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# CANADA MEDICAL RECORD

AUGUST, 1902.

## Original Communications.

### GYNECOLOGICAL CASES.

#### AT THE SAMARITAN HOSPITAL FOR WOMEN, MONTREAL.

Under the care of A. Laphorn Smith, M.D., Surgeon-in-Chief of the Samaritan Hospital; Gynecologist to the Western Hospital; Gynecologist to the Montreal Dispensary; Professor of Gynecology in the University of Vermont, Burlington; Professor of Clinical Gynecology, Bishop's University, Montreal.

The following cases, although of no particular interest on account of rarity, are worth while reporting, because they are just the ones which are constantly coming under the care of the general practitioner, by whom indeed many of them were sent to the hospital.

On the first of January, 1902, there was admitted Miss T., who had come to my office a week before, complaining for two years of pain in her back and side, which prevented her from earning her living. On examination I found a large mass on one side of the pelvis and a smaller one on the other side. I diagnosed pus tubes, and possibly that the appendix was involved, as she had greatest tenderness over MacBurney's point. After the usual preparation, including three hot baths and strychnine and laxatives until the bowels were thoroughly emptied, the abdomen was opened; there were no adhesions of the bowels, and without any difficulty I enucleated a pus tube as large as an orange from Douglas' *cul de sac*. The ovary on this side was so densely connected with the tube that I removed the whole of it, but the ovary on the left side was not so much involved, so only three-quarters of it was removed with

the tube, which was hard and swollen, and closed. The quarter of an ovary was allowed to remain, as she was only twenty-four years of age, and was engaged to be married. She made an excellent recovery and was hard at work in a wholesale millinery store seven weeks after, and has had no pain or inconveniences of any kind since.

On the second of January Mrs. M. was admitted for cystitis; she was a working woman exposed to cold; she was kept in bed for one week on Buchu tea, hot lemonade and hot douches, with the result that she was quite cured, and has had no return of it since.

On the fifth of January Mrs. McN. was sent by Dr. Sharpe for a femoral hernia, for which she had been wearing a truss for fifteen years until there was a raw ulcerated surface the size of a silver dollar. Some of the staff raised the question whether it was safe to open the peritoneal cavity in the presence of an ulcerating surface on the skin. I might mention here that this never debars me from operating, as I have absolute faith in my ability to disinfect even such a surface with permanganate, oxalic acid and bichloride of mercury. The sac was found and the ring formed by Gimbernat's ligament and Poupart's was divided; the sac was opened; the bowel, which was adherent, was replaced in the abdomen, the sac was tied off and the femoral ring closed by four interrupted chromacized catgut stitches, one of which lasted so long that it was thrown off by nature three months later, without, however, causing much inconvenience. She has been working hard ever since, keeping a grocery store and supporting nine children. I might also add that I have done more than fifty hernia operations, inguinal, femoral, omental and ventral, every one of which has been a perfect success, some of them on quite old women, and all of them wearing a truss and incapacitated from doing hard work until they were operated on, since which they have been completely cured.

On the 7th January a Mrs. B. came in for metritis; she had had double hydrosalpina removed five years before by me at the Western hospital, since which she has been troubled off

and on with digestive troubles partly due to intestinal adhesions, but also to excessive eating. She was relieved by hot douches.

On the 8th January Mrs. W. W., aet. 24, came in for retroversion with fixation, which always means diseased tubes. She suffered intensely at her periods and also from dyspareunia, which caused great unhappiness in her home; she had never experienced any sexual feeling, as her trouble dated back since she was a young girl working in a factory for long hours. As both tubes were closed and the ovaries were hard and cystic, and I was anxious that she would not have any more periods, I removed both ovaries, and did ventrofixation, using two silk-worm gut stitches. Her nervous system was completely shattered so that it was several months before she was quite well, her convalescence being retarded somewhat by the buried stitches causing a sinus, which necessitated their removal. She is now in good health and lives very happily with her husband, her sexual feeling having appeared soon after her operation and being stronger than the average ever since. I mention this because there is a general opinion that sexual feeling is lost by removal of the ovaries, while our experience here has been quite the contrary.

Mrs. H. W., a sister-in-law of the previous patient, also came on the 8th January, principally for dyspareunia, which was so severe that she had made up her mind to leave her husband, as married life caused her such torture. I had already treated her for nearly a year, during which time I repaired a lacerated cervix, which was immediately followed by pregnancy and confinement in due course, but she continued to suffer so much with menstruation and intercourse that I believed that I was justified in removing the ovaries. The result has been most satisfactory; a perfect convalescence and a happy home ever since. These two patients and their husbands are most grateful.

On the 13th January Mrs. R., aet. 34, was sent by Dr. Carmichael, principally for sterility. There was a long conical cervix, and the uterus was retroverted, but easily replaced. The cervix was amputated, the uterus curetted and

the round ligaments were shortened. The uterus is well up, but she had a little trouble with one buried silk-worm gut stitch which worked its way out two months later. So far she has not become pregnant, although many other Alexander cases have done so. Patients attach so much importance to this little inconvenience, quite forgetting that the operation has restored them to health, that I now feel very loath to leave any buried non-absorbable ligatures, preferring to use chromacized catgut.

On the 15th of January three patients were admitted. A Mrs. B., 29 years of age, came to the Montreal Dispensary, stating that she was obliged to earn her own living, as her husband had deserted her three months before, and that for two years she had been suffering almost constant pain in her ovaries, which was worse at her periods. I removed them a few days later, and has been heard of since much better.

Mrs. S. had her tubes and ovaries removed two years before for large pus tubes, from which operation she made a very good recovery, so that she was able to work as cook in a large boarding-house. She came in for a week's rest, and then returned to her work, and I mention the case because there is a popular impression that a woman is never good for much after a laparotomy. I could recall several hundred cases to prove the contrary.

Mrs. G., age 50, the mother of eighteen children, was the third case admitted that day. A few days later she was operated on for piles, which were very large, and which I removed by the method I always employ: a Whitehouse operation by which the whole of the pile-bearing area was removed, after tying off in four segments; and then the mucous membrane of the rectum was united to the skin with a running black silk stitch. The result was all that could be desired; she has been seen since and has no trouble. We take care in all cases of piles to keep the bowels liquid with compound liquorice powder.

On the 20th a Miss A. came in for a week's rest. She had had fixation of a floating kidney two years before, but

had to work very hard ever since, and never got into robust health. She was able to go back to her work in the factory.

On the 23rd a Mrs. J., 38 years old, came in and was curetted for menorrhagia by one of the staff, but a week later bleeding began again; so at the request of her physician I curetted and applied equal parts of Churchill's iodine and carbolic acid, and then removed a large lacerated and everted cervix. The effect on her general health was excellent, and a few weeks later she became pregnant, which is a good proof of the benefit of the operation, as she had had no child for ten years before.

On the 29th January a Mrs. B. was sent in by Dr. Harvey for symptoms of tubal pregnancy, but after watching her for three weeks we decided that it was a normal pregnancy.

On the same day a Mrs. W. was sent in by Dr. Deeks for symptoms of tubal pregnancy, but after careful observation I came to the conclusion that the irregular hemorrhage and pain were due to some other cause, which was treated, and she is now well. These two gentlemen deserve the credit of being on the lookout for tubal pregnancy. I am sure that no case of this disease could escape their notice.

On the 31st of January Mrs. S., aet. 42, had been in before sixteen months ago when she had dilatation, curetting lacerated cervix and complete laceration of perineum operations, which were most successful. She also had Alexander's operation on the round ligaments, which, although successful in keeping the uterus up, did not relieve her pain. So I decided that I would open the abdomen and look for adhesions, which were found and freed, and one cirrhotic ovary was removed and the uterus fixed to the abdominal wall. She made an excellent recovery, and is now working as general servant, at very hard work.

This comprises all the cases admitted in January, 1902. In my next article I will report an interesting series of cases operated on in February.

# Selected Articles.

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## THE ILLNESS OF THE KING.

The *Lancet* (London), of July 5, writing upon King Edward's illness, says: The present condition of His Majesty the King and the future progress of his health can be gauged best by a full consideration of the case from the very beginning. Our readers will be able to follow the thread of our remarks if they read in connection with them the brief account of His Majesty's illness which appeared in our second edition last week, and which we reprint below. Firstly, was there any condition present which might predispose to the developments of perityphlitis? Although no reference appears to have been made to it, it is far from unlikely that the severe attack of typhoid fever from which the King suffered in 1871 may have had some etiological connection with his present illness. The ulceration of the bowel in typhoid fever is especially severe near the ileo-cecal valve, and adhesions occurring as a result of the intestinal ulceration, especially when the attack has been prolonged, are not uncommon. Adhesions of this nature are liable to produce displacement and torsion in the neighbourhood of the cecum, and it is now recognized that in this way the circulation may be distinctly interfered with, and that such disturbances of position and circulation are important predisposing causes in the production of perityphlitis. So that it is quite possible that the attack of enteric fever from which the King suffered more than thirty years ago may be really connected with the illness from which he is suffering now.

The present attack appears to date from some ten days earlier than the operation. For it was on June 14 that the King first complained of abdominal discomfort, but it was slight, and did not interfere with the journey to Aldershot. At midnight of the same day abdominal pain came on, and Sir Francis Laking was summoned and was able to relieve the urgency of the symptoms; and on the next day, June 15, His Majesty was seen by Sir Thomas Barlow. Up to this time the signs and symptoms were indefinite, and though they were sufficient to suggest the possibility of perityphlitis, no trustworthy diagnosis could be made. On the afternoon of the 15th a chilly fit occurred; this was in all probability a real rigour, and marks the time at which, from the after-history of the case, we may conclude that suppuration com-

menced. We may interpret these symptoms by the light of our later knowledge as follows: The commencement of the perityphlitis dates from the first abdominal discomfort of which the King complained on Saturday, June 14. It may have been connected with the great fatigue of the previous day, and the taking of a late supper; but it is quite possible that neither had anything to do with it. During Saturday and Sunday the inflammation extended and set up an adhesive peritonitis. To this was doubtless due most of the pain of which the King complained. Then pus began to form around the cecum. This suppuration was localized by the adhesions which had already formed between the adjoining coils of intestine, and if our suggestion be correct as to the influence of the attack of typhoid fever, old adhesions remaining from that illness may have assisted in confining the suppurative process. By Monday, June 16, the King had recovered sufficiently to bear well the drive to Windsor, for he arrived there without fatigue. On Tuesday signs began to appear which rendered certain the nature of the affection, and when he was seen on Wednesday, June 18, the local manifestations were well marked. In the right iliac fossa there was a well-defined, somewhat firm swelling, with distinct tenderness, but no very marked pain independently of pressure. The temperature was raised and the diagnosis could be made with ease and certainty. Then would arise the question of operation. There are some in this country, and still more abroad, who advocate operative measures at the earliest possible moment, but by indiscriminate operation in all cases, without regard to the exact nature of the local condition, the best results are not obtained. It cannot be disputed that a large number of cases of perityphlitis recover without surgical aid, and that many others result in the formation of a localized abscess which may be evacuated without necessarily disturbing the cecum, without, indeed, it ever being established that inflammation in its vicinity was the cause of the trouble. The great danger in perityphlitis is general septic peritonitis. What may be called the "natural" method of prevention of this complication is by the formation of peritoneal adhesions, shutting off the focus of infection from the rest of the peritoneal cavity. To attempt to disturb the cecum while this process of localization of the suppuration is going on, can only lead to the hastening of the evil which it is desired to avert, for the breaking down of the protective adhesions will almost



certainly cause the generalization of the peritoneal infection. There is the less need to discuss the question of the superiority of early or late operation, seeing that we have no proof in the King's case that the appendix was inflamed, but we may be permitted to express our complete approval of the course adopted by His Majesty's medical advisers.

With complete rest on Thursday, Friday and Saturday the King's condition improved, the temperature fell to normal, and he felt better in himself, and the improvement continued during the Sunday so that on Monday His Majesty was able to journey to London by train. Up to Monday, June 23, it had been hoped that care and rest had served the patient so well that the necessity for active surgical treatment had passed away. This was only in accord with the earnest wish of the King, who was extremely anxious to carry out, at whatever pain to himself, the arrangements that had been made. On Monday, however, the probability of the presence of pus in the right iliac fossa was suspected, and on the morning of Tuesday, June 24, it became clear that suppuration had occurred. The iliac swelling was again obvious, the pain had increased, and the temperature was once more elevated. All these signs pointed clearly to the formation of a localized abscess. The danger of delay was great. The formation of pus was evidently proceeding rapidly, and the abscess was extending. In such circumstances the impossibility of sanctioning any attempt at carrying out the coronation ceremony was at once obvious. Nay, more, the necessity for the immediate evacuation of the pus was urgent, for if no outlet for it were provided the far greater danger of general septic peritonitis was imminent, a condition in which surgical interference is too often of small avail. Lord Lister and Sir Thomas Smith agreed that an operation was imperative, and the King gave his assent reluctantly, not because of the pain or the risk to himself, but because he knew the severe disappointment the change of plan would occasion to the many thousands who were assembling in honour of his coronation.

To Sir Frederick Treves was committed the heavy responsibility of performing the operation. An incision was made a short distance above Poupart's ligament on the right side; the wound was steadily deepened, but it was not until it had obtained a depth of some four and a half inches that pus was reached. This was evacuated, and the abscess cavity drained by means of two rubber tubes. By the evacuation

of the pus and the subsequent drainage the immediate risk of the involvement of the general peritoneal cavity was averted, and thus the danger of the disease was greatly reduced. The effects of the operation soon showed themselves. The pain from which the patient had suffered severely was markedly relieved, the temperature rapidly fell, and it was evident that the septic absorption had ceased. It was possible for his medical attendants to announce on the same evening that the King's condition was as good as could be expected after so serious an operation, that his strength was well maintained and that the pain had diminished. There was an addendum to the effect that it would be some days before it could be said that the King was out of danger; this was a necessary warning to the public, for it may happen that the extension of the suppurative process does not cease with the evacuation of the pus.

During the earlier part of the first night after the operation His Majesty was restless and did not sleep, but after one o'clock some sleep was obtained. A fairly comfortable day followed and but little pain was experienced except at the dressing of the wound. His strength was fairly well maintained. On the second night he had some refreshing sleep, and he improved in all respects, and the state of the wound continued satisfactory. On Friday, June 27, it was announced that a fair night had been passed, and that the temperature remained normal. On Sunday, the fifth day after the operation, the King was sufficiently recovered to permit his being moved on to a couch for a few hours, and up to the time of writing the improvement has steadily continued. A fair amount of sleep is obtained, the King's strength increases, and the wound continues to progress in a satisfactory manner. It is, of course, most important that the abscess cavity should close completely, and from the bottom; otherwise an intractable sinus would be not unlikely to result. The wound is, therefore, packed with gauze, and this necessarily occasions no small amount of pain. This is unfortunate, but cannot be avoided, and it is consoling to remember that the pain will decrease with each dressing.

We have followed the illustrious patient's progress from the commencement of his illness to the present time and we are now in a position to consider the prognosis. The dangers which may arise may proceed from the patient's constitution, or be connected with the local lesion. As to

the King's general constitution there is but little cause for anxiety. At his age, sixty-one years, he is probably as strong as the average of his subjects, and, apart from the harassing nature of his duties and the energy and zeal with which he has ever undertaken all that he is called upon to do, there has been nothing materially to impair his general health. The severe attack of typhoid fever in 1871, to which we have already alluded, served for a time to weaken him, but the effect was transient. It cannot, however, be doubted that the grave disappointment which the King feels at having to postpone the coronation may exert some depressing effect on him. To dispel as far as possible any untoward mental or sentimental condition must be the best endeavour of those around his bedside. Turning to the local conditions, we find several possibilities of harm. The wall of the abscess cavity is formed by coils of small intestine, which have become adherent owing to adhesive peritonitis; some of these adhesions have probably already commenced to organize. Somewhere in this wall there may be a peccant appendix matted to the intestine by exuded lymph; from it and from the other parts of the wall of the abscess cavity pus may be still secreted. The chief danger is the extension of the suppurative process to the general peritoneal cavity, but day by day the adhesions localizing the mischief are growing stronger, organization proceeds rapidly and before long they will be strong enough to resist any strain to which they may be subjected. The danger from this cause has steadily grown less and less with every favourable bulletin. Again, the risk of the absorption of septic products from the abscess cavity is now very small, as all tension has been removed and the granulations which have formed offer an effective resistance to the passage of the toxins into the blood-vessels and lymphatics; at any rate, the state of the temperature shows that now no absorption is taking place. The chance of the occurrence of general septicemia may be disregarded. On the critical view of the situation of the King it may be said that there is great promise of a speedy and safe recovery from his illness; speedy, we say, though many weeks must elapse before he is well, for we must bear in mind the severity of the illness and of the operation performed for its relief; and safe because the probability of any complication supervening is remote. On the maintenance of his strength, apart from care in dressing the wound, depends mainly the recovery of His Majesty.

One further point requires consideration. If, as we may not unreasonably hope and expect, the King recovers from his illness, will a recurrence be likely or will it never be necessary to interfere with the appendix? The answer which would be given by those surgeons who have had most experience in abdominal surgery would surely be "No." When an abscess has developed in connection with the appendix and has been successfully drained, it is rare, indeed, for any recrudescence of mischief or for any further operation to be required.

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### THE VALUE OF AN OCCASIONAL CONVULSION IN CERTAIN CASES.

BY WILLIAM P. SPRATTLING, M. D.

Medical Superintendent of the Craig Colony for Epileptics, Secretary of the National Association for the Study of Epilepsy, etc.,  
Soneya, N. Y.

It is hard to imagine anything more contradictory on its face than to say that a convulsion could ever be of value; yet I am convinced that such is sometimes the case, for two classes of individuals have come under my observation in which occasional convulsions were productive of good. The first includes epileptics in which prolonged periods of mental disturbance or insanity are prevented through the occurrence of a fit; the second, selected cases of insipient alcoholism in which a persistence in the drinking habit would probably lead to confirmed epilepsy, were it not for the emphatic warning given by the convulsion.

Epileptics of a certain type make up the first class, and includes those in which the disease seems dependent on fluctuating internal causes; on the action of certain toxins as yet unisolated, and but little understood, and which grow in intensity until a limit is reached, when their toxicity is in some manner neutralized or destroyed by a convulsion, only to repeat again and again the same process of development, growth and decadence, the latter occurring each time as the result of one or more epileptic convulsions. These periods of exacerbation are not, as a rule, fixed in time, although I have seen a few cases in which there seemed to be some evidence of periodicity.

Epilepsy generally manifests itself by a sudden and more or less appreciable discharge of nervous energy in some part of the brain, and we know that experimental epilepsy may be produced in the lower animals in various ways, as, for in-

stance, by the application of electricity to the brain cortex, and by introducing certain substances into the circulation, such as ammonium carbammate, alcohol and other toxic fluids. Now the action of toxic substances introduced from without is not essentially different from those produced within, and, relatively, they are of importance to the individual only in so far as he may or may not have power of control over them. In the former cases, those in which toxic agencies are introduced from without, his control over them may reasonably be assumed to be absolute, *i. e.*, he may introduce them or not, just as he chooses; while in the latter, in the case of agencies having a like action and generated within, he may or may not be able to prevent their origin.

When a man who is well along in years begins to drink and has a convulsion as the result, he had better let alcohol alone at once, for that convulsion meant an emphatic protest on the part of the brain that it cannot be subjected to such evil influences without the risk of pronounced injury to the general welfare of the individual. All amateur alcoholics would not have such a warning, and only those who suffer a constitutional loss of resistance on the part of the nervous system to the action of alcohol, especially need it, and such individuals ought to admire the wisdom of Nature in providing it.

In some cases, perhaps in most of them, a convulsion, after all, may be regarded as only a protest on the part of Nature against the presence of an irritant of some kind in a part of the body where it ought not to be, and it only remains for science to locate and determine the nature of the irritant.

A man of 40—the exponent of an eminent calling—an athlete in proportion, strong, vigorous, robust, and in every respect the picture of health, consulted me some five years ago for what he called “fainting spells.” A thorough examination of his condition left me at a loss at first to account for his convulsions, but on close questioning he shortly admitted occasional over-indulgence in strong drink at times when “good fellowship was being put to the test.” I warned him earnestly; told him that as often as he applied the match, just so often would the powder probably explode; but he was unable at first to quit the practice, and about every two months, for a period of two years, he would have one and sometimes two well marked convulsions after his periods of dissipation. Finally—being a man who often spoke in public—he had a very marked convulsion in a

place and manner that embarrassed him exceedingly, but which had the salutary effect of bringing him to his senses, for after that he submitted to proper treatment, abstained from further indulgence in alcoholic drink, and for three years now has not had a convulsion. This man stood in danger of sooner or later becoming a confirmed epileptic; not because there was any distinctive cause in his condition capable in itself of producing epilepsy, but because there was in him an inherent tendency to convulsions which would only appear under proper excitation, and which, being forced to appear a sufficient number of times, would give rise to a condition that might continue to create them independent of the action of an immediate excitant.

Such convulsions, once established, are termed "Habit Epilepsy," and they express conclusively the power of education possessed by the central nervous system.

In the second class of cases in which an occasional convulsion helps to preserve the mental life of the patient, it is far more difficult to determine and remove the cause. In many of them the convulsion seems to come as the termination of an obscure auto-toxic cycle that varies in duration in different individuals and that bears some similarity, in its upward period, at least, to the "Folie Circulaire" or the Circular Insanity of the French. It seems evident that the specific cause of the fit in these cases is something that permeates the entire organism; something that comes and goes, causing a sort of Psychic tide that rises and falls; that grows and develops in intensity, exerting a pernicious influence on the daily life of the patient by making him do and say things not in harmony with his normal state, which abnormalities the patient will exhibit in proportion to his powers of inhibition, until the limit is reached and the mind loses its direction and control. The powers of further inhibition finally being destroyed, the nervous storm breaks with great force and violence, the poison is neutralized or destroyed, equilibrium is restored, and all is quiet and serene once more.

A fairly typical illustration of this class, in her own language, by E. M., an intelligent woman of 43, and now a patient at the Craig Colony, is of interest.

"This is now the 22nd of February, 1902. I had four very severe attacks on the 31st of last January. I felt the attacks coming for a long time before they came. I was exceedingly nervous and irritable; things did not go right.

I scolded about everything, and was unable to hold things in a proper manner. When I picked up my brush and comb I would drop them, and when I walked I stepped crooked—one foot would keep making mistakes, and I didn't know which foot it was. They said it was the left. I could not sleep at all. I lay thinking of things that had happened and that was not pleasant. I tried to put them out of my mind by thinking of what I had read. I like history, and I tried to think of some character in English history about which I had read. I have a strong will and feel that I can control my thought at most times, but for days before the attacks come on I am unable to do so. They go off about everything, and I try to make them come back, but they won't. They get worse every day and night, and, finally, they all get jumbled up together and I don't know anything. Then the attacks come on and after that I am all right—everything clears up and I see things as they really are. I lose all my nervousness and can act naturally."

The same psychic phenomena are witnessed in insane epileptics, who are prone to show indications of an approaching seizure. "In asylum life," says Bevan Lewis, "amongst the intelligent class of nurses the fact is universally recognized that a premonitory stage of great irritability is often seen, and the effect of a convulsive attack will be to clear up the mental atmosphere." In our experience, delusions, hallucinations and illusions are very rare in the average epileptic, sane or insane; during the inter-paroxysmal period, but are more common during the pre-paroxysmal stage, nearly always disappearing with the fit. Personally I come in contact with large numbers of epileptics at regular times each week, and it is easy to detect psychic evidences of an oncoming attack, in many cases days and even weeks before the attack occurs. Such cases would seem to offer an inviting field in which the comparative study of living matter in the most comprehensive manner, during, as well as between, the periods of disturbance that culminate in convulsions, might be pursued to advantage; and especially do they emphasize the necessity for studying and treating the epileptic *strictly on an individual basis*.

Nor is it enough now to speak simply of epilepsy, for our knowledge of its manifold types and causes would seem to require that we make every effort to be more specific and define which one of the epilepsies we may have under consideration.—*Albany Med. Annals*.

# Progress of Medical Science.

## MEDICINE AND NEUROLOGY

IN CHARGE OF

J. BRADFORD McCONNELL, M.D.

Associate Professor of Medicine and Neurology, and Professor of Clinical Medicine  
University of Bishop's College; Physician Western Hospital.

### TINNITUS AURIUM.

This annoying and persistent symptom is dependent upon a variety of conditions. In the experience of many otologists, nearly as many patients apply for treatment for this condition as for impaired hearing. The relief of deafness is often easier than the abatement of subjective noises. A classification of the symptoms should relate to the underlying conditions, but this is impossible. The following may be regarded as a convenient provisional arrangement :

1. Conduction sounds or noises due to occlusion or impaired mobility of some portion of the sound-conducting apparatus.

2. Blood sounds or noises produced by the blood-current in vessels in or near the ear, and due either to disturbance of the local or general circulation, and to abnormalities in the size, shape or position of the vessels.

3. Labyrinthine sounds or noises due to alterations in the pressure within the labyrinth.

4. Neurotic sounds or noises due to increased irritability of the auditory nerve.

5. Cerebral sounds or noises due to lesions of the auditory centers in the cerebral cortex.

In the search for these various causes, evidences of disease in any portion of the conducting apparatus should be carefully looked for by a thorough physical examination. The history of the case should be obtained and an accurate description taken of the character of the sound. A careful functional examination should be made, and diseases of other organs or the digestive tract, or circulatory disturbance, should be looked for. In addition, the effects of certain drugs in relieving or aggravating the tinnitus should be noted.

A physical examination of the ear is never to be omitted, because any lesion of the conducting apparatus is an impor-



tant contribu. factor to the production of tinnitus. From the patient we can learn the character of the noises, whether unilateral or bilateral, simple or elaborated, constant or intermittent, pulsating or uniform, and the pitch. The latter is of importance, for, generally speaking, low sounds suggest tympanic and high sounds labyrinthine involvement. The pitch is best determined by holding a tuning-fork, 256 D. V., opposite the patient's ear and requiring him to decide whether the pitch of the subjective sound is higher or lower than that of the fork.

The length of time during which tinnitus persists is of some importance, as sounds of tympanic origin rarely persist for a great length of time. The subjective noise persisting constantly from childhood to adult life suggests an anomalous position of the vessels. Elevation of the lower tone limit suggests tympanic disease, while the lowering of the upper tone limit points to labyrinthine disturbance.—Philip D. Kerrison, *Laryngoscope*.

#### TREATMENT OF GASTROPTOSIS.

A lengthy article upon the displacements of the stomach, together with a discussion of the diagnostic criteria, is concluded by some excellent remarks upon treatment. Tight lacing and heavy clothing hanging from the waistbands should be forbidden. Clothing should be supported from the shoulders. The patient's habits should be rigidly scrutinized. Rest for at least an hour after meals, flat upon the back, with the clothing loosened, is a useful measure. Food should be taken in small quantities and should be digestible and adapted to the gastric secretions. A diet applicable to all cases cannot be given, as the amount of food is dependent upon the amount of hydrochloric acid secreted, and this is largely determined by the presence or absence of dilatation. Two measures are to be insisted upon, namely, that the food shall not be too great at one time, and that there shall be a period of rest after each meal. Lavage is not required unless retention demands it.

The stomach is to be held in place by a belt or abdominal bandage, so as to exert pressure from below upward and backward; the ordinary elastic supporter is best for the purpose. A simple binder is usually not sufficient. The lower edge of the belt must be firmly held against the pubis by perineal bands. If this counter-force is not employed, the belt invariably slips upward, and the satisfactory effects

of upward pressure cannot be obtained. Pads are useful in connection with the belt; they should be from three-fourths to one and three-fourths inches in thickness, so placed as to exert upward pressure. Such a pad may be advantageously placed below the displaced pylorus. In total descent it is well to employ two pads parallel to and a little above Poupart's ligament. Without pads it is rarely possible to restore the stomach to its normal position. In cases where the abdominal walls are thin, it is difficult to exert sufficient upward pressure by a belt alone, and in such individuals the pads are indispensable. Any apparatus for retaining the stomach cannot be shown to be satisfactory until the organ is shown by inflation to be in its normal position when the apparatus is in place. The belt should be snugly fitted and worn fairly tight around the hips, while the upper border should be loose. The proper application of such a belt is shown by almost instant relief of the symptoms. Such an apparatus, however, does not produce a cure. It only aids the stomach wall in recovering its tone.

Operative measures in this condition are advised hesitatingly, as it is impossible to state of what value they may be in permanently relieving the condition. Until such time as the indications for operation are more clearly defined than at present, it is wise to restrict the surgical treatment of the condition to those cases in which the symptoms are clearly traceable to peritoneal adhesions, or those which are not amenable to more conservative measures. When the trouble is aggravated by a relaxed pelvic floor this should be remedied, and where there is much separation of the recti Webster's operation is to be recommended.—J. D. Steele, *Philadelphia Medical Journal*.

#### TREATMENT OF RINGWORM.

At the Vanderbilt Clinic, in which a large number of cases of ringworm are treated every year, a preparation composed of one drachm of crystals of iodine to an ounce of goose grease has proven to be the most effective remedy. It is applied twice a day until it produces a reaction, as shown by a little swelling of the patch; then once a day is sufficient. In two or three weeks the hair falls from the patch, but it grows again, after which the affected area is restored. The first application of the remedy may cause a little pain, but this lasts only a few moments, and even children do not complain. When used upon the bearded portions of the

face, the applications are more painful than when the scalp is the part treated. If such reaction occurs the remedy can be suspended for a day or two, substituting some bland ointment. Many cases of ringworm of the face have been cured in three weeks. The goose grease is regarded as an essential in the preparation of the ointment, and this is sometimes difficult to obtain, as commercial samples of goose grease are often made from other fats which have a low melting point.—G. T. Jackson, *Medical Record*.

### URIC ACID FALLACIES.

Dr. Frank Billings, of Chicago, thus sums up from medical literature the theories concerning uric acid, gout and the morbid conditions which occur co-incidentally with gouty states:

1. Uric acid probably does not exist in the blood in health.

2. Uric acid is probably formed in the kidney from two sources: (a) From urea interacting with some antecedent of urea, probably glycocine in the kidney. The large amount of uric acid excreted by birds and reptiles and the presence in the blood of these animals of urea, and not uric acid, points rationally to this source of uric acid in these animals, and it is rational to infer that a part at least of the uric acid excreted by mammals, including man, is formed in the kidney in this way. (b) From the nucleins of the body by oxidation probably in the kidney.

3. That uric acid is not poisonous. That the presence of uric acid in the blood as the quadriurate or biurate probably means it has been absorbed from the kidneys.

4. That defective kidneys are the cause of the accumulation of urates in the blood because of insufficient excretion.

5. That antecedent kidney disease is commonly formed in so-called lithemic states which have often been attributed to the irritating effects of uric acid upon the kidney capillaries and the cells of the tubules.

6. That the lesions formerly attributed to uric acid are probably due to the toxic effect of the alloxuric bases.

7. That the presence of these lesions in the kidneys and in the connective-tissue elements of the body leads not only to accumulation of the urates in the blood, but also furnishes a proper condition of tissue for the deposition of the urates as concretions in joints and fibrous tissues.

8. That the degree of alkalinity of the blood has no influence upon the presence of the urates in the blood.

9. That the deposited biurate concretions cannot be re-dissolved out of the tissues by an attempt to increase the alkalinity of the blood and fluid by the use of alkaline medication.

10. That the presence of concretions of the urates in the body comprises the sum total of its pathologic effects.

11. That the so-called uric acid diathesis, the influence of heredity, the bad habits of life, alcoholic indulgence, lead poisoning, etc., consists in a condition or tendency to disintegrate a quantity of neuclein far in excess of the amount usually split up, with resulting increase of uric acid and alloxuric base formation.

12. That the condition of the urine as to the presence of uric acid is in single specimens not indicative of the blood state in relation to the presence of urates.

13. The chemical reaction of the urine bears no relation to the presence of uric acid in the urine and blood, nor does it indicate the chemical reaction of the blood.

Some of the fallacies of uric acid are therefore:

1. That uric acid is toxic.
2. That it is a causative factor in any disease except gout.
3. That "uricacidemia," meaning acid blood, does not exist.
4. That the chemical reaction of the blood may be altered by the use of medicinal quantities of the alkalies or by diet.
5. That uratic deposits may be dissolved out by the administration of alkalies.
6. That lithia is a uric acid solvent of unusual potency.
7. That uric acid is an abnormal constituent of the urine.
8. That an excess of uric acid in the urine at one time, or a deficiency at another time, indicates an abnormal condition in reference to uric acid.

9. That rheumatism is due to uric acid.—*Northwestern Lancet.*

#### **THE TREATMENT OF PNEUMONIA BY ANTIPNEUMOCOCCUS SERUM.**

Sears (*Boston Medical and Surgical Journal*, December 12, 1901, *Maryland Medical Journal*) reports twelve cases of lobar pneumonia treated by the antipneumococcus serum, the effort being made to select only those cases of which treatment seemed likely to modify the outcome, thus excluding those in which death seemed practically inevitable, and also those whose age or general condition made recov-

ery highly probable. An attempt was also made to select only those cases which entered the hospital early in the course of their illness, although this requirement could not be rigorously fulfilled.

Other measures were not excluded, and cold sponging, oxygen inhalation, salt infusion and various stimulants were used in the cases when their administration seemed desirable. Eight of the twelve cases were over thirty years old; of the other four cases, one was excessively alcoholic, and two others confessed to its moderate use.

Of the eight cases over thirty years of age, three used alcohol to excess, two others had mitral regurgitation and nephritis, and one arteriosclerosis. Albumen was found in the urine in ten cases, in four in considerable amount.

Three patients died, i.e., the mortality was about the same as the usual hospital rate of all patients with this disease.

In the nine recoveries the temperature returned to normal, in one of the fifth day, in one on the sixth, two on the seventh, three on the eighth, and two on the ninth. Thus the serum treatment did not seem to shorten the course of the disease, and the only conclusion that can be drawn in this connection is that the course of the disease is not lengthened.

The treatment, according to Sear's experience, is certainly no specific against the pain resulting from the inflamed pleura, and "yet it seemed, even in the fatal cases, that the patients were peculiarly comfortable" under its use.

It was impossible to assert that the injections had any effect upon the fever in these cases.

No ill-effects, except occasional skin eruptions, with pain and swelling of the joints, were met with. "A great practical objection to its use is our ignorance of the strength of the serum and the consequent inability to measure the dose."

Taking all things into consideration, however, the unfavourable character of the material, and the fact that in but four cases the injection was given before the third day, Sears concludes that the results of the use of the serum in these twelve cases justifies a further trial of this form of treatment.

#### **SPEECH AS A FACTOR IN THE DIAGNOSIS AND PROGNOSIS OF BACKWARDNESS IN CHILDREN.**

G. Hudson Makuen. (*Journal American Medical Association*, October 12, 1901. *Maryland Medical Journal*).

The subject of this paper is one of more than usual im-

portance. The expression "backwardness in children" has a rather indefinite scientific meaning. According to the common acceptance of the term, the backward child is one who is below the average intelligence of children of the same age. A more scientific definition would make the term "backward child" mean one who is not living up to his own possibilities or capabilities. In the present paper Makuen regards backwardness as a disease.

The diagnosis of backwardness is not difficult. All children who do not, cannot or will not keep up with their classes must be regarded as backward and should have careful attention. The object of Makuen's paper is to consider to what extent a study of the speech of children will aid us in a diagnosis. Freedom of speech is an absolute essential to the normal development of children, and defect of speech, however slight, makes an impress on the child's mentality and prevents him from doing all that he would otherwise be capable of doing. The author cites several cases in point.

A young man, aged nineteen years, was regarded as an imbecile. He could not speak, read or write intelligently; his expression was vacant and staring. His speech was wholly unintelligible. His whole mental condition was thought to be due to his lack of power of expression. On examination it was found that the patient had a defective tongue. The genio-hyoglossus muscle was too short, and bound the tongue down to the floor of the mouth. A simple operation was performed to give a free tip to the tongue. A systematic course of training for the purpose of using the tongue followed for about one year. The imbecile youth soon became one of the leading business men of the city.

From a study of a series of similar cases he draws the following conclusions:

1. It is not always possible to determine at a glance the cause of backwardness in children.

2. Backwardness in children is not always due to a central lesion, but may be the result of arrested cerebral development, due to some abnormality of structure in the peripheral organs.

3. A very common cause of backwardness in children may be some abnormality of structure in the peripheral organs of speech.

4. So closely are the speech centers related to the ideational centers of the brain that any impairment of the one generally results in a corresponding impairment of the other.

5. The best method of arriving at even a proximately correct prognosis in case of backward children is to apply the speech test, or, in other words, to ascertain by careful study and experiment to what extent the faculty of speech may be impressed, and it will be found that in those who are susceptible to training in what may be called the refinements of speech are the ones for whom we may promise the best results, and that possibilities for general development will be proportional to the capacity for speech development.

### TUBERCULOSIS.

Dr. B. K. Rachford in the *Archives of Pediatrics* for December, believes that the keynote of treatment of tuberculosis in infancy and childhood is to maintain nutrition by a proper diet. As the importance of nutrition becomes more and more paramount the younger the patient and in artificially fed infants, the problem presented is one of the greatest difficulty. Milk and cod-liver oil remain the foundation-stones of the treatment, and the next most important agents are fresh air and sunshine. The fresh-air treatment of tuberculosis is, he thinks, even more important in the infant and child than in the adult, and if faithfully carried out will give better results. He especially insists upon the great value of guaiacol in the treatment of tuberculosis in infancy and childhood, and believes that it far out-classes all other drugs in this condition. He recommends its use by inunction in the form of this prescription:—

R	Guaiacol.....	3	1
	Lanolin .....	5	4
	Lard .....	3	4

One level teaspoonful to be rubbed into the chest at bedtime each day. He has used this prescription for eight years in these cases in infancy and childhood, and is convinced of its great value. Guaiacol is one of the few drugs which, when applied to the skin, is rapidly absorbed by the lymph-channels and so carried into the general circulation. Its great value in the treatment of lymph-node tuberculosis in infancy and childhood probably depends on the fact that by inunction it can readily be brought into contact with the diseased lymph-nodes and so act as a lymphatic antiseptic. While of great value in children, it is of comparatively little value in adults, because in the first place the lymphatic glandular system is more active in the child, and in the second place adult tuberculosis is as a rule not that of the lymph-nodes. In acute tubercular conditions

he directs that a level teaspoonful of the ointment be rubbed into the skin over the abdomen and chest night and morning for ten or fifteen minutes, after the fever and symptoms have been controlled, then two or three times a week as long as may be necessary. In tubercular peritonitis the good results are equally evident, and when the active symptoms are in abeyance he frequently substitutes the carbonate of guaiacol internally for the inunction. A mixture of the carbonate and milk sugar is readily taken by children, and it is especially valuable in the treatment of intestinal and mesenteric tuberculosis.—*The Cleveland Medical Journal.*

**THE OBSTETRIC FORCEPS: MAY WE NOT SAFELY USE THEM IN EVERY CASE OF LABOR? \***

BY FREDERICK LEAVITT, M. D.

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ST. PAUL.

As long ago as the beginning of the 11th century, AVICENNA, that most celebrated Arabian physician, is said to have described the use of an instrument which could be applied to the head of the fetus and thereby aid delivery. Not until the time of the Chamberlens, however, more than 500 years later, was the modern forceps invented. For several generations this family of physicians kept the "art of delivering pregnant women in difficult cases by means of instruments" a secret, and it was many years after their death that models of the obstetric forceps were found in a secret room of Chamberlens' house. Since then improvements have been made from time to time, till now the forceps seem to fulfill every requirement.

When the forceps must be used, though an important theme for consideration, is a phase of the subject that I shall not discuss at this time. However essential it may be for one to know when the operation is imperative, at present I wish only to inquire how freely we may apply them. So then, putting to one side the accepted rules as to when forceps are demanded, let us consider when, if ever, their use is denied.

You will find that many of the rules laid down by distinguished obstetricians of a century ago were promulgated with the idea of discouraging the abuse rather than the

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\*Read at the 34th annual meeting of the Minnesota State Medical Society at Minneapolis, June 18, 1902.



conservative use of the forceps. It is stated that at one time instrumental interference was frequently had recourse to unnecessarily; that nature was seldom or never allowed to accomplish her object. The hand was constantly thrust into the uterus, instruments were employed to extract the child, and the rudest means used to bring away the placenta. Thus a great revolution was effected in the practice of the age, and obstetricians were taught to rely more implicitly on the power and beneficence of nature. DENHAM, who flourished during the first quarter of the 19th century, states in his work on Midwifery, that however cautiously applied, the evils arising from the unnecessary and improper use of forceps are so great that the world would doubtless be better off if no such instrument had ever been contrived for, or recommended in, the practice of obstetrics. A rule that he considered practical is stated thus: "The head of the child shall have rested for six hours as low as the perineum, that is a situation which would allow of their application, before the forceps are applied, though the pains should have altogether ceased during that time." A generation later we find obstetricians teaching more liberty in the use of the forceps. For example, in 1841, Ramsbotham wrote, "if the head have been locked for four hours, and made no progress for six or eight hours, without waiting the limited twenty-four hours, or even twelve, the forceps may be applied." Some of the indications for instrumentation as laid down by him were subsiding pains, failing strength, sinking spirits, anxious countenance, rapid pulse, rigor, great tenderness of the abdomen over the uterus, green discharges, preternatural soreness of the vulva, with heat and tumefaction of the vagina. Teachings that hold good to-day.

The statement was made in a recent article by Laphorn Smith, that while the forceps has saved the lives of hundreds, it has shipwrecked the lives of thousands. While I cannot believe this to be true, I do believe that many of the bad results accompanying parturition are wrongfully charged to instrumental interference.

Ever since the days of Israel, when Sarah, the patriarch Jacob's wife, perished at the hands of a midwife, medical history has been full of warnings; and, indeed, we are still far from always knowing when nature may be aided by art. It may properly be contended that the best success comes through conservatism, and that the physician who is inclined to apply radical measures in the treatment of his cases stands in danger of doing more harm than good. On the other hand, I dare say, many of us err now and then in allowing things to take their own course.

Writers and instructors of to-day, like those of old, have thrown into their teachings an element of precaution, while in their own practice they make use of the forceps with the greatest freedom. I have known this to be the case in some instances. Would it be safe to teach our students differently? This leads up to the inquiry, Does instrumental delivery add greatly to the dangers of labour? Are the complications and sequelae enhanced by the proper, or, to make it less exact, the careless use of the forceps? The point I aim to make is, that physicians *may* safely apply forceps in every case where time will permit, after the completion of the first stage of labour; that when this stage is over the obstetric moment has arrived when the patient may be placed in position and instruments employed with benefit.

The advanced stand taken in the practice of obstetrics must ultimately bring the art entirely within the realm of surgery. It is only when viewed from this standpoint that we note any marked progress being made in the past or towards which we may look for greater perfection in the future. In this age of cleanliness we dare do things that might not safely have been undertaken years ago. It is barely half a century since the blades of the forceps, in order that the patient should not be shocked by their metal clang, and that their introduction might be less likely to injure the parturient structures, were covered with leather and kept well lubricated with neat's foot oil. Could one imagine a more favourable nidus for bacterial growth outside a culture tube!

Personally it is my experience that where the forceps has been used no bad results have followed, neither in the immediate consequences to the soft parts, nor in delaying convalescence. In fact, it is frequently noted that the patient's strength is less dissipated, and the puerperal period passed with greater comfort, following instrumental aid, than when exhausted by tedious though spontaneous delivery. Of course it goes without saying that in many instances there is little demand for forceps, and, in fact, time will not permit of their application. But where the second stage has lasted long enough to make proper preparations for the operation, their use need not be delayed until some note of warning informs us of danger. At the City and County hospital it has been my custom to deliver nearly every case with instruments, and during a service of five years we have had no complications resulting therefrom. It may be claimed that obstetrics as practiced in institutions permits of more interference with less evil results than in private practice. In a measure this is true, yet

we are all able to bear testimony to the astonishingly good results amongst the lowly. Even in the hovel, where not a single thing is sterile, except, perhaps, a pot of boiling water on the kitchen stove, we have seen our cases recover rapidly and satisfactorily. If in maternity hospitals instrumentation is a rational procedure, then why is it not even more so in the homes of our patients? If we look upon accouchment as a surgical measure and conduct it accordingly, I believe that results will be better than if treated otherwise. The practice of conducting parturition under the bed clothes, to my mind, is reprehensible. It may be esthetic, but it is not surgical nor even sanitary.

Let me draw a picture or two. Mrs. A. and Mrs. B. are both about to be confined. Mrs. A. has engaged the services of a physician who looks upon parturition from a medical standpoint; who considers his responsibility at an end when the cord is severed and the parents congratulated. During labour he urges voluntary effort on the part of the patient, contriving appliances whereby she may lay out her strength upon the footboard of the bed, or possibly he may volunteer to be the other contestant in the tug of war going on. In vain does she beg of him to help her and in vain does he assure her that he is doing all that he can. If everybody's strength holds out baby is finally born. With slight variations this is the common conduct of normal labour. On the other hand Mrs. B. is to be attended by a physician who assures her that straining and struggling serve only to tire her out and that it is unnecessary. Her prayers for help are not unheard. An anesthetic is given, she is placed crosswise of the bed, the hips well to the edge of the mattress, and the feet placed upon the knees of the accoucheur or supported on either side by assistants. The external parts are cleansed, the instruments which have been boiled and brought to hand are cooled in a solution of lysol, the physician draws on a pair of rubber gloves, the forceps are slipped over the head of the fetus and the labour concluded completely under control. Progress may be closely watched, the parts kept clean, the perineum more easily protected, repaired if lacerated, the placenta delivered, and the toilet made with a minimum of contamination. Furthermore, much time may be saved and the patient's strength husbanded.

If I were asked to select from my armamentarium the instrument with which I would most unwillingly part, I assure you, fellow practitioners, there would be no faltering decision. Directly I should go to my case and grasp those dual blades, and nothing but a losing fight could wrest them from me.—*St. Paul's Medical Journal.*

**HINTS ON TREATMENT OF SCIATICA.**

Stevens' "Manual of Practice of Medicine" gives the following terse and valuable hints on the treatment of sciatica:—"In the acute stage rest is essential. Hot fomentations or linear blisters may be applied along the course of the nerve. Deep injections of morphine, antipyrin or cocaine may be required to relieve the pain. In rheumatic cases, full doses of the salicylate of sodium are useful. In chronic cases, prolonged rest is desirable. Counter irritation should be made by frequent small blisters, by the actual cautery, or by acupuncture. Deep injections along the course of the nerve give much relief, and one of the following remedies may be employed: Morphine and atropine, cocaine, antipyrin or plain water. Electricity sometimes does good. Internally, iodide of potash in small doses is useful; in syphilitic cases it should be given in large doses. The following combination is efficient:

- R Tinct. aconite root..... 5 ij
- " belladonna..... 5 ij
- " cimicifuga ..... 5 ij

M. Sig.—Twelve drops every four to eight hours."

**TREATMENT OF ACNE.**

Dr. Lusk, in a case of acne, characterized by papules, pustules and comedones, and caused by errors of diet, constipation and menstrual disturbance, recommended proper treatment for the general condition and used locally the following lotion :

- R Zinc sulphate ..... ʒ—ij
- Sulphuret of potash..... ʒ—ij
- Sulphur, precip.....q. s. ad. ʒ iv
- Aqua rosae.....q. s. ad.

M. Sig.—The zinc and potash should each be dissolved in half the quantity of water, and the second added to first slowly, with constant stirring. The sulphur should be first made into a paste with the resulting solution, and then thoroughly mixed in mortar.—*Post-Graduate.*

**TUBERCULOSIS AND CHILDHOOD—A RESUME.**

(By WILLIAM JACOBSON. *Journal of Tuberculosis*, Jan., 1902).

The author calls attention to the early recognition of the disease: "The child is the father of the man, whatever knowledge is disseminated for the good of the child will certainly make a stronger man," "Human cells are the defenders against incoming agents of destruction." Heredity is our inheritance of these cells; if these are powerful, i.e., our heredity is good, we shall conquer these enemies; if

not they will overpower us. Cell activity is marked in childhood; in disease the task to be overcome will be proportionate to the relative heredity strength. Our endeavours should be to fortify this cellular resistance and avoid cellular irritability, and thus prevent or stay the disease.

He speaks of the difficulty of diagnosis because of the absence of bacilli from the sputum, these being swallowed by young children. Also of the dangers of test injections. Calls attention to our early recognition in the diagnosis of the parts involved in tuberculosis, viz., skin, subcutaneous tissues, mucous, serous and synovial membranes, pia mater, glands, bones, lungs, liver, spleen, kidneys, testes. We should be able to differentiate between tuberculosis and other diseases in which they are involved.

Glands are infected first, proved by finding bacilli in them and not in the lungs. Glandular enlargements in children are the forerunners of more serious future troubles. Bearing in mind these facts, diagnosis can be made. Calls special attention to hectic fever, emaciation, ulceration of skin, mucous membranes, swellings of the joints. Lungs, if suspected, may show only a few crackling rales below the nipples and in the scapular region. The lower lobe of the lung in young children may show a cavity, whereas in adults we seek the upper lobe. Enlargements of abdominal glands, diarrhoea, griping after food, are common. Loss of appetite, fretfulness, pyrexia, disturbed sleep, clenched hands, point to tuberculous meningitis. After this the rapid pulse, headache, vomiting and pupillary signs. Then follow the contracted pupils and slow pulse, stupor, hemiplegia and coma.

Tubercular iritis is rare; the diagnosis is made chiefly by its chronicity. Middle ear disease may be due to the bacilli; again, mastoid disease is often due to them. It is wrong not to interfere surgically with them. Cold abscesses are often present in infants. In respect to treatment he emphasizes the necessity of daily bathing with cool water as one of the best stimulants to cell activity. Exercise is enjoined, well ventilated rooms, no overcrowding as in tenements. He calls special attention to building of proper tenements with roof gardens, where children can play at all times of the year. Proper medication, and in very badly diseased children, their isolation in sanatoria is advised. By these means we can combat the disease and tend towards the termination of this dread affection.—*St. Paul Medical Journal.*

**DILATATION OF THE HEART IN CHILDREN.**

(EUSTACE SMITH, M. D., F. R. C. S. *The Practitioner*, London, January, 1902).

The author is of the opinion that moderate cardiac dilatation in children is not infrequent and that it exists quite apart from any valvular trouble. It may arise from over-exertion at play, rapid growth, nephritis, bronchopneumonia and infectious fevers, being common in acute rheumatism and influenza. The physical signs are said to closely resemble pericardial effusion. The shape of the cardiac dullness is said to be characteristic, reaching upwards far above the third rib and its right border is continued downwards and outwards to the right fifth interspace to join the liver dullness, instead of curving upwards to the infra-sternal notch. Attention is called to the fact that in rheumatic cases the dilatation is accompanied by endocardial murmurs from inflammatory thickening. In moderate dilatation the discomfort is not great, the heart returning to normal as the general nutrition improves. It is in the cases of acute illness when the dilatation is rapid that the condition becomes serious, the dilatation affecting the auricles as well as the ventricles, and is due to degeneration of the heart muscle, the danger being in proportion to the degree of degeneration. The destruction of muscle fibre is said to be greater in diphtheria and influenza than in rheumatism. In any case where there is rapid broadening of the area of dullness, especially if vomiting, coldness of the surface and partial collapse co-exists, the prognosis is regarded as grave. In all cases of acute disease where dilatation is present, the patient should remain constantly in the recumbent position, all starchy foods avoided, also grapes, baked apples, oranges and acid fruits, relying on milk, custards, strong soups, yolk of egg and stale bread or rusks until the stomach is able to take care of boiled fish, chicken, etc. It is recommended that the drug treatment of the original disease be continued. Strychnia pushed to the point of toleration in connection with a suitable preparation of iron and alcohol. For the moderate dilatation occurring in anemic children, nothing is required in addition to means calculated to improve digestion and general nutrition, and to forbid their engaging in those games that require violent exercise.—*St. Paul Medical Journal*.

**CREOSOTE AND CREOSOTE.**

Merck & Co., in a communication to the American Pharmaceutical Association, call attention to a great danger in-

to which the careless or unwary doctor may fall in prescribing creosote. Only beech wood creosote should be used internally. We reproduce a Merck label in which is contained the caution: "Caution.—Whenever creosote is indicated for internal medication, this kind (wood creosote) should be dispensed; and under no circumstances should so-called 'creosote' from coal-tar be given internal use unless explicitly so directed. Wood creosote and 'coal-tar creosote' are two different substances. They do not consist of the same chemical ingredients; and they differ very largely in their action on the human body. Wood creosote is comparatively harmless; while 'coal-tar creosote' is distinctly poisonous. A substitution of 'coal-tar creosote' for wood creosote may, therefore, cause the gravest consequences."—*Texas Medical Journal*.

#### HARMLESS ALBUMINURIA.

Wm. Osler (*N. Y. Med. Jour.*) records a number of interesting cases of men past fifty who were found to have albuminuria and an unfavourable prognosis given accordingly, who, nevertheless, survived this discovery for many years. He concludes that at this period of life, albuminuria, or even the presence of a few tube casts in the urine, is not at all infrequent and not always serious. They are, however, always danger signals, and should be warnings to "go slow," especially as regards the quantity of food eaten. The points on which one should lay special stress as indicative of serious disease are:

1.—Persistent low specific gravity of the urine, 1.008 to 1.012.

2.—The state of the heart and arteries. Marked sclerosis of the peripheral arteries, with the apex beat of the heart an inch or two outside of the nipple line and a ringing, highly accentuated aortic second sound.

3.—The presence of albuminuric retinitis.

#### DIAGNOSIS OF BILIOUS COLIC.

The first symptom of gall-stone colic is usually pain at the pit of the stomach, which in some instances extends round the waist; it may run to the right shoulder, oftentimes down into the right iliac fossa, sometimes in the back, and sometimes it is more severe just beneath the heart. It may form a girdle or sense of constriction around the waist; cold perspiration breaks out over the patient, owing to the intense pain; a waxy palor comes on, which is follow-

ed by reaction in a few hours, fever running up to 103-4° or 105° F., depending largely upon the idiosyncrasy of the patient. We may find the temperature to reach 105° F. in a bad attack of gall stone colic. Every evidence of approaching death is present. There is often a deep-down boring pain in the epigastrium, a little to the right. If, in addition, we find jaundice coming on within a few hours from the beginning of the attack, we can say that it is due to occlusion of the bile ducts. If we find an enlarged gall bladder there must be something to cause it, and we may infer that the ducts are occluded, and if it be the first, second, or third attack it is most likely to be caused by a stone. We may have distension of the gall bladder with mucus, perhaps some muco pus, not bile, because the bladder is not often distended by bile, it being only the receptacle for the overflow of bile; when it can not get out of the common duct it dams up and fills the bladder.—*Amer. Practitioner and News.*

#### SEPSIS FOLLOWING LABOUR AND ABORTION.

W. O. Henry gives the following rules: (1) Remove early with the finger, sharp curette and flushing, all debris, decidua, blood clots and sloughing tissue which may be infected from the uterus, and from all raw surfaces in cervix, vagina and vulva; (2) Dry all these raw surfaces, and freely apply to them ninety-five per cent. carbolic acid, washing away the surplus acid with sterile water; (3) Unless hemorrhage requires, leave no tubes or packing of any kind in either vagina or uterus; (4) Have simple carbolized two per cent. vaginal douche used twice a day thereafter; (5) Open the bowels freely with calomel, one-half grain every hour for four hours, then follow with Rochelle salts until sufficient action has occurred; (6) Give three grains sulphate of quinine every four hours, followed by fifteen drops tincture of chloride of iron, in water; (7) Give good nourishment with milk, eggs and stimulants every four hours; (8) Let this be the routine, early treatment, and more radical measures will rarely be indicated; (9) Fixation of uterus, with infiltration in Douglas' *cul de sac* or ligaments, or pus in tubes or ovaries must be treated by opening and draining through vagina; (10) Multiple abscesses in uterine walls, or infection of walls or pelvic cavity, call for removal of uterus, and all else necessary by the vaginal route. The abdominal route in all acute cases is dangerous, and seldom, if ever, justifiable.—*Annals of Gynecology and Pediatrics.*



**ACETOZONE IN THE TREATMENT OF TYPHOID FEVER.**

The writer reports twenty-five cases of typhoid fever treated with this new intestinal antiseptic. The duration of the disease was reduced in a large number of them to fourteen days, the time being reckoned from the development of definite symptoms. This series of cases was remarkably free from bowel complications, and where they were present, in those admitted after the disorder had persisted for some time, they quickly disappeared. There were no deaths and but few terminal expressions of the infection.

The treatment pursued in all cases was to thoroughly move the bowels by grain doses of calomel combined with aloin and guaiacol every two hours until the intestinal canal was emptied. The patient was then given from 1500 to 2000 cubic centimeters of a solution of acetozone that had been prepared twenty-four hours before. The diet was restricted to milk, to which was added acetozone. In addition the same substance was atomized and inhaled. In some cases the acetozone was given in capsule, five grains in sugar of milk, three times daily.

The first effect of the acetozone is an increased secretion of the kidneys. This is soon followed by a pronounced decrease of the odour of the stools and a marked diminution of the microorganisms found in the intestinal dejecta. As a result of his observations, the writer concludes that acetozone is an efficient germicide that is innocuous to man and is readily eliminated. In the treatment of typhoid fever it will destroy the source of the infection if brought in contact with it. In typhoid it obviates the intestinal infection and toxemia, preventing the development of complications and lessening the duration of the disease.—E. WASDIN, *Therapeutic Gazette*, vol. XXVI, No. 5, p. 289, May 15, 1902.

# SURGERY.

IN CHARGE OF

**ROLLO CAMPBELL, M.D.,**

Lecturer on Surgery, University of Bishop's College ; Assistant Surgeon, Western Hospital ;

AND

**GEORGE FISK, M.D.,**

Instructor in Surgery, University of Bishop's College ; Assistant Surgeon, Western Hospital.

## **THE SIGNIFICANCE PATHOLOGIC AND CLINICAL OF ABDOMINAL PAIN.**

A lengthy article is summarized by the statement that under no circumstances should the pain be masked by opiates until after a thorough physical examination. In all cases of abdominal pain, the accompanying physical signs should be carefully considered. When hemorrhage is suspected the abdomen should always be explored. If the patient is in collapse and too weak to undergo exploration, preliminary infusion of salt solution should be made into the veins and under the skin. When the pain is excruciating and the abdomen shows signs of infection, exploration should be made at the earliest possible moment. The site of the initial pain, as described by the patient and friends, should indicate the place for the incision where the other symptoms leave the operator in doubt. The history and signs other than pain must be relied upon for an exact or reasonably positive diagnosis. When some of the unusual abdominal lesions are suspected, exploration should be made. In some cases it may be useless, but if resorted to as a routine procedure in all cases it would save the greatest number of lives. When there is the least doubt, the genuineness of the pain should be tested as thoroughly as possible. The pain of an atypical typhoid, of a pleurisy, of a pneumonia, must be guarded against. When typhoid is prevalent in a community the greatest precaution must be taken lest the surgeon be misled by the pain. One should be on his guard lest he confuse the pain of simple functional disturbances with that of organic disease. When uncertain as to the significance of pain, the doubt should be given the patient and a surgical exploration made. Finally, when no exploration is indicated pain should be controlled by morphine, hypnotics, or, if necessary, by general anesthesia. With few exceptions, chiefly cases of renal and biliary calculi, the pain that demands general anesthesia indicates operation.—*M. H. Richardson in Boston Medical and Surgical Journal.*

**THE SURGICAL TREATMENT IN MITRAL STENOSIS.**

Sir Lauder Brunton, in a preliminary note (*Lancet*, Feb. 8, 1902), proposes a very striking innovation in the field of surgery, it being no less than an attempt to relieve mitral stenosis by surgical means. The method has not yet been attempted on a human being, but he has carried out some experiments upon lower animals, which would lead one to think that the method is possible. The clinical history of mitral stenosis, and the mechanical impediment offered to the circulation, afford an inviting field for surgical speculation. These patients, when in hospital and under treatment, make a partial recovery, there is improvement in the circulation, the edema subsides, and they leave the hospital so far improved that it is possible for them to take up their usual occupation. In a few days or weeks they are back again with a recrudescence of all of the symptoms. This is repeated for months and years until an intercurrent pneumonia or involvement of the kidneys puts an end to the chronic ailment.

The experimental work of Brunton has been devoted to solving some questions connected with the technique of such an operation. As to whether the valve should be cut through at right angles, or whether the opening should be enlarged by an incision between the leaflets, is a matter upon which he is undecided, but thinks that the latter method would be preferable. In cats he has used knives made from hat-pins, to divide the valves. He has not decided as to the best form of knife; this depends upon whether the surgeon decides to operate from the auricle or the ventricle. The latter is less likely to bleed. The knife need not be much thicker than a needle. In exposing the heart in a human being, the incision should be made along the left edge of the sternum, outward along the lower borders of the third and fifth ribs, connecting their outer ends by a third incision, dividing the fourth and the fifth ribs. The flap thus made is turned back on the sternum, the external attachments of the ribs being sufficiently flexible to yield to the pressure. The lung is then pushed back and the pericardium freely divided. If the operation is made through the auricle, it would probably be necessary to incise one rib higher.

In his experiments he has been astonished at the ease with which the heart goes on beating in spite of its being handled. He ventures to suggest this operative procedure in view of the excellent results in surgical wounds of the heart.—*Medicine*.

### ADRENALINE AS AN ADDITION TO SOLUTIONS FOR LOCAL ANESTHESIA.

The removal of a sebaceous cyst, the opening of an abscess, or similar minor operation, is facilitated by the suppression of hemorrhage. The application of sponges to a bleeding surface causes more or less pain unless the anesthesia is perfect. If adrenalin is added to solutions for local anesthesia there is an immediate blanching of the skin and the operation is quite bloodless. If one drop of 1 to 1000 adrenalin chloride is injected under the skin, a slight burning sensation is felt, but there is no anesthesia. Within one minute an area of skin about two inches in diameter becomes blanched and remains so for from six to twelve hours. With weaker solutions proportionately less effect and of shorter duration is produced. When local anesthetics such as cocaine or eucaïne are associated with the adrenalin, there is the same blanching of tissues, but there is no interference with the local anesthetic action of these drugs. It has been the practice of the writer to add adrenalin chloride in a proportion of 1 to 5000, or 1 to 20,000 to solutions of cocaine for local anesthesia. Under such a solution only the larger blood-vessels bleed when they are cut, and there is very little oozing. In none of the cases was secondary hemorrhage noted.—*C. A. Elsberg in American Medicine.*

### ABDOMINAL ROUTE FOR APPROACHING RECTAL TUMOURS.

Robert Abbe, New York, says that, first, operative method for cancer in different parts of the rectum must still be elective; there is no one method that applies to all. The perineal route is still the most available for very limited and very low down growths. The Kraske sacral method is available for a moderate number of growths which exhibit slight malignancy as to infiltration, and are not more than a short finger length within the anus. But the abdominal method combined with those just mentioned more nearly meets the present attitude of surgery in seeking as wide and thorough extirpation as possible for malignant growths.

Second, the artificial inguinal anus had best always be made at the time of operation, and need not be done beforehand.

Third, when the section of the rectum is made well up to the sigmoid, the ends of the severed gut should be in-

verted by a stout silk purse-string suture for more perfect cleanliness and handling.

The question of disposing of the upper stump is one that may well appeal for solution. Whether to put it on a severe stretch and attempt to bring it into a perineal or sacral wound, or to make at once a lateral inguinal colostomy, is a question. The writer's argument is for the latter for the following reasons :

1. In the combined method it settles at once all uncertainty and delay by having it brought out of an inguinal cut before the patient leaves the Trendelenburg position, thus leaving the operator free to confine his whole thought to most thorough enucleation of the cancerous rectum.

2. It removes the anal discharges forever from the pelvis, and thus takes away one source of renewed irritation of any remaining cells of disease.

3. If the base of the bladder proves to be involved in the complete operation and a possible leakage occurs, the danger of mixed urinary and fecal contamination are obviated.

The results of newly established artificial ani in perineum or sacrum are such that continence of flatus and feces cannot usually be hoped for, even to as great an extent as in an inguinal colostomy, therefore, inasmuch as a T bandage or napkin will usually have to be worn, the inguinal has no disadvantage.

5. When then the operator begins with the idea of turning the sigmoid colon end up into the groin permanently, he is much freer to dissect the highest part of the rectum and lower sigmoid with the hemorrhoidal vessels, and then clean out all infected lymphatics from the pelvis, *ab initio*.

The operation as a whole is thereby simplified and abbreviated as well as made more thorough.

6. The great majority of cases with return of disease ultimately require artificial anus, and it should be anticipated in all by this preparation.—*Annals of Surgery*.

#### **SOME POINTS CONNECTED WITH THROMBOSIS.**

Sir William Bennett cites two cases of thrombosis and makes some interesting remarks on them. The first was that of a woman, aged 49, who was operated on for femoral hernia. There was nothing unusual noticed at the operation, which was performed in the ordinary way. The temperature rose slightly the next day, as commonly happens, but did not subside, although the wound healed perfectly by first intention. Ten days after the operation

the temperature rose rapidly to 103.5 F., and she complained of pain in the left leg. Examination showed that there was thrombosis of the saphena vein, as well as commencing thrombosis in the femoral vein. She now became very seriously ill; the thrombosis extended rapidly upwards, and as it extended into the belly the opposite limb became similarly affected. She remained very ill, had one or two rigours, and looked like a person suffering from septicaemia. About four weeks after the onset of the thrombus in the lower limb she had an attack of pulmonary embolism, and nearly died. A large flowing mass came away from over the sacrum, exposing the bone and leaving a great cavity. She slowly recovered, and eventually left the hospital well.

The second case was also a woman, aged 27, who was admitted for a severe attack of appendicitis with a high temperature, and an operation was immediately performed. She was intensely anaemic at the time of the operation. She did very well afterwards, and a week later it was found quite accidentally that one of her lower limbs was swollen. She complained of no pain, thus differing from the case mentioned first. Extensive thrombosis of the femoral and iliac veins was found, and on the following day a sudden attack of pulmonary embolism occurred, from which she nearly died. Here, then, was a case of thrombosis occurring after an operation in which the patient was doing well and free from any suspicion of sepsis, followed almost immediately by embolism. In the other case the embolism did not occur till very much later, until, in point of fact, the thrombus had commenced to disappear. In the second case the embolism occurred during the process of the growth of the thrombus. These are two very different conditions, and their importance is great. The thrombus in the first case was the result of septic conditions; in the second the clotting was purely passive. The second patient's blood clotted in the veins because she, being weak and intensely anaemic, had been called upon to bear the shock of what was to her a serious operation, which lowered her vitality considerably.

It is well to bear in mind that all patients of the anaemic type are very prone to blood clotting, and that a certain percentage of them, if placed in bed and kept absolutely quiet after an operation or accident, by which their already feeble physique is still further reduced, are very liable to get thrombosis, more especially in the lower extremities, although the clotting may occur in other parts. There are two other varieties of passive thrombosis to which it is worth while to direct attention. The first

is that which is prone to follow any exhausting disease, such, for example, as enteric fever, the thrombosis following upon which is frequently passive, not septic, and the second is that which follows upon great loss of blood. There is a tendency in many subjects—notably those of the anaemic kind on the one hand and those of the robust “gouty” type on the other—to the occurrence in bed, when in a condition of apparent good health, and kept absolutely quiet for a considerable period—such quiet as, for example, may be necessitated by an operation on the knee joint, severe abdominal cases, or any other cases of severity. Thrombosis is not, for an example, very rare in certain types of patients laid up suddenly with fracture, the thrombosis occurring as often as not in a sound limb.

The practical bearing of this matter is the following: In all operations of expediency, such, for example, as the radical cure of hernia, operations on varicose veins, etc., when performed upon patients in sound general health, who up to the time of coming under treatment have been following their ordinary callings or amusements, it is wise, and in many cases necessary, that the patients should be kept in bed for some days prior to the operation, so that the absolute rest entailed by the operation comes less abruptly upon them—a period of modified rest in the flat position intervening between the ordinary habits of life and the total rest which should follow upon the operation. In all cases of thrombosis, whether septic or aseptic (*i.e.*, passive), no matter what the cause may be, there is a certain period in each variety at which embolism is more prone to occur than at any other time. A proper appreciation of this fact is of some importance, since the time at which embolism is prone to occur is that during which absolute rest for the patient should be most rigidly enforced. In the first case (the septic one) embolism did not occur until three or four weeks after the onset of the thrombosis, and no embolus became detached until the thrombus had not only ceased to grow, but had commenced to disappear; the embolism, in fact, occurred at the time of the softening of the thrombus. The importance of this clinical point is as follows: The period of danger from embolism in a *septic* case of thrombosis is at the time of softening, *i.e.*, when the patient is apparently on the verge of convalescence. On the other hand, in the second case, in which the thrombus was *aseptic*, extensive thrombosis occurred very soon after the operation, and on the following day embolism occurred whilst the thrombus was increasing in size—a clinical sequence which illustrates admirably the fact that in aseptic thrombosis the danger

of embolism is greater during the formation of the thrombus, and not at the period of resolution, the exact reverse of the condition holding good in septic thrombosis.

The practical bearings of these facts upon treatment are the following: In septic thrombosis the greatest care should be taken to ensure absolute rest during the period of resolution; in aseptic cases the greatest call for rest is during the period of the formation of the thrombus. In septic cases on no account should patients be allowed to move until the thrombus has entirely disappeared; in aseptic cases, on the other hand, there is no objection to a little movement when the thrombus has ceased to grow, and there is certainly no reason for maintaining complete rest until it has entirely disappeared; in fact, in the latter period some movement is beneficial.

With regard to the treatment of these cases of passive thrombosis, rest of course is absolutely necessary during the progress of the disease. Medicinally the best treatment is what is called the alkaline treatment—alkalies with excess of ammonia will do more to hasten the disappearance of these passive clots than anything else. Locally warm applications are comfortable, and perhaps to some extent promote absorption. When the veins are varicose, if the application has some hardening effect on the skin (Lot. Plumbi, for example) so much the better—when the veins themselves are normal, water fomentations effect every purpose. In the late stage of aseptic thrombus, massage, when used with understanding, is of great service; but by those who are without considerable experience it should not be used, as in such hands it may be dangerous.—Sir William Bennett, *Lond. Clin. Jour. Post Grad.*

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## Jottings.

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Aromatic sulphuric acid, in doses of from ten to twenty drops in chamomile tea, taken at bed time, arrest profuse perspiration.

In the delirium of typhoid fever, or in acute delirium from whatever cause, dilute hydrobromic acid in full doses is almost a specific.



When chilly from exposure, breathe very deeply and rapidly and the increase in bodily warmth will be surprising.

Camphor should be dampened with alcohol when it is desired to powder it. Then it can be rubbed into an almost impalpable powder.

When a urinary antiseptic is needed try lithium benzoate. It is eliminated through the kidneys, increases the flow of urine and sedates the urinary tract.

Always be on the lookout for "walking typhoid." If a man comes to you "feeling sick" be sure and take the temperature and inspect tongue and abdomen.

If you would act upon the duodenum, give calomel and podophyllin; if upon the illium or jejunum, give senna or jalap; if upon the descending colon or rectum, use aloes.

Dr. Weil claims that vomiting in pregnancy can be relieved by a twenty per cent. solution of menthol in olive oil, ten drops, taken in sugar whenever the nausea appears.

The use of stramonium is more effective in spasmodic asthma than belladonna, because it produces a greater relaxation of the involuntary bronchial muscles.

In the treatment of purpura hemorrhagica, large doses of the tincture of the chloride of iron, as much as forty drops every two hours, are advised.

In neuralgias about the face or head three minium doses of the tincture of gelsemium every half hour will often act almost miraculously, and leave no ill effects.

The injunction into the rectum of eight or ten drops of tincture aconite will enable you to pass a catheter into the urethra, which before could not be done.

For sciatica collodion, tincture of iodine, liquid ammonia, equal parts. To be applied widely over the parts with a camel's hair brush.

In Europe smoking is growing so rapidly in favour among the fair sex that on some of the Belgian railroads smoking compartments are to be provided exclusively for women.

Cyanosis with a weak and rapid small pulse, low arterial tension, great feebleness of the heart's action, demands digitalis. This is especially true where the lungs are involved in disease.

Always direct that iodide of potassium be taken in milk. Large doses are then well borne.

When the grass is moved use the damp grass for the carpet in the same way as you would employ tea leaves. The grass revives the colors in a wonderful way, and removes all spots and dust.

Boy or Girl—Which Will It Be?—If the expectant mother walks slowly, flat-footed, has sunken eyes, and craves oysters, it will be a boy. If she walks quickly, with elastic gait, has full eyes and craves sweetmeats, it will be a girl.

Ten to twelve parts of water and one part of ammonia will preserve soft rubber any length of time. Keep rubber pipes, etc., in a glass jar filled with the above solution. Use for your ammonia bottle a rubber stopper; it is better than a glass stopper.

Dr. L. D. Bulkley says that for some time past he has prescribed ichthyol by the mouth, 10 to 15 drops, in capsules, three times daily, and finds that this, through its action on the liver and intestines, will cure nearly every case of hemorrhoids. In fact, he looks upon its internal use as a specific.

When lime has got into the eye something must be done at once. Wash the eye thoroughly with a large quantity of warm water—for a little water but adds to the trouble by slaking the lime—and then introduce a solution of sugar and water. This is superior to solutions of vinegar or dilute acids, because sugar forms an insoluble compound with lime.

Dr. Boskowitz, of New York City, asserts that lobelia will cure spasmodic stricture "as if by magic," and in permanent stricture where it is impossible to pass the smallest sound, the difficulty will be easily overcome after a single application of the drug. He drops into the urethra about fifteen drops of fl. ext. lobelia, then closes the meatus, and holds the lobelia in the urethra for a few minutes.

Several sufferers from writers' cramp are reported to have obtained great relief by becoming enthusiastic golfers. This game requires the use of the upper extremities just to the degree adapted to people who have lived a sedentary life. The movements are necessarily coordinate, and they are combined with proper exercise of the lower extremities, and a large amount of time is passed in the open air.

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## Editorial.

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### WHAT SHALL BE DONE WITH THE PROFESSIONAL MIDWIFE?

An article under the above title from the pen of Dr. Lewis, of New York, and published in "Medicus," issued at Frederick, M.D., has given us food for reflection. According to the figures published by the New York City Board of Health, it would appear that during the year 1891 there was reported 80,735 births. Of this number, 42,253 were reported by physicians and 38,482 by midwives. For the previous year the figures are very much the same. It would appear that the medical profession of that city shows an undivided opinion, that great evils are wrought by reason of the incapacity and negligence of these midwives. Dr. Lewis states that the hospitals and dispensaries of that city are daily witnesses to the criminality which permits ignorant women to act as medical guardians at the birth of the child. The consensus of opinion which holds this ignorance responsible for the many cases of ophthalmia neonatorum, and of ruptured perineums and of lacerated ora uterorum that are met with at the medical charities is unbiased, it is gleaned from the actual experience of the men who lead in these several specialties. The true

cure would be to prevent women to attend midwifery cases who are not possessed of the knowledge essential to practice medicine generally. Such a view is Utopian—especially where our cities are crowded with a cosmopolitan population, and even in the country. It is of the greatest importance that women who intend to act as midwives should be educated to the highest possible degree in their specialty. We should judge from the tenor of the article we refer to that practically there are not any restrictions to the practice of Midwifery. We do not wonder, therefore, that the medical profession of New York is called upon so constantly to treat the results of midwifery neglect. "We know," writes Dr. Lewi, "that the asylums for the blind are being crowded with children rendered sightless, because of the neglect, criminal or otherwise, of these midwives." In Canada, and in this Province of the Dominion, matters are not so bad as they appear to be in New York. We make a fair attempt at making those women who desire to become midwives qualify themselves—and be licensed to practice. We feel, however, that there is much to be done, and which should be done, to educate them to a much higher standard. The necessity for this higher standard being reached would eliminate a class of women, now allowed to enter, whose natural intelligence and education is such that it is impossible to bring them to the required level. The true test of this being reached must be the examination. This should be conducted in a thoroughly strict manner, and, if not passed most satisfactorily, the license ought to be refused. No special pleading should be allowed to have weight—such as "their living depended on it." We have known such to have an effect. Think of the untold misery these women can cause, not only to the unfortunate mother, but to the child just ushered into the world. We fear that this thought has not sufficiently fixed itself on the attention of those who have in the past been placed as guardians at the portals where these women seek admission. We have, however, in many parishes in this Province women who prac-

tice Midwifery, and who have no qualification beyond the fact that they have attended many cases. Scientific education they have none, and they are the *bête noire* of the qualified physician possibly residing within a few doors of her. For a mere pittance they attend a woman in labour who very often afterwards carries with her a condition the result of ignorance, and which makes her life a burden for the rest of her existence. Surely something might be done to remedy this evil. The interference of the Provincial Medical Board in such cases should be pushed to its fullest extent, not only as a protection to its legally qualified member, but in the best interest of the health and comfort of the mothers of our country.

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## Personals.

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Dr. Von Eberts (M.D., 1897), who has been Medical Superintendent of the Montreal General Hospital, has resigned, and his resignation took effect on the 31st August.

Dr. Turner (M.D., McGill, 1891), who has been one of the House Surgeons of the Montreal General Hospital for the past year, has been appointed Medical Superintendent of that institution in succession to Dr. Von Eberts. He took up the duties of his new appointment on the 1st September.

Dr. R. F. Ruttan, who for the past eleven years has been Registrar of the Faculty of Medicine of McGill University, has resigned, and has been appointed Professor of Chemistry, vacant by the resignation of Dr. G. P. Girdwood.

Dr. Girdwood has resigned the Chair of Chemistry in McGill University, and has been appointed Emeritus Professor.

Dr. W. H. Drummond (M.D., Bishop's, 1884), the well-known dialect poet and author of "The Habitant" and "Johnny Courteau" and other poems, received in June last the honorary degree of D.C.L. from Toronto University. Dr. Drummond is Professor of Medical Jurisprudence in the Medical Faculty of Bishop's University.

A statue to Pasteur was unveiled on 3rd August at his birth place, Dole, Jura. The occasion was celebrated with laudatory orations.

## OBITUARY.

Dr. Thomas Christie, of Lachute, Que., and Member of the Dominion Parliament for Argenteuil, died on the 5th of August from an attack of pneumonia. Dr. Christie was seventy-eight years of age, and was born in Glasgow, Scotland. He came with his parents to Canada when he was five years of age, and with them settled in the neighbourhood of Lachute. He graduated as Doctor of Medicine in 1848 from McGill University and for fifty-four years practised his profession. Not only was he the ideal Country Doctor—but from a comparatively early period of his life he took an active interest in public questions, and thus gradually stepped into political life. In politics he was a liberal, but he enjoyed in a remarkable degree the friendship of members of both political parties. Such a good man, both in medicine and politics, will be greatly missed.

The medical profession of Montreal were not only grieved but startled on the 7th of August to hear of the death of one of their number, Dr. J. A. S. Brunelle, which took place somewhat suddenly the previous day at Mountain View, N. Y., where he had a summer residence. Although of late not in the best of health, few of his friends were aware of it, and his death came to them with unexpected suddenness. By those who knew him best, he was greatly liked, for he had a sunny smiling nature. Dr. Brunelle was born at St. Hyacinthe in 1882. He graduated from Victoria College—Montreal School of Medicine and Surgery.

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## Book Reviews.

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**Grayson's Laryngology.**—A Treatise on the Diseases of the Throat, Nose and the associated affections of the Ear. By Charles P. Grayson, M. D., Lecturer on and Instructor in Laryngology, in the Medical Department, University of Pennsylvania. In one octavo volume of 540 pages, with 129 engravings and 5 colored plates. Cloth, \$3.50 net. Lea Brothers & Co., Philadelphia and New York, 1902.

The many treatises frequently issued on this subject make it a very difficult matter for a new author to furnish a late production that would justify its appearance and contain merit sufficient to distinguish it from the many predecessors. Dr. Grayson has sought to make his work more concise in treatment than most authors by

giving under each disease but one plan to pursue, and that one consisting of what he has found to have been most successful in subduing symptoms and shortening the duration of disease throughout his large *clientèle*. To meet exceptional cases, he has added a few modifications to this routine plan.

Although essentially a volume upon Laryngology, the author recognizes the necessity for inclusion of Ear Diseases in the work, and gives a modern and complete synopsis of what is requisite in this section.

Altogether the book is a very presentable one, containing good paper, clear type and plates, and commends itself to both student and practitioner, particularly on the basis mentioned, as a useful contribution in the special field of Throat, Nose and Ear Diseases.

G. T. R.

**Diseases of Women.**—A Manual of Gynecology designed especially for the use of students and general practitioners, by F. H. Davenport, A. B., M. D., Assistant Professor in Gynecology, Harvard Medical School. Fourth edition, revised and enlarged, with 154 illustrations. Lea Brothers & Co., Philadelphia and New York, 1902.

This is a handy volume of a little over four hundred pages, and appears to be a model of conciseness and clearness. Its main objects are to give the student clearly, but with considerable detail, the methods of examination and the simple form of treatment of the most common disease of the pelvic organs, and in the second place to help the busy general practitioner to understand and treat the gynecological cases which he meets in his everyday practice. Special attention has been paid to the description and explanation of many minor though important points which are ordinarily omitted in text books, but which are nevertheless of great value. The book aims to be practical, and is therefore devoted principally to diagnosis and treatment, to the exclusion of unsettled theories. There are so many good points in the book that we cannot mention all of them, but we are pleased to see that the author prefers a basin of warm water and castile soap for lubricating the finger instead of using oil or grease, because the latter adheres both to the finger and to the dish. Another good point is the advantage of training the left hand for digital examinations so as to keep the stronger right hand for depressing the abdominal wall and holding instruments. The author gives some good advice when he says that a satisfactory examination cannot be made on a soft bed; the patient should always be examined on a table; but the table must be covered with a soft quilt or blanket and covered with a sheet so as to take away from the patient the idea that she is on a table. We cannot emphasize too strongly another advice given by the author, namely—no matter how busy you are, take the time to write a brief

but clear statement of each case when she comes for the first time to your office; give every one a fresh page and number and index it, and you will find such a book of the greatest value, increasing with each year. The reviewer advises a book of at least one thousand pages of foolscap which will last many years. For patients seen for the first time at their houses, take down some bedside notes and transcribe them into the case book the same day. In making pelvic examinations, he says, have the patient remove the corsets and empty the bladder first beforehand, as the nervous condition causes the bladder to fill quickly and thus renders the examination impossible or useless. These are only a few points, but they may suffice to illustrate the exceedingly practical nature of the work.

A. L. S.

**The Practical Medical Lines of Year Books**, under the general editorial charge of Gustavus P. Head, M.D., Professor of Laryngology and Rhinology, Chicago, Post Graduate School, Vol. vii, *Materia Medica and Therapeutics, Preventative Medicine, Climatology, Forensic Medicine*. Edited by George F. Butler, Ph. G., M.D., Henry B. Favill, A.B., M.D., Norman Budge, A.M., M.D., Harold N. Mayer, M.D., June, 1902, Chicago. The Year Book, Publishers, 40 Dearborn Street.

Sharp, terse and concise is the manner in which the various subjects embraced in this small volume are treated. It is up to date in every way.

F. W. C.

**The Neuroses of the Genito-Urinary System in the Male, with Sterility and Impotence**. By Dr. R. Ultzmann, Professor of Genito-Urinary Diseases in the University of Vienna. Second Edition. Revised, with notes and a supplementary article on Nervous Impotence, by the translator, Gardner W. Allen, M.D., Surgeon in the Genito-Urinary Department of the Boston Dispensary; Instructor in Genito-Urinary Surgery in Tuft's Medical College. Illustrated. Pages, 198. 12mo. Price, extra cloth, \$1.00, net, delivered. Philadelphia: F. A. Davis Company, Publishers, 1914-6 Cherry Street.

A most worthy little book, on a very interesting and important subject. The paper used has no gloss, and all details are a well-known standard of the F. A. Davis Company. Very little change has been noted in the revised portion, which shows what a master was Professor Ultzmann. The supplementary article on nervous impotence is most interesting, and does credit to the translator, Gardner W. Allen, M.D.

G. F.



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MEDICAL NEWS.

New York and Philadelphia.