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A MONTHLY JOURNAL OF

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Vol. XIII.

HALIFAX, NOVA SCOTIA, DECEMBER, 1901.

No. 12.

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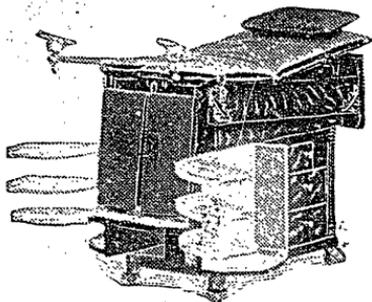
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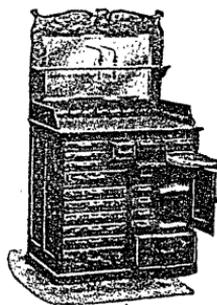
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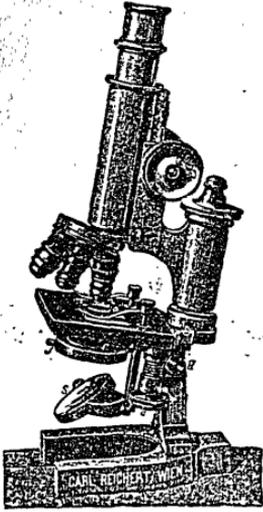
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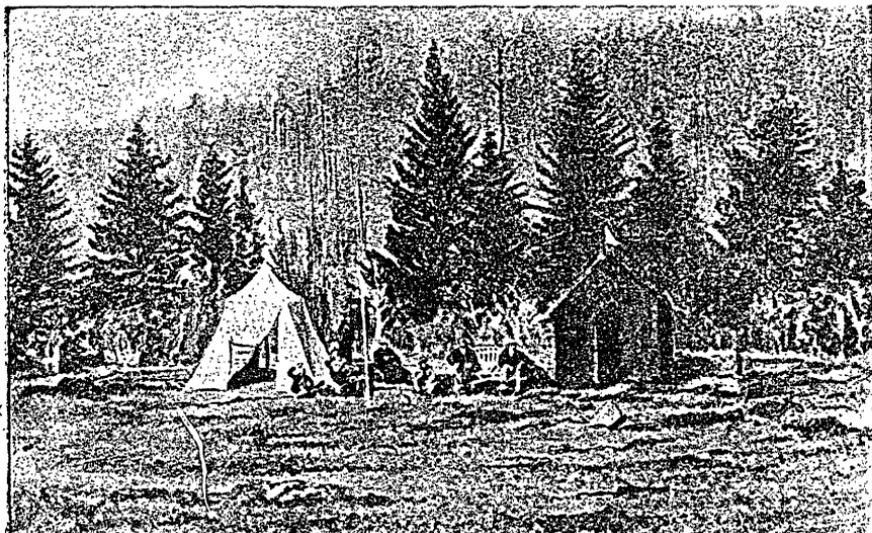
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A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. XIII. HALIFAX, N. S., DECEMBER, 1901. No. 12.

Original Communications.

OBSERVATIONS ON THE TREATMENT OF FRACTURES.*

By A. I. MADER, M. D., Halifax, N. S., Instructor in Practical Surgery, Halifax Medical College.

The treatment of fractures is a subject of such prime importance to each of us that although I may fail to add to your knowledge of the subject, I may be pardoned for attempting to interest you.

Perhaps no surgical subject have we such a uniform experience in. Whether in general practice in the city or country we all have this class of injuries to deal with. These form a considerable proportion of our most anxious cases. In our success or failure in these we may succeed or fail to restore the natural symmetry and beauty of the body; succeed or fail to restore the functions of limb or organ; succeed or fail in relieving our patient's incapacity to earn a livelihood at his usual occupation. Indeed we may succeed or fail at times to relieve pain or save life.

The frequency of occurrence of these accidents and the fact that they require prompt treatment is opposed to specialism. Hospital reports, even in large centres, show comparatively small numbers of individual fracture except perhaps those which demand operative treatment by the open method. Surgeons in this city have remarked on the infrequency of fractures in their hospital work. No doubt the clear atmosphere and good side-walks of Halifax, and temperate habits of our citizens accounts for much, but another reason must lie in the fact that a vast number of fractures occurring in patients of all ages

* Read before meeting of Maritime Medical Association, Halifax, July 3rd, 1901.

receive home treatment. It follows that hardly one man can say he has had an extraordinary experience in the treatment of these injuries.

In looking into the literature of this subject, I was surprised to learn how unsatisfactory the results of treatment on the whole are. Professor Helferich in his work on fractures and dislocations gives the following statistics: Out of one hundred and twenty-one cases of fractures of the femur 34 per cent. only were completely cured, 66 per cent. remaining permanently damaged. The average duration of time before a cure was obtained was thirteen and a half months. Out of nineteen cases of fracture of the neck of the femur 12 per cent. died, 12 per cent. were cured, while the remaining 76 per cent. received permanent damage. Of a series of 250 cases of fractures of the leg bones, humerus and forearm the percentages of complete functional recoveries were 78 per cent. for the leg, 72 per cent. for the humerus, and 87 per cent. for the forearm. He counts his patient cured when he is able to work again, and gives the cause of the unfavorable results and the long period of time required for treatment the following, viz:—Displacement of fragments, stiffness of neighboring joints, sometimes hypertrophy of the callus, delayed union, pressure on nerves and oedema of the limb. Scudder, of Boston, has carefully analyzed the results of 35 cases of fracture of the femur treated in the Massachusetts General Hospital. These were seen or reported six years after the injury. The results are about similar to the German figures. The cases occurring in childhood recovered completely. Of the 16 occurring in adults, only 5 were completely free from pain and stiffness. The remaining 11 cases have limited knee movement, aching in the thigh, pain after exercising, and in wet weather, weakness of the whole leg and slight lameness on walking. Of the 6 cases occurring in old age, average age 58, none had functionally perfect results. It is worth noting that these American cases were all treated with Buck's extension, long splint, and plaster dressing during convalescence.

It seems that although modern science applied to surgery has done something in aiding the diagnosis of fractures—yet very much remains to be done before perfection can be attained in methods of treatment.

Literature published during the past ten years shows a change in treatment from over-immobilization and enforced rest of the fractured

bone and of the adjacent joints for long periods of time, to more freedom of motion, less splinting, less bandaging, combined with the use of massage, passive motion, and the particular innovation of what is termed the ambulatory plan of treatment of fractures of the lower extremities.

In these observations I wish to review for the most part those simple methods now in use which give the patient the greatest freedom, and aims to avoid the ill effects of splints and prolonged rest, and to discuss briefly the apparatus best adapted to modern methods of treatment, as fresh air, massage, early passive motion, and ambulatory treatment.

When I was an undergraduate in medicine, not more than a dozen years ago, we were taught that an important cause of delayed union was frequent removal of splints to observe the condition of the fractured limb, due to over-anxiety on the part of the practitioner. Now, although want of fixation in certain cases is no doubt responsible for delay or nonunion, we are taught by able surgeons that in a case of delayed union the first thing to do is to apply the splints more loosely so as to allow some motion between the fragments. This method has been found to give prompt results in many cases. It has long been known that a fracture of the lower extremity, followed by delayed union, prompt healing is obtained by putting the patient on crutches with say a plaster splint. Whether the slight motion at the points of fracture produced by the patient moving about on crutches, or the improved condition of the local circulation when in the dependent position, or the improvement in the general health of the patient, who is now allowed to get fresh air and sunshine with improved appetite, regular bowel action, and good sleep, produces the good result, we find reason to believe that a fracture will consolidate more rapidly if the fixation is not absolute and if the limb is not in a state of perfect rest. If the muscles are allowed to act upon the bone to some extent, I mean, of course, consistent with keeping the fragments in apposition and preventing displacement until the provisional callus supports the fragments. Pathologists point out that the provisional callus is normally thrown out among the fragments and forms a temporary splint in a couple of days and remains there until the bone consolidates.

Now it has been observed that this provisional callus is about absent in certain cases where absolute fixation is obtained. It is in these

cases that nonunion most frequently obtains; in other words one cause of delayed or nonunion of fractured bone must be too complete fixation. Now if these observations are correct, certain of the general principles laid down in the treatment of fractures must be changed, or indeed we may say are being gradually changed. For example the rule which is noted in nearly all text-books in surgery, viz: "Fix the joint immediately above and below the fracture," will gradually disappear from text-books. This may now be placed instead: "In treating a fracture of the shaft of a long bone, in the majority of cases, it is not necessary to fix the adjacent joints, except perhaps occasionally, for a very short time; but when it is decided to keep one or both joints immobilized in order to keep the fragments in position, care should be taken to remove the apparatus early and frequently so that passive motion and massage may be applied."

We have here a wide field to cultivate. We will not only have our patient with broken legs walking around using the fractured limb in a few days—the ambulatory method, which has now become a recognized mode of treatment, but also more rational methods of treating fracture of the upper extremity will become more generally used. The perhaps absurd method of having the right arm in a sling for a couple of months after fracture of the arm should have been given up long ago, yet this method is still recommended in many recent works.

In the treatment of fracture of the humerus, the internal rectangular splint has been used more frequently than any other apparatus for both fractures of the shaft and neck. It is the most inefficient splint to keep the fragments at rest that could possibly have been devised, because by fixing the elbow joint, the shoulder joint being free, any motion of the forearm causes motion at the seat of the fracture. When the arm is in the usual sling, movements of the head or neck, as in walking or stooping, the long leverage composed of the forearm and lower fragment produces undoubted motion at the point of the fracture. This is not a new idea, but was pointed out by Hamilton many years ago as a cause of nonunion, which is more frequent here than in any other long bone. The observation is correct as far as movement between the fragments are concerned, but there may be much error as to its being the cause of nonunion. May this movement not have reduced the number of cases of delayed union in the humerus? But if this much movement can be allowed, consistent with a good result

in a majority of cases, why not allow the poor sufferer to button his clothes, feed himself, or earn his living, using an apparatus to fix the fragments more perfectly and allowing the forearm perfect liberty?

Simple coaptation splints to the upper arm and then allow the patient to use the extremity all he chooses from the first is a method of treatment no authority, as far as I know, has yet had the courage to recommend. Yet it is reasonable to believe that this method would give as firm fixation to the fragments as the internal rectangular splints in common use. Now, with the elbow free and the forearm in a sling, simple coaptation splints to the humerus give good rest to the fractured bone. The method of enclosing the whole extremity in plaster of paris with spica of the shoulder does less when all things are considered.

The method so nicely described by Scudder, with coaptation splints and a swathe of adhesive plaster around the arm and body, but the elbow quite free from fixation, forearm in a simple sling, is the most rational method to use until union is obtained. This author recommends taking down the dressing completely once a week, and after three weeks omit the swathe, and finally in a week or more omit the coaptation splints, but keeping the arm in the sling to the end of about eight weeks. This method of after treatment could be very much improved by allowing the patient to use his forearm and hand to dress or do some light work in one, two or three weeks according to the amount of union observed at the dressing, but to retain the swathe until the union is firm. The simple arm and chest bandage would do very well during this period. This modification would allow the patient to use his hand one month earlier and I believe would be quite as conservative.

Splints are at best necessary evils and should be discarded whenever practicable. Jones of Liverpool has introduced the method of treating all fractures about the elbow joint except fracture of the olecranon without splints. He believes that splints and bandages are responsible for most of the stiff joints. After reduction of fractures of the lower end of the humerus, if the joint is placed at an acute angle, the muscles and tendons keep the fragments in firm apposition. The body and the forearm are the splints. The hand is bandaged closely to the neck. DaCosta, of Philadelphia, and Scudder, of Boston, warmly recommend this method, the latter using an

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obtained by an open operation to suture the fragments together. The poor results obtained in treating fractures of the neck of the thigh bone, is due no doubt to the difficulty of immobilizing this part. Senn's apparatus, which includes in plaster of Paris the injured limb, pelvis and sound limb as low as the knee, with special screw pressure over the trochanter on the injured side is an excellent method for thin patients. Thomas' hip splint, or Ridlon's modification of the same, is, I believe, the ideal apparatus for any case of fracture about the hip joint. We should in the absence of proper apparatus specially avoid pully or elastic extension. Liston's long splint or some modification of it with perineal band would do far better because we then get fixed extension and rest to the part, at least when the patient is quiet. Treating the old and feeble patient and neglecting her fractured hip, which we so often hear, is sheer nonsense. Fractures of the lower third near the knee-joint require much good judgment, but the complete reduction of the fragment, the double inclined plane with perhaps tenotomy of the tendo Achillis and early passive motion are the indications.

A few years ago Professor Stimson, of New York, prophesied that the fad known as the ambulatory plan of treating fractures of the leg had reached its height in America, and he spoke unfavorably of it. He was, however, mistaken, as more American surgeons are using this plan each year, and it will soon be recognized as the best method of treating fractures below the knee, if not the whole lower extremity.

The method consists of not only getting the patient about on crutches, but to have him use the broken limb. It is asserted that this plan of treatment not only lessens the patient's sufferings, but also hastens union by the stimulation of walking. The method has its most enthusiastic advocates on the continent of Europe, especially in Germany. One German authority reports 111 fractures of the leg and 22 fractures of the thigh, many of them compound, treating them successfully by this method. It is used in fractures as high as the middle of the thigh. The dressing extends from an inch below the sole of the foot, and the weight is transferred to a point above the seat of the fracture.

In fractures of the ankle it is necessary to carry the dressing as high as the tubercle of the tibia. In fractures of the leg as high as the middle of the thigh. In fractures of the lower half of the thigh and patella, as high as the spine of the ilium. Simple plaster of Paris

is most generally used for fractures of the leg. In treating fractures of the thigh, Taylor's or Thomas' hip splint is most used. The well foot requires an extra sole. I notice that observers who are not favorable to ambulatory treatment for thigh fractures recommend these splints together with rest, and note that the treatment of fractures of the thigh by weight and pulley is unsatisfactory.

Perhaps the simplest and best way to use ambulatory apparatus is the plaster of Paris splints applied as follows: An assistant makes sufficient extension by grasping the leg below the fracture. The extremity being previously prepared and covered with a flannel bandage, the point of fracture being covered with a light plaster of Paris coaptation splint, and this again covered by a flannel or piece of sheet wadding. A layer of cotton batting or oakum being applied to the sole beneath the flannel bandage the thickness being three-fourths of an inch. The splint of ordinary plaster of Paris strengthened with thin pieces of wood is now applied in the usual way with 10 or 12 extra recurrent layers of bandage over the sole. If for fracture of the ankle or leg, particular care must be taken about the tuberosity of the tibia and head of the fibula to make it a little stout and firm at these points. If for fracture of the thigh care must be taken to make the dressing firm about the bony prominences, malleoli, heel, etc., so it may hold them firmly and produce extension while counter extension is produced where the plaster firmly encircles the tuberosity of the ischium and pelvis. I should use the ordinary adhesive plaster extension apparatus to the sides of extremity below the fracture and incorporate them into the plaster of Paris below. Then the bony prominences below could be well padded and little or no extension would be made upon the knee-joint. I have used to some extent the ambulatory dressing and can vouch for the simplicity of application and comfort given patients with fracture of the leg.



MULTIPLE OSTEOMYELITIS FOLLOWING TYPHOID FEVER WITH REPORT OF CASE.*

By G. A. B. ADDY, M. D., St. John, N. B.

George H., aged 24, resident of this province, first came under my care and treatment four years ago, suffering from severe pain in right knee, most marked over inner tuberosity of the tibia; which had been present for nearly four weeks, coming on during convalescence from typhoid fever.

Outside of having one or two severe accidents, the patient always enjoyed good health, until he went to England; there contracted typhoid fever, and went through rather a severe attack. During convalescence period he commenced to complain of pain in the region of the right knee-joint, which was supposed to be rheumatic. Thinking that perhaps he was in for another siege, he came home.

When I first saw him, he was very much emaciated, temperature keeping about 101, and pulse 100. Careful examination of the chest revealed nothing. Just over the inner tuberosity of the tibia on the right leg there was a distinct swelling, very tender, and could be easily distinguished from the general puffing that there was along the joint.

An anæsthetic was given and a free incision made over this area, and softened bone with broken down tissue curetted; after thorough irrigation with 1-2000 HgCl₂, it was then plugged with iodoform gauze. This treatment with little variation was kept up. In about three months it was entirely healed, and his condition was very much improved. He then commenced to complain of pain in the right arm about the middle third of the radius; this was incised, curetted, and treated as above. It took nearly three months to heal up. When the second focus was about healed, pain was complained of in the left hip, and not for two weeks was I able to locate the exact seat of infection; during which time I kept up a free application of tincture of iodine. After I was able to locate the infected area, it was treated the same as the two previous, but not with the same success. It remained a running sinus for nearly two years. His general condition, however, was improving, the discharge practically stopped, and he was able to go about, and showed every sign of making a complete recovery, when he contracted la grippe, rapidly went down, and eventually died.

*Read before New Brunswick Medical Society, July, 1901.

This was practically a case of multiple osteomyelitis following an attack of typhoid fever.

Acute suppurative osteomyelitis is an expression indicating an acute inflammation of the marrow of bone terminating in suppuration. The traumatic variety was familiar to surgeons before antiseptic surgery was practiced. It resulted from direct exposure of the medulla to infective micro-organisms from without.

The traumatic form had been recognized for a long time by surgeons as a distinct and most serious wound-complication, but the spontaneous form, occurring without an open communicating wound, was not understood until quite recently.

Bacteriological research has established the fact that the non-traumatic form is a suppurative inflammation of the medullary tissue caused by infection with pus-microbes.

There are four stages in a typical attack of acute osteomyelitis; the first is that of localization of the infectious or exciting agent. The second stage is that of local outbreak, consisting in the ordinary process of inflammation in the bone, that is, in the medulla of the bone. After this, the inflammatory process passes to the third stage, that of encapsulation of the abscess, and the formation of sequestra. The fourth stage is that of repair.

In the second stage, that of purulent infiltration, there is an inflammation of the bone marrow; the foci of inflammation break down by the formation of pus, and this process progresses in the direction of the epiphysis, and toward the periosteum, which is infiltrated and often elevated by the inflammatory products, forming swellings of greater or less size. From the periosteum, the products of inflammation make their way to the surface through the soft parts. The inflammatory process may proceed to the joint ends of the bone, and break into the joint.

The third stage of osteomyelitis is that of encapsulation and the formation of sequestra.

The fourth stage or stage of repair, consists in the separation of the sequestra, and their spontaneous or surgical removal.

The question is asked how do these pus-microbes get into the medulla of bone without there necessarily being any abrasion of the skin? Infection usually takes place by pus-microbes which have found their way into the circulation from a suppurating wound or through the respiratory or intestinal mucous membrane, and which

localize in the medullary tissue prepared for their reception and pathogenic action by anatomical peculiarities of the capillary vessels. These peculiarities of the capillary vessels in the medullary tissue are twofold: first, their calibre is four times greater than that of the arterial branch that supply them; secondly, the small vessels in the medullary tissue are devoid of proper vessel-wall, and appear more like channels or excavations than blood-vessels.

These conditions exercise a potent influence in determining the implantation of infected leucocytes.

Osteomyelitis usually attacks the long bones, generally those of the lower extremities.

The occurrence of osteomyelitis after typhoid fever is by no means uncommon, and such inflammation has been attributed to the presence of the bacillus of typhoid fever. This bacillus has been found in the pus of osteomyelitis under such circumstances, and in some cases is said to have been unaccompanied by any coccus or other bacillus.

When the infection is from the Klebs-Eberth bacillus of typhoid, suppuration rarely occurs.

The differential diagnosis of this disease is of the utmost importance to the surgeon. This case was firstly treated for typhoid fever, which he may have had; then for articular rheumatism, and lastly osteomyelitis.

The acute and most serious forms of osteomyelitis have been mistaken for typhoid fever. The prominence of the grave general symptoms, and the absence of early local signs, are responsible for many of the mistakes. In some cases it is almost impossible to make a diagnosis until the local symptoms become more prominent.

To rheumatism, osteomyelitis sometimes bears a close resemblance, and it is especially difficult to differentiate when the disease is near the epiphysis, as was the case in this patient.

Primary suppurative periostitis is an exceedingly rare disease. It usually occurs as a secondary affection in the course of osteomyelitis.

Traumatic periostitis, without invasion of pus-microbes, does not occur. Without microbes there can be no periostitis. A great deal of harm has followed the practice of surgeons who persist in regarding suppurative periostitis as a common primary disease. The treatment adopted upon this ground is not adapted for the primary osteomyelitis which precedes it. Extensive necrosis, serious joint complications, pyæmia, and death are some of the consequences which follow such a wrong diagnosis, and the treatment adopted to meet the indications of a secondary disease in place of the original affection—osteomyelitis.

Selected Articles.

VERDICT OF CORONER'S JURY IN DEATH OF THE CAUSTON CHILD.

Last night in the Central Police Station building, Coroner D. E. Berryman, with a jury, held an enquiry into the death of the six year old daughter of Oscar Causton, which occurred on Wednesday, from lockjaw, following vaccination.

After hearing the evidence of Mrs. Causton, mother of the dead child, Mr. Hawker, druggist, who performed the vaccination, Dr. H. G. Addy and his son, Dr. G. A. B. Addy, who attended the patient after she developed symptoms of tetanus, was taken, the jury rendered this verdict: "We find that the child died of tetanus, caused by the use of impure vaccine. While we believe that every precaution was used in this particular case, we would strongly recommend that the operation of vaccination should in no case be practised by others than certified medical practitioners."

The jurors were:—Elisha Cosman (foreman), John S. Currie, R. T. Worden, Francis McCafferty, Thomas Seeds, David Watson and George Thompson.

Dr. G. A. B. Addy was called as the first witness. As he commenced giving evidence Mrs. Causton arrived and the witness stood aside to allow her evidence to be taken first.

THE CHILD'S MOTHER.

Mrs. Causton said her daughter, who was seven years old, had never been ill up to the time she was vaccinated, four weeks ago. The vaccination was performed by Mr. Hawker in his store on Prince William Street; paid Mr. Hawker 50 cents for the vaccination. Mr. Hawker, she thought, was vaccinating other persons at the time. Did not notice them paying for the service.

The coroner asking for a description in detail of how Mr. Hawker performed the vaccination, Mrs. Causton broke into tears telling of Mr. Hawker exclaiming "What a dear little arm," as he inserted the needle. The arm was not washed by the druggist, she said. About the seventh day after the vaccination the arm grew sore. "About a

week later my husband removed the shield from the arm, which had a bad appearance. Then we visited Mr. Hawker, who examined the arm, saying he wished all his vaccinated persons would turn out like that. Mr. Hawker prescribed ointment to rub on the affected parts, but this I did not procure." Did not consult Mr. Hawker afterwards. Dr. G. A. B. Addy, who was consulted on November 18, prescribed without coming to the house. He prescribed medicine which was administered. Drs. H. G. and G. A. B. Addy and Dr. Baxter came to the house on the evening of November 19. The little girl was stiffened up then. Death occurred at 1 o'clock Wednesday afternoon.

Mrs. Causton saying Dr. Addy, sr., was her family physician, Coroner Berryman asked her why she did not have him to vaccinate her little child.

Mrs. Causton replied that she called at Dr. Addy's office for that purpose, but his place was crowded.

WILLIAM HAWKER TESTIFIES.

William Hawker, in his evidence, said he was in the drug business for 37 years. Previously, for four years and a half, was in the Imperial Army Hospital service in Ireland, St. John and Fredericton. Was a dispenser of medicine and had general charge of an hospital, assisting physicians in operations and, in their absence, prescribing for the sick in urgent cases. Passed examination before an army board.

Coroner Berryman—During your 37½ years' experience, have you confined yourself to a legitimate drug business?

Witness—As I understand the business, I have. In late years I have not visited the sick in their homes. I do prescribe for persons who visit my store under certain conditions. Have never attended confinements.

Continuing, Mr. Hawker said he vaccinated the Causton child and used Mulford's vaccine. Used needle sent in package. Could not remember if he vaccinated two or three persons just previous. In every case needle was sterilized, and he gave his hands antiseptic treatment after each operation.

"I consider vaccination a surgical operation, and I am confident I am competent to vaccinate persons," said Mr. Hawker.

He did not consider that untrained persons were competent to perform the operation.

The coroner—How do you account for this case?

Witness—I can't account for it after the precautions I took. When I saw the child the second time, I considered it an effective vaccination. Believed that by careless vaccination disease could be communicated from one person to another. Understood that a number of druggists vaccinated and prescribed more or less.

Later in his testimony Mr. Hawker said after his 40 years experience he considered that a man could be competent to prescribe without the qualification of a college education.

The coroner—Then this sending boys to college to study is all a humbug?

Witness—I do not say that.

To jurors Mr. Hawker said all his vaccinations were under one method. The lymph used was considered to be the best in the market. Explaining to the coroner, the witness said he vaccinated about 100 persons. In about two-thirds of the cases he washed the arms. In conclusion, Mr. Hawker said he had no idea how the child contracted tetanus.

DR. H. G. ADDY ON THE STAND.

Dr. H. G. Addy described his visit to the Causton child, whom he found to be suffering from tetanic convulsions. Being told the child had been vaccinated, he examined the arm and found the vaccination was not a proper one. Had a hemorrhagic appearance with a hard scab over it. On a second visit to the child in company with his son and Dr. Baxter, made a diagnosis which showed tetanus, which he observed on his first visit earlier in the day.

The coroner, asking how he accounted for the tetanus, the witness explained that it could only be produced by contracting the germ of tetanus. As a rule tetanus germs accumulated in manure heaps.

Then, describing the method of developing and procuring vaccine, Dr. Addy said he was conveying his theory that the vaccine used on the child was impregnated with the germ of tetanus.

At the close of his evidence, Dr. Addy qualified his statement that the vaccination on the Causton child was not a proper one, saying he meant the development was improper instead of the operation.

DR. G. A. B. ADDY.

Dr. G. A. B. Addy, bacteriologist of the General Public Hospital, told of his attendance in the case. The child died from tetanus, a disease caused by a germ which might have entered the system at the

time of vaccination or afterwards. It might have been contracted by inoculation of the vaccine or subsequently from another source when the wound was exposed. The period of incubation was from four to fourteen days. Did not think the germ was transmitted in the Causton case by a needle used on another person. Considered vaccination a surgical operation and any other than a registered physician performing the work for fees to be an infraction of the law. According to Mr. Hawker's evidence he thought that he took the ordinary precautions in making the vaccination.

THE CORONER'S ADDRESS.

The coroner, in reviewing the evidence, said the question arose if Mr. Hawker, with his long experience, was qualified to perform the operation of vaccination. He (the coroner) thought that Mr. Hawker had taken the ordinary precautions. It ought to, he thought, be determined if Mr. Hawker under any circumstances should be permitted to practice vaccination. Whether Mr. Hawker was qualified but not legally authorized to vaccinate was a point which could be considered. The coroner also mentioned that there was a conflict in the evidence on how the germ was contracted and pointed out to the jury that full deliberation should be taken before attributing it to the vaccine. Such a finding, he added, would be calculated to demoralize the community, obstruct the Board of Health in their efforts to fight the outbreak of smallpox and probably ruin the particular firm who manufactured the vaccine.

If the theory of Dr. H. G. Addy were correct it would not have made any difference whether physician or druggist had performed the vaccination.

After 20 minutes' consideration the jury rendered the verdict given.—*St. John Telegraph*, Nov. 22nd.



THE DIAGNOSIS OF SMALLPOX.

BY JAY F. SCHAMBERG, A. B., M. D., of Philadelphia, Professor of Diseases of the Skin, Philadelphia Polyclinic and College for Graduates in Medicine; Assistant Attending Physician to the Municipal Hospital for Infectious Diseases.

The detection of smallpox in its pustular stage, particularly in well-marked eruptions, is a facile matter even for the merest tyro in medicine. The picture of a profuse pustular variola can scarcely be taken for anything else. The diagnosis of the disease, however, on the first and second day of the eruption in mild cases, and especially in the absence of an epidemic may present perplexities. Before the appearance of the eruption the diagnosis is difficult and often impossible. It may be surmised, but it is seldom safe to affirm anything beyond a strong suspicion. I recently saw an unvaccinated young man who was suddenly taken ill with fever, headache, backache, chills, vertigo and vomiting, a syndrome perfectly characteristic of the initial stage of smallpox; yet the lad did not develop this disease. The symptom which, as a rule, first attracts the attention of the patient is headache. This is often referred to the occipital region, and may be of an excruciating character. At other times it is moderate, and in mild cases may be entirely absent. In many patients the disease is ushered in with a severe chill or with a succession of creepy sensations. In still other cases severe and persistent vomiting is the first manifestation. In such patients the diagnosis of acute gastritis has occasionally been made. The vomiting may be accompanied by diarrhoea. Some patients describe the earliest symptoms as general muscular and joint pains with especial reference to the knees.

Many cases begin with severe headache and weakness of the lower extremities. Backache, however, is an inconstant symptom and is absent perhaps in 30 or 40% of cases. It is said to be more frequently present in severe than in mild cases, and in hemorrhagic smallpox it is likely to be violent in intensity. Very many patients, even in mild attacks, complain of vertigo; this is particularly manifest upon the patient's assuming the vertical position. Some patients, during the last days of the period of incubation develop a more or less sudden

loathing for food, and this complete anorexia may continue for some days. The initial fever may reach 104° or 105° even in cases which prove to be mild. High temperature is likely to be accompanied by delirium, and in children by convulsions. Not infrequently profuse sweating may follow the rise of temperature.

The above prodromal symptoms vary greatly in intensity. In unvaccinated cases they are usually severe. On the other hand, in mild cases the symptoms may be so insignificant as barely to attract the patient's attention. In the vast majority of cases a fairly satisfactory history of the initial symptoms will be volunteered by the patient. In other cases, close and specific interrogation of the patient will often recall to him forgotten symptoms.

Information as to exposure to smallpox and the character of the patient's vaccine condition are important factors in an early diagnosis. Too often the importance of the knowledge imparted by the character of the vaccination scar and the date of the inoculation is underestimated. If a patient presenting suspicious symptoms of smallpox shows a typical scar from a vaccination performed within a few years this constitutes strong presumptive evidence against smallpox.

During the initial stage smallpox may be confounded with typhoid fever, meningitis, influenza, typhus, scarlet fever, measles, etc. A number of patients, during the present epidemic were suspected during the initial stage of having *typhoid fever*, and the closely scrutinized abdomen exhibited what was at first thought to be "rose spots," but which later proved to be variolous papules. The sudden onset of high fever, the tendency to vomiting, and the well-marked backache will usually cause one to suspect something other than typhoid fever. However, in atypic cases the symptoms may be strongly suggestive of the above-mentioned disease.

Both *variola* and *meningitis* may be characterized by intense headache, vertigo, vomiting, delirium, coma and convulsions. Without localizing symptoms the latter disease might for a few days be difficult to exclude. *Influenza* may closely simulate the early symptoms of smallpox, and, indeed, time alone may afford the means of differentiating the two diseases.

The true eruption of smallpox is occasionally preceded by a prodromal rash which may be morbilliform, scarlatiniform or purpuric in character. This usually makes its appearance about the second day of the initial symptoms, but may occur either earlier or later than this

period. The purpuric form consists as a rule of small pin-head sized petechiæ, often closely crowded together upon an erythematous base, and occupying as favorite regions the lower part of the abdomen, the genitalia and the upper parts of the thighs. The morbilliform and scarlatiniform eruptions may also occupy these regions or may be diffusely scattered over the body surface. Welch states that in his experience these rashes have occurred more frequently in varioloid than in severe smallpox. Recent observation of four or five such eruptions tends to confirm this view.

The morbilliform rash may be mistaken for *measles* with which eruption it has much in common. I am inclined to think that as a rule there is less elevation of this eruption than in that of measles, the finger passed over it often failing to detect the maculæ. The rash ordinarily disappears in from 12 to 24 hours. Measles may also be confounded with the beginning true variolous eruption. These lesions are, however, smaller than those of measles, are more shotlike, and are disproportionately profuse on the face and hands. There is absence of the catarrhal symptoms affecting the bronchi, nose, and conjunctiva, absence of the more or less characteristic lesions of the buccal mucous membrane, and furthermore a remission of the febrile symptoms on or shortly after the appearance of the eruption. The last-named phenomenon and the absence of early tonsillar and throat symptoms will help to distinguish smallpox from *scarlet fever*.

In the eruptive stage, smallpox may be confounded with chickenpox, syphilis, impetigo contagiosa, pustular acne and drug eruptions.

Smallpox may be distinguished from chickenpox by attention to the following data:—

1. *Prodromal Symptoms*.—Fever, headache, backache, chills, vertigo, nausea, etc., occur two or three days before the outbreak of the variolous eruption. In exceptionally mild cases, however, these may be slight or even absent. In chickenpox the fever and the eruption appear practically together.

2. *Constitutional Symptoms*.—More severe in smallpox.

3. *Distribution of Eruption*.—In smallpox the eruption involves with predilection face, arms, hands and legs; upon the trunk the lesions are more sparse. In chickenpox the eruption is most profuse, as a rule, upon the trunk, chiefly upon the back. Smallpox prefers the exposed surfaces, chickenpox the covered.

4. *Character of the Lesions.*—In smallpox they begin as firm “shotty” papules, which slowly increase in size and develop into vesicles and pustules. Vesicles are uniform in size and often show umbilication. They are multilocular and difficult to rupture with the finger-nail. Chickenpox lesions begin as “dewdrop like” vesicles which have a velvety feel. They are unilocular, thin-roofed, can be easily ruptured with the finger-nail, and vary greatly in size.

5. *Manner of Eruption.*—Chickenpox eruption comes out in successive crops, and the lesions may be seen in the varying stages of development. Smallpox eruption comes out in a single crop and the lesions usually remain uniform in character.

6. *Course of Eruption.*—Smallpox lesions undergo a gradual evolution from papules to crusts in the course of eight to ten days. Chickenpox lesions last several days and then crust. In the mild smallpox epidemic of a few years ago the lesions matured more rapidly than in the old-time smallpox, but the course of the eruption was nevertheless much longer than in varicella. The severity of the eruption is no absolute guide in the differential diagnosis. Severe cases of varicella may look far more formidable than mild cases of variola. I have seen undoubted smallpox in unvaccinated individuals with but two or three lesions present, and the general symptoms correspondingly mild.

The pustular syphiloderm, particularly that variety known as the varioliform syphilide, may at times present a striking resemblance to smallpox, and may require careful study to be differentiated therefrom. During epidemics of smallpox such cases are frequently regarded as variola. These pustular eruptions are not always the first cutaneous manifestations of the disease, but may follow upon the macular or papular syphilides. They may occur from the second month to the end of the first year of the disease. They are more common in negroes than in whites, and in the debilitated and under-nourished than in robust individuals.

History.—In syphilis one may obtain information concerning the initial lesion and perhaps an antecedent eruption; also the presence or former existence of mucous patches, alopecia, tonsillar ulceration, iritis, remains of chancre, etc. In smallpox there must be a history of exposure to the contagion of variola.

Initial Symptoms.—This complex of symptoms is well marked in smallpox two or three days before the appearance of the eruption.

In the pustular syphiloderm there may be moderate fever and general aches and pains, preceding by several weeks the outbreak of the eruption. On the one hand there is no such remission of the febrile symptoms on the appearance of the cutaneous efflorescence as is seen in smallpox, and on the other hand the constitutional disturbance during the prodromal period and later during the eruptive stage is much less severe and prostrating. Patients with a pustular syphilide are not apt to seek their beds.

Eruption—The syphilitic eruption comes out in successive crops it may or may not be more extensive upon the trunk than upon the face. The papules are often firm, but are apt to acquire vesicopustular summits rather than become vesicular or pustular in their entirety. They never progress to those large full, hemispheric pustules which are so characteristic of variola. The vesicopustules dry into small, brownish crusts, which when cast off disclose to view infiltrated elevated papules or at times exulcerated bases. Often a little epidermal collarette is seen, showing beginning desquamation of the base of the lesion. The lesions are not invariably uniform in size, and often papules and pustules are interspersed. Occasionally there is a tendency to grouping, which is best noted about the alae of the nose, commissures of the mouth, border of the hair, etc. Untreated the eruption is prone to ulceration producing punched out excavations. The palms of the hands and soles of the feet, which are so constantly beset with lesions in smallpox, are rarely attacked in the pustular form of syphilis. The writer has seen one lesion on the thenar eminence in a varioliform syphilide but even this is exceptional. The eruption of syphilis, as a rule, pursues a distinctly slower course than that of smallpox.

Despite these differentiating symptoms, there occur at times cases which defy even the experienced eye to make an immediate diagnosis. Observation of the patient for a few days will usually disclose the true nature of the disease.

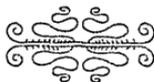
A confounding of smallpox with *impetigo contagiosa* can come only from misunderstanding of the nature of the latter disease, which is a purely local dermatosis resulting from inoculation of the skin with pyogenic microorganisms. The eruption is usually limited to the face and neck, although occasionally a few lesions may be present upon the hands. The trunk and lower extremities are, as a rule, entirely free. The lesions do not ordinarily exceed a dozen in number. They

are usually discrete, thin-roofed vesicles or blebs, which rapidly become turbid and dry into yellowish flat crusts. These are cast off, leaving faint reddish stains. The vesicopustules are extremely superficial and flat and appear to be on the skin rather than in it. The disease being local in character there is neither fever nor any other systemic disturbance. The eruption is both contagious and autoinoculable, the infection occurring through direct or intermediate contact. The disease is considerably more common in children than in adults.

Mild cases of varioloid exhibiting but a few papulopustules about the face may bear a close resemblance to *acne*. The history of exposure, the existence of an initial stage and the normal evolution of the lesions will usually enable one to arrive at a correct diagnosis.

The same data are of differential importance in excluding papulopustular eruptions occasionally produced by ingestion of the iodides.

During epidemics of smallpox the anticipatory attitude of the physician's mind will often lead him to suspect and diagnose as variola diseases which bear only a superficial or remote resemblance to it. Thus patients with febrile herpes, herpes zoster, erythema multiforme and other ordinary skin diseases have at such times been sent to smallpox hospitals. Contrariwise, in the absence of an epidemic, mild cases of smallpox are very likely to be overlooked. A diagnosis should not be based upon any one feature of the disease, but upon the *ensemble* of symptoms.—*American Medicine*.



THE TREATMENT OF SYPHILIS, WITH SPECIAL REFERENCE TO THE BEST METHODS OF ADMINISTERING MERCURY.*

BY WINFIELD AYRES, M. D., Genito-Urinary Surgeon, Bellevue Hospital, O. D. P., New York; Instructor in Genito-Urinary Diseases in New York University and Bellevue Hospital Medical College; Instructor in Genito-Urinary Diseases in the New York Post Graduate Hospital, etc:

The author calls to mind the fact that mercury has been used in the treatment of syphilis for over 400 years, and there are few physicians, to-day, who do not use it in some form. Although the method of treatment with mercury is still discussed, he is firmly of the opinion that there is no hope of eradicating the disease unless the full dose is given constantly for something like three years. The treatment should begin just as soon as the diagnosis can be made. There is no ground for supposing that enucleation of the chancre has the effect of aborting the disease. If a positive diagnosis cannot be made from the appearance of the initial lesion, general tonic treatment should be instituted.

In some cases the protiodide controls the symptoms, but in the majority it is of very little use. Experiments with mercuriol were conducted at Bellevue Hospital, for eight and a half months, with 180 cases; the histories of 95 of these are recorded. The remainder could not be kept under observation and are therefore passed over. The dosage of the mercuriol, regulated either by reaching the point of tolerance or control of the disease, varied from one-half to six grains. In 64 of the 95 cases the disease was controlled as follows: in two weeks, 8; three weeks, 12; four weeks, 14; five weeks, 6; six weeks, 5; seven weeks, 2; two months, 8; ten weeks, 2; three months, 5; and four months, 1. The remainder are marked thus: decidedly improved, 17; improved, 8; no improvement in two weeks, 3; no improvement in four weeks, 1; and no improvement in three months, 2. The latter were all dispensary patients and it is uncertain whether they took their medicine regularly.

The writer states that his plan was to increase the dose steadily

*Abstract of an original paper by the author in *The Lancet* (London, Eng.,) October 19th, 1901.

from one grain until the symptoms were controlled, or there was a slight tendency on the part of the teeth and gums to become tender. If the symptoms were not controlled before the physiological effect of the mercuriol made itself felt, small doses of potassium iodide were added, and in every case where the mercuriol was taken according to directions, with the exceptions noted above, the symptoms were controlled.

In 67 out of the 95 cases tabulated, no other medicine than mercuriol was given. In 15 out of the remaining 28, the addition of iodide of potassium was found to be sufficient to control the disease, while in 6 others the addition of an iron tonic sufficed for this purpose.

The cases are not reported at length, but a few of the more remarkable results and some cases in which other medicines failed to control the disease are briefly mentioned.

Case 1 had been taking bichloride for one month with very little improvement. Under mercuriol, three grains maximum dosage, the symptoms were under control in five weeks.

Case 2 had been under biniodide of mercury (one-sixteenth of a grain) and potassium iodide (five grains), which caused iodism. His symptoms were controlled in one month under half a grain of mercuriol.

In Case 3 unguentum hydrargyri had failed to control the disease. The patient was put on mercuriol and the dosage pushed up to six grains three times a day. The disease was thoroughly under control in seven weeks.

Case 4 had been on three-eighths of a grain of biniodide of mercury and twenty grains of potassium iodide for two months. The medicine caused nausea and vomiting. Having been put on mercuriol and the dosage gradually increased to five grains three times a day, the symptoms were controlled in three weeks.

Case 5 had been taking hydrargyrum bichloride (one-twelfth of a grain) three times a day, under which an eruption on his face had faded, but the eruption on his body still persisted. His symptoms disappeared in two weeks under a maximum dose of three grains of mercuriol three times a day.

Case 6 had been on bichloride of mercury (three-sixteenths of a grain) for three months, in spite of which he had palmar syphilide of an eczematous variety. All appearances of the disease disappeared after he had been one month on mercuriol, his maximum dose being three grains three times a day.

Case 7 had been taking one-quarter of a grain of mercuriol and fifteen grains of potassium iodide, with the result that the eruption had decidedly improved, though not to the extent that it should have done. There were thickened red patches on the face, covered with scaly eruptions. The symptoms almost entirely disappeared within three weeks under a maximum dosage of five grains of mercuriol three times a day and fifteen grains of potassium iodide.

Case 8 had been treated with inunctions of mercury, under which the eruptions disappeared, but the pains in the bones still persisted. He was relieved in three weeks under a maximum dosage of four grains of mercuriol three times a day.

Case 9 had been taking other forms of mercury for six months. The form which had done him most good was bichloride. Yet one-fifth of a grain did not entirely control the disease. He had been taking that for two months when he was placed on mercuriol. The dosage in his case was pushed up to six grains three times a day, and at the end of seven weeks all his symptoms had disappeared.

Case 10 had been taking medicine off and on for two years, but his symptoms never disappeared entirely. After being two weeks on mercuriol (two grains three times a day) with the addition of potassium iodide, all symptoms had disappeared.

Ayres, in conclusion, states that he uses mercuriol in his private practice to the exclusion of all other drugs. His experience is that he gets better results. He has found no form in which mercury can be given with such good results as in that of mercuriol.



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Editorial.

SMALL POX IN ST. JOHN.

Since the outbreak of small pox in St. John on 30th September there have been sixty-eight cases up to 5th December. There have been fourteen deaths, seven in the Epidemic Hospital and seven outside. As a number of cases have appeared within the last week, it cannot yet be considered that the epidemic is about at an end. While exact figures are not available, it can be stated that a large number of those affected have never been vaccinated.

It is unfortunately true that many people wilfully avoid vaccination at the hands of the public vaccinator and so cause much trouble to the city and themselves. The fact that general vaccination is done largely in the interests of the community, rather than in that of the individual, is not appreciated by a considerable mass of people.

Owing to the Epidemic Hospital being fully occupied, the Board of Health have purchased a property situated outside the city at a cost of \$7000.00, and consisting of buildings surrounded by a considerable area of ground. The new hospital will certainly be much more favourably situated than the present epidemic hospital which now stands in the centre of the city close to the General Hospital. It will soon be in use, and it is to be presumed that after the present outbreak has passed over, that should small pox case arise, they will not be placed in the city contagious hospital but will be sent out of the city to the new building.

No cases have arisen in the General Public Hospital for two weeks and it is hoped that quarantine will soon be removed, so that the active duties of hospital work may again be resumed.

SMALLPOX IN KINGS COUNTY, N. B.

There have been five cases of smallpox with two deaths, and one case of varioloid. The patients who died were suffering from a malignant type of the disease—the genuine hemorrhagic form. The disease broke out in two centres in the county, the infection in each instance being traced to St. John.

The first case was a man who had been sick a week with what was thought to be typhoid fever, a regular physician not being called in until the day he died. He had not been vaccinated of late years, if ever. Of the twenty people who came in contact with the sick man, but three took the disease, all members of the family, though two were married and living away from home. The one that died had slept on the bed with his father, and was one of the last to be vaccinated. He died on the sixth day of the disease. None of them had ever been vaccinated previous to the first case being diagnosed. The son that died was supposed to have caught the disease from the cow a few years ago. Dr. T. E. Bishop, of Norton, who had heroically assisted the Chairman of the Local Board of Health in taking the necessary precautions to prevent the disease from spreading, was put in charge of the patients.

In the other centre a woman was found on the sixth day of the disease, which became of a confluent type. No physician had seen her. Of the five unvaccinated children in the house, ranging in ages from 11 months to 13 years, and the half dozen other people who had come in contact with the patient, all escaped but the baby, who had a very mild attack of varioloid. The quarantine has now been raised on all the houses but this one.

T. H. W.

“F. B. E.” ON THE MEDICAL PROFESSION.

The following clipping has been received for publication. It set forth the special correspondent to the Montreal Herald's estimate of the medical profession in St. John. Should any of the profession interested or informed on the subject care to write in reference to this matter, the columns of the MARITIME MEDICAL NEWS are open to them.

But the article will probably be considered unworthy of much comment. It is generally understood that the positions of medical

officers were promptly filled and without the slightest difficulty. The number of physicians who are prepared to take up an unpleasant duty is always considerable,—they have never failed in any community and under any circumstances. This does not trouble the special correspondent who is evidently suffering from an ailment of some personal nature :—

“ST. JOHN, N. B., Nov. 2.—St. John now has nine cases of smallpox. If there were a thousand the people could hardly be more frightened. Everybody is being vaccinated, and the doctors are reaping a rich harvest. At \$1 a scrape some physicians have earned over \$100 a day, and young doctors, whose doors are rarely darkened by patients, have made enough in the last few days to buy their winter's fuel or to pay for their engagement ring. A sad feature of the situation is that some of the doctors have allowed the commercial to outweigh the other consideration. There are some practitioners who have hardly lived up to the traditions of their profession. Some have not been ready and willing to sacrifice everything in the interests of their fellow-men. Some, if reports are true, have fallen far short of showing even common manhood in the face of the danger threatening the community. There are stories, seemingly well authenticated, of physicians—old practitioners—who, when they discovered that a patient had smallpox, quietly left the house, turning the case over to another doctor, thus escaping the loss of patronage that would follow public announcement of their attendance on a smallpox patient. There is a story told of one case that was passed to four doctors before it reached a man with sufficient courage to declare what it was and to call on the authorities to take the needed precautions. It is to the credit of the younger men—those who had only their lives to risk—that they have not been found wanting in this trying time.

FACED DUTY BRAVELY.

Dr. T. E. Morris and Dr. W. L. Ellis, when they saw the way their professional brethren were behaving, came boldly forward and took the responsibility of diagnosing the cases and of treating them. Both these young men are graduates of old McGill. Dr. Ellis offered to go into the infectious hospital, and, to the credit of the nursing profession be it said, there were nurses in plenty ready to go with him, to shut themselves off from all communication and to assist in the care of the cases. Dr. Morris, on his part, agreed to stand in the gap for his timid professional brethren, shouldering the responsibility of deciding on every case, and of seeing that all quarantine orders of the Board of Health are carried out. Thus the matter stands to-day. These two faithful doctors are on duty, and the others are reaping the golden harvest. Dr. Morris is generally shunned and ostracised, while the doctors who first see the smallpox cases and pass them on to him for

the verdict they know but will not render, are enjoying all the pleasures of life in St. John. Of course, there are physicians here who have not been called in connection with any of the cases, and it is not insinuated that they would act as have those who have been called. If the disease should become epidemic—and fortunately there is little likelihood of this—their chance will come, and then the people will learn if they are made of sterner stuff.” * * * *

F. B. E.

VACCINATION, TETANUS AND ILLEGAL PRACTICE.

A Report of the Coroner's Inquest will be found in the present issue of a fatal case of tetanus arising in connection with the vaccination of a child by a chemist in St. John. The verdict arrived at by the jury was an extraordinary one and has received much criticism. Indeed so absurd was it, that the public have been little affected by it and have passed it by.

The fact that there has been but one case with the very large and general use of the same lymph, the fact that children's hands and nails are well known to be usually anything but clean, and that vaccinated arms are itchy, and the fact that the tetanus bacillus is widespread are sufficiently obvious to make it very probable that the germ in the above mentioned case was not introduced by means of impure vaccine.

But there is another important point in the case, and that is the vaccination was performed by a chemist, and one not qualified under the law to perform that which is really an important operation. In his evidence, the chemist stated that he had vaccinated about 100 persons and in about two-thirds of the cases he washed their arms!

The mother of the child stated that she paid the chemist for the vaccination.

It is unnecessary to say more in reference to vaccination by unqualified persons than that it is improper, illegal, unsafe and to be strongly condemned.

The attention of the Medical Council of New Brunswick, it may be assumed, has already been drawn to this case, and if not, no doubt the Council will before long take up the consideration of this matter in an active and vigorous way. There would not appear to be the same difficulty in obtaining evidence in this as in some other cases that exist in the community at the present time. The profession properly look to Medical Councils for the suppression of illegal practice. There are always opportunities open for the exercise of activity by Medical Councils.

Society Meetings.

NOVA SCOTIA BRANCH BRITISH MEDICAL ASSOCIATION

The annual meeting of the Nova Scotia branch of the British Medical Association was held at the Halifax Hotel on Nov. 20th, 1901, at 8.30 p. m.

Dr. Thomas Walsh, Vice-President, occupied the chair in the absence of the President, Dr. G. C. Jones, who was unable to be present.

The minutes of last meeting were read and confirmed. A letter was read from Dr. N. E. MacKay, resigning as a member of the branch, which was accepted. The Secretary read his annual report of the work done by the branch and council, and also a schedule of attendance. The report was adopted.

The election of officers then took place, and resulted as follows:

President.....Dr. T. W. Walsh

Vice-President.....Dr. N. F. Cunningham.

Treasurer.....Dr. M. A. B. Smith (re-elected).

Secretary.....Dr. C. D. Murray (re-elected).

Council:—Drs. Murphy, Kirkpatrick, Ross, Mader, Trenaman, Cunningham and Goodwin.

Representative on Council and Parliamentary Bills' Committee:—
Surgeon-General O'Dwyer, A. M. S.

Votes of thanks were passed to the Treasurer and Secretary for their valuable services.

Dec. 4th, 1901. Dr. T. W. Walsh, President, in the chair.

Meeting of branch was held at the Victoria General Hospital at 8.30 p. m. Minutes of last meeting were read and confirmed.

Dr. E. A. Kirkpatrick, being called upon, first showed several modern instruments for the removal of adenoids. He then exhibited a case of suppurative disease of the frontal sinuses on which he had operated. At first no pus was found, but later it came on freely. Hydrogen peroxide was used to keep the parts clean. Where previously there

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Of all samples collected and analyzed those of our manufacture ALONE proved in each and every instance to be up to the standard.

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had been several ounces of pus a day, at present there was very little. The different methods of opening the sinuses with the trephine and chisel were described.

Dr. R. E. Mathers referred to the occurrence of cough in cases of ethmoid suppuration.

Dr. F. W. Goodwin referred to a case of an opening into the frontal sinuses.

Dr. C. D. Murray mentioned his own experience with antrum trouble.

Dr. M. Chisholm related a case of necrosed bone in which he had opened up the frontal sinuses five years ago with a satisfactory result.

Dr. Chisholm then exhibited a case of nævus of the forehead which followed an injury five years ago. The tumor was extensive, considerably raised and pulsated. He cut down and ligatured the temporal artery and smaller vessels about the tumor, a reduction of tumor following; electrolysis had also been used.

He also showed a case of dislocation of the hip of five months' standing. After many efforts at reduction the patient came to the hospital with partial paralysis of motion and sensation in the leg and some displacement or dislocation of the upper part of the femur. An attempt had been made to get a fluoroscope image and skiagraph, but with not much success.

He then exhibited a case of possible carcinoma of the upper part of the nose in a man aged 72 years. When a child he cut his nose leaving a permanent scar, where one year ago a wart developed. This was cauterized and nose ulcerated to about the size of a silver dollar. It bleeds easily, bone is bare and partially destroyed. The diagnosis between cancer and syphilis was then discussed. Lately the patient has been given large doses of potassium iodide, as the characters of the ulcer in many respects are suspicious of syphilis.

A case of injury to the foot was also shown by Dr. Chisholm, on which a modification of Pirogoff's amputation had been performed.

Dr. Ross discussed the case of ulceration of the nose, and the difficulty of a diagnosis. The incidence of a syphilitic ulceration following an injury was spoken of, and reference made to a case following a kick from a horse was referred to.

Drs. Goodwin, Mader, Walsh, Murphy, and Weaver discussed the case of dislocation.

Dr. Weaver said that it was particularly difficult to get a fluoroscopic image of the hip on account of the thickness of the muscles, but another attempt would be made.

Dr. Mader discussed the use of large doses of potassium iodide in syphilitic cases.

Dr. Ross then presented a case of dermatitis exfoliativa in a woman over 60 years of age. Disease began six years ago disappearing to some extent at intervals until one year ago, since which time it was constant. The possibility of its having developed on psoriasis was mentioned. The case was treated with an ointment containing acid salicylic and liquor carbonis detergens, with cod liver oil internally, and improvement soon began and now shows little of the disease,—two months after admission.

Dr. D. A. Campbell mentioned a case which he had seen that existed for six or eight years and was very rebellious to treatment. Herpes zoster developed on one side of the abdomen with hæmorrhagic contents. Sloughing occurred and patient died from sepsis.

Dr. C. D. Murray showed a case for diagnosis. Patient was a boy eleven years of age who had been affected with a fine tremor of the hands for years which becomes exaggerated on attempting to use the hands. The case was discussed by several members, but no definite conclusion reached as to the diagnosis.

The meeting then adjourned after which the members sat down to a well spread table where they enjoyed the hospitality of Messrs. Kenney and Puttner.



Matters Personal and Impersonal.

Dr. W. P. Reynolds, now of Aldridge, Montana, was married at Butte City, to Dr. Winnifred B. Braine, formerly of this city, on the 12th inst. The interested parties are both recent graduates of Dalhousie University. The NEWS extends its congratulations and also to the following gentlemen who have recently joined the ranks of matrimony: Drs. S. J. McLennan, of Sydney, T. H. Smith, of North Sydney, and A. Culton, of Ferrona.

Dr. Oscar Dorman, who for some time was surgeon on the cableship "Minia," resigned his position and started for London to take up post-graduate work. Dr. F. J. A. Cochran, who recently practised in New Campbellton, C. B., has been appointed to succeed Dr. Dorman.

Dr. W. F. Smith, of this city, recently returned from a *successful* hunting trip—so he says. The many friends of the genial doctor are, however, losing patience in the possible forlorn hope of enjoying a moose-steak. Another local medical gentleman some years ago shot a specimen of the "bald-head" variety—quite a rare species.

Frank A. Ruf, President and Treasurer of The Antikamnia Chemical Company has just purchased a lot 80x109 feet, for \$20,000.00 cash, on which his Company will begin the erection early in spring, of a new "Antikamnia Laboratory," five stories high, covering the entire lot. The improvements will cost about \$45,000.00 irrespective of the laboratory apparatus and appliances which will be of most approved pattern, from Darmstadt, Germany. The Antikamnia Chemical Company is one of America's, if not of the world's best known pharmaceutical concerns and justly so. Energy, enterprise and push, backed up by the judicious and liberal use of printers' ink, in keeping their line of preparations in touch with the medical profession, from one end of the universe to the other, have made it so.

We respectfully wish to apprise our readers, on the faith of positive assurance to us that not one of the recent tetanus fatalities following vaccination at Camden, Atlantic City, Bristol, Brooklyn, Cleveland, and St. John, N. B., succeeded the employment of vaccine

put up by Parke, Davis & Co. In not a single solitary one of these cases was their vaccine used.

Dr. Hugh L. Dickey, formerly practising in Charlottetown, has arrived in the city where he will now reside. Dr. Dickey, as before will confine his work to eye, ear, nose and throat diseases.

The NEWS extends its sincere sympathy to Dr. J. A. Sutherland, of Springhill, whose wife died so suddenly on the 13th inst. Dr. Sutherland was on a professional call when his wife was seized with convulsions and died before he returned.

The Medical Board of the Victoria General Hospital remembered Mr. W. W. Kenney, the superintendent of that institution, on the occasion of his recent marriage, by presenting him with a handsome quartered oak, golden finish, china closet.

Mrs. Finn, wife of Dr. W. D. Finn, of this city, unfortunately contracted smallpox and is now at the smallpox hospital. Dr. Finn went with his wife to the hospital and we are pleased to learn that there is a very good chance for her recovery.

Dr. H. M. Hare, who practiced in China, for some years, has returned and will open an office in the north-end of the city.

Obituary.

DR. ROBERT MCLEARN.—We regret to report the death of Dr. Robert McLearn, of Fredericton, N.B., which occurred in that city on the evening of the 30th of November, after a ten day's illness of bronchitis, complicated with heart trouble.

Although his illness was serious, few outside of his immediate relatives expected it to end fatally, so the sad news of his untimely death at the age of forty-seven has cast a gloom over the city where he was very popular.

Dr. McLearn was born at Tatamagouche, N. S., but has lived in

New Brunswick for over twenty years. He graduated from New York Medical College in 1880, and for a short time practised in Newcastle, N. B. In 1885 he moved to Fredericton, and on the death of Dr. Brown in 1893 was appointed medical officer to the Royal Regiment, and filled the position most ably. At the time of his death he held the rank of Lieut.-Colonel. On several occasions he acted as principal medical officer to the Militia camps at Sussex and Aldershot, N. S., and had hosts of friends among militia men. He leaves a widow, daughter of the late Hon. Allen Davidson of Newcastle, and a son. His parents reside in Halifax. Dr. McLearn was of a bright and happy disposition, and was one of the most popular practitioners, both with the laity and members of his own profession. On Monday, December 2nd, he was buried with military honors. A brief service was held at the house by Canon Roberts, and the body was borne thence to the Rural Cemetery on a gun carriage, with a firing party composed of the full strength of No. 4 company, R. C. R. I. The following officers acted as pall-bearers:—Lt.-Col. Loggie, Lt.-Col. Dunbar, Surgeon-Major Bridges and Capts. Fisher, Hawthorne and Winslow. Other officers of No. 4 company attended as mourners, with Messrs. Allen and James Davidson of Newcastle, and P. O. Inspector McDonald of Halifax, brother-in-law of deceased.

DR. FRANK D. BEER.—Another member of the profession has passed over to the majority in the person of Dr. F. D. Beer, at his residence in Charlottetown, on the 5th of December, 1901. Dr. Beer was in failing health for some time, having suffered from severe attacks of angina pectoris and heart affection. He was born in the city of Charlottetown, on December 24th, 1838, and was therefore 63 years of age. He graduated from Harvard Medical College in 1860. He resided for a short time at Centreville, Bedeque, where he married the daughter of the late Stephen Wright, and then moved to Charlottetown where he had since practised until failing health compelled him to abandon the more active duties of his calling. He was for some years a member of the Medical Council. As a citizen he was respected and highly regarded, taking a lively interest in all that made for the religious, moral and commercial advancement of the community. He was socially well connected and leaves to mourn, besides a sorrowing widow, a family of four, viz:—two sons, Frank Robert, now in

British Columbia, and Capt. Stephen George, of the South African Constabulary; and two daughters, Mrs. Alex. Anderson, Rochester, New York and Mrs. John Longworth, Brandon, Manitoba; also, two brothers L. L. and F. H. Beer of this city, and two sisters, Mrs. Olive Jones, Moncton, and Mrs. Full, Lynn, Mass. They have the sincere sympathy of the entire community and of the medical profession of which Dr. Beer was a respected member. The medical profession of the city of Charlottetown followed his remains as mourners to Sherwood Cemetery on the 7th Dec., inst., together with a large concourse of citizens showing their great respect and esteem for him

Book Reviews.

PRINCIPLES OF SURGERY. By N. SENN, M. D., etc., Professor of Surgery in Rush Medical College, Chicago. Third Edition, 1901. Published by F. A. Davis Co., Philadelphia.

It may seem an ungracious thing to say anything in disparagement of any book by Professor Senn, especially of one which has been everywhere so well received. Yet, while conceding this to be a most valuable and interesting book we are bound to say that the title is misleading.

One of Professor Senn's reasons for writing this book is, as stated in his preface, that recent works on Surgery "are defective in those parts relating to the matter treating of the fundamental principles of the art and science of Surgery." And his aim is to write a book on the "Causation, pathology, diagnosis, prognosis and treatment of the injuries and affections which the surgeon is most frequently called upon to treat" But he has apparently been so impressed with "the recent great discoveries relating to the etiology and pathology of surgical diseases" that he has forgotten half his purpose, and indeed it seems to us that a more suitable title for the book would be:—"The Pathology of Surgical Diseases." A glance over the table of contents shows this to be the case. And even this pathological character is not complete, for it is almost entirely a bacteriology. The subject of Tumours is indeed to be treated in another volume, but there are many surgical diseases not yet traceable to the malign influence of any microbe not even mentioned in this book. And the whole subject of surgical injuries, except that of wounds is left out.

We yield to none in our appreciation of the importance of bacteriology, but we protest against so exaggerated a view of its importance as results in a book on the "Principles of Surgery" written "for the student and general practitioner," which ignores any other factor in disease than the

microbe, and passes by the whole field of surgical injuries. One-fifth of the book deals with surgical tuberculosis, but there is nothing about fractures or dislocations, twenty-five pages on actinomycosis, but nothing about hernia, not a word on burns or scalds, but a dozen pages and a wealth of illustration on blastomycetic dermatitis.

We must admire the wide learning, the scientific ardour and the tireless energy of Professor Senn, but we have to say that the practitioner who buys this book as a guide to the "causation, pathology, diagnosis, prognosis and treatment of the injuries and affections which the surgeon is most frequently called upon to treat," will be disappointed.

There is a sense, however, in which he will not be disappointed. The book is a most interesting one, and many of the illustrations are beautiful and instructive. We are glad to see that the "Text-book of Pathology" by Prof. Hamilton of Aberdeen is largely quoted, and some of his exquisite drawings reproduced.

There are also many valuable practical hints on the treatment of wounds, and on various operative procedures. From the description on page 39, of Thiersch's method of skin grafting, one might infer that the whole thickness of the skin was required and that pieces an inch square are the proper size. Half the thickness of the skin is amply sufficient, and a graft may be cut six inches long if required.

The chapters on septicæmia and pyæmia are interesting and those on suppuration are notable examples of the practical application of pathological principles. But if we would single out any part of the book, it is that dealing with tuberculosis; this alone is well worth the price of the book. Prof. Senn was one of the earliest and strongest advocates for the iodoform treatment of tuberculous abscesses; his description of the method is clear and his results most encouraging.

Notes.

I have employed the Pepto-Mangan (Gude) in a case of marked secondary anæmia with profuse gastro-intestinal hæmorrhages due to an ulcer of the stomach, with most excellent results. The patient, an extremely weak woman who was somewhat disinclined to take any kind of medicine, praised within a short time the very agreeable taste of the preparation, and her appetite and condition of nutrition improved very rapidly, so that at present she exhibits a very healthy appearance. Pepto-Mangan has been regularly continued in her case.

According to my other experiences I am warranted in concluding that your Pepto-Mangan, owing to its agreeable taste and ready digestibility even in the presence of impaired gastric function, belongs to our most valuable ferruginous preparations.

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DR. AUG. HAMMER,
Medical Councillor: City Phys.

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many diseases and affections which call for just such a combination, we might mention la grippe, influenza, coryxa, colds, chills and fever, dengue and malaria, with their general discomfort and great debility. We would also especially call attention to the wide use of Antikamnia & Codeine Tablets in chronic or semi-chronic pulmonary diseases. The following concise statement from Dr. W. B. Morford, No. 1521 Tasker Street, Philadelphia, is worthy of note. He says:—"I find antikamnia in combination with codeine, to be almost a specific in the coughs of phthisis. In a recent case of "old fashioned" or catarrhal consumption I obtained most satisfactory relief for the patient, from a most distressing cough, with Antikamnia & Codeine Tablets.

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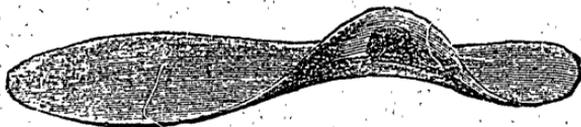
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