the alumni of the local medical college made some recommendations to the Hospital with regard to expansion of the staff and better use of the clinical opportunities of the hospital. More recently, one member of the medical staff, who is noted alike for his scientific attainment and public spirit, at a meeting of the staff and board of management, proposed that the appointments be left in the hands of the Winnipeg Medical Society and the Medical Staff of the Hospital. This proposal was severely condemned by some of the staff who believed in holding tight, and so have ended all steps in the line of reform.

The past has been a very satisfactory session at the Manitoba Medical College. There was a graduating class of 18, and about a similar number writing for the license. It will probably be a five year course after this year.

The Sisters of St. Boniface Hospital have under consideration plans for an addition, costing about \$100,000. It is expected that the work of construction will commence soon.

After having been free for nearly a year, Winnipeg was visited by smallpox again. The disease was brought in by some immigrants from Glasgow, Scotland. Eight of them were in the smallpox hospital with a moderately severe type of disease and two cars more of the party were quarantined as "contacts."

Plans are being considered for a new college, as the present structure is quite inadequate. The future of Winnipeg and the west is very promising and it is felt that the Medical College must keep abreast of the times.

The annual report of the Winnipeg General Hospital for 1903 is to hand. Total number of patients treated was 3,354, an increase over last year of 14 per cent.

The report goes on to deplore the lack of accommodation and the necessity of refusing applications for admission.

The outdoor department had 3,483 consultations. This department is about to be enlarged by the Hospital, a step which must be viewed with grave distrust, as tending to encourage a form of hospital abuse so prevalent in other cities.

The total hospital death-rate was  $7\frac{1}{2}$  per cent.

Of the different diseases, first comes typhoid fever, the Winnipeg hospital always having a large number of cases, the past year there being 268 cases, with a mortality of 10 per cent.; scarlet fever 37 cases, mortality 34 per cent.; and diphtheria 133, mortality 7 per cent.

In skimming over the surgical report one notes 993 operations with a mortality of 38. One removal of the Gasserian ganglion is noted, the patient, however, succumbed.

Of prostatectomies, there were only 3, (all *supra pubic.*) with one death.

Hysterectomy was performed 5 times with a mortality of 2.

Quite a number of new men have settled in Winnipeg even since the new year. They must be attracted by some of the large incomes some of the city practitioners are making in real estate.

Dr. Mort McEwen, well known in the city, being a graduate of Manitoba Medical College and a native of Brandon, has resigned the position of house surgeon in Vancouver General Hospital, which position he has held for a number of years, and intends going on an extended tour.

## MEDICAL SOCIETIES AND GATHERINGS

ONTARIO MEDICAL ASSOCIATION, 14TH, 15TH, 16TH JUNE, 1904.

### HYDATIDIFORM MOLE AND ITS RELATION TO CHORION EPITHELIOMA.

Dr. C. J. Hastings, Toronto, took this topic for his paper. The various theories advanced by the earliest writers to explain this condition were briefly considered. Early in the 6th century Amidi taught that each vesicle contained a living embryo. Later, the echinococcus was blamed for the condition. Velpeau first showed the cysts to be distended villi.

Among the causes given for this condition are diseases of the blood vessels, disease of the lymphatics, and degeneration of the mucous in the villi. The whole chorion is usually diseased; sometimes the placenta alone is involved. Marchand demonstrated that it was the epithelial covering of the villi more than the stroma that was affected and that both the syncytium and Langhan's layers of cells underwent profuse and irregular proliferation. The terminal blood vessels disappeared, the stroma degenerated, and the cells necrosed, (the fluid contents is not mucin but serum.)

Symptoms usually manifest themselves before the tenth week. To the usual signs of pregnancy there is added a sudden bloody discharge and a disproportionately large uterus with no evidence of foetal life. Constitutionally, there are anaemia and debility, with pressure symptoms and pain.

The diagnosis is made from the enlarged uterus, the irregular flowings, with the absence of foetal signs. Exploration may be necessary. Twins and threatened abortion must be differentiated.

The treatment is to empty the uterus at once, using the finger or the long-handled ovum forceps to remove the neoplasm. Firm retraction must be secured subsequently.

The vesicles are characteristic; their mode of attachment to the main stem and one to another is by a pedicle. The embryo may or may not be found. Dr. Hastings further pointed out the fact that chorion epithelioma is frequently preceded by hydatidiform mole.

He presented a series of three cases illustrating the condition, and the relationship to deciduoma malignum.

Mr. I. H. Cameron called attention to this condition as illustrating an epithelial growth from the foetus to the mother tissue. He cited a



case of a woman pregnant of an hydatid one year after the menopause followed by abortion and a subsequent deciduoma malignum.

Dr. McIlwraith pointed out that secondary infections in deciduoma malignum frequently disappeared after operation.

#### THE TREATMENT OF APPENDICITIS IN PREGNANCY.

Dr. John Sheahan, St. Catharines, presented a most carefully prepared paper on the treatment of appendicitis in pregnancy. The question as to whether or not the surgeon should interfere in these cases was ably discussed. Until quite recently, non-interference has been the practice; now, however, in acute infective cases pregnancy must be considered no bar to immediate and radical operation.

Dr. Sheahan reported the following case: Mrs. B., aet. 25, primipara, 4 months pregnant, no history of previous appendicular trouble, was seized with sudden severe pain in the hepatic region. The following day the temperature and pulse were normal, and there was also a frequent desire to urinate with pain in the bladder and over the liver. Three days later there was a chill, followed by a temperature of 104, a pulse of 140, respirations 30, and some vomiting. There were pain in hepatic region and tenderness over McBurney's point with but slight rigidity. Two days later, a thickened and inflamed appendix was removed, an uninterrupted recovery following. At the eighth month, premature labor was induced for albuminuria with the birth of a dead child.

A summary of 100 cases, prior to 1899, showed that abortion most frequently followed operation; when pregnancy went to full term the foetal mortality was 50 per cent.

The same causative factors as exists in uncomplicated cases, pregnancy itself only affecting those cases where the appendix hangs over the pelvic brim or where the enlarging uterus separates the adhesions of former attacks, or presses on an appendicular enterolith.

The frequent occurrence of abortion, estimated at 40 per cent. is referred to the intimate vascular connections existing between the appendix and the uterine adnexa. Cases with abscess involving the uterus are most unfortunate as the uterine contractions aid in extension of the pus.

The uterine tumor prevents palpation. The muscles are stretched and the intestines are pushed up. The following points are important: 1. A history of constipation; 2. the sudden onset of acute abdominal pain in right iliac fossa; 3. the localization of the pain over McBurney's point; 4. vomiting; 5. high temperature and rapid pulse; 6. rigidity of right rectus; 7. examination per vagina under anaesthetic is advisable.

Conditions such as right tubal pregnancy, acute salpingitis, cholecystitis, gall-stone colic, and kidney crises must all be carefully differentiated.

In simple catarrhal forms, the prognosis is good without operation; all other cases are favourable if operated on early. Abrahams however says the prognosis is gloomy. He observed 16 cases with 8 deaths and an infant mortality of 66 per cent.

An inflamed appendix is a source of extreme danger and, as its removal is attended by few additional dangers to the mother and foetus, Munde's dictum is, "Treat the case early, regardless of pregnancy." W. Meyer of New York lays down the following rules: 1. Operate within 12 hours in acute perforating appendicitis. 2. A rapid pulse (116 to 120) is an indication for operation. 3. In case of doubt, operation is better than waiting. 4. A sudden lull for ten or twelve hours is an indication for operation. 5. The recurrence of an old appendicitis during pregnancy also demands surgical interference.

Dr. Webster, Toronto, advised operation by the vaginal route in pelvic peritonitis during pregnancy. It entailed less shock to the patient. He reported a case of suppurating appendicitis with pelvic abscess opened by this route with excellent results.

#### ANOMALIES IN FOETAL DEVELOPMENT.

Dr. J. H. Peters, of Hamilton, read a paper on an interesting case of monstrosity, and exhibited the foetus. There was an absence of the abdominal walls, with extrusion of the liver and bowels. There was no indication of genital organs. He regarded the case as belong to the class called celosoma by Dr. Hirst.

Mr. Cameron, Toronto, pointed out that external genital organs being absent merely meant that the testes which in the foetus were abdominal organs had not descended.

#### OCCIPITO-POSTERIOR PRESENTATION.

Dr. Macdonald, Toronto, read a paper on this subject in which he advocated rotation of the head by hand, the patient being anaesthetised. The child's body should be rotated by external manipulation.

Dr. Barrick, Toronto, endorsed the methods of Dr. Macdonald. In cases where the head is out of proportion to the pelvis, how can we use the forceps? The rotation or quarter turn may be impossible when the pelvis is narrow. My treatment is, where the child is viable, perform version as it preserves the mother from injury.

Dr. A. F. McKenzie, Bracebridge, noted the importance of the paper but took issue with Dr. Macdonald's percentage for posterior pre-

sentations. In his experience there were about 20 per cent. of such cases but nature generally rotates them herself. He emphasized the importance of diagnosis; it is not always necessary to insert the hand, external palpation being sufficient, especially if the abdominal walls are thin. In vaginal examinations, if the anterior fontanelle is felt first, the case is generally left occipito-posterior presentation.

Dr. Hastings, Toronto, drew attention to the importance of strict asepsis, and emphasized the usefulness of abdominal palpation as an aid to diagnosis.

Dr. Todd, Toronto, said in his experience the method of introducing the hand and rotating the head was accompanied by a greater mortality to the child.

Dr. Hunter, Parkdale, advised leaving the cases largely alone and not meddling with them. Nature would nearly always correct the position and effect delivery.

Dr. Temple, Toronto, said early anterior rotation forward is always the treatment for posterior presentations. He could see no reason for an increased mortality provided surgical asepsis was maintained.

Dr. McIllwraith, Toronto, thought that leaving these cases to nature for a time and then applying the forceps was a cause of increased mortality. He advised early anterior rotation.

Dr. Ross, Toronto, explained on request of Mr. Cameron, his father's method of treatment in these cases. He passed two fingers in front during a pain and the head rotated itself on them.

Dr. Macdonald, in reply, could see no reason for an increase of mortality by the introduction of the hand. The following points are essential: 1. Choose your time, *i.e.*, before the membrane's rupture, the os being dilated. 2. Fully anaesthetise the patient. 3. Cleanse the parturient canal and your hands, rotating the head the quarter turn; rotate the shoulders by external manipulation. 4. Keep the occiput down and in position until the forceps are on and locked. Then make traction in the correct direction.

#### LORENZ TREATMENT OF CONGENITAL HIP DISLOCATION.

Dr. H. P. H. Galloway, Toronto, exhibited a patient with congenital bilateral dislocation of the hips, treated by the Lorenz bloodless method. He also gave a brief review of the present status of the Lorenz method. The case presented, Dr. Galloway explained, was one of the fortunate ones in which he had been able to secure a perfect result. He showed a number of photographs, illustrating the various stages in the treatment of this patient.

The results gathered from an exhaustive study of reports of cases treated by the Lorenz method may be summarized as follows: Lorenz reports 50 per cent. of unilateral cases cured and 25 per cent. of bilateral cases cured. A report of 94 cases operated on by the Lorenz method gives 10 per cent. cured, 50 to 60 per cent. good results, 20 to 30 per cent. failures. By good results is meant that anterior transposition is accomplished, the head of the bone not being replaced in the acetabulum, but considerable improvement in the gait being effected. By Hoffa's method, which differs slightly from that of Lorenz, 30 per cent. of unilateral cases and 7.7 in bilateral cases are reported cured, with 50 to 60 per cent. anterior transpositions.

The results of the Lorenz American tour are exceedingly disappointing, most cases have relapsed, the conditions not being at all good. Sherman gives the following dangers in the method: (a) Paralysis from injury to the nerves; (b) fractures of the pubic or femur; (c) gangrene of the limb.

It would appear from the study of these statistics that to get one perfect result ten cases must be put up in dressings for six to eight months. This is highly undesirable, as in 60 per cent., a few weeks only are necessary to accomplish anterior transportation. Dr. Galloway pointed out that the great difficulty in reducing the dislocation is the constriction of the capsule which exists between the head and the acetabulum. He advised cutting down anteriorly, slitting this constriction and replacing the head. In conclusion he expressed his opinion that the Lorenz method was fast losing ground.

Dr. B. E. McKenzie, Toronto, said diagnosis of congenital dislocation is usually easy, but to exclude infantile paralysis is sometimes a difficulty. The value of x rays in diagnosis is well illustrated by the excellent photographs presented by Dr. Galloway. Other reasons of failure in reduction are that sometimes the head of the femur is absent or is very small, or there may be no acetabulum or a very small one. The anatomical conditions are such as to render failure inevitable. He reported fifteen cases with three cures.

#### THOUGHTS ON CANCER.

Sir W. H. Hingston, Montreal, read an able paper on the above topic. It appears in this issue.

Moved by Mr. Cameron, Toronto, seconded by Dr. Harrison, Selkirk, that the hearty thanks of this Association be tendered to Sir Wm. Hingston for his most excellent paper.—Carried with applause.

Dr. Dickson, Toronto, said the electrical treatment of epithelioma of the face is accompanied by good cosmetic results. He advocated the

establishment of a chair of Electrical Therapeutics in the University. He referred to the method of electro-metallic treatment with the decomposing of mercury and zinc forming an oxychloride of mercury and zinc, as being especially useful in epithelioma of the tongue, and sarcoma. He advised the ray treatment to follow operation on malignant cases, citing examples to show that the secondaries frequently disappeared under the raying.

Dr. W. Oldright, Toronto, gave an account of a case of amputation of the breast in which he had not removed the glands in the axilla; with a good result. He believed that the glands should not always be removed.

Dr. A. McPhredran, Toronto, discussed the importance of early diagnosis in gastric carcinoma. The patient should be submitted to careful examination with special attention to the age, pain and discomfort in the epigastrium, its nature and relation to food, etc. Many cases may be relieved if diagnosed sufficiently early.

Dr. John Hunter, Toronto, emphasized the importance of good hygienic and systematic after treatment in these cases. It helped to prolong their lives.

Sir Wm. Hingston in reply, supported Dr. Dickson's electrical treatment. In operations he aimed to cut wide of the growth and considered it a great misfortune if during the course of the operation he should see the cancer. Never operate for purposes of diagnosis. Take time and exercise patience. The less experienced the man, the sooner he will operate.

#### PLACENTA PRAEVIA.

Dr. McIlwraith, Toronto, read this paper. From a careful consideration of the various methods of treatment, the conclusion was reached that when you decide to interfere in these cases, i.e., when the foetus is dead, or the mother in danger from hemorrhage, the best method of procedure is to do a combined or Braxton-Hicks version, bringing down a leg and then leaving the delivery to nature. The leg serves to check hemorrhage whilst by leaving the case to nature you avoid serious post-partum hemorrhage from laceration of the cervix or rupture of the uterus. To perform version, dilatation of the os sufficient to admit of the introduction of two fingers is all that is necessary. When the os is not dilated, plug the cervix with iodoform gauze or a lysol tampon and repeat if necessary in from four to six hours. Champetier de Ribe's bag is not satisfactory. For rapid dilatation no instrument is equal to the skilled use of the fingers.

Dr. Holmes, Chatham, said he had tried and discarded most methods. The tampon had given him the best satisfaction in most cases. The patient should be in a hospital or under the constant care of a trained nurse. No patient should be left alone in the country with the danger of a hemorrhage coming on suddenly. The doctor related an instance in which he had spent a whole week in the country watching one patient. The tampon should be sterile but in introducing it do not draw the uterus down as when the tenaculum is taken off the uterus returns to its position leaving a space between it and the tampon. Use a Syms' speculum and introduce the cotton tampons one by one until the canal is packed full. The pains will come on rapidly and the presenting part come down and check the hemorrhage.

Dr. W. J. Wilson, Toronto, would not risk the tampon if the waters had come away.

Dr. John Hunter, Parkdale, thought it important to resuscitate the patient before commencing delivery.

Dr. McIlwraith, in reply, expressed his opinion that the tampon kills the child and is not sufficient in checking severe hemorrhage,

#### THE TECHNIQUE OF INTESTINAL ANASTOMOSIS.

Dr. N. A. Powell, Toronto, gave a very interesting and instructive demonstration of Technique of Intestinal Anastomosis by Elastic Ligature and other devices. He first traced the history of Intestinal Anastomosis making mention of Senn's bone plates, Murphy's button and McGraw's elastic ligature. "The trend of opinion to-day is to do away with complex devices, the surgeon endeavoring to become more proficient in manipulation." The doctor performed two gastro-jejunal anastomosis illustrating the method of employing the elastic ligature and the later improvement by means of the triangular stitch introduced by Dr. R. S. Weir and J. W. Maury, of New York.

#### PAIN IN THE UPPER ABDOMINAL ZONE.

Dr. Geo. Hodge, London, in an exhaustive paper, reviewed the causes and diagnosis of pain in the upper abdominal zone. Among the causes noted were pleurisy; pneumonia; gastric crisis; caries of the dorsal vertebrae; uraemia; appendicitis in the early stage; cardiac cases (*a*) pericarditis, (*b*) angina, (*c*) aneurism; rheumatism, especially in children; subphrenic peritonitis following gastric ulcer; hyperacidity of the stomach; hypersecretion with spasmodic vomiting; gastric ulcer; carcinoma of the stomach; chronic gastritis; in the liver, abscess, carcinoma, Hanot's hypertrophic cirrhosis, cholecystitis, cancer of the

gall-bladder, cholelithiasis; of the spleen, movable spleen, infarct, abscesses, spleno-medullary leukaemia; in the pancreas, acute pancreatitis, chronic pancreatitis, cystic disease, and cancer; in the intestines, duodenal ulcer, impacted faeces in the transverse colon; and in the kidney, nephroptosis, nephrolithiasis, abscess, tuberculosis, and malignant disease.

Dr. H. A. McCallum, London, complimented Dr. Hodge on his masterly paper. He drew attention to the difficulty of diagnosis in cholecystitis, reciting a case with pain over the gall-bladder with rigidity, following typhoid fever. It proved to be suppurating cholecystitis.

Dr. McPhedran, Toronto, also complimented Dr. Hodge on his excellent treatment of this important subject, in which mistakes in diagnosis are extremely numerous. He drew attention to the fact that many abdominal lesions were accompanied by identical symptoms, the pain in the early stages being practically always referred to the umbilicus. He called especial attention to diaphragmatic pleurisy complicating central pneumonia, and to a tender area just to the right of the eleventh dorsal vertebra, described by Boas, and occurring invariably in cholecystitis. In faulty conditions of the gastric secretion, especially accompanied by an excess of hydrochloric acid, the pain is extreme and is not relieved by food or the administration of antacids, this class of patients, moreover, are neurasthenics and bear pain badly. The stomach contents varies greatly, it may be scanty, or copious if associated with pyloric spasm.

Dr. Oldright, Toronto, said the pain of appendicitis and perforation of the intestine was frequently referred to the upper abdominal zone.

Sir. Wm. Hingston, Montreal, was pleased to note that Dr. Hodge, in his most exhaustive enumeration of causes, had not forgotten to mention that most important condition, uraemia. He instanced a case in which he and a confrère had been puzzled by this condition causing severe pain in the stomach for some time.

Dr. Holmes, Chatham, gave the history of an interesting case, the patient had been sick for three or four years with pain in the right side, extending from the iliac region to the liver. Paroxysms of severe pain with acute suppression of urine, followed by a copious discharge of pus in the urine, occurred at various intervals. The diagnosis lay between appendicitis, movable kidney, and suppurating cholecystitis. An exploratory incision over the region of the gall-bladder revealed a tongue-like projection of the liver, which in some mysterious way pressed on a suppurating kidney and under certain conditions prevented the discharge of pus. He was at a loss to satisfactorily explain the mech-

anism of this action. The patient was immediately turned on his side, and a nephrectomy performed, a perfect cure following.

Dr. Marlow, Toronto, called attention to small hernial protrusions of fat in the linea alba sometimes producing severe pain. He had seen two cases.

Dr. Webster, Toronto, said pain may be due to dislocation of the spleen with rupture of the gastro-splenic omentum. Tumor of the ovary and herpes zoster were other causes of pain.

#### LITHOTOMY VERSUS LITHOLAPAXY.

Dr. C. B. Shuttleworth, Toronto, gave a complete and critical review of this subject. From statistics of all the large hospitals available the writer concluded :—

(a) Litholapaxy is certainly the operation of election in all simple cases of stone in the urinary bladder.

(b) When the stone is too hard, or too large, to be crushed through the urethra, or by the lateral method without injury, the suprapubic method should be adopted or, perhaps, better, perineal lithotrity.

(c) When the stone is encysted, or associated with a tumor of the bladder, or prostate, choose the suprapubic route and remove both at the same time. The mortality of a large number of cases is about twenty per cent. by the suprapubic method.

(d) Where there is a tight, deep urethral stricture, especially when fistulæ exist, requiring a long operation to overcome, select the suprapubic or median perineal operation.

(e) In ankylosis of one or both hip joints, which interferes with the use of urethral instruments, and excludes all perineal operations, do suprapubic lithotomy.

(f) In the presence of foreign bodies in the bladder, which may form the nucleus of a calculus and resist the lithotrite, perform one of the perineal methods.

(g) Although litholapaxy applied to children is very successful in the hands of experts, for the present, lateral lithotomy is the safer operation for the general surgeon.

(h) Litholapaxy should be carried out, whenever possible, when senile degenerations exist, or when there are morbid changes in the genito-urinary apparatus, and the necessary treatment afforded to the complication, either before, or after, litholapaxy.

Dr. Cockburn, Hamilton, claimed as a matter of practical importance, we do not get a sufficient number of cases to afford the necessary practice to become expert in the operation of litholapaxy. The suprapubic



method has undoubtedly a bad record, but it is an easy operation to perform and with no chance of blank lithotomy. The safest method is perineal litholapaxy, but I consider the method of dilating the prostatic urethra with the finger, as advised by Reginald Harrison, a dangerous proceeding. The surgeons should practise the operation on the cadaver.

Dr. Powell, Toronto, drew attention to the importance of litholapaxy as a method of extracting stones from female children. He instanced two cases; one a girl five years old from whom he removed a large and a small calculus weighing 241 grains by litholapaxy. This was some years ago and so far as he knew, was the first instance of the method being employed in female children. At the request of Dr. Bigelow, these cases were published, the first being given in full in Skene's text-book on the diseases of women. The method has now become the established procedure. "I have never been able to overcome my dread of the suprapubic route based on the mortality reports of the large hospitals. So far I have only removed 107 stones by the suprapubic method, but it is only fair to say, however, that 106 of these came from one case. On the whole, I prefer the lateral section, when the case is not suitable for litholapaxy."

Dr. Primrose, Toronto, regretted that he had not heard the whole paper, but considered the suprapubic method quite as difficult as the perineal operation. He told of a case where the surgeon attempted litholapaxy and failed, then anaesthetised the patient and attempted the suprapubic method, which was given up after wounding the peritoneum twice, the patient was finally put in the lithotomy position and the stone extracted with the greatest ease by lateral section. He took issue with Dr. Shuttleworth's tables of the mortality of the various methods, pointing out that the more difficult cases, those with prostatic complication were the subjects of suprapubic section. Consequently the mortality compared unfavorably with the simpler cases in which the other methods were employed.

Dr. Ross, Toronto, had recently visited Mr. Freyer in London, and had seen some of his work. Mr. Freyer has become so skilful in litholapaxy that he now practically never cuts for stone.

Dr. Webster, Toronto, wished to know which method would be employed with encysted stone.

Dr. Shuttleworth thanked the gentlemen for the interest taken in the discussion. His statistics had been gathered from a great number of cases in large hospitals and embodied the results of operations on all cases.

## TREATMENT OF OPHTHALMIA NEONATORUM.

Dr. Perry Goldsmith, Belleville, read a paper on this subject. He advocated the use of argyrol in the treatment of the affection.

Dr. Trow, Toronto, did not consider that Dr. Goldsmith should call his treatment unorthodox, in fact, he considered it quite the orthodox method. He emphasized the importance of the careful treatment of the cornea. Argyrol is a God-send in many ways. A 20 per cent. solution may be dropped into the eye and, if the child is lying down, will reach all parts of the conjunctival sac. No thickening of the conjunctiva results as with the old painting method, in which abrasion of the cornea was so dangerous. Cocaine should be used with caution, it hardens the cornea and causes some proliferation of the epithelium. Bichloride does this also and should not be used in eye work. Protargol has not the advantage of being painless as is argyrol.

Dr. Goldsmith replied that theoretically the bichloride is of no use as it precipitated with mucus and forms an insoluble albuminate of mercury.

## THE DIAGNOSIS OF SMALL POX.

Dr. C. A. Hodgetts, Secretary of the Ontario Provincial Board of Health, read a carefully prepared paper on this important subject. He condemned the practice of looking for a certain definite clinical picture. He thought the terms varioloid or modified small-pox should be applied only to cases occurring in those who have had small-pox, or been vaccinated. The disease in Ontario has been most prevalent in January and February. The virulence of the contagion appears to be direct relation to the severity of the attack. The incubation period is 12 days, but in mild attacks it may be 15. The initial symptoms are not unlike an attack of grip, the running from 100° to 102° F. and lasts from 24 to 72 hours. The temperature then drops to normal or may be sub-normal with the appearance of the eruption. A severe initial stage may be followed by a severe eruptive stage, or vice versa. The eruption appears in a few hours to 72 hours after the onset. It is at first macular, then popular and soon becomes vesicular. While popular the skin has a shotty feel. The distribution is mainly on the face and extremities. They may be in one crop; but oftener it is in several. From 1 to 3 days may elapse before it comes fully out. Vesicular stage lasts about three days, rarely five. The rash increases in size to that of a pea and the vesicles contain serum. The vesicles are multilocular and do not collapse on being pricked. Some are umbilicated. By the fourth and fifth days, the vesicles are changing to pustules. These dry and

shrink and are often shed from the face by the tenth day. Such is the course of the typical cases now prevailing in the Province. They last about 21 days. In the recent outbreak the cases have been characterised by the mild onset, the abortive nature of the eruption, the absence of constitutional depression and secondary fever, and the mildness of the infection. The disease must be distinguished from chicken-pox, impetigo contagiosa, pustular syphiloderms, urticaria papulosa and acne.

#### THE GRAVENHURST HOSPITAL FOR TUBERCULOSIS.

Dr. Parfitt presented an account of the work done by the Free Hospital for Incipient Tuberculosis recently opened in Muskoka by the National Sanitarium Association. He appealed to the members of the profession for a fuller recognition of the importance and need of this work, pointing out that the Hospital was dependent upon the charity of the public, and the medical profession could do a great deal towards keeping its doors open to the needy poor by their co-operation. He presented statistics of the Hospital showing that excellent results followed the systematic out-door treatment, and closed his most interesting paper with a hearty invitation to the members of the Association to visit the Free Hospital and see for themselves the out-door treatment in active operation.

Dr. J. N. Elliot, Gravenhurst, joined with Dr. Parfitt in inviting more of the profession to visit the Sanatorium. He assured them of a hearty welcome, and was quite convinced that the visit would be of profit to themselves.

Dr. Goldsmith, Belleville, had visited the institutions and could testify to their excellent work, especially in laryngeal cases. The patients were under the constant supervision of the resident physicians, and received treatment, inhalations, applications, etc., once or twice daily if necessary. He had no hesitation in advising patients to go to the Sanatorium.

Dr. Milner, Toronto, from his experience in examining for life insurance, was convinced that the early diagnosis of phthisis, in which stage it was favourable for Sanatorium treatment, was often overlooked. He considered it the duty of every family physician to examine carefully, at least once every six months, those of his patients with a phthisical tendency. He should pay special attention to hæmic murmurs and the character of the breath sounds.

Dr. Trow, Toronto, related the experience of a patient, a neurasthenic, phthisical, sallow-faced book-worm, who lived in a tent at Gravenhurst through the summer, and through most of the severe winter months, coming back to Toronto robust and healthy.

Dr. Parfitt, in reply, regretted to say that laryngeal cases usually do badly unless the patient be in otherwise good health. He was sorry that physicians would continue to send to the Sanatorium patients in advanced stages of the disease with only a few more months to live. He would much prefer to have patients sent merely on suspicion, as they were prepared to make most delicate tests by means of tuberculin and the injection of sputum into guinea pigs.

#### CASES ILLUSTRATING THE DIFFICULTIES OF DIAGNOSIS AND TREATMENT OF TUMORS.

Dr. Wm. Oldright, Toronto, exhibited specimens of tumors removed in which the diagnosis had been complicated. He related the history of of these cases and gave a resume of the differential diagnosis.

Dr. Perfect, Toronto Junction, asked how Dr. Oldright would control vomiting following abdominal section.

Dr. Oldright said vomiting after operation is often difficult to control. Washing out the stomach is useful, and a hypodermic of morphia over the epigastrium may be successful in stubborn cases.

#### DISCUSSION ON SERIES OF LIFE INSURANCES.

On Wednesday morning a very excellent series of papers, dealing with the various phases of Life Insurance as it more especially interests the doctor, was read by the following gentlemen: Dr. H. P. Frank, Brantford; Dr. F. Le M. Grasset, Toronto, Canada Life; Dr. R. J. Dwyer, Toronto; Dr. Edw. Ryan, Kingston, Canadian Order Odd-fellows; Dr. H. C. Scadding, Toronto, Canada Life; Dr. B. J. Riordan, Toronto, North American Life; and Mr. Percy C. H. Papps, A.I.A., Actuary Manufacturers' Life.

A vote of thanks was moved by Drs. Harrison and Davison to Mr. Papps for his interesting and instructive paper.

These papers and the discussion on them will appear in a future issue.

#### THE RELATIVE IMPORTANCE OF THE CLINICAL AND BACTERIOLOGICAL EVIDENCES IN DIPHTHERIA.

Dr. Sheard, Toronto, said: I have not thought it wise, Mr. President and Gentlemen, to present to you a set paper this evening, but shall submit some ideas with the object of eliciting an expression of opinion from those members of the profession assembled here. Many physicians imagined that the discovery of the Klebs-Loeffler bacilli and the proof that injecting them into guinea pigs and cats produced diphtheria, settled the question beyond further discussion. But I make bold to state that

the physician who imagines we know all about diphtheria is confronted with difficulties and troubles at every turn. I am fully convinced we cannot depend exclusively on the findings of the bacteriological examinations in these cases. There are many cases which present no physical signs but in which the bacilli are undoubtedly present and the generally accepted opinion that when the Klebs-Loeffler is present we have diphtheria is not always true. Whether the absence of symptoms is due to a personal immunity or not I am not prepared to say.

There are four distinct varieties of Klebs-Loeffler bacilli; the long forms, the short, the attenuated, and the pseudo-bacilli. They produce soluble toxins and are sometimes associated in their actions with pus organism, these toxins produce the symptoms which we designate diphtheria.

I have a series of seven cases diagnosed as posterior fibrinous rhinitis in which not one, but a series, of bacteriological examinations failed to reveal the presence of the Klebs-Loeffler, but each case was followed by paralysis. We generally admit with paralysis we have diphtheria. The virulence of diphtheria varies much according to the seed, the mortality sometimes being over 90 per cent. I remember a man from Buffalo with diphtheria who stopped at the Brown Hotel; seven new cases developed from exposure, of whom six died. Some time ago a Russian family of nine, set out for Toronto; two of them died at sea of diphtheria, two more in Montreal, and two others in Toronto. All this bears out the teaching that diphtheria is due to a particular form of vegetable organism and, as such, is subject to the laws which govern the growth of all seed in various soils.

1st. The sequelae are due entirely to the toxins, the extent of the membrane being of no consequence in this connection. If we have cellulitis and no adenitis, the condition is most serious, the toxins entering the nerve trunks and destroying their vitality. The sequelae may be expected at any time from the third week to the third month.

2nd. Many conditions are due to the associated pus organisms, such as the secondary eruptions, which are identical with those of septicaemia, and in no way dependent upon the Klebs-Loeffler.

Another form of bacterial diphtheria is the post scarlatinal type in which, during the second week of the fever, the patients have the Klebs-Loeffler but exhibit no symptoms, they invariably get well, and are not infective. I have records of 16 such cases. Again we have the association of scarlet fever and diphtheria, the diphtheria not following the scarlet fever, but both diseases existing simultaneously in the same patient, as the result of two separate exposures—the incubation period

of scarlet fever being four days, whilst that of diphtheria being about six days. At the Isolation Hospital we have a separate ward for these mixed cases. Again, we have those cases of post-diphtheretic scarlet fever, where the scarlet fever follows closely on the heels of diphtheria, and where, in spite of any form of treatment, we have a mortality of over 80 per cent. And, as these cases occur as frequently in private houses as in hospitals, they cannot be accounted for by infection from one hospital patient to another. A frequent experience at the Isolation Hospital is to have whole families sent in, half of whom are suffering from diphtheria the other half from scarlet fever, showing the correctness of Sydenham's contention that there exists a far greater intimacy between these two diseases than the private physician would care to admit.

I can report several cases in which, after weeks of most energetic treatment, the bacilli could not be gotten rid of and, though such cases were discharged, no new cases have been known to result from them. One patient in the scarlet fever ward developed otitis media, in the discharge from which the Klebs-Loeffler bacilli were found. He was discharged and no resulting cases have been reported. From these experiences, I am convinced that when the bacillus of diphtheria exists in the pus it is innocuous and non-virulent.

In conclusion, these questions naturally arise: 1st. Is scarlet fever antidotal to diphtheria? The answer appears to be in the affirmative. 2nd. Does not diphtheria aggravate scarlet fever? The answer again is "yes." 3rd. Is the difference in the two diseases due to the evolution of a soluble toxin by the Klebs-Loeffler bacillus? Osler once said to me "If the rash appears, disappears, and re-appears, it is, in all probability, a septic rash." The scarlet fever rash we know does not appear and re-appear, but there are many septic cases, such as recurring erysipela-tous rashes, all closely connected clinically with diphtheria and scarlet fever.

#### THE TREATMENT OF DIPHTHERIA BY ANTITOXINE.

Dr. McMahan, Toronto, followed Dr. Sheard with a paper upon "The Uncertainties of Diagnosis and the Necessity of Early and Vigorous Treatment of Diphtheria." He emphasized the importance of the early injection of adequate doses of antitoxin in all suspected cases, even before the results of a bacteriological examination could be obtained. He called attention to the great reduction in the mortality, especially of laryngeal cases, since the introduction and the general use of antitoxin. In his own practise he was pleased to report that since he had adopted

the rule of early and efficient treatment with antitoxin, he had not had a single death. From the reports of the Hospital for Sick Children, he was convinced of the effectiveness of immunizing doses of antitoxin and advised that members of a family in which a case occurred should each receive adequate immunizing injections.

Dr. A. R. Cordon, Toronto, strongly verified Dr. McMahon's statements and expressed himself in favor of the early, abundant and fearless treatment with antitoxin.

Dr. Allan Baines, Toronto, said: I must congratulate Dr. McMahon upon his happy experience with antitoxin. I wish it to be emphatically understood that I am a believer in antitoxin, but I can report no such good results. In one case I injected 4,000 units, followed in four hours by 2,000 units, in four hours again by 2,000 more units—in all 8,000 units in eight hours, but in spite of this the patient died. Pure cases of diphtheria are benefitted by antitoxin, but those cases of mixed infection with the streptococcus and the staphylococcus are not cured by antitoxin. It is just ten years ago since this question was thoroughly thrashed out in the Pediatric Society at New York when this same conclusion was reached.

Dr. W. J. Wilson, Toronto, said: My experience is the same as Dr. McMahon's. My practice is to inject antitoxin early, take swabs in all suspicious cases, and make my own cultures, in this way I have a report in eight hours. I believe calomel fumigation and intubation to be valuable adjuncts in the treatment of laryngeal cases but my rule is, "When in doubt use antitoxin." A difficulty we encounter is that when swabs are sent to the Health Office on Saturday evening, no report can be received until the following Tuesday morning.

Dr. John Ferguson, Toronto endorsed Dr. McMahon's position. I use antitoxin freely and early, and in young children rather increase the size of the dose than diminish it, as their tender constitutions have little power in producing self-immunity. Concerning the cases of mixed infection, with the staphylococcus or streptococcus present, I maintain that if you can control the Klebs-Loeffler bacillus, you materially aid the child in its struggle. I am pleased to report that I have not had one death since using antitoxin. In all, I have had nine intubation cases, three before the period of antitoxin, and all died; and six since the introduction of antitoxin and all recovered.

Dr. B. Z. Milner, Toronto, said: I wish to call Dr. McMahon's attention to the fact that there is diphtheria in the Sick Children's Hospital at present and that recently when I wished to operate on

several cases, I was informed that they were in the isolation ward with diphtheria, and this in spite of immunizing injections.

Dr. Sheard, Toronto, asked Dr. Machell concerning 15 cases in the Children's Home. Did these all receive immunizing doses?

Dr. Machell, Toronto, said, as far as my memory serves me, I believe all did not receive immunizing doses from being ill and that but one or two cases occurred in those patients where immunizing doses had been given. Diphtheria varies markedly in epidemics. In some epidemics all die, in others all get well.

Dr. F. N. G. Starr, Toronto, pointed out that the cases at the Hospital for Sick Children, where the present epidemic commenced, were in children from eight to ten years old, and that the ordinary immunizing dose of 500 units for a child of two or three years was not sufficient for these older children.

Dr. John Hunter, Parkdale, expressed the opinion that the mortality was greater with the use of the antitoxin than without it.

Dr. Webster, Toronto, has never seen any good result follow the use of antitoxin after the child once had diphtheria. Of four cases in one family, sent to the Isolation Hospital, one only received antitoxin and it was the only one which did not recover.

Dr. A. A. Macdonald, Toronto, believes in the effect of immunizing doses, but that in most cases the dose is too small. Do the thing early and do it thoroughly. Is not your experience the same as mine in laryngeal cases. Formerly, did not practically all our laryngeal cases die, but is it not now your experience that the child suffering from marked dyspnoea after the injection of the antitoxin soon commences to breathe freely and easily.

Dr. McMahon, in reply, reiterated his former statements and said that if Dr. Webster had used antitoxin immediately the little girl would not now be under a small mound on the hillside.

Dr. Sheard, in reply, wished to be understood that there were other things in the treatment of diphtheria besides antitoxin; such as cleansing sprays and swabs; and moreover that laryngeal cases will die in spite of antitoxin from laryngeal stenosis. He doubted the immunizing effects of antitoxin.

#### THE LUNCHEON.

On Wednesday afternoon, the Association held its annual luncheon. The affair was a most enjoyable one, excellent speeches being given by Premier Ross, Hon. Mr. Harcourt, Dr. Harrison, Selkirk and Dean Reeve. Immediately after the luncheon, through the kindness of the Automobile



Club the members of the Association were treated to a ride around the city.

#### DISEASES OF THE PROSTATE.

A series of papers were read on this subject by Drs. Bingham and Marlow, of Toronto, and Dr. Holmes of Chatham. These papers will appear in THE CANADA LANCET in an early issue.

Dr. Bruce, Toronto, preferred the suprapubic operation, although he had not acquired the dexterity of Mr. Freyer who shelled out the prostate in two minutes. He had never met with any special difficulty in reaching the gland in fat patients. Within the last month he had operated on one very stout gentleman and by pressing the prostate forward from below had experienced no difficulty in removing it.

Dr. Powell, Toronto, had not intended to take part in the discussion, but was drawn into it by the good-natured raillery of one of the speakers. He was pleased to say that although he dreaded the suprapubic route, he had as yet no mortality in the operation. Statistics from large centres, however, showed the operation to be attended with a mortality of about 20 per cent. He cited a recent aggravated case and had just that day received a letter from the patient announcing that he was able to dispense with his catheter.

President Ross, told of a recent visit to Mr. Freyer, in London, and gave short extracts from letters of rejoicing nobility upon whom Mr. Freyer had operated for enlarged prostate. Duke — writes, "Dear Dr., — I can now pump ship like a two-year-old." Earl — writes, "Dear Dr. — I tell you I can now make the pot hum, etc."

Mr. Cameron, Toronto, was pleased to have heard Dr. Holmes' interesting and able paper. He agreed that the older perineal route was the better method. It was not absolutely necessary to damage the urethra in all cases. He took exception to the expression, the anatomical middle lobe as there is no middle lobe to the prostate. He regretted to report a serious mortality by the suprapubic method. He did so, however, out of the hope that those present might benefit from his misfortune. Within the last year and a half he had done 15 suprapubic sections with 5 deaths. Two of the fatalities could not be attributed to the operation, one being due to facial erysipelas and the other to hemiplegia; but the other three, who were promising and otherwise healthy patients, died suddenly, one acutely insane in 24 hours who had been perfectly well 12 hours after the operation; one unaccountably without either hemorrhage or shock in about 20 hours having been in excellent condition 12 hours after the operation; and the last in about 48 hours of albuminous oedema of the lungs, the pulse and temperature having been normal and

the general condition excellent 12, 24 and 36 hours after the operation. With the old perineal operation, he had had no mortality.

Dr. McKinnon, Guelph, operated wholly by the suprapubic method. He considered it much easier, involving less danger of wounding the rectum, and rarely followed by fistulae. His mortality had not been great. The perineal route is simple, involves less shock to the patient, but is frequently followed by fistulae. He reported a series of cases with successful operations and recovery, in patients from 65 to 83 years old. He had only had two deaths.

Dr. Olmstead, Hamilton, thought all methods are simple to those practised and skilled in the method of their choice. On the continent, the perineal method was used almost exclusively and with great success: while in England and Canada, the suprapubic route was the method of election and enjoyed the same success. He advocated the more frequent use of the cystoscope. Freyer was able to announce good results, and he was surprised that with the immense amount of material at his disposal he did not announce more of them, because he was able to carefully select his cases. In Canada we could not so pick and choose but were forced to do our best to relieve all sufferers. In his mind the one objection to the suprapubic method was the poor drainage obtained.

Dr. Holmes, in reply, strongly advised more careful study of the Bottini operation. No general anaesthetic was required, and he believed it had a great future before it.

Dr. Bingham, in reply, said the contracted bladder was easily raised by the hand in the rectum. The bladder should be sutured to the abdominal wall before opening.

#### NEURASTHENIA IN SOME OF ITS RELATIONS TO INSANITY.

Dr. D. Cambell Myers, Deer Park, gave a paper on this topic. He held that neurasthenia may run on into confirmed insanity. He urged proper hospital treatment for many cases of incipient insanity.

Worries, annoyances, shocks, losses, auto-intoxication had much to do with the causation of neurasthenia. A marked characteristic of the diseases was the readiness with which the brain fatigued, the slightest exertion in many cases producing exhaustion. From introspection some of these patients gradually passed on to the formation of delusions. In the treatment of neurasthenia the causes must be sought for and corrected. Rest, seclusion, hydrotherapy, electrization, massage, and feeding were the points requiring careful attention. The recovery was sometimes very slow.

Dr. McKenzie, Bracebridge, emphasized the importance of the subject, stating that neurasthenics were frequently met with in country practice.

These cases fall easy victims to the quacks. It was a matter of great difficulty to carry out isolation in many cases.

Dr. John Ferguson, Toronto, held that neurasthenia and the earlier forms of insanity are several links in the same chain, the exact situation of the boundary line is beyond human judgment. Pronounced cases of neurasthenia or insanity are easy of diagnosis, but between these there is a series most puzzling to us all. The question is one of physical disturbance, the great feature being that the slightest mental effort produces exhaustion. Again, the nerve system becomes so depleted of all energy that physical exertion is impossible. The condition is a nutritive change first, followed later by an anatomical one. The dendrites fail to absorb sufficient nutriment from the brain matter and the slightest possible effort exhausts this limited supply. Disorganization sets in and the sickly, weakly, though normal, cell becomes a morbid and pathological one, and ultimately disappears. The conditions producing these effects are: (1) Prolonged worry; (2) sudden mental shock; (3) overwork and insufficient rest; and (4) some toxæmia which affects the brain, injuring the nerve cell.

Dr. Hunter, Parkdale, would like to know the position hydrotherapy occupied in Dr. Myer's treatment. A woman under his care, suffering from a pronounced form of neurasthenia, for whom he had prescribed a cold bath every morning, preferably at 5 a. m., followed by a brisk bicycle ride, was now a perfect picture of ruddy health.

Dr. Bruce Smith emphasized the use of hydrotherapy in treatment, the etiological value of toxæmia, and the importance of early recognition of the symptoms in neurasthenia. "Insanity," he concluded, "is the culmination of nervous derangements in the patient, undiscovered and uncorrected."

Dr. Holmes, Chatham, thought that women are born with unstable nervous systems, and later in life misfortune overtakes them which lower their vitality and produce the symptoms of neurasthenia. We must search carefully for the cause. It may be a movable kidney, an inflamed gall-bladder, faulty position of the uterus, inflammation of the ovary, laceration of the cervix, or eye strain. The correction of these conditions, he believed, would in most cases result in the entire disappearance of the nervous symptoms. In a case of puerperal insanity, recently under his care, he repaired a torn cervix, and the insanity disappeared. Many cases also were due, he believed, to auto-intoxication from the alimentary canal.

Dr. McPhedran, Toronto, remarked that cases on the borderland between neurasthenia and insanity are difficult of diagnosis. Neuras-

themia should include all cases of nerve prostration. For example, in one patient weakness of digestion may be the prominent feature, another patient cannot sleep or rest, still another may have disturbed cardiac action, but all are neurasthenic. He believed that there should be better provision for more careful attention to the incipient insane. There should be one or more stations for temporary treatment of such patients, and wherein incurable and curable cases could be separated. This would materially relieve the asylums, and save the patient from the stigma attached to having been an inmate of an asylum for the insane. There are such institutions in Europe and in the United States.

An inherited difference in the vitality of tissue is responsible for the easy break-down in neurasthenics. Some have poor vitality of brain, of kidney, or of stomach, with the result that these organs are readily exhausted.

Dr. W. J. Wilson, Toronto, agreed with Dr. Holmes that putting all the organs right and changing the environment of the patient would accomplish many cures. He deprecated the wholesale removal of ovaries for trifling causes, the ultimate result being bad.

President Ross could not agree with Dr. Holmes. Some years ago, through the kindness of Dr. Beemer, of Mimico Asylum, he operated on a number of women patients, repairing lacerations, correcting uterine displacements, etc., with no change in the mental condition of the patients. They were insane before, are insane yet, and will probably remain so.

Dr. Myers, in reply, thought any pathological condition should certainly be treated, but improvement in the mental condition could not always be expected to follow. He could see no reason why an operation on a woman's uterus should necessarily influence the condition of her mind.

#### SKIN DISEASES.

Dr. A. McPhedran gave a clinic on the following cases of skin disease :—

(1) *Impetigo contagiosa*.—The disease is contagious, most commonly occurring on the face or pubic regions, and due to the streptococcus or staphylococcus, or, as some believe, to a specific organism. The disease tends to recur from time to time.

Treatment consists in cleansing and the application of antiseptic ointments, such as ung. hyd. amm. chlor., or better, resorcin, 20 to 30 grains in an ounce of lanolin. The principle in the treatment of all skin diseases is, to cleanse and apply antiseptic, soothing or stimulating applications.

(2) Erythema Multiforme.—The trouble commenced in March, four years ago, as a vesicular eruption occurring on the hands, face and neck, *i.e.*, the exposed parts only. The eruption lasted all summer, faded in the fall, leaving no mark. It returned in the March of the following spring, and went through the same cycle. The lesions are first vesicular, then pustular, and finally coarse crusts, which drop off in a few weeks, leaving faint marks. No inflammation precedes the vesiculation. It is, doubtless, purely a congestion with a serous exudate, followed by an exudate of leucocytes and ultimate crusting.

(3) Acne and eruption on the leg, syphilitic or tubercular.—The treatment of acne is difficult in phlegmatic types. Stimulate until slight desquamation and then soothe. R. Resorcin, gr. 20; B. Naphthol, drachms  $\frac{1}{2}$ ; sulphur, dr. 2; green soap and vaselin, aa. oz. 1.

To soothe the leg ulcer, use these:—Zinc oxide, 1; gelatine, 2; glycerine, 3; aqua, 4. Add, if necessary, ichthyol, 2, 3, 4 or 5%.

(4) Tinea tonsaurans.—This affection is difficult to cure, as the micro-sporon is deep down in the hair follicles. Two principles to be observed are thoroughness and perseverance, *i.e.*, use any parasiticide and keep it up. R. Sulphur, drs. 2; Lanolin, oz. 1; or Chrysarobin, d.s. 1, to the ounce.

(5) Cycosis non-parasitica.

(6) Leucoderma in a man with pernicious anaemia.

Dr. H. B. Anderson exhibited the following cases:—

(1) Urticaria pigmentosa.—Present since birth. Small wheels, leaving yellowish, or brownish pigmentation spots; recur at intervals in the same spot, leaving a deeper stain. The pigmentation is due to the escape of red blood corpuscles and deposit of their pigment. (2) Weeping Eczema. (3) Psoriasis. (4) Exhibition of Cholene crystals from the blood of a nerve case, prepared by Dr. F. H. Scott, according to the method of Dr. Haliburton. (5) Molluscum fibrosum.—A man with many hundreds of small cutaneous tumors.

#### STRAIN IN RELATION TO DISEASE OF THE HEART AND AORTA.

Dr. H. B. Anderson showed the following specimens: (1) Rupture of the aorta following rapid walking. The patient dropped dead. Specimen presented by Dr. Powell. (2) Rupture of the left ventricle during the passage of a stomach tube in a woman *aet.* 60. (3) Rupture of the sinus of Valsalva with aneurismal dilatation pressing into the right heart. Captain on a boat, *aet.* 55, attempted to carry a heavy tie, fell unconscious, suffering from tachycardia, and died nine months later. (4) Dissecting aneurism, involving the whole of the

descending aorta down to the bifurcation of the iliacs. One brother died of aneurism. Patient moderate drinker, generous liver, no history of syphilis. After a week of unusual exertion, was seized with a sudden pain and a sense of weakness and died the same night. The blood had burst the middle and inner coats of the aorta and made a false passage for itself under the adventitia.

#### METHOD OF RECORDING CHEST EXAMINATIONS.

Dr. Elliott, Gravenhurst, gave an illustrated paper on the advantages of a pictorial record of chest examinations. The method commended itself for ease, simplicity, and efficiency to all present. Dr. Elliott very kindly offered to explain the details of the system with illustrations, etc., to anyone who cared to communicate with him.

#### A GROUP OF MALIGNANT DISEASES.

Dr. R. N. Fraser, Thamesville, reported six cases of malignant disease, occurring in succession in persons who had waited upon each other, or occupied the same bed or room.

Dr. W. J. Wilson, Toronto, recited the case of a gentleman in Germany who, by mistake, drank the stomach contents from a patient with gastric carcinoma, and he himself died of cancer some months later. Another case where a physician, by mistake, sucked up the stomach contents of a cancer patient from a tube, and died of cancer some fifteen months later.

Dr. Ferguson, Toronto, referred to the excellent record of family cases of malignant disease reported some time ago in a number of the *British Lancet*.

Dr. Marlow, Toronto, asked if the undescended testicle in No. 5 of Dr. Fraser's series had been found to be cancerous?

Dr. Fraser, in reply, did not wish to give the impression that he held cancer to be infectious. It is probably auto-infectious. He could not answer Dr. Marlow's question, as the gland had not been examined.

#### THE SURGICAL RELIEF OF EPILEPSY.

Dr. A. Primrose, Toronto, gave the report of a case of epilepsy which had been benefited by operation.

Dr. Dickson, Toronto, explained the method of localizing motor centres in the cortex by electrodes from a faradic current. Experimenting should not be done as it involves great shock to the patient.

Mr. Cameron, Toronto, thought lesion giving rise to cortical irritation should be removed. What is epilepsy? It is a discharge of nervous energy from the motor centre, where the cells go off at half-cock. He

believed case 1, of Prof. Primrose, was a hystero-epilepsy, probably a disciple of Captain Marryatt's. There is no use operating unless you can find some local lesion. Personally, he had not met with much success in the operation; the patients were better for about a year, but the epilepsy almost invariably returned.

Dr. John Ferguson, Toronto, remarked that statistics show that less than 5 per cent. of epileptics are relieved by surgical procedures. Idiopathic cases, with focal symptoms, and especially Jacksonian epilepsy, are the favorable cases. Cases operated on almost invariably recur owing to the contraction of cicatricial tissue, and the last condition is worse than the first. He reported a case caused by depressed fracture, on which he had operated with complete recovery.

Dr. Bruce, Toronto, reported a case of traumatic epilepsy in which he removed some of the cortex, corresponding to the hand centre. At first there was paresis of the hand, but this recovered and, later on, the patient developed epilepsy on the opposite side. "So I transferred him from a right-handed to a left-handed epileptic."

#### ARID REGIONS IN THE TREATMENT OF PULMONARY CONSUMPTION.

Dr. J. Frank McConnell, Las Cruces, gave a most instructive paper on the influence of arid regions in Colorado, New Mexico, and other places on pulmonary tuberculosis.

Dr. Oldright, Toronto, complimented Dr. McConnell on his excellent paper. Was always pleased to meet their former students and learn of their successes. He asked Dr. McConnell to explain the action of the alfalfa in stopping dust.

Dr. Wishart, Toronto, thought we should congratulate ourselves on the information gained from this paper. It will be of great assistance in directing patients to suitable health resorts. He asked the doctor about the winds and the feeding in the arid zone.

Dr. Hunter, Toronto, had visited the arid regions and could add his testimony to that of Dr. McConnell. The medical men in those districts were prominent physicians from New York and other large cities forced to live in these health resorts. "Do not load your patients down with directions how to live, but place them in the hands of resident medical men." He would like to know about the disinfection of houses and the removal of patients in Pullman cars.

Dr. Cameron highly complimented the writer; the paper was as full of pabulum as an egg, and might be well taken as a model.

Dr. Webster, Toronto, said many consumptive people have but limited means, and cannot afford to take long journeys and live in expensive resorts. Many of them are able to get well right here in Toronto.

Dr. McConnell, in reply, said the alfalfa meadows were effective barriers to the dust. Patients were better to provide themselves with tents and then they ran no risk of infection from houses. One could live comfortably on \$10 a week.

#### PAPERS BY DRs. MILNER, WISHART AND BRUCE.

Dr. Milner, Toronto, read a paper on Lympho-sarcoma; Dr. Wishart of Toronto, one on Double Otitis Media; Dr. Bruce, Toronto, reported a case of Resection of the Caecum for Carcinoma.

#### INFLAMMATION OF THE LACRYMAL APPARATUS.

Dr. G. H. Burnham, of Toronto, took this topic as the subject of his paper. He stated that lacrymal apparatus is divided into two parts—that which forms the tears and that which carries them away. The canaliculus may be dilated by a fine probe and the passage and sac cleansed by a proper syringe, or drops. Inflammation of the lacrymal sac may be caused by injury, by irritating particles getting into it, or by stricture of the nasal duct. The inflammation of the sac may become very acute, accompanied by pain and swelling. An abscess may form. The nasal duct is formed of mucous membrane and periosteum and is frequently the seat of stricture. In obstruction of the nasal duct and inflammation of the sac, the canaliculus is divided into the sac. Some dilate the nasal duct by passing probes, increasing their size till large ones are introduced, and sometimes inserting a style. Dr. Burnham does not agree with the custom of passing very large probes; he does not go above No. 4. The passage is cleansed by means of an antiseptic, and a style is inserted. In some days the style is removed and the passage treated with cocaine and adrenalin, and disinfected. The style is re-replaced. In some cases it is a very difficult matter to pass the probe and much force may be required. Strictures in the canaliculus and nasal duct may have to be divided.

Dr. Wishart asked Dr. Burnham if the inferior turbinate was not frequently enlarged close to the outlet of the nasal duct, and if cauterization was not indicated? Would like Dr. Burnham to explain more fully what he meant by the constriction bands in the canaliculis lacrymalis?

Dr. Burnham replied that where the turbinate was enlarged it should certainly be treated. By the constrictions he meant little cicatricial bands which prevented the free passage of the probe into the lacrymal sac and had to be divided time and time again until no obstruction was offered.



## DIAGNOSIS OF KIDNEY DISEASE.

Dr. Hackett, Detroit, gave an exhaustive account of the newer methods of renal diagnosis.

He referred to the value of the cystoscope in determining the condition of the bladder mucosa and the opening of the ureters. When methylene blue is given by the mouth, it should appear in the ureters in 15 to 30 minutes. If it does not appear on one side for 60 minutes, there is disease on that side. Indigo-carmin may be injected into a muscle to make these tests. The urine may be obtained from each kidney separately by catheterization, or by segregation. In the latter, the bladder is raised up between the opening of the ureters, allowing the urine to collect in two separate portions of the bladder. The freezing point of urine, cryoscopy, is of some value, as the freezing point of the urine from the diseased kidney, is less than from the sound kidney. He referred to the phloridzin test. If .005 gram be administered by the hypodermic method, in 15 minutes sugar will appear in the urine, but much more freely from the healthy kidney. Increase in the concentration of the blood is a sign of renal insufficiency. The value of x-rays was mentioned as a means of diagnosing calculus in the kidney.

## A CASE OF MYXŒDEMA.

Dr. Trebilcock, Enniskillen, reported a case of severe anaemia due to myxœdema.

Dr. Rudolf, Toronto, thought Dr. Trebilcock had given a most classical picture of myxœdema pure and simple. The firm swelling noted was not characteristic of pernicious anaemia, and the marked improvement following the exhibition of the thyroid extract was a positive therapeutic test.

## NOTES OF AN UNCOMMON CASE OF RECTAL SURGERY.

Dr. Clouse, Toronto, reported an interesting case of rectal tumor, which ultimately was cured by operative measures.

## DIAGNOSIS OF FUNCTIONAL HEART MURMURS.

Dr. Rudolf gave a paper on this subject. Functional murmurs, as first described by Laennec, are soft and blowing in character, occurring most commonly in the position of the pulmonary area, opposite the second left costal cartilage, and in no way connected with valvular diseases. They are due not to anaemia as so often taught, but to a condition of hypotonus of the muscles of the circulatory system. That is, there is a relaxation of the sphincter muscles guarding the mitral and tricuspid orifices, and permitting of a leakage. In the pulmonary

area, the fibrous band around the orifice permits of no dilatation, but the muscular structure of the pulmonary artery permits it to dilate and, consequently, we have a condition in which the blood stream flows from one chamber, that is the right ventricle, through a relatively constricted orifice, into the dilated pulmonary artery. This is the most favourable arrangement for the production of a murmur. Dr. Rudolf laid down the following rules to aid in the diagnosis of a functional from organic murmurs:—

(1) They occur in adolescence and young adults. (2) They are more common in males than females. (3) They all occur during ventricular systole. (4) While the pulmonic area is the most common situation for functional murmurs, it is a rare site for organic murmurs, congenital stenosis being the only one found. (5) Functional murmurs are heard in the neck, e.g., Bruit de Diabie. (6) As the general health improves, functional murmurs tend to disappear, organic murmurs on the other hand tend to get louder with increasing strength. (7) Functional murmurs are soft and accompany rather than displace the first sound. (8) They are not so widely propagated as are organic murmurs. (9) They vary under certain conditions, e.g., they are louder after exertion and are especially increased on lying down. (10) The pulmonic second sound is accentuated early, even before the murmur is heard, this is not so in organic pulmonary stenosis. (11) They are accompanied with little signs of dilatation or displacement of the apex. (12) Cardio-respiratory sounds are sometimes mistaken. Ask the patient to hold his breath and they will disappear. (13) Signs of failing compensation are rare in functional cases. (14) The patients are not conscious of the existence of the murmur. An analysis of the patients in the surgical wards of H. S. C. showed that in 60 per cent. functional murmurs were present. An analysis of a number of wards in the T. G. H. and St. Michael's Hospital showed the existence of functional murmurs in 50 per cent. of the patients. (15) Fever gives rise to functional murmurs. They occur in 66 per cent. of scarlet fever cases, and are apt to occur in rheumatic fever. A useful rule in this connection is, "Functional murmurs tend to occur late in fever, e.g., rheumatic fever, while endocardial murmurs appear within the first ten days." (16) Pressure has not much effect as a rule in altering functional murmurs.

Finally, we are all too apt to conclude that there is organic disease when we hear a murmur, and we are too easily soothed into believing the patient organically sound when no murmur can be discovered.

## MOTIONS, RESOLUTIONS, ETC.

Moved by A. McPhedran, seconded by N. H. Beemer,—That in the opinion of this Association there exists an urgent need for the establishment of hospital accommodation for the temporary reception and treatment of suspected and incipient cases of mental alienation. The establishment of such institutions offers the only efficient means for the cure of such cases and would save many of them from the stigma of having been incarcerated in an Asylum for the Insane. Carried.

Moved by W. H. Smith and seconded by F. Fenton,—That the thanks of this Association be extended to the Automobile Club of Toronto, for the kindness exhibited to the members in the very pleasurable ride about the Parks of the city. Carried.

Votes of thanks were also passed to the President and Senate of the University of Toronto, for the use of the Medical Building; to the retiring President, the Secretary, the Assistant Secretary and other officers of the Association for their painstaking work in arranging for this excellent meeting.

The motion of Drs. Cameron and Thistle, that the Ontario Medical Association be changed to constitute a branch of the British Medical Association was on motion of Drs. Powell and McPhedran, referred to a committee to be named by the incoming President and Mr. Cameron, which committee should report to this Association. In connection with this, Mr. Cameron pointed out that the membership fee of one guinea to the British Medical Association included the subscription for the British Medical Journal. By constituting this Association a branch of the British Medical Association, we would in no way interfere with our own autonomy. Dr. Bingham pointed out the difficulty already existing in getting men to attend the Ontario Medical Association and that the matter was one of too much importance to be passed over hurriedly. Dr. Ferguson thought the Association should exercise due caution before obligating its members to any additional expense in the matter of fees.

A motion was also passed granting \$100 to the Ontario Medical Library Association.

## INCOMING OFFICERS.

The following officers were elected for the ensuing year: President, Dr. Wm. Burt, Paris; 1st. Vice-President, Dr. J. L. Davison, Toronto; 2nd Vice-President, Dr. Geo. Hodge, London; 3rd Vice-President, Dr. E. Ryan, Kingston; 4th Vice-President, Dr. T. H. Middlebro, Owen Sound; General Secretary, Dr. Chas. P. Lusk, Toronto; Asst. Secretary, Dr. Samuel Johnston, Toronto; Treasurer, Dr. Fred. T. Fenton.

### ADDITIONS TO THE COMMITTEES.

The following names were elected by the Nomination Committee, to serve on committees: Credentials.—Dr. Olmstead, Hamilton; Dr. Boyd, Bobcaygeon. Public Health,—Dr. Trimble, Queenston; Dr. Fraser, Thamesville. Legislation,—Dr. H. D. Livingston, Rockwood; Dr. Jas. Sampson, Windsor. Publication,—Dr. E. E. King, Toronto; Dr. John Hunter, Toronto. By-Laws,—Dr. Alex. Taylor, Goderich; Dr. W. J. Charlton, Weston. Ethics,—Dr. H. A. McCallum, London; Dr. T. McKeough, Chatham.

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### THE TREATMENT OF INEBRIATES.

Some time ago a movement was set on foot in Toronto with the view of urging upon the public and the Government of the Province the need for better provision for the treatment of inebriates. Considerable progress has been made and a number of influential persons have identified themselves with the organization. Dr. A. M. Roseburgh is secretary.

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### THE PAN-AMERICAN MEDICAL CONGRESS.

This Congress, which meets every third year, will hold its meeting this year in Panama in the latter part of December.

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### THE MEDICAL DEPARTMENT AT ST. LOUIS.

This is one of the departments of the Congress of Arts and Sciences. The medical department is to be divided into twelve sections. The chairman of this department is Dr. Wm. Osler. An excellent program of papers and addresses has been arranged for the meeting, which is to commence on 20th September.

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### THE CANADIAN MEDICAL ASSOCIATION.

This Association meets in Victoria and Vancouver, B. C., from 23rd to 26th August. Dr. Dunstall, the President, and his committee, are working hard to secure a good meeting.

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### AMERICAN CONGRESS OF TUBERCULOSIS.

This International Congress at the St. Louis Exposition on October 3, 4 and 5, promises to be a great success. Already very many leading scientists have expressed their intention of being present.

## UNIVERSITIES AND COLLEGES

### THE ONTARIO MEDICAL COUNCIL EXAMINATIONS.

The following candidates passed the final examination of the College of Physicians and Surgeons of Ontario, June, 1804 :---

Abbott, S. F., London; Armstrong, J. R., London.  
 Biggar, L. J., Toronto; Bell, F. M., Kingston; Bond, A. T., Ryckman's Corners; Brewster, R. S., Beeton; Blanchard, N., Sunderland; Babb W. F., Carlinford; Blakeman, F. W., Stratford; Branscombe, M. R., Picton; Blair, H. G. F., Ashton.  
 Cullen, E. K., Toronto; Chambers, W. J., Lockalsh; Chapman, G. R., London; Croft, L. V., Middleville; Cryan, J. H., Demorestville.  
 Dickey, J. S., North Williamsburg; Duggan, C. E., Oil Springs; DeHaitre, E., Rockland; Dodd, F. J., Ottawa.  
 Fisher, R. O., Ashgrove; Frederick, E. V., Campbellford; Fraleigh; A. J., Bloomfield; Foster, N. J., Kagawong.  
 Gemmell, W. T., Seaforth; Greenway, G. E., Little Britain; Graham, W. A., Toronto; Gallie, W. E., Barrie; Gilmour, C., Toronto.  
 Hair, C. H., Lavender; Harris, R. B., Prince Albert; Hunt, J. G., London; Hunt, W. B., London; Holmes, K. H., Chatham; Hendry, W. B., Toronto; Hill, F. W., Ottawa; Houston, D. H., Belleville; Hodgson, E. L., Toronto.  
 Jamieson, H. C., Guelph; Kerfoot, W. J., Minesing; Kingster, C. E., Ruscombe; Kidd, J. H., Warsaw.  
 Lang, M. H., Langford; Leeson, J. D., Toronto; Little, Isabella, Toronto.  
 Moore, H., Athens; Magee, C. F., North Gower; Meldrum, W. N., Ayr; Marshall, G. E., Toronto; Munro, J. H., Maxville; Mugan, P. J., Toronto; Murray, D. C., Newton; Munro, D., Blytheswood.  
 McLean, H. C., St. Thomas; McCulloch, J. M., Durham; McCulloch, E. A., Thomasburg; McIntosh, J. A., Vankleek Hill; McLaughlin, R., Cumberland; McKinley, W. W., Seeley's Bay; McIntosh, G. E., Mississippi Station; McCarthy, D. M., Kingston; McLellan, J., Toronto; McCartney, G. E. R., Carlisle; McColl, T. H., Wallacetown; McLean, Hector, Glenceo; McInnes, A., Bognor.  
 O'Reilly, B. S., Toronto; Oille, J. A., Sparta.  
 Proctor, A. D., Ottawa; Phillips, J., Hewett; Perkins, M. J., Toronto; Quinlan, P. F., Stratford; Ross, F. A., Guthrie; Richardson,

G. A., Stouffville; Ross, V., Guthrie; Robinson, E. J., North Williamsburg; Reid, Victoria, Kingston; Rowntree, J. W., Thistleton.

Staley, A. A., Wolfe Island; Singer, S., Toronto; Secord, W. H., Brantford; Singleton, A. H., Newboro; Smith, Geo. E., Toronto.

Taggart, E. A., Ottawa.

Ward, G. H., Napanee; Willson, A., Russell; Williams, W. T., St. Thomas; Woolner, W. A., Toronto; Wilson, G. E., Toronto; Weir, B. C., Strathroy; Williams, E. J. F., Brockville.

Young, J. M., Renfrew.

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### UNIVERSITY OF TORONTO GRADUATES.

The following have passed the final examination in medicine:—

A. H. Adams, H. J. M. Adams, R. W. Anderson, G. B. Archer, W. D. Beaton, J. H. Bennett, M. W. Berwick, G. M. Biggs, E. E. Binns, J. W. Brien, H. R. Bright, F. J. Brodie, H. R. H. Bryan, T. D. Buck, W. A. Burr, E. C. Burson, D. D. Campbell, A. H. W. Caulfield, F. E. Chalmers, C. W. Clark, W. B. Clarke, G. W. Crosby, W. E. Cruickshank, F. B. Day, A. F. Demary, O. T. Dinnick, W. Dixon, J. A. Duncan, G. E. Eakins, F. S. Eaton, M. H. Embree, E. G. Evans, B. J. Ferguson, W. L. C. Gilbert, J. Graham, W. H. Harvey, W. B. Hendry, T. R. Henry, A. L. Hore, P. J. F. Houston, A. M. Kennedy, J. F. L. Killoran, A. Kinghorn, N. D. Kyle, A. J. Leach, I. S. Le Drew, M. H. Limbert, R. McCaffrey, R. J. A. McComb, P. J. McCue, E. A. McCulloch, R. J. P. McCulloch, A. H. McFadden, P. McGibbon, J. K. McGregor, D. C. McKenzie, D. F. McKinley, J. P. McKinnon, W. E. McLellan, J. G. McLeod, M. A. McQuade, A. F. Malloy, J. J. Matheson, P. J. Muga, T. Mulligan, D. C. Murray, C. R. Newman, K. D. Panton, L. A. C. Panton, W. Reid, W. G. Reive, A. Ross, A. L. Russell, A. Scarlett, A. E. Schultz, F. H. Scott, F. J. Sheahan, G. M. Shaw, G. E. Smith, R. G. Snyder, J. B. Stallwood, F. N. Stephens, A. E. Stewart, A. B. Sutton, W. F. Thorn, A. D. Unsworth, K. H. Van Norman, F. S. Vrooman, S. B. Walker, T. A. Watterson, F. E. Watts, J. W. Wighman, W. A. Wilson, W. W. Wright. Hygiene—A. A. Jackson, R. D. Nasmith. Mental Diseases—W. S. Ford, F. E. Fyle. M. Galbraith, J. H. Todd.

J. A. Kane will be admitted to the degree of bachelor of medicine on passing in physics of the first year. G. W. Thomas will receive the degree on passing in chemistry of the second year.

The following are required to pass supplementary examinations before completing the final examination:—Medicine—W. S. Ford, F. E. Fyle, M. Galbraith, H. Jones, R. Van Sickle. Clinical medicine—W. H.

Carveth, F. F. McEwen, J. H. Todd, A. C. Woods. Surgery—A. A. Jackson, J. W. Lord. Clinical surgery—A. C. Woods. Surgical anatomy—F. E. Fyle, M. Galbraith, A. A. Jackson, H. Jones, F. F. McEwen, R. D. Nasmith, L. S. Stewart, J. H. Todd. Pathology—M. Galbraith, H. L. Burrin. Obstetrics—W. H. Carveth, W. S. Ford, W. E. Fyle, H. Jones, J. H. Todd, R. Van Sickle. Therapeutics—W. H. Carveth, W. S. Ford, J. W. Lord. Medical jurisprudence—H. Jones.

Medals—Faculty gold medal, R. J. P. McCulloch; first faculty silver medal, A. Kinghorn; second silver medal, R. W. Anderson; third silver medal, S. B. Walker.

Scholarships—First year—I. W. C. Shier; 2. O. A. Cannon; second year; 1. J. H. Holbrook; 2. A. S. Moorhead.

Prizes—Daniel Clark prizes in medical psychology—1. R. J. P. McCulloch; 2. K. D. Pantou.

Post graduate scholarship—The Geo. Brown memorial scholarship in medical science. For this scholarship A. Kinghorn, S. B. Walker, R. J. P. McCulloch, H. R. Bright, G. B. Archer and K. H. Van Norman ranked in the order named.

The following are eligible for admission to the degree of M.D.:—  
J. A. Oille, A. A. Small, C. E. Treble.

#### McGILL MEDICAL EXAMINATIONS.

The pass list numbers about 82 from a total number of 98 undergraduates for the year. The Holmes gold medal, for highest aggregate in all subjects forming the medical curriculum was awarded to J. A. Nutter, B.A., of Montreal, while the final prize for the highest aggregate in fourth year subjects goes to J. L. Robinson, of St. Mary's, Ont. The honors for aggregate in all subjects are as follows:—

1. Robinson, J. L.; 2. Nutter, J. A., B.A.; 3. Lincoln, W. A.; 4. Meakins, J. C.; 5. Miller, V. L., B.A.; 6. McKenty, F.; 7. Fyshe, J. C., A. B.; 8. Coffin, J. W.; 9. Gillis, J. E.; 10. Faulkner, J. A., B.A.

The following have successfully passed their examination in fourth year medicine and will receive the degree of M.D.:—

Ainly, W. E., B.A.; Alford, J. H.; Atkinson, H. S., Bentley, J. S., B.A.; Black, J. C., Blakeman, F. W., passed at Christmas; Bonin, R. P. Carnochan, W. L. C., passed at Christmas; Charman, F. D., Chipman, W. W., Coffin, J. W., Cook, W. J., Crack, I. E., B.A., Cram, W. J., Crosby, P. C., Crowell, B. C., B.A., Davidson, H. D. J., Dickson, W. H., passed: Dillon, W. P., Douglas, E., B.A., Dunn, J. F., Eaton, C. E., Faulkner, J. A., B.A., Fisher, E. M., Fisher, F., Folkins, C. G., Ford, H. S., Fraser, S., Fyshe, J. C., B. A., Gibson, G. M., Gibson, R., Gillis, J. E., Gilroy, J. R.

Gormley, J. C. Graham, R. W., Grant, N. P., Greenwood, W. T., Harrison L. L. B.A., Hogan, F. J., Hotchkiss, E. A., Howitt, H. O., Hutchinson, J. W., Johnson, J. G. W., M.A., Judson, A. H., Kerr, H. H., Keys, M. J., Lauchland, L. C., B.A., Lincoln, W. A., Lippiatt, H. T., Losier, A. J., MacKenzie, A. B., MacKid, L. S., McIntosh, L. DeC., McKentry, F. McKenzie, R. P., McLachlan, D. C., Markson, S. M., Martin, J. C., Meakins, J. C., Miller, C., Miller, V. L., B.A., Murphy, H. H., B.A., Nagle, S. M., Nutter, J. A., B. A., Park, A. W., Preston, C. E., Price, Joe., Quain, B. P., Rankin, A. C., Redford, L. L., B.A., Richardson, C. A., Richardson, C. A. C., B.A., Robinson, J. L., Rogers, J. T., B.A., Sellery, A. C. Ph. B., Sims, H. A., Smith, C. A., passed at Christmas; Stewart, J. A., Tanner, C. A. H., Warick, Wm, Wilson, O. M., Wilson, T. R., B.A., Wood, H. G., Wright, G. A., Yorston, F. P. M.A.

Third year prize man—H. C. Mersereau, Doaktown, N.B.

Sutherland medalist—J. H. MacDermott, Gordontown, Jamaica, B. W.I.

McGill Medical Society, Senior prizes—First prize, V. L. Miller, B.A.; second prize, J. A. Nutter, B.A.

Honors in aggregate of all subjects—1. H. C. Mersereau; 2. J. H. McDermott; 3. H. A. Leslie; 4. F. J. Tees, B.A.; 5. H. C. Burgess; 6. F. A. C. Scrimger, B.A.; 7. G. F. Moffatt, B.A.; 8. T. R. B. Neels; 9. W. Dykes; 10. J. D. McLean; 11. J. A. C. Tull; 12. J. A. Munro; 13. E. T. F. Richards; 14. H. S. Muckleston, M.A.; 15. J. W. B. Hanington; 16. E. H. Henderson, B.A.; 17. A. Cumming, B.A.; 18. B. W. Robertson; 19. J. H. Mason; 20. W. G. Pruyne, B.A.

Besides these the degree of B.A. was granted to Messrs. T. A. Lomer, A. B. Chandler and Fraser B. Gurd, who are pursuing a double course in the faculties of arts and medicine, and the degree of B. Sc. (Arts) and B. Sc. (Science) respectively to Messrs. J. S. McDiarmid and M. B. Atkinson.

Special diplomas of public health were granted to Drs. F. C. Douglas and John A. Lundie, B.A.

The McGill Medical Society junior prizes have been won by F. J. Tees, first prize, and R. J. Monahan, second prize, both of Montreal.

Second year prize man—R. S. MacArthur, Summerside, P. E. I.

Senior Anatomy prize—J. W. Turnbull, Springhill, Ont.

Honors in aggregates of all subjects—1. MacArthur, R. S.; 2. Lomer, T. A.; 3. Turnbull, J. W.; 4. Shaw, R. McL., B.A.; 5. Crowe, H.S., B.A.; 6. Williams, C. S.; 7. Hunter, A. W.; 8. MacDonald, P. A.; 9. Fraser, D. R.; 10. Weldon, R. C., jr.; 11. Sheahan, J. J.; 12. Gilles, G. E.

First year prize man—R. M. Benvie, Salt Springs, Pictou, N. S.



Junior Anatomy prize—R. M. Benvie, Salt Springs, Pietou, N.S.

Honors in aggregate of all subjects—1. Benyie, R. M.; 2. Peters, F. Lew, B. A.; 3. McNab, N. A.; 4. Whitelaw, W. A.; 5. Farris, H. A.; 6. McLennan, A. L., B.A.; 7. Lannin, G. E. J.; 8. Thomson, J.W.; 9. Healy, J. J.; 10. Porter, J. F. S.; 11. Rublee, O. E., B.A.; 12. W. F. Edwards; 13. Trufanc, J. H., A.B.; 14. Landry, A. R.; 15. Logie, F. G.

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### LAVAL UNIVERSITY MEDICAL GRADUATES.

The names of the graduates who have succeeded in winning the degree of M.D. are given below. The honor lists, including those students who have attained to the highest standing in the various classes of the fourth year, are given first.

Attained the degree of M.D. winning first-class honors—Belanger J. E. Cousineau, J. A. Demers, Albert Lubel, Hyacinthe.

Attained the degree of M.D. with second-class honors—Dube Ls. Felix; Dufresne, Eugene, Desmarais, Henri; Grenette, J. A.; Martin Auguste; Meunier, Joseph; Malcheloose, M.; Monette, Francis; Parisian; Leo; Parisian, W.

Passed for the degree of M.D.—Bouin, Adrien · Beauregard, G. E. Chapron, Philea; Chagnon, D.; Choquette, Alfred; Desnos, Louis; Desaray, Charles; Dupuis, Zephirin; Foley, Joseph; Gagner, Emmanuel; Gagnier, Rodrigue; Gaudet, Lucien; Gatien, J. A.; Gravelle, James; Herbert, Oswald; Landry, Eugene; Labelle, Emile; Lachaine, Edmond; Landry, L.; Lachance, F.; Marcil, Alfred; Pelletier, Antoine; Poirier, Armand; Renaud, L. H.; Vamdamaigne, Isaac.

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### BISHOP'S MEDICAL COLLEGE.

The medal, prize, honor and pass lists in all final sessional examinations of the fourth year in the faculty of medicine at Bishop's Medical College are announced as follows:—

Medalists--Wood gold medal, T. J. Donnelly, fourth year.

Nelson field medal—J. J. McGovern, fourth Year.

Chancellor's prize—F. W. Watier, fourth year.

David silver medal—S. L. Lucas, second year.

Anatomy prizes—F. E. Norton, first year; F. J. Mullen, second year

Histology prize—S. L. Lucas and F. Gavin, second year.

The following have successfully passed and are entitled to the degree of M. D., C. M.:—R. F. Barrett, Montreal; G. N. Briggs, Montreal; H. W. Byers, Montebello, Que.; C. F. Crutchlow, Montreal. T. F.

Donnelly, New Carlisle, Que.; F. J. Garraty, Richmond, Que.; B. A. MacGregor, Fournier, Que.; J. J. McGovern, Richmond, Que.; F. W. Watier, Montreal; A. E. Wilson, Montreal.

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#### MANITOBA MEDICAL COLLEGE GRADUATES.

M. D.—George Arlington Brown; Alex. Murray Cambell, B. A. Spurgeon Campbell; Nelson George Cooper; James Archibald Hamilton, John Power Howden; Fred Inglis, B. A.; Percy Herbert Miller; Robert Ernest Monteith; Sidney James Shepard Peirce, B. A.; Daniel Norman Ross; Andrew J. Slater; William Turnbull; Harry Jackson Watson.

C M.—Alex. Murray Campbell, B. A.; Nelson George Cooper; James A. Hamilton; Percy Herbert Miller; Sidney J. S. Peirce, B. A.; William Turnbull.

#### SCHOLARSHIPS

Third Year—George Hector Craig, B.A., \$80; Herbert Samuel Sharpe, \$50.

Second Year—William Alex. Cluff, \$80; Wm. Wesley Lorne Musgrove, \$50.

First Year—Fredk. William Andrew, \$80; Andrew Pritchard MacKinnon, \$50.

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#### FIFTH YEAR IN QUEEN'S.

A change is desired by Queen's medical faculty in the regulation of the Ontario Medical Council regarding the fifth year work at medical colleges. At present only students who get positions are exempt from a special fifth year course of lectures and demonstrations. Queen's desires that this be changed and that any medical graduate be entitled to try the final council examination who has been a house surgeon for a year or has served a year with a qualified practitioner or has attended clinics in a recognized hospital for at least a year.

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#### QUEEN'S MEDICAL FACULTY.

At a meeting of Queen's medical faculty it was decided that the matriculation standard of the Ontario Medical Council was high enough at present. A lawyer will be appointed to give a series of lectures in connection with the subject of medical jurisprudence.

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## EDITORIAL

### MEDICAL EDUCATION.

Much has been written and said upon the subject of medical education. With all our colleges and hospitals and qualifying bodies, it is bound to be a live topic, and, like the poor, will be ever with us.

One of the topics of much interest is the degree of preliminary education that should be imposed upon the student, prior to his entry upon his professional studies. Many think that an arts standing should be exacted. There can be no two opinions upon the subject. The degree of general education should be good. It will be of the utmost value to the student himself to be compelled to possess a liberal knowledge of the fundamental subjects of general culture. Such knowledge will aid him throughout life in his distinctively professional studies.

It is incumbent upon colleges to demand of their students a becomingly high standard of character. It is much better that a student be arrested in the early part of his academic career than that he be allowed to proceed to a degree and then meet with failure, because of some serious defect in his character. The medical profession should be only for those who can do it honor. The *British Lancet* a few years ago contended that the sifting in the first two years should be thorough and searching.

The balance between the scientific work of the first two years and the clinical work of the second two years in Canada is as good as in any other good country in the world. Most of the provinces throughout the Dominion are adopting a five years' course of study—the first two to the scientific subjects, the second two to the practical and clinical subjects, and the fifth year to hospital work or practice with a doctor.

With regard to hospital experience there is room for much improvement. It is the cry from most of the cities where colleges are located there is a dearth of material. But it must be admitted that much valuable material is not being utilized at all. The medical staff of the medical colleges cannot possibly also be the physicians and surgeons to all the hospitals. Professor Osler made the happy suggestion last fall at

the opening of the New Medical Buildings in Toronto that arrangements should be made with the various hospitals, not only in Toronto, but in other cities and towns, whereby they would take groups of the students and afford them the use of the material in these hospitals. Get rid of jealousy, and this plan can be worked out to the advantage of the colleges, the students and the hospitals.

By such a plan the students would be brought into contact with a wide range of opinion and methods of work, both medical and surgical. It would go a long way to enlarge their interest in the study of their professional work, and it would bring many of the hospitals of the country into living touch and sympathy with the various colleges. It would have a stimulating effect on the hospitals also. We hope to see something done along this line soon.

A few years ago, it would have been practically impossible to have thought of trying the experiment of starting a post-graduate course of instruction. But times have changed. Some of that rare cement, which Dr. Osler spoke of and which is able to bind men together, was found. As a result, the two medical colleges became one, jealousies disappeared on better acquaintanceship, and this year a very successful post-graduate course was inaugurated in Toronto. The same thing may just as well be done in other cities.

#### THE ONTARIO MEDICAL ASSOCIATION.

The 24th meeting of the Ontario Medical Association was held in Toronto, June 14, 15 and 16.

In the first place we notice that the attendance was not large. About 180 members registered, or about 5 per cent. of the practitioners of the Province. But, small as the attendance was, there were only 27 from points outside of Toronto. This is an unpleasant feature of these annual gatherings, and if there be any cause for it, it should be sought out and remedied, if possible.

With regard to the reading of papers, a glance at the programme shows that 28 were contributed by Toronto doctors, and 16 by those from outside the city.

As to the papers themselves no fault could be found. They were of such a high standard of excellence as would have done credit to any medical society, and it is a matter for regret that there were not a larger number present to benefit by hearing them or to take part in the discussions.

It is a very difficult matter, indeed, to arrange a programme to suit all, and we know how diligently the committee on papers worked to

secure good papers and addresses, and to kindle an interest in the association throughout the Province.

Nor is the committee on arrangements deserving of less praise. Everything went off well. The luncheon, the concert and automobile drive were very much enjoyed.

We certainly think that an effort should be put forth to have the transactions published in book form. We believe that it would be a great incentive to the profession to keep in touch with the work of the association and pay the annual fee, or purchase the volume at such a price as would pay for the cost of the same. In this way the work of the association would have a wide and permanent usefulness which it does not now possess. Its proceedings are scattered among a number of medical journals but have no distinctive value in this form. The papers might be published in these journals, but they should also appear in book form.

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#### DECIDUOMA MALIGNUM.

A number of terms have been applied to this disease, such as chorionic epithelioma, sarcoma deciduo-cellulare, cyneytioma malignum, and carcinoma cyneytiale.

The chorion is a foetal structure, and consists of two layers, an inner connective tissue one, and an outer epithelial. From this foetal structure numerous projections arise, known as the chorionic villi, and containing much epithelium.

Deciduoma malignum has been regarded by some as a sarcoma and by others as a carcinoma. The latter view is the one now generally accepted as correct.

But it is worthy of note that this very malignant form of epithelial cancer of the uterus arises from a diseased condition of the epithelial cells of the chorionic villi, a foetal layer of epithelium. Thus we have a malignant degeneration of the foetal epithelium extending into the maternal tissues, and producing there a very malignant form of epithelioma. This is a genuine instance of one person being infected by another.

Another feature of this form of epithelioma is that it is spread freely by the blood vessels, and metastases may be found in other organs especially in the lungs. The reason for this vascular form of metastases is that relationship of the blood vessels in the uterus to the chorionic villi.

One more feature is also held as established that the disease always follows a pregnancy which may go on to term, or be lost prematurely, or result in a hydatidiform mole. It has also been observed that many cases of hydatidiform moles end in deciduoma malignum.

## PERSONAL AND NEWS ITEMS.

Dr. F. D. McGrattan, of Port Perry, was married June 29th to Miss Jenkins, of Toronto.

Dr. Herbert Eilerslie and Miss Annie Bonnar, both of Bolton, were married on June 6th.

Dr. Henry C. Wade, of Bracebridge, was married, June 1st, to Miss Fenwick, of Toronto.

Dutton has a new doctor in the person of Dr. W. T. Hamilton who comes from Stratford.

Dr. S. Cowans and Miss Lillian May Fitzsimmons, both of Brockville, were married on 16th June.

Dr. J. W. N. Shepherd, of Victoria, B. C., and Miss Wallaston, were married in the early part of June.

Dr. H. F. MacKendrick, of Galt, has gone to Britain for a post-graduate course in Edinburgh and London.

Dr. Lelia Davis has removed from 189 College Street to the Alexandra Apartments, University Avenue.

Dr. Carscadden, one of the veteran physicians of the County of Elgin, had a severe illness during the early part of June.

Dr. Jameson, of Durham, recently sustained a painful accident to his ankle by having to jump from his buggy to save himself.

Dr. W. P. Caven and Mrs. Caven of Gerrard street east, Toronto, have left for England, and will return the first week in August.

Dr. M. James, M.P.P. for Nipissing, who has been very ill for several weeks, has now almost entirely recovered, and is able to get out.

Dr. Price Brown sailed from Montreal for Liverpool on the 1st inst. He expects to return from Europe during the first week in September.

Dr. and Mrs. Robertson, of Ottawa, have gone on a trip to California and British Columbia. En route they will spend a week or two at the World's Fair, St. Louis.

Dr. Goodwin, of Elkhorn, Man., has returned from his trip to Britain. He spent considerable time in professional studies in several of the large British hospitals.

Dr. L. Secord, of Brantford, who has been for the past seven years Medical Health Officer to the Six Nation Indians, has sent in his resignation to the Department. Dr. Secord will in future devote all his time to his professional work in the city.

Dr. Homer McLay, who for the past two years has been clinical assistant at the asylum, London, has severed his connection there and will engage in practice. Before leaving he was presented with a purse and an address expressing gratitude felt for many kindnesses shown by him during his stay there, and regret at his departure.

The main object, when a physician desires to sell his practice is to do so with the least publicity possible so as to avoid injuring his practice in case a sale is not made. In order to do this every prospective purchaser before receiving the name and address of the vendor should be bound legally and morally as to honorable dealings and strict secrecy and not to offer opposition in case a sale is not made. These data, have been worked out thoroughly by the Canadian Medical Exchange which has been conducted by Dr. Hamill for the past 10 years and we cordially recommend the same to our readers when they are thinking of making a change of residence.

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## OBITUARY.

### C. W. CHAFEE, M.D.

Dr. C. W. Chafee died at his residence, 614 Spadina avenue, on the morning of 26th May, of a heart affection, which had afflicted him for over a year. He sought relief, but in vain, by a trip to Bermuda, and also to Scotland. He was a son of the late I. M. Chafee, at one time a prominent merchant of Peel County, and is survived by a sister, Miss Chafee, and a brother, Rev. A. B. Chafee, of Cobocok.

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### C. L. COTTON, M.D.

Another instance of the risks to which the surgeon is exposed in the practice of his profession is the death of Dr. C. L. Cotton, of Cowansville, Que., at the General Hospital in the town. Dr. Cotton, in an operation, wounded himself slightly on the finger with a needle. Blood poisoning set in, resulting in the removal of Dr. Cotton to the hospital, where he expired June 15th. Dr. Cotton was one of the best known men in the Eastern Townships.

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### V. H. MOORE, M.D.

Dr. V. H. Moore died suddenly on 8th June. He had been ill for months, but his condition of late had seemingly improved, and he was seen on the street every day. The end came in a stroke of paralysis. The doctor was born near Brockville on Feb. 4th, 1848, of Irish parentage. He was a graduate of Queen's, and in 1890 was given a fellowship by the Royal College of Physicians and Surgeons. For years he had been a member of the Medical Council, and in 1889 was Vice-President, and in 1890 President of the College of Physicians and Surgeons of Ontario. At his death he was still a member of the Medical Council. Up till within a short time he was surgeon of the 41st Regiment, and took a deep interest in military matters.

## T. B. WADE, M.D.

Dr. T. B. Wade, of Port Maitland, N. S. died recently from overwork. He was a popular and successful physician, and leaves a widow and five children

## C. P. CAMERON, M.D.

The death occurred at Westville, N.S. 26th May, of Dr. C. P. Cameron, from pleurisy and complications from blood poisoning. He was most popular in the community, where he has practised for the past year. He was twenty-five years of age, and a graduate of Dalhousie. The body was taken to his home at St. Peters (C. B.), for burial.

## ROLLO CAMPBELL, M.D.

The announcement of the death of Dr. Rollo Campbell, while not unexpected by those acquainted with the severity of his illness, came as a shock lately to a large circle of friends. Some four weeks ago Dr. Campbell was taken ill with typhoid fever, and was removed to the Western Hospital. Dr. Campbell was the eldest son of Dr. F. W. Campbell, Dean of the Faculty of Medicine of Bishop's College. He was forty-one years of age. He graduated from Bishop's College in 1887 then spent one year in Europe, and, shortly after his return, became demonstrator of anatomy, and afterwards professor of anatomy, in the same college. He subsequently became lecturer on surgery, which office he held at the time of his death. He was surgeon-major of the Royal Scots, and took an active interest in the affairs of the regiment. He was looked upon by his fellow-practitioners as an exceptionally able physician and surgeon, and he had built up a very large practice. Dr. Campbell was married nine or ten years ago to Miss Fletcher, who with two children survive him. The funeral which was a military one, took place on Thursday afternoon 2nd June, from his late residence, 50 Mackay Street.

## GASPARD ARCHAMBAULT, M.D.

The death of Dr. Archambault, a well known Montreal physician, occurred at his home, 377 St. Denis Street, 14th June.

He was born at L'Assomption, Que., on January 15th, 1851. His father was Camile Archambault, Notary, of the same place. He attended St. Mary's College, and studied medicine at the Victoria University, from which he graduated with honours in 1873. In 1879 he was appointed attending physician at the Sisters of Providence Dispensary and at the Hotel Dieu Hospital, and professor of dermatology at Laval University. In 1878 he was married to Miss L. Papin, daughter of the Hon. Joseph Papin, M.P. By his death Montreal loses a talented, honest and devoted citizen.