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THE BRITISH MEDICAL ASSOCIATION.

THE 74th Annual Meeting of the British Medical Association, held in Toronto August 21st to 25th, and at which about 2200 Medical men registered, was pronounced by all an unqualified success.

Besides the large number in attendance from the British Isles and every Province in the Dominion, and almost every State of the Union, there were representatives from Germany, France, Switzerland, Belgium, Malta, Br. Guiana, New Zealand, China, West Indies, Bermuda, Newfoundland, Phillipine Islands, Australia, Madras and Bombay.

Dr. Reeve made an ideal president. The association has now more than 20,000 members.

The sections met *promptly* at 9:30 each morning and continued until 12:30. The general addresses were delivered in the afternoon or evening.

The papers will appear in the usual avenues.

The social side of the great convention was well looked after. The various committees, and the Toronto profession generally, are to be congratulated on the completeness of their arrangements. The next meeting will be held at Exeter, England with Henry Davy, M.B., F.R.C.P. (London) as president.

RE-ORGANIZATION OF THE CANADIAN MEDICAL ASSOCIATION.

AT the annual meeting of the Canada Medical Association, held in Halifax 1905, a special committee was appointed to consider the question of re-organizing the Association.

This committee reported on August 20th last, in favor of re-organization along the lines of the British Medical Association, and submitted a draft of the proposed Constitution and By-Laws. The appointment of such a committee was in itself sufficient evidence of the wide-spread dissatisfaction. For years, despite the energetic efforts of the successive presidents and their associates, the meetings of the Canada Medical Association have been disappointing in their results. The reason seems to have been a general lack of vital interest on the part of the profession. A few have been faithful, but only a few. We are bound to think the large majority have looked upon the meeting of the association as an opportune time for a short vacation—a refreshing of the body rather than the mind—and in this spirit have lent their presence. These, it is true, swell the numbers, but they are to the society what useless adipose is to the individual: their very presence is a menace to the life of the institution.

If the physician or surgeon expects to derive any benefit from the meeting, or be of any value to it, he must go prepared by careful study and research to discuss intelligently the subjects coming before the association, or at least that section of it, in which he is more vitally interested. This implies the announcement of the subjects for discussion one year in advance. We believe this should be done. To know the traditional facts regarding a disease is not sufficient, and to add new ones requires time and opportunity. The general addresses should be delivered by men, who from their wide experience or scientific research, are competent to lead—and to lead successfully we must lift.

The Canada Medical Association should be the mouth-piece of the Canadian profession. It is scarcely likely that the Roddick bill would have met the fate it did, had it had behind it the force of a strong national organization. The State

would be the gainer too, for instead of one or two men advising the government on matters of public health, the whole profession would indirectly have a voice. This leads to the next consideration, viz., the establishment of a journal. Without doubt the very existence of the association is dependent on the publication of an up-to-date journal. As McCallum of London pointed out at the recent meeting, to publish an article in a Canadian journal seemed about tantamount to consigning it to the flames or locking it up in a drawer. The infrequency with which Canadian journals are quoted abroad is familiar to all. This we venture would not be the case had we a journal bearing the imprimatur of the Canadian profession. We are not ungrateful to the independent medical press of this country. They have done what they could, and an official organ will not displace them any more than the *British Medical Journal* has displaced the *Lancet* or *Practitioner*. The question of financing a journal of the Canadian Medical Association with our present numerical strength is a serious one. It must of course be a strictly ethical publication. We are of the opinion a monthly journal is all that should be attempted at present.

The association having been duly constituted no time should be lost in appointing an energetic organizer. His duty would be to increase the membership and establish where possible branches of the parent association. He need not be a medical man. The necessity for such an officer will be apparent to any one who will take the trouble to glance over the registration list at any of our annual meetings. At the Halifax meeting, for example, there were only 222 in attendance, and of this number less than 200 actually registered and paid their annual fee. It may be pointed out in this connection that the British Medical Association, which has now a membership of upwards 20,000, had only 140 members in 1832. Still, we are moving at a faster pace, whether a better or not, and it seems most important that the whole scheme should be carefully outlined and submitted at the next annual meeting of the association and in such a way that it may take form. The report should not deal in vague generalities, but in minutest details; it should include the estimated cost of publishing the journal, the salary of an organizer, &c., suggestions as to management,

&c. Only in this way can the scheme be fairly launched, or when launched safely guided from the rocks until it has reached the midstream.

JAS. THIRD.

WE are in receipt of a copy of report of the fifth annual meeting of the Canadian Medical Protective Association. While by far the greater number of its members hail from Ontario, it is gratifying to note the growing interest in the Association on the part of our confreres of the sister provinces.

The Treasurer's statement shows a healthy and sound financial condition, the solicitor's report furnishing abundant reason therefor. During the past year out of four actions laid against members of the Association two were dismissed at the trial, one was settled out of court, the defendant obtaining judgment for dismissal of action; the fourth case was abandoned by the plaintiff and did not come to trial.

The organization of this Association has clearly had the desired effect—that of quashing unjust and malicious claims against medical men. As no member of the profession is immune to such actions being laid against him, it is to be hoped that the membership will be largely increased during the coming year.

MEDICAL RESULTS.

FOUR STUDENTS AWARDED THEIR DEGREES AS A RESULT OF THE SUPPLEMENTAL EXAMINATIONS IN MEDICINE.

The following gentlemen obtained the degree of M. D. C. M. at the fall supplementary examination.

G. F. Cliff, Carleton Place, Ont.

R. S. Devlin, Montreal, Que.

H. T. A. Jamieson, Montreal, Que.

E. G. Twitchell, Burlington, Vt.

THE APPLICATION OF MODERN HOSPITAL METHODS TO THE TREATMENT OF THE INSANE.*

FROM year to year and from age to age the world of science progresses. Succeeding generations profit from the mistakes and learn from the experience of their predecessor. Not only are we progressing in a puerly scientific manner, but in all those side lights of our existence we are leaning more and more to generous and humane instincts. Especially is this instinct of humanity discernible in the greater care bestowed on sick and afflicted whether these be either physical or mental sufferers. 'Tis a far cry now from the general administration of our hospitals for mental diseases to the days when Pinel struck down the iron shackles from the afflicted in the hospitals of Paris. Cruelty, torture, violence, even restraint, have been gradually banished from our hospitals for mental disease. The paternalism of the State and the growth of private beneficence tend to the solution of problems heretofore beyond our power. The self sacrificing devotion with which scientists give their lives to the solution of the difficulties besetting humanity make the outlook in mental research hopeful in the extreme. For while great advancements have been made in clinical treatment of the insane, a wild field in therapeutics and pathology yet remains. In the cultivation of the hospital spirit and in the application of modern hospital methods of therapeutics and research lies the hope for the future. The open air treatment, bathing in open water, employment and hammock rest, therapy, "the gradual re-education for co-ordinated occupation", the influence of music, games, sports, pertain more particularly to well established sanatorium and asylum practices. They are in a measure outside the methods of general hospitals, though of unmistakable value. The first essential is a staff of trained nurses, both male and female, that proper nursing and efficient hospital practices may be thoroughly adopted and effectively prosecuted. Another, though probably less important, end is served through the training of nurses in the diffusion of knowledge regarding the care and treatment of mental diseases. Facilities for the administration of hydrotherapy in its various forms and a skilled reliable service therefore

*NOTE.—Read before the British Medical Association, Toronto, Aug., 1906.

is a prime necessity. In the acute cases and in the excited stages of mania and dementia, the continuous bath affords the speediest method of alleviation. The hot pack has long been recognized as a valuable aid. But the continuous application can be better attained and more generally and thoroughly carried out by the bath system. In the quieting nervous influence, the elimination of toxines, the producing natural sleep, the continuous bath, affords the best results. The soothing effect of the continuous bath in allowing the patient to produce control and maintain it is most encouraging. For similar reasons the hot air bath is an important adjunct. The use of saline infusions in cases of auto intoxication produced by imperfect metabolism has secured a permanent place in hospital practice. In various septic conditions the delirium and fever have been reduced, circulatory and central involvement have been relieved in a marked manner by the intravenous, submammary and subcutaneous or rectal administration of saline solutions. What part auto intoxication plays in disturbed mentality has not been definitely determined. But of the value of saline therapy there can be no doubt. In one case of acute mental confusion due to insulation its remedial effects were beyond question. The nurses in our hospitals should have special instructions in dietetics, and full facilities for this important branch of our work should form a part of every properly conducted hospital. The subject of feeding our patients is a most important and a most troublesome one, unless proper facilities for special dietaries are at hand a most valuable adjunct to treatment is wanting. The part played by massage and electrotherapy is of great interest. No doubt in many instances it is overestimated, in many instances abused. But in proper cases and wisely directed, it has its beneficial effects. Time and study on the part of our asylum physicians are necessary to bring out the best value of this line of treatment. It cannot be done hurriedly, nor by the inexperienced, nor without proper apparatus. But proper apparatus for electrotherapy should be a necessary adjunct for every properly equipped hospital for the insane. The need of more general pathological work in connection with our asylums is one of the most urgent demands of the hour. No hospital for the sick of any pretension could continue its work

with any hope of success without the aid and guidance of skilled pathologists. Indeed the general practitioner of to-day who is ambitious for the successful issue of his work must needs possess a thorough knowledge of bacteriology and pathology. He has his microscope and necessary equipment and brings them to his assistance in the performance of his work. But our asylums, where so much valuable and necessary work remains to be done, are contributing practically nothing to pathological study. By means of the microscope and through the labors of pathologists light has been shed on many forms of disease by which humanity has for years been afflicted. And surely it is not too much to hope that aided by patient and well directed pathological work we may yet attain more scientific and accurate knowledge as to the cause of insanity. Through the microscope we may see the light. The work to be of value must be undertaken with thoroughness and system. Well equipped pathological laboratories should form an essential part of every hospital for the insane. In many instances the work might be done in connection with and by the pathologists of adjacent schools and hospitals. If such an arrangement could be made unnecessary outlay would be obviated. But the ideal can only be obtained by the clinical and pathological study going together hand in hand. To undertake this work the medical staff must be relieved of the burthen of administration work. Classification in our hospitals for the sick is a primary essential, and justly so. Sufficient accommodation is readily found for such an end. A patient suffering from the delirium of typhoid or pneumonia would be isolated, to prevent his disturbing the entire ward, and that especially directed therapeutic measures may be successfully applied. It has always appeared to me that the mentally sick should receive like consideration. Above all, should help and accommodation be sufficient that acute cases might receive constant treatment. To apply hot baths, massage, special dietary, the hammock treatment, and so on, during the day, and then for want of nurses to be compelled to administer a soporific and lock the patient up at night, is quite unfair to the patient and renders abortive any special line of therapeutics. Provision should be made for the reception of patients with infectious diseases. To permit a patient

in the advanced stages of consumption to remain in the same wards and dormitories with non-infected patients seems little short of a criminal act." And yet how many asylums have attempted to make even the slightest effort to meet this condition. For the treatment of purely physical conditions a properly equipped operating room should form a necessary attachment of every hospital for the insane. I do not urge unnecessary surgical interference, but certainly where organic lesions occur they should receive surgical attention for the physical as well as for psychic effect attained. Our hospitals for the sick are open to medical students and for clinical purposes to all who would enter therein. Their halls have witnessed the triumphs of the greatest men of all ages, their teachings, clinical. Research work has been such a gift to humanity that humankind can never repay the debt. Men eminent in the world of medicine have loved these hospitals as the source of their inspiration, the fountain of their intellectual life. I make a plea for opening the wards of our hospitals for the insane to the medical student, to the clinician, for the spread of knowledge, the advancement of science, the protection of the race. It is within the memory of most of us the hospital dread. "He has gone to the hospital," was a message of almost sinister import. The methods of our modern hospital for the sick has changed all this. Expert nursing, efficient administration, greater individual attention, make the hospitals of to-day when necessary a matter of eager selection. With wider clinical methods, personal contact of the student with the patients in our hospitals for the insane, earlier diagnosis and more efficient equipment must result. I feel, too, that when the hospital idea is fully understood there will be less odium attached to those who seek treatment therein. With the life history and habits of the spirallae of relapsing fever our students and practitioners are in theory intimately acquainted. We follow with animation Koch's labors on sleeping sickness, though few, if any, of our young men will ever observe a case. Yet of relapsing mental conditions and of that sleeping mental sickness, how many of our young men go forth with even an elementary knowledge? In our general hospitals the student and clinician have profoundly impressed on him every physical element necessary to

complete knowledge of the physical life in hand, its hereditary conditions, social environments. Before his mind he can pass in review the cellular strength and weakness of the organism with which he has to deal. But with varying mental conditions the general practitioner is not much concerned. Our hospitals for the insane should open wide their doors for clinical study, that a wider knowledge and closer contact may generate a widespread interest in the prevention and cure of mental disease. The patient infected with tubercle may take the hospital treatment and go forth again to years of economic and social life. There may be a recurrence or reinfection. Years of teaching have brought this knowledge to the public. The public should be taught the value of early and proper treatment of mental disease and that mental restoration thus obtained may be permanent. To the physicians attached to our hospitals for the insane should fall the duty of leading in this movement. To me there appears no valid reason why asylum physicians should live a life apart from their co-workers in other fields of medicine, nor should their institutions be regarded as other than hospitals for the treatment and cure of disease. May we not expect to see the day when treatment in such hospitals will leave no shadow on a name.

DR. E. RYAN.

SOME COMPLICATIONS FOLLOWING THE THIRD STAGE OF PNEUMONIA.

IN speaking of the stage of resolution a lobar pneumonia from a pathological standpoint Coats says.....“The cells and fibrin in the air vesicles undergo fatty degeneration and the plugs soften.....The fatty degeneration and disintegration of both cells and fibrin result in the conversion of the exudation into an emulsion which fills the alveoli and, having a yellow or greyish brown appearance resembles pus in its naked-eye appearances.”

This material is gotten rid of in two ways—by expectoration and by absorption. The largest amount is usually absorbed. Coincident with these changes in the exudation other changes take place in the lung tissue itself tending towards its return to the normal condition. In a brief way the pathological process involved in resolution of pneumonia lung tissue is thus stated.

There are unhappily other less fortunate processes which ensue in some cases of lobar pneumonia.

One is purulent infiltration of the lung where the inflammation does not cease and the softened exudation becomes filled with leucocytes and true purulent infiltration occurs. In some cases this passes on to abscess of the lung. Again, in haemorrhagic forms of pneumonia or in cases where the patients have been addicted to alcohol the process sometimes terminates in gangrene.

Another unfavorable result, though of rare occurrence, is the prolongation of an acute pneumonia into a chronic form.

In the event of such a termination the lung becomes the seat of "chronic inflammation without anything of a tubercular nature." These cases vary in severity and may last from a few weeks to months, the graver forms often proving fatal. In this connection I wish to refer to a case of pneumonia that came under my notice last April. The young man was sent to the hospital here on April 21st, suffering with a fairly sharp attack of pneumonia. His family history was good, his habits were model, and he was of naturally splendid physique. The attack alluded to had a gradual beginning. He complained of a pain in his right side for some days previous to the actual onset of the trouble. He said also that during this time, while he still kept on at his work, he would feel feverish in the afternoons. His brother, a medical graduate, took his temperature a couple of evenings before he went to the hospital and found it to register about 102° . Sometimes he felt chilly, but the onset was not marked by any distinct rigour. His temperature on the evening of his admission to the hospital was $103\frac{1}{2}$. The site of the pneumonic process was a fairly well defined area in the lower right lobe posterior aspect. The sputum was scanty though characteristic, and upon bacteriological exami-

nation showed the pneumococcus as the predominating bacterial form. From the date of admission to hospital his case ran a comparatively typical course, and ten days later the crisis occurred, the temperature dropping to normal. The following evening, however, the temperature rose to $99\frac{2}{3}$, and two days later there was an evening register of $101\frac{1}{4}$.

The patient began to have heavy sweats during the night, accompanied by a marked remission in temperature. There was very little cough and very scant expectoration.

Physical examination revealed the original dull area not diminished in size, and the dullness was moreover of a peculiar wooden or flat character. At this juncture we explored with a needle, but found neither serum nor pus. It may be noted here that in these non-tubercular consolidations of the lung fluid is not apt to appear in the pleural cavity, owing to the fact that there is no contraction but rather increased density and some swelling of the lung tissue. The temperature tracing for the following two weeks showed a gradual ascent, the range at the end of the second week running up in the evening as high as $103\frac{1}{2}$. During the night there would be a copious sweat, and the temperature would drop 2° or more. Repeated examination of the sputum showed no tubercle bacilli. Dr. Connell reported a form of streptothrix which came from the trachea and upper air passages. It was found, however, that although this bacterial form was present in large numbers, that it had no connection with the solidified lung.

In a few days the temperature began to decline, and we decided to send the patient home, notwithstanding the presence of a persistent afternoon temperature. During the whole period the patient kept up remarkably well, both in spirits and in strength. The affected side was treated at first with sinapisms, and later with thermafuge. Internally he was given good doses of creasote carbonate. Soon after his return home steady improvement began.

He was placed in a hammock out of doors on fine days, and at all times his room windows were left wide open to allow free entrance to the fresh, pure air. In a very few days the temperature dropped to normal and remained so, and finally the patient made a complete and satisfactory recovery.

The insidious onset, the remittent temperature, and the pseudo crisis, followed by four or five weeks of prolonged temperature, at once placed this case in the category of the chronic types.

The naked eye appearances of the lung in cases of acute pneumonia which have a prolonged course and have become chronic are not unlike those in the stage of grey hepatization. "The lung is bulky and dense and feels solid to the touch. When cut into it has usually a grey color, although sometimes a tint of red, but it has a smoother surface than that in hepatization and the tissue is much tougher. To this condition the term iron grey induration is sometimes applied. The minute changes consist of an increase in the thickness of the alveolar walls. This thickening is caused by the overgrowth of connective tissue. Along with this interstitial new formation there is commonly thickening and adhesion of the pleura." On thorough examination of the patient a few weeks later the chest was found to have returned to an almost normal condition.

The best results in the treatment of these cases are obtained by placing the patient in the recumbent position out of doors. When the weather is inclement the room windows should be open. A generous diet and tonics usually complete the cure.

W. G. MYLKS.

REPORT OF CASE OF "CLAW HAND" (PARALYSIS OF ULNAR NERVE).

P. Mc., aet. 60, admitted Oct. 16, 1905, discharged May, 1906.

Chief Complaint.—Paralysis of part of left arm, forearm and hand supplied by ulnar and median nerves, especially noticeable in left hand, where the deformity known as claw hand paralysis is seen.

Family History.—Father was drowned at the age of 45 ; mother died at 69 from decline and worry ; two brothers, aged 67 and 62, alive and well ; no hereditary family weaknesses.

Personal History.—Following his vocation as a sailor he was mixed up in many fights, was a heavy drinker, used tobacco freely, was in the habit of going on prolonged sprees, has had delirium tremens, had been burnt badly when young. During a drunken spree in September, '04, he slipped on the dock, dislocating his left shoulder, but was so drunk he didn't know the nature of the injury and went about for two days and a night unattended, until his arm and hand becoming so painful brought him to his senses, and he had a doctor put the limb back into position. Two days after the arm was set he was out with his arm in a sling, and remained with it so for days, when the bandage was removed, but there followed severe pain, especially in the palm of the hand and near the elbow, he says, with a dead feeling between these two points, along with considerable swelling of the parts, while movement of the wrist and fingers was greatly impaired. Then followed stiffness of the muscles of the fingers and at the wrist, together with a gradual wasting of some of the muscles of the arm, forearm and hand. The patient says the stiffness is more noticeable in warm than in cold weather, and now the injured limb is paler and colder than the right one. There is now no deformity noticeable about the shoulder region and all movements at this joint seem normal.

The patient entered the hospital in October, 1905, suffering an acute attack of delirium tremens, and was given bromides to quiet him. Considering the nerves separately considerable of an abnormal character is found which from the history and sudden onset of the paralysis would lead one to think more of ulnar paralysis than of the other condition—progressive muscular spinal atrophy—with which it might be confused. In this case the paralysis is flaccid and of a lower neuron type. The muscles supplied by the circumflex seem nearly normal with perhaps some slight atrophy of the deltoid and maybe a drooping of the shoulder. The sensory area covered by this nerve is in good condition. There is a depression, somewhat marked both above and below the left clavicle,

probably due to paralysis of the pectorals; sensation is practically normal over pectorals. There is some disorder of sensation on the ulnar side of the wrist, palm, over the hand and of the little and part of the ring fingers, back and front, due to injury to the ulnar. There is considerable weakness in flexion and ulnar adduction of the wrist, due probably to paralysis of the flexor carpi ulnaris, also supplied by the ulnar. There is a marked degree of weakened hand grasp, especially in the little and ring fingers, due to greater paralysis of that part of the flexor profundus which is supplied by the ulnar than that supplied by the median. The innermost lumbricals and all the interossei are paralyzed because there is loss of adduction and abduction of the fingers, and besides the first phalanges cannot be flexed, while the second and third cannot be extended, giving the deformity known as claw hand. The interosseous spans are all very prominent, while the short muscles of the little finger seem paralyzed, and also some of the thumb muscles, probably the adductores, transversus and obliques, because there is imperfect adduction of the thumb. The hypothenar eminence is flattened on account of a wasting of the muscles on the ulnar side.

There is some anaesthesia over the palmar aspect of the radial side of the hand and front of thumb, but the natural feeling, or almost the natural, is present over the index and middle. There is some paralysis of the abductor, opponens and outer half of the flexor blevis (median), so that the thenar eminence is wasted and adduction is impossible. There must be some paralysis of the two outer lumbricals, as there is some loss of flexion at the metacarpo phalangeal joints of the index and middle fingers. There is some difficulty in pronation of the hand and arm on account of paralysis of pronator radia teres. There is some paralysis of the flexor carpi radialis, causing slightly defective wrist flexion on the radial side. There is very little loss of power of hand grasp on the radial side, i.e., the distal phalanges of the first and second fingers can be flexed fairly well, so little paralysis of the flexor longus pollicis, flexor sublimis, and median half of the flexor profundus, the ulnar half being more paralyzed in this man's case. The wasting of the thumb muscles is mixed. There is some

slight atrophy of the biceps, coroco-brachialis and brachialis anticus, supplied by the musculo-cutaneous; the triceps is also withered to some degree (musculospiral), but the rest of this nerve seems intact. The patient says that with some use of the electric current sensation returned to a slight degree, especially on the side of the hand most completely paralyzed, i.e., the ulnar.

W. H. PATTERSON.

THE TREATMENT OF RINGWORM.

IT is a simple matter to treat successfully a ringworm of the general surface of the body, nor is the task rendered difficult when the parasites have invaded but the superficial tissues of the hairy surface. The case, however, is entirely different when the parasites have found their way deep down in the tissues of the scalp, beard or genito-crural region. In these cases months and sometimes years are necessary to effect a cure.

Until quite recently ringworm in all its types and in all its situations was thought to be due to one fungus—the trichophyton. Since the recognition of the plurality of the fungi causing this disease the way to treatment has been more easily blazed and followed.

Briefly stated, the fungi consist of two principal varieties, the microsporion Audouini or small-spored fungus, and the trichophyton megalosporion or large-spored fungus; of the latter there are two chief species, the endothrix and ectothrix, and of these there are several sub-species. Neither the source nor botanical position of the fungi have as yet been worked out.

On the non-hairy surface the parasites do not penetrate to any appreciable extent and are therefore easily destroyed. Parasiticides capable of destroying the ringworm and all other cryptogamic parasites *in vitro* fail when the hairy surface is the

seat of the lesion, since no antiseptic is believed to penetrate the hair follicle to a greater depth than one millimetre. The hair of a child is implanted in the skin up to a depth of four millimetres, and as is well known the parasites of ringworm involve its root to the terminal enlargement of the hair-bulb. It is evident, then, that the ordinary parasiticides are useless when the deeper tissues are the seat of lesion. This suggested depilation.

Depilation with careful surface disinfection readily effects a cure in most cases, but depilation in ringworm is not always easy.

The hair in ringworm of the scalp cannot be pulled out, root and stalk, but breaks at its most diseased portion, and the spores remain only to continue their work of reproduction. In ringworm of the beard, the so-called tinea sycosis, the hairs do not break off quite so readily, and much may be accomplished in this situation by patient depilation with a pair of small tweezers. The process, however, is painful. To offset this the almost universal practice has been to induce a sufficient folliculitis to loosen the hairs so that they might be easily extracted, bringing of course the fungus with them. For this purpose iodine, oleate of copper, chrysarobin, and especially croton oil, have been extensively employed.

Recently, however, Sabouraud of Paris has shown that the X ray is a more satisfactory depilatory agent than any of these. It has the virtue, too, of being painless. The X ray is not a parasiticide in the ordinary sense of the word, as we endeavoured to show as early as 1898*. By the X ray the hair of the infected area may be made to fall out, leaving a smooth bald spot entirely free from stumps, and when the hair grows again after an interval of a few weeks, the new hairs are found to be free from the parasite, providing a careful surface disinfection has been kept up for at least two weeks after all the hairs in the affected area have fallen out.

Early in 1905, or shortly after the publication of Sabouraud's researches, we began using the X ray in the treatment of ringworm after the method devised by him. Sabouraud's

*Queen's Medical Quarterly.

method consists in a single exposure of the affected area for about 20 minutes. The duration of the seance is marked, however, not by the watch, but by the acquirement of a certain standard tint, by a disk of paper coated with platino-cyanide of barium and placed at a distance of eight centimetres from the centre of the tube. These disks are on the market as "Sabouraud's pastilles".

After a time, however, we began to look on the pastilles in much the same way as the cook does upon the sand-glass and with the same result.

Our method has been about as follows: The tube is enclosed in an impermeable sheath or in a box properly lined, the object being to protect the healthy portions of the patient and also the operator from the rays. The box which we have used for several years seems to meet every requirement. It is of wood, 24"x14"x12", with a lid on upper surface, the whole attached to a wooden upright by a thumb-screw arrangement which permits of the box being raised and lowered, and also tilted as required. In the front is a circular opening, the size of which is regulated by a revolving diaphragm. The interior of the box has supports for the tube and is covered with twelve coats of ordinary white lead. The lead thus applied does not absorb all the rays emitted from the tube, but those passing through it seem to be innocuous. We prefer a soft or medium tube with a spark gap of about 3 inches. A milliamperemeter may be inserted in the secondary circuit, but while helpful is not really essential. It is best, we think, for the average operator to regulate the current by the degree of penetrating power of the ray. A current giving the outlines of bones of fingers fairly distinctly, the bones themselves appearing quite dark, at a distance of 15 centimetres from the centre of the tube answers very well.

While depilation can be accomplished by any degree of vacuum of tube it is better to adopt a certain standard and note variations. These variations may be due to varying conditions of current, atmosphere or tube, or perchance idiosyncrasy of patient. In such cases experience alone can decide the course.

The patient: If not more than three patches, all may be treated at the same sitting. First paint the diseased area with

tr. iodine, then crop the hair as close as possible, going one centimetre beyond the affected portion. Direct patient to put head against the opening in box, adjust the diaphragm to the exact size of cropped patch, place tube so that its centre will be 15 centimetres from the patch, and apply the light for ten minutes. Follow this course with each area. If more than three, divide the number of patches and treat on successive days. It is better to paint each patch with tr. iodine just before exposing it to the rays. In this way there is less likelihood of treating the same patch twice on the same day. As a rule four exposures are sufficient. These are given on alternate days, so that the treatments occupy precisely one week.

Inasmuch as the fungus is not destroyed by the ray, to prevent re-infection swab the diseased area nightly with carbolic and glycerine (1-20) and apply each morning an alcoholic lotion, containing tr. iodine, to the entire scalp. If there is an impetiginous tendency, substitute olive oil for the glycerine or use an ointment of white precipitate. It will be noticed that this method entirely disregards the variety of parasite that is etiologic. The X ray is simply a depilatory agent.

It has appeared to us in a recent series of cases, due to infection from a pet cat, and in which the megalosporon ectothrix was the parasite present, the time required for depilation was somewhat shorter than that required for the microsporion. From a limited series, however, no definite rule can be laid down. Generally the hairs begin to fall out about the sixteenth day from the first treatment, and the defluvium is complete by the twenty-fifth day. A mild parasiticide should be applied for two weeks longer. In experienced hands the treatment of ringworm by the X ray has at present no equal.

JAS. THIRD.

A CASE OF PELIOSIS RHEUMATICA.

MRS. F., act. 45, while in a debilitated condition due to overwork developed an attack of acute rheumatism. At different times the knees, ankles, elbows and hands were attacked, and all the usual symptoms of acute rheumatism were present. Co-incident with the development of the articular trouble there appeared on the legs and arms wheals of various sizes, ranging from the size of a split pea to areas three inches in diameter. These wheals were sharply marked off from the surrounding tissue; some of them had a faint purplish hue, and all of the larger ones were swollen, tense and painful. In a few days, while still remaining elevated and quite tender, they became less tense and firmer, the subcutaneous tissue apparently being quite densely infiltrated. The smaller ones were indistinguishable from the ordinary rheumatic nodules so often seen in the rheumatism of childhood. The arthritis cleared up rapidly under salicylates, but the urticarial nodules and masses remained in a tender brownish condition for some days. As soon as the parts could stand it massage and later stimulating liniments were employed and iron and arsenic administered. The whole trouble cleared up in about two weeks. The pain in the joints was severe for the first day or two, but after that the patient declared that there was no pain there, but she complained greatly of the pain in the large wheals.

A. R. B. WILLIAMSON.

CLUB FOOT AND MANIPULATIVE TREATMENT OF THE CONGENITAL TYPE.

Read before the Norwegian Hospital Alumni, Brooklyn, N.Y., April 15, 1905.

There are four simple varieties.

First.—Talipes equinus, extended or plantar flexed foot. Patient walks upon heads of meta tarsal bones with the heel elevated.

Second.—Talipes calcaneus, dorsi-flexed foot. Patient walks upon os calcis, toes elevated.

Third.—Talipes varus, inverted foot. In this variety the foot is adducted, inner border of the sole is elevated, and the outer border depressed so that the weight falls to the outer side of the centre of the foot.

Fourth.—Talipes valgus, everted foot. This is the reverse of varus. The foot is abducted and sole everted so that the weight falls on the inner border of the foot.

The compound varieties are more common and are as follows :

1. Talipes, equino varus—the extended and inverted foot.
2. Talipes, equino valgus—the extended and everted foot.
3. Talipes, calcaneo varus—the flexed and inverted foot.
4. Talipes, calcaneo valgus—the flexed and everted foot.

Etiology very important as treatment depends on etiology.

1. Congenital—grown into deformity before birth.
2. Acquired—perfect at birth, but has at a later date become distorted due to

“A”. 83 % Anterior Poliomyelitis by paralysis of groups of muscles.

“B”. 12 % Cerebral paralysis either congenital due to maldevelopment, or acquired due to hemorrhage, embolism, thrombosis, or to disease.

“C”. 3 % local causes,—traumatism to nerve trunk, contraction of a scar after severe burn or direct injury.

3. Non-deforming, not very often recognized, and rather uncommon.

CONGENITAL TALIPES.

Etiology.—Inheritance may be considered, and its influence is sometimes apparent. The most reasonable explanation is the mechanical, due to remaining for a variable period of time in a constrained or fixed position in utero. It may be due to interlocking of the feet, or to direct pressure from intra-uterine or extra-uterine tumors, and sometimes entanglement in the cord may account for the deformity. This form of Talipes may be combined with evidence of impaired or arrested development, such as harelip, exstrophy of the bladder, spina bifida and absence of patella. (The writer has seen two cases

of double congenital talipes in combination with double dislocation of hips, and in one of these cases there was also a posterior luxation of both knees).

It seems to be most common among males, and about 43 % of the cases are double, 31 % are in the right foot, and 26 % in the left foot.

The ordinary type of congenital C.F. is the equino-varus. Sometimes there is a moderate degree of knock-knee, and also the tibia may be twisted on its axis.

The position of the foot in early infancy is simply an exaggerated attitude of planti flexion, adduction and supination. The internal structure of the foot is rearranged to correspond to the external contour, thus the relation of bones to one another, and even the shape of the individual bones are more or less altered as the deformity is more or less of an exaggeration of the attitudes that the normal foot is capable of assuming. Changes are most marked in astragalus and os calcis.

Anatomy, C.C.F.

In all cases of cong. C. F. the scaphoid bone will be found articulating with the side of the head of the astragalus rather than with the anterior surface. The articulation is more toward the underside of the astragalus, leaving the head thus uncovered. The scaphoid may be distorted so as to articulate at one end with the tip of the internal malleolus. The tarsal bones are not in their normal position. The cuneiform bones follow the displacement of the scaphoid, also the metatarsals and phalanges, so that the long axis of the fore foot forms a right angle, or even an acute angle, with the axis of the leg.

In fully developed cases, adults or older children, the alterations in position and shape are more noticeable in the following bones, os calcis, cuboid, astragalus and scaphoid.

The os calcis is drawn from a horizontal to a vertical position, or approaching it, also rotated more or less on its vertical axis, so that its anterior extremity is directed outward and the posterior inward, and thus the anterior articulating facet is oblique to the axis of the bone. The cuboid maintains its connection with the os calcis, but follows the inward direction of the anterior extremity of the foot.

The astragalus is so rotated that only the posterior portion of its superior articular surface is in contact with the inferior articular surface of the tibia, and the anterior part of its anterior facet projects beneath the skin of the dorsum of the foot. The shape of the bone is also altered by the twisting inward of the head and neck so that the anterior articular surface looks inward instead of forward.

In cong. C. F. no paralysis of muscles exists, but the contracted muscles seem more developed than the lengthened muscles. The muscles of the leg atrophy from disuse, and the leg is much smaller and the feet shorter than normal.

CLASSES OF DEFORMITY, C.C.F.

1. When the foot can be brought nearly into a normal position by manipulation with the hand.
2. When the axis of the foot can be brought into the line of the axis of the leg, but the foot cannot be brought to a right angle.
3. When little alteration can be made by manual manipulation of the foot.

TREATMENT OF CONGENITAL CLUB-FOOT.

"Just as the twig is bent the tree is inclined". The best time to treat congenital club-foot is before the weight of the body interposes its mischievous influence. In the plastic and formative stage of new-born child the misshapen structures are sure to yield, no matter how rigid and unpromising they seem to be on first examination, to the gentle and firm pressure of continuous leverage. Each added month makes a congenitally deformed foot if neglected more obstinate. If over correction is not secured by the time the baby begins to walk it is time to find out whom to blame, the physician, or the parents, for failure to follow instructions or to bring the case to the attention of the physician often enough. The main object seems to be to keep the feet as nearly as practicable their natural appearance, or overcorrected, and nature will do the rest. The means employed depend upon the physician and the emergency of the case. The difficulties of treatment are increased when the child begins to walk, when the problem presented is how to make the patient strike the ground with his feet at such an

angle that he will stamp his feet straight instead of crooked. Growth is a prime consideration, as it adds increasing weight and activity, which if directed will promote recovery in the most effective way, or if neglected will surely lead to resistant and inveterate deformity.

A club-foot treated in infancy may be perfectly cured both in function and in form. A club-foot treated later on in childhood will leave behind a certain amount of atrophy. No other deformity presents such a record of failures and incomplete cures, of relapses after apparent cures, of tedious and ineffective treatment by braces, and of unnecessary and mutilating operations.

In our choice of mechanical appliances to hold the foot in its over-corrected position as reached in the first manipulations, we select the plaster bandage. In using the plaster great care must be taken to avoid undue pressure, irritation of the skin, or insecurity of the bandage. The advantage of the retention of the foot by the plaster is very marked, especially in the fact that the muscles on the back and inner side of the leg of an infant are relatively hypertrophied as compared with those on the front and outer side that are disused, so by limiting all motion the harmful effects of the muscular activity of the foot are counteracted.

The first plaster should be put on very thin, when child is two or three weeks old, preceded by preliminary manipulation by the nurse, and the deformity corrected slightly—as far as possible toward the abducted position without causing discomfort. This is removed at the end of a week and the same process gone through with until at the end of four or five weekly applications the foot can be held in the attitude of extreme equino-valgus. So far we have only treated the varus condition; now we must turn to the equinos. In this force is needed to stretch the tendo-achillis, and care must be used in manipulating that the os calcis is really drawn downward by a lengthening of the tendo-achillis, and not that the fore foot is over-corrected. The reduction of the equinos may be more difficult, but should be entirely corrected in three or four months. The advantages of the plaster over mechanical appliances, such as braces and splints, are numberless, but the

principal one is the fact that the plaster is entirely under control of the surgeon, and no meddling can interfere with the treatment, whereas in the case of a brace, or splint, it is very easy to loosen a strap or change a bandage under the mistaken idea that the brace hurts the child's leg.

In some cases it may be necessary to do a tenotomy or tendon lengthening on the tendo-achillis, which is the most resistant of the shortened tissue. When the foot has been forced into position it is retained for several weeks to allow the interval between the separated ends of the tendon to fill in with new tissue.

In older children the deformity may be corrected rapidly, but the same principle applies. The deformity must be over-corrected and retained there until the immediate tendency toward deformity has been overcome. The patient may be anaesthetized, and using one hand as a fulcrum on the affected foot with the palmar surface resting on the os calcis and cuboid, the other hand acts as a lever with the forefoot exerting alternate pressure and relaxation against the first one stretching all resistant structures, under this steady manipulation the foot soon loses its rigidity and its elastic recoil toward deformity. It may even be necessary to divide the tendo-achillic to help matters. The foot after over-correction is put up and retained in plaster, this plaster coming above the knee, and being rather heavy the patient is allowed up the next day and encouraged to use the leg. The plaster is changed at the end of four weeks, and left on for varying periods of six weeks to six months. In most instances the plaster is replaced at the end of three months by a simple leg brace worn inside the shoe and with a calfband. Now the second stage of treatment is begun, consisting of massage of the foot and leg to stimulate the growth of the atrophied muscles and methodical manipulation of the foot several times a day. This stage of the treatment is very important and must be under the direct supervision of the surgeon.

Forcible manual correction may be employed with advantage from two to ten years.

According to Mr. Little, of Liverpool, who has tried Phelps' operation in some 37 cases, the classes of cases suitable for it are :

1. Those cases of such severe deformity that careful and persistent treatment by milder methods has failed to effect a cure or "cases of necessity".

2. Those chiefly in hospital practice which owing to poverty or indifference are neglected as regards after treatment. He performs it as follows:—"Makes a V shaped incision with base towards the outer border of the foot with the apex over the tuberosity of the scaphoid. Everything is divided except vessels and nerves. Occasionally he divides the neck of the astragalus. Tendo achillis is then cut and flap laid across the wound and held in place by silk worm gut sutures. Put in a board splint for about a day or two, and then the granulating area is skin grafted. This is put in best position attainable in plaster of paris. The operation is contra indicated because of the difficulty of predicting what the ultimate results of growth and pressure may be and the danger of severe flat-foot following.

R. G. MOORE.

RECURRENT OCULOMOTOR PARALYSIS.

CASES of recurrent paralysis of the third nerve are so unusual that a report of the following will be of interest. In the ordinary text-book nothing will be found referring to the condition. Of recent books Ball's Ophthalmology and DeSchweinitz' new edition, Diseases of the Eye, each has a few words on the subject. Ball says it is always monocular and occurs in young females. The case I am recording has lasted throughout the life of a young woman and has now become bilateral. Ball says the lesion is in the nerve trunk. DeSchweinitz places it in the root of the third nerve. The symptoms are violent unilateral headache, nausea and vomiting and then paralysis of the third nerve. The attacks are periodic and may last from a few days to long periods or may become permanent.

E. M., female, aged 17, first seen December, 1905. Well marked paralysis of third nerve. There is ptosis, outward and slightly downward deviation of the eye, impaired movement of the eye except outward and downward, fixed semi-dilated pupil and loss of accommodation. The history given is of a first attack of severe pain in the head at the age of fifteen months, followed by vomiting and the condition of the eye described, this passing off in a few weeks. Since then she has had six or seven attacks every year, some of them lasting only for a day, others for several weeks. Pain is always in the right side of the head. If the vomiting were brought under control quickly the eye did not become affected. When she came to see me it was because the strabismus and ptosis had lasted longer than usual, i.e., for several weeks. At the end of July, 1906, seven months later, it had not improved under treatment, so that it may now be regarded as permanent. On the other hand, the left eye has now become affected suddenly, without pain or vomiting, and the paralysis is more complete.

In a case such as this the prognosis is quite unfavorable and the benefit to be derived from alteratives or stimulants very uncertain. It was formerly thought that such paralysees must be nuclear, but a number of them have been demonstrated to be due to basal lesions. Some of those thought to be nuclear are really fascicular and not a few of the rest are basal. Bernheimer has, however, noted several instances of multiple nuclear paralysis.

J. C. CONNELL.

SOME POST-MORTEM NOTES.

A. B., 13 days old, died May 19th, 1904. Infant had been fretful for a few hours, but as no sufficient cause of death was manifest an autopsy was ordered, and this was held six hours after death.

Body of male infant 18 inches long; skin slightly jaundiced and somewhat cyanatic.

Head—No lesions found on examination of brain or its membranes.

Neck and Thorax—The nasal and oral cavities were normal, but the right tonsil and lateral and posterior pharyngeal

wall were covered with a false membrane in which the diphtheria bacillus was found on microscopic examination and also isolated by culture. The larynx was markedly oedematous and showed considerable watery froth in its lumen. The lungs were well distended except a few scattered lobules which were collapsed. The blood was very dark. The right chambers of heart and the large veins were engorged with dark blood. Foramen ovale and ductus arteriosus closed.

Abdomen—Very little food in stomach or bowel, but this was bile stained. Viscera were all normal.

On after inquiry it was found that a nurse, who had taken charge of the baby when a week old, had been exposed to diphtheria a few days previous and no doubt carried the infection to the infant, though she herself had no clinical symptoms of diphtheria.

(2.) J. Anton, aged 51 years, dying Aug. 19th, 1905. Had been an inmate of Rockwood asylum for some years previous to death. About midnight he called the guard on duty in the ward, and when the guard came rose up from his bed and staggered into guard's arms, dying before the doctor could be summoned from another part of the building. There was a quite free haemorrhage from nose just previous to death.

On inspection twelve hours after death there was found an extensive symmetrical swelling of the neck extending from angles of jaw to clavicle.

On examination this swelling was found to be due to an extensive extravasation of blood beneath the deep cervical fascia, the blood extending back to vertebral column up to vault of pharynx and floor of mouth and below into anterior and posterior mediastinal spaces, reaching to the diaphragm and into roots of lungs.

The heart was quite normal, but the aorta and the branches given off from the arch showed patchy atheroma with fatty and early calcareous degeneration of media, and also were dilated somewhat, the left sub-clavian and its branch the thyroid axis and especially the inferior thyroid branch of the latter being particularly so. This latter artery just before it passed into the postero-inferior border of the thyroid gland showed a

aneurysm measuring $\frac{3}{8}$ of an inch in diameter, and this had ruptured and was the source of the haemorrhage.

The other organs were quite normal except the kidneys, which presented well defined lesions of chronic interstitial nephritis.

The haemorrhage from the nose was no doubt due to rupture of a nasal vein, caused by damming back of blood into head by the pressure of the cervical haemorrhage.

(3.) R. McCoy, aged 55 years, an inmate of Rockwood asylum for a number of years previous to death, which occurred on 11th March, 1906. Death was sudden, as patient got up from dinner table and walked to a nearby chair and almost at once fell forward and when picked up was dead. Patient had never complained except the day before, when he told the asylum physician on his round that he had a sharp pain high up in his chest, pointing to aortic region. The autopsy was held 24 hours after death.

Head and abdomen showed nothing of import.

Thorax.—On removing the sternum a thin sheet of blood was found in the anterior mediastinum and the pericardial sac bulged forward. On opening this sac it was found distended with blood, 30 ounces being removed. The heart was slightly enlarged (11 ozs.), muscle pale from pressure, but walls and valves normal. The aortic arch showed general dilatation, being nearly twice the usual size, and the intima showed diffuse atheroma with numerous calcareous plaques and also a thin sheet of laminated clot on the convexity of the lumen. The wall had given away with a slit-like opening $\frac{3}{4}$ inch long, the lower end of which was $\frac{3}{4}$ inch above the aortic valve, thus allowing escape of blood directly into pericardial sac. There was some extravasation of blood between the adventitia of aorta and the pericardium, thus accounting for escape of blood into the mediastinum, and probably accounting for pain complained of the day before death.

W. T. CONNELL.

A SIMPLE AND EFFECTIVE METHOD OF DISINFECTATION WITH FORMALDEHYDE.

IN a recent publication by the Illinois State Board of Health, Health, entitled Practical Disinfection, the method of generating formaldehyde gas by combining formalin with potassium permanganate, as first publicly suggested by Dr. Johnson of Sioux City, Iowa, receives the complete sanction of the board after a full series of carefully controlled experiments of the method had been carried out. These confirm similar findings of the State Board of Health of Maine. As the method requires very little apparatus, is comparatively cheap and effective, it deserves more extended use. The room to be disinfected should be sealed up carefully, and all articles that cannot be soaked in disinfectant solution, boiled, etc., should be well spread out so as to allow free action of the gas when generated. For every 1,000 cu. ft. of air space $6\frac{3}{4}$ ozs. of powdered permanganate of potash should be put in the apparatus and to it added 16 ozs. of formalin. As the gas is liberated very quickly the operator must retire at once and close and seal up door of exit. The room must be closed for at least six hours. As the method generates considerable heat and as it is advisable that this be retained to assist complete generation of gas a special form of apparatus is required. The apparatus advised consists of a double bottomed tin container with flaring (funnel-like) top covered with asbestos paper and with a layer of asbestos between the two layers at bottom. The dimensions given in the circular are: Total height $15\frac{1}{2}$ inches, height of flaring top 8 inches, diameter of bottom section 10 inches, diameter at top of flaring top $17\frac{1}{2}$ inches. In absence of this special apparatus (which any tinsmith can make) an ordinary milk pail set tightly in a wooden bucket works almost as well. This method does away entirely with the various types of lamps and other generators. Of course this or no other method of gaseous disinfection suffices for the thorough disinfection of a sick room, but after the aerial disinfection has been carried out the room must be thoroughly cleaned and the floors and wood work well *scrubbed* with 1-000 bichloride solution and the room then freely opened to air and sunshine. Such articles of bedding (sheets and blankets) and of clothing

as can stand it should be soaked in 1-100 carbolic acid from 10 to 12 hours before being sent to laundry. These methods, if properly carried out, ensure the maximum of efficiency for ordinary practice. From the writer's experience even these procedures far surpass those now practised in most parts of this province.



QUEEN'S MEDICAL LABORATORIES.

WE have much pleasure in publishing for the first time this cut of the front elevation of the proposed new building for the Medical Laboratories. Before this is in print work on the excavation will be under way, and possibly the foundation will be completed this season. The delay in beginning has been due to an effort to secure assistance from the Dominion Government in return for the large amount of free research

work which has been carried on for the Federal authorities during the past fifteen years. A final answer has not been given, but the members of the government are sympathetic. The grant may be in the form of the quarrying and cutting of the stone for the building by the provincial penitentiaries in Ontario and Quebec. Although there has been much time lost in proceeding with the work it is still possible to have the building completed by October of 1907.

MEDICAL NEWS AND NOTES.

Doctors Third and Kilborn attended the meeting of the British Medical Association in Toronto.

Dr. J. C. Connell has just returned from a fortnight's visit to New York.

Dr. V. Barber (Queen's '97) and family, of Brooklyn, N. Y., visited Kingston on a holiday trip early in August.

Dr. H. Tandy returned to Kingston in July after three months abroad, chiefly in London. He intends locating in Parry Sound.

Dr. George Dalton, of Manhattan Eye and Ear Hospital, N. Y., paid Kingston a short visit in August.

Dr. Etherington has returned from London, Eng., where he has been doing some special work in anatomy and embryology.

It is with much regret we record that on Oct. 3rd Dr. G. E. McIntosh, of the class of '03, practising at McDonald's Corners for the past two years, died of typhoid fever. He had been married only on August 24th, and his wife (a trained nurse) is also down with the disease.

The Hotel Dieu Hospital authorities have finally taken a step long desirable in the appointment of a resident house surgeon. Dr. F. J. O'Connor, of the class '06, has secured the position.

Typhoid fever is very prevalent this autumn throughout New and Eastern Ontario, especially in the villages and towns. Patten-Kofer's observations on the relationship between prevalence of typhoid and other intestinal affections and lowness of the ground water would be borne out by the conditions which prevail this season. As is now well known, it is not the "lowness

of the ground water", but the greater danger at such season of *contamination* of the water that is the actual factor in accounting for such prevalence.

At the meeting of the Board of Governors of the Kingston General Hospital in September, it was almost unanimously decided that the system of government by a lady superintendent, in vogue for the past three years, must be ended if the best interests of the hospital were to be preserved. It was also decided to appoint a medical superintendent at October meeting. At this latter meeting Dr. A. D. McIntyre, of Petrolia, was elected, his chief opponent being a local physician. Dr. McIntyre is a graduate of Queen's of the class '01, and served for some months as house surgeon in the hospital, afterwards practising with his father at Glencoe. Later he took a post-graduate course in Chicago, and a year ago settled in Petrolia, where he has succeeded in establishing a good practice. Knowledge of Dr. McIntyre's ability and energy assures us that he will make a success of his new position and will build up the hospital to a higher standing than ever in this city and and district.

The University classes in the Faculties of Arts, Science and Medicine were opened on Wednesday, Sept. 26th. The attendance in all Faculties is increased, but full returns of registration cannot be secured until after Oct. 16th (University Day), which is the last day for registration. On Oct. 8th 46 freshmen were registered in Medicine, and this will be increased to 50 or more before close of registration.

BOOK REVIEWS.

WE have just received the second report of the Wellcome Research Laboratories of Gordon College, Khartoum, Sudan. It is quite a pretentious volume and contains a very interesting series of reports and observations. These cover a

wide range of subjects, though most are connected with the special diseases of man and animals met with in the country. The most interesting reports are probably those on the distribution of mosquitoes and their relation to malaria, and upon trypanosomiasis in man, cattle and mules. There are also some interesting notes on human, animal and vegetable pests, while the report of the chemist will well repay reading. The report is well illustrated and its contents bear witness to the activity of the staff, and stand, too, as a marked evidence of the remarkable change which has taken place in the Sudan, which well within a decade was practically a howling wilderness under the control of the Khalifa and unsafe for white men.