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Original Communications.

ON THE IMPORTANCE OF AN EARLY RECOGNITION OF LOCOMOTOR ATAXIA.—DO THE EYE SYMPTOMS ASSIST US?*

BY J. T. DUNCAN. M.B., M.D., C.M., TORONTO.
Ophthalmologist to the Western Hospital, etc.

As physicians, we all wish to recognize, at the earliest possible moment, any disease which we may be called upon to treat. But in the case of locomotor ataxia—tabes dorsalis—it is of particular, I might almost say of supreme, importance, to make an early diagnosis. Is there any special reason for making such a statement? I answer yes, because the earlier this disease can be brought under treatment, the more hope there is of success.

Some, however, would object to the term "success" as applied to the treatment of tabes. Practically, they hold treatment to be useless, except in so far as palliating the symptoms is concerned. If this be true, if treatment is useless, then it makes little difference how early or how late we recognize the disease. If we can but palliate some of the symptoms, such, for instance, as the lightning pains, we may wait until these appear, and allow the pathological process to progress until inco-ordination has so developed as to render the man a useless member of society. But this disease is not the hopeless one it is often supposed to be. The trend of modern medical thought is to consider the treatment of locomotor ataxia as hopeful, at least in its earlier stages.

As we are all aware, tabes dorsalis has three stages. 1st. Pre-ataxic, or the stage before the staggering gait comes on. 2nd.

* Read at the Annual Meeting of the Ontario Medical Association, Toronto, June 19th and 20th, 1901.

Ataxic, when inco-ordination has produced the staggering gait.
3rd. Paralytic.

It is in the pre-ataxic stage that the greatest success may be looked for in treatment.

To emphasize this fact, let me quote from a great European authority, Babinski, a sentence giving the results of his own experience. He says: "I believe I do not exaggerate when I say that in my hospital practice I see from 200 to 300 cases of tabes each year, and of this number I do not see more than 15 to 20 who are clearly ataxic subjects. In my private practice I have numerous patients who have for many years been affected with tabes, as judged by its characteristic signs, and who, without retaining an absolutely perfect form of co-ordination, have continued at their usual employments, and have never passed the so-called pre-ataxic stage."

Judged by the older conceptions of this disease, when it was looked upon as almost hopeless, and reading such a statement as this, we may well say: How is it possible to attain such brilliant results? I answer, Because now the pre-ataxic stage can be recognized, and the case brought under treatment early. If we think for a moment of the morbid anatomy, we can see how hopeless, in the majority of instances, late treatment would be; although, even in late cases, arrestment of the disease can be accomplished. The principal morbid changes found, as we know, are sclerosis of the posterior columns of the cord, and foci of degeneration in the basal ganglia. Now, ataxy does not appear until the posterior columns have degenerated. If these columns are destroyed, irreparable damage has been done. True success consists in preventing destruction of nerve tissue; to do this, we must be able to recognize the pre-ataxic stage. What are the symptoms of this stage?

Osler gives them as (1) pains, (2) ocular symptoms, (3) loss of the knee-jerk. These are all pre-ataxic symptoms, but it has not yet been definitely ascertained which, in the majority of instances, is the earliest. I believe the ocular symptoms will be found to occupy that position. The eye symptoms are, of course, well known to all of us. Some of them are found in almost every case of locomotor ataxia.

But it will be well to get these symptoms clearly before our minds; then we shall endeavor to determine the question of their priority and of their value.

They are (1) strabismus, or squint; (2) ptosis, or drooping of the eyelid; (3) the *fixed* pupil (Argyll Robertson pupil); (4) inequality of the pupils; (5) optic atrophy.

1. The strabismus of tabes has characters of its own. It often comes on suddenly. It is very likely to be temporary. It may last but a few days or weeks, and may recover as sud-

denly as it came on. It may produce double vision. Any of the muscles may be paralyzed, therefore the squint may be in any direction. Although usually temporary, the squint may be permanent.

2. Ptosis.—The ptosis of tabes may be single or double; generally it is single, only one lid drooping. The ptosis, like the squint, may be temporary or permanent.

3. The *fixed*, or immobile pupil.—On looking at the pupils, no abnormality may be observed. Upon covering them with the hands, however, they do not dilate, nor on exposing them to a bright light do they contract. They are fixed—immovable. (They do diminish in size, however, on convergence; this is the Argyll Robertson pupil).

4. Another pupillary symptom is seen in tabes, namely, inequality. This is generally due to the contraction of one pupil. The vast majority of tabetic patients have one or other of these pupillary symptoms. Berger claims that 97 per cent. of cases of locomotor ataxia show some pupillary symptom.

5. Optic Atrophy.—This produces more or less failure of sight. The atrophy is "grey" and it is "primary." The retinal vessels are not affected in size.

These, then, are the eye symptoms which are encountered in tabes, viz.: Strabismus, ptosis, fixed pupils, unequal pupils, and optic atrophy. Are they the earliest indications of tabes? Osler puts "pains" as the first of the pre-ataxic symptoms. Unquestionably, the diagnosis of tabes is generally made first from the pains; but that is readily explained by the fact that pain speedily drives a man to his physician, but fixed pupils do not. For a fixed pupil produces so little inconvenience, that it may exist for months before it is noticed. But even when pain sends the patient for advice, how often the doctor will find Argyll Robertson pupils existing at the same time? The same remark may be made in regard to loss of the knee-jerk. In such cases, then, the eye symptom has preceded the pain, although it was not noticed. And not infrequently this symptom (fixed pupil) is noticed long before the pain comes on. So with the other ocular symptoms. A patient, in adult life, consults his physician for a suddenly-appearing squint, or ptosis, or for an optic atrophy, and he may have had no pains or other noticeable symptom of tabes. If no cause is discovered for these eye symptoms, we are certainly justified in suspecting locomotor ataxia. In such cases, the eye symptoms are the earliest indications of the disease.

Cases are on record making all these facts clear. Neurologists and ophthalmologists the world over are insisting more and more upon the importance of these ocular symptoms as being among the earliest indications of the disease. In this connection I

would refer you to a paper recently published in the *British Medical Journal*, by C. O. Hawthorne, "A Clinical Study of Thirty Cases of Locomotor Ataxia." He says: "A step forward in our knowledge . . . of locomotor ataxia has been the recognition of the fact that ocular disturbance may precede the evidence of any spinal lesion;" and again, "the cases may be held to justify the view that an optic nerve atrophy, an ocular paralysis, or the Argyll Robertson pupil, must be regarded as affording a definite basis of suspicion . . . of locomotor ataxia." In view of what has been said, I think we may fairly admit that the eye symptoms will, in many cases, most materially assist in the early recognition of locomotor ataxia; but in order to this, these symptoms must be fully understood, carefully examined, and their indications never neglected. How often, in former years, has a patient perhaps casually mentioned to his physician that he had a squint, and had double vision for a couple of weeks, but it passed away, and he thought little of it. Or that he had drooping of one of his eyelids; or that his sight had failed unaccountably of late? Any such statements now would rouse in the mind of the physician the gravest suspicions; he would look upon them as danger signals, and would act accordingly.

In endeavoring to sum up this matter, I would emphasize the following points:

1. The extreme importance of the early recognition and treatment of tabes.

2. That the eye symptoms, in a certain number of cases, precede all the others.

3. That if, especially in an adult male patient, any one of the ocular symptoms be discovered, the case should be thoroughly investigated, even if no other symptom be discerned, and kept under observation until clearly understood.

4. But that if, in the course of such investigation, even our other ocular symptoms be found, the case is probably one of locomotor ataxia.

5. That if such a case be left untreated, ataxia may be expected to appear after a longer or shorter time; but, if treatment be instituted, the patient may remain in the pre-ataxic stage, and continue to be a useful member of society.

SYPHILITIC FEVER OCCURRING AS A COMPLICATION IN A MATERNITY CASE.

REPORTED BY HELEN MACMURCHY, M.D.

In commenting on Dr. Fitcher's paper (which appeared in the *New York Medical Journal* of June 22nd, 1901, and is reproduced in the present issue of THE CANADIAN PRACTITIONER), the *Lancet* (July 27th, 1901) remarks that "in syphilis, fever of such degree as to attract attention seldom occurs, but the subject is well worthy of investigation." The following case, which occurred in the "Burnside" department of Toronto General Hospital, under care of Dr. A. H. Wright, is interesting in this connection.

A. K., aged seventeen years.

At the onset of labor, July 17th, 1901, six o'clock p.m., the head nurse reported a sore (of which the patient had never before complained) upon the inner aspect of the right labium minus. On examination, this sore was found to be much inflamed and indurated, about two inches in length and one inch broad, with a central ulcer of characteristic appearance. The head pressed on the perineum at about 8.15 p.m., and remained there one and one-half hours.

Acting under instructions from Dr. K. C. McIlwraith, the house surgeon in charge applied axis-traction forceps and delivered the child at 9.45 p.m., no laceration occurring.

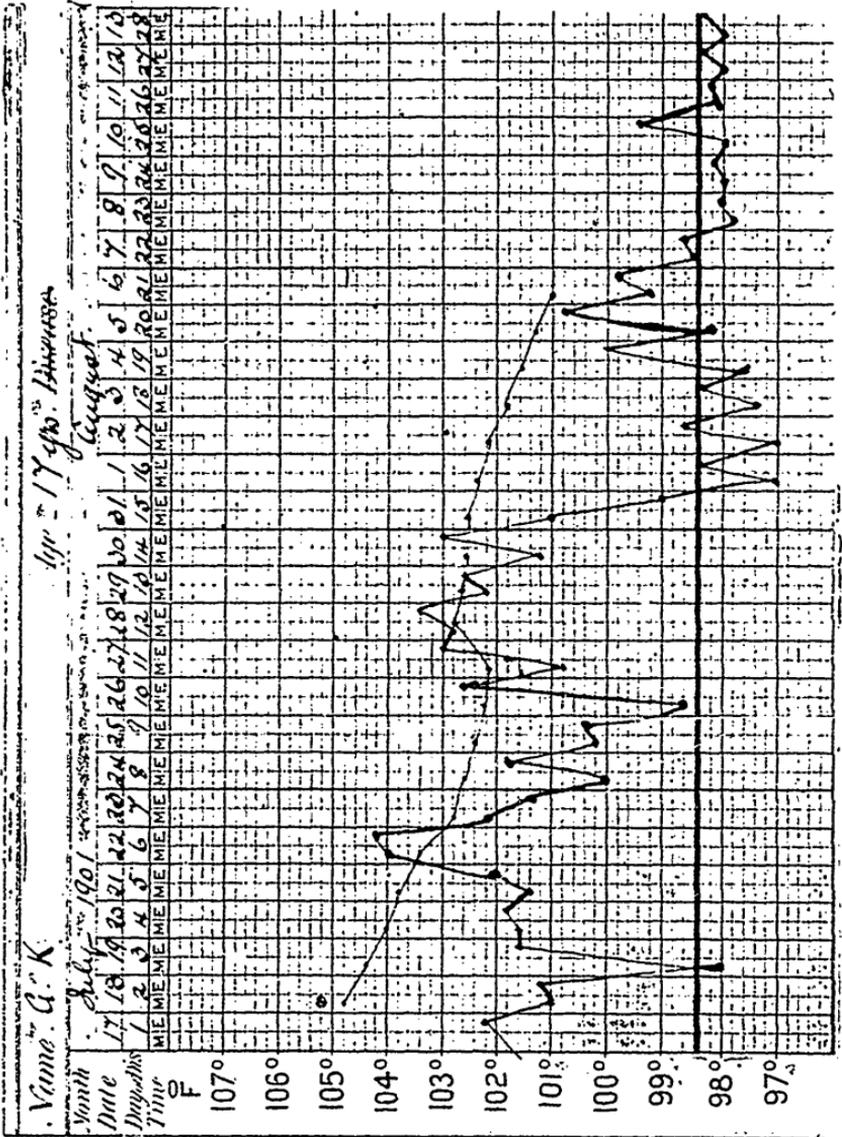
The accompanying copy of the "Burnside" chart shows the temperature and indicates the involution of the uterus. Thus the position of the umbilicus \odot is five and one-fifth inches (thirteen centimetres) above the symphysis pubis, and the fundus uteri on the fourth day was four inches (ten centimetres) above the symphysis.

No explanation of the high temperature suggested itself, except that it was due to syphilitic infection, and the patient gave a history which supported this view.

The infant was resuscitated with difficulty by the Sylvester method. Hot and cold water were also used. Repeated hemorrhages from the cord were finally controlled by the application of collodion and acetanilid. Weight of infant at birth, six and one-half pounds. The mother made an excellent recovery, reporting herself on September 4th as quite well and strong. The infant was quite well on leaving the "Burnside," but the

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mother, on September 4th, stated that sores had appeared which, from her description, were probably specific.



Treatment.—Iodoform and calomel were dusted freely over the sore, but caused so much irritation that a solution of lysol (3i, or 1 dr. to the pint) was used instead.

Internally, m. 20 of hydrarg. bichlor. 1 in 1000, were given four times a day, well diluted, but this treatment had to be discontinued at the end of a week on account of nausea. An inunction of ungu. hydrarg. was then ordered.

At the time of discharge the sore was almost entirely healed. No other symptoms whatever developed.

(The statement made by the writer in the *Lancet*, which has been quoted by Dr. MacMurchy, is entirely misleading, if not incorrect. There is probably in all syphilitic patients, more or less fever, especially during the secondary stage, which is recognized in at least a fair proportion of cases. In syphilis contracted during pregnancy, as has been pointed out by Sigmund, Spiegelberg, Lusk, and others, there is a more rapid and severe development of the primary symptoms, while the secondary are usually very mild. It may be that fever during the primary stage in pregnant women is not uncommon.—A. H. W.)

HERNIA. TEN YEARS AFTER ABDOMINAL SECTION.

BY A. GIBSON, M.B., HILLSBURG.

Mrs. S., aged 78 years, stout, weight before trouble began about 150 pounds. Always strong and healthy up to about ten years ago, when she was operated upon for ovarian cyst, from which she made a good recovery. Incision for operation was made in linea alba. She first consulted me for palpitation and shortness of breath, in October, 1899. Again in December, 1900, when she suffered considerably from her heart (cardiac neurosis). In February, 1901, I attended her with pneumonia, from which she recovered. On June 5th, 1901, was called back again for her heart. I then found an irregular, dilated heart, extreme breathlessness, sleeplessness, sitting in chair all the time, some edema of ankles, considerably emaciated. From this date on the edema increased, and extended up into abdomen, with some peritoneal and pericardial effusion. Had to give morphine to relieve distress.

For a few days before July 28th she had felt better, and was able to be around. On the morning of the 28th she took a dose of mag. sulph., and about 3 p.m. went out to the water closet, and while sitting on the seat pressing to expel the feces, she put a hand on each side of the abdomen and pressed backward, downward and inward. While doing this something gave way, and she screamed and fainted. I was sent for at once, but as she lived six miles out in the country, it was over an hour before I arrived. I found her on a

sofa, with bowels protruding from a rent in the abdominal wall. She had bled profusely, and pulse was imperceptible, but she was quite rational, and explained how it happened. I sent at once for an assistant, but it was some hours before he arrived, by which time she was unconscious, and seemingly about to expire at any moment, but she lingered on till about 6 a.m. on the 29th, or about fifteen hours after the accident.

Post mortem examination revealed about four or five feet of intestine, together with some omentum protruding from the rupture in the abdominal wall. The tear was in the site of the old cicatrix, extending from near the pubes to the umbilicus, and the skin only was torn for over an inch upwards, and to the left. I could easily insert the whole hand into the abdominal cavity through the wound. The abdominal cavity was pretty well filled with blood clots. On examining the intestine, I found it to be torn directly across, the tear extending through the mesentery to the spine, hence the extensive bleeding which took place. The stomach and bowels were in a healthy condition. Now what were the causes of the rupture? I have been wondering what part the following conditions played in the etiology, viz.: the cicatrix, the dropsy, the pressure and senile atrophy.

Selected Article.

SYPHILITIC FEVER, WITH A REPORT OF THREE CASES.

(From the Service of PROFESSOR WILLIAM OSLER.)

BY THOMAS B. FUTCHER, M.B., BALTIMORE,

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While its protean characters are universally recognized, physicians do not sufficiently appreciate the fact that syphilis is often responsible for many cases of obscure fever, which clear up only when proper antisyphilitic treatment has been instituted. Even when the fever is associated with a recognizable syphilitic lesion it is often attributed not to the syphilitic infection, but to some other cause, and treated accordingly. The cases, however, which most frequently give rise to an error in diagnosis are those in which at the time there is no outward manifestation of the disease, and where the primary syphilitic infection, with possibly secondary or tertiary symptoms, has occurred so long before that its bearing on the fever is lost sight of. Many cases of syphilitic fever, being unrecognized, are treated as one or other of the acute infectious diseases. The treatment being ineffectual, a more careful physical examination of the patient reveals, possibly, a slight thickening of the clavicles or tibiæ or some evidence suggestive of visceral syphilis. Suspicions are then aroused that the fever may be of specific origin and antisyphilitic treatment is begun with a prompt return of the temperature to normal. That this late syphilitic fever is not sufficiently recognized is shown by the fact that few of the writers on syphilis refer to it. Rarely is it mentioned in text-books, though both Osler and Musser emphasize the importance of bearing it in mind in fevers of obscure origin. The purpose of this paper is to draw attention to this interesting symptom and to report a few cases of syphilitic fever which have been admitted to Dr. Osler's wards in the Johns Hopkins Hospital.

Syphilitic fever may occur at various periods during the course of the infection.

1. It may occur, in very rare instances, so long as three or four weeks before the onset of the secondary skin eruption. This early fever is puzzling and is likely to be attributed to some other cause until the eruption makes its appearance.

2. It may precede or be coincident with the appearance of the secondary eruption. This is the so-called "fever of invasion," and it is a very common and important symptom of secondary syphilis.

3. The fever may occur at any time during the course of the secondary or tertiary stages. The late occurrence of the fever is a most interesting feature. In Case III, for instance, it occurred twenty-nine years after the disease was contracted.

The "fever of invasion" is rarely absent at the onset of the secondary symptoms. It is sometimes wanting, however. It usually precedes the appearance of the secondary eruption by a week or ten days. Rarely does it antedate the eruption by more than two weeks. Practically all authorities now agree that this fever is a symptom of the invasion of the system by the organism believed to be the cause of syphilis or by its toxic products. At an earlier date some observers were inclined to attribute it to some coincident infection. At the onset of the fever there is often a transitory erythema of the skin which disappears, to be followed by the true syphilitic roseola a few days later. Lang states that the fever of invasion is seldom ushered in by a chill. It is usually accompanied by headache, malaise, general depression, and rheumatoid pains throughout the body, which are most annoying in the afternoon. The height of the fever varies greatly in different cases. It may only be moderate, not reaching above 101° F. On the other hand, the daily elevation may be much higher, the afternoon temperature reaching as high as 104° F. to 105° F. Lang quotes Stoll as authority for the statement that the fever of invasion in syphilis is usually of a definite remittent type, and states that all syphilologists who have studied this symptom of syphilis agree on this point. All cases do not conform to this rule, however. The fever of invasion, as well as the syphilitic fever associated with the late manifestations of the disease, may present any one of the following three clinical types of fever:

1. A mild continuous pyrexia, where the temperature ranges in the neighborhood of 101° F. Osler states that this type is not uncommon in the fever which ushers in the constitutional symptoms.

2. A remittent type of fever, with morning drops toward normal and evening exacerbations. This, as already stated, is considered the usual character of the fever of invasion.

3. A definite intermittent fever. This is the most remarkable form of all and is the type which is most likely to lead to error in diagnosis.

Syphilitic fever, although usually a secondary manifestation, may occur late in the disease. The febrile diseases for which such a fever is only too often mistaken, are malarial fever,

typhoid fever, tuberculosis, and sepsis. Where general pains and joint-pains accompany the fever, the diagnosis of rheumatism may be made.

The following case was one of unusual interest and illustrates how puzzling some of the cases of syphilitic fever may be during the period of the fever of invasion :

Case I (Hospital No. 32480).—*Syphilitic fever of remittent and intermittent type, commencing at least twenty-seven days before the appearance of the secondary eruption. Fever ushered in by a chill, followed by sweating.*

L. B., a woman, married, aged thirty-four years, was admitted to the gynæcological department of the Johns Hopkins Hospital on September 28, 1900, complaining of abdominal pain. The family and personal histories then obtained were unimportant.

The abdominal pain of which the patient complained on admission began three weeks before she entered the hospital. The night before admission she had a shaking chill, followed by a profuse sweat. The patient was examined by Dr. G. B. Miller, who found a pelvic abscess, with evidences of a double salpingitis. On September 29th and 30th the temperature ranged between 98.7° F. and 101° F. This fever may quite possibly have been due to the local pelvic inflammation. On October 1st the pelvic abscess was evacuated *per vaginam* by Dr. Miller. The temperature failed to drop, and on October 4th it rose to 104.2° F. On this date there was a slight erythema of the skin of the body. As it was thought possible that one of the acute exanthemata was developing, the patient was transferred to the isolation ward. The erythema proved transitory, however, and had disappeared by the following day. This febrile paroxysm, on October 3rd and 4th, was ushered in by a definite chill and accompanied by profuse sweating. The temperature fell very slowly and had not reached normal before another febrile attack occurred on October 6th, the temperature rising in the evening to 105.5° F., falling rapidly and reaching normal at midday on October 7th. Subsequently, there was a third exacerbation of temperature, commencing on October 9th and lasting until October 11th, the temperature reaching 104.2° F. on October 10th. On October 14th a fourth febrile attack occurred, the temperature rising to 103° F. From this time on, the temperature gradually fell, but there were still slight elevations of temperature in the evening.

The case naturally occasioned a great deal of worry. It was thought that there might still be a focus of suppuration in the pelvis. Pelvic examination showed the local condition to be perfectly satisfactory, and no pus focus could be found. The heart and lungs were normal. There were no rose-spots. The leucocytes were frequently counted and were practically normal

throughout, the highest count at any time being 10,000. The spleen was distinctly palpable, and it was thought possible that the case might be one of a typical typhoid fever. The Widal tests proved negative. The character of the fever suggested strongly an æstivo-autumnal malarial infection, but repeated examinations of the blood failed to show any malarial parasites.

On October 17th the patient was transferred to the medical service of the hospital, there being no further indication for isolation and it having been decided that the fever was not due to any pelvic complication. The physical examination of the patient, however, failed to throw any light on the obscure fever from which the patient had suffered. The patient was feeling much better in every way and, as the temperature was elevated only about one degree each day, she was discharged on October 21st, apparently practically well. There was no evidence of any skin eruption when the patient left the hospital. The provisional diagnosis was "intermittent fever of doubtful origin."

The subsequent history of the case was of great interest and clearly explained the cause of the obscure fever. On October 30th the patient returned with a definite macular and papular secondary syphilitic eruption, the diagnosis being confirmed by Dr. Gilchrist. On November 4th, when she again returned for observation, the face, shoulders and arms presented a definite macular eruption, and over the front and back of the chest there were scattered papules and an occasional pustule. There was general enlargement of the superficial lymph glands, the epitrochlear glands being the size of hickory-nuts.

Inquiry was now made into the venereal history of the patient's husband. He admitted exposure to infection on July 4, 1900. On August 11th he came to the Johns Hopkins Hospital Dispensary for treatment, and the records show that he then had a hard chancre on his penis. On August 27th he returned with a macular syphilitic eruption, and again, on September 15th, he was treated for a gonorrhœal urethral discharge.

On questioning the patient, she could give no history of the onset of the primary sore, nor were there any evidences of a chancre made out at the time of the operation, although it was not specially looked for.

The points of interest in this case are: (1) The impossibility of establishing a diagnosis until the secondary skin eruption became manifest; (2) the occurrence of chills and sweating and the close resemblance of the fever to that of æstivo-autumnal malaria; (3) the absence of any definite relationship between the fever and eruption which did not appear until practically four weeks after the onset of the fever; (4) the subsidence of the temperature to nearly normal a considerable time before the appearance of the skin eruption and without antisiphilitic treatment.

A case very similar to the above has been reported by Burney Yeo. The patient had a fever ranging as high as 104° F. to 105° F., with daily oscillations of from 5 to 6 degrees. An interesting feature of his case was that the fever began between twenty-five and thirty days after the exposure, and between three and four weeks before the appearance of the secondary eruption.

Case II (Hospital No. 10581).—*Syphilitic fever of a remittent and intermittent type which for weeks was suspected of being typhoid fever and treated as such. Diagnosis established by the discovery of periosteal thickening over the clavicles and by cessation of the fever the beginning of treatment with potassium iodide.*

N. R., a man, married, aged thirty-nine years, was admitted to Dr. Osler's service in the Johns Hopkins Hospital on August 8, 1894, complaining of pains all over the body. The family history was unimportant, with the exception that his father had died of pulmonary tuberculosis. The patient had always been a healthy man. He had had gonorrhœa, but denied ever having had lues. He used alcohol in moderation.

The patient had been ill and unable to work for three weeks previous to admission. During this period he had felt feverish at times. Nausea, vomiting, and diarrhœa were complained of during the week previous to his entering the hospital. He had not had headache or epistaxis, but had complained of aching pains in the back and extremities and of general weakness. There had been a steady loss in weight, but the patient had not been confined to bed previous to admission.

The physical examination of the patient failed to reveal anything to account for his fever and other symptoms. There was a corneal opacity of the right eye, which, however, was believed to be due to perforating corneal ulcer occurring during childhood. The examination of the thoracic organs was negative. There were no typhoid rose-spots. The liver was not enlarged, but the spleen palpable four centimetres below the costal margin. The superficial glands were not enlarged. There were several pigmented scars on the right shin, but there were no nodes on either tibia. The blood examination was negative for malarial parasites. The urine was normal and did not show the diazo reaction.

As already stated, the patient apparently had irregular fever for three weeks previous to admission. On the day he entered the hospital his temperature rose to 103.4° F. at 8 p.m. The pulse and respirations at the same hour were 92 and 20 to the minute. A two-hour temperature record was taken and, from August 8th to September 12th, there was persistent fever. At times the temperature ran a fairly continuous type, but usually

was remittent or intermittent in character, the evening exacerbations reaching as high as 102° F. to 103° F. Owing to the fact that the patient was admitted to the hospital at a season when typhoid fever was prevailing, and, taking into consideration the character of the fever and the enlargement of the spleen, it was strongly suspected that the case was one of typhoid fever, and the patient was given cold sponges. The diagnosis was always in doubt, however. At no time did rose-spots appear, and the urine never gave the diazo reaction. The case occurred before the Widal reaction came into use.

On September 12th Dr. Thayer made the following note: "Both clavicles towards their sternal ends are remarkably thickened and bowed. They feel remarkably as if the thickening were due to an old periostitis. Both ulnæ and tibiæ are free from nodes. There is a distinct scar on the glans penis, and the patient says that he had a sore on the prepuce."

It was thus suspected for the first time that the fever might be of syphilitic origin. Accordingly, on September 12th, potassium iodide in fifteen-grain doses three times a day, the amount being gradually increased from day to day. The effect on the temperature was most striking. On September 13th there was practically no change, the temperature reaching 102.4° F. at 8 p.m. From this day on it steadily fell, reaching normal on September 16, four days after the potassium iodide was started. It remained normal during the rest of his stay in the hospital. He was discharged from the hospital on October 3rd, feeling perfectly well.

The day the patient left the hospital Dr. Osler made the following note: "This case is of exceptional interest in connection with the fever of lues. Although he had no rash, no visceral lesion, only chronic periostitis of the clavicles, which are now symmetrically enlarged, the history of lues, the presence of the periostitis, and the drop in the temperature after specific treatment was started, seem to justify the suspicion if not conclusion that this case is one of luetic fever."

This case illustrates very well how closely some cases of syphilitic fever resemble typhoid fever, both in the clinical symptoms, and to a less degree in the character of the temperature. It also shows the importance of carefully examining the condition of the long bones in fevers of doubtful origin, for in this patient the cause of the fever was determined by the discovery of periosteal thickening of the clavicles. Prentiss published a similar case of syphilitic fever with remittent temperature, in which typhoid fever was first considered. The presence of a pharyngitis and the development of a suggestive-looking ulcer over the right tibia led to the suspicion that the patient was probably suffering from syphilis. Treatment with

potassium iodide and mercury was followed by an immediate return of the temperature to normal.

Case III (Hospital No. 5796).—*Syphilitic fever, characterized by intermittent chills with fever, and treated first as a case of malaria. Fever occurred twenty-nine years after the primary infection and yielded readily to antisypilitic treatment.*

W. W., single man, a physician, aged fifty-seven years, was admitted to the Johns Hopkins Hospital in Dr. Osler's service on August 24, 1892, complaining of having suffered from chills and fever. He had had typhoid fever at fourteen, and diphtheria at twenty-eight years of age. In 1864, at the age of twenty-eight years, he contracted syphilis and developed definite secondary symptoms. Later, he had deep ulcers on his body which were apparently tertiary lesions. These persisted for three years, but eventually yielded to mercury and potassium iodide. In 1882, while in good health, a sore developed in the popliteal space and another in the hairy scalp. He again took specific treatment and the lesions cleared up.

About June 15, 1892, several sores appeared on his body, which, from the description given, were apparently rupial in character. About two weeks before admission to the hospital some tenderness and swelling developed over the sternum and in the left shoulder-joint. About the end of July the patient began to have definite recurring attacks of chills and fever, the temperature rising to from 102° F. to 104° F. The physician in attendance thought that the chills were of malarial origin and gave quinine in daily dose of twenty grains, without any effect on the fever. A few days before the patient entered the hospital Dr. Osler saw him in consultation. A definite history of recurring chills was obtained, but the examination of the blood showed no malarial parasites. The fever was regarded as probably of luetic origin, and potassium iodide in increasing doses was begun. When the patient entered the hospital a few days later, on August 24th, the chills had ceased, but he was still having evening elevations of temperature to 101° F. Under the iodide the temperature gradually fell, and by September 14th reached normal and did not become elevated afterward. The patient remained in the hospital until November 2, 1892, on which date he was discharged, feeling perfectly well.

The case just related illustrates the error so often made of mistaking syphilitic fever for malaria. The late occurrence of the fever, namely twenty-nine years after the syphilis was contracted, is of great interest. This is a longer period after infection than in any case of which I have been able to find records in the literature. A remarkable case of syphilis fever is reported by Sidney Philips. His patient, a woman, had regular intermittent chills, fever and sweating occurring every

other day over a period of eight months. Early in the illness the paroxysms occurred daily, but later presented a typical tertian intermittent type, and the fever was practically identical with that of tertian malaria. Quinine was given a thorough trial, without any effect on the temperature. The fever began to fall very soon after the beginning of the administration of iodide of potassium and reached normal in a few days. In this case the fever occurred nine years after the syphilis was contracted.

Syphilitic fever is mistaken for tuberculosis even more frequently than for malaria. The patients may present themselves complaining of fever, sweating at night, loss of weight, general malaise, and possibly some pain in the chest. The examination of the lungs may show a few râles, which renders the case very suspicious. In other instances the diagnosis is made without any signs in the lungs or elsewhere in the body pointing to tuberculosis. Janeway has drawn especial attention to the prevalence of this error in diagnosis. He points out that the mistake is not made alone by physicians of little experience, but often by those of well-established reputation. In a most interesting paper he cites six cases of syphilitic fever which had been interpreted and treated as tuberculosis. The cases had subsequently come under his personal observation. Four of these had been sent to health resorts for phthisical patients without benefit. Careful examination and inquiry into the history of each case led to a diagnosis of syphilis, with prompt disappearance of the fever and restoration of the health of the patient after the commencement of specific treatment. Morgan reported a case of syphilitic fever of intermittent type, in which acute miliary tuberculosis was for a considerable time suspected. The absence of tubercle bacilli from the sputum and the existence of a luetic history led to the administration of potassium iodide, with prompt recovery from the symptoms and cessation of the fever.

Other cases of syphilitic fever could be cited, but the three cases reported above suffice to draw attention to the main points of interest in the consideration of this interesting symptom of lues.

The following points may be emphasized in connection with syphilitic fever:

1. In all cases of fever of obscure origin the possibility of it being syphilitic should be borne in mind.

2. Experience has shown that physicians of reputation, as well as those of limited experience, are prone to mistake the condition for one of the acute specific fevers.

3. The affections for which syphilitic fever is most often mistaken are malaria, typhoid fever, tuberculosis, sepsis, and occasionally rheumatic fever.

4. The fever may occur as early as four weeks previous to the appearance of the secondary skin eruption, or, what is of greater importance, late in the disease after tertiary manifestations have existed probably for years. In case III it occurred twenty-nine years after the primary lesion.

5. The fever may be continuous, remittent or intermittent. The remittent type is regarded as the most frequent form in the fever of invasion. The fever is often associated with chills and sweating.

6. Careful examination of the long bones and viscera for evidence of tertiary lues should be made in all cases of fever of obscure origin.—*N.Y. Med. Journal.*

Society Reports.

CANADIAN MEDICAL ASSOCIATION.

The thirty-fourth annual meeting of the Canadian Medical Association opened at Winnipeg, Manitoba, on the morning of the 28th of August, and continued for the two following days. There were in attendance over 175 members from all parts of the Dominion, the second largest gathering in the history of the Association, and the meeting itself has been pronounced the most successful of any yet held under the auspices of this Association. There were several visiting doctors from the United States.

Dr. H. H. Chown, of Winnipeg, the President, occupied the chair, while Dr. F. N. G. Starr, of Toronto, discharged the duties of secretary.

In the absence of Chief Justice Killam, Dr. J. H. O'Donnell, one of the oldest practitioners in the West, delivered the address of welcome. He referred to the conditions present in 1869, when Winnipeg was an outpost of civilization, and gave interesting references to Drs. Cowan, Curtis J. Bird, Beddom and Bund, who were already in the West when Dr. O'Donnell moved there in 1869. His address was very much appreciated by the members of the Association.

Dr. R. W. Powell, of Ottawa, the past-President of the Association, then introduced Dr. H. H. Chown, the President-elect.

Dr. Chown on rising to reply was received with hearty cheers, testifying to the high esteem in which he is held by his fellow-practitioners throughout the Dominion. He briefly thanked the Association for the honor they had conferred upon him at the meeting in Ottawa one year ago.

Dr. Starr, the Secretary, presented his annual report. It referred to the meeting at Ottawa last year, to the attendance of 153 members—which was an increase over former meetings in that city, to Dominion Registration, and to the formation of a Physicians' Protective Association.

Dr. Edebohls, of New York, and Dr. Sutton, of Pittsburg, were welcomed to the convention and requested to participate in the discussions.

The Question of Medical Defence.

This was introduced by Dr. Russell Thomas, of Lennoxville, Que., who had been delegated by the St. Francis District Association to present this subject to the Canadian Medical Association. He made a strong plea for the formation of a Medical

Defence Union, and thought that all were agreed of the necessity for such. He supported his contention by citing two or three cases already well known to medical practitioners in Canada, and after showing that such defence unions were a success in England, he concluded by outlining the plan of medical defence already in vogue and supported by the St. Francis District Medical Association, which he was authorized and prepared to hand over entire to the Canadian Medical Association. The discussion of this important matter was deferred until later on in the session.

Address in Medicine—"The Question of Medical Education."

Dr. J. R. Jones, of Winnipeg, delivered this address. In opening his remarks, he referred to the unsolved problems of medical education, the importance of which were especially manifest in view of the establishment of a Dominion Medical Board. Uniform or equivalent curricula, he thought, would greatly facilitate paving the way for the accomplishment of this object. He thought that the great aim of the Canadian Medical Association should be to create a Dominion Medical Board upon such a sound and enduring basis, that the qualifications could be registered in every province in the Dominion. They should not only be Canadian, but Imperial, capable of registration in Great and Greater Britain. There should be no special education for the profession of medicine, and the defect in the preliminary education of medical students should be corrected. The standard is not high enough. Many students came into the medical colleges, their minds totally unprepared, undisciplined, not competent to engage in the different studies of a profession with advantage. Dr. Jones would not eliminate Latin, but would go a step farther, and advocate a more general knowledge of Greek, as Greek was *par excellence* the language of science. He quoted from two eminent authorities who favor the retaining of classical education as a training for professional studies—Dr. Alexander Hill, a member of our own profession, who is Master of Downing College, Cambridge, and Professor Jebb, of Berlin. He referred to medical matriculation examinations, and deplored the lamentable defects in the English paper, the most neglected subject in our primary schools. From an experience of many years as an examiner at the University of Manitoba, Dr. Jones has concluded that the teaching of English takes a very subordinate position in our schools. The defect was a universal one: and it was obvious that if English should become a prominent subject of the medical matriculation examination, every student ought to be able to express his thoughts coherently and intelligently. The didactic lecture came in for adverse criticism, and defects and useless

waste of time, which could be more profitably employed, were pointed out. Persistent work in the dissecting room under the guidance of an experienced demonstrator, who will describe, discuss and constantly orally examine the student, is a rational and effective method of teaching anatomy. Medical jurisprudence and sanitary science were not properly taught.

Dr. Jones supported the "case" method of teaching; and, from personal experience, he favors the English system of clinical clerkships and dresserships as the most feasible, practical and thorough for the development of medical teachings. He referred to the question of Dominion registration, and pointed out two serious objections to Dr. Roddick's bill—first, the great number of the representatives on the council, entailing expenses beyond, at least, our immediate resources; and second, the fact that one of the contracting parties to Dominion registration may secede, and the elaborate fabric, the work of many years, tumble to the ground. The able paper of Dr. Jones was received with much gratification by the Association.

Dr. R. B. Nevitt, Dean of the Woman's Medical College, Toronto, in moving a vote of thanks to Dr. Jones for his excellent paper, stated that he had placed his finger on the weak point of medical education. Dr. S. J. Tunstall, of Vancouver, seconded the motion for the vote of thanks, and also congratulated Dr. Jones for the excellent manner in which he presented his subject.

Dominion Registration.

Dr. T. G. Roddick, of Montreal, who has so long and so ably advocated this much-to-be-desired measure, delivered a stirring address on the subject, ably reviewing the subject of Inter-Provincial registration from the time of its inception to the introduction of his bill at the last session of the House of Commons. The special committee appointed on this question had not yet reported, so the discussion was postponed until that committee had a chance to meet, and report later on in the session. Dr. Roddick now seems to hold to the opinion that the suggestion of Dr. Britton, of Toronto, that representation by population, for Ontario at least, would be advisable.

Infectious Pneumonia.

Dr. W. S. Muir, Truro, Nova Scotia, read this paper. He reported four cases, all of which had occurred between the 1st and the 13th of April of this year, in the same house and in the same family. The first occurred in a child of ten years, the disease terminating by crisis on the 6th day, the child making a good recovery. A sister, age 14 years, contracted the disease;

terminated by crisis on the 9th day, but followed two days after by left-sided pleuro-pneumonia. This proved fatal. The third occurred in a sister of 15 years of age, beginning with a pain on the left side and terminating on the 10th day by crisis and recovery. Number four developed pneumonia but recovery was quick, the patient being about in two weeks. There was no influenza in the town at the time. Dr. Muir spoke of the organism of pneumonia, its cultivation and its detection.

FIRST DAY—AFTERNOON SESSION.

PRESIDENT'S ADDRESS.

As this was the first time that the Canadian Medical Association met in Manitoba, Dr. Chown referred briefly to the future of that important province. Although less than 10 per cent. of the arable land was under cultivation, Manitoba's farmers would this year have a crop estimated at 85,000,000 bushels of grain. He then referred to the work performed in Winnipeg for the purpose of making that city a healthy one, and in spite of the level nature of the land, an excellent system of sewers had been introduced through all the streets; and efficient arrangements had been made for regular flushing of the sewers by means of tilting basins at the upper end of each main sewer. As Winnipeg has two rivers at her doors, the problem of removing sewage was easily and safely solved. Dr. Chown then referred to the water supply, and said that the people of Winnipeg enjoyed as pure water as could be found in the world. An examination of the city water would show that there were in it only nine to thirty colonies of bacteria. The water is taken from an artesian well seventeen feet in diameter and forty-eight feet deep, and although they have been pumping for months a supply of from two million to three million gallons per day, there is not the slightest evidence of any diminution of the amount flowing in. The well is supposed to tap an underground passage which runs from Lake Manitoba, and as this lake is 130 miles long the supply is inexhaustible. The underlying rock formation in that section of Manitoba is a magnesia limestone and, consequently, the water contains a large amount of the carbonate of lime and of magnesia, and is too hard for satisfactory use in boilers and hot water appliances. This is overcome by using Clarke's method of softening, by precipitation of these carbonates through the action of lime water; and the softening plant is unique on this side of the Atlantic. Dr. Chown then referred to the question of tuberculosis, and thought that Koch's tentative denial of the oneness of tuberculosis of man and tuberculosis of cattle still needs the proof of non-inoculability from cattle to man. He instanced cases of young

farmers free from tuberculous taint living in newly-built houses harboring no bacilli and separated by long distances from their neighbors, in whom tuberculosis constantly makes its appearance; and we have here an experiment on a wide scale, and if you can eliminate heredity, house infection and contagion from other cases, to what cause can you describe the origin of these outbreaks? Medical education, the plan of Dominion Registration as introduced by Dr. Roddick, malarial fever, proprietary drugs, the progress in surgery and the future of bacteriology and hematology were subjects ably dealt with; and in concluding, Dr. Chown felt that a duty rested upon the medical profession to get at the true cause of all forms of disease and rescue the public from both the honest fanatic and the ignorant pretender by doing not only all what these claim, but doing more and doing it better.

Sir James Grant, of Ottawa, moved a vote of thanks to the President and characterized the address as extremely interesting and instructive. Dr. J. L. Bray, of Chatham, seconded the motion.

Epidemic Cerebro-Spinal Meningitis.

Dr. James McKenty, Gretna, Manitoba, presented this paper, which gave an account of an epidemic occurring in North Dakota during the winter and spring of 1893. It occurred within an area extending fifty miles from east to west and twenty miles from north to south, and was comparatively definitely limited. About 70 persons were seriously ill and almost as many others suffered from mild manifestations of the disease. Of the seventy cases twenty-five ended fatally, a mortality of about 35 per cent. In the practice of Dr. McKenty there occurred some thirty cases, a brief record of twenty-two of these being kept. The average age was seventeen years; the youngest fifteen months; the oldest thirty-eight years. The duration of the illness extended from twelve hours to fifteen weeks. No post-mortem was made in any case. Dr. McKenty then described in detail the clinical aspects of several cases.

Splenic Anemia, with Case.

Dr. A. J. Macdonnell, Winnipeg, contributed this paper with the history of the case. This was an exceedingly rare disease. In 1898 the number of cases recorded did not exceed thirty, but since that time there have been fifty additional cases reported. R. N., aged 27 years, born and lived all his life in Manitoba; family history good; environment good; has never had malaria; habits and mode of life good; positively never had syphilis. The present illness began in August, 1899. Felt heavy

on the right side, with a feeling of fulness and weight. In January, 1900, gave up work on account of muscular weakness. There was no vomiting. The patient consulted Dr. Macdonnell in March, 1900, walking into his office with considerable difficulty. There was no enlargement of lymphatic glands. Enlargement of the stomach could never be percussed or palpated. Liver dulness was practically normal. There was no jaundice or pain in the liver region. The patient succumbed to the disease, but no post-mortem was held. Another case occurring in a patient aged seventeen was reported. Dr. Bell made a blood count in this case, which at different times ranged 3,540,000, then 3,600,000, then 3,400,000, with 7,602 white-blood cells. In this case all the other organs were normal. And there seemed to be no predisposing cause in this case. Dr. Macdonnell stated that only ten autopsies had been made on people dying from this disease. He referred to the conditions found post-mortem in these cases. The treatment was stated to be rest, diet, and vigorous doses of arsenic. The mortality is set down at 20 per cent. As far as operation is concerned, physicians will not be satisfied until it is clear that the patient recovers from the operation as well as from the disease. If we are sure of our diagnosis, then surgical intervention is deemed advisable.

Physical Development.

Dr. J. N. Hutchison, of Winnipeg, read a carefully prepared paper on Physical Development. The paper did not deal with anything new, but called attention to and emphasized certain facts of considerable importance. He considered that children were sent to school at too early an age, and as a result there was danger of brain over-work. He insisted upon the necessity of having healthy parents—and deplored the system of education which develops the mind at the expense of the body. He was an advocate of periodical lectures by duly qualified physicians to separate classes of boys and girls on the subject of sex; but the primary responsibility in this matter he placed upon the parents. There would be real progress in the prevention of tuberculosis when people, the subject of the disease, recognized that they should not marry. The paper, which was listened to with close attention, closed with a reference to the problems of those unfortunates, who are neither mentally or physically qualified for the duties of life.

Report of Cases Treated with Super-Heated Dry Air.

Dr. W. H. Pepler, of Toronto, introduced this subject in a paper which cited his experience and observations in the treatment of certain cases by this plan or process. He briefly de-

scribed the apparatus and the method of treatment. It only takes twenty minutes to reach a heat of 300° F. The average duration of the application of the heat is forty-five minutes. The physiological and therapeutical effects noticed were referred to as dilatation of blood vessels, etc. He administers the treatment one hour after mealtime, with due regard that there shall be as little as possible excitement and exertion. He has not seen any ill-effects from the treatment. He first gave notes of the case of a patient, a man aged 35 years, who had suffered for some time from varicose ulcer of the right leg, with considerable pain. This patient had a treatment of thirty-five minutes duration, and was able to walk home with very little discomfort. After three times, in ten days, the ulcer was very much reduced in size. The second case was a patient twenty-two years of age, who had been troubled with rheumatism for two years past. A temperature of 320° was employed with good satisfaction. Several other cases of rheumatism and eczema were reported. The treatment in each case proved highly satisfactory, patients never complaining of any discomfort, and all expressing satisfaction with the treatment. Dr. Pepler subjects a considerable portion of the patient's body from a temperature of 280° to 320° F. The results are often not apparent for some time after treatment.

Dr. McAdam, of Battleford, asked Dr. Pepler if he had ever tried the treatment with high temperature, where he had any doubts of the condition of the heart.

Dr. MacDonald, of Brandon, referred to a case which had come under his observation in which there was heart trouble. Perspiration occurred freely but with no effect in a depressing way upon the circulation. Treatment in this case was continued for two weeks, but he had never determined that there had been any effect upon the heart, although there was a small heart lesion at the time.

Dr. Pepler, in reply, said he could not speak personally as to any deleterious results from weak heart. Of course there were many cases reported where heart trouble was present. He personally had never noticed any heart or head symptoms in his cases. He thought with care there would be no bad results.

Orthopedic Treatment of Deformities and Disabilities Resulting from Diseases of the Nervous System.

Special reference to tendon transposition by Dr. B. E. McKenzie, of Toronto. He spoke of disabilities and deformities resulting from paralysis, some of which were commonly regarded as hopeless; but the conditions of a great majority of them were remediable and should receive a considerable amount of attention. He was at some pains to

explain the respective motion of joints, particularly the ankle joint and knee joint, especially calling attention to the normal conditions of equilibrium, and then showed how the muscles of some of the groups at times become paralysed and the balance and equilibrium thereby destroyed. Mechanical treatment was often necessary, and often efficacious as well; massage and electricity had their respective places, but he made particular reference to the method of treatment that had been in vogue for twenty years, and had been introduced on this continent by Dr. Parish, of Philadelphia. He went carefully into an explanation as to how muscles can be transferred from their usual point of action, and then he gave an account of several cases in which he had successfully accomplished this. In his opinion amputation of a limb because of apparent disability should seldom or never be resorted to.

In answer to Dr. McAdam, Dr. McKenzie disapproved of jackets in the treatment of curvature of the spine.

Dr. Clarence Starr, Toronto, stated the subject was of great interest to him, as he was interested pretty largely upon the same lines of surgery. Dr. McKenzie has indicated a large number of cases of paralysis which can be wonderfully helped by operative procedures.

Dr. Starr thought that Dr. Bowlby, of Boston, deserved a great deal of credit for the work he has performed in this connection.

Dr. H. B. Small, of Ottawa, referred to a case Dr. McKenzie had operated on. In this case, previous to operation, the boy had great difficulty in arising from the sitting posture, and when walking he had to rest every few yards. After the operation he was very much improved, and when Dr. Small last saw him, about a week ago, he could walk very easily, and never had to support himself. The improvement during the last four or five weeks was especially very marked.

SECOND DAY—MORNING SESSION.

Mild Smallpox.

Dr. G. A. Kennedy, McLeod, Alberta, presented this paper. It dealt with the recent outbreak of the disease in the North-West Territories, an outbreak which was widespread and which had existed for some time before its true nature was recognized. Dr. Patterson, Quarantine Officer for the Dominion Government, was satisfied that there had been 1,500 cases. A noteworthy fact was that the greatest number of cases occurred among the French halfbreeds, who had never been vaccinated; and further, Indians on reserves had not suffered to any great extent, as annual vaccination is the rule. Not one case was seen or heard of among Galicians, Doukhobors or

Roumanians, which was due to the fact that compulsory vaccination was the rule in youth, and then they had been re-vaccinated on their recent passage across the Atlantic and at Halifax. Fifty per cent. of all cases were extremely mild in character; forty per cent. were cases of typical varioloid; ten per cent. were severe, almost confluent. The mortality was slight, only thirteen deaths occurring: and the disease prevailed fully as much amongst adults as amongst children.

Dr. Muir, Truro, Nova Scotia, discussed the merits of the different vaccines on the market, and the paper was further discussed by Dr. MacDonald, of Brandon, Dr. Inglis, of Winnipeg, Dr. D. H. Wilson, of Vancouver, and Dr. Montizambert, of Ottawa. The latter considered it would be unfortunate if the impression went abroad that any doubt existed in the minds of the members of the Canadian Medical Association, as to the true nature of the disease which had been epidemic for some years. He considered the facts presented in Dr. Kennedy's paper relating to the Doukhobors and Galicians were perhaps the most valuable portion of it. At the close of this discussion the following resolution was moved by Dr. R. S. Thornton, seconded by Dr. J. L. Bray, and unanimously adopted: "Resolved, that in view of the general prevalence of smallpox throughout the continent, this Association desires to urge upon the profession and the public generally the necessity of vaccination and re-vaccination."

Chronic Ulceration of the Stomach, Simulating Cancerous Disease.

Relation of a case of Gastro-Enterostomy with Murphy Button. Recovery. By Dr. J. F. W. Ross, Toronto.

This occurred in a woman twenty years of age, the condition of whose stomach had been bad for three years. She was a nurse in the training school of a hospital, and her gastric conditions grew gradually worse and worse. Dr. Ross was asked to see the patient by Dr. E. B. O'Reilly, Hamilton, in December, 1899. He found her emaciated with the opium habit already formed. In January, 1900, he again saw her with Dr. Griffin, of Hamilton. At this time rectal alimentation was being persevered in with considerable benefit. In March, 1900, she was discharged from the hospital, and remained well for two weeks. As soon as food passed into the stomach, great rigidity of the right rectus muscle was noted. When the patient came under Dr. Ross's attention she weighed about 75 pounds. As malignant disease of the stomach is rare at this age of life, it was difficult to diagnose the tumor as such, and the symptoms pointed to the pyloric end of the stomach. It was not possible to say whether cancerous or not. The symptoms pointed to

the presence of ulcer, but the thickening easily made out led to the belief that malignant disease had been grafted on to the ulceration. Some dilatation also could be made out, but the rhythmic muscle waves, so characteristic of pyloric obstruction, could not be found; but a large growth was found at the pyloric end. The case was looked upon as hopeless, and decision was arrived at not to remove the growth, but to give temporary relief by gastro-enterostomy. This was done, and the patient made an uninterrupted convalescence. Eleven months after the operation the patient weighed 140 pounds, and looked the picture of health. On examination of the abdomen no mass could be felt, and the patient was not suffering from any gastric symptoms at all. Dr. Ross then went into the literature on the subject, quoting Fagge, Sydney Martin, Monihan and Mayo Robson.

Dr. Laphorn Smith, Montreal, began the discussion, stating that the case was especially interesting to him, but rather from the general practitioner's point of view. He believes that no case of cancer of the stomach ever begins as cancer of the stomach. First there is some sort of irritation of the mucous membrane. This irritation finally becomes chronic ulcer, and upon this the germ of cancer is engrafted, or whatever it is which is the essential constituent of the cancerous process.

Dr. Martin, Montreal, discussed the importance of the examination of the stomach contents in these cases.

Dr. Bruce, Toronto, stated that he had an experience with a case a year ago, which corresponded closely to the one Dr. Ross has reported. His patient was thirty-eight years old.

Dr. Gilbert Gordon, of Toronto, thought we should look at these cases from the standpoint of the physician as well as from the standpoint of the surgeon.

Dr. Howitt, of Guelph, stated that the second case of ulceration of the stomach upon which he operated was one of acute perforation.

Dr. Ross thanked them for the reception they had given his paper.

Some Forms of Hyperacidity and Their Treatment.

Dr. C. F. Martin, of Montreal, presented notes of some interest, judging from the results of systematic examination of the gastric contents. The unfortunate general employment of the term dyspepsia is responsible for the disregard of this condition. In the case of organic disease, producing excessive secretion, the diagnosis is often difficult. He gave the history of two cases in illustration, the second being in an individual forty-five years of age, who gave the usual history of having been ill for six months. There was no obstruction of the

pylorus, but simple dilatation, and the diagnosis was hyperchlorhydia with simple dilatation of the stomach. He also referred to the medical treatment following gastro-enterostomy.

Dr. Macdonnell, of Winnipeg, discussed this paper.

Medical Defence.

The report of the Committee on Medical Defence was here presented by W. S. Muir, of Truro, Nova Scotia. It reported favorably on the formation of a Medical Union, and the organization thereof was immediately perfected. It will be known as the "Medical Protective Association," will be incorporated, and will have for its object the protection of the character and interests of medical practitioners in Canada. It will further promote honorable practice, will aid in suppressing or prosecuting unauthorized practitioners, and will seek to advise and defend or assist in defending members in cases where proceedings involving questions of professional principle or otherwise are brought against them, and other like matters. Dr. R. W. Powell, of Ottawa, was elected President; Dr. McKinnon, of Ottawa, Secretary; and Dr. James Grant, jun., of Ottawa, Treasurer.

Report of Committee on Dominion Registration.

It is proposed to secure an amendment to the B. N. A. Act, or to take advantage of section 91 of that Act, and under it obtain legislation from the Dominion Parliament by which the profession in Canada might form a Dominion Council, which could be supplemented by legislation by the various provinces recognizing any certificate of standing issued by the Dominion Council as entitling a holder to practice in such provinces. Dr. Muir approved of Dominion registration, and spoke for the Province of Nova Scotia. Dr. Jones voiced the sentiments of the profession for Manitoba. Drs. A. A. Macdonald, and J. L. Bray, endorsed the scheme for Ontario. Dr. Russell Thomas spoke for Quebec. Dr. Christie said that New Brunswick was in favor of Dominion registration. Dr. Lafferty said the North-West Territories were favorable.

SECOND DAY—EVENING SESSION.

Cancer of the Uterus, With Lantern Demonstrations.

This was a very interesting and profitable demonstration, conducted by Dr. Thos. S. Cullen. In introducing Dr. Cullen, Dr. Chown spoke of him as a young Canadian who had gone wrong in having removed to the United States and having never returned. Dr. Chown considered that the experimental

work pursued by Dr. Cullen if done in Canada, would meet with as signal success as that which attended his labors in the United States. For over an hour Dr. Cullen was engaged in showing a large number of excellent lime-light views, the results of microscopic examinations of tissues; each view was lucidly explained by the demonstrator. At the close of his excellent demonstration Dr. Cullen was accorded a hearty and unanimous vote of thanks, moved by Dr. Eccles, of London, and seconded by Dr. Gray, of Winnipeg, and carried amid great applause.

Skin Diseases, With Lantern Demonstrations.

This was another valuable demonstration, and was conducted by Dr. Francis Shepherd, of Montreal. He first exhibited and demonstrated cases of blastomycetic dermatitis, and further spoke of a few cases which he had seen of this disease. Views were given also of cases after treatment with iodide of potash. Some interesting views were those caused by drug eruptions, of which he showed two or three due to salicylate of soda. In one of these Dr. Shepherd said the lesions first came out with large welts like urticaria. This is rather a rare form of drug eruption. It appeared after two doses of ten grains each of the drug. One case almost died of acute laryngitis from the eruption in the throat. Amongst other views shown were papular purpura, which is generally associated with rheumatic attacks, psoriasis of the nails, X-ray burns as the result of one application, and most interesting were cases of smallpox, one showing pustules upon the palm of the hand; particularly interesting, as in adults you never see chickenpox upon the palm of the hand, but you invariably do smallpox. Views of feigned eruptions were also shown. This demonstration proved so interesting to the members that Dr. Shepherd was frequently called upon to give more or go on.

The Varieties and Distribution of Bacillus Diphtheriae and their Clinical Significance.

Dr. F. F. Westbrook, of the University of Minnesota, presented a paper on this subject, primarily from the laboratory point of view. He exhibited a carefully prepared chart showing in tabulated form the results of numerous examinations in schools, and stated the conclusions which he deduced from these facts. Formerly, it was believed that the bacillus remained localized at its point of entrance, but now within recent years, however, careful observations have shown that the toxins had been distributed throughout the body and the bacillus itself found in organs far removed from the atrium. From evidences of 230 cases of diphtheria at autopsy, observers had called attention to

the frequency with which the bacillus of diphtheria was found in the organs of the body. The bacillus and its toxins have been shown to be capable of producing lesions which differ greatly from each other, as in ulcerative endocarditis, meningitis, etc. In summarizing, Dr. Westbrook said where each school was reported and where great care was taken in the isolation of clinical cases with typical form, the percentage was very small.

**Removal of Hairy Tumor from the Stomach, weighing 23 ounces.
Specimen. Recovery. By Dr. H. A. Bruce, Toronto.**

The subject of this case was a woman, aged 26; she had been married six years and had two children. A lump was noticed in the abdomen two months previous to the birth of the last child. Patient had no symptoms. The lump was about five inches in width and it could be lifted forwards. It reached to within three inches below the umbilicus. It gave the patient no special discomfort, there being absolutely no symptoms present. Dr. Bruce advised exploratory incision. This was done on July the 22nd last at St. John's Hospital, Toronto. On opening the abdomen in the middle line the spleen and kidneys were found in a normal condition, but there was a large mass in the neighborhood of the stomach. The surgeon could make out the mass lying free in the stomach, a portion extending through the pyloric end of the stomach. An incision was made into the stomach and the tumor removed. After removing the mass of hair, the opening of the stomach was closed in the usual way. Hot salt solution was given for two hours and nutrient enemata for six hours. Twenty-three hours after the operation sips of hot water were given by the mouth. Forty-eight hours after operation patient was given one half an ounce of milk and lime water every hour. She left the hospital on the 20th day. The tumor was entirely of hair exactly the same color throughout and the same color as the hair on her head. It was about 24 inches in length, being about two inches in diameter at one end and gradually tapering down to a point at the other. Dr. Bruce considered this case rare and offered no solution as to how the hair got into the stomach. There were no evidences of hysteria present in the patient. There are some specimens of hairy tumors in the McGill Museum at Montreal.

THIRD DAY—MORNING SESSION.

A Case of Transplantation of the Ureter for Cure of Uretero-Vaginal Fistula. By A. Laphorn Smith, Montreal.

This occurred in a married woman, thirty-four years of age, who came to Dr. Smith on the 1st of July, 1901. During parturition, forceps were employed and the vagina lacerated, and

ever since there has been a constant flow of urine by the vagina. Operations for her relief had been performed in England without success. Dr. Smith had seen Sanger perform an operation of this character in Leipsic when he was there three years ago, namely, to open the peritoneum running over the large vessels at the brim of the pelvis and to feel for the artery, see the vein and pick up the third tube, which was the ureter. The operation was done in the highest Trendelenburg posture. A very small incision was made in the peritoneum lining the pelvis in the line of the ureter, a silk ligature was passed around it and then the ureter was severed a little above the ligature. The end of the ureter was split open to a distance of a third of an inch. A slit was then made obliquely into the right upper corner of the bladder and the ureter stitched into it, the mucous membrane of the ureter to the mucous membrane of the bladder with very fine chromicized catgut. This is the first time this operation has been done in Canada, and Dr. Smith stated that not a drop of urine had passed through the fistula since.

Syphilis as Seen by the Ophthalmic Surgeon.

This paper was read by Dr. F. Buller, Montreal. In commencing his paper, Dr. Buller expressed the hope that it would elicit a little discussion. It often falls to the lot of the ophthalmic surgeon to discover the presence of active syphilitic virus where the disease had long been considered cured, or that the subject cherished the belief that there was no more to fear from it. The ophthalmic surgeon is scarcely, if ever, called upon to treat the disease in the primary stage. The largest share of his work is in connection with the tertiary period, and in this class of case the disease has been apparently cured for a long period of time. Dr. Buller considers that the time at which the syphilitic lesion makes its appearance is always a very important element in the diagnosis. Discussing medication, Dr. Buller does not believe that the protiodide of mercury, at least as ordinarily administered, is a reliable anti-syphilitic. He appears to favor the inunction method first and then grey powder. The following took part in the discussion of this paper: Dr. Lafferty, of Calgary, Dr. Muir, of Truro, Dr. Laphorn Smith, of Montreal, and Dr. Shepherd, of Montreal, who also condemned the protiodide treatment.

The Present Outbreak of Smallpox in America.

This subject was presented, by Dr. H. M. Bracken, Health Officer, Minnesota. He outlined the origin of and traced the course of many outbreaks in various parts of the State of Minnesota. The case of a porter on the Great Northern Railway,

who arrived in St. Paul in March, 1899, was mentioned as the source of the outbreak. He was supposed to have contracted the disease in Seattle, and when told that he had smallpox he said that if so there was plenty of the same disease where he came from. Other epidemics were spoken of in various parts of Minnesota with a total of 9,429 cases, and the disease has still many centres in that State. It is impossible to locate positively the source of the present widespread epidemic further than that it spread from the southern and south-western States into North Dakota, Minnesota, Nebraska, Montana and Texas. Dr. Bracken showed that returning soldiers from the Philippines were not responsible for its introduction. He suggested that it was probably imported into the United States by Cuban refugees before war broke out between that country and Spain.

An interesting discussion took place on this paper. Dr. Russell Thomas wanted to know where the best vaccine was manufactured, a product that could be relied upon.

Dr. Inglis, formerly Medical Health Officer, Winnipeg, related his experience in the schools of Winnipeg, and spoke of some of the bad effects resulting through impure vaccine.

Dr. Bracken in reply:—Vaccine was frequently spoilt by not being kept in proper temperatures, as it was constantly being shipped in cans which were too hot, and subsequently kept in warm offices. The Health Commissioner of Minneapolis kept all his vaccine in an ice-box, but, of course, not frozen, and had obtained good results. Replying to a question in regard to isolation, Dr. Bracken favored eighteen days' quarantine.

The Necessity of a Recognition and Isolation of Trachomatous Patients in Canada.

In the absence of Dr. W. Gordon M. Byers, Montreal, Dr. C. F. Martin, of the same city, read this paper. The paper recited the history of a young girl from Glengarry County, Ontario, who came to the clinic at the Royal Victoria Hospital, Montreal, with a most intense condition of granular lids. She had been unable to open her eyes properly for months past, and her vision was reduced to the counting of fingers. The seriousness of her disease had not been recognized at home, as she mixed freely with other members of the community. Another case was referred to in the County of Leeds, and in this case as well no precautions had ever been taken to prevent the spread of the disease. Dr. Byers believes that there are many unrecognized and untreated cases scattered here and there throughout the Dominion. The disease is said to be prevalent in districts of Manitoba and certain centres of the Eastern Counties of Ontario, and others in Quebec. The trachoma problem has had to be faced by one government in Europe, and the matter has

been brought to the attention of the Dominion Government, which has not yet taken any action thereon. Dr. Montizambert stated that the question of exclusion of trachomatous immigrants had been under consideration by the Government for some time. He considered these people somewhat undesirable immigrants.

A Few Notes on the Treatment of Typhoid Fever.

Dr. J. L. Bray, of Chatham, discussed this subject under medicinal, dietetic and hygienic headings. The first, he thought, might be eliminated, except in cases where complications arise, and he thought a certain amount of medicinal treatment useful during the initiatory stages. He was in the habit of employing calomel. Tympanites could be avoided to a great extent by a proper diet. In feeding, he now gives but very little milk, but that little always peptonized. He believes in making the patient drink two or three quarts of pure water in the twenty-four hours. Albumen water with sugar may be given from the first. After the first two weeks he gives liquid peptonoids, or some of the numerous preparations of beef, jellies, mutton broth, or a soft-boiled egg.

As regards the hygienic treatment, the bedding and the night clothes should be changed daily. The room should be kept thoroughly ventilated, admitting plenty of fresh air and sunshine. The patient should be sponged frequently with tepid water, and you get just as good results from tepid water as from sponging with very cold water or the cold bath, and it is not so distasteful to most patients. In hospital practice, Dr. Bray uses the electric fan after using the tepid water. He has found this plan very satisfactory, especially in young and sensitive children.

Dr. Russell Thomas discussed the paper, and said that he had found the ice-cap beneficial, that it did not disturb the patient, and had a decided effect in reducing the temperature.

THIRD DAY—AFTERNOON SESSION.

The Address in Surgery.

This was delivered by Dr. O. M. Jones, Victoria, B.C., and it proved a very able and masterful effort. He opened his address with a reference to surgical diseases in Western Canada as compared with those in the East, and stated that he had often found western sufferers more impatient, which often demanded severer methods. He illustrated this by citing a humorous incident. A lodging-house keeper, on learning that one of her boarders was to have an operation performed on a Wednesday, wrote to the surgeon asking that it might be postponed until

Friday, as her daughter was to be married on Thursday, and they didn't want the corpse home until after the wedding. The address dwelt mainly with the surgery of the stomach, and related the deductions Dr. Jones has arrived at from his own experience of twenty-six cases. His first operation upon the stomach was in 1893—a case of pyloric obstruction in a wiry woman. Senn's plates were used. This patient died in three days, the result not being encouraging; and Dr. Jones attributed the failure to the use of catgut, instead of silk sutures. The introduction of Senn's plates and the Murphy button gave a great interest to intestinal surgery, as before 1890 operations on the intestines were rare. He discussed the preparation for operation, and first spoke of gastrostomy, an operation which he had performed five times, for ulcer of the esophagus. In four of the cases the operation was performed with very excellent results. He then discussed the class of cases in which pylorotomy is indicated, and said that rapidity of operation in these cases is the very important factor; prolonged operation has generally proved fatal. A suitable case should be cancer of the pylorus. The time occupied in performing the operation is not great. In one of his cases he performed posterior gastro-enterostomy, and this patient still lives, and it is now nearly three years since the operation. Gastro-enterostomy was next discussed. This Dr. Jones considered the most important and most interesting part of the whole subject. It is the most frequent and the most useful, and the simplest of all the operations performed upon the stomach. It is performed for pyloric cancer, ulcer and stenosis, and for gastric ulcer, dilatation, etc. Nothing can be simpler than this operation performed with the Murphy button. Dr. Jones has used it in fourteen cases, and in only one case was there any trouble. In two of his cases, which died from shock, he examined one, and found perfect union. He has found that the passage of the button has taken from fourteen days to four months; and in several cases he has not been able to obtain the button. A recital of several cases followed, which proved very interesting. Dr. Jones closed his paper with a few words on perforating duodenal ulcer.

Dr. F. J. Shepherd, of Montreal, proposed a vote of thanks; Dr. A. A. Macdonald, of Toronto, seconded this, and Sir James Grant, of Ottawa, supported the motion, which was unanimously passed by the Association.

[This address will be published in our next issue.]

A Surgical Procedure for the Relief of Ovarian-Tension Pain.

Dr. Henry Howitt, Guelph, Ontario, read this paper. Is not pain frequently, if not usually, caused by tension on some nerve filament? In Dr. Howitt's opinion the answer should be in the affirmative. The operation Dr. Howitt employs is quite simple.

The ovary is exposed, and then a number of cross sections are quickly made through the tense capsule in such a manner as to divide it. Then the larger Graffian follicles are opened. These are merely touched with carbolic acid. If the capsule is thickened a portion should be removed. Hemorrhage has never been troublesome. Adhesions give rise to no complications. Dr. Howitt recited the histories of two or three cases in support of the operation.

Dr. Laphorn Smith stated that he had never heard of this operation before, and considered that it was original with Dr. Howitt.

Symposium on Tuberculosis.

Prof. Russell, of the University of Wisconsin, introduced this subject in a careful yet exhaustive paper on human and bovine tuberculosis and their inter-relation. The importance of any phase of investigation relating to tuberculosis and its relation to milk is unquestioned in these latter days when the general public is beginning to appreciate, for the first time, the magnitude of the problem that confronts them in attempting to lessen the ravages of the "great white scourge" of the human race.

In considering this subject it may be approached from two points of view: (1) From the standpoint of animal industry; (2) From that of public health.

BOVINE TUBERCULOSIS AND ANIMAL INDUSTRY.

The rapid extension of the disease among cattle within the last few decades has forced upon breeders and dairymen the necessity of considering this subject whether they desire it or not. It is customary in many quarters, even yet, to decry all consideration of this matter as unnecessary, inexpedient, and harmful to the dairy interests. But as is too frequently the case, the motive for such action rests upon a financial foundation, and many breeders are averse to a calm, judicious discussion of the matter simply because it may mean financial loss to them.

Since the introduction of the tuberculin test as an aid in the diagnosis of the disease in cattle, it has been positively determined that the malady, at least in its incipient form, is very much wider spread than was formerly supposed, but it by no means follows that all animals that react to the tuberculin test are actually in a condition in which they or their product are dangerous to man and beast.

The slow, insidious nature of the disease that characterizes it in the human is also to be found in the cattle, and not infrequently an animal may be infected with the seeds of the disease for a considerable time—even a year or so—without showing

in any degree physical symptoms that are manifest to even the animal expert. Such animals are not diseased in the ordinary meaning of the term, *i.e.*, they are not capable of transmitting the disease, either directly or indirectly, through their milk supply or meat. The affection in such cases is latent, generally confined to various lymphatic glands; but animals so affected are, however, potentially dangerous, for the latency of the disease may be overcome through the operation of various factors, and the chronic type may thus be awakened into an acute phase. It is in this way that the disease spreads slowly and unperceived through a herd. Before it has made such inroads as to cause actual death of any considerable number of animals, many more have acquired the trouble, at least in the earlier phases. Necessity of controlling its spread and eradicating it is evident for the sake of the herd itself, if from no other point of view. Successful animal industry, especially with cattle, requires that herds shall be kept free from all taint of this disease. As to treating milk, Prof. Russell said pasteurization and sterilization were the two best forms of applying heat to destroy the organism. He recommended the rotatory pasteurizing machine, one of which has been used in Winnipeg for some years, as the best method of removing organisms from milk.

Dr. Good, of Winnipeg, in discussing the paper said that it afforded him some relief to learn that milk is not so dangerous after all. He stated that he had been avoiding milk and all organic fluid for the past year or two, but he was glad to know that he could now go back to its use with the same freedom as in his younger days. He then moved a vote of thanks to Prof. Russell, seconded by Dr. McArthur, which was unanimously adopted.

Dr. A. J. Richer, of Montreal, contributed the next paper on the Sanitarium Treatment of Tuberculosis. This treatment had been introduced by Dr. Trudeau in America under great difficulties, and at the present time this distinguished scientist was able to house and treat over one hundred individuals in his institution. According to Dr. Richer, the treatment is made up of rest, out-door life, over-feeding and medical supervision. This latter was described as the keynote to success in phthisical treatment. Over-feeding was also emphasized.

The last paper was contributed by Dr. Gilbert Gordon, of Toronto, and it referred to the etiology and the early diagnosis of pulmonary tuberculosis. He spoke of the early stages of the disease, and thought that we ought to be able to diagnose it before the appearance of the bacilli in the sputum. Direct inheritance he considers very rare. The inhalation of

dried sputum is the most direct cause. Dr. Gordon considered that we are woefully behind in Canada in fighting this plague, and more money should be spent by governments and philanthropic individuals in fighting this disease. He went carefully into the symptoms of the pre-tubercular stage, and considered that a persistent cough was a very dangerous symptom.

An important discussion took place upon this topic. Dr. Lafferty warned the profession in Ontario against sending advanced cases to the North-West Territories. Dr. Barrick, of Toronto, pointed out that Ontario was leading in regard to the treatment of tuberculosis, and he hoped to see the Sanitarium brought with a wide open door to all conditions of life. Dr. Brett, of Banff, suggested that the Association should pass a resolution pointing out to the Parliament of Canada the necessity of providing for the establishment of sanitarium for the benefit of the community.

The report of the Nominating Committee was presented by Dr. W. S. Muir, Truro, N.S., who expressed regret at having to accept the resignation of their general secretary, Dr. F. N. G. Starr. Montreal was selected as the place of meeting in 1902, and a suggestion was left with the members of the Association that they meet in British Columbia the following year.

These officers were selected for the ensuing year: President, F. J. Shepherd, Montreal. Vice-Presidents—Prince Edward Island, S. R. Jenkins, Charlottetown; Nova Scotia, T. F. Macdonald, Hopewell; New Brunswick, Wm. Christie, St. John; Quebec, J. Alex. Hutchison, Montreal; Ontario, Bruce L. Rirdan, Toronto; Manitoba, A. J. Macdonnell, Winnipeg; North-West Territories, H. G. McKid, Calgary; British Columbia, J. M. Lefevre, Vancouver. General Secretary, George Elliott, 129 John Street, Toronto; Prince Edward Island, H. D. Johnson, Charlottetown; Local Secretaries: Nova Scotia, J. W. McLean, North Sydney; New Brunswick, W. L. Ellis, St. John; Quebec, C. F. Martin, Montreal; Ontario, H. A. Bruce, Toronto; Manitoba, J. T. Lamont, Treherne; North-West Territories, G. A. Kennedy, Macleod; British Columbia, O. Morris, Vernon. Treasurer, H. B. Small, Ottawa. Executive Council, Jas. Stewart, T. G. Finley, J. M. M. Elder.

The Winnipeg meeting of the Canadian Medical Association will go down in the annals of the history of that Association as the best meeting ever held under its auspices. On the first day alone 130 members registered, and the total number at any time present reached 175, a number considerably larger than that at Ottawa last year, and second in point of numbers to the meeting at Toronto, in 1899. Many new members were elected, particularly from Ontario, Manitoba, the North-West Territories and British Columbia. Every province was

represented at the Association meeting, with the single exception of Prince Edward Island, one delegate coming as far as North Sydney, Cape Breton. The meeting was generally voted a pronounced success; and certainly the profession in Winnipeg and Manitoba, and the citizens of Winnipeg, more than eclipsed, in point of social functions, any previous meeting. The reception by the Board of Governors of the Winnipeg General Hospital, the reception by the ladies of Winnipeg at Wesley College, the special trip down to old Fort Garry, where Mr. and Mrs. Chipman extended their hospitality to the members and their wives and invited guests from Winnipeg, the visit to the Ogilvie Mills, the reception at Government House by Lieutenant-Governor and Mrs. McMillan, and the special trip out to Brandon through the great wheat belt of Manitoba, with the entertainment provided by the ladies of Brandon,—all will stand as a series of social functions which have never been surpassed, and will probably remain unsurpassed in the history of the Canadian Medical Association meetings. One of the best and most important discussions took place on the formation of a Medical Defence Union, and it is very gratifying to have to record that such an organization was unanimously supported by the Association. All the leading officers of this Protective Association are located in Ottawa, and Dr. Russel Thomas, of Lennoxville, P.Q., along with W. S. Muir, of Truro, N.S., is deserving of much praise for the great good work he has performed in this connection. Much regret was expressed at the resignation of the general secretary, Dr. F. N. G. Starr, of Toronto, who has so long and so faithfully, so ably and so energetically discharged the responsible and important duties of this position. At a time when the Association is so prosperous, it is due to the new general secretary that a united and earnest effort be put forth by all the members of the Association to continue that prosperity.

LONDON TUBERCULOSIS CONGRESS.

Dr. A. McPhedran, who was the only Toronto physician in attendance at the London Tuberculosis Congress, arrived home August 18th. He was seen at his home by a *Globe* reporter and while he accorded Dr. Koch the chief place in the assemblage, he was disinclined to give much weight to the theories put forward by the eminent German scientist. Dr. McPhedran said:

“It was a very large and very well managed congress, there being probably three thousand present. The discussions were very interesting and profitable. Of course, the most important

feature of the Congress was the announcement made by Dr. Koch. His conclusions, however, were not accepted by the great body of the Congress, as they were not supported by sufficiently conclusive evidence. His experiments went to show that the larger animals could only, with difficulty, be inoculated by the germs of human tuberculosis; but, of course, the evidence he could bring forward that human beings were not liable to be infected by bovine tuberculosis was, to say the least of it, not strong. Naturally, no evidence in the way of experiments could be produced, and conclusions will have to rest upon observations made in various parts of the world as to the effect on human beings produced by tuberculous food.

"It was the almost unanimous feeling of the Congress that so strong and definite a conclusion should not have been derived from the facts at hand, as they did not justify such positive opinions. It was also thought that in any case the law respecting the sale of diseased milk or food should not in any degree be relaxed. In view of the great importance of the subject, it seems the duty of the governments of all countries to make due provision for its thorough investigation. Doubtless in the near future much will be heard from various parts of the world on the results of the investigations that will be set on foot.

"As to the prevention and management of tuberculosis, the keynote of Koch's address, as well as of the proceedings of the Congress generally, was the necessity of pure, fresh air. The English profession particularly was practically carried away by the sanitarium treatment of consumption. They seem to forget that, with the great mass of humanity, it is impossible to give them the benefits of sanitarium, and that the same good can be obtained under judicious management at the homes, where the homes can be made healthful.

"Dr. Koch pointed out that in no other country had the reduction of the mortality from tuberculosis been so great as in Great Britain, where it had been reduced by about 45 per cent., and in no country was there such large provision made in the way of special hospitals for consumption. However, in no other country was there so many sanitarium in existence as in Germany, where life and sickness insurance contributes to the support of sanitarium.

"Many of the addresses and papers given were interesting and of great practical importance, and it is to be regretted that our sanitarium in Muskoka was not represented at the meeting. One danger, however, is that the profession as well as the public may in some measure lose their heads and attribute to sanitarium what belongs to fresh air and good sanitary conditions.

"It is not at all likely the authorities in England will relax in the least any of the precautions they take to prevent the

importation of diseased cattle or meat, and the Canadian people will be wise to observe the strictest precautions in the exportation of these products. Fresh air and clean sanitary surroundings are just as important for cattle as for human beings. The surest way to prevent the disease and to cure those that have it is to give them an abundance of fresh, pure air and fresh, clean, airy stables.

“At the closing meeting of the Congress many resolutions were passed, and among the most important were those that directed attention to the fact that tuberculosis is spread by impure air, and the dirty habit of expectorating in houses or in public places, on sidewalks or public conveyances, where the sputum may dry and be carried by the air so as to be inhaled. In many places it is made a punishable offence to expectorate in such public places. In a New York street car, for example, I observed a notice that spitting was punishable by a fine of \$5.00.

“From the social side the Congress was eminently successful, many of the leading people, as well as the profession, doing everything in their power to make the sojourn of the delegates in London both pleasant and interesting.”

Dr. McPhedran said many of the States and towns of the United States were officially represented at the Congress, while Ontario was not.—*Toronto Globe*.

Editorials.

COMPULSORY REGISTRATION OF MIDWIVES IN ENGLAND.

There exists in England the "Association for Promoting Compulsory Registration of Midwives," of which the eighth annual meeting was held June 28th. The objects of the Association are the establishment by legislation of the proper training of midwives, and the supervision of their practice. The chief desire of the society is to have midwives properly educated, so that they may be able to conduct a normal case of labor; and also that they may be able to detect anything serious in the condition of the patient, and send promptly for a regular physician when he is required. As the law now stands we are told that any one, even though she be unskilled or disreputable, is allowed to place a plate on the door, and practise midwifery. Dr. Malins, Professor of Midwifery in the University of Birmingham, in a recent address expressed a hope that the time would come when "midwives will be duly trained, licensed, registered, and submitted to proper legal supervision and control. In the interests of suffering humanity, in the cause of the poor, and in the wisdom of a broad philanthropy, we cannot and we ought not to withhold opportunities of improving their knowledge." This high-toned grandiloquence is fine, if you refrain from looking at its ludicrous side.

It is difficult, so far as British medical journals are concerned, to get a fair conception of the arguments against licensing midwives. We understand, however, that some of the "masses" think that no laws should be enacted which will prevent poor women from obtaining friendly help from neighbors or ordinary midwives. Some physicians object because they may lose many guinea fees. Many at present acting as midwives fear that they might not be able to qualify. A certain number—we don't know how many—take higher ground, and say that partially educated women should not be given a diploma and license to practise midwifery after a three months' training, because such a short course is insufficient for the purpose. This

is about the only line of argument that we in Canada can thoroughly understand and properly appreciate. We do not consider it possible for a person in a course of three, or even six, months to become qualified to conduct an ordinary case of labor. Therefore we are entirely opposed to granting such half, or less than half, educated midwives a license to practise midwifery.

THE OBSTETRICAL SOCIETY OF LONDON AND THE EXAMINATION.

We have heard much about the action of this society, and the diploma it grants to midwives. We learn the following from the *British Medical Journal*. In 1872 a committee was appointed to consider the question. It was generally recognized that many midwives were ignorant and incompetent, and it was decided to institute an Examining Board composed of six Fellows of the Society to hold practical examinations and test the competency of the candidates to practise as midwives, and to give certificates to those who *passed*. The certificate contained the statement that in the opinion of the examiners the successful candidate was a skilled midwife, competent to attend natural labor. For certain reasons the certificate was changed in 1895 so as to simply state that the holder had "passed to our satisfaction the examination in midwifery instituted by the Obstetrical Society of London." On the certificate appeared the note: "This certificate confers no legal qualification to practice under the Medical Acts."

The chief among the regulations for the examination is the requirement of a certificate showing that the candidate prior to the examination has personally attended and examined at least twenty persons during labor, and has watched the progress of an equal number of cases (not necessarily the same) during the week following labor. There appears to be at present no regulation requiring a candidate to have attended a course of lectures, although the candidates usually do so. The examination consists of two parts—a written and an oral practical examination. Special training is given in numerous hospitals, the courses extending over varying periods

of from three to six months. The fees demanded at many of the hospitals are twenty-five guineas. At some of the maternities it is stated by the authorities that a good knowledge of the work can be obtained in from six to eight weeks. In other institutions they can take a pupil, and "finish her off in six weeks." We have only to state in connection with the great midwife work done by the Obstetrical Society of London that we quite approve of the note before referred to: "This certificate confers no legal qualification to practise under the Medical Acts."

NATIONAL SANATORIUM ASSOCIATION.

The Executive Committee of the National Sanatorium Association met on Wednesday, August 7th, at the Muskoka Cottage Sanatorium, Gravenhurst. The following were present: W. J. Gage, W. E. H. Massey, Hugh Blain, Dr. N. A. Powell, Secretary Walter James Brown, Superintendent Ambrose Kent, Architect D. B. Dick, and Dr. J. H. Elliott, the Physician-in-charge. The committee found the capacity of the institution severely taxed, a number of patients were occupying tents, and a number more were on the waiting list, as no accommodation could be provided for them. The physicians reported an increasing number of applicants in whom the disease was too far advanced for successful treatment.

The committee visited the building site of the Gravenhurst Free Hospital for Consumptives, which is located about half a mile nearer the town than the Muskoka Cottage Sanatorium. The mason work is well advanced, and from all appearances the building will be ready for patients by November 1st next. This new institution is to be supported by voluntary contributions.

The principal business of the meeting was to discuss the plans of the Toronto Home for Consumptives, submitted by Architect D. B. Dick. A part of the plan, of special interest to the medical profession, is to provide facilities for instructional purposes. At the present time the hospitals throughout the country do not make provision for the study of tuberculosis. The prospects are favorable for the early completion of

the Toronto building. Tenders will be invited as soon as possible, so that the entire work may be finished within the next few months.

HYSTERICAL RELIGION AND SCIENCE.

A short time ago we were introduced, in the daily papers of Toronto, to the doings and sayings of the advocates of Divine Healing. It will not be amiss to pass under review a few of the remarkable statements made at the gathering held in Munro Park a few weeks ago. In what we shall say we are aiming no shaft at anything that is good or worthy in religious thought; nor do we desire, in the least, to say a single word against the teachings of the Nazarene.

But there is a limit to all things. When men and women, who have paid no special attention to disease, and who know practically nothing about pathology undertake to descant upon these topics and the cure of disease, the public should be duly warned. It is an easy task for these people to shout about the wonderful cures they perform, but it is only reasonable to ask for proof. Their cases should be properly attested by competent physicians or surgeons before and after the so-called cure.

No doubt certain imaginary ailments have been cured in the past at the shrines of the old Greek and Roman gods, at the feet of the Egyptian sorcerers, and by the Indian medicine man who appealed to the virtue of some charm, or the Great Spirit on the top of the mountain, or to the white goat-skin nailed to the pine tree. From such circumstances and events grew up a belief in the efficacy of mysterious agencies in the cure of disease. What better could be expected in the days of Homer, when he speaks of the spleen as the seat of the mind and feelings, and as being surrounded by black bile?

One thing stands out as at once a refutation of the claims of Divine Healers: That we have never yet been furnished with proof of organic diseases being cured. If God is pleased to cure diseases by the methods of these healers, why is it that He does not save the life of some devout and lovely Christian character who is ill of cancer or granular kidney? Surely it cannot be alleged that God has only the power to cure functional

disorders, but falls short of that requisite for the organic affections! Further, it will not be contended by the most extreme Divine Healers that the proper degree of faith is only found among those functionally afflicted, but that none of those who have had cancers, or tumors of the brain, or sarcoma of the bones, have been able to appeal with such faith as to gain the ear of the Creator. It is not denied that the Creator has power to cure a cancer, but He only chooses to do so when proper means are employed.

If a person has been genuinely cured by faith, on any one occasion, of a real disease, there can be no logical escape from the conclusion that he can be cured again and again. In this way it can be shown that with the proper balance of faith he can live on forever. Each time he becomes ill he is cured, and so on *ad infinitum*. But more. The same faith that can cure can avert. He need never be ill. Nay, more. The same faith that can prevent diseases and cure them, can maintain perpetual health, perpetual youth in the tissues. They neither wear out nor die out. On their own ground these mistaken people are driven into the *reductio ad absurdum* of establishing God's law, man is mortal, as a fallacy!

Returning to the recent convention, one person was claimed to have been cured of consumption, but there was no proof of the bacilli being found. Another person had some trouble with his voice. We all know how often this is a mere form of hysteria, or passing nervousness, especially about the age of puberty, when the trouble began. A third case was that of a person who had a terrible eruption on her face. She was in a hospital for a time. In a short time she got well. What have we here? Does not every physician see the ear marks of some dermatitis that got well, and very likely largely through what was done for her in the hospital. And yet another had been cured of almost total deafness and threatened loss of voice. Hysterical deafness, blindness, aphonia, lameness, numbness, vomiting, *et al*, are not new. They were present in the siege of Troy, during the days of the Jewish captivity, and among the fakirs in the Buddhist temples. But, *mirabile dictu*, this is not all. A tooth was pulled and there was hemorrhage. The elders are called in. At this juncture the artery contracts and retracts and closes by a blood-clot, just as happens in the foot.

of a tom cat, or in the scalp of a Dyak of Borneo, who is not supposed to pray nor to call in the elders of his church. One other person had brain disease, heart disease, nervous debility and indigestion. A grand quadruple alliance, but such as at once declares its nature as not nearly so formidable as a little bit of a tubercle in the supra-renal glands, and much more amenable to the influence of a fanciful mind over some fanciful symptoms that led the person to think she had four grave diseases.

When and where is all this wild ignorance to end? Is it not about time that persons who do not study diseases should cease preaching upon them? Surely, it is not too much to ask that those who are guided by sound methods of Biblical criticism should denounce all such visionary and wrongful applications of holy writ. If there is anything laid down in the New Testament with greater emphasis than another, it is to make due use of the means at our command.

What about the child that is too young to pray, or has not got praying parents? Or what is to be the fate of the man ill with pneumonia or typhoid fever, where there is too much stupor for him to place faith in any subject or person? Must the man who is rendered unconscious by a blow on his head receive no treatment because, in his helpless torpor, he is totally oblivious of his own existence or the existence of anything else? A child is ill with diphtheria. Are the onlookers to pray or to send for a competent physician who can administer the antitoxine, or other proper remedies? These misguided people are guilty of a grave offense against society by propagating erroneous opinions.

SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION.

Among the many societies of specialists in medicine and surgery which have come into existence during the last few years in the United States, we know of none that has met with greater success than the Southern Surgical and Gynecological Association. That success, as is well-known, has been largely due to the untiring and unselfish efforts of one of the most eminent surgeons of the "Sunny South," Dr. W. E. B. Davis, of Birmingham.

ham, Alabama, who was one of the founders of the Association, and for thirteen years acted as its secretary. We have received a copy of the transactions of the thirteenth annual meeting, held last November, at Atlanta, Georgia, and learn from it that Dr. Davis has resigned, and Dr. W. D. Haggard, jun., has been elected in his place.

Dr. Davis, in replying to a very cordial vote of thanks, pointed out that the society was organized to give the surgeons of the South a chance to come to the front. It had grown and expanded to such an extent that it is now a Southern association only in name. Men from all, or nearly all, parts of the United States have become members; but its meetings are held in the South, and its officers are Southern men. He concluded by making pleasant references to his successor, whom he designated a scholarly, ambitious and worthy man—a son of one who did more than any other member in the interests of the organization, especially in its early days.

THE AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS.

In this association we have another instance of an organization which owes its success largely to the indefatigable efforts of its distinguished Secretary, Dr. Wm. Warren Potter, of Buffalo. The last meeting was held in Louisville, Kentucky, in September, 1900. We find from a copy of the transactions just received that the meeting was one of the most successful in the history of the society. One of the ablest and most interesting papers presented was that by Dr. Henry Howitt, of Guelph, on "Perforated Gastric Ulcer," with notes on four cases. He expressed an opinion that in some cases it was advisable to operate before perforation occurs. In order to avoid any misconception as to his views in this connection, we will quote his own words: "It is far from my desire to be put on record as an advocate for operative measures in all cases of gastric ulcer before perforation, but I would certainly not hesitate to advise it to a patient whose life has been made miserable for a long period by the disease, especially if he has frequent attacks of gastralgia, and more or less interference

with the calibre of the pyloric orifice. In such, and other grave conditions due to the trouble, I cannot comprehend any valid objection to at least making an exploratory incision, and, if possible, relieving the condition." The next meeting of this association will be held in Cleveland, Ohio, September 17th to 19th inclusive, under the presidency of our genial friend from Alabama, Dr. W. E. B. Davis.

CANADIAN MEDICAL ASSOCIATION.

There appears to be only one opinion about the recent meeting of the Canadian Medical Association held in Winnipeg—it was in all respects good. It was probably the most representative meeting that the Association has known. All sections of the Dominion were well represented. This was as it should be. Never were greater efforts put forth by the local profession of any city or province in making the preliminary preparations. Never did a president use his personal influence to better purpose. Never was a response to an invitation to attend any meeting more hearty than that given by the visiting members on this occasion. We have much pleasure in publishing a report in this issue.

The next meeting of the Association will be held in Montreal, under the presidency of Dr. Francis Shepherd. Montreal has always given a loyal support to our National Medical Society, and the meetings held there have always been good and interesting. Those who attended the Montreal meeting of the British Medical Association will never forget how the citizens of that city, both medical and lay, shine as hosts. We congratulate Dr. Shepherd on his election to the presidency. The general feeling in this part, and probably in all parts of Canada, is that no better choice could have been made.

Among the physicians from the west that travelled east were Drs. Tunstall and Lefevre, of Vancouver, and Dr. Jones, of Victoria, who spent a few days in Toronto. We learned from them that the profession of those two cities on the Pacific Coast are very anxious to have a meeting of the Association in British Columbia in 1903. They expect to extend a very cordial invitation to the Association at the Montreal meeting of 1902.

UNIVERSITY OF TORONTO—SENATE ELECTION.

The following are the names of all candidates who have been nominated by the graduates in medicine, and who alone are eligible for election by such graduates :

WILLIAM HENRY B. AIKINS, M.D., of the city of Toronto.

IRVING HEWARD CAMERON, M.B., of the city of Toronto.

JAMES METCALFE MACALLUM, M.A., M.D., of the city of Toronto.

ADAM HENRY WRIGHT, B.A., M.D., of the city of Toronto.

In accordance with the University Act, 1901, s. 29 (2), no ballot is required for the election of representatives of graduates in medicine, and accordingly those named will be reported to the Senate as elected by acclamation.

—*Extract from official circular issued by James Brebner, Registrar.*

Mr. Riddell and Judge Street are elected by acclamation to represent the graduates in law, and Mr. C. H. Mitchell is elected to represent these in Applied Science and Engineering. Nineteen candidates are nominated by Arts graduates (twelve to be elected), and thirteen by the graduates of Arts and Science of Victoria College (five to be elected). Votes are to be given by closed voting papers delivered to the Registrar at his office, between the hours of ten o'clock in the forenoon and four o'clock in the afternoon, on any day between the second Wednesday of September and the first Wednesday of October (both days inclusive). No voting paper shall be counted which has not been furnished by the Registrar.

Personals.

Dr. C. J. Alloway, of Montreal, visited Toronto September 5th.

Dr. G. S. Bingham, of Toronto, returned from Europe, September 4th.

Dr. Donald McGillivray left Toronto August 19th for a trip to the Upper Ottawa.

Dr. Harold W. K. Anderson, Victoria, B.C., was married to Miss McCosh, July 15th.

Dr. Allen Baines, of Toronto, returned August 14th, after a trip to Boston and New York.

Dr. Murray McFarlane, of Toronto, returned from a trip to the Pacific Coast, August 24th.

Dr. John Archibald Marquis, of Brantford, was married to Miss Buckingham, August 14th.

Dr. Robert J. Dwyer, of Toronto, has moved to 404 Bloor Street West and resumed practice.

Dr. W. A. Young, of Toronto, returned August 13th after spending a holiday at Atlantic City.

Dr. W. W. Ogden returned to his home in Toronto, August 6th, after a visit to the Georgian Bay.

Dr. R. Barrington Nevitt, of Toronto, left for a two weeks' trip to Quebec in the latter part of July.

Dr. W. E. Struthers (Tor., '97,) leaves for Europe this month to spend one year in post-graduate work.

Dr. Beattie Nesbitt, of Toronto, spent the month of August at the Queen's Royal, Niagara-on-the-Lake.

Drs. E. A. Spragge and E. A. Peaker, of Toronto, spent a portion of the summer at Windermere, Muskoka.

Dr. Charles Sheard, of Toronto, went to New York and Newport for a holiday trip in the latter part of August.

Sir William Hingston, of Montreal, after spending a holiday in England left London for his home August 22nd.

Dr. C. B. Shuttleworth, of Toronto, left, August 25th, for Europe, where he will spend one or two years at post-graduate work.

Dr. W. B. Geikie, of Toronto, spent a portion of the summer in Prince Edward Island. He returned to his home August 12th.

Dr. Harry B. Anderson, Professor of Pathology, Trinity Medical College, Toronto, was married to Miss Northway, August 14th.

We are pleased to be able to announce that Dr. Frank J. Farley, of Trenton, has quite recovered from a severe attack of typhoid fever.

Dr. R. M. Coulter, Deputy Postmaster-General, after spending a well-earned holiday at his old home in Aurora, returned to Ottawa August 12th.

Dr. E. D. Carder, Toronto, a Toronto General Hospital house physician of last year, has been appointed surgeon to the C. P. R. steamer, *Tartar*.

Dr. P. H. Bryce returned to his office August 1st after a visit to Muskoka. He reports great improvements in the sanitary condition of cottages and hotels in that district.

Dr. A. A. Knox, a graduate in Arts and medicine of the University of Toronto, who has spent the past year at post-graduate work, has returned to Canada. He reached Toronto August 13th.

Professor Wm. Osler, of Baltimore, spent the greater portion of August in North Berwick, Scotland. He expected to spend a few days in London, and then return to Baltimore about September 15th.

Dr. W. T. McArthur, (Tor., '95) of Los Angeles, California, has recently returned from Edinburgh, where he was admitted to Fellowship of the Royal College of Surgeons. He paid a short visit to Toronto early in August.

Dr. Thos. S. Cullen (Tor., '90), of Baltimore, was married, August 22nd, to Emma Jones, daughter of the late Dr. Beckwith, of Indiana. Dr. and Mrs. Cullen passed through Toronto, August 24th, on their way to Winnipeg.

Dr. Thos. B. Fitcher (Tor., '93) is practising in Baltimore. Although he has ceased to be a resident of Johns Hopkins, he still retains a connection with that hospital, having been appointed Associate Professor in Medicine.

Dr. A. McPhedran, of Toronto, during his recent visit to England, attended the Tuberculosis Congress in London and the meeting of the British Medical Association. Some of his remarks on the former will be found on page 514, clipped from the *Toronto Globe*. Dr. A. McPhedran, has retired from general practice and is devoting himself entirely to consultation work.

Dr. Chown, of Winnipeg, paid a short visit to Toronto about the middle of September.

Dr. Charles O'Reilly, Superintendent of the Toronto General Hospital, attended the annual meeting of the American Association of Superintendents of Hospitals, New York, September 10th, 11th and 12th, and was unanimously elected Vice-President.

Dr. Price-Brown's book on "Diseases of Nose and Throat" must be growing in popularity. Last year it was placed on the list of text-books of the University Medical School and Trinity Medical College. This year, in its annual announcement, the New York Polyclinic has also entered it upon its list of acknowledged text-books.

Dr. Arthur E. Ross, a graduate in Arts and medicine of Queen's University, who went to South Africa with the second Canadian contingent as hospital sergeant, and some time after his arrival was appointed surgeon to the Royal Canadian Dragoons. He remained in South Africa until June last, when he returned to Canada. He visited Toronto August 7th.

Dr. Bruce Riordan, of Toronto, and Dr. Hutchinson, of Montreal, left early in August on a trip to the Pacific Coast. They visited first San Francisco, where they were the guests of Mr. E. H. Fitzhugh, General Manager of the Southern Pacific Railway. They then went north to Victoria, and returned east by way of Vancouver, Banff and Calgary to Winnipeg, which city they reached in time for the meeting of the Canadian Medical Association.

Thos. McCrac, B.A., M.B. (Tor.), has been appointed Senior Resident Physician Johns Hopkins Hospital, Baltimore, in the place of Dr. Thos. Fletcher, resigned. Dr. McCrac went to London, England, in June, and at once went up to the examination for membership of the Royal College of Physicians, and passed. He returned in August, and passed through Toronto, August 26th, on his way to his old home, Guelph. After four days he returned to Baltimore.

Obituary.

MR. JOHN C. CARLAW.

We announce with deep regret the death by drowning, August 8th, of Mr. John C. Carlaw, of Parkdale, a third-year student of Trinity Medical College, Toronto.

MR. ARTHUR INGLESTROM WOOKEY.

Mr. A. I. Wookey, a bright and promising student of the fourth year in the Medical Faculty of the University of Toronto, died at St. Michael's Hospital, Toronto, September 2nd. The cause of his death was meningitis, following typhoid fever.

OVERTON F. MACDONALD, M.D.

Dr. O. F. Macdonald, who had been in practice in Toronto for thirteen years, was in poor health for some time, his mind suffering as well as his body. His friends were greatly shocked and grieved to learn that he committed suicide August 7th, shooting himself through the heart. He was 39 years old, and left a widow and one child.

DR. JOHN BARNHART.

Dr. Barnhart was one of the oldest practitioners in this country. He received his license from the old Medical Board in 1834. He practised for many years in Streetsville, but removed to Owen Sound about twenty-five years ago, where, notwithstanding his advanced age, he was engaged in practice until recently. He died in Toronto at the residence of his son-in-law, 7 Ross Street, August 9th, aged 88. He received his general education in the Royal Grammar School, of Toronto, and the greater part of his medical education in New York. He was, however, for a time a student of the late Dr. Widner, and acted as his assistant during the cholera scourge of 1833.

Correspondence.

THE BIRTH OF A SOUL.

To the Editor of the CANADIAN PRACTITIONER AND REVIEW :

SIR,—A clear and simple definition of the Anglo-Saxon word Soul is essential to a full and complete comprehension of our subject. Soul is Anglo-Saxon, and is synonymous with mind. Mind is derived from the Sanscrit and means, to think. The soul, then, is that which thinks, and is the vital principle which constitutes our life and being. It is a part of, and essentially of the same nature as, the universal soul or life. It is also the intelligent principle which reasons, wills, designs and exercises memory and judgment. It is susceptible of being influenced by the spiritual and material environment, and is the centre from which emotions radiate. It is a spirit and non-material, and therefore possesses neither shape nor form. It becomes manifest by clothing itself in matter, which it would seem was created for that purpose. It develops an individuality from environment, but never ceases to be indissolubly a part of the universal soul. It is therefore immortal.

According to the Bible, God made man out of the dust of the earth, and when all the complex organs, internal and external, had been perfected, He breathed into the cold, clayey nostrils the breath of life, and the image became a living soul.

The philosopher Plato, as well as some of the early Christian fathers, including Origen, believed in the pre-existence of souls; but in the sixth century the Church condemned this belief; and theologians now assume that the souls of mankind are the progeny of the special and distinct creation to which I have referred.

Let us try to see if exact science and knowledge can be made to sustain this assumption.

Man, like all other animals and reptiles, has his beginning in a minute particle of matter known as protoplasm, a chemical compound of carbon, oxygen, hydrogen, nitrogen and phosphorus. This particle of protoplasm develops into an egg, or ovum. The human ovum originates and is developed in small sacs known as graafian follicles, which are situated in and just under the surface of the female ovaries; and if we care to examine the living follicle microscopically, we may see the work of egg production beautifully and wonderfully exemplified.

The first stage in the process of ova development consists in the secretion of a particle of granular fluid by the lining mem-

brane of the graafian follicle. This fluid is known as undifferentiated protoplasm; it is a living fluid, and differs from artificial protoplasm in being contractile, irritable, receptive, secretory, respiratory and reproductive. In other words, it is a living product of living tissue. In some part of this particle of fluid protoplasm, an opaque spot is soon seen; this is known as the germinal spot, or nucleolus. Soon a network of fibrillæ is seen radiating from the nucleolus through the surrounding fluid. This fluid is known as the germinal vesicle and is readily distinguished by its transparency from the yolk in which it is suspended. The thick, transparent envelope which surrounds the yolk is known as the zona pellucida. The ovum is now mature and awaits the rupture of the graafian follicle, which permits it to escape and to commence its brief, or otherwise, life's career.

At the moment of its expulsion from the graafian follicle, it is seized by the fimbriæ and conveyed into the fallopian tube, through which it passes into the uterine cavity where, if it have not yet done so, it may meet the spermatozoa on their undulatory and vibratory journey upwards. If there are no spermatozoa *en route*, the ovum dies and is cast off. Why, we may ask, does the ovum, failing to meet the spermatozoa, cease to exist? We may assume that it was living and vigorous when it left the ovary, and that had it been properly nourished in transit, it would not have arrived *in utero* a starved and famished weakling, with hardly a spark of vitality left. Such, however, is the condition of most ova when they arrive *in utero*, and we cannot say positively whether or not nature intended to have the ova impregnated and fertilized while lying in the graafian follicle, immediately after expulsion therefrom, or while they are in transit through the tube. It may occur in any of these locations.

In virgins, it would seem, all ova inevitably die. Yet it is conceivable—no pun meant—that an ovum may be developed of such robust vitality that it may arrive *in utero* strong, vigorous and healthy, attach itself to the endo-metrium and evolve an embryo. This would be an instance of parthenogenesis. Such a conception, however, rests on the assumption that the living ovum is a distinct organic entity, and that the spermatozoa are not essential to the perpetuation of its life.

The spermatozoon, like the ovum, consists of protoplasm and possesses ameoboid properties. Its vitality is intense; and its purpose and function seems to be to stimulate, invigorate and nourish the less vigorous and insufficiently rationed ovum. The spermatozoon, also, dies unless it meets an ovum; but should it meet an ovum, it penetrates its enveloping membrane in an ameoboid fashion, and gives up its life, substance and identity

to save the dying ovum and perpetuate the race. The ovum or germ cell, and the spermatozoon, or sperm cell, then, are mutually dependent on each other for their preservation and perpetuation as two in one.

Both the germ cell and the sperm cell are particles of living matter, yet it is only when the one is absorbed by the other, that a human soul is brought into existence. Does the union of these two living cells generate a soul spontaneously, or does each individual cell contain the fragmentary elements of a soul whose only aim and thought is to become united with its opposite complement and become a whole souled being? But let us assume that the ovum possesses a whole soul; then it must follow that it got it while it lay in its little nest in the ovary from the female owner of the ovary. If this be so, does the spermatozoon possess a soul too, or only life? But my contention is, that life is synonymous with soul. Therefore the wedding of the weakling souls of the ovum and spermatozoon gives birth to a strong and vigorous soul endowed with the potentiality and intelligence necessary to incarnate itself in human form.

J. BAUGH, M.D.

Hamilton, July, 1901.

HOSPITAL VS. PRACTITIONER.

Editor of CANADIAN PRACTITIONER AND REVIEW.

SIR,—For many years it has been the custom with most hospitals to provide free medical and surgical attendance to the patients who paid \$2.80 for their bed. This is entirely wrong. The hospital should decline to do more than give a bed and hospital attendance to those who are not within its walls in the form of paupers.

A man has a good farm and a large stock. He could not by any means obtain the certificate of his municipality for free hospital maintenance. He goes to some city or town where there is good hospital accommodation and pays \$2.80 a week. This, in many instances, carries with it free medical and surgical attendance. By this means some member of the medical profession is cheated out of his fee. There is not a single argument in favor of such a course.

The only patients that should be regarded as the wards of the hospital are those who come to it as paupers. If a man chooses a cheap bed in a hospital, that is no reason why he should receive free treatment any more than if he took a cheap room in a hotel. When a person goes into a hospital and pays his own way, the arrangement for his medical and surgical treat-

ment is entirely a matter for himself to make. The hospital should assume no responsibility in this matter, when the person does not come to it as a pauper. A person who pays for his own bed has no claims on the hospital corporation for his treatment.

I call upon the medical profession to put an end to this abuse. If a person goes into a hospital and pays \$2.80 a week because this is all he can afford, he will have no difficulty in arranging with some practitioner for his services. This responsibility should always rest with the patient. But when it comes to free attendance upon persons who are well able to pay, a gross injustice is done the medical profession by the hospital which has a rule calling upon its staff to give free attendance on those who are not paupers. I go further and say that members of the profession are doing their fellow-practitioners a wrong when they consent to act on a hospital staff under such conditions. I am glad to state that some hospitals act properly.

GENERAL PRACTITIONER.

Book Reviews.

Saunders' Medical Hand Atlases—Atlas and Epitome of Ophthalmoscopy and Ophthalmoscopic Diagnosis. By PROF. O. HAAB, Director of the Eye Clinic in Zurich. From the Third Revised and Enlarged German Edition. Edited by GEO. E. DESCHWEINITZ, Professor of Ophthalmology Jefferson Medical College, Philadelphia. With 152 colored lithographic illustrations, and 85 pages of text. Philadelphia and London: W. B. Saunders & Co. Toronto: J. A. Carveth & Co. 1901. Price, \$3.00 net.

Professor Haab's atlas has long been recognized as a standard in Germany and in England. The latest German edition translated, edited and published in America is now before us. The book is in two parts. The first part may be spoken of as the epitome of ophthalmoscopic diagnosis. It gives full consideration as to the best methods of using the ophthalmoscope; indicates how to conduct an ophthalmoscopic examination; gives descriptions of the fundus oculi, or "eye ground," normal and pathological, and, as it were, lays the foundation for the proper use of the plates. The second part is the Atlas proper. It consists of 152 colored plates. These plates represent almost every condition of the fundus likely to be seen by any one using the ophthalmoscope; and they reproduce the appearances so perfectly as to render easy the recognition of the conditions. In regard to these lithographs, it is no flattery to say that they are as well executed, and as life-like, as those in the more expensive volumes. The publication of this volume is opportune, for few practitioners care to invest much money in an expensive atlas which is rarely used. Here we have a book at moderate cost, and so good as to be simply indispensable to every one who can use an ophthalmoscope, unless he is already provided with a good atlas.

Saunders' Question Compend—Essentials of Refraction and of Diseases of the Eye. By EDWARD JACKSON, A.M., M.D. Third Edition. Revised and Enlarged. 261 pages, 82 illustrations. Philadelphia and London: W. B. Saunders & Co. Toronto: J. A. Carveth & Co. 1901. Price, \$1.00.

That author who undertakes to convey a good knowledge of any subject by means of question and answer must have a very thorough grasp of the essentials of that subject. Dr. Jackson, Emeritus Professor of Diseases of the Eye in the Philadelphia Polyclinic, evidently has such knowledge of his subject. The facts communicated in this book are clearly and forcibly put, the illustrations are good, the lines of treatment put forward are reliable, and the ground is covered as well as it is possible to do in a book of this size. To those who desire to study the subject by this method the book may be recommended.

J. T. D.

Selections.

The Relation of Bovine to Human Tuberculosis.

An unusual flutter has been caused in the medical profession, as well as in scientific circles generally and among the laity, by the declaration of Professor Koch at the London Congress of Tuberculosis, that it is impossible to transmit bovine tuberculosis to the human subject. This idea, which is by no means original with Professor Koch, is based on certain researches he has recently conducted, in which he found it impossible to infect cattle with the sputa or the bacilli from cases of tuberculosis in man. The lay press, with characteristic eagerness to create a sensation when news is scarce, have accepted the learned Professor's opinions as absolute statements of fact, and, in consequence, have drawn hasty conclusions and have indulged in much absurd comment wholly unwarranted by the data brought forward by the observer. It is always unsafe to accept the dictum of any investigator, no matter how eminent, unless substantiated by positive evidence. While any opinion expressed by so competent an authority as Dr. Koch is worthy of all respect and of careful investigation, it would be exceedingly unwise to accept it as oracular. The medical world cannot forget the unpleasant reaction and the discredit to medicine that followed his premature announcement of a cure for tuberculosis a few years ago. Moreover, since the tuberculin *fiasco*, Koch's contributions to medical science have not been such as to re-establish him in the full confidence of the profession, and many regret that he did not allow his fame to rest on the sure foundation of his splendid achievements earlier in his career.

In his investigations into malaria and Texas fever, he showed a tendency to arrogate to himself credit for discoveries in which others had preceded him many years, and this disinclination to give due credit to fellow-workers in the field of Science has been particularly resented on this side of the Atlantic. Besides, what is now heralded in the secular press as an epoch-making discovery—that man is insusceptible to bovine tuberculosis, was suggested by Theobald Smith and others some years ago, but in the guarded and dignified manner of careful investigators. From the impossibility of using human subjects for experimental purposes, there is no direct proof forthcoming that man cannot be infected by the organisms of bovine tuberculosis. Because he found it impossible to produce the disease in animals by inoculating them with the germs of human tuberculosis, Koch concludes that the diseases in man and cattle are entirely different, and, therefore, reasons apparently by analogy, that man is not susceptible to bovine tuberculosis. Such

evidence certainly does not establish his contention, and will not convince. So far as weight of authority goes, he is opposed by the general opinion of the Congress at which his paper was read; by Virchow, Professor McFadyean, and certainly by the majority of clinicians in all parts of the world. The matter must still be considered one of the unsettled problems in medicine. The general interest stirred up by Koch's announcement will undoubtedly stimulate research in the matter, which is probably the greatest result that will follow on what he has said.

To jump, from Koch's opinions, to the conclusion that all the restrictions heretofore placed on the sale of the milk and meat of tuberculous animals are entirely unnecessary, and that there is no danger to be feared from the consumption of these articles, is an absurdity for which it would be unfair to hold him responsible. No doubt a little sober second thought on the part of those who expected an upheaval in the present sanitary regulations, with a repeal of the laws passed for the public protection, will convince them that, be the outcome of further investigations what they may, milk and meat from animals suffering from tuberculosis or other diseases will never be either safe or desirable for human food. Too thorough and stringent precautions can never be taken to insure that such potent carriers of infection reach the consumer in as pure and wholesome a condition as possible.

Considering the ill effect of the heat of the dog days, the medical profession can well afford to smile at the silly clap-trap in the way of editorial criticism offered by some of the lay press in reference to the alleged unnecessary precautions against tuberculosis upon which we have insisted for many years.—Editorial, *Canada Lancet*.

Enema after Abdominal Operations.

At the Boston City Hospital following abdominal sections it is seldom that cathartics of any kind are employed by the mouth. During the first twenty-four hours no attention to the unloading of the bowels is usually given. Then, no voluntary action having taken place, an enema, high into the rectum, is given, consisting of the following:

R	Epsom salts	(50% sol.
	Turpentine	
	Glycerine	aa. $\frac{3}{4}$ ii.
	Water	$\frac{3}{4}$ vi.

The injection is held in the bowel as long as possible by the patient.

It is well to anoint the inner thighs and buttocks in order to prevent irritation of the parts should they come in contact with the turpentine by mischance.—*Clinical Record*.