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EDITORIAL.

DOMINION REGISTRATION.

The unfortunate condition of compound, comminuted fracture of the medical profession to which Professor Osler referred in his address in Montreal some years ago, still remains with us. The reason is that there is some unfortunate feelings of jealousy in some quarters. We hope this will not last long.

All the apparent difficulties would soon vanish if the various Medical Councils would only agree to unite and form one common board. Can one imagine anything more absurd than the condition of the medical profession in Canada? We have political federation between the various Provinces, but the medical federation is of the lowest kind, and only exists between such provinces as accept each other's qualifications. This should not be.

We hope that the several Provincial Medical Societies and the Canadian Medical Association will make this subject a living issue during the coming season, and keep up the agitation until the whole matter of Dominion Registration has become an accomplished event.

Let Dominion Registration once be the order of the day, and any little unevennesses will soon vanish. The members of the profession from the different Provinces meet at the Canadian Medical Association and read and discuss papers. In this case they are on common ground and frankly admit that no one Province has a monopoly of learning. If all the Provinces cannot unite, let as many as can, and thereby form a nucleus around which the others may gather.

THE CONDITION OF THE MEDICAL PROFESSION.

The group of Provinces which form the Dominion of Canada does not lend itself readily to the successful formation or maintenance of a National Medical Association.

The three Provinces in the far East are cut off from the rest of the Dominion by the long range of territory forming the Province of

Quebec, where the members of the profession are mostly of the French race and language.

Then, again, Ontario is separated from the Western Provinces by a long range of country around the head of the Great Lakes that renders inter-communication with Manitoba and westward a rather rare occurrence.

For Medical Society purposes Canada falls naturally into four sections: 1. New Brunswick, Nova Scotia and Prince Edward Island in the East. 2. Quebec for the French-speaking practitioners. 3. Ontario, and the English-speaking practitioners of Quebec. 4. Manitoba, Saskatchewan, Alberta and British Columbia.

It seems to us that it is practically impossible to overcome the barriers that either distance or language have erected. Out of about 6,000 practitioners in Canada, it is exceedingly rare for the Canadian Medical Association to muster more than 400 at any one of its gatherings, and often is far below this number.

These very reasons have given rise to the Maritime Medical Association, an association of French practitioners, an active and useful Ontario Medical Association, and a strong desire for a Western Medical Association for the doctors west of Winnipeg.

For these very reasons the Canadian Medical Association has made but little real progress in over forty years; has at present but a small membership, and only a few hundred dollars in the treasury. It is all very well for this association to talk about aiding research work and publishing a journal of its own, but these things require money. We have pointed out before that there is already an excellent medical journal for the Maritime Provinces. The French-speaking physicians have two journals. There is an English one in Montreal and four in Toronto. Now there are two in the West; one in Winnipeg and another for Saskatchewan. We would be glad to support an organ of the Canadian Medical Association if we could be shown the ways and means for its establishment..

A WESTERN MEDICAL ASSOCIATION.

The signs of the times point clearly in the direction of the formation of an inter-provincial association in the West for the four great Provinces west of Winnipeg. In this movement we heartily concur. It is a movement in the right direction.

It is quite clear that the members of the profession from Winnipeg to the west coast cannot give much attendance upon the Canadian

Medical Association, as it cannot meet often in the West, and the distances render it impossible for many of them to attend the meetings when these are in the East.

Then, the West has its own special problems to deal with. If Dominion Registration cannot come soon, surely Manitoba, Saskatchewan, Alberta and British Columbia might form a group of Provinces where the narrow provincial lines would cease. If they did this, these provinces would soon be the governing portion of the Dominion.

If for no other reason than that it would compel the other Provinces to federate medically, we wish the four western Provinces every success in their efforts to form a flourishing Western Medical Association. What will do good to them cannot do harm to the rest of Canada. We have often expressed shame that we have not had Dominion Registration long ago.

THE CANADIAN MEDICAL ASSOCIATION.

This association will hold its 42nd meeting in Winnipeg this year on 23rd, 24th and 25th August. We would urge upon as many of our readers as can arrange for a holiday to take the same to suit the date of this association, and make Winnipeg the objective point.

No matter what may come up for discussion, the meeting is always worth attending. There is a social side to it that repays one well for his trouble of being present. Efforts are being made in this respect by the profession in Winnipeg that will leave nothing to be desired by the time of the meeting.

But there is a scientific side, and this must not be underrated. There is a gathering in of a vast amount of experience, both from reading and clinical observation. No one who has any receptiveness could be in such an atmosphere for several days and not leave feeling a new inspiration for his profession, and an enlarged capacity for doing his work better than before.

Further, there is the business side to be considered. Under this aspect may be included such discussions as Dominion Registration, A National Health Bureau, The Publication of a Journal, etc. These topics are very important, and the Winnipeg meeting should speak with no uncertain sound. Two of these should receive very careful consideration, namely, Dominion Registration and A National Health Bureau.

The duty of the profession is to attend the meeting. Then each one should make a determined effort to contribute something to the

proceedings of the meeting. Each one should prepare himself in advance for a thorough debating of that subject in which he finds himself most interested. Such preparation would stamp the meeting as one of the most valuable in the history of the association.

LIQUOR IN CHOCOLATES.

A short time ago three dealers in chocolates in Toronto were fined by the Police Magistrate for selling chocolates containing liquor. There is no doubt about the facts in the case, as all three pleaded guilty and accepted the fine of $50.

One can hardly imagine that it was a mere thoughtless act on the part of these persons to keep such goods for sale. On the other hand, it cannot be argued that they entered upon such a business for the good of the public. The only conclusion that one can come to is that these goods were kept for sale in the hope that they would be popular and, thereby, yield a good profit.

It is difficult to imagine that these dealers did not regard such a trade as wrong. Any one who handles chocolates for sale will soon know what class of persons are his customers. This sort of goods soon pass into the hands of comparatively young persons, many of whom never tasted a drop of alcoholic liquor before they partook of the doped chocolates.

We think that all such acts as this should be punished with marked severity. There is no excuse for them. One might just as properly offer for sale cigars containing opium, because they might sell well, regardless of the harm they might do. All attempts at drugging or doping foods or drinks sold for the proper use of the people must be stopped.

THE INSANE AT LARGE.

In our last issue we drew attention to the danger of the insane at large. During the month that has just gone past a number of cases of homicide and suicide have been recorded in the press of the country as the unfortunate acts of the insane. The following may be taken as a type:—

"Mrs. ——— this morning murdered her three-year-old son, W., and then committed suicide. The deed was done in a moment of insanity, brought on by illness. Her husband left the house at 7 o'clock to open his store, and when he returned, an hour later, for

breakfast, he found the place locked. He knew his wife was ill and was fearful of her actions, etc."

The foregoing goes to show that the unfortunate person was of unsound mind when her husband left her, as he "was fearful of her actions." Such would not have been the case in any other sort of illness than insanity. To go out of the house for the purpose of opening a store does not, in our judgment, afford sufficient reason for leaving a helpless child at the mercy of one of whom it could be said by her husband: "He knew his wife was ill and was fearful of her actions."

The position we took in our last issue we are prepared to adhere to and still further emphasize. There are many who will not seek proper care for the insane unless they are compelled to do so. They are afraid that it may lead to some outlay of money, or they do not like the stigma of a relative being committed to the asylum. Neither of these reasons should be allowed to weigh in a matter of such importance.

A very considerable portion of the responsibility for the deeds of the insane should be placed upon the shoulders of those who should take care of them. A man is held to be responsible for the unlawful acts of his dog. He should be made responsible for the acts of his insane wife. This would compel him to place her in a proper institution or surround her with a proper guardian. Parents should be held to account for the acts of an insane son, so long as he remains under their roof. In like manner a brother should be held accountable for the conduct of his insane brother, provided the former keeps in his house the latter.

Were such statutes in force, people would not be quite so willing to imperil the lives of others ,by keeping in their homes insane persons. They would be forced to pay for the keep of the insane in some institution, or secure the help of a competent person to look after them, or, not being able to do either of these, would avail themselves of the charity side of the asylum system in all the Provinces.

But the law should be made much stricter in the matter of tramps and vagrants, or such persons as are suspected of insanity. Any one who has no occupation and is trying to live as a vagrant or tramp should be placed under arrest at once until he can give a proper account of himself. If it turns out that he is mentally unbalanced he he should be sent to an asylum. If he is not of unsound mind, but will not settle down to a proper mode of life, he should be deprived of his liberty as a criminal and made to perform public service for the State as an offset for the cost of his maintenance. Such treatment would lessen very promptly the number of our tramps and vagrants.

To send them to jail has no specially deterrent effect on them. It is often a temporary boarding house expedient with them. But a long term of imprisonment at hard labor is the last thing they desire. Pick up a tramp wherever he may be found and give him hard labor for the benefit of the public until he is willing to become a safe and respectable citizen. If he is not willing to become such, then confiscate his labor to the State during his natural life.

The wages due these men can be credited to them and applied to the purpose of supporting those they should be supporting if following a proper life. This would serve a second good purpose and often prevent a wife and children becoming a burden on the community.

We hope to see some one in each of our Provincial Legislatures take this matter up. The Federal Government could well co-öperate in legislation that is so much needed.

PUBLIC EFFORT IN THE CONTROL OF DISEASE.

It has often been said that governments should not be too paternal, and do too much for the people. There is no doubt a good deal of truth in the saying that the gods help those who help themselves. While this is true there is much that the public should do, indeed, must do, for the general weal of mankind, and for the prevention and cure of disease.

No one man could keep up an institute for the treatment of rabies. It has become an accepted rule of practice that the insane of a country should be cared for in large institutions. In like manner the sick poor are cared for in hospitals, and the consumptives in sanatoria for such cases.

But the public, that is the municipality, the Provinces and the Federal Government, must not rest here. There is much more that must be done. Private citizens do not dig canals for trade and commerce, nor do they construct harbors for shipping, and fortifications for the protection of the people. The public is only now becoming alive to its great responsibilities in the matter of the health of the people.

Very many, far too many, die each year of preventable diseases. Typhoid fever carries off its thousands, and these mainly in the prime of life. Why? Because municipalities sell polluted water to citizens. Very many die of diphtheria because the patient or his friends are too poor to secure a dose of the life-saving antitoxine. This should not be the case. A poor child is struggling for its life against an attack of this serious disease. The community owes it to all to protect life,

and, therefore, to save life. Every municipality should furnish free antitoxine to the poor. It would be a splendid investment.

Then, again, take tuberculosis. The loss of 10,000 lives, and a vast amount of sickness, loss of time, and outlay of money, are the tolls we are yearly paying for our carelessness. This problem is too gigantic to be met by private effort, however well-intentioned. The governments must devise ways and means. This can be done by compelling counties and cities to furnish accommodation for their consumptive patients. The general purse might supplement these efforts, but the problem must be faced. There would be a terrible outcry if an enemy invaded the country and killed 10,000 a year and wounded 40,000 more; and this is what the tubercle bacillus does. Britain spent millions in money and sacrificed many a life to vindicate her honor and set free three subjects who were wrongfully imprisoned in Abyssinia. But Britain, as a government, has given nothing towards the prevention of consumption. Such subjects as pure milk, pure water, pure food, aid for the sick poor, the prevention of preventable diseases, the prevention of sickness, and the prolongation of life, are all matters that come directly under the purview of the State in the widest sense. It is a vast deal cheaper to any country to pay something to prevent consumption than to be paying out for the support of the helpless orphans that are left by the untimely deaths of their parents.

Too much attention is given to warships and soldiers, and not enough to the health of the people. Study the death reports for the proof of this statement.

HOSPITAL CONSTRUCTION.

Of late years there has been a marked change in the prevailing ideas with regard to hospital architecture. The views now held all make for simplicity.

The buildings should not be ornate and expensive. Simple neatness should run through the whole building. They should be as nearly fire-proof as possible, and the reasons for this are apparent to all.

Hospital buildings should be located and erected in order to secure the maximum amount of sunlight. It has now been conceded that pavilions should run north and south, so as to secure the forenoon sun on one side, and the afternoon sun on the other.

With regard to ventilation the concensus of opinion is now turning strongly in favor of direct airing of the wards by means of the windows, with proper arrangements to direct the currents of air upwards, and away from the patients.

All wards should be so arranged that the patients can be taken out with as little trouble as possible, to the lawn for open air treatment, when the state of the weather permits of such. There should be a free use of the verandah for open air treatment.

It is estimated that in this country quite satisfactory hospital accommodation can be secured for about $800 per bed. Expensive woodwork and marble, etc., are only good as means of wasting money.

Closets and bath rooms should be in a tower attached to the pavilion, but so arranged that no odor can enter the wards. This is the only proper and sanitary method.

The diet kitchens for the various wards should be located so as to be convenient for the nurses doing their work, but not too close to the closets.

The whole subject resolves itself into a cheap building which will not burn, with plenty of air and light for the patients, and free from distracting noises.

TOBACCO AND THE YOUNG

It is not stating the case too strongly that tobacco is responsible for many a mental and physical wreck among the young. It would be somewhat of a waste of time to quote authorities in substantiation of the baneful effects of the use of tobacco by those who are in their growing and developing years.

Careful observations, made by competent persons and on a sufficient number of persons, prove that the use of tobacco by growing boys very materially lessens the rate of growth and the mental grasp of things corresponding with the age.

The train of nervous disturbances are well-known. Among them may be mentioned vertigo, fatigue, irritability, failure of memory, tremors, poor circulation, etc. These come from the toxic effect of the alkaloid on the nerve centres.

On the digestive organs the effects of the use of tobacco are well known. Nausea, loss of appetite, vomiting, gastralgia and many other digestive derangements have become familiar as occurring among youthful users of tobacco.

The depressing effects of tobacco on young persons are seen in the case of disease and the way in which it retards recovery. In many instances no progress can be made towards cure until the use of the tobacco has been entirely given up.

The medical profession has a grave responsibility here. Its plain duty is to urge the non-use of tobacco until growth has been completed.

ASSYRIAN MEDICINE.

There appeared in *Edinburgh Medical Journal* of February, a very interesting article from the pen of Dr. John D. Comrie, on the subject of "Medicine Among the Assyrians." The Semitic races that supplanted the Scythians founded the Kingdom of Babylon about 3,000 B.C., and Assyria about 2,000 B.C.

Of about 20,000 tablets dealing with a great variety of subjects, somewhere from 500 to 1,000 treat of medical topics. Many diseases are mentioned, and in many instances quite fanciful lines of treatment are laid down. At Barsippa, near Babylon, there was a place of learning, and there are reasons for supposing that it was mainly for medical studies. A physician is mentioned as acting as a healer and a priest in Babylon as early as 2,700 B.C.

The code of Hammurabi, a king of the First Dynasty of Babylon, bearing the date of about 2,000 B. C., lays down many rules regarding the practice of medicine, and also says what the physicians' fees shall be. These laws go to show that at that very remote period in the history of Assyria, the physician enjoyed a high social position.

There were certain heavy penalties for careless acts on the part of a physician, or for malpractice. There was a fair advancement in surgery. Operations, such as that for cataract, appear to have been known, and the laws of refraction were in a fair stage of advancement and lenses were made use of to aid sight.

The court physician of those early Babylonian days was a person of marked distinction.

He had under him a number of other doctors. The Rab-mag, or court physician, records that in the case of nose bleeding the dressings had been applied wrongly on the outside. He says that the assistant should have applied the dressing inside of the nose. This looks like our tamponing.

About the same period in Egypt a court physician is spoken of as being in great favor with a king of the Fifth Dynasty, about 2,700 B.C. There are a number of ancient papyri dating from 1,000 to 2,000 B.C. In the Hermetic books of Egypt of very ancient date, there was a good deal of attention given to medicine. Six of these books dealt with the body, diseases, instruments, drugs, the eye, diseases of women.

Some very interesting copper surgical knives have been found in a tomb of about the date of 1,500 B. C. A number of strange formulæ are given, but the following for baldness is unique: Lion's fat, hippopotamus fat, crocodile fat, goose fat, snake's fat Nubian ibex fat, of each equal parts.

ORIGINAL CONTRIBUTIONS.

THE CLINIC IN THE CORNFIELDS.

By ERNEST HALL, M.D., Vancouver, B.C.

Note on Hernia.

IN direct hernia, and always when the patient is above fifty years of age, the procedure is worthy of note. After ligature of the sack

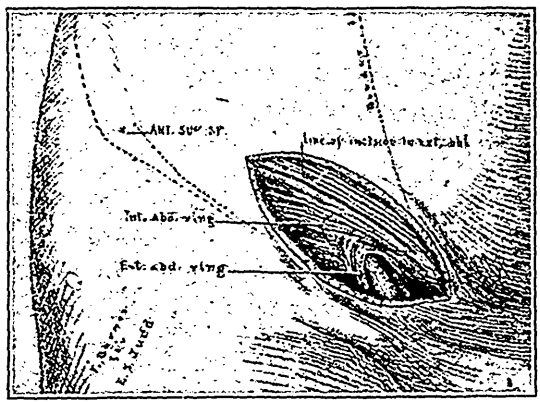

Fig. 1. Line of incision in external oblique muscle.

and its fixture within the abdominal cavity, the cremaster muscle which is frequently hyphertrophied is stitched to the transversalis, and the

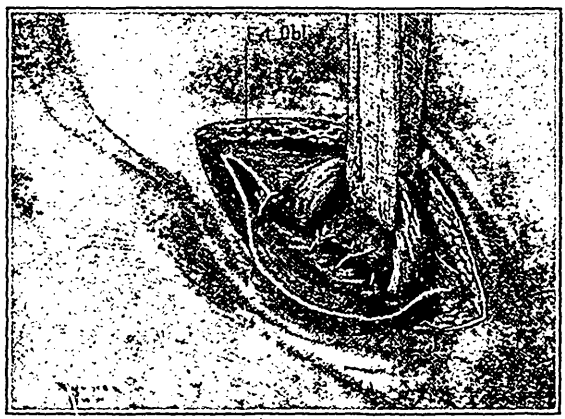

Fig. 2. Showing method of transplanting the cord.

sheath of the rectus, sometimes the rectus muscle, to the deep part of Pouparts ligament. The conjoined tendon is next stitched to Pouparts,

and further outwards the internal oblique. The third layer is made by stitching the external oblique (which has been slit up a quarter of an inch above the ring) to Pouparts ligament. Upon this layer the cord is placed, and over it is stitched the aponeurosis of the external oblique which is attached to the Pouparts ligament, and stitched to the muscle above the ring, thus placing three layers below the cord. (1) the cremaster to the transversalis. (2) the sheath, or part of the rectus muscle, the conjoined tendon and further outward the internal oblique

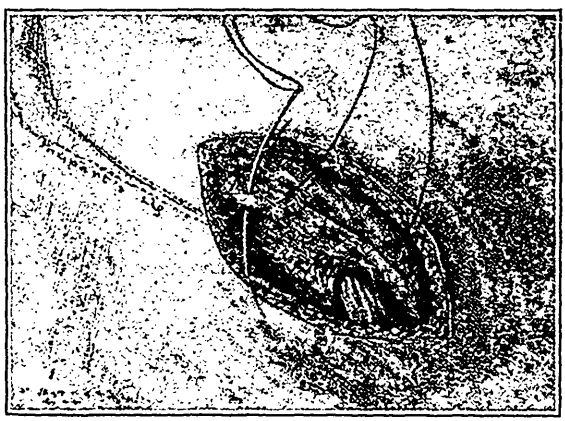

FIG. 3. Method of overlapping the aponeurosis of the external oblique.

to the deep part of Pouparts ligament, and (3) the upper section of the aponeurosis of the external oblique to the more superficial part of Pouparts, and above the cord one layer, that part of the aponeurosis of the external oblique which is attached below the Pouparts is stitched over the cord as high as possible to its own muscle. Always know where the point of your needle is in operating for hernia. The illustrations are from Dr. Judd's article.

ULCER, GASTRIC AND DUODENAL.

Sixty per cent. of all ulcers are in the duodenum. Sixty-one per cent. of all gastric ulcers are in the male. Seventy-seven per cent. of duodenal ulcers are in the male. Ninety per cent. of gastric ulcers are found in the pyloric region. They are usually single, but may produce a contact ulcer upon the opposite mucous surface.

Hyperacidity is an influential factor in the production of symptoms, the pain flatulence and vomiting are in proportion to the acidity. Not so much the degree of acidity as the amount of the acid secretion—hypersecretion rather than hyperacidity. Little or no value is given to

the results of stomach analysis. Functional hyperacidity may give symptoms difficult to differentiate from ulcer. Low acidity may be present late in the disease when anæmia and emaciation has reduced the vitality below the producing point. With lowering of acidity the pain lessens. In pernicious anæmia the conditions may simulate ulcer. A blood count is necessary to distinguish.

Trauma is also a factor in the production of ulcer; produced by the grinding of food. Eighty per cent. of gastric ulcers are associated with the pylorus. Duodenal ulcers are frequently in that part where the spurt of the acid chyme from the stomach strikes against the bowel wall.

Other factors in the causation of ulcer are anæmia, loss of local resistance and toxæmia. Thrombosis, embolism, perverted nerve influence are not given much consideration in the production of ulcer. Dr. Mayo has never seen an ulcer in the jejunum after gastro-enterostomy.

Periodicity is usually a prominent factor in the history of ulcer. The attack may be sudden. The pain, sour eructations and vomiting are worst from two to five hours after meals, and continuing for days or weeks. Then a period of intermission, lasting possibly for months. These intermissions gradually become shorter until the patient is rarely free from pain. Dr. Mayo says that many of these cases have been "cured" twelve to fifteen times before they come to him.

Vomiting of food in ulcer does not take place except in obstruction or in the presence of some complication, "but gulping up of mouthfuls of bitter, burning acid liquid from the fasting stomach is the most important symptom of ulcer, and when associated with food relief and hunger-pain, goes far to establish the diagnosis of ulcer." (Graham). The patients frequently state that after they have slept a while they gulp up a few mouthfuls of bitter fluid as if they had sucked a lemon. Frequently a glass of milk or a biscuit will give relief. To make these cases surgical, all that is required is the determination of obstruction. —The retention of food in the stomach for more than seven hours. The test meal usually given is raisin cake, or underdone rice is given at night. If, in the morning, any remnants of the food remain in the stomach, it indicates obstruction, and the case ceases its medical career and becomes surgical. In alcoholic stomachs where the muscle is sluggish, more than one test is necessary to prove obstruction. The time of vomiting in ulcer is usually when the stomach is empty. When the ulcer is situated near the cardia it may be within a few hours after meals, when in the duodenum, not until four or five hours after meals. The vomitus is usually the residue of the meal mixed with acids and mucus. Hydrochloric acid, if vomiting is early, buteryc acid if the vomiting is late.

Gas in ulcer is prominent and annoying. When belched up, relief is afforded for a time. This may lead to the habit of air swallowing.

Pain in ulcer is not referred, remains localized in the epigastrium, the greatest point of tenderness may be left of the median line, in duodenal ulcer it is to the right. Pain in the back is only found when the ulcer is upon the posterior wall or when adhesions exist. The pain is burning, gnawing, may resemble gallstone pain but shorter. The pain is extreme when the ulcer is approaching perforation. Spasm of pylorus is a prominent factor of pain in ulcer. Time of pain from two to five hours after a full meal. In ulcer it is the time of the pain more than the character that is important. The heartier the meal the longer the relief. When food or alkalis fail to give relief, look out for cancer. In neurotic conditions, in atony, or dilated stomach food causes uneasiness. When the ulcer is on the lesser curvature or near the cardia the food relief is shorter.

Pyloric spasm is due to some irritation of the sympathetic, associated with disease of some part of the mid-gut causing intermittent spasmodic closure of the pylorus, with reversed peristalsis and vomiting. Lesions of the mid-gut uncomplicated will not produce it. The stomach being secondary in its function to that of the bowel, has not the privilege of deciding when it shall empty itself, but must await notice from the mid-gut. The stomach is but a convenience, passive and subservient to the mid-gut, and in health subservient to the duodenum, and in disease subservient to any irritated portion of the mid-gut. When a dispute as to authority arises, the duodenum rules the stomach.

Perforation of appendix, and perforation of duodenal ulcer are frequently confounded. Early in perforation of duodenal ulcer the pain will be over the appendix for the first few hours. One in eighty-six cases of perforated duodenal ulcer will be opened for appendicitis. Twenty-five per cent. of duodenal ulcers will perforate usually under the liver and rarely produce peritonitis. Multiple perforations are toxic in origin. The contents of the stomach and duodenum are practically sterile. Not so further down. Look out for the last few inches of the ileum.

Out of one hundred and forty-one cases of ulcer in the duodenum in this clinic, seventy-five per cent. were correctly diagnosed, ten per cent. were called gall stones, fourteen per cent. were called gall stones or duodenal ulcer, and six per cent were determined by exploration.

In all conditions of pain in the upper abdomen exclude Deitels crisis, the gastric crises of locomotor ataxia and caries of spine.

The complications of ulcer are hemorrhage, perforation, adhesions, obstruction and malignant degeneration. Cancer of the stomach in sixty-

two per cent. of the cases develops upon an ulcer base. Duodenal ulcers rarely become cancerous. Only one case of primary duodenal cancer has been seen in this clinic.

The surgical indication in ulcer is obstruction. When complications arise, tumor (all tumors are surgical) obstruction, when food ceases to give relief, or when nutrition is failing—operate. Hemorrhage when not backed by ulcer history is not here considered surgical. Ninety-five per cent. of these hemorrhages will cease. Hemorrhages from acute ulcers, mucous erosions are medical. Will not operate unless the hemorrhage is becoming exhaustive.

One single large hemorrhage from the stomach is usually not from ulcer but from cirrhosis of the liver. In ulcer the hemorrhages are repeated.

The medical treatment of ulcer is the reverse of our early teaching. The diet should be ample. A liberal diet of mixed nourishing food. Starvation is not beneficial, it does not remove the cause; in fact it is detrimental. Ulcer will not heal unless the nutrition be maintained. Olive oil can be used with excellent results by many. It soothes the ulcer, opens the bowels, reduces acidity by relieving irritation, and relieves the stomach as it is digested in the small bowel, but some cannot take it on account of the butyric fermentation that it occasionally produces. Most patients find that subnitrate of bismuth and calcined magnesia in ten-grain doses, or according to its action upon the bowels, combined with iron and arsenic, results beneficially. Modified Blaud's pill is frequently prescribed.

Gastro Enterostomy.

Gastro Enterostomy is no longer considered a drainage operation, with an unobstructed pylorus the food will not pass through a gastro enterostomy opening, but through the natural passage. This operation is restricted to cases of pyloric obstruction and to cases of ulcer in which pyloric obstruction is expected to follow.

The technique has been a little altered on account of two cases of hemorrhage. Three layers of sutures are now placed in the posterior wall, the first serous, the second, placed after the section through the serous and muscular coats of the bowel and stomach has been made and penetrating all the coats, the third, placed after the mucous membrane has been cut through, passes through all the layers and over the free edges. Since this procedure has been followed there have been no post-operative hemorrhages. Many gastro enterostomies done before the exact indications for the operation were understood, are being undone.

Appendicitis.

Between three and four thousand diseased appendixes are here removed annually. In cases where the appendix lies over the ureter, blood is frequently found coming from the right ureter and symptoms of stone in the ureter are often present. Exclusion of this condition is a matter of diagnostic routine. Adhesions of the appendix to the psoas muscle may simulate hip-joint disease. Several children have been sent here with extension apparatus on, when investigation has shown only chronic appendicitis. Hemorrhage from the stomach is occasioned in appendicitis, with no pathological condition in the stomach to account for it. Also jaundice, due to infection secondary to pyloric spasm. All patients are examined per rectum when there is an abscess pointing towards the rectum. Dr. C. H. favors opening with the cautery through the rectum. In one case out of ten the only symptoms that a diseased appendix gives are wholly reflex. In one hundred cases of stomach trouble in which the symptoms were wholly referable to the gastric region, which were operated upon and presented no gastric, hepatic nor duodenal disease, a pathological condition of the appendix was found. The removal of the appendix was followed by complete relief in ninety per cent of the cases. The recognition of these sympathetic results of chronic irritation from a diseased appendix is receiving consideration, and it is hoped that soon the differential diagnosis between gastric conditions dependent upon chronic appendicitis, and gastric conditions from local causes can be made. In cases of appendicitis that are profoundly septic and present symptoms of obstruction of the bowels, operation is deferred and the stomach tube freely used.

Diagnosis Between Chronic Appendicitis and Ulcer.

In a lecture delivered by Dr. Graham before the Surgeon's Club, the differential diagnosis between chronic appendicitis and chronic ulcer was touched upon. Dr. Graham stated that in the gastric symptoms produced by chronic appendicitis there were: (*a*) No cessation of pain or inconvenience after taking food. (*b*) The attacks bear no relation to meals. (*c*) And the attacks were very irregular as to periodicity; not related to the seasons as apparently the attacks of gastric ulcer are, which so often occur during spring and fall. "Stones" in the appendix, and irregular involution, that is commencing in other parts than the tip, are the conditions most frequently responsible for gastric distress. These irritations playing upon the sympathetic produce pyloric spasm, thus disordering local function.

Exploratory Opening.

In all cases of stomach trouble of sufficient severity, not relieved by treatment, a surgical examination is indicated, and that early, before

the undertaker's symptoms become fully developed. Failing to find duodenal, gastric or gall tract trouble, the appendix must be sought for, and in the vast majority of cases the cause will be found there. Almost every day a stomach case is opened and closed with the words "too late." Cancer of the stomach in its early stages is as amenable to surgical cure as that of the cervex, viz., 25 per cent. of the cases. Preparations of pepsin are no doubt as serviceable if poured down the patient's pants as poured into his stomach. Proprietary medicines must be good since the manufacturers ride in automobiles, while the doctors who prescribe them take the street cars and the patient walks —that is if he is able. The general practitioner must recognize early the symptoms of organic disease and appreciate their seriousness and call the surgeon before malignancy has asserted its claim.

Gall Stones.

Five out of six cases are in females. Ninety per cent. have borne children. Usually the patient dates first history of attack from pregnancy. May be accounted for possibly by the increased liver toxæmia of pregnancy. Innocent gall stones do not exist. The only innocence lies in the diagnostician *re* the trouble. Operative interference in gall stones is as necessary as in chronic appendicitis. A single attack of jaundice complicates a patient's chances. Jaundice is caused by localized peritonitis, infection of ducts, obstruction and cancer. In sixty-two per cent. of the cases the common duct passes through the head of the pancreas, and pancreatitis may cause swelling and obstruction of the duct. Four per cent. of gall bladders containing stones become carcinomatous, in twenty per cent. of cases the gall stones produce serious results. In twenty-eight hundred gall stone operations the mortality here has been two per cent. In seven hundred cholecystestomies the mortality rate is a little higher. Three hundred and sixty-two consecutive gall tract operations with seventy-one common duct drainage cases are here tabulated without a death. Cases are not operated upon during an acute attack of jaundice. Hemorrhage in operations upon the gall ducts is not due to lack of coagulability of the blood, but to some toxæmia from the pancreas. Jaundice coming on without pain usually indicates malignancy, if prolonged and not increasing in degree leads one to suspect pancreatitis. Cholecystectomy is done in one quarter of the cases, only when the gall bladder is destroyed. It is not without function, but has two important parts to play, one as a storehouse for bile to relieve pressure upon the common duct, and the other to secrete mucus. After the gall bladder is removed the common duct is found dilated, and experi-

ments have shown that bile injected into the pancreas causes acute pancreatitis, but bile mixed with mucus will not cause inflammation. In eighty-five per cent. of the cases gall stones are correctly diagnosed at this clinic. Seven per cent. called either gall stones or ulcer, one per cent. called duodenal ulcer, and seven per cent. called appendicitis or gall stones. In one hundred and sixty-eight cases of pancreatitis operated upon, one hundred and forty were associated with gall stones.

In all cases in which the common duct is opened a rubber drain with the "eye" cut in it is inserted into the common duct and pushed up into one of the hepatic ducts with the eye turned towards the other hepatic duct. The length of the common duct above the opening is measured by the finger and a catgut suture placed through the rubber tube, passing through the edges of the common duct opening, thus securing the drainage tube in place. A second stitch is placed behind the tube. A second split rubber fish-tail drain is placed against the opening in the tube and another placed in Morrison's pouch. The mortality of a drained tube as compared to one closed tightly is twenty per cent. less. When the gall bladder is removed a clamp is left upon the cystic duct for the double purpose of affording drainage if necessary, and to immobilize gauze packing placed against the liver from which the bladder has been removed to effectually control oozing.

Fibroids.

Twelve per cent. of women have fibroids. Sixty-two per cent. cause symptoms. Of those causing symptoms, thirty per cent. will cause death within five years, twenty-two per cent. will undergo degenerations, of these fourteen per cent. will be benign, four per cent. necrotic and four per cent. malignant. Forty-two per cent of cancer of the body of the uterus is associated with fibroids. Malignancy of the opposite wall of the uterus to that in which the fibroid is located is found in three cases out of a thousand.

Fibroids do not disappear at the menopause; but those containing much blood shrink. It is the lessened amount of blood, not the disappearance of tissue that causes some to become smaller.

Ten per cent. of operations for fibroids done here are myomectomies. This is the operation of choice before the age of thirty, but the mortality is slightly greater than that of hysterectomy. In seventeen myomectomies during pregnancy recovery ensued without miscarriage. Pulmonary embolism does not follow operations upon the uterus more frequently than operations upon other parts. It is not due to a clot forming at the site of a ligature and carried to the

lungs, but to a condition of blood or the blood-vessels which predisposes to the formation of a clot within the auricle. Keeping the patient prone for a number of weeks is probably a contributing factor of much importance. Except in malignancy, supravaginal (subtotal) hysterectomy without curetting or disinfection of the cervix is the operation of choice, the uterus being removed in from three to five minutes. After completing the operation the sigmoid is packed into the lesser pelvic cavity, and covered with omentum. This effectually prevents the small bowel from getting into trouble. The ovaries, if healthy, are left. Dr. Mayo stated their function or non-function was none of his business. Healthy tissues must not be removed. In myomectomy, Dr. Mayo emphasizes putting in the uterine sutures loosely. Necrosis follows wherever a stitch is put in sufficiently tight to blanch the tissues.

Removal of the Rectum for Carcinoma.

The patient was a female with a part of the carcinomatous mass projecting from the anus, and the disease extending three inches up the bowel, but not invading the vagina nor bladder.

The bowel was first encircled with a double purse string linen suture, thus completely sealing the anus. A circular incision one inch from the anus, and one extending from this to the coccyx gave ample room. After the severing of the levator ani from the rectum, Dr. Mayo introduced his hand, freeing the rectum with its fat and glands from the vagina and uterus in front, and the sacral fascia behind. This occupied as little time as is required to tell it. The peritoneum was next carefully entered, all bleeding points clamped, and the sigmoid drawn tense. This put on stretch the anterior peritoneal fold of the meso-sigmoid, which was clamped and secured sufficiently to enable enough of the sigmoid to prolapse to make up for the amount of bowel removed. A ligature linen was then put on the bowel sufficiently above the growth and tightened. The bowel was then cut and the base burned with the cautery. The wound was then cleansed of remaining fat and glands, the clamps removed, and the peritoneum stitched closely around the sigmoid. The levator ani were approximated and the bowel stitched to them. The bowel being fixed in the position of the extirpated anus, the wound was closed, a drain inserted behind the sigmoid. The closed bowel favors primary union. It will remain closed for five or six days, the patient being fed on albumen water, strained soups and water. If gas troubles to any great extent an aspirator needle is inserted into the bowel for relief.

DOUBLE MULTILOCULAR BROAD-LIGAMENT CYSTS.

By EDWARD REGINALD SECORD, M.D., C.M., Brantford, Ont.

THE ordinarily accepted description of broad ligament cysts is that they arise from distension of remnants of the Woolfian tubules in the broad ligament, are usually slow growing, are unilocular, are pedunculated or sessile, depending on the direction of growth, and are usually filled with a clear limpid fluid of low specific gravity, which may assume different hues in aged cysts if there has been intracystic hæmorrhage.

Their removal, if entirely sessile, may be difficult, in some cases it being necessary to ligate the ovarian and uterine arteries of the opposite side, cut across the uterus at the junction of the cervix and body, and remove the cyst from below upward, much in the same way that fibro-myomata are usually attacked.

The following case which I wish to place on record is remarkable for several reasons:

(1) The comparatively rapid development of the tumor.

(2) Its bilateral character.

(3) Its multi-locular nature, thus differing markedly from the usual parovarian cyst.

(4) The comparative ease of its removal by enucleation.

Mrs. S., Aet. 50. Married, mother of three children, two years past the menopause.

Complaints:—A tumor of the lower abdomen.

Personal History:—Had an attack of cholecystitis about two years ago. Otherwise always healthy.

History of Illness:—Enlargement of the lower abdomen was first noticed about six months ago. It did not cause much pain or pressure symptoms, but has gradually increased in size up till the present. The patient pursued her occupation of scrub-woman up until a few days previous to her operation.

Present Condition:—A fairly well nourished woman of about fifty. Pulse, temperature, and respirations normal.

Abdomen:—Is occupied in its lower half by a tumor, somewhat more prominent on the right side, extending upwards to about the umbilicus, with a distinct forward boss-like projection whose apex is about four inches below and two inches to the right of the navel, and another similar boss lower down on the left side. The whole mass is very slightly movable, is hard with a suggestion of elasticity, is not fluctuating, and is not particularly tender.

Vaginal Examination:—The cervix is small. The vaginal fornices are filled with a hard, springy mass, continues with the abdominal

mass. The cervix and tumor move together through a very slight area. The body of the uterus cannot be differentiated.

Diagnosis :—Lay between that of a fibro-myoma of the uterus or a large, broad ligament cyst. Owing to the hardness of the mass, absence of fluctuation, and inability to move the cervix separately, I was inclined to the former view.

Operation :—A median abdominal incision was made from umbilicus downwards over the tumor. The peritoneum being opened disclosed an evidently cystic mass, lying below the peritoneum, occupying the whole pelvis and extending upwards into the abdomen, lifting the peritoneum with it so that laterally that membrane was continued directly onto the side wall of the abdomen, anteriorly onto the dome of the bladder, and posteriorly onto the sigmoid and sacral promontory. It was now seen that the lower left-sided boss was a separate mass from the right-sided. There was no trace of the infundibulo-pelvic ligament on either side; apparently it was entirely obliterated by the upward growth of the cyst. The round ligament on either side was, however, plainly visible. The peritoneum was fairly freely movable over the mass, and just beneath it appeared a considerable plexus of large veins.

Feeling that removal would be facilitated by lessening the bulk of the mass, I pushed a trocar into the most prominent area. About a cupful or more of yellowish glistening fluid came away, and apparently only the apex of the boss-like mass had its tension lessened any. Pushing the trocar still further in, fluid of an entirely different character, clear and limpid like water, escaped, only in limited quantity, however. The trocar was removed, the hole closed by forcipressure, and the peritoneum incised over the mass for about two or three inches on either side of the forceps. Pulling on the forceps with the left hand, and peeling off the peritoneal layer, which contained the large veins before spoken of, with the gauze-covered forefinger of the right, the entire mass was slowly but gradually enucleated.

It was about the size of a child's head, and occupied the pelvis down to the pelvic floor, which was left completely bare by its removal. There was comparatively little hæmorrhage; an occasional vein was torn, some of which were closed by forceps, but the majority were left, as they did not bleed much while the tension was maintained on the cyst wall. The cavity left by the removal of the tumor was packed with a couple of large gauzes and attention was directed towards the other side. The body of the uterus could now be felt at the mesial side of the remaining tumor. The left-sided cyst was now removed in an identical manner, only it was not punctured first. The peritoneum was merely incised and peeled off the cyst. One of the loculi

was ruptured during the proceeding and a small quantity of clear fluid escaped.

When removed this cyst was about twice the size of the fist, and was made up of the conglomeration of about a dozen small loculi, some containing clear, limpid, watery fluid, and others thicker yellowish, glistening liquid.

The cavities left on both sides were now narrowed down as much as possible by a row of catgut sutures which rolled in a large part of the lax peritoneal tissue, a strip of gauze was packed into each space and brought out at the lower angle of the incision. All clots of blood were removed from the pelvis, the lower abdomen flushed out with saline, and the incision closed in three layers.

After-Treatment.—The gauze was removed in twenty-four hours. Vomiting was troublesome for the first two days, but except for the considerable range of temperature shown in the appended chart, recovery was uneventful. This temperature was probably due to coagulation in the large veins in the cyst wall, with subsequent absorption of the clot. The pulse rate, the entire absence of chills or sweats, the primary wound healing, and the entire absence of any purulent collection, would indicate that it was an aseptic process.

Remarks:—The method adopted seemed to be the only way to remove this tumor. Owing to its bilateral character, attack from below by ligature of the ovarian and uterine arteries of the other side, and division of the uterus, was impracticable.

Although the operation was somewhat lengthy, it was not particularly difficult, and at no time was hæmorrhage troublesome. This I ascribe to care in keeping close to the cyst wall, leaving the large veins undisturbed under the peritoneum.

The absence of fluctuation in the tumor, noted in the preliminary examination, was no doubt due to its multicystic character.

NOTES UPON THE CONDITION OF MEDICAL REGISTRATION IN CANADA.*

By A. 3. THOMPSON, M.D., McDonald's Corners, Ont.

MR. President and Fellow Members,—It is not intended that the following remarks should exhaustively cover the whole field; but rather that a general view of the state of Medical Registration in Canada be presented to this meeting, together with some suggestions as to possible and desirable reforms, so that those present will be able to discuss the subject to advantage.

* Read before a meeting of the Ottawa Valley Medical Association, Arnprior, Jan. 13th, 1909.

Prior to Confederation, in 1866, Medical registration had not received very much attention from the legislators of the various and distinct Provinces, or colonies, which after that date became known as the Dominion of Canada. Those who remember what they read of the negotiations which led up to the union of all the Provinces, cannot but recall the jealousy with which so-called Provincial Rights were safeguarded in the terms of Confederation. Now, it is quite fitting that such rights be protected; but too much care and caution cannot be exercised in first determining what are Provincial Rights and what are not. We submit that in this particular instance an imperfect and incorrect conception of provincial rights has greatly curtailed the freedom and the rights of medical citizens of Canada to the present hour.

While the following details refer more particularly to the Province of Ontario, they are generally quite applicable to all the other Provinces that originally entered Confederation. Special reference will be made, later on, to British Columbia, Manitoba, Alberta, Saskatchewan and the Yukon.

The College of Physicians & Surgeons of Ontario was first incorporated by a Dominion Act of Parliament, passed in 1866. This was repealed by the Legislature of Ontario in 1869, and a Provincial measure, commonly known as the Ontario Medical Act, passed in 1874, which, with subsequent amendments, regulates the affairs of the medical profession.

Of the various teaching bodies established in the Province of Ontario, which granted degrees in medicine, not one of them confers legal status to practice to the holder.

Twenty-five years ago it was a common practice for graduates in medicine to go over to Great Britain, spend some time in the hospitals of Edinburgh, London or elsewhere, then go up for examination before some of the examining boards in medicine, obtain a British qualification, and returning home, secure registration in Ontario upon their L.R.C.P. or L.S.A. as the case might be, thus evading the examination demanded by the College of Physicians and Surgeons of Ontario.

This the Ontario Med. Council objected to, and made certain representations to Hon. Oliver Mowat, the then Premier of Ontario. He took the matter before the Privy Council as an infringement of Provincial Rights, of which he was the champion. The Privy Council ruled that the Imperial character of British medical registration did not apply to self-governing colonies; this ruling taking effect in July, 1887, effectually prevented the practice complained of.

In the Ontario Medical Act there is a clause providing for reciprocity in registration between Ontario and other Provinces which

reads somewhat as follows: That when it is shown by an applicant for registration in Ontario that the course of study in medicine and surgery in his Province is equal to that required by the curriculum of the College of Physicians & Surgeons of Ontario, and that the said Province provides for reciprocal registration of Ontario qualifications, such *applicant "may"* be registered.

The practical value of this reciprocity clause is destroyed by the use of the word "may," and it is quite justifiable to believe that this word was used with that intent. We know of a case where the applicant fulfilled every legal requirement of the Ontario Medical Act in asking for registration under this clause, to be refused by the Med. Council because it was *"may"* not *"shall."*

Turning to the Province of Manitoba, in the early seventies the resident medical men there secured incorporation as the College of Physicians and Surgeons of Manitoba on similar lines to that of Ontario. They proceeded to surround themselves with a legal fence to keep out all competitors save those whom they had to recognize, or those who complied with their demands. In passing one can hardly avoid questioning the motives of those who, because they had the power, denied the validity and worth of degrees issued by their Alma Mater to others, having themselves no greater claim to recognition as medical men.

Early in the next decade, about 1882-83, a number of the medical men of Winnipeg organized, and obtained incorporation as the Manitoba Medical College, giving to the youth in the West an opportunity of securing a medical education at home. As the officials of the College of Physicians & Surgeons of Manitoba were nearly all members of the faculty of the Manitoba Medical College, the absurdity of granting medical degrees with one hand and destroying, or at least questioning their validity, with the other, became apparent, and the examining body felt bound to recognize as registerable those degrees which as a medical college they granted.

About this time other teaching bodies in the Province became deeply interested in questions relating to standards, granting of degrees in Arts, etc. As a result of deliberations between several bodies interested, a plan for the formation of the University of Manitoba was formulated and agreed upon. The University of Manitoba thus formed consisted of representatives from all the teaching bodies in the Province, and also from the College of Physicians and Surgeons of Manitoba. This university board was not a teaching body; its duties were rather, if the term might be used, executive. It was the sole authority in the Province for the purpose of granting degrees in

Arts, Medicine, etc.; for regulating the standards required; presiding over and conducting all examinations, etc.

The beauty and simplicity of this arrangement in reference to medical qualifications is complete and has worked perfectly ever since its adoption. The medical student goes through his course at Manitoba Medical College. He passes all his examinations before the University Board, on which both the Medical College and the Medical Council have representatives, and upon securing his parchment can at once be registered upon payment of a fee.

About the same time the medical men in the North West Territories became organized in corporate name as the College of Physicians & Surgeons of the N. W. T., upon the same exclusive lines laid down in the older Provincial Medical Acts. But as the early officials of this latest Medical Council were at the time, or had been associated with Manitoba Medical College, it was expressly provided that graduates in medicine from Manitoba University were registerable in N. W. T. upon payment of the registration fee only. Within the area then known as the North West Territories and forming part of it was the Yukon, now organized into a separate Territory, with a Medical Council of its own. Alberta and Saskatchewan Provinces are formed out of a part of the N. W. T.

In 1900-01 we were instrumental in securing an amendment to the N. W. Medical Ordinance, which provided that a British subject, legally qualified to practice medicine in Great Britain or any of the Provinces of the Dominion of Canada, could secure registration in the N. W. T. upon payment of the prescribed fee only. The examination was not exacted. This amendment opened the N. W. T. to every registered practitioner in Canada, and is to-day the most liberal clause in any of the Provincial Medical Acts extant.

Finally, British Columbia can boast of the most exclusive Chinese-protective wall around the practice of medicine that exists anywhere on this Continent. Up to a few years ago (and there has been noted no change in their Act) the Medical Council of British Columbia recognized no degree in medicine from anywhere, save such as had been recognized by the laws of the Province prior to the incorporation of the Medical Council. British Columbia covers a large area; is sparsely settled, the towns are few, and every choice location has its full complement of doctors. To have new men seeking entrance, meant keener competition for those already established. The jealousy with which the "old timers" regarded new comers as "Paul Pry's" was not the exclusive characteristic of ranchers; it pervaded all grades of society, being well developed in the policy of the Medical Council. We have personal knowledge of a candidate for registration being told

in the middle of the examinations, by a fellow-candidate, that the Council had determined not to let him pass as a punishment for having practiced for six weeks before presenting himself with his one-hundred-dollar fee, for examination, and they did not. Other instances could be given of a similar nature. Every fresh aspirant for registration appears to have been looked upon as a possible and undesirable rival, and treated accordingly.

At this point reference will be made to methods adopted regarding medical registration in countries outside of Canada, from a study of which we may be able to indicate the direction that reforms in ours might take.

In the States of Oregon and Washington the Governor appoints the Medical Examiners, chosen from men of standing in the profession, and resident in the State for not less than five years, whose duty it is to examine all candidates for medical registration. The Examiners are paid fees and mileage by the State. The candidate pays an examination fee of ten dollars in one State and fifteen in the other. This includes registration if successful. If he fails he can go up again within six months and try it again without any additional fee. If he disputes the verdict of the examiners he can appeal to the County Court Judge, who examines all papers relating to the case. If the appeal is sustained, the Court orders the Examining Board to register the appellant in accordance with its judgment. If the appeal is dismissed, the appellant pays all costs. Infractions of the medical law are punished with heavy fines or imprisonment. The fines in excess of costs of prosecution by the State are paid into the Public School Fund.

In Great Britain and Ireland the various universities and schools that provide a medical education are empowered to grant degrees whose validity are admitted by the General Medical Council of Great Britain and Ireland, and are registered for a fee of five pounds—about $25.00, which registration entitles the holder to practice for life or good conduct amongst over forty millions of a population at home, and is recognized throughout the British Empire, except in certain of the Provinces of Canada.

The objections to the Canadian system of medical registration are many and serious.

1st. It makes a mock of Canadian citizenship.

2nd. It makes that a crime in law which is a virtue in morals, viz., healing the sick. Let a physician go outside his Province in the line of his calling and he becomes, in the eyes of the law, a felon and is treated as such.

3rd. The expense and vexation of the numerous and unnecessary examinations in order to obtain legal status in other provinces are unreasonable to a degree without any counterbalancing advantage. It becomes an especial hardship when an elderly physician desires to reside and practice in another part of the Dominion. It is a much more difficult matter for him to pass the prescribed examination, than for a recent graduate, yet the balance of skill and knowledge would almost invariably be with the senior physician.

4th. It makes it possible for a body of irresponsible men, who may be directly interested in restricting the number of their competitors, to say to the Provincial and other universities: "We do not believe your examinations are honestly conducted, therefore we must ourselves examine your graduates," and there is no appeal from their decision.

5th. It has a tendency to dull the sense of responsibility on the part of medical colleges, etc., as the onus of conferring legal status rests upon other shoulders.

6th. The basic argument in favor of the present system rests, to put it mildly, upon a fallacy. It is always asserted that the public needs the protection which the Medical Councils afford. This is not correct. The protection enjoyed by the public rests upon the common law of the land, and not upon certificates issued by Medical Councils. Let a registered physician neglect or misconduct a case, he will find his registration no bar to an action against him in the courts, and certainly it failed to protect his patient.

The anomalies of medical registration in Canada have long been admitted. Recently Dr. Roddick, of Montreal, endeavored to frame a Dominion Medical Act to cope with the situation, but so far no practical result has been achieved. Discordant notes from the several Provinces resisted all attempts to harmonize them. In any event, the act would have been in the nature of a compromise, and had all the defects of such a measure.

We are of the opinion that there is not one Provincial Medical Act in existence that would stand, if put to the test. The British North American Act gives to the Provinces the control of their educational institutions, but no less specifically retains to the Federal authority all control and regulation of trade and commerce.

We submit that this question of practising a profession comes under the Federal authority. The right to prescribe a course of study upon the completion of which a degree is conferred, is one thing, but it is an entirely different matter to forbid a man exercising the skill and knowledge he has acquired. This is certainly a matter of trade and commerce.

Now, a word as to proposed reforms. The first and most obvious one is to sweep away Provincial distinctions. If a man is fit to be registered in Ontario or Quebec, he is equally fit to be accepted, or registered, in all other Provinces of the Dominion.

A Dominion Medical Act, establishing a standard and providing for Dominion Registration, should be passed as part of the Federal prerogative. All practitioners at present registered should be eligible for Dominion registration upon payment of a moderate fee. All teaching bodies like the University of Toronto, of Queen's, of McGill, etc., should have legal status given their degrees, providing they conform to the Dominion standard of medical education; failing this their graduates would have to pass before the Dominion Medical Board in order to obtain Dominion registration, or better still, revoke their charter if they fail to come up to the standard required—an extreme measure not at all likely to be required, as the disadvantages associated with such inferior medical schools would drive students away from them. The instinct of self-preservation would operate to the advantage of both students and college. The existing Provincial Medical Councils might either be abolished or their powers and functions be united with the universities of their respective Provinces, as in Manitoba.

In conclusion, must we not admit that behind all arguments put forth in defence of Provincial restrictions, as they exist to-day, lies the real, the true reason, viz., the desire to shut off competition; to mitigate as much as possible the fierce struggle for existence. We would ask has that respite been secured to us by these restrictions? We must truthfully admit failure. And if success had crowned such efforts, what is the inevitable result bound to be? Securely resting upon the protection of the law; incompetence and loss of prestige with the public, the multiplication without end of quacks, charlatans, imposters, patent nostrums, ad infinitum, had surely overwhelmed us. The truth of this is to be seen in Germany—a country where law and the police are omnipotent, with its one hundred thousand quacks.

What right has the medical profession to expect or deserve protection from competition more than other classes—farmers, miners, etc. None whatever.

How, then, are we to secure that measure of professional and financial success which we feel is our just reward for the time, labor and expense involved in acquiring our profession? Surely this is a legitimate and reasonable aspiration, and there must be a legitimate way way to achieve it. There is; it lies, not by way of restrictive acts of Parliament, but by each one of us doing his work so thoroughly, to the utmost of his ability, that the competition will be on the part of the public to secure his services.

MEDICAL ETHICS..*

By A. JAMIESON M.D., Arnprior, Ont.

MR. President and Gentlemen,—A first thought might suggest to you that a paper on Medical Ethics was unnecessary, nor is a code of written ethics required, as every individual in the profession is, of course, supposed to be a gentleman, actuated by a lofty professional spirit, striving to do right and to avoid wrong, and even were there no written rules at all the vast majority would naturally conform to the rules of justice and honor as far as they understood them. As a consequence each one's actions, when scanned by watchful and knowing eyes, might probably be considered fair in nine cases out of ten, while the tenth might honorably err or conclude differently on some mooted point, or might be found differing in opinion only from some jealous or crafty, unprincipled competitor with whom an honorable agreement might be impossible.

In view of these and many other facts it has been found necessary to have a code of written ethics for regulating the conduct of physicians toward each other and toward the public generally.

Once you have located it is very natural to expect your near medical neighbors to pay you a visit of courtesy for the purpose of establishing reciprocal and friendly intercourse whether previously acquainted or not, but if they fail to do so it should not be too quickly construed as discourteous or ill-willed.

Signs.—All signs should be neatly made and correctly lettered, for even one's sign makes an impression either good or bad on the public.

It is better to put Dr. on your sign than M.D., it looks better and is understood by all. To put physician and surgeon or other compound additions on your sign is unnecessary. Your signs should be neither too large nor too numerous; one of black smalt with gold letters is the neatest and most attractive. One such sign on the front wall for daytime, and a glass one with black letters in the window to be seen at night when your office is lighted are sufficient. A polished brass sign of medium size engraven with your name and the letters filled in with black and mounted on a finished board is also neat and stylish.

Professional Card.—A professional card should consist of name and address of office, also office hour if you wish. It is deemed unprofessional to state where you graduated, how long in practice, when you took your post-graduate course, display your different degrees, also positions you hold as Coroner, Notary Public, or Public Health Officer.

* Read at the meeting of the Ottawa Valley Medical Association, 13th January, 1909.

It is quite ethical to do your own dispensing, and absolutely necessary to keep a case of medicines handy for emergency cases and night calls.

Office Patients.—The rules regarding former attendance are much less stringent in floating office practice than in regular family practice, and it is not essential to inquire whether an office patient is under the care of another physician or not. I believe that all of the most eminent physicians prescribe for all ordinary office patients with but little regard as to who has been attending.

Emergency Cases.—When called in an emergency to prescribe for a patient who is under the care of another physician, it is better to leave a copy of your prescription that he, knowing its exact charter, may be able to judge whether or not he should continue its use. When you reach a patient whose friends have, in the excitement, sent for a number of physicians with no special choice among the , it is well to send a messenger or note to the others to cancel the call and save them trouble by informing them their services will not be required. When called to attend a case previously under the care of another physician, especially if the patient and friends are dissatisfied with the treatment, or if the case is likely to prove fatal, be carefully just. Do not disparage the previous attendant by expressing a wish that you had been called sooner, criticize remedies or throw them out, at the same time looking wise and expressing the opinion—a few doses more and all would be over. This is mean and cowardly. In all such cases do not fail to reply to the questions of the patient or friends that your duty is with the present and future, not with the past. Anyone upon whom you encroach in an unprofessional manner will feel justified in retaliating with your own weapons. See, moreover, to enhance your profession in public esteem at every fitting opportunity, and defend your brethren and profession also when either are unjustly assailed.

Never visit a patient who is under the care of a brother physician as a smelling committee or medical detective for the patient's benevolent society, employer, friend or anxious relative without the distinct sanction of the attending physician; be also extremely discreet and chary of visiting patients under the care and treatment of other physicians, even for social purposes. Never take charge of a patient recently under the care of another regular physician without first ascertaining that he has been formally notified of the change.

Consultation.—It is not only unprofessional but mean and cowardly, also a mark of weakness, to refuse to consult with another physician. Should you do so the one you refuse to meet is justified in giving his opinion and even to take charge of the patient if required

by the friends. When a wish is expressed for a consultation by patient or friend, don't think it is a want of confidence in you, if such were the case you would be dismissed, but consent willingly. Ascertain what time would be suitable for the consulting physician. Don't always make a point to hold consultations in the night with any other object than considering it absolutely necessary. If you were the consulting physician and arrived first, be careful not to examine the patient before the arrival of the attending physician. Have a short history of the case given you before examining the patient. The attending physician should precede you on entering the room, and introduce you. After making your examination, retire to a private room for consultation. If happily you agree, so much the better. If any suggestions are to be made, make them in private. Call in the interested friend or relative and give him the benefit of your consultations, always remembering to be extremely careful not to reflect on the attending physician, but always uphold his treatment and diagnosis. Always leave the house together, and never under any circumstances take charge of a case in which you are called in consultation. We all know there are one thousand unwritten ways to show an ethical spirit and a thousand undefinable ways to evince an unethical one.

Some physicans consider it quite ethical to do a certain amount of boasting about the number of horses they use up in a year, wonderful cures, operations, collections, etc. It may be all right to blow, but don't blow too hard, on the one hand it may lead to jealousy and on the other to a belief that the Annaniases are not all dead yet.

While alive to your own interest, do not follow up every trifling ethical infringement, difficulty or apparent contradiction. A certain amount of jarring and clashing in a profession like ours is unavoidable. Allow liberally for these. Bury pettishness and narrowness in the ocean of oblivion, and maintain a friendly attitude toward all fairly disposed neighboring physicians. Strive to rise in the profession, not by pulling others down, but by skill in prescribing, relieving and curing disease, also professional tact and business sagacity.

And finally, gentlemen, let us never forget the glorious, old-fashioned Golden Rule, the climax of all ethics laid down by Confucius and quoted by our Saviour, "Do unto another what you would he should do unto you, and do not unto another what you would not should be done unto you."

CURRENT MEDICAL LITERATURE

MEDICINE.

Under the charge of A. J. MACKENZIE, B.A., M.B., Toronto.

RECOGNITION OF PERFORATED GASTRIC AND DUODENAL ULCERS.

In the *Medical Record,* Dec. 19th, '08, Tilton calls attention to some points that are useful in the recognition of these conditions. The importance of the history cannot be too strongly emphasized, the history may be vague, but pain, vomiting, or blood in the past or recent indigestion may give the key. The history of the onset is usually characteristic, a sudden, sharp. excruciating pain in the epigastrium, which may appear without warning or cause, or may follow a strain in itself quite insufficient to cause such a result. As to location of the pain; if the perforation is at the pylorus or in the duodenum the pain will most likely occur to the right of the middle line, if in the cardiac region it will be to the left. Of course it soon becomes generalized, but in duodenal perforation it is often in the right iliac fossa; with the pain there is always collapse.

Examination of the abdomen usually shows a marked rigidity, especially of the recti above the umbilicus; tenderness is usually marked, and at the first is localized as the pain, but soon becomes diffuse, though there is often a persistent point of maximum intensity. Disappearance of the liver dulness is of little value, there is but little escape of gas as a rule, and the onset of peritonitis is followed by distension of the colon. Vomiting during the first 24 hours is the exception, there may be initial vomiting, which soon stops, to reappear with the occurrence of peritonitis. In most acute cases there is a free interval when the symptoms improve and the physician may be lulled into a false security and operation deferred until the appearance of peritonitis adds to the danger; this quiet period is the most favorable for the use of remedial measures.

A STATISTICAL STUDY OF RENAL AND BILIARY COLIC.

In the *Medical Record,* Dec. 12th, '08, there is an article by Symonds, Chief Medical Director of the Mutual Life of New York, in which he investigates the records of that association for the last 30

years to decide the importance of a history of renal or biliary colic on the risk. A group of 895 lives were studied, all being carefully scrutinized to eliminate disturbing factors; the results were as follows:

1st. Renal colic is an impairment, the effect of which becomes more pronounced with each year of age, and of insurance. This seems to be due to the fact that in some cases it is an indication of a permanent and progressive lesion. The causes of death indicate that this lesion is in the kidneys and arteries.

2nd. It is not unfair to assume that care in testing the urine and in determining the blood-pressure would exclude many of the cases which are thus permanently affected.

3rd. The time which elapses between the attack and the examination seems to be of comparatively small consequence in determining the value of the risk.

4th. When the attack occurs below the age of forty, the mortality will probably be good if our examination has been carefully made.

5th. When the attack occurs above age forty, it is a question whether a rigid examination will secure satisfactory results, though I am of the opinion that modern methods of diagnosis will give us a reasonable mortality.

6th. The combination of overweight and renal colic is very serious.

7th. Any person who has had an attack of renal colic should regularly, every few months, have his urine examined and his blood-pressure determined. He is sitting under a sword of Damocles which only constant watchfulness may prevent from falling. The profession generally regard a renal calculus as an acute condition which may be serious while it lasts, but which is generally recovered from with no permanent damage, when the stone has been passed in the urine. They should realize that this is not so in all cases, but that some are left with a permanent lesion of an insidious character which is progressive and ultimately fatal.

There were only 223 cases who showed a history of a single attack of hepatic colic without other impairment and in which the history was such as to leave no doubt as to the correctness of the diagnosis. In these he found:

1st. The lesion is more serious than renal colic, and the mortality is higher.

2nd. The mortality is not influenced by age.

3rd. A careful study of tables III., IV. and V., shows that the effect of the impairment disappears in a certain number of years, about ten.

4th. Prior to about ten years after the attack, the mortality is high, and it is not now apparent how any methods of diagnosis will materially modify this result.

A NEW WRINKLE IN ETHER INDUCTION.

Perhaps the greatest single factor in diminishing the danger of anesthesia of whatever character is the use of as little anesthetic as is necessary to produce unconsciousness to pain or abolish the reflexes of the patient. The administration of narcotics before anesthesia is one of the methods adopted to reach this end, while all improvements in the technique of narcosis aim at a similar result. To these two methods Klapp had recently added a third, namely, the artificial diminution of the circulating blood during anesthesia by stopping the circulation in the extremities with the help of elastic bandages. Experimental work on animals has uniformly shown that such diminution of the circulating blood enables the production of anesthesia with a much smaller amount of the anesthetic, while the awakening from unconsciousness very rapidly follows the admission of the circulating blood to the vessels of the extremities. Dr. zur Verth had an opportunity to try this method in Bier's clinic in Berlin, and reports very favorably upon it in the *Münchener medizinische Wochenschrift* for November 17, 1908. He administered anesthetics in over one hundred cases after preliminary bandaging of the lower extremities; the arms were never cut off from circulation because of the greater danger of injury to the nerves in the upper extremities. The results fully bore out the data of experimental work: Less anesthetic was used in all these cases than usually, strong individuals being easily anesthetized by means of the ether drop method; the recovery from anesthesia followed almost immediately the removal of the bandages from the legs; no injurious after-effects were noted. Besides these manifest advantages of the new method one more is mentioned by zer Verth, the possibility, namely, of performing what may be called autotransfusion in case of any accidents during anesthesia; in case of chloroform especially the blood of the extremities, rich in carbonic acid gas, may act as a powerful physiological stimulus to the respiratory centers that are so powerfully depressed by this narcotic. Further trial with this limitation of the circulating blood in anesthesia will be awaited with interest proportionate to the importance of any logical proposal aimed at the diminution of the risks that are ever present in the administration of anesthetics.—*Medical Record*

THE HOME TREATMENT OF TUBERCULOSIS.

C. L. Minor, Asheville, N. C. (*Journal A. M. A.*, March 6), speaks of the necessity of applying the same hygienic and disciplinary measures in the treament of tuberculosis at the patients' homes as in sanatoria. These include, reduced to their simplest terms: First, the personal medical oversight of the patient, which Minor thinks can be accomplished by seeing him two or three times a week, and when he becomes sufficiently well trained, once a week may be sufficient. If the patient can be made to keep a diary, giving not only his physical condition but also his acts and, so far as possible, his mental life, and have it shown to the physician on each visit, the supervision can be rendered so much the more effective. Second, discipline and supervision, which depend largely on the personality of the physician, aided by the good-will and co-operation of the patient. Third, instruction. In tuberculosis the relation of the physician and his patient is in one aspect that of teacher and pupil, the patient seeking not only renewed health, but also instruction as to what will enable him to keep it. In tuberculosis the patient should understand something about his disease, and while it is not desirable for him to know too much, he will fight it more intelligently if properly instructed. He will lose, of course, outside of a sanatorium much of the instruction that he would receive from the example of his fellow patients, but nevertheless much can be done in this line. Fourth, systematic and hygienic living. While it will be more difficult than in a sanatorium, it can be secured if the patient is intelligent and the doctor is painstaking. Fifth, nursing. In incipient cases a nurse is not at all necessary, save in some intercurrent condition, such as an exacerbation or hemorrhage, and the patient is better for being obliged to care intelligently for himself. In advanced cases, of course, a nurse is a comfort and an essential. Sixth, location, housing and feeding. These depend on the patient's financial means, but in large towns public benevolence and tuberculosis dispensaries have done much to ameliorate the conditions of the poor consumptive. The physician, however, should keep close track of these points. Seventh, climate. This, of course, also depends on the financial conditions, but the last two or three years have shown us how much can be done even under relatively unfavorable conditions. Much can be accomplished by a painstaking, interested physician who is also a good teacher. Eighth, effect of example and *esprit de corps*. This is another point where home treatment can not equal a sanatorium and it will be advisable for the physician, if possible, to put his patients, recognizing social conditions, etc., in a well-managed house if not in a regular sanatorium, rather than leave them in their

homes. Taking it all together, Minor believes that, save for the beneficial influence of example and climate, all the conditions attained in sanatoria can be secured for all except the very poorest class and the criminal poor. The psychic treatment may be approached from two standpoints, that of the patient and that of the physician. The qualities needed by the patient, in the order of their importance, are: (1) Will power and determination; (2) earnestness and purposefulness; (3) cheerfulness and patience; (4) intelligence and interest. A weak-willed or frivolous patient is less promising, so far as these qualities predominate. Cheerfulness is not so essential but is a valuable aid, and in so prolonged a disease as tuberculosis, patience is a great advantage. The lack of intelligence in the patient is a great drawback and, other things being equal, the results are infinitely improved when the mind is alert and keen. The social and financial conditions also have a bearing on the treatment. The best results may be expected from those having more normal social ideals, cultivated and intelligent, but not too much bitten by the society bee. Those below a certain class make the poorest patients owing to their inability to put into practice customs and habits alien to their past training. A crusade against the hygienic condition of the average workshop and the filthy spitting habits of the average workman will have to be undertaken. Patients so low financially and socially that they can not secure the proper conditions under any circumstances or appreciate them if obtained, should be taken care of in charitable institutions and should never be returned to their former surroundings if they recover. In conclusion, Minor speaks of the importance of the first interview in gaining a patient's confidence and obedience, and in establishing proper relations between the physician and patient and also the importance of the personality, teaching ability and enthusiasm of the physician.

TYPHOID EPIDEMIC STARTED BY BACILLUS CARRIER.

L. L. Lumsden and W. C. Woodward, Washington, D. C. (*Journal A. M. A.*, March 6), gave the history of an outbreak of typhoid fever, which was confined to the patrons of two dairymen in Georgetown, D. C. In investigating the epidemic it was found that both of these dairymen obtained a portion of their milk from a farm on which a typhoid bacillus carrier was discovered and the stoppage of the supply from which caused the cessation of the epidemic. The conditions as to sanitation, etc., on this farm were not altogether satis-

factory, but there had been no previous infection traced to it and the individual found to be a bacillus carrier had not had the disease for eighteen years. The question therefore arises whether she had been a carrier all that time, in which case it would seem there should have been trouble before, or whether she had become recently infected and, being immune herself, harbored the germs without incurring the disease. The authors think, however, that one exercising ordinary care as to cleanliness of person, as she apparently did, would not frequently contaminate the milk and, considering the frequency and length of the intervals in which bacilli are absent from the excreta of pronounced chronic bacilli carriers, a number of contaminations might be needed before infection would occur in which organisms, alive and virulent, and sufficiently hardy to survive, would be introduced into the milk. The contamination with typhoid bacilli once having occurred, it is readily conceivable that the infection could survive on the dairy utensils and so more or less constantly infect the milk for days and even weeks. The victims in this epidemic were mainly free users of milk, women and children being principally affected. Although the infection might not have reached the milk if the sanitary arrangements had been perfect and much greater care been used in its handling, the possibility that there may be typhoid bacilli carriers among the dairy employes, and their liability to get infection on their hands from time to time, should be considered in determining if any degree of cleanliness short of absolute surgical, would be sufficient to safeguard the public. To enforce this in a large city would be extremely difficult, if not impracticable, while official supervision of the pasteurization of the milk supply, if done at distributing depots, would be entirely practicable, much less expensive, and a more certain seafeguard against infection.

SURGERY.

Under the charge of H. A. BEATTY, M.B., M.R.C.S., Eng., Surgeon Toronto Western Hospital and Chief Surgeon Ontario Division, Canadian Pacific Railway.

THE TREATMENT OF CHRONIC URETHRITIS.

Dr. Francis H. Birmingham, in *The Medical Times*, concludes his paper thus:—

In the treatment, the first step to be taken is to thoroughly explore the urethra and determine and locate the cause. This can generally be

accomplished by the flexible bulbous bougie or the metallic one, though I consider the flexible the preferable. By its use stricture, congested, granular and sensitive areas can be determined. Also of great value is the endoscope, not only for diagnostic purposes but for treatment as well, and in using the endoscope it is better to use as large a tube as the urethra will admit. In those cases where the cause lies in some constitutional disorder, or the predisposition to catarrh, and where the examination of the urethra fails to reveal any local cause, except a mild catarrhal inflammation, general tonic treatment will usually suffice, such as iron, nux vomica, cod liver oil, etc., sometimes the vegetable astringents, and often small doses of turpentine or cantharides.

Local treatment is not often called for in these cases, but if the catarrhal condition is pronounced, the passage of a full sized sound, which will squeeze out the contents of the dilated follicles, and then the injection of a mild astringent such as zinc sulphate, lead acetate, alum, hydrastis, hemamelis, or the application of a mild solution of iodine or tannic acid and glycerine. The use of astringent ointments is recommended also by some authors. I do not favor their use.

Those cases which are dependent upon the rheumatic diathesis, syphilis or tuberculosis, must, of course, be treated by suitable constitutional remedies. The existence of granular and congested patches is easily determined by the bulbous bougie and the endoscope. In withdrawing the bougie slight resistance and some tenderness mark the location of your granular and congested area, and frequently there is a little bloody mucous brought out on the bougie. They should then be examined by means of the endoscope.

The normal urethral mucous membrane appears as a pale pink, while the granular patches are of a bright carmine red, uneven, generally flecked with little dots of grayish adherent mucous and bleeding readily. They require for their cure local applications, though sometimes the passage of a full sized sound every second day is sufficient, acting by squeezing out the pus from the distended follicles and by stimulating the mucous membrane sufficiently to produce absorption of the infiltrated material. Should these means fail, direct application must be made to the affected area through the endoscope, and when this is necessary it is most important to locate the exact spot and make your application directly to it, being careful not to touch the surrounding healthy mucous membrane.

The best remedies in these cases are silver nitrate and copper sulphate, and they may be used in varying strength up to thirty grains to the ounce. If the affected area is sufficiently near the meatus, the application may be made through the urethral speculum or metascope.

In some of these cases of granular patches there exists a slight thickening of the mucous membrane underneath. These infiltrated patches are usually found in the pendulous portion, and cases of gleet from this cause defy all treatment until a urethrotomy is performed and the infiltrated thickened tissue divided. The most frequent cause of chronic urethritis, of course, is organic stricture. It is not within the scope of this brief paper to go into the causes, varieties, pathology and treatment of stricture, and I will only say that when stricture exists it must be treated by some one of the many means at our command; gradual dilatation, divulsion, internal or external urethrotomy or electrolysis, all have their advocates and all their advantages. When the stricture occurs at the meatus, there is only one proper way to treat it, that is, by dividing it with the knife. Any attempts at dilation are useless. That also holds true where we have a meatus too small to admit a full-sized instrument.

In many cases of chronic urethritis the inflammation seems to be maintained by a narrow meatus. The operation is extremely simple, but care must be taken to insert the blade of your blunt pointed bistoury well in and cut down horizontally and in the median line, making your opening a little larger than is necessary in order to allow for the necessary contraction in healing.

When the prostatic urethra is the seat of the inflammation, treatment must be given by the deep urethral syringe, using a solution of nitrate of silver or sulphate of copper, first irrigating the whole canal with a mild antiseptic solution passed into the bladder, then when the patient has passed it out, washing the canal going and coming; make your instillation of silver nitrate, beginning generally with a solution of half a grain to the ounce and increasing half a grain at each treatment which should be given about every four or five days until it reaches as high as ten grains to the ounce. It is rarely necessary to go above that.

In those cases where the prostate or vesicles or both are involved, and they are many, they are treated on the same lines with the addition of a thorough massage which is most important, given with the finger in the rectum, the movements being made from left to right and then vice versa toward the symphysis. This clears out the ducts, helps to decrease the congestion and leads to the absorption of the chronic inflammatory material and gives tone to the muscular structure.

Just a few words more in regard to one other form of treatment for chronic urethritis, that is by soluble astringent and so-called antiseptic bougies. They have their advocates and may have their uses, but I consider them useless and in many cases harmful.

OBSERVATIONS ON RENAL DIAGNOSIS.

Dr. Charles H. Chetwood, in *Boston Medical and Surgical Journal* for March 4, gives some excellent suggestions on this difficult subject. He discusses fully such topics as ureteral cystoscopy, ureteral catheterism, and segregation of the urine. He then examines into the value of the functional tests. First he takes up the qualitative methods, such as cryoscopy, or the freezing point; the percentage of urea; the observation of the time when sugar appears in the urine after the injection of phlorodzin; the indigo-carmine reaction. The quantitative reactions are taken up, as the total volume of the freezing point; total volume of urea. He concludes his paper in the following words:

1. In concluding I would reiterate the statement that it is by judicious selection and combination of the various available tests that the best results are obtained and the most satisfactory preliminary diagnosis accomplished in surgical lesions of the kidney.

2. It is impossible and superfluous to resort to all tests in every instance. Reliable confirmation is what is sought for, as regards, first, the kidney in which the lesion is existing, and, second, the condition of the remaining kidney, especially when nephrectomy is a possibility.

3. When there is an obvious variation from the normal, simple cystoscopic examination may be sufficient to determine in which kidney the lesion is located; and the indigo carmine or phloridzin test, accompanied by segregation or catheterization of the ureter, will usually furnish the desired information as to the condition of the other kidney.

4. When the ureter of the unsuspected kidney is normal in appearance and the quantity and quality of the urine it secretes are also normal, and when additional evidence is afforded by the positive result obtained with phloridzin or indigo carmine, there need be no indecision.

5. When the ureteroscopic picture is uncertain, however, and when the result with phloridzin is likewise uncertain, with a possible unfavorable discrimination as regards one kidney, diagnosis is much more difficult, and it becomes necessary to resort to all of the various methods until a net result is sufficiently decisive to warrant conclusions.

6. In reaching a decision in obscure cases, it should be remembered that a diseased kidney may exert restraint upon the functional capacity of the opposite organ, especially in the case of phloridzin glycosuria, when by means of the other differential tests a sufficiently definite net result must be sought to justify a satisfactory diagnosis preparatory to operation.

7. Inasmuch as the progressive development of cystoscopic and functional diagnosis represents so important an element in urological technic, the skillful routine employment of these means is essential to the supremacy of the genito-urinary surgeon in this field of surgery.

RUBBER GLOVES AND THEIR SUBSTITUTES.

G. Becker (*Deut. med. Woch.*, December 10th, 1908) says that Unna recommended, in 1886, covering the hands with a layer of soap, in order to cut off the bacteria present in the deeper parts of the epidermis, when it was required to disinfect the hands. Mikulicz suggested using thread gloves, Perthes suggested using silk stockinette gloves, and Wölfler suggested leather gloves; but all these methods proved to be insufficient for the purpose. Friedrich found a solution of the difficulty in 1898 in the shape of rubber gloves. It has been shown that these can be sterilized, and provided that no cuts or tears are present, the field of operation may be kept free from bacteria from the hands of the operator by their means. The sterilization may be carried out by means of steam or by boiling. Steam has the advantage that the gloves can be used in a dry condition. The author shows that the fears which have been expressed that the steam may not penetrate into the interior of the glove is not well founded, and he has found experimentally that gloves sterilized by steam are sterile inside and outside. Various devices have been suggested to guarantee the full action of the steam, such as stuffing the fingers with wool or other material, hanging the gloves up by the fingers, or putting them on nickel skeletons, but all of these devices are unnecessary. There is, however, no doubt that sterilization does attack the rubber, and after two applications of steam the gloves tear very easily. Boiling is better tolerated, but this has the disadvantage that after the process the gloves become sacklike and no longer fit the fingers. It is uncomfortable to wear gloves which have been boiled. Gloves are therefore costly as a means of protecting against infection by the hands. An advance has been made in this direction by the introduction of a method of disinfecting the surface of the glove by washing it with water and soap for three minutes, and then disinfecting for two minutes in corrosive sublimate solution. A further disadvantage of gloves is found in the fact that they can be cut by instruments, and then the danger of wound infection is greater than if no gloves had been worn at all. It was to overcome these disadvantages that certain substitutes for rubber gloves have been introduced. The author mentions two of these, Klapp's chirosoter and Wederhake's dermagummit. The first named is a solution of a waxy and balsamic body in carbon tetrachloride, which is sprayed on the hands and rubbed until dry. It is suposed to fix the bacteria in the deeper layers of the epidermis, as paraffin fixes the specimen in embedding. Becker has experimented with soiled hands and chirosoter, and has found that relative and not absolute sterility of the surface of the skin could be obtained by this means. He mentions that the space beneath the nail is not completely shut off, and that reliable results can

therefore not be expected. Dermagummit is prepared by Dr. Degen and Kuth's factory in Düren (Rhine), and is a patented solution of gum elastic vulcanized by iodine. It is sold in sterile bottles, and should be applied to the hands after those have been disinfected in the usual manner and dried with a sterile towel. The rubber solution is rubbed on the hands until a thin layer covers every part, and is then allowed to dry. It is advisable to powder the surface with sterile talc or caolin to prevent the hands from remaining sticky. Each application to the hands costs from 4 to 6 pfennigs (1 pfennig is nearly one-hundredth of a shilling), but the cost of removing the layer must be added to this. The removal can be done with carbon tetrachloride, ether, or benzine. First Becker tested whether chemical substances like the ferrocyanide of potassium could pass through the layer, and he found that this was not the case. Next he tested the efficacy of the sterilization process. Hands were infected with prodigiosus cultures and then covered with dermagummit. On rubbing sterile potato on the hands some remained sterile, some showed growth, but none showed as free growth as did the control potatoes rubbed on the hands before the dermagummit was applied. Passing silk behind the nails of the ordinary hands after treatment with dermagummit removed micro-organisms which grew well on agar. Probably the drawing of the silk through cut into the rubber coating. Although he admits that when the hands are disinfected before the application of dermagummit the bacteria are very largely diminished, he does not consider that we have any right to rely on the absolute sterility of hands treated with this material. He claims that sterile rubber gloves are more reliable, and even when soiled these can be rendered absolutely sterile in five minutes with water, soap, and perchloride of mercury; 8 per cent. formaldehyde or formogen achieves the same effect in one minute.—*British Med. Journal,* 27 Feb., 1909.

THE TREATMENT OF HÆMORRHOIDS.

In an article by G. Sandberg in the *Klinische therapeutische Wochenschrift,* which is abstracted in the *Bulletin général de thérapeutique* for January 15, 1909, it is remarked that the chronic constipation which afflicts sufferers from hæmorrhoids is the most difficult symptom to treat. A vegetable diet is recommended. Breakfast should consist of tea and milk, and white bread with honey or jam. Later, at 11 a.m., from one-half to one pint of buttermilk may be taken. For luncheon a purée of green vegetables is prescribed, together with stewed fruits. In the afternoon it is directed to drink the same quantity of but-

termilk as in the forenoon. Vegetables and jellies should be taken for dinner, and three small wineglassfuls of a mild wine or cider may be permitted. At night a cold compress should be applied to the abdomen, covered with a dry compress. In the morning the abdomen is bathed with cold water, or dry friction is employed, followed by the application of alcohol well rubbed in. When the constipation is of long standing give a purgative of the following composition:

℞ Potassium bitartrate,
Sublimed sulphur.....aa ʒiiiss;
Pulverized rhubarb.....gr. lxxv;
Pulverized licorice..... ʒiv;
Syrup of lemon..... ʒiss;

Enemas and drastic purgatives are contradicted in patients suffering from hæmorrhoids, who should be instructed to take physical exercise (barring horseback riding and bicycling).

Itching and fissures are best treated by the application of a tampon bearing an ointment of boric acid; or bromocoll, cocaine, or Noridal suppositories, the active constituent of which is calcium chloride, may be used.

Hæmorrhage is best treated by the injection, after the intestine has been evacuated, of five drachms of a ten per cent. solution of calcium chloride in water, according to the method of Boas. This treatment should be continued for several weeks. If, however, the hæmorrhage is excessive and weakening, resort should be had to surgical measures, by total extirpation, or by the injection into the hæmorrhoidal sacs, by means of a very fine Pravaz needle, of from two to five drops of a solution of one part of phenol in four parts of glycerin.—*New York Medical Journal.*

GYNÆCOLOGY AND ABDOMINAL SURGERY.

Under the charge of S. M. HAY, M.D., C.M., Gynæcologist to the Toronto Western Hospital, and Consulting Surgeon, Toronto Orthopedic Hospital.

PERFORATING WOUNDS OF THE UTERUS INFLICTED DURING THE COURSE OF INTRAUTERINE INSTRUMENTATION.

Aimé Paul Heineck, Chicago, (*Surgery, Gynecology and Obstetrics,* October, 1908) analyzes over 160 cases. His conclusions are:

1. Pseudo-perforation of the uterus though of exceptional occurrence, is a condition that occasionally confronts the surgeon.

2. Spontaneous perforations of the uterus, due to pre-existing pathological conditions of this organ, can and do occur.

3. Perforating wounds of the uterus, intra-peritoneal or extra- peritoneal, have a morbidity and mortality, increasing in direct ratio with the inexperience, carelessness and uncleanliness of the operator. The expert recognizes at once the making of a false passage and institutes proper treatment. High surgical skill may convert an apparently hopeless case into a recovery. In the 154 cases reported, there were 42 deaths, 108 recoveries. The result is not stated in 4 cases. Expectant treatment was pursued in 66 cases. There were 21 deaths in this series. Laparotomy, including what intra-abdominal repair appeared necessary to the operator, was performed 72 times. There were 52 recoveries, 17 deaths and 3 unstated results in this series. Vaginal hysterectomy was done 15 times; there resulted 10 recoveries, 4 deaths and one result not stated.

4. Dilatation of the cervical canal and instrumental curettage of the uterine cavity are, owing to their associated dangers, not office operations. The rule should be:

(*a*) No uterine curettage without general anesthesia.

(*b*) No curettage without ample cervical dilatation.

6. Intra-uterine instrumental maneuvers should only be attempted by those:

(*a*) Who are thoroughly conversant with modern surgical asepsis and antisepsis. In an uncomplicated perforating wound of the uterus, the traumatism of the uterus plays but a secondary rôle; the pre-existence, or the implantation of infections at the time of perforation or subsequently, commands the situation.

(*b*) Who are capable of recognizing malpositions of the uterus as well as pathological conditions of that and of neighboring organs.

(*c*) Who are acquainted with the dangers incident to the successive steps of the intrauterine operation, which they are performing. The steel dilator is an instrument of too much power, and the curette is too dangerous a weapon to be used by the novice.

7. Once the uterus is perforated, all further instrumentations must be suspended. If it be imperative that contents of the uterus be removed, this must be done by digital curettage, or it may be done with a curette, whilst the uterus is being watched through a laparotomy incision.

8. A perforated uterus should never be mopped or swabbed with caustics or irritating antiseptics.

9. A perforated uterus should never be irrigated. Every case, in which it is definitely stated that the perforated uterus was not irrigated, recovered.

10. Vaginal hysterectomy is an operation not to be performed in the treatment of perforating wounds of the uterus. It involves:

(*a*) The sacrifice of an organ which may not be perforated.

(*b*) The sacrifice of an organ, which, though perforated, most always can, with little difficulty to the operator and with much advantage to the patient, be saved.

(*c*) It does not enable the operator to either exactly determine the presence or absence of other co-existing intra-abdominal lesions, nor does it enable him to repair them.

11. If the perforated wound has been inflicted upon a non-septic uterus during the course of an aseptic intra-uterine maneuver, in the absence of complicating abdominal lesions, recovery is the rule.

12. The treatment of perforating wounds of the uterus is determined largely by the following conditions:

(*a*) The septicity or asepticity of the uterus and its contents.

(*b*) The septicity or asepticity of the perforating instrument.

(*c*) The presence or absence of co-existing vascular, omental or intestinal lesions.

(*d*) The size and number of the perforations. A piece of omentum may prolapse through a large rent. A coil of gut may become incarcerated or strangulated in a large perforation.

13. Treatment.

(a) If the uterus is non-septic, if the perforation instrument be aseptic and it can also be reasonably assumed that there is an absence of omental or intestinal or important vascular lesions, the treatment to be followed is one of "armed expectancy." The patient must be confined to bed and immobilization enjoined for at least three days. She must be carefully watched. A suppurative cellulitis, signs of internal hemorrhage, etc., call for intervention. A wick of gauze may be inserted into the uterus, but it should not be introduced much beyond the internal os.

(*b*) In all cases in which there has been a prolapse of the omentum, or of intestines into the uterine cavity, in all cases in which associated injuries to the intestines or omentum co-exist, or in which there are reasons to fear a significant internal hemorrhage, laparotomy is urgent.

(*c*) Once the abdominal wall has been opened, the visceral lesion must be repaired. The uterine puncture, if small, need not be sutured. If large or of the nature of a tear or a laceration, it is better that it be sutured. One or two layers of sutures may be used. Whether small or large, if the perforation be the seat of hemorrhage, suturing is indicated.

14. A healed perforation of the uterus apparently does not interfere with the normal development and the normal termination of a subsequent pregnancy.—*American Journal of Surgery*, Jan., 1909.

THE ANATOMICAL BASIS FOR SUCCESSFUL REPAIR OF THE FEMALE PELVIC OUTLET.

I. L. Haynes, New York, (*American Journal of Obstetrics*, December, 1908), has made a careful anatomical study of the muscular and fascial structures of the pelvis in nulliparous and parous women to determine the factors which bear upon successful treatment of perineal lacerations and rectocele. The anterior part of the pelvic outlet (it should be borne in mind that the erect posture of the outlet is practically parallel with the horizon) is formed by the triangular ligament, which Haynes for short calls the "perineal shelf"; the posterior part by the levator ani and pelvic fascia. The median portion of the levator runs between the inner surface of the pubis at the side of the vagina and rectum forming an inverted Y, one arm inserted in the perineal body, the other into the coccyx (pubo rectalis or pubo coccygeus). Still more mesially is a continuous muscular layer composed of the sphincter vaginæ and sphincter ani which runs from pubis to coccyx; this Haynes calls the pubo-coccygeal hammock.

He exposes the muscles by a perineal flap-splitting operation. The pubo-coccygeus fibers are seen on either side and are united in the median line sufficiently high to obliterate the highest point of the rectocele. These sutures must be passed deep laterally to include both muscle and fascia. A more superficial layer of sutures is then taken in order to approximate the transversus perinci, sphincter vaginæ and ani. The skin and mucosa are then sutured vertically. Of course appropriate measures are also taken to overcome associated lesions, such as cystocele, lacerated cervix, etc.—*American Journal of Surgery*, Jan., 1909.

THE ULTIMATE RESULTS OF THE ALEXANDER-ADAMS' OPERATION.

W. Hannes, Breslau, (*Zentralblatt für Gynäkologie*, December 5, 1908), reports upon 147 operations performed for mobile retroflexion. Besides exposing the round ligament, the peritoneal reflectim was regularly opened in order to grasp the strongest part of the round ligament. It was possible to re-examine 71 women. Three showed recurrence, the others being perfect anatomically. In one case a double hernia was found. Fifty-one women had subsequently borne children. Twenty-five women still complained of pain; in fourteen of these the disease could be explained by non-gynecological troubles. On the whole, the results were very satisfactory, especially in regard to subsequent normal pregnancy.—*American Journal of Surgery*, Jan. 1909.

SOME CONSIDERATIONS ON THE PATHOLOGY OF EXTRA-UTERINE PREGNANCY, WITH A NOTE ON TREATMENT.

Dr. Macfarlane said that Dr. Cameron had given a complete *résumé* of the pathology of extra-uterine pregnancy. He had a case of pyosalpinx which in its history was typical of tubal pregnancy. He agreed with the treatment of doing posterior colpotomy in many cases

Dr. Nigel Stark said the cause of pregnancy in the tube was unknown. He had operated on a patient twice for this condition. In his experience it was more common in hospital patients than among those of the better classes. Salpingitis as a causation is now denied, the erosion of the tubal mucous membrane being due to the action of the syncytium. Dr. Stark had one case where pregnancy was of nine days' duration; at the time of the tubal rupture the hæmorrhage was enormous. He has had a case of tubal and uterine pregnancy at the same time. Dr. Laurie's case, in his opinion, was very typical. It is not good practice to operate at once unless the bleeding is going on; it is wiser to wait until the patient has recovered from the shock. Posterior colpotomy may cause infection of the peritoneal cavity from the vagina.

Dr. Laurie thought that the sooner the operation is done the better, as a second rupture might occur. He has had cases do well without operation.

The President asked if operation in the vagina was for diagnosis. He did not agree with Dr. Stark that this condition is more common in hospital practice, as there are so many more patients to draw from. The President thought the sooner a case was operated on the better.

Dr. Cameron agreed with Dr. Laurie that immediate operation was necessary, as the hæmatocele was not under control in the abdomen. He always had the abdomen prepared for abdominal operation when doing a vaginal one.—*Glasgow Med. Jour.*, Dec., '08.

GASTROTOMY FOR FOREIGN BODY.

Duncan Macartney, M.A., M.D., Assistant Surgeon, Glasgow Infirmary, in *The Glasgow Medical Journal* for December, 1908, reports that the patient, Baby O., aged 6 months, was admitted to Ward XIII. of the Western Infirmary, on 4th September, 1908, while I was acting for Dr. Dalziel. The story was that the baby's mother had been using a steel button-hook that evening to encourage the "cutting" of a tooth, and by some inadvertency the button-hook slipped out of her hand and was swallowed by the child. Dr. Barron, of Bellshill, who was called in, had the little patient "screened," and finding that the button-hook was in the stomach, sent the case in to the Western Infirmary.

On admission the child was quiet and not suffering in any way, so that immediate operation was not deemed necessary.

A skiagram taken showed the foreign body lying at right angles to the long axis of the stomach. The accompanying diagram shows the position and relative size of the body. Successive skiagrams were similar to the one here, the hook remaining fixed in position.

On 7th September, under chloroform, and after the abdominal wall was prepared, an incision was made rather to the left of the middle line. When the cavity was laid open the left finger and thumb gripped the foreign body and brought it through the wound. A small incision over the hook allowed of its easy removal. The small wound (in the pyloric end of the stomach) was then sutured in three layers, and the abdominal wound carefully closed.

A rise of temperature occurred on the second day after operation, but soon passed away, and the recovery was uninterrupted by any complication.

Sips of saline solution were given at intervals during the first twenty-four hours; after that, natural feeding was adopted, the breasts of the mother being carefully cleansed and prepared as if for operation.

The child was dismissed twenty days after operation.

The button-hook was one of the folding variety; when folded it was $3\frac{1}{4}$ inches long by three-quarters of an inch broad. Considering the extreme youth of the patient, and the size of the swallowed object, I judged it right to operate.

Dr. Logan Taylor assisted, and Dr. W. C. Mackie gave the anæsthetic.

OBSTETRICS AND DISEASES OF CHILDREN.

Under the charge of D J. EVANS, M.D., C.M., Lecturer on Obstetrics, Medical Faculty McGill University, Montreal.

ON THE MANAGEMENT OF PLACENTA PRÆVIA.

Placenta prævia, according to Fiessler in *Münch Med. Wochen.* No. 4, 1909, has always been attended with considerable mortality, particularly of the child. The methods of treatment have been combined version, (Braxton Hicks), tamponade, rupture of the membranes, and internal version. The author discusses these methods of treatment and their attendant mortality.

To-day treament of placenta prævia by tamponade alone has disappeared, the mortality of the mother running as high as 25.9 per cent. In the Halle 66 per cent. of the cases treated with tampon

developed fever in the puerperal period, against 25 per cent. of those treated by other methods. The author in his clinic found 60 per cent. of the patients treated by tampons developed fever against 30 per cent. of those treated by other methods. In Germany the tampon treatment of placenta prævia has been abandoned, though it is still of use occasionally to check hemorrhage to gain time for other methods of treatment.

The treatment by rupture of the membranes is, according to Hammerschlag, limited to cases of low attachment to the placenta or the mildest cases of placenta prævia lateralis. Usually even in these cases when resorted to, other methods of treatment, rapid extraction or forceps, is necessary to conclude the case.

The author then discusses the attendant complications; sepsis, extensive laceration of the uterus, and hæmorrhage. The author dwells on the frequency with which extensive laceration of the cervix follows extraction of the child in cases of placenta prævia.

Of 75 women treated by version who left the clinic alive, 23 were in the hospital longer than 20 days, 13 developed puerperal fever, 19 on leaving still showed marked anæmia, and three cases were only saved from bleeding to death by means of extirpation of the uterus. These results speak for the unsatisfactory nature of the treatment.

Of 84 children, only 16 left the clinic alive, in the author's experience.

The author quotes extensively to show the fœtal mortality in various forms of treatment of placenta prævia.

The employment of hydrostatic bags has not materially affected either maternal or fœtal mortality. The author points out that the proper placing of a bag in a case of placenta prævia is attended with considerable difficulty. Dilation of the cervix by means of the Bossi instrument, he thinks, does not come into the question; has the tendency for it to bring about extensive lacerations.

The only safe way to penetrate the uterine cavity consists in the employment of some form of cutting operation in which the whole wound comes under the eye in the field of operation. For this reason Classical Cæsarean Section has been so strongly recommended by American operators in the treatment of the placenta prævia.

Duhrssen recommends vaginal Cæsarean section.

The author thinks that on account of either version or forceps after vaginal Cæsarean section for placenta prævia must be attended by further lacerations of the uterus. Besides which the suturing of the uterine wound is attended with great difficulty.

The author concludes by stating that recent advances in obstetric surgery enable us to overcome the altered physiological condi-

tions and the changes in the lower uterine segment consequent upon placenta prævia, by means of extra peritoneal hysterotomy, which greatly reduces the maternal mortality and practically obliterates the fœtal mortality. The great advantages of the operation are the absolute control of the extent and position of the uterine wound, the feeling of security in the avoidance of hæmorrhage, particularly in the much feared post partum period.

The author then concludes his paper with a report of 111 cases of placenta prævia occurring between the first of January 1898, and the first of November, 1908, in the Tubigen Frauen Klinik. Seventy-five cases were delivered by version, of which 8 died; 7 cases were delivered by vaginal Cæsarean section, of which 3 died; 9 were delivered by means of extra peritoneal hysterotomy with no deaths.

A REPORT UPON 1,000 TUBERCULIN TESTS IN YOUNG CHILDREN.

L. Emmett Holt, *Archiv. of Ped.*, Jan., 1909, made his observations from which the conclusions were drawn on children under two years of age in the Babies' Hospital, New York City. The ophthalmic test was made 615 times. The tuberculin was obtained from the Rockefeller Institute, and had been percipitated with 65 per cent alcohol. The first half of the series of tests a 1 per cent solution of tuberculin was used, and this was diluted to .5 per cent for the remainder.

Of the 615 ophthalmic tests, 38 of the subjects had positive tuberculosis as revealed by autopsy or the presence of bacilli in the sputum. Of these 38, 25 gave a positive reaction, 10 a negative, and 3 a doubtful reaction. In 21 of the cases probable tuberculosis was present; of these 19 gave a positive reaction, and 2 a doubtful one. Of 555 cases classed as probably not tuberculosis, 2 gave a positive reaction, 7 a doubtful reaction, and 546 did not respond at all. In one case which was proved not tuberculosis by autopsy positive reaction was obtained.

Positive reactions were obtained in 14 patients under one year old, one child being only two months of age.

The skin test of Von Pirquet was employed 217 times. The tuberculin was diluted with sterile water to 25 per cent strength. With a sterile needle three short linear scratches were made on the extensor surface of the fore arm and into the middle one the tuberculin was rubbed.

The reaction usually began in from 6 to 8 hours, rarely later than 24 hours. A bright aurœla appeared, slowly spreading from the line of scarification for about a quarter of an inch. In the more marked cases there was some induration. The maximum reaction was obtained in from 24 to 36 hours, after which it faded away in the course of 2 or 3 days, though it may last as long as a week. Though the intensity of the reaction varied considerably, it was generally perfectly definite, and in no instance was the result considered doubtful.

Of the 217 tests, 22 of the cases showed positive tuberculosis, revealed by autopsy, sputum, or operation. Of these 12 gave a positive reaction and 10 a negative reaction, but in all of the negative reactions the test was made on extremely sick children and hence was of little value. Twenty of these cases showed evidence of probable tuberculosis, 15 giving a positive reaction and 5 a negative. Of 172 cases classed as probably not tuberculosis, but three gave a positive reaction. Three cases that proved positively by autopsy not to be tuberculosis gave a negative reaction.

The skin test possesses certain undoubted advantages in that it is easy in application, does not require close observation, and does not give rise to serious or unpleasant circumstances.

The puncture reaction test was employed in 38 cases, 1/100 mgr. being the usual dose employed. These patients were all submitted to the skin test as well, the reaction in each case corresponding absolutely. The conclusion the author reached was that the puncture test possesses no advantages over the scarification test and that it was more troublesome in application.

The fever reaction to tuberculin injections the author found to be quite as reliable in young children as in older patients. He did not consider the reaction definite unless the temperature of 102° F. was reached.

He employed a dose of $\frac{1}{2}$ mgr. for infants under six months, and 1mgr. for those older. Injections of tuberculin were employed 130 times. No local reactions were observed. The temperature usually began to rise in from 6 to 12 hours after the injections and reached its maximum in from 4 to 8 hours. In no case were any serious symptoms observed. Out of these 130 cases, 28 showed positive tuberculosis either by autopsy or as a result of operation, etc. In 22 of these a positive reaction was obtained, while four gave a doubtful reaction, and two failed to react at all. Probable tuberculosis was diagnosed in 21 of these cases, of which 18 gave a positive reaction and 3 a negative. In 80 cases classed as probably not tuberculosis a negative reaction was obtained in 78, a positive reaction in one, and a

doubtful reaction in another. In one case that proved by autopsy to be free from tuberculosis a positive reaction was obtained.

On the whole, the results obtained by the different tests corresponded. The results from any of the tests cannot be regarded as conclusive. The skin reaction is more characteristic and less likely to be doubtful than are some of the eye reactions.

The author generally concludes that the skin test is the most satisfactory. "While of the greatest assistance in diagnosis, the various tests are always to be taken in connection with the general symptoms and the physical signs. Taken apart from them, however, they may be very misleading."

FRACTURE OF THE PELVIS IN HIGH FORCEPS DELIVERY.

R. M. Harbin, *Jour. A. M. A.*, Jan. 30th, 1909, reports this case.

A primipera, 20 years of age, well nourished. After 48 hours of labor and ineffectual attempts at delivery with axis traction forceps, was seen by the author in consultation.

He found the head in L.O.A. position at the brim, unengaged. The pelvic measurements were not taken.

He was able to effect delivery with the ordinary long forceps after one hour's application, stating that no undue force was used. A feeling of "crepitation" was noted as the head was descending.

The child was stillborn, and weighed eight pounds. Examination revealed a separation of the symphysis pubis to about 1.5 c.m. The urethra was torn and displaced to the right. There was a fracture of the right ascending ramus of the ischium about 3 c.m. below the symphysis.

The patient had a septic temperature for a month. An abscess developed on the left side above Poupart's ligament, which was opened and drained, but a sinus persisted. It is stated that the fractured bone united promptly, but at the end of the second month septic pneumonia developed, and the woman died three months after delivery.

PROLONGED AND TEDIOUS LABORS AND FORCEPS DELIVERIES COMPARED AS CAUSES OF EPILEPSY, IDIOCY, AND CEREBRAL DIPLEGIAS.

As an Ex-President of the American Neurological Association, Dr. J. W. Putnam, in his paper, presents in the *Buffalo Med. Jour.*,

February, 1909, serious truth that cannot but make a grave impression upon conscientious obstetricians.

The author quotes extensively from obstetric and pediatric literature as well as from other medical works, and concludes that from these writings of eminent men that preventable accidents of birth are a common cause of idiocy and epilepsy.

All the authorities quoted agree that idiocy, epilepsy, and cerebral palsies of childhood are due to one of three causes; asphyxia, injuries of the head by forceps, and injuries from prolonged compression.

He appeals to the profession to take steps to reduce these accidents of birth to a minimum.

INTUSSUSCEPTION: WITH ESPECIAL REFERENCE TO CHILDREN.

J. F. Erdmann, M.D., states *Post-Graduate*, Jan., 1909, that operating upon 11 children ranging in age from 4 to 22 months for intussusception he found that four cases, in which he excised portions of intestine of various lengths, all died; while 7 of the cases in which reduction was all that was necessary, recovered. He states that all cases in which he has performed excision of the bowel for intussusception during the past 10 years have died. He urges, therefore, most emphatically, early operation as being most likely to relieve the condition

Discussing the symptoms he states that in 50 per cent. of the cases no tumor can be found on palpation, one reason for this being that the costal margin on either side may hide it.

He then quotes in extenso from a paper written by himself on this subject, giving the details of the operation he prefers. He considers that inflation of the bowel is not only not useful, but actually dangerous. Enemas are successful in an extremely small proportion of cases in reducing the bowel.

URINARY INFECTION A COMMON CAUSE OF FEVER IN INFANCY AND CHILDHOOD.

M. J. Lippi, in a short paper, gives brief reports (*Archiv. of Ped.*, Jan. 1909) of six illustrative cases. The diagnosis usually depends upon urinalysis. The treatment is simple and satisfactory, in most cases consists of hexamethylenamin in doses of 5 to 15 grains daily.

The author concludes that in any acute febrile condition in infancy not accounted for by gastro entric or respiratory infection, urinary infection may be suspected. The condition is a common cause of atypical fever in infants or young children. Enuresis may mean cystitis or cystopyelitis.

ELECTRO-THERAPEUTICS AND RADIOLOGY.

Under the charge of JOHN STENHOUSE, M.A., B.Sc., Edin., M.B., Tor.

THE X-RAY IN FRACTURES.

C. C. Simons, Boston, in the *Boston Medical Journal* (Jan. 28, 1909) holds that every fracture should be radiographed. It is in the best interests of the patient and it is always a safeguard to the physician. Owing to the many erroneous conclusions which may be drawn from any x-ray picture, the interpretation thereof should be made by an expert, thus a normal epiphysis in a young subject may easily be mistaken for a dislocation or fracture. Where it is possible, two views should always be taken, an antero-posterior and a lateral, this alone determining the true amount of displacement.

Such x-ray pictures are valuable for three reasons:—1st, as an aid to diagnosis, particularly in doubtful injuries involving joints, such as combined fracture and dislocation at the elbow or wrist; 2nd, as a means of showing the accuracy of the reduction when the splints are in position; and 3rd, the causes of faulty or delayed union are made clear as in the presence of a loose fragment or interposition of muscle or fascia between the broken ends. The union of ulna and radius by a large callus is also a case in point.

X-RAY DIAGNOSIS OF URINARY CALCULI.

E. W. Caldwell in the *Boston Medical Journal* thus sums up an interesting article on the diagnosis of calculous conditions of the genito-urinary tract:

1. The Rœntgen ray furnishes the most accurate single means we have for the diagnosis of urinary calculi.

2. It has the advantage over other methods that it not only indicates the presence or absence of calculi, but their size, position and number as well.

3. When a small calculus is shown in the ureter, the size and shape of its shadow will sometimes enable us to predict that it will be passed, and that operation for its removal will be unnecessary.

4. Occasionally conditions other than lithiasis may be indicated, such as tuberculosis, abscess and diseases causing a change in the size, position or outline of the kidney, or a fibrous thickening of the lower part of the ureter.

5. The x-ray is not infallible, and in incompetent hands may be very misleading, but under the best conditions it is exceedingly accurate.

6. The indications given by it often decide the important question of operation.

7. Such examinations should, therefore, not be undertaken lightly or entrusted to careless and incompetent persons, nor to those who have not a proper appreciation of the responsibility involved in deciding a question upon which may depend the health or even the life of a fellow being.

PARTIAL THYROIDECTOMY COMBINED WITH RŒNTGEN TREATMENT IN BASEDOW'S DISEASE.

In the twenty-fifth anniversary volume of the *Post-Graduate* (1908) Carl Beck emphasizes the importance of using the x-ray either alone, or preceding and following operation. The most useful feature of the x-ray treatment is that the gland can be reduced gradually so that the reduction is virtually regulated by the operator, whose instinct will lead him to avoid hyperthyroidosis as well as hypothyroidosis. Thus in cases showing all the classical symptoms, exophthalmos, tremor and tachycardia there is a gradual reduction in the size of the gland and pari passu disappearance of the symptoms. Treatments were given every second day for a week and twice a week thereafter. Irradiation was given for five minutes through the tubular diaphragm, using considerable energy with soft tubes until there was either a marked decrease in size or a dermatitis reaction.

Nearly all patients received in addition fairly large doses of Fowler's solution, up to twenty drops, three times a day, provided the digestion was not disturbed, in which case it was temporarily discontinued. The diet was carefully controlled.

The conclusions are summarized as follows:

1. Slight thyroid enlargement in Basedow's disease should be treated by the Rœntgen diphragm-method at short intervals.

2. Large Basedow goitre should be treated by the combination method, namely, the larger lobe is to be removed under local anesthesia

and without the use of antiseptics of any kind; the other portion to be irradiated as soon as the reaction from the operation is over.

3. In advanced cases of Basedow's disease, where alarming symptoms forbid immediate operative interference, *Rœntgen treatment* should precede the operation until improvement.

TREATMENT OF MALIGNANT GROWTHS BY THE HIGH FREQUENCY SPARK.

Dr. Friedlander, San Francisco points out in the *California State Journal of Medicine* that while Strebel first used the high frequency spark in the above conditions, it was Keating Hart, of Marseilles who, in 1906, first aroused real interest in the question. Since then it has been endorsed by Czerny, Doyen and Pozzi.

Friedlander maintains that in rapidity and cosmetic results it is incomparably superior to either caustics or the use of the knife, while it has none of the dangers of the X-ray. Naturally, the results in deep-seated growths are still *sub judice*.

The apparatus used is a 12-16 in. induction coil and an Oudin resonator with a petroleum condenser and containing sufficient windings to give a 6-8 in. spark from a metal pointed electrode. In rodent ulcer this spark, at a distance of 2-3 inches, rapidly induces local anæsthesia and hence obviates the use of either general or local anæsthesia. The growth is sprayed for from 40 seconds to one minute. To confine the sparks to the part treated, Friedlander, after experimenting with cardboard and rubber, has found dentists' modelling compound superior to anything, and as it forms an exact cast it maintains its position to perfection. For deep growths an anæsthetic is required. The patient lies on a wooden table, and a glass or vulcanite mask is used. A spark of 6-8 inches is used for from 10-45 minutes and the patient is so highly charged that severe burns would follow the touch of metal; hence the above precautions. The sparked area is removed by curette or knife and the wound thus made is again sparked for from 10-15 minutes. Hæmorrhage is also controlled by means of the spark. The parts are then approximated or drained as may best suit the conditions. A unipolar pointed copper electrode is used.

This treatment produces anæmia of the normal skin, cutis anserina, rupture of sub-cutaneous vessels, vesication, desquamation and eschar, section through it showing round cell infiltration, hæmorrhage and vacuolization of the interna of the arteries (Czerny). In malignant tissues the cells are swollen, vacuolized and do not stain, in marked contrast to

the connective tissue which still stains clearly. The spark has thus, like the X-ray, a predilection for embryonal tissue, but is successful where the X-ray fails, particularly in epitheliomata with a hard border or surrounded by epithelial perles.

In any case the high frequency spark is of the highest value in controlling discharge and hæmorrhage from inoperable ulcerating growths.

FULGURATION IN CANCER.

The treatment of cancer by fulguration seems to have been definitely adopted by French surgeons.

The term "fulguration," invented and applied by Dr. Keating-Hart, is an electro-surgical operation which, as its name implies, is divided into two periods—the operation proper and the application of the electric spark of high frequency.

These manœuvres being very painful, local or general anæsthesia is necessary.

The patient being placed under the influence of an anæsthetic, a preparatory application of the electric spark is made so as to soften the tissues of the neoplasm to render them more amenable to the curette and anæmify the surface.

Immediately after this fulguration, the tumor is excised with the bistoury and the raw surface carefully scraped with the curette. Fulguration is then practised, which has for almost immediate effect the arrest of the bleeding.

Keating-Hart uses a special electrode of his own invention to operate. This electrode is either straight or curved, so as to be able to act in every region. The spark does not act solely by the heat it develops in burning the morbid tissue; the cells of the neoplasm melt, so to speak, under its influence, while it stimulates the vitality of the neighboring healthy tissues.

The duration and dosage of the sparks are difficult to fix precisely, as a great deal depends on the operator, his experience in fulguration, and the immediate effects on the tissues. In any case, no portion of the wound should be neglected, and the edges particularly should receive special care.

Almost at the beginning of the fulguration the hæmorrhage is rapidly arrested; the surface becomes white, but soon afterwards it takes on a blackish-grey aspect. The operation terminated, the wound is dressed.

Dr. Keating-Hart insists on two very important points: First, each time that it is not possible to completely remove all the cancerous masses the region must be submitted to continued refrigeration by means of the ice bag or an uninterrupted current of iced water; secondly, oxygen water only must be used, more or less diluted, for washings and dressings.

In cases where dry dressing is sufficient, he powders the wound with perborate of soda. A few days after the operation, ordinary antiseptics, such as iodoform and aristol, may be used.

As to the consecutive phenomena, the first to be noticed are complete and absolute suppression of pain, and an extremely abundant secretion of the wound, requiring the dressing to be changed several times a day, followed a few days subsequently by active granulation. The wound is completely cicatrised in from eight to ten weeks.

Dr. Bizard, who has made a special study of this treatment, says that, although fulguration cannot be applied indiscriminately for every visceral or cutaneous cancer, yet it cannot be denied that it constitutes an excellent method for a whole group of neoplasms which were hitherto regarded as entirely inoperable. It is the only method which allows hope to be entertained for the most desperate cases, such as cancers of the face invading the cavities and gaining the osseous canals and inaccessible infractuosities which have resisted every treatment, medical or surgical.

One great advantage of this new treatment of malignant disease is that it is absolutely inoffensive, since Keating-Hart used it in over 200 grave operations without one accident.—*Medical Press and Circular.*

THE "FULGURATION" TREATMENT OF CANCER.

Professor von Czerny, in a communication to the German Surgical Society (of which this abstract appears in the *Zentralbl. f. Chirurgie*) tells his experience of the "fulguration" treatment of cancer as seen in the Heidelberg Samaritan Hospital.

In this hospital, where the treatment of cancer is especially studied, four-fifths of the cases admitted are suffering from an advanced stage of cancer, a stage which will not yield satisfactory results with the ordinary methods of treatment.

The technique of the proceeding is carefully described, showing how a Rœntgen ray apparatus can be utilised, how brush discharges (Funkenbuschel) from 10 to 20 cm. long can be obtained, and how these are cooled by being passed through a stream of carbon dioxide or compressed air. The electric sparks are allowed to play on the tumor from

five to forty minutes, the brush being constantly shifted from one place to another. The patient must be deeply anæsthetised.

The carcimatous tissue having been thus treated is removed by a sharp spoon, the hard edges being cut away by scissors or scalpel, and the electric discharge again applied for about ten minutes.

There is no doubt that this "fulguration" is a powerful method of disorganizing cancer cells, but it is extremely difficult to be certain that their vitality and power of proliferation is absolutely destroyed. The other tissues are necessarily destroyed at the same time; thus a great deal of connective tissue is formed with the resulting contraction and deformity of the parts.

The results of 120 "fulgurations" performed in this way (59 subjects) are given. Of these 59 subjects 4 were sarcomata, which also yield to this form of treatment. The results are fairly encouraging, but not very convincing. There does seem, however, to be a place for this method of treatment—*e.g.*, in widespread cancer of the skin, in recurrent and inoperative cancer—by doing away with the discomfort of foul discharges, of hæmorrhage, and of pain, and by allowing moderate comfort. Czerny also suggests its use in cases of lupus, tubercular ulcers, &c.

It ought to be pointed out that "fulguration" often produces very painful burns around the seat of operation.—Robert B. Carslaw in *The Glasgow Medical Journal.*

PERSONAL AND NEWS ITEMS.

ONTARIO.

Dr. T. A. Bond has removed from Maxwell, where he practiced his profession for some time, to Shelburne.

Dr. H. A. Thompson has located in Shelburne, taking over the practice of the late Dr. Steele.

Dr. F. S. Snider, of Waterford, has been appointed sheriff of the County of Norfolk.

Dr. C. A. Page, who graduated a year ago, and who has taken a post-graduate course in Edinburgh, has located in Toronto.

Dr. Ferguson, of Ethel, has gone to Europe, where he will engage in study in Edinburgh, London and Germany.

Dr. G. R. McDonagh, who has spent some months in South America, will return to Toronto about 1st April.

Dr. W. W. Ogden, who is one of the oldest members of Toronto's Board of Education, has been very ill, but is now convalescing.

Dr. W. T. Parry was appointed by the City Council to the position of Jail Surgeon in Toronto.

Dr. James A. Robertson, of Stratford, has gone for a trip to Italy and Egypt.

Dr. Glasgow, of Welland, the president of the Ontario Medical Council, has been ill for some time, but is convalescing.

Dr. Wilford, formerly of Blyth, has passed his examinations in Edinburgh.

Dr. McComb, of Milverton, has gone to South River, and will enter upon the practice of his profession there.

Dr. George W. Badgerow, who formerly practised in Toronto, and who has for some years been in London, has been appointed surgeon to the Hospital for Diseases of the Throat, Golden Square.

Kingston has taken a wise stand in insisting upon vaccination as a condition for admission to the public schools. This is the only safe rule when smallpox is prevalent.

Dr. John Caven and wife have been spending a couple of months in Florida. This change was the result of their experiences in the White Star liner's wreck. They returned to Toronto about the end of March.

Dr. James H. Richardson, one of the oldest and best known members of the medical profession, has been very ill at his home in Toronto. He is improving.

Dr. Hackney, of Ottawa, is in London doing special work. He holds the positions of Clinical Assistant at Moorefields Eye Hospital and Registrar of the Central London Ear, Nose and Throat Hospital.

Dr. Robertson, of Dunchurch, will be located for some time in Sudbury to look after the sick and injured in connection with the work of railway construction.

Dr. G. H. Wade, of Cobourg, is giving up practice for the present, and going to Calgary to take charge of organization work for the I. O. F.

Mr. W. J. Gage has offered a prize of $100 and a gold and silver medal to fourth and fifth year students and graduates of one year's standing, for the highest standing on a special examination on tuberculosis.

An effort is being made to secure a laboratory for Hamilton. The Board of Health, the Hospital Board and the Medical Society are acting in conjunction in this matter. The City Council and the Government will be approached for aid.

It is estimated that the Consumptive Sanatorium for London will cost about $20,000. The city voted $5,000, Hon. Adam Beck has sub-

scribed $1,000, and others have given up further amounts. The scheme will no doubt be successful.

Dr. Herbert J. Hamilton, of Toronto, and President of the Ontario Medical Association, received a cut on his head from a piece of glass from the window of his cab, which was struck by a street car. The driver was thrown off the cab and rendered insensible.

At the annual meeting of the Lambton County Medical Association Dr. Chapelle was elected president; Dr. Bradley, vice-president; Dr. McDonald, secretary-treasurer; Drs. Logie and Bradley, auditors; and Drs. Newell, Dunfield and Hubbard, the committee on ethics.

There is now in Gravenhurst a private sanitorium for the care of tuberculosis patients. It is conducted by Mrs. E. G. Fournier, and is called the Minnewaska. Dr. Parfitt will have charge of the patients. The rates will run from $8 to $15 per week. Mrs. Fournier has had institutional experience in Ann Arbor and Fort Wayne.

QUEBEC.

Dr. H. S. Birkett, Montreal, has been elected president of the Association of Military Medical Officers.

A friend of McGill University will give $100,000, provided the governors raise $400,000. Another friend has given $25,000.

Dr. George T. Ross has been appointed Secretary of the Western Hospital, Montreal, in place of Dr. Hackett, resigned.

Drs. Louis and Laberge are the Honorary Presidents of the Hospital St. Luc, Montreal.

Mr. Rodolphe Forget, M.P., has interested himself in the raising of money for the reconstruction of the Notre Dame Hospital, Montreal.

By the latest report from the Montreal Hospital for the Insane there were 535 inmates. This gives a net increase for the year of 47. Dr. T. J. Burgess thinks that the increase was due to the class of emigrants coming into the country.

Dr. C. W. Duval, of Montreal, has been appointed Professor of Pathology, Tulane University, New Orleans. For some time past he has held the dual positions of Pathologist to the Montreal General Hospital and Lecturer on Pathology at McGill Medical College.

In the Royal Victoria Hospital the death rate was 6.07 per cent. The entire building has now been rendered fireproof. The income amounted to $172,171.14 and the expenditures to $165,396.71. The balance will be applied to reduction of indebtedness. The cost per day was $1.16.

From the *Montreal Medical Journal* the news comes that on the 17th of January there were 255 cases of typhoid fever in the hospitals of Montreal. The water and milk supply of that city must be in a bad condition. The *Standard* newspaper has undertaken an investigation on its own acount into the matter. The death rate per 100,000 has been as follows: 1903, 31.45; 1904, 31.89; 1905, 18.11; 1906, 37.08; 1907, 33.26.

The annual meeting of the Western Hospital, Montreal, was held January 19th, 1909. Dr. F. J. Hackett read the medical report. During the year there were treated 1,361 patients, an increase of 639 over the previous year. Of these 1,361, 797 were Protestants, 488 Catholics, 72 Jews and 4 of other faiths; 478 were medical cases, 754 surgical; 1,289 were from Montreal and 73 from other outlying districts. There were 702 men and 589 women and 70 children under twelve years of age. Of the 61 deaths occurring during the year, 21 took place within 48 hours of admission into the institution, making the death rate 4.48 in all, or 2.93 over 48 hours' admission.

The report of the Royal Victoria Hospital shows that during the year 3,699 patients had been admitted, an increase of 301 from the previous year. There were 2,106 Protestants, 1,154 Roman Catholics, 387 Hebrews and 52 of other faiths; 1,863 were free patients, 1,154 public ward patients, paying 50 cents and one dollar per day, and 735 private ward patients; 2,680 were residents of Montreal, and 1,019 came from districts outside of the city. The total days of hospital treatment aggregated 84,204, as against 81,902 during the previous year, an increase of 2,302 days. The average number of days' stay in hospital per patient was 22.9, as against 24.10 the previous year. On the 1st January, 1908, there were 218 patients in the hospital remaining from 1907, and during the year 3,688 were discharged, of whom 2,133 were well, 1,076 improved, 143 not improved, 125 not treated, and 211 died. Remaining in hospital 31st December, 1908, 229.

MARITIME PROVINCES.

Dr. H. V. Kent, Truro, has been spending some time in Virginia for his health, and is now much improved.

Dr. E. Blackadder and J. S. Carruthers have been appointed to the Halifax Dispensary staff.

Dr. J. C. MacDonald was elected Mayor of Westville, Dr. D. Stewart for Bridgewater, Dr. J. E. Jones for Digby, and H. B. Webster for Kentville.

Dr. W. D. Murray, of Tangier, Dr. W. T. Smith, of Halifax, and Dr. H. Ross, of Hazel Hill, are doing post-graduate work in London and New York.

Dr. N. S. Fraser, of St. John's, and Dr,. P. A. McGarry, of Canso, have recovered from recent illnesses, and Dr. A. C. Hawkins from the effects of an injury.

A movement has been started in St. John for the purpose of establishing in New Brunswick a league for the prevention of tuberculosis. A circular has been sent out inviting others to take an interest in the work. Dr. J. R. McIntosh, of St. John, has acted as secretary.

There has been a good deal of discussion, some of it not too mild in its manner, over the question of hospital organization. The German system is strongly urged, with its chief of clinic at the head of the various sections. In the discussion there has been an airing of personal feeling, the dragging forth of some cases that had given rise to some criticism.

WESTERN PROVINCES.

Dr. B. E. Toughen, formerly of Trowbridge, has gone to Grassy, Alberta, where he will carry on both his practice and a drug business.

In Winnipeg for January the number of births were 367, marriages 162, and deaths 126.

Dr. Young, the Provincial Secretary, intends at next session to introduce a bill providing for the medical inspection of public schools.

The next regular meeting of the Saskatchewan Medical Association will be held in Saskatoon.

Dr. Whyte, of Winnipeg, has gone for a period of post-graduate study to Chicago, New York and Baltimore.

Dr. D. O. Tabor is removing from New Castile to Lethbridge, Alberta.

The British Association for the advancement of Science will meet in Winnipeg from August 25th to September 1st. Communications should be addressed to the Hon. Local Secretary, University, Winnipeg.

Ninette, in Manitoba, has been chosen as the site for the sanatorium for tuberculosis. Dr. Stewart has been selected to carry the work on and complete the organization.

Winnipeg has now a hospital for children. Mrs. J. H. R. Bond merits much praise for her efforts in this cause. The hospital was opened on the 5th of February.

A deputation representing the hospitals of Alberta waited on Premier Rutherford to ask that the per diem grant for patients be increased from 50 cents on non-paying and 25 cents on paying patients be increased to 50 cents on all.

From the *Saskatchewan Medical Journal* it is learned that there are 300 regular practitioners in that Province. It is hoped that every practioner will join this association, and by paying $2.00 a year enable the committee to conduct the journal.

The Saskatchewan Medical Association has commenced the publication of a journal. No. 1 has arrived and presents an attractive appearance. This youngest of the list will find a cordial welcome among the exchanges of all our Canadian medical journals. Communications should be addressed to Dr. Harry Morell, box 209, Regina.

The 42nd meeting of the Canadian Medical Association will be held in Winnipeg 23, 24, 25 August. Dr. H. H. Chown is chairman of the local committee on arangements, and Dr. Harvey Smith is acting secretary. Dr. R. J. Blanchard is president. Those desiring accommodation should make their needs known, as there may be heavy demands on accommodation on account of the meeting of the British Association for the Advancement of Science, about the same time.

The Winnipeg Hospital Commission has reported that the cost of extension of the hospital should be borne by the City, the Province, the Dominion and subscriptions; that municipalities pay $1 a day for their patients; that there be accommodation for private and semi-private patients; that Winnipeg pay 75 cents a day for poor patients; the Medical Superintendent be a permanent officer and supreme in authority; that the city's representation be reduced from 8 to 5; that the cost per bed varies from $1,000 to $1,500; that large hospitals are more economical than small ones; that a civic controlled hospital should be managed by a commission; that the Dominion should assist, owing to so many poor emigrants arriving; and that other revenues would come from patients, the City, the Province and donations.

BRITISH COLUMBIA.

Dr. S. J. Tunstall, of Vancouver, purposes attending the International Medical Congress in Budapest.

Dr. C. J. Fagan, Victoria, has been again elected secretary of the British Columbia Anti-Tuberculosis Society.

Dr. Dolby, after spending a time in Britain in post-graduate work, has settled in Vancouver.

A field ambulance is being started in Vancouver. The ambulance corps will be a separate organization and consist of about 90 persons.

In New Westminster for 1908 the births numbered 321, the marriages 136 and the deaths 317.

Dr. R. W. Irving, Superintendent of the British Columbia Tuberculosis Sanatorium at Tranquille, reports that the institution is in demand, and that 47 were admitted last year.

Dr. Ernest Hall, one of the esteemed contributors of the *Canada Lancet*, spent the winter in California, and gave a series of lectures in San Francisco to the University students.

Dr. C. J. Fagan, of Victoria, has been studying the milk question at the request of the Provincial Government and has made a full report. His report is educative and is intended to pave the way for needed legislation.

Dr. Underhill, the Medical Health Officer for Vancouver, reports a reduction in the death rate from 13.05 for 1906 to 9.8 per 1,000 for 1907. The number of contagious and tuberculous cases was considerably reduced.

Dr. William T. Bull, the eminent New York surgeon, died February 22nd. He had been suffering for some time from cancer of the neck. The disease caused œdema of the lungs toward the end of his illness. He was born in 1849. Von Bergmann's surgery was translated and edited under his supervision.

FROM ABROAD.

The recent German Charity Ball which was held in the Waldorf-Astoria, New York, realized $11,000.

Dr. William Osler is expected to be present at the dedication of the Medical and Surgical Library of Baltimore on 13th May.

Dr. William T. Shoemaker, of Philadelphia, has been awarded the Alvarenga Prize for his essay on Ritinitis Pigmentosa.

Stringent laws have been enacted in the Philippine Islands against the importation and use of opium for other than medical purposes.

The International Opium Commission began its work in Shanghai a short time ago. Bishop Brent was elected president.

Sir John Watt Reid, honorary physician to the King and to Queen Victoria, died recently at the age of 86.

The Transvaal Medical Council has decided that any person holding a qualification which entitles him to practice in the country, may register any other titles or qualifications he may possess.

It has been decided to form a Transvaal Committee of the South African Branch of the Army Nursing Reserve Service. His Excellency, the High Commissioner, has taken an active interest in the movement.

Mr. Henry Phipps has doubled his gift to Johns Hopkins for Psychiatric Hospital. It was found that $500,000 was not sufficient and the sum is now made $1,000,000.

A report comes from Bombay that success has been attained in the treatment of leprosy by the use of a vaccine from the bacilli of the disease.

A bill has been introduced into the Legislature of the State of Pennsylvania with the object of establishing a State Board of Medical Examiners, in lieu of the three qualifying bodies now in existence.

In New York a short time ago there were 200 brought before the magistrate for spitting in public places. They were fined. It is intended to maintain the campaign.

Sir Shirley Murphy has been awarded the Bisset Hawkins Medal of the Royal College of Physicians for his work in the interests of public health, especially in London.

According to the Public Health Act of Britain, it has become necessary to give notice of all cases of tuberculosis among those who are receiving or have to seek relief under the poor laws.

Professor S. Kitasato, Director of the Infectious Diseases Institute of Tokyo, was recently elected to the Honorary Fellowship of the Royal Society. This high distinction was conveyed to him in Latin.

Professor Ramon Y. Cajal, of Madrid, the famous anatomist, and one of the winners of the Noble Prize, has been made a Senator of Spain.

A series of eight lectures is being given in the Golton Laboratory on the subject of National Engenics. Karl Pearson opened the course with a lecture on "The Purport of the Science of Engenics."

Lord Strathcona recently sent a check for £2,000 to Lord Balfour, of Burleigh, Chairman of the Queen Alexandra Sanatorium, Davos, in aid of the institution.

At a recent meeting of the Prussian Academy of Sciences, Professor Orth read a paper in which he claimed that there was no evidence as yet in support of the parasitic origin of cancer.

Emperor William, of Germany, has withdrawn his veto regarding the monument for Virchow. Permission is now given to have it located in the Karl Platz, near the charité.

Sir Robert Boyce, of the Liverpool School of Tropical Medicine, has been asked to visit the West Indies and to institute hygienic reforms there. He will commence his investigations almost at once.

Mr. Alban H. G. Doran, who held the position of senior surgeon to the Samaritan Hospital for Women, London, has recently resigned, and was given a complimentary dinner.

A Royal Commission on University Education in London has been appointed. It is expected that a scheme will be evolved that will materially better the interest of medical education.

The physicians in Newark, N. J., organized themselves into a Library Association. The fee is $3 a year. With this sum they supply themselves with journals and books. The plan is working well.

A very strong effort is being made in Berlin to reduce the evil of patients obtaining free attendance at the various charities, who are able to pay. Of late some real headway has been made.

In the United States, the law for some time past has demanded the inspection of oyster beds. The first report has been issued and bids fair to giving a good deal of protection to prevent oysters being contaminated by typhoid fever infection.

It is pleasing to note that in Britain the people are beginning to wake up as to the necessity for providing proper institutions for the early treatment of insanity. The gift of Dr. Henry Mandsley of £30,000 has given the movement considerable impetus.

The Medical Press and Circular raises a protest against the medical profession giving free public lectures on matters of health. It is contended that if such lectures are desirable the State should do so and pay the lecturers.

It is estimated that the medical profession of Chicago do charitable work to the amount of $7,000,000 upon people who are able to pay. This would be equal to $2,500 to each registered practitioner in the city.

In England the attendance upon members of friendly societies and lodges in a number of places at so much per head per annum amounts to only 3½d. a visit. The doctors are taking a stand against such fees.

Leprosy is still quite prevalent in some parts of the world. It is estimated that there are over 500 cases in Norway, and over 600 in Greece and surrounding parts. There are still many cases in France. In India it is thought that there are at least 130,000 lepers.

In nearly all the London hospitals, and in most of the hospitals throughout England, rules are to be found debarring the holders of Scotch or Irish diplomas from appointments. This has caused much discussion and annoyance.

MM. Beusaude and Rivet, of Paris, have reported a case of serious poisoning by the use of bismuth subnitrate. The patient suffered from tuburcular ulceration of the bowels. There were present distress in breathing, cyanosis, convulsions, subnormal temperature, etc.

Berlin, Germany, is taking up with a good deal of energy the question of providing accommodation for pay patients. At present, in Berlin, hospital accommodation is only for poor patients, so that those who could pay can receive no private or special atention.

In Vienna certain diseases take a leading place in the mortality returns. Of 34,188 deaths, 5,690 were due to consumption, 3,113 were caused by inflammation of the lungs and pleura, and 2,857 were due to heart trouble.

Professor D. G. Hamilton died on 19th February. For some time he was Professor of Pathology and then held a similar position in the

University of Aberdeen. He was an extensive writer on pathology and was an excellent teacher.

The New York Association for the Blind has done much good work. It has induced other societies to act, and an effort is being made to interest physicians and nurses to take every precaution to prevent ophthalmia neonatorum, and to have it treated efficiently in all cases where it occurs.

In the Philippines an effort is being put forth to lessen the frequency of disease from intestinal parasites. Hookworms, whipworms, amœbæ, etc., are the most common. The pail system is being enforced and the excrement is buried. The results have been very gratifying so far.

Dr. Dawson reports that of the patients admitted into the Farnham House for Mental Diseases, England, 29.4 per cent. were insane from some dithetic cause, 47 per cent. from moral and physical tear and wear, and 23.6 per cent. from toxic causes. In 71 per cent. there was a neuropathic heredity.

Dr. John Lindsay Steven, of Glasgow, died a few weeks ago. He was 51 years of age. He was clinical assistant to Professor McCall Anderson. He won the Brunton Memorial Prize; he followed David Newman in the lectureship in pathology, and took up clinical medicine in the University course.

The British Medical Association will meet this year in Belfast from 23rd July to 31st July, under the presidency of Sir William Whitla. The address in medicine will be given by Dr. Frederick Taylor; the address in surgery by Arthur E. J. Barker; that on obstetrics, Sir John W. Byers; and the popular address by Dr. J. A. McDonald.

The Sixteenth International Congress will meet at Budapest from 29th August to 4th September, 1909. The subscription to this scientific gathering is 25 crowns in Austro-Hungarian currency, which may be sent by post office order to Professor D. de Elischer, Esterhazy-vtca, Budapest.

In December last, late President Roosevelt sent a message to Congress urging that a Bureau for the study and care of child life should be established. As a result of this action, a bill was introduced to create a Children's Bureau, which is to investigate and report upon all matters pertaining to the welfare of children and child life.

The death rate per 1,000 last year in a number of the large cities of the United States was as follows: Chicago, 14.10; St. Louis, 14.53; Cleveland, 14.61; Buffalo, 15.45; Pittsburg, 16.49; New York, 16.89; Philadelphia, 17.46; Baltimore, 18.35; Detroit, 18.46; Cincinnati, 18.46, and Boston, 18.10.

In France there has been formed a new organization known as The Syndicate of Social Medicine. The objects of this organization are to work with labor societies in securing for the poor the right to select their own medical attendant; to secure for the medical attendant a fair remuneration, and to aid in the promotion of hygienic conditions.

MM. Lenoir and J. Camus have carefully studied the question of the transmission of tuberculosis infection through the air. They reported their findings to the Academy of Sciences of Paris to the effect that dried sputum will carry the bacilli, and also the bacilli may be carried several metres from the bed of the sick consumptive.

Dr. S. Weir Mitchell, of Philadelphia, reached his eightieth birthday, on the 15th of February past, in the enjoyment of good health. Dr. Mitchell has been a distinguished author and practitioner of medicine, and has also acquired a world-wide reputation as a writer of general fiction of a very high order of merit.

Sir F. Treves, Sir W. Ramsay, Sir J. J. Thomson, Hon. R. J. Strutt and Mr. Henry Morris, constitute the Council of the Radium Institute that is to be established in London. This institute will carry on research work and treat suitable cases. It is intended for the rich and poor alike. The only similar institute is in Paris.

A short time ago a doctor was called upon to give evidence in a London court. He took his own Bible with him, and refused to kiss the one in the court room. The judge fined him for contempt of court. The decision was appealed, but was upheld on the ground that the authority of the courts must be sustained. This case has given rise to much comment on the part of the medical profession.

Dr. W. Roger Williams has made a special study of cancer. He reviews the literature fully and concludes that the Jensen mouse tumor is not a true cancer; that cancer cannot be communicated from one person to another; that benign neoplasms rarely, if ever, become malignant; that cancer is not infectious, and that it is caused by nutrition and predisposition.

At a recent meeting of the Society for the Study of Tropical Diseases, Dr. W. C. Hossack, who has been a good deal in India, contended that there were some grounds for thinking that the rat flea was not so common a cause for the spread of plague as had been taught. The other speakers did not agree with him, and held firmly to the rat flea theory.

Since the British Medical Benevolent Fund was established, in 1836, £70,000 have been distributed in temporary grants in aid of doctors or their families in need. A larger sum has been paid out in annuities. The only qualification for the receipt of aid is that of need.

If the distress is temporary it is met by a grant. If it is permanent it is relieved by an annuity.

The German Medical Bill aims a severe blow at unqualified practice. It prohibits treating persons or animals at a distance, and it puts some important restrictions on the sale of secret remedies. The bill forbids the advertising of secret remedies in any but trade journals. The penalties are six months' imprisonment and a fine of $375, or either.

From *School Hygiene* we learn that the examination of 1,500 unselected children in the New York schools showed that from 80 to 90 per cent. required some form of treatment. When the parents were interviewed, consent for the proper treatment was secured in about 95 per cent. of the cases. Most of this work is carried on by nurses.

"Kissing the Book" has been the cause of a good deal of angry remarks of late, and Sir W. J. Collins in the House of Commons asked Mr. Herbert Gladstone if the matter was under consideration. The latter stated that it was, now that it was known that disease had been contracted in this way. One would think that laying the hand on the Book would do just as well as the objectionable practice of kissing it.

The third report of the British Royal Commission on Tuberculosis gives much new and valuable information. Proof is adduced to show that cows suffering with visceral tuberculosis may yield a milk containing a virulent bacilli, though the udders be quite healthy. Emphasis is also laid upon the increasing amount of evidence to the effect that bovine baccilli will infect man.

In Berlin, a short time ago, a person sued a Christian Scientist for the return of fees paid for treatment. The lower court dismissed the case, but the higher court ordered the repayment of the fees. It was held that the claims of the Christian Scientists' methods did not entitle them to the protection of the courts. Further, it was held that patients' lives were endangered by Eddyism.

Professor Galli, of Rome, has issued an appeal for aid for physicians and their families who suffered so severely by the earthquakes in Italy. Already in Europe a number of medical journals have opened subscription lists. It is stated that some of the families of doctors who lost everything are without shelter, food, or clothing. Any aid sent from this country would be gladly welcomed by Professor Galli.

Rupert Wells, M.D., who claimed to be able to cure cancer, has been refused the use of the mails by the United States Postoffice Department. The *Journal of the A. M. A.* for February 20th gives a full exposé of this "cure." The Government of the United States is

to be congratulated on refusing postal privileges. This country might copy in some instances.

The Government of Austria has appropriated $1,100,000 this year for medical education. Vienna gets $360,000, Prague $260,000, Gratz, Leuberg and Innsbruck each $90,000 and Cracow $120,000. There are to be paid 112 ordinary professors, 57 extraordinary professors, 293 assistants and 76 technical officers. Extensive additions are to be made to the buildings in Vienna, Prague and Cracow.

The United States District Court, Southern California, has given a very important decision regarding abortions. The court held that it was unlawful to send by mail anything, whether material or ideal, designed or intended for the purpose of aiding in any way the procurement of abortions. No instruments, or suggestions or methods, or treatment, can be sent by mail under this ruling.

The Supreme Court of Washington has decided that it is unlawful for osteopaths, magnetic healers and such like, to use the word "Doctor," "Dr.," or "Physician," before their names, or the letters M.D., or M.B., after their names, unless they possess these qualifications. In other words, such titles cannot be used to deceive the public.

Dr. Frederick Paterson, a former head of the State Lunacy Commission, states: "There are in the State of New York 30,000 insane in the various institutions, and it is estimated that 20 per cent. of these, or 6,000 patients, owe their insanity to alcohol. In all the asylums of the United States there are about 150,000 patients. This would give about 30,000 caused by alcohol.

The report of the committee appointed to inquire into the health of the school children in London shows that most of the children have defective teeth; that at least 60,000 have defective vision; that ringworm is very common; that there are many cases of adenoids and otitis, and that there are a great many examples of general debility.

In New Zealand the law regarding patent medicines enacts that no person shall put in an advertisement any statement that is false regarding the merits of any remedy. That any one who violates the law in this respect is liable to a fine of $500 for the first offence, and $1,000 for the second and subsequent offences. The act makes publishers of papers also responsible for misstatements in advertisements of secret remedies.

Dr. H. B. Dickinson, a well-known medical practitioner of Hereford, England, was prosecuted for not immediately reporting a suspected case of scarlet fever. Rather than expose his patient to the

risk of isolation in the hospital for such cases, he waited until the diagnosis became clear. For this delay he was prosecuted by the municipal authorities. He was acquitted, but was not allowed the costs of his defence. Justice must have been asleep!

Of late foot and mouth disease has attracted considerable attention owing to its prevalency in New York and Pennsylvania. The disease first came to Canada and the States from England in 1870, by the importation of infected animals. There are serious sequels, such as abscesses, sloughing of the hoofs and septicæmia, though the mortality is low. The leading characteristics in cattle and man are dulness, fever, the appearance of viscles, erosions, then healing.

The staff of the *Internationales Centralblatt für Laryngologie* presented Sir Felix Semon, of London, Eng., with a silver box in the shape of a volume of the journal. It contained on the lid the inscription: "In love and respect as a token of their acknowledgement of his valuable services to laryngology, and in grateful recollection of his courteous consideration of themselves." Sir Felix has acted as editor for 25 years. He will be succeeded by the vice-editor, Dr. George Finder, Berlin.

OBITUARY.

W. E. BURGAR, M.D.

Dr. W. E. Burgar, one of the oldest practitioners in Welland County, passed away at his home on 14th March. He had been in poor health for some time, but that morning felt so much better that he resolved to go upstairs. He did so and had just reached the landing coming down when he fell and never regained consciousness. Death was due to the bursting of a blood vessel.

Deceased was of United Empire Loyalist stock. His grandfather, Joseph Burgar, took an active part in the War of 1812, and his father, George, was in the Loyalist ranks in 1837. Dr. Burgar got his degree at Queen's in 1868 and practised in Welland County ever since.

M. LEESON, M.D., C.M.

Dr. Leeson, who was engaged in practice in Brandon, Man., was accidentally killed.

S. H. GLASGOW, M.D.

Sinclair Holden Glasgow, M.D., one of the most prominent medical men of the Niagara Peninsula and president of the Ontario Medical Council, died at his home, 14th March, from an attack of diabetes. He had been a sufferer from the malady some years ago and it returned early this year. A month ago he suffered the amputation of a toe and never rallied from the operation.

Dr. Glasgow was born in 1855 in the Township of Stamford. He obtained his medical degree at Toronto School of Medicine in 1878 and immediately began practice in Welland, which he continued until his death. He held the positions of jail surgeon of the county and division surgeon of the Grand Trunk Railway. He had been for a number of years representative of District No. 8 on the Medical Council. He took a prominent part in military affairs and was lieutenant-colonel of the Second Dragoons.

JAMES AYLEN, M.D.

Dr. James Aylen was the oldest physician in Aylmer. His death took place on Saturday, 6th March, at the age of 81 years. At one time he had a large practice and took much interest in Masonic affairs.

CHARLES E. BARNHART, M.B.

Dr. Barnhart died at Owen Sound in his 77th year. He graduated from the University of Toronto in 1859. He was in practice in Owen Sound for 50 years. He was well respected and had a large practice.

T. W. CARLOW, M.D.

Dr. Carlow died on the 5th of February at his home in Campbellford. He was in his forty-fifth year, and has been in failing health for some time.

P. F. CASGRAIN, M.D.

Dr. Casgrain, who had practised in Montreal for some years, died there recently, after a lingering illness. He graduated at Laval in 1875.

JOHN HUTCHINSON, M.D.

The late Dr. Hutchinson was in his 62nd year. For many years he practised in Fordwich and St. Thomas. On removing to Toronto he became the medical officer in charge of Dr. Hutchinson's Sanitarium, at 218 Simcoe street.

MORTON L. DIXON, M.D.

Dr. Dixon, well-known throughout Leeds County, died 17th March, at his home in Frankville, of peritonitis, having been ill only a few days. He was born in 1863. He was at the time of his death a member of the Board of License Commissioners for Brockville District. A widow and one daughter survive.

BOOK REVIEWS.

THE CHANGING VALUES OF ENGLISH SPEECH.

By Raley Husted Bell. Hinds, Noble and Eldridge, Publishers, New York, 31, 33, 35 West 15th Street. Price, $1.25.

If Dr. Bell were not the author of several books of verse, he would still be known as a poet—for it seems to be impossible for him to hide the poetic that is within his soul. With Dr. Bell the poetic and artistic are ever crying for expression. These characteristics are plainly to be seen in all his prose writings. During the time when he was actively engaged in the practice of medicine, his contributions to current medical literature attracted a good deal of attention, particularly on account of his style. His fondness, however, for the scientific *method* never forsook him, and he has retained his fellowship in the American Geographical Society and his membership in other scientific bodies. He found time to write a book on English called "The Worth of Words," which has passed through several editions. His success in this field is a sufficient assurance that "The Changing Values of English Speech" is well worth a careful reading. The present work, while designed to supplement "The Worth of Words," discusses English from a different and higher viewpoint. It shows much originality of thought and a wide range of painstaking, scholarly investigation. *Besides, it is a piece of beautiful literature.* There is not a dry paragraph in its 304 pages. The book is not without wit and humor, while being golden with poetic thought and expres-

sion. It is rare to find these characteristics of literary excellence combined in worthy and serious scientific discourse. That the author has accomplished this unusual feat will not be denied even by unfriendly critics.

DIABETES MELLITUS.

Three Lectures on the Pathology and Treatment of Diabetes Mellitus, viewed by the light of present day knowledge, delivered before the Royal College of Physicians of London, by F. W. Parry, M.D., LLD., F.R.S., consulting Physician to Guy's Hospital, Honorary Physician to King Edward VII Hospital. Reprinted from The Lancet, Nov. 21, 28 and Dec. 12, 1908.

Dr. Pavy has long been known as an undoubted authority on diabetes mellitus. The three lectures before the Royal College of Physicians of London give an excellent summary of his teachings upon this very important subject. He holds that carbohydrates are taken up by the tissues at the points where they come into contact with the tissues. This theory would do away with the glycogenic theory, which has done duty so long. He then explains the appearance of sugar by the breaking up of protein, which yields sugar to one-half its weight, this sugar having been taken up from the food. By a suitable non-carbohydrate diet for sufficient time, stability is again restored more or less completely. We are pleased with these lectures and recommend them cordially.

COAKLEY ON THE NOSE AND THROAT.

A Manual of Diseases of the Nose and Throat. By Cornelius Godfrey Coakley, A.M., M.D, Professor of Laryngology in the University and Bellevue Hospital Medical College, New York City; laryngologist to Columbus Hospital, the University and Bellevue Hospital Medical Clinic; Consulting laryngologist to the New York Board of Health; Member of the New York Academy of Medicine, Society of the Alumni of Bellevue Hospital, Medical Society of the County of New York, Medical Society of the State of New York, American Laryngological, Otological and Rhinological Society, etc. Fourth edition, revised and enlarged. Illustrated with 126 engravings and 7 colored plates. Lee & Febiger, New York and Philadelphia, 1908.

This work of Dr. Coakley's has been very popular. It has passed through one edition after another in such rapid succession that it is quite clear it has met with the favor of the medical profession. It is not too condensed to be of service to the specialist, and it is so clear and simple in its teachings that it is particularly useful to the general practitioner. The illustrations are excellent, especially those in colors. The author describes treatment and operations that are regarded as trustworthy. This feature is commendable, as there is no reason why books should be loaded with effete methods. The book will give

satisfaction to all who secure a copy. The publishers have done their share in the best possible style.

BACTERIAL FOOD POISONING.

A Concise Exposition of the Etiology, Bacteriology, Pathology, Symptomatology, Prophylaxis, and treatment of so-called Ptomaine Poisoning. By Prof. Dr. A. Dieudonné, Munich. Authorized translation, edited, with additions, by Dr. Charles Frederick Bolduan, Bacteriologist Research Laboratory, Department of Health, City of New York. 8 vo., 128 pages, cloth, prepaid, $1.00 net. E. B. Treat & Co., Medical Publishers, 241-243 West 23rd Street, New York.

Published less than a year ago, Prof. Dieudonné's manual on "Bacterial Food Poisoning" has already become favorably known as one of the best presentations of the subject. In the present translation, the editor has incorporated descriptions of a number of recent outbreaks of food poisoning, elaborating upon prophylaxis applicable to American conditions, and also going more fully into detail on the subject of treatment. He has slightly rearranged the material so that paragraph headings could be inserted and the subject of all chapters discussed in the same sequence. An index has also been added to facilitate reference, and this, with the other changes and additions, greatly enhances the value of the volume.

DISORDERS OF THE BLADDER.

Clinical Diagnosis and Treatment of Disorders of the Bladder with Technique of Cystoscopy. By Follen Cabot, M.D., Professor Genitourinary Diseases, Post-Graduate Medical School; attending Genitourinary Surgeon, Post-Graduate and City Hospitals, New York. 8 vo., 25 pages, 41 illustrations, 1 colored plate, prepaid $2.00. E. B. Treat & Co., Medical Publishers, 241-243 West 23rd Street, New York.

This book has been written for the guidance of the general practitioner, the chief aim of the author being to give practical methods for the diagnosis and treament of disorders of the urinary bladder. After considerable experience with both the medical and surgical sides of the subject, the need of such a book has become apparent.

Many practitioners in the past have felt that the technique of cystocopy was beyond their reach, but the recent improvements and reduction in cost of the instruments for this purpose have brought it within the reach of all, thus enabling them to accurately diagnose and successfully treat various hitherto obscure disorders of the bladder and kidneys.

While cystoscopy has justly been accorded an important position as a means of diagnosis and also in the treatment of many disorders, all useful methods have been discussed.

THE NAUHEIM TREATMENT.

The Nauheim Treatment of Diseases of the Heart and Circulation. By Leslie Thorne, M.D., B.S., Dur., M.R.C.S. Eng., L.R.C.P., London consulting physician to the St. John's House of Rest, Mentone, late Medical Examiner London County Council Technical Education Board. Third edition, London: Bailliere, Tindale & Cox, 8 Henrietta Street, Covent Garden, 1909. Price, 3s. 6d.

This little volume, most attractive in appearance, is largely a reproduction of the author's views already given to the profession in the pages of the *Lancet*. The book is handsomely illustrated, and this adds much to its usefulness. The object of the author is to enable practitioners to give the treatment to those who require it and are unable or unwilling to go to Manheim. The treatment is modified so as to suit home administration. The author places confidence in this system of treatment. We also think it has a distinct place. This book is a very clear statement of its application.

LIGHT AND HEAT.

The Therapeutics of Radiant Light and Heat, by William Burham Snow, M.D., author of "A Manual on Electro-Static Modes of Application, Therapeutics, Radiography and Radiotherapy, and Currents of High Potential and Other Frequencies;" Editor of the Journal of Advanced Therapeutics; and late Instructor in Electro-Therapeutics in the New York Post-Graduate School. New York: Scientific Authors Publishing Co., 1909.

The whole subject of light and heat is coming fast into the arena of therapeutics. It is well that every practitioner should keep himself posted on these subjects, even if he does not practise them. This book is carefully written and gives what is essential upon the subject matter of the book in brief and concise form. The author is well known, and needs no introduction. His book is a good one in the fullest meaning of the word.

PROGRESSIVE MEDICINE.

A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., and H. R. M. Landis, M.D. Vol. 1. March, 1909.

This volume contains surgery of the head, neck and thorax, by Charles H. Frazier, M.D.; infectious diseases, acute rheumatism, influenza and pneumonia, by Robert B. Public, M. D.; diseases of children, by Floyd M. Crandall, M.D.; rhinology and laryngology, by D. Braden Kyle, M. D.; otology by Arthur B. Duel, M.D. This volume is thoroughly up-to-date. The articles are written in a readable and interesting manner. This series is an excellent one, and this volume is in keeping with the high standard of the others. There is a complete index. The paper and type are the very best.

MISCELLANEOUS.

DEFINITION FOR PRACTICE OF MEDICINE.

The Herbst Medical Bill has been introduced into the State Legislature of Pennsylvania. This bill provides that every person who desires to practise medicine in the State of Pennsylvania shall pass an examination before a State Board of Medical Examiners composed of eight physicians and the State Superintendent of Public Instruction. The new law will abolish the old plan of three separate examining boards. The bill also contains the following definition of the practice of medicine:

"That a person practices medicine within the meaning of this act who holds himself or herself out as being able to diagnose, treat, operate upon or prescribe for any human disease, pain, injury, deformity or physical condition, and who shall either offer or undertake, whether with or without drugs, medicines or instruments, and whether with or without fee therefor, by means or method to diagnose, treat, operate upon or prescribe for any human disease pain, injury, deformity or physical condition; provided however, that this act shall not apply to the practice of dentistry, the regulation of which is now provided for by law."

CATAPLASM OF KAOLIN.

By PAUL CALDWELL.

Probably no preparation of the Pharmacopœia has received as much attention from pharmacists as the cataplasm of kaolin. As yet there seems to be no one who has been able to so manipulate the official formula for it as to produce a satisfactory product. I have before me extracts from papers on it, written by six different men eminent in pharmacy, and no two of them agree on a plan of procedure and only one is of the opinion that the Pharmacopœia is right.—Abstracted from the *Druggists' Circular.*

It is a matter of small moment whether or not pharmacists can make this preparation, as it is at best but a poor imitation of antiphlogistine, for which it is recommended as a substitute. Up to date no one has successfuly imitated a $20 gold piece, and the same may be said of antiphlogistine. As long as the Denver Chemical Mfg. Company maintains the high standard it has set for its product there will be little necessity for the druggist to worry over methods of manufacturing cataplasm of kaolin.—Ed. *Druggists' Circular.*

MEDICAL COLLEGE AT PEKIN.

The Chinese Emergency Appeal Committee, of which Sir Robert Hart, formerly Inspector-General of Customs in China, is president, issued a non-sectarian appeal for $500,000 for the purpose of developing a medical college in Pekin and three medical schools elsewhere. The idea is to provide for a thorough medical training upon modern lines for the Chinese. It is proposed to establish training colleges for Chinese teachers within the co-operation of the missionary society represented at the Shanghai conference last year.

ACUTE PROSTATITIS.

In the treatment of acute prostatitis salicylic acid internally in five-grain doses and sanmetto in teaspoonful doses tends to diminish the source of the infection, reduce the existing inflammation and encourage resolution. The sanmetto being a mild, soothing resolvent diuretic also tends to allay the suffering of the patient. If the urine is acid, citrate of potassium in ten-grain doses will aid in relieving irritation and tenesmus. As further measures for reducing inflammation, light diet, absolute rest in bed, free movement of the bowels and local application of heat by means of sitz baths, or hot water bag, should be enjoined. If the sanmetto is kept up urinary retention is not likely to supervene, unless there is a previously hypertrophied prostate; in that case the bladder should be emptied by a soft catheter at intervals, still keeping up the use of sanmetto. The prostate should not be massaged during the inflammatory state, but during the period of resolution massage will aid the process.

CYSTITIS.

In the treatment of all cases, rest in bed, with the hips elevated, will often give more or less relief from the strangury and the constant desire to urinate; by elevating the hips the urine accumulating in the bladder flows away from the most congested and sensitive part of the bladder. Some recommend opium and belladonna to control the pain. Heat to the perineum and above the pubis, and hot sitz baths will greatly relieve the tenesmus, and to some extent lessen the congestion of the mucous membrane of the bladder. Sanmetto should be freely given, each dose in half wineglass of hot water, and if the urine is acid, potassum citrate will render the urine less irritating.

OSTEOPATHY IN BRITISH COLUMBIA.

The British Columbia Medical Bill before the Legislature of that Province provides for the practice of osteopathy as follows: Nothing in this Act shall prevent or prohibit any duly qualified osteopath from practising his profession for reward or gain within the Province of British Columbia from and after the passing of this Act: Provided that all practitioners of osteopathy within the meaning of this Act shall be duly qualified osteopaths of a recognized school or college of osteopathy; and for the purpose of this Act, a recognized school or college of osteopathy shall be deemed to be an institution recognized by the American Osteopathic Association: Provided, further, that before any such osteopath shall be lawfully entitled to practise osteopathy within British Columbia, such osteopath shall take and successfully pass an examination satisfactory to the Council in the following subjects: Anatomy, physiology, chemistry, toxicology, pathology, bacteriology, histology neurology, physical diagnosis, obsterics, gynecology, minor surgery, hygiene, medical jurisprudence, principles and practice of osteopathy: The Council, for the purpose of such examination of applicants for registration as osteopaths under this Act, shall appoint an osteopath, who shall prescribe the examination of such applicants in relation to the principles and practice of osteopathy: any duly qualified osteopath who shall successfully pass such examination of the Council of the College: Provided that such osteopath shall be restricted and shall be entitled to be registered, under this Act, as a member of the college: Provided that such osteopath shall be restricted wholly to the practice of osteopathy.

THE CANADIAN MEDICAL EXCHANGE.

This Exchange is conducted by Dr. Hamill, Medical Broker, for the purchase and sale of medical practices and properties. He states that besides having from 15 to 20 desirable practices for sale at the present time, he also has requests from over eight different villages without a doctor, where there are most inviting opportunities to work up a practice. These latter openings would suit young doctors, or any medical men who would be satisfied with making about $2,000 per year.

Full particulars of the former or latter will be cheerfully given to any physician who cares to write Dr. Hamill, Janes Building, Toronto.