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Dominion Medical Monthly

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I

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VOL. I.] TORONTO, ONT., NOVEMBER, 1893. [No. 5.

ORIGINAL ARTICLES.

(No paper published or to be published elsewhere as original, will be accepted in this department.)

A BRIEF HISTORY OF THE RECENT OUTBREAK OF SMALL-POX IN TORONTO.*

BY J. E. GRAHAM, M.D., M.R.C.P. LOND., PROFESSOR OF MEDICINE,
TORONTO UNIVERSITY.

In response to the request of your honoured President, I have written in the following brief notes the history of the outbreak of variola, which took place in Toronto, in September and October, 1892, about a year ago.

The points which are of special interest in the histories of these few cases are (1) the great difficulty, as well as the great importance of making an early diagnosis; (2) the difficulty of distinguishing in some cases the symptoms and signs of varioloid from those of vaccinia; and (3) the great value of general vaccination as a prevention to the spread of small-pox.

On Sept. 12th, a patient was admitted into No. 5 Ward of the Toronto General Hospital, suffering from interstitial hepatitis and nephritis, with cardiac complication. His temperature was elevated when he entered the hospital, and a rash shortly afterwards appeared which proved to be that of confluent small-pox. The patient died during the pustular stage, thirteen days after his admission into the hospital.

The ward-tender H., who attended the patient above mentioned, was taken ill Sept. 25th and the eruption appeared on the 28th. This case ran the typical course of a moderately severe form of variola. The rash was slightly confluent over the face and discrete over the remainder of the body. The temperature chart, as you will see, was also quite typical, high during the stage of invasion, nearly normal during the first five days of the eruption and rising again when suppuration took place. Unfortunately the conjunctivæ were severely attacked and the sight of one eye was permanently injured. Otherwise he made an excellent recovery. He had never been vaccinated.

The nurse, Miss C., who had also been in attendance upon the first case in Ward No. 5, was the next victim. She exhibited febrile symptoms, together with severe pain in the back and head on Sept. 26th, and the rash appeared on the 29th. This proved to be a case of varioloid. The pustules were more abundant on the face than on the body, but were nowhere confluent. In fact the rash was largely confined to the face. The temperature chart in this case was also quite typical of varioloid, and there is nothing specially to note in the history. The patient made a good recovery. A few superficial cicatrices remained on the face. She had been vaccinated during childhood.

Both of these patients were at first isolated in the attic of the Toronto General Hospital, and afterwards, on Oct. 7th, sent to the temporary small-pox hospital.

On Oct. 12th, Dr. W., the resident assistant physician, who had charge of Ward No. 5, in which the first patient was treated, and who had been more or less in attendance on the ward tender and nurse, was suddenly seized with chills, followed by high fever, with severe pains in the back and stomach. On the third day a scarlatinaform rash appeared, which spread over nearly the whole of the lower part of the trunk and lower extremities. On the fifth day the rash disappeared, and a few papules were noticed, about a dozen in number, which rapidly became pustular and soon underwent desiccation. As the papules appeared the constitutional symptoms entirely subsided. The temperature during the period of invasion ranged about 102° to 103° , and fell when the papular eruption appeared. Dr. W. had been vaccinated in childhood, and was again vaccinated on Sept. 26th without result. This case presented great difficulties in diagnosis.

The fever and severe pain in the bowels at first suggested peritonitis, then the scarlatinaform eruption suggested the possibility of the prodromal rash of variola, or perhaps the erythema accompanying some other septicæmic condition. The pustules were so few in number and disappeared so quickly that the case might almost be considered to have been one of variola sine eruption. Owing to the doubtful character of the attack the patient was isolated in the attic of the hospital, and was not sent to the temporary building erected for the small-pox cases. During the course of the disease I was in great doubt as to its true character, but after its full development, and upon taking all the facts into consideration, the only conclusion I could arrive at was that Dr. W. suffered from a very mild form of varioloid. If the vaccination done in Sept. 27th had been successful the difficulty of making a diagnosis would have been much greater, as is shown by the history of the next case.

Nurse M., who had spent a good deal of time with Nurse C. in the early part of her illness and who was vaccinated on or about Sept. 26th, was on Oct. 10th taken ill with chills and fever, together with pains in the back and limbs. Her arm was at the same time much swollen, and the skin as far as the elbow presented a reddened inflamed appearance. On the third day after the commencement of the fever a scarlatinaform rash appeared over the lower part of the abdomen and lower extremities, which ran its course in about three days. Upon the disappearance of the rash, the fever and other constitutional symptoms subsided and the patient, although a little weak, felt otherwise quite well. No papules or pustules appeared on any part of the body. The patient was isolated in the attic of the hospital until her recovery. The opinion generally expressed by those who saw her, an opinion in which I concurred, was that the fever and rash was due to the vaccination. It would, however, be extremely difficult to prove that the case was not one of variola sine eruptione.

Dr. M., who had charge of the ward-tender and nurse while they were in the attic of the hospital, was vaccinated on Sept. 29th. The vaccination was not successful, and on Oct. 2nd he removed the dried blood with his finger-nail, inflicting a slight wound. The part shortly afterwards became inflamed, and in eight days from this date, on Oct. 10th, he was seized with chills and fever. At the same time the seat of the vaccination was occupied by a large characteristic pustule and a general subcutaneous cellulitis existed throughout the arm. The glands in the axilla were swollen and movement of the limb produced pain. For the first two or three days we were of opinion that the constitutional symptoms might be altogether the result of the inflammation of the arm. On the third day, however, the temperature fell nearly to normal and a number of papules, about 100, appeared on the face and upper part of the trunk, which presented a hard, shot-like feel. These changed rapidly to vesicles and pustules passing through the typical stages in a very short time. After the commencement of the eruption and upon the subsidence of the temperature the case was diagnosed as one of varioloid, and the patient was sent to the small-pox hospital.

The question might here arise, might this not have been a case of vaccinia, in which the pustule was delayed in development, and in which the eruption became general? The decision was given in the negative. It is a little doubtful if such a condition exists as a general vaccination. It is at any rate very rare. Many of the cases reported under this head have been the result of secondary inoculation or a simple pustular eruption. In this case the papules presented the usual marked shot-like feel, and ran the ordinary course of variola.

The patient made a good recovery, and a few indistinct scars were all that remained after the disease disappeared. Another interesting question arises in connection with this case. Might it not be possible that the patient inoculated himself when he removed the dried blood from the seat of vaccination. On Oct. 2nd he was then in close attendance upon the two small-pox patients, and might possibly have conveyed the virus on his finger-nails. The eruption appeared on the 10th, just eight days after inoculation, the time usually occupied by the stage of incubation in such cases. It is, of course, impossible to decide this point, as the Doctor was constantly exposed at the same time.

Dr. B., who practises in a suburb of Toronto, called to see the patients, the ward-tender and nurse, on Thursday, Sept. 22nd, and remained about fifteen minutes in the wards. The Doctor is a careful observer, and, no doubt, closely inspected the eruption. On Thursday, Oct. 6th, exactly two weeks after exposure, prodromal symptoms commenced, viz., an occipital headache, which gradually increased in severity on the following Saturday, the constitutional symptoms became intensified. He then experienced a feeling of pain and stiffness in the muscles of the back, constriction of the chest and sore throat. His appetite, however, remained good and he did not notice any loss of strength.

On Saturday, he experienced a slight anorexia, a peculiar irritable feeling over the whole body, difficult to describe, pain in the joints and in the lumbar region. He suffered from marked insomnia. Temperature at night, 102°.

On Monday, the pain in the back increased in severity, and was also felt in the region over the lower ribs, in the joints, especially the right knee and ankle. Headache continued, appetite gone. Pharynx very red and painful.

On Tuesday afternoon I saw the patient. We discussed the possibility of variola, but as the temperature had not been high and on account of the congestion of the

mucous membrane of the pharynx, swelling of the joints, and especially on account of the long time which had elapsed since exposure, we thought the case was probably one of subacute rheumatism and prescribed soda salicylate and phenacetine. The temperature that night rose to $102\frac{2}{3}^{\circ}$.

On Wednesday a few shot-like papules appeared on the face and at the roots of the hair. On Thursday the pains became much less severe and the papular rash extended over the scalp and right side of the face. A few spots only were scattered over the chest and arms, and one or two on the palm of the right hand. Temperature fell to 99° .

The attack may be said to have ended with the exception of great bodily weakness and depression (pulse 40-50), a condition possibly due to the anodyne and antipyretics he had taken. No secondary fever followed. The rash seemed to abort largely in the vesicular stage, as only a few pustules were formed. The skin presented a smooth surface in about ten days after the commencement of the eruption. Convalescence was rapid and uninterrupted.

I have given the history of this case more in detail, as it presented many very interesting points. (1) The long stage of incubation, sixteen or seventeen days from the time of exposure until the first rise of temperature. Fourteen days are given as the maximum length of the stage of incubation. The cases reported in which this stage was apparently prolonged to twenty-two or twenty-four days were probably instances in which the poison may have been carried about the person some days before actual contagion took place. (2) The mildness of the constitutional symptoms in the stage of invasion. The pulse remained about 100-110, and the temperature did not rise higher than $102\frac{3}{4}$.

The pain in the back was not more severe than in other parts of the body. As a general rule the constitutional symptoms of varioloid are very severe, even in the milder cases. Altogether the diagnosis was extremely difficult, and was not made until the appearance of the eruption. The misleading features were the length of the stage of incubation, the comparatively speaking mild constitutional symptoms, and the prominence of the joint pains.

Dr. B. had been vaccinated when a child, and no doubt the mildness of the attack was due to that fact. As soon as the eruption appeared he was removed to the small-pox hospital, where he remained some weeks. It will thus be seen that the number of individuals attacked was six, and that of these five recovered. Of the latter all had been vaccinated except the ward-tender, and he only had the confluent form on the face. It is surprising that the disease did not make further ravages. The limited character of the outbreak can be explained in two ways: (1) The general adoption of vaccination, and (2) the complete isolation of the patients, when the diagnosis was made certain.

One would have supposed that patients in Ward No. 5, in which the first case occurred, might have contracted the disease. So far as I recollect the patients in adjacent beds suffered from typhoid fever, and according to some authorities the presence of this disease renders the individual impervious for the time to the small-pox virus. It might be interesting here to relate, although not bearing directly upon the subject, that in the typhoid cases vaccinated, the vaccinia ran a typical course; in one, however, the development of the vesicles was immediately followed by a relapse of the fever much more severe than the original attack.

The question of most importance suggested by the histories of these cases is: How early can a diagnosis be made; not a positive diagnosis, but one which would

lead to the taking of proper precautions to prevent its spread? The two symptoms which should lead one to suspect small-pox are: (1) The sudden rise of temperature; (2) The severe pains in the back, aching of limbs and nausea with or without vomiting.

The sudden rise of temperature may occur in pneumonia, scarlet fever and erysipelas. Pneumonia can usually be distinguished by the frequency of the respirations, as well as by other auscultatory signs. And in erysipelas the local signs present themselves early. Much attention should be paid to the presence of severe pain in the back.

A case which I had to do with in my first year in Toronto often occurs to me in this connection. A few months after commencing practice I became connected with the volunteer force, as assistant surgeon to the 10th Royals. In the month of June I accompanied the regiment to camp at Niagara, and on the morning of our arrival, while the tents were being put up, I was called to see one of the men who had been taken suddenly ill. I found the patient in a high fever, and suffering from a severe pain in the back; no eruption. Knowing that small-pox existed at that time in the city, the presence of that disease at once occurred to me, and I concluded to send the patient back as soon as possible. Fortunately the boat had not left, so that the man returned to Toronto that forenoon. He suffered from a severe attack of variola.

The presence of variola in the neighbourhood is no doubt a great aid in forming an opinion.

In the first cases our suspicion may be sufficiently aroused to put us on our guard, but a definite conclusion cannot be arrived at until the eruption appears. The presence of the initial rashes is an important element, and one which is sometimes very confusing.

Dr. Savill, in a recent paper on the diagnosis of small-pox in its early stages, expresses the belief that these initial rashes are comparatively rare. In the six cases I have related, they were present in two, one of variola and one of vaccinia. These rashes are either scarlatinaform or morbilliform in character, and occur on the second or third day of the stage of invasion. The principal characteristics which distinguish them from measles or scarlet fever are: (1) Their appearance over the lower part of the trunk and the thighs, but in some cases they are more general; (2) They disappear in one, two or three days; (3) They are not accompanied by the symptoms either of measles or scarlatina.

Even when the papular eruption peculiar to variola appears there may still exist some doubt as to its character. The most striking feature is the peculiar, hard, shot-like feel of the papules, which are first found on the forehead or at the roots of the hair. Dr. Savill recommends careful examination of the forehead by passing the fingers over the surface even before the appearance of papules. They can be felt before they are seen. The accompanying fall of temperature and subsidence of constitutional conditions is, of course, a great aid to diagnosis, as such a change does not take place with any other eruptive fever.

One of the greatest difficulties we experienced in the recent outbreak was the diagnosis between varioloid and vaccinia. Such difficulties must frequently arise, because so many vaccinations are done when a case of variola appears.

It will be noticed that a great similarity existed between the cases of Dr. W. and the Nurse M. Both suffered from high temperature, both had prodromal rashes, which bore a striking resemblance to one another, and in both cases the temperature fell on the disappearance of the rash. In Dr. W.'s case, however, the vaccination was

not successful, his temperature was higher, and on its fall a number of shot-like papules presented themselves, which underwent development into vesicles and pustules. If the vaccination in Dr. W.'s case had been at all successful, the diagnosis would have been much more difficult, if not impossible.

The diagnosis between varioloid and varicella, although generally not difficult, may occasionally give rise to a good deal of doubt. In New York State, some years ago, an epidemic of varioloid was mistaken for varicella until two or three undoubted cases of small-pox made their appearance.

The severe constitutional symptoms and the prolonged character of the stage of invasion are the principal means of diagnosis until the eruption appears, which, in varioloid, presents the peculiar shot-like feel. The soft character of the papules, the very superficial vesicles, and their appearance in successive crops, are very characteristic of varicella.

Measles are sometimes mistaken for small-pox, and instances have not infrequently occurred in which actions for damages have been taken for sending patients suffering from that disease to the small-pox hospital. The greater severity of the constitutional symptoms in the stage of invasion, the absence of marked catarrhal conditions, and the presence of the hard, shot-like feel to the papules, will be sufficient in most cases.

Then, as Dr. Savill remarks, the element of time is an important one in diagnosis, so that the age of the eruption should be carefully noted. At the end of twelve hours the papules of measles begin to fade, those of small-pox get harder and larger, and after an interval of two days, become vesicular, whereas varicella is vesicular almost from the very commencement.

In these days, when vaccination is so generally practised, the majority of cases of small-pox are mild—some so mild as to be mistaken for acne. In the mildest cases of varioloid, however, there are some constitutional symptoms, and in acne the age of the spots and the presence of comedone are sufficient to make a distinction.

Some years ago, when an *interne* in the Brooklyn City Hospital, a patient was admitted in a partially comatose condition, and before a history of his case could be obtained he died. His body was in many parts covered with a rash, which strongly resembled confluent small-pox. In such a case the want of knowledge of the previous history of the patient may make the diagnosis somewhat uncertain.

I have not spoken of the peculiar odour as an aid in diagnosis, as it is only developed until all doubt is past as to the nature of the disease.

My experience in the recent, as well as in former, outbreaks teaches me that cases of varioloid occur in which a diagnosis is almost impossible, even when the disease is fully developed, and that the proper management of such cases require complete isolation, and at the same time their not being exposed to the virus of the disease while any doubt exists. A special ward for such doubtful cases should exist in connection with the Isolation Hospital.

The expectant plan was followed in the treatment of conjunctivitis the following solution was used: Atropia sulph., grs. ii.; resorcin, grs. v.; acid boracic, grs. x.; aq. distillat, $\bar{3}$ i. At the same time the eyes were bathed with a warm boracic solution. No local treatment was used to prevent pitting. Mild disinfectant sponge baths were used for the purpose of cleanliness and sterilization.

As to the pathology of small-pox, little has been added to our knowledge in recent years. It is probable that it, as well as the other exanthems, are examples of germ diseases; but the micro-organism peculiar to it has not yet been discovered.

Vaccinia, the virus of which is in all probability a modification of that of variola, has been thoroughly investigated by Dr. Martin, of Boston; but I am not aware that he has yet arrived at any definite conclusion. The importance of the presence of pus organisms has been fully substantiated. It is doubtful if we can add much to the following conclusions arrived at by Dr. Sydenham over two centuries ago :

“As to what may be the essence of small-pox, I am, for my own part, free to confess that I am wholly ignorant, the intellectual deficiency being the misfortune of human nature, and common to myself and the world at large. Nevertheless, when I carefully weigh the evidence derived from the above-named symptoms, it suggests to me the idea of inflammation—of an inflammation specifically different from all others—of an inflammation, both of the blood and humour. In clearing herself of this, nature is at work during the first two or three days at the digestion and concoction of the inflamed particles, with the intention of afterwards discharging them upon the surface of the body for the sake of maturation, and finally of expelling them from her boundaries under the form of little abscesses.”

ULCERS OF THE LEG AND VARICOSE VEINS.

BY W. W. BREMNER, M.D., TORONTO.

Late Assistant Surgeon to the Hospital for the Ruptured and Crippled, New York.

Ulcers of the leg are very frequently found to be difficult of cure. Many methods have been advocated for their treatment. The object of this paper is to bring to the notice of the Canadian profession a very simple and successful method of treatment which has proved, after an extensive trial, both in private and hospital practice, very satisfactory in the relief and cure of that rather difficult class of cases.

It consists in the application of a perfectly flexible and absorbent dressing in such a way as to restore the venous circulation and remove all œdema from the leg, at the same time absorbing all the discharges and permitting of free and painless exercise.

The materials chiefly used are circular cotton bandages (knitted), three inches wide in six yard rolls, absorbent lint and suitable ointments and lotions. There is no special ointment suitable to every case, but each case must be considered separately. Whatever kind of ulcer, or wherever situated on the leg, the bandage must be applied in the same way.

To apply the bandage and dressing, cut a piece of absorbent lint the size of the wound, and apply to it the ointment thought suitable; place this on the ulcer, and over it place several thicknesses of lint larger than the ulcer. The patient should be seated in a chair and place his foot on a stand of the same height. Wherever the ulcer is situated, the bandage must be applied so as to evenly compress the whole leg from the toes to the knee, making the pressure rather greater at the lower portion of the leg. No reverses should be employed, and it requires many more turns on the ascending portion of the leg, where only the top edge of the bandage holds, than are required on and above the calf. This is important, as too much pressure above congests the lower portion of the leg. It makes a much nicer finish to put on the last roll from above downwards, thus keeping in the loose lower edges. Four rolls (twenty-four yards) are required at least, for each case; two rolls on the leg and two for washing. In heavy patients it is better to use more bandage. The idea is to have the pressure so regulated that the venous circulation is restored to its natural condition, while the arterial is unaffected. The change thus produced in an ulcerated and œdematous leg is like

that produced by proper drainage in an unwholesome swamp. The dressing should be changed on an average every second day. In the great majority of cases in private practice and in those coming to the Hospital for the Ruptured and Crippled, New York, this was found sufficient.

When the ulcer is cured, it is better to continue the bandage for several months. Patients can be taught to apply it themselves. Free exercise is most beneficial, and patients can continue their work as usual; in fact, the very first application usually relieves most of the pain. In varicose veins the bandage should be applied in the same way, and on the whole is much superior to elastic stockings.

In recent wounds of the leg this method of bandaging shows to greatest advantage.

In acute synovitis of the knee, or indeed of any joint, it is most valuable; giving an even, constant pressure unobtainable by any other means. It is most useful after adhesions in a stiff joint have been forcibly broken up.

A synopsis of the first 100 cases of ulcer treated by this bandage is appended, but is omitted for lack of space. The average period of treatment was five weeks. Eighty per cent. of the patients were permanently cured (many of these cases being very chronic); in most of the remaining twenty per cent. the pain was relieved and the swelling removed.

39 Bloor Street East.

CLINICAL NOTES.

ANTE-PARTUM DECOMPOSITION OF THE PLACENTA, WITH MATERNAL INFECTION.*

BY G. S. CLELAND, M.D., TORONTO.

During the evening of December the 17th, 1891, I was asked to see Mrs. R., aged 34. She informed me that she had had several severe chills, followed by fever, and was then suffering with headache and an aching over the body generally. She did not direct my attention to severe pain in any particular location; temperature, 104 F.; pulse rapid. I ascribed her condition to an attack of la grippe, which was then prevalent. About 5 o'clock the following morning I was summoned and found her recovering from a chill more severe than any previous. Her condition was altogether much worse, the temperature being 107.2 F.; pulse, 160. I then endeavoured to ascertain some other cause for her condition. She had been married about six months, menstruation taking place regularly, and having no other symptoms of pregnancy, she did not think herself pregnant. On examining the abdomen, I found the uterus enlarged and apparently gravid; there was no vaginal discharge. The temperature did not remain high, but gradually lowered so that in half an hour after, when Dr. A. F. McKenzie saw her with me, it was 105 F., and fell somewhat lower before we left her. Larger doses of sulphate of quinine than she had been having during the night were ordered. I saw her several times through the day, when she appeared to be improving. In the evening—that is, twenty-four hours after my first visit—I was again summoned, but being engaged, requested Dr. McKenzie to see her. On his arrival he learned that the fœtus had been expelled and destroyed, so that he did not see it. He however, removed the placenta, which was decomposed and very offensive; after irrigating the uterus, he left the patient comfortable. She ultimately made a good recovery.

* Read at Toronto Medical Society.

Reports of Societies.

THE CANADIAN MEDICAL ASSOCIATION.

(Continued from last number.)

Reported by DR. J. N. E. BROWN, Official Stenographer of the Association.

ADDRESS ON SURGERY.

Dr. Hingston, of Montreal, gave the address on Surgery. It consisted of an historical review of the subject. He held that in Egypt, before the time of Moses, many so-called modern operations were practised. The Greeks considered surgery a divine art. Pythagoras, about 600 B.C., elevated surgery to a science. The Egyptians and Greeks practised nephrotomy, used tents, issues and noxas, and trephined the skull; they also practised percussion as an aid to diagnosis, and drew fluid from the chest. Hippocrates made use of immediate auscultation as a means of recognizing disease. But the fall of the Macedonian Empire seriously interfered with the progress of surgery. The Alexandrian school were skilful in abdominal surgery. They first used the catheter 2200 years ago Anthonius crushed stone in the bladder. There was another retrogression in the science at the time of the Cæsars. Celsus found that there might be rupture of brain substances without fracture of skull. He was first to describe the *contre coup*. Helodnius opened the bronchial tubes. The Arabians were credited with greater proficiency in surgery than history will justify; but to them we owe the preservation of Egyptian surgery. The suturing of wounds was practised by Albicasis, also the incising of the kidney for abscess. The Council of Tours forbade the clergy to spill blood. By this prohibition surgery was divorced from medicine and got a serious set-back. When Columbus discovered America the physicians of Europe were not superior to the medicine men of the aborigines of America. Vesalius laid

the foundation of modern surgery. Paré advocated cupping for displacements of the uterus. Wiseman, in Britain, was original but crude. His reports of successful treatment of cancer are so remarkable as to arouse suspicion as to the accuracy of his diagnosis. Wiseman believed in the magic royal touch for the king's evil.

Surgery, the speaker went on to say, preceded medicine in this country. The Governor of Nouvelle France, was always asking for surgeons to be sent out. The people did not need physicians. Dr. Hingston then described the marvellous advances of surgery during the past forty years in the treatment of many surgical cases; but was sorry that in some cases this divine art had so degenerated to a commercial question, owing to the greed for gold spirit which had extended to some of the members of the profession. He especially cauterized the practice of those one-idea gynæcologists who referred all female disorders to the uterus and instituted a daily tinkering process as a means of obtaining money.

THURSDAY MORNING.

Dr. Holmes, of Chatham, read a paper which consisted of a report of two cases of laparotomy for unusual conditions. The first gave a history of miscarriage preceded by hæmorrhage, and this was followed by pain in the left iliac region, where a swelling was discovered like an orange in size and shape, two inches to the left of the uterus, and fluctuating. Laparotomy was performed, and an ovary containing three ounces of pus removed. The abdominal cavity was flushed and usual dressings applied: no drainage tube. The important point in the case was that there was no disease of the tube. This was unique as far as he was able to make out from the records.

The second case Dr. Holmes had seen after the patient had been ill ten days. Pain was present in right iliac region where

the attending physicians detected some hardness. Chills and fever, constipation, vomiting and great prostration were succeeding symptoms: also great tympanites. No tumour could be made out at this time. Exploratory incision was deemed necessary. Appendix was sound. There was no obstruction, but peristalsis was absent. The gut was stitched to the wound, with the idea of incising if bowels did not move soon. This had to be done, the patient being then almost *in extremis*. A copious evacuation of fecal matter from the fistula took place. Stimulants could then be retained, and the patient improved. But the fistula was a great annoyance. Dr. Holmes made several unsuccessful attempts to close it, but failed. Patient was then transferred to Harper's Hospital, Detroit. Resection of the affected portion of bowel was made and the ends joined by Murphy's buttons. Patient made a good recovery. The doctor showed the kind of button used, and gave a report of operations in which it had been successfully employed.

Dr. Atherton agreed with Dr. Holmes that abscess of the ovary without affection of the tube was rare. In regard to peritonitis with paralysis, he found puncturing, to allow the gas to escape, a good measure, two or three times if necessary. He had seen no trouble arise from such proceeding. This might be tried and laparotomy avoided.

Dr. Holmes replied to this by saying that he had employed this measure, but it was in cases where the abdominal walls were thin. Where the walls were thick, as in the case reported, he considered it unwise. In fact, when the abdominal wall was opened, one of the assistants introduced a small trochar, but without relief of the symptoms.

Dr. Bell, of Montreal, then presented a paper on "SOME UNUSUAL CONDITIONS MET WITH IN HERNIA OPERATIONS." The doctor reported five cases, all of

marked interest. The first was a case of hernia in a woman aged fifty-five. There were not the symptoms of strangulation, but she suffered great pain. Temperature, 102; pulse, 100; bowels open. The tumour was situated in Scarpa's space in right groin, looked livid red, was indurated at the base and fluctuating—a pointing abscess, in fact. It was opened: a pint of fetid, sanious pus escaped. A mass of omentum protruding was cut off. Then the interesting point in the case was noticed—in the centre of the mass was a tubular cavity resembling the large intestine. It was stitched into the skin wound. To the outer side of the mass the appendix was found strangulated and sloughy. This was removed and bowel returned. Patient made a good recovery.

The second case was one of congenital inguinal hernia attached to the bottom of the tunica vaginalis. The hernia was easily reducible, but would not stay so. It was so troublesome operation was decided upon. Was omental and the peculiarity was, which accounts for the inability to retain it, a hyditiform cyst growing from the omentum and adhereat to the bottom of the sac of the tunica vaginalis testis, just long enough to allow the hernial contents to escape within the internal ring, and yet short enough to maintain constant traction upon this portion of omentum and bring it down in spite of any truss. The protruding omentum was tied and the cyst was removed. Patient made a good recovery. This was a unique case, Dr. Bell thought.

The third was a case of congenital cœcal hernia in a child three years of age. Hernia had existed from birth and was irreducible. Radical operation done. Through the peritoneum, the cæcum and ileum could be made out, and were found adherent to the cord. Even after splitting canal it was impossible to reduce. When peritoneum was opened and traction made on ileum, it readily slipped

back. The superfluous neck of the sac was dissected away and the remainder sutured down around the cord, the conjoined tendon brought over and sutured to Ponparts' ligament and canal closed by a suture.

The next was a most interesting case where there was hernia of a tubercular ovary and tube, through the inguinal canal of a female infant. It was diagnosed omental hernia,—was solid to feel, freely moveable, pediculated, and gave an impulse when child cried. Was exposed but seen not to be omentum. Resembled undescended testicle, but patient was female. Was removed—diagnosis still uncertain. Operation finished successfully. Subsequent microscopical examination revealed tubercular cystic ovary.

The final case cited was a most interesting one—suppurative inflammation of hernial sac simulating strangulation. Onset sudden (from a fall), and constitutional symptoms rapid, calling for immediate action. Cutting down sac was found very thick and oedemations from which, upon incision, half an ounce of sero-pus escaped. It was occluded above. Another incision was made into the sac above the occlusion and a loop of small intestine scarcely constricted, slipped back into abdomen. Patient got entirely well. The doctor inclined to think patient had suffered from hernia before, that sac had become shut off, and that the reputed recent cause merely pressed it further down, and the manipulation for reduction had set up an inflammation, possibly through the agency of the amoeba coli, which went on to supuration.

Dr. Canniff asked how Dr. Bell diagnosed the omental tube which was cut off from intestine.

Dr. Bethune detailed at length a case of strangulated hernia which was not operated on, on account of stubbornness of patient. Suppuration occurred, and a fecal fistula established, which finally closed and patient made a good recovery.

Dr. McFarlane, President of the Ontario Association, and Dr. Temple, delegate from that body, were invited to seats on the platform.

Dr. Bryce was not present to read his paper on "PROPHYLAXIS IN TUBERCULOSIS," but his paper was handed in as read.

THURSDAY, P.M.

The Association assembled in Victoria Hall at 3.30.

Dr. McPhedran addressed the Association on the subject, "THE MORE RECENT METHODS OF DIAGNOSIS AND TREATMENT OF DISEASES OF THE STOMACH." He said that formerly it was taught that the stomach was the principal and only organ of digestion, but now it was known that the whole alimentary tract takes part in the digesting process. He said the function of the stomach was three-fold, viz.: 1, To receive food and to partly change starchy and albuminous food into absorbable bodies. 2, To prevent the fermentation of the food. 3, To discharge its contents partly into the blood, but chiefly into the duodenum.

For the first three-quarters of an hour no free hydrochloric acid was, he said present in the stomach, as it combined with the albuminates, if present; there was hypersecretion of it, which arrested the digestion of the starches. It reached its maximum in amount in four or five hours. The gastric juice retarded the action of, or destroyed more germs, specific and non-specific, than any of the other digestive ferments. The duration of normal digestion, he said, depended on the character and amount of the food, also on the age of the patient. The symptoms of stomach disorders were multiple and various until the last decade; our knowledge of gastric disorders depended on experiments and symptoms, accidents, etc. Now we owe much of our knowledge to the stomach tube. This, he said, should be soft. The patient not only readily became accustomed to it, but even often would

request its use. An approximate knowledge of the stomach's contents would, in most cases, be all that was requisite for the physician in active practice. A test breakfast should be given consisting of a round of toast or a dry roll, with a cup of water or of weak tea or coffee, without sugar or milk. This should be withdrawn from the stomach after one hour's digestion. The acidity of a normal stomach, he said, should be due to lactic acid for the first thirty or forty minutes, after this time to free hydrochloric acids. These acids were discovered by Uffmann's and Clinberg's tests respectively. It had been taught that absence of hydrochloric acid indicated carcinoma. This was not so. It might be absent in other conditions and present even excessively, in this. However, it could be said that its persistent absence formed strong evidence in favor of cancer. The tube was useful in discriminating between gastric catarrh and carcinoma. The washing out would be followed by improvement in cases of the first, but not much in the second.

Its principal use, however, was in dyspepsia, in determining the solidity of the contents. On this our treatment could be based. The lavage stimulated the gastric gland secretion, and stimulated the muscular walls to renewed activity. Proper diet and general treatment would suffice to cure many cases. This treatment was particularly useful in alcoholics, also in infantile disturbances. Constipation was relieved by its use, also the gastric neurosis; reflex vomiting of pregnancy, the patient being fed through the tube. This subject was one of immense importance on account of the immense frequency of the disease of the stomach, four-fifths of all the ailments medical men were called on to treat being caused by derangement of this organ.

Drs. Ferguson, Wesley, Mills, Gardner and Praeger discussed the paper.

The meeting then divided into sections,

Dr. I. H. Cameron presiding over the Surgical side, while Dr. Moorhouse presided over the Medical.

SURGICAL SECTION.

Dr. Primrose presented a paper, subject, "A LARGE SARCOMATOUS GROWTH IN THE NECK, WITH SECONDARY DEPOSIT IN THE LUNG." It was found in a boy four years of age, a patient in Victoria Hospital, Toronto, under Dr. Cameron. It extended on the right side of the neck from the median line in front to a point near the vertebral spine, and from the lobule of the ear to the clavicle. Was noticed two years and three months before, corresponding to the region of the right lobe of the thyroid gland. Caused little pain, was somewhat lobulated, with prominent veins coursing over its surface. Fluctuation distinct. Measurement on tumour side of neck, horizontally, $15\frac{1}{2}$ inches; left side, 6 inches from lobule of ear on right side (over tumor), to outer extremity of the clavicle 7 inches, on left side, $2\frac{1}{3}$ inches. Left pupil twice the size of right. Some dysphagia. Child died in July. The tumor was found in the P. M. to possess several processes, but it had not infiltrated or eroded the surrounding tissues, a point to be considered in the diagnosis. There were secondary deposits in the lungs. The anatomical relations of the various structures adjacent were much altered. The large vessels on the tumour side were entirely obliterated; those on the left side were enlarged. The processes spoken of were in the direction of least resistance. The muscular structures in the neighborhood were atrophied.

In the upper part of the tumour there was a predominance of fibrous tissue, and septa of this tissue divided it off into lobules of spongy tissue. A peculiar condition was found in the spinal cord, the cord being surrounded below the dura mater, by a mass of tissue, resembling in gross appearance the tumour growth, out it was not the same. It contained con-

nective tissue corpuscles and nerve cells and fibres. Its nature Dr. Primrose had not made out. The tumour itself was examined microscopically, and proved to be sarcomatous. The beauty of Dr. Primrose's paper was that he had frozen transverse sections through the child, which exemplified in a most splendid way his paper. The sections were much admired by the Association. Photographs of the same were also presented for inspection.

Dr. Praeger spoke in high terms of the paper and the sections.

Dr. R. Ferguson, of London, then gave a report and presented "A RECENT SUCCESSFUL CASE OF CHOLECYSTOTOMY." The symptoms of gall-stones in this case were for a long time obscure, the pain being referred to the epigastrium; no pruritus, *feces* lacking the characteristic colour, and the absence of jaundice. Pulse and temperature remained normal. She had many attacks of pain which were relieved by hot appliances and morphia. These paroxysms did not appear or disappear suddenly. Gastric ulcer, gastritis and intestinal colic were excluded. Gastralgia was probable. Stomachic treatment gave no relief; the ordinary treatment for gall-stones afforded no relief. But finally some of the typical symptoms of gall-stones began to show themselves. Patient was transferred to the hospital with a view to operation. But after lying quietly for two or three weeks, she improved so much that she went home, operation being postponed. But she soon became worse. On one occasion she had felt, after a severe paroxysm of pain, a dropping of something in the region where the pain existed. Operation was gone on with. Eighty gall-stones removed. The edges of incision of the gall-bladder were sutured to the edges of the wound. A cough retarded the process of healing. Repair did not take place well. Suppuration set in. Parotitis in left gland set in; also a localized peritonitis. The attacks of pain returned. Dr. Ferguson then tried to insert a catheter through into

the bile duct, which he thought he accomplished. The side of the catheter appeared to grate on some hard substance, but improvement took place, and patient returned home in ten and one-half weeks after the operation. But in four weeks the symptoms re-appeared, pain very severe, chloroform had to be administered constantly, as morphia seemed insufficient. She inhaled thirty-six ounces. Another operation was decided on. The incision was extended downwards $1\frac{1}{2}$ inches lower, allowing exploration with the finger in the region of the bladder. A body $2\frac{1}{2}$ inches long, $\frac{3}{8}$ inch thick, was scooped out of the gall-bladder. Its structure had not been determined. The opening in gall-bladder was secured by a purse string suture, and a drainage tube inserted into bladder. Patient made a good recovery, although very nearly collapsed at the close of this operation. The pain in the second instance, the Doctor thought, might have been due to the presence of the mucous cast (if such it was), which might have been forced out of the bile ducts into the bladder. The Doctor's paper was valued highly. The patient was present, and the seat of operation exposed for inspection. A small biliary fistula was still to be seen, but in other ways the patient seemed perfectly well.

Dr. Cameron, chairman of the section, asked why cholecystectomy might not be done in such cases rather than cholecystotomy.

Dr. Praeger had had a case where the pain was referred to the epigastric region. The Doctor then outlined the case. It proved to be much like Dr. Ferguson's, only that the stones were in the duct, instead of in the bladder, and adherent to each other. In closing, the edges of the bladder were stitched to the sides of the wound. He was of the opinion that cholecystectomy should be preferred to cholecystotomy.

Dr. Meek had seen and helped with Dr. Ferguson's case, and agreed with him as

to the causation of the recurrence of pain after the first operation. Dr. Meek cited another case in which the peculiarity was the immense dilatation of the bladder, one they had recently operated successfully upon. He was surprised to hear that Tait had adopted cholecystectomy instead of cholecystotomy.

Dr. Prager told of a similar case he had to that of Dr. Mack; the bladder contained one and a half pints of bile and some forty stones.

Dr. Smith, of Fingal, then reported on Dr. Mack's last case, which was under his care. Patient was doing well. A point he dwelt on was that the temperature, at the time of operating, was 105. In three hours it was normal and had remained so.

Dr. Cameron then spoke of the propriety of removing the gall-bladder. In cases, especially where there was great distension and the presence of a number of stones, that operation was preferable. There would thus be less danger to the peritoneum after the operation; the performance of a biliary fistula is done away with. The bile, instead of escaping externally, should take its natural course and thus carry out its digestive function in the intestines. Dr. Cameron spoke of the administration of very large doses of glycerine, two or three ounces each hour of the paroxysm, for the relief of cases of gall stones. He supposed it acted by its hydragogue effects—dehydrating, and thus relieving, the swollen mucous membrane. He had seen satisfactory results from its use.

Dr. Ferguson said he had tried equal parts of glycerine and succinate of iron (about half an ounce of glycerine), four times a day.

MEDICAL SECTION.

"SOME OF THE USES OF SULPHUROUS ACID,"* was the subject of a paper read by Dr. Arnott, of London.

Dr. Hodge presented "THREE CASES OF FRIEDRICH'S ATAXIA IN ONE FAMILY: two sisters and a brother. Father had

*Will be published in this journal.

eczema of the legs so badly that he was obliged to use crutches, also had leucoderma of hands. A paternal uncle suffered from hemeralopia. These were the only neurotic points in the family history. The first, M. W., æt. 41, had a history of falling downstairs, having since then a weakness in the legs. Got worse since she was ten years of age. Now patient could not walk without support. Staggered while standing, even with eyes open. Left alone, falls forward. Gait like one drunk. Leg muscles suffer only atrophy of disuse. Legs sensible to pain, touch, and temperature variation. Has pain now and then in right hip. Plantar reflexes normal; patellar increased. Feet in condition of talipes varus. Marked curvature of spine. Upper extremity normal. Pupils act normally. When she fixes to either side, there is marked horizontal nystagmus. Face not symmetrical—mouth drawn to left side. Tongue, on protrusion, turned to right and exhibits fibrillar twitching. All senses normal. The second, Sarah, æt. 37, has suffered since she was 13, but nothing wrong with the gait till six years ago, at which time she received a hurt in the knee. Now she cannot walk without a cane. She would fall forwards if unsupported. In most respects she resembles her sister. Her speech is slow and not very plain.

The brother, æt. 36. Feet began to deform at 15. When eyes were closed he would fall backwards. Gait wide-legged and zig-zag, and sometimes stamping. Lying down, he can do all the ordinary movements of the legs. In prominent symptoms, much like sisters, Right hand is claw-shaped. Atrophy of muscles of hands. Left hand somewhat affected, too. Curvature of spine. Suffers with excessive sweating.

Drs. Meyers, Macallum, Mills, Arnott and Moorehouse took part in the discussion; Dr. Hodge replying.

Dr. McKeough then followed by reading a paper on "PUERPERAL ECLAMPSIA."

In all cases the urine should be examined, more especially in primipara, who make up $\frac{7}{8}$ of the cases. Albuminuria, however, was not always followed by eclampsia. The prophylactic treatment should be directed to diet, and the use of eliminatives. Fluid diet—milk being best—should be recommended. Salines should be given to keep the bowels free; while, for the skin, nothing was so good as the daily hot bath for twenty minutes, the temperature or immersion 99° , and gradually raised to 112° . Ice might be applied to the head, and large quantities of water should be freely given the patient. If after this treatment the albuminuria is still present, labor should be induced. The success, the reader of the paper then described. If any nervous symptoms showed themselves chloroform should be administered. One should always keep in mind in treating such cases three points in the etiology, heightened vascular and nervous tension; the presence of some poison, probably from the kidneys, in the system, and the presence of the fetus in utero. If eclampsia comes on in spite of all previous treatment the steps should be, first, sedative; second, eliminative, and, third, induction of labor. The doctor referred to venesection. In certain plethoric cases it might prove useful. But in trying it as a last resort, in two cases, it did not save them; in fifty cases in Guy's in which it was performed, 30% died. Immediately after, in twenty-four cases where it was used, $20\frac{1}{2}\%$ died.

Dr. Wesley Mills, of Montreal, then took up the subject, "PECULIAR FORMS OF SLEEP OR ALLIED CONDITIONS." He gave a report of his observations of the *arelomys nonas* (woodchuck) during a period of five years, and more particularly during its season of hibernation. With the phenomena presented, he compared strikingly similar phenomena in two or three cases in human individuals. Some of the points were the periodicity of the attacks of stupor, abstinence of food and

consequent emaciation, great slowing of respiration and circulation, the partial cessation of stupor to attend to urination and defecation, the tendency to increased reflex action. The Professor's account of the letargic conditions in man was listened to with exceeding interest, the cases, some of them being authentic, having come under his own observation. The Professor, as an evolutionist, contended that these tendencies were analogous to those in the lower animals, and inherited, so to speak, from them. Although Dr. Mills takes this advanced view, he says he is inclined less than ever to pooh-pooh what is said regarding trances and other similar popular notions.

Dr. A. B. Macallum, of Toronto, while admiring Dr. Mills' able paper very greatly, took some exception to his views. He contended that pathological conditions in the subjects whose cases were cited caused the lethargy; no such change in the brain of the lower animal, so far as he knew, took place. The subject, however, was one of extreme interest in connection with medical psychology—question of the relationship of periods of lengthened sleep to mental disease. Dr. Mills would be prepared, he said, to believe, in the Rip Van Winkle legend.

Dr. Cameron regretted that Dr. Mills had been obliged to omit the latter part of his paper, which dwelt with the real nature of the hibernating and allied conditions. It would have been interesting to have heard a comparison between such various conditions as sleep, ordinary coma, the somnolent form of status epilepticus, etc. Regarding the pigmentary and fatty changes Dr. Mill spoke of, all were familiar. Dr. Cameron inclined to think it was a question rather of pathological chemistry than a gross pathological change.

Dr. H. A. Macallum, gave Dr. Bucke's tide-theory, that sleep was influenced by, or in the same manner as, the tides. The child's sleep corresponded to the two periods of rest between tides.

In reply, Dr. Mills said that changes had been seen in the brain cells of hibernating animals. He believed the object of the condition was for preservation of life. In winter, when it was difficult to get food, the woodchuck did with little or none. On account of his peculiar condition, inherited, no doubt, from his sluggish ancestors of ages ago, "Sleepy Jo" (one of the cases reported) found it agreeable to his constitution, and economical, to spend that portion of time when sustenance was difficult to obtain, and weather inclement, in the lethargic state. Regarding the Rip Van Winkle story, he (Dr. Mills) thought it was like Shakespeare's, a case in which the genius anticipated the science.

Dr. D. C. Meyers, of Toronto, then read a paper on "MULTIPLE NEURITIS." *

"OPHTHALMIC MEMORANDA" was the subject of Dr. R. A. Reeve's paper. He referred to the progress that had been made in ophthalmology since the introduction of such instruments as the ophthalmoscope: also in the treatment of such affections as trachoma, lymphomata, astigmatism, stricture of the lachrymal duct, etc. The speaker outlined the present treatment for such affections and methods of employing surgical therapeutics where necessary. He discussed at some length the subject of sympathetic ophthalmia.

Dr. Osborne, in discussing the paper, spoke of the necessity of treating the nasal catarrh which was found in many cases of lachrymal duct affections. He also spoke of the great value of the ophthalmometer in astigmatism.

Dr. Reeve replied.

Dr. Harrison, the President elect, was then voted into the chair. Votes of thanks were heartily given to the retiring president, the medical profession of London, and the railroads.

Dr. Anglin moved that the usual honorarium be given to the Secretary. Carried.

*Will be published in this journal.

Dominion Medical Monthly.

All literary communications, exchanges, and books for review, should be addressed to the DOMINION MEDICAL MONTHLY, 50 College Street, Toronto.

Address all business communications to the Publishers, THE MEDICAL PUBLISHING CO., OF TORONTO, Box 418, Toronto, Canada.

TORONTO, NOVEMBER, 1893.

THE LABORDE METHOD IN ASPHYXIA.

In the August number of this journal we drew attention to the merits of the Laborde method of restoring life in cases of apparent death from drowning, asphyxia of new-born children, etc. In France, Spain and Italy, this method is already well known to the profession, and practised with signal success. Dr. Aubin, of Marans, France, after describing an obstetrical case (primipara) in which he had administered chloroform and delivered by the forceps, proceeds to say that (*La Tribune Médicale*) the child when born did not cry, and was completely cyanosed and motionless. There was no pulsation in the umbilical cord, and when the latter was cut the blood which issued from it was quite black. Confiding the delivery of the placenta to the nurses, "I immediately practised on the infant rhythmical tractions of the tongue, and after a quarter of an hour observed slight respiratory efforts. I observed that the cyanosis diminished before the movements of respiration became visible, which proves that under the influence of the tractions, hæmatisis goes on (so to speak) in a latent fashion. The treatment was kept up for about twenty minutes, until the baby cried. The infant is at present in perfect health." A similar

case is reported by Dr. Gougeux, of Calvados. A good deal of time was spent in endeavours to restore the infant to life by the use of flagellation, the hot bath, friction with alcohol, insufflation subsequent to cleaning out the throat, and artificial respiration. These having failed, resort was had to the Laborde method. To the surprise of the doctor and his assistants, after two or three minutes' work, respiration was re-established and the child recovered.

Dr. Springer, of Alencon, reports a case where a man who had been withdrawn insensible from a pit, which contained manure and the waste of a seltzer water factory, was treated unsuccessfully for twenty-five minutes by artificial respiration, friction, cold affusion, etc.

"Having secured a dressing forceps I seized his tongue with it, and at the second traction an inspiration occurred followed by a series of others.

"For an hour and a-half the respiratory movements became slow and ceased as soon as the tractions were suspended, after that time the traction could be discontinued. The coma did not disappear until after thirty-six hours, during which time all sorts of means were used to rouse the patient."

Certain points in this case are decidedly worthy of attention. The long duration of the coma, showing the intensity of the poisoning, enables one in a certain way to measure the intense exciting power exercised by the tractions on the respiratory centres, more particularly when we reflect that twenty-five minutes of artificial respiration had produced an entirely negative result.

Then again, in similar cases, it shows the necessity of perseverance, however precarious the final result may appear on beginning the treatment.

From the report of these cases, and those we have already quoted, it will be evident to our readers that the Laborde

method has a very wide range of utility, and that it may be employed with advantage in cases of suspended animation, produced by various causes. We shall be pleased to receive reports from physicians who have had occasion to apply it in practice.

DOMINION REGISTRATION.

This journal has already spoken out with no uncertain sound on the desirability of modifying the present system of medical registration, so that a physician who is qualified in one province would be regarded as qualified in another.

It is to be hoped that the many influential medical societies this winter shall take the matter up, and approach the proper authorities so as to have the existing regulations modified in such a way that there will be a common standard of qualification and a common registration for the entire Dominion.

Dr. Sheard, in his address before the Canadian Medical Association at London, spoke freely in favour of something being done in this important matter. We are glad to learn that our contemporaries, the *Maritime Medical News* and the *Montreal Medical Journal* both speak upon this topic in the October numbers in an approving manner, and direct attention to the fact that there is now a wide-spread demand for some change.

It will not do any longer to pooh-pooh this feeling. It has come to stay. Canada is our country, and we should have the privilege of following our regular occupation in all parts of it without restriction. A physician, qualified to practise in one province, should be entitled to practise in another province without the humiliation of another examination at the hands of examiners, often his juniors; and, in many cases, as practitioners, his inferiors in experience if not also in learning.

We quote from Dr. Sheard's address: "I may express the hope that the time is

not far distant when there will be some central examining board or boards for the whole Dominion, when a license from such a board will be a qualification to practise from one end of the country to the other."

VETERANS OF THE WAR OF 1812.

It will be a surprise to many of our readers to learn that pensions are still being paid by the Dominion Government to survivors of the War of 1812. According to the Auditor-General's Report for 1893, there are fifty-two recipients. The youngest is ninety years of age, the oldest 105. The great preponderance of French names is remarkable as showing the toughness and enduring qualities of the French "habitant." With half-a-dozen exceptions, all reside in Eastern Ontario or in the Province of Quebec. The amount disbursed is \$3,260.

THE LODGE PRACTICE.

No medical practitioner who has had any experience with lodge practice will uphold it for a moment. The reasons against it are many and weighty.

In the first place, the physician agrees for a certain sum to perform an unknown amount of work.

In the next place, he is destroying his independence, to a great extent, by engaging beforehand to attend any person or persons. He places himself in the position of being abused in a most merciless manner, as has often happened within our knowledge. He is also lowering his dignity very much by allowing himself to stand for election against another member of his profession.

Let societies exist if they will, and let the doctor join as many societies as his time, money, or inclination may permit of; but he should not attend at a tendered price. It would not be so bad if he took a society as he attends a family, and ren-

dered his bill in the usual way and at the usual rates.

Left to the medical men themselves, we do not see much hope of this evil being abolished. If some refuse to take lodges, others will not, and so the evil is perpetuated. It would relieve every physician in this matter at once if there were some legislation amending the Ontario Medical Act, so as to render it an unconstitutional act to do contract practice as it now exists in lodges.

By such an Act physicians would be greatly benefited. All this competition for the lodge and electioneering would at once cease. One physician, who is a member of a lodge, would have no grounds to suspect another physician, who is also a member of the same lodge. Some of the worst examples of bad feeling that we have ever met with between members of the profession have arisen out of this electioneering in lodge practice.

It is to be hoped, in the interests of the public and the profession, that the Medical Council, the Medical Defence Association and the medical societies will appoint committees to look into this whole question. These committees should have power to confer with each other, and formulate some honourable method of dealing with this great evil.

We trust that no one will run off with the idea that we are advocating a union or combination for the purpose of controlling prices. Nothing of the sort is in our mind. But, while this is true, we strongly urge that some action be taken to prevent all sorts of unions and combinations getting the mastery over us, and controlling us through the lodge-room.

The same amount of work will have to be done then as now, but with this difference, that we will do what we are paid for, and be paid for what we do. We are informed by one physician in this city who received about \$100 from one lodge that, during the period this remuneration cov-

ered, he rendered services amounting to about \$300. We all see the evil effects of lodge practice, let us now do something to remedy the abuse.

THE BEST TREATMENT OF PHTHISIS.

Several times already we have referred in our columns to the value of rest in the treatment of phthisis. The text books, usually found in the hands of students, do not contain any explicit information upon this important question.

Many years ago Bartholow called attention to the bad effects of allowing consumptive patients to take exercise while they had fever; and in more recent years Volland, Dettweiler, Keating and others have directed attention to this matter.

In a recent number of the *American Lancet*, Dr. T. J. Mays again discusses the subject. His arguments are sound. The ground which he takes admits of no contention.

We refer with much pleasure to the resolution passed in the Section of Climatology at the Pan-American Medical Congress, recommending the erection of national hospitals and homes for the infected poor.

THE TREATMENT OF SYPHILIS.—Dr. L. Duncan Bulkley (in September *Post-Graduate*) remarks that in the treatment of syphilis, mercury still holds the front place. He condemns strongly the habit of trying different preparations of mercury. The attending physician should become familiar with the action of some one form of mercury and adhere to this.

In the early stages of the disease, the author recommends mercury with chalk, after the method of Jonathan Hutchinson. He used the drug in the form of grain tablets. The patient is to take one every two or three hours. When the treatment should be more energetic, give

two tablets each alternate dose. Should salivation threaten, the dosage can readily be reduced.

The treatment by inunctions and injections the author does not recommend.

In the later stage of the disease, the mixed treatment is preferred. This consists in combining "the mercury in the same mixture with small doses of potassium iodide, together with iron and nuxvomica and gentian. This should be continued throughout the secondary stage.

In the tertiary stage, and for the later lesions, when serious symptoms threaten, the mainstay is the iodides. These should be given in large doses, well diluted, and on an empty stomach. Vichy is a good vehicle to give the iodides in. Mercury should also be used in these conditions; but it should be pushed freely and by inunctions as it gives rise to less irritation in this way.

The duration of treatment must vary with the case and the patient. It may be laid down as a rule, however, that two years' faithful treatment is a minimum period. Some cases will require a much longer period. The treatment must be kept up until the patient is free from the danger of later manifestations.

ANTIRABIC VACCINATIONS AT PASTEUR'S INSTITUTE IN 1891.—Mr. H. Pottevin, in the *Annales de l'Institut Pasteur* (June, 1892), gives a detailed statistic of the vaccinations practised at this establishment during the year 1891. During the year in question, 1,564 persons have undergone treatment. Nine patients died of hydrophobia, giving a mortality of 0.57 per cent.

As five of the patients unsuccessfully treated died fifteen days after the end of the treatment, they should not be counted in forming an estimate of the efficacy of the vaccinations. As a matter of fact animals inoculated, after trephining, under the *dura mater* with the virus of common

hydrophobia, take generally from fourteen to eighteen days to develop the disease. It follows, then, that when the first symptoms appear in a patient in less than fifteen days after the last inoculation, it must be admitted that the nervous centres have been attacked by the poison during the treatment, and the treatment, not being finished, cannot show all its power.

The real mortality in 1891 was therefore 0.25 per cent., the lowest obtained up to the present day, as will appear from the following table :—

	Patients.	Deaths.	Mortality Per Cent.
1886.....	2,671	25	0.94
1887.....	1,770	13	0.73
1888.....	1,627	9	0.55
1889.....	1,830	7	0.38
1890.....	1,540	5	0.32
1891.....	1,559	4	0.25
Total...	10,992	53	0.57

This result is very likely due to a more thorough appreciation of the danger arising from bites of rabid animals, and a better application of the treatment.

Of the five patients who were attacked with hydrophobia before the treatment was ended, four had been bitten in the head. The special danger of bites in this region of the body is due to the fact that the virus has but a short distance to travel in going from the head or face to the brain or the upper part of the medulla spinalis.—*La Tribune Médicale.*

TREATMENT OF SCABIES AT ST. LOUIS HOSPITAL, PARIS, BY PROF. FOURNIER (*Journal des Connaissances Médicales.*)—The patient strips naked and rubs himself from neck to heel with soft soap for half an hour. During a second half hour he remains in a bath and continues his frictions. After leaving the bath Helmerich's Ointment is rubbed all over his body. The patient dresses and remains in this condition for twenty four hours, after which he takes a cleansing bath. His garments are exposed to a temperature of 230° F. in a disinfecting stove to kill any parasites which might be present in them.

The theory of the treatment is easily explained: the frictions and the bath open the burrows in which the sarcoptes reside, and the ointment kills them.

Out of 12,294 patients treated in 1890, only three or four per cent. have required the treatment repeated. Unfortunately, it is rather painful, and the eminent specialists of the St. Louis Hospital, Messrs. Bazin, Hardy, Lailier, Vidal, Besnier, have endeavoured to render it less painful and more rapid, while at the same time keeping it cheap, prompt and sure.

Professor Fournier uses the following lotion in civil practice:

℞ Glycerine.....	200	grams.
Gum tragacanth.....	5	"
Flowers of sulphur.....	100	"
Subcarbonate of potash.....	35	"
Essence of mint.....	}	aa 1 gr. 50.
" lavender.....		
" cloves.....		
" canella.....		

In the hospitals of Vienna preference is given to a slower treatment. Men are interned in an hospital for five days, and women for from five to seven.

The following local treatment is used:

℞ Beta naphthol.....	15	grams.
Soft soap.....	50	"
Chalk.....	10	"
Axunge.....	100	"

ULCER OF THE STOMACH.—Dr. Germain Sée, in a communication to the Paris Academy of Medicine (*Gazette des Hôpitaux*), 21st September, makes the following statements:—

1. There are two varieties of ulceration of the stomach, both the result of over acidity, aided by anatomical conditions and circulatory troubles, entirely different from acute or chronic gastritis.

2. The gravest form of ulcer is that where there is bleeding, caused by the rupture of a diseased vessel. Here the hyper acidity can and ought only to be sought for in the intervals between the hæmorrhages by the aid of the stomach

tube, which is a real danger at any other time. Once the over acidity is recognized, it leads the treatment which should be first, the use of the anti-acids; and second, of milk, meat, albumin, which neutralize the acidity. The excessive acidity causes spasm of the pylorus and leads to dilatation. Abundance of water should be drunk to lessen the strength of the gastric juice.

3. The second form of gastric ulcer is the simple peptic ulcer. This form is recognized mainly by dyspepsia, gastralgia, vomiting and heartburn. This has been called by the Germans "nervous dyspepsia." It was formerly called catarrh of the stomach. This, however, is quite wrong. True catarrh of the stomach is not an over acidity, as in the ulcer. The true diagnosis rests on the examination of the gastric juice.

4. The over acidity may last day and night for a long time, as in chlorosis, before any ulcer forms. Strong suspicions may be entertained that there is an ulcer if the pains are severe and paroxysmal, and when the vomitings are severe and frequent. The other characteristics are identical in the two conditions of excessive acidity with and without an ulcer.

NON-OPERATIVE TREATMENT OF SALPINGO-OVARITIS.—Dr. Geo. E. Shoemaker, of Philadelphia, in *New England Medical Monthly* for October, 1893, makes the following remarks on the above subject:—

1. There are many cases of salpingitis, ovaritis, or a combination of both, that improve very much, or even recover altogether, by suitable non-operative treatment. These cases, however, are liable to relapse on subsequent exposure or injury.

2. In treating these cases a full course of the rest cure may be necessary. Every effort should be made to restore the lost balance of general health by good feeding, electricity, massage and tonics.

3. The best application is the elastic

wool tampon. The wool should be well powdered with boric acid, and covered by a thin layer of cotton. These tampons should be very carefully applied by the aid of a Sim's speculum, or with the patient in the knee-chest position. The tampon is good for two to four days. It exerts a mild pressure and supporting influence on the congested tissue.

4. When endometritis exists, the patient should be thoroughly prepared, and the endometrium carefully curetted. This is not followed by any increase in the tubal trouble, and has the effect of relieving the endometritis.

5. Pessaries cannot be used until all adhesions have been relieved, and the organs replaced. In this way their use comes in rather late in the management of these cases, if indeed they are used at all. To use them while there are adhesions or displacements is only to do harm.

6. Cases that cannot be relieved or cured by the non-operative treatment, demand the removal of the diseased tubes or ovaries. The true conservation of the patient's health demands this.

CALOMEL CONJUNCTIVITIS.—Dr. H. Friedenwald, of Baltimore (in August issue of *Am. Jour. Ophthalmology*), gives an account of several cases of severe conjunctivitis, caused by dusting calomel into the eye while the patients were taking potassium iodide internally. The potassium iodide soon appears in the tears, and comes into contact with the calomel. A reaction takes place, one of the results being the formation of mercuric iodide. The author has proven experimentally on rabbits that the internal administration of the iodides and the local application of calomel to the eye give rise to severe inflammation. Hirschberg's, Fricke's and Schlaefke's observations, and chemical analyses in such cases, are cited by the author. The paper is a valuable contribution.

THE APOPLECTIC PULSE.—Dr. Chas. L. Dana (in the *Post-Graduate* for August) has an article on the above subject, from which these statements are taken :

1. There is a class of cases in which the arteries are extremely dilated, and their walls thin and soft.

2. Persons of this class, if they have apoplexy, have hæmorrhage and not thrombosis.

3. The treatment is different from that indicated for persons who have rigid arteries and actual high tension.

4. The treatment is essentially directed to strengthening the vascular system, and lessening peripheral resistance. This is done by giving the tincture of iron and salicylate of soda, and putting them on a fruit and vegetable diet, with a little meat and some milk.

5. Careful watching of these patients enables one to protect them against other attacks.

REMOVAL OF ELEPHANTIASIS TUMOUR OF SCROTUM.—Dr. R. Martin Gil (in *Gaceta Med. Catalana*, Sept., 1893) gives an account of a case of elephantiasis arabum of the scrotum. The patient noticed the swelling first in 1880. When the tumour was removed it weighed thirty pounds. The patient weighed 158 pounds and was in his sixtieth year. A clamp was applied to the scrotum to control the hæmorrhage. The wound was dressed, for the first three days, with bichloride solution, one in two thousand. Afterwards the wound was dressed with iodoform. He was discharged from the hospital on the twentieth day. At no time was there any fever.

THE CURABILITY OF SYPHILIS.—Dr. W. R. Gowers (*Inter. Med. Mag.*) expresses the opinion, in his lecture on syphilitic hemiplegia, that syphilis cannot be regarded as a curable disease. He contends that it is impossible to say that any case is

cured, as, after the most thorough treatment there are often recurrences. Mercury and the iodides have a powerful influence over the organisms of the disease and the new tissue formations they have given rise to. But the germs of the bacterial organisms of the disease are much harder to destroy than the organisms themselves. Thus there may be left in the system, untouched by treatment, the germs of the disease. The removal of all the symptoms does not free the patient from the liability to a return of the disease. He holds that for a period of at least eight years the patient should take iodides for three weeks twice a year.

TREATMENT OF ERYSIPELAS BY ICHTHYOL.—M. Hallopeau (*Gazette des Hôpitaux*, 5th Oct.) remarks on the value of ichthyol in the treatment of erysipelas, that the treatment lasts for about two days, and the disease for about three. The use of ichthyol is due to M. Juhel-Renoy. It consists in circumscribing the erysipelatous patch by the application of the following :

Gutta-Percha	gram. 25
Chloroform	" 25
Ichthyol	" 25

The patch is smeared over with the following ointment :

Vaseline	
Ichthyol	aa

These applications do not give rise to much pain. The only inconvenience is the discolouration of the skin. Tincture of iodine, in ten-drop doses, night and morning, does good.

ANALGESIA BY COCAINE.—In a recent article in the *Revue Generale de Clinique et Therapeutique*, M. Gauthier describes how hypodermatic injections of cocaine can be given without danger. He recommends that trinitrine be added to the solution of cocaine. He says that trini-

trine is entirely opposite in its action to cocaine, being in an eminent degree the vaso dilator medicament, controlling in a wonderful degree the symptoms of cardiac and cerebral ischæmia, and like cocaine producing its effects a few minutes after injection but in a totally inverse fashion. From one to three minutes after an injection of two or three drops of the alcoholic solution of trinitrine 1 to 100, the skin of the patient becomes warm, the face reddens, the eyes become injected, the ears buzz, etc.

The following is M. Gauthier's formula:

Water	10 grams.
Hydrochlorate of cocaine	.30 cent.
Alcoholic sol. of trinitrine,	
	1-100, x drops.

M. Gauthier adds that this form of injection has always been satisfactory.

FORMULA OF A COMPOUND ANTISEPTIC.—The following formula designed by Mr. De Christmas, is published in the *Annales de l'Institut Pasteur*. It is a combination of different antiseptic substances, and is almost equal in power to bichloride of mercury without any of the inconveniences of the latter.

Carbolic acid	9 grams.
Lactic acid	2 "
Salicylic acid	1 "
Menthol	10 centigr.

This compound, called by the inventor, phenosalyl, is very slightly toxic, since, although possessing half the activity of the mercurial salt, it can be used in weak solutions, viz.: 5 and 7.5 to 10,000 of water. A strength of 20 to 1000 completely sterilizes tubercular sputa (one part of sputum to five of the solution) after an exposure of fifteen minutes.

The compound is prepared by heating the three acids together until they are liquified, and then adding the menthol. It is quite soluble in glycerine, and may be easily dissolved in water up to a proportion of four per cent.—*Rev. Scient.*

Items, Etc.

An International Chemical Congress will be held at Brussels, 1894.

Manitoba Medical College has upwards of a hundred students this session. The college has been refitted.

The total number of matriculated medical students in the universities of the German Empire in the summer semester of 1893 was 8,838.

A new supply of "Hydatid cases" have been recently added to the hospital clinics at Winnipeg, by the arrival of a fresh batch of Icelandic immigrants.

The official prospectus of the University of Vienna shows that during the summer session of this year the total number of students in the medical faculty was 2,610.

By the will of the late C. B. Beck, of New York, the New York and Presbyterian Hospitals of that city each receive a legacy of about half a million dollars. Could our Canadian millionaires do better than remember the hospitals when making their last will and testament?

IN Great Britain, the regular university professors in the medical departments usually receive from \$3,000 to \$5,000 a year for their lectures. In many of the American universities, as Johns Hopkins, Pennsylvania, etc., the salaries are quite as good. In the University of Toronto, we learn, the salaries paid to the professors for last session were about \$440.

St. Boniface hospital, Manitoba, is building an addition to accommodate a hundred patients. The new operating theatre on the top story will be one of the most com-

plete and convenient in Canada. The staff consists of surgeons, physicians and specialists. Dr. A. H. Ferguson, surgeon-in-chief; Drs. McArthur and J. O. Todd, surgeons; Drs. Lambert, Popham and Deschambault, physicians; Drs. Dame and McDiarmid, gynaecologists; Dr. Hutton, anæsthetizer. The building will be ready for patients on the 1st of November.

The Editors have to cordially thank the physicians of Canada for their appreciation of the columns of the *DOMINION MEDICAL MONTHLY*, as a medium for placing their cases and views before the whole profession. To such an extent, in fact, is this the case that in future they cannot promise to insert in any given issue letters of more than one page in length. They are very desirous to receive more especially short reports of cases in practice from their country brethren of the scalpel, as they feel that the active country practitioner meets many rare and interesting cases, the chronicling of which would be of much value to the profession.

We learn that a deep interest is being taken by the profession of Ontario in the matter of Medical Council elections, and that already there are several candidates in the field. There are many questions of importance to be considered, and the months to elapse before the elections can be used to advantage. It has been suggested that the voters should ascertain the views of the various candidates upon such subjects as inter-Provincial or Dominion registration, lodge practice, and the payment of members of the Council, before casting their ballots. Many members of the College express themselves as being in favour of doing away with the fee of ten dollars per day for attending Council and committee meetings, thinking that the honour attached to the position should be sufficient remuneration.

Personals.

Dr. J. H. O'Donnell represented Manitoba at the World's Sanitary Congress, Chicago.

Dr. M. B. Ferguson, brother of Dr. A. H. Ferguson of Winnipeg, has returned from Europe, after spending three years there.

Dr. W. J. McGuigan, of Vancouver, has left for an extended trip. He will visit the medical centres of this continent in addition to those of Europe.

Sir Andrew Clark was stricken with paralysis, Oct. 19th, when talking with a patient at his residence in London. The day before the attack he presided at the Royal College of Physicians during the Harveian oration. He died Nov. 6th.

We are pleased to state that Dr. A. H. Ferguson, Professor of Surgery in the Manitoba Medical College, has joined our editorial staff. He will keep the readers of the *MONTHLY* advised concerning matters medical in the prairie province.

Book Notices.

Public School Physiology and Temperance.
By WILLIAM NATTRESS, M.A., M.R.C.S.
Eng. William Briggs, Toronto.

This little volume of about 200 pages has been authorized by the Education Department as a text-book for the public schools. The book, though small, deals with a wide range of subjects. Under each section the author very judiciously works in what he has to say on smoking and drinking. The physiological part is well up to date, and the explanations clear and well arranged for the readers into whose hands the book is to be placed. The chapters on "Aids to the Injured," "The Prevention of Disease," and "Physical Exercise" are particularly good. This is one of the few small books that can be recommended.

Manual of Practical Anatomy. By D. J. CUNNINGHAM, Professor of Anatomy and Chirurgery, University of Dublin. Vol. 1., Upper Limb: Lower Limb: Abdomen. Young J. Pentland, Edinburgh and London.

Many will remember the former fasci- culi of this work. It has now been very much modified in form. It appears in two volumes, of neat size. The matter has also undergone very thorough revision. We are glad to note that the author pays so much attention to sections, made through the part he is describing. The aid to be derived from frozen sections cannot be overestimated. The cuts are, as a rule, clear and well chosen to assist the student. Taken all in all, "Cunningham" is the best practical anatomy with which we are acquainted.

Correspondence.

The Editors are not responsible for any views expressed by correspondents.
Correspondents are requested to be as brief as possible.

IS ALCOHOL A SEDATIVE AND DEPRESSANT?

EDITOR DOMINION MEDICAL MONTHLY:

SIR,—In your issue of October you publish such a report of my remarks on Dr. Harrison's paper on alcohol, that I fear anyone reading it will think I have taken leave of my senses. I therefore request that you will do me the favour to allow me to correct any such impression.

As your readers will see, Dr. Harrison had introduced the subject in an excellent article, entitled "Is Alcohol in all Cases and in all Doses a Sedative and Depressant?" I took exception to this statement of the question, as no drug ever did or ever could be expected to act exactly alike in all cases and under every circumstance. I said that even water or milk, under certain circumstances, proved very harmful.

I said that the profession is divided over a question which is not an absurdity, but the plain, simple question, Is the

general action of alcohol that of a stimulant or a sedative? In other words, does alcohol stimulate and strengthen a patient, or does it merely produce a false appearance of improvement by rendering the patient less sensitive to morbid impressions?

I said that not only was the general profession divided, but that eminent authors are divided, and that even hospitals are divided, as instance, the Temperance Hospital, in London, England, and another in Chicago. In proof that those holding the stimulant theory do not have it all their own way, I pointed to the paper by Prof. Wilkes, of Guy's Hospital, read before the British Medical Association in 1891, in which he says: "Those medical men who according to preconceived or ancient notions have styled alcohol a stimulant, have really been watching its sedative action." I remarked that during the spirited discussion which followed, no one questioned this statement. Hundreds of medical men, especially in the Old Country, hold the sedative theory, as well as very many of the profession in this country.

To shew that the authors are divided, I pointed to "Whitla's Materia Medica and Therapeutics," now held to be one of the best, if not the best, book on the subject for students. It says: "We will never understand the action of alcohol as long as we regard it as a stimulant."

I might also have cited among the authors, Dr. B. W. Richardson, who has expended more time and labour over this question than any other man living or dead; also Dr. Norman Kerr, of London; Dr. Davis, of Chicago, author of "Principles and Practice of Medicine," and many others of less note.

I also tried to point out that whilst many would agree that alcohol is a sedative, as evidenced by their prescribing it to procure sleep or to soothe an excited nervous system, yet these very men would prescribe it as a stimulant in the next case to which they were called. The same Babel of ideas was exhibited during the

discussion of Dr. Harrison's paper. One distinguished professor said that alcohol acted as a stimulant, a narcotic, and an anodyne all in the same case and at the same time. There may be reason in this, but it lies too deep for me. It reminds me of the Irishman who invented a gun to shoot out of both ends, but when he had it completed he never could be sure which end it would go off at. I pointed out this confusion of ideas, and urged for free, full, and kindly discussion.

The truth seems to be that those who hold such views, when they want a narcotic effect, prescribe alcohol; when they want a stimulant effect, they prescribe alcohol; and when they would soothe pain they prescribe alcohol—like the juggler who will give you any kind of drink you call for out of one bottle. Of course, there is no authority for such loose views, as most of the old authors manfully take the stand that alcohol is a food and a stimulant. It requires little reflection to see that this will not hold water, for surely if it be a food and a stimulant it should be valuable in all severe tests of endurance. Yet Ringer says, "Varied, repeated and prolonged experience and the testimony of army medical men prove that troops endure fatigue and the extremes of climate better if alcohol is altogether abstained from." Many other quotations might be given to shew the inconsistency of those who advocate the stimulant theory.

I would here also take exception to Dr. Harrison's statement that he "finds a considerable number of conscientious and able medical men who claim that alcohol is not of the slightest use in the cases in which we have been in the habit of prescribing it; that it is not only not a stimulant, but a powerful sedative and depressant." The statement is self-contradictory. I presume that all medical men agree that sedatives are frequently useful. How, then, could anyone, after admitting that alcohol is a powerful sedative, claim it is of no use?

I think the Doctor has misunderstood what was meant. I know there are many able men who claim that even as a sedative or narcotic, alcohol is inferior to others which we have at our command. Those who have embraced the sedative theory have generally done so after years of painful groping for the truth, and will not be found to be entirely devoid of intelligence. The main argument on which the stimulant theory rests is that of individual experience, than which I claim there is nothing more delusive. It has nothing more than a suggestive or confirmatory value. While individual experience is one of the tests to which every question must be submitted, yet it is only one, and that one of the least importance. All sorts of absurdities have found refuge under its wings, such as chaulmoogra oil, chian turpentine, elixir of life, etc., etc.

Why did profuse bleeding hold its own so long? Because the experience of the patient and the physician showed that it gave relief to present suffering. And it would have held its own yet if a clever mind had not demonstrated that a much larger number died of those who were bled than of those who were not. Let a similar test be applied to alcohol; have a hundred cases of a certain disease treated with the ordinary doses of alcohol and a similar number without. I for one will bow to a test like that if fairly conducted. I would also bow to clinical experience if it were backed by reason; but individual experience alone which for ages refused a mouthful of cold water to a fever-parched patient and sheltered so many abominations as cures, I must decline to follow blindly.

Dr. Harrison has rather an original argument to which I wish to direct attention. He says: "When your patient is nearly moribund—when it is evident that the weight of a feather thrown into the wrong scale must be fatal, and you give a decided dose of brandy; if brandy be a sedative, its effects must necessarily be

fatal. The mere fact that the patient rallies under its effects in this frightfully low condition, shows that it cannot be a depressant." I must admit that the Doctor has prognosis down to a finer point than any other man I ever saw when he can tell to a feather-weight how near a patient is to death. I have seen a number of able and experienced practitioners at a patient's bedside decide there was not the slightest chance of recovery, and yet they were wrong, and *vice versa*.

The assured way in which he speaks of patients so nearly dead being snatched from the grave by alcohol would lead young practitioners to believe that many patients at death's door will recover if they administer brandy enough. Allow me to tell them that I tried that dodge for many years, and it fooled me every time.

Up till a few years ago few of my patients went to heaven sober, yet I failed to observe in any single case such a marvellous result. And now I think I see more patients rescued simply by conserving the powers of nature. But that is only my "individual experience."

Moreover, the Doctor has not told us of what his patients were dying. If it were of nervous shock, I might be inclined to agree with him that alcohol might seem to do good, and in some cases have real value. But a patient dying of exhaustion of the forces of nature can hardly be helped by the administration of a drug which will cause a well man to stagger or even put him asleep.

Sir William Gull, in 1877, said: "The advantage of alcohol is its effect on the nervous system, for the time being rendering the patient more indifferent to the process going on. And the Encyclopædia Britannica says: "Alcohol relieves weariness by paralyzing the power to feel it." So in a similar manner does alcohol cause a patient to feel better by taking away or diminishing, for the time, his power to feel the unpleasant effects of the disease. I

grant that in this way it may occasionally be useful when given for a short time only, but when given for a length of time I believe it does a great deal of harm; and when we require a sedative we have others which in most cases are far superior to alcohol. I trust I have said nothing which could give offence to the gentleman who was so good as to introduce the subject and to devote so much care to it. My only desire is to set myself right and to have this subject thoroughly ventilated.

London.

H. ARNOTT.

IS ALCOHOL A SEDATIVE AND DEPRESSANT?

EDITOR DOMINION MEDICAL MONTHLY:

SIR,—The paper by Dr. Harrison, reported in yours of Oct. 1st, is interesting, inasmuch as it opens up a debatable subject in which the profession of medicine is much interested. Excusing me for the interpolation, but I think the title of the paper should have been, from the arguments adduced, "Is alcohol a sedative or a stimulant?" This is not only a medical question, but has taken its place, and is here to stay, in the realm of politics and social economics. Is alcohol a sedative and depressant? In arguing this out on parallel lines, we must take into consideration the circumstances under which it is administered, and is it possible for a drug to have a double action? You give alcohol to a man whose venous circulation is congested, and full of carbon; whose system is filled with effete and excrementitious matter, with an oppressed brain, and it becomes a dangerous depressant. Give it to the nervous invalid, whose system has been drained by debilitating discharges, or worried by mental trouble and physical disease, and then it is a valuable sedative. Give it to the victim of neurasthenia, with his bankrupt brain and bloodless spine, for it is better than strychnine, or phosphorus, or all the

vaunted drugs used in that terrible disease—to him it is a sedative most acceptable to his poor, worn-out system. Give it to the pale, emaciated victim of consumption, whose consuming fires are burning up the vital spark too quickly, and it stands between him and death, and offers a substitute for his own flesh and blood—to him it is a glorious sedative. And oh! you rich and young and healthy, you do not require this elixir; your lines are fallen in pleasant places; look out some poor victim, sinking under this terrible disease, who cannot afford to procure it. And lastly, give it to the old man, shaken with palsy in his second childhood, tottering towards the grave, and it will sooth his passage, and give him blessed sleep, and carry him back again to the days of his youth, when he was young and strong and foremost amongst the reapers in the field; to him it will be a sedative—the milk of old age. There are few doctors who could not give so many instances of the beneficial effects of alcohol as a stimulant, as recorded in the paper, if not blinded by prejudice and fanaticism. In the year 1848, there was a young doctor (*εγώ*) taken sick with one of the dreadful remitting fevers peculiar to the lowlands in the Island of Jamaica. He is not responsible for what occurred during this illness. In consequence of the delirium that attended it, he only received it from a kind friend who stood by him during this trial. After a lapse of twenty-seven days the fight was almost over. The attending physician, who lived twenty miles away, came on that day and announced that there was no hope, and advised that the carpenter on the estate should prepare a box for the moribund patient, as the obsequies are not ornamental or very prolonged in that country. This friend, in conjunction with another, sat up for the last time. The latter, who had had some experience in the fevers of that country, suggested that as it was a hopeless case, they should administer a

good dose of brandy. The patient made no resistance, and the liquor went down by gravity. The pulse returned, and a gradual warmth diffused itself over the body; the dose was repeated, and the patient returned to consciousness. In 1857, the writer was surgeon on board a troop-ship crossing the Atlantic, laden with seven hundred souls, men, women and children. For some reason, the tug appointed to pull the ship through the Channel, was not up to time, and she stood on her way without it. Contrary winds prevailed and stormy weather set in, so that it was more than six weeks before the port of Quebec was made. John Bull, careful of the health and comfort of his soldiers, had provided for the men each one pint of porter, and for the women with babies two pints. From the unexpected length of the voyage all the medical comforts were exhausted. The first effect of the loss of the beer was that the women who had children at the breast became dry—"the paps gave no suck." One after another of the little ones was consigned to the deep, for want of their proper nourishment. In this emergency, I asked to see the bill of lading of the ship *Zou*. I found that there was a consignment of bottled porter to a firm at Quebec. I made a requisition to the captain for it, and it was forthcoming. The women had their porter again, and the lacteal fluid made its appearance also, much to the benefit of the little creatures. Can a drug have a double action? Alcohol is allowed to be an antipyretic, by lowering an abnormal temperature it becomes a sedative, and from the effect produced it then acts as a tonic. Dr. Paris classes narcotics, antispasmodics, tonics and astringents under the head of stimulants. He says: "Substances which, in a moderate dose, occasion a temporary increase of the actions of the nervous and vascular systems, but which are followed by a greater depression of the vital powers than is

commensurate with the degree of previous excitement, and which is generally followed by sleep." He thus defines narcotics and sedatives, and proves alcohol to have a double action. Many practitioners anticipate this, and combine a narcotic with a stimulant. A favourite prescription of my old master's used to be: Liq. opii sed, 25 drops; Hoffman's anodyne, 30 drops; tinc. lavand, 30 drops, and 1 oz. of camphor, mixture, and it seldom failed to give relief. The two most active principles of opium are morphia and narcotine, which would appear, from the researches of M. Majendie, to exert very different effects upon the animal system, the former imparting to opium its soporific, the latter its exciting property; whence it is proposed to remove this latter principle in order to render its effects milder, and at the same time to divest it of those objectionable properties, which so greatly limit its medicinal utility.

The great question of the prohibition of alcohol is now before the public, and if the Medical Faculty is the conservator of the public health, it behoves it to speak out in no unmeasured terms of the dangers attending such a policy. Whilst the press is silent, afraid to open its mouth, it is the duty of the medical organs to stand between reason and fanaticism, and to prevent so objectionable a measure from being placed upon our statute books.

Yours, etc.,

HENRY B. EVANS.

Picton, Ont.

Progress of Medical Science.

AN OPERATION FOR INGROWING TOE-NAIL.

BY SAMUEL E. MILLIKEN, M.D.,
Lecturer on Surgery at the New York Polyclinic.

Although some diversity of opinion exists as to the treatment of ingrowing nail, it is my opinion that the principal conditions to be overcome are the follow-

ing: 1st, removal of the irritating part of the nail; 2nd, excision of the infected soft parts, and 3rd, the prevention of suppuration during the healing process.

It is not only needless but harmful to remove the entire nail, particularly from the great toe, as the subsequent irritation of the shoe will be a great source of inconvenience to the patient. Any attempt to remove the nail in part without excising the infected soft parts will often be followed by suppuration, and hence considerable delay in the recovery.

The operation which I have performed for four years (the originator of which I do not know), is first to inject from five to ten minims of a four per cent. solution of cocaine into the end of the toe, with the smallest hypodermic needle, taking care that the anæsthetic be deposited as far back as the matrix, and immediately apply some form of constriction at the base of the toe that the circulation be thoroughly controlled. In from three to five minutes the area to be operated upon will be anæsthetized, when the scalpel is thrust alongside the ingrown part and the soft parts are transfixed. The first cut (Fig. 1) should be made parallel with the nail until the end of the toe is reached. The flap left should be cut off with a separate stroke of the knife, and on a slant until the matrix is exposed. With a pair of sharp-pointed scissors, about one-fifth of the nail is separated (Fig. 2) and the segment pulled out with a pair of dressing forceps. The whole denuded surface should be thoroughly curetted so as to remove any infected tissues and to insure the complete destruction of that part of the nail.

Dressing.—Before removing the constriction, the surface should be dusted with iodoform and covered with a small piece of rubber tissue. By taking that precaution, the granulations will be prevented from shooting up into the meshes of the gauze overlying.

The absorbent gauze can best be applied in the form of a roller bandage, and thus accomplish the part of an hæmostatic. For the prevention of infection from without, the whole toe is covered with rubber tissue and additional pressure made by a simple roller bandage.

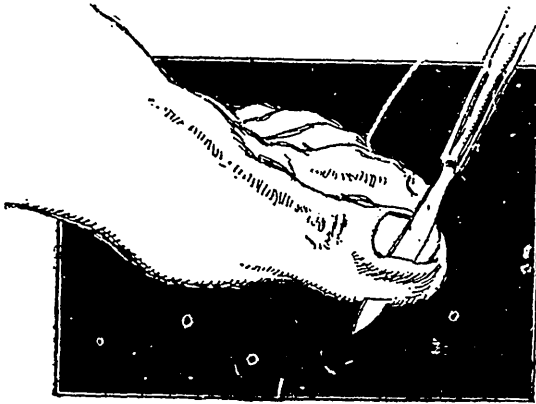


FIG. 1.

When the constrictor is removed, if there be hæmorrhage, by elevating the foot for half an hour it may be controlled.

The only indication for re-dressing the wound during the first forty-eight hours, will be the pain from too much pressure, and this may be relieved by changing the outside bandage without exposing the parts to the external air. By applying the same protective dressing twice a week, complete cicatrization will usually occur in 15 days.

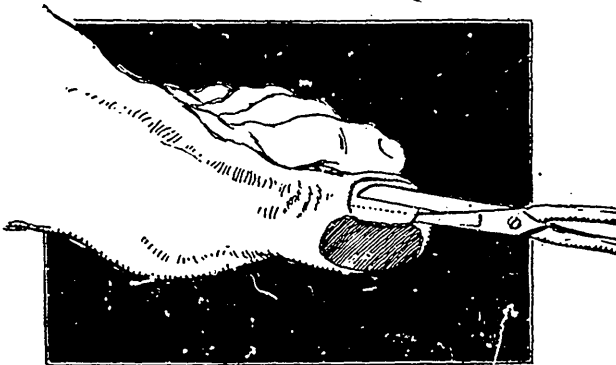


FIG. 2.

The inside of the nail is here illustrated, because the operation is best shown.

Advantages.—1st. With all infected and irritating tissues removed, the patient can go about with comparative comfort.

2nd. The matrix being removed in part, the nail will grow symmetrically.

3rd. Both sides may be operated upon simultaneously and yet have the toe protected by more than half the nail.

4th. The cicatrix resulting, prevents the soft parts bulging out and becoming irritated by the nail afterward.—*New York Polyclinic.*

YELLOW FEVER IN BRAZIL.—The British Consul at Santos, in a recent report, states that yellow fever has been present in Santos, Brazil, for the last five years. It has varied in intensity from time

to time but has never disappeared. The mortality among seamen during the height of the pestilence last year was enormous, and as all who died were buried within two hours, it was practically impossible to trace individuals. In many cases no register was kept even of their names. It is known, however, that men were dying for weeks at the rate of thirty to forty a day. At the time of the Consul's report there were between two and three hundred cases of

yellow fever in the hospitals. The danger was considerably aggravated by the fact that seamen during their enforced stay in Santos have every facility to obtain a very cheap and injurious form of rum called cascaca, and are thus encouraged to live a disorderly life. Recent regulations, however, have considerably alleviated their

condition, since they are now permitted to be discharged from the ships on which

they arrive, and to take ship on outgoing vessels at the first opportunity. The Consul also states that small-pox is extremely prevalent in Santos.—*British Medical Journal.*

STATEMENT

OF THE SUMS PAID TO EACH MEMBER OF THE MEDICAL COUNCIL FOR TRAVELLING EXPENSES AND HOTEL ACCOMMODATION WHILE ATTENDING COUNCIL AND COMMITTEE MEETINGS.

The following is taken from Sessical Return No. 86, which was brought down by order of the Legislative Assembly on 5th of May, 1893. It is from the Treasurer of the Medical Council, and gives a detailed statement of payments to members of the Medical Council for *travelling and hotel expenses* during the years 1890-91-92.

PAYMENTS TO MEMBERS OF THE COUNCIL FOR HOTEL AND TRAVELLING EXPENSES, JUNE 13, 1891.

To whom.	No. of days hotel at- lodgeance.	At \$3.50 per diem.	Travelling Expenses.	Total.
Dr. D. Bergin	7	\$24 50	\$21 50	\$46 00
" John L. Bray	7	21 00	13 80	34 80
" Wm. Britton	5	17 50	Nil.	17 50
" C. J. Campbell	6	21 00	9 30	30 30
" A. G. Fenwick	6	21 00	9 30	30 30
" W. T. Harris	6	21 00	4 75	25 75
" G. Henderson	6	21 00	10 25	31 25
" James Henry	5	17 50	3 50	21 00
" A. J. Johnson	5	17 50	Nil.	17 50
" J. W. Rosebrugh	6	21 00	4 50	25 50
" Fife Fowler	6	21 00	11 00	32 00
" James Fulton	6	21 00	9 80	30 80
" George Logan	7	24 50	17 00	41 50
" L. Lutton	6	21 00	9 80	30 80
" A. Ruttan	6	21 00	19 00	31 00
" V. H. Moore	6	21 00	14 50	35 50
" D. L. Philip	6	21 00	4 75	25 75
" R. B. Orr	5	17 50	Nil.	17 50
" James Thorburn	5	17 50	Nil.	17 50
" W. B. Geikie	5	17 50	Nil.	17 50
" Henry W. Day	7	24 50	8 75	32 75
" George M. Shaw	6	21 00	4 50	25 50
" A. F. Rogers	7	24 50	17 00	41 50
" W. H. Oliphant	5	17 50	Nil.	17 50
" J. A. Williams	5	17 50	5 00	22 50
Total	..	\$510 50	\$189 00	\$699 50

PAYMENTS TO MEMBERS OF THE COUNCIL FOR HOTEL AND TRAVELLING EXPENSES, JUNE 14, 1890.

To whom.	No. of days hotel at- lodgeance.	At \$3.50 per diem.	Travelling Expenses.	Total.
Dr. D. Bergin	8	\$28 00	\$20 50	\$48 50
" John L. Bray	7	24 50	13 80	38 30
" Wm. Britton	5	17 50	Nil.	17 50
" C. J. Campbell	5	17 50	9 30	26 80
" H. W. Day	5	17 50	9 10	26 60
" A. G. Fenwick	6	21 00	10 00	31 00
" Fife Fowler	6	21 00	11 00	32 00
" W. B. Geikie	5	17 50	Nil.	17 50
" W. T. Harris	5	17 50	4 50	22 00
" G. Henderson	6	22 75	8 25	31 00
" James Henry	5	17 50	3 75	21 25
" A. J. Johnson	5	17 50	Nil.	17 50
" George Logan	6	22 75	16 00	40 75
" L. Lutton	6	21 00	9 30	30 30
" J. McArthur	5	17 50	9 25	26 75
" V. H. Moore	7	24 50	14 00	38 50
" W. H. Oliphant	5	17 50	Nil.	17 50
" R. B. Orr	5	17 50	Nil.	17 50
" D. L. Philip	5	17 50	4 50	22 00
" A. F. Rogers	7	24 50	19 00	43 50
" J. W. Rosebrugh	5	17 50	5 00	22 50
" J. Russell	5	17 50	5 00	22 50
" H. Ruttan	5	17 50	10 00	27 50
" James Thorburn	5	17 50	Nil.	17 50
" J. H. Williams	5	17 50	5 90	23 40
Total	..	\$490 00	\$190 15	\$680 15

PAYMENTS TO MEMBERS OF THE COUNCIL FOR HOTEL AND TRAVELLING EXPENSES, JUNE 18, 1892.

To whom.	No. of days hotel at- lodgeance.	At \$3.50 per diem.	Travelling Expenses.	Amount.
Dr. D. Bergin	5	\$17 50	\$24 00	
" John L. Bray	5	21 00	13 50	
" Wm. Britton	5	17 50	Nil.	
" C. J. Campbell	5	17 50	8 20	
" A. G. Fenwick	6	21 00	10 00	
" W. T. Harris	5	17 50	4 00	
" G. Henderson	5	17 50	9 00	
" James Henry	5	17 50	3 00	
" A. J. Johnson	5	17 50	Nil.	
" J. W. Rosebrugh	5	17 50	3 50	
" Fife Fowler	5	17 50	13 00	
" James Fulton	6	21 00	9 80	
" George Logan	5	17 50	23 00	
" L. Lutton	6	21 00	9 80	
" A. Ruttan	5	17 50	10 00	
" V. H. Moore	6	21 00	15 00	
" D. L. Philip	5	17 50	4 00	
" R. B. Orr	5	17 50	Nil.	
" James Thorburn	5	17 50	Nil.	
" W. B. Geikie	5	17 50	Nil.	
" Henry W. Day	5	17 50	7 60	
" J. Arthur Williams	5	17 50	5 00	
" A. F. Rogers	5	17 50	23 00	
" Thos. Miller	5	17 50	3 50	
" E. Vernon	5	17 50	3 50	
Total	..			\$657 40

ALL PAYMENTS MADE TO MEMBERS OF THE COUNCIL FOR HOTEL AND TRAVELLING EXPENSES IN CONNECTION WITH COMMITTEES.

Cheque.	To whom.	To whom Paid.	Service.	Details.	Amount.
5	.....	Dr. Henry W. Day..	Committee re Legislation....	6 days' hotel, \$21.00; trav'lg exp. \$17.50	\$38 50
6	Apr. 24, 1891.	" A. F. Rogers ..	" " " "	10 " " 35.00; " " 38.00	71 00
2276	May 9, " "	" Jas. Thorburn ..	" " " "	9 " " 31.50; " " Nil	31 50
6	" 10, " "	" D. Bergin	" " " "	2 " " 7.00; " " 25.50	32 50
2291	" 27, " "	" D. Bergin	" re Education	13 " " 46.50; " " 75.50	121 00
2302	June 13, " "	" John L. Bray ..	Select Com. re curriculum ..	2 1/2 " " 5.75; " " 11.00	19 75
2331	" 16, " "	" A. J. Johnson ..	Committee re curriculum ..	5 " " 17.50; " " Nil	17 50
2	" 17, " "	" Jas. Thorburn ..	" " " "	5 " " 17.50; " " Nil	17 50
3	" 17, " "	" W. H. Oliphant ..	" " " "	4 " " 14.00; " " Nil	14 00
2423	Mar. 17, 1892	" V. H. Moore	" re Legislation	2 " " 7.00; " " 13.75	20 75
4	" 17, " "	" H. W. Day	" " " "	2 " " 7.00; " " 8 25	16 25
5	" 17, " "	" J. A. Williams ..	" " " "	1 " " 3.50; " " 6.00	8 50
6	" 17, " "	" A. J. Johnson ..	" " " "	1 " " 3.50; " " Nil	3 50
7	" 17, " "	" D. Bergin	" " " "	1 " " 3.50; " " 25.50	29 00
8	" 17, " "	" Fife Fowler	" " " "	2 " " 7.00; " " 13 00	20 00
9	" 17, " "	" Wm. Britton	" " " "	1 " " 3.50; " " Nil	3 50
2430	" 17, " "	" Jas. Thorburn ..	" " " "	1 " " 3.50; " " Nil	3 50
1	" 17, " "	" R. B. Orr	" " " "	1 " " 3.50; " " Nil	3 50
2	" 17, " "	" C. J. Campbell ..	" " " "	1 " " 3.50; " " 6.50	10 00
4	" 17, " "	" W. B. Geikie	" " " "	1 " " 3.50; " " Nil	8 50
9	Apr. 7, " "	" J. Arthur William	" " " "	1 " " 3.50; " " 5.00	8 50
					\$192 75

COMMITTEE re LEGISLATION.

No. of Cheque.	Date.	To whom Paid.	No. of days attend-ance.	At \$10 per diem.	Hotel al- lowance per diem at \$3.50	Travelling expenses.	Total.
2263	April 18, 1891	Dr. A. F. Rogers	4	40	\$14 00	\$18 00	\$72 00
4	" 23, " "	" V. H. Moore	4	40	10 50	15 50	66 00
5	" 23, " "	" Henry W. Day	7	70	21 00	17 50	108 50
6	" 24, " "	" A. F. Rogers	10	100	35 00	36 00	171 00
8	" 24, " "	" R. A. Pyne	to cover	er disburse- mnts	for cabs	\$1.50.	2 50
2275	May 9, " "	" James Thorburn	9	90	31 50	25 90	121 50
6	" 19, " "	" D. Bergin	4	40	7 00	25 90	72 50
							614 00
2423	Mar. 17, 1892	" V. H. Moore	2	20	7 00	13 75	40 75
4	" 17, " "	" H. W. Day	2	20	7 00	8 25	35 25
5	" 17, " "	" J. A. Williams ..	1	10	3 50	5 00	18 50
6	" 17, " "	" A. J. Johnson ..	1	10	3 50	.....	13 50
7	" 17, " "	" D. Bergin	2	20	3 50	25 50	49 00
8	" 17, " "	" Fife Fowler	2	20	7 00	13 00	40 00
9	" 17, " "	" Wm. Britton	1	10	3 50	.....	13 50
2430	" 17, " "	" James Thorburn ..	1	10	3 50	.....	13 50
1	" 17, " "	" R. B. Orr	1	10	3 50	.....	13 50
2	" 17, " "	" C. J. Campbell ..	1	10	3 50	6 50	20 00
4	" 17, " "	" W. B. Geikie	1	10	3 50	.....	13 50
9	April 7, " "	" J. A. Williams (on 6th April).....	1	10	3 50	5 00	271 00
2453	May 6, " "	" R. A. Pyne	to cover	er disburse- mnts	stenogra- pher,	.....	18 50
							27 80
Total							\$317 30

W. T. AIKINS, Treasurer.