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Original Communications.

TWO CASES OF REMOVAL OF THE GALL-BLADDER BY FINNEY'S METHOD.

BY INGERSOLL OLMSTED, M.B., TORONTO.

Physician to the City Hospital, Hamilton, Ont.

Recently while in conversation with Dr. J. M. T. Finney, Associate Professor of Surgery at Johns Hopkins Hospital, that gentleman described to me an operation for disease of the gall-bladder, which he had been lately practising, and which he had given a description of before the Johns Hopkins Hospital Medical Society, when reporting some cases which he had operated on for colicystitis.

As the gall-bladder is known to have little or no use in the human system, it seems as rational to remove a diseased gall-bladder as it is to remove a diseased appendix.

Many operators have been in the habit of removing the gall-bladder in case of stone, where it has been found difficult to attach it to the peritoneum, and drain it in the usual way. In these operations the gall-bladder has been separated from the liver, the cystic duct traced down and ligated, and a gauze drain has been placed over the abraded area of the liver as well as one extending down to the stump of the duct. frequently in these cases there has been a leak from the duct, forming a fistula, which took some time to close.

Dr. Finney, in his operation, leaves a flap on either side of the liver attachment of the gall-bladder, composed of the sero-muscular coats, sufficient when the two are approximated to completely cover up this abraded area. The stump, on the

other hand, is treated like an appendix stump, thus preventing any ordinary possibility of a leak from this source.

Any one conversant with gall-bladder surgery can always be certain of absence of stones in the common duct, as this is palpable in the whole of its course, and any stone so small as to escape detection could pass as readily through the common duct into the intestine as through the cystic duct into the gall-bladder.

In cases, however, where there is obstruction to the outlet of the common duct, through neoplasm, the gall-bladder may be useful to form an anastomosis with the duodenum in order to obviate such an obstruction. These cases, however, are rare, and at best are unfavorable ones for operation.

When the gall-bladder is diseased it is best to get rid of the whole organ without opening its cavity, thus precluding the possibility of infection from that source.

The following two cases illustrate the success of this method of treatment:

In the first case I followed Dr. Finney's description, with the exception of one or two small details. The history is as follows:

Mrs. B., aged 67, widow, first consulted me four years ago, for pain in the left hypochondrium. There was some rigidity of the abdominal muscles, with tenderness over the region of the pain, as well as over the upper part of the right rectus; there was a slight rise in temperature, increased frequency of pulse and constipation. Rest in bed for a few days, with mercurial and saline laxative, relieved the symptoms. There was no palpable tumor, but for several days slight tenderness remained over the region of the gall-bladder, as well as on the left side just beneath the edge of the ribs.

She is a small spare woman, rather a nervous temperament, and has been troubled for years with constipation and hemorrhoids. She has had ten children, eight of whom are alive. She is a moderate eater, and never has used spirituous liquors.

During the last four years she has had slight returns of the pain, which was invariably referred to the left side. In September, 1901, I was called and found her suffering from her old trouble. Her condition was much the same as on previous occasions. She had not lost flesh since last seen. Her temperature was $99\frac{1}{2}$ and pulse 80. She had sickness of the stomach and pain in the left side of the abdomen under the ribs, but no vomiting. In palpating the abdomen the recti were found somewhat rigid, and a small swelling could be felt beneath the right rectus, extending within about two inches of the umbilicus. On manipulating this swelling she had pain, which she referred to the left side, and not over the region palpated.

With deep inspiration this lump could be felt to descend. The abdominal muscles were very thin, and a distinct peristalsis of the bowels could be seen. Rest in bed with a laxative relieved her condition so much that on the third day after the attack, when making my call, I found her out of bed and down stairs. An operation was advised.

She called me again November 22nd. During the last two months she had lost nineteen pounds, and had been troubled with little gripy pains in the upper and left side of the abdomen, she was much weaker and had but poor appetite.

The notes made at this time are as follows :

The abdomen is rather flat, skin wrinkled, frequent peristalsis, apparently of the small bowel, is seen. On the right side beneath the rectus there is a nodular mass which is continuous with the liver, about two and a half inches in length and two inches in breadth. This tumor moves downwards with inspiration, and is quite tender to touch, and when palpated gives pain in the left side. Nothing abnormal can be detected in any other part of the abdomen. The heart and lungs are normal. The urine contains neither albumin nor sugar.

She was removed to the city hospital.

November 26th, 1901 : Incision was made about four inches long, through the outer third of the right rectus, beginning a short distance from the costal margin. The muscle was separated by means of blunt dissection and the peritoneum opened. The gall-bladder was found enlarged and full of calculi, one of which could be felt in the upper part of the cystic duct ; over the fundus of the gall-bladder were numerous adhesions which bound it to the hepatic flexure and beginning of the transverse colon. The liver was markedly hob-nailed. Over the gall-bladder was a tongue of cirrhotic liver. The abdomen was carefully explored, but no other abnormality found.

After elevating the gall-bladder the adhesions were separated between forceps.

An incision was now made, beginning near the fundus of the gall-bladder on the right side, and about half an inch from its attachment to the liver through the serous and muscular coats, extending the whole length of the gall-bladder down to the commencement of the cystic duct. By means of blunt dissection between the mucous and muscular coats, posteriorly, the gall-bladder was lifted out of its bed until a corresponding point on the left side of the gall-bladder was reached, when a similar incision was carried down through the two outer coats on the left side ; in this way the entire gall-bladder was separated from the liver, with the exception of those parts of its two outer coats, which were left attached to that organ, forming,

as it were, a flap on either side of its liver attachment. The cystic duct was now traced down until a point about half an inch away from the hepatic duct was reached. The outer fibrous coat of this duct was separated from the mucous coat so as to form a cuff, which was shoved back so as to allow the mucous coat to be ligated close to its junction with the hepatic duct and divided just externally to the ligature, thus allowing the gall-bladder to be removed. The little stump was now wiped off, the cuff drawn back and closed with fine silk, in a manner similar to an appendix operation.

After carefully ligating all small bleeding points, a continuous suture of catgut was placed, beginning at the stump of the duct and running up, bringing the aforementioned flaps together, thus leaving a complete serous covering over the liver. It was not found necessary to tie any bleeding points in these flaps.

As the adhesions which had been separated from the gall-bladder formed a broad abraded area, a continuous suture of silk was run through them, bringing the peritoneal coats together, thus leaving a much nicer condition of the parts.

The abdomen was now closed by means of a continuous silk suture, which extended through the peritoneum and posterior sheath of the rectus. The anterior sheath of the rectus was now stitched with another continuous suture of silk, this approximated the separated muscular bundles of the rectus, and as no sutures were passed through them caused very little injury to the muscle. The usual subcuticular wire suture was now inserted, dressing applied and patient returned to bed.

The operation occupied three-quarters of an hour and the patient was in a very good condition when removed to her bed. Her convalescence was uninterrupted.

Wire suture removed on the eighth day and everything found perfectly healed. She was allowed to sit up in bed on the tenth day, get up on the fourteenth day, and returned home on the eighteenth day.

The lumen of the gall-bladder was not opened, and there was no chance of infection.

The second patient was seen with my friend, Dr. J. T. Rogers, of this city, on April 6th, 1902. The history is as follows:

Mrs. C., aged 46, is a medium-sized, well-nourished woman, with good family history. She has had seven children, and four miscarriages. Youngest child eight years old. In 1875 she had an attack of inflammation of the bowels. In 1885, following confinement, she had septicemia. When pregnant, she has always felt more or less pain in lower and right side of the abdomen. In November, 1900, she was confined to her

bed for a few days with a pain in her right side over the liver, sickness of the stomach, vomiting and slight fever. During the last eighteen months she has had slight returns of this pain, which seemed to shoot through to the right shoulder blade, and was accompanied usually by sickness of the stomach, distention of the abdomen and vomiting. She always seemed relieved after vomiting. Two days ago she was taken with a severe pain in the right side, vomiting, chills and fever, and anorexia. Dr. Rogers was summoned. She had a temperature of 101, suffering a great deal of pain, which required an opiate to relieve. The following day a well-marked tumor could be made out beneath the right rectus.

Note, April 6th: There is a tumor at the outer side of the right rectus, just below the edge of the liver. It is about two and a half inches in width and three inches in length, parallel with the rectus, and extends downwards to the level of the umbilicus. It has a smooth outline and can be separated from the kidney, which is felt behind. It is tender on pressure. The pain shoots through to the back beneath the right shoulder blade and is accompanied by sickness of the stomach.

The patient was removed to the city hospital and operated on immediately.

The abdomen was opened through the right rectus in the usual way. A large distended gall-bladder was seen, which contained a large stone. Imbedded in the upper part of the cystic duct there was another large stone the size of a hickory nut. Owing to the distention of the gall-bladder it was found very difficult to manipulate this organ in order to enucleate it, consequently it was grasped with two clamp forceps, surrounded with gauze packing and aspirated. About six ounces of thick mucus, containing a large amount of pus cells, was removed, the puncture wound wiped with gauze, then touched with pure carbolic acid, and closed with clamp forceps. This partial emptying of the gall-bladder facilitated the subsequent steps of the operation very much indeed. It was now treated in the same manner as in the preceding case. The muscular coat was very much infiltrated with serum, which gave it a very light yellow appearance, and the contrast between the muscular and mucous coats was very great, as the latter was a deep reddish brown color. Two little branches of the cystic artery were ligated. After closing the stump and stitching the flaps together, the caput coli was drawn up into the wound, disclosing a very much thickened appendix with a bulbous extremity at the end of which was a strong round adhesion attaching it to the small bowel. The adhesion was divided, appendix removed, and stump invaginated, the abdomen closed in the usual way.

The operation occupied about an hour. Convalescence was uninterrupted. Patient was dressed on the tenth day, and allowed out of bed on the fourteenth day, returned home three days later.

Both of these patients did remarkably well, and the advantages of this operation over the old method are so great that one cannot help feeling that it is a great step forward in the surgery of the gall-bladder.

THREE CASES OF PUERPERAL SEPTICAEMIA, TREATED WITH ANTISTREPTOCOCCUS SERUM.

BY K. C. McILWRAITH, M.B. TOR., F.O.S. ED.

Case 1.—Mrs. R., aged 38. Abortion about the fourth month. Admitted to Toronto General Hospital June 25th, 1901, under the care of Dr. Ross. Irregular fever, as shown by the

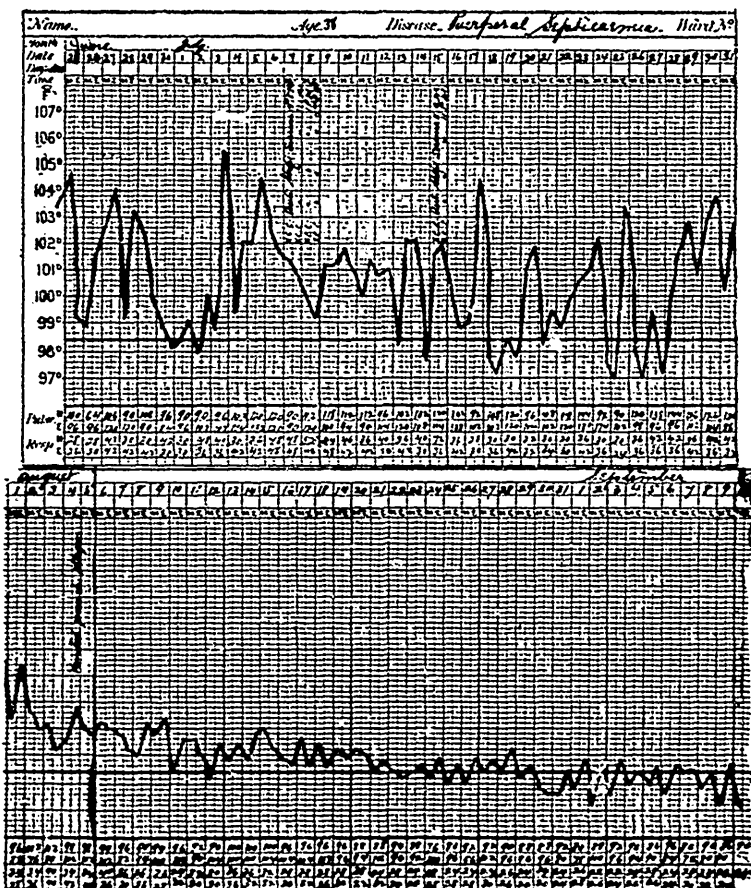


chart. I first saw the patient about the 5th of July. There was then some dulness and prolonged expiration at about the level of the third rib anteriorly in the left lung. Patient placed on strychnine hypodermically and whiskey and

quinine by the mouth. Serum was given on July 7th at 12.30 p.m., 10 c.c., and at 11 p.m. 10 c.c. Next morning she looked and felt very much better. Two more doses of 10 c.c. each were given on the 8th, and the patient continued to feel very much better. The supply of serum gave out at this time. On the 15th two more doses of 10 c.c. were given, and as before the patient felt and looked much better for a time after it.

This woman was strong and a good patient, aiding in every way in the fight that was being made for her life. She hung betwixt life and death, having occasional rigors and vomiting spells until the 4th of August, when she coughed up a considerable quantity of greenish, very offensive pus. The discharge of this nature continued for two or three days, and she gradually recovered, being discharged well on the 10th of September. I think that in this case the serum was not given soon enough or in large enough doses, and not kept up long enough.

Case 2.—Mrs. W., aged 26, primipara. Admitted to Toronto General Hospital January 28th, under the care of Dr. A. H. Wright. Temperature 103, pulse 96; 10th day of the puerperium. Physician reported that she began to have fever on the third day of the puerperium, and that he had curetted the uterus twice. ℞ Calomel in divided doses, followed by magnesia sulph.; whiskey ℥i. every 4 hours. Child taken from breast.

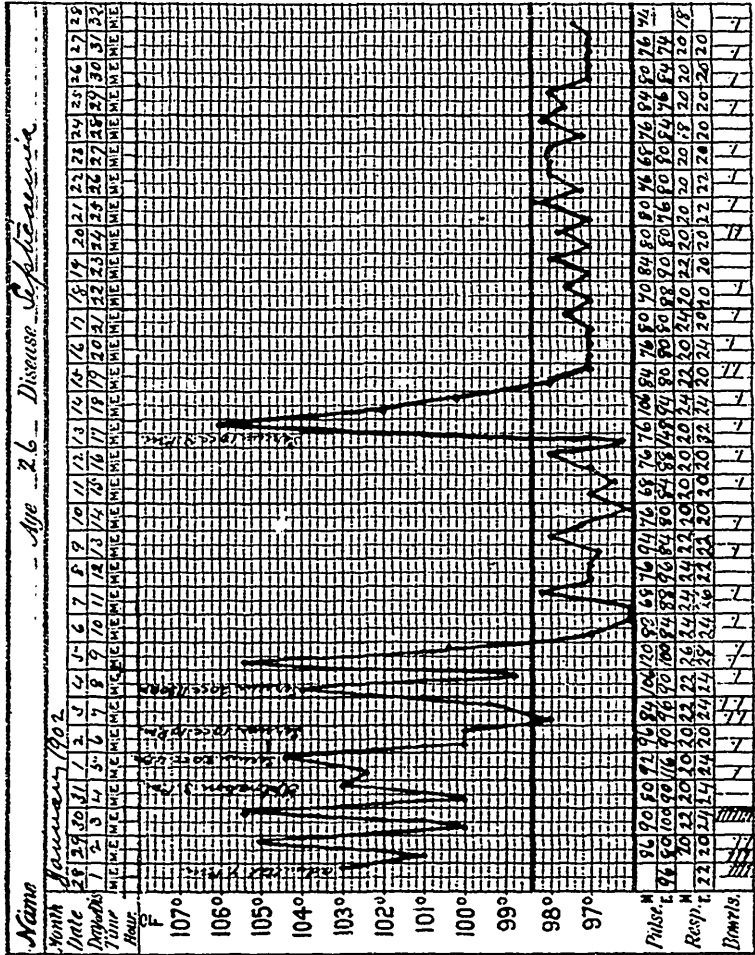
January 29th.—Bowels very freely moved in the morning. By noon temperature, 99½, pulse 88. Patient did not look or feel badly. Uterus distinctly subinvolved. Temperature at 8 p.m., 105, pulse 80, respiration 20. ℞ Quin. sulph. grs. i., q. 4 hours. Liq. strych. mms. iii., hypo. q. 6 hours.

January 30th.—Temperature 100, pulse 90, respiration 22 in the morning; temperature 105½, pulse and respiration not recorded at night.

January 31st—Temperature 100, pulse 80, respiration 20 in the morning. The uterus was explored under chloroform in the afternoon. The walls were found to be smooth, and no membranes, clots, or portions of placenta present. There was a quantity of yellowish discharge in the uterus, some of which was removed in a sterilized pipette for bacteriological examination. The uterus was washed out with a creolin solution, and a quantity of iodoform gauze introduced. At night she had a chill, temperature 103, pulse 90, respiration 24. The discharge showed abundant streptococci in the smear.

February 1st.—Morning temperature 102½, pulse 92, respiration 20. At 4 p.m. the temperature was 104½, pulse 116, respiration 24. After consultation with Dr. Wright 20 c.c. antistreptococcus serum were given by hypodermic injection between the shoulder blades. One hour later the temperature

was 105, pulse 102, respiration 24. Two hours later 105½, pulse 100, respiration 30. Soon after this the patient went to sleep, and the temperature fell steadily until February 2nd, noon, it was 97½, pulse 80, respiration 20. The improvement in the patient's general appearance and feelings was very



marked. Bouillon cultures from the discharge gave pure growths of streptococci. A guinea-pig injected with some of the discharge did not show at this time, nor subsequently, any sign of infection. At night the patient's temperature was 100, pulse 90, respiration 20. Serum 10 c.c. given.

February 3rd.—Temperature remained at 98, pulse 88 all morning, going up to $99\frac{2}{5}$, pulse 96 at 6 p.m.

February 4th, 6.30 a.m.—Temperature 104, pulse 110, respiration 24, falling by noon to $101\frac{1}{5}$, 108 and 24 respectively. Serum 20 c.c. given. Temperature at 6 p.m. $98\frac{1}{4}$. Patient slept well all night.

February 5th, 4 a.m.—Temperature 106, pulse 136, respiration 24. Temperature fell steadily all day until by midnight it was 98. Pulse 86 and respiration 24.

February 6th to 13th.—During this period (8 days) the temperature varied between 96 and 98. The patient looked well, slept well, felt well and ate well. On the afternoon of the 13th the patient was allowed to sit up for a few minutes. Had a severe chill. By 7 p.m. temperature 106, pulse 148, respiration 32. Serum 10 c.c. given.

February 14th.—Temperature falling steadily all day. Patient felt well and wondered why she was kept in bed.

February 15th, 7 a.m.—Temperature 98, pulse 84, respiration 22. During the rest of the patient's stay in the Hospital her temperature varied between 97 and $98\frac{1}{4}$. She was allowed up on the 24th, and left the Hospital on the 28th, having been 14 days without fever. The yellowish discharge had gradually ceased, and the uterus could no longer be felt per abdomen. On March 10th her husband told me that four days after her return home she had "felt chilly," but that since then she had been getting stronger every day, and was able to attend to her duties. During the whole of this illness the patient did not look as ill as her temperature seemed to indicate. I attribute this, in part at least, to the stimulating treatment given. I have noticed this fact before under similar circumstances. The fact that the guinea-pig did not die from the injection of the material obtained from the uterus is not unusual. Animals are not specially susceptible to micrococci taken from the human subject. The sense of well-being after serum injections was very well marked in these two cases. The clinical condition, namely, the continued fever of septic type, and the smooth-walled, empty uterus was itself sufficient to establish a diagnosis of septicæmia, though the bacteriological finding was strongly confirmatory. The chill which followed the exploration of the uterus is the rule in such cases.

Case 3.—Mrs. E.—Admitted February 22nd, 10.45 p.m. Temperature 100, pulse 120, respiration 34. Brownish, offensive discharge from uterus.

February 24th.—Uterus explored under chloroform, found empty and smooth-walled. The only organism recovered from the discharge was a long bacillus.

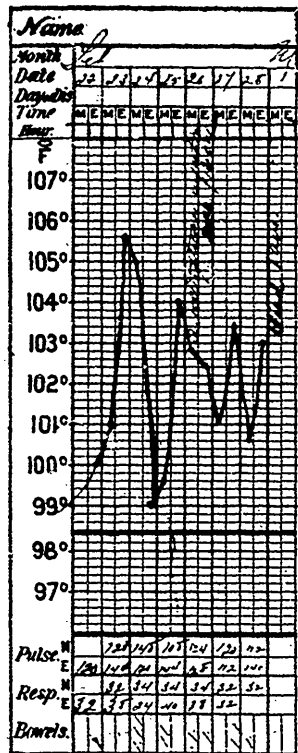
February 25.—Feeling better. Temperature 99 this morning, 104 at night.

February 26th.—20 c.c. serum given, producing no apparent effect whatever.

The patient was given the same general treatment as Case 2, with the addition of saline enemata Oi, q. 6 hrs. She developed pains in her ankles and shoulders. Sank rapidly, and died February 28th. In this case also the diagnosis of septicemia was made from the clinical condition.

In conclusion, I wish to express my obligations to Professor Mackenzie and Dr. Goldie for their aid in the bacteriology of these cases; to Professor Ross for permission to report Case 1, and to Professor Wright for permission to report Cases 2 and 3.

NOTE.—The subject of serum therapeutics is still somewhat indefinite. The standards of strength of most of the anti-toxic serums are, to a certain extent, uncertain. Probably the only exceptions at present are the anti-diphtheritic and anti-tetanic serums. The doses and the effects of dosage in the case of these two serums are fairly definite, and the results in the treatment of diphtheria and tetanus have, in the opinion of the great majority of clinicians, been eminently satisfactory. I think we have good reason to hope that in the near future



we may get equally satisfactory results from the use of anti-streptococcic serum in suitable cases. I watched carefully one of the patients referred to by Dr. McIlwraith, and I certainly thought that she showed improvement (sometimes most marked) after each injection. In the majority of cases, however, which have come under my observation the patients appeared to derive no benefit whatever from the use of the serum. Sometimes this was probably due to the fact that the dosage was too small. The initial dose should be not less than 20 c.c. Sometimes I have reason to believe the serum was worthless. I think the serums on the market now are much more reliable than those manufactured four and five years ago.

A. H. WRIGHT.

A CASE OF VOMITING OF PREGNANCY.

BY EVERETT S. HICKS, PORT DOVER.

The case about to be reported is no doubt an exact counterpart of many another case, but it may be of interest from the fact that the new treatment, viz., the use of saline enemata, credited to Condamin in the April issue of the PRACTITIONER, had been thoroughly tried for ten days prior to my having read the report of his cases. It was not successful in this instance.

Mrs. A. B., aged 22 years, came to my office about middle of March complaining of continuous nausea, soreness of the epigastrium, and of a lump moving from the stomach to the throat. Patient was of slight build, in appearance not at all rugged. Family history good. She has had previous good health except for severe attacks of dysmenorrhea. Questioning elicited the fact that the last menstruation had been missed some two weeks before. A diagnosis of probable pregnancy was made. Directions as to diet and the general management were given and a mixture of bismuth with an alkaline stomachic prescribed.

March 31st. Saw the patient at her home. She tells me she has been unable to retain any food for a week and a half. Examination reveals a poorly developed cervix, a pin-hole os and an anteflexed uterus. Absolute rest in bed with rectal feeding and saline enemata was continued for ten days. Patient was free from excessive vomiting the first three days but nausea was continuous. She became steadily worse. All the medicines catalogued were tried in succession. If any practitioner has a fond hobby in any one drug I would be pleased to hear of it and tell him of its effect in this case. In conjunction with medicinal measures, blisters were applied to the epigastrium and on the neck, the cervix was thoroughly dilated, cocaine and carbolic acid applied and the cervix bled by multiple puncture. I advised consultation towards the end of April with a view of producing an abortion. My consultant advised waiting and we tried other medicines without effect. On Sunday, April 27th, we agreed to produce abortion. Patient was at that time very thin, irritable, despondent and very weak, temperature 98, pulse 96, weak and compressible. After rendering everything aseptic a sound was passed well up to the fundus and moved around freely. Some flowing followed, Monday, April 28th—No pains; sound passed again. Tuesday, 29th—No pains but a little flowing. Patient was given strychnine hypodermically and saline enemata with foods, temperature normal, pulse 110. Dull curette was used with the idea of

separating the membranes from the uterine wall. Wednesday, April 30th—No pains. Common No. 10 male elastic catheter inserted and pushed up until about an inch only projected from the cervix. It was left thus in the uterus. May 1st—No pains. Flowing more profusely in the afternoon. May 2nd, 2 p.m.—Catheter still in uterus, pains coming on feebly, pulse 120 and thready, patient pale, face pinched, ears cold. Strychnine was given freely and saline enemata. A little chloroform at midnight enabled me to scoop out ovum and membranes entire with the finger. Ovum obtained was about nine weeks old. May 3rd—Patient weak, pulse 110, but able to retain nourishment. She has since been making a good recovery with no complications.

It would be well to note :

1. The early onset of the severe vomiting when about two weeks pregnant.
2. The length of time (six weeks) without nourishment by the stomach.
3. The advisability of early rectal feeding.
4. The uselessness of medicines and all non-operative measures in this case.
5. The difficulty in producing abortion.
6. The immediate improvement when the cause was removed.

From a study of this case one feels that no one method of treatment is reliable. Saline enemata are useful but not curative. Each case must be a law to itself, but it would seem foolish with our patient extremely weak to wait day after day. If we fail then we almost certainly will lose the case. If we must make mistakes let them rather be a little early than a little late. Common horse sense tells us what to do, namely, to remove the cause and our doing so will in these severe cases help to keep down our percentage of failures.

COMPLICATED PREGNANCY REQUIRING SURGICAL INTERFERENCE.*

By T. K. HOLMES, M.D., CHATHAM.

Among the many perplexing cases that come under the care of the general practitioner, few appeal to his skill and sympathy more strongly than cases of pregnancy complicated by pelvic or by abdominal conditions requiring surgical interference. The natural desire for children, and the dread all good women feel of any operation that jeopardizes the life of an unborn child, make them reluctant to submit to what is often the only chance of life for either. Pregnant women often bear surgical operations well. Recently, several cases have come under my care that have encouraged me to deal with these complications in a radical way, and with well founded hopes of success, such as could not have been entertained a few years ago.

For convenience and clearness, it will be better to divide these cases into two classes: Those in which there is a possibility of saving both mother and child, and: Those in which the nature of the complication offers no hope of saving the latter.

A woman, about thirty years of age, had been ill for a couple of weeks but had not consulted a medical man. There had been a chill at first, and fever had been thought to be present more or less every day thereafter until the final attack (on the twelfth day after the chill) that nearly ended her life: during these days also, there had been some pain and tenderness in the right iliac fossa.

She was four months pregnant. On the morning of the twelfth day of illness she was attempting to sweep, when a sudden pain in the abdomen caused her to sink upon the floor. She was lifted to a bed and Doctors Wright and Millen, of Wheatley, sent for. They found her in great pain and suffering from shock. There was a decided fulness on the right side of the uterus, perceptible on the outside of the abdomen; but it gradually grew less and, in a few hours, disappeared altogether in the general fulness that became apparent over the whole abdomen. The physicians quite reasonably decided that it was a ruptured tubal pregnancy, and Doctor Wright telegraphed me to operate.

I saw her about 4 p.m., and on opening the abdomen in the median line was surprised to see a copious discharge of thin, watery pus, and on searching for its origin located it at the appendix, which was discovered to be bent sharply on itself

* This has also appeared in the *Detroit Medical Journal*.

and in an advanced stage of disease. It was at once removed, and subsequently the entire abdominal cavity flushed until the water returned quite clear; a drainage tube was then inserted at the lower angle of the wound and the incision closed. The drainage tube was removed by Doctor Wright after forty-eight hours, and recovery occurred without any unusual symptom. The patient was eventually delivered of a healthy child, at full term.

The second patient was referred to me by Doctor Dewar, of Windsor. She had not been wholly well for several months, manifesting, every day, a temperature a degree or two above normal and a pulse, generally, of from 90 to 110. She was nearly four months pregnant when I first saw her, and there was a mass at the right side of the uterus and somewhat behind it, not very large, but tender and immovable, and in a position to obstruct the passage of a child at full term. The history of the case led me to think it was an abscess with very thick wall, and I advised that it either be removed by immediate operation or an abortion produced and the operation performed later. She was subsequently seen by one of the most skilful surgeons in Detroit, whose opinion and advice coincided with my own. She was placed in Harper Hospital (Detroit), by her regular attendant, and the request made that I should operate, which I did, having the advantage of the advice and assistance of Doctors Dewar and Donald Maclean.

The mass proved to be a solid fibroid growth, springing from the right side of the uterus and a little posterior to it, and very near the junction of the cervix and body. It was enucleated by splitting the capsule, and the cavity closed by continuous silk sutures, placed deeply so as to arrest all hemorrhage, and without drainage. There was a good deal of vomiting for two or three days, but she made a good recovery and was delivered at full term without any unusual occurrence.

The third woman had borne two children, and came to consult me on account of a swelling on the right side of the abdomen as large as a cocoanut. She was four months advanced in a third pregnancy. The tumor was smooth and movable, but its presence gave her a great deal of pain.

Presuming, because of its rapid growth, that it might become dangerous before or during confinement, I advised removal; and having gained her consent, opened the abdomen and succeeded without difficulty in getting it away. It proved to be an ovarian cyst with a long pedicle. Recovery was rapid and she carried the child to full term and was delivered without any unusual occurrence.

A patient, forty years old, had been married only about eight months when she was referred to me by Doctor McKenzie, of

Kingsville. Examination revealed an irregular uterine fibroid, the uterus filling the pelvis and extending above the umbilicus. There were symptoms of pregnancy, but the most urgent distress arose from pressure symptoms.

On opening the abdomen great difficulty was experienced in getting the mass out of the pelvic cavity sufficiently to secure the uterine vessels; and it was only by employing pressure from below upwards, through the vagina, traction being made at the same time from above by means of volsellum forceps, that this was accomplished. After complete hysteromyomectomy had been performed, examination of the uterus revealed a four months' fetus.

There was considerable shock for a few hours, but she rallied well under the influence of saline transfusion and made an excellent recovery.

The next case was referred to me by Doctor Davis, of Kent Bridge. She was a young woman of healthy appearance, married only a few months. After missing one menstrual period by about fourteen days, she was attacked with pain and flowing, and soon after there was discharged what was thought to be decidual membrane. These symptoms continued for a couple of weeks, when there appeared, in addition, a slight rise of temperature and great nausea.

Examination revealed a solid mass behind and to the right of the uterus; and the cervix was pushed to the left and upwards behind the pubes. A diagnosis of extra-uterine pregnancy was made, and she readily consented to an operation, which was performed as soon as complete preparation could be made.

On opening the abdomen there were found, in the walls of the uterus, seven fibroids, varying in size from a walnut to a large orange, when it was at once decided to remove the whole organ.

On dividing the cervix a portion of soft bloody tissue was caught in a piece of gauze and the wound thus protected from infection. After removal the uterine canal was split open and the fetal mass found partly in the right tube, and partly interstitial, occupying the adjacent wall of the uterine body. Recovery was satisfactory in every way.

The sixth patient was referred to me by Doctor Hanks, of Blenheim. She was thirty-four years of age, had been married about a year, and was thought to be pregnant about four months. She first consulted Doctor Hanks on account of sudden severe pain in the pelvic region, closely resembling the pain and faintness so commonly observed in partial rupture of the sac in tubal gestation. Doctor Hanks, on examination, discovered a tumor in the right iliac fossa and decided that the

indications all pointed to extra-uterine pregnancy, an opinion I corroborated. On operation the tumor proved to be of a rather soft nature, but was enucleated without difficulty, leaving the pregnant uterus. It was impossible, in closing the wound in the uterus, to control all oozing, as the tissue was so vascular that at every puncture of the needle it bled freely. After much delay, and when the hemorrhage seemed to have stopped, I closed the abdomen without drainage, and for a month all went well. At the end of that time labor pains came on and she miscarried. Again all went well for nearly another month, when she was suddenly seized with most violent abdominal pains, and vomiting became persistent, accompanied by extreme tympanitis. These symptoms developed so severely and suddenly that it was decided to reopen the abdomen to ascertain the cause thereof, and if possible afford relief. As soon as the anesthetic was begun, her condition became so alarming that it could not be continued, and the operation was abandoned. She sank rapidly and died four hours after. Permission for an autopsy could not be obtained.

All surgeons who have had experience in the performance of myomectomy know what great care is necessary in closing the wound in the uterine wall so as to completely arrest bleeding. In a pregnant uterus the difficulty is greatly increased, and especially in a case like the last, where every prick of the needle causes persistent hemorrhage. It is impossible to determine with certainty the cause that induced fatality, but it may have been from slight hemorrhage which afforded a medium for bacterial infection.

Unless a fibroid occupy a position that would render delivery at term impossible, I believe it is better not to interfere until after the puerperium.

Selected Articles.

A CASE OF RECURRING OR RELAPSING VARIOLA.

BY PROFESSORS F. MATONI AND A. SOLARO,
Of the Cotugno Hospital, of Naples.

As in other infectious diseases, so also in variola, the question of relapses has often engaged the attention of medical men. Although, as Curschmann* properly observes, these are to be accepted with caution; yet they are not to be considered as impossible, having been verified by the best authorities, who have also quoted authentic cases. We, ourselves, in the late epidemic, which is now drawing to a close, have seen some of these in the Cotugno Hospital. Cases of relapse after a very short interval are not very exceptional, as one of us (Professor Matoni) when examining the records of cases of variola in this hospital for a statistical work now in course of preparation, found many cases which might be added to that related by Montefusco† (1886), and one especially, which we shall now report, as it is brief and convincing, and moreover occurring in a child.

The patient was Irolla S., of Naples, seven years old, vaccinated in early infancy with positive result, but with one incision only, showing on the right arm a small vaccination scar. He was admitted to the hospital for the first time on June 30th, 1901. At the time of admission he showed macules and papules scattered over the body and on the face, and had been ill four days. Professor Romanelli made a diagnosis of vario-loid. The temperature was 37.5. The first of July the temperature was 37.2 a.m., 37.5 p.m. A few vesicles could now be seen forming. On the 2nd July the temperature rose in the evening to 37.8, and the vesicles already began to dry up. On the 3rd July, crusts began to form without further rise of temperature. These began to fall on the 4th July. On the 5th the boy was declared convalescent, and on the 9th he left the hospital. About seven days later, on the 16th July, the child again entered the hospital with a diagnosis of discrete variola at the beginning of the pustular period. The temperature was 37.5, and rose on the evening of the 17th to 38.3, when the pustules were more fully developed. From the 17th to the 20th the temperature did not fall below 38. On the 20th the pustules on the face began to dry, but those on the body, which were

* Curschmann. Variola in Ziemssen "Pathology and Therapy," II. P., p. 207.

† Montefusco. A case of relapsing variola after a very short interval (1886).

very numerous, remained unchanged until the 24th, when they, too, began to dry. On the 25th the child was convalescent and left the hospital on the 15th August. The diagnosis of variola was recorded on the hospital journal by the same director, Professor Romanelli. The treatment in the first attack was only the local use of a liniment, and in the second a phenic lemonade with the local application of borie vaseline.

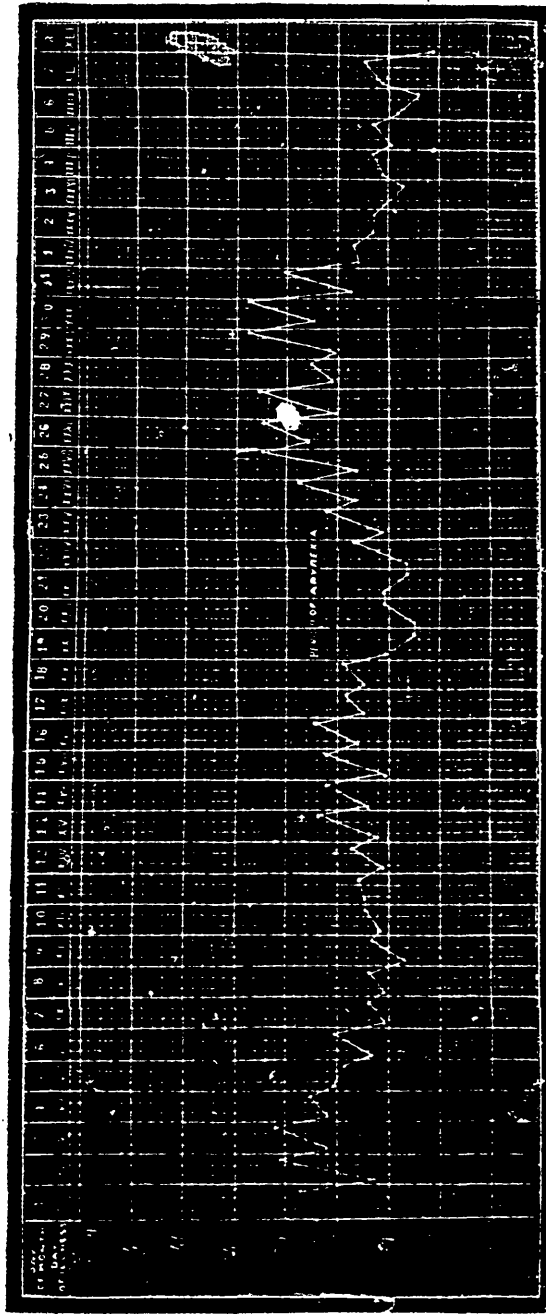
This case resembles that of Montefusco in many points. The age of the patient (Montefusco's was 14 years old, ours 7); the great susceptibility to infection in both, both having been successfully vaccinated in infancy; and finally, the recovery—differing only in the fact that in our case the second attack was worse than the first. This case, like his, is very convincing because it occurred in an hospital for contagious diseases, and was treated both times by the same doctors, thus eliminating the objection usually made in cases of recurrence which are not seen by the same doctor. It is difficult to be mistaken in such cases as these, treated in hospitals for contagious diseases by doctors who see the disease in all its forms and stages, and where are available the very best means of investigation for correcting a diagnosis. They therefore prove the possibility of a recurrence of variola after a short interval. However it was not with such recurrences that we wish to deal.

The observation which we are about to make has a different value and importance, since, as far as we know, it has not been treated of in literature, but may constitute a special form of variola which it is well to recognize and record. In truth, the case studied by us, presents a course so peculiar that it is to be distinguished from every kind of anomaly which is described in the books.

In this case, it is not a question of those forms of discrete or confluent variola in which the eruption, instead of being completed in 24 or 36 hours, as is the rule, takes place very gradually, so that while on one part the macule is becoming a papule, on another a new macule is just appearing; and thus the same patient may present on his own body all the different stages of the disease co-existent. Such is not our case.

A. E., 45 years of age, was admitted to the hospital on the 1st October, 1901. She had been vaccinated and had four separate scars, but had never been re-vaccinated. She was of delicate constitution. She had had no serious sickness, and up to the present time had enjoyed perfect health. This illness began three days previously with headache and fever. The second day an eruption appeared on her face. On admission there were scattered papules on the face and on other parts of the body, especially on the legs, but on the abdomen many were confluent. The tongue was coated; evacuations normal;

MATONI E SOLARO.—A CASE OF RECURRING OR RELAPSING VARIOLA.



* Beginning of the tertiary fever of variola.

temperature in the axilla 38.9. She left the hospital, fully recovered, on the 11th November.

During her stay in the hospital she had two febrile periods, the first from October 1st to October 18th; the second from October 22nd to November 1st. Between these was a period of apyrexia, of three days' duration.

In the first febrile period her temperature reached its highest point, 39.2, when the papules were becoming vesicles and pustules were forming, but there was no defervescence between the end of the eruption and pustulation, that is to say, there was absent that afebrile period which generally precedes the secondary or suppurative fever. Having reached its highest point, the temperature fell, but never reached normal in the evenings. Another rise of temperature occurred on the 13th of October, coincident with the formation of crusts over the whole body—constituting the tertiary or drying fever of Leo[†] and Wunderlich,[‡] which is not mentioned, however, in recent authors, but which we have so often seen in our cases that it can be definitely related to this important stage of the disease, when the crusts are forming.

After this rise the temperature became normal for the first time on October 19th, when there was desquamation and a general improvement.

At this time, when the disease seemed to be at an end, and when the patient was apparently convalescing, the urine was examined. We then found that the albumin, which on the 5th day was diminished, was increased again, and with this, too, the diazo-reaction which is very frequent in variola. The next day the scene changed. The patient suddenly grew worse; answered questions with difficulty; the temperature rose and a new exanthem appeared, progressing from the initial rash to pustulation, then drying up and desquamating. With pustulation and drying up the temperature rose, and at the same time the general condition changed. Thus we had a new attack of the disease, more severe than the first.

We had met with nothing like this in other patients, and after having assured ourselves that we had made no mistake in the method of invasion, in the appearance, the form and the course of the exanthem, in the temperature, the general condition and the urine, which were all characteristic of variola, we came to the conclusion that we were treating a new attack, or rather a relapse of the disease; and not finding any example in literature we decided to publish it.

Before, however, handing it over to the judgment of others, we wish to refer to two facts which might be open to objection.

† Leo. Arch. d. Heilk. (1864).

‡ Wunderlich. Medical Thermometry. Naples, 1873.

The first is, that the fall of temperature, which we regarded as a period of apyrexia (October 19th to 21st), was due to the salipyrine which was administered on October 17th and 18th. In reply to this, the dose given (one gramme on 17th and one-half gramme on 18th) was too small to cause the fall of temperature, and further, the low temperature continued after the suspension of the medicine. Moreover, the remedy was used to combat a prodrome of the new attack, namely, the headache. The second objection is that, instead of being a relapse or recurrence, it might be an attack of erysipelas. It is quite true that variola sometimes resembles erysipelas (confluent variola of the face), and erysipelas sometimes resembles variola (swelling of the face and especially of the eyelids), but it is not difficult for any one who has had experience to distinguish them by the clinical manifestations alone. In variola there are never wanting in the uniformity of the redness and swelling, raised red points which are never to be seen in erysipelas. If pustules appear in the latter, they appear later than in variola, in which they are contemporaneous, or nearly so, with the initial exanthem. In erysipelas the swelling is accompanied by intense pain, which is absent in variola, or if present, it is never in inverse ratio to the swelling. The rash or erythema of variola never presents that sharply defined margin which, even if limited, is so characteristic of erysipelas, being present if there be only a small spot of erysipelas. The shedding of the skin in large flakes is more often seen in variola. In our case the swelling of the face and hands took place two or three days after the initial rash, and after papules and vesicles had been formed for more than thirty-six hours on the affected parts, this being the usual course in variola when the confluent vesicles begin to suppurate; whereas in erysipelas the swelling takes place almost at the same time as the erythema. The temperature in our case was not that of a case of erysipelas.

Finally, to confirm still further what we have said, we wish to add that in the Cotugno Hospital, both for some months before and during the entire illness of our patient, there was not a single case of erysipelas, while, for special reasons, it was not possible at that time to search for the streptococcus of Fehleisen with the corresponding tests of culture and inoculation.—*Translated from Giornale Internazionale delle Scienze Mediche, by HARLEY SMITH.*

THE MISSION OF SOCIETIES FOR THE PREVENTION OF CONSUMPTION IN THE ANTI- TUBERCULOSIS CRUSADE.*

By S. A. KNOPF, M.D., NEW YORK.

For the modern methods of curing tuberculosis through outdoor life, proper hygiene, and good food we are primarily indebted to the English people. It may not be generally known that even the earliest efforts in sanatorium treatment were inaugurated by an Englishman in the person of Dr. George Bodington, of Sutton Goldfield, Warwickshire, England; and as a veritable pioneer in aërotherapy we must not forget that princess among nurses who helped to cure the English physician, Bennett, of consumption, the great and good Florence Nightingale. Brehmer and Dettweiler, of Germany, were the pioneers of the sanatorium treatment of consumption as it is now almost universally practised, and as American pioneers of modern phthisiotherapy we must not fail to mention our distinguished colleagues, Dr. E. L. Trudeau, of the Adirondack Cottage Sanatorium, and Dr. Vincent Y. Bowditch, of Boston.

To summarize our present knowledge and to state the basis on which our societies for the prevention of tuberculosis should work, we might say we now know that tuberculosis, especially in its pulmonary form, is an infectious, communicable, preventable, and in many instances absolutely curable disease; furthermore, that it can be cured in nearly all climates where the extremes of temperature are not too pronounced and where the air is relatively pure and fresh. In other words, it is not always necessary for a consumptive patient to travel long distances and seek special climatic conditions, but in most instances he has a chance of getting well even in his home climate.

It seems to me essential that those of us who labor not only with tuberculous patients but also with their friends and relatives, and a large portion of the community, whose sympathy we desire to enlist in our cause, should know the true status of a consumptive. Whether we work under the name of a society for the prevention of tuberculosis, or sanatorium association, or an anti-tuberculosis movement of any kind, we must never, never be considered as an anti-consumptives' society. The consumptive must know that every member of an anti-tuberculosis society is his friend, that we labor for

*Abstrac. of an address delivered by invitation before the Canadian Association for the Prevention of Tuberculosis, at its annual meeting, April 1, 1902, at Ottawa, at which His Excellency, the Governor-General, the Earl of Minto, presided.

him and not against him; that we try to lessen his burdens, and that we are the last to make him feel as if he were an outcast from society. To do the work in this spirit will be the first and most essential duty in the mission which a society for the prevention of tuberculosis should fulfil.

I would suggest that every pamphlet which may be issued by a society for the prevention of tuberculosis, every lecture which may be printed for the cause, every newspaper report which is sent forth, should include a declaration which should read about as follows:

"Consumption is a preventable and curable disease. The sooner the patient puts himself under the care of a competent physician the greater are his chances of recovery. The well-trained physician is the most competent person to guide the patient in the means to prevent reinfection of himself or the infection of his fellow men. Consumption, or pulmonary tuberculosis, is not cured, and never has been cured, by quacks, patent medicines, or any other secret remedies. The most modern and most successful methods of treating consumption consist solely and exclusively in the scientific and judicious use of fresh air, sunshine, water, abundant and good food, and the help of certain medicinal substances when the just-mentioned hygienic and dietetic means do not suffice in themselves to combat the disease.

"The thorough and constant supervision of the pulmonary invalid, the immediate intervention when new symptoms manifest themselves or old ones become aggravated or do not disappear rapidly enough, the prescription of proper food and drink, can only be had at the hands of the thoroughly trained physician."

With educating our consumptive friend, those living with him, and the public at large as to the methods of prevention and means of cure the mission of a society for the prevention of tuberculosis by no means ceases. Our work has only commenced. We must now solve the question which I have asked above: What can we do to better the condition of the consumptive poor and those of moderate means?

The well-to-do patient can easily be advised to better his unhygienic environments; with the poor it will be far more difficult. When our work brings us into the presence of a consumptive wage-earner, living in a tenement house in a few badly ventilated and badly lighted rooms, with the earnings of better days gone, with scanty food and scanty raiment, we wish we could do, not one thing, but many things. First of all, we should wish we could take this poor sufferer to a sanatorium where he would have the best chance of cure and where the possibility of reinfecting himself and infecting his wife and

children would be removed. We should then wish to examine all the members of the family, to find out if there were any who had already contracted the disease, and, if so, take them, too, in the earliest possible stage to a sanatorium for complete recovery.

What a vast amount of work there is to do! What a grand mission a society for the prevention of consumption has to fulfil! Where shall we find shelter for the consumptive poor, who not infrequently, owing to an unjustified and cruel phthisophobia (exaggerated fear of the presence of consumptives), are little welcome anywhere? The sanatorium must be to the poor consumptive not only a place of cure, but also a haven of rest. There are not enough sanatorium and hospital facilities for the consumptive poor, either in your country or in mine. Thousands of consumptives are allowed to die annually, not because their disease could not be cured, but for the simple reason that there is no place in which to cure them.

The beneficent influence of sanatorium education is so true that it has been even demonstrated that in the villages of Goerbersdorf and Falkenstein, where five of the most important and flourishing German sanatoria are situated, the mortality from tuberculosis among the villagers has actually been decreased by one-third from what it was before the establishment of these institutions. The villagers voluntarily followed the hygienic regulations, which are obligatory for sanatorium inmates. This shows how wrong our phthisiophobic friends are when they object to the establishment of a well-conducted sanatorium for fear of contagion to the neighborhood.

If a community will erect a sanatorium for its indigent consumptives, this institution will prove to be a hygienic educator to all the inhabitants. The patient returning home, whether cured or only improved, will have become a practising expert in the prevention of tuberculosis.

Let me, lastly, demonstrate to you that the communities which you will seek to interest in the establishment of sanatoria will gain financially by placing their consumptive poor in time in such an institution. It is estimated that there are in New York State about 50,000 tuberculous invalids. Of these, probably one-fifth belong to that class of patients which sooner or later become a burden to the community. These 10,000 consumptives, absolutely poor, will sooner or later have to be taken care of by the public general hospitals. While they may not stay in one hospital for twelve months continually, they will certainly occupy a bed in one of the public institutions for that length of time before they die. According

to the last annual announcement of the public charity hospitals of New York, the average cost per patient per day in the general hospitals was \$1.16. Thus the cost to the commonwealth will be \$4,234,000 per year for caring for the 10,000 consumptives.

What would be the expense if they were taken care of in a sanatorium? Experience in this country and abroad has demonstrated that the maintenance of incipient cases in well-conducted sanatoria can well be carried out for one dollar per day. If these 10,000 were to be sent to a sanatorium in time, at least 6,000 of them would be lastingly cured after a maximum sojourn of 250 days, at an average expense of \$250 per capita. Thus, for \$1,500,000, 6,000 individuals would be made again bread winners and useful citizens. If the remaining 4,000 invalids were kept in the sanatorium one year before they died, it would cost \$1,460,000. Thus, taking away from the tenement districts 10,000 consumptives, curing more than half of them and caring for the other half, and destroying 10,000 foci of infection will cost \$2,960,000. If we do not take care of them in the earlier stages of their disease, they will probably all die, since this 10,000 represents the absolutely poor who now live under the most unhygienic conditions; but before dying they will have cost the community \$4,234,000.

Before concluding, let me beseech you not to rest here with your labors. After you have removed multiple centres of infection from tuberculosis, after having erected sanatoria for tuberculous adults and children, there will still remain, if not the most important, at least equally important factors of predisposition to tuberculosis which we shall find in the badly housed, in the badly clothed, in the underfed, and in the overworked individual. A society for the prevention of consumption must make it one of its duties to work for the better housing of the poor. Let it be known to employer and employee, to every landlord and tenant, to rich and to poor, but particularly let it be known to the dwellers in the crowded tenement districts, that it is as dangerous to breathe foul, vitiated air as it is to drink foul and infected water. Sweatshop work and unsanitary factories and workshops should not be tolerated in this enlightened century. The eight-hour law and the prohibition of child labor should be enforced everywhere if the underlying factors of the propagation of tuberculosis are to be removed.

All children at school should have more outdoor instruction and more physical culture than they have now. It is wrong, nay, it is even a crime, to push the intellectual culture of children to the detriment of their physical growth and development. Children in our public schools should be

taught the value of sensible dress and be equipped with the knowledge of elementary hygiene.

All such knowledge you should disseminate whenever and wherever you can. Yet, important as this dissemination of knowledge and the propaganda of sanatoria are, there still remains some work which you are called upon to do if you want to fulfil the whole mission of a society for the prevention of consumption in the antituberculosis crusade. You will have to appeal to the great philanthropists of your country for material help. Without their aid, the municipalities and the health boards will be handicapped in your fight against this common foe, for no community has public funds enough to cope alone with the tuberculosis problem. Plead with those noble souls who have given and are giving so much for educational institutions to examine the work you are doing.

The help of your statesmen and philanthropists is needed also in another direction. You will recall that I spoke a few moments ago of the many things we should like to do for the family in the tenement home, of which several members were afflicted with tuberculosis. There is one more thing we should wish to do, of which I have not yet spoken, and that is to induce that family to leave the crowded city and move to a smaller town or village, if it is at all possible for them to do so. There they could find larger and more commodious quarters for less money. Urge them to take up agricultural pursuits or to seek at least such occupation as will demand outdoor life. I know all this will not be easy, but I see in connection with this problem a large field for true statesmanship and practical philanthropy. By making farming more profitable the statesman will stop the ever-growing tendency of emigration from village to city. By erecting and endowing institutions for healthful amusements in country districts and thus making life more attractive, the philanthropist will confer a lasting benefit upon old and young and indirectly increase the wealth, health, and happiness of a large portion of the population.—*Abstract N. Y. Med. Jour.*

Progress of Medical Science.

OBSTETRICS AND GYNECOLOGY.

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

Tumor Complicating Labor.

F. W. Kidd gives the history of a woman of 34, whom he saw when $4\frac{1}{2}$ months pregnant and found she had a fibroma about the size of a hen's egg springing from the posterior wall of the cervix. As it encroached very little upon the cervical canal, it was deemed inadvisable to attempt any interference until the beginning of labor; when that time arrived, it was apparent that the tumor had so increased in size as to prevent the descent of the head, or the dilation of the cervix. Accordingly the tumor was enucleated through the vagina, and three days later a living child was spontaneously delivered. The mother was able to leave the hospital in four weeks with the child doing well.—*Medical Press*.

Vaginal Hysterectomy During Pregnancy.

J. H. Carstens describes the case of a woman of 26 with an enlarged uterus about the size of four to five months' pregnancy. There was a nodule where the cervix had been, evidently the recurrence of a cancerous growth which had been removed about a year before. The uterus was absolutely closed, but the symptoms indicated a clear case of pregnancy. Prompt operation was decided upon. The patient was anesthetized, scissors were plunged in where the os should have been, the fetus delivered and vaginal hysterectomy performed. The whole operation was performed in fifteen minutes, the woman made a splendid recovery and now seems perfectly well. Carstens has collected thirty-two similar cases reported by various authors, and this table shows that operations are very successful and are indicated in all cases of uterine cancer complicated by pregnancy.—*New York Medical Journal of Obstetrics*.

A New Method of Treating the Persistent Vomiting of Pregnancy.

Condamin (*Medical Press*, March 26th, 1902) gives a new method of treatment of persistent vomiting of pregnancy. The writer says that although it cannot be said that the principle is altogether new, it is still so excellent that it should be more

widely known than it is. The author sees in such vomiting a sign of intoxication and an indication for removal of the toxic substance, whatever it may be. It is his constant endeavor to provide a substitute for the induction of the abortion that such cases generally end in. For some time past he has invariably been able to dispense with this by adopting the following line of treatment: Absolute abstinence from food for from eight to ten days; daily injections into the rectum of three to four liters of artificial serum in quantities of 300 grammes, with or without the addition of opium; in case of absolute intolerance on the part of the rectum, hypodermic infusion; after ten or twelve days' abstinence from food, gradual return to feeding by the mouth.—*The Medical Age*.

A Treatment of Abortion.

The occurrence of an accident in the hands of a general practitioner has induced Sellheim (*Münch. med. Woch.*, March 11th, 1902) to consider the treatment of abortion. The case was that of a woman aged 34, who had had five normal confinements previously. She had a hemorrhage on the fourth month of her sixth pregnancy, and on the third day a practitioner was called in. He found an offensive discharge and pyrexia (temperature 103° F.) He therefore cleared out the ovum by means of Winter's forceps. In so doing he perforated the uterine wall, and dragged a coil of intestine out at the vulva. On recognizing what had happened he plugged the vagina, and had the patient taken immediately into the hospital. Sellheim discovered at the operation, which he performed, that the uterus had been torn jaggedly, and that the lower end of the descending colon and sigmoid flexure had been detached from the mesentery and opened. The wounded intestines were resected, and the uterus and appendages removed. The patient made a good recovery. Sellheim first depicts the conditions of pregnancy and of abortion in the second, third, fourth and fifth months, and then proceeds to deal with the practical deductions. He directs his remarks to the general practitioner and not to specialists, and suggests the best methods which the former should adopt in order to incur little risk for the patient. No interference may be undertaken in ordinary cases. This rule admits of exceptions: First, in cases of severe anemia produced by a profuse hemorrhage, or by long-continued slighter bleeding; secondly, when portions of the ovum are retained; and thirdly, in cases which have become septic. The most rational method of arresting hemorrhage is to remove the ovum completely. If this has left the body of the uterus, and is retained partially or totally in the cervix or vagina, a speculum should be introduced, and if the finger cannot easily

complete the removal, ovum forceps may be used. On the other hand, when the ovum is still in the body of the uterus, one or two fingers should be introduced, and while counter-pressure is exercised by the other hand from the abdominal wall, the sac separated completely from the uterine wall. Once it has been separated, it can usually be removed by combined action of the internal finger and expression from without. The whole process can be made more easy if one seizes the anterior lip of the cervix with vulsellum forceps (double-toothed), and administers an anesthetic. Sellheim urges that the operator must not be disturbed by the hemorrhage, but must rely on the fact that this will cease on completion of the abortion. It may be that the cervix is not permeable for the finger. In this case he advises thorough plugging of the uterus, cervix and vagina with sterile iodoform gauze. The cervix must be brought into view with a Sims's speculum, the direction of its canal be ascertained by means of a uterine catheter or sound, and the size of the uterus by bimanual examination and not by the sound. The vagina is to be thoroughly irrigated, cleansed and dried, and then the strips of gauze introduced with smooth ovum forceps. All one's efforts should be directed toward keeping the ovum intact. At times it may be necessary to substitute a sound for the forceps in packing the uterus. If the ovum is not cast out after twenty-four hours, the plugging is to be removed, the passage again thoroughly disinfected, and a second packing undertaken. The next point which Sellheim raises is, whether small portions of the decidua vera, which may be left behind after the abortion should be removed. He considers that one may leave portions of decidua vera behind, but all else must be cleared out. The diagnosis that the whole contents come away can be made from inspection of the ovum. Failing this, one can be guided by the bleeding. Ordinary lochial discharge follows complete abortion, while severer loss indicates some retention. If one has had the necessity of assisting the removal of the ovum, it is a good plan, on completion of it, once more to introduce the finger and to examine the uterine cavity. In removing the remains of an incomplete abortion, if possible only the fingers should be used; but should instruments be required, these must always be employed under the guidance of the finger in the cavity of the uterus. Only when the uterus is well contracted, and when some time (if possible fourteen days) has elapsed since the actual abortion took place, is it a justifiable procedure to curette the uterus? At times the hemorrhage persists after the completed abortion. In such cases uterine irrigation with chlorine water generally suffices to control this. Failing this procedure, the uterus must be packed. In septic cases, he especially warns against the

use of the curette. Ovum forceps may be used with care. He concludes by giving a short description of the instruments to be used in carrying out the treatment of abortion.—*Epitome British Medical Journal.*

Pilocarpine in Eclampsia.

Howard Cornell reports a case in the April number of the *Alkaloidal Clinic*. He says: As the hot pack did not cause sufficient perspiration I gave hypodermically pilocarpine gr. $\frac{1}{2}$, which is theoretically the most efficient and rapidly acting remedy that we have in this class of cases. The principal contra-indication urged is that of its depressant influence. The pilocarpine induced extensive pulmonary edema, causing extreme dyspnea, cyanosis of the face and extremities, and the pouring forth of large quantities of mucus from the mouth and nares, which in her unconscious condition was extremely dangerous, and of such serious import that I was afraid she would die from the mucus in her bronchial tubes. The condition caused by the pilocarpine was more serious for the time being than the convulsions. She became violent, and hoping to check the mucus I gave a hypodermic injection of morphine gr. $\frac{1}{4}$ and atropine gr. 1-100, with good result, quieting the patient and checking the excessive secretion of mucus. The convulsions finally ceased after two hours and she remained comatose until 3 p.m. As there is nearly always edema of the lungs present, pilocarpine is dangerous, and should be discarded in eclampsia. My reason for reporting this case is because I do not think that pulmonary edema has been given sufficient prominence, as a result of administering pilocarpine.

[We are in entire accord with Dr. Cornell in this conclusion.]

K. C. M.

The Importance of Rickets in Girls from an Obstetrical Standpoint.

C. S. Bacon, Professor of Obstetrics, in the *Chicago Polyclinic*, has an article in the April number of the *Clinical Review* on this subject. Some cases are cited illustrating the nature of the pelvic deformity to which rickets may give rise, and the resulting difficulty in labor; and the diagnosis and treatment of rickets are dealt with. We are especially interested, however, in the author's statement that rachitic contraction of the pelvis occurs in from 3 to 7 per cent. of all women. We venture to think that these figures are too high for Canada. Nevertheless, measurements taken in the city maternities indicate that minor degrees of pelvic contraction are more common in this country than is generally supposed.

K. C. M.

OPHTHALMOLOGY AND OTOLOGY.

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

Purulent Ophthalmia of the New-Born.

E. Lander (*Cleveland Medical Journal*) says that statistics show the serious character of this disease. It is estimated that at least 25 per cent. of the blindness that exists in the civilized world to-day is the result of purulent ophthalmia. This blindness, beginning as it does with life itself, so handicaps the individual affected that, instead of becoming a producer, he remains more or less a consumer only, and to that extent a charge upon society.

By a brief calculation he shows that the financial loss to the United States alone, caused by this disease, is not less than \$7,500,000 (7½ millions) annually. Most of the European governments, and of the States, require by law that all cases of purulent ophthalmia shall be reported to the authorities, in this way classing it with diphtheria, scarlet fever, etc. It is generally admitted that infection takes place during delivery.

Knowing the source and cause of purulent ophthalmia in the new-born, our treatment is naturally divided into prophylactic and curative. Prophylactic measures are essentially those which belong to the obstetrician and may be considered under two divisions: those adopted before the child is born, and those adopted after the child is born. The first necessarily must be an attempt to free the vagina of all pathogenic germs by thorough washing out with an antiseptic fluid regularly, some days before expected confinement. It is not difficult to understand how next to impossible it is to render a septic vagina completely aseptic. However carefully the irrigation is done, there are likely to remain some germs hidden away among the folds of the mucous membrane. The second division has to do with the destruction of the germs that may have entered the conjunctival sac during the passage of the head through the vagina. For this purpose different germicides have been used. The best results were obtained from the 2 per cent. silver nitrate and 1 per cent. bichlorid solutions. The disadvantage of the bichlorid solution is the greater irritation it causes. The procedure is very simple. As soon as the child is born the face is wiped clean, the eyelids are separated with the fingers, and a drop of a 2 per cent. silver nitrate solution is allowed to fall on the eyeball. While this is the original Credé method, we believe it to be a safe precaution to follow the application of silver nitrate solution with an application of sodium chlorid solution to neutralize any excess of the former.

Curative treatment must be carried out with much energy regardless of the tender age of the patient. One of the first necessities is to keep the conjunctival sac free from pus. This is best accomplished by the frequent use of warm 3 per cent. solution of boric acid. Ice cold applications must be used three times daily, from one to three hours at a time. They may be pledgets of lint taken off the ice. (Caution must be used in these applications. So long as the lids are much swollen they may be pushed, but if there is little swelling of the lids the cold may seriously affect the cornea.) Among the many germicides used to destroy the micro-organism, the most popular still is a solution of silver nitrate, 1 per cent. The author does not recommend protargol.

The Mydriatics: The Motive and Method for their Employment.

In a valuable article (*The Ophthalmic Record*, January), S. D. Risley discusses the use of the mydriatics in the correction of errors of refraction. As there is much difference of opinion on this point the article is timely. It is, however, the so-called "oculist-optician" that opposes their use; there is pretty general agreement among ophthalmologists of experience in regard to their value. The design of the author is primarily to discuss the motive for the employment of mydriatics. He first considers what the "model eye" is, and he considers the emmetropic to be the model one, and therefore needing no correction by glasses. Any departure from emmetropia he regards as an abnormality—abnormality leads to disease. And he considers that the prescribing of correcting glasses for defective or diseased conditions is not the function of the optician, but of the ophthalmologist.

The first duty of the surgeon is to remove the cause of the diseased conditions by prescribing suitable glasses, and thus do away with the eye-strain, upon which pathological change depends. Some of these cases, such as simple hyperopia, can be corrected without a mydriatic, and thus get present relief. But even in those cases the correction is not full, and they have to return in a few weeks or months to get a stronger glass. But if astigmatism of even a low degree is present, or if there are pathological changes in the fundus, it is almost impossible to get a proper correction without the use of a mydriatic. And it must be observed that the mydriatic is not only used for its cycloplegic effect, but for its therapeutic properties, since its calming effect over the nerve supply of the eye is an important factor in relieving the pathological states of the fundus oculi. Where there are such states of the fundus, homatropine will not have the same curative effect as atropine.

Cases are given to show the necessity of applying a mydriatic in a very large percentage of cases of asthenopia applying for relief.

Advancement Operation Performed by the Aid of a New Tendon Ticker.

The older operation of dividing one of the tendons in the treatment of strabismus is giving way to that for advancing the opposite tendon. This advancement is often accomplished by folding the tendon upon itself, and then suturing. To facilitate this folding, various instruments for "tucking" the tendon have been devised. F. C. Todd (*Ophthalmic Record*) has described an instrument which has several advantages, among which may be mentioned that the bulk of the instrument lies on the cheek, out of way of the operator, and that one prong is introduced under the tendon when the prongs are crossed, but when the tuck has been taken the prongs are separated, and so do not interfere with the introduction of sutures. In operating, the tendon having been exposed, the prongs are inserted, then separated by a set screw to just the extent the operator wishes to make his "tuck." The sutures then can be readily inserted through the three layers of tendon, one at the upper and one at the lower border. Then another black silk suture is passed through the loop, and ultimately the conjunctival flap is stitched down.

J. T. D.

PEDIATRICS.

IN CHARGE OF ALLEN BAINES, W. J. GREIG, AND W. B. THISTLE.

Primary Intestinal Tuberculosis in Children—(*Archives*, December, 1901, by BOVAIRD, New York).

British writers claim that a very large number of cases of tuberculosis in children are produced by infection of the intestinal tract by tuberculous milk. Americans (notably Holt) claim that the cases of this kind are rare, and that intestinal infection is secondary to that of the air passages, *i. e.*, that the primary lesion is in the lungs. In support of this claim, he gives the result of 250 autopsies made on tubercular children, by himself and Northrup, and in these there was only one case of undoubted primary intestinal infection.

This discussion is rendered more interesting in view of the doubt cast by Koch on the identity of human and bovine tubercle bacilli.

The above article contains nothing original, but is a summary of writings and cases given by various American and European writers. His conclusions are:

1. That English (chiefly London) reports alone show considerable numbers of cases of primary intestinal tuberculosis.
2. That it is a rare affection in or about New York, little more than $1\frac{1}{2}\%$ of the cases of tuberculosis having this origin.
3. That the proportion of tuberculous cases found at autopsy in New York is lower than that of European observers.
4. That the evidence connecting tuberculosis among children with the consumption of milk of tuberculous cows is very scant.

Treatment of Tuberculosis in Infancy and Childhood, with special reference to the use of Guaicol—(*Archives*, December, 1901, RACHFORD).

Tuberculosis in infancy and childhood is essentially a disease of the lymphatic structures. From its point of entrance into the body the bacilli are arrested by the nearest lymph node, the chief of these to be infected being the tracheo-bronchial and mesenteric lymph nodes. These lymph nodes may be the only organs affected for a long time and, in fact, the disease may never go farther, but often in susceptible cases the intestinal tract or the pulmonary tissue may be affected. The writer claims that the prognosis of these cases in childhood is much better than it is in adults, and hence the importance of early diagnosis, and refers to an article of his in the *New York Medical Journal* in 1895, on the "Symptomatology of Tuberculosis of the Lymph Nodes."

Treatment.—The most important point is proper nutrition: next in importance is fresh air, and thirdly the use of guaicol. He refers to an article published by him in 1894, in which he dwells on the value of inunctions of guaicol. He has continued to use this ever since, and has become more convinced of its value.

R Guaicol, ℥i.
Lanolin, ℥ii.
Adeps, ℥v.

Sig.: A level teaspoonful to be rubbed into the chest at bed-time.

The *raison d'être* of this treatment is that guaicol is rapidly absorbed by the lymphatics, and thus comes directly in contact with the bacilli in the lymph nodes. It has very little value in the tuberculosis of adults. In tubercular peritonitis, the good results following this treatment show themselves at once, and

the author has frequently seen the distended, tender and board-like abdomen lose its tenderness, etc., within a period of three weeks.

When the active symptoms subside he often substitutes the carbonate of guaicol internally for the inunction treatment. This may be given mixed with a little milk-sugar. Guaicol holds first rank as an intestinal and pulmonary antiseptic, and one of its uses may be in the control it has over the growth of the streptococci which are so often associated with the bacillus of tuberculosis.

In the chronic forms of tuberculosis, or even in the acute tuberculosis, after the active symptoms have been controlled by rest, fresh air, diet and the guaicol treatment as above outlined, ol morrhuae is one of the most valued remedies, and should be given as a matter of routine.

Iodide of iron, while of doubtful value when fever is present, is very useful in treatment of the anemia of tuberculosis. Arsenic and malt are referred to. And it may be necessary and expedient to resort to surgical proceedings under certain conditions.

Case of Myotonia Congenita—(*Archives*, December, 1901, by GARDINER, Colorado Springs).

Voluntary motion was performed more slowly than normal, but increased in speed when repeated many times. Also that fright, anger or any emotion increased the difficulty. After a period of muscular repose, he can walk or stand with extreme difficulty. He moves as if overcome with sleep, or if he were wading in water; after a time he moves more quickly and can run, at first slowly, lifting his legs as if made of lead, then faster and more naturally, and finally he can run almost as well as would a rather slow and clumsy boy of his age. After a rest he is again so stiff that if suddenly called on to exert himself he will stumble and fall like a log, incapable of motion. His muscles are larger than normal, biceps eight inches, calves eleven inches. Height three feet nine and a-half inches, and weight fifty pounds. Muscular system developed much beyond that of a boy of his age, and his muscles have the appearance of those of an adult who has been an athlete, the hypertrophy being pronounced. The boy is six years old.

Myotonia Congenita, or Thomsen's Disease, is described as a malady the chief feature of which is that in the execution of voluntary movement of any kind the muscles brought into play remain contracted for some time. Cause unknown, but a great width of muscle fibre is found, ranging from $\frac{1}{32}$ to $\frac{1}{8}$ of an inch, normal fibres averaging $\frac{1}{32}$.

Value of the Widal Re-action in Children—(By MILTON A GERRHAL).

Six hundred and seventy examinations had been made in one hundred and ninety-nine cases, and of these eighty-four were typhoid and eighty-one gave the re-action. Eleven of the cases gave the re-action by the seventh day.

Blackadar, in a series of forty-three cases, found the re-action in 70% before the second week.

The Widal test was of greater importance in children than in adults, because of the frequently atypical character of typhoid in children.

W. J. G.

How to Read in Bed.

If every one reading lying down will so arrange his lounge or bed that the light comes over the head without striking the eyes, and falls well upon the page; if he will hold his book at a long reading distance, and take care that the line of letters shall be at right angles to the line of vision, all of which may require a book-rest, he can be sure of doing his eyes no more harm than if he were sitting up. More than this, there is much positively in favor of reading lying down. The recumbent posture allows more rest of all the bodily structures than the sitting posture, and there is greater possibility of resting and repair in that position. Those who have tried it know the benefits accruing, after a hard day's work, from the rest possible when doing a long night of reading, which the press of business makes almost an absolute necessity. One more fact is to the credit side of the score. Whenever possible we bring gravity into play to relieve congestion, especially that of a passive type. It has long been recognized that throwing the head slightly back beyond the perpendicular brings gravity into play to empty the veins which are principally over-filled by prolonged eye-work, but why this is not carried to its logical conclusion is a mystery. It is plain that placing the head back in a horizontal position so absolutely meets the whole problem of a relief of congestion by gravity—and it is such a very important problem—that it seems strange that people with weak eyes do not habitually practice reading in a recumbent position, with the head raised only so much as is necessary to make the position perfectly comfortable. Such advice, carried out with absolute care as to light and the position of the book, would in the case of a thousand busy people add largely to the number of hours which reading could be indulged in without detriment to the eyes or general health.—*Dietetic and Hygienic Gazette.*

Editorials.

THE ONTARIO MEDICAL ASSOCIATION.

The twenty-second annual meeting will be held in the Educational Department, Toronto, on June 4th and 5th.

The preliminary notices have been in the hands of the members for several weeks, and thus far the list of papers promised augurs well for the success of the meeting. The Committee looks for a still further response and more general contribution to the programme, as it is only by the co-operation of the profession that success may be assured.

A new departure in this year's meeting will be a session entirely devoted to the exhibition of clinical cases. While it is natural to suppose that the majority of these cases will be from Toronto, it is hoped that members from outside the city will endeavor to contribute to this section of the work. To facilitate this as far as possible, arrangements have been made with the railroads by which patients brought for presentation at the meeting may enjoy the same privileges—as regards reduction of fare—as are extended to members of the Association.

It may be well to emphasize the fact that such reduction is in proportion to the number of railroad certificates presented to the Secretary at the time of the meeting, and not on the total attendance at the meeting. There has been some misunderstanding in the past on this point.

The provisional programme will be sent out on May 20th, and it is desired that all titles of papers and notes of clinical cases be in the hands of the Secretary prior to that date.

Some of the subjects which will be brought up for discussion are: "Dry Labors," "Obstetric Emergencies," "Placenta Previa," "Anesthesia," "Pneumonia," "Cerebro-Spinal Meningitis," "Primary Tracheal Diphtheria," "Ventre-Fixation," "Anomalous Forms of Smallpox," "Cerebral Embolism," and others.

Communications *re* papers, etc., may be sent to Dr. Fotheringham, 36 Carlton Street, Chairman of Committee on Papers, or to Dr. H. C. Parsons, General Secretary, 72 Bloor Street West, Toronto.

VEGETARIANISM.

The recent increases in the prices of meat have driven many to complete or partial vegetarianism. This is similar to the results that have obtained in some of the European and Asiatic countries where large sections have adopted a vegetable regimen not from choice but from stern necessity. Some of the learned German physicians are discussing the subject from a scientific standpoint. Professor Hueppe argues that as the anthropoid ape was connected with the evolution of man, the primeval man could not have been a vegetarian. The ape that most resembles man lives on nuts, eggs, little birds and insects, just as the Arabians do at the present day. He thinks it probable that in the struggle for existence man gave up nuts and eggs and became an eater of meat. Later he used a mixed fare of meats and vegetables. Later still came the strictly vegetable fare.

What is a vegetable? The question seems simple enough; but, at the same time, is not altogether easy to answer. We may take one of the ordinary definitions, such as, a plant used or cultivated for food for man or domestic animals, as the turnip, cabbage, potato, bean, etc. What is the difference between vegetables and fruits? If our first question were definitely answered the second would be scarcely necessary. It is really difficult to fully answer either question. Vegetables and fruits are sometimes loosely distinguished by the usual need of cooking the former, while the latter may be eaten raw. But, as Webster tells us, the distinction often fails as in the case of quinces, barberries and other fruits, and lettuce, celery and other vegetables. Tomatoes, if cooked are vegetables, if eaten raw are fruits.

The eating of vegetables only became possible to any extent after the invention of cooking. There is no doubt that a mixed dietary is the most suitable for a civilized man. However, we know that a man may live and thrive on vegetables alone. It is fortunate, therefore, that if meat gets very expensive we can get along without it. Again, if on an average we consumed only half as much meat as is our custom now, we would be much better off, both physically and financially.

THE ABOLITION OF MALARIA AND YELLOW FEVER.

One of the greatest sanitary discoveries of our day has received a notable endorsement by the "Report of Vital Statistics of the City of Havana year 1901" [and January, 1902], "made by Major W. C. Gorgas, Surgeon U.S.A., Chief Sanitary Officer. Bergy tells us that "the theory of the propagation of yellow fever by mosquitoes was advanced by Dr. Carlos J. Finlay, of Havana, as early as 1881." In 1900 a commission of the Army Board, with Surgeon-Major Reid as President, was sent to Cuba, and as a result active work was instituted in 1901. Briefly, this consisted in measures for destroying the *Stegomyia* mosquito and its larvæ, and more immediately in keeping the mosquito away from all persons affected with yellow fever, and thus preventing the reception and carriage of infection from infected persons to those not infected and non-immune.

Dr. Gorgas says we have pretty definite data for believing that yellow fever has been endemic in Havana since the English occupation in 1762, and although the general clearing up and sanitary measures introduced have immensely lessened the general death rate, they have had little effect upon the yellow fever; and the same remark is true of the various processes of disinfection of places and material. Tables are given of deaths from yellow fever for the last forty-five years, and by months for the last ten years. From these Dr. Gorgas draws many interesting figures, and touches upon the influence of immigration of non-immunes. Our space forbids our giving these. We take from the table of the last ten years some figures which will briefly and conclusively show what has been effected. In the eleven years April, 1890, to March, 1901, there has been an average of over 466 deaths from yellow fever, the lowest two being 128 in 1898, and 122 in 1899 (little immigration), whilst the number mounted up to 302 in 1900. From April, 1901, to January, 1902, inclusive, the number has been five, and there is hardly a possibility that any new case should arise in January, February or March. The figures by months are even more striking. The reader will bear in mind that the mosquito crusade was commenced in March, 1901. We give all the

months; but the months October to January show the most remarkable contrast.

Months.	Average Deaths.	Minimum Deaths.	Deaths in 1900-1.	Deaths in 1901-2.
April	12	0	0	0
May	18	0	2	0
June.....	40	1	8	0
July	70	2	30	1
August	84	13	49	2
September.....	70	18	52	2
October	66	25	74	0
November.....	48	13	54	0
December	29	8	20	0
January.....	14	1	7	0

We have not given any figures for February and March, as the reports for those months of 1902 are not to hand.

In the text of the report Dr. Gorgas says: "Still more marked is the fact that since September 28, 1901, no cases at all have occurred, particularly when it is considered that October and November rank among the worst months for yellow fever. Not only was this result obtained from a city full of non-immunes with infection in all parts of it, but there were half a dozen infected towns in railroad communication with Havana. Constant intercourse was kept up and no interference with commerce occurred. Goods of all kinds were allowed to come into the city freely. No restriction was put upon bringing in clothing, bedding, and so on, from these infected points. The only infected material from the towns looked after was the sick man, who was carefully sought out and screened from mosquitoes."

Amongst the tables of "work done" the *Stegomyia* Brigade and the "Anopheles Brigade" have distinct tables. In general terms, the measures for stopping the breeding of mosquitoes have been similar to those elsewhere employed, but on a very systematic and extensive scale: drainage and ditching, pouring petroleum on surfaces of still water, protecting household supplies by screens, breaking up and emptying out supplies containing larvæ, etc. The general orders contain provisions for the destruction of mosquitoes by fumes of sulphur dioxide, formaldehyde, insect powder, etc.

Dr. Gorgas states that there has been a great decrease in the amount of malaria, and we see in one of the tables that its

death rate for 1901 is less than for the ten preceding years, though not much less than that reported for 1890. We would be glad, and hope at some time, to have more detailed statements to add to the fine work already done by Manson, Ross, Mattei, Sambon and Low, Grassi, and our fellow-countryman Elliot and others, in giving the Anopheles his due. The reporter has figures in his tables in support of his statements of the lessenings of the general death rate, including those two prominent scourges tuberculosis and smallpox. In regard to the latter, however, we would point out that there was a similar lull in smallpox in 1882-6, inclusive. It would be interesting to know the causes of this and of the subsequent exacerbations, especially interesting to us of the North American continent and of Europe, at the present time.

The report is a valuable contribution to sanitary science. Besides what we have already noticed, the Department has done a lot of work in general sanitation, and bacteriological examinations of blood and cultures, and sputa, in connection with Malta fever, filariasis, malaria, typhoid, glanders, diphtheria and tuberculosis. The workers of the Army Sanitary Department have had exceptional advantages and opportunities by reason of the material at hand, and the discipline and authority which they could employ. At the same time they have had serious responsibilities and dangers. Some of them have heroically fallen on a battlefield as glorious as any of those in which the enemy were fellow-men. All honor to them. Those who have survived we congratulate on their grand achievement, of demonstrating practically one of the greatest discoveries of our day.

We regret that the Army Department has to hand over its work, and trust that the demonstration which it has made will have its effect in stimulating the incoming *regime* to follow up the sanitary improvements instituted.

W. O.

SUIT FOR MALPRACTICE.

Drs. N. J. Hopkins and A. M. Clark were the defendants in a recent vexatious suit for alleged malpractice. The daughter of the plaintiff sustained a very serious fracture of the arm in June, 1901. For certain reasons, among them being that of non-union, amputation was performed by a third physician.

The plaintiff, Mr. John Lynburner, entered suit, claiming \$10,000 damages. The case was tried in Cayuga before Mr. Justice Ferguson, and was concluded April 17th. After hearing the evidence on both sides the Judge dismissed the action, holding that the doctors did all that medical skill could suggest for the patient.

IMPORTANT SUIT IN THE SUPERIOR COURT IN EQUITY, MASSACHUSETTS.

In the case of the Breitenbach Company, complainant, *v.* The Thayer Company, defendant, a verdict was rendered in favor of the complainant. We quote as follows from the decree of the Court:

COPY.

"The above entitled cause having come on to be heard, and a trial having been had, and the evidence offered by each party having been received and considered, and it appearing to the Court that the use of the wrapper and package employed by the defendant for its preparation of iron and manganese, as described in the Bill of Complaint, is calculated to deceive the public and enable the defendant's preparation to be passed off as the preparation of the plaintiff known as Gude's Pepto-Mangan, it is hereby ordered, adjudged and decreed, that the defendant, Henry Thayer & Company, its directors, officers, agents and servants, be and they hereby are enjoined from making or using in any way, the terra cotta colored wrapper with white letters thereon, and the package in connection therewith, heretofore used by the defendant, for its preparation of iron and manganese, or any other wrapper or package therewith which imitates the wrapper used by the complainant, the M. J. Breitenbach Company for its Gude's Pepto-Mangan, and from selling or offering for sale any preparation of iron and manganese in any package or wrapper of a terra cotta color with white letters of the same style, shape and general arrangement as those of the aforesaid wrapper used by the plaintiff, the N. J. Breitenbach Company."

Personals.

Dr. W. H. B. Aikins visited New York early in May.

W. E. Struthers, M.B. '97, has removed from Huntsville to Lanark, Ont.

Dr. Arthur Small, of Toronto, was married on May 12th to Mrs. Barnes, of Chicago.

John Crawford, M.B. '94, who has until recently practised in Dakota, is now in Everett, Wash.

Dr. H. H. Sanderson, of Windsor, Ontario, is now spending some time in London, England.

Dr. Ingersoll Olmstead, of Hamilton, was married on May 17th to Miss Edith Hamilton Wood.

Dr. E. E. King attended the annual meeting of the American Genito-Urinary Association at Atlantic City.

Dr. Bruce L. Riordon, of Toronto, returned May 16th from New York and Boston, where he had spent about ten days.

Dr. Elliott, Superintendent of the Muskoka Cottage Sanitarium, Gravenhurst, spent a few days in Toronto early in May.

S. H. McCoy, M.B. '92, of St. Catharines, Ont., is now in England. His address is 17 Torrington Square, London, W.C.

Dr. Graif, of Vancouver, is attending the Post-Graduate Medical School, doing special work on the eye and ear. He will shortly go to England and continue his special work in London.

The following Canadian doctors are registered at the Canadian Government Office, London: Doctors F. L. M. Grasett, F. C. Hood, R. J. Dwyer, F. W. Marlow, C. E. Treble, W. Cerswell, E. Weir.

Dr. Price Brown spent the latter part of May in Boston and New York. His chief purpose was to attend the annual meeting of the American Laryngological Association, which met this year in Boston.

Dr. Robert Harbottle, of Burford, was released from the Central Prison, April 30th, after being retained a little more than three months. After his trial for shooting with intent to kill he was sentenced to imprisonment for twelve months.

Dr. A. W. Mayburry, of Toronto, started May 17th, for England and the Continent, where he will visit the principal hospitals with regard to research work in connection with diseases of nose, throat and chest. He will be absent about three months, and on his return will resume his special practice at 253 Spadina Avenue.

Recently Professor Ramsay Wright delivered a lecture on "Malaria and the Mosquito," before the members of the Kent County Alumni Association and their friends. The lecture was very largely attended, and, at the close of the meeting, Dr. T. K. Holmes, M.D. '67, moved a vote of thanks to the lecturer, which was seconded by Rev. J. H. Osterhout, B.A. '00

The following Canadian practitioners have recently passed the necessary examinations to admit them to membership in the Royal College of Surgeons, England: Dr. Charles Buckingham Shuttleworth, Trinity Medical College, Toronto; Dr. Walter Henry Phillip Hill, McGill University, Montreal; Dr. Henry Ardagh Kingsmill, Western University, London, Ontario.

At the June Convocation the Senate of the University of Toronto will confer the degree of LL.D. upon the following gentlemen: The Honorable John Douglas Armour, Chief Justice of Ontario; W. H. Drummond, M.D., Montreal; Rev. J. Munro Gibson, D.D., London, Eng.; the Honorable J. M. Gibson, K.C., Attorney-General of Ontario; the Honorable Richard Harcourt, K.C., Minister of Education of Ontario; James P. Whitney, K.C.; James J. Foy, K.C.; Ira Ramsen, President of Johns Hopkins University; Christopher Robinson, K.C., Chancellor of Trinity University; Maurice Hutton, Principal of University College; R. Ramsay Wright, Dean of the Faculty of Arts; John Galbraith, Dean of the Faculty of Applied Science and Engineering; R. A. Reeve, Dean of the Faculty of Medicine. The degree of Doctor of Music will be conferred upon Mr. F. H. Torrington.

Book Reviews.

The Four Epochs of Woman's Life. A Study in Hygiene. By ANNA M. GALBRAITH, M.D., Author of "Hygiene and Physical Culture for Women." Fellow of the New York Academy of Medicine, etc. With an Introductory Note by JOHN H. MUSSEY, M.D., Professor of Clinical Medicine University of Pennsylvania. 12mo volume of 200 pages. Philadelphia and London: W. B. Saunders & Company, 1901. Cloth, \$1.25, net.

Dr. Mussey in his introductory note intimates that the truths expressed in a modest, pleasing and conclusive manner in this book should be known by every woman. We hope the women of Canada can manage to exist without any such book for a long time to come.

Medicine, Surgery and Hygiene in the Century Review. By EZRA HORTLEBERT STAFFORD, M.D., Member of the College of Physicians and Surgeons of Ontario, Physician to the Hospital for Insane, Toronto; Associate Editor the *Canadian Journal of Medicine and Surgery*, Lecturer to the Women's Medical College, Toronto, etc. London, Toronto, Philadelphia: The Linscott Publishing Company, 1901.

This is Volume III of the Nineteenth Century series, published by the Linscott Company in twenty-five volumes. The author has shown himself to be a writer of no mean ability in the past by the publication of many interesting brochures on certain subjects in science. In this volume he gives us a plain and untechnical account of the progress of medicine and surgery in the nineteenth century, which will be found interesting by lay and medical readers alike. We desire to congratulate our friend Dr. Stafford on the signal success which has crowned his efforts to give us a very charming book.

A Practical Manual of Insanity. For the student and general practitioner. By DANIEL R. BROWER, A.M., M.D., LL.D., Professor of Nervous and Mental Diseases in Rush Medical College, in affiliation with the University of Chicago, and in the Post-Graduate Medical School, Chicago; and HENRY M. BANNISTER, A.M., M.D., formerly Senior Assistant Physician Illinois Eastern Hospital for the Insane. Handsome octavo of 426 pages, with a large number of full-page inserts; Philadelphia and London: W. B. Saunders & Company, 1902. Canadian Agents: J. A. Carveth & Co., Toronto. Cloth, \$3.00, net.

This work, intended for the student and general practitioner, is an intelligible, up-to-date exposition of the leading facts of psychiatry, and will be found of invaluable service, especially to the busy practitioner unable to yield the time for a more exhaustive study. The work has been rendered more practical

by omitting elaborate case records and pathologic details, as well as discussions of speculative and controversial questions. Certain special features of the work, also broadening its field of usefulness, are the mention of the forms of insanity not usually met with in hospitals, and the including of a comparative table of classification and a chapter on some of the ethical questions relating to insanity as they may arise in the practice of medicine. Indeed, we know of no work of its scope that covers the field so completely, yet concisely and clearly.

A Text-Book of Surgery. By DR. HERMAN TILLMANN, Professor in the University of Leipsic. Translated from the seventh German edition by Benjamin T. Tilton, M.D., Instructor in Surgery Cornell University, and John Rogers, M.D., Instructor in Surgery Cornell University. Edited by Lewis A. Stinson, M.D., Professor of Surgery Cornell University. Vol. I. The Principles of Surgery and Surgical Pathology, with 516 illustrations. New York: D. Appleton & Co. Cloth, price 00.

This is a new translation, being from the last seventh German edition, four German editions being issued within the last seven years. It has been revised so as to embrace the latest facts and teachings. It is a work of three volumes, the other two yet to follow. In this volume there are three sections on general principles; first, those governing surgical operations (preparation of the patient, anesthesia, procedure and precautions during operations); second, methods of applying surgical dressings, including the preparation of them, bandaging, etc.; third, surgical pathology and therapy, and very fully these are taken up. Some of the bacteriological plates are in colors. A considerable amount of space is devoted to a subject which has of late been largely discussed both in our various societies and in the columns of the *British Medical Journal*—the various phenomena connected with chloroform and ether, morphine, chloroform, narcosis, etc. An interesting tree of a hemophilic family is traced by Lossen through four generations, showing transmission to males through females. A and his wife were not bleeders; they had four sons and two daughters; three of the sons were bleeders and neit' r of the daughters, but one of the daughters had eight sons, 1 bleeders, and three daughters not bleeders. Her sister had five sons, all bleeders, and four daughters not bleeders. Two of A's sons had two girls and a boy between them, all non-bleeders. In the fourth generation, out of twenty members there was only one bleeder, the son of a daughter's daughter. A great deal of attention is given in the first and second sections, respectively, to all the various general and local anesthetics, of which a great variety is mentioned, as also to a great variety of anti-septics and modes of preparing ligatures and dressings.

The American Year-Book of Medicine and Surgery for 1902. A Yearly Digest of Scientific Progress and Authoritative Opinion in all branches of Medicine and Surgery, drawn from journals, monographs and text-books. Arranged, with editorial comments, by eminent American specialists, under the editorial charge of GEORGE M. GOULD, A.M., M.D. In two volumes—Vol. I, including General Medicine; Vol. II, General Surgery. Price, per set, \$6.00; per volume, cloth, \$3.00 net; half morocco, \$3.75 net. Philadelphia: W. B. Saunders & Co., 925 Walnut Street. Toronto: J. A. Carveth & Co., Canadian Agents.

The plan of issuing the Year-Book in two volumes, inaugurated two years ago, met with such general favor with the profession that the publishers have decided to follow the same plan with all succeeding issues. Each volume is complete in itself, and the work is sold either separately or in sets. This arrangement has a two-fold advantage. To the physician who uses the entire book, it offers an increased amount of matter in the most convenient form for easy consultation, and without any increase in price; while the man who wants either the medical or the surgical section alone secures the complete consideration of his branch without the necessity of purchasing matter for which he has no use. The contents of these volumes, critically selected from journals, monographs and text-books, is much more than a compilation of data. The extracts are carefully edited and commented upon by eminent American specialists, the reader thus obtaining, not only a yearly digest of scientific progress and authoritative opinion in all branches of medicine and surgery, but also the invaluable opinions of the leading American specialists. As usual, this issue of the Year-Book is not lacking in its illustrative feature; for, beside a large number of text-cuts, the Surgery volume contains five, and the Medicine volume four, full-page inserts. In every way the Year-Book of 1902 fully upholds, if it does not strengthen, the reputation won by its predecessors.

Contributions to Practical Medicine. By SIR JAMES SAWYER, Knt., M.D. (Lond.), F.R.C.P. (Lond.), F.R.S. (Ed.), F.S.A., Senior Consulting Physician to the Queen's Hospital; formerly a Professor of Medicine, Professor of *Materia Medica and Therapeutics*, and Professor of Pathology in the Queen's College; Physician to the Birmingham and Midland Hospital for Sick Children, President of the Midland Medical Society, Vice-President of the New Sydenham Society, and President of the Clinical Board of the General and Queen's Hospitals, etc. Third edition. Revised and enlarged. Birmingham: Cornish Brothers, 1902.

This series of clinical lectures and observations, emanating from so well known an authority as the author, must be expected to contain something of value; nor is the reader disappointed. The observations on insomnia are very pertinent, dealing practically with a subject that often taxes our resources; so also are the remarks on constipation and intestinal obstruction. The value of inspection as a means of diagnosis in

diseases of the lungs and pleura, and the importance of accentuation of the second pulmonary sound in cardiac affections, are emphasized with the precision of the practical teacher. The author has in his nineteen contributions given us the advantage of his large clinical experience. His suggestions in the treatment of gastralgia, hemorrhoids, eczema, chorea and asthma will undoubtedly be appreciated by many, as will his suggestion for the use of ether as a menstreum in medication by the skin, and the use of calcium chloride in the night sweats of phthisis.

Johnson's First Aid Manual. Suggestions for prompt aid to the injured in accidents and emergencies. Edited by FRED. B. KILMER. Illustrated. Pp. 113. New Brunswick, N.J.: Johnson & Johnson, 1901. Cloth, 50 cents.

This handbook is full of practical suggestions for those rendering first aid to the sick and injured. The subject matter is good, and the illustrations make the text most comprehensible to the lay mind. It is designed for use with Johnson's Accident Case, but apart from this it makes a very useful source of information for those desiring instruction in the means to be adopted in emergencies.

Anesthetics. A practical guide to the administration of anesthetics. By R. J. PROBYN-WILLIAMS, M.D., Senior Anesthetist and Instructor in Anesthetics at the London Hospital; Lecturer on Anesthetics at the London Hospital Medical College; Assistant Anesthetist at the Dental Hospital of London. London: Longmans, Green & Co., 1901. Toronto: The Copp Clark Co., Limited. 200 pages. Cloth. Price, \$1.60.

This is an eminently practical handbook, designed to meet the wants of the early students of anesthesia. The general state of anesthesia is carefully considered in detail, and the difficulties and dangers practically dealt with. The descriptions of apparatus are confined to those in general use, and are explained by means of diagrams. Fifty pages are devoted to the use of nitrous oxide, alone and with oxygen; while ether, chloroform and their mixtures receive full consideration. A chapter on the choice of the anesthetic is most practical. The section on local anesthesia is brief but useful. It is a book intended for the student, and as such we highly commend it. Much also will be of value to the general practitioner. C. J. C.

Report of "Vital Statistics of the City of Havana" made to Brigadier-General Leonard Wood, U.S.A., Military Governor, Head-Quarters Department of Cuba. By Major W. C. Gorgas, Surgeon U.S.A., chief sanitary officer.

A review will be found in our editorial columns.

Selections.

SURGICAL HINTS.

Warts and moles may be removed by touching them daily with glacial acetic acid, which must not be permitted to touch the healthy skin. If this is carefully done no scar will be left.

Since, in modern surgery, it has been recognized that the skin is the principal source of infection, it is well, in operating, to use one knife to cut the skin and to replace it by another for the deeper work.

In all emergency cases of operations in which the patient shows any evidence of bronchitis, begin the treatment of this condition at once. A good sized dose of digitalis with one of the salts of ammonia before operating is useful.

It is never likely that gonococci are present in the female genitalia when the mucous membranes appear to be perfectly healthy; on the other hand, they may be present in any case in which an unhealthy secretion appears, however mild the latter may be.

After amputations, never wait to apply an artificial limb beyond the time when the stump is well healed and the patient is strong again. Disuse of the stump for too long a time makes it less able to stand the artificial limb. The only exception to this rule is where the operation was done for malignant disease, where early pressure and concussion might favor a return.—*International Journal of Surgery.*

Night Sweats in Phthisis.

All physicians know the difficulty of keeping the night sweat of phthisis in control. Almost every known remedy has been tried since the Greeks used agaricin down to the present. Graves and Stokes used Dover's powder, which in time gave place to mineral acids, zinc and belladonna, atropine, and a host of other specifics. To the long list Nolda adds tannoform, the external use of which he recommends. In seven out of eight cases in which he had the front and back of the thorax dusted with powdered tannoform it checked the sweating (*Berl. Klin. Woch.*). This method of treating the symptom has the advantage of not interfering with the digestive function, which is usually so imperfectly performed in such cases, neither does it in any way preclude the use of any of the other

antisudorifics. The powder of itself should prove an agreeable application to the skin and promote the comfort which is such an essential factor in producing sleep in such cases.—*Medical Press and Circular*.

Rheumatic Arthritis.

The following is recommended as a relieving application in this painful affection :

℞ Salicylate of methyl	℥ iv.
Chloroform	℥ ii.
Menthol	gr. xxx.
Lanoline	℥ ii.

M.

S.—Apply to part.—*Clinical Review*.

To Remove Dandruff.

According to *Merck's Report*, among the remedies which have been found to be most serviceable in the treatment of dandruff are resorcin, tannoform, salicylate acid and boric acid. The following mixture is recommended as being most efficacious :

℞ Resorcin	℥ i
Tannoform	℥ i
Acidi salicylate	gr. v

M. Dissolve the powder in three ounces of alcohol and one ounce of water and filter. Sig.: Apply locally to the scalp.

Or:

℞ Resorcin	℥ i
Acidi borici	℥ ss
Aquæ	℥ v

M. Sig.: Apply locally to the scalp.

The foregoing ingredients may be incorporated with an ointment if desired, such as aquæ unguentum rose (cold cream), adeps lanæ hydrosus, petrolatum, etc.—*Medical Fortnightly*.

A New Theory of Uremia.

The pathology of the condition to which *en bloc* the term uremia is applied remains very obscure, in spite of numerous hypotheses and speculations based on the results of necessarily more or less limited and imperfect researches. Uremia is generally assumed to be the organic manifestation of functional failure on the part of the kidney, in other words, a disease consequent upon, and directly due to, defective elimination. Nevertheless, physiologists and pathologists are by no means agreed as to the nature and significance of the body or bodies alleged to be retained; indeed, the assumption does not reach higher

than mere surmise. It may be conceded that renal insufficiency is the prime factor in the production of the symptoms collectively described as uremia, but it must not be forgotten that renal inadequacy may apply to and explain two very different forms of functional disturbance. The trend of modern research has been to confirm Brown-Séquard's contention in favor of all organs possessing an internal secretion, even in respect of so distinctly an excretory organ as the kidney. The possibility therefore suggests itself that inadequacy of the internal secretion of the kidney may in whole or in part explain the symptomatology of this affection. In support of the existence of an internal renal secretion, Rose Bradford instanced the curious fact that partial removal of the kidney in animals does not necessarily cause any marked modification in the quantity and quality of the urine, yet, in spite of the normal excretion of urea, a marked increase is noted in the proportion of nitrogenous extractives contained in the muscles, from which he infers that the diminution in the quantity of internal renal secretion favors exaggerated disintegration of the muscle substance and perhaps of other tissues. In another direction it has been shown that the injection of dilute solutions of renal substance markedly prolongs life in artificially induced uremia, and the same effect is produced by the injection of normal blood, and especially of blood from the renal vein. These experiments would appear to justify the assumption that the kidney elaborates and passes into the blood some substance which acts as an antitoxin to some other substance or substances as yet unidentified, the harmful effects of the latter being due to their stimulating effect on tissue metabolism, *e.g.*, waste. The data at our command are not yet sufficiently precise to enable any practical scheme of treating uremia on these lines to be formulated, but it is well within the scope of possibility that means may be found of averting this, the outcome of renal inadequacy, in the same way and on the same principles as in the treatment of myxedema, by the methodical administration of thyroid substance.—*Medical Press and Circular*.

Delusions Peculiar to Inebriety.

There is no one symptom of mental change so constant in inebriety, as the delusive faith in the ability to stop all use of spirits at any time. This delusion of free will begins from the first use of spirits and grows with increasing intensity down to the last moment of life. Continuous failures and the experiences of years, without a single confirmatory instance sustaining this belief of ability to stop, make no impressions on the mind. On all other topics there may be a general recognition

of cause and effect and the lessons of experience, but in relation to drink, this delusion grows constantly. The demand for spirits as a controlling power in the organism is unrecognized, and the mind seems taxed to find reasons for explaining the inconsistencies that come from its use. This delusion of strength, to stop at any time, is encouraged by the friends who believe it to be true, and condemn the patient for failure to carry it out. No matter what conditions or necessities may exist for abstaining, spirits are used, and the patient insists that he cares neither for the taste or effects of spirits, and can stop at any moment. This belief is sincere and emphatic, and should a free interval occur in which no spirits are taken, this is considered evidence of the will power to stop at any point. The use of spirits in conditions where personal interests and that of the patient's family suffer, and where the act is practically suicidal, are explained as mere lapses which could have been prevented by a mere act of the will. This delusive state is unrecognized by temperance revival movements and many reformatory efforts, where the central object is to awaken the free will, which is supposed to be simply dormant. In many instances these very efforts intensify and fix the delusion of free will, making recovery more and more uncertain. It is curious that this most insane faith should not be recognized from the every-day experience of failures to abstain by nearly all inebriates. As a symptom of disease, this is beyond all question, and is really more distinct than any other delusion.—*Journal of Inebriety.*

The Treatment of Chronic Bronchitis in the Elderly and Aged.

Henry Campbell, in the *British Medical Journal* of October 12, 1901, briefly sums up the chief points of a paper by him on this topic:

In treating chronic bronchitis in those past middle life, the toxicity of the blood should be kept as low as possible.

The air breathed should be pure, and nasal breathing insisted on.

The diet should be a bare sufficiency, and alcohol indulged in sparingly, or not at all.

Every ounce of superfluous fat should be got rid of.

The general health should be maintained at the highest possible level.

A vigorous circulation should be maintained.

Every precaution should be taken against breathlessness.

Breathing exercises should be resorted to in order (among other things) to preserve the mobility of the thorax.—*Therapeutic Gazette.*

Miscellaneous.

THE PRACTICAL PHYSICIAN.

"The vast increase of our knowledge in both medicine and surgery during the past quarter century is so bewildering that I do not wonder that the student of to-day, even after a four years' course, feels himself quite at sea when he starts out into actual practice. He has been trained to examine the blood in order to make a diagnosis of malaria or anemia, he will not say whether a patient has typhoid or not until he has found the Widal reaction, and although he may find dulness in the chest and high temperature, crepitant râles and bronchial breathing, he is not willing to risk a diagnosis of pneumonia until a specimen has been sent to the laboratory and the pneumococcus has been discovered. Of course, he thinks it a waste of time to study the clinical appearances and symptoms of diphtheria when he can send a culture to the Board of Health and have the diagnosis made for him.

"Far be it from me to underestimate these valuable aids to diagnosis, but I merely wish to emphasize the importance of the clinical side of medicine and surgery, and to impress upon your minds the value of the older methods of determining the nature of disease. You will not all practice in large cities; many of you will be called to treat patients far from the laboratory and even from your own microscope, and you will have to make a diagnosis without their help, and you should, in most cases, be able to do so."

The above quotation is taken from an address of Dr. William B. Coley, which was delivered before the Jefferson Medical College Society of Philadelphia. It embraces a suggestive truth, which is applicable to the present age of medical practice, and it furnishes us a text for thoughtful reflection. We see and hear so much which pertains to the accurate and scientific consideration of pathology nowadays that it is quite natural for us to exist in a professional atmosphere, which occludes the practical experience of the physician who has never had many advantages. We are bound at all times to look into the achievements of the past and admit that there is some virtue in the practice which existed before we knew so much about science.

The treatment of disease is, in a sense, an art, and it may be entirely independent of the extreme scientific knowledge which now prevails. To be sure scientific advancement is a necessary accomplishment, and it should be cultivated and sought

for with unrelenting determination. Our perfected knowledge of pathology has helped us in diagnosis and preventive medicine, but it can never supplant or equal the practical utility of experience. While the revelations of the laboratory are teaching us new ideas relative to the habit and propagation of disease, the practical theory of the curative principle is too frequently lost sight of. The doctor who plods along in the everyday experience of practice is still able to give us many points regarding the management of disease. It is often a serious question whether the physician of large experience and practical attainment is not able to do more good at the bedside than all the students with up-to-date accomplishments.

This train of thought is not to be interpreted as a reflection upon the modern teaching and the modern education. It is rather a suggestion of a greater need to adopt the plain teachings of experience in conjunction with all that science may tell us. We have many illustrations of the highly accomplished physician, who perchance is a successful teacher, and who knows all about the principles of pathology, and yet this very man may be an utter failure in the treatment of disease. This shows the need of two acquirements which must be gained by every successful practitioner. First, he must inherit or cultivate the intuitive principle which comprehends the character of disease and the management of the same through the agency of his treatment. Secondly, he must utilize his scientific knowledge to the end that he may practically apply it to dethrone disease. Any other method in the acquirement of medical education is bound to bring about eventual disappointment in practice.

One has only to look into many of the standard text-books of present date to see how much is said of etiology and pathology and how little is said about treatment. It might also be inferred that when the diagnosis is made the physician's duty is performed. Is it a wonder then, if this line of thought prevails in colleges, that students enter upon their practice with so little ability to take care of disease? If it were only necessary to find the pneumococcus to treat pneumonia or discover the Widal reaction to manage typhoid fever, then the extreme laboratory idea would be the correct theory. This, however, is not sufficient, as we know; the young doctor must understand how to relieve the lung consolidation by means of his remedies and general treatment else his patient may die; he must know how to care for the febrile condition of typhoid, after the blood analysis has been made, or the toxemic danger gains supremacy. And so we might apply illustrations without number to show the necessity of something more than the scientific knowledge of disease.

We so often hear the expression that "diagnosis is the important thing with every practitioner." Indeed it is important but it is not by any means *the* important thing. One may make a direct diagnosis and confirm it by the *post mortem*, but the mandatory requirement should always be the perfect treatment. This can only be settled as we understand the use of our remedies and allied treatment; therefore we should study disease in relation to remedies; our teachers and authors should instruct us in pathology only in association with the clinical idea of treatment. It will not do to say that this or that remedy "may be tried"; there must be some practical deduction which affiliates the remedy with the symptoms of the disease.

Many physicians come into our midst having the precedent of a foreign clinical education and a diagnostic ability as their only resource. We expect much from their attainments, but the doctor with the clinical idea, and the practical experience will often discount them with his results. This does not mean that the pathological knowledge of disease is unnecessary, but it does mean that the principle of treatment must be applied with the pathology.—*The Clinique*.

Medica! Men and Gifts from Patients.

A case of great importance to the medical profession has been recently decided in the law courts. The action was brought by the executors of an old lady of eighty to recover from a medical practitioner at Bromley £800. It appears that the money was given to him in four several sums, one of £500, and three of £100 each. The first gift was made in September, 1899, and the last a few days before her death, which took place on March 23rd, 1900. The executors brought no charge against the defendant of fraud or misrepresentation, or any direct or indirect misconduct in obtaining the money, but simply that, having regard to his position as medical attendant upon the deceased, he was incapacitated from receiving or retaining gifts when the donor had no independent advice. Neither was it alleged that the deceased was not in a perfectly competent mental condition. The case was heard last week by Mr. Justice Swinford Eady in the Chancery Division. The Judge ruled in favor of the plaintiff, and said on the admitted facts the defendant must repay the whole of the money with interest. It seemed to his Lordship that it was of the greatest importance to give full force to the rule that forbade gifts from patients to medical attendants unless the donors had independent advice. A stay of execution was granted to allow an opportunity of appealing against this judgment. The application of a similar principle would render nugatory a great many

gifts to churches, to charitable institutions, and to private individuals. Meanwhile, any medical men who are fortunate enough to meet with patients who are grateful as well as wealthy will do well to bear the above case in mind.—*Medical Press and Circular*.

The Specialist in Surgery.

Modern surgery presents a field whose vastness is due to investigators in special lines. In other words, the specialist is responsible for the fact that its boundaries are ever receding towards a horizon whose limits are beyond our ken. As simplicity and accuracy always result from all scientific efforts, however, the laborious researches of the original seekers finally end in the establishment of certain fixed principles and technical methods. Out of chaos order is evolved, and the measures finally adopted and recognized gravitate towards the central point of general surgery and become a part of it. The stupendous achievements of gynecology, for instance, are more and more tending to become a part of the province of the general surgeon, whose special skill makes it easy for him to learn new manipulations, and to acquire the needed dexterity. And so in the surgical services of our hospitals we may be present at a clinic in which the operator will prove to be equally competent in the various fields of gynecology, genito-urinary, and rectal work, and the treatment of nearly all surgical conditions and diseases. While a few men may have looked upon this as an encroachment upon what they had been led to consider as being territories of their own, it cannot be doubted that it not only is a beneficial growth, but that it is also one whose increase is inexorable and will never be stayed. That many, however, will always pause when confronted with the enormity of the region laid bare before them, is unquestionable. They will limit their studies to certain portions of the field, and there will, as long as our art endures, be men who will achieve special distinction along certain lines. But as the general knowledge increases it will become more difficult to acquire a well founded reputation as a specialist, and the work accomplished will hence become of a higher order. That this is an end devoutly to be hoped for is becoming more and more clearly apparent every day. Anesthesia and aepsis have so robbed of terrors the work of surgeons that there are many who step in where angels fear to tread, and, in the forcible words of Dr. Wm. M. Polk (*Medical News*, Feb. 1st, 1902): "The curse of our profession to-day is the half-baked, underdone specialist, and this country is full of them." The surgical specialist of to-day must begin as a general surgeon, and rise to specialism in virtue of peculiar aptitude for and

interest in some branch of his work. The general practitioner must be better instructed in surgery, because he usually is the arbiter who decides whether the surgeon shall be called in; but the surgeon himself must be worthy of the honor conferred upon him, and it is only by strenuous work and special training that he can fit himself to fill properly his place.—*International Journal of Surgery.*

Insurance Company's Medical Examiner Cannot be Agent of Person Insured.

In an action by Mrs. George Sternaman against the Metropolitan Insurance Company, to recover on a policy on the life of her husband, the question to be determined by the New York Court of appeals was whether, when an applicant for life insurance makes truthful answers to all questions asked by the medical examiner, who fails to record them as given, and omits an important part, stating that it is unimportant, the beneficiary could show the answers actually given, in order to defeat a forfeiture claimed by the company on account of the falsity of the answers as recorded. It was agreed in Mr. Sternaman's application that the medical examiner, who was employed and paid by the company, should not be its agent, but solely the agent of the insured. The court, in reversing the Fourth Appellate Division of the Supreme Court, holds that while the parties to the policy could agree that the person who filled out that part of the application to be signed by the insured was the latter's agent, they could not agree in this manner in regard to the blank to be used by the medical examiner. The medical examiner of an insurance company is the agent of the company, and not of the applicant. The knowledge he acquires, his interpretation of the answers given, and his errors in recording them are the knowledge, interpretation and errors of the company itself. The company is, therefore, estopped from taking advantage of what it thus knows and what it thus does, when it issues a policy and takes the premium. After stating that the power to contract is not unlimited, Judge Vann, speaking for the court, says: "Parties cannot make a binding contract in violation of law or of public policy. They cannot in the same instrument agree that a thing exists and that it does not exist, or provide that one is the agent of the other, and at the same time, and with reference to the same subject, that there is no relation of agency between them. . . . They cannot by agreement change the laws of nature or of logic, or create relations, physical, legal or moral, which cannot be created. In other words, they cannot accomplish the impossible by contract." Chief Judge Parker and Judge Gray dissented.—*Boston Medical and Surgical Journal.*

Taste or Test.

A well-known Brooklyn physician of Spanish extraction has not yet mastered the intricacies of the pronunciation of the English language. Some time ago the doctor had occasion to send a specimen of urine for chemical examination to a druggist who attends to this work for the physician. A servant was dispatched with instructions that the druggist should "taste" it. The fluid was in an ordinary wine bottle, and the German druggist eagerly swallowed a good-sized draught, and immediately declared it to be the worst wine he had ever had the misfortune to sample. When the doctor informed him that it was a specimen to "test" chemically, the druggist was enlightened but not satisfied.—*Med. Record.*

Glass Vaccine Points—A New and Original Idea.

One of the most interesting developments in vaccine points is undoubtedly that recently placed upon the market by the H. K. Mulford Co., of a flint glass point, similar in size and shape to that of the ivory point. Every propagator of vaccine, as well as user, has recognized the limitations of the ivory or bone point, inasmuch as it could not be properly sterilized either by dry heating, which chars it, or by the use of antiseptic solution of powder, which would be absorbed in the bone and destroy the vaccine virus itself, and for this reason experiments have been carried on covering a period of years, to secure a proper substitute in glass which, from the start has been recognized as the ideal, if it could be properly produced. Mulford Company have succeeded in doing this, they have under their management a large and completely equipped glass plant on their vaccine farms at Glenolden, for the manufacture of such glassware as they use in connection with antitoxin and vaccine. It is the only glass plant in the world that employs exclusively women.

The glass point permits of thorough scarification, it is easily and thoroughly sterilized, and is supplied by the H. K. Mulford Co., either in form of dry points, or what is superior to these dry points, the glycerinized form of vaccine; this is the same vaccine employed in the glycerinized tubes, and is thoroughly tested and free from pathogenic organisms. The glass point is first sterilized, then tipped with glycerinized vaccine, which has been carefully tested bacteriologically and physiologically to prove its activity and purity, after that it is encased in sterile glass capsule, which is then hermetically sealed, thus permitting handling of the point without any possible contamination, and it is in point of fact, the ideal form of vaccine, representing the purest and most active.

There is no advanced charge made for the glass glycerinized points, and we endorse them as being the most advanced step forward in the marketing of a pure and aseptic vaccine.

No Restrictions Placed on Lepers in New York.

In the report of the Leprosy Commission of the Marine Hospital Service, sent to the United States Senate by the Secretary of the Treasury on March 24th, it is stated that out of 278 cases of the disease now in this country, seven are in the city of New York, four in Brooklyn and three in Manhattan. While formerly lepers found in New York were isolated, at present no restrictions are placed upon them, as it is held by the health authorities that in this climate the disease has no contagious element.—*Boston Medical and Surgical Journal*.

The Open-Air Treatment of Tuberculosis.

Since the meeting of the British Congress on Tuberculosis there has been a general exploiting of the necessity of open-air treatment in this disease. It bids fair to become a fad, and as such to be prescribed in an indiscriminate fashion, which will sooner or later bring a valuable means of treating tuberculosis into undeserved discredit.

A few articles have appeared which have shown an understanding of the basic principles in the treatment of this disease and in the application of the open-air method to the indications. Others manifest overweening confidence in the method, thinking all that is necessary is to turn patients into the open air to have them get well.

One is reminded of the general discussion upon the cold-bath method of treating typhoid fever. Exploited as it was as a cure-all in this disease, and from being indiscriminately employed, it is now used with some definite idea of its limitations and some individualizing of the treatment. Even with a treatment so near a specific as quinine in malarial fever, it is still necessary to pre-cribe it with judgment in reference to its absorption, and with a dosage based upon individual indications.

In the open air treatment of tuberculosis, it is not sufficient that a patient be turned out-of-doors to live in a tent in order to have him recover. Indeed, tent life may be even more objectionable than living within doors, as ventilation of a tent in the cold season when the openings must be closed and the interior heated with a stove may be much poorer than in the average house. Much can be done in the home open-air treatment of tuberculosis, particularly in the rural districts and smaller towns. Most houses can be provided with a balcony or other suitable shelter which admits of the details being carried out with some degree of persistence. For the town dweller, the open-air treatment to be efficiently applied must be in a sanitarium or in a camp especially prepared for tuberculosis patients. The treatment must be under medical supervision and must be individualized.