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Saskatchewan Medical Journal

VOL. 2. APRIL, 1910 No. 4

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THE SASKATCHEWAN MEDICAL JOURNAL

VOL. 2 | APRIL, 1910 | No. 4

Original Memoirs

*GYNECOLOGICAL CLINIC OF ADJUNCT PROF. ABRAM BROTHERS, AT THE NEW YORK POST-GRADUATE MEDICAL SCHOOL AND HOSPITAL

CASE 1. CARCINOMA OF THE CERVIX UTERI.

Notes taken by Dr. H. U. Robinson

Clinical Assistant in Gynecology, New York Post-Graduate Medical School and Hospital

According to the history just read we learn that the woman, Mrs. B. L., is 4[illegible] years old and married 28 years. Her family history is negative, and, excepting some bladder trouble in girlhood, her previous personal history is negative. During her married life she has given birth to nine children of whom three are living—the oldest being 24 years of age and the youngest 2½ years. One of the deliveries required instrumental assistance. A number of the children were prematurely born in the eighth month of pregnancy.

The menses at the age of 20—six months after marriage; recurred at intervals of four to five weeks; lasted four to seven days; and flowed in moderate quantity.

She has had recently some trouble from frequent and, at times, painful micturition, and from a sense of bearing-down at the vaginal outlet, as well as from a leucorrheal discharge and backache.

* Reprinted by special permission from the Post-Graduate, March, 1910.

Her main complaint, however, is a marked irregularity in her menstrual flow which has made its appearance in the course of the last six months. Instead of the tendency toward retardation which, in her former life, was the rule, she now swung over to the opposite extreme and menstruates in anticipation of the normal four-weekly cycle. The inter-menstrual period has now contracted to an interval of two or three weeks. Besides the frequency in the recurrence of the flow she states that it never ceases before the expiration of a full week, and that, in this time, the flow is profuse and exhausting. The leucorrheal discharges, which make their appearance during the cessation of the sanguincous show, are profuse but not especially offensive in odor. Although she has not weighed herself in recent times, she feels that she is losing ground and that her tone, stamina, strength and vigor are below par to such an extent that she eats little, looks pale, and hardly has strength enough to attend to her arduous household duties.

While the two members of the class are confirming the findings in this woman's case let us recapitulate the main points in the history and dovetail them into the results of our physical exploration in order to make a diagnosis or, at least to determine for us the next step to follow.

You will have noted that although this woman began to menstruate late—namely at the age of 20 and *after* her marriage—her periods, instead of indicating a tendency to end early, have gone off at a tangent in the opposite direction and have not only increased in profuseness but have recurred at progressively shorter intervals. In other words she has developed a condition of metrorrhagia as contradistinguished from menorrhagia. Personally, I have very little use for either of these terms in the domain of medical nosology when employed as labels for pelvic conditions. To my mind, they are never more than qualifying terms of pathological conditions which are the cause of the free flow of blood at regular or irregular menstrual periods. I pointed out this cloak of indifference or inability to make the real diagnosis in pelvic diseases of women, by men in our profession (who took charge of these cases and who would not or

could not clearly see the underlying etiological factor or lesion) in a paper on this subject which I read before the Post-Graduate Clinical Society a dozen years ago. In that study, which was strictly built on the solid granite foundation of my own personal cases in hospital, dispensary and private work and which included hundreds (since then thousands) of observations, I reached the conclusion, which I still maintain, that there is no such thing as normal menstrual "types" which deviate from the four-weekly interval. Of course one or a few days' anticipation or retardation can be ignored in many cases, as of trifling significance. But such "types" as a three or four-weekly, or per contra, a five or six-weekly; aye, even the normal four-weekly type, when associated with profuse, exsanguinating and debilitating hemorrhages—will be found, after careful examination and study, to owe their origin and existence to a positive lesion in one or other of the organs of generation. There is only one exception that I know of to this rule and that applies to certain blood conditions, like hemophilia, in which the large losses of blood during the menstrual flow or the post partum state are the immediate result of the lesion in the blood-vessels or of the altered composition of the blood and do not primarily arise from the pelvic organs.

The history of this patient points out a lateness in life at which menstruation set in—namely at the age of 20 or 21. We have all been taught to regard early menstruation as practically equivalent to a late menopause and *vice versa*. While I have never devoted myself to a personal study of these "laws," from the vast number of histories to which I have access, I do not hesitate to acknowledge that my attitude, from vague, general impressions, acquired in the course of a quarter of a century in professional harness, is rather skeptical than otherwise. Of one thing I am certain—and this case proves it—and that is that retarded or irregular menses at the outset (which, after all, is ordinarily the rule) will show a retarded climacteric and menopause when certain pathological conditions supervene. This is particularly true in certain forms of endometritis, fibrosis uteri, and neoplasms like fibroid tumors and carcinomata.

I should also add, in passing, that the normal sexual desires in women who evidence a tardy onset of menstruation are not necessarily influenced prejudicially in this respect. In fact I know of a number of women, and we may also perhaps include this woman, in whom the determination to enter the marriage state was expedited by the exaggeration of sensualistic propensities. One of these women had, to my knowledge, five children and had never menstruated. This observation, as well as many others, has convinced me in spite of the strong antagonism of giants in gynecology—like the late Lawson Tait—that the older authors were right when they claimed that there was a "community of interest" between the ovaries and the uterine mucosa and that the sanguineous discharge from the uterine interior was inspired by an influence derived from the ovary. While this is unquestionably the rule, still every gynecologist of experience has met with exceptions in which ovulation, perhaps for years, has been active during the state of adolescence and preceding puberty, as well as at the other end of life, and, perhaps, for years after the woman had passed the change of life. The opposite condition have we also met with, particularly after double oöphorectomy in which menstruation continued for varying periods of time and which had to be explained by the assumption that an undiscovered third ovary had been left behind, or that the operator had unwittingly left a fragment of ovary in the stump, or that the menstruating "habit" of the uterus had not been eliminated even after complete extirpation of both adnexa. In other words I am trying to lead you up to my own conviction and that is that ovulation may be going on without menstruation and menstruation without ovulation under certain physiological as well as pathological conditions. The appearance of this woman and the circumstance that she has borne children convinces me that, even if she had not menstruated six months after her marriage, she would nevertheless have conceived, because I have the strongest of impressions that the ovaries were functionating in a normal manner. I make this statement deliberately and advisedly because of one trenchant experience. A woman had given birth to five children

and had never menstruated. She had been married before menstruation had set in. She had become pregnant (because her ovaries were normal and functionating) and naturally became amenorrheic for a period of nine months. After delivery and during a period of more than a year her menses failed to show because of the physiological relationship between lactation and menstruation. Before weaning the baby she became pregnant again because her ovaries were functionating, and necessarily, there was a renewal of the furlough which permitted or commanded the menstrual function to keep out of sight. In other words, an apparently abnormal condition was established by the interlinking of a chain consisting of ovulation, impregnation and lactation; which, acting like some of our trusts, squeezed and kept menstruation off the stage.

Besides the irregular and profuse uterine bleedings there is very little of importance in the history to note. It may be observed, however, that the tendency of these hemorrhages at the age of 45 years—at a period of life when we should rather seek conditions tending to result in a *decrescendo* or diminution in the quantity of blood—in this woman indicates just the opposite state of affairs. I cannot accentuate this point too much, and, should you leave this clinic with an open mind, I beg of you to discard from your memory everything else, if you wish, but to remember only this statement; in examining a woman, during the climacteric or beyond the menopause, who comes to you with irregular uterine bleeding, *think first of the possibility of uterine carcinoma.* Once you have satisfactorily excluded this condition you may then take into consideration hemorrhagic or senile endometritis, the "irregular bleedings" of the menopause, fibroid tumors or other neoplasms, senile colpitis, etc. But the only hope for a woman afflicted with a uterine carcinoma is its *early* recognition by the family doctor and its *early* removal by the gynecologist.

You may have noted that we practically have ignored, in the history of this woman, the absence of pain, the freedom of an odor to the leucorrheal discharges, and the fact that there is a complete absence of cachexia or pronounced mal-nutrition. The

reason for this intentional oversight is based on the fact that, because of the undue accentuation of these factors by some of our writers of text books, many of our younger and unsophisticated confrères follow a policy of expectation; as a result, when the progressive growth of the neoplasm and involvement of glands and neighboring viscera or structures have had full play and the patient has at last, as a result of exhausting and debilitating hemorrhages, slowly but steadily climbed up to the top of the pyramid into the zone of cachexia—she has already passed beyond all hope of human aid! Therefore, while it is well for the judicial and careful physician to study every feature, subjective or objective, of a patient suspected of having carcinoma of the uterus, *never wait for cachexia* as your crucial or determining evidence. The diagnosis will then have been made too late!

The physical examination of this patient made by the two matriculates and myself reveals a lacerated perineum, cystocele and an abnormal condition of the cervix uteri. The adnexa, as well as the uterus itself, show nothing of a pathological character. The uterus is anteflexed but it is not enlarged. In other words we can exclude fibroid or other tumors of the uterus, tubes and ovaries. Endometritis alone is presumptively not the lesion causing the metrorrhagia, because of the character of this cervix. You will observe by the sense of touch, which later can be confirmed by ocular inspection through the lumen of a speculum, that the anterior portion of this lacerated cervix has a peculiar, crumbling or brittle feel to the finger and that, under very slight manipulation with the finger or finger nail, portions or fragments easily break away and start up a hemorrhage. A little of this growth could be secured and, by the aid of the microscope, an absolute diagnosis could be established of malignancy. In every case, where the element of time does not enter as an urgent factor, this can and should be done. To the experienced gynecologist, who has had many of these cases pass under his observation, the diagnosis is pretty conclusively established before the confirmatory report reaches him from the laboratory—for there is only one condition which exists at the

cervix in the form of a crumbling neoplasm and that is the "cauliflower cancer of the cervix." That is the diagnosis in this woman's case. It will be confirmed by a laboratory report in short time. At present there is no lymphatic involvement, or parametric invasion, discoverable by the examining finger.

I had intended to extensively discourse this morning on the pathology, etiology, symptomatology, differential diagnosis and treatment of carcinoma of the uterus. But the policy of our School is opposed to long, didactic lectures, and very properly so; for, whatever any of us could tell you of these things, you could get much better and more thorough information, at first hand from your text books. Hence I epitomize and condense to the smallest possible space my final remarks concerning this case.

Carcinoma of the uterus may originate in the *portio* (or external surface of the cervix); or in the *cervix proper* (*i.e.*, the lining mucous-membrane of the cervical canal); or in the *uterine interior*. From these situations the malignant process may extend in any or every direction by contiguity or lymphatic routes. The carcinomata of the cervix are the most rapid and dangerous in their course.

All authorities are unanimous in the opinion that surgery of the most radical kind is imperative as soon as the diagnosis has been made. In fact, some of our best operators (and I have, on various occasions, followed their example) have adopted a plan, in doubtful cases, of having the sections or scrapings prepared with the aid of a freezing microtome and examined by a competent expert, while the patient is under the influence of the anesthetic, and reporting the microscopic findings at the time. This course permits the operator to perform either a radical operation or perhaps only a curettage, as the report of the pathologist at the time might indicate.

The operations for carcinoma of the uterus vary in the different cases. Because of the absence of parametric invasion, the early stage of the disease, and the probable absence of lymphatic involvement, this case would suggest to me a vaginal hysterectomy as the operation of choice. Were there doubts

as to the presence of lymphatic glands infected with carcinoma (not simply affected sympathetically and only inflammatory in character) the indication would be to attack the condition through the abdomen, possibly even to the extent of doing an extensive Wertheim extirpation. With the parametrium involved, the question of any kind of radical work would naturally drop out of sight and only palliative procedures—like the use of the actual cautery—ought alone to be considered.

CASE II. FIBROSIS UTERI.

This woman is 40 years old, married 18 years, has had four children, the oldest 17 years ago. One of the children was stillborn, 12 years ago, and delivered in the absence of doctor or midwife. Her menstrual history, previous and subsequent to marriage, was normal up to several months ago, when she began to lose blood in large quantities at each menstrual period. Under local treatment in our clinic this symptom has improved very much, so that the amount of blood loss is now practically normal. She used to suffer from profuse leucorrheal discharges, but they have also mostly disappeared. She still complains of a sense of weight in the pelvis, causing pain in the lower abdominal and lumbar regions.

The physical examination of this woman's pelvis excludes everything abnormal to the trained and expert examining hands excepting an old laceration of the cervix and a large, heavy uterus with the surface suggesting at various points, slight irregularities.

We make the diagnosis of bilateral laceration of the cervix, without eversion or erosion. The uterus itself, however, is the seat of a chronic metro-endometritis which, in recent years, has been classified under the name of fibrosis uteri. Personally I do not like the name, because it suggests a serious lesion and a closer relationship to the real neoplastic conditions which are recognized by the formation and growth of the true myomata of the uterus. As a matter of fact, when small nodules are present, I think that the older name will cover the diagnosis and moreover protect the patient perhaps from a severe major

operation; for hardly any surgeon or gynecologist would care to recommend a hysterectomy because a few little nodules had been discovered by some specially expert fingers. Moreover, we know that certain races, like those of the colored women of this country, show a large percentage of fibroid tumors of varying sizes which never reach the operating table and are discovered only in the autopsy room.

In the cases of fibrosis uteri with or without the small fibrous nodules, the principal lesion consists of a hypertrophy of the muscular wall in addition to the inflammatory lesions of the mucosa. I have seen the fibrous change in the muscular wall of the non-pregnant uterus reach such a degree that, instead of the normal one-eighth to one-quarter of an inch, the thickness measured one-half and even three-quarters of an inch. Of course, such a degree of hypertrophy, associated with a diseased endometrium, would account for the leuchorrheal discharges, excessive menstrual bleedings, and the dragging pains of which these patients complain. Nevertheless, I have not reached that degree of conviction which might have permitted me to report a large number of hysterectomies done for this lesion. As a matter of fact I feel justified in still following the course of procedure, planned by my teachers, who were contented with performing a simple but thorough curettage. With a lacerated cervix, and, possibly, imperfect pelvic floor, reparative procedures are also indicated. In cases of retroflexed or prolapsed uteri a fixation operation appropriate to the individual case should be superadded.

In this woman's case the line of treatment has been purely palliative, and we refer her back to the outdoor department for further care. In view of the success with which our assistants are meeting there is absolutetly no indication, at least for the present, to consider the question of operation at all.

The palliative or non-operative treatment of a case of this kind is very simple. The principal things to bear in mind are the inflamed endometrium and the heavy uterus. The former condition causes the leucorrheal discharges and uterine hemorrhages; the latter feature is accountable for the dragging

pains in the back or inguinal regions. To get at the endometrium, various solutions (like nitrate of silver, acetic acid, carbolic acid, etc.) have been recommended. By means of the Shultze (or better the Boldt) intra-uterine syringe, these solutions can be injected into the uterine interior. A note of warning should be properly sounded at this point; for the procedure, unless employed by skilled hands, is at times associated with positive danger. For my own part, when intra-uterine treatment is called for, I prefer the cotton-covered Playfair applicator. Whether the one or the other method is to be employed, the *conditio sine qua non* must be a pervious utero-cervical passage easily traversed by either instrument. In the presence of marked stenosis, occlusion or obstraction, full dilatation of the cervical canal must precede any form of local treatment.

The heaviness of the uterus, in these cases, tends to cause varicosity and congestion of the adjacent structures and the dragging pains of which these patients complain. To combat this disagreeable condition we employ properly supporting abdominal elastic binders or corsets. The patient douches herself, several times daily, with hot solutions, in large quantities, while lying on her back on a metal bed-pan with the hips elevated as much as possible—so that the upper vaginal tract is more or less continuously bathed in the hot solution, which must be at least 110 to 115 degrees Fahrenheit. In the mean time tampons—variously medicated according to conditions present—are introduced by the physician in order to act as a supporting column from below. Under this plan a large proportion of the cases get along without operative intervention of any kind.

CASE III. BILATERAL SALPINGO-OÖPHORECTOMY; ADHESIONS.

Mrs. A. B. is 34 years old, married five years and has never been pregnant. Her menstruation began at the age of 16 and was regular during the next three years. Excepting an occasional bloodstain, she was in a condition of amenorrhea during the following two years. After this, menstruation became

normal. She then came to this country and her periods came on at intervals of two weeks. Because of some painful pelvic condition, attributed to a bilateral salpingo-oörphoritis, she was operated on in a Hoboken hospital about five years ago. Since then menstruation has ceased.

She complains of pain in the lower abdomen and back—especially when the bowel is constipated—and this alternates with itchiness and sticking pains all over the body.

The vagina is small and the small uterus is discovered buried in the hollow of the sacrum.

The adnexa were evidently removed at the time of the operation and no effort apparently was made to secure the uterus from the backward toppling resulting from the removal of the lateral broad-ligament support. There are sensitive areas to be felt in various locations about the uterus, which are attributable to adhesions at the site of the broad-ligament stumps. The uterine backward displacement of a fixed character is responsible for the sufferings of which she complains, especially when the bowels become constipated. Bands or adhesions between the uterus and sigmoid flexure or rectum account for both the constipation and the concomitant pains.

Owing to the fact that my time has expired I cannot go thoroughly into this case. I can only say that adhesions are among the most discouraging sequelæ of operative work. To reopen the abdomen and break them up is not as satisfactory as might be assumed, for recurrence is almost inevitable. The best operators try to prevent the formation of adhesions by leaving no raw wounds or stumps at the time of the primary operation.

LABORATORY METHODS FOR THE GENERAL PRACTITIONER

THIRD PAPER

In our last article we digressed somewhat and inserted a chapter, really, on the various diseases which could be diagnosed by the microscope, but we believe it was space well used.

We will now pass on to the instruments and material required for micro-biological methods of diagnosis.

Microscope, with sub-stage condensor, two oculars, 1 and 2 inch. Three objectives, ¼ inch, ⅛ inch, and 1-12 inch; the latter, oil immersion lens.

As the microscope is the most important laboratory instrument, it must be of a good make. The shape, size, and adjuncts of the body or stand of the microscope itself are of comparatively little moment; but it is absolutely necessary that it be faultless in its construction. It mist also be capable of adjustment for use with the most powerful objectives, and with Abbe's condenser, or some other similar arrangement.

Any one of the following makes may be depended upon.

Zeiss, Leitz, Bausch & Lomb, Spencer.

A bottle of immersion oil.

½ gross slides, clear colorless glass are preferable.

½ oz. cover glasses ¾ inch square and not thicker than 0-18mm.

One platinum wire needle.

One platinum wire loop.

A pair of cover glass forceps.

Spirit lamp.

One dozen test tubes assorted.

Glassware, comprising watch glasses, small glass funnels, etc.

Filter paper.

Litmus paper.

Stains, (Grubler & Co., Leipsig, may be obtained in 30 gram. bottles all ready for staining, may be depended upon.)
Methylene blue. Alkaline.
Carbol-Fuchsin.
Gabbet's Bacill-Tinction, No. 1.
Gabbet's Bacill-Tinction, No. 2.
Bismarck Brown.
Gentian Violet.
Eosin.
Wright's Stain for Blood.
The above table stains should be kept in 30. cc bottles with pipette corks.
Clearing and mounting media.
1 oz. Analine Oil.
1 oz. Xylol.
1 oz. Canada Balsam in Xylol.

Chemicals:
Ac. Acetic Fort.
Ac. Hydrochlor. Fort.
Ac. Nitric Fort.
Caustic Soda.
Lig. Ferri Perchloride.
Solution Sodium Chloride (26% saturated.)
Solution Potassium Ferrocynide.
Solution Capri Sulph.

Other apparatus and material will be added from time to time and will be discussed when the particular procedure is being described.

In the manipulations necessary certain maxims should be followed: For instance, all instruments, apparatus, and glassware used should be cleaned before laid away. In every case where a platinum loop or needle is used for making a smear it should be carefully heated in the flame before and after using.

If by accident a drop of any material be spilled on table or floor it should be at once covered with 1-1000 solution of bichloride of mercury. (A bottle of this solution may be kept for this purpose.)

The demonstration of the Bacillus Tuberculosis in sputum is one of the commonest and at the same time one of the simplest of all bacteriological examinations required, and called for, but while a common and simple matter, it must be carried out in all details with the same care and technique as is necessary to a successful outcome in a much more difficult and complicated procedure, and this demonstration of bacillis tuberculosis will serve for a type for all smear or film preparations, which urges us to give in all detail.

The article on Professor Osler which appears elsewhere in this issue was taken from "T. P.'s Weekly." We have no apologies to make for its reproduction. It is inserted in the hope that it may inspire us to "Go thou and do likewise."

THE SASKATCHEWAN MEDICAL JOURNAL

HARRY MORELL, M.D., C.M., *Chairman of Publication Committee*

All communications relating to this publication should be sent to the Saskatchewan Medical Journal, Regina, Saskatchewan, Canada. Box 1106.

Editorial Notes

The Roddick Bill again

This session of Parliament has been prorogued, and there is again postponed the long looked for relief from an intolerable and quite unnecessary position. We marvel at the patience of Dr. Roddick, who has for years been in charge of the proposed Act in the House of Commons.

On account of this vital question to every active medical practitioner in Canada, from East to West, and also that the meeting of the Canadian Medical Association will take place at Toronto in June, we place before our readers a *résumé* of the whole matter which is the subject of the leading editorial in April number of the "Montreal Medical Journal."

THE CANADA MEDICAL ACT.

It will be remembered that at the meeting of the Canadian Medical Association, held in Winnipeg in August last, the question of revising the Canada Medical Act, 1902, came up for discussion. It was found that for certain reasons, three of the provinces refused to join the others in beginning the work made possible by this Act. A large and influential committee was therefore formed, consisting of representatives of all the Councils, and of the profession generally throughout the provinces, for the purposes of assisting Dr. Roddick in obtaining from the

Dominion Parliament, an amendment, to the effect that when five or more of the provinces agreed on the terms of the Act, the scheme of registration, so far as they were concerned, could be established.

The committee met in Montreal on the 16th November last, all the provinces, with the exception of Alberta and Saskatchewan, being represented. A lengthy discussion took place, in which the delegates from one of the larger provinces objected strenuously to any such amendment, contending that, unless all the provinces consented, the Act would be unconstitutional. After a time, however, it was found possible to come closer together than had been anticipated, and a series of amendments were drafted to satisfy those provinces previously objecting. These amendments were subsequently printed and sent to the various councils for their approval. In fact, everything was practically ready for presentation to Parliament, when the executive in British Columbia telegraphed, urgently pleading for delay, being unwilling, in fact, to go further without submitting the amendments to the entire profession in that province. As the time for presenting bills had already nearly expired there was no alternative but to postpone the introduction of the Amended Act. Dr. J. B. Black, member for Hants, had kindly consented to take charge of the Bill, and had practically secured the co-operation and support of the medical men in the House. The disappointment was, therefore, universally felt.

As to the amendments proposed by the Committee, these had reference chiefly to the subjects of preliminary education, to the scheme of representation, and to the so-called retroactive clause. It was originally intended that the Dominion council should take some cognizance of preliminary education. It is now proposed to leave that subject entirely to the provinces, whose councils, or whose representatives on the Dominion council shall be obliged to satisfy themselves that the matriculation passed by candidates for the Dominion license is of sufficiently high standard. While this concession may seem, to the casual observer to be a matter of vital importance, there is every reason to believe that it will work out to the satisfaction of all.

The scheme of representation, originally based on census returns, will now give two representatives, on the Dominion council, to each of the provinces, and on account of their greater size, one additional to Ontario and Quebec. The universities, as originally proposed, shall each have one representative; and the Governor General in Council shall appoint three members, each of whom shall reside in a different province. In addition, there shall be three members elected by such practitioners in Canada as by the laws of the province wherein they practise are now recognized as forming a particular and distinct school of the practice of medicine; and as such are by the same laws entitled to practise in the province. Each of these shall also reside in a different province.

As to the retroactive clause, so-called, the original draft practically read that when a person properly qualified had been engaged for six years in the active practice of medicine in one or more of the provinces of Canada, he shall be entitled to be registered under this Act as a medical practitioner, without examination. The amendment extends the period to ten years; but further provides that if the medical council in any province be not satisfied with the period of years thus prescribed, it may exact an examination in final subjects from the practitioners seeking registration in that province.

With reference to the vital question of examination, it is thought now that the Dominion council will relegate to a corps of assessors the supervision of the primary examinations as they are being held in the various universities of Canada; while the Board of Examiners to be known as the Medical Council of Canada Examination Board shall undertake the examination of all candidates in the final subjects only. This will greatly lessen the expense, besides economising time. The examinations will be held only at those centres at which there is a university or college actively engaged in the teaching of medicine, or having hospital facilities of not less than one hundred beds.

It is not the intention by the Act to disturb the *status quo*, so far as the provincial boards are concerned. These will expected to satisfy themselves by examination or otherwise,

regarding the qualifications of candidates seeking a license to practice in one of the provinces only. Doubtless, in time, some of the smaller provinces especially, will refuse to examine, thus obliging all to come armed with the Dominion license. Besides, there being nothing in the Dominion Act to regulate taxation and the discipline of the profession generally, it will be seen that the provincial bodies must, for purposes of that kind, also continue to exist.

It is earnestly to be hoped that the delay in bringing the Amended Act before Parliament during the present session, will not seriously endanger the future of the measure. It is desirable that all the Provincial councils shall be well represented at the meeting of the Canadian Medical Association in Toronto, in June next, when the work of the Winnipeg committee will be fully reported and discussed.

A communication has been received from a prominent medical man who protests and points out that a certain person employed by the Provincial Government, who is and for some time has been in the habit of attending to private patients. We have been asked to make enquiries regarding this. This matter will be taken up in a later issue. We shall be glad to hear from any of our readers on this subject.

Another matter has been brought to the attention of the editorial department. The question is: "On complaint, will the Council of the College of Physicians and Surgeons prosecute an unqualified person that administers anaesthetics?" We are quite clear on this question, and give the opinion that if a person who is unregistered and unqualified, and is in the habit of giving an anaesthetic, he may be proceeded against in the ordinary methods contemplated by the Act, Cap. 28, sec. 64.

Canadian Medical Association

For the 43rd annual meeting of the Canadian Medical Association in Toronto on the 1st, 2nd, 3rd and 4th of June, transportation arrangements are in force on the standard certificate plan, with the exception of British Columbia, where the regular summer tourist rate will prevail. All intending delegates should consult with their ticket agents when purchasing first-class transportation to Toronto as to rates, dates of sale of tickets, time limits, and routes. For these purposes the Association and the Canadian Dental Association are coupled; and fare will be single for going and returning if three hundred are present at the two conventions holding standard convention certificates, between Halifax and other eastern points and Laggan and Coleman, B.C. The first general session will be held on the afternoon of the first day, when the President-elect, Dr. Adam H. Wright, Toronto, will be installed in office and the opening ceremony will take place. Following this there will be a report of the milk commission by the chairman thereof, Dr. Chas. J. Hastings, Toronto, and addresses by Dr. Evans, of Chicago, Dr. North, of New York, and others. On the evening of the first day, Dr. Harringham, of London, England, will deliver the address in medicine which will be followed by the discussion on Dominion registration. The sections which have exceptional programmes will meet in the forenoons. On the afternoon of the second day, Thursday, there will be an excursion to Niagara Falls and a dinner at the Clifton House. The address in surgery will be delivered Friday afternoon by Dr. Murphy, of Chicago, followed by a symposium on ex ophthalmic goitre, and at 5.30 p.m. the annual meeting of the Canadian Medical Protective Association will be held. Friday evening the address in obstetrics by Dr. Henry Coe, of New York, followed by a symposium on the psychoneuroses. A general session will be held Saturday forenoon, and about eleven an excursion will be taken to Guelph to visit the Ontario Government institutions in the Royal city.

Professor William Osler

PEOPLE who are inclined to despond about the decadence of the old country and its small chance of success against the rising young giants of the world, may profitably remember that Britain has always had an extraordinary faculty for absorbing new blood to refresh her old strains. The most composite nation in the world has kept its energy alive by never-ceasing alien immigration. We are doing it now more vigorously than ever. Oxford has been galvanized into new life by the advent of two hundred picked young scholars and athletes from over seas, who are leaving their imprint upon every field they enter. When Oxford had to fill that most venerable of all academic chairs—the Regius Professorship of Medicine—she defied all precedents and brought over William Osler from the Johns Hopkins University of Baltimore. It was simply the wisest appointment of our generation, a daring raid upon the new world to remedy the deficiencies of the old. As long as we are capable of that sort of thing we need not despair of ourselves.

A GREAT TEACHER.

For Osler is the greatest medical teacher of his time. He has been teaching all his life, moving from one field to another, and at every step bringing an inspiring influence to bear upon the organization that has been fortunate enough to detain him for a time. The details of the career of a successful man are generally dull enough reading. In Osler's case they are so remarkable that they may be recited as they stand, without sounding as an extract from a catalogue. They are an epic of labour and achievement. Born 61 years ago in one of the little Ontario townships, William Osler was the sixth son of an English

clergyman, a Cornishman, and a Cambridge graduate who went out as a missionary in 1837. Young Osler went to Toronto for his education. Montreal and London followed up the work that Trinity College, Toronto, had begun, and then he came across the Atlantic to add an European polish to the comparatively rough teaching he had acquired in his native land. University College, London, and the Medical schools of Berlin and Vienna brought him in line with the most advanced medical knowledge of the day. At 25 he was summoned to Montreal as professor of the institute of medicine at McGill University. For ten years he worked there and built up a reputation as a teacher and inspirer of others that soon spread far beyond the limits of his city. He was over in Europe on a vacation when he got a letter asking him to stand for the professorship of clinical medicine at the University of Pennsylvania. He took it for a hoax, and did not answer it until corroborative evidence came. In his own words:

"Dr. Mitchell cabled me to meet him in London, as he and his good wife were commissioned to 'look me over,' particularly in reference to personal habits. Dr. Mitchell said there was only one way in which the breeding of a man suitable for such a position, in such a city as Philadelphia, could be tested: give him cherry pie, and see how he disposed of the stone. I had read of the trick before and disposed of them genteelly in my spoon— and got the chair."

Five years in Philadelphia made him the most popular man in the city, and the most efficient teacher in the university. And then he moved on again. "The test of the true American," it has been well said, "is the impulse to move on," and in this respect no truer American than Dr. Osler ever lived. This time his move was an epoch-making one. He was called to be professor of medicine in the Johns Hop-

kins University of Baltimore. In 1889, when he went to it, the strangely-named university was not even a name to Europeans. Now it stands in the first rank in the world as a medical school. Sixteen years of Osler's work were responsible for that elevation. It was at Johns Hopkins that he perfected his methods as a medical teacher, and gathered to himself the reputation that led to his final call to Oxford in the year 1905.

A FRIEND TO YOUNG MEN.

It was the opening of the Johns Hopkins Hospital which had called him to Baltimore. There he found himself faced with a great problem of organization. It was universally expected that the newly-founded medical school would make a new contribution to higher medical education, and would not content itself with merely falling into line with the many overworked hospital schools of the country. Osler solved the problem by demanding from those who entered the school a far higher standard of qualification than was known elsewhere, and by giving a fuller responsibility and ampler opportunities to the selected men who walked the wards of the Johns Hopkins hospital. Withal, he had a unique capacity for inspiring enthusiasm and a selfless devotion to the art of medicine in those who worked under him. Perhaps the greatest of all his secrets was his attitude to young men. In England, unfortunately, our older men tend too often to suppress their juniors. They deliberately try to keep them in their places, to teach them their insignificance. A young man has to fight his way upward with little encouragement through a great deal of cold water. Osler would have none of this. He made it always his object to know and understand the young men, to find out the promising and earnest

ones, to encourage them and to help them on with his cheery friendship. He does not wait for them to come to him, he seeks them out, and they freely help themselves from the stores of his knowledge and his sympathy.

HIS WIDE CULTURE.

No harder worker ever lived. Scientific monographs do not lend themselves to verbiage, so it may be faintly realized what is meant by the fact that a partial record of his publications down to the year 1907 fills fifteen columns of the quarto catalogue of the Surgeon-General's Library at Washington. His great book on the "Principles and Practice of Medicine," has reached a seventh large edition. He has edited a "System of Medicine," in seven large volumes. He has written authoritatively on every aspect of the art of medicine which has come within his ken during his vast clinical experience. Even the best medical men tend to narrowness in their scientific brilliance, but Osler is one of the two or three leading physicians who are men of really wide culture. He is a humanist of the great days of humanism, a scholar, a thinker, a public man. He is, incidentally, a passionate bibliophile. While still an American professor his lectures and addresses on general topics had become famous. With ampler leisure he has been able to indulge this side of his activity by the publication of several fascinating volumes, "Science and Immortality" (1904), "Aequanimitas and Other Addresses" (1904), "Counsels and Ideals" (1905), "Thomas Linacre" (1908), "An Alabama Student and other Biographical Essays" (1909)—here we have in the mere by-products of a busy, scientific teacher an output equal in quantity and quality to the product of a literary specialist.

THE REAL MAN.

But when all is said, the man is greater than his work. Osler might have had all his ability, yet he might have done little with it if he had not possessed also a personality of pure gold. The love of his fellows has come to him wherever he has wandered, and he has been a wanderer since his boyhood. An amusing passage from a valedictory oration delivered in New York before his departure for England gives some idea of the place to be filled in the hearts of his colleagues. These are the words of Dr. J. C. Wilson:

"The remarkable thing is that the further he moves the more he is missed. There is no authentic record of the state of mind of that far settlement of Ontario which he left in early infancy, nor of the nature of the repast by which his departure was celebrated. But when he left Toronto there were tears and sorrow and something to eat; and when he left Montreal, the same, with singing; and when he took his departure from Philadelphia we had emotions we could not suppress, together with terrapin and champagne; and now he is going to leave the country there is universal sorrow and the largest medical dinner ever cooked."

It has been his fate to give the most striking possible refutation of his own theory of old age, a theory, by the way, which merely sprang from an ebullition of post-prandial jocosity. At 61 he is a marvel of youthful vitality and elasticity. He brings with him into musty lecture room and pedantic common rooms of Oxford a fresh breeze of virility and optimism and large humanity. He has shaken our old men, and sounded the charge to our young men in the army of medicine, and by the charm of his personality he has wrought new links to bind together the old world and the new.

News Items

On Monday March 28, while engaged in conducting an inoculation test, Dr. A. B. Wickware, a member of the staff of the Dominion biological laboratory at the experimental farm, Ottawa, was accidentally injured by rabies, and it is believed has contracted the disease. After communicating with the provincial health officer, Dr. C. A. Hodgetts at Toronto, Dr. Wickware immediately left for New York for treatment at the Pasteur institute.

Rev. Percy Billings, pastor of the Swedenborgian church, has resigned from the Ontario legislature suffrage association because of the appointment of a medical committee to work for inspection before marriage. "I feel that such an association has no right to interfere in the matter any more than they have to force a man to become a vegetarian," he said.

On Saturday night, April 9th, an At Home smoker was given jointly by the Regina branch of the British Medical Association and the Regina Clinical Society to the guest of the evening, Dr. George D. Porter, commissioner of the Canadian Association for the Prevention of Tuberculosis. During the course of the evening Dr. Porter gave a great deal of information respecting the steady growth of this association for the stamping out of the white plague. All the provinces in the Dominion, with the exception of Alberta, were combining for the eradication of this dread disease. Saskatchewan was doing her share in the work and already several local leagues have been formed. These local leagues are formed, and for every twenty members one representative may be sent to the provincial convention which will in all probability be held in Regina. An extremely pleasant evening was spent.

Book Notices

Aids to Microscopic Diagnosis, By *Ernest Blake Knox, B.A., M.D.* (Dubl. Univ.). Bailliere, Tindall & Cox, London, England. Price 2/6 (62c).

A small volume consisting of 156 pages. "The object of this handbook is to supply those preparing for examinations with a work for revision purposes." There is crowded into this small book an immense amount of information which will be appreciated by those who want the elements of microscopy at their finger tips.

Clinical Memoranda for General Practitioners. By *Alex. Theodore Brand, M.D., C.M.*, and *John Robert Keith, M.D., C.M.* Bailliere, Tindall & Cox, London, England.

In a book of 207 pages the authors include notes on almost everything, from pneumonia to hyoseine-morphine anaesthesia in normal labor. No claim is made, however, that this work is "a comprehensive medico-chirurgical vade-mecum," but it is "designed to be of service to general practitioners and to help, especially the junior commencing practice." And it will.

International Clinics. Quarterly. Vol. 4, Nineteenth Series. These are illustrated clinical lectures and especially prepared original articles on all subjects of medical and surgical science by leading members of the Medical Profession throughout the world. Edited by W. T. Longcope, M.D., Philadelphia. J. B. Lippincott Company, Philadelphia, London and Montreal.

This volume upholds the reputation of former issues. We mention especially a report of a clinic by W. L. Rodman; "Color Photographs in relation to Surgery," by Dr. C. B. Longenecker; "Diagnosis of Cancer of Uterus," by J. S. Cullen, M.B., Baltimore, besides many other interesting lectures and clinics by prominent men.

EMERGENCY SURGERY FOR THE GENERAL PRACTITIONER. By *John W. Sluss*, Professor of Anatomy, Indiana University School of Medicine, etc. Second edition revised and enlarged, with 605 illustrations, some of which are in colors. Bound in limp leather. P. Blaikston's Son & Co., Philadelphia. Price $3.50.

MEDICAL DIAGNOSIS. A manual for students and practitioners. By *Charles Lyman Greene, M.D.*, St Paul. Professor of medicine and chief of the department in the College of Medicine, University of Minnesota, etc. Third edition. Revised, with 7 colored plates and 248 illustrations. 725 pages. Bound in limp leather. P. Blakiston's Son & Co., Philadelphia. Price $3.50.

CONGENITAL DISLOCATION OF THE HIP. By *J. Jackson Clarke, M.B.* (Lond.), *F.R.C.S.*, senior surgeon to the Hampstead and North-West Hospital, etc. 92 pages and many illustrations. Bailliere, Tindall & Cox, London. 1910.

THE SEXUAL LIFE OF WOMEN. By *E. Heinrich Kisch, M.D.*, University of Prague. Translated into English by M. Eden Paul, M.D., and published by Rebman Co., New York. Price $5.00.

The Sixty-First Annual Report of the Superintendent of Central Indiana Hospital for Insane. Indianapolis.

The April issue of "Annals of Surgery" contains many good articles; included are the following: "Pus in the Abdominal Cavity," by John B. Deaver, of Philadelphia; "The Treatment of Diffuse Progressive Free Peritioitis," by Arpad G. Gerster, M.D., of New York. This number is particularly good and contains full page illustrations, with over one hundred and sixty pages of text.

HARRY MORELL.

Personals

Dr. Barrett, of Osage, Sask., who has been laid up during the past two weeks with an attack of fever, is able to be around, though his strength has not returned.

Dr. Oskar C. Gruner, Clinical Pathologist to the General Infirmary, Leeds, England, has been appointed Pathologist to the Royal Victoria Hospital, and Lecturer on Pathology at McGill University, Montreal.

The Lumleian lectures at the Royal College of Physicians were this year delivered by Professor Osler, Regius Professor of Medicine at Oxford.

Dr. A. S. Gorrell has removed his office to Rooms 3 and 4, Masonic Temple Building, Regina.

Charles Sheard, M.D., who is well known to the old "Trinity" men, has resigned as health officer of the city of Toronto, having held that post for eighteen years.

Dr. Porter, the able secretary of the Canadian Anti-Tuberculosis League, having spent about six weeks in Western Canada, has left for his home in Toronto. The doctor's wife and family accompanied him during his western tour.

Dr. F. A. Clarkson, and Dr. J. G. Fitzgerald, of Toronto, have left for Europe and will be absent for a couple of months.

Dr. H. T. Machell, Dr. John Cavan and Dr. A. H. Garrett, of Toronto, have returned from the Southern States.

Some of the prominent Regina physicians are interested in the formation of a sanitarium which will be situated within twenty miles of that city. This is not, we understand, a tuberculosis institute, and is to be operated on ethical lines. It is to be a winter and summer health resort, fitted up with all up-to-date apparatus, as electric baths, etc. Cases which are mental, physical, etc., will be taken.

Correspondence

GREATER BRITAIN AND THE ANNUAL MEETING, 1910.

Sir: The Colonial Reception Committee is particularly desirous of bringing the Annual Meeting, to be held in London in July next, to the notice of all medical practitioners residing in the Dominions beyond the seas, as affording them an unusual opportunity of visiting London both for the scientific purposes of the meeting and also for social intercourse with their fellow-practitioners throughout the Empire.

The Colonial Reception Committee, in conjunction with the Colonial Committee of the Central Council, desires through the medium of this journal, to extend a very cordial invitation personally to all medical practitioners in the colonies, and assures them of a hearty welcome to the Annual Meeting and to the capital of the Empire.

Great efforts are being made by these two committees to arrange such entertainments as it is hoped will meet with the approval of their colonial brethren, and so add to the success of the meeting of 1910.

We are, etc.,

EDMUND OWEN, *Chairman Colonial Reception Committee.*
DONALD ARMOUR. *Hon. Sec. Colonial Reception Com.*

429 Strand, London, W.C., Jan. 3rd.

Obituary

SIMPSON—At Toronto, on the ninth of April, Dr. G. Reid Simpson. The doctor was a graduate of Toronto University of the year 1895, and up to four years ago practiced at Hamilton, Ontario.

SMITH—At New York City, April 8, Dr. Andrew Heermange Smith, in his seventy-third year. Dr. Smith was a very prominent practitioner of New York, and served in the medical corps of the regular army. He was greatly respected and much admired, both by his professional colleagues and by the community.

ROBB—At Cleveland, Ohio, Mrs Hunter Robb, on April 15th. As Miss Isabel Hampton she was the first founder of the training school of the Johns Hopkins Hospital. The New York Medical Journal has this to say:

THE LOSS OF A NOBLE WOMAN.

"By the death of Mrs. Hunter Robb, briefly narrated in our news columns, the profession of nursing, the profession of medicine, and the American people have met with a grievous loss. Mrs. Robb was of Canadian birth and early training, but her matured powers had had their chief play in the United States. She was educated as a nurse, and her beneficent activities were shown in more than one of our large cities. When she married Dr. Robb, an American physician of national reputation, and even when she had become the mother of children, she did not falter in her devotion to the care of the sick; it is but a short time ago that we published an important communication of hers (see the New York Medical Journal for January 15th).

"Mrs. Robb's influence in alleviating the sufferings of the sick and in the improvement of hospital administration cannot

well be overestimated. The medical profession gratefully acknowledges the value of her collaboration in its endeavors to give greater effectiveness to its activity in the service of humanity. She was a noble woman, and her memory will be cherished so long as medicine endures.

A DISTINCT ADVANCE IN BACTERIN THERAPY.

The secret of success in bacterin therapy is to be found in the dosage, as to amount and interspacing. Sufficient bacterin should be injected to keep the opsonins in the blood at high tide, avoiding unnecessarily large doses—for opsonins are wasted in taking care of excess—and not repeating too frequently, thus preventing the tide from rising to the maximum. On this account a graded system of syringe containers has been adopted by the H. K. Mulford Company in place of the ampuls previously employed for supplying bacterins for dispensing.

The great disadvantage of the ampul container was its inflexibility. After the first dose was removed from the ampul there was always the risk of contamination, and many physicians preferred to discard the remainder rather than to take the risk.

This objection is overcome by the graduated syringe containers. Each package contains four syringes of bacterin, marked "A," "B," "C" and "D" respectively. Each syringe being marked in fifths, for an approximate measuring of dosage —the scale being sufficiently accurate for all practical purposes. It will thus be seen that there are twenty or more doses in each package and no waste.

The syringe container has also the advantage of removing all danger of infection through an imperfectly sterilized hypo-

dermic syringe. The syringe, with its plunger and needle, is carefully sterilized in the laboratory before it is filled.

When the rapidly growing importance of bacterin therapy is considered, the value of this improvement in technique introduced by the H. K. Mulford Company will be at once appreciated. The Typho-Bacterin immunization of armies against typhoid fever is becoming a potent agent against the scourge responsible for more deaths in war than the bullets of the enemy; the use of Neisser-Bacterin, in the hands of physicians who have learned to use it, is proving a most effective weapon against the great black plague; the mortality from pneumonia has already been reduced by the use of Pneumo-Bacterin; and other infectious diseases are yielding to bacterins after resisting the usual forms of treatment—all of which goes to prove that bacterin therapy has come to stay, and any system of dispensing bacterins which places these products in the hands of the busy practitioner in a convenient and economical form should be heartily welcomed.