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MEDICINE & SURGERY

VOL. XX.

HALIFAX, NOVA SCOTIA, JUNE, 1908.

No. 6.

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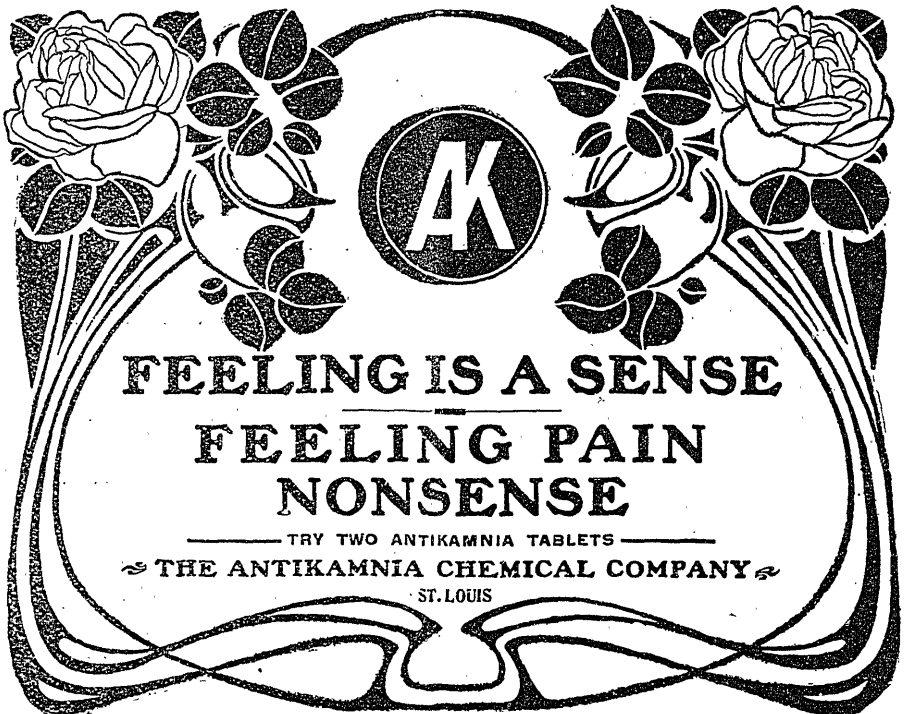
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THE MARITIME MEDICAL NEWS

VOL. XX., JUNE, 1908, No. 6

Puerperal Fever.

A paper from the pen of A. K. Gordon, entitled, "Notes on the Treatment of Puerperal Fever," appears in the *British Medical Journal* for April 25. Gordon holds that puerperal fever is wound fever. The wound is present after every labour at the placental site. When it becomes infected we may have (1) Rapidly generalized septicæmia, from passage of the organisms directly into the veins of the part. This form is usually fatal in from one to three days, and the circulating blood generally contains streptococci. (2) Direct extension through the Fallopian tubes to the peritoneal cavity, and resulting general suppurative peritonitis. (3) Extension as far as the Fallopian tubes only, with formation of adhesions, shutting off the general peritoneal cavity, resulting in the occurrence of pyosalpinx, pelvic peritonitis, or tubo-ovarian abscess. (4) Lymphatic extension, causing parametritis, which may go on to suppuration. The infecting agent in all forms is usually a streptococcus, but the colon bacillus is often found later. Occasionally the whole system becomes invaded by this bacillus as a terminal infection. The following points must be observed in treatment: (1) The avoiding of anything that may interfere with closing of the placental site, such as the retention of placental tissue, etc. (2) Care should be taken that no other wound be made, e.g., with the forceps. (3)

Infection of the wound should be avoided by abstention from too frequent vaginal examinations, and by the wearing of rubber gloves. (4) Douching the vagina is seldom necessary and always risky. A rubber syringe should never be used. (5) The vulva should be kept covered by an antiseptic pad. There are two main modes of treatment: The passive and the active. The former is based on the belief that between the organisms and the host lies a barrier of leucocytes which should be left intact and not destroyed by any local disinfection. The writer, however, believes in active treatment—curetting and swabbing with strongly bactericidal chemicals. In the treatment of the septicæmic conditions themselves there is nothing equal to large quantities of sterilized saline solution given per rectum or subcutaneously. With these may be combined calomel and alcohol, both in fairly large doses. Antipyretic drugs are usually harmful; cold water is the best treatment for pyrexia per se. Antistreptococcic serum is useful in a limited number of cases only, but is never harmful. The serum should be polyvalent, i.e. prepared from many strains of streptococci, some of which should have been obtained from cases of puerperal fever. At least 50 c.c. should be given subcutaneously, and twice as much is preferable. The dose should not be repeated, as joint pains and pyrexia are apt to result. The type of case in which these bactericidal

serums are of benefit is that in which the streptococci are present in the circulating blood. They probably do not affect the local lesion at all, and their value in checking absorption of toxins from the lesion is problematical. They are not supposed to have any antitoxic value.



Burns and Scalds in Childhood. Writing in the *Medical Record* for May 9th, under the caption "Some Considerations in the Management of Burns and Scalds in Infants and Children," Medwin Leale states that the scars and deformities after burns and scalds in children are often more severe than they would be if better treatment were given them. Shock is much more severe than in adults and every means should be adopted to lessen it. Loss of body heat is an important factor and congestion of the internal organs plays a large part in the causes of death. In dressing the burns it is very important to keep the wound absolutely aseptic. Hands and dressings should be absolutely sterile. The wound must be carefully irrigated with sterile solutions, of which the best is hydrogen peroxide in warm solution of one to six or one to ten. This is followed by warm solution of boric acid. When the injury is superficial the author uses thin ointment of sterile zinc oxide in olive oil, made freshly at the bedside. This is spread thinly on sterile gauze. When involving the papillary layer burns do best when protected with thin rubber tissue. Constitutional treatment is of great importance. Paregoric is the best preparation of opium to use in children to relieve pain.

**Typhoid
Fever.**

In a paper which appears in the *Journal of the American Medical Association* for May 9th, J. H. Landis says that while the pathologic changes in typhoid are probably more widely known than those of any other disease, there is still a great difference of opinion as to its treatment. He insists on the importance of rest to the inflamed and ulcerated digestive tract, hence the necessity of restricted feeding. The rest, moreover, should be given to the body generally, the brain, heart, liver and kidneys as well as the digestive tract. Company should be debarred, rest for the digestive tract means a minimum amount of food to handle; rest for the liver and kidneys, a minimum amount of functional activity; for the heart, the absence of drugs, especially alcoholic ones that paralyze its muscle, or by dilating the vessels and reducing their tone generally increase the area of the circulation. He especially deprecates the use of alcohol, which he thinks increases delirium, paralyzes rather than stimulates the heart muscle, diminishes the necessary leucocytosis, irritates the gastric mucosa, the liver and the kidneys and embarrasses digestion and excretion generally. The possibility of exchanging typhoid fever for chronic alcoholism should also be borne in mind. Although almost every drug in the pharmacopeia and many of those out of it have been tried in this disease, a great majority of patients would recover without any medication whatever. The tendency is to recovery, the complications are the cause of the mortality. The sick room should be free from pictures and bric-a-brac, and well lighted. A dim light at night brings out objects in the room with an indistinctness that favours

the production of hallucinations, sometimes terrifying ones, causing accidents. In Landis' wards in St. Mary's Hospital, Cincinnati, milk, in half pint doses not oftener than once in four hours and not more than four times a day, has been the diet in the majority of cases. This has been continued until the temperature has not gone above the normal for seven days. The only exception has been when fever in the afternoon was regarded as due to lack of food. After that period clear soups, soft boiled eggs and custards are allowed and the effect is watched. If no bad effects are seen, vegetables free from tough fibres, bread and butter and meats are added, and the patient is brought back to a full diet in the course of ten days or two weeks. He is allowed to sit up on the tenth or twelfth day for fifteen minutes, and the time allowed out of bed each succeeding day is doubled till he is up and about whenever not asleep. The routine medication in all cases has been one-tenth grain doses of acetate of lead, dissolved in a teaspoonful of water every two hours. No specific action is claimed; Landis believes that this drug acts as an intestinal antiseptic; that it limits fermentation; almost wholly eliminates meteorism and diarrhoea, and in doing so encourages digestion and absorption and puts the bowel in good shape for recovery. No attempt was made to reduce fever under 103 F. When above that, two grain doses of acetanilid were given. Occasionally cold water injections into the bowel were used with good results. The cold bath was not employed. Hæmorrhages were treated with absolute rest and withholding of food for at least twelve hours, and the use of calcium chloride. Severe headache yielded in a number

of instances to hypodermic injections of ergot. Vomiting was treated by rest to the stomach, and diarrhoea by small doses of castor oil or calomel. The pain of pleurisy and pneumonia is better relieved by dry cupping over the chest than by morphine. Two cases of pneumonia followed by bowel perforation suggested the query whether there is a connection between these complications. The liability of a pleuritic effusion becoming purulent or of a latent tuberculosis becoming active should not be lost sight of. The total number of cases was 303, with 7 deaths, a mortality of 2.3 per cent. The Widal test was not found of much use, as it was positive, as a rule, only after the enlarged spleen and rose spots should suggest the possibility of tuberculosis. In two cases the temperature reached 107 F., both patients died; in another, complicated with malaria, it reached 108 F., but the patient recovered. One patient, with repeated bowel hæmorrhages, also vomited a large amount of bright red blood, and Landis thinks it was one of the rare cases of typhoid ulcer of the stomach. The patient recovered after a tedious convalescence. Of the seven deaths, one was from suicide by jumping from a window in delirium; two were from pneumonia in confirmed alcoholics, one of these also had perforation; one was complicated with sepsis from an abscess in the abdominal wall; one was from meningitis; one case was complicated with diaphragmatic pleurisy, and in one case the complication causing death could not be ascertained, a postmortem having been refused.

Sources of Error in Gastric Diagnosis Charles Sumner Fisher, writing in the *Medical Record* for May 23, says that exploratory laparotomy is not always to be used to solve the question of diagnosis of abdominal diseases. Gastroenterostomy that gives immediate relief may not end in permanent relief, since the same faults of digestion remain, and sometimes the direct passage into the intestine is not a permanent advantage. Carcinoma of the stomach cannot always be diagnosticated by the cardinal symptoms, since emaciation and cachexia may not occur until late in the disease. A lack of ambition in a middle-aged person previously of active habits is a valuable sign. Most sources of error in diagnosis involve conditions of the pylorus. Presence or absence of a tumour is disguised by incomplete infiltration. Such conditions exist in small nodular growths at the pylorus, tubular infiltration of the pylorus, spasmodic reflex contractions, and duodenal obstruction just beyond the pylorus. Among remoter influences that may affect the pylorus and cause obstruction are sudden mental irritations, atmospheric changes, and hysteria. Two conditions near the pylorus may cause doubt of its normality—distention of the hepatic flexure of the colon and prolapsed kidney. The author gives differential diagnosis and tests for atony and gastric catarrh.



Bacteriology of General Paresis. The following editorial from the *New York Medical Journal* for May 23, may be assumed to represent with fair accuracy the opinion generally held by American psychiatrists upon the etiology of general paralysis: "Of all the mental diseases, general paresis stands out as the

most distinct and the most hopeless. From the days of Bayle to the present time steady advance has marked the progress in our understanding of this disease process, and in the comparatively recent monumental work of Alzheimer and Nissi it would appear that, from the pathological standpoint at least, this disease has found a firm underlying foundation and an anatomical interpretation for all time. Etiologically, however, the view is still troubled. Notwithstanding the general conviction—founded on the insecurities of statistical analysis and the more thorough and apparently definite findings of Wasserman and Plaut relative to the presence of a syphilitic antibody in the cerebrospinal fluid of most paretics—that syphilis is the fundamental aetiological factor, there still remain difficulties in the way of interpreting this disease solely in the light of its being a syphilitic final product acting on nervous tissues.

"It is for this reason that the studies of Ford Robertson and the discovery of his so-called *Bacillus paralyticans* have aroused considerable interest and given rise to protracted discussions, the latest of which took place at a recent meeting of the American Medicopsychological Association.

"The scientific world has not accepted the Ford Robertson findings, nor yet is it prepared to accept the therapeutical results alleged by him and his followers in this and other countries; yet the contentions are entitled to be heard and the evidence reviewed. At the meeting in question, Dr. John D. O'Brien, of Massillon, Ohio, reported some further observations on the aetiology and treatment of general paresis, in which he reasserted his belief in the causal relation of the pseudodiphtheroid *Bacillus paralyticans* to paresis, and

also reported some measure of success in the treatment of this disease by "vaccines" prepared from this organism. Work done in the Cincinnati Sanatorium under the direction of Dr. F. W. Langdon, confirmatory of Dr. O'Brien's position, was also brought forward. On the other hand in an exhaustive analysis of some of the bacteriological findings, post mortem and ante mortem, in one hundred cases of mental disease of various types, Dr. E. P. Gay, Dr. E. T. Richards and Dr. E. E. Southard, of Hawthorne, Mass., established the facts that terminal infections were very frequent in mental disorders, and that a vast variety of organisms might be found. More particularly it was shown by their studies that members of the pseudodiphtheria group, to which *Bacillus paralyticans* belongs, are very frequent saprophytes, being found in the skin, bronchial mucous membrane, and genitourinary tract, and even occurring in epidemic frequency in certain laboratories under diverse conditions. They were unable to find this organism in the cerebrospinal fluid in paretics, living or dead, and when found it could be established that such findings resulted only as a result of faulty technique.

"In the discussion it developed that other workers had come to the same conclusions—that, from personal observation, the work of the Scotch bacteriologist did not come up to the technical requirements of exact bacteriology, and the general conclusions drawn were that it was not proved that the *Bacillus paralyticans* had any relation to general paresis; that, if it had, it was a saprophyte that perhaps played a part in causing a secondary septicæmia in paretics; and that the therapeutical deductions might have some

value relative to the treatment of such secondary infections, but had no real relation to the underlying process. From this latter standpoint, further studies were thought to be desirable."

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Tuberculin Therapy.

Paul H. Ringer, in an article contributed to the *Journal of the American Medical Association* for May 2, considers tuberculin a most valuable remedy in pulmonary tuberculosis, but it should not be trusted to the extent of neglecting other necessary measures. It is the most valuable adjuvant, he says, to fresh air, rest, good food, that we possess in the treatment of the disease. Of the available varieties of tuberculin, Ringer prefers Denys' tuberculin, which has the advantage of not having been subjected to heat, as best suited for the production of an antitoxin immunity. Tuberculin may be employed in incipient cases without ulceration or bacilli in sputum; in uncomplicated, non-febrile, first and second stage cases; in fibroid cases without febrile temperature; in febrile cases in which the temperature does not drop under treatment by rest and in which fever is due to the tuberculo-toxin alone and not to mixed infection. In such cases it should be administered with the greatest caution, in infinitesimal doses at long intervals. It can also be used in advanced third-stage cases occasionally, not as a curative agent, but to aid in relieving distressing symptoms. Here its use must be guarded and its dosage most minute. It is contraindicated when there is great emaciation or weakness, in third-stage cases with mixed infection and in hæmorrhage. It is also contraindicated in heart disease on account of the possibility of reactions affecting compensation,

in marked increase of pulse or loss of weight during its administration, and in complications, diabetes, nephritis, liver cirrhosis or nervous diseases. The patient should implicitly follow orders and before treatment the course of his temperature should be accurately ascertained by the physician. It is best administered in the morning so as to have no un-seen reaction, which is defined by Ringer as the result of an overdose and therefore undesirable. The various types of reaction, cutaneous, local and systemic, are described. Ringer uses eight different strengths, varying in a decimal ratio, of Denys' tuberculin, ranging from 0.0001 mg. to the cubic centimeter up to the undiluted product. No. 1 contains 1|10000 mg. to the c.c. and is used only for febrile cases; No. 2 contains 1|1000 mg. and so on. Injections, if no reactions occur, are given twice a week; in febrile cases beginning with 0.1 c.c. of the weakest solution; in non-febrile cases he begins with the next higher; in each case at first injecting only 0.1 c.c., and increase is made by 0.1 c.c. each time. When solution No. 6 is reached the interval between doses should be lengthened to five days, and it should be still further lengthened with still higher doses—up to from ten days to two weeks before the maximum dose is reached. If it is reached, it will generally be well to stop the injections for a time. If no reactions occur to delay the treatment, it will take about a year to reach the maximum dose. Of course, each case will have to be considered by itself, and the physician will have to use his best judgment in each. If reactions occur the treatment may have to be suspended for the time or even smaller dosage be employed temporarily. The author finds that

patients tolerating increasing doses are not so liable to exacerbations and relapses as those not so treated, and that more permanent cures result with tuberculin than when it is not used. Many patients who steadily become worse in spite of fresh air, etc., recover under tuberculin. The chronic toxæmia of the disease is astonishingly reduced with its use and symptoms such as cough and expectoration disappear or are greatly lessened.

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Air-Borne Infections.

In a paper appearing in the *Medical Record* for May 16, entitled "Air-Borne Infections, Their Mode of Entrance: Preventive, Abortive, and Ameliorative Treatment," W. Sohier Bryant, New York, calls the first or pharyngeal tonsil the gate of invasion of all infectious diseases. It serves as a primary seat of local infection, and this infection can be prevented by care and treatment of the tonsil. The nasopharynx and tonsils should be treated with cleansing and astringent solutions. General hygiene will increase the opsonins, strengthen the mucous membrane, and produce a normal fluid mucous secretion that will destroy the infecting germs before their entrance.

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Channels of Communication in Tuberculosis.

In an article by S. McC. Hamill, appearing in the *Archives of Pædiatrics* for April, the following conclusions are reached: (1) That it is impossible to gain knowledge concerning the point of entrance either from the location or the degree of the tuberculous lesions. (2) Fætal infection has been proven, but is not common. (3) Infection through the mouth, tonsils, and pharynx is frequent; and may be produced by inhalation or ingestion. (4)

Primary inhalation infection through the lungs does occur. (5) Infection through the intestinal tract is definitely proved. (6) The bronchial glands and lungs may be infected through the intestinal tract as well as through the lower respiratory tract. (7) The relative significance of the various modes of infection is difficult to determine, for it has been clearly shown that from whatever point the tubercle bacilli may be introduced they may eventually reach the bronchial glands and lungs without leaving any evidence as to the mode of entrance.



The Treatment of Eclampsia. J. F. Moran, writing in *Journal of the American Medical Association* for May 2, says that while the etiology of eclampsia is not yet definitely known its clinical phenomena and pathology point to a probable intoxication of maternal, foetal or combined origin. Its frequency could be greatly diminished if a more careful supervision of women in pregnancy were exercised. The mere examination of the urine for albumin during the latter weeks of pregnancy is not sufficient; the total solids excreted, the constitutional symptoms, and the hygienic conditions must all be carefully observed. The occurrence of eclampsia is rarely without warning, and when the symptoms of a pregnancy nephritis increase in spite of prophylactic measures and brain symptoms threaten, it is highly important to terminate the pregnancy, and the quicker the better. In case of sudden onset, with undilated cervix, the operation of vaginal Casarean section may be required for sufficient prompt delivery. The views as to the use of narcotics in eclampsia are changing, and the large doses of morphine recommend-

ed by Veit are not advised. In the beginning of the attack, while the mind is intact and the susceptibility of the nervous system is preserved, there is no objection to the use of morphine, as its quieting effect is salutary, but in unconscious and comatose states it is best to withhold narcotics. Chloroform is a cardiac depressant, and this, with its bad effect on the hepatic and renal functions, should limit its administration to the whole time when intervention is required. Chloral hydrate is a valuable remedy, but it is not always tolerated; Moran has found it useful in the prodromal stage and also after delivery. He has also found nitroglycerin useful when reduction of arterial tension and diuresis were desired after delivery. As eliminatives, he recommends croton oil and elaterium during the attack, and when the patient is able to swallow, the saturated solution of magnesium sulphate to further eliminate the poison from the bowels. Diuretics have but a slight and inconstant effect. The free use of normal salt solution, three or four pints every few hours, is also recommended as a rational measure. When there is a full quick pulse, cyanosis and labored respiration, great benefit may be derived from venesection. It is particularly serviceable when the seizures continue after delivery. The result in any given case will depend on the severity of the attack, the judgment and skill of the physician and the rigid observance of asepsis. Essential to success is a well thought out plan of prompt but not overzealous procedure based on the various phases of the disease, combined with a knowledge of the condition of the cervix and the changes which it must undergo before pregnancy can terminate or be terminated.

Epidemiology of Diphtheria. A very interesting and suggestive article, entitled "The Epidemiology of Diphtheria in the Light of a Possible Relationship Between the Diphtheritic Affections of Man and Those of the Lower Animals," is contributed by L. W. Sambon, to the *Lancet* for April 18th. The author refers to widespread prevalence among animals of a disease which, if not diphtheria, is at least much like it, and is caused by micro-organisms presenting morphological characteristics similar to those of the Klebs-Löffler bacillus. It is an old and commonly accepted belief that diphtheria may be conveyed from the lower animals to man, and vice versa. It has several times been noticed that diphtheria epidemics in man have occurred simultaneously with epizootics of a similar nature in animals. The inoculation of susceptible experimental animals with human diphtheria bacilli has resulted in the reproduction of the disease. It would seem that there is a similarity between diphtheria and tuberculosis in that either disease is transmissible from man to animal and from animal to man. Sambon contends that diphtheria may be conveyed by means of milk and eggs, and suggests this fact as a possible explanation of the frequency of the disease in young children, into whose dietary these articles of food enter largely. It is probable that the disease is introduced into towns by means of these foodstuffs, although of course, it may also be introduced by infected human subjects or by infected animals, more particularly by birds, such as pigeons and sparrows. The pigeon is found in large numbers in the parks and squares of cities, and it is quite conceivable that horses and sparrows contract the dis-

ease from them. The cat, a natural enemy of the sparrow, may contract diphtheria from that bird which is likely to fall an easy prey when paralysed by the disease. The habits of the cat expose it in other ways to infection by the diphtheria organism. This animal, after prowling in field and gutter, has access to the bedroom, and sleeps on the bed with and is fondled by the children. Cats have been noticed to suffer simultaneously with man in many outbreaks of diphtheria. But in diphtheria as in plague, one particular kind of animal seems especially concerned in the wide spread of the disease. In plague the rat appears to be the special agent in the dissemination of the disease. In the case of diphtheria this distinction probably belongs to the pigeon.



The American National Health Department The Committee of One Hundred's plank for national organization of public health was adopted by the Republican Party of Ohio, in the recent state convention. The wording calls for: "The Centralization of Existing Health Agencies into a National Department of Health." This is the plan of the Committee of One Hundred without change, and in furtherance of the programme, local advisory committees are being organized throughout the United States as vigilant committees of public health by the American Health League, and with power to pass resolutions and to bring all legitimate pressure to bear upon members of Congress with a view to the re-election of members who have gone on record in favour of an extensive programme in connection with the greatest of all necessities, the prevention of the needless waste of human life from preventable diseases.

EDITORIAL.

MARITIME MEDICAL ASSOCIATION

ALL things point to a most successful meeting of the Maritime Medical Association at Halifax this year. The dates fixed are the first and second of July, at which time Halifax looks its very best, and those who feel the inland heat trying, may look forward to the refreshing breezes which make Halifax so attractive to the tourist at this season. A very attractive programme is promised, which assures a most profitable session. In addition to the addresses of the President of the Maritime Medical Association and the Medical Society of Nova Scotia (which society merges this year with the larger association) there will be addresses and papers by several distinguished visitors, notably, Dr. John MacRae, of Montreal, and Drs. F. B. Lund, Percy Brown and T. W. Johnson, of Boston, and Dr. A. Fred Miller, of Saranac. New Brunswick will be represented on the programme by Drs. Atherton and Irvine, of Fredericton, T. D. Walker, of St. John, Ferguson, of Moncton, and Mercereau, of Rexton. From Prince Edward Island, Dr. H. D. Johnson, of Charlottetown, will furnish a paper, while Nova Scotia contributors will include Drs. H. K. McDonald, M. A. Curry, R. E. Mathers, J. F. Lesel, and F. E. Lawlor, Halifax; J. G. McDougall, Amherst; G. H. Cox, New Glasgow; H. A. March, Bridgewater; C. P. Bissett, St. Peters; J. F. McDonald, Shubenacadie, and Woodworth, Kentville.

It is expected that a number of others will take part, although they have not as yet definitely committed

themselves, and there can be no doubt but that an ample array of timely papers will be provided.

The social side will be by no means neglected. The local committee have in view a noon-day luncheon, and a visit to the Studley Quoit Club late in the afternoon of the first day, and a harbour excursion on the evening of the second day. The proposition is to serve tea on the steamer on this occasion, and it is hoped that the boat clubs on the North West Arm will co-operate and arrange for an illuminated concert on the evening of this day. Should this not prove feasible, a smoker or some such entertainment will be provided for this evening. Suitable arrangements will be made for the entertainment of ladies accompanying members.

It is unnecessary to refer to the importance of this meeting, and to the desirability of a large attendance. It becomes more evident every year that more thorough organization of the profession must be effected, and there can be little doubt but that this pressing matter will demand some consideration at the coming meeting. It is therefore the apparent duty of every member of the profession to attend, if possible, and to assist by voice or vote in furthering the interests of the association.



HONORS FOR DR. BENT.

On another page will be found an account of a presentation made to Dr. Charles Bent, of Truro, by his fellow practitioners in that town.

Dr. Bent, who has practised his profession for sixty-one years, has not only won the esteem and affec-

tion of his colleagues, but has been chosen by his fellow citizens to occupy some of the most onerous, as well as honourable positions in the public life of the town. Leading citizens who were present on the occasion bore testimony to the value of his public services, and the affectionate regard with which his medical friends spoke of him testified to the integrity and courtesy of his professional relationships.

It is well to show an appreciation of our old friends while they are still

with us, as well as to honour their memories, and our brethren in Truro are to be congratulated upon their kindness of heart and their good sense, in thus showing their respect to one who has practised his profession so long and so uprightly.

It is pleasant to know that Dr. Bent, after more than sixty years of work, is still able to carry on his practice, and that his mind appears to be as alert, his eye as bright and his smile as gay as it could have been in the middle of last century.

SEE programme of
Annual Meeting of
the Maritime Medical
Association on page
235. Is it not in itself
a strong inducement for
you to attend? Meet-
ing will be held in Hali-
fax, July 1st and 2nd.

PLEURISY.

By A. F. EMERY, M.D.,

St. John, N. B.

(Read before Saint John Medical Society, April 29th, 1908.)

PLEURISY is an acute or chronic inflammation of a whole or a part of the pleural membrane, characterized by the formation in the pleural cavity of a fibrinous, sero-fibrinous or purulent exudation.

This paper will only refer to a few points on sero-fibrinous pleurisy, especially in regard to etiology and treatment by thoracentesis.

In Osler's "Medicine" sero-fibrinous pleurisy arising from inflammation is divided into three groups:

(1) Tuberculous pleuritis, the largest division.

(2) Infections (non-tuberculous) next in frequency, and a well defined class.

(3) Other cases difficult to group, as venous stasis, on which an inflammation is superimposed.

PATHOLOGY IN PLEURISY. — The inflamed pleura becomes dull, opaque and grayish white in colour, deep red in places. It becomes thickened sometimes to the extent of almost half an inch. An abundant exudate forms which may be thrown into folds or projecting masses of various shapes.

The extent of pleural involvement varies, and the amount of fluid exuded varies very much in different cases.

Under the microscope there is desquamation and degeneration of the epithelial cells. The subserous tissue is swollen. The surface of the pleura is covered with a fibrinous layer containing pus cells and serum. Proliferating cells and capillaries push out into the fibrinous deposit,

which eventually, in many cases, leaves fibrous tissue which may form adhesions with the opposing pleura or may undergo fatty metamorphosis and gradually become absorbed. However, many parts of the pleura may permanently remain united by bands of adhesions.

THE EFFUSION.—This begins generally to form in the first few hours of the disease. It is quite variable in its character. It is usually clear and amber coloured, often with slight flocculi of fibrinous material floating through it. In some cases it is very cloudy. No sharp line divides it from purulent effusions. The amount of fluid is variable; as much as 150 ounces have been present. In reaction it is somewhat acid.

Inflammatory effusion generally has a sp. gr. of 1018 or more. In pleural transudates the sp. gr. is generally below 1018.

Albumin is present to extent of about 4 per cent. In a general way the leucocyte count shows below when there is no complication present as tuberculosis or pneumonia.

ETIOLOGY. — The micro-organisms to be found in the fluid of pleurisy are principally confined to three varieties, (a) the tubercle bacillus, (b) the pneumococcus, and (c) the streptococcus.

The tubercle bacillus is a frequent cause of pleurisy, and probably one of the common causes, but not the only cause of fibrous adhesions.

The bacillus tuberculosis plays an important part in serous effusions, in which it has been claimed, by different observers, to be the princi-

pal cause in from 22 per cent. to 68 per cent. of cases

The pneumococcus and streptococcus are presented in fewer cases of sero-fibrinous pleurisy than in fibrinous pleurisy or empyema.

Other organisms have been occasionally found.

Where tuberculosis cannot be demonstrated in any part of the body, especially in the lungs, the cases of effusion are then generally classed under the head of non-tuberculous pleurisy. In this class of cases about 40 per cent. afterwards show some signs of tuberculosis.

A few observers claim that almost all cases of pleurisy are due to the tubercle bacillus, but they have not been upheld by either clinical or bacteriological investigation.

ABSORPTION AND EFFUSION.—Serous fluids as a rule absorb spontaneously. Purulent fluids may remain indefinitely if not removed by operation.

Larger serous effusions are not quickly absorbed. Small effusions without much fibrin, and which interfere little with respiration or intrapleural pressure, are most favourable for absorption. Osmosis plays an important part.

PROGNOSIS.—The immediate prospect of primary sero-fibrinous pleurisy is good. In 500 cases, four died suddenly, due to pressure, etc.

If a non-tubercular or infectious origin can be established the prognosis is favourable.

THORACENTESIS.—Tapping should be done when there are present (a) pressure symptoms, such as severe dyspnoea, cyanosis, or rapidly developing heart weakness. (b) A large amount of fluid with dislocation of heart and mediastinum, even without pressure symptoms; and (c) smaller amount of fluid when other means

have failed to bring about absorption within a reasonable time. The presence of increased temperature is not a contra-indication with pressure symptoms and larger effusions. Thoracentesis should be done without delay, as also in bilateral effusions of medium amount.

Whether small or medium sized effusions should be tapped is a disputed point. It is better not to tap when only small amounts of fluid are present.

In medium effusions removal of part of fluid seems to remove some of the intra-pleural pressure and promotes absorption. Removing in any case enough of the effusion to relieve pressure on surrounding organs and also intrapleural pressure seems to afford all the benefit that can be obtained by tapping.

To remove all the fluid early, leaves bare two inflamed and rough surfaces which soon become adherent, and causing future pain and inconvenience.

The lower pleura contains most of the diseased surface covered with a rough mass of fibrin and a certain small amount of effusion, serves as a splint and keeps the opposing surfaces apart until nature has done her work in bringing them to a practically normal condition.

Fifty fluid ounces are as much as can be safely removed at once, although much larger amounts are often taken away.

Thoracentesis performed with an aspirator connected with a small trocar and camula instead of a sharp needle seems to be the best method.

The utmost care must be taken with instruments, hands and chest, to keep from infecting the wound and changing a serous fluid into a purulent one.

In a general way pleurisy with sero-fibrinous effusion and not complicated with evident existing tuberculosis has a good prognosis. We have in mind about thirty cases in which tuberculosis has not shown it-

self in from four to ten years after the first sickness. Apparently about 50 to 75 per cent. of all cases of fibrinous, sero-fibrinous, or purulent pleurisy develops tuberculosis within ten years.



ADDRESS TO THE PHARMACY CLASS OF 1908.

By *EDMUND F. S. JENNER,*
Digby, N. S.

(President Nova Scotia Pharmaceutical Society.)

THE examinations for this year are over, and I am glad to inform you that not only is this the largest class numerically that I have seen since I became a member of the examining board, but it is by far the most satisfactory one.

For some time past the papers submitted to the board of examiners have been in some cases weak, in others mere burlesques on a pharmacy examination. We have dealt with them according to their merits, rejecting the majority of the candidates; and this year the class seem to have realized that the Pharmaceutical Society of Nova Scotia is no diploma mill, but an institution whose diploma cannot be obtained without study and intelligence. Last year I had occasion to speak very plainly on the botany papers, and Mr. Buckley called your attention to the slack way in which the dispensing was done.

This year some of your botany papers are good, some are passable, two only are mediocre as the average

botany paper sent in in 1907. I can assure you, gentlemen, that it affords us no pleasure to reject candidates. We want registered men as assistants and managers of branch stores, but it is almost impossible to get them at the present time. It is not the fault of the examiners, that this is the case. It is the fault of the candidates who imagine they can pass this examination without study or application.

This year is, I am glad to say, an exception to the previous two years. A number of you gentlemen will graduate. There will be several more registered pharmacists in the course of a few days and it is the gentlemen who hope to graduate to whom I wish to address the following remarks:

The average student in pharmacy (in the country at least) has three principal assets when he graduates: his health, his diploma, and his good name. I am not a doctor, so I will refrain from saying anything to you about health preservation.

Your second asset, your diploma, is worth a little consideration. Owing to the stringent enforcement of the Canada Temperance Act and the local license Act in certain localities, a brisk demand has arisen for qualified druggists who will officiate as under-studies for saloon keepers who have been driven out of business, or who are unable to conduct it as openly as they formerly did.

The Pharmaceutical Society does not propose to interfere with the administration of the Canada Temperance, or any other Act, nor will its officials act as spies or informers. The criminal law of Canada has given ample powers to the local authorities to deal with offences, and punish offenders.

We do, however, claim the right to protect our diploma from being used as the shield for an illicit bar; and if the Act we now have is insufficient to enable us to deal with offences of this kind, we propose to appeal to the legislature for additional powers, which will enable us to censure, suspend, or expel members of the Society who are persistent law-breakers. It is with the greatest regret that I inform you that at least two registered druggists, and one qualified doctor (who is also registered as a druggist) are reported to the council as being the paid assistants of ex-bar-keepers. Furthermore, there is a call at the present time for two or three more registered druggists to fill positions where they will be the paid servants of men who do not know castor oil from calomel, and where their principal occupations will be the illicit vending of the liquors usually spoken of as "booze."

Some of you, gentlemen, may have already received offers from the

parties I allude to. For God's sake do not accept them—far better go up to the Citadel, take the King's shilling, and wear his uniform. That is no disgrace to any man; but by prostituting your diplomas to run an illicit bar, you disgrace both yourselves and your profession. The men now engaged in this illicit business are no credit to the Society, they never were, and unless they amend their ways, they never will be.

Now I spoke of another asset you all possess in addition to your health and your diplomas—Your good name. You know as well as I do how to preserve your reputations as good citizens. I wish to caution you against one way in which you can easily lose your reputation as pharmacists with the medical profession. I allude to the practice of allowing the manufacturers of all kinds of secret nostrums to use your name promiscuously for advertising purposes. No matter how attractive the proposition may be, no matter how much "free advertising" you may receive, be most guarded how you allow any concern whatever to push their preparations over your signature.

I would ask you to be especially careful in the case of remedies which are advertised as emmenagogues, remedies for female weakness, consumption or venereal disease.

It is not the use of the remedies (so-called) which does the harm; it is the time lost by the patient in getting proper treatment. Hundreds of people are trying to stave off regular treatment to-day by the use of quack medicines, who will only resort to it when neglect has rendered them past the treatment of the best

physician or the skill of the best surgeon in Canada.

It is "up to you" gentlemen, to use your influence on one side or the other. You can act as adjutants to the illicit liquor dealers, and under-studies to the army of quacks if you wish to. On the other hand you can become, not the drudge or under-study, but the right hand man of the physician, the confidante and friend of the best people in your community, an exponent of ethical pharmacy, and an honour to the profession you have chosen.

I hope and trust that you gentlemen who have passed the examina-

tion will consider what I have said most earnestly. It is an order thrown at your head by the president of the Society. It is advice tendered by a man who takes a deep interest in his profession, to men who are just entering it—men who I hope to see an honour to the vocation they have chosen.

To you gentlemen who have failed, I can only say, "Better luck next time." I may or may not be on the examining board. If I am and you satisfy the examiners, it will be with the greatest pleasure that I affix my signature to your diploma.



A FEW NOTES COLLECTED FROM THE LITERATURE ON THE SUBJECT OF ACETONURIA IN RELATION TO ANÆSTHETICS.

By PHILIP WEATHERBE, M. B., Ch. B.

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RECENTLY in one number of the *Lancet*, seven cases of "Delayed Chloroform Poisoning" were reported from the hospitals with a mortality of 66 2-3 per cent., these cases occurring within the period of seven months. This ought to be a sufficient reason for us to be on the look-out for such cases, as it is a condition which has evidently often escaped detection, and is thought by some to be of frequent occurrence.

As this subject is a comparatively new one it would be well if all cases observed were reported.

The important part chloroform plays in surgical work should be a sufficient inducement to look for a speedy remedy. Synonymous terms used are "Delayed Chloroform Poisoning," "Acid Intoxication," "Acidosis," "Acetonæmia," "Aciduria" and others.

Petters, in 1854, was the first to recognise acetone in urine in relation to diabetics.

Kaulish went one better and in the same year found acetone in diabetics urine and considered this to be the cause of diabetic coma.

Bashanelli, in 1890, was the first to observe instances of toxæmia following the administration of chloroform.

To Guthrie is due the credit of first drawing attention to cases of delayed chloroform poisoning and doing valuable work on the subject, publish-

ing his report and series of cases in the *Lancet* of 1894.

Becker, in 1894, reported three fatalities following anæsthesia in diabetics in which acetonuria was present at the time of operation, and in 1895 he examined 251 cases and found acetone or di-acetic acid in 167. The condition appeared to be independent of the nature of the anæsthetic or the duration of the anæsthesia, and was more severe in cases of pre-existent acetonuria. While children were the most liable, adults were not exempt.

These observations are confirmed by English and American writers, but most regard chloroform as the anæsthetic most likely to cause this condition.

In the majority of cases acetonuria is the only symptom, but occasionally definite toxic symptoms occur and death may ensue.

Brewer, in 1902, reported a fatal case of appendicitis and ascribed the cause of death to acetonæmia.

Beesley, in 1906, records in the *British Medical Journal* 46 cases of acute perforative appendicitis in children, showing the difference in the mortality between cases anæsthetised by chloroform and ether. Out of 19 cases of acute perforative appendicitis where chloroform was administered 14 died. Of 3 cases of acute perforative appendicitis where a mixture of chloroform and ether was used one died. Of 24 cases of

acute perforative appendicitis where ether alone was administered only two died, and the death in these two cases was not due to acetonuria, and no fatty infiltration of the liver was present at the post mortem.

In all the fatal cases after chloroform anæsthesia there were symptoms of acetone poisoning, and fatty infiltration of the liver was always found after death.

Kelly's statistics, reported in the *Annals of Surgery*, 1905, of 400 cases taken within four months at the 'Boston City hospital', showed that symptoms of acid intoxication were present in 46, of whom six died. In 17 cases symptoms were present on admission; in 10 cases within 24 to 48 hours after the administration of ether, in 2 cases after the administration of nitrous oxide. In 17 cases symptoms were not present at the time of admission, but developed later without any anæsthetic being administered, and for which no cause could be assigned.

Of these 46 cases acetone and diætic acid separately or combined were found in the following: eleven cases of appendicitis, fourteen cases of contusion and fractures, two of gastric disease, two of carcinoma, three of severe lacerated contused wounds, two of localised septic processes, two of cerebral concussion, one of salpingitis, one of acute multiple suppurative osteomyelitis, one of floating kidney, one of fæcal fistula and enterocolitis, one of epilepsy, one of tubercular cervical glands, one of burns and typhoid fever, one of diabetic gangrene, one of hæmorrhoids, and one of alcoholism.

Stiles, after exhaustively treating of the subject with Macdonald in 1904, and publishing the report in the *Scottish Medical and Surgical*

Journal, gave up the administration of chloroform in his operative cases at the Edinburgh Children's Hospital and resorted to ether administration which he found more satisfactory. He now uses a mixture of chloroform and ether.

Experiments on animals show chloroform inhalation to be much more harmful than ether.

Casper said long ago "it could no longer be doubted that chloroform when it does kill does not always do so suddenly.—There is such a thing as chronic chloroform poisoning." Ostertag, of Berlin, in his experiments on dogs, proved that by chloroforming dogs for one hour daily during many days, fatty degeneration occurred, especially fatty infiltration of the liver and fatty change of the cardiac and skeletal muscles as well as the kidneys and stomach.

Beesley writes: "Acetonuria of varying degree, follows the administration of every general anæsthetic, but symptoms of intoxication only occur when the kidneys are failing to excrete the acetone, and death occurs from the kidneys not being able to excrete sufficiently.

Acetone is produced rapidly and excreted quickly by the kidneys, lungs and bowels.

Elimination is retarded by constipation.

Chronic acetonuria appears as a result of constant absorption of toxic substances whose source may or may not be discoverable.

Acute acetonuria occurs at the outset of acute infective conditions, and the quantity of acetone excreted is great. Should chloroform be administered at this time the extra amount of acetone formed by the action of the drug may stop excretion and poisoning may result.

The symptoms of acid intoxication are very constant. A peculiar apathy is present at first, with restlessness, intervals of excitement and delirium which in fatal cases pass on to coma before death. The breath has a sweetish odour of acetone or sometimes chloroform, which is very marked in severe cases. The tongue is furred and the appetite poor. There is slight fever. Vomiting appears early, becomes more frequent, and the vomitus is dark in appearance like "coffee grounds," due to altered blood. Constipation is often present and the urine contains acetone.

Post mortem examinations show fatty infiltration of the liver as the one constant feature in this condition. The size of the liver has no relation to the amount of fatty change. This is often only distinguished under the microscope. But the liver on section feels greasy, and drops of oil can usually be squeezed out, which appear on the surface. The kidneys show fatty infiltration of the convoluted and straight tubules. The heart is often flabby and pale in colour, and shows signs of fatty infiltration. The skeletal muscles may show fatty change in marked cases. The intestines are sometimes filled with altered blood and Peyer's patches may be congested and possibly ulcerated. Oedema of the brain may be present.

Acute yellow atrophy of the liver, phosphorus poisoning, and diabetes, all stimulate to a certain extent this condition. Hæmorrhagic fluxes are not common in either phosphorus poisoning or acute yellow atrophy as they are in the above condition. In the cases following anæsthesia there is only fatty infiltration, and not degeneration, as in both acute yellow atrophy and phosphorus poisoning.

The simplest tests for acetone and diacetic acid in urine are the two following:

To 5 c.c. of urine add one crystal of sodium nitroprussate, and make strongly alkaline with a strong solution of sodium hydrate. This should be well shaken in a test tube and by adding glacial acetic acid to this the presence of acetone is shown by a purple colour being imparted to the foam. The presence of diacetic acid is shown by a Burgundy red colour appearing on the addition of a strongly aqueous solution of ferric chloride to the urine.

Jackson Taylor simplified this test in the following way: He adds a strong ammonia solution to a solution of sodium nitroprusside and urine. The strong ammonia, if added carefully, remains on top. Should acetone be present even in minute quantity a well marked ring of magenta appears within from one to three minutes, and gradually spreads upwards. The strength of the sodium nitroprusside is important. It should be prepared freshly. A few crystals dissolved in a test tube of water are sufficient.

The treatment has been so far unsatisfactory. The following have been tried with benefit in some cases.

A sharp purge is given at the commencement. When milk can be taken sodium citrate is added, bicarbonate of soda may be given in large doses, as much as thirty grains to a child, four hourly until the urine becomes strongly alkaline. When nothing is retained by the mouth, normal saline is injected into the rectum along with sodium bicarbonate. It may also be infused into the tissues. Nutrients should be given and stimulants in the form of brandy, strychnine and adrenaline, are useful.

I think large quantities of normal saline solution might with advantage be infused into the subcutaneous tissue of the thighs, allowed to run in slowly for many hours at a time, and repeated often. This has been successful in cases of diabetic coma and might be of service in delayed chloroform poisoning.

Quite recently carbohydrates have been advocated before and after operations as a form of treatment.

Carbohydrate starvation may predispose to post-anæsthetic acetonuria. Waldvogel pointed out that patients who took carbohydrates freely before and after operations seemed to be less liable to acetonuria. Therefore it has been suggested to give carbohydrates in cases of poisoning, or before anæsthesia as a preventive, and not to starve patients too long before operations. Dextrose may be given in the following way: by the mouth, or by rectal infusion of a 10 or 20 per cent. solution, or intravenously in a 6 per cent. solution.

In some cases reported, it seems almost incredible that with an anæsthesia of seven minutes such serious changes can occur in the organs, although fatty infiltrations of the liver can occur with remarkable rapidity. Guthrie's explanation to this was that there was some fatty change before the administration and the drug simply increased the condition of fatty change. It has also been noted that this condition occurs more commonly in rickety, tuberculous and septic conditions where the patients are wasted. It was also thought possible that these cases are often being treated with cod liver oil and that

some of the oil had been deposited in the liver cells.

It is a well-known fact that diabetic subjects are bad patients for anæsthesia.

There is now no doubt whatever that there is such a condition as post-anæsthetic toxæmia, and that the administration of the drug is the actual cause of death.

Formerly it was thought that death might have been due to many other causes irrespective of the anæsthetic. Sepsis, carbolic acid poisoning, fat embolism, iodoform and mercurial poisoning, and others can all be excluded as the cause of death, as well as shock, for death has occurred after an operation for circumcision with an anæsthesia lasting only seven minutes.

It has been said idiosyncrasy plays an important part in many of the deaths from chloroform anæsthesia. Waldvogel thinks acetonuria after anæsthesia is due to fat destruction caused mainly by the toxic action of the anæsthetic.

Patients suffering from rickets, sepsis, tuberculosis, diabetes, starvation, and possibly a pre-existent fatty condition of the liver, appear to be more susceptible and more easily poisoned by chloroform than do other patients.

At the present stage of our knowledge we are not in a position to make very definite statements on this subject, or whether chloroform is more harmful than other anæsthetics. Now that the drop method of giving ether has come into vogue it may be preferable more frequently to administer this drug to children.

TUBERCULOUS DISEASE OF HIP-JOINT.

By DR. H. K. MACDONALD, M. D., C. M.

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(Read before the Halifax and N. S. Branch British Medical Association.)

MR. President and Members of the Nova Scotia Branch of the British Medical Association. My first word must be one of thanks for the honor you have conferred upon me for the second time since becoming a member of your society, to address you.

The subject upon which I wish to engage your attention, namely, "Tuberculous Disease of Hip-joint," for a short time, is by no means, as you are all aware, a new one. The literature is exhaustive, and the chapters in all the text-books form very important parts of the volume, and if by a general resume of the chief clinical and pathological points, I can evolve a profitable discussion, I shall consider my efforts not in vain.

The term "Tuberculous Disease of Hip-joint" has several synonyms, tuberculous coxitis, morbus coxæ, hip-joint disease, etc., but tuberculous disease of hip-joint is probably best.

It certainly is more specific and implies more than any other term and means a chronic, destructive disease due to "tubercle bacillus," that unless arrested, results in loss of function and deformity of joint. No one, for a moment, will doubt the importance of this marked affection as tuberculous disease of the hip-joint is the most common and the most important of the affection of the joints, ranking only second to Pott's disease. The statistics, in large cities, are appalling. Out of 7,845 cases of this disease treated in the out-patient department of the Hospital

for Ruptured and Crippled in New York city during the period of fifteen years, 2,230 were tuberculous hip-disease, while the remaining 5,617 included all the other joints. I mention this to show the frequency of the disease in large cities. Perhaps in our smaller cities and towns the same statistics do not exist. Yet we know tuberculosis in its many forms is very prevalent and there are few practitioners to-day but have had one or more cases of tuberculosis of the hip-joint. In my own practice I have had two cases in the past two years.

The disease is certainly one of early childhood. In 1,000 cases tabulated by Ashley, 88.1 per cent. were in the first decade of life, and 45.6 per cent. of these cases were from three to five years of age. The disease is slightly more common in males than females. In the 1,000 cases referred to 55.3 per cent. were in males. In 3,307 cases at Ruptured and Crippled Hospital, New York city, 53 per cent. males. Right side as in other joint affections more often affected than left. In the 1,000 cases tabulated, 506 in right 483 in left, and in 11 cases both joints were involved.

The pathology of the disease is interesting and a thorough knowledge of the anatomy of joint is important.

(1.) The disease usually begins in several minute foci in the neighborhood of the epiphyseal cartilage of the head of the femur. Here the circulation is more active and here the newly formed bone is least re-

sistant. The bacilli having gained entrance are carried by the blood and more often deposited at this point where under favorable conditions the disease is established. The minute foci unite and soon the normal tissue is replaced by granulation tissue. In some cases the local resistance is sufficient to confine the process to the interior of the bone, but in the large proportion of cases, the disease forces its way into the joint.

Next the lining or synovial membrane becomes involved and finally the adjoining surface of the acetabulum becomes involved as well.

(2.) The disease sometimes commences about the epiphyseal junction of the acetabulum, some authorities claim as often as in head of femur. In these cases early clinical symptoms are somewhat different, patient is particularly susceptible to movements of the trunk, or lateral pressure, on hips, or if advanced a Roentgen photograph shows greater destruction of acetabulum than of head of femur.

(3.) Again, the clinical symptoms may differ. The symptoms may be few in number, but enough to draw your attention to the joint and on examination you find considerable swelling. In these cases the disease probably commenced in the synovial membrane proper, and at this stage there is no marked involvement of head of bone or acetabulum. Primary disease of the synovial membrane is, however, rare, and certainly very uncommon in childhood.

In the common form of the disease which we may call the osteal, evidences of irritation early manifest themselves. The synovial membrane becomes congested. The amount of fluid in joint is increased, lining

membrane becomes thickened and granular, and as the disease progresses so does the anatomical elements which enter into the formation of joint become changed.

Adhesions may form between folds of synovial membrane, and capacity of the joint is lessened, or if the fluid is large in amount may burst through capsule and escape into the tissues around the joint. In other cases where the local condition is confined to the bone itself, it may produce typical "coxa vara." In other cases head of bone may be separated and we get a displacement of shaft, all tending to produce deformities, which it is hard to diagnose. But in the great percentage of cases the joint is perforated and the head of the femur and acetabulum is involved to a greater or lesser degree. The destructive effects are increased by the pressure of the diseased surfaces against one another, and all aggravated by the spasm of the muscles, and as a result of this we get greater loss of substance at upper and back of acetabulum and upper part of head of femur than elsewhere, and the weight of the body produces the common clinical symptom of displacement upwards with perhaps partial formation of a new acetabulum.

COURSE OF THE DISEASE.—In the very earliest stages the joint is simply sensitive, the early symptoms varying with the activity of the infection. The susceptibility of the patient and the degree to which the weakened part is subjected. This sensitiveness is indicated by the involuntary adaption of the body to the weakness of the affected joint, whereby, as is popularly expressed, "the patient favors the affected leg." The symptoms which usually attract the

patient's attention or the attention of parents or friends are pain and limp followed by stiffness, distortion, etc. Pain is not so important or so significant, as the disease in its early stages is by no means a painful one, and although patients are usually brought for treatment on account of pain, on examination we oftentimes feel, that the disease existed long before the acute exacerbation called attention to its character.

When the disease commences in the bone, as we have already said, infection usually spreads to synovial membrane, causing a general infection of the joint. If the affection left untreated, there is spasm of muscles surrounding the joint and this causes head of femur to press firmly against upper and back part of acetabulum. If case is still allowed to go untreated, we get the usual symptoms: (1.) Dislocation of head of femur, although not a true dislocation, as it still retains its connection with the acetabular cavity, followed by (2) abscess formation, which may or may not communicate with the joint. The common seat of abscess formation is in front of the joint, less frequently posteriorly about gluteal fold. Some times abscess may point at upper and inner part of thigh close to perineum. In rare cases may burrow upwards beneath Poupert's ligaments or occupy the iliac fossa and give rise to one of many forms of pelvic abscess.

Abscesses may form in connection with primary acetabulum disease, and may spread upwards into iliac fossa or downwards into rectal fossa, or may find their way into the buttock through one of the sacro-sciatic notches.

Oftimes the early characteristic pain is "pain in the knee" referred

as in the pain of so many joint affections to the distribution of the nerves, terminal filaments of which are irritated. The hip joint is supplied by branches from the anterior cural, the great sciatic, the sacral plexus and the obturator, but the pain is, more often referred to distribution of the obturator, to inner side of the knee. The pain of hip-disease in many instances is rather an occasional, than a constant symptom, the inductions being dependant upon sudden or unguarded movements or direct injury. Persistent pain is more common in later stages and usually indicates increased tension, either within the bone or within the joint. Pain at night is important, usually attracts attention where pain in day time is unnoticed, usually an indication of an acute infection and is attributed to the relaxation of voluntary and involuntary muscles, allowing sudden movements which forces sensitive parts together. If disease is acute child is found lying awake holding its thigh. In less sensitive cases child does not wake but simply moves or is restless and moans.

Direct local pain and sensitiveness to pressure are unusual at this stage, unless the tissues overlying the joint are implicated, as in abscess formation.

The "limp" is the most important of the preliminary signs of the disease. A "limp" is a change in the rhythm of the gait, and any interference with the function of the limb will cause this irregularity. In the early stages the limp, however, is due more to sensitiveness of the joint than to any marked restriction of function. We have evidence of this in the fact that the patient favours the joint by resting on the affected limb for a

shorter time than on its fellow, and by bearing more weight upon the front of the foot than on the heel. When the joint becomes very sensitive the patient bears practically all the weight upon the front of the foot, slight planar flexion being combined with slight flexion at the knee and hip and thus the characteristic symptom of what is known as the first stage of the disease is produced. This limp is a constant symptom of hip-disease, usually more noticeable in the morning or in changing from an attitude of rest to one of activity.

Stiffness, due to reflex muscular spasm, is claimed by the best authorities, such as Whitman, of New York, to be by far the most important symptom of the disease. It is the expression of the inability of the joint to perform its full function. It often precedes the limp and it remains long after pain has ceased to be a symptom and until repair is complete. The muscular spasm limits motion in every direction to a greater or lesser degree, according to stage of disease and the degree of spasm corresponds to the sensitiveness of the joint rather than to the amount of destruction which has taken place. As we all know the spasm varies from day to day, so that in the acute exacerbations, motion may for some days be so restricted as to simulate ankylosis. One of the cardinal things to remember in examining any joint, is that reflex muscular spasm is always an indication of a sensitive or inflamed joint, not necessarily tuberculous in character, as it may be the result of an injury, but if the spasm is chronic in nature and confined to a single joint,

it is, in childhood at least, almost always tuberculous in character.

As the disease progresses motion is still further lessened by adhesions and contractions within and without the joint.

The distortion in the limb is due to the constant muscular spasm which is bound to produce certain changes in the attitude of the limb, slight flexion being the earliest symptom of distortion, accompanied later by abduction and external rotation and apparent lengthening of the limb, the symptoms of which you are all familiar with, followed by the period of apparent shortening in which we get increased flexion, adduction and inward rotation, indicating that the limb is of little use, drawn into a position where it may be as little used as possible. It is claimed by some authorities that locomotion has a distinct influence in the production of the distortion, as in cases of hip-disease in infancy, the position of adduction may persist throughout, although the muscular spasm may be intense. This latter position as has been called the "second stage" is usually an indication of acute and disabling pain and of corresponding intensity of muscular spasm. It is perhaps the most destructive stage of the disease and is the attitude characteristic of the so-called "natural cure" when mechanical appliances have not been used in the treatment. The changes in the contour of the limb in the early stages are caused in great part by the attitude of the limb. The broad and flat appearance of the buttock on the affected side, the disappearance of the gluteal fold, the deepening of the inguino-femoral fold are all accounted for by the different

attitudes characteristic of the different stages of the disease.

The atrophy is an important symptom. It is always appreciable and always demonstrable. If well marked it indicates that the disease has existed for some time. The atrophy affects the muscle of the entire limb, but usually more marked in the muscles of the thigh than in those of the calf. Atrophy of the muscle is usually accompanied by atrophy of the bone as well. Contrasted with this atrophy there is relative hypertrophy of the sound limb in order to carry on its extra share of work.

DIAGNOSIS.—The Diagnosis of this condition, except perhaps in the stage of inception, is usually easy after a systematic examination has been made.

Local inflammations such as enlarged glands in groin, strain of muscles of thigh, or diseases of genitals may produce flexion and pain, but inspection usually reveals a true condition of affairs. Synovitis, anterior poliomyelitis, rheumatism, scurvy, infectious arthritis, acute epiphyseitis, extra articular disease, osteo arthritis of hip, Pott's disease, sacro Iliac disease, coxæ varæ congenital dislocation of hip, hysterical joint and other affections have all distinguishing features.

X-ray pictures are of more value in demonstrating deformity than in establishing early diagnosis, especially in childhood, when so large a part of the extremity of the femur is still cartilaginous.

The rays or pictures are of great value in showing us the destructive effect of the disease in the head of the femur or acetabulum, and thus

giving us a clearer conception of the pathological condition present that would be otherwise impossible. The X-ray pictures to-day, combined with the clinical symptoms and physical signs, certainly give us a more exact idea of pathological condition, helps us in our prognosis, and assists us in our treatment.

Although prognosis is of considerable gravity, tuberculous disease of the hip is nevertheless often attended by recovery if suitable treatment be carefully carried out for a greater length of time than is usually the custom. If seen early and careful treatment is begun at once, recovery without shortening and with a considerable degree of mobility can be looked for, provided, of course, that the joint be kept perfectly fixed during the treatment. Attempts at passive movements are distinctly contra-indicated. Passive or any kind of movements tends to the dissemination of the disease and increased stiffness when process concludes. Even after abscess formation, a considerable number recover with satisfactory joints, if careful aseptic treatment is carried out. Where it is possible to keep the case aseptic from first to last of treatment, prognosis is much better and the life of the patient is only threatened from a development of tubercle elsewhere, as pulmonary tuberculosis, tubercular meningitis, etc.

TREATMENT.—The treatment of the condition is *local* and *general*. The local treatment varies according to the clinical stage of the disease. In the first stage of the disease, that is, slightly flexed abducted and rotated outwards and before there is any enlargement of the acetabulum or absorption of the neck of the femur.

The limb must be efficiently immobilized, and the first point to decide is whether rest and splints alone are sufficient or should they be combined with extension, and this will depend upon whether the disease is primarily synovial or whether there is a deposit in the bone with infection of the joint and destruction of the articular cartilage. If disease is purely synovial, extension is not indicated as there is little or no muscular spasm, but if there are tubercular deposits infecting the joint there will be thickening of the bone and spasm of muscles around the joint and then extension is clearly indicated in order to overcome the muscular spasm. The spasm presses the inflamed surfaces together and tends to produce rapid absorption and shortening, hence overcome the spasm by extension.

In making extension it is essential to prevent rotation of the limb. Use of sand bags, etc. is necessary, but if patient is unruly then a long splint is indicated.

In primary synovial disease, when extension is not indicated, the Thomas hip splint, single or double, as the case may be is recommended, and that a good result may be obtained it is absolutely essential to overcome the flexion, and when the Thomas splint is used, it must be employed as he himself recommended, namely, in the form of a straight bar simply curved where it lies over the Buttock. The other part of the apparatus being absolutely vertical. Where pain is very acute, actual cautery gives good results. In cases where there is marked adduction or if the child becomes very restless, it is better to use the Double Thomas Splint, which con-

sists of two bars instead of one. The use of the Phelps box in other cases is of great value, as you all know the Phelps box is essentially a large trough for the head and trunks, diverging into two narrower troughs below for the lower extremities. The advantages of this apparatus is that the patient can be kept lying flatter and more comfortable than in the splint; adduction is prevented and extension can be carried out if necessary. The child can be carried about or wheeled about in the fresh air, without disturbing him. The important thing in this stage of disease is rest, and whatever splint be employed, it is essential that the patient should not get up even on crutches until all signs of the acute condition, namely, pain and tenderness on pressure have entirely disappeared.

Operative interference is rarely indicated in this stage of the disease. If the exact diagnosis of which however, is impossible of a deposit of tubercle in the head or neck of the femur could be made, cutting down and removing the focus before the joint is involved would be indicated. Again in some cases where the disease is progressing rapidly and where the condition is due to a deposit in the bone, which has burst through into the joint, arthrectomy might be of service. In the hip-joint the operation is difficult to perform, but when indicated in such cases, cutting down, removing as much as possible, then filling joint cavity with iodiform, emulsion, and glycerine, is useful. After such a procedure the acute symptoms often subside.

In the second stage of the disease where there is destruction of cartilage and enlargement of the acetabu-

lar cavity without abscess formation, *extension* is of special value. In this stage absorption is going on and the acetabulum is becoming enlarged, so that unless means be taken to overcome the muscular spasm, the shortening will increase in spite of the most careful fixation of the joint. The essential points in the treatment during this stage are to prevent the shortening, and the reduction of the three important symptoms of this stage, namely, the increased flexion, the adduction and internal rotation. Suitable extension properly applied, at first along the line that the limb has assumed, readily overcomes the spasm of the muscles. The flexion is lessened, also the adduction, and the rotation can be overcome by fixing a piece of board at right angles to axis of leg behind the knee. If extension is carried out carefully, in time, the extension can be made with the limb in the position of abduction. After the limb has been got into good position and the muscular spasm has subsided, a double Thomas splint may be fitted in order to keep up the abduction. A double splint should always be used. This apparatus should be worn for a year after disease seems cured. Otherwise the muscular contraction will recur and the deformity will be reproduced. In some cases on account of spasm in the adductors it is impossible to get the limb in good position or in a position of abduction and tenotomy of adductors may be necessary. It is important that no force should be used to restore the limb to its proper position, otherwise aggravation of the disease is almost certain to occur, possibly with dissemination of the tubercle.

The question of operative interfer-

ence, particularly as to whether excision of the hip should be performed or not, often arises at this stage. Some surgeons strongly recommend operation, others are opposed to it.

The objection to operation is that it is practically impossible to get rid of the whole disease satisfactorily, and scraping not only fails to completely eradicate the disease, but is apt to lead to dissemination of the tubercle. A considerable number of cases are recorded in which tubercular meningitis has followed so directly after an excision of the hip, that there can hardly be any doubt but that it was caused by the operative procedure. Another great objection to early excision is the imperfect functional result which follows.

Mr. Watson Cheyne, although opposed to it on the grounds that complete removal of all the diseased tissues by operative measures is impossible, says in his admirable work upon the subject, "that there are cases in which excision at this stage of the disease is proper procedure." He says that (1) those cases in which the disease is progressing in spite of careful treatment, where the tenderness does not subside, where the fullness in the groin increases, where the "starting pains" at night continue and where there is evidence of steady progress of the disease.

(2) Those in which it is evident there is primary acetabular disease, in which recovery is not taking place, this is shown particularly by thickening of the tissues on the inner surface of the acetabulum which can be felt per rectum.

(3) Those in which the head of the bone cannot be kept in place satisfactorily.

During the third stage of the disease or when suppuration is present,

we have presence either of unopened abscesses or of sinuses resulting from the opening or rupture of them. Deformity in this stage very similar to that already existing in second stage and the treatment varies according to whether the (1) abscess is opened or (2) if sinuses are present. Where there is an unopened abscess operative treatment is necessary, because the case in which a chronic abscess has become absorbed under rest and care are so rare that without operative interference a cure cannot reasonably be looked for.

Given a case in which abscess formation is well developed. The question arises what operation shall we do? Shall we open and merely treat the abscess or shall we do a more radical operation? Such as excision of the joint, and in this manner try and completely remove the disease. I think it is generally admitted that treatment of the abscess cavity is the first indication and not to interfere with the actual joint disease at first. Excision under such circumstances, is long and difficult, and with an abscess present there is great danger of fresh infection of bone taking place. In treating an abscess cavity, a very free incision is made over it, as much as possible of abscess sac is exposed before incising it, then with scissors clip away abscess wall as thoroughly as possible, then use curette thoroughly. Some surgeons lay emphasis upon the use of a flushing curette. The risks of general infection is not nearly so great, as curetted material is flushed out of the wound at once. After abscess has been scraped out thoroughly, about an ounce of 10 per cent emulsion of iodiform is thrown into the cavity. Wound is stitched

up without drainage and dressings applied. The results of this procedure, if it can be carried out are extremely good. Success depends entirely upon strict asepsis. Many abscesses are cured and wound often heals by first intention.

If however wound fails to heal, dead bone and septic sinuses being present and there is evidence of extension of the disease, then excision of hip is indicated, provided of course that patient's general health is good enough to permit of operation.

Before proceeding to excision, sinuses should be thoroughly scraped and swabbed with pure carbolic acid.

The treatment during the stage in which recovery has taken place or is progressing satisfactorily, demands occasionally that something be done. In some cases deformity is so severe that some thing to remedy it is necessary. In cases where there is still no movement of the joint, tenotomy of the adductors and extension in the abducted position sometimes is of benefit, but usually cases are so severe that they do not respond to this, and we have to bear in mind the possibility of any time, setting up an acute infection. Excision of joint is sometimes indicated, but the removal of a wedge-shaped piece from neck of femur or simple division of femur below the trochanters is often practised with good results.

Local treatment in tuberculous affection of hip-joint would not be complete without reference to Bier's congestive treatment. The results obtained are not very encouraging and the method is not very practicable so far as hip-joint is concerned.

GENERAL TREATMENT.—So far as general treatment is concerned, it is not necessary for me to occupy your time and attention ; general sur-

roundings, good foods, attempts to increase the opsonic powers of the blood are all indicated. Before closing let me make some reference to the use of tuberculin. Some observers have been obtaining the most promising results from the use of tuberculin, in cases of joint disease as well as other tuberculous affections. These observers have now established the fact, that the injection of a minute dose about 1-200

of a miligram, causes, after a primary depression of the opsonin (the negative phase) an increase. At the time of the increase, local lesions have a marked tendency to clear up. The increase drops away after a time and then another injection is given. Repeated injections are given every four or five days, and many cases are reported where marked improvements have followed in hip-joint disease.



SOCIETY MEETINGS.

ST. JOHN MEDICAL SOCIETY.

APRIL 1ST, 1908.—The meeting this evening was given over to the discussion of a motion of Dr. Corbet re attendance on private and semi-private patients at the General Public hospital, notice of which was given at a previous meeting.

The motion was to the effect that this Society requests the Commissioners of the General Public hospital to devise ways and means so that any regular practitioner of New Brunswick may attend private or semi-private patients whether such practitioner is or is not attached to the visiting staff.

Dr. Corbet, in opening the subject, told of the introduction of such measures elsewhere in public hospitals, and asked for a free discussion on the subject.

Drs. Inches, Gray, James Christie, Hetherington, Emery, Crawford, Curran, Pratt and Bentley, continued the discussion.

The motion on being put to the meeting was declared carried.

APRIL 22ND, 1908.—Dr. Curran read a very interesting paper on "Temperature and its Clinical Significance." The theories of Virchow, Traube and Liebermeister were discussed as well as the more recent work of Sajous.

Stress was put upon the fact that it is not the elevation of temperature that does the harm, but rather the toxic cause.

The conclusions arrived at were (1) that variation of temperature is under nervous control. (2) That there are heat regulating centres. (3)

That the gravity of a given case cannot always be determined by the thermometer reading. (4) That the indication in febrile conditions is to aid elimination by diaphoresis, diuresis and hydrotherapy; and (5) that antipyretics, except in well-selected cases, do harm.

Dr. Corbet thought it was often necessary to treat the symptom. He found antipyretics very useful at times, particularly aconite, veratrum and acetanilid.

Dr. T. D. Walker considered the subject from a surgical standpoint, where he thought there was less room for speculation. If temperature went up pus was looked for. He did not approve of antipyretics, but commended hydrotherapy.

The discussion was continued by Drs. Warwick and James Christie.

APRIL 29TH, 1908.—Dr. Emery entertained the Society with a paper on "Pleurisy," (appearing in this issue of the NEWS) confining his remarks to the sero-fibrinous variety, of which there are three classes: (1) Tuberculous pleuritis. (2) Infective pleuritis. (3) Cases of obscure origin. About forty per cent. of cases classed as non-tubercular develop tuberculosis in from four to ten years.

Dr. Emery advocated thoracentesis for large effusions, but where the quantity of fluid is small, he considered it better left alone, as the inflamed pleural surfaces were kept apart and adhesions less likely to form. He preferred a good sized trochar to a small needle. For the initial pain, strapping is useful, but morphia will probably have to be us-

ed. Potassium iodide and triplex pill are useful, and hygienic treatment with proper food and tonics are necessary during convalescence.

Dr. Emery described the symptoms in his own case.

Dr. Skinner spoke of the purulent form, remarking upon the good recovery these cases usually made.

Dr. Warwick told of some cases seen at post-mortem. He thought there were very few cases of pleurisy where adhesions did not form.

Drs. Corbet, Melvin, Curran and Bentley also discussed the paper.

MAY 13TH, 1908.—Dr. Gray reported for committee re "appointment of a medical inspector of Health and Schools" that they had urged upon the Municipal Council the necessity of the appointment of such an officer, but the council found themselves unable to make the necessary appropriation at present.

Dr. Pratt reported that Board of Health will shortly carry out the recommendation of this Society re taking charge of the disinfection of premises after infectious diseases.

A resolution of condolence on the death of Dr. J. Henry Scammell, was received and entered on the minutes, a copy being sent to the relatives.

Dr. White exhibited a thyroid (parenchynators) removed that day from a young boy.

Dr. Anglin then read a very complete paper entitled "Suicide," which is to appear later.

MAY 27th, 1908.—The annual meeting was called to order by President Lunney.

The Secretary's report for the year was as follows:

May 27th, 1908.

MR. PRESIDENT AND GENTLEMEN:

In presenting the Secretary's report for the Session of 1907-08, the 28th year of the St. John Medical Society, I would call your attention to the fact that the past year has been a unique one in the history of the Society. According to the programme drawn up there were 19 scheduled meetings. We have never lacked a quorum, and, although thirteen members neglected to fill their engagements on the dates assigned them, other material was procured, and no meeting has gone by default.

This is much better than in 1906-7, when four meetings were missed, and in 1905-6 when the number was six.

In addition, four special meetings were called during the year. The session opened on October 2nd with an address by the President, and in regular order the following have contributed papers:

Dr. Pratt—Appetite.

Dr. Bentley—Vomiting.

Dr. Corbet—Liberty.

Dr. Rowley—Another Point of View

Dr. Warwick—The Laboratory and the General Practitioner.

Dr. Crawford—A Few Hospitals.

Dr. Roberts—Remarks on Diphtheria.

Dr. Day—Scarlet Fever.

Dr. Melvin—Independency of Mind.

Dr. T. D. Walker—Some Rare Forms of Suppuration.

Dr. Thos. Walker—Temperature in Disease.

Dr. McIntosh—Spontaneous Disappearance of Disease.

Dr. Travers—The Causation of Insanity.

Dr. G. B. Addy—The Contagion of Pneumonia.

Dr. Gray—The Importance of the Early Diagnosis of Heart Disease in Children.

Dr. Curran—Temperature and its Clinical Significance.

Dr. Emery—Pleurisy.

Dr. Anglin—Suicide.

The following gave demonstrations:

Dr. Skinner—Pseudo - hypertrophic Paralysis.

Dr. White—Cranial Topography.

Dr. MacLaren gave a Surgical Clinic at the General Public hospital.

Pathological specimens were shown by Dr. T. D. Walker, Dr. Murray MacLaren, Dr. Skinner, Dr. Warwick, Dr. McIntosh and Dr. White.

During the summer of 1907 an efficient committee consisting of Drs. Christie, Anglin and Corbet was entrusted with improving the Society's rooms, with the result that during the past session our meetings have been held under more pleasant—to say nothing of more comfortable—surroundings.

The Society has memorialized the Council of Physicians and Surgeons of New Brunswick, asking that steps be taken to secure reciprocal registration with Great Britain.

A committee from this Society approached the local Board of Health asking them to take full charge of the fumigation of premises after infectious diseases. We are pleased to know that the Board has viewed with favour our recommendation, and will put it into effect in the near future.

A committee was appointed to confer with like committees from the King's County Dairyman's Society, and the Board of Health re legislation, aiming at improving the city's milk supply.

A committee in conjunction with a committee from the Board of Health pressed upon the Municipal Council the necessity for the appointment of a medical inspector of Health and Schools. Lack of funds prevents such an officer being appointed at present.

On the 1st of August last it was the pleasure of the Society to present a congratulatory address to Dr. William Bayard on the 70th anniversary of his graduation.

On the 6th of January, 1908, the venerable doctor departed this life full of years and honours. The members of this society attended the funeral in a body, and the regular meeting on January 8th adjourned after the reading of the minutes out of respect for its late honorary member.

On April 25th, 1908, the Society lost one of its most valued members in the death of Dr. J. Henry Scammell, a former president. A very large number of the profession attended the funeral on April 27th.

The Society by-laws have been printed and copies distributed to each member.

Membership application blanks have also been printed, and a programme of meetings drawn up as during the previous year and distributed.

ANNAPOLIS-KINGS MEDICAL SOCIETY.

THE annual meeting of the Annapolis - Kings Medical Society was held at the Aylesford Hotel, Aylesford, on June 4th.

Reports of the president, Dr. G. E. DeWitt, and the secretary, Dr. W. F. Read, were read, showing the affairs of the Society to be in a very satisfactory condition. Most of the doctors of the two counties are now members of the Society.

The following resolution was moved by W. B. Moore, seconded by J. B. March and passed, that this society request the legislature to make more definite the regulations which obtain in reference to individual inspection of schools, public buildings, factories, etc., that this request be sent to the Provincial Secretary, the Nova Scotia Medical Society and to the county medical societies, and that the secretary, Dr. W. F. Read, Dr. S. N. Miller and the President, Dr. G. E. DeWitt, be a committee to advise in reference to

the carrying out of details in connection with this resolution, that there may be regular systematic inspection of schools, public buildings and factories, and that proper sanitary conditions be enforced.

Officers were elected as follows:—

G. E. DeWitt, president; S. N. Miller, Vice-President for Annapolis County; W. B. Moore, Vice-President for Kings County; W. F. Read, Secretary-Treasurer. Other members of executive:—A. S. Burns and S. E. Shaw.

The annual dinner was served in excellent style by the management of the Aylesford Hotel, and was a very enjoyable occasion.

The next meeting will be held in August at Wolfville, when a public meeting will be held in the evening to discuss the question of municipal sanatoria, and the dissemination of information in reference to tuberculosis. Competent speakers will address the public meeting.

COLCHESTER-HANTS MEDICAL SOCIETY.

THE annual meeting of the Colchester-Hants Medical Society was held in Truro, May 19th. At the afternoon session, after the minutes of last meeting were read and adopted and the reports of committee received, the officers for the year were elected, as follows:

President, Dr. C. I. Margeson, Hantsport; Vice-President, Dr. M. S. Dickson, Great Village; Secretary-Treasurer, Dr. H. V. Kent, Truro; Executive Committee, Drs.

S. L. Walker, Truro, and C. H. Morris, Windsor.

Dr. C. I. Margeson read a very able and instructive paper on "Epidemic Malignant Dysentery" as it occurred in Hantsport in 1885 as a result of the slaughtering of a large number of black fish.

A discussion followed on the "Management of the Second Stage of Labour," by Dr. S. L. Walker, Dr. E. E. O'Brien, Dr. V. F. Conner, Dr. J. W. T. Patton, Dr. F. F. Eaton and Stephen T. Philips.

At the evening session, Dr. John Stewart, of Halifax, gave an address on "Gall Stone Disease." After a hearty vote of thanks was tendered

Dr. Stewart for his presence and address, the meeting adjourned to meet in Windsor on August 18th, 1908.

LUNENBURG-QUEENS MEDICAL SOCIETY.

THE Lunenburg-Queens Medical Society met at Bridgewater, Tuesday, June 9th. It being the annual meeting the election of new officers took place, resulting as follows:

Dr. W. H. Macdonald, Rose Bay, President; Dr. J. W. Smith, Liverpool; Vice-President; Dr. R. H. Burrell, Lunenburg, Secy.-Treas.; Dr. L. T. Penney, Lunenburg, Dr. C. B. Trites, Liverpool, additional members of Executive.

A committee was appointed to memorialize the local government, urging an extension of the capacity and usefulness of the government sanatorium, and suggesting the appointment of a capable resident physician for the institution.

Dr. A. M. Hebb reported a case of two unsuccessful attempts at poisoning by carbolic acid (2 ounces) and by Strychnine (5 grains).

Dr. W. H. Macdonald reported a case of hydatid mole with cysts of the ovaries.

Dr. F. S. Messenger reported an interesting case of retention of urine.

Dr. Slauenwhite reported a case of meningitis.

All the above gave rise to interesting and instructive discussions.

Dr. S. L. Walker, of Truro, was present and took part. Society meets at Chester in August.

In the evening a public meeting was held under the joint auspices of the above Society and the Lunenburg-Queens Anti-Tuberculosis League. Dr. Smith L. Walker, of Truro, delivered an excellent address dealing with the Economics of Tuberculosis." His address was full of valuable information and useful practical suggestions. Dr. H. A. March, M.L.A., and Dr. Burrell, Secretary of the League, also addressed the audience in a bright and instructive manner. Mr. H. H. McIntosh, Inspector of Public Schools, was elected President of the League in succession to Dr. H. K. Macdonald, who had left the county.

The Medical members of the Anti-Tuberculosis League will during the latter part of the year, deliver public addresses in the different parts of the two counties, in which the nature and prevention of the disease will be discussed.

ERRATUM.

ST. JOHN MEDICAL SOCIETY.

The following paragraphs belong to the report of the St. John Medical Society and should have appeared after the last paragraph on page 231. By mistake they were left out of the form and the error was not detected until the form was run off.

Four regular members were elected during the year, viz.: Dr. M. Ellen Douglas, St. John; Dr. W. A. Ferguson, Moncton; Dr. D. R. Arnold, Westfield; and Dr. R. C. Ruddick, St. John.

Dr. Gray, of the General Public hospital staff, was made a provisional honorary member.

There were thus two deaths and four new members, making a total membership of 48 regular and 2 provisional, the largest number the Society has ever had.

The number of members who have attended one or more meetings was 40, (in 1905-06 it was 30). The average attendance was 13.5 per meeting. In 1906-07 it was 10.5 and in 1905-06 it was 9).

In conclusion I would again refer to the fact that during the past session the membership has reached the highest point in the history of the Society, the average attendance has been increased and the scheduled number of meetings held.

All of which is respectfully submitted.

J. S. BENTLEY,
Secretary.

The Treasurer's report showed a balance of \$15.00 to the Society's credit.

The election of officers for the ensuing year resulted as follows:—

President—Dr. C. M. Pratt.
Vice-President—Dr. J. S. Bentley.
Secretary—Dr. T. D. Walker.
Treasurer—Dr. James Christie.
Fin. Secretary—Dr. G. G. Corbet.
Librarian—Dr. M. Ellen Douglas.
Pathologist—Dr. Wm. Warwick.

The president appointed the following room committee.

Dr. G. R. J. Crawford.
Dr. S. Skinner.
Dr. G. G. Corbet.

The members then adjourned to White's, where a dinner was held and a couple of hours very pleasantly spent, with speeches and cigars.

CANADIAN MEDICAL ASSOCIATION.

AT the annual meeting just held in Ottawa, the following officers were elected for the ensuing year:

President—Dr. R. J. Blanchard,
Winnipeg.

Secretary—Dr. Elliot, Toronto.

Treasurer—Dr. H. P. Small,
Ottawa.

Finance Committee—Drs. Fotheringham, Toronto; Starr, Ottawa; Powell, Ottawa; Bell, Montreal; Armstrong, Montreal.

Chairman of Committees; Medical Legislation—Dr. A. T. Shillington, Ottawa.

Medical Education—Dr. Reeves,
Toronto.

Public Health and Hygiene—Dr. Hastings, Toronto.

Amendments to the Constitution—
Dr. Small, Ottawa.

Necrology—Dr. Elliot, Toronto.

Winnipeg was chosen for the next place of meeting.

Programme of Annual Meeting of the Maritime Medical Association, Halifax, N. S., July 1st and 2nd, 1908.

WEDNESDAY, JULY FIRST, 1908.

Morning Session, 10.00 A. M. to 1 P. M.

1. Enrollment.
2. Reading of Minutes.
3. Reports of Committees.
4. Report of Treasurer.
5. Correspondence and Bills.
6. Appointment of Nominating Committee.
7. Case Report—"A Rare Case of Hermaproditism."—Dr. F. J. White, Moncton.
8. Paper—"The Treatment of Procidencia."—Dr. T. W. Johnson, Kearney Hospital, Boston.
9. Case Report—"A Case Treated by the Bier Suction Cup."—Dr. J. Fred. Lessel, Halifax.
10. Paper—"Some Remarks on Post Operative Treatment in Abdominal Section."—Dr. H. K. MacDonald, Halifax.
11. Case Report—"Large Suppurating Non-Peduncular Cyst—Operation—Recovery."—Dr. W. H. Irvine, Fredericton.

1.00 P. M., Luncheon at Halifax Hotel.

Afternoon Session, 2.30 to 4.30 P. M.

1. Address—Dr. John Stewart, President Medical Society of Nova Scotia.
2. Paper—"The Roentgen Diagnosis of Urinary Calculus."—Dr. Percy Brown, Boston.
3. Address in Surgery—"What Modern Surgery Can Accomplish in Diseases of the Stomach."—Dr. F. B. Lund, Boston City Hospital.
4. Case Report—Dr. F. E. Lawlor, N. S. Hospital, Dartmouth.

5.00 P. M., Visit to Studley Quoit Club.

Evening Session, 8.00 to 11.00 P. M.

1. Address—Lieut.-Governor Fraser.
2. Presidential Address—"The Recoil of Professionalism."—Dr. M. Chisholm, Halifax.
3. Paper—"Gastro-enterostomy, with Report of a Case."—Dr. A. B. Atherton, Fredericton.
4. Paper—"Sarcoma, Treatment by X-Ray and Excision."—Dr. S. R. Jenkins, Charlottetown.

5. Paper—"Constipation."—Dr. G. W. T. Farish, Yarmouth.
6. Paper—Title to be announced.—Dr. E. D. Farrell, Halifax.

THURSDAY, JULY SECOND.

Morning Session, 9.30 A. M. to 1 P. M.

1. Report of Nominating Committee.
2. Election of Officers.
3. Unfinished and New Business.
4. Paper—"Chronic Dacryocystitis, The Radical Treatment."—Dr. R. Evatt Mathers, Halifax.
5. Case Report—"Subdural Abscess Complicating Mastoiditis."—Dr. Geo. H. Cox, New Glasgow.
6. Paper—"The Physiology of Vision and Other Senses."—Dr. A. P. Crockett, St. John.
7. Paper—(a) "Some Popular Fallacies as to the Cause of Certain Diseases."
(b) "Notes on Medical Ethics."—Dr. P. C. Woodworth, Kentville.
8. Discussion in Obstetrics—"Occipito-Posterior Presentation."—Dr. M. A. Curry, Halifax.
Dr. T. D. Walker, St. John.
Dr. A. J. Cowie, Halifax.

Afternoon Session, 2.30 to 5.00 p. m.

1. Presentation of Cases—Dr. E. A. Kirkpatrick, and others, Halifax.
2. Paper—"Osteopathy."—Dr. J. P. MacInerney, M. P. P., St. John.
3. Paper—"The Early Diagnosis of Phthisis."—Dr. A. Fred. Miller, Saranac Lake, N. Y.
4. Address in Medicine.—Dr. John McCrae, Montreal.
5. Paper—"The Practical Use of Sera and Vaccines."—Dr. E. W. Cushing, Boston.
6. Paper—"Abdominal Tuberculosis."—Dr. W. A. Ferguson, Moncton.
7. Case Report—Title to be announced—Dr. H. D. Johnson, Charlottetown.
8. Paper—Title to be announced.—Dr. J. F. Macdonald, Shubenacadie.

Harbour Excursion—5.00 P. M.

Smoking Concert—8.30 P. M.

DR. CHAS. BENT HONORED.

ON the evening of May 19th, the fellow practitioners of Dr. Chas. Bent, of Truro, entertained him at a banquet at the Stanley House, and presented him with an address, accompanied with a gold-headed cane, that bore this inscription:

PRESENTED TO DR. CHAS BENT
BY HIS
FELLOW PRACTITIONERS.

The address was as follows:

TO CHAS. BENT, ESQ., M.D.

In view of the fact that sixty-one years ago the University of Pennsylvania conferred upon you the degree of Doctor of Medicine, and as you have been all these years actively engaged in the practice of your profession, it seemed fitting that your fellow practitioners should show their appreciation of your devotion to duty, and of the high standard of citizenship which you have always maintained.

It falls to the lot of very few members of the medical profession to be thus actively engaged for so many years.

It must be a source of pride to you to know, that out of four hundred and sixty medical practitioners in the province, you have the distinction of being the longest in practice, and you are to-day the oldest living graduate.

During all these years you have been closely identified with the growth and organization of the medical profession in Nova Scotia.

Being one of the founders of the Nova Scotia Medical Society, you must have watched with interest its ever increasing usefulness.

Ever since the organization of the Colchester Medical Society in 1883, and its amalgamation with the Hants County Medical Society in 1907, you have been closely identified with everything pertaining to its welfare, and a regular attendant at its meetings. Your contributions to the work of the Society have been always marked by that keen knowledge of one skilled in the art and science of medicine.

You have been the ideal student practitioner. And your labours have been characterized by the conviction that the work in which you are engaged does not end with the College Course, but is a life course.

We venture to think that your success in medicine has been largely due to the *routine* and *system* which have always characterized your work.

Professor Wm. Osler says of the student practitioner: "Begin early to make a threefold category: Clear cases, Doubtful cases, Mistakes.

"It is only by getting your cases grouped in this way that you make any real progress in your post-graduate education; only in this way that you can gain wisdom with experience.

"It is a common error to think that the more a doctor sees, the greater his experience, and the more he knows."

Cowper drew a most skilful distinction in his oft-quoted lines:

"Knowledge and wisdom, far from
being one,
Have oftentimes no connection.
Knowledge dwells
In heads replete with thoughts of
other men;

Wisdom in minds attentive to their own.

Knowledge is proud that he has learned so much;

Wisdom is humble that he knows no more."

Although busily engaged with a large general practice, you found time to devote to the civic interests of the town. Having served as a councillor for two years, 1880-01, and having been elected to the office of Mayor, 1882, and re-elected in 1883, you have been closely identified with the civic as well as the professional life of the community.

We beg you to accept the accompanying gift as a slight expression of our appreciation of your skill and ability, and of your unflinching courtesy to your conferees, and of your arduous and self-sacrificing labours in the public interest.

Convey to Mrs. Bent our sincere congratulations, with the hope that you both may enjoy many years of usefulness.

H. V. KENT,

On behalf of his
Fellow Practitioners
of Truro.

DR. BENT'S REPLY:

TO THE MEMBERS OF THE
MEDICAL PROFESSION
AND FRIENDS:

Gentlemen,—I can assure you that I never felt more embarrassed in my life than I do at the present time. I feel at a loss to find language to express my feelings in a suitable way on this eventful occasion in the history of my long professional career, for your thoughtful and pleasing address, accompanied by such a testimonial as you have presented me

with to-night to celebrate the sixty-first anniversary of my entrance into the active practice of medicine. It is needless to say that it comes as a great surprise to me to be thus honoured, while at the same time it is most gratifying and acceptable to be remembered in this way by so many fellow-practitioners and kind friends, and I thank you most sincerely for the great compliment you have conferred on me by this act.

It is said that a faithful friend is the medicine of life, and when so many have shown their friendship by this gracious act to-night, I feel the virtue of it will prolong mine, which you refer to as being the longest in active work of any medical man in this province.

I have always been fond of the profession, and while I am able I shall continue in the work which I have chosen, owing to the exhilarating idea of being instrumental in affording relief to suffering humanity, which reconciles every difficulty, however great.

"Our life is chequered with pleasures and woes,
That chase one another like waves
of the deep."

The medical profession is a noble one, being both ancient and honourable, and has two objects, the preservation of health and its restoration when lost. If the student of to-day is governed by the traditions of the past, and inspired by the hopes of the future, working diligently in the great field of medical science, his lot shall not be an unhappy one and his reward shall be well assured.

I have seen a good deal of surgery in my early practice, which was done without anæsthetics or antiseptics, *i.e.*, previous to their discovery, and under difficulties not encountered at

the present day, and it was surprising to witness the courage and fortitude shown by the afflicted while undergoing major and minor operations, and as a general rule with favourable results. Surgery, during my time, has made gigantic strides since the discovery of chloroform by Simpson, and a sepsis by Lister, which have enabled surgeons to perfect their technique, and devise and undertake new operations that would never have had a place in surgery but for these advances.

The profession is noble because many of Christ's most gracious acts were the curing of the sick, healing of the maimed, the giving of sight to the blind, and the restoring of reason to the mentally deranged.

When I commenced practice in Truro in 1853, which was by request, the condition of affairs was altogether different from what is found to-day.

For instance, there were only six practitioners in the whole of Colchester County, one besides myself in active work in Truro. This shows at a glance the actual work that was required to answer the demands of such a scattered population, extending to Upper Stewiacke, Shubenacadie, Earltown, Tatamagouche, Londonderry, Economy and Five Is-

lands, to which places occasional visits had to be made, as well as in the adjoining counties of Pictou and Hants. Now there are twenty-eight practitioners in the town and county, with a population of two thousand less than there was thirty years ago.

At the time above mentioned it took three days to visit Halifax by coach and attend a medical society meeting. I believe I was the only one present outside of the city when the first medical society of the province was organized, and it is still in existence and in a flourishing condition.

I shall ever cherish the kindly sentiments of this social entertainment and the generous expression of affectionate regard, and the scenes of this evening will ever be associated with your kindness and the gift you have presented to me.

Permit me to say that your reference to Mrs. Bent is much appreciated by her, and she desires me to assure you of her sincere wishes for your future health and prosperity.

I again thank you and express the sentiment that when our work is finished and our term of life ended, we may each receive the welcome message of our Master; "Well done, thou good and faithful servant, enter thou into the joy of thy Lord."

PERSONALS.

DR. E. D. Farrell, after several months of surgical work at Vienna, has resumed practice. Dr. Farrell remained for some time in New York on his return, and also attended the Canadian Medical Association meeting at Ottawa.

Dr. Edward Blackadder, who came to this city from Westport, N.S. some months ago, is conducting the editorial department of the *Acadian Recorder*. Dr. Blackadder is a facile writer and his editorial work in the *Recorder* has attracted considerable attention.

Dr. G. M. Campbell was recently elected Deputy-Mayor of this city.

Dr. R. A. H. MacKeen, of Glace Bay, has returned from a prolonged trip to the West, very much improved in health.

Dr. A. J. Cowie has removed to 76 Spring Garden Road.

Dr. N. E. McKay and family sailed last month for England.

Dr. L. M. Murray has lately returned from a trip to the Pacific Coast.

Dr. F. S. Yorston, of Truro, recently returned from post-graduate work in New York.

Dr. John MacKenzie, of Port Mulgrave, has just returned from a six weeks course at the Post-Graduate Hospital, New York.

At the proceedings in connection with the opening of a new operating room at the St. John General Public Hospital, a number of visitors were present, including Dr. John Stewart, of Halifax, a former pupil of Lord Lister, who gave an address on the early work of the great surgeon.



OBITUARY.

THE death occurred at his home in Pubnico, N. S., on April 25th, of Dr. William Gordon Barton, after an illness of seven days of pneumonia.

Dr. Barton, who was probably one of the oldest medical practitioners in the province of Nova Scotia, was born in Dublin 88 years ago. He received his early education at St. Joseph's College, Clondalkin, and Trinity College, Dublin, at which latter university he remained for three years as Classical English and French teacher. After travelling in France and Spain for a while, he came to America in 1848, and was for ten years Classical, English and Spanish teacher at St. Anne's College, Wilmington, Del.

He graduated in Arts and Medicine at the University of New York in 1858, and practiced medicine in Newtown, North Carolina, until the breaking out of the Civil War, when, not being in favor of slavery, he was compelled to leave the country. Boarding a ship at Richmond, Virginia, which he thought was going to Boston, but afterwards found was a blockade runner owned by the late Captain E. K. Clements, of Yarmouth, and bound for Halifax, he arrived in the latter city in 1861. He afterwards went to Pubnico.

where he spent the remainder of his life and practiced medicine until about twelve years ago, when he was succeeded by his son.

He has two sons in the medical profession, Dr. W. J. Barton, of Pubnico, and Dr. Frederick Barton, who is in the employ of the Isthmian Canal Commission, Panama.

Dr. Barton was a linguist of some note, speaking Italian, Spanish and French fluently, as well as having a good knowledge of Latin and Greek. His thesis in Latin at the University of New York on graduating, won for him considerable praise at that time. He was a man of great physical endurance and vitality, and had little or no sickness during his long life, until he was seized by that most fatal of diseases which kills both young and old.

Besides conducting a large practice, he was always a tireless student, being often found by his family in the early morning where he had been left at night deeply engrossed in some musty volume of Virgil or Homer, totally oblivious to the passage of time. His mind was bright and active until the end, and the closing years of his life were spent in a perusal of ancient history and a study of his classics, which were his chief pleasure and delight.

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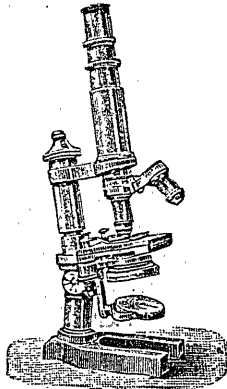
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