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THE

MARITIME MEDICAL NEWS.

A MONTHLY JOURNAL OF

MEDICINE AND SURGERY.

Vol. X. HALIFAX, NOVA SCOTIA, JANUARY, 1898. No. 1.

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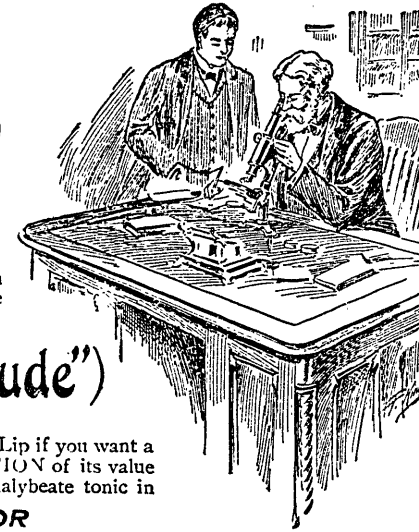

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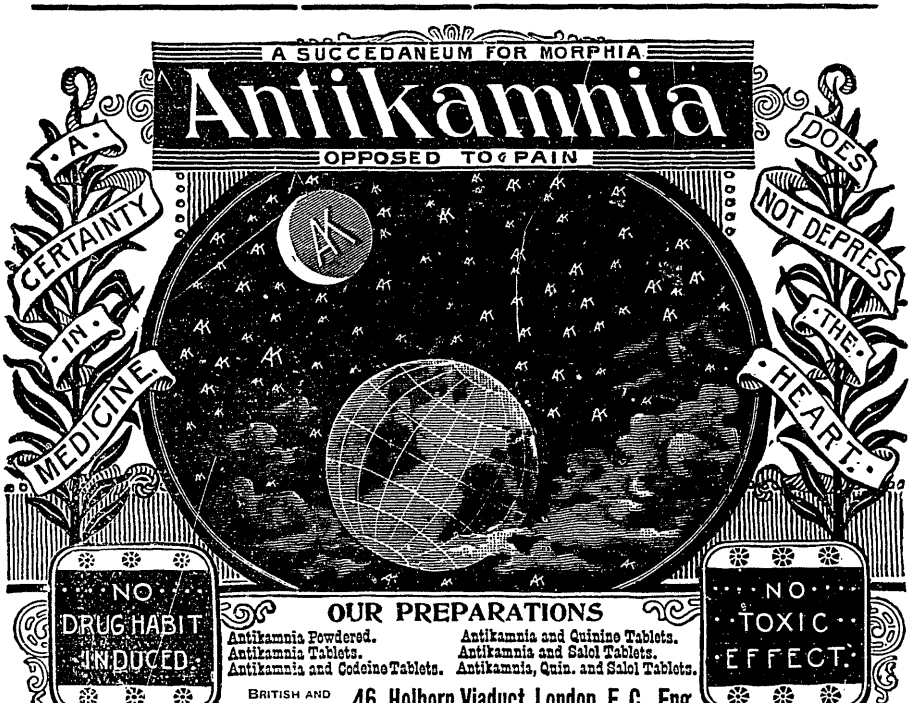

THE

MARITIME MEDICAL NEWS,

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VOL. X. HALIFAX, N. S., JANUARY, 1898. No. 1.

Original Communications.

THE RELATIVES OF TONSILLITIS.*

By J. R. McINTOSH, M. D., St. John, N. B.

The relatives of tonsillitis are a numerous family. Tonsillitis has ancestors in the shape of hereditary predisposition and the immediate exciting cause, be that what it may. Of these, I have little to say.

It has contemporary relations in the disorders, the troubles, and the pathological conditions which may at the time accompany acute or chronic affections of these organs.

Its progeny are those sequelæ—early and late—which, according to recent ideas, are all too apt to be engendered by that well-known tetrad of lymphatic tissue encircling the faucial opening at the embryonic point of junction of epiblastic and hypoblastic layers.

You are acquainted with the clinical picture and the appearance of enlarged tonsils. You know that if the faucial tonsils are enlarged the chances are greatly in favor of at least some enlargement being present in the pharyngeal tonsil, while any great amount of increase in the size of the lingual tonsils is somewhat rare before puberty.

Such enlargements in the limited space of the naso-pharynx and fauces must give rise to a certain amount of mechanical obstruction. You can readily understand how they would interfere with swallowing—how, too, nasal breathing would be interfered with and mouth breathing be brought into play to supplement it. And you can also well understand how such enlargements of themselves can and do interfere with

* Read at meeting of Maritime Medical Association, July, 1897.

the ease and clearness of speech, which, in persons so affected, becomes thick and guttural. You can also understand how the opening of the eustachian tube into the naso-pharynx, lying as it does between two masses of lymph-adenoid tissue, might be encroached upon, as it constantly is, when Luschka's tonsil is enlarged and dragged upon by the enlarged faucial tonsil, and so, entirely by mechanical means—if no other elements come into play—becomes so distorted or affected as to interfere with the functions of the tube in its relation to the sense of hearing. These masses of lymphatic tissue, however, are subject to inflammations, and, from various causes, are ever in a state of unrest. They are frequently to be found in a state of chronic congestion, and are ever ready to become actively so, which leads to two things: one, a chronic weeping from their own surface: the other, a chronic congestion and thickening, and so a weeping from the mucous membrane covering the surrounding parts—one, in fact, of the many forms of catarrh by which this region is affected. This, now, is a new element added, and to what in addition may it give rise? We must remember that each succeeding congestion or inflammatory attack affects a wider area of the mucous membrane around, hence the area of thickened and congested membrane spreads, and at last reaches other important organs. It spreads up the eustachian canals, blocks them, and suppuration takes place within the middle ear. It spreads toward the larynx, and there the vocal cords become congested by it, as well as by the unmoistened and unwarmed air respired by the mouth breather, and huskiness and hoarseness of the voice may follow from this cause, while in the fauces themselves the constant accumulation of mucous calls for constant clearing of the throat and expectoration.

If these conditions were the only ones that were to affect the rest of the body as a result of a pathological state of the tonsils, they of themselves would be sufficient to attract a large amount of attention, both from the general as well as the special practitioner; but there are a number of other diseased conditions which have a most intimate relationship to the tonsils when diseased, and to understand them we must study the functions of the tonsils in health and know how these functions become modified in disease. Here we at once enter on debated or unsettled ground.

In all probability, however, they have an absorbent function in health, and it is generally conceded that their action in this respect is greatly increased in disease. This, of course, more particularly applies

to the interstitial elements of the organs, for at present we can only look upon the crypts by analogy as having a secreting function, though in health this action must be extremely limited in degree. In pathological conditions, however, this function may, and often does, become markedly increased, and then pours forth from their openings a more or less continuous supply of caseous mucoid material and degenerating epithelial debris.

Taking these two functions of absorption and secretion into consideration, we have food for further thought, and to it we may add the well ascertained knowledge that the throat is habitually infested with various species of bacteria, differing greatly in their power and mode of action, as well as the toxines they produce—"products which the abundant lymphatic tissue of the tonsils renders easy of absorption."

With such considerations before us, our thoughts at once revert to diphtheria, the microbic origin of which, within and around the tonsillar tissue, is fairly well established; and also to scarlet fever, which has its initial and chief lesion in the same site, though absolute proof of the individual microbe which gives rise to it has not as yet been arrived at.

There the microbes, under some favorable condition of local tenderness or impaired health, gain an entrance within the epithelial elements and so admission into the substance of the gland itself, and thence they and their products give rise to the local manifestations and the more distant and general disturbances which accompany these diseases. And when this occurs in what we look upon to be normal sized and fairly healthy tonsils, how much more serious is the attack likely to be in a case where the adenoid tissue of the throat has been the subject of repeated attacks of an inflammatory trouble, and how much more readily and likely is the poison to attack such weakened tissue and find a ready passage through it to the rest of the body.

For a long time medical men have considered that there is more than an intimate relation between rheumatism and tonsillar disease, and of late that opinion has been gaining in strength. The clinical evidence which so often points to an acute or subacute tonsillitis as the precursor of an attack of acute rheumatism or other rheumatic manifestation, becomes strengthened and is easily understood if we assume its bacterial origin within the tonsils. True, the special microbe or microbes which give rise to such a condition remain as yet undistinguished, but many arguments have been adduced from the clinical aspect of these cases to show that there is a marked analogy between its course and that of an

infective disease manifesting itself within the body. Further than this, in regard to the relationship of tonsillitis and rheumatic fevers, I need only add in the words of Sir Willoughby Wade, that "the facts of rheumatic fever have not been harmonized or explained by any as yet recognized theory. They can be harmonized and explained by the hypothesis that they also are due to poisons generated by microbic growths. In a large number of cases we find microbes which commonly produce toxines multiplying in a part so freely supplied with lymphatic tissue as to render the entrance of toxines into the system exceedingly easy and therefore probable. We find also microbes in the closed follicles and the epithelial cells. Do not all these considerations afford a strong presumption that rheumatic fever itself has a microbic origin?"

Of the present state of our anxiety in regard to tuberculosis and its communication to mankind, I do not propose to say much. It is important, however, to note the part the tonsils play in such cases, and I believe it is but little known that many an innocent looking, and maybe only slightly enlarged tonsil, showing no external appearance of any serious internal mischief, is really in its interior the hotbed of growth for tubercular deposits which later become absorbed and affect the system with its pernicious results through the submaxillary and cervical glands.

That such cases should be so masked in their character and void of the naked eye appearances of tubercular disease, adds greatly to the difficulty in recognizing them at an early period, and also explains their tardy and accidental discovery by pathologists. The bacilli in such cases gain access to the tonsils by inhalation, or food swallowed, and to prove that the latter is possible, tuberculous food experimentally given to animals has produced infection in the lymphoid tissue of the fauces and at the base of the tongue; while the interesting statement is also added that the organisms pass easily through the ordinary epithelial investment of the parts without any erosion of the surface being present.

There are many other forms of bacterial growth which flourish within the mouth and have their headquarters within the tonsils, to which I would like to recall your attention, but to take them individually into consideration is quite unnecessary. One group, however, stands out prominently and might be described as giving rise to the streptococcal throat—a condition where a sharp and sudden fever with

or without rigor and considerable dysphagia, owing to the greatly inflamed condition of the throat, comes to have a remarkable likeness to a diphtherial affection or a scarlatinal throat with pseudo-membranous formation, from the manner in which the mucous membrane in these cases rapidly becomes infiltrated with leucocytes and streptococci, and so simulates the appearance of a false membrane.

In addition to this form, however, we must not forget the less serious staphylococcal throat—the suppurative lesions of which tend to remain localized, and so contrasts with the streptococcal forms, which have no such limitations.

These forms of "infectious" tonsillitis are far from infrequent and give rise to many of the lesions affecting other organs of the body. You have all seen, I have no doubt, some form of cardiac trouble, infectious nephritis, or other disease follow in the wake of a sore throat, and thought little of the relationship between the two as to cause and effect. But now bacterial investigation is beginning to explain these phenomena, and many a case of broncho-pneumonia, purulent pleurisy, various forms of adenitis, synovial affections and acute forms of osteo myelitis, as well as enlargement of the spleen, and other troubles, have been directly traced to one of the several forms of coccal disease by which the tonsils are so frequently affected.

We are now beginning to see that the progeny of tonsillitis forms a much larger family than we once thought, and yet we have not exhausted them, for we have still to mention the convulsive seizures and other forms of nervous troubles which an enlarged Luschka's tonsil may excite in children, as well as the irritating cough and dysphagia with superadded hysterical manifestations, that enlargement of the lingual tonsil is apt to excite about the climacteric time of life.

I am not willing here to state to what degree disordered digestion may be due to enlarged or diseased tonsils. I leave you to speculate for yourselves and draw your own conclusions. I cannot, however, conceive that the constant pouring out from enlarged and diseased crypts of decomposing exfoliated cells and degenerating mucoid material can act otherwise than injuriously in the long run upon the digestive organs, especially in young persons, and so seriously interfere with that part of assimilation which should be at its best during growth and development and when the joy and zest of appetite should be keen.

In regard to taste and smell, repeated observations go to show that these senses are always more or less affected where enlarged tonsils have

existed for some time. This, however, never becomes of serious moment.

Such is a brief epitome of some of the troubles to which the tonsils may give rise in one way or another in disease. I have not attempted here to consider more than the bare facts—any detailed consideration of them would have rendered this communication too prolonged. I think, however, you will agree with Dr. Wolfenden in regard to the part played by bacteria when he says that "the pathological enlargement of the tonsil in which a chronic process of catarrh is almost invariably present in the lacunæ or crypts, forms not only the best culture medium for a large number of micro-organisms, but gives them the opportunity of invading and affecting the system. Whether micro-organisms reach the tonsil by the circulation or, what is more probable in the vast majority of cases, through the mouth, chronically enlarged or catarrhal tonsils are a source of danger to the individual, forming one ready mode of access to the general system for micro-organisms. The treatment of such cases is obvious."

For my own part, I may add that I think I have given you sufficient reason why such pathological enlargements should be treated radically for other causes; and, in conclusion, I would emphasise the statement that, when once it becomes necessary, the sooner it is done the better, for it is then much less likely to be followed by secondary troubles that in many cases can only be partly relieved at a later period.

ANÆSTHETICS IN MIDWIFERY.*

By J. J. CAMERON, M D., Antigonish, N. S.

Shortly after their discovery in 1846, anæsthetics were used in midwifery as well as in general surgical practice, and from that time to the present day. Yet after so many years of experience there seems to be room for discussion, and there is not that unanimity of opinion as to the *value* and *choice* of anæsthetics in midwifery one would expect to find in the consideration of a question so pregnant with clinical data. There are yet some who dispute the value of anæsthetics in midwifery operations, and question the right to use them in certain cases. In the early history of anæsthetics, Rainsbotham, who was, perhaps, the best exponent of the obstetric art in his day, took this view and deprecated the use of anæsthetics in midwifery. Sir James Simpson, to whom belongs the credit of having been the first to administer ether during labour, and also of having discovered the value of chloroform as an anæsthetic in midwifery cases, took the opposite side and shewed that in many departments of midwifery anæsthetics were of undoubted practical value. The objections raised in Sir James Simpson's day are now largely regarded as specious, and anæsthetics are known to be of practical value in most midwifery cases, in eclampsia and in certain irregular labour pains.

The question of the *choice* of the anæsthetic, though, is not yet quite settled. In considering this question, information touching the relative safety of the various anæsthetics is of course important. The available information is based upon the records of clinical experience. "Despite all records and every precaution the unexpected will sometimes happen, and to the end of time there will, in all probability, be an occasional death from anæsthesia." Looking over the surgical records we find that in the year 1891 the German Surgical Society, comprising sixty-six European surgeons, reported 23,000 cases to whom chloroform had been administered; with six deaths, or one death to 3,776. The most recent statistical table on the subject of anæsthetics is that prepared by Dr. Gould. In this table there are included 638,461 administrations of chloroform with a total of 170 deaths; 300,157 administrations of ether with a total of 18 deaths—giving a mortality in chloroform anæsthesia

* Paper opening discussion in Midwifery at meeting of Medical Society of Nova Scotia, Pictou, July, 1897.

of 1 in 3,749 and in ether anæsthesia of 1 to 16,675. Many years ago Dr. Richardson, of London, placed the number of deaths from chloroform as 1 to 3,000. If we admit that the question of safety dominates all others, we are forced by these records to the conclusion that ether, in surgical practice at least, should at all times be preferred to chloroform.

If, however, *safety* were the *only* consideration, nitrous-oxide would be the anæsthetic used, as it is the safest of them all. In proof of this the *Lancet* commission for the clinical study of anæsthetics collected 17 deaths as having occurred during the administration of nitrous-oxide gas, giving the mortality from this drug as much less than from ether —being not more than 1 in 5,000,000. As a matter of experience we know nitrous-oxide, altho' the safest, is not the agent used either in midwifery or in general surgical practice. Thus the claim of *safety* has certain limitations.

In this connection it is hardly necessary to mention the minor anæsthetics, such as bichloride of methylene, pental and ethyl bromid. On account of their depressing and erratic action and the difficulty of getting them pure, they may be dismissed from the list of anæsthetics practical in midwifery.

The mixtures of chloroform, ether and alcohol, such as the A C E mixture, have been employed, but are more dangerous than the drugs of which they are composed, and should be discontinued. The plan of beginning with one anæsthetic and continuing with another is very different to giving the two simultaneously, and is a method rather to be commended.

In midwifery, then, we rely almost entirely upon ether and chloroform. Each has its votaries, careful observers on either side claiming pre-eminence for the one of his choice. Whether we choose ether or chloroform must depend upon the character of each particular case—whether we need prolonged anæsthesia for the purpose of performing an important operation, or whether we are using it for a short time, or merely to lull the sensibilities and make the pains more tolerable. There are certain specific rules that guide us in making the choice. Except in cases requiring prolonged anæsthesia, such as version, difficult forceps operations, etc., chloroform should be preferred. Both ether and chloroform are to be given subject to the restrictions that obtain in ordinary surgical cases, as for example, in organic disease of the heart and lungs. Ether should not be given in organic brain disease—including tumour—nor in atheromatous blood-vessels. Chloroform should not

be given in anæmia of the brain. Hare says that total muscular relaxation should never be caused by chloroform. Its employment is indicated in Bright's disease, owing to the fact that anæsthesia may be obtained by so little chloroform that the kidneys are not irritated, whereas ether, on account of the large quantity used, would irritate these organs. In cases of aneurism and atheroma, where the shock of an operation would be greater without than with an anæsthetic, chloroform should be employed, since the greater struggles caused by ether and the stimulation of the circulation and blood-pressure might cause vascular rupture. In bronchitis, too, chloroform is to be preferred.

For some unknown reason parturient women seem able to take chloroform with more safety than men or women under ordinary circumstances. (Hare.) This is a clinical factor that physicians who habitually administer chloroform during labour realize. The excitement of labour in some way guarantees the system against the deleterious influences of chloroform, and this might be a plea for the general use of chloroform in labour cases. However, this is said not to be absolutely correct, since death has occurred under the anæsthetic use of chloroform during parturition. As already hinted the unexpected will sometimes happen to the end of time, and one swallow does not make a summer even if that swallow is of chloroform. It may be that the view which attributes special safety to chloroform in obstetrical cases took its origin from the fact that the customary obstetrical position in England and in America is upon the left side. This is said by Buxton to be the correct physical and physiological position in its administration. He thinks that every patient should be placed upon the left side while chloroforming him. "The tendency to heart-failure and to respiratory failure is lessened during the parturient act owing to the fact that the uterine contractions are constantly driving the blood to the brain through the heart; and again the efforts of the parturient necessarily entail free oxygenation of the blood." (Grandin and Jarman.) It has seemed to me that perhaps the restrained breathing caused by labour prevents the taking of large quantities of the drug into the lungs, and that allowance should be made for greater admixture with atmospheric air, more rapid diffusion and more speedy elimination. At any rate we know that chloroform acts more freely and is more agreeable than ether, and as simple anæsthesia is all that required in the great majority of midwifery operations chloroform will be found more convenient, is more easily managed and leaves no marked after effects. Ether, on the other hand, is safer, and insensibility under its use more prolonged.

It is a remarkable fact that chloroform is much less lethal in hot climates than in colder regions. In India, South America and the States along the Gulf, it is much more commonly used than ether, and with alleged freedom from ill effects. A plausible explanation of this is that at high temperatures chloroform diffuses very rapidly and consequently escapes from the blood and lungs with extraordinary rapidity.

In most of my own cases of normal labour, I give small doses of chloroform towards the end of the second stage, first, because I believe chloroform to be the best obstetrical anæsthetic, and, secondly, because it gives comfort to the patient. Under its use the woman remains conscious of her surroundings, and at a moment's notice I am enabled to relieve her of its influence, and yet accomplish a number of desiderata. We take the edge off the suffering, so to speak; we abolish in a measure reflex excitability: we assist in the relaxation of the muscles of the pelvic floor, which otherwise would have to yield to the pressure of the presenting part; and we are even enabled to relieve spasm of the uterine muscle. An anæsthetic, with some exceptions, should not be given during the first stage, nor after the birth of the child. "As a rule, obstetric anæsthesia is called for only when the presenting part reaches the pelvic outlet. Then is the time when abolition of the contractions is desirable, for the double purpose of saving the woman the intense agony of the final expulsory act, and the integrity of the muscles and fascia which form the diaphragm of the outlet."

Indirectly, I have, I think, proven that chloroform is the obstetrical anæsthetic par excellence, as ether is the surgical anæsthetic. I have not, however, lost sight of the consequent truth that caution is necessary in giving chloroform in large quantities except in cases of violent puerperal convulsions and other critical conditions where promptness is important. It is a depressant to the circulation, lets go its hold much less rapidly than ether, and has a tendency to accumulate in the brain tissues. Lauder Brunton in a recent publication says: "If we drive chloroform into the trachea or air heavily laden with chloroform into the lungs by artificial respiration it will be absorbed in sufficient quantities to paralyze the heart."

A VISIT TO THE WILLARD PARKER HOSPITAL.*

By M. A. B. SMITH, M. D., Dartmouth, Class Instructor in Practical Medicine and Lecturer on Therapeutics at the Halifax Medical College.

Although the Willard Parker Hospital is not entirely a diphtheria hospital, and while I intend to say a word of its bacteriological department, the management of diphtheria there has led me to write a short paper on this visit.

Soon after arriving in New York I attended an interesting lecture on Classification of Infectious Diseases by Dr. Hermann H. Biggs, Chief Bacteriologist of the Board of Health of New York. Dr. Biggs, it will be remembered, read an exhaustive paper on "Preventive Medicine in the City of New York," at the Montreal Meeting of the British Medical Association in September last. In this classification the professor divided infectious diseases into: 1. Contagious. 2. Communicable, non-contagious. 3. Wound. 4. Infectious non-communicable. Among the communicable non-contagious diseases, with tuberculosis, cholera and typhoid fever, he placed diphtheria. After hearing this lecture I called to see him, and he kindly invited me to visit the two chief Bacteriological Laboratories of the Health Department; one at the Willard Parker Hospital, the other at the Criminal Court Building.

The Willard Parker Hospital is situated at the foot of East 16th St., close to the East River, and is well located for the isolation of infectious diseases. Cases of diphtheria and of scarlet fever in New York, which it is thought best to send to hospital, are removed to this institution. Besides this department it contains a large hospital and research bacteriological laboratory. Here tests are made on guinea-pigs and rabbits for the diagnosis of rabies; and tests of laboratory products, diphtheria antitoxin, tetanus antitoxin, etc., and numerous experimental investigations relating to the infectious diseases are carried on.

I first had a talk with Dr. Biggs. I said: "Since you classify diphtheria as one of the non-contagious diseases, do you quarantine diphtheria cases, as we do in Halifax, by placing a watchman on guard day and night before the house in which the disease exists, to prevent people going in or out?" He replied that he considered that kind of quarantine worthy of the middle ages, but not of this. I asked him if the

* Read at meeting of N. S. Branch British Medical Association, Dec. 18th, 1897.

board or health placarded each house in which the disease occurred so that it would be made conspicuous. He answered that they did nothing of the kind. I said: "Then do you, when you disinfect the house, remove the paper from the walls and destroy the furniture?" He replied: "I should not think it necessary to remove the paper from the room in which there had been a case of diphtheria." "But," I said, "with the utmost care as to disinfection, I have found the disease reappear in a house four and five weeks after even the elaborate disinfection I have referred to had been practiced." Dr. Biggs then went on to say that he believed this continued infection was chiefly due to the persistence in the throat of the convalescent patient, of the Lœffler bacilli. These might remain in the mouth for many days after the signs of the disease had disappeared. In twenty-five per cent. they persist for three weeks or longer. They might remain there for six weeks. These germs are conveyed to the well by the use of spoons and forks or perhaps slate pencils. They might be received on handkerchiefs or towels, toys, books, etc. Kissing was a ready way of their conveyance. He stated he believed there was insufficient evidence of the diphtheria bacillus being conveyed directly through the air from one person to another. What he considered to be necessary was that the patient should be isolated and the apartment placarded—and that the utmost care should be taken as to the disinfection of the discharges just as in typhoid fever. Further, that every child of the family in which the case occurred should be immediately immunized with 250 units of antitoxin. This immunization would last for a month. In addition, these children should be prevented from going to school, as, even while they were themselves immune, they might have diphtheria germs in their mouth and throat. In every instance in which a culture proved the diagnosis of diphtheria, at the end of ten days a secondary culture is made by the attending physician or district medical inspector, to determine whether the diphtheria bacilli are still present in the throat; and subsequent cultures are made at short intervals until the examinations show that the organisms are no longer present. The convalescent patient is kept strictly isolated from the well till examination proves this.

I then visited the diphtheria ward, a white protecting gown having been given me, as well as to the other members of the house staff. I made the following notes of the method here practiced of treating diphtheria. Of course, the antitoxin is administered, usually about 1500 units, immediately on the entrance of a diphtheria patient. Its power

for good is very greatly lessened after the fourth day of the disease, but still it is given in all stages. It is administered with an Edson antitoxin syringe, in the side, below the nipple. The syringe consists of a rather large graduated glass cylinder tapered to a point at one end, on which fits, upon the ground glass tip, an ordinary hypodermic needle. The piston is covered by a piece of rubber tissue sheeting, which is drawn over the piston each time it is used, before it is driven into the cylinder. This cylinder can always be kept sterile. The patient is usually given a calomel purge. If there is dyspnœa, before it becomes severe, intubation is performed. There were two or three little intubated patients the day I was there. They seemed to be quite comfortable. Whiskey is administered freely, sometimes as much as a teaspoonful to an infant every hour. The very best means of controlling vomiting is found to be lavage of the stomach with plain water. Then

℞ Cerii Oxalat.....gr. x.
Sodæ Bicarb.....gr. xx.

in a pint of milk. The most usual external local treatment of the throat is a linseed poultice. The nares and the throat are thoroughly washed with normal saline solution, in frequency from every two hours to twice a day, according to the severity of the case. The manner of doing this is as follows: The little patient is thoroughly wrapped in a flannel blanket, arms to the side, so that he cannot struggle. About his shoulders is pinned a piece of rubber sheeting, to keep them dry. He is then placed on a table, with a Kelly's pad under the head, to carry off the water. The head is then turned to one side and a strong stream of warm saline solution, from a fountain syringe, is directed first into one nostril and then the other, till they are thoroughly cleansed. Then a stream is sent through the mouth into the throat till it is thoroughly irrigated. This procedure does not, after the first moment or two, seem to distress the patient, and it is very thorough and satisfactory. No other internal local application is made to the throat. No other internal medication is ordinarily given in the acute stage. In fact, I may say in passing, that I was, in my visits to all the hospitals, surprised at the small amount of medicine given in acute diseases. I was impressed with the thoroughness of the method of cleansing the throat and nose. Compared with the swabbing that we have been accustomed to do, which has been so unsystematic and ineffectual to reach the whole surface of the throat and nose, this seemed to me much more reasonable and effectual. The whole treatment of diphtheria here is simple and rational.

Speaking of the success of the recent methods of treatment of diphtheria in New York at the Montreal meeting last September, Dr. Biggs said: "Investigation further shows that a special reduction in the mortality from diphtheria and croup, amounting to nearly 40 per cent., has occurred since the introduction of diphtheria antitoxin with the beginning of 1895. The reduction has taken place in spite of an increase in the number of reported cases of this disease. Up to the beginning of 1895, there had been a steady increase for some years, in the mortality from diphtheria and croup, and for the year 1894 the death rate was higher than from any other single disease, excepting tuberculosis and pneumonia—pneumonia really including a number of different affections."

After thorough cleansing of the hands, and an exchange of white gowns for scarlet ones, we visited the scarlet fever wards. Here the medication seems to be almost *nil*. Either heat or ice is applied locally to the throat. For a case of nephritis with a full, tense pulse, I noticed a prescription of nitroglycerin gr. $\frac{1}{250}$ q. 3 h. and of chloral gr. v. q. 4 h. per rectum. This patient was also given a hot pack at a temperature of 140°.

Dr. Wm. H. Park, Bacteriological Diagnostician and Inspector of Diphtheria, is in charge of this hospital laboratory. Dr. Park kindly showed me the different departments of this laboratory. Examinations are here made for the diagnosis of diphtheria, tuberculosis, typhoid fever and rabies. With regard to Widal's test for typhoid fever it appears that a positive diagnosis may be reached in 50 per cent. of the cases and a probable result in half the remaining cases. Dried blood and blood serum are both used. It is thought that the test may prove satisfactory by the use of dead typhoid bacilli. I was given a few capillary tubes used for the collection of the serum. These I show you. The ends can be sealed with heat or wax. I also show you the form of blister. It is simply a piece of cantharides plaster the size of a ten cent piece, to which, for the protection of the blister, is attached a bunion plaster. The diphtheria antitoxin, which comes from the stable at 154 East 57th St., is tested and bottled here. Of course, the only test of its strength is its effect upon guinea pigs. These, in a large number of cages, together with other cages containing rabbits, I saw in another department. Some were dying, some dead, and some quite lively, according to the immunizing power of the different antitoxins with which they were innoculated.

I have not space to continue the account of this visit, further than to say that I ended a very enjoyable morning feeling that I had visited one of the points in the fore-front of the battle against disease, which is being carried on in New York by very thorough and able men, and that which has been accomplished is but the earnest of that which will be achieved.

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Selected Article.

REPORT ON LEPROSY. INVESTIGATIONS IN INDIA AND EGYPT.

By Dr. GEORGE STICKER, of the University Giessen.
Translated by G. R. J. CRAWFORD, M. D., St. John, N. B.

The bacillus discovered by Hansen in 1871, by its peculiar properties, which serve to discriminate it from those similar and later found micro-organisms—the bacilli of tuberculosis, glanders and lupus—also by its exclusive presence in leprous patients, possesses great, perhaps a decisive importance. in the diagnosis of leprosy.

Up to the present, however, only by analogy can this germ lay claim to be regarded as a direct etiological factor in the disease.

Neither artificial culture experiments nor actual transference of the bacilli to animals or man, have as yet succeeded. The question as to whether lepra is propagated by inheritance or contagion, must therefore be decided without the positive aid of either culture or inoculation experiments. Two facts, however, should have long ago settled the contention between the advocates of these diverse opinions.

First, leprosy shows a greater tendency, in family lineage, to decline or extinguish than to preserve or propagate itself through future generations.

It dies out if the younger generations, with their leprous parents, are brought at once, and are permitted to grow up under, more favorable life conditions.

The leprous Norwegian who wanders into North America, there begets children and grandchildren who remain sound and healthy.

Children remain for the most part exempt from leprosy if they are sufficiently early taken away from the diseased parents, and especially from leprous surroundings. The Indian Leprous Commission of 1893 has anew set forth, and with considerable stress emphasized, this fact. It might be also remarked that the experiences of this commission were directly opposed to the old idea of heredity being an important factor in the spread of this loathsome disease.

Second, leprosy can appear in persons, with best family histories, when such individuals have had long residence and close intercourse with those afflicted with the disease.

The unobjectionable observations of Dr. Hawtry Benson, and the mournful example of the heroic Father Damien, besides hundreds of others quite as well known, go to establish beyond doubt this second proposition. Those positive results naturally go farther in proof of its contagiousness than the negative fact, which is equally true, that thousands who have been subjected to those influences have escaped infection. Unquestionable is the fact of the infection of whole masses of people with lepra in historic times. The Southern States of the North American Union, the tropical regions of America, many stretches of land in South Africa, New Zealand, and numerous islands of Polynesia, *knew nothing* of the plague, which at present rages among its natives and colonists, before the last few decenniums or centuries.

This fact speaks with certainty of the wide diffusion of the germs—and with great probability of its contagiousness, of which latter fact, neither Moses in bible history, Galen or Aretæus, in classic ages, nor the more modern investigators Cullen and Forest, seemed to have the least doubt of the way in which the probable "excitor" or germ of leprosy *leaves* the diseased organism, and the locality where it first affects the healthy organism. After the sifting of present facts, little more has been discovered than was given more than 1900 years ago by that as yet unsurpassed presentation of the subject by the great Aretæus of Cappadocia, in which he states that the spread of leprosy takes place by means of the respiratory tract. This author held elephantiasic or tubercular leprosy to be a general disease whose primary affection or lesion was hidden.

The discovery of the bacillus of leprosy by Hansen, and the probable theory of the spread of the disease, has had the effect of drawing the attention of investigators to the discharges of leprous subjects, in order to obtain an idea as to the location from which those discharges most constantly and most abundantly proceed, and thus to estimate the greatness of dangers and risks from the intercourse of healthy individuals with those suffering from this loathsome affection.

The Hansen bacillus has been found in the contents of skin tubercles, in the blood of the diseased tissue, in the serum of blisters artificially produced, in sweat, in urine, in semen, in sputum. In this way has been demonstrated a constant throwing off of the bacilli to the outside world.

To ascertain or trace the way by which these germs enter into the system, many recent attempts through inoculation experiments in the skin, the nerves and the different cavities of the bodies of animals have hitherto failed ; as have the older innoculations of a similar kind in the human subject.

So the most important question in the pathogenesis of leprosy, viz: the entrance locality of the excitor of the disease into the healthy organism, still remains unsolved.

However, this does not change the suppositions and conjectures from the standpoint of analogy, that probably in wound of the epidermal tissue, or the open ducts of the sebaceous glands, the hair follicles, the sweat glands and perhaps the uninjured mucous membrane of the respiratory tract, the first collection or colony of leprosy-exciting germs secures entrance.

During my stay in Bombay, as one of the Indian Pest Commissioners, accompanied by R. Koch, the leader of the German delegation, a visit was made to the Lepra Asylum of Mantua.

As we passed through the long rows of patients, this gentleman gave his opinion as to the infection danger in these cases.

He believed that the greatest risks were from those patients suffering from recent tubercular leprosy. In contrast with those cases of the so-called "heilform" or stationary and nervous leprosy it might be said that the recent tubercular cases were alone dangerous.

In his institute in Berlin, Dr. Koch found in one of his patients affected with tubercle of the nasal mucous membrane, an immense quantity of lepra bacilli ; this gave rise to the suspicion that the numerous leprous patients with signs of nasal obstruction, hoarseness, etc., threw off bacilli from the tubercles of the mucous membrane of the nose, upper air passages, throat and bronchial tubes, in great abundance, and of a virulent character, and therefore such patients should be specially isolated from healthy individuals, and even from those leprous patients suffering from the milder forms of the disease.

The opportunity of investigating what in Germany was practically to me a strange disease, was sufficiently enticing. Therefore, when my work was completed as a member of the Pest Commission, the remaining six weeks of my stay in India, and afterwards on my return journey, for some weeks in Egypt, I devoted myself diligently to the study of this disease, hoping incidently to prove, if possible, the correctness of the observations of Dr. Koch, just referred to.

In the following two propositions I have thrown together the results of my investigations.

1. The part from which in all leprous patients, during the longest period of their disease, the lepra bacilli pass (regularly and for the most part in enormous quantities) to their surroundings, is the nose. Besides the nasal excretions, sometimes, though comparatively seldom, comes the sputum and broken down skin tubercle in consideration, as bacilli-carriers; the remaining discharges of the leprous patients fail to be of any practical importance in the sense of the infection carriers.

2. The part of the healthy body first attacked, perhaps without exception the first, is the anterior section of the nasal mucous membrane, mostly the mucous membrane of the cartilaginous part of the septum.

Leprosy sets its primary impression upon the nasal mucous membrane, as does chronic glanders. It is primarily a nasal disease in the same sense as syphilis is at first a primary disease of the sexual organs, or as tuberculosis is at first a primary disease of the apex of the lungs.

The proposition referring to the importance of the nasal excretions as infection-carriers in leprosy is founded upon the investigation of the nasal mucous membrane of 143 lepers. Of those 143 cases, 57 suffered from tubercular, 68 from nerve, and 28 from the mixed form of the disease.

In the 57 cases of tubercular leprosy, in only *two* cases were nodules found in the nasal mucous membrane. Sometimes no change of any kind was discovered, or so insignificant that only the most accurate examination could prevent them from being overlooked. Mostly, however, as I shall afterwards specially refer to, there were found deep destructive processes, which presented somewhat the picture of syphilitic ozœna, and which would be very liable to be mistaken by the superficial observer for that disease.

If I had in my investigations of the nasal excretions only included those cases with tubercle in the nasal mucous membrane, my work would have been very quickly ended, and practically without result.

The systematic examination of the nasal contents in all patients, without regard to the presence or nature of local changes, resulted as follows:

Of 57 patients with tubercular leprosy, 55 had lepra bacilli in the secretion which I removed with a catheter from the diseased or apparently healthy places of the cartilaginous septum, the floor of the nose, or merely collected from the secretion which sometimes freely flowed through the anterior nasal passages.

In the two patients in which the bacilli in the nasal excretions were absent, the first had showed no indication of the progress of the disease for seven years.

In this patient there was on the nasal septum a flat ulcer, with a rough floor and scanty purulent discharge.

The second patient had likewise observed no progress of the disease for years, and showed only a few dried up tubercles on the buttocks and legs. The nasal mucous membrane showed widespread atrophy and the scanty purulent secretion contained ordinary diplococci in abundance.

Of the 68 cases of nerve lepra, 45 had bacilli in the nose. Of the 23 patients without bacilli, in all, with the exception of four, in the last number of years no apparent progress of the disease was observed.

Among the 28 with the mixed form of leprosy, the bacilli were found in the nasal excretions of 27. The exception was a lad of 12 years of age, with a few not very characteristic tubercles on the legs and a single anæsthetic spot upon the upper part of the thigh.

Altogether, in 153 leprous patients, the bacilli of Hansen were found in 128 cases in greater or less abundance in the nasal discharges.

From the results I have already attained, and from further investigations which will be reported later, the view becomes more distinctly impressed upon me, that the nose not only is the part out of which the lepra bacilli regularly, and in all stages, pass from the body of the diseased individual, and, under special conditions, find their way into the healthy organism, but at the same time it is the part in which regularly the first infection takes place; that in the nose the primary affection is to be found, which during the long years of the incubation stage of the disease, is often, in spite of numerous symptoms, overlooked by both patient and physician.—*Münchener med. Wochenscrift, Sept., 1897.*

THE

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Editorial.

IN OUR TEENS.

In wishing our readers a very happy and prosperous New Year, we desire it to be noted that we begin a new year with the New Year, and that we are now in our teens. As far as "the editorial we" are personally concerned, we have ceased to expect much happiness in the sanctum chair, and we might as well "fess up" that we don't know what prosperity is, but we are still hopeful for ourselves, and have not become so spleened by the buffetings of the world but that we rejoice in the happiness and prosperity of others. It is, therefore, with the utmost cordiality that we extend the season's greetings to our subscribers, advertising patrons and exchanges.

During the year now past, we have met with some encouragements—and some discouragements. We have added materially to our list of subscribers, and have been favoured with the patronage of several firms who had not previously placed advertising with us. On the other hand, we have not had so generous an interest shewn in the department of our journal entitled "ORIGINAL COMMUNICATIONS" which we had hoped for. Our desire is to make the NEWS thoroughly representative of the thought and opinion of the medical men of the Maritime Provinces. We wish to be the medium through which the world may learn that we physicians of Nova Scotia, New Brunswick and Prince Edward Island are not sluggards, and that our place in the onward procession is well towards the front. As this is but subservient to the interests of the profession, we feel that we ought not to lack support, and as we enter our teens we again appeal to our friends to lend us the helping hand we most need—the benefit of terse accounts of clinical experiences, and of the concepts born of mature deliberation.

We will endeavour during the year 1898 to make the NEWS more interesting and more valuable than it has been in the past. We ask,

though, the lenient consideration of our deficiencies—which we acknowledge to be many. But the publication of the NEWS is wholly a labour of love. As a commercial venture we are not a success, and we continue to exist in order that the profession in the Maritime Provinces may not be without an organ. Under the circumstances, then, are we presumptous in feeling that we are deserving of encouragement, and should be subscribed to and contributed to by every physician in our constituency?

THE VICTORIAN ORDER OF NURSES.

The NEWS has been asked why it has not made editorial reference to the scheme, proposed by LADY ABERDEEN, of commemorating the diamond jubilee of our gracious sovereign by establishing an order of nurses to provide attendance upon the ill who, by reason of impecuniosity or of isolation from the centres of habitation, are at present unable to benefit by the skill and the experience which the trained nurse takes with her into the sick-room. Our answer to the question perhaps discloses a weakness. Our attitude towards the movement has been one of passive neutrality. The "scheme" has, until quite recently, been so little evolved, that we felt indisposed to "take sides," but preferred to remain neutral until it could be decided just what the proposed order should accomplish.

And we are still neutral. We are very glad to testify to our admiration of LADY ABERDEEN, and to commend the goodness of heart which has prompted her excellency to promulgate an institution which aims at the amelioration of suffering and the increase of the home-comforts of the sick poor. But we respectfully submit that her excellency should have been advised by those who know more than herself of the ways of our people, and of the difficulties which would have to be overcome before so elaborate a scheme could be made practical. We are quite willing to suppose that no slur was intended, altho' there certainly seemed to be an implication, in the preliminary circular, which stated that Canada needed more Dr. MacLures than she has. But the sympathy of the medical profession on behalf of the order is not to be gained by the importation of an American physician to expatiate upon the necessity for an order of nurses—a matter upon which he is not half so well qualified to speak as many a Canadian practitioner who has gone through scores of experiences which would thrill the pen of Ian MacLaren as it has never yet thrilled, whose knowledge of the state and needs of the "country" folk is perfect, but whose opinion

is unasked. The persistence with which LADY ABERDEEN has pressed for the accomplishment of her suggestion, in spite of very little encouragement and very much opposition, is admirable. Perhaps she has never before shown so much strength as in her present determined effort to organize an institution of proportions stupendous enough to awe the most experienced financier. But that her plan may succeed, she needs and must have the earnest co-operation of those members of the medical profession who are best acquainted with the habits and the requirements of the people to whom her excellency wishes to extend the benefits of a nursing order. Those physicians whose practice is among the wealthy and the aristocratic; those earnest clergymen whose acquaintance with the poor may be intimate, but is far less intimate than that of the "average" practitioner; those good women whose talents demand wider reaches than the home circle allows, and who throw themselves impetously into any and every scheme which promises a fair field for usefulness—they may be all very pleasant and very congenial associates, but they can never advise so well, in a matter of this sort, as could a committee of shrewd, plain-going physicians, whose vocation brings them into close association with, and thus gives ample opportunity for observance of the needs of, the poor.

The original suggestion, as outlined in the first newspaper advices, was quite impracticable, and did not receive the support of any in the profession save a few whose acquaintance with the promoter forbad opposition on the score of diplomacy. Since then numerous modifications have been made, which, in the main, have tended to lessen the objections to the scheme held by the medical profession. All these, however, are matters of common knowledge, and need not be again reviewed.

Now there are good features in the scheme, as well as objectionable ones, and it is neither generous nor just in anyone to condemn the project without giving due consideration to the pros as well as to the cons. None can find fault with the motive which has prompted her excellency to advocate an order of nurses. None should oppose a measure which would assure relief to sufferers, be they poor or be they rich. But caution is necessary, and so is a careful consideration of the temper and of the actual requirements of the people. Haste should certainly be made slowly in such a matter as that under consideration.

We think both sides should be advised. Those who favour the establishment of the order should be more willing to concede to the propositions of medical men—should admit the better position of medical men as far as opportunity for forming correct judgements is concerned, and should respect their opinion accordingly. Those in opposition should be careful that their opposition be not merely factious, but that their objections should be well founded. And on the common ground that whatever is a true benefit to mankind is always worthy of support, let there be an earnest, honest endeavour made to adjust varying opinions in such a way that a workable scheme may be evolved—a scheme which will permit of the advantages of skilled nursing being extended to worthy poor people without any interference with the rights and interests of anyone. Surely such is not an impossibility.

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Society Meetings.

SAINT JOHN MEDICAL SOCIETY.

DR. G. A. B. ADDY, Vice-President, in the Chair.

NOV. 24, 1897.—"Post-diphtheritic Albuminuria." This subject was introduced by Dr. Thos. Walker. He referred to the case of a boy aged seven years, who had an ordinary attack of diphtheria which yielded to treatment in three or four days. Eleven days later the child had an attack of acute tonsillitis. For this he was given chlorate of potash and perchloride of iron, and in three days he had recovered. A few days later the child was observed to have a puffy face and complained of pains in the head, and vomiting. There was highly albuminous urine. These symptoms have now subsided, leaving a trace of albumen. This was the first case of marked albuminuria following upon diphtheria that the speaker had observed. The experience of the members was invited and also their views as regards the inflammatory effect that chlorate of potash is said sometimes to exert upon the kidneys. In this case fifteen grains of the salt had been administered daily. The albuminuria would seem to be due to the diphtheritic toxin.

Dr. McIntosh had experienced several cases of post-diphtheritic albuminuria, and hardly considered that there was danger in administering chlorate of potash continuously.

Dr. Inches had never attributed any of his cases of albuminuria to the use of chlorate of potash.

Dr. Daniel had not observed this complication following diphtheria, at least not to the extent of showing dropsy.

Other speakers followed in the discussion.

DEC. 1, 1897.—"Nasal Obstruction." A paper on this subject was read by Dr. J. R. McIntosh, and will appear in a future issue of the NEWS.

Dr. Morrison referred to the necessity of operating on the turbinated bone, especially when jammed against the septum. It was important to save the covering of mucous membrane by dissecting it off, on account of the glands contained in it, which secrete fluid to the extent of twenty ounces in twenty-four hours. This fluid has for its function the moistening of inspired air. The too free use of caustics should therefore be avoided.

Dr. G. A. B. Addy referred to the large turbinate bones in children, which in time diminish in size.

Dr. McIntosh, in closing the discussion, said that the younger the patient the less should one attempt operative procedures on the nose. Nasal obstruction in children under five years of age is rare, except when at the anterior and posterior ends of the nasal cavity.

DEC 8, 1897.—"Leprosy." A case of this disease was shown by Dr. Daniel. The subject was a young man, a mulatto and a native of Bermuda. He had not been out of his birth place until recently, when he came to St. John. The disease was of the tubercular variety, the increased folds of the skin of forehead, thickened nose and tubercles were noticeable, while there were also pigmented anæsthetic areas on the legs.

"Migraine." Dr. Olding read a paper on this subject. The frequency in women was referred to. The chief causes, such as gastric disturbances, constipation, emotion, fatigue, gouty and rheumatic conditions, and eye, ear and nose conditions, were discussed and their appropriate treatment suggested.

Dr. Daniel thought the stomach was commonly responsible for the attack.

Dr. Bruce referred to the effect upon the eye such as glimmering. One pupil may become dilated, and occasionally the attack is accompanied with loss of hearing and sight. Iron and arsenic are of great benefit.

Dr. Crawford considered that vitiated atmosphere was an important cause.

Dr. McIntosh spoke of ocular defects and of tobacco as causes of migraine.

Drs. Mott and Inches referred more particularly to the important part that gastric disturbances play in this ailment.

DEC. 15, 1897.—"Leprosy." Dr. Crawford read a translation that he had made of a recent and interesting paper by Dr. George Sticker, of Giessen, Germany, and which appears elsewhere in the present issue. The reference to the important part considered to be taken by the nose and nasal mucus is especially interesting.

Dr. J. Berryman referred to the late International Leprosy Conference which held to the contagiousness of leprosy, although expressed with great moderation. Leprous rhinitis was also discussed. The tubercle bacillus may be distinguished from the leprous bacillus, which it resembles very closely, if plain watery solutions of the dyes are used for straining, i. e., solutions free from aniline, oil or phenol. The lepra bacillus stains with a watery dye quite as well as with one containing a

"mordant," and retains the stain under treatment with acid. The tubercle bacillus stains only with a dye containing a mordant.

Dr. March discussed the characteristics of leprosy, quarantine regulations, and the disease as it is in Hawaii.

Dr. Morrison referred to emigrants from Iceland, China and Russia, who had carried leprosy into the North-West of Canada.

Dr. MacLaren stated that leprosy is known to have existed in New Brunswick for about eighty-one years, that it is practically confined to a district of about forty-five miles of sea coast on the north shore, and that the French, with about ten exceptions, none recent, have been the entire sufferers. It may be estimated that there have been about 230 cases of leprosy up to 1888.

The speaker urged that in addition to the present plan adopted, of segregation in the lazaretto, for eliminating the disease, that the houses in which leprosy had developed among the inmates be destroyed and replaced by the Dominion Government. This could readily be done, as the houses are of a very modest description, their number quite few, and the expense would be very moderate. Leprosy in New Brunswick is diminishing, but very gradually.

Dr. G. A. Addy exhibited stained specimens of Hansen's bacillus which he had obtained from the nasal mucus of the Bermuda case. He also obtained them from tubercles of the face.

NOVA SCOTIA BRANCH BRITISH MEDICAL ASSOCIATION.

Dec. 3, 1897.—Dr. Goodwin reported a very interesting case of progressive muscular atrophy. (Report of case will appear in the next issue of the NEWS.)

Dr. Doyle reported four cases of malignant disease of the stomach, giving a very detailed account of the progress of each case while in the hospital.

The pathological specimens of the same were shown and explained by Dr. Hattie.

Remarks were made on these cases by Drs. Farrell, M. A. B. Smith, Murray, and others.

Dr. M. A. B. Smith then read an account of a visit to the Willard Parker Hospital. (This paper appears in the present issue of the NEWS.)

A prolonged discussion followed on the methods adopted in the above hospital, as well as on the care of diphtheria cases in this city, Drs. Farrell, Jones, Chisholm, Walsh, Trenaman, and others taking part.

Dec. 17, 1897.—A letter was read from the Hon. Secretary of the Jamaica branch in reference to yellow fever in that locality. It was decided that the communication be acknowledged and that the matter come up for discussion at a future meeting.

Dr. Hattie showed a specimen of tubercular ulceration of the bowel and a gall-bladder packed with gall stones from the same patient.

Dr. Doyle said that this patient came to the hospital suffering from uncontrollable diarrhœa of two months duration. As much as one half a grain of opium was given three times a day without producing any result. The patient died one week after admission. There was no history pointing to any affection of the gall-bladder excepting some tenderness over that region, but no tumour.

The discussion on "Typhoid Fever" then ensued.

Dr. Chisholm, in opening, said that his mind reverted to the fact that nearly every year this subject had been before the branch for discussion. Taking the subject up, he found it to be both a large and a small one—too large for any one speaker to deal with exhaustively, and a small subject on account of so much already said and written. He thought better just to refer to one or two features. The typhoid germ gains entrance chiefly through the mouth, and then takes possession of the mucous membrane of some part of the alimentary tract, and the ptomaines so produced must circulate through the portal circulation. If there is any value to be derived from antiseptic remedies, we must destroy the germ in the mucous membrane. But the poison has already entered the portal circulation, and we cannot expect to kill the germ by the use of any antiseptic that we may administer. If, though, we can not kill locally by remedies that get into the portal system, we can inhibit the growth of the germ.

He then referred to the theories of Osler. Dr. Chisholm had been in the habit of using internal antiseptics. Facts must tell and experience be our guide. If we find a certain line of treatment working well, we are justified in holding to that treatment. He had been in the habit of using carbolic acid and chloroform—two minims of the former and half a dram of the latter—in syrup of orange and water, every four hours.

He had frequently seen the temperature become normal in a fortnight. He knew the method was not original with him, it having been suggested in Australia and India. He believed chloroform was one of the best germicides for the typhoid germ. The antiseptic treatment is a wide one, many ones having been tried by different observers with

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have been so perfected that they dissolve almost instantly in water, and a tumberful of Lithia Water *of a known strength* can be quickly, easily and economically made by dropping one or more of these tablets into a glass of moderately cold water, producing a pleasant and palatable draught.

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various results. One writer reported the good results of boric acid, ten to fifteen grains three times daily, stating that as a rule the fever and diarrhœa subsides in three to five days,—which seems a little too good. Dr. Cunningham, whom he regretted was not present, is firmly impressed with the good effects of sulphite of soda as an antiseptic, with salol, giving much better results than the expectant treatment. In fact it would be very queer if in this disease we were only in the position of lookers on. The dietetic treatment was of supreme importance and we should in no case, when the temperature was elevated, omit the treatment by cold. The method adapted to private practice was then discussed. As regards dietetics, there is a large amount of nitrogenous elements concentrated in the blood which tends largely to increase the delirium. There is nothing more irrational than the administration of beef tea. It was like banking fires; this point being illustrated by referring to cases in the Victoria General Hospital. We should confine our diet chiefly to milk, and stimulants when necessary. Although he would prohibit beef tea in large quantities, there may be cases where two or three ounces a day may be allowable. He had been sorry for using biscuits with milk, but he had never been sorry for using milk alone. Milk is so very excellent a food, and contains the proper amount of fat, held in emulsion. Flint recommends the giving of fats, on the theory that the fats are more burnt up than the nitrogenous material. There are those who hold that fatty degeneration is caused by excessive temperature, but of late, doubts have been thrown on this idea. He then referred to the deficiency of liquids, and remarked that the sensibilities were blunted if water were kept from the patient. It is questionable if we give half enough water to our fever patients. By its use we get rid of the exudates, and fatty degeneration is not seen. He concluded by remarking that in his line of treatment he gave his fever patients plenty of water.

Dr. Murray said that he also wished to confine himself to the treatment. There were one or two points referring to the hygienic treatment which Dr. Chisholm had passed over. There should be, if possible, the best hygienic surroundings and absolute quietness. There was a liability of the temperature rising from excitement, as seen on a visiting day at the hospital. In private houses a room should be properly prepared with a spring bed, in fact two beds. The bed coverings should be very light and the room should be kept at an equable temperature.

He then referred to the very great importance of thoroughly washing out the mouth with one of the aromatic antiseptics, and the import-

ance of constantly watching the patient, especially on the verge of delirium. Regarding diet, a curd of milk may be as indigestible as meat; a solid curd might give rise to as much mechanical irritation as solid food. The important point as regards quantity was not to overload the stomach. When we find milk curdling we must give it in small quantities, or with aerated waters, or peptonized. To some patients it is indigestible or disagreeable, then we can give it flavored with coffee or caramel. He would give the food in small quantities with great regularity, but would not disturb the patient at night. He would also recommend plenty of water to be given. There was very little dispute as to the efficiency of alcohol; the statistics of the Temperance Hospitals where no alcohol is used, showed from 14 to 16 % of deaths. The only other point he would refer to was that the constipation was often as severe, if not more so, than the diarrhœa. He would combat this by giving calomel in the early stages and saline purgatives later.

Dr. D. A. Campbell, referring to the pathology of the disease, said that for some time past there had been a warm discussion as to the relation between the typhoid bacillus and the bacillus coli communis, but the typhoid bacillus has sufficient characteristics to distinguish it from any bacillus. If these organisms were practically identical, it would shatter many points of treatment and prevention. He then referred to the effect of the bacillus on the blood and the importance of blood serum as an aid to diagnosis. Speaking of the etiology, it has been definitely proved that oysters may play a part in disseminating the disease, the presence of the bacillus having been demonstrated and cases traced to that source. We are recognizing more fully every day that while the bacillus is a factor of great importance, it is rarely of itself the occasion of a fatal result. That the complicated cases, while started by the typhoid bacillus, are continued by the micro-organisms of the pyogenic group, and we can accept the statement that a case, early treated, judiciously managed, and carefully dieted, will do well; but, when not seen early, may die. The simple cases usually recover; the mortality occurring amongst the complicated cases, nearly all being due to secondary infection. Therefore the avoidance of secondary infection should shape our plan of treatment. So far as our knowledge goes, we can not destroy the bacillus after it has once gained access to the tissues. We have no means of obviating secondary infection, but we can counteract the action of the toxines on the tissues, and favour the elimination of the toxines, and thus minimize the risks of secondary infection. As

regards treatment, he spoke of the extreme importance of fresh air and referred to the practice of putting patients in tents. The purer the air and the freer the atmosphere from germs, the less the risks from secondary infection. Rest was also important, physical and mental. All authorities agree that the diet should be liquid, milk being the staple article. The object is to secure a diet which shall be nutritious and digestible, and one that leaves but little residue. The objections to various meat broths are certainly sound, but in practice they seem to vanish, and benefit may result from their administration. All observers are almost unanimous that alcohol should be given in typhoid fever, but at what time in the disease, is a disputed point. Many withhold it in simple cases and use it when indications arise. He favoured its use from the very beginning, no matter how mild the case might be. It has a beneficial effect on digestion and its antiseptic qualities tend to prevent intestinal decomposition. The dose, however, need not be large. Coming to the medicinal treatment, at the very outset it was disputed ground. There were no serious objections made by any observer as to giving mild purgatives at the beginning, but there are many authorities who advocate the careful administration of mild purgatives all through the disease, while others condemn the practice very strongly. This is not a new question, but Murchison's extensive experience settled the question for many years. He then referred to the discussion at the Canadian Medical Association, introduced by Dr. Thistle of Toronto, in which Dr. Osler took part and condemned the practice of giving purgatives very strongly, in a manner which struck him (Dr. C.) as being very dogmatic. He (Osler) stated that he had treated over 500 cases by the cold water method with a mortality of 7%, and if any gentleman could show a like result he might then consider the other's method. Dr. Thistle, who advocated the continuous use of purgatives, reported over 400 cases with a mortality of a shade less than 7%. Dr. Campbell then referred to the use of intestinal antiseptics. Nothing had been said by the previous speakers regarding the use of the mineral acids; they aid digestion and are valuable antiseptics. The importance of keeping the mouth clean and free from germs was then referred to, and if this be done we avoid all complications above the clavicle and some of those that occur in the lungs.

Dr. Doyle said he had looked up the results in the Victoria General Hospital. As far as he could remember about 300 cases showed a mortality of 13.64%. In some years the mortality was high, especially in 1881, while in another year there were 20 cases without a death.

Dr. Campbell said he had gone over 400 cases in the records of the V. G. Hospital and found the mortality to be about 12.2%. He thought that the high rate of mortality in 1881 resulted from a crew of a steamer coming from Philadelphia, all of whom died very shortly after their admission to the hospital.

Dr. M. A. B. Smith referred to the plans of treatment adopted in three of the leading hospitals in New York, the Roosevelt, the Presbyterian and Bellevue. The medicinal treatment at the first named was sulphocarbolate of bismuth and pepsin, at the Presbyterian, salol, whilst at the Bellevue there was no routine medicinal treatment. The Brand treatment was adopted in all three, which they looked upon as their sheet anchor.

Dr. Jones spoke of the importance of prophylaxis, especially as regards the milk supply. He referred to the unsatisfactory conditions of supplying Halifax with milk, and thought that some control ought to be exercised over the farmers in the country. A recent outbreak in Clifton, England, was alluded to, an article from the current number of the *B. M. Journal* being quoted. Dr. Jones concluded by stating that Halifax as a rule was very free from typhoid, most of the cases coming from outside the city.

Dr. Farrell questioned whether we should not call many cases of continued fever occurring from the months of October to December, typhoid; if so, typhoid was common during these months. He then spoke of a number of points in treatment, especially to the value of hygienic and antiseptic measures. If many of the micro-organisms are not on the surface, that does not lessen the value of antiseptics, for some of the germs must be destroyed. He advocated the use of a mercurial purge at the commencement of the disease. He thought it was wise not to depend on any one particular plan, but use both plans and do not depend upon one battery as Osler does.

Dr. Goodwin referred to the use of internal antiseptics, saying that calomel was supposed to be changed into the bichloride. He never omitted to use calomel, and regarded it as of the greatest service.

Dr. Trenaman spoke of the number of cases occurring in the north and north-west suburbs of Halifax, where there was no water or sewers, and the soil was not rocky. He thought that most of the cases came from outside the city.

Dr. Jones moved the adjournment of the discussion to some time in March, when a report would be presented of the cases occurring in Halifax and if possible their etiology.

Dr. McKay then gave a report of a case of villous tumour of the rectum.

Matters Personal and Impersonal.

Dr. H. H. McNally, formerly of the cable steamer Mackay-Bennett, has been taking a post-graduate course "across the pond." His numerous friends will be pleased to learn that he is flourishing and was much pleased with the great advantages obtained in a medical centre like London. The doctor devoted most of his time at Great Ormond Street Hospital for Sick Children and St. John's Hospital for Diseases of the Skin. He recently returned from London and will probably resume practice in Fredericton.

Dr. Norman F. Cunningham has been appointed to the chair of medicine at the Halifax Medical College, rendered vacant through the resignation of Dr. Somers. The work in surgery heretofore undertaken by Dr. Cunningham has been entrusted to Dr. Murdoch Chisholm, who will continue to teach, also, clinical surgery. It is felt that these changes in the faculty will prove to be very satisfactory, and that they will materially further the interests of the college. Professors Chisholm and Cunningham both enjoy the reputation of being excellent teachers, they are accorded a high place in the esteem of their professional brethren, and are very popular with the students. A good account is expected of them, and the college is to be congratulated upon the happy solution of a difficulty which presented itself on Dr. Somers' resignation.

Trusting that it is never too late to extend felicitations, the NEWS steps forward to offer congratulations and best wishes to several young members of our profession who have recently identified themselves with the army of benedicts. Drs. F. S. Yorston and Bret Black, of Truro, A. A. Schaffner, of Lawrencetown, Percy Woodworth, of Kentville, and W. H. Macdonald, of Rose Bay, are each and all young men of excellent repute and professional standing, and will have on their entrance into wedded life, the best wishes of many friends. That much happiness, long life and continued prosperity may be the portion of each, is the cordial wish of the NEWS.

We are indebted to Messrs. E. B. Treat & Co., Medical Publishers, New York, and also to the Newspaper Collection Agency, of Chicago, for tasty calendars for 1898.

In maintenance of its custom, the New York *Medical Record* has issued a winter health resort number (bearing date Nov. 27, 1897), which is replete with interesting information relative to the winter climes best suited to various types of invalids. The enterprise manifested by the *Record* is most commendable, and we trust may meet with the reward which it deserves.

The subjoined clipping from the editorial columns of the St. John *Globe* of Nov. 27, 1897, is of interest, not alone on account of the involvement of a member of our profession, but because of the uniqueness of the case:

"A jury has, after investigation, decided that there is redress for a citizen who, through civic negligence, is deprived of his right to vote. In this case the plaintiff, a professional man, paid his taxes in due time, and, under the law, this gave him the right to vote at an election for Mayor and aldermen. On the day of polling he went to the place where he should deposit his ballot, but as his name was not on the voting list the polling officer could not receive it. An effort was made to get the matter straightened out at the City hall, but through some error or negligence this could not be done and the poll was closed without the citizen having voted. He brought an action against the city. A jury allowed him damages to the extent of one hundred dollars. Whether this verdict will stand in law or not remains to be seen, but it is evidence, at least, of the value which public opinion as represented by a jury places upon the right to vote and emphasizes the view that the civic authorities should safe-guard carefully the trust committed to them in regard to the civic franchise. When the Common Council makes provision that a man cannot vote unless his taxes are paid by a certain date it is bound in equity to protect the voting rights of the man who does pay his taxes, and it deserves to suffer if by failure on its part the citizen is deprived of his right. The action will probably cost Dr Crawford a good deal more than all the damages which he will get, but it is in the assertion of individual rights by men who have the pluck and boldness to do so that public interests are served. Eternal vigilance is necessary to individual freedom."

The NEWS is under obligations to the trustees and faculty of Bellevue Hospital Medical College for a kind invitation to be represented at the laying of the corner stone of the new college building, which took place on the thirteenth of November last. It will be remembered that the college suffered severe loss by fire some months ago, and the new building is being erected to make good that loss. And it does more, for the new building will be both more commodious and better adapted to the

teaching of medicine than was the old building. We trust that, with the opening of the new building there may come a new lease of life to Bellevue, and that she may have a future no less glorious than her past has been.

The *Medical Times* celebrated its silver anniversary in December by issuing a very creditable special number enclosed in an artistic and appropriate cover.

A beautifully illustrated pamphlet entitled "The Lofoten Islands and their Principal Product" has lately been issued by Messrs. Parke, Davis & Co. A well-written history of the cod-fishing industry in that region is instructive reading to all physicians. The improved cod liver oil, as put up by this reliable firm, is not made by the old and odorous process. Instead of waiting till the fishing season is over, the livers, fresh, clean, and select, are bought daily from the fishermen, and immediately transferred to their oil-refining factory on board a vessel specially equipped for this purpose. Messrs. Parke Davis & Co. will gladly send a copy of this pamphlet to any of our readers who may request one.

The calendar issued by the Antikamnia Chemical Company last year attracted considerable attention on account of its originality, and we are pleased to see that "Skeleton Sketches" are continued this year. The present series is a credit to the designers, the figures represented being picturesque in their grotesqueness. Any physician who has not received this unique calendar may secure a copy by enclosing his printed card or prescription blank to the Antikamnia Chemical Co.

Book Review.

INTERNATIONAL CLINICS.—A Quarterly of Clinical Lectures on Medicine, Neurology, Surgery, Gynæcology, Obstetrics, Laryngology, Ophthalmology, Pharyngology, Rhinology, Otology, and Dermatology, and specially prepared articles on treatment. By Professors and Lecturers in the leading Medical Colleges of the United States, Germany, Austria, France, Great Britain, and Canada. Edited by Judson Daland, M. D., Philadelphia; J. Mitchell Bruce, M. D., F. R. C. P., London, Eng.; and David W. Finlay, M. D., F. R. C. P., Aberdeen, Scotland. Volume III, seventh series. Published by J. P. Lippincott Co., Philadelphia; Canadian Representative, Charles Roberts, 593A Cadieux Street, Montreal.

This volume contains articles of a very practical character and is fully up to the standard of those previously reviewed. The wide sphere covered by the many different departments, enables all searchers after medical wisdom to gather something that will be helpful in the turmoil of active practice. Such chapters as Hæmoptysis and its Treatment, by Mays; the Treatment of Tuberculosis, by Bridge; Hæmaturia, by Tyson; Practical Points in the Diagnosis of Inherited Syphilis in Infancy and Earliest Childhood, by Samson; Muscle Failure of the Heart due to Chronic Alcoholism, by Steell; Therapy of Suppurative Kidney, by Manley, are a few of the articles containing material of great merit. The editors deserve special praise in selecting material that will prove most useful to the busy practitioner.

THE CARE AND FEEDING OF CHILDREN.—By L. Emmett Holt. Second Edition, 104 pages. Price 50 cents. Published by D. Appleton & Co., New York.

This little book is written in the form of a catechism, and is intended for the use of mothers and children's nurses. It contains much useful information, plainly and tersely presented, and is a book which the physician who is acquainted with its merits will gladly recommend to those who have to do with children. Careful instructions are given upon the care of the new-born babe, and upon the preparation of artificial foods. A list of foods allowable and of those not allowable is provided, as is also a series of formulæ for food productions. The symptoms which should lead to the suspicion of the development of the infectious and other acute diseases of childhood are mentioned, and simple instructions given as to what may be done pending the doctors arrival.

THERAPY OF THE CLINICS OF THE ROYAL AND IMPERIAL HOSPITAL OF VIENNA.—Translated and Revised with notes from the last two compilations of Earnest Landesmann, M. D., formerly Second-Assistant of the Vienna Royal and Imperial Hospital. By John H. Metzerott, M. D., Assistant to the late Prof. Johann Schnitzler, of the University of Vienna, and for three years Assistant to Marcus Hajek, M. D. Published by J. H. Metzerott, M. D., 1110F Street, Northwest, Washington, D. C. Price, $3.00, cloth; $3.50, half sheep, and $4.00, sheep.

This work is a handy compendium of the methods and remedies employed at the largest hospital in the world: this institution with its new addition and affiliated hospitals containing nearly 10,000 beds. Over 2,200 prescriptions are given in this volume, and therapeutical directions for the general and local treatment of disease, explicitly written, and divided into departments representing the different branches of medicine. An outline of the treatment of syphilis in all its stages, as well as details of Prof. Neumann's method of giving mercurial injections, together with all other methods of treatment, represents a very valuable chapter. About 140 pages are devoted to children, from the clinics of Professors Widerhofer and Monti, about 30,000 children being treated in the former's department annually. Some 60 pages are devoted to the ear, coming from such authorities as Gruber and Politzer. The names of Fuchs, on the eye, and Kaposi on the skin are also well-known as authorities in their departments. A valuable chapter on internal diseases by Prof. Nothnagel, is especially arranged regarding the employment of remedies for general and symptomatic treatment. Eighty pages on surgery from Professors Gussenbauer and Albert contain a great amount of knowledge in a limited space. Ultzmann treats of the genito-urinary system and Krafft-Ebbing, diseases of the mind. Internal diseases, which take up 120 pages, are from the wards of Neusser, whose ability as one of the foremost clinicians of the day is well known. Emanating as it does from many of the world's greatest diagnosticians, this work can be commended to our readers who will find it an extremely useful book.

THE TREATMENT OF ALCOHOLISM.—By J. M. French, M. D. Reprinted from *Medical and Surgical Reporter.*

ALCOHOLISM IN WOMEN. ITS CAUSE, CONSEQUENCE AND CURE.—By Agnes Sparks, M. D. Reprinted from *Medico-Legal Journal.*

A DISTINGUISHED PHYSICIAN-PHARMACIST. HIS GREAT DISCOVERY, ETHER-ANÆSTHESIA. By Joseph Jacobs.

BOOKS OF THE MONTH.

A CLINICAL TEXT-BOOK OF SURGICAL DIAGNOSIS AND TREATMENT.—By J. W. Macdonald, M. D. 8 vo., p.p. 798, 328 illustrations. Cloth, $5.00; half morocco, $6.00 net. Published by W. B. Saunders, Philadelphia.

Dr. N. F. Cunningham, Dartmouth, N. S., Professor of Medicine, Halifax Medical College, used Parke, Davis & Co.'s Anti-Diphtheritic Serum in fifteen cases of diphtheria last September, with satisfactory results in every case. Last week he was called to a case at Waverley, which terminated fatally, owing to the child being in a hopeless condition before the serum was administered. He immunized the four other children with 250 units each; ten days have elapsed, and no symptoms of diphtheria have developed.

CONTINUED GOOD RESULTS.—The January, 1894, number of the *Qwarterly Jounnal of Inebriety* published under the auspices of The American Association for the Study and Cure of Inebriates, Hartford, Conn., U. S. A., says through its able editor, T. D. Crothers, A. M., M. D.—"Antikamnia is one of the best remedies in influenza, and in many instances is very valuable as a mild narcotic in neuralgias from alcohol and opium excesses. We have used it with best results." In a letter of more recent date to The Antikamnia Chemical Company, Dr. Crothers writes: "Antikamnia continues to improve in value and usefulness, and we are using it freely." *The Edinburgh Medical Journal*, Scotland, says, regarding antikamnia:—"In doses of three to ten grains, it appears to act as a speedy and effective antipyretic and analgesic." *The Medical Annual*, London, Eng., says:—"Our attention was first called to this analgesic by an American physician whom he saw in consultation regarding one of his patients who suffered from locomotor ataxia. He told us that nothing had relieved the lightning pains so well as antikamnia, which at that time was practically unknown in England. We have since used it repeatedly for the purpose of removing pain, with most satisfactory results. The average dose is only five grains, which may be repeated without fear of unpleasant symptoms."

We would call attention to the advertisement of Messrs. Simson Bros. & Co. in this issue, of Wine of Creosote. The line of Pharmaceutical preparations which this firm make are equal to any, and the neat and substantial way in which they are put up is a credit to the manufacturers.

DOCTOR:

Your library is not complete without the HYPNOTIC MAGAZINE. Cost of this handsome monthly, including premium book on SUGGESTIVE THERAPEUTICS, is only One Dollar ($1.00) a year. Send for sample copy.

THE PSYCHIC PUBLISHING CO., 56 5th Avenue, Chicago.

FOR SALE.—A perfectly new (unused) copy of the last edition of Webster's International Dictionary. Thumb index. Will be sold at a bargain. Address K. J., care MARITIME MEDICAL NEWS.

WANTED.—Trustworthy and active gentlemen or ladies to travel for responsible, established house. Monthly $65.00 and expenses. Position steady. Reference. Enclose self-addressed stamp envelope.

The Dominion Company, Dept. V., Chicago.

Chocolate-Coated TABLETS.

One Hundred and Fifty-four of the most Popular, Staple and Quick-selling Formulæ Added to Our List—A True Chocolate Coating—Beautifully Finished, Readily Soluble, and Strictly Faithful to Label.

The line of chocolate-coated tablets recently added to our price list, and now swelling the orders of the profession, comprises a carefully selected list of standard formulæ. In point of external finish the new line challenges comparison with the most beautiful products of American and foreign laboratories. At a glance the physician will be struck with the thin coating and small size, the latter being reduced to the last limits consistent with good pharmacy.

The quality of these products is in every respect as unexceptionable as that of our regular lines of compressed and triturate tablets. The ingredients are of the finest material; the excipients carefully chosen; the solubility as nearly perfect as the formulæ will permit.

Our line of chocolate-coated tablets comprises many ill-tasting and malodorous substances which are now perfectly disguised by the chocolate investment.

The new tablets cannot fail to meet with the admiration of all who give due weight to pure materials, conscientious manufacture, and exquisite finish. Samples and price list furnished on request.

Parke, Davis & Company,

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