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## ORIGINAL ARTICLES.

### NOTES ON HYDROCHLORIC SUPERACIDITY, WITH REPORTS OF CASES.

BY GRAHAM CHAMBERS, B.A., M.B.

Physician to St. Michael's Hospital; Assistant Physician to Toronto General Hospital.

According to my experience excess of hydrochloric acid is a very common functional sign in cases of gastric indigestion. This acid is no doubt the secretion of the border or oxyntic cells of the peptic glands. The size of these cells varies with their activity. When quiescent they are smaller than when their secretory function is active. In cases of hydrochloric hyperacidity, where the secretory function of these glands has been morbidly active for a prolonged period, proliferation of both the border and chief cells can be frequently demonstrated in some parts of the mucous membrane of the stomach. This fact should be kept in mind, as the greater the proliferation of the glandular elements the more difficulty will be experienced in affecting a cure.

As stated above, hydrochloric superacidity is a common result in analyses of gastric contents. It may be present in hyperchlorhydria, hypersthenic gastritis, hypersecretion, ulcer, carcinoma, gastropptosis, atony, as well as in some of the neuroses other than those mentioned in the foregoing list of diseases. It is quite evident therefore that this functional sign alone is of little value in differentiating the above diseases. But it is a sign that must be considered in the treatment of every one of them.

Let us now consider the etiology of excess of hydrochloric acid. As far as known at the present date, the causative agents may be conveniently described under two heads:—

- (a) Local irritation.
- (b) Mental disturbances.

However, in many cases both of these conditions are important factors in the development of the morbid condition.

The stomach may be over-stimulated in several ways. Stagnation of food may affect it. I ascribe the hyperacidity which is frequently found in gastropptosis and atony to this cause. Again, too rapid eating may bring about the same result. The stomach is not a gizzard and

should receive the food in a thoroughly masticated condition. If, in place of this, the food is gulped, then excessive stimulation of the glands of the stomach must necessarily follow.

Hyperacidity is also a frequent result of eating excessively of foods which are known to markedly stimulate the secretion of hydrochloric acid. Acid, meats, salt, fruits, pickles, spices, spirits, sugars and coarse vegetables are believed to be the most potent in this particular, whereas bread, milk, well-cooked cereals, tender vegetables, etc., are only mild stimulants. That meat is an active stimulant of secretion of hydrochloric acid is supported by the fact that the gastric juice of carnivorous animals is always highly acid and that the glandular elements of their stomachs are always very highly developed. Fruit is also apt to cause excessive secretion. I believe that more cases of hydrochloric superacidity are due to uncooked fruit than to any other form of food.

Mental and moral causes also take an important part in the development of many cases of this condition. I have met several cases in which the commencement of the trouble appeared to date from a disappointment, excessive mental work, etc.

The symptoms of hydrochloric superacidity will vary with the disease of which the excess of acid is only a functional sign. Nevertheless there are certain symptoms which are usually present, and of these pain half an hour to three hours after eating, relieved by eating, or by an antacid, is the one which is most frequently complained of. The reason why the pain appears at this time is readily understood. As soon as food is taken in the stomach hydrochloric acid begins to be secreted, but it is immediately fixed by the proteids of the food, forming an acid albumen. As soon as all proteids are satisfied then the acid remains free in the stomach. This usually happens about three-quarters of an hour after eating an average-sized meal. In cases of hyperacidity the acid is secreted more rapidly than normal and as a result free hydrochloric appears earlier during digestion. As soon as the acid accumulates above a normal proportion it is apt to cause pain by irritating the mucous membrane of the stomach. When albuminous food or an antacid is taken the acid becomes fixed and the pain is for a time relieved.

The treatment of hyperacidity will depend to a certain extent upon the disease in which it occurs as a sign. Thus the treatment of ulcer would be quite different from that of the neurosis, hyperchlorhydria. Nevertheless there are certain general rules which one should follow in all cases of excessive secretion, and it is to these alone I wish to refer in these notes. The diet should always be of a bland, unirritating nature. Some advise the use of meats alone in cases of hyperacidity. They maintain that the albuminous food will fix the free hydrochloric acid and thus prevent it irritating the stomach. But we know that meat is a most potent agent in stimulating the secretion of hydrochloric acid and thus would be detrimental in affecting a cure. About three years ago I frequently used a meat diet in the treatment of this condition, and I found that it was unsuccessful in many cases. A mixed diet of very tender meats, milk, bread, butter, cereals, etc., appears to me to be more rational. This form of diet fixes the free acid and at the same time will not stimulate the secretion of hydrochloric

acid to the same extent that a meat diet will. Fruit, pickles, coarse vegetables, sugars, and spirits should not as a rule be allowed.

The medicinal treatment is more or less alike in all cases of hyperacidity. Ext. belladonae, ext. cannabis indicae, bismuth carbonat, ext. cocæ, are all useful sedatives to the mucous membrane of the stomach. Taka diastase may be used with advantage in many cases as it assists in the digestion of starchy foods. Sodium bicarbonate and calcined magnesia are generally required to neutralize the excess of acid. Strychnine and hydrastine are the drugs to be depended upon in cases of atony. Conheim, of Berlin, recommends the administration of olive oil in cases of spasm and obstruction of pylorus. I have used it in two cases with apparent advantage in chronic ulceration with symptoms of pyloric obstruction. Bitters, acids, pepsine and irritating cathartics are contra-indicated.

CASE 1, HYPERCHLORHYDRIA.—A. T., aged 22, female, single, consulted me in August, 1900, on account of pain after eating. She stated that she had suffered for three weeks, and previous to that date had always good health. She had always been very regular with her meals and as a rule had eaten plain food. She was very fond of fruit and had eaten freely of it during the summer months. The pain for which she sought advice began about an hour after eating and lasted as a rule from one to four hours. Occasionally the pain would continue to the following meal, when it would be relieved for a time. She stated that baking soda would always relieve it for a short time. Her appetite was good and her bowels were constipated. She did not complain of belching, heartburn, flutulency, nausea or vomiting. I gave her a test breakfast and analysed the gastric contents with the following result: quantity, one ounce; mucus, about normal; total free HCl, 34; total acidity, 78. Lugol's solution gave marked violet color.

The position of the stomach was found to be normal.

DIAGNOSIS:—Hyperchlorhydria.

TREATMENT:—Diet: white bread, butter, milk, strained gruels, well cooked cereals, scraped meat, tender meats. Fruits, pickles, coarse vegetables were strictly prohibited.

Medicinal treatment consisted in the administration of a large dose of bismuth subnitrate every morning, a capsule containing ext. belladonae, ext. cannabis indicae, ext. cocæ and taka diastase during each meal, and two teaspoonfuls of calcined magnesia an hour after each meal. The bowels were regulated by solid ext. cascara.

Under this treatment she rapidly improved, and in a fortnight was able to digest an ordinary meal without discomfort.

In this case it was quite clear that the excessive secretion was due to increased functional activity of glands, and that there was probably no proliferation of the glandular elements.

CASE 2, GASTROPTOSIS WITH HYDROCHLORIC SUPERACIDITY.—Mrs. K., aged 35, mother of one child, consulted me on Feb. 1st, 1900, on account of pain after eating, and weakness. Her health had been poor for about eight years. She had been treated for prolapse of the uterus, inflammation of the ovaries, and hæmorrhoids. About the beginning of this

year she began to suffer from pain after eating. The pain would usually come on about 4 p.m., and would continue until she ate her tea, when it would be relieved for about two hours. It would then commence again and continue until midnight. The pain was very severe at times. There was neither nausea nor vomiting, but if she could make herself vomit the pain would stop. The patient also complained of flatulency, belching, heartburn and constipation. The tongue was slightly furred. The appetite was fair.

I gave her a test breakfast and analyzed the gastric contents with results as follows: quantity expressed, three ounces; mucus about normal; total free HCl, 42; total acidity, 78.

On inflating the stomach with air the lesser curvature was found to be lower than normal, and the greater curvature passed across the abdomen about two inches below the umbilicus.

TREATMENT:—Abdominal bandage; bland diet, such as recommended in hyperchlorhydria, to be taken in three meals a day as far apart as possible; a mixture of bismuth carb., tinct. belladonnae, tinct. nux. vom. and arom. fl. ext. cascara sagrad. before meals.

Under this treatment the patient rapidly improved and at the present date is quite free from pain after meals.

In this case I believe that the hyperacidity was due to the stagnation of food. The application of the bandage was no doubt the principal factor in affecting a cure.

CASE 3. Ulcer of Stomach preceded by symptoms which usually indicate hyperacidity.—M. C., aged 24, female, patient of Dr. Geo. Balmer, Toronto. I saw her in consultation on Feb. 1st, 1901. Patient had measles in childhood, otherwise had good health until she was 14 years of age. During the following year she began to eat cloves, and suffered a good deal of pain in the stomach while doing so. After two months the pain became so severe that she gave up the habit, and her stomach gave her no further trouble for some years.

At the age of 19 years she began to suffer from hiccoughs and eructations of gas, which would come on about an hour after eating, and last as a rule about half an hour. These symptoms continued for about two years, when she began to have pain in the region of the stomach after eating. The pain would usually come on about an hour after eating and continue an hour. It would frequently radiate to the left shoulder. The pain was always worse after eating salt pork, tough beef, pickles, onions, etc. She did not suffer nearly so much after eating farinaceous foods such as bread, porridge, etc. She did not vomit until Jan., 1900. During that month she was travelling to Winnipeg and vomited and retched for five days. Since then she had no further vomiting until hemorrhage took place on Jan. 26th, 1901, but she suffered more or less from pain after eating.

On Jan. 23rd, 1901, the epigastric pain became much more severe, and on the 26th Jan. she vomited blood. The hemorrhage recurred on the 29th Jan. and again on the 2nd Feb. Since the last hemorrhage the patient has gradually improved.

TREATMENT.—Dr. Balmer saw the patient for the first time on Jan. 26th, and ordered her a hypodermic of morphine sulphate, a mixture of

bismuth subnitrate and codeine phosphate, an icebag to be applied to the epigastrium, and to be nourished by nutrient enemata. After the hemorrhage on the 29th Jan. the bismuth mixture was discontinued and when the haematemesis again recurred on 2nd Feb. everything was withheld from the stomach. This form of treatment was continued for one week when she was allowed a teaspoonful of peptonized milk every two hours by the mouth. The food—peptonized milk, Wemalta and Allenbury's No. 3—by the mouth was gradually increased and a corresponding decrease was made in the nutrient enemata and finally all the nourishment was given by the mouth on Feb. 20th. The patient has at present (March 1st) no gastric distress and only slight eructations of gas.

Gastric ulcer is usually complicated by hyperacidity. In this case the hyperacidity appeared to have preceded the ulcer, but in many cases no such history is obtained.

CASE 4.—J. J., aged 23, consulted me on Feb. 11th, 1901, on account of heaviness and pain after eating, headache, and general lassitude. Family history negative. Patient had good health until 20 years of age, when he suffered for six months from the same symptoms on account of which he now sought advice. He recovered from this attack and had good health until last summer, when he began again to suffer from the same symptoms. The subjective symptoms are flatulency, heaviness after eating, headache, constipation, and occasionally pain after eating. The symptoms are always more marked after a large meal. The headache was always more marked after a large meal or after eating fruit. The appetite was good.

Analysis of the gastric contents after a test breakfast gave the following result:—Quantity 4 ounces; mucus normal; total free HCl 32; total acidity, 70.

The stomach was distended with air and found to be dilated. The water test showed diminished motility, and the splashing sound was readily made out beyond the normal limits.

DIAGNOSIS.—Atonic dilatation with hydrochloric superacidity.

TREATMENT.—A capsule containing *ext. nux. vom.*, *ext. belladonae.*, *ext. cascara sag.* and resorcin before each meal and a bland concentrated diet. The meals were to be taken as far apart as possible. The patient found that he was able to digest his food best when he ate a very light lunch.

Under this treatment the distress after eating quickly disappeared, but he still occasionally suffers from the pain in the head.

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## LATENT APPENDICITIS \*

By J. A. GRANT, Jr., M.D.

St. Luke's Hospital, Ottawa.

I wish to use the title of my paper in a restricted as well as in its fullest sense, that is inferring from the clinical data there is a latency of the absolute conditions present: a grave condition, impossible of diagnosis, as well as an absolutely latent appendicitis, which may be diagnosed only after operation. Not only may the attack be latent, the symptoms of such slight nature that a physician is not consulted, nor even has the patient any symptoms referable to the appendix, but also the gravity of the condition may be latent, the symptoms so slight that many a man would be inclined to treat the case medicinally and await developments, thus greatly reducing the patient's chance of recovery.

Case I.—I was called to see M. S., a young girl aged 11, suffering from severe pains in the right iliac region. The patient has had the usual diseases of childhood, and with the exception of these has always enjoyed good health. She had suffered at times from colicky pains in the intestines, but has never had to lay up or leave school. On the morning of May 24th she was suddenly seized with pain over the appendix, accompanied by vomiting. I removed her to the hospital at once, and on admission found her temperature at 100, pulse, 90, marked tenderness over the region of the appendix; no dulness, but considerable rigidity of the abdominal wall. As the symptoms became more aggravated, I operated the following morning. On examination numerous firm old adhesions were found in the neighborhood of the appendix, binding the caecum firmly to the abdominal walls in many directions. These adhesions were broken down after considerable difficulty, and on bringing the appendix to the surface, it was found acutely inflamed and covered with recent lymph. It was removed and the patient made an uneventful recovery. The fact that this was the first attack that the patient had had to her knowledge, coupled with the presence of numerous old firm adhesions matting the appendix, caecum, and abdominal wall together, shows that there must have been repeated attacks of inflammation in the neighborhood of the appendix that had not caused sufficient symptoms to interfere with the ordinary routine of her life.

Case II.—A. S., aged 26, was admitted June 10th, 1900. Patient was seized three days ago with pain in the right iliac region, and stated he had never had a previous attack. On admission to hospital there was distinct dulness over McBurney's point, nausea, temperature 100, pulse 84. He had had a good night, slight pains at times; slept about five hours. Next morning his temperature was 100, pulse 78, pain very slight, dulness, no nausea or vomiting. He was removed to the operating room, and on making an incision I found the appendix twisted on itself, rup-

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\*Read before the Medical Society of Ottawa, Feb, 1901.

tured at the angle and gangrenous. Many adhesions were present, binding the appendix to the surrounding tissues. The caecal wall in the neighborhood of the adhesions was highly inflamed and almost purple in colour; considerable pus was present. The appendix was removed, parts dusted with iodoform, and a large iodoform gauze drain packed around the caecum. Patient was discharged July 5th, having quite recovered. In this case the illness dated from three days previously, the pain was localized, but not severe, and even intermittent. There was no vomiting, but simply a feeling of nausea. The temperature, while under observation, was only a fraction over 100, and the pulse ranging between 78 and 90. There was distinct dulness over the appendix. Thus the slightness of the symptoms, and short duration of the attack, would hardly lead one to expect to find such a grave condition of affairs, a gangrenous appendix, perforated, and a caecal wall acutely inflamed.

Case III.—Mr. T., aged 29, was admitted to hospital, June 12th, suffering from pain in the iliac region. For some years he had been subject to similar attacks of pain, which passed away in a few days under household measures. The present attack failed to do so, and for the first time a doctor was called in. Two days before he was suddenly seized with pain and severe vomiting, since which time the pain had been constant. On admission to hospital he had a temperature of 102, pulse 98, complaining of weakness and nausea, but no pain. The following day his temperature was 98 3-5, pulse 76, occasionally attempts at vomiting, pain and tenderness in the right iliac region, and some slight distention of the abdomen. At 12 o'clock that day, 3rd, he was operated on, and on opening the abdomen, commencing general peritonitis was found, pus having oozed through the peritoneum as soon as it was incised. There were numerous recent adhesions and some old ones in the region of the appendix. The appendix itself was gangrenous and the colon in its neighborhood was fast becoming so. The appendix was removed, parts carefully dried and dusted with iodoform, iodoform gauze packed freely around the stump, and a large gauze drainage left in the wound. The patient, contrary to my expectation, made an uneventful recovery, and was discharged cured 23 days afterwards. This case was more serious in its aspect, but certainly the man's condition would hardly have led one to suspect general peritonitis and a gangrenous appendix.

Case IV.—Mrs. B., aged 24, had several slight attacks of appendicitis which always yielded to hot fomentations. The present attack began Monday, December 12th, with acute pain over the appendix, tenderness and vomiting. On the 14th she was removed to hospital, and on admission her temperature was 99 2-5, pulse, 100, nausea was present and she had tenderness over the appendix. I operated that day, and found numerous adhesions, the appendix almost gangrenous, distended with pus, and on examining it later it was found that it was on the point of rupturing.

Case V.—Miss E., aged 24, had always enjoyed good health up to one year ago, when she had her first attack of appendicitis. Three months later she had her second. Both attacks were slight. Since then she has been almost an invalid, unable to stand exertion, more or less abdominal

pain present, intestinal indigestion, abdominal fulness and distress, bowels very irregular, general debility and indisposition to work. These symptoms kept on until July last, and, as she was rapidly losing ground, I removed her to hospital. Her temperature on admission was 99, pulse 88, there was slight tenderness and pain over the appendix, which on operation was found to be markedly congested and distended with fluid and adherent to the colon. On removal it was found that a stricture was present at its proximal end, and the appendix was filled with a purulent looking material. Recovery was uneventful. There is no doubt that her impoverished condition during the preceding six months was due to the absorption of faecal toxins from the appendix, as having had her under observation ever since the operation in July last her condition has been one of perfect health, never having felt better in her life. The case was rather chronic, but the symptoms up to the time of the operation were very indefinite, and it was only the fact of former attacks having occurred made me decide to operate, and the operation proved that the constant absorption of the poisonous contents of the appendix was fast undermining her health, and might at any time have assumed an acute aspect.

Case VI.—S. McF., aged 25, was admitted to hospital January 21st, complaining of pain in the right iliac region. Two days ago she was suddenly seized with a sharp pain in the epigastric region, which lasted till the following day. There were periods of relief, lasting about an hour or more. On the second day the pain shifted to the right iliac region, and has been continuous in character. She vomited four times on the second day of the attack. No history of former attack. On admission January 21st, her temperature was 100, pulse 94. She complained of pain in the right iliac region, some tenderness, well marked dulness, no rigidity or tympanites. She was kept under observation for 36 hours, during which time there was no material change in her condition, the marked dulness being the most characteristic condition found. There had been no vomiting since her admission, her temperature had fallen to normal, her pulse 80, but marked dulness, some tenderness, and pain over McBurney's point. On examination in the region of the appendix, the finger detected a large mass apparently the size of an egg, and on bringing this to view the appendix was found pointing backwards, and the base for one-quarter of its length apparently healthy; the outer three-fourths of the appendix was imbedded in a large mass of inflammatory material, binding it firmly to the posterior surface of the caecum; the whole mass was almost purple in colour, and felt as if there might be some pus towards the centre of this rapidly becoming necrotic mass. On breaking down the adhesions, which were so firm as to require ligature in several places, it was found that pus had not yet formed, nor had the appendix ruptured. The remaining adhesions were tied, the appendix liberated and removed. From the amount of inflammatory exudation and its deep purple colour there is little doubt that this mass would have suppurated or become gangrenous in a short time. My first intention was simply to free any pus that was present, clean out the abscess cavity, and treat the case by drainage. Having entered the mass and

found no pus, and having disturbed the adhesions considerably, I thought it wise to remove the offending member, although the appendix was still buried in inflammatory exudation. By ligaturing this mass in sections, the appendix was liberated and removed with very slight hemorrhage. Considering this was a first attack, and only dated since the Saturday previous, five days, no vomiting, temperature normal, pulse 80, and only marked dulness with some pain, one would scarcely expect to find such a large mass of firm vascular inflammatory exudation well advanced towards gangrene.

Mansell Moullin in a paper on "Early Operation on Appendicitis" read before the Harveian Society of London last October, stated that of the symptoms by which cases which would recover of themselves might be distinguished from those that would require operation, the pulse was the most reliable guide. If at the end of 36 hours, while the patient was lying in bed, it was over a hundred a minute, or if in the course of the last few hours it had increased much in frequency, there was no doubt that the attack was a severe one, and that operation would be required. The temperature was no certain guide unless it continued to rise. The intensity of the pain was of great significance, and so were also, but perhaps in less degree, local tenderness, muscular resistance, and a sense of fulness in the right iliac fossæ. Vomiting, constipation and other symptoms usually present could not be relied upon in the same measure. Great stress was laid upon the absence of any individual symptom being of no account, and that operations should be performed in any case in which the pulse was very rapid, even if other symptoms did not point to any great degree of intensity. Here, there is an attempt to estimate the importance of individual symptoms, but so far it must be acknowledged that we are unable to tell with any great degree of certainty what is the actual condition of affairs present. I have purposely given notes of some of my cases where the condition of affairs was much more severe than the clinical symptoms have indicated. It is our goal to be able to diagnose accurately the pathological conditions present, and to estimate the importance of each individual symptom, or rather the importance of the individual symptoms present, as we so often find so many cardinal symptoms absent. It is this very fact of the latency of the conditions present which has such great bearing on the question of operation. Moreover, very rapid pathological changes are liable to take place in any case and at any time, so that no one can state in any given case, no matter how simple to-day, what the conditions will be to-morrow. Our inability to estimate individual symptoms, the grave latent conditions, associated with apparently innocent clinical symptoms, the rapid changes that are liable to take place for the worse in any case, our improved operative technique and aseptic surroundings, together with the percentage of recoveries that we can boast of, all have an important bearing on the future treatment of this disease, and lead me to think that appendicitis is a surgical disease, and the time to operate is as soon as the condition is diagnosed.

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## RADICAL CURE OF LARGE UMBILICAL HERNIA

By DR. W. J. HUNTER EMORY.

Surgeon to Grace Hospital, Toronto.

On the 18th day of January, 1898, Mrs. C. was admitted to Grace Hospital, seeking relief from a very painful condition caused by extensive ulceration in the skin and subcutaneous tissues, covering a large umbilical hernia of long standing. Patient fifty years of age. First noticed protrusion twenty years before. Nine years before, when hernial protrusion was the size of a large orange, she stated that she had consulted Dr. Bull, of New York, who advised against operative interference on the grounds that the extreme corpulency of the patient would render an operation not only very hazardous, but unlikely to result in permanent success. The photograph accompanying was taken just before the operation, after the patient had been three weeks in bed on a restricted diet, with active catharsis, which had reduced the size of the hernial protrusion by at least one half. When first admitted the coverings of the hernia were tense, with numerous ulcers over the surface varying from the size of a pea to that of a half dollar, due to pressure. These healed readily under treatment, and on the 27th day of January the following operation was performed for the radical cure of the hernia, assisted by Dr. G. P. Sylvester.



Hand Grasping Hernia.

An incision was made over the central portion of the mass, opening peritoneal covering. The omentum was found densely adherent to the peritoneum throughout the entire surface, and was separated with great difficulty, being also intimately adherent to the intestines, colon, and stomach, as well as to the parietal peritoneum. When the omentum was

completely separated, a large mass of it, being ragged and torn, was ligatured in sections with catgut, and excised. The adhesions between the various coils of the jejunum, about ten feet of which occupied the hernial sac, and the transverse colon, the major portion of which also occupied the hernial sac, and the stomach, which was entirely protruded through the hernial ring, were gradually separated with great difficulty, and the hernial opening had to be enlarged before the stomach could be returned to the abdominal cavity. When all the contents had been returned to the abdominal cavity the entire hernial sac was excised, including the peritoneal sac and the integumentary structures forming the covering. The peritoneum was then closed by continuous catgut suture; the fibrous structures which unite to form the "linea alba," were firmly united by mattress sutures of silver wire, the remaining layers being closed separately by continuous catgut sutures.

The patient suffered considerably from symptoms of shock during the first few hours, but by the end of twelve hours had reacted nicely, and the convalescence was normal up to the fifth day, when, from some cause, suppuration occurred in the abdominal wound. This, however, was not to be wondered at, considering the very great amount of adipose tissue present. The suppurative process continued for about ten days—the wound eventually healing, and a very firm cicatrix resulting, and at the date of writing no recurrence has taken place, though over three years have intervened.

## SELECTED ARTICLES.

### FACTS ABOUT SMALL-POX AND VACCINATION.

Issued by the Council of the British Medical Association, January 19th, 1898.

#### 1. The Mortality from small-pox is much less now than in prevaccination times.

Bernouilli, the famous mathematician, calculated that no fewer than 15,000,000 of human beings in the last century died of it every 25 years. Stüssmilch, an eminent statistician of the time of Frederick I, estimated that nearly everyone had small-pox, and that it carried off a twelfth part of mankind. In London in 1660-79, of every 80,000 deaths, 4,170 were from small-pox. In Iceland in 1707-9, it killed 18,000 persons in a population of 50,000. In Glasgow, a large and very insanitary town, in 1783-1800, of 31,088, deaths or burials from all causes, 5,959 were due to small-pox. Chester, which on the other hand was described by an eminent authority of the time as a town of "almost incredible" healthiness, had fewer than 15,000 inhabitants and contained in the year 1775 only 1,060 persons, or one in 14, who had not had small-pox. In Kilmarnock, with 4,000 or 5,000 inhabitants in 1728-64, of every 1,000 children born alive 161 died of small-pox. In the village of Ware, in Hertfordshire, after an epidemic in 1722, only 302 persons in a population of 2,515 had never had the small-pox. Such examples could easily be added to. Great diminution of small-pox mortality occurred after the introduction of vaccination where small-pox inoculation never prevailed, and also in places where small-pox inoculation had prevailed.

#### 2. The greatest diminution in the small-pox mortality is found in the early years of life, in which there is most vaccination

In Geneva in the period 1580-1760, during which there were 25,349 small-pox deaths, 961 of every 1,000 were under 10 years of age. In Kilmarnock in 1728-64, of every 1,000 small-pox deaths, 988 were under 10 years of age. In a total of 36,755 deaths from small-pox at all ages occurring in Kilmarnock, Edinburgh, Manchester, Warrington, Chester, Geneva, and the Hague in various prevaccination periods from 1580 onwards, 17,252 were under 2 years of age. In the present day, on the other hand, vaccination being performed in infancy and having its greatest protective influence in the earlier years of life, small-pox has to a great extent departed from children and transferred itself to later and less protected ages. In London in 1884, of 1,000 small-pox deaths, only 343 were under ten years old. But this calculation includes both vaccinated and unvaccinated persons. In the vaccinated community the corresponding figures were not 343, but 86; and in the unvaccinated, not 343, but 312. Among the unvaccinated the 612 is better than the Geneva

961, and the Kilmarnock 988 of prevaccination times. Vaccination, by lessening the opportunities for infection, and increasing the intervals between epidemics, has helped even the unvaccinated. Yet among the unvaccinated in London, Leicester, Dewsbury, and Gloucester, small-pox is still to a great extent a disease of childhood.

In prevaccination times, small-pox, measles and whooping cough were diseases of childhood. Measles and whooping cough are still diseases of childhood, but small-pox, and especially fatal small-pox, has been to a very remarkable extent driven from vaccinated childhood by means of vaccination. In the same way, what still remains of it can be driven from later periods of life by means of revaccination.

The manner in which small-pox differentiates between the vaccinated and unvaccinated is seen in the incidence of the disease in towns where it has recently prevailed. In Gloucester, for example, there had been extreme neglect of infantile vaccination, and the disease attacked a school and spread there, the scholars being children. In Leicester the infection was accidentally introduced into the scarlet fever hospital and the children being unvaccinated the disease began to spread there. The hospital was then emptied of scarlet fever and no more cases were admitted, and in the town of Leicester scarlet fever cases increased to thousands. In Warrington on the other hand, infantile vaccination had been well carried out, but there was a want of adult revaccination and the disease fastened on the workmen in a large ironworks. Then the workmen's committee in charge of the sick fund resolved "that any member who remains unrevaccinated after Monday, November 2<sup>nd</sup>, 1892, shall not be entitled to any sick benefit should he be afflicted with small-pox;" and in consequence over 1,400 men were revaccinated by the works' doctor, and many others privately. The result was that after the middle of December there were only 12 cases among the employees, and the health officer of Warrington reported that these were among men who had refused revaccination or joined the works subsequently.

The following table teaches a lesson that cannot easily be misread.

*Percentage of total small-pox deaths borne by children under 10 years of age in recent outbreaks.*

	Vaccination Default in antecedent years.	Percentage of total small-pox deaths borne by children under 10 years of age.
Warrington	Very slight	22.5
Sheffield	Very slight	25.6
London	In 1883-91, 10 per cent.	36.8
Dewsbury	In 1882-92, 32.3 per cent.	51.8
Gloucester	In 1885-94, 10.6 to 85.1 per cent.	64.5
Leicester	In 1883-92, 43.8 to 80.1 per cent.	71.4*

\*Or 66.6. The difference depends on the exclusion or inclusion of three deaths which occurred owing to the attack of several children in a scarlet fever ward through proximity to the small-pox hospital.

**3. In countries where there is much vaccination and re-vaccination relative-ly to the population, there is little small-pox.**

In Prussia both vaccination and revaccination are compulsory, and small-pox mortality is almost abolished.\* Beginning with the year 1816, it is found that in that country previous to the law of 1874 the small-pox death-rate was 309 per annum per million of population. Since then, ending with 1892, it has been 15, and in the last ten years of the period only 7. Moreover, the compulsory vaccination age is the second year of life, and investigation showed that in 1886-90 more than two-fifths of the few deaths that occurred from small-pox were under two years of age. In Austria where vaccination is not compulsory, the rate instead of being 7 per million as in Prussia, was 458 in the same period. In Belgium also vaccination is not compulsory, and in 1875-84 it had a rate of 441 per million as compared with Prussia's 22 in the same period. In Italy since 1888 vaccination of infants has been compulsory, as has revaccination of children attending *public* schools. Already a great improvement is indicated. In 1881-90 the small-pox death rate was 355 per million per annum, and in 1891-94 it was only 65. At the time of the European epidemic of 1870-75 Scotland, England, Sweden and Bavaria had a compulsory vaccination law, and their small-pox rates per million in the worst years were 1,470, 1,830, 1,660 and 1,660 respectively. Prussia, Holland and Austria had no general compulsory vaccination, and their rates in the worst years were 5,060, 5,490, and 6,180. Coming to 1877-86, with vaccination not compulsory in Austria, with only infantile vaccination compulsory in England, and with vaccination and revaccination compulsory in Prussia, the average death rate per million from small-pox in the capitals of these three countries was in Vienna 670, in London 250, and in Berlin 10. In London the rate would have been less but for the disease spreading from the small-pox hospitals that it then contained.

**4. In classes among which there is much vaccination and re-vaccination there is little small-pox.**

In epidemics, as in London, Sheffield, and Warrington, re vaccinated postman and policemen remained safe in the midst of exposure to infection. Sir Charles Dilke stated in 1883 that the average strength of the permanent postal service in London was 10,504 in 1870-80, and yet during all that period including the great epidemic, there was not a single death from small pox, and only ten slight cases. In 1891-94, the employees of the General Post Office were over 55,000, yet there was only 17 cases of small-pox and one death, though postmen owing to the nature of their duties are specially exposed to infection.

In the Army and Navy, where a large majority of the men are successfully revaccinated, there is very little small-pox—very much less than before revaccination become so prevalent.

No persons are so terribly exposed to infectious diseases as are the nurses in fever and small-pox hospitals. As regards fever nurses, Dr.

\*As regards the Prussian vaccination laws see BRIT. MED. JOUR., 1894, vol. ii, p. 1213 and Dr. Edwards in *The Practitioner* of May, 1896

Collie, Medical Superintendent of Homerton Hospital, declared that "the only way in which nurses become seasoned against fever is by taking the disease." At Homerton, Stockwell, and Liverpool Road Fever Hospitals, in the ten years ending 1881, 133 of the staff were attacked by various fevers, and 25 died. The Gateshead Medical Officer wrote: "Every nurse who has been more than a fortnight in the typhus wards has suffered from typhus." In Newcastle in 1882 only 5 out of 14 nurses escaped typhus, and among the 9 attacks there were two deaths. In the Hospitals of the Metropolitan Asylums Board in 1887-95, no fewer than 704 of the attendants contracted scarlet fever, diphtheria, or enteric fever.

How is it as regards small-pox? At Homerton Hospital in 1871-77 366 persons were employed. All but one was revaccinated and she was the only one who took small-pox. In the Highgate Hospital the Royal Commission found that since May, 1883, of 137 nurses and attendants 30 had had small-pox before entering the service. Of the other 107 all except the gardener were revaccinated, and the gardener was the only one who took small-pox. In the Sheffield hospitals, in the year ending 31st March, 1888, there were treated 1,798 small-pox patients. The total number of attendants, etc., was 161. Of these 18 had had small-pox previously and escaped attack; 63 had been vaccinated in infancy, of whom six were attacked and one died; the other 80 were successfully revaccinated, and not one contracted small-pox. In Leicester, however, where vaccination is neglected, some of the nurses refused revaccination. In the outbreak there the total hospital staff consisted of 40 persons. Of these 14 had either had small-pox or had been revaccinated before the outbreak, and 20 were vaccinated owing to the outbreak. Among these 34 (14 and 20) one mild case occurred in a nurse whose revaccination was ten years old. Six of the 40 nurses appear to have been imbued with anti-vaccination opinions, and refused revaccination. Only one of the six now needs any protection against small-pox. Five of them took it and one died.

5. **In places where small-pox prevails it attacks a much greater proportion of the unvaccinated than of the vaccinated, especially where the vaccinations are comparatively recent.**

In the Homerton Small-pox Hospital in over 10,000 cases treated by Dr. Gayton nearly 21 per cent. were unvaccinated, and among children under 10 the unvaccinated were no less than 47.6 per cent. The unvaccinated at this time (1873-84) in the population from which the cases were drawn did not amount nearly to 21 per cent. much less to 47 per cent. On the other hand, there is one hospital (Highgate) which does not admit children under seven and which draws its patients from a more universally vaccinated section of the population, and this hospital differed from others in London in that the percentage of unvaccinated patients was found to be much less, the difference being due to the difference in the ages of admitted cases, and the difference in the prevalence of vaccination in the population from which cases came.

**6. In houses invaded by small-pox in the course of an out-break not nearly so many of the vaccinated inmates are attacked as of the unvaccinated in proportion to their numbers.**

Taking children under 10 years old, in infected houses in Dewsbury, 10.2 per cent. of the vaccinated were attacked, and 50.8 per cent. of the unvaccinated; in Leicester, 2.5 per cent. of the vaccinated, and 35 per cent. of the unvaccinated; in Gloucester 8.8 per cent. of the vaccinated, and 46.3 per cent. of the unvaccinated. These places are selected here because they are centres of antivaccination, as to which it cannot be truthfully alleged that the unvaccinated are weakly children whose vaccination has been postponed by medical certificate, or that the vaccinated and unvaccinated children belong to different classes especially when they are compared in the households actually invaded by the disease. It is urged by antivaccinationists that vaccination does not protect against small-pox, but on the contrary tends to weaken the system against all disease. Yet the vaccinated were attacked in much less proportion than the unvaccinated.

**7. The fatality rate among persons attacked by smallpox is much greater, age for age, among the unvaccinated than among vaccinated**

Taking the 10,403 cases treated in Homerton Hospital in 1873-84, the deaths among the vaccinated 8,234 were 869, or 10.5 per cent., and among the unvaccinated 2,169, were 938, or 43.4 per cent. We shall see shortly that the deaths among the well vaccinated were only 3 per cent. Taking the epidemics in three towns, Dewsbury, Leicester and Gloucester, where vaccination has been neglected, we find that under 10 years of age, among 72 vaccinated children attacked, two died, or 2.7 per cent., but among 961 unvaccinated children attacked 350 died, or 37.3 per cent. Taking persons over 10 years old, among 1,959 vaccinated persons attacked, there were 136 deaths or 6.9 per cent., and among 31 unvaccinated persons there were 75 deaths, or 22.6 per cent. Again it is to be noted that as vaccination was practically optional in these towns, the unvaccinated children, according to anti-vaccination theories, should have been more able to resist death by smallpox than those who had been subjected to an operation which is alleged to weaken the system and render it more liable to disease and death.

**8. It cannot be truthfully alleged that independently of vaccination smallpox is a milder disease now than in former centuries.**

If it were the case, as is sometimes argued by anti-vaccinationists, that the smallpox fatality rate in last century was about 18 per cent.\* of persons attacked, then the much higher rate now occurring among the un-vaccinated would show the disease to be much more severe now than then. But in the last century, as in the present century, the fatality varied greatly in different outbreaks, as does the fatality of scarlet fever,

\* This rate is based mainly on a prevalence of the disease in certain towns in the West Riding of Yorkshire in certain years between 1720 and 1730, but no average, either for a century or for a country can be calculated on such limited data. (*Vaccination Vindicated*, pp. 57-59.)

diphtheria, measles, etc., in the present century. And in epidemics in the present century, whether they be mild or severe, whether the fatalities be few or many, and whether there be much or little vaccination in the community, it is found that both the attack rate and the fatality rate are much greater in the unvaccinated than in the vaccinated in proportion to their numbers.

**9. The degree of protection conferred by vaccination corresponds to the thoroughness with which the operation has been performed, three or four marks being much better than one or two, and a large mark much better than a small one.**

In Dr. Glayton's 10,403 cases at the Homerton Hospital, 2,085 had good marks, and the fatality rate was 3 per cent.; 4,854 had indifferent marks, and the fatality rate was 9 per cent.; 1,295 were alleged to be vaccinated, but had no marks, and the fatality rate was 27 per cent.; and 2,169 were unvaccinated and the fatality rate was 43 per cent. Taking "good" marks only, and attending to their numbers, Dr. Gayton found that with one mark the fatality rate was 4.1 per cent.; with two marks, 3.3 per cent.; with three marks, 2.3 per cent.; with four or more marks, 1.5 per cent. The cases on which these percentages are founded were 529, 649, 518 and 389 respectively. Taking nearly 7,000 cases observed in recent years, the Royal Commission found that the smallpox fatality rate in persons with one mark was 6.2 per cent.; with two marks, 5.8 per cent.; with three marks, 3.7 per cent.; and with four marks, 2.2 per cent.

It is comparatively seldom that cases come to hospital with the smallpox eruption so far advanced and profuse as to obscure the vaccination marks, but in hospital statistics in this country a column is provided for "doubtful" cases, and if the figures for any large hospital be examined it will be seen that the inclusion of such cases either as "vaccinated" or "unvaccinated" does not alter the lesson taught by the statistics.

**10. Sanitation cannot account for the facts above set forth.**

Whooping cough and measles deaths still belong to childhood as in the last century, while smallpox deaths have been removed from childhood to later periods of life. How could sanitation account for this differentiation? If it be suggested that because sanitation confers a special benefit on children it may have altered the age incidence of smallpox, the answer is got by looking at facts. In Germany, as we have seen, vaccination is not compulsory till the second year, and over 40 per cent. of all the smallpox deaths occur under two years of age. In Scotland the vaccination age is six months, and children under six months make just about the same contribution (138 deaths per 1,000 deaths) to the total smallpox deaths as they did (139 deaths per 1,000) before the vaccination law was passed. But in the next half-year of life—the half-year of vaccination—the contribution has fallen from 153 to 47. Surely this is vaccination and not sanitation. In a community attacked by

smallpox, how could sanitation at home protect postmen going from door to door day after day in the infected districts? In Leicester, how could sanitation account for the revaccinated nurses escaping smallpox, and the nurses who had refused revaccination taking smallpox? How could sanitation cause smallpox to pass over vaccinated children and seize on unvaccinated children in houses invaded by smallpox in Dewsbury and Leicester and Gloucester? How can sanitation have caused the fatality of smallpox cases to be much less among the vaccinated than among the unvaccinated in these towns, especially if vaccination weakens the system and makes it less resistant to disease as is alleged by anti-vaccinationists? How could sanitation cause children with three or four vaccination marks to have a less fatality from smallpox than children with one or two vaccination marks? In Glasgow, while sanitation was going from bad to worse in the early part of the century, vaccination was introduced and smallpox underwent an enormous diminution, though hospitals and isolation and disinfection were entirely out of the question. In Gloucester vaccination had been neglected and in 1891 the secretary to the anti-vaccination league declared to the Royal Commission that Gloucester was a very clean town and had always been well abreast of sanitary improvements, and that its death-rate was very low. The Board of Guardians also wrote to the Commission on the same lines. But smallpox came, and the town suffered from a terrible epidemic, and ever since then the anti-vaccinationists have been declaring that there was a great want of sanitation in Gloucester. What was wanting was vaccination.

For convenience the Registrar-General many years ago grouped together places whose death-rate was low and classified them as "healthy districts." They were nearly all found to be sparsely populated rural districts where, though houses may be damp and overcrowded and other insanitary conditions prevail, there is little opportunity for infection. In such places, in spite of bad sanitation, there is a lower death-rate than in towns, because, independently of sanitary effort, the atmosphere is purer. Also there is less small-pox, and it comes at a later average age, because there is less facility for spread of infection on account of the smallness of the population and the distance of house from house and village from village. In such circumstances, though there is little sanitary effort there is little small pox, and unvaccinated persons have a better chance of escaping small pox attack than they have in large towns where sanitary arrangements are more elaborate.

**11. Though isolation of small-pox cases in hospitals is a useful auxiliary to vaccination it is no substitute for it.**

In an unvaccinated nation it would be utterly impracticable to provide sufficient small-pox hospitals. For whooping cough and measles hospital accommodation has not been seriously attempted, though these diseases cause an enormous mortality. Where, owing to vaccination liability to small-pox is limited, hospitals are very useful and help to give time for general revaccination. But in an unprotected community their almost certain breakdown is obvious. Who would have attended to the

sick in Leicester if all nurses had had the same experience as the nurses who refused revaccination? In an unprotected community, instead of smallpox being limited, it would spread in rapidly widening circles. Where a person protects himself by vaccination and revaccination he can defy smallpox. He carries his protection with him wherever he goes and a father can obtain protection both for himself and his family. Even if isolation in hospitals were made more stringently compulsory than vaccination has ever been in this country there could be no complete security. The protection of the individual might fail at any moment. It would depend not on himself but on other people. His cordon of protection would be a chain, the measure of whose strength would be its feeblest link, and over not one link would he have efficient control. Failure of parents to observe the symptoms of illness; failure to call in a doctor; failure of the doctor to recognize smallpox; failure in promptitude of removal; inadequacy of hospital accommodation; insufficiency of disinfection of persons and things—these would be among the risks to which even a law of compulsory isolation would leave him exposed. Obviously the risk of collapse of voluntary isolation would be much greater.

## 12. Vaccination is very safe.

Nothing done by human beings is entirely without risk, but the risks of vaccination have been grossly exaggerated. Some of the earliest antivaccinationists held that the countenance of a vaccinated child might be transformed so as to assume "the visage of a cow." Later on, in the 'fifties, vaccination was accused of making people bald-headed, short-sighted, lazy, and of causing degeneracy in music, painting, oratory, poetry, etc. Still later, the habit has been to get statistical returns of increasing and decreasing diseases from the Registrar-General, and to attribute the increasing diseases to vaccination, and to use the decreasing diseases to illustrate the view that smallpox also might decrease without vaccination. But a disease may be increasing at one time and decreasing at another. Thus at one time cholera and enteric fever and scarlet fever were blamed on vaccination, but when these diseases began to decrease, their decrease was, and still is, held to show the needlessness of vaccination.

One foul disease in particular has been blamed on vaccination. It happens that since Leicester gave up vaccination that disease has increased there much more rapidly among infants than in the rest of England. So also erysipelas, while it decreased in England by 16 per cent., increased in Leicester by 41 per cent. Similarly, diarrhoea, dysentery and bronchitis, all of which have been blamed to vaccination, increased much more in Leicester than in England. The periods under comparison are 1863-67 and 1883-87. It is not to be supposed that the increase in these diseases is due to want of vaccination, but if instead of increasing they had diminished in Leicester, it is undeniable that their diminution would have been attributed by antivaccinationists to diminution in vaccination, just as increase of many sorts of disease has been attributed by them to vaccination where vaccination is not neglected as in Leicester. The Royal Commission made most careful search for injuries resulting from vaccin-

ation, and, after the fullest consideration, arrived at the deliberate conclusion that such injuries are "insignificant" and "diminishing" and can be still further diminished. So insignificant are they that vaccination is nowhere more nearly universal than in the families of medical men, who love their children as other men do, and who know much better than other men can do, the exceeding safety of vaccination.

**13. Calf lymph is now available to Boards of Guardians, etc., for the vaccination of every child in the country.**

Reverting to the foul disease which has formed the principal allegation by antivaccinationists, it is to be noted that the use of calf lymph makes its occurrence through vaccination an absolute impossibility, as calves are not subject to that disease.

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### SOME FACTS IN REGARD TO THE TREATMENT OF INFLUENZA.

There are very few diseases which in their early stages produce such mild symptoms, and which on the other hand are capable of being so rapidly fatal in their results, as influenza. There is probably no malady in which careful nursing and the avoidance of exposure will so certainly produce recovery in the ordinary individual as this disease; and conversely, there is no illness which if subjected to poor nursing associated with exposure is capable of producing more serious consequences. While the patient may feel generally wretched in the early stages of invasion, he often does not feel sufficiently ill to force him to his bed. His fever is often moderate, and strength at this period is not sufficiently decreased to impress upon his mind the necessity of its preservation by absolute rest. The result is that very frequently the patient keeps on his feet, as does a case of walking typhoid fever, until his vital energies are so sapped that he becomes not only bed-ridden but in desperate straits, and then it is that the physician is called upon with the expectation that he will give speedy relief. Unfortunately, in many of these cases, consolidation of the lung, feebleness of the heart muscle, or renal complications are important factors in the case which cannot be speedily dissipated, and which often resist all our efforts at betterment.

Undoubtedly much more can be done in the way of prophylaxis when a person is taken ill with influenza than can be accomplished by active medicinal interference, and the prospects of rapid recovery are always in direct proportion to the willingness of the patient to lie by for a few days when he is first taken ill. Ever since the great epidemic of influenza which swept over the country in 1889 and 1890 and thereabouts, physicians have constantly met with cases of cardiac disease which have dated their illness from the attack of grippe suffered at that time. Many of these patients previous to that epidemic were already sufferers from valvular affections of the heart, but were unconscious of the valvular defect until the influenzal poison so sapped the strength of their heart muscle that a rupture of compensation occurred. In other instances persons who had previous to that illness perfectly healthy hearts have now apparently perfect valves, but nevertheless suffer from evidence of heart feebleness, continuously or upon marked exertion. In these cases the influenzal poison seems to have expended its energy solely upon the heart muscle and produced a cardiac asthenia which it is often impossible to overcome. Many of these cases of cardiac asthenia depend upon the patient having disregarded his physician's advice and insisted upon getting out of bed before the heart muscle had time to recover from the disease. Every patient should be told when taken ill with influenza that the surest way to reach perfect recovery is to call upon all the vital functions of his body to the least possible extent during his illness, resting

assured that the old motto of "Make haste slowly" holds true most emphatically in this disease. In many instances no other treatment than this advice is really needed, although in many of them it is advisable from the very beginning of the illness to administer some mild alkaline diuretic, which is perhaps best represented by the following prescription :

R Potassii citratis, ʒ ij;  
 Spiritus ætheris nitrosi, f ʒ j;  
 Aquæ dest., q s. ad f ʒ iv. M.  
 S: Dessertspoonful every four hours.

This prescription will maintain urinary flow, be slightly antipyretic in its influence, will perhaps aid in the destruction of the toxic materials, and certainly will aid in their elimination by the kidneys; and it cannot be doubted that free diuresis for the purpose of eliminating the impurities of the body is an important part of the treatment of all infective diseases.

For the muscular and bone pains of influenza the application of a hot-water bag or hot brick to the part of the body which is in greatest suffering will often be efficacious, and is much better than the administration of coal-tar products, which are apt to help produce cyanosis and nervous depression, and which give the kidneys additional work in elimination. But if these symptoms are marked, acetanilid in what is well known as the migraine tablet, which contains two grains of acetanilid, half a grain of citrated caffeine, and one grain of monobromated camphor, may be administered several times a day; or in its place phenacetine and salol, as these preparations seem to depress the circulation less than some of the other coal-tar combinations.

If an irritable cough, unassociated with distinct bronchial or pulmonary trouble, annoys the patient, doses of codeine, say one-tenth to one-fifth of a grain, may be administered several times a day with advantage; and if headache is marked and of a congestive type, with cold in the head and frontal fulness, a hot mustard foot-bath repeated several times a day will often give relief, and is a much better method of treatment than the administration of drugs.

In some cases of influenza the heart seems to be considerably depressed by the action of the disease, and it is necessary to administer stimulants. But in the great majority of instances, if the patient will remain flat on his back in bed the use of stimulants is unnecessary, and if they can be avoided it is best not to administer them. If they are given, moderate doses of the alcoholic stimulants are probably best, particularly if whiskey or brandy is administered, in the form of hot lemonade, which, while acting as a stimulant to the circulatory system, will also increase the activity of the skin and kidneys in eliminating toxic materials. We do not think that the fever ought ever to be lowered by coal-tar products, but always by sponging with tepid water; or, if the temperature is very high, by the use of the so-called sponging or rubbing of the body with a small piece of ice, using active friction with the other hand, and keeping cold applied to the head so as to avoid cerebral congestion during the sponging. Where patients object to the use of cold

water or ice, alcohol and water, half and half, may be employed, and in other instances a mixture of equal parts of warm vinegar, warm water, and alcohol may be used with advantage, in that sponging with this liquid not only cools the skin but opens the pores, washes off effete materials, soothes the peripheral sensory nerves, and by so doing tends to produce sleep.

Another drug which is of value because of its influence in increasing secretion of the skin, and because it relieves pain in the muscles and bones, is Dover's powder. But this substance often seems to produce secondary depression in blond, sanguine persons, and because of the opium it contains is liable to increase constipation, which should not be encouraged in the presence of a condition where it is desirable to aid in elimination as much as possible.—*Therapeutic Gazette.*

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### ENEMAS.

The position has much to do with the comfort of the patient and more so with the effect of the enema. The following positions are most used :—

Sims's or left lateral, in any cases where the patient can be placed without discomfort or danger of tearing stitches, as in a recent laparotomy.

Dorsal in any case where patient cannot be turned on the side, and in giving rectal irrigations.

Right lateral when complete laceration of perineum exists.

Genu-pectoral, or knee-chest, position when giving rectal irrigations or when giving medicated enemas, as in cases of dysentery, etc.

Trendelenburg's position immediately after an operation when stimulating or saline enemas are given, especially if the sphincter-muscles are relaxed.

An evacuant enema consists of either pure water to which is added a little salt or soap-suds. This enema should not be very large, 1 to 2 pints being a sufficient amount. It can be given either high or low, but the latter is most commonly used.

A purgative enema is given when an increased peristaltic action is desired, and consists generally of some irritating medicine mixed with water, salt solution, or soap-suds. The following prescriptions have proved very efficient :—

℞ Turpentine,  $\frac{1}{2}$  ounce.  
Mag. sulph., 1 ounce.  
Castor-oil, 1 ounce.  
Warm water, 1 pint.

℞ Ox-gall, 15 grains.  
Turpentine,  $\frac{1}{2}$  ounce.  
Glycerin, 1 ounce.  
Castor-oil, 1 ounce.  
Soap-suds, 1 pint.

The ox-gall should first be dissolved in a little warm water.

In cases of severe constipation, when the fæces are clogged in the lower bowels, it will often be necessary to remove them with the fingers, then inject 5 to 8 ounces of warm olive-oil, which should be retained for one hour, followed by an evacuant enema. In cases of operation upon the perineum, rectum, etc., the bowels should never be allowed to be moved the first time after the operation without an oil enema; this will prevent much pain and irritation to parts surrounding the stitches.

An antispasmodic enema is given in cases of colic either in adult or child. This enema gives great relief to patient in cases of tympanites. It is best given in Sims's positions. If the flatulence is caused by fer-

mented food, a purgative should be given by mouth, and an enema consisting of:—

℞ Mag. sulph., 1 ounce.  
Turpentine,  $\frac{1}{2}$  ounce.  
Hot water,  $\frac{1}{2}$  ounce.

given high will often give great relief. Flatulence that occurs in pregnancy is relieved by injecting through a hard-rubber syringe the following:

℞ Yelk of an egg;  
Turpentine,  $\frac{1}{2}$  ounce.

well beaten together.

An astringent enema is given to reduce chronic inflammation; to check diarrhœa and hæmorrhages from the bowels. It consists generally of starch and opium and some astringent:

℞ Tannic acid, 10 grains;  
Tinct. opii, 15 grains;  
Mucilage of starch, 2 ounce,

injected cold after each defecation.

In cases of bleeding and irritating ulcers in the rectum:—

℞ Nitrate of silver, 5 grains;  
Water, 1 ounce,

injected cold once or twice, and is very effectual.

A stimulating enema is given in cases of low vitality. A stimulating enema should always contain some salt, should be hot, and given high in large or small quantities depending on the circumstances. It consists of some kind of alcoholic fluid, such as whisky, brandy, or pure alcohol. The pure alcohol should only be given one-half dose.

℞ Whisky or brandy,  $\frac{1}{2}$  to 2 ounces.  
Normal salt sol.,  $\frac{1}{2}$  to 4 pints.

Strong coffee with whisky is very good stimulating enema in cases of morphine poisoning, and is given in quantities, as  $\frac{1}{2}$  pint to 2 ounces.

A nutrient enema is given to nourish the system through the bowels when nothing can be retained on the stomach. All food given through the rectum should be predigested or peptonized, should contain salt, and be warm. The quantity should be small, but repeated often. The bowels should first be well cleansed, then quieted, if necessary, by aid of tinct. opii, 15 minims, or cocaine,  $\frac{1}{4}$  grain, in solution injected through a small glass syringe. The enema is always given high, and between each enema the bowels should be well flushed with normal salt solution to remove all irritating remains. A nutrient enema is best given through a funnel and tube, but a Davidson syringe can be used if the nurse is gentle and careful. The patient should be placed in either Sims's, dorsol, or Trendelenburg's position, according to circumstances.

To peptonize milk, chicken-broth or soup, beef-tea, oyster-broth or soup, or clam-broth or soup, one may use 15 grains of bicarbonate of soda and 5 grains of pancreatin to each pint of fluid used. The powder is dissolved in a little water; then the fluid, which should be tepid, is added, and the vessel containing this preparation is placed in a large vessel containing water at a temperature of 90 F. The water must reach the

margin of the food to be peptonized, which should remain in the water for exactly twenty minutes. If it remains longer or at a higher temperature it curdles and is unfit for use. After the food is peptonized it should be placed on ice and reheated when needed. Leibig's beef-extract and Wyeth's beef-juice are very good agents, and do not need to be peptonized.

The following prescriptions are valuable :—

- ℞ Either  
Milk,  
Chicken-broth,  
Beef-tea,  
Oyster-broth,  
Clam-broth, 8 ounces.
- ℞ Liebig's beef-extract 1 ounce.  
Hot water, 4 ounces.  
Whisky,  $\frac{1}{2}$  ounce,  
Sodium chloride, 15 grains.
- ℞ Wyeth's beef-juice 1 ounce.  
Tepid water, 1 ounce.

This nourishment should be repeated every three or four hours as needed.

A forced enema is given in cases of obstruction of the bowels and small tumors of the bowels in children. It consists of large quantities of plain tepid water or oxygen. The rectum should be emptied, then plugged with a rubber cork, through which the nozzle of the syringe is introduced, and the anus should be strongly supported to prevent expulsion of the enema. This treatment is very painful, but is sometimes very successfully administered. Hanna Kindbom (trained nurse and Hospital Review).—*Monthly Cyclopaedia*.

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## SOCIETY REPORTS.

### TORONTO CLINICAL SOCIETY,

Stated meeting March 6th, 1901.

Dr. George A. Peters, the vice-president, in the chair.

Visitors present:—Dr. Clarence Starr, and Dr. Ryerson of the Sick Children's Hospital.

#### Case of Convulsive Tic.

Dr. R. D. Rudolf presented the patient and read notes of the case. This condition of tic really means a jerk or twitch or spasm. He referred to an exceedingly good article on the subject in Clifford Allbutt's System of Medicine by Dr. Russell, who divides it into four different classes. Dr. Rudolf thought that the first class that of simple tic, which is sometimes called habit spasm, was very badly named because it was not always due to habit. The other part of the name is also wrong; it is not convulsive; it is simple because the patient utters no ejaculations.

J. B., aged fifty-seven years, who came complaining of twitching of the muscles of the face and neck, and the duration of whose illness was then about fifteen months. He had been married seven years; no children. There was no history of spasms of any kind in any of the members of his family. His previous history showed that he had always been strong; and there was no history of venereal disease. Outside of his present trouble he was strong and healthy. The present attacks began six months ago; began by a great deal of twitching of both eyes; and much worse when walking about. When he was sitting still he was not troubled with it at all. Dr. Rudolf saw him first in March of last year; that was six months after the commencement of his illness. He suffered then from spasms of the eyelids, coming on at irregular intervals. The patient occasionally assumed a condition of risus sardonius. He was decidedly worse in December. It involved the facial muscles as well as the orbicularis palpebrarum. This almost makes him blind. There is nothing abnormal in any of the muscles of the neck. When sitting quietly he is pretty steady. The twitchings are rapid—about one hundred and twenty to the minute. When he tries to open the eyes, he momentarily succeeds, but spasm in face and neck sets in. His forehead wrinkles up and relaxes; and he assumes the risus sardonius condition. The strands of the platysma stand out like cords. The sterno-mastoid also involved. The head is occasionally drawn forward and to the right side. If the eyelids are forcibly opened, the condition is found to involve the external muscles of the eyes so that the eyes are rolled about. The tongue does not seem to be affected; and speech is unaffected. When he stands the spasms are worse and so close his eyes that he is partially blind. His head rotates from side to side and he endeavors to hold it with both hands. Saliva increases in the mouth, and a peculiar snuffing

induced. These are very constant in the disease. The eyes were examined by Dr. Reeve, who found them practically normal beyond a little presbyopia. There is a good deal of watering of the eyes. Romberg's symptom is absent. The knee jerks are absolutely gone, when tried a few weeks ago. There is no headache, but occasionally pain about the muscles of the neck when the spasms are on. There are no abnormal sensations anywhere. The spasms are all gone when he is asleep. He is almost, if not quite, as bad when sitting in the dark as when sitting in the light. He can sit or lie in bed with his eyes closed and be pretty free from the spasm, but if he opens them the spasms begin at once. The act of opening them brings on the spasms—in the light. When the spasms are very bad, he puts his hands to his head and neck, and by pressure he slightly controls them. It is quite evident that this case belongs to the first class of Dr. Russell, viz., simple tic. He has not any of the verbal ejaculations, except under sufficient provocation. It is certainly not psychical.

As regards the cause of this condition. There have been numerous causes mentioned. It is frequently habit. Blephorospasm from conjunctivitis, and lasting long years after the irritation has gone. Habit spasm is a bad name because it is not present in all cases. It is not hereditary in this case. The age: most commonly it commences in youth, but occasionally, as in this man, who was fifty-five or fifty seven when it commenced. Irritation from some scar is another cause, but there is no such cause to be found in this case. The most common cause, or associated condition, seems to be some error in accommodation. Dr. Sinclair found error of accommodation in forty-one out of forty-nine cases,—quoted by Dr. Russell. There is very little wrong with the eyes in this case. The case is a typical one. Dr. Osler mentions that a dozen of these cases may be attending any clinic. Dr. Rudolf does not think them so common. He came across a very slight case this winter. In the treatment he has tried various remedies. Bromides had no effect at all. Nitro glycerine absolutely had no effect here. At present the patient is taking liquor arsenicalis—five minims three times a day. Dr. Rudolf thinks he is slightly better than he was at first.

The patient was examined by the Fellows present and it was found that the man had a large right scrotal hernia.

Dr. Oldright asked whether the zinc salts were of any worth in these cases.

Dr. Primrose referred to scars as a cause of tic; and asked whether it is common to have a unilateral condition in these cases, or common to have both sides involved, or one side only.

Dr. Peters asked if Dr. Rudolf had discovered any reflex exciting cause excepting the hernia, which he has had a great many years; for instance, anything in the Schneiderian membrane, and if stuttering has any relation to this disease. He also referred to the case of a bandsman in one of the city bands, who stutters very badly, who jerks his head to the side frequently and utters ejaculations. Dr. Peters has noticed quite recently that someone has been operating on these cases by cutting the seventh nerve and transplanting the spinal accessory into its distal end. He claims in that way to have got rid of the spasms, without having

complete paralysis. This operation had done it in two or three cases with beneficial results. Possibly, taking out a section of the orbicularis muscle might relieve the intensity of the eye spasm.

Dr. Rudolf in reply: He thought that stuttering would come under the heading of the co-ordinated form of tic, not this unco-ordinated form. He has seen cases of that kind,—inspiratory form of stuttering. Cutting the facial nerve and joining it to the spinal accessory might do in a unilateral case, but does not see what good it could do in this case where the condition is generalized. Dividing of the orbicularis muscle on both sides might possibly do some good. The prognosis at the present is very poor indeed. Regarding Dr. Primrose's question, if due to a scar, would it be unilateral,—he does not think so always. Dr. Reeve strongly suspected there would be a scar somewhere. Dr. Rudolf has not tried the zinc salts. The prognosis is exceedingly poor, and Dr. Rudolf stated he was glad of the suggestion of operation on the orbicularis palpebrarum. The condition now, practically makes the patient blind. The man has had right inguinal complete hernia for forty years.

### Tendon Transplanting in Paralytic Deformities.

Dr. Clarence L. Starr by invitation presented this paper with the histories of four cases. The treatment of paralytic deformities has been until recently by means of mechanical support, and where operative treatment had been added, it was in long-standing deformities, and in these a simple operation has been done and the necessary mechanical support applied afterwards to prevent relapse. The outlook for that has not been bright. Within the past few years other attempts have been made to prevent or correct deformity. In 1881, transplanting of the peroneal tendon into the tendo-Achillis was first performed. One cannot claim that the operation will cure or is applicable in the large number of cases of deformities. Some are, however, completely cured. Operation is clearly indicated where a group of muscles are left unimpaired while others are paralyzed. Better results may be looked for here than elsewhere. Dr. Starr then reported the following four cases in detail.

Case 1. A boy five years of age, who had had acute infantile spinal paralysis with complete paralysis of the right limb. The peronei muscles remained inactive. The patient walked on the outer border of the foot entirely. The tendon of the peroneus longus was isolated; a second incision made above the ankle joint, and the tendon of the tibial is anticus exposed. These tendons were united. The foot is now perfectly flat.

Case 2. A young girl fourteen years of age. Perfect valgus was present in this case—equino-valgus, the calf muscles being paralyzed as well. It was desirable to get a firm base of support in the right leg. An oblique incision was made from above the outer malleolus downwards and inwards so as to expose the peronei tendons and the tendo-Achillis. The brevis was divided and carried underneath the tendo-Achillis and attached to a slip of the flexor longus hallucis. The peroneus longus was then divided and attached in the same way to the tendo-Achillis. The

wound was closed and splints applied. Passive motion was commenced in three weeks; and in six weeks the patient was able to bear her weight upon it, and she is now able to walk.

Case 3. A young lad aged 18 years with marked valgus deformity resulting from infantile paralysis. He walked with a stiff and awkward gait. An oblique incision was made over the extensor tendons. The extensor longus digitorum was isolated. This patient was allowed to walk in six weeks; and his gait was very much improved.

Case 4. This patient, a boy aged five years, was presented to the Fellows. He had had an acute attack of paralysis in July '99, which involved both lower extremities. The right gradually improved and is now apparently totally recovered; the left, only partially deformed, showed the regular typical club foot. In January 1901, the peronei and extensor muscles were permanently paralyzed, giving no response to the faradic current. The boy walked altogether on the upper surface and dorsum of the foot. Walked distinctly on the outer side, the plantar surface being turned inward and backward towards the opposite foot. There was marked toe drop except in the great toe. The boy was operated on January 23rd when a curved incision was made exposing both peronei and the tendo-Achillis. The wound healed by primary union were removed only a few days before his being presented to the society. There is noted marked improvement in the position and stability of the foot. The plantar surface comes in contact with the floor at every step.

A great deal may be done for these otherwise helpless class of deformities, and it is essential that primary healing be secured or the operation will prove useless latterly. Kangaroo tendon should be used in these operations; silk is likely to come out later on. Motion should not be allowed until four or five weeks, as tendons unite very slowly. In this case the extensor communis digitorum was attached to the tibialis anticus.

It is absolutely necessary if you use a mechanical support of any kind to replace it by a larger one so that the patients are thoroughly disgusted when they arrive at adult life. Dr. Primrose has suggested the possibility of nerve grafting; but Dr. Starr did not remember ever hearing of any case where that had been attempted. He had heard it discussed in the American Orthopedic Association.

### Unusual Dilatation of Bladder.

Dr. William Britton presented these pathological specimens and described the conditions present in each patient. The first occurred in a gentleman, 75 years of age, who has always lived a careful life. He had come to Dr. Britton last winter complaining of difficulty in voiding his urine. He had to use more force than was natural. Dr. Britton examined him and found what appeared to be a tremendous cyst of some character extending up as far as the lower margin of the ribs on the left side, the greater part of the tumor appearing to be to the left of the median line. The doctor used the catheter the following day and drew off seventy or eighty ounces of urine. The character of the urine was

the same as was found subsequently at post mortem. After a few days he was seized with coma and died in this comatose condition after seventy-two hours. A post mortem examination was made by Dr. H. B. Anderson. Found prostate very much enlarged; ureters much dilated; kidneys about normal in size, but evidence of hydro nephrosis. Bladder was full with about seventy or eighty ounces. The urine was limpid, almost as clear as water. Dr. Britton did not know the exact quantity of urine he was voiding prior to his coming to see him. The sp. gr was 1,008. Bladder was a great deal hypertrophied. The walls were thickened, and there were very small extravasations beneath the mucous membrane.

### Cancer of Stomach.

The case of cancer of the stomach occurred in a man who in ordinary health weighed 196 lbs., a machinist by occupation. He had always lived the life of an old country Englishman, that is, he ate as much as he wanted to. He was very robust, and Dr. Britton had known him for ten years. Last fall he began to become emaciated. He was reduced from his former weight of 196 pounds to 117 pounds. That would seem to be almost beyond belief. He had been suffering about a year and one half with the ordinary symptoms of cancer, except that he suffered from no pain from first to last. In the first instance, one and one half years before he was seen by Dr. Britton, he had discomfort in the stomach which would continue for two or three days when he would vomit large quantities of undigested food, and would be relieved by drinking large quantities of water. The intervals of relief became shorter and shorter. Dr. Britton was not able to find any tumor and nothing but positive evidence of closure of pylorus. He was fed per rectum for two weeks during which time he gained seven pounds in weight. He was seen by Mr. Cameron who performed gastro-duodenostomy. He died a short time afterwards. On opening the stomach it was found to be very much enlarged, the walls being very much thickened. At the pyloric extremity there was a soft cancer attached to the walls all round, but there was sufficient opening so that the doctor could pass his finger easily through the pylorus. When food entered the stomach, the cancer was pressed down and acted as a sort of ball valve. There was no exit from the stomach to the intestines. Before the operation, Dr. Anderson made an examination of the contents of the stomach, and the details of the report pointed towards the existence of cancer. HCl was not present. No lymphatic glands were affected at all. The cancer was a very small one, and it was extraordinary that it should have caused death by starvation. The lungs were in a perfectly normal condition, and the other organs of the body as well; no metastasis.

Dr. Fotheringham asked if a microscopical examination had been made as to the exact character of the new growth.

Dr. Rodolf asked the composition of the nutrient enemata which produced the large gain in weight.

Dr. Peters thought it a remarkable feature of the case, the pronounced loss in weight with so small a growth; and the fact that the

cancer had evidently produced death in the end was one which would appear to have been amenable to treatment by pylorotomy, there being no enlargement of glands and no metastasis of the liver. He considered it a rare condition to find cancer as old as this without these conditions being present. Most cases when discovered are so far advanced that you cannot remove the pyloric end of the stomach on account of metastasis etc. Symptoms of cancer of the pylorus are very slight in character for a long time, and by the time a positive diagnosis has been made it has gone past the reach of the surgeon. Gastro-enterostomy was the proper operation had the patient been strong enough to stand it.

Dr. Primrose began the discussion on the bladder case. A question which has occurred to him in connection with a case recently under his care—whether it is wise to interfere at all with a greatly distended bladder, or whether it is not wiser to open abdomen and establish drainage. He further referred to several cases in his own practice.

Dr. Silverhorn asked whether Dr. Britton had any difficulty in passing a catheter.

Dr. Oldright mentioned a case where a man had not passed urine for 36 hours, he drew off 60 ounces of urine. What does Dr. Britton consider was the cause of death in his case?

Dr. Britton stated he did not look upon it as a case of sepsis.

Dr. Peters had stated there must be something else than that.

Dr. Britton in reply stated that a microscopic examination had been made of the stomach and the report was cancer. The enemata consisted of thoroughly peptonized milk.

As to the bladder case, he had not been able to assign the cause.

GEORGE ELLIOTT,

Recording Secretary.

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## MISCELLANEOUS.

### EMERGENCY HOSPITAL AT THE PAN-AMERICAN.

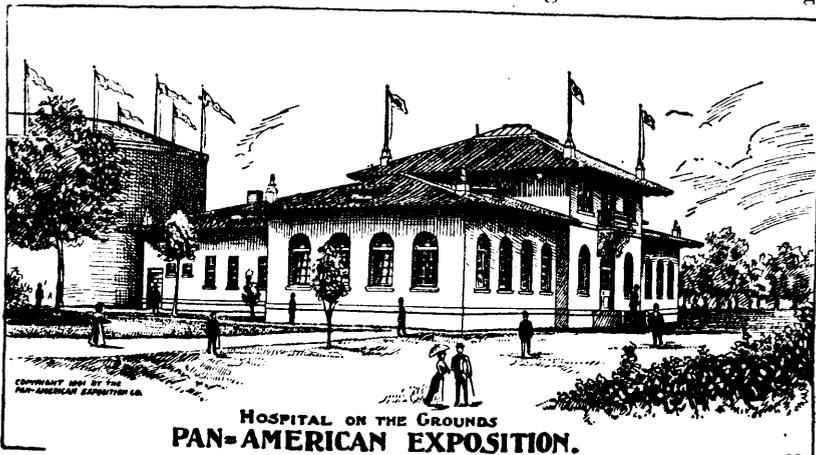
By HERBERT SHEARER.

A very pretty hospital building stands near the west end of the Mall. Floor area rather than elevation is a prominent feature in the construction of this important adjunct to the exposition. Utility, first, last and all the time is the prime consideration in this design though it is by no means a case of utility unadorned. In conformity with the general Exposition plan the free Spanish renaissance has been treated, in this instance, with a strong leaning towards the old mission interpretation.

Having a frontage of 90 feet on the Mall ; the main wing has a depth of 38 feet with a height of but one story, except in the center, where it assumes the form of a square tower with a rounded top. This tower attains to the pretentious height of two stories surmounted with two flagstuffs. One staff supports the Exposition flag and from the other waves the well known red cross banner, the only universal international emblem that is recognized and revered in all countries.

A rear wing one story high runs back from the center portion a distance of 56 feet with a width of 32 feet. This form of construction lends itself readily to this picture-que reminder of the early struggles of our first missionaries.

Color, here as everywhere throughout the grounds, adds its mantle of beauty to the odd and in many cases obsolete methods of construction, penetrating, rather than clothing the building in the warm changing



tints of the sunset. A low wandering adobe mission house covered with heavy red tiling, its weather stains retouched by the gorgeous rays of the departing sun, may be readily imagined while looking at this rehabilitation of the past.

Any antiquated illusion that may be conveyed by the outside appearance of this building is, however, at once dispelled by a visit to the interior.

Modern arrangements that are both convenient and sanitary mark every feature. Approved medical and surgical appliances have been carefully selected in regard especially for their adaptability to emergency work and the exigencies that are likely to arise.

The main hospital entrance is from the Mall opening directly into a handsome rotunda decorated with tropical plants and suitable hangings of pictures, drapery, etc.

The main office is situated at the farther left hand corner of this rotunda where it is carefully tucked away under the staircase forming an irregular alcove. It contains telephone and electrical annunciator, and messenger call service, with other modern and necessary appurtenances.

As this is lighted from above and encircled by a round gallery opening through the upper story the effect is very pleasant and agreeable. The first floor front contains in the extreme western wing, two male wards with seven cots each, a bath room, physician's office, a morgue and a linen chest. The eastern wing contains a woman's ward, large enough to hold a dozen cots, with direct communication to the woman's bath room. This wing also contains an office for the superintendent of nurses, private physician's office, a linen closet and other conveniences.

The upper story is intended for the use of the resident physicians and the necessary attendants. It is fitted up with four pleasant, comfortable bedrooms and a bathroom. The rear wing extending back from the main entrance, contains the operating room, sterilizing department and instrument cases. Immediately across the hall is the emergency bathroom and patients' waiting-room. Still farther down the corridor is located the kitchen, pantry and dining-room, which is intended for the use of patients only, as the staff have their culinary department in the service building situated but a few yards distant. In the extreme southern end of this wing is the storage room for electrical ambulances; this room also contains a station for recharging the batteries; electricity for this purpose being brought from an electric circuit provided for the electric launches on the Grand Canal. In addition to the two electrical ambulances, a steam or gasoline motor ambulance will be provided to be ready in case of a possible failure of the electrical current. The building is provided with natural gas for heating purposes and for cooking when necessary for the patients.

Water, gas and electricity is carried to every part of the hospital in the most approved manner.

The building is plastered throughout and rendered sanitary and germ proof so far as possible, in every instance. The staff in attendance are uniformed to grade according to universal custom.

In the matter of equipment and appliances, everything is of the newest and best. A new litter attracts considerable attention; it is carefully balanced and so arranged that one attendant can operate it easily and noiselessly as it runs on two wheels about 20 inches in diameter which are fitted with large inflated rubber tires. Sterilizing apparatus with an apartment for instruments and another for towels and linen, is another necessary arrangement.

Roswell Park, M.D., is the Director, Vertner Kenerson, M.D., Deputy Director and Dr. Alexander Allen, is the resident physician, a staff which will at once inspire confidence in all who are acquainted with these gentlemen or their work. The efficiency of this department is an illustration of the manner in which the Exposition is designed and executed in all its departments. Everything has been carefully arranged according to a great comprehensive plan, the details of which have been worked out in every instance with careful conscientious precision.

In regard to the importance of this adjunct to the Exposition it may be said that up to the first of March five hundred and four cases have been treated on the grounds, only one of which proved fatal. These include all forms of sickness and accidents to workmen employed upon the

construction work. In this connection it is well to note that the number of cases treated at the Omaha Exposition was about three thousand while the history of the hospital at the World's Fair in Chicago gives a total of 11,602 medical and surgical cases treated, resulting in 69 deaths.

It is hoped to have less use than this for the hospital at the Pan-American though in the immense crowds who will attend, no doubt, many individuals will have occasion to appreciate the provision that has been made in this direction.

**THREE DANGEROUS OPERATIONS.**—J. B. Deaver, (*Philadelphia Medical Journal*) protests vigorously against the abuse of three common operations in gynecology. First of these is repair of lacerated cervix. The condition is so common that it is more normal than pathological. In the absence of special indications, such as the cancerous diathesis, it had better be left alone. Salpingitis, pyosalpinx and adhesions strongly contraindicate, and endometritis should be previously corrected. Curettement of the uterus is a dangerous operation and calls for a rigid observance of aseptic and anti-septic details. In acute endometritis, the possibility of perforation and in chronic endometritis, the possibility of lighting up a latent salpingitis must be borne in mind. The presence of gonococci positively contraindicates curettement. Divulsion of the cervix should never be done except under anesthesia and with complete cleanliness. It ought never to be done in the office. It is unsatisfactory in cervical stenosis and a failure for the correction of flexions.—*St. Louis Medical Review*.

**ORGANO-THERAPY IN GYNECOLOGICAL THERAPEUTICS.** Harvey P. Jack (*International Jour. of Surg.*) says that there has been more advance along the line of organo-therapy than in any other department of experimental therapeutics. The use of thyroid extract in cretinism and myxœdema is well known, but medication almost as specific, and results almost as striking, are to be obtained by the use of this and the parotid, mammary and ovarian gland extracts in gynecological therapeutics.

Thyroid extract is one of the most reliable vaso-constrictors, and in gynecology its use is indicated in hemorrhagic affections of the uterus and in various forms of pelvic congestion; the best results are to be expected in fibromas and pathologic conditions of recent development. Polk has noted also an increase in nervous and muscular energy, improved nutrition and lessening of pain. Shober has obtained equally good results in fibromas from the administration of mammary gland extract, and it is not followed by the symptoms of thyroidism. It controls the hemorrhages, reduces the size of the tumors, and in some cases causes their disappearance. It does not seem to have any effect on the hemorrhages of inoperable cervical cancer, as does thyroid extract. This may be explained by the fact that thyroid extract has a special catalytic action upon the epithelial elements of the endometrium. In two cases of inoperable cancer of the uterus in the writer's practice, thyroid extract controlled the hemorrhage, and in one case the pain. Parotid extract is the best remedy for dysmenorrhœa and ovaritis. Pelvic exudates soften and are often absorbed. Menstruation becomes regular, less in amount

and shorter in duration, while the headaches and nervous symptoms so often accompanying the monthly period are, as a rule, cured.

The ovarian extract is indicated in all cases of nervous trouble at the menopause, and also where it is desirable to increase the flow from the uterus. The ovary has, besides its function of ovulation, another almost as important, that of internal secretion, and, like the thyroid, secretes an active oxidizing agent, spermin, that aids in the metabolism of the blood.

Parotid extract is the best ovarian sedative, and ovarian extract the best ovarian stimulant. It is probable that as we learn more of the different physiological effects of each gland, as studied alone and in combination, more exact therapeutic application may be deduced and gland therapy may take the place, in a large measure, of surgical procedures.—*Am. Gyn. and Obst. Jour.*

**SURGICAL HINTS.** Never minimize to a patient the importance of any operation. They all offer certain dangers, and no branch of your art may be considered as of a trivial nature.

If you are compelled to put on a bandage rather tightly, it is well to warn the patient that it must not be removed, but that, if it becomes painful, a few snips of the scissors will give relief.

No operation about the mouth, such as removal of the tongue, or about any of the orifices of the body, ought to be undertaken without previous methodical disinfection continued for several days.

Never be in a hurry to amputate in wounds of the fingers or hand. Observation under treatment by antiseptics will often result in saving important parts, which at first seemed quite hopeless.

In small abscesses, occurring in infected wounds, whether they involve the whole or only a portion of the wound, there is no better treatment than the removal of stitches, washing out with peroxide of hydrogen, and thoroughly painting the pyogenic surfaces with tincture of iodine.

It is a fault of many operators that they are constantly asking questions of the anaesthetist during operations. Only employ a man you can trust, and then leave him alone to bear the sole responsibility of his share in the operation. He may have a hard enough time in coping with a patient who takes the anaesthetic badly without being disturbed by constant admonitions.

**INDIGESTION.** T. Lauder Brunton lays down the following rules for the treatment of chronic function in dyspepsia: The first rule is to eat slowly, masticate thoroughly, and insalivate completely; three things which are by no means always the same. The next rule is to take solids and liquids separately, the latter in the shape of hot water on rising in the morning, between eleven and twelve in the forenoon, about four or five in the afternoon, and at night before going to bed. When these rules do not suffice to remove the dyspepsia, the patient must take his farinaceous and proteid foods at different meals alternately, a farinaceous meal at breakfast-time and again at five o'clock, and meat or fish meals at midnight and at eight o'clock. In some cases it will be found advantageous to supplement the gastric juice with a little acid and pepsin. A little alkali with calumba may be given before meals, or if there is gastric

catarrh some substance containing tannin, such as infusion of gentian, may be preferable. In cases with flabby tongue perchloride of iron with quassia will probably be of more service. When there is gastric dilatation which will not yield to the measures above mentioned, it may be necessary to wash out the stomach in the morning or at night.—*The Clinical Journal*.

TREATMENT OF THE GRIPPE.—Knowing that influenza, as rheumatism, is particularly frequent during the cold and wet season, and has for the mucous membrane a predilection analogous to that of rheumatism for the serous membranes, Dr. Bourget, Professor Medical Clinique, has been experimenting on the effects of a treatment similar to that of rheumatism. His liniment is composed as follows:—

Salicylic acid, ʒj ;  
 Salicylate of methyle, ʒijss ;  
 Essence of eucalyptus, ʒj ;  
 Camphorated oil, ʒj ;  
 Spirit of juniper, ʒiv.

A portion of this mixture is rubbed strongly over the chest and the back of the patient, who is then closely covered up to the chin with the bedclothes. The heat of the bed caused evaporation of the aromatic essences, and favours the absorption of the salicylic acid, and the patient experiences a sensation of *bien être*.

Not only for influenza has Prof. Bourget used this liniment with success, but also in several affections of the respiratory organs.—*Medical Press and Circular*.

#### AN OINTMENT FOR CHRONIC BLEPHARITIS.—

R Binoxide of mercury..... 1½ grains ;  
 Lead water..... 10 drops ;  
 Petrolatum..... 5 drachms.

M.

To be applied night and morning to the free edges of the lids.—*N. Y. Medical Journal*.

HEMORRHOIDS.—In the *Richmond Journal of Practice* for January, John G. Rennie gives a plan of treatment in painful hemorrhoids.

His method of treatment includes rest in bed with elevation of hips, light diet, contents of bowels soluble, and cleanliness. To avoid constipation he uses cascara, 20 to 30 minims of the fluid extract once or twice daily.

He uses the following prescription locally :

R Acid carbol.  
 Menthol..... a.a. gr. xii  
 Cocaine hydrochlorate..... gr. xiv  
 Acid Tannic..... gr. xvi  
 Vaseline alb. .... q.s. ʒi

M. Sig. For local use.

—*Charlotte Medical Journal*.

## LUMBAGO AND MUSCULAR RHEUMATISM.—

Menthol .....	20 gr.
Salicylic acid .....	1 $\frac{5}{8}$
Chloral hydrate.....	
Camphor.....	aa 40 gr.
Powd. capsicum .....	90 gr.
Croton oil .....	5 gtt.
Petrolatum .....	2 $\frac{3}{4}$

Rub in vigorously, a small quantity at a time.—*Med. Fortnightly.*

## CHRONIC ECZEMA AND PSORIASIS.—

R Creolin .....	$\frac{3}{8}$ ss.
Hydrarg. ammon .....	gr. x.
Petrolati .....	$\frac{3}{8}$ i.

—DAVID WALSH.—*Medical Record.*

Infuse in:

Boiling water .....	250 gm.
Filter and add:	
Asafoetida .....	4 gm.
Yellow of egg .....	No. i.

S. For rectal use.

## ANTINEURALGIC PILL.—

R Zinci valerianat.....	0.05 cgm.
Quininæ valerianat .....	0.10 cgm.
Ext. opii.....	0.01 cgm.
Ext. bellad .....	0.05 cgm.

For one pill. S. Two to six daily.

—YVON.

## SWEATING IN PHTHISIS.—

R Scopoliaë (alkaloid) .....	0.015 mgm.
Spt. vini rect ..	6. $\frac{1}{2}$ gm.
M. S. Gtt. x. three times daily.	

—DUCKWORT AND DUNSTANT.—*N. Y. Medical Record.*

# The Canada Lancet

A MONTHLY JOURNAL OF MEDICAL AND SURGICAL SCIENCE, CRITICISM  
AND NEWS.

The Oldest Medical Journal in the Dominion : Established 1867.

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## EDITORIAL.

### MEDICAL AMALGAMATION IN TORONTO.

As the LANCET by an editorial in April last inaugurated the movement for a friendly approach between the two medical teaching bodies in Toronto, it may be not out of place to detail the course of the negotiations with that end in view now brought to a close by the refusal of the Corporation of Trinity Medical College to assent to the terms formulated by the joint committee. While negotiations were pending we refrained from any comment which might be a breach of confidence or which might tend to make more difficult the delicate adjustments necessary in such an undertaking. Now that the joint committee which has had the matter in hand is dissolved, a statement of the sequence of events in the negotiations is permissible, and is, moreover, due to the profession at large.

After the failure to secure by the "McKay Bill," at the last session of the Legislature, better relations between Trinity Medical College and the Provincial University, many prominent members of the two medical teaching bodies in Toronto thought it to be an opportune time for the burying of old differences and for uniting in a scheme for placing medical education

in Ontario on a more satisfactory basis. At their instance the Senate of Toronto University appointed a committee to act as a joint committee with one appointed at the same time by the Corporation of Trinity Medical College. The personnel of this joint committee was as follows: From the Senate of Toronto University—Rev. Principal Caven, Chairman, with Sir Wm. R. Meredith, Chancellor, Mr. Justice Moss, Vice-Chancellor, Sir John Boyd, Hon. S. H. Blake, Drs. I. H. Cameron, A. H. Wright and A. B. McCallum. From Trinity College there were Drs. W. B. Geikie, Dean of the Faculty; J. A. Temple, F. Le M. Grasett, Chas. Sheard, J. L. Davison, N. A. Powell, G. A. Bingham and J. T. Fotheringham, with Dr. D. J. G. Wishart, the Secretary of the Corporation. This joint committee met before the summer vacation and appointed a sub-committee, composed of Dr. Cameron, Chairman, with Drs. Wright and McCallum, and Drs. Temple, Powell and Davison, to confer as to the general principle of amalgamation and its feasibility. This sub-committee's report was brought in, received and adopted by the joint committee in June, 1900, and was to the effect that amalgamation was desirable, and that no insuperable obstacles to its accomplishment presented themselves. In October the sub-committee was enlarged by the addition of Drs. Charles Sheard and R. A. Reeve, Dean of the Faculty of Toronto University, with Dr. Sheard as Chairman, and was instructed to prepare a statement of appointments, emoluments and other details as a tentative basis for the formation of a new joint Faculty. This they did after many laborious seditments, and submitted their report to the joint committee shortly after the New Year. The joint committee received this report and, prior to laying it before the Senate of Toronto University and the Corporation of Trinity Medical College, the bodies from whom it had its origin, thought it wise to transmit it to the two Medical Faculties concerned, for an expression of their opinion as to the details proposed, and for further suggestions and amendments.

The Toronto University Medical Faculty made no response to the request of the joint committee for an expression of their opinion, and the reply received from the Corporation of Trinity Medical College dealt rather with a proposal in favour of "federation upon broad lines," with retention of their identity as a teaching body, than with amalgamation and the conditions proposed by the sub-committee. This being submitted as Trinity's final statement in the matter, the joint committee, having no further purpose to serve, dissolved, and the negotiations may be held to be at an end.

Other facts that appeared during the negotiations may be mentioned.

The scheme, so far as the general principle at any rate was concerned, met with favour and support; firstly,—from the Senate of Toronto University, particularly its lay members; secondly, from the Government, which unofficially but plainly announced its sympathy with the project; thirdly, we believe from a majority of the members of both medical faculties. There seems to have been uncompromising opposition to amalgamation by certain members of both medical faculties for reasons that do not appear on the surface, and this minority was able to prevent the consummation of a project which we believe met with very general endorsement by both the profession and the public.

Notwithstanding that the episode seems closed, we venture to reiterate the opinion expressed a year ago—that an amalgamation would have been the best, if not the only means of settling present difficulties and disagreements, and laying the foundation for a permanently satisfactory system of medical education in the Province. It must appear to the most casual observer that, while undergraduate teaching in this city is well up to the standard at present prevailing in other centres, we have not arisen to the fulness of our undoubted opportunities in the matter of medical research and direct contributions to scientific medical literature, and we feel assured that these most desirable ends would be greatly advanced by uniting all our resources and energy to further them.

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### AUTOINTOXICATION IN RELATION TO INSANITY.

As a result of the excellent research work that has been carried on during the past few years in the asylums for the insane in Europe and America, much knowledge has been gained of the etiology of insanity, which brings the treatment of many cases within the range of practical therapeutics, where hitherto little hope of cure would have been held out. Both as regards prevention and cure the study of insanity has thus assumed a position of much greater importance to the general practitioner, who can no longer afford to disregard derangements or diseases of such moment to the afflicted individual and his friends, nor to think that his duty as a physician is done when the unfortunate has been relegated to a place of confinement. In no class of disease has progress been so much retarded by reason of their being too often regarded as outside the realm of pathology, as if insanity were due to supernatural agencies rather than the result of gross or minute structural lesions in the brain. Fortunately more rational ideas now prevail and the relationship of mind and matter are better understood. Hazy, indefinite, almost superstitious, ideas, previously held, have given place to more rational conceptions and the basis

of a definite pathology has been laid, with a more or less satisfactory classification based on etiology, or on structural changes in the brain itself. The result has been to create a new interest in a field hitherto much neglected. One need only mention the good work that has followed upon more attention to surgical treatment in the insane, even though at times certain individuals may have allowed their enthusiasm to carry them to extremes in reference to it.

The more careful study of the influence of morphine, cocaine, alcohol and other poisons in producing mental disease, as well as of the bacterial toxins in causing the delirium and other psychoses so often seen in the acute infective diseases, has thrown a flood of light upon the etiology of insanity in general, productive of excellent practical results. The relationship of the brain and its functions to the general nutrition is also more clearly understood, thus explaining the effect of chronic diseases of the liver, kidneys, bowels, etc.,—conditions associated with auto-intoxication—in upsetting the mental equilibrium of susceptible persons. Hamilton, Berkeley and others have particularly called attention to this matter and insisted on its importance.

Many instances have been quoted where removal of the source of toxæmia—as constipation or obstipation, has been followed by a prompt cure. The treatment is so simple and rational that such a possible cause should always be borne in mind. A careful inquiry into the etiology of all cases of insanity coming under the physician's notice would not infrequently discover conditions amenable to treatment and restoration to health from a condition otherwise hopeless.

In view of the fact that other countries are doing so much to assist the scientific study of insanity and whereas the increase of cases in Ontario is continually calling for more accommodation for confining these unfortunates at a great expense to the country, it seems a pity that our local legislature does absolutely nothing towards establishing facilities for research work in this direction, with a view to preventive measures.

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### THE PROPOSED BILL FOR THE TREATMENT OF INEBRIATES.

In the January number of *THE LANCET* we gave an abstract of the proposed bill for the treatment of inebriates. This bill, it will be remembered, was drafted by the Public Health Committee of the Ontario Medical Association and a committee of the Prisoners' Aid Association, and was ratified by the Ontario Medical Association, in June last. The principle of that bill, it will also be remembered, has been endorsed

by the Canadian Medical Association and by the Toronto Medical Society. The bill was drafted a year ago at the request of the Premier of Ontario, was endorsed by the medical members of the Legislature, so that it was fully expected that the bill would have been introduced last session. We now learn, we must confess, to our surprise, that it is quite possible that it may not even be brought down this session. At an interview with the Provincial Secretary a few weeks ago, he stated that although the members of the Government and the inspectors of prisons were in full accord with the provisions of the bill he could not state when it would be introduced.

Failing to introduce the bill last session—from whatever cause—we took it for granted that it would be brought down without fail this session, and we expected that reference would be made thereto at the opening of the legislature. While we cannot conceal our disappointment at this set back, possibly no good would result from denouncing the Government for its reprehensible tardiness in dealing with so important a question. Having failed to move the Government by deputations and direct application, it now remains to be seen what may be accomplished by an appeal to the individual members of the legislature. We doubt that one member in ten really understands the question. If the members once understood the question we believe the bill would be introduced and passed without difficulty this session. Here is an opportunity for missionary work on the part of each member of the profession throughout the Province. Copies of the proposed bill will be furnished members of the Medical Council from whom they may be obtained. If each member of the profession would procure a copy and would bring the question personally to the attention of his representative in the Ontario Legislature, the whole question, we feel assured, would be settled in short order. Let each member of the profession realize his responsibility in this important matter and act accordingly.

Copies of the bill may also be obtained of Dr. Rosebrugh, Confederation Building, or to Dr. Gilbert Gordon, 646 Spadina Avenue, Toronto.

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### THE MALPRACTICE SUIT AGAINST DR. CONERTY.

We have previously called the attention of the readers of THE LANCET to the genuine hardship inflicted upon Dr. J. M. Conerty of Smith's Falls in having to defend a suit for malpractice that has been dragging through the courts for the past five years. In fighting this case Dr. Conerty has not only been upholding his own rights and honor but those of the profession. The prolonged litigation has almost ruined him finan-

cially and in the absence of any medical defence union, this is a case where his medical brethren should show their sympathy and appreciation by coming to his assistance. We cannot do better than quote from a circular issued to the members of the profession in No. 17 medical district by their representative, Dr. R. W. Powell, of Ottawa.

"The annoyance, indignity and financial loss involved in the defence of such an action—particularly when the plaintiff is penniless—is a hardship which should arouse our sympathies. Dr. Conerty has made a good fight and is determined to do so to the end. His interests in the case are largely our own. It is in the absence of any medical protective or defence association that I am compelled to make this appeal and I hope that every physician in this division will do honor to himself and his profession by contributing whatever sum he may feel disposed to in order that the professional standing of a brother practitioner may be vindicated. A moderate subscription from each one of us would be greatly appreciated by Dr. Conerty—with whose consent I am making this appeal. Any subscriptions to me will be acknowledged and forwarded."

We hope the appeal made by Dr. Powell may meet with a ready response by the profession throughout the Dominion. THE LANCET will be pleased to receive and acknowledge subscriptions to enable Dr. Conerty to bring the case to a satisfactory termination. The final hearing has been set for April 29th. Besides individual subscriptions, various local medical societies could greatly assist by following the example of the Medico-Chirurgical Society of Montreal in voting a sum for the defence of a case in which all are interested.

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### THE ONTARIO MEDICAL ASSOCIATION.

The annual meeting of the Association will be held in Toronto on June 19th and 20th. The committees have been at work for the past two months and the arrangements are now well under way. The Committee on Papers, under the guidance of Dr. Machell, have arranged for discussions on the following subjects, which it is thought will be of interest from medical, surgical and pathological aspects alike,—*Gastric Ulcer* and *Empyema*. The discussions will be opened in each case by a physician and a surgeon by short papers, and general discussion will follow.

There will also be a discussion on Extra-uterine Pregnancy.

As this Association is the Provincial medical body, it is hoped that all parts of the Province will be well and fully represented, not alone by the presence of members or those intending to become such, but in the active interest in the proceedings, of which it is the privilege of all to partake.

In the course of a few days cards of notice will be sent to all members informing them of the date of meeting, and asking for titles of papers or reports of cases to be presented. It will assist the committee in their work if the titles of papers be sent to the secretary at an early date.

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### POST HOC ERGO PROPTER HOC.

The following delightful document was recently handed in anonymously at the door of a house in Toronto which bore the yellow placard of diphtheria. The naïvete and childlike faith of the writer of it, his absolute disregard of cause and effect, his evident kindness of intention, find their full and adequate explanation in the legend inscribed at the foot of the manuscript:—"Receipt from Ireland." The medical man who was in charge of the case, and who is so ungrudgingly credited with sufficient capacity to "easily treat the boil," need not be much of a philosopher in order to keep his temper, and, instead of resenting too violently the attempted interference with his management of the case, to ruminate upon the extraordinary persistence of the Galenian theory of *humours* in the public mind in general, and the perennial fount of humour, usually as here, unconscious in the Hibernian mind in particular:—

#### "SURE CURE FOR DIPHTHERIA.

Lately given to one after we have lost one child--we wish we had known of it before.

Get 4 salt herrings right in the brine. Slice them in thin long strips. Wrap them thickly all round the throat. Bind them round with cotton strips, and flannel afterwards. Let them be on all night. In the morning a boil will be raised through which the badness will come instead of going into the system. Of course the doctor can easily treat the boil.

FROM A SYMPATHIZER."

Receipt from Ireland.

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## EDITORIAL NOTES.

### The Medical Act of British Columbia.

An attempt is being made at the present session of the Provincial Legislature of British Columbia to get an amendment to the Medical Act so as to allow all graduates of recognized colleges or licentiates from any part of Great Britain or her colonies to practice there without further examination.

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### Colonial Doctors in the Imperial Service.

Legislation is being procured at the present session of the Imperial Parliament which will qualify graduates of colonial colleges for appointment on the Royal Army Medical Staff. It was felt by many that an unjust slight was placed upon colonial medical officers during the South African campaign in this matter.

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### When Did They Happen?

Several deaths among children in Toronto, Canada, have been traced to eating ice-cream which had been re-frozen.—*The Medicus*.

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## PERSONAL.

Dr. J. F. W. Ross has returned to Toronto after a two months holiday in the West Indies.

Dr. Samuel Lavine (Trinity '99) is opening an office on John street, Toronto.

Dr. Harry Watson (Trinity '97) is assistant surgeon with the American forces at Manilla.

We are pleased to learn that Dr. Price Brown, of Carlton street, has returned from the south greatly improved in health.

Dr. Nattress, we are glad to know, has returned from The Welland, St. Catharines, much improved in health.

Dr. W. T. Rush (Trinity '97) has returned to Toronto from mission work in British Columbia.

Dr. John M. Macdonald (Trin. '97) has been appointed associate coroner for the county of Halton.

Dr. G. A. Peters has been given command of the new corps of Mounted Infantry being raised in Toronto, with the rank of major.

Drs. A. H. Wright, W. P. Caven and Crawford Scadding sail for Europe in April, where they will spend some months.

Dr. Hugh A. McCallum, of London, Ont., has passed the examinations for the M. R. C. P. of London.

The engagement of Dr. Victor McWilliams, of Peterborough, to Miss Sheppard, daughter of O. B. Sheppard, Esq., of Toronto, is announced.

Dr. F. S. Pope (Trin. '98) of Victoria, B. C., is doing past graduate work in London, England; as also is Dr. A. R. Perry (Trin. '97).

Dr. D. A. McGillvray has returned from Europe and will take Dr. Fotheringham's practice during his absence in England.

Dr. Wm. McCallum, of Jarvis street, will have the sympathy of the profession in the death of his brother from appendicitis.

Dr. Fotheringham sails for England in a few weeks, where he will devote his attention to diseases of the skin and nervous system for some months.

Dr. D. M. Anderson (Trin. '98) for the past two and a half years surgeon on the "Empress of India," has returned to Toronto after a trip to Australia, South Africa and England.

Dr. G. B. Smith, of College St., Toronto, will have the deepest sympathy of the profession in the death of his wife on Mar. 17th, after a short illness.

Dr. T. H. Prust (Trin. '99) of Eastern Mich., was married on March 20th to Miss Vina Belleghem, daughter of D. Belleghem, Esq., of Peterboro'. THE LANCET offers congratulations.

Dr. E. C. Ashton (Trinity '98), formerly house surgeon in the Hospital for Sick Children and afterwards medical superintendent of the Gravenhurst Sanitarium, is beginning practice in Brantford.

Dr. G. Sterling Ryerson is to be congratulated on being one of the new Knights of Grace of the Order of St. John of Jerusalem, an honor conferred at the same time upon Mr. Frederick Treves and Mr. A. D. Fripp.

Capt. Frederick Fenton, A.M.S., has just completed a course of ten lectures to No. 4 Bearer Company. Under the popular commanding officer, Major Fotheringham, this unit is one of the smartest and most admired in the Toronto garrison.

Dr. Robert Kippen, of St. Thomas, was recently bequeathed \$78,000 by a grateful patient in Sault Ste. Marie, who died a short time ago. The doctor had attended her free of charge in the days of her poverty, and in prosperity she did not forget his kindness.

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## OBITUARY.

### Dr. C. E. Martin.

We regret to announce the death at Whatcom, Washington Territory, on March 11th, of Dr. C. E. Martin of Toronto. Dr. Martin was 69 years of age at the time of his death. He was a graduate of the Rolph School of Medicine, began practice in Lindsay, afterwards removed to Oshawa and finally took up his residence in Toronto some 25 years ago, where he continued in active practice until a few months ago. During the American war Dr. Martin served in General Sheridan's cavalry. The deceased was well known and highly esteemed by both the public and the profession in Toronto who will deeply regret his death. He was a Liberal in politics and a member of the Anglican church. Two sons, graduates of Trinity Medical College, are practicing in the western States and Mrs. (Dr.) Norman Allan, of Toronto, is a daughter.

### Mr William R. Warner.

It is with feelings of profound sorrow that we announce the death of Mr. William R. Warner, which occurred on the morning of Wednesday, April the 3rd, 1901. His business career, covering a half century, was not only long, but honorable, and his impulses as a man were kindly and generous. We feel that his loss will be shared by all who came in contact with him in either trade or social circles.

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## CORRESPONDENCE.

Toronto, March, 1901.  
 DEAR SIR,—I beg to announce that I have just returned from the United States where I have been perfecting myself in the science of correcting visual defects with glasses.

I have studied under some of the most efficient masters of this science in New York, Philadelphia, Boston and Detroit.

I have fitted my apartments with the most modern appliances for detecting and measuring defects of sight.

I make no charge for consultation.

I recommend glasses only when absolutely beneficial.

I guarantee my fitting to be satisfactory in every particular, and prices reasonable.

Trusting I may have a share of your patronage.

DEAR MR. EDITOR,—Perhaps you may think it worth your while to comment upon the amazing thickness of the skin of the gentleman who returns from the land of freedom from the exigencies of professional decency, and "circularizes" us as above. The rampant commercialism which announces that his professional training is of no value and therefore is given free, has as its necessary corollary the next announcement in his precious circular that he will not sell glasses when they are not

needed. This is on a par with the notice which calls upon men of breeding not to expectorate upon the parlor carpet.

The only way by which the optician, fully fledged after a two weeks' course, can be met, is by imposing a similar course upon all students in medicine, a very slight addition to the present curriculum, and one which would at once retain such work in medical hands, and give the public much better service. I would suggest that the Council make this a part of the course in the 5th year of study now exacted.

Yours faithfully,

J. T. FOTHERINGHAM.

## BOOK REVIEWS.

### THE JOHNS HOPKINS HOSPITAL REPORTS, VOLUME VIII. NOS. 3-9.

The volume deals with typhoid fever in its various phases, and is a compilation of valuable monographs, containing elaborate statistics and observations on many new points.

The surgical treatment of perforating typhoid ulcer is taken up by Drs. Finney and Cushing. I. Dr. Finney gives an historical review of the operation, classifies 112 cases collected from literature, with his own cases, gives valuable hints as to signs of perforation, indications for operation, technique, the value of blood examination as an aid in diagnosis, etc.

II. Dr. Cushing records 3 cases operated upon by himself and refers to the same points as to signs, etc., as in the former paper.

III. Dr. Simon Flexner's article on "Unusual Forms of Infection in typhoid fever," and "Typhoid Fever without Intestinal Lesions," is exhaustive and most valuable.

IV. Dr. I. P. Lyon, takes up the subject of coincident typhoid and malarial infection.

V. Dr. J. F. Mitchell records 8 cases of oesophageal complications, some from literature, others from personal observations. The paper treats of oesophagitis, ulcer, stricture, with symptoms and pathological anatomy.

VI. Haemorrhagic typhoid by Dr. L. S. Hambruger.

VII. Puerperal infection with bacillus typhosus by Dr. George Dobbin, is an historical review and report of a carefully studied case.

VIII. Gall-bladder complications, by Dr. Charles Camac, includes cholecystitis, cholelithiasis and such conditions

IX. Dr. Osler, hemiplegia in typhoid, with record of 4 cases.

X. Hepatic complications by Dr. Osler, includes a comprehensive review of such conditions as, (a) focal necroses as described by Reed, (b) 6 cases of jaundice arising from catarrhal states, toxic abscess, gall-stones, cholangitis and pyelephlebitis, (c) abscess.

XI. The results of Widal's reaction are reviewed by Dr. Norman Gwyn. In 265 cases of typhoid positive reactions were obtained in 99.6%. A short article is given by the same writer on the "Disinfection of infected typhoid urine."

XII. A case of early oculo motor paresis in typhoid fever is reported by Dr. Charles P. Emerson.

XIII. Dr. Hugh H. Young's paper on chronic cystitis due to the typhoid bacillus is something new and instructive.

XIV. Dr. Osler gives a summary of the cases of typhoid under observation from 1889 to 1899 This is most complete and exhaustive.

XV. The special features, symptoms and complications taken up in the same manner are embodied in another article.

XVI. The last paper is on "Observations on the blood in typhoid fever." The technique is described at length. The blood of uncomplicated cases is first dealt with and later the blood changes occurring with the advent of complications.

Such a series of carefully recorded observations is a valuable contribution to medical literature.

H. C. P.

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### A SYSTEM OF PRACTICAL THERAPEUTICS.

By Eminent American and Foreign Authorities. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics, Jefferson Medical College ; Physician to Jefferson College Hospital, etc. Philadelphia. New (2nd) edition thoroughly revised. In three very handsome octavo volumes, containing 2593 pages, with 427 engravings and 26 full-page colored plates. Per volume, cloth \$5.00, net ; leather, \$6.00, net ; half morocco, \$7.00, net. Lea Brothers & Co., Publishers, Philadelphia and New York.

Volume II of Hare's system of Practical Therapeutics deals with the treatment of fevers and of diseases of the respiratory, circulatory, digestive, renal and nervous systems and of the skin. The opening chapter on typhoid fever is contributed by the editor, Dr. Hare. The author clearly outlines the power possessed by the physician in dealing with the disease, and its limitations and then proceeds to discuss prophylaxis and the treatment to be adopted in guiding the patient through his illness. Dr. Hare does not think that antityphoid inoculations are likely to give results at all comparable to those obtained in vaccination for smallpox—an opinion with which most authorities will agree. In discussing therapeutic measures in general he gives a qualified approval of the cold bath in selected cases but condemns the use of the coal tar antipyretics. Altogether the chapter deals with the matter under discussion in the most careful and conservative manner and represents the safest teaching at the present day.

Dr. J. M. Anders writes a very satisfactory chapter on the treatment of malarial fevers.

Acute tonsillitis, influenza and acute articular rheumatism are dealt with by Dr. F. A. Packard in three unpretentious chapters. In a system of therapeutics we think the use of guaiacum in acute tonsillitis might have been mentioned.

In discussing the treatment of diphtheria Dr. Floyd M. Crandall strongly approves of antitoxin. The same author deals very satisfactorily with spasmodic croup and rickets and diseases of the mucous membrane of the mouth.

The articles croupus and catarrhal pneumonia are contributed by the editor and are up to the high standard one would expect.

Diseases of the heart and vessels are dealt with by Dr. W. H. Thompson of New York, Dr. F. C. Shattuck, of Boston and Sir Lauder Brunton, authorities well qualified for the task, which has been satisfactorily performed. We can scarcely agree with Dr. Thompson that digitalis can only benefit the heart as a nervine and is therefore a temporary makeshift. By stimulating muscular contraction and thus filling the coronary vessels better it must improve the nutrition of the heart muscle, Dr. Thomas G. Ashton contributes the chapters on diseases of the stomach. The articles are excellent, though possibly too short to be exhaustive.

A most complete practical and altogether commendable chapter is that by Dr. Wharton Sinkler on headaches and neuralgia.

Dr. J. H. Musser contributes the article on diseases of the liver and spleen. Dr. N. S. Davis those on diseases of the kidney. The treatment of diseases of the nervous system, including insanity is fully discussed by Allen M. Starr, Chas. K. Mills, F. H. Dercum, H. M. Bannister, Joseph Collins, Ed. N. Brush, and Hugh T. Patrick and the volume concludes with a number of short, concise, but thoroughly satisfactory monographs on the treatment of skin diseases by Henry N. Stelwagon.

A perusal of this volume discloses much for praise and little for adverse criticism. The various articles are concise, practical and up to date and represent the best teaching and practice of the present day. The volume will be found most satisfactory and no medical library should be without it.—H. B. A.

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**Clinical Examination of the Urine and Urinary Diagnosis. A Clinical Guide for the Use of Practitioners and Students of Medicine and Surgery.** By J. Bergen Ogden, M.D., Instructor in Chemistry, Harvard Medical School; Assistant in Clinical Pathology, Boston City Hospital; Medical Chemist to the Carney Hospital; Visiting Chemist to the Long Island Hospital, Boston. 416 pages Illustrated. Philadelphia, W. B. Saunders & Company, 1900. Canadian Agents, J. A. Carveth & Co., Toronto, Ont. Price \$3.00.

This work presents in a clear and concise manner the chemistry of the urine, giving detailed methods of analysis, both qualitative and quantitative. Many illustrations and a number of colored plates are introduced, showing normal and abnormal ingredients of urine.

The latter half of the work is devoted to the diagnosis of disturbances and diseases of the kidneys and urinary passages. The clinical symptoms of each disease is given in brief with the peculiarities of the urine in each affection and also in certain general diseases of the body.

The colored plates and illustrations are beautifully executed and add much to the value and appearance of the book. The text, paper and binding are creditable to the publishers. From a chemical standpoint this publication is wonderfully complete in detail and a careful perusal of its pages shows that all the standard authorities on the subject have been freely drawn upon and all recent methods of examination of urine have been embodied in this volume.

We can recommend the work to the student of medicine as a full and concise treatise on the clinical examination of urine. To the busy practitioner, who has neither the time nor opportunity to consult the literature on medical and surgical diseases of the urinary organs, this work will prove invaluable.—C. B. S.

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### SAUNDERS' MEDICAL HAND-ATLASES

**Atlas and Epitome of Diseases Caused by Accidents.** By Dr. Ed. Golebiewski, of Berlin. Translated and edited with additions by Pearce Bailey, M.D., Attending Physician to the Department of Corrections and to the Almshouse and Incurable Hospitals, New York. With 40 colored plates, 143 text-illustrations, and 600 pages of text. Cloth, \$4.00 net. W. B. Saunders & Co., Philadelphia. J. A. Carveth & Co., Toronto, Canadian agents.

This work contains the first systematic description ever published of the injuries produced by accident and the consequences and sequels resulting therefrom. It represents a full and scientific treatment of the subject of accident injury; the functional disability caused thereby; the medico-legal questions involved, and the amount of indemnity justified in given cases. The text of the book is extremely complete, especially in its descriptions of functional disorders. The subject lends itself particularly well to illustration, and the illustrations have been chosen with discrimination and executed with skill. The beautiful lithographic plates are models of artistic and lifelike representation. The subject is one of the utmost importance in these days of expert evidence in personal injury cases.

The work is indispensable to every physician who sees cases of injury due to accidents, to advanced students, to surgeons, and on account of its illustrations and statistical data, it is none the less useful to accident insurance organizations. Canadian agents, J. A. Carveth & Co., Toronto, Ont.—G. A. B.

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### ENCYCLOPAEDIA MEDICA.—VOL II,—BRACHIAL PLEXUS TO DIGESTION.

Under the general Editorship of Chalmers Watson, M.B. Published by Wm. Green & Sons, Edinburg. Canadian Agents, J. A. Carveth & Co., Toronto, Ont. Price \$5.00 per volume.

In the second volume, the excellencies which characterized the first volume are fully maintained. The articles on Burns, Climate, Cornea,

Digestion and Metabolism are especially to be commended. The brain is treated in a series of five articles contributed by Bruce, Taylor, Rissien Russell, Fleming and Cotterill. In all some fifty-six subjects received treatment. Among the more important writers in these being Saundby, Habershon, Mansell Monllin, Julu and Allingham.

The work is certainly up-to-date, and of good value. The articles are not too long. The treatment which each subject receives is original, and such as makes it appear before the reader as something entirely new and fresh. This is the best encyclopædia in the market.—D. J. G. W.

### SAUNDER'S MEDICAL HAND ATLAS SERIES.

An authorized translation from the German of the revised and enlarged edition of the atlas and epitome of Gynecology by Dr. Oskar Schoffer, obstetrician and gynecologist, in the University of Heidelberg, and edited by Richard C. Norris, A.M., M.D., of Philadelphia, with 90 colored plates, 65 text illustrations and 308 pages of text; price \$3.50. W. B. Saunders & Co., Philadelphia and New York.

The water color plates are really excellent, the artistic effects striking and the representations true. The clinical notes explanatory of the drawings are concise and the suggestions as to treatment are good. The method of teaching by appealing to the eye as well as to the ear is most valuable and is of the greatest assistance to the student in acquiring a minute and easy grasp of the conditions described. The drawings illustrating the different normal positions of the uterus, as well as those showing the presence of abnormal growths in the pelvis, are especially instructive. The book on the whole is a valuable one.

The Canadian agents are J. A. Carveth & Co. Toronto.—D. G. G.

### FRACTURES.

Carl Beck, Surgeon to St. Mark's Hospital and the New York German Poliklinik, 255 pages and 70 illustrations. Price \$3.50. W. B. Saunders & Co., 1900, Philadelphia. J. A. Carveth & Co., Toronto.

There are but few works that deal exclusively with fractures. The present one combines excellent arrangement with the latest usefulness of Röntgen rays in such cases. By practically exposing the fracture to view, it enables the surgeon to verify or not his anatomical opinion in any given case. The old difficulty of wrestling with an obscure fracture in the vicinity of a large joint, endeavoring to determine whether there was fracture alone or fracture-dislocation is done away with in a large measure. Many excellent photographs illustrate special points in this connection. Recognizing that after all this is but an aid and corrective to the right appreciation of the diagnosis and treatment of fractures—the author in this work very clearly and systematically deals in two parts with the subject. In the first, "Fractures in General," and in the second, "Fractures of Special Regions." We like the style of the whole work and its

general get-up. It is not over-burdened with details, yet the descriptions are sufficiently clear, the plates are good, the printing unusually clear and easy to read. It is well worthy of a place in medical libraries.

F. Le M. G.

### A TEXT BOOK ON PRACTICAL OBSTETRICS.

By Egbert H. Grandin, M.D., New York, Gynecologist to the Columbus Hospital, and George W. Jarmin, M.D., Instructor in Gynecology in Columbia University, is just entering upon its third edition, "revised and enlarged." F. A. Davis & Co., Philadelphia.

This is a book of 500 pages, tastefully gotten up, with a very attractive external appearance. The print is plain and easily read. The plates are particularly good and instructive, especially those in Part II. These are artistic in character and of great assistance to the student in understanding the text.

The work is preeminently a "practical" one, and while it avoids the mistake of leading its readers into a maze by too voluminous descriptions, it perhaps goes to the other extreme of condensing over much, especially the theoretical side, thus making the book a little more difficult to read.

Chapter IV., "The Diagnosis of the Presentation and of the Position of the Fœtus" is especially good and shows evidence of being carefully prepared; likewise chapters VII and X. "The management of normal and abnormal Labor," and the "Pathological Puerperium." The teachings on the whole as to treatment are safe, and the book an excellent one and should be of the greatest value to the practitioner, as well as to the student.—D. G. G.

### THE INTERNATIONAL TEXT-BOOK OF SURGERY.

By American and British Authors. Edited by J. Collens Warren, M.D., LL.D., Professor of Surgery at Harvard Medical School, Surgeon to the General Hospital, Massachusetts, and A. Pearce Gould, M.S., F.R.C.S., Surgeon to Middlesex Hospital, etc. In two volumes Cloth, \$5; sheep or half Morocco, \$6. W. B. Saunders & Co., Philadelphia. Canadian Agents, J. A. Carveth & Co., Toronto, Ont.

The second volume of this new work on surgery is now before us. This volume, devoted to regional surgery, confirms still more thoroughly the wisdom of the editors as shown in the former volume. With its 471 illustrations and eight full page plates in colors, in addition to its splendid text, the subject is made very plain and is presented in a highly practical way. The conciseness of the text is very marked, nothing being admitted for the sake of "padding." Where there is so much that is really excellent, it is perhaps unwise to particularize, but the chapters on "The Diagnosis of Abdominal Diseases," by Mayo Robson, is in our estimation one of the very best things that has been written on the subject.

W. B. Saunders & Company (Philadelphia), are certainly to be congratulated upon the general appearance of the volume.—GEO. A. B.

## PUBLISHERS' DEPARTMENT.

### FEMALE NEUROTICS—THEIR TREATMENT.

Prof. Chas. J. Vaughan, Chair of Gynaecology, Atlanta College of Physicians and Surgeons, writes: "Cerebro-nervous affections peculiar to women associated with pathological disturbances of the reproductive organs are legion, and most trying to physician and patient. Physicians are aware of the wide prevalence of these nervous disorders, for comparatively few women are entirely free from some phase of the ailment. Neurasthenia, neuralgia and other manifestations, either of an active or passive character, are common and are always peculiarly rebellious to treatment. Neuralgia constitutes the great cause of danger from the employment of hypnotics and narcotics, which only afford relief by numbing, but effect no cure. On the other hand, the formation of a drug habit rather aggravates the condition from which relief was originally sought. I have found nothing so well suited to these cases as five-grain antikamnia tablets, administered in doses of from one to three tablets and repeated every one, two or three hours according to the attendant's judgment. These tablets not only afford complete relief without fostering a drug habit, but they do not endanger weakened hearts. Their exhibition is attended with no unpleasant after effects. I use them in preference to any other preparation in the treatment of female neurotics and experience demonstrates that they are safest and best."

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### DECEIVING THE PALATE.

In a recent issue of a medical journal appeared the following item:—

"A somewhat clever ruse, practised for the purpose of administering cod-liver oil to those who object to it, is described as breaking up a conspiracy among the patient's olfactory, optic, and pneumo-gastric nerves. The patient probably confesses he likes sardines so without his becoming aware of the trick, the preservative cotton-seed oil is emptied away and the sardine box is filled with fresh cod-liver oil, of which every day the patient unconsciously takes a substantial amount."

About the same time that the above appeared in print another authority vouchsafed the information that "a ferruginous water, prepared by keeping a few iron nails in contact with water for a few days, serves to fully prevent the odor and taste of cod liver oil from being noticed. The mouth is to be rinsed with the water both before and after taking the oil."

These articles take one back to the days of the stage-coach, the hand-press, the tread-mill and the spinning-wheel, and the conviction is forced home that many people do not progress with the age in which they live. Physicians of the modern school have come to the realization that plain cod-liver oil is too violent in its action to be safely administered to patients whose stomachs are in a weakened condition. But in order that the full strength of cod-liver oil may be secured, and at the same time additional benefits derived from other valuable bone-building and blood-enriching properties, the careful practitioner prescribes Scott's Emulsion of cod-liver oil. He gives this the preference over all others because during the twenty-six years of its existence it has proved invaluable in the treatment of all cases requiring cod-liver oil combined with hypophosphites of lime and soda and glycerine. It is not necessary to resort to such subterfuges as above cited in order to get the emulsion into the system. Grown folks take it without the slightest hesitancy, while children, however young, become really fond of Scott's Emulsion.