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# THE CANADIAN PRACTITIONER AND REVIEW

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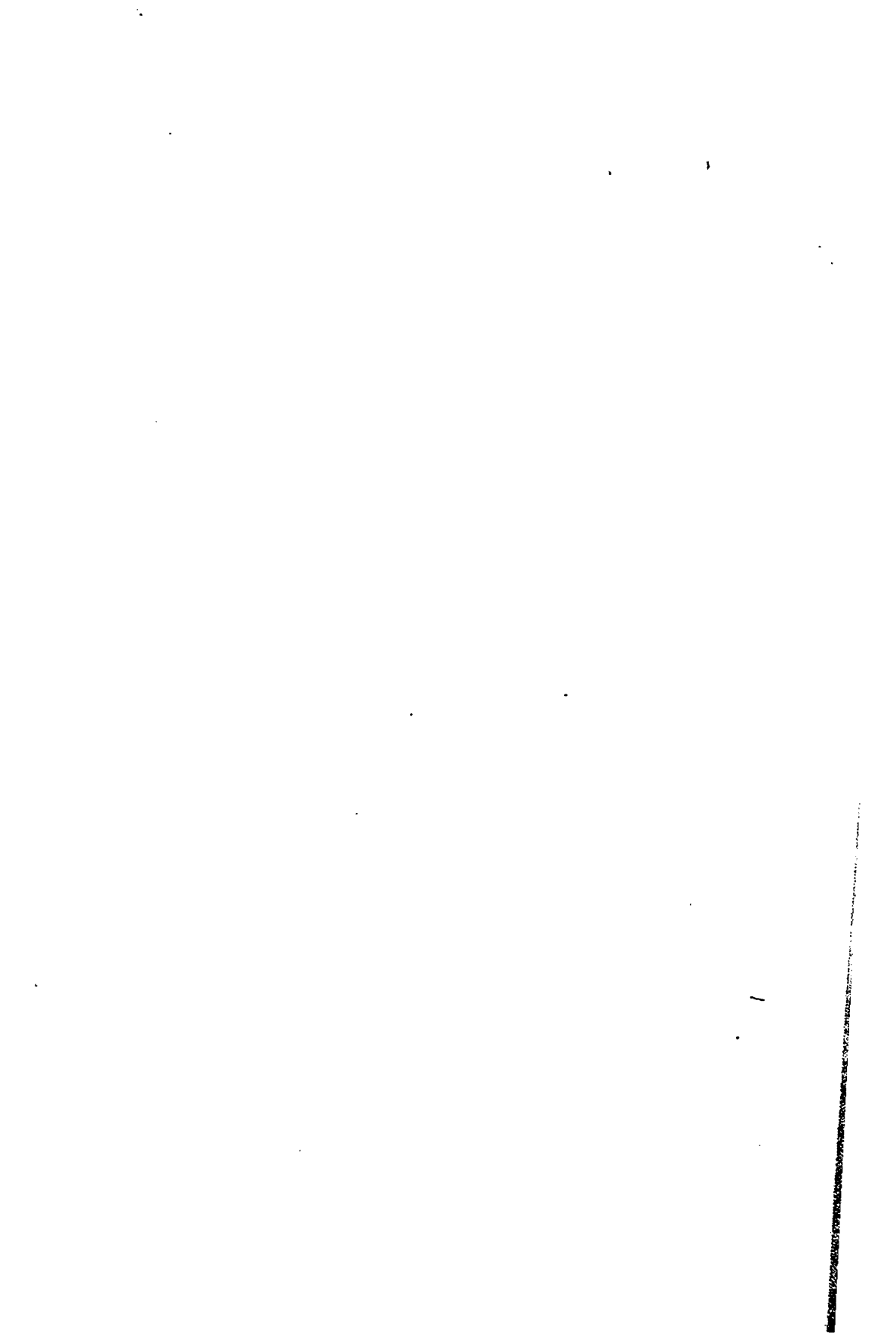
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NO. 1

## Original Communications.

### REPORT OF A CASE OF ACUTE RHEUMATISM.\*

BY HAROLD C. PARSONS, M.D., TORONTO.

Miss McB., aged 44 years; the family history showed one brother died of tuberculosis at 27 years; a sister of appendicitis; the father of tuberculosis; the mother of nervous trouble. Regarding the personal history, the patient has had typhoid fever, diphtheria, mumps (at 24 years) and pneumonia. Had uterine myoma removed four years ago. Six years ago, after severe mental shock, began to have dizzy fits, buzzing in the ears, attacks of unconsciousness, with falling (several daily), progressive loss of hearing, vomiting; thought it Meniere's disease; controlled by bromide. The present illness began November 25th, 1902, with acute tonsillitis and pharyngitis; throat very sore and red, not much swelling, but pain along the sterno-mastoid muscles; swallowing painful. Temperature 103 degrees F.; pulse, 120; tongue very coated; breath foul. Sodium salicylate and hydrogen dioxide spray prescribed. On November 27th temperature was 101 degrees F.; pulse, 100; pain on swallowing, with pain down the neck. November 29th, much improved. Throat, red; not sore; irritable cough. November 30th, over right patellar tendon is an area  $2\frac{1}{2}$  by 2 inches slightly raised, bright red and very tender. No swelling of joint; no pain in movement of joint except when above area is stretched. December 1st, about the area there were several smaller ones at sides of the knee, some slightly raised, others flat, all highly hyperemic. They vary from 0.5 to  $2\frac{1}{2}$  to 3 cm. in diameter, all very tender; can be pinched up, but this is very painful. The edges of some are raised, but the rise is gradual. The patches are any and every shape, round, oval, but mostly irregular in outline. Temperature, 100 degrees F.; pulse, 88. The same condition is seen on left knee, a large patch over the patellar tendon, and smaller

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\*Read before Toronto Clinical Society, Dec. 2nd, 1902.

ones, twelve to fourteen, over sides of the joint. Down the shins, on both sides, is a line of similar spots, mostly raised and very tender. They tend to run together into a line. There are a few scattered spots on the inner and outer sides of the legs; none posteriorly. Similar lesions have appeared along line of tendons over front of ankles, painful to touch, but not on movement. They are also over the metatarsophalangeal joints, very painful to touch, but not on movement of joints. There is marked redness over both malleoli, both sides, and very tender. Twenty-four hours later there is swelling and redness below the malleoli, and later pain on movement of the ankle joints. The heels are also very tender. About the same time there was a strikingly symmetrical eruption above both knees on the front of the thighs and sides of the lower thirds of the thighs of similar area: some flat, some raised, and from 1 to 2 cm. in diameter. Several are 3 cm., quite raised and coming to a point, very tender, but at no time any fluctuation or suppuration, vesicles or pustules. Each lesion lasted four to seven days. The pain lasted three or four days, and the spots gradually faded, leaving a faint yellow discoloration for a day or so longer, and the raised ones a wrinkled surface. On December 2nd there was pain in the left side, cough, and pain on deep inspiration. Pleural friction was heard in mid-axillary line. All subsided in two days. There was no effusion to be found. The mental condition was very strange, very dull and drowsy, and when aroused very emotional; frequent wanderings and marked tremor of the hands. The eyes were rolled up; no squint; no focal signs. This continued until December 7th, the mind clearing somewhat by that time. Temperature, 98 to 99.5; pulse, 88; the heart and lungs clear. That day the patient complained of pain in the epigastrium, but an examination revealed no tenderness, no rigidity, no tympanites. Early on the morning of the 8th of December the patient complained of severe pain in the right iliac fossa. The nurse noticed some distension. Temperature, 100 degrees F. at 11 a.m.; pulse, 99. The abdomen was slightly distended, resonant. The abdominal respiratory movements were lessened; no visible peristalsis. The whole right side of the abdomen was rigid and hard; left much less so. The right side was very tender, and also over the appendix. The left side could be palpated freely, but deep pressure here caused pain on the right side. The liver and spleen were not enlarged, vaginal and rectal examination was negative. The tongue was coated, but not more so than previously. Mr. Cameron saw the patient with Dr. Parsons that afternoon. All the signs lessened in two days. During this time, December 5th and 6th, on the palms, and base of fourth finger, both sides, there was an area of irregular red-

ness, not over the joints but more towards the wrists, not painful but exceedingly tender on pressure; no pain on movement; gradually subsiding in two to four days. Much the same condition on plantar surfaces of both feet at the metatarso-phalangeal joints. The elbows show a few flat erythematous patches about the joints and along the crests of the ulnæ. The joints are alright. The symmetry is striking. December 9th, the nurse reports increase of the mental signs; very restless; constant, low, muttering delirium; patient tore the bandages from the legs. December 10th, there were some involuntary evacuations of the urine and feces. Temperature, 101 degrees F.; pulse, 88. Heart and lungs clear; the abdomen soft and normal. Skin lesions on the proximal phalanx of fourth finger and adjacent side of little finger. From the 9th to the 15th the patient was quite unconscious. On the 15th Dr. Fotheringham saw the patient. The temperature had reached 101 degrees F.; pulse, 80-88. The face was drawn slightly to the left; convergent squint in right eye; flexor rigidity general, but most marked in left arm. All reflexes were normal and there was no ankle clonus; meningitis or some cerebral lesion present. The patient was conscious again on December 15th. On December 16th the patient complained of pain under both jaws. Both submaxillary regions were swollen, indurated and tender; no fluctuation. On December 19th the temperature was 102 degrees F., and swallowing was very difficult; breath foul; breathing labored; again unconscious—perfect stupor. The jaws were rigid; could not examine the throat. Fearing edema of the glottis or retropharyngeal abscess, Dr. Parsons had Dr. Wishart on the 19th examine the patient under chloroform, but the examination was negative. On December 20th the temperature was 99 to 101.8 degrees F.; pulse, 64; fed by bowel. By December 27th the mental condition had cleared up; temperature lowered. By December 31st the patient was normal and recovery was continuous but gradual.

The following points in this case were noted by Dr. Parsons: Pharyngitis, erythema nodosum, arthritis and peri-arthritis, pleurisy, peritonitis, meningitis (unconscious nine days), angina Ludovici; all non-suppurative. Rheumatic affections of throat are recognized; erythema nodosum (rheumatic), arthritis and peri-arthritis (rheumatic), pericarditis, a frequent complication; endocarditis, joint surfaces, etc.—why not by analogy, pleura, peritoneum and meninges?—and all were non-suppurative. Question: Septic; rheumatic? Urinalysis on December 3rd showed that the urine was cloudy, amber, acid, sp. gr. 1015: albumin (a trace), squamous epithelium and hyaline casts. On December 7th it was the same, and again, on December 10th, same; uric acid and a few hyaline casts.

## SYMPTOMS OF ACUTE RHEUMATISM.\*

By W. P. CAVEN, M.D., TORONTO.

In view of the great differences in the manifestations of rheumatism as ordinarily seen in adults, and those occurring in children, I have thought it best to describe them separately. In the first place I will describe the symptoms as met with in adults.

I. RHEUMATISM IN THE ADULT.—Rheumatic fever has no definite incubation period. The onset of rheumatism is usually gradual and is preceded in a great many cases by a few days of malaise, sore throat and irregular pains in the limbs and joints. Rarely, however, the characteristic acute symptoms may set in very abruptly. At the onset chilliness is often met with, but well marked rigors are not frequent, and when they do occur there are generally several of them. There is seldom headache. The appearance of the tongue is somewhat characteristic, being flabby, teeth marked and covered with a white fur. Twenty-four hours after the onset the disease is usually fully developed, the marked features being pyrexia, pain and joint affections, the condition of the skin and of the urine.

(a) *As to the Pyrexia.*—The temperature is in most cases severe in proportion to the number of joints affected, yet as Fagge says, "Even Wunderlich was unable to recognize any typical course" beyond the fact that it is usually highest in the evening (except in cases of hyperpyrexia). The highest temperature is reached early in the disease—from the second to the fourth day—and rarely exceeds 104 F. Under treatment, as a rule, it rapidly falls. The pulse is often very rapid, large, full and bounding, and sometimes dicrotic.

(b) *Pains and Joint Affections.*—Pain usually commences in one of the larger joints—knees, shoulders, ankles, wrists and hands—and rapidly becomes very severe. When in pain the joints are kept in characteristic positions; the knees slightly flexed, the ankles extended, the elbows flexed, the wrists extended, and fingers of the hand slightly turned towards the under side. The joints are swollen, hot and reddish as well as acutely painful. One of the most characteristic features of acute rheumatism is the suddenness with which the joint affection clears up in one joint and flies to another. One day a joint may be extremely painful, swollen and hot, and the next be free from pain and present an almost normal appearance. The swelling around the joint differs from that of gout inasmuch as it does not pit on pressure, nor does desquamation of the epi-

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dermis occur, nor are the surrounding veins dilated. Extensive joint effusion is rare and much of the enlargement is due to the periarticular tissues being infiltrated.

(c) *Conditions of the Skin.*—Profuse sweating is one of the marked symptoms of acute rheumatism. Stress is often laid on the sour smell and acid reaction as a diagnostic point in acute rheumatism. However, one meets with exactly the same smell in persons in perfect health who do not change their under-clothing after free sweating; and as to the acid reaction, different parts of the skin, in the same person, may be shown to present an acid, alkaline and neutral reaction to litmus paper. Associated with the sweating we often find a copious eruption of sudamina; this may, of course, be met with in any febrile state accompanied by sweating. The vesicles are at first clear and transparent, then their contents become milky and their bases slightly inflamed and reddened.

(d) *Condition of the Urine.*—Careful research into the condition of the urine has thrown no light on the cause of the disease; it presents the same features as in other fever conditions. It is reduced in quantity owing to the free sweating; it is of higher specific gravity—1020 to 1030—of high color from the large quantity of hematoporphyrin and small quantity of urobilin. It is very acid in reaction; clear when first passed; deposits abundant urates when cooled, and, usually, some uric acid crystals.

(e) *Conditions of the Blood.*—Anemia is often a marked symptom; it is associated with some leucocytosis. Fibrin is greatly increased, more so than in any disease except pneumonia, but coagulation is slower than usual; red cells may be diminished 1,000,000 to 2,000,000; hemoglobin is especially diminished; changes in form of cells are usually slight. The degree of leucocytosis varies with the severity of the case. Polynuclears are absolutely increased, lymphocytes (mononuclears—*Cabot*) absolutely diminished.

2. SYMPTOMS AS MET WITH IN CHILDHOOD.—Here we meet with marked differences in symptoms from those seen in the adult—prominent among which differences are the slight articular manifestations and the absence of the profuse acid perspiration. The onset in children is very frequently marked by an attack of tonsillitis. The tonsillitis is seldom of great severity and a suppurative rheumatic tonsillitis in children is exceedingly rare. There is nothing distinctive in the clinical appearance of rheumatic tonsillitis, and cases can only be pronounced rheumatic when other evidences of rheumatism are present.

(a) *Pyrexia.*—This is a much less conspicuous symptom in children than in adults. In contrast with what occurs in other complaints, in rheumatism, the younger the child the less the

tendency for the temperature to be raised. In ordinary cases without complications, as pericarditis or chorea, the temperature seldom ranges above 101 F. I will refer here to an interesting clinical fact, that in children who have sustained a sharp attack of rheumatism with considerable degree of pyrexia, the temperature may be persistently raised at some period of the day for months; it being known to reach even as high as 104 F. without any injurious effects on the child.

(b) *Pain and Joint Affections.*—Pain is almost invariably present at some time or another in every attack. Often it is the only symptom complained of, but it seldom is as severe as in adults. It cannot be too carefully remembered that in the vast majority of cases the so-called "growing pains" of children are rheumatic. Physiological growth is a painless process, and growing pains are undoubtedly pathological. We all know how common it is to find endocarditis in children, often producing mitral stenosis, where the only symptom of rheumatism has been these growing pains. The joint affections in children are, as a rule, severe and more transient than in adults. The knees, ankles and wrists are the joints most often attacked; when the smaller joints are attacked the case is usually a severe one. The fitting character of the joint affection is one of the features in the child as well as in the adult. Although the joint affection in children is usually of a minor degree, yet we must not forget that some degree of arthritis or pains in the joints is a feature in by far the greater number of cases.

(c) *Condition of the Skin.*—The skin in children is, as a rule, hot and dry, differing in this respect from that of adults. Rheumatic children, however, are very prone to sweating on slight exertion in the intervals between attacks. I will here refer to the occurrence of subcutaneous fibrous nodules attached to the tendons and fascia. They are much more commonly seen in children than in adults, and Cheadle has shown their close association with severe endocarditis. In size they vary from a pin's head to a large pea, and are most numerous on the fingers, hands and wrists, but also occur about the elbows, knees and spines of the vertebræ and scapule. In children they are mostly found on the backs of the elbows and over the malleoli. They are not tender. Histologically the structure of the nodule is similar to that of the nodular growths on the cardiac valves. (Fletcher worked these out.—*J. H. Bulletin.*)

## COMPLICATIONS OF RHEUMATISM.\*

By JOHN L. DAVISON, M.D., TORONTO.

Perhaps the most important complication of acute articular rheumatism is endocarditis. The cause of the lesion is due, no doubt, to either a dissolved toxin or a very abundant infective agent in the blood. This irritant affects chiefly connective tissue membranes, and especially such as are exposed to friction. For we see the endocardium affected exactly where the surfaces come into contact. It seems to require the mechanical effect of friction, added to the toxin, to produce the inflammation.

Of course, in every case of acute articular rheumatism the medical attendant watches daily for symptoms of this very serious complication. May I add a word of warning as to those cases in which the symptoms of rheumatism—so well given just now by my friend, Dr. Caven—are masked, where the disease is so apparently light as to its usual manifestations, that the patient is not put to bed, and may even be following his usual avocation. I think I have seen hearts left weak for the remainder of the span of life through neglect of careful examination for this grave lesion, in cases where the pain and disability were so slight as to allow the sufferer to take baneful exercise. Especially is this liable to happen in young subjects.

The pathology of the disease has been taken up by Dr. Anderson, but whatever be the *materies morbi* which produce the lesion, I believe that it sometimes attacks the endocardium without giving any other sign, which would surely attract the attention of the medical attendant to rheumatism, so that it would be well to examine the heart in every case where there is any doubt as to the nature of the ailment for which you are called in. Let me repeat that I regard this as very necessary in young children. I have more than once discovered endocarditis in children where "growing-pains" was the only symptom given, and where I have been called in to find the child going to school, or playing in and out of doors with the lesion well marked.

The subject is worthy a whole evening from this or any other Clinical Society, but having merely mentioned it, I must pass on, saying, however, that this complication occurs in perhaps 20 per cent. of all cases, but that epidemics of rheumatic fever vary greatly as to severity and frequency of complication.

*Pericarditis.*—This complication, which is also of grave importance, occurs in perhaps 14 per cent. of all cases of acute articular rheumatism, subject to the same variations as first

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spoken of, due to severity, etc., and needs the same care for discovery as does the endocarditis, in mild and sub-acute attacks of rheumatism. Looking upon the pericardium as a large lymphatic space, we see the irritant gain admission to the space, and by the motions of the heart on the fluid of the sac, the poison is carried to all parts of the space, so that the whole surface, both parietal and visceral are usually affected at once. Before leaving the heart, I should mention dilatation of the right heart, and a febrile murmur not due to endocarditis; also a myocarditis with granular and fatty degeneration is observed very early with dilatation of the left ventricle. Symptoms referable to heart lesion, such as pain, palpitation and dyspnea, may not be disregarded, even when no bruit or friction sound is present.

*Pleurisy.*—The pleural membranes are quite frequently involved. Especially does the left pleura suffer when the pericardium is infected. The signs of dry pleurisy are usually well marked, and rarely is there much serous exudate. Coryza, tracheo-bronchitis, laryngitis and affections of the muscles of the throat are frequently present in the early stage.

This leads me to speak of follicular tonsillitis, which is regarded by many as related to rheumatism. The recession of the disease under salicylates would favor this view, though no doubt the cases in which such treatment fails are due to other than rheumatic infection. I think we get numerous cases in cold damp, or cold dusty weather of true rheumatic throat with simple, not follicular, tonsillitis and a general engorgement of the pharynx with involvement of the surrounding organs, stiffness and soreness of the neck and throat muscles, with general malaise and some febrile movement. These cases, which I have been in the habit of calling rheumatic sore throat, nearly always yield readily to anti-rheumatic treatment.

Pneumonia and edema of the lungs need only be mentioned in passing as rare complications of the disease we are considering, seen in the acute stage.

*The Skin.*—Time will only permit me to enumerate most of the skin lesions which are seen as complications of rheumatism. They are roseola, urticaria, erythema nodosum and multiforme, herpes facialis, petechiæ, general subcutaneous and submucous hemorrhages and subcutaneous nodules. Purpura is rare, unless Schönlien's disease, *peliosa rheumatica*, be considered as such. It is really an erythema and not a purpura, as the discoloration disappears at first under pressure. The subcutaneous nodules are seen most frequently in young subjects. They are found mostly on the fingers, dorsal and lateral surfaces of the hands, but may occur almost anywhere. Levison, of Copenhagen, mentions them as appearing especially on the front and back

of the head. They are fairly movable, more or less painful, and disappear with the other symptoms of the disease, or sometimes last for weeks. It is interesting to note, as bearing on the relationship of the disease, that similar nodules appear in rheumatic subjects who have either endocarditis, chorea, or tonsillitis, with no joint lesion. They are composed of round and spindle cells and attached to the tendons of fasciæ. It may be said that similar nodules are met with, independent of arthritic disease.

*Hyperpyrexia.*—I have never seen a case of genuine hyperpyrexia. It is perhaps the most important of all the causes of death in acute rheumatism. It is attended with severe brain symptoms, though, as Hilton Fagge says, the existence of meningitis has been disproved. Levison also says that while there may be hemorrhage, edema or hyperemia in cerebral rheumatism, there is no true meningitis. When the temperature runs over 105 degrees, with profuse sweating, there is imminent danger of hyperpyrexia, in which the mercury rises to 107, 108, 109 or 110 degrees F. It is worthy of note that in these cases of hyperpyrexia the mercury mounts very rapidly. Thus Wilson Fox, in his analysis of twenty-two cases, gives one in which the temperature rose from 103.5 to 109 degrees F. in two hours. As the treatment to be of any service should be instituted at once, before the higher centres become demoralized by the extreme heat of the blood, careful nursing should be the rule in all cases of rheumatism. Also, it should be remembered that the evil symptoms of any complication may show themselves in cases "which had seemed to be attended with little or no risk," as Fagge says. He instances one of Ringer's patients who was supposed to have recovered and about to leave the hospital next day, when cerebral symptoms set in, of which he died within two hours with a temperature of 110 degrees F. The first indication of the onset of hyperpyrexia seems to be a sudden loss of all pains, so that the patient finds he can move joints which were heretofore painful, without suffering. This seems a good omen, but unless the temperature falls at the same time it should make the physician fear impending danger, and use the thermometer at intervals of ten, twenty or thirty minutes. Interesting as this complication is, I must pass on, having briefly touched upon what seems to me the most important points in connection with it.

*Chorea.*—The association of Sydenham's chorea and arthritis has been noted for more than a century. Bright (1802) says that rheumatism was then distinctly recognized as one of the causes of chorea; and all the way down through medical literature, even up to the present, the association has been recognized.

In a small volume of Osler ('94) on chorea he discusses the question, gives cases and the opinions of many writers on the subject, statistics, etc. He says that, as insisted upon by See and Roger, the arthritis in many cases precedes the chorea. In other cases the chorea precedes the rheumatism. In this connection, he (Osler) speaks of the manifestations of rheumatism in childhood being extremely varied and often so slight as to be overlooked, a point to which I have already referred. His statistics, which are too full and complex to give here, show conclusively, a relationship between chorea and rheumatism. He gives German See's conclusions as follows: Of two rheumatic infants, one at least will be choreic; of five choreic children, two will be rheumatic. Roger concluded that articular rheumatism, chorea, and endocarditis were three terms of one and the same pathological state or phase—*la chorei rheumato-cardiaca*.

*Examination of the Question.*—The German writers show a small percentage of coincidence, while English writers give from 20 to 50 and even 70 per cent. Sir Dyce Duckworth's figures are 78 per cent. Osler's percentage is about 21. Cheadle (*B. M. J.*) states that 77 per cent. of his cases of chorea had had previous endocarditis. Axenfeld states that the relationship of chorea to heart disease (endocarditis) is generally recognized under three conditions, as when (1) the chorea precedes the endocarditis, (2) when the endocarditis precedes the chorea, and (3) when they begin synchronously, or nearly so.

*Appendicitis.*—The rheumatic origin of appendicitis is worthy of a few words. Burney Yeo believes in the gouty and rheumatic origin of the disease. McNutt, of San Francisco, in the *American System of Practical Medicine* gives the following: "A patient, now aged 15, had appendicitis when eight years old, and again when ten. There was circumscribed peritonitis each time, but no pus and no operation. In the past two years he has had two attacks of tonsillitis which readily yielded to sodium salicylate. His mother is a great cripple and has suffered from rheumatism since he was five years old. Would the appendicitis have yielded to the sodium salicylate? The rheumatic origin did not occur to me at the time."

I shall now enumerate without remark the other diseases and conditions which are set down by various writers as being complications of rheumatism: Peritonitis, hemorrhage from bowels and uterus, acute nephritis, albuminuria, hematuria anuria, ankylosis, mental disease from emboli, muscular abscesses, synovial abscess, suppuration in joints, cystitis, hydrocele, orchitis, peripheral neuritis, rheumatism of the scalp, neuralgia, and sciatica.

## SURGICAL INDICATIONS IN RHEUMATISM.\*

By R. B. NEVITT, M.D., TORONTO.

The characteristic ambition of the surgeon is to attain perfection of treatment, that of the physician to attain perfection of diagnosis. The instinct of the surgeon is to be satisfied with just so much of a diagnosis as will enable him to decide upon a line of treatment. The physician trained and accustomed to the patient solving of difficult diagnostic problems is not content with a utilitarian diagnosis. He wants to find out all that possibly can be found out. The first essential is accuracy of diagnosis, and until an accurate diagnosis is made all treatment must be haphazard and unscientific.

The diagnostic sins of the physician have been visited upon that grand old organ, the liver, while under the shield of that vague term, rheumatism, the surgeon has often taken refuge.

I have no doubt that many cases of Charcot's disease of the joints have been buried with the label of rheumatism attached. Nor can there be much doubt but that cases of joint tuberculosis have been laid at rest with a similar legend affixed. As our experience enlarged our diagnosis improved, and we are able to differentiate and to classify more accurately.

The definition of rheumatism as a disease of the joints, often associated with inflammation of the heart, and due to exposure to cold and wet, is not sufficient for the present day. For some years there has been a tendency to regard rheumatism as a specific disease of microbic origin, and claims have been advanced and proven to the satisfaction of their advocates that a specific diplococcus has been discovered, cultivated and inoculated, with the result of setting up an arthritis with all the ear marks of rheumatism. I do not feel called upon to enter into the discussion of the arguments *pro* and *con* of this thesis. These, no doubt, will be sufficiently elaborated by my colleagues this evening. But accepting the view as above enunciated, the analogy to scarlatinal gonorrhoeal rheumatism, to tubercular, septic and rheumatic arthritis becomes more clearly marked than the clinical symptoms have hitherto permitted. It follows from this that the significance of the rheumatic diathesis is curtailed to very slight proportions, if indeed it exists at all. It has long been a matter of observation that rheumatism has no effect upon the healing of surgical wounds; that at most a trauma occurring in a rheumatic subject may be followed by long-continued swelling and by persistent pain in the part, and that aside from the high fever and associated depression, and

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from the cardiac complications, rheumatism has no influence on surgical operations. I would not, however, have you infer that I would choose a patient suffering from acute rheumatism as a subject for surgical attack.

Surgically, rheumatism possesses interest from a diagnostic point of view. It has frequently occurred to me, and in this I feel sure that I may claim your sympathetic indulgence to meet with patients with joint effusion whom I felt constrained to hand over to my colleagues on the medical side. On the other hand, cases of arthritis have been turned over to the surgical wards after the diagnostic and therapeutic skill of the physicians had been vainly exercised upon them.

The following history illustrates this point so well that I crave your indulgence while reciting it. A young man now 24 years of age, whose father died of pneumonia; the mother alive and suffers with chronic bronchitis, and several members of the family have perished with tuberculosis of the lungs and brain. At the age of 7 years was attended by me with an affection of the knee joint, diagnosed and treated as tubercular arthritis, and recovered. A number of years after this he was treated by another physician for an affection characterized by pain and swelling in many of the joints. He was told he had rheumatism. He recovered. He is now a motorman on the street cars. Some two years ago he applied to me for help for his right knee, which began to be painful and to swell, and whose functions were becoming limited. The trouble began insidiously and progressed slowly. He attributed the trouble to the action of the foot pressing against the ratchet of the brake, causing a constant and at times a severe strain upon the knee. It was this joint which I had treated some seventeen years ago. I put him to bed and put on a plaster-of-Paris splint, and gave him a prolonged rest. While he was in bed and wearing the splint the other knee became swollen and painful and continued so for some weeks. The pain and swelling under persistent rest gradually subsided and passed away, and after eight or ten months the plaster was removed from the right knee and he was allowed cautiously to resume active use of the limb. He has now returned to his work with only slight impairment of function. Was the diagnosis in the first attack correct? Was it correct in the second attack? And in the third attack what was the nature of the affection?

Again, cases of osteomyelitis have not been recognized as such, but have been treated as rheumatism. I recall one case in particular in which a child was admitted to the Hospital for Sick Children with the diagnosis of rheumatism. My confrere on the medical side handed the case over to me, when I found the hip joints full of pus and subsequently the elbows and

shoulders became similarly affected and necrosed bone was removed on more than thirty occasions from the humerus, the jaw, the ribs, the ulna and radius, both femora and both tibiae, and eventually the child recovered. Cases of a similar character can be recalled by many of you.

It has long been my custom to exercise considerable care in inquiring into the diathetic conditions of a patient, and in many instances it has seemed to have been of benefit to the patient, and although at present we may not attribute so much influence to the diathesis as formerly, yet the influence of the inquiries have been beneficial as contributing to greater accuracy in diagnosis.

The so-called gonorrhœal rheumatism and rheumatic arthritis, as a matter of fact, should no longer be considered as rheumatism. Yet, since they have so long occupied a position in the category of this disease, it is as well not to exclude them from our consideration of the subject.

Rheumatism holds but a small place as a provider of surgical work. At one time tuberculosis was almost wholly a medical disease, and it is only of late years that the knife of the surgeon has beneficently attacked the medical territory of renal diseases. So in the not-distant future the surgeon may revel in the rheumatic provinces of the physician. Indeed one advanced and prominent physician has conceived and proposed a surgical operation designed for the relief of mitral stenosis, due to rheumatic endocarditis.

Tonsillitis, which occurs so frequently in rheumatic subjects and is so favorably influenced by the salicylates, is no doubt an example of a mixed infection, and the painful and distressing abscesses that form about the mouth and neck are due to the absorption of the ordinary pyogenic microbes. The rheumatic coccus, entering at the same time, is slower in its growth, and may remain latent for a long time to result finally in an attack of rheumatism.

The glandular tissues which enter into the formation of the appendix vermiformis may likewise offer a peculiar affinity for the rheumatic coccus. The association of appendicitis with rheumatism at all events is sufficiently frequent to permit of its being regarded as an etiological factor.

If the glandular structures of the tonsil and the appendix offer a frequent entrance to the rheumatic infection it would be a curious matter for observation to discover how excision of the tonsils affects the rheumatism. Does it prevent future attacks, and does excision of the appendix render one less liable to attacks of rheumatism? Cases of excision of these glandular tracts are now surely sufficiently numerous to base statistics upon.

Rheumatic affections of the serous sacs, the pericardium,

pleura, and peritoneum occur and often demand surgical interference, which must be rendered independently of the primary disease. Rheumatic affections of the nerves, as sciatica, sometimes call for surgical help in the way of stretching the nerve. Osteitis, periostitis, and so forth, may call for linear osteotomy, or indeed for trephining, before relief is obtained.

The infrequency of suppuration, which is a marked character of rheumatism, most probably affords an explanation for the paucity of surgical operations in the joint affections. Yet in the arthritis of gonorrhœal rheumatism opening and irrigation of the joint affords an efficacious and expeditious method of obtaining relief in obstinate cases.

In chronic rheumatism, osteotomy, and the removal of dendritic growths has in many cases been followed by relief and by restoration of the function of the joint; but its application is limited and can only be considered when one of the larger and more important joints is the seat of trouble. It would appear hopeless and uncalled for to attempt operation where many joints were involved and the disease is progressive.

Operation may be considered in cases of malposition of a limb, or where tendons are glued together, or even in cases of true bony ankylosis. Most often massage and careful mechanical treatment is required. Brisement force is, in my opinion, not judicious except to obtain ankylosis in a more favorable position. In nearly every case, after the forcible breaking down of adhesions, the subsequent attempts at passive motion become so painful that the patient refuses to have them continued, and the joint falls back into ankylosis. A plan to prevent ankylosis is by interposing a film of metal between the raw surfaces.

In chronic rheumatic arthritis operation in the way of excision of a joint has been done and proved of benefit in selected cases. In rheumatism the lesions are in the tissues around the joints, in the fibrous tissues enveloping the joints, and if the synovial membrane be affected, the effusion is serous in character, and at most only false ankylosis is introduced.

In chronic rheumatism there is very little tendency to destruction of the tissues of the joints and no tendency to the formation of new bone about the joint. No medicinal agent, no electrical application will suffice to arrest the course of rheumatic arthritis unless associated with proper mechanical treatment.

Arthritis, embolism and aneurysm frequently are of rheumatic origin and may call for operation in order to obtain relief or cure.

Torticollis is sometimes caused by rheumatism of the cervical vertebræ; it may be distinguished from the ordinary forms of torticollis by the absence of tension in the sterno-cleido-mastoid muscle. Operation is not called for, but rather massage of the affected vertebræ and general rheumatic treatment.

The association of hemophilia with rheumatism has been mentioned by various authors. The connection has been refuted by others and the arthritic and muscular and periosteal pains explained by the presence of effused blood. Still the relation might be borne in mind when contemplating operation upon a rheumatic subject. Rheumatic iritis, though it has no distinctive features aside from its association, may require the usual operations called for in ordinary iritis. Primarily rheumatism offers but little for the surgeon's knife, but its secondary effects may open up a wide field for operative surgery.

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### RHEUMATIC CONDITIONS IN THE UPPER AIR PASSAGES AND IN THE ORGANS OF SPECIAL SENSE.

By J. O. ORR, M.D., TORONTO.

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Rheumatism as a causative agent in diseases of the upper air passages and organs of special sense has not received as much attention from the recognized authorities on those diseases as one might expect from the enormous amount of literature written thereon. In fact it is scarcely recognized at all by some, and by others only as a probable exciting cause, or an indirect contributor. There are but few diseases upon which the authorities generally agree as being caused by rheumatic poison.

Gradle, of Chicago, in his recent work says, "Rheumatic conditions as such are not of frequent occurrence in the upper air passages." "Rheumatism," he says, "has no definite relation whatever to any nasal lesion." On the other hand, Haviland Hall considers chronic rhinitis to be caused, in some cases, by rheumatism or to occur more frequently in chronic rheumatics.

Hay fever was by many authorities some years ago said to be purely of rheumatic origin. It certainly does in a few cases bear in its clinical history some similarity to rheumatic diseases. It, however, is now recognized purely as a neurotic disease, and as such occurs more frequently, and in a more aggravated form, in patients with a lowered vitality, and only as a cause of lowered vitality can rheumatism be recognized as an etiological factor in hay fever.

Bosworth attributes naso-pharyngeal catarrh in some cases to rheumatism, but this is extremely doubtful. Naso-pharyngeal catarrh is of frequent occurrence, more so in those of a tubercular than rheumatic tendency. I have not in my practice met with a case I could connect with the rheumatic habit. Tonsillitis alone of all the diseases in this region has given rise to a more



general discussion, and all agree that between it and rheumatism there is some undoubted connection; but as to what that connection really is, all do not so generally agree. Fowler, in his recent work, states that tonsillitis precedes acute rheumatism in as many as 80 per cent. of the cases, while more conservative authorities place it between from 5 to 20 per cent. It occurs also in a very considerable number of cases during the course of the rheumatic attack. In fact few cases of acute rheumatism run their course without more or less inflammation of the tonsillar region, and few cases on the other hand of tonsillitis run their course without the patient complaining of some rheumatic pains; but that acute suppurative inflammation of the lymphoid tissue surrounding the tonsil should be caused by rheumatic poison does not seem to me to satisfactorily explain its cause.

In the ear, rheumatic conditions are more serious and more generally met with. Myringitis is no doubt due in some cases to the rheumatic poison. There is a variety of this disease characterized by a very slight redness of the *membrana tympani*, and excessive injection of *shrapnel's* membrane associated with slight pain at irregular intervals, aggravated by movement of the ossicles. There is defective air conduction with subjective noises of a blowing character. This condition, while comparatively frequent, is, I believe, due entirely to rheumatism. It runs a very chronic course, and in most cases (unless vigorous treatment is early adopted) ends in those forms of so-called dry catarrh of the middle ear, in which the hearing is seriously and permanently affected.

Affections of the ossicles of rheumatic origin are also met with, especially in those forms of progressive deafness in which we have fixation of the stapes, combined with ankylosis of the ossicles, associated with most distressing noises in the head, which are so disagreeable alike to patient and physician.

In the eye we have eczematous conditions of the lids and cornea that may be due to rheumatic virus, although I think this improbable. However, paralysis of the external ocular muscles is undoubtedly caused in many cases by rheumatism.

Of the diseases of the eye none can be so directly attributed to rheumatism as certain forms of iritis, especially that form which is characterized by severe pain, and which recurs with regularity at certain periods of the year. It occurs mostly in chronic rheumatic patients. It has a great tendency to relapse under the slightest provocation, and may occur in one or both eyes. It yields readily to treatment, and recovery is complete without any ill results, especially if at the outset means are taken to prevent the formation of adhesion of the iris.

These are the principal conditions recognized by the leading authorities on those subjects that are with any certainty connected with the rheumatic habit.

## THE TREATMENT OF RHEUMATISM.\*

By J. T. FOTHERINGHAM, M.D., TORONTO.

The remarks one may have to make upon treatment are of necessity largely determined by the trend of the discussion of the topics which have preceded. A systematic statement of the treatment of rheumatism must be very brief to comply with the limitations imposed as to time. It is difficult in any case, but particularly so in the case of rheumatism, to do more than generalize, as it is not the disease but the patient which we have to treat, and in the absence of the patient only general statements would appear possible. Furthermore, the term has come to be not a specific but a general one, and the state of pathological opinion on it is, to say the least, unsettled. Bearing in mind the now generally accepted view as to the infective origin of rheumatism, the first indication for treatment would seem to be prophylaxis. The tonsils may be looked upon as a frequent point of ingress of the infection, and hence, particularly in children, recurring tonsillitis, urticarias, erythemas, and similar skin affections, thick, scalding urine, transient pains, specially so-called growing pains; fleeting pyrexia, nocturnal restlessness, palpitations, pleurisy and other suspicious symptoms, should all be promptly guarded against by anti-rheumatic treatment.

No definite line of treatment can be laid down, but rheumatism always gives abundant scope for skill and care. With marked tendency to natural recovery, but with no definite time-limit, and with distinct tendency to relapse, it is difficult to determine the part played by drugs in establishing a recovery, and hence the great list of drugs which have been recommended. Some manifestations are easily controlled, such as arthritis; others with the greatest difficulty, for instance, carditis.

Another general statement which may be made is that depleting treatment, such as bleeding and purging, is bad.

One may attempt to systematize the treatment, at any rate in his own mind, but cannot hope to say anything new; but if, on the other hand, in his attempt to say something of interest, one drops into details, one's remarks on treatment are apt to end, as military men would say, "in the air."

The three main lines which a statement of treatment may reasonably be expected to take are: (1) Treatment of acute rheumatism; (2) treatment of chronic rheumatism; (3) that of complications.

1. TREATMENT OF ACUTE RHEUMATISM.—With regard to the treatment of acute rheumatism, the infective view of the origin of this disease compels regard to the question of constitutional

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resistance. Vigorous treatment by powerful drugs may do harm by reducing the individual's resisting power more effectually than they control the disease. Poynton declares that he believes that in dangerous and complicated cases of visceral rheumatism, specially in carditis, the best results come from palliative measures, rest, careful feeding and nursing, moderate doses of salicylates for pain and arthritis, stimulants for cardiac failure, small doses of opium for cardiac distress and sleeplessness, proper elimination, mild tonics, in convalescence; in short, a watchful but gentle treatment. Under such measures some of the most desperate cases have rallied, and fewer have gone to the bad with the sudden development of urgent symptoms. With these remarks one may state that the treatment of acute illness resolves itself into (a) constitutional and (b) local measures:

(a) *Constitutional*.—Absolute rest in bed. This is of prime importance, specially with children, as tending to avert possible attacks of carditis, or to control them if developed. Fortunately pain usually compels this. The room should be warm and of even temperature, well ventilated but without draughts, specially during the sweating stage of the illness. The bed should be firm and well made, better high and narrow, and adjusted especially with regard to the difficulty which even a strong nurse will have in handling a patient to whom even the least movement may cause great pain. The personal and bed-clothing should be woollen, but not too abundant, as the drenching and ill-smelling perspirations must be specially considered. The diet should be in the main, fluids, preferably milk. Fats, while of the utmost value in chronic, are contra-indicated in acute rheumatism as apt to impair digestion while the fever lasts. Carbo-hydrates, specially farinacea, are the mainstay of the nurse, while sweets are almost more unsuitable in acute than in chronic rheumatism. As to proteids, there is a singular unanimity among physicians of high repute against their use in acute rheumatism. Latham insists that beef-tea and similar meat preparations cause relapses. Fish, poultry and white meats may be gradually resumed after the temperature has been normal a week, the red meats later and with caution.

*Drugs*.—As is the fashion in these days, drugs have been left to the last in the inventory of the means of cure. While their name is legion, and the majority of them useless, there are some of undoubted value. First in the list (1) I would place purgatives, specially mercurial salines used early. Next I would mention (2) vascular depressants, as aconite, veratrum viride, and cimifuga, which were used in presalicylic days, and if given early are doubtless of value. (3) Antipyrin and antifebrin are sometimes of distinct service, even though depressing, in those

few cases in which salicylates fail, till then they should not be exhibited. (4) Methylene blue, salophen, aspirin (or acetyl salicylic acid), trimethylamin and propylamine, guaiacum, colchicum, rhus toxicodendron, and sulphur, are a few of the drugs which have been found more or less useful in isolated cases. Opium, and especially in the old days full doses of opium and nitre, was occasionally used, and may be used still, specially in cases of cardiac complication, and where salicylic treatment has not proved satisfactory. (5) Alkalies, such as the citrate, acetate, and bicarbonate of potash, form a very important group. In ordinary acute cases doses of 30 grains every four hours are to be used, till the urine has been rendered neutral, when the dose is gradually reduced. After specially large doses there is a distinct tendency to depression, and in some cases marked diarrhoea. (6) I have purposely left to the last any mention of the salicylates. Bearing in mind the infective theory, I would mention quinine with this group, which used specifically has often been useful, specially in the later stages. These drugs act principally by rendering the blood and tissues unfit culture mediums for the cause of the disease, the explanation being similar to that given for the benefit derived from these drugs in other infective disorders, such as pneumonia.

The drugs usually employed are salycin, salicylic acid, salicylate of soda, oil of wintergreen, and salol—the later on account of containing a high percentage of carbolic acid being dangerous in full doses, and the danger increasing directly with the youth of the patient. Also, I would mention the less common salicylates of bismuth, lithium, etc. In speaking of the treatment of acute rheumatism it need scarcely be mentioned that the use of the salicylates has outlived all adverse criticism. They are not now looked upon as productive of visceral complications nor of relapse, though they are not believed to give quite the same security against them as alkaline treatment, or rather a treatment in which alkalies and salicylates are combined, and I think that the great majority of practitioners now would look upon it as almost malpractice to refuse to a patient the relief of pain and fever which this treatment affords. It was introduced first in 1876 almost simultaneously by Stricker, F. Traube's assistant in Berlin, and by Dr. Maclagen, of Dundee. Willow tea is said to have been known for generations by the Hottentots and Boers of South Africa as a remedy for rheumatism. Among bad effects from the use of salicylates must be mentioned: (1) Nausea and vomiting, with epigastric pains; (2) enfeeblement of the heart's action. The exact effect of the drug in this direction is difficult to determine, as heart failure in rheumatism has been ascribed by the opponents of the salicylates to the drug and by its defenders to the effect of the disease on the heart muscles.

(3) A third undesirable effect, or group of effects, is the cerebral symptoms—deafness, giddiness, and noises in the ears, sometimes severe headache and even delirium. Disturbances of this sort, due to the salicylates, are very likely, if they occur, to be accompanied by a lowered temperature, as if the temperature remains high they may reasonably be attributed to the fever. Another occasional bad effect from over-dosage is epistaxis. Much of the adverse criticism of the drug is due to the error sometimes committed of withdrawing it not gradually, but suddenly on cessation of pain or fever; a great mistake. In spite of prolonged investigation and fairly complete knowledge of the action of salicylates so far as pharmacology goes, their specific mode of action in rheumatism, as yet ill-understood, as is admitted by so late an authority as Hale White in his text-book of 1901. It is likely that the infection finds a specific antidote in the drug, as that of malaria meets one in quinine.

(b) *Local*.—The local treatment of acute rheumatism consists of course of rest, warmth, special coverings and hot applications. The simpler the applications are the better in acute rheumatism. Elaborate liniments and counter irritant applications while useful in chronic, are useless in acute rheumatism, Fuller's lotion of laudanum and bicarbonate of soda, the one to relieve pain and the other to neutralize the over acid secretions of the skin, is quite sufficient. Indeed, in view of the excessive perspiration, oiled silk and other impervious coverings are undesirable. A warm flannel covered with wool and many-tailed bandage is usually the best. One will occasionally meet with most happy results from the inunction of say 30 drops of oil of wintergreen over the inflamed joint. The oil of birch, *betula lenta*, known as betulol, I have seen act like magic used in this way.

When one thinks, not of the joint affections, but of the muscles, lumbago, etc., one has much the same to say about treatment, except that local stimulants, and massage are all of distinct service in the latter case—that is, with the muscles. Dry heat is usually more relieving than moist.

2. TREATMENT OF CHRONIC RHEUMATISM.—The treatment of chronic rheumatism, like that of acute, falls into the two divisions of local and constitutional. The constitutional treatment of chronic rheumatism is in just as unsatisfactory a state as its pathology, as there are allied conditions, such as rheumatoid-arthritis, gonorrhoeal rheumatism, etc., which are not infrequently mistaken for the true rheumatism. As compared with acute rheumatism, the relative value of constitutional and local treatment is almost reversed, since while the former is still very important, the latter is of much greater importance than in acute conditions. The line of action, too, depends partly upon whether the disease is muscular or arthritic.

*Constitutional.*—Before any specific measures one must place food. Whatever view we may hold on the pathology of this condition, there is no doubt that malnutrition exists. Anemia is, as a rule, plainly marked, and therefore food must be abundant, varied, fresh and digestible. Fresh fruits and vegetables; a due proportion of starches; sweets limited, or quite excluded, as well as malted and most spirituous liquors (particularly beer and sweet wines), and meats being used rather freely. More particularly fats are a necessity, as shown by the value of cod-liver oil in such cases. Onions and celery are two vegetables of which such authorities as Whittall speak highly. Onions especially are valuable on account of the high proportion of sulphur which they contain. Extremes in diet are usually unsafe. Fads, such as the Salisbury treatment on the one hand, and vegetarianism on the other, are a mistake. As to medicines, they may be grouped into the two classes, of alkalies and alteratives on the one hand, and hematinics on the other. The first group contains all the iodides, specially sodium iodide, arsenic and sulphur, and, of course, the ordinary potash and soda salts. The danger in their use lies in forgetting that alteratives without good food and exercise are depressing and aggravate the anemia already present. The alkaline cachexia of patients who go without supervision to the various anti-rheumatic water-cure establishments is familiar to us all.

*The Iron Treatment.*—As to this treatment, details cannot be given. Suffice it to say that the form which I have found most useful is the soft Bland's mass with arsenic, made by Duncan and Flockhart. Salicylates are useful for pain, given in moderate quantities. Ziemssen says one dose at bedtime of 40 grains or so. Sulphur, both internally and externally, is sometimes of marked value: a heaping teaspoonful in honey or marmalade each morning and the powder freely dusted over the wool with which the inflamed joint is dressed.

3. COMPLICATIONS.—The surgical or orthopedic treatment of the results of chronic rheumatism has already been taken up by Dr. Nevitt. We now reach, finally, the third main subdivision of rheumatism—that of complications. The two main complications of acute rheumatism are carditis and hyperpyrexia. As to heart complications, no attempt can be made to discuss the topic through lack of time. It is one on which many a volume has been written.

*Hyperpyrexia.*—This one may define as being a temperature of 105 degrees F., especially if it has been reached rapidly, with signs of going on up. One must then remember that the heat-regulating mechanism is hopelessly upset, and therefore attempts to control the situation by drugs are probably useless. *A priori*, one would use antipyrin, antifebrin or phenacetin, as the

increased temperature is due to increased heat production, not to diminished heat loss, and these drugs act by diminishing the heat production through their effect upon the oxidation processes in the body. The authorities agree that time spent on them is wasted, and that the cold pack or bath used at once gives the only means of escape. Besides being a waste of time these drugs are depressing to the heart, already sorely tried by poison and fever.

Dr. Armstrong, of Buxton, has spoken strongly in favor of the immediate use of the cold bath, and believes that in many cases the time spent in cold sponges or baths has determined a fatal issue. His method and rules are that the patient should be immersed in water at 92 degrees F., which should be cooled down to 72 degrees F., and the patient kept in usually from ten to thirty minutes, with ice to the head, until the temperature falls below 100 degrees F. The condition of the heart calls for careful consideration during this procedure. On replacing the patient in bed, warm blankets and hot water bottles should be applied. The bath should be repeated as often as the temperature reaches 105 degrees F.

I can only close my contribution to this symposium with congratulations to the other Fellows on the programme upon the character of the discussion, and with thanks for the pleasure they have given me as I listened. As for my own share in it, I can only express the hope that it may be half as serviceable in systematizing our ideas on the subject to the rest of you as it has been to myself.

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## SEPTICEMIA AND THE CURETTE.

BY H. PLYMPTON, M.D.

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To attempt to break up an old established custom in any line of life is at best a thankless job, and one likely to call down harsh criticism upon the head of the daring iconoclast.

To attempt to uproot old prejudices existing in favor of a certain line of practice in surgery, and diametrically oppose such practice, is to invite from some adverse criticism of the harshest kind. The only recompense for this is a logical refutation of, or concurrence in, the argument advanced on the part of other members of the profession. This latter is what I hope for, and if I provoke a discussion or start a line of thought in the minds of half of the readers of this article, I shall have achieved all I started out to do.

Curetting the uterus to remove fragments of afterbirth or other *debris*, has been taught in our medical schools from time

immemorial, and it is firmly fixed in the receptive and retentive mind of every medical student that the first move following any such abnormal uterine condition is to cleanse the uterus by means of the curette.

That the organ should be thoroughly and aseptically cleansed admits of no argument, but that the work should be done with the curette, I deny most emphatically.

The majority of cases of death following the decomposition of fetus or placenta in utero are caused by the use of the curette, and I hold that septicemia may be avoided if a more rational procedure be resorted to.

The condition of the uterus containing septic matter is one of great congestion, the thickened walls being coated internally and over the os with a thick, brown, tenacious mucus. The congestion is active, and therefore the more dangerous in the event of the admission of septic matter into the circulation.

If the curette is used, denuding the walls of their protective covering, an immediate vaccination takes place with a septic virus, septicemia following in an incredibly short space of time (chemical metamorphosis is marvellously rapid in the circulatory system) and death quickly ensues.

If, without using the curette, we can remove the septic matter from the uterus without disturbing the mucous covering, and enable the uterus of itself to expel the coating, we shall have taken a long step forward in the treatment of this class of uterine cases.

The uterus, by reason of its congestion, may be made to perform a self-cleansing act by exciting the exudation of the serum of the blood into its cavity, thereby washing itself out, and expelling all septic matter instead of absorbing it.

This process of exosmosis is induced by a properly combined alkaline solution at a temperature above 100 degrees, and a strict avoidance of bi-chloride, carbolic acid, formaldehyde, or any antiseptic of an acid reaction or astringent nature, which would coagulate the fibrin and albumen of the blood.

My method of procedure is as follows :

1. The gentle removal of whatever fragments are lying in the uterine cavity, by means of forceps, care being taken not to tear from the walls any adherent piece.

2. The gentle flushing of the uterine cavity with the alkaline solution (100°), the reservoir containing the fluid being not more than two feet above the level of the hips.

If the flushing could be continuously administered for a few hours (say two or three) the conditions would be more speedily reduced to normal, but the discomfort of the position of the patient (on a douche pan) prevents this, and a flushing once



every two hours with one quart of solution is about the limit of treatment.

For flushing the uterus, I use a small dilating uterine douche, and as there is plenty of room for the escape of fluid and fragments, there is no danger of fallopian colic or salpingitis. The first flushing is frequently followed by contractile pains and expulsion of any previously adherent pieces, together with much of the mucus.

A tablet of Ext. Cannabis Indica..... gr.  $\frac{1}{4}$   
 Ext. Ergotin..... gr.  $\frac{1}{2}$

every hour till desired effect is produced will contract uterus and alleviate pain. The bowels should be moved freely, both by euema and catharsis.

During the interval between douches, the patient should be kept on her back, with the hips sufficiently raised to permit the retention in the vagina of as much of the alkaline solution as it will hold.

The rapidity with which this treatment will reduce temperature, relieve pain, stop vomiting and remove offensive odor is marvellous to one who has not tried it. Sometimes two flushings are sufficient to cleanse the uterus thoroughly; vaginal douches being all that are needed subsequently to complete the work.

Uterine congestion is speedily relieved, and the uterine discharge changes from brown, thick, bad smelling mucus, to a thin transparent one, accompanied or followed by more or less of a flow of blood.

A reduction in the frequency of the flushings is desirable as soon as a tendency to return to normal conditions begins to be observed, as it frequently will within twenty-four hours. Then simple vaginal douches every three hours with an occasional uterine flushing if symptoms indicate it.

The action of exosmosis (and endosmosis, for there is every reason to believe in the absorption of some of the fluid) is what is desired to relieve the existing congestion, as in a bronchitis, pneumonia, congestion of kidney, congestion of any mucous membrane, etc., and is the most rational means of restoring to normal condition.

I do not wish to be understood as decrying the use of that most valuable instrument the curette, but only the abuse of it, to wit: its employment under such conditions as make it practically a sharp weapon loaded with septic matter, dangerous beyond the poisoned arrow of the Malay, or the fang of cobra, and utterly opposed to our modern ideas of antiseptis.

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# GLIMPSES FROM THE HISTORY OF MEDICINE.

BY H. S. HUTCHISON, M.B.

## I. INTRODUCTION.—THE MEDICINE OF ANTIQUITY.

The study of the history of medicine has ever been a source of delight to the master minds of physic. By Hippocrates the Great, and through all ages, we find the physician urged to devote attention to its pages. The noble light which it casts upon the profession of the past, the opportunities which it affords of placing on their proper relative bases the currents of thought of the present day, and the grand examples which it contains of the heights reached by the earnest development of human resources, are all factors which render intelligent consideration of it a positive duty.

Each year, at the present time, much new and pleasurable reading is published, dealing for the most part with single phases in this history, and this fact may make of interest a series of brief outlines of the periods of medical thought and activity with short references to the great men of each, culled from the rather extensive works on the subject and arranged in consecutive order.

The medicine of antiquity, that practised before the age of the Roman Empire, differs from subsequent systems in one great essential. It was theurgic. Though guided by influences of divinities of various sorts, however, a link of interest with the past is formed for us by the fact that there seems to have always been a middle man to supply the demands of human nature, and this individual's relationship with his sick fellows resembles surprisingly the rôle filled by the physicians of the present day. The peoples whose medical development took place along such lines include the Egyptians, Indians, Babylonians, Medes, Persians, Jews, Chinese and Japanese. Owing to the association of religion with the art of healing in all instances but the last two, the actual workers in the field were, in the first place, priests. Hence with some nations, as in the case of the Levites amongst the Jews, men of one caste alone were entitled to follow the paths of medicine. It is certain, however, that such men devoted their best energies towards their medical rather than their priestly work, and as the race progressed a separation invariably sprang up between the two fields, until with the fuller ripening of the people a gradual specialism appeared amongst its doctors. Thus we read of herb-doctors and knife-doctors, the names of men famous as oculists have been preserved to us since the time of ancient Egypt, and we are assured that later still there were physicians

for each part of the body. In China and Japan, in spite of the influence of deities, the medical profession has always been distinctly separate from the priests, and were it not for the nature of the people might be expected to have reached great heights, which is happening for the first time only in the last century.

In only one of the above countries can we find no trace of definite practitioners who were consulted at their offices and paid visits to the homes of the sick. In Babylon it was the custom to expose their sick on the streets to be interrogated of passers-by as to symptoms. In the case of any of the latter having come through the same experience, it was his duty to explain the means successfully adopted. Thus it is to Babylon we must give credit for a system which, standing the test of time, exists in many places at the present time to serve the useful purpose, no doubt, of counteracting the too scientific tendency of modern medicine.

No lack of medical literature seems to have hampered any of these peoples, and in most cases abundant writings, supposedly of divine authorship, were forced upon the physicians with definite instructions set forth which could not, under pain of punishment, be departed from. Thus the Egyptians, in their celebrated Papyrus Ebers (now in Germany), had a work which was a compilation of the writings of the God Thot, together with those of the most skilled physicians of all countries at the time, a famous Egyptian filling the duties of editor. Thus at so early an age have we evidence of international medical intercourse! The Persians and others were similarly guided by Zend-Avesta or Living Word, the work of a great priest, Zoroaster, who lived about B.C. 1000. It was acknowledged in the pages of this work, however, that the "Word" needed practical help in the curing of disease, but a cure under its directions was claimed to affect the soul as well as the body. The Jews had for their foundation an extensive work known as the Talmud. The Indians and the Chinese had many laborious books, of which those possessed by the latter were used entirely, also by the Japanese.

Medical education varied from the oral teaching of the Indians to the laborious memorizing *in toto* of voluminous Chinese books in Japan, to the bedside teaching of others, and to the presence in Egypt of five medical colleges, with libraries, laboratories and students' residences. In China, however, it has been possible for anyone to assume the title of doctor and to commence the practice of medicine without any preliminary education.

The knowledge acquired by these peoples must certainly seem wonderful when it is considered that, in the first place,

the most ignorant superstitions were brought to bear on causes; treatment and outlook, and in the second place, no accurate knowledge as to anatomy could be formed on account of religious objection to dissection. In therapeutics, purgatives, bathing, cupping, the use of enemata and of emetics, were common-sense measures which underlaid many fanciful remedies. In physiology, such experiments as successfully removing the spleen in animals had been performed. In midwifery, though it was the custom in ancient times for women to attend to the duties of the lying-in chamber, yet the physicians were always brought in when difficulties presented themselves, and hence a knowledge of treatment, at least, was necessary. Thus in India considerable skill in cephalic and podalic version, embryotomy and Cesarian section was possessed, and in Japan several centuries ago a celebrated and worthy obstetrician sprang into prominence whose writings show a knowledge of embryology and other aspects of the branch. It is in the use of the knife, however, that the greatest strides were made by all, the people of the Ganges being the boldest. Circumcision, venesection, laparotomy, herniotomy, cranial surgery, operations for imperforate anus and plastic surgery all being practised before the Christian era.

A curious operation for stone is described in which by two oiled fingers in the rectum the stone was pushed forward to make a projection above the symphysis pubis, whence it was removed by excision, a warning being uttered to leave no spicules behind in the bladder.

The preparation of mummies by the Egyptians was to some extent connected with the medical workers, and in any case is of interest. The brain being removed through the nasal cavities by means of hooks, and the abdomen being emptied, the two cavities created were filled with spices. The body was then placed in caustic soda for seventy days, after which it was removed, wrapped in fine linen, and placed in an air-tight coffin. The fact that most of the mummies found seem to be the remains of great dignitaries is accounted for probably by the costliness of the process.

In both India and amongst the Jews the inoculation of natural and artificial virus of smallpox was practised as a preventative measure, and it is quite possible that a knowledge of this may have given no little strength to the courage of Jenner in advocating his views with such persistence!

The remuneration received by the medical men by the different races of antiquity seemed to result in most cases, favorably. In Egypt golden and silver models of the diseased part of the patient were given as fees, together with wine and fine meats. The Persians had a regular tariff, the form of exchange

being in the way of cattle. Thus the chief of a tribe paid with a farm, and the son of a family with a large ox, and the famous doctors of the day were consequently owners of great numbers of animals. In China, affairs were so favorable for the physicians that the government issued an official notice to the people that, as physicians were in the habit of refusing to see patients before one p.m., and many were accustomed to sit up very late smoking opium and drinking, they should only receive one half their fee if they did not come at once when needed. In Japan, unfortunately, a prophet advised people to refrain from paying physicians well, lest they should neglect their professional duties, and the custom is to pay according to the success of the treatment. And yet Japan is not the most advanced medical nation in the world!

In spite of the theurgic element in medicine the position universally accorded the physician amongst these peoples was one of high respect. He in turn must observe certain forms of conduct, and we find in Indian writings the following qualities set forth for a doctor to possess: "Absence of passion, chastity, temperance, amiability, veracity, generosity, consideration for the sick, earnestness, a desire for knowledge, freedom from boasting, secrecy, and above all reflection and independence of thought." A goodly list and one not diminished in practical value because of its age. In seeking in the literature mention of the opinion held in regard to the position of the physician, no less a source than the Old Testament need be consulted, wherein we find the following noble sentiment: "Honor a physician! The skill of the physician shall lift up his head, and in the sight of great men he shall be in admiration. When thou feelest sick call upon God, and bring the physician, for a prudent man scorneth not the remedies of the earth."

## Society Reports.

### AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS.

Fourteenth annual meeting, held at Washington, D.C., September 16th, 17th and 18th, 1902. The President, Dr. Edwin Ricketts, of Cincinnati, O., in the chair.

#### **Removal of the Gall-Bladder Through the Lumbar Incision.**

Dr. Walter P. Manton, of Detroit, reported the case of a patient 38 years of age, the mother of five children (two abortions), never robust, but able to attend to her domestic duties. She had suffered from a number of gastric attacks, but there had been an absence of symptoms pointing to disease of the biliary tract. Examination showed a loose left kidney, while the right kidney, displaced downward and inward, appeared to be double its normal size and had certain projections which led to the diagnosis of nephroptosis, with probable cystic metamorphosis of the kidney. At the operation, through the nephropexy incision, the fatty capsule of the kidney was found to be embedded in adhesions, which had given rise to the appearance of the enlargement. The kidney, which was normal in size and structure, was delivered on the back and placed astride the wound. Below the kidney pouch a distended gall-bladder, containing fluid and nineteen gallstones the size of hazelnuts, was found surrounded by adhesions. This was enucleated, tied off at the cystic-duct, and removed. The kidney capsule was split and peeled off to the lateral line, fixation sutures were introduced and the organ was returned to its place. A strip of gauze for drainage was carried from the upper angle of the external wound to the stump of the cystic duct. The patient made a good recovery.

#### **Abdominal and Pelvic Surgery and Drainage.**

Dr. Joseph Price, of Philadelphia, said that the more progressive and successful specialists practised most extensive sponge packing or drainage. The modern operator did the same by his gauze pack or the dry operation. A number of operators, doing fairly good work by the suprapubic route, condemned or partially rejected drainage. Some of them, he said, never learned and never would learn how to handle drainage well. After abandoning the suprapubic route, these men were placed in the uncomfortable position of admitting that drainage

did what they had refused to do by suprapubic surgery. About all the reported operations were coming from operators opposing drainage or practising it only when they were compelled to do so.

#### **Tetanus Following Abdominal Section, Due to Infected Ligatures—The Angiotribe in Abdominal Surgery.**

Dr. Walter B. Dorsett, of St. Louis, detailed at length two cases, which were of women who had undergone ventrofixation of the uterus, or adhesions of the uterus to the surrounding tissues, due to previous inflammatory conditions. The material used for fastening the uterus was kangaroo tendon. This was the source of infection. He had used the angiotribe successfully 25 times, as follows: abdominal hysterectomy, 10 times; hemorrhoids, 1; pus tubes 5 times; extrauterine pregnancy, 4 times; dermoid cyst, 1; ovariectomy, 3 times, and one in a case of vaginal hysterectomy. He concluded that (1) patients upon whom it had been tried suffered less post-operative pain; (2) no adhesions to stumps had followed; (3) no secondary hemorrhage had followed; (4) it can be applied, when two instruments were used, alternately by the operator and the assistant without the fear of the slipping of a ligature knot, and in less time.

#### **Ruptured Pus Tubes.**

Dr. Charles Greene Cumston, of Boston, spoke of two methods of dealing with pus tubes; one by posterior colpotomy, followed by incision and drainage of the sac, while the other was to remove the tube, and if the condition was bilateral to do a total hysterectomy. Drainage of the perforated pyosalpinx through the vagina was naturally the easiest and least dangerous method. The vagina was incised, and then the pyosalpinx and the walls of the pus tube might be united to the vaginal wall by means of forceps. The best treatment for perforated pus tubes is by abdominal incision. The extirpation of perforated pyosalpinx is particularly urgent in those patients in whom drainage by posterior colpotomy had been unsuccessful, and also in tuberculous lesions of the tubes.

#### **Pelvic Abscess and its Treatment.**

Dr. Herman E. Hayd, of Buffalo, spoke of a class of cases in which vaginal incision and drainage, supplemented by curettage, should be first employed to eliminate the pus, and then an abdominal section should be done later to relieve the patient of her suffering. Large collections of pus, low down in the pelvis, in a moribund woman are best evacuated through the vagina. He spoke in reference to strong women who were suffering

from acute streptococcic infection, who had high temperatures with great pain and tenderness, and under ordinary circumstances ready to submit to major operations, and in whom an acutely tender mass could be felt low down in the pelvis on one or both sides, at times filling up the cul de sac of Douglas. For these, early vaginal incision was imperative and was without danger. The mass would diminish in size; the danger of rupture would be minimized, the pain and symptoms would subside.

#### **Starvation Treatment for Appendicitis Irrational.**

Dr. John B. Deaver, of Philadelphia, said his experience of ninety-eight cases for two and a half months past had furnished the objections to the rest or starvation treatment. An early operation, preferably in the stage of appendiceal colic, was the only rational procedure he had found, and was the best treatment to reduce the mortality in acute appendicitis. The so-called rest treatment failed to check inflammation of the peritoneal structures and in the majority of cases did harm to the patient. The statistics he presented supported the argument. He was willing to grant that operation in the presence of an acutely inflamed general peritonitis was attended by great risk to life, and therefore it was often wise to defer operation, hoping that the inflammatory process would become localized. This was often his practice; but the starvation plan of treatment promised no more in such cases than the mere common practise of abstaining absolutely from giving opium, keeping the bowels freely open by cathartics, or, as some physicians preferred, a hydragogue cathartic, which was both antiseptic and germicidal, giving nourishment by the rectum, when the stomach was intolerant, and using ice or heat locally in the shape of poultices or hot turpentine stupes.

#### **Presidential Address.**

The subject was "Our Shortcomings: Let Us Reason Together," delivered by Dr. Edwin Ricketts, of Cincinnati.

#### **Four Cases Illustrating the Difficulties of Diagnosing Appendicitis.**

Dr. William Wotkyns Seymour, of Troy, reported these cases in abstract. Case 1 had previously been operated upon for appendicular abscess. He found a suppurating solid tumor of the ovary. Temperature at the time of operation was 107°; pulse, 180; recovery. Case 2 was a woman with contracted pelvis delivered of a dead child. Twelve days later there were symptoms of inflammation in the right iliac fossa, appendicular or tubal, the result of infection. Operation revealed a sup-



purating gangrenous fibroid of the right anterior uterine wall, which was enucleated, followed by recovery of the patient. Later he did Cesarean section on this patient; mother and child well seven weeks after operation. In case 3 he was summoned to a case of appendicitis some fourteen miles distant in the country. His diagnosis was ovarian cyst with twisted pedicle. The mass had increased twofold since his previous visit to the attendant. Removal of the cyst was followed by recovery of the patient. Case 4, woman, single, age about twenty-two. Pains and intense tenderness in appendicular region began with joint pains. Examination of lungs showed bronchial breathing at left base; the next day diffuse bronchial breathing over both lungs. Appendicular symptoms less marked. Toxemia of some sort: no appendicitis.

#### **Intrauterine Fibroids Complicating Pregnancy, and Retained Placenta Associated with Intrauterine Fibroids Complicating Pregnancy.**

Dr. M. A. Tate, of Cincinnati, collected thirty-nine cases from literature, and reported two personal experiences. Analysing these forty-one cases, he showed that in nine cases the names of reporters were given. In six the tumor became gangrenous; hemorrhage was a prominent symptom, occurring in eighteen cases; three polyps were expelled spontaneously; seven polyps were removed; in three the polyp was not removed; in ten labor was normal; in four labor was difficult; in two the child was destroyed; one was a case of turning, and the other a breech; in four the tumor was discovered before labor, in all of the rest, afterward; four cases were reported in which labor set in before time; two were at the fifth, and two at the seventh month. The following complications were reported: septicemia, eight; measles, one; puerperal mania, one; retained placenta, four cases. Cold applications, iodides, ergot, whiskey, vinegar, packing of uterus with gauze, and removal of tumor. Causes of death: hemorrhage, three; sepsis, three; peritonitis, one; and collapse, one, making in all eight cases. If all of the other cases, including the nine without histories, recovered, there would be thirty-three recoveries and eight deaths, a mortality of 19½ per cent.

#### **Abdominal Section During Pregnancy.**

Dr. J. Henry Carstens, of Detroit, had had the following complications of pregnancy: Appendicitis, five; hernia, one; fibroids, four; abdominal hysterectomy, one; vaginal hysterectomy, three; ovariectomy, three, and miscellaneous three, or altogether, twenty cases and five deaths; mortality, 25 per cent.

This included all his cases for many years back. To-day he thought the mortality would be less. Acute diseases which required prompt operation could be operated upon notwithstanding pregnancy. Tumors that would interfere with labor should be operated on. Tumor above the brim of the pelvis, or which could be shoved above the brim of the pelvis, need not be interfered with; still, as a rule, all tumors took on a very rapid growth during pregnancy, and the increase in size might interfere with the various functions of life and then surgical intervention was required.

#### **Deciduoma Malignum.**

Dr. Lewis S. McMurtry, of Louisville, reported a case. Speaking generally from a clinical standpoint, the disease presented a well-defined history. The disease appeared after abortion or labor, the tumor being situated upon the endometrium of the body of the uterus. Of 128 recorded cases, in 40 per cent. the disease appeared after mole pregnancy. Hemorrhage was the first and most conspicuous symptom, and was not controlled by curettage. The discharge was usually offensive, especially in the advanced stage. The disease had a marked tendency to early metastasis; the lungs and vagina were the most common sites for metastatic deposits. The disease was so rapid in its course that the period from first symptoms until the death of the patient was only a few weeks or months. The only successful treatment was the early and complete extirpation of the uterus. In the author's case the disease appeared in a woman of thirty-five immediately after abortion. Persistent hemorrhage and fetid discharge from the uterus prompted operative intervention. The uterus and its appendages were removed by abdominal hysterectomy, and the patient made a prompt recovery.

#### **Perforating Ulcer of the Duodenum.**

Dr. John B. Murphy, of Chicago, reviewed the etiology, pathology, and diagnosis of duodenal ulcers, and considered the surgical treatment of perforation. He also gave an analysis of twenty collected cases. The diagnosis of perforating ulcer was difficult, or, practically impossible without an exploratory laparotomy. In many cases there was no evidence of duodenal disease previous to the perforation. The most important physical sign, in addition to those of perforative peritonitis from perforations in other portions of the intestinal tract, was the flatness of the superficial piano percussion note in the right hypochondrium. The leucocytosis in one case, the only one in which it was seen, was pronounced, showed an inflammatory condition, in contradistinction to the usual absence of it in intestinal obstruction and fat necrosis of the pancreas. Leucocy-

tosis, however, was not a necessary manifestation of perforation or of inflammation. It was often entirely absent in typhoid perforations. Collapse was absent in duodenal perforation except when associated with severe hemorrhage. In all cases of perforated peritonitis operation should be done at the earliest possible moment after the perforation, and experience showed that the mortality was in direct ratio to the length of time that elapsed between the perforation and the operation. Of thirteen cases operated upon more than thirty hours after perforation, all terminated fatally, while in twelve cases, where less than thirty hours had elapsed, 66 $\frac{2}{3}$  per cent. recovered. The operation must be complete—that is, it must be pursued to an effective suture of the perforation. Drainage was insufficient, as of eighteen cases treated by drainage alone, all died. The suture of the opening can be easily inserted, as in 98 per cent. of the perforating ulcers into the peritoneum the opening was in the duodenum, its most accessible portion. Where duodenal perforation was suspected, the incision should be through the right rectus muscle. It could then be carried upward to the costal arch, or downward to the symphysis pubis without dividing any of the transverse muscles. The incision through the rectus muscle was the one which he commonly made in operating for appendicitis. It could be enlarged upward or downward without interfering with the muscle fibres.

### **Peritoneal Tuberculosis.**

Dr. Rufus B. Hall, of Cincinnati, maintained that tuberculosis of the peritoneum in women is not a rare affection. It occurs often enough to make it necessary to consider it in the differential diagnosis of all obscure diseases in the pelvis and abdomen. In a large majority of cases there were no appreciable manifestations of tuberculosis in other parts of the body. The symptoms simulated several other conditions in the pelvis and abdomen. The diseases most likely to be confounded were the recurrent attacks of appendicitis of the catarrhal form, small fibroid tumors, with old tubo-ovarian disease, and recurrent attacks of pelvic inflammation. If the case is one of tuberculosis, however, the temperature chart will suggest this disease if the record is taken every four hours for a period of ten to fifteen days. In no other condition is there such exact regularity in the afternoon rise of temperature. Cases of tuberculosis of the peritoneum in which there was encysted dropsy, or an accumulation of pus or serum, should be operated on; after the necessary surgical repair the abdomen should be drained. Vaginal drainage in women is preferable, because it gives perfect drainage and prevents ventral hernia.

### Surgical Treatment of Perforated Gastric Ulcer with General Infection of the Peritoneal Cavity.

Dr. H. Howitt, of Guelph, Ont., said that acute perforation with general infection of the abdomen, was usually caused by the acute, round ulcer, but might occasionally take place in the course of a chronic ulcer, especially when it was situated on the anterior wall. All the phenomena of acute perforation might result in either form of ulcer in a more indirect manner by the formation of a localized abscess, which afterward ruptured internally. In peritoneal perforation with general infection medicinal remedies are useless. Early, bold and thorough surgery alone can save the patient. When patient is anesthetized an incision from ensiform cartilage to pubis should at once be made, the bowels eviscerated and protected, then the stomach examined and the perforated part brought out of the wound as far as possible and the field guarded by sponges. The perforation might be excised, but it is generally merely closed with two or more rows of silk sutures. Every pouch and corner in the abdomen should be thoroughly inspected and flushed clean. Drainage tubes are used, not placed in the wound, but through stabs, one at the back in each flank depression below the kidney, and one in the lower abdomen to the right or left of the incision for the pelvis. After the intestines are replaced and omentum is spread over them and fastened below the lower end of the wound with a suture or two, the incision is closed as quickly as possible and dressed. In a desperate condition of the patient, a pint of peptonized milk or other suitable liquid food may be injected into the jejunum during operation.

The author said in conclusion that he was aware that many surgeons strongly objected to evisceration, but he maintained that it was impossible by any other known method to make certain that the cleansing of the peritoneum had been done thoroughly. Imperfect toilet is followed by more shock, and is vastly more dangerous than hours of properly managed evisceration.

Papers were also read by Drs. C. L. Bonifield, of Cincinnati; F. F. Simpson, of Pittsburg; Walter B. Chase, of Brooklyn; J. J. Williams, of Philadelphia; A. Goldspohn, of Chicago; Miles F. Porter, Fort Wayne, and L. H. Dunning, of Indianapolis.

# Progress of Medical Science.

## MEDICINE.

IN CHARGE OF W. H. B. AIKINS, T. M. McMAHON, H. J. HAMILTON,  
AND INGERSOLL OLMSTED.

### A Case of Syphilis Complicated by Diabetes Mellitus—By DOCTOR LINGI MOSCA.

Having had the opportunity of treating, under Prof. Tommaso De Amicis, a woman suffering from constitutional syphilis complicated by diabetes mellitus, in whose case there appeared a distinct relation between the two diseases, I have thought it worth reporting.

S. C., 40 years of age, was a married woman, belonging to Naples. Her father died at the age of 45 of heart disease, and her mother at 50 of *diabetes mellitus*. Two sisters and a brother are healthy. She began to menstruate at 15, and was married at 22. She had only one child, a son, still living, and possessed of a good constitution. Up to 1897 she enjoyed good health. In October, 1897, being with her husband in Calabria, she began to feel poorly, complaining of wandering rheumatic pains and of constant cephalalgia, more intense at night. These symptoms, not yielding to various drugs, continued to become more severe, so as to keep her from sleeping. Some months later there appeared a general cutaneous eruption, chiefly pustular; and at a later period iritis in the right eye. She came to Naples to consult Prof. De Amicis, who diagnosed a typical constitutional syphilis and advised specific treatment, giving the preference, owing to the gravity of the symptoms, to the hypodermic injections of the sublimate. Under this treatment she quickly improved, the pains disappeared, and later, about one month, the iritis and the syphilodemia.

After an interval of 70 days, the woman, who up to this time had been rather fat and robust, began, without appreciable cause, to lose flesh and to suffer from general fatigue, notwithstanding abundant nourishment. Examination of the urine by Prof. Arena, revealed the presence of diabetetic sugar in the proportion of 30 grammes per litre. She was put under the usual alimentary treatment, but in two months analysis of urine showed that the sugar was increased to 33% in spite of the restricted diet. Emaciation progressed; the general prostration continued; disturbance of the digestive tract showed itself by anorexia, slow digestion and lessened assimilative power. This was followed by a relapse of the specific symptoms (pustular

syphiloderm, less confluent than before, with iritis in the left eye). Subjected again to the treatment by sublimate hypodermically, with the internal administration of sodium sodide in progressive doses, without omitting the special mixed diet, there was observed an improvement not only of the syphilis but also of the diabetes. The sugar rapidly diminished; digestion and assimilation improved, and after two months of rigorous treatment, not a trace of sugar was found in the urine.

Some months later the specific symptoms reappeared (intense headache, with periostitis of the tibia in both legs), together with the digestive troubles and a marked weakening of the sight of the left eye. Analysis of the urine showed again sugar, 20 grammes per litre. The injections of sublimate were repeated, with the internal iodide treatment, and after a month and a half she was again completely relieved, and the urine was free of sugar.

The following year, after an interval of several months, she again became ill, with similar symptoms. This time the gastrointestinal condition was more severe, being accompanied by serious fermentation and high fever, so that it was feared she would not recover. After the fever fell, the energetic specific treatment was resumed with similar happy results.

These relapses of the syphilitic phenomena recurred from time to time, always associated with diabetic crises and digestive disturbances. These attacks always yielded to the same treatment, and there was never the slightest indication of mercurial intolerance.

The question of the relation between syphilis and diabetes is still a doubtful one. The cases of diabetes in which one can with certainty assert the exclusive and direct influence of syphilis are very rare.

In 1860 Lendet published an important paper on "Cerebral Syphilis with Diabetes." Later, Frerichs, in 1861, reported two cases of diabetes with syphilis. In 1865 Prof. Jacksh, of Prague, in an article on syphilitic convulsions, dealt with the possible existence of a specific diabetes, which would explain the good results attributed by Scott, Franck and Van Hoven, to the use of mercurial preparations in some forms of diabetes. Lecorché, in his treatise on diabetes in 1877, confirming the possible existence of diabetes as a manifestation of specific infection, thus expressed himself: "One cannot any more dispute the existence of syphilitic diabetes than that of gouty diabetes." A case of syphilitic diabetes was reported by Deker in 1889. Jullien gave it as his opinion that we cannot doubt the existence of an early syphilitic glycosuria, independent of the nerve lesions, which, at an advanced period of the disease, can give rise, secondarily, to sugar in the urine.

On the contrary, several authorities exclude such an influence. Cantani, in 1876, asserted that in many cases of specific cerebral lesions, there existed no diabetes. Maurice said: "In spite of the authority of pathologists, I consider the pathogenic influence of syphilis on diabetes very doubtful."

In the case reported above, the influence of syphilis on the evolution of the diabetes was perfectly clear. The mechanism of the production is not easy to interpret. There existed in the patient general hereditary conditions predisposing to the development of glycosuria. There were also frequent gastro-intestinal disturbances, which became intensified during the exacerbations of the diabetes. Such a condition might be referred to changes in the secretions, especially those of the pancreas and liver; and it is well known that the altered function of these organs can, in predisposed subjects, cause diabetes. Evidently the general nutritive disturbance caused by the constitutional infection (given the hereditary predisposition), must have been the fundamental cause of the glycosuria, the powers of assimilation of the organism being notably diminished. The course pursued by the two forms of disease and the marked influence of the specific treatment on both, confirmed their direct relation, excluding the possibility of simple coincidence.—*Translated from Giornale Internazionale delle Scienze Mediche*, by HARLEY SMITH.

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## OBSTETRICS AND GYNECOLOGY.

IN CHARGE OF ADAM H. WRIGHT, JAMES W. F. ROSS, ALBERT A. MACDONALD  
AND K. McILWRAITH.

### Use of Forceps.

In the *St. Paul Medical Journal* for August appears an article by Leavitt of the University of Minnesota. The writer propounds the question. "May we not safely use the forceps in every case?" His answer is, "The point I am to make is, that physicians *may* safely apply forceps in every case where time will permit, after the completion of the first stage of labor; that when this stage is over the obstetric movement has arrived where the patient may be placed in position and instruments employed with benefit."

We do not like the nature of this question. Physicians should not aim at demonstrating what they *may* do or what they *can* do, but rather at what they *ought* to do in the interests of the patient. We do not think that this end will be achieved by applying forceps at the end of the first stage in every case where time permits. Even for the most experi-

enced the so-called high operations are more difficult, and fraught with more danger to both mother and child than the lower ones, and nature, for a time at least, may generally be given a chance with advantage to the patients.

Leavitt complains that in the matter of use of the forceps teachers are often not so conservative in their practice as in their teaching. We do not understand that Dr. Leavitt teaches his students to use the forceps in the manner he describes above, but we venture to hope not what Dr. Leavitt might do with impunity could scarcely be so done with tyros. We incline, however, to agree with the doctor in thinking that forceps may often be used to cut short labors, even though in process of time and nature they might come to a happy end themselves, and to believe that a better puerperium is often so brought about.

K. C. M.

#### Placental Transmission.

In the Johns Hopkins Hospital reports, Vols. 3, 4 and 5, Lynch gives notes of three cases of typhoid fever in pregnancy.

In the first case the patient aborted about the 12th day of the disease, during the 5th month of pregnancy. Bouillon inoculated with liver and blood of the fetus gave cultures of the typhoid bacillus. The Widal reaction of the fetal blood was negative.

The second case gave birth, about the 40th diet day of the disease, to a child in the 36th week of gestation. The child lived 72 days. The Widal reaction of its blood was negative, and at the autopsy no micro-organisms were recovered from its tissues.

In the third case the patient aborted, during a relapse of typhoid, at six months. No autopsy was held, but the infant's blood gave a negative reaction to the Widal test.

In the paper a great deal of interesting information culled from literature, is given as to placental transmission in other diseases.

#### Accidental Hemorrhage.

No part of the Rotunda system of midwifery has given rise to more controversy than the method of treating accidental hemorrhage. The following description of the method is taken from an article by Colclough, late Extern Maternity Assistant, Rotunda Hospital, which appears in the August number of the *Jour. of Obstet. and Gyn. of the British Empire*:

1. *Plugging the Vagina.*—Hastings Tweedy described the process in a paper, "The Vaginal Plug in Accidental Hemorrhage." The method in use at the present time differs a little



from that employed when Tweedy was Assistant Master. The plugs used are small tampons of sterilized cotton-wool, about the size of a large walnut, hysol, creolin, and perchloride of mercury are the antiseptics used. After all the necessary antiseptic precautions usual for any obstetric operation have been taken, a catheter is passed, and the operator proceeds to plug. The patient is placed in the lithotomy position, and the fingers of the hand which was not used for cleaning the vulva, etc., may be used for plugging, and the other hand acts as a speculum. The plugs are taken out of the solution separately; the first one is placed in the posterior forvix, and the fornices are packed with a fair amount of pressure. Each plug is put in with a purpose to form a ring around the cervix, and packing is continued systematically downwards until no more can be introduced into the vagina. The operator then takes a large strip of iodoform gauze and places it over the plugs, which will be projecting from the vagina, instructing an assistant with clean hands to hold the gauze in position while the binder and T bandage are put on. The iodoform gauze is not always used, but the author has found it of great practical value.

No anesthetic is necessary; it will only be required if the patient is very restless, and it is a remarkable fact how little is necessary to render the patient quiet—merely a few whiffs.

2. *Application of the Binder and Perineal Bandage.*—The binder should have been placed under the patient before the plugging, etc., was commenced. It is now brought down into position, while the patient is swung round into bed. Strong pins and a stout binder are needed. The first pin must be placed above the fundus, as near to the ensiform cartilage as possible, and the binder secured extremely tight downwards as far as the symphysis. Lastly, the perineal bandage is put on, pinned well up the binder in front, three couples of pins being required. The patient is then rolled over on to her side, and the bandage secured at the back in the same way, the assistant keeping up steady pressure with his hand on the iodoform gauze. The plugs are thus kept in place until thoroughly secured by the tight perineal bandage. In this manner pressure is made on the front of the uterus and abdomen by the tight binder, and the uterus is forced downwards as well as on to the firm mass of plugs. The abdomen and abdominal veins will also be compressed.

Many interesting cases are cited, and a comparison made between this and other methods of treatment. We consider the method a good one.

K. C. M.

## OPHTHALMOLOG / AND OTOTOLOGY.

IN CHARGE OF J. T. DUNCAN AND J. O. ORR.

### **Injury to the Eyes of Children While Learning to Read.**

C. J. Swan (*The Clinique* abstracted in the *Medical Review of Reviews*) believes that the eyes of children are injured by learning to read at too early an age. Five and six years of age is when many children learn to read. At that age the eyes, like the remainder of the body, are not developed, and the strain upon the ciliary muscle in accommodation is much greater than later in life. A greater effort in convergence also is necessary, since the refractive condition of early childhood is normally hypermetropic of greater degree than that at puberty. There is still another way in which the young child's eyes are strained more than those of an adult in reading. An adult glances at a word, a line, a sentence, and comprehends the meaning at once from the general appearance and arrangement of the letters, while the child in order to read a sentence must study closely each letter of each word, just as the adult would be obliged to do were he reading a foreign language written in unfamiliar characters.

After a child begins to read, teachers study the forcing of young minds as horticulturists study the forcing of plants, but with much less wisdom and knowledge of the inevitable results. The child's undeveloped eyes are strained by overwork, the retina becomes congested, and headache and other asthenopic symptoms are complained of in many cases, but not in all, since the eye of the child is often harmed without causing him to complain of strain which would be intolerable to an adult. On account of lack of exercise and outdoor air, the appetite and digestion of many young children are poor, and their entire bodily physique is weakened at the expense of over stimulating their mentality. Not only is the eye injured by excessive use with the consequent production of myopia and astigmatism, but the brain is forced into a precocious exercise of its functions at an age when it is too weak and undeveloped to escape harm. There results in many cases a nervous irritability which is analogous to the nervous prostration of overtaxed adults. In fact, it is a question whether many cases of adult nervous prostration are not due to over strained brain and nerves in childhood as primary causes.

In this connection Dr. Swan quotes Herbert Spencer as follows: "The brain, which during early years is relatively large in mass but imperfect in structure will, if required to perform its functions with undue activity, undergo a structural advance which is disproportionate to its age, but the ultimate

effect will be a falling short of the size and power that would else have been attained. And this is probably the chief cause why precocious children who, up to a certain age, were carrying all before them, so often stop short and disappoint the high hopes of their parents."

Dr. Swan concludes his paper with the following recommendations:

1. The child to learn to read not until at least eight years of age.
2. No reading outside of school hours until eleven years old.
3. Select the sort of reading for recreation which will excite the growing brain least while being sufficiently interesting to hold the child's attention. There are such books.

The author does not mean to say that all, or even a large proportion of children, are materially affected by the present forcing methods of education. Nature stands much abused with the help of inherent vitality and hereditary powers of recuperation. But it is the weak and enfeebled child who suffers by this vicious system. The boy who is too full of mischief or too lazy to study will probably escape lasting injury. Most children live fairly normal lives; it is the nervous and irritable child who is the precocious product of a forced mentality, and these children early haunt the offices of the oculist and neurologist.

### Causes and Treatment of Glaucoma.

In the *Ophthalmic Record* for October, 1902, Prof. W. Schoen of Leipzig, Germany, has an article which runs entirely counter to the accepted ideas in regard to glaucoma. The common theory in regard to this disease starts with the supposition of high tension in the affected eye, while the common treatment may be summed up in one word—Iridectomy.

Schoen says: "The first to mention increased tension as one of the symptoms of glaucoma seems to have been Plattner."

Afterward Albrecht von Graefe declared this symptom to be the cause of all the others in real glaucoma, excluding an *amblyopia cum excavatione* which he did not believe to be caused by increase of tension. However, when Donders asserted that the amblyopia must also be looked upon as glaucoma, von Graefe extended his theory to cover this form also. The adherents of this theory grant that in a very great number of cases no increase of tension has been observed. Some years ago the President of the American Ophthalmological Society stated that he was accustomed to diagnose glaucoma in the absence of increase of tension, and that it was recognized by all that increase of tension was not a necessary symptom of glaucoma.

This fact is explained by the adherents of the tension theory on the ground that the examinations were made during the intervals of increased tension.

According to these data a definition of glaucoma simplex would read: Glaucoma simplex is a form of glaucoma in which the tension occurs always during the absence of the surgeon! If the patient could but live in the presence of his surgeon he would never suffer from an attack!

The theory was supposed to account for the cupping of the optic nerve. But as a matter of observation the deepest cuppings are frequently found in cases which show absolutely no increase of tension, and *vice versa*.

The origin of iridectomy as a remedy for glaucoma is not clear. Evidence is lacking that the iris has anything to do with the tension of the eye, and if iridectomy is expected to relieve the glaucoma by lessening the tension, what effect would it have in glaucoma without increased tension?

Iridectomy was exploited as a sure preventive of blindness. Of three hundred glaucomatous eyes under my care (says Schoen), forty-five had already been operated upon by others, and all were completely blind, although every patient had been promised preservation of existing visual acuity.

For the first twelve years of my work in ophthalmology I was a sincere adherent of this theory and applied it repeatedly.

But Dr. Javal's two cases of glaucoma, which were iridectomized with perfect technique, became totally blind. These cases caused my first serious doubt of the efficacy of the procedure, but it was fully five years later before I finally succeeded in ridding myself of my prejudices in favor of the method.

It is quite easy to recognize the premonitory signs, not only of glaucoma simplex, but also of the other forms of glaucoma. Increase of tension must be relegated to the rank and file of glaucoma symptoms.

In 1884 I stated that 80 per cent. of glaucomatous eyes were either hypermetropic or astigmatic; 13 per cent. afflicted with insufficiency of the recti-interni, and the remainder presbyopic, and I quoted many cases where the progress of glaucoma was checked by correcting these errors. Since then a number of cases have been reported by others, showing cures made by the same means.

Now, looking back over the histories of three hundred cases of glaucoma afore mentioned, I repeat with conviction, that every eye can be guarded against glaucoma if it can be seen early enough by an ophthalmologist who is accustomed to observe the preliminary symptoms. When fully developed it is absolutely impossible to cure the disease by any known method.

J. T. D.

## Editorials.

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### DR. ADOLPH LORENZ.

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Dr. Adolph Lorenz is a native of a small Silesian town, a graduate of the University of Vienna, and after graduation was privileged to work under those masters of surgery, Billroth and Albert. Anyone knowing the thoroughness of German or Austrian assistant's training, knows that his foundations must be laid wide and deep. Thus was Lorenz prepared for the very brilliant and scientific work he has since done in orthopedic surgery, and particularly in the study of the pathological anatomy and treatment of congenital dislocation of the hip.

If we were to judge solely by the utterances of the daily press of the United States, we would be inclined to characterize him more or less of a charlatan. In the eyes of the profession here, the hysterical reports, and the half-page cuts of these newspapers place him in a very unenviable, and to a greater or less extent the surgeons who entertained him, in a very undignified position.

We cannot but feel that, if he is reported correctly, he should have more guardedly expressed himself to the sensation-loving reporters, for no matter how great an enthusiast he may be, he could scarcely be justified in saying, as he is reported in one interview, that the case upon which he had just operated would be a perfect result, not only as to position but as to function and weight-bearing. None knows better than he that it will be months after he has returned to his own side of the Atlantic before it will be determined whether or not the result will be satisfactory.

We can, however, hold Professor Lorenz responsible for only the smallest part of the excitable presentation of his work through the press. There were at least two other factors which contributed to it. First, the fact that he was called from Vienna to examine and operate on the daughter of a multi-millionaire; second, the fact that reporters were evidently admitted to the clinics and probably supplied with information of a technical character by some of the medical men

present. The first factor was under nobody's control, but the second was controllable and the medical men in charge should be held responsible.

Some members of the profession are uncharitable enough to say that this "playing to the gallery" is characteristic of orthopedists, as some of our own papers contained what looked like an inspired statement concerning a patient who was treated here and afterwards taken to see Lorenz.

In spite of the fact that we cannot sympathize with the *heroics*, we recognize the fact that Lorenz, by his enthusiastic following up of the subject, has placed us in a position to treat with a large degree of success what was until recently a hopeless and helpless deformity.

Whether the *bloodless* method will supersede all other methods is possibly doubtful, for many orthopedic surgeons are finding that cases which are impossible of reposition and retention by the bloodless method are curable by the open method, splitting the joint capsule, or even enlarging the acetabulum if necessary.

The cases operated on by Lorenz during his visit were not taken indiscriminately as some are led to suppose, nor were they cases which baffled American surgeons, but were selected cases with what was considered a hopeful outlook.

This visit to America will doubtless do much good in other ways than by the direct relief it brings to those operated upon. It ought to stimulate orthopedic surgeons to greater endeavor to satisfactorily handle this class of cases. A greater good, however, should be apparent in the stimulation given the general practitioner to make early diagnosis, as it is only in the early cases that the best results may be hoped for.

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### LORD LISTER'S JUBILEE.

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We in Canada are enthusiastic admirers of Lord Lister. We learned to respect him many years ago; we learned to love him when we saw him during his visit to us in 1897. He completed his fiftieth year as a member of our profession last month. As Mr. Howard Marsh tells us in his Bradshaw Lecture on infective arthritis, delivered before the Royal Col-

lege of Surgeons, England (*Brit. Med. Jour.*): "On December 9th, 1852, a certain candidate passed his examination and became a Fellow of the College. He came from Essex, and his name was Joseph Lister."

The Lister Jubilee number of the *British Medical Journal*, December 13th, is an exceedingly interesting one. It contains a number of valuable papers contributed by distinguished foreign surgeons "in honor of the man who is revered by the surgeons of the whole world," and also "the testimonies and appreciations of men who saw Lister's work and its first beginnings, and closely followed its triumphal development."

Lord Lister graduated B.A. in 1847, and M.B., 1852, University of London. During his student life he worked faithfully in the laboratories, carrying out original investigations in physiology and pathology. He was also active in the hospital wards, and was one of the first house surgeons under the late Sir John Eric Erichsen. After graduating, he went to Edinburgh, where he continued his researches in physiology and pathology. While in that city he became closely connected with the late Professor Syme. He was appointed Regius Professor of Surgery in the University of Glasgow in 1860, and did much of his earlier work in connection with antiseptic surgery in the Royal Infirmary of that city. His work in Edinburgh and Glasgow made him famous, and in the latter part of 1876 he was induced to go to London and take a position on the staff of King's College Hospital. He entered on his duties there with the distinct understanding that he was to have complete seclusion of his own wards, with a house surgeon and nurses completely under his control.

One of Lister's greatest achievements was his conquest of London. It was quite a simple matter to capture the greater part of Europe and North America, but it was quite different in regard to the metropolis of England, whose surgeons are slow in showing their appreciation of any one coming from Birmingham, Glasgow, or Edinburgh. However, as Mr. John Wood told us years ago: "Lister continued to work with earnestness and zeal, and gradually but surely gained ground until he finally triumphed, to such an extent that he practically overcame all opposition. His uniform kindness and courtesy towards his opponents did much to secure this happy condition of things."

## THE TREATMENT OF INEBRIATES IN ONTARIO.

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The proposed legislation for the treatment of inebriates in Canada, which was outlined in the JOURNAL last year and laid over by the Ontario Government, is coming up again this year, and will doubtless become law. All the large Medical Associations in Canada, also the Prisoners' Aid Association have endorsed its provisions and urged it to be passed.

The bill, in brief, provides for the following: "(1) Placing all cases of drunkenness, except the confirmed jail 'rounder,' experimentally on probation on suspended sentence, and under the supervision of a probation officer. (2) Imposing a fine and permitting the fine to be paid by instalments to the probation officer. (3) In cases in which the inebriety has become a disease, the probation officer be given authority to place the dipsomaniac for a few weeks' treatment in a cottage hospital, or in an inebriate department in a general hospital. (4) The cost of treatment to be considered as a loan, to be repaid after treatment and while still on probation. (5) Cases of able-bodied inebriates, not reformed or not reformable by these simple and inexpensive methods, to be sentenced to prison on cumulative sentences. (6) Old and feeble confirmed inebriates to be provided for in county or city poorhouses. (7) A special per capita Government grant made to hospitals to promote the treatment of dipsomaniacs. (8) A medical officer appointed by Government to organize inebriate wards in general hospitals, and special cottage hospitals for the treatment of dipsomaniacs in Ontario where such hospitals are necessary, to provide for and supervise the medical treatment in said hospitals, and also to provide for home medical treatment for probationers in proper cases. (9) Three physicians of standing in the province to be appointed as a committee of consultation to co-operate (without salary) with the medical officer."—*From the "Quarterly Journal of Inebriety," October, 1902.*

This bill is practical and is evidently the result of a very thorough study of the inebriate, particularly of the means and measures found valuable in the care and treatment. This law will be no experiment. It has been tested in many of its provisions and found to be practical. While the general plan is new, it outlines the experience and conclusions of a large number of observers, and its success is simply a question of the men to carry out its provisions. The measure will practically solve some of the great temperance problems upon which so wide a division of opinion exists. The army of inebriates is increasing and the burdens from their presence in every community are becoming heavier; hence all students will welcome this new measure as the application of more exact measures and claims



recognition of the means for care and prevention. Great credit is due to Dr. Rosebrugh for his untiring efforts in creating public sentiment in favor of this measure, and we are confident that this bill will lead all the world as a new economic movement to diminish the misery and crime which associate and follow alcoholic drinking. It is evident that measures of like character must be adopted by every state in the Union before they can successfully treat the drink problem.

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### THE QUARTERLY MEETING OF THE PROVINCIAL BOARD OF HEALTH.

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Amongst the many matters of interest which engaged the attention of the Provincial Board of Health at its recent quarterly meeting was one of financial importance to the medical profession. Some people have got so accustomed to take for granted the charitable acts of medical men, that they often think the doctor should serve the public—the body politic—for nothing. Recently a medical practitioner was engaged to attend certain poor typhoid patients and safeguard the community by proper attention to their cases. The municipal authorities endeavored to shirk payment, and the matter came up before the Provincial Board. To any of our brethren who are similarly treated it will be useful to find that the Public Health Act contemplates the employment and payment by the municipality for the proper care of persons suffering from “smallpox, diphtheria, scarlet fever, cholera or typhoid fever.” (Sec. 93 and others), and the authorization of two members of the local board of health is sufficient warrant. (Sec. 57 and others.)

It is a long time since we severed association with our friends the barbers, but boards of health have of late been taking up the question of the propagation of syphilis and other forms of contagious diseases by the armamentaria and medicamenta of the barbers. Another Provincial Board has been securing the co-operation of some of the leading members of the Barbers Association in providing for instruction and licensing of barbers, inspection of shops, the sterilization of their appliances and maintenance of aseptic technique. A conference was held with them at the office of the Board during its recent meeting, and the matter was well received. In many of the better class shops the same feeling is expressed.

During the whole summer and early autumn the bacteriologist of the Board, Dr. John Amyot, has been in Berlin, Ont., making experiments in connection with the sewage farm there.

His report we will deal with more in detail in our next issue. Meanwhile, suffice it to say, observations of great value to the scientific world have been made. We all know how much we are indebted to the State Board of Health of Massachusetts for its admirable experiments at Lawrence, Mass. The work at Berlin will add much to our knowledge of the chemical change wrought in sewage by bacterial action in the septic tank, contact bed, etc. Lengthy tables are given of observations of the amounts of ammonia, free and albuminoid, in specimens taken hourly before and after treatment, and of the oxygen consumed, and valuable conclusions drawn as to the limitations of dosage and the capacities of bacteria at various stages and under varying circumstances. The effect of waste products of various industrial processes added to the sewage, and the nature of their substance and processes are also stated. The whole document will be published in the next annual report of the Provincial Board of Health.

Amongst the encouraging features of public health work were letters of congratulation from some localities on the successful stamping out of smallpox. From the reports of epidemics in some of the neighboring States the vigilance of the Provincial and local authorities deserves both to be commended and supported. The percentage of fatalities justifies the warnings made in one of the former reports of the Provincial Board.

A matter of serious consideration drawn at the recent meeting was the present status of the vaccination question, the apathy and neglect in the face of grave danger, and the opposition in some instances. Several circumstances conduce to the latter; the officious spoutings of superficial and vain-glorious cranks, and sometimes the single factor of a bad man in a community has been unreasonably and unreasoningly allowed to cancel all the unknown quantities of lives saved from death by the ravages of smallpox—unknown quantities, but fairly surmisable if we turn to the statistics of epidemics when vaccination has not been practiced. Apathy and neglect arise to a certain extent from the fact that in the absence of an epidemic in a locality, vaccination and its enforcement are not made the strict business of any person, and the family doctor feels that his motives may not be considered disinterested should he press the matter, and bovine vaccine is not as reliable as vaccine of older days. To mend these conditions the Board has in view the simplification of the Vaccination Act, and the making of more definite and reliable provision for vaccination. When the question comes before the profession and the public, it is to be hoped the medical men will discuss it with the Provincial Board, that we may all come to a harmonious conclusion and action.

Various matters were discussed in connection with the typhoid which has been so prevalent. Very many practitioners in all parts of the Province have been availing themselves of the laboratory of the Board for obtaining the diagnostic aid of the Widal test, when the disease has been in a stage of uncertainty.

There are other matters, the consideration of which we must defer for the present.

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### MEDICAL ITEMS.

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On New Year's Day, at 10.30 a.m., Dr. Albert Ham, organist of St. James' Cathedral, with a number of the choirmen and boys, paid a visit to the Hospital for Sick Children, and sang Christmas carols and hymns for the children. It was a very beautiful song service, and the children were delighted.

The following graduates of the Training School for Nurses of the Toronto Western Hospital have been appointed as lady superintendents, or head nurses, of the following hospitals: Mrs. Annie Yorke, Orthopedic Hospital, Toronto; Miss Mabel Ireland, eye and ear section, Manhattan Hospital, New York; Miss Annie Inch, Stonega Hospital, Virginia; Miss Estella Gunn, Royal Alexandra Hospital, Fergus; Miss Pauline Ottaway, Aberdeen Hospital, New York.

St. Michael's Hospital is to have another new wing. For this purpose the two lots adjoining the hospital property on the north side have been purchased. The houses will be remodelled and used as the maternity ward, which at present occupies space upstairs in the south part of the hospital. The latter is needed for additional accommodation in the surgical department. Later, a building will be put up connecting the new maternity ward and the hospital proper. There are about 150 patients in the hospital at present.

The Board of Governors of the Toronto Western Hospital acknowledge the following donations for the benefit of the hospital: Mrs. McPherson, Stratford, \$100; Mr. McNely, \$5; Mrs. W. C. Tanner, \$2; Mr. G. P. Magann, \$100; Charles Cockshutt, \$100; Beal Brothers, \$5; Duntroon Camp, No. 107, Sons of Scotland, \$3; Mr. Jex, \$1; E. B. Osler, \$200; the Wyld, Darling Company, \$100; Dr. Hooper, \$100; Dr. McKibbon, \$100; Dr. Porter, \$100; Dr. J. H. McFaul, \$100; Dr. J. T. Clarke, \$100; Dr. Allen Shore, \$100; Mrs. Herbert Langlois, \$10; Canada Printing Ink Co., \$5.

## Personals.

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Dr. Archie Beecher, of London, visited Toronto, December 20th.

Dr. E. J. Murphy, of Metcalfe, spent his Christmas holidays in Toronto.

Dr. A. Fisher (Tor. '02) has settled in East York in the place of Dr. Webster.

Dr. R. A. MacArthur, of Chicago, spent his Christmas with his relatives in Toronto.

Dr. John A. Amyot paid a visit to Baltimore and New Orleans in the latter part of December.

Dr. Arthur A. Small's office address in Chicago is 100 State Street; house address, 575 East Division Street.

Dr. Augusta Stowe-Gullen returned to Toronto, December 12th, after a stay of some weeks in New York.

Dr. J. D. Webster (Tor. '98) has removed from East York to 232 Shaw Street, Toronto, the residence of the late Dr. J. M. Hart.

Dr. T. Harry Ashby (Trin. '78), after living in England for many years, has returned to Canada and commenced practice in Toronto, 133 Avenue Road.

Dr. A. A. Dame, formerly of Toronto, after practising for two years in Thornhill, has returned to the city and resumed practice, being now located at 19 Howland Avenue.

The readers of the *Practitioner* (English) are likely to regret deeply the decision of Mr. Malcolm Morris to retire from the editorial management of that able journal, as announced in the issue for December.

Sir William Hingston, of Montreal, delivered the chief address at the dedication of the new addition to Rush Medical College, Chicago, December 17th. The new building and its equipments came into existence chiefly through the generosity of Dr. Nicholas Senn.

Dr. Wm. W. Jones (Tor. '96), after practising for three years in Conn, Wellington county, went to London, England, where he was engaged in post-graduate work for nearly three years and passed his primary examination for the Fellowship. He returned to Canada early in December, and after spending a few weeks with his friends will return to England.

## Obituary.

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### ANGUS C. McDONNELL, M.D.

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Dr. McDonnell, one of the leading physicians of Montreal, died January 2nd, aged 74.

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### MRS. (DR.) C. K. CLARKE.

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Mrs. Clarke, wife of Dr. C. K. Clarke, medical superintendent of the Rockwood Asylum for Insane, died of cardiac disease December 25th, aged 47.

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### MR. MURRAY COHEN.

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Mr. Murray Cohen (B.A., Tor. '99), of Toronto, a student in his fourth year in medicine at the University of Edinburgh, died of pneumonia, December 13th, aged 24.

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### STANLEY SANFIELD CORNELL, M.D.

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Dr. Cornell, of Athens, Leeds County, died of influenza December 2nd, aged 37. He graduated M.D., Queen's University, Kingston, in 1886.

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### WILLIAM LINDSAY, M.D.

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Dr. Lindsay died of apoplexy at his late residence, Strathroy, December 9th, aged 59. He graduated, M.D., Victoria University, in 1869, and became L.R.C.P., Lond., in 1873.

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### DENNIS NUNAN, M.D.

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Dr. Nunan, of Guelph, died December 12th, aged 64. After graduating at Ann Arbor in 1867 he spent two years in the Toronto School of Medicine. After completing his course he settled in Guelph, and continued to practice there up to the time of his last illness. He did a large practice, especially among his co-religionists of the Roman Catholic Church.

**ALEXANDER YOUNG SCOTT, B.A., M.D.**

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The friends of Dr. A. Y. Scott were greatly surprised and shocked to learn on New Year's morn that he was ill, with little or no chance of recovery. His physician's fears were well founded, and death came on the morning of the 3rd. The immediate cause of death was endocarditis, following typhoid fever of two years ago. One week before he died he was seized with a fainting fit while delivering a lecture in the College of Pharmacy. This was the beginning of the end, as he never rallied sufficiently to give hope of recovery.

Dr. Scott was born in Stratford in 1861, and graduated B.A., Toronto, in 1882, and M.D., Trinity, 1887. After taking his degree in Arts he was for some years on the teaching staff of Upper Canada College. He became Professor of Chemistry and Botany in 1891 in the Toronto College of Pharmacy, and remained so until the time of his death. He took a deep interest in military matters, and went through the North-West Rebellion campaign. He took an active part in the establishment of the Field Hospital Army Service, and was a major of one of the companies.

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**ANSON SOVERILLE FRASER, M.D.**

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Dr. A. S. Fraser, of Sarnia, died after a lingering illness from Bright's disease at his late residence, December 31st, aged 56. He was one of the best known and most highly respected physicians of Western Ontario. He was born in London and received his medical education in Kingston. He graduated M.D., Queen's University, in 1869. Soon after graduating he commenced practice in partnership with the late Dr. Bucke afterwards Superintendent of the London Asylum for Insane. He was for nine years ('91-'99) Examiner in Physiology for the Ontario Medical Council. He was largely instrumental in the establishment of the Sarnia General Hospital in 1896 and was president of the Hospital Board until last November when he resigned on account of ill-health. His student days in medicine extended from 1865 until 1902. In this respect he was much like the late Dr. George A. Tye, of Chatham. In fact these two men resembled each other to such an extent that we can scarcely think of one without the other. Both were noted for their ability, industry, and modesty of a rare and charming sort.

## Correspondence.

### MUSKOKA AND CONSUMPTIVES.

*To the Editor of CANADIAN PRACTITIONER AND REVIEW.*

SIR,—Neither time nor inclination have I had until now to notice the communication of Dr. Elliott in the PRACTITIONER of September, in respect to my remarks on Muskoka as unsuited for consumptives in your issue of August. Nor shall I now, for like reasons, enter into a continued correspondence on the subject. Kindly favor me, however, with space for a few sentences.

No salary is paid to nor advantage received, directly or indirectly, by me for naming as I did a few of the best localities for consumptives and giving my often asked for opinion of Muskoka.

"Had your correspondent studied the meteorological condition;" and "why did it not occur" to him "to look up the records," Dr. Elliott writes.

Let me inform him that it is not *my* practice to write of that of which I do not know; that I have, and am familiar with, all the meteorological reports of Ontario, and many others; and that almost before he was born I assisted in the preliminary work of getting that service established in Ontario.

It strikes me that many places, in about the same latitude and with about the same mean temperature, record a much lower percentage of humidity than almost 76, more than three-fourths of complete saturation, as given for Gravenhurst; indeed, not many places record so high, I think. However that may be, I gave the practical facts; though "fogs" were not mentioned in my communication.

And it appears to be well known that the late lamented Dr. Graham resigned his position as a trustee of the National Association when that locality was decided upon for their sanitarium, and mainly on account of its humidity, with, too, its want of elevation. Though afterwards the doctor consented to act for a time as medical adviser.

Respecting the results of the work in the sanitarium over which Dr. Elliott presides, I have no wish to write here. But if he will kindly excuse me, I shall have to decline to read his paper "showing marked improvement in 120 out of 155 cases in all stages" treated there, preferring, as I do, naturally, the "showing" of many isolated clinical facts.

In conclusion, permit me to refer especially to the last three words of the above quotation from Dr. Elliott's letter, as being

most remarkable. He writes, "in all stages." Not long ago, one of the trustees of that institution, in a public meeting in this city, stated that their "charter" did not permit them to take any patients except those in the first stage of the disease, and that they kept strictly to the charter. This, too, is the unequivocal experience of many physicians here in respect to the rejection by the authorities of the institution of individual patients, hardly past the first stage, and not very ill: rejection of such patients who were able and ready to pay the "charitable" rates charged there, and when there was known to be vacancies, or room, in the Sanitarium.

Toronto, Ont.

EDWARD PLAYTER.

## Book Reviews.

**The American Text-Book of Obstetrics.** In two volumes. Edited by RICHARD C. NORRIS, M.D.; Art Editor, Robert L. Dickinson, M.D. Second edition, thoroughly Revised and Enlarged. Two handsome imperial octavo volumes of about 600 pages each; nearly 600 text-illustrations, and 49 colored and half-tone plates. Per vol.: cloth, \$3.50 net; sheep or half morocco, \$4.00 net. Canadian Agents, J. A. Carveth & Co., Toronto.

This is a work for the student and practitioner alike. It makes clear those departments of obstetrics that are at once so important and usually so obscure to the medical student. The obstetric emergencies, the mechanics of normal and abnormal labor, and the various manipulations required in obstetric surgery are all described in detail, and elucidated with numerous practical illustrations.

Since the appearance of the first edition many important advances have been made in the science and art of obstetrics. The results of bacteriologic and of chemicobiologic research as applied to the pathology of midwifery; the wider range of surgery in treating many of the complications of pregnancy, labor, and the puerperal period, embrace new problems in obstetrics, some of which have found their place in obstetric practice. In this new edition, therefore, a thorough and critical revision was required, some of the chapters being entirely rewritten, and others brought up to date by careful scrutiny. A number of new illustrations have been added, and some that appeared in the first edition have been replaced by others of greater excellence.

By reason of the extensive additions the new edition has been presented in two volumes, in order to facilitate ease in handling.



## Miscellaneous.

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### The Open Air Treatment of Consumptives.

Not only, as Dr. William Murrell, of London, has expressed the opinion in regard to the open air treatment of consumptives, is this method "bidding fair to come under the baneful influence of routine," but there is a growing tendency to the adoption of measures in its application which are so extreme that they can not be too heartily condemned. "There is a mean in all things, but unfortunately some of the exponents of open air treatment seem still totally oblivious of the truth of this maxim. Patients who have active symptoms are being placed in open tents and especially constructed three-walled buildings (buildings with one side left open) and exposed to all conditions of weather in a way which is quite unnecessary and often harmful.

It is not our purpose to oppose out-of-door life in the treatment of phthisis. Much good is to be accomplished by the intelligent application of this method in properly selected cases, and the benefits of pure air and sunlight are self-evident. But in order to obtain pure air and sunlight it is not essential to resort to extreme measures. Pure air and cold air are not necessarily synonymous and, as every one knows, an abundant supply of pure air can be obtained in a properly ventilated, comfortably heated sleeping room. Besides, when patients are exposed to extremes of cold weather they must be kept warm artificially, and this amounts to the same thing as the maintenance of a comfortable temperature in the sleeping apartment, except that in the first instance hardship and discomfort are added.

While in certain dry, salubrious climates, there is no objection to keeping patients out of doors at night, the proposition becomes a very different one in a rigorous winter climate. If we picture to ourselves a patient with active symptoms, high fever, night-sweats, etc., in an open tent, awaking in the midst of a cold winter night with, perhaps, the snow sifting in upon and about his bed and with his night-clothing damp or wet with perspiration, and if we consider that this patient is subjected to the choice either of lying in his damp garments or of incurring the exposure attendant upon rising to change them, his escape from the occurrence of complications in the way of severe colds, bronchitis, or pneumonic inflammation about caseous or necrotic foci, would seem to be a matter of providential dispensation, rather than an evidence of good management.

It has been said that patients out of doors run a considerably lower temperature than when in doors, but presumably these observations relate to mouth temperatures. Inasmuch as the temperature of the mouth, or of the axilla, is influenced by that of the surrounding medium, the amelioration of fever, under such circumstances, is rather apparent than real. With even a normal or subnormal oral temperature that of the rectum will often be found three or four degrees higher in such patients.

Those who are making a fad of open air treatment and are resorting to extremes in its employment argue that exposure hardens the patient. This is not to be denied, providing that the latter does not succumb to the hardening process. Surely such methods are not suitable in active stages of the disease. If they can have any value whatever, it can only be in the nature of prophylaxis in cases in which the trouble is latent or arrested. Even then the hardening process should not consist in methods in which the patient can not or will not persist after his discharge from treatment. People have for countless generations dwelt in houses and the social conditions of a modern civilization indicate that they will continue to do so. They will not live in tents in all sorts of climates, and although the individual may have successfully been hardened by extreme exposures, a return to usual environments and mode of life will prove such means to have been worse than useless and of no avail as a protection in later years.—*The Journal of Tuberculosis*.

### Sentimentalism and Horses' Sun Bonnets.

Truly, in these humanitarian days, it is not a little amusing to note how in many cases kindness is swallowed up in vapid unreasoning sentimentalism. There never was a more striking instance of this transformation than in the use of the sun bonnet for horses. It is true that horses die on hot days out in the sun, but it is equally true that they die on cold and wet days. In ninety-nine cases out of a hundred the poor brute dies of heart failure, induced by overwork. The majority of horses are overworked, both in speed, weight to be carried or drawn, and duration of hours of toil, to say nothing of their sufferings from hunger and thirst, the lash of the whip, the constant stoppages and restarting necessary in crowded traffic, and the torture of the bearing-rein. To put a sun bonnet on the head of this much-abused brute is a sheer mockery. There is no proof that any horse ever suffered from the effects of the sun's rays falling upon his head. Among the human race it is now a well-recognized fact that so-called "sunstroke" is due to a microbial invasion of the body; in other words, it is a

kind of specific fever, and can be contracted in the shade. The Dumb Friends' League, an excellent society, might husband its resources by declining to pander to the last fad of unreasoning sentiment which decks out the horses in the streets with millinery grotesque and unsuitable enough to gratify the soul of the most foolish of feminine leaders of fashion.—*Medical Press and Circular*.

### The Doctor and His Health.

The death rate among physicians is relatively high, much higher than the average. This should not be so. True it is, that the busy medical man is subjected to unusual dangers, such as exposure to contagious diseases, and to the most trying weather of both winter and summer, as well as to unavoidable irregularities in his times of eating and sleeping. He is often tempted to bolt his food or leave a half-finished meal and rush off to a suffering patient, and not seldom may have little sleep for several nights in succession. He must frequently endure the strain of great anxieties, and become so exhausted at times as to beg the privilege of a few minutes' respite for sleep while on his rounds.

All these experiences tend, of course, to shorten the life of the busy physician, to wear out his vitality prematurely and hasten his end. Yet there is much to be said on the other side. In many respects the doctor, even the general practitioner, has advantages over the majority of his fellows, which properly employed, should and would raise the longevity of the profession to near the average if not above it.

Though he is exposed to deadly contagions, he knows better than others how to protect himself against them, and, in fact, it is comparatively rare that physicians succumb to such causes of death. Though his hours for eating and sleeping are frequently encroached upon, the doctor knows, or should know, that most men eat by far too much and that an entire meal can be omitted occasionally not only without harm, but with a gain to the organism by giving the digestive system a needed rest; also that the more temperately one eats and drinks, up to a certain point, the less sleep one needs. And while it is true that some excessively timid or sensitive physicians worry seriously over their critical cases, this is not the rule; the well-balanced men in the profession—and none others should be in it—meet their responsibilities bravely and calmly, not letting their anxieties or sympathies, however strong, run away with their judgment or disturb too much their equanimity.

Most specialists, it may be, are too much confined indoors, too sedentary, but general practitioners, who fortunately make up the great bulk of the medical guild, spend necessarily a very

large share of their time riding or walking in the open air under good hygienic conditions, and know how to protect themselves securely against severe weather. Their many hours spent daily out of doors do much more to invigorate them and promote longevity than their occasional exceptional dangers from rough weather or periods of overstrain can counteract, provided always they live in other ways as hygienically as possible.—*Edit. International Med. Magazine.*

### Some Things not Learned on the Benches.

Dr. Rockwell (*American Medicine*) gives some shrewd advice on various subjects. The following are pregnant sayings:

The most important thing in therapeutics is a knowledge of what not to do.

The most dangerous member of society is the doctor who never makes a mistake.

In medicine, more truly than in any other field of human activity, "all things are possible." It is well to bear this in mind.

He cannot obtain the highest professional success who only knows medicine.

Find out who "runs" the family, and then you "run" her—this discovery will prove of great value.

Administer medicine personally whenever possible. The dose you give has a higher curative potential than that administered by the patient's friends.

Never prescribe anything until you have perfectly definite and distinct reasons for so doing.

Don't blame your nurses for everything. They have some rights, and are not always conspiring to do your patient harm or put you out of the case.

Expedition in performance is almost as important as accuracy in performance. Do your work with precision and despatch.

Never "give up" a patient.

This last piece of advice deserves to be written in letters of gold. Sir James Paget strongly urged that even in the most hopeless-looking cases of cancer the practitioner should never merely fold his hands in despair. This simply makes medical practice the "meditation on death" which was imputed to some of the old Greek physicians. The doctor should dispute every inch of ground with the enemy, and should take as his rule of conduct an adaptation of an old saying, *Dum spirat spero.*

With regard to this point we may be allowed to relate an instructive story which, though it may have been told before, will bear repetition. A patient had an enlargement of the

liver. Sir William Jenner, who was called in, with characteristic frankness pronounced the disease to be cancer, for which there was nothing to be done, and went his way. The friends thus left to struggle with a hopeless situation sought counsel of another oracle. Sir Andrew Clark was summoned, and after careful examination agreed that there was a tumor which was not indeed of a benignant character, but which, if not exactly curable, could be considerably alleviated by the resources of medical science. Sir Andrew continued to attend the patient till his death several months afterwards; and even if his life was not prolonged, it was certainly made much less burdensome to himself and to those about him by the physician's *savoir faire*.

Don't tell your neurasthenic there is nothing the matter with him; it is not the truth.

Another conveys a counsel of perfection which it is often quite impossible to follow in practice—

If you cannot tell a patient the truth, don't tell him anything.

Perhaps the most valuable of all Dr. Rockwell's maxims is the following:

Possess yourself of an irresistible, indestructible optimism. It is the keystone of the arch, success.

We are reminded of the story of Sir Richard Quain's professional *début*. When a young man he was taken by an experienced physician to see a serious case. Before entering the sick room he composed his features to a gravity which he thought appropriate to the occasion, but was at once rebuked by his mentor, who exclaimed: "For heaven's sake, man, don't look so funereal! The poor devil will think you are the undertaker!"—*London Practitioner*.

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FREE CONSUMPTION HOSPITAL.—The New Year season has brought to the trustees of the Free Hospital for Consumptives at Gravenhurst the following subscriptions: H. P. Dwight, \$500; Jos. Leslie, \$300; E. B. Osier, M.P., \$100; Walter Mann, \$50; Dr. E. A. White, Kinmount, \$50; The Patterson Manufacturing Co., \$25; Park, Blackwell & Co., \$25; Mrs. J. H. Mitchell, \$25; J. A. Allan, Perth, \$25; Bishop of Huron, \$10; J. A. Graham, \$10; Robert MacLaren, St. Catharines, \$10; MacLaren & Co., Limited, St. Catharines, \$10. The beneficiary societies in all parts of the Dominion are, with few exceptions, sending contributions ranging from \$2 to \$15 each. The Public and High Schools, Sunday Schools, and Church Societies have also been generous in their givings.