

Technical and Bibliographic Notes / Notes techniques et bibliographiques

The Institute has attempted to obtain the best original copy available for scanning. Features of this copy which may be bibliographically unique, which may alter any of the images in the reproduction, or which may significantly change the usual method of scanning are checked below.

L'Institut a numérisé le meilleur exemplaire qu'il lui a été possible de se procurer. Les détails de cet exemplaire qui sont peut-être uniques du point de vue bibliographique, qui peuvent modifier une image reproduite, ou qui peuvent exiger une modification dans la méthode normale de numérisation sont indiqués ci-dessous.

- Coloured covers /
Couverture de couleur
- Covers damaged /
Couverture endommagée
- Covers restored and/or laminated /
Couverture restaurée et/ou pelliculée
- Cover title missing /
Le titre de couverture manque
- Coloured maps /
Cartes géographiques en couleur
- Coloured ink (i.e. other than blue or black) /
Encre de couleur (i.e. autre que bleue ou noire)
- Coloured plates and/or illustrations /
Planches et/ou illustrations en couleur
- Bound with other material /
Relié avec d'autres documents
- Only edition available /
Seule édition disponible
- Tight binding may cause shadows or distortion
along interior margin / La reliure serrée peut
causer de l'ombre ou de la distorsion le long de la
marge intérieure.
- Additional comments /
Commentaires supplémentaires:

Continuous pagination.

- Coloured pages / Pages de couleur
- Pages damaged / Pages endommagées
- Pages restored and/or laminated /
Pages restaurées et/ou pelliculées
- Pages discoloured, stained or foxed/
Pages décolorées, tachetées ou piquées
- Pages detached / Pages détachées
- Showthrough / Transparence
- Quality of print varies /
Qualité inégale de l'impression
- Includes supplementary materials /
Comprend du matériel supplémentaire
- Blank leaves added during restorations may
appear within the text. Whenever possible, these
have been omitted from scanning / Il se peut que
certaines pages blanches ajoutées lors d'une
restauration apparaissent dans le texte, mais,
lorsque cela était possible, ces pages n'ont pas
été numérisées.

THE CANADIAN PRACTITIONER

EDITOR:

ADAM H. WRIGHT, B.A., M.D. Tor.

ASSOCIATE EDITORS:

JAMES F. W. ROSS, M.D. Tor.

JOHN CAVEN, B.A., M.D. Tor.

EDMUND E. KING, M.D. Tor.

PUBLISHERS:

THE BRYANT PRESS, 20 BAY STREET.

VOL. XX.

AUGUST, 1895.

[No. 8

Original Communications.

PUERPERAL INSANITY*

By N. H. BEEMER, M.B.,

Medical Superintendent Asylum for the Insane, Mimico.

THE subject which the committee handed me, a few weeks ago, as a theme for a short paper, was "Puerperal Insanity." Though possibly not as interesting, from a scientific point of view, as some other forms of mental disease, from the standpoint of frequency and curability there is, perhaps, no other form of mental disease of greater general interest or practical importance.

Puerperal insanity differs in no essential respect from other forms of mental disease—that is to say, it is not itself a distinctive form, but it embraces other forms, and these several forms are classified according to the leading characteristics of the disease; the event which determines the attack provides the name of the disease, puerperal insanity, and its chief subdivisions are puerperal mania, puerperal melancholia, and puerperal delusional insanity.

*Read at the Meeting of the Ontario Medical Association, Toronto, June, 1895.

In the physical history of woman there are three crises at which periods the strain upon the nervous system is exceptionally great, namely, puberty, the puerperal state, and the menopause. If the mental constitution be unstable in any way, there must necessarily be greater probability of a breakdown at one of these crises than in the intervals between them ; and in our everyday experience we find this to be the case, for mental disease is peculiarly liable to develop in woman at one of these periods.

There are two other mental alienations occurring during the function of reproduction, namely, those of pregnancy and lactation, but those are not strictly classed as puerperal insanity.

Technically speaking, puerperal insanity is the mental disease which occurs within the first six weeks after confinement ; most of the cases occur within the first two weeks, while a few may be seen to develop after the technical limit. One of the most scientific and experienced alienists of our age finds that five per cent. of all the cases of mental diseases among women belong to this form, and that one in every four hundred labors is followed by it.

Causes. As already stated, the constitutional mental instability forms the essential groundwork and prerequisite for this and other forms of mental aberration. Most mental constitutions are inherently so sturdy that insuperable mental strain or overpowering shock will kill the body before the mind will give way ; but all are not so constructed. In some persons there is, unfortunately, though nothing to their discredit, less power of resistance in their cerebral cells ; that is to say, there is a greater susceptibility to depressing influences, and accompanying, or independent of, this condition there may also be found a diminished facility for recuperation, or even lessened cell nutrition. It is easy to see how such a person, when subject to the unusual functional activity succeeding childbirth, or the shame of illegitimate motherhood, or the concurrent lessened supply of nutrition and defective assimilation, or imperfect metabolism—I say, it is easy to understand how a mental constitution at other times in good working order may be, by such causes, at least temporarily disturbed. Given, then, a mental constitution with inherent defective resistive power of the cerebral cells, and we shall find that all influences which attack and sap the stores of physical vitality will, in the puerperal state, operate towards the development of puerperal insanity.

This disease is twice as frequent when the children are born out of wedlock, because of the attending shame and humiliation, and also because of the insufficient care and nursing received by mothers in such circumstances. Shock, resulting upon the receipt of bad news, will sometimes usher in an attack ; want of care and proper food, and having to get out of bed too early, are often contributing causes. About one-third of

all the cases are those who have become mothers for the first time ; prolonged or instrumental labor and post-partum hæmorrhages are also occasional causes. But, while each of these circumstances may appear to be the determining cause, the puerperal condition itself is alone the well-prepared foundation for the development of this disease. We have all, probably, seen toxæmiâ the cause of mental disease independently of the puerperal state, and if, under less suggestive circumstances, it should rank as a cause, how much more probable is it that many cases of puerperal mental disease may be properly ascribed to it.

I spoke, a little while ago, of the imperfectly-equipped mental constitution as the groundwork of all mental disease, so that an unusual strain like that attending the puerperal state would cause a breakdown. Let me ask you to go with me a little further in this direction, and let us consider if the strain incident to the puerperal state is all directed upon the nervous system. I think you will agree with me that it is not. If the inherent nerve-force of the cerebro-spinal system becomes somewhat exhausted from the strain of the reproductive function, it must surely follow that the functions of the digestive and eliminative organs will become likewise impaired, if from nothing but defective nervous supply. The diversion of the nervous supply current to the mammæ for the establishment of their function would also serve to diminish the supply current to the assimilative and eliminative organs. If, then, we have diminished nerve force to the organs of assimilation and elimination, not only because of exhausted central nerve cells, but also because that impaired current coming from the exhausted centres is diverted to a new functional development, shall we not surely have both defective assimilation and imperfect elimination? Another incidental and suggestive fact in the clinical history also points to this conclusion, namely, that about eighty per cent. of the puerperal cases occur within the first fortnight after accouchement. If the naturally sensitive cerebral cells can resist the effects of the elements circulating in the blood as the result of impaired assimilation and elimination, for the first two or three weeks after confinement, or until those functions are again established, the danger is practically over. And just here is a practical point in the prevention, rather than the treatment, of puerperal insanity. If the attending physician have knowledge of the unstable character of the nervous system of his patient, and if the labor be instrumental, or greatly prolonged, {or succeeded by post-partum hæmorrhages, it would be incumbent on him to see that his patient should be guarded from all other subsequent exhausting or annoying circumstances for a longer period than the conventional week after confinement.

There is perhaps no other circumstance in domestic life so appalling and dramatic as the conversion of the joyous season succeeding the ad-

vent of the firstborn into a season of woe and misery ; there is a romantic anticipation surrounding the child-bed of the new mother, and the hopes alike of both gladdened parents are centred in their little offspring. When, therefore, the mother-love is not only lost but reversed, and when she not only "forgets her suckling child," but tries to strangle it, the dismay and sorrow and disappointment of the heartbroken father and other friends cannot be portrayed. It is impossible in words to give a true clinical picture of this powerfully affecting scene, but the more common clinical symptoms are the following : Generally the onset of the disease is sudden ; the patient does not sleep, but does not show the want of rest ; she does not take food, yet she has no hunger ; she will not converse, but is dull and apathetic, and seems preoccupied ; her joyous, happy condition of a few days previous passes away, and she appears to be absorbed by some subject to which she gives no expression. The product of her love becomes the object of her hatred, and her husband, and perhaps her doctor, become her worst enemies ; she thinks her food is poisoned and refuses it ; she thinks there is some one in the house or under her bed or at her window at night who has enmity in his breast and desires her destruction ; while she will fly from her imaginary pursuer's wrath, she may use the first instrument within her reach to accomplish her own self-destruction. She may fear that her child, if allowed to grow to maturity, will be wicked and abandoned, and to prevent this she will attempt, and sometimes succeed, in destroying it. Soon, if the attack be maniacal, she begins to chatter and talk to everybody, or to herself, and without reference to coherence of subject or comment ; she exhibits no care for her own conduct or her own body, and she is quite insensible to the interest and solicitude of those about her. There is now no ground for the least experienced observer to doubt about her condition ; the change is sharp and sudden, and it sometimes apparently occupies no longer in point of time than the change from daylight to dark.

Having sketched in a hurried way the more prominent causes and symptoms of puerperal insanity, let us now give a little consideration to its treatment. As puerperal insanity under favorable circumstances is so often curable, it is also above all other forms the one to which prompt and decisive measures should be addressed. An examination of the causes of the disease will convince us that defective nutrition underlies many of the cases, and experience has abundantly proved that judiciously administered nourishment is the physical salvation of the woman. She must be fed, nourished, whether she agrees to it or not ; if she be properly nourished, she will likely live and recover her mental soundness ; but if the depraved nutrition of the cerebral cells be not overcome she will die, or suffer chronic mental disease, which is not very different. How to nourish a patient is a

problem which every physician has to face every day, and the various answers which he will give to the problem at different periods of his life are almost amusing. At one time he will think he is sure that good results follow the administration of the various preparations of Maltine; then at another season he will feel sure that cod-liver oil and its compounds offer the most available nutritive elements; then perhaps the syrup of hypophosphites may become his sheet anchor in the process of nutrition, while it, in turn, may be succeeded by liquid foods of beef and iron and peptonoids. Doubtless all these and other pharmaceutical nutritives are of much value in their appropriate places, but for the ordinary everyday work of the nation, for the nourishment of men and women who do the work of the world, food which is prepared by the housewife or the cook in the kitchen has been found to answer all the requirements. To come to particulars, milk and eggs and meats and vegetables and fruits contain the nourishment most available and most needed by the patient; hot milk regularly administered is of the greatest value; custards rich with eggs, and egg-nog, and meats minced and broiled, are all generally assimilable, though not invariably suitable to every case. As soon as the bodily strength will permit it, occupation of some sort should be found for the patient; and just here there are two facts to be borne in mind, namely, that the muscle cells may not be impoverished to the same extent as the cerebral cells, because the elemental combinations which the muscle cells select from the blood stream for further nutrition are not necessarily the same as those selected by the cerebral cells for their own nutrition. I mean to say that cerebral-cell exhaustion is possible without extreme co-existing muscle-cell exhaustion, not only from unequal expenditure of cerebral-cell force, but from unequal and insufficient supply of nourishing elements to those brain cells; consequently physical exercise and employment may be of the greatest consequence to the patient. The other thing to bear in mind about employment is that if some of the cerebral cells in the motor tract are evolving motor energy, as evidenced by the dancing, rapid walking, gesticulations, and tearing of clothing by the patient, it is much better for the patient that this energy should be directed in its expression into some useful avenue rather than to allow it to expend itself in destructive habits, or to imprison it by means of mechanical restraint, and thus permanently damage the cells.

Nerve depressants, otherwise called hypnotics, had better be entirely discarded than injudiciously employed; indeed, when the patient recovers under their use, it is rather in spite of them than because of them. The temptation to use hypnotics is great, and often considered pressing; after natural sleep the patient is stronger and the cerebral cells are better nourished; the feeling of both physician and friends commonly is that, if sleep

can be induced by therapeutic agents, the patient's condition will be like that after natural sleep. But what is really the physiology of therapeutic sleep? Is not the consciousness of the individual hushed because the cerebral cells are rendered unresponsive by the absorption of the therapeutic agent? Does it seem reasonable that the cerebral cell, rendered insensible by the hypnotic, is in a favorable condition to receive nourishment from the already impoverished blood stream, which has also been loaded with the hypnotic? How much more scientific would it be to induce sleep by feeding the cerebral cell through frequent administration of nourishment to the patient? First of all, then, among the measures for the patient's restoration, comes nourishment, and after it come bathing, massage, and employment, and all these can best be secured through the aid of a trained nurse. I believe every case of puerperal insanity should have the advantage of the services of a trained nurse from the first day of the disease. If this important measure be neglected or postponed till the second day it may be too late, for the patient meantime may take her own or child's life. The trained nurse is of value in another way than the advantage of her professional services; her presence gives the friends assurance that the patient will be properly cared for, and saves the patient the annoyance and irritation of having her loved ones, whom she now hates, constantly in attendance upon her. Many of the puerperal cases may be advantageously treated at home, but great care must be exercised not only that ample nutrition is attended to, but also to make sure that the patient does not inflict some injury upon herself or upon her child. The patient may recover gradually or rapidly; perhaps 50 per cent. recover in three months, and 85 or 90 per cent. of those who do recover do so within six months; occasionally recoveries take place after a much longer duration.

I believe one of the first questions which the regular medical adviser strives to answer in these cases is whether his patient shall be treated at home or sent to a hospital for insane. Nine physicians out of ten desire the counsel of some one who has had a large experience in mental diseases to direct them on this question, and just here I crave your indulgence if I give respectful expression to the emphatic protests which I have so often heard against the unwisdom of our Ontario laws in regard to this subject. The government—I mean the people of Ontario—generously and humanely declare that the insane and idiotic, when not possessed of property, shall be maintained at the public expense, and the government wisely appoints medical men to conduct our asylums for these disabled men and women. The government requires its superintendents and medical officers to be properly equipped for the scientific management and treatment of all forms of mental diseases, and their opportunities for observation and research in the large institutions should qualify them to speak with some

degree of definiteness about the management of the acute cases. It would be natural to suppose that, if the attending physician of any private patient suffering from mental disease desired the counsel of a medical superintendent or medical officer of an asylum, it could be readily obtained, but this is not the case ; the men who have been so exceptionally placed by the government to acquire an intimate and practical knowledge of mental diseases are required by that government to decline to give counsel to the attending physician who is in search of it, on the ground that the asylum officer might interfere with private interests. Asylum superintendents are repeatedly asked by the attending physicians in cases of mental disease to meet them at the bedside of the patients and advise whether home or hospital treatment should be pursued ; on the answer to this question may depend the recovery or non-recovery of the patient. In every other department of medical science the family physician may command the services of the specialist, but in this department, where there is the greatest need, that privilege is denied him. I am not pleading the cause of the medical officers, though I believe consultation with outside practitioners in mental cases would benefit them greatly, not only by forcing them to keep well read in the recent literature of mental diseases, but also by enabling them to observe the initial symptoms of mental diseases which exhibit themselves before the patients have been transferred to the asylums. Neither am I specially called upon to plead the cause of the attending physicians in these cases, though their position is one of unnecessary hardship. But I am pleading in the interest of the newly-diseased mind of the woman who cannot plead for herself, and who, if granted access to the services of the specialist in the early stages of the disease, may sometimes escape the odium which wrongly attaches to an asylum residence. On the other hand, sometimes recovery would follow the speedy removal to the hospital for insane, whereas the more delayed removal would result in another additional patient being placed for life as a ward in the government hospital. It would seem, therefore, that there would be a fourfold advantage arising from such consultations, if they were allowed, namely, a professional advantage to the medical officers ; an unquestioned satisfaction to the attending family physicians ; a pecuniary saving to the government ; and, what is of greater consequence than all the rest, the patient herself would have all the advantage which the study, devotion, and experience of the alienist could give her.

MODERN EXPERIMENTAL SURGERY ON MAN AND WOMAN.*

A CRITICISM OF OPERATIONS DONE AND THE RESULTS OBTAINED.

By J. F. W. ROSS, M.D. TOR.,

Lecturer in Gynæcology in the Woman's Medical College; Gynæcologist to St. John's Hospital,
Toronto General Hospital, and St. Michael's Hospital.

ONE who criticizes is open to criticism; his intentions should be honest and his criticisms free from all feelings of personal animosity. My criticisms of the surgery of the present day, or, at least, of that branch of it with which I am most intimately associated, are the result of personal convictions. My views may change, but these are the views that I hold at the present time.

Owing to the great strides that surgery has made since Lister introduced his antiseptic theories, much of the surgery of the past fifteen years has been, to a certain extent, experimental in its nature. All that has been experimental can be looked back upon and reviewed in order that any mistakes may be corrected.

Owing to the former great mortality accompanying surgical procedures, many operations that should have been done were left undone, and, with our present knowledge, we criticize the surgeon of the past, and consider that he failed to save life by neglecting to perform an operation that, to us in our present light, appears trivial. With equally as good reason, the surgeon of the past might, were he to rise from the tomb, criticize the operator of the present, and tell him that, in his opinion, he performs unnecessary and useless operations. We are enabled to do so much with so little danger that we are apt to forget where we should stop.

Many new surgical procedures will be introduced year after year, but there are few of them that will stand the greatest test of all, the test of time. To the generations yet unborn many of these operations will be forgotten and ignored, just as we ignore many of the procedures of the past. Mr. Smith turns a stitch to the left instead of to the right, and the operation becomes Smith's hernia operation. Mr. Jones stitches from

*Read before the Ontario Medical Association, Toronto, June, 1895.

below upwards instead of from above downwards, and the birth of Mr. Jones' latest operation is complete, heralded about from town to town by the pages of the medical journals, another immature nursling to confound the already overburdened medical student. The dead heroes of our surgical past were brainy men, endowed with common sense, great thinkers; but, perhaps, more modest than some of the operators of the present day, they performed these operations with a stitch up and a stitch down, but forgot to mention the fact, as they thought it was only the outcome of the exercise of a little common sense. It is wise that surgical procedures that are *bona fide* departures should bear the name of the surgeon introducing them, but it is little short of surgical piracy to add some slight addition to a surgical operation and add the name of each of those making such petty additions to the name of the originator of the operation. After a time the name of the original thinker, of the one who first brought the operation to the notice of the profession, is entirely lost.

With the development of our country small hospitals have been built in many of the towns, and much good surgical work is being done in these hospitals. There is a large amount of trashy literature circulated among the members of the profession, and this literature, unfortunately, influences those who read it, to a certain extent. With a hospital in which to operate, with a diminished mortality incident to the adoption of aseptic surgery, and with trashy literature to recommend unwise operations, there is a danger that surgery may do too much. Unless one is behind the scenes and knows something of the standing of a writer in his own community, he is liable to accept much that emanates from his pen as true, and the outcome of a large experience, whereas the information of the would-be authority is in reality culled from books and his own imagination. Many of the deductions found in papers printed cannot be relied upon, but of course the journals cannot be held responsible for this fact. Frequently a superstructure is built without a foundation, or, if there is a foundation, it is entirely in the imagination of the writer.

For instance, a writer details fifty or one hundred cases of pelvic inflammation successfully treated by the use of electricity. All of these cases, after waiting for a certain interval of time, recovered; in the interval electricity was used. We know that many such cases will improve, and that many will entirely recover if left alone, and when they are not treated by electricity. But as electricity was used in the fifty or one hundred cases above referred to, and as the cases recovered, therefore the electricity produced the result.

Another professional brother proceeds at once to spay such cases, to remove inflamed tubes and ovaries, and the patients rapidly recover; they have no more pelvic peritonitis, they are soon in robust health, but,

nevertheless, unsexed and unable to further propagate their species. Such an operator is, no doubt, honest in his intentions, and convinced that, because now and then one of these cases will take on a malignant form of inflammation and die, therefore operation is required in all cases in order to save life. The old-fashioned gray-haired family physician could, no doubt, teach both of these professional brethren a lesson. He could relate case after case of pelvic inflammation following labor or miscarriage, with high temperature, rapid pulse, tympanitic abdomen, in which perfect recovery took place after rest in bed, purgation, or, on the other hand, the use of opium. He would prevent these gentlemen from treating with electricity or the knife cases of ovarian neuralgia in young unmarried girls ; a neuralgia resulting from anæmia, resulting from overwork, resulting from mental fatigue, resulting from onanism, resulting from blighted hopes and disappointed affections ; he would prevent the use of the knife for the relief of women with pelvic pains of indefinite character, women with large families, overwrought in body and mind ; he would prevent the use of the knife in many other cases in which pelvic disease is simulated. A little chloroform and a well-practised finger should prevent mutilation in these cases. As the superintendent of a lunatic asylum once said to me, "Some of these women have from the first one foot over the threshold of a lunatic asylum." One operator takes out one ovary, another operator takes out the other, and then a third considers it necessary that the uterus should be removed—that, in fact, it should never have been left behind. And after all these operations have been performed the patient eventually shows pronounced symptoms of insanity, and the seat of the disease is found to be in the central nervous system.

Even where pelvic inflammation has occurred and adhesions have formed, the patient may for years enjoy the best of health. If an abscess forms in the ovary, or if pus collects in the tube, coeliotomy is demanded. In such cases the gray-haired practitioner is entirely beyond his depth, and were we to follow him he would lead us into serious error ; he would have us avoid the knife when it should be used, he would have us allow such patients to suffer for years when they should be relieved by a surgical operation.

To guide the modern young woman, I would employ the old-fashioned practitioner and the common-sense mother. By them pelvic massage, one of the most revolting of modern medical procedures, would be at once tabooed. The uterus and ovaries would be kept in the pelvis, and would not be permitted to migrate to the brain. Our young women would not be permitted to cross the Atlantic to enter institutions for the treatment of imaginary womb troubles. These transatlantic institutions exist, and are filled with American girls who receive the pelvic massage treatment at

regular intervals. It is amazing that such a procedure should have taken hold of the minds of an intelligent profession. When such institutions exist many young women, under the guise of ill-health, are enabled to live in the indolence that appears to suit their tastes. When carefully watched by intelligent nurses their pains disappear, and the consensus of opinion of their own sex is that their ailments are imaginary, and that they only suffer when the doctor is around. These patients almost insist that their ovaries must be removed, and with the introduction of the new dogma, after the ovaries have been removed, they will perhaps return and insist that the uterus must be taken away, as it has now become the fashionable offending organ. If the bladder and rectum were also removed, and they lived, they would still remain uncured, they would still live on the same indolent life, they would still take their morphine, and remain an incubus to their long-suffering friends. One of my house surgeons recently humorously remarked, regarding a certain case, that the patient required rather a trephining of the skull than a cœliotomy for the removal of her ovaries.

These hysterical women will allow themselves to be mutilated without offering a single complaint. In one day I performed cœliotomy on two cases. I was anxious to satisfy myself upon the very point I am at present discussing. I drew up the ovaries, found them free from adhesions, found them healthy in character, found the Fallopian tubes affected with no disease, and dropped the organs back again into the pelvis. Each patient expressed herself as free from all her old pains within twenty-four hours after the operation. One patient was not made acquainted with the fact that her ovaries had not been removed, and she soon became pregnant, much to her disgust. Her symptoms have now developed in a new direction; she is suffering from excessive uterine hæmorrhage. This hæmorrhage only occurs when she is out of the hospital; the nurses are unable to find any trace of it when she is admitted for treatment.

In connection with the ovary there is much that requires careful study. From my own experience, I find that a woman will continue to menstruate with one ovary and with both Fallopian tubes removed. From my own experience, I find that a large percentage of fibroid tumors diminish in size, to a marked degree, if they do not totally disappear, after the removal of the ovaries and tubes. Whether the removal of the ovaries alone would be sufficient to produce this result or not, I cannot say. I have seen tumors extending above the umbilicus almost entirely disappear after this surgical procedure has been carried out. Many abdominal surgeons have come to the conclusion that if a small portion of ovarian tissue is left behind menstruation is liable to continue. It is a well-known fact among farmers that, if during the performance of the operation of castration a large portion of the cord is left intact, subsequent engorgement of

the corpora cavernosa and coitus are possible, and, further, that the animal retains more of its resemblance to the entire male. From this, I think we learn that the operation of oophorectomy for fibroids should be a very thorough one, that no ovarian tissue should be left behind.

From the fact that this operation is so successful in causing the disappearance of these tumors, the surgeon should hesitate before he decides to perform hysterectomy. On one occasion I drew up a fibroid tumor growing from the left broad ligament, intending to remove it, but, after inspecting its attachments, I found that its removal would be accompanied by the greatest possible danger to life, from the fact that it was growing between the leaves of the broad ligament into the pelvis. I, therefore, removed both ovaries and tubes and replaced the tumor in the abdomen. It was impossible to repack it into the pelvis, but, notwithstanding this fact, the patient made an excellent recovery. Within twelve months, this tumor has diminished to one-third its original size. Menstruation has all but ceased.

Vaginal hysterectomy for small fibroids is, in my opinion, an uncalled-for procedure until after oophorectomy has been performed. In a very occasional case hæmorrhage may continue, and the operation of hysterectomy may be indicated. No woman can suffer a total extirpation of the uterus without undergoing a serious mutilation; this mutilation is a more severe one than that caused by the performance of the operation of oophorectomy. I am performing more oophorectomies and fewer hysterectomies than formerly. If all women suffering from fibroid tumors would submit themselves early to the operation of oophorectomy, large fibroids, that a few years ago were so common, would become very scarce, and an immense amount of suffering would be avoided.

For cancer of the body of the uterus, vaginal hysterectomy is called for at the earliest possible moment. In cancer of the cervix uteri, only one of two surgical procedures should be carried out, either high amputation of the cervix or vaginal hysterectomy. Neither of these operations should be performed if the vaginal wall and the vaginal lymphatics have become involved. With this involvement recurrence of the growth will be rapid, and the woman, while running great risk of her life, gains but a short respite from death. Where no such invasion has occurred, and these are the cases that rarely come under our observation, the woman runs the risk of her life, but gains a great respite from death. The use of the curette and of caustics may produce a certain amount of mental calm by causing the patient to believe that something is being done to alleviate her suffering and prolong her life.

The operation of hysterorrhaphy is one that I have never yet performed. To my mind, it is a useless operation and quite uncalled for. On one occa-

sion I pinned the cornu of the uterus into the anterior abdominal wound to keep a retroflexed uterus out of the cul-de-sac of Douglas. The symptoms were not relieved ; the patient still complains of her old aches and pains.

It is a well-known fact that after a supravaginal amputation of the uterus for fibroid tumor a pedicle is left fastened in the lower angle of the wound. This gradually disappears, until it finally leaves a granulating pouch that heals from the bottom. The remnant of the cervix and skin are thus intimately united in a firm scar. No sooner has the clamp been removed than the stump of the cervix begins to drop back into the pelvis. In a few months the stump of the cervix has become separated from the skin and the scar has become stretched. In a couple of years the cervix will be found to have resumed its old position in the pelvis. How, then, can we hope to hold the fundus uteri against the anterior abdominal wall by means of a few adhesions ? If a permanent stitch be placed and left imbedded in the tissues, it becomes a menace if pregnancy occurs. If the stitch is cut, the woman will, in all probability, miscarry ; if the stitch is not cut, the woman will, in all probability, miscarry. The operation of hysterorrhaphy is not an ideal one, and I do not believe that it is an operation that has come to stay. It may be performed for a time by a few, but will not be performed by the large mass of conservative gynæcologists.

The same criticism may be offered regarding Alexander's operation (shortening the round ligaments). The same criticism may be offered regarding the operation of nephorrhaphy ; I consider it a useless surgical procedure, and I have never yet cured a patient on whom I have performed the operation. Movable kidney is a very common affection. A movable kidney in a neurotic woman may be stitched to the side, but the nerve symptoms will still remain. Some operators claim that the kidney remains in position ; in the cases on which I have performed the operation, the kidney has again become movable. I fail to understand why a few adhesions should remain unstretched after the performance of this particular operation. Other operators have found this drawback to the operation, or they would not have suggested the use of the buried sutures. I would allow no surgeon to place a buried suture in either of my kidneys for the purpose of keeping it immobile. The right kidney can be palpated in its entirety in a large majority of moderately fleshy women who have borne children. In these women the lower end of the left kidney can be felt. I frequently find the kidneys quite mobile in young men. The symptoms attributed to movable kidney will frequently be found, on closer inspection, to have some other origin.

Nephrectomy bears to nephrotomy the same relation that hysterectomy for fibroid tumors bears to oophorectomy. Nephrotomy should be tried

in a large number of cases before nephrectomy is resorted to. In one case I even controlled severe hæmorrhage, after splitting down the kidney for the purpose of removing an impacted calculus, by means of forceps pressure, and thus avoided the performance of the more serious operation of nephrectomy. Four or five pair of forceps were left protruding from the wound for a period of thirty-six hours. The shock of nephrotomy is not nearly so great as the shock following nephrectomy.

Of late a surgical tidal wave has been flowing in, carrying on its crest several new procedures. The intestines have been attacked with vigor. Cancer of the pyloric end of the stomach, that a few years ago was deemed incurable, has become an object of attention. Anastomosis between the stomach and the duodenum has been performed; the pyloric cancer, in other cases, has been removed. When a patient has become affected with cancer of the stomach, his death sentence has been passed. Owing to the fact that the stomach plays an important part in the process of digestion, patients suffering from a gastric growth become rapidly emaciated. An emaciated and half-starved patient ill withstands the shock of any serious operation. Anastomosis of the stomach with the intestines in such a case is, at best, but a miserable makeshift, when the patient is suffering from cancerous disease of the pyloric end of the stomach. I have refused time and time again to perform this operation. The introduction of various mechanical devices by which the operation is rendered easy has not altered my opinion regarding the matter. To anastomose the stomach with the intestines and leave the cancer behind can only add but a little while to the patient's life, and the removal of the cancer itself, if the patient should be fortunate enough to recover from the shock of such a serious operation, gives but a very short interval of freedom from recurrence.

Operations for removal of cancer of the rectum above the reach of the finger should be placed in the same category. Cancer of the rectum is a disease that usually occurs in elderly people; the lymphatics of the rectum are very abundant, and this portion of the bowel has large glands lying in its immediate neighborhood. These lymphatics are very early affected, and the removal of the cancerous rectum does not remove the cancerous disease. The operation of intestinal anastomosis and removal of a cancerous rectum on an elderly and emaciated patient is a very severe one, and, if successful, it will only prolong life for a short time. On this account, I have refused to perform the operation.

Intestinal anastomosis for a non-malignant stricture, fæcal fistula, intussusception is an operation that will prolong the life of a patient to an indefinite length of time. The mechanical appliances lately introduced as an aid to the surgeon are worthy of the highest praise, but, owing to the facility with which anastomosis can now be accomplished, I fear that anastomosis will be produced in cases that would be better off if left alone.

The operation of removal of the breast is one that is unaccompanied by danger to life. If a patient is suffering from cancer of the breast, and the lymphatics and skin of the axilla are seriously involved, I frequently refuse to operate, feeling that there is but little to be gained by operation. If this be so in an operation in which the mortality is *nil*, how much more does it apply in cases in which the mortality of the operation is much greater, and in which the chances of subsequent eradication of the disease are diminished !

It is but a few years since pelvic cellulitis became transformed into pelvic peritonitis, salpingitis, and ovaritis. But a few years since the knife was called upon, and pus tubes and pus ovaries were enucleated and removed. As the operation for removal of pus from the pelvis became popularized, surgeons became imbued with the idea that operation presented the quickest means of effecting a cure in cases of pelvic inflammation, and not only in cases of pelvic inflammation, but in cases of pelvic irritation.

Of late another wave has washed the sands of surgical research, and has left behind it a few grains of sand. The sand may glitter and sparkle in the sunshine, but will soon be washed out to sea. I refer to the operation of vaginal hysterectomy, when performed for the relief of pus tubes. It has been stated that a woman who has pus tubes has also a septicly infected uterus, and that to cure her the uterus must be removed. Women who have been spayed in times past are now being submitted to a second operation by a certain section of the modern school. Having operated on nearly one hundred cases of pus tubes, and having met with bowel adhesion and bowel perforation in many cases, I cannot understand how it is possible to complete such operations in a satisfactory and scientific manner through the vagina. That adherent ovaries and tubes and adherent uterus can be readily removed by the vagina, I will admit ; and, further, that it is easier to remove healthy ovaries and tubes and uterus through the vagina than through an abdominal opening. The operation can be performed with the greatest of ease, but I must deny that it is possible to remove large pus tubes and ovaries that have perforated into the small intestine, the bladder, and the rectum, through the vagina with anything like the degree of safety that they can be removed through the anterior abdominal wall. It would be just as sensible to take out every kidney that is affected with a stone impacted in a small abscess cavity as to take out the uterus when the ovaries and tubes are the organs affected. *If so-called gynecological surgery becomes a little more aggressive, the general practitioners will begin once more to become their own gynecologists ; they will be afraid to recommend a consultation with a specialist.*

Within the last few years the appendix vermiformis has taken up a good deal of the attention of the profession. The public has become

alarmed, and every attack of colic means an attack of appendicitis in their eyes. They have become so impressed with the necessity of early operation, as represented to them by the profession, that it is sometimes difficult to persuade them that an operation is not required. A few deaths of prominent men have taken place subsequent to the operation for the removal of this appendage, and there has been a partial revulsion of feeling. *The physicians have begun to think that the surgeons have gone too far.* The lay press has ruffled its feathers over the matter. Some have preached the doctrine that, if symptoms of appendicitis occur, you should operate at once; this is altogether too sweeping. The surgeon only sees the bad cases, and bases his opinion on these cases. The physician sees a large number of the milder cases that never come under the surgeon's observation. Each case must be judged on its own merits, and it is therefore unwise to send out broadcast over the country an opinion that such radical measures are required. Many cases of inflammation of the appendix occur and abscess forms, and is either opened externally or cures itself by perforation into the bowel. When abscess has formed, the knife should be used. In the early stage of the disease, when the bowels are distended, pulse rapid, temperature high, operation, to my mind, does more harm than good. In these fulminating cases, the increased shock of operation will turn the balance the wrong way. The cases in which operation is called for in the interval between the attacks are rare, when we take into consideration the number of patients who, at some period of life, have suffered from an attack of this disease. Nature indicates to us the cases in which operation should be performed in the interval between the attacks. The temperature will remain elevated, the attacks will recur at frequent intervals, the general health will suffer, and when the operation is performed a small pocket of pus, holding from a teaspoonful to a table-spoonful, will be discovered.

In my early cases I was anxious to remove the appendix, but at present I leave it alone, if there is danger of breaking down adhesions during the search for it. I am satisfied to drain the abscess cavity for the time being in such cases. After an attack, I have seen the tip of the appendix entirely severed from the remainder, with new adhesions and a new blood supply, and the base sealed over, and as entirely obliterated as if its obliteration had been the result of the surgeon's ligature. Such a case is, of course, self-cured. One attack of appendicitis, from which there has been perfect recovery, is not sufficient indication for the subsequent performance of a surgical operation. It has even been suggested (whether in earnest or not, I do not know) that each infant should be subjected to coeliotomy for the purpose of having its appendix removed. *The present generation seems as anxious to invade the peritoneum as the former generations were to avoid it.*

Men and women may suffer from gallstones for years, and may require no operation. The results of these operations are very satisfactory. In some cases operation is urgently demanded. Unless operation is urgently demanded, it should not be forced upon the patients; they should be called upon to choose for themselves. If they desire relief by means of the knife, such relief should be granted.

I feel satisfied that within the next ten years the waters of the great surgical flood that has swept over this continent and the continent of Europe will fall and regain their normal level. An abatement of the flood cannot come too soon.

481 SHERBOURNE STREET, TORONTO.

FLAT-FOOT.*

BY B. E. MCKENZIE, B.A., M.D.,

Lecturer on Orthopædics and on Surgical Anatomy in the Woman's Medical College, and Surgeon to the Victoria Hospital for Sick Children, Toronto.

THE term "flat-foot" is not a happy one, as it does not correctly describe the conditions commonly referred to under this designation. Having reference to all departures from the normal conformation of the foot, that which will be described in this paper may be said to be always a weak foot. On the other hand, however, it is not proposed to discuss all varieties of weak feet.

In order to judge rightly concerning the various abnormal shapes and conditions in which the foot may be found, and its numerous deficiencies of action, a familiar acquaintance and intimate knowledge of its normal architecture¹ and a thorough understanding of its proper functions are essential. When compared with the hand, it is observed that the latter is intended for acts of manipulation and dexterity, as seen in the short carpus and long phalanges, permitting a wide range of independent motion to each finger; while the foot is primarily adapted for weight-bearing under such circumstances as presuppose the power to move the superincumbent weight easily and without concussion, as seen in the longer arched tarsus and short, strong digits fitted on their under-surface to apply themselves intimately to the surface tread upon.

The bones, ligaments, and muscles of the foot are so arranged and related as to form two sets of arches, a longitudinal and a transverse. The piers of the former consist of the tubercles of the os calcis behind, and the distal ends of the metatarsal bones in front. The latter is more correctly described as a half arch, its outer pier, consisting of the cuboid and fifth metatarsal, receiving a good support by an approximate contact with the ground, while the inner pier receives only the support afforded by the inner portion of the longitudinal arch. Thus the transverse arch of one foot is the complement of that of the other. The internal division of the longitudinal arch consists of the posterior two-thirds of the calcaneum, the scaphoid and cuneiform bones, and the three inner metatarsals; the outer

*Read before the Toronto Medical Society.

division is formed by the calcaneum in its whole length, the cuboid, and the fourth and fifth metatarsals. The inner portion bears the greater part of the weight of the body which is transmitted through the astragalus which overhangs the sustentaculum tali, and so inclines inward from the calcaneum that its external superior border is directly over the middle of the calcaneum.

In walking, the weight of the body transmitted through the astragalus, as the keystone of the combined arches, falls upon the feet alternately, not directly downward, but with an impact downward and outward, the direction of the force as the weight comes upon the right foot being downward and to the right, while in stepping upon the other foot there is an element of force moving to the left as well as downward. The transverse arch, being well supported in its outer piers, is well calculated to withstand this outward impact as the feet are called upon to bear alternately the weight of the body.

The arches are supported in normal degree of curvature by muscles and ligaments chiefly, the bones being but little shaped to attain that purpose. The outer portion of the longitudinal arch is reckoned by Lorenz to be a little more than five and a half inches between piers, and its highest point in a good ligamentous preparation to be three-fourths of an inch from the ground. The inner portion has nearly the same span, but is much higher.

The most important ligaments concerned in the prevention of excessive flattening of the arch are the inferior calcaneo-scaphoid, the two plantar calcaneo-cuboid ligaments, and the various slips of the tendon of the tibialis posticus, as they pass to find attachment to the different tarsal and metatarsal bones. The plantar fascia also forms a powerful "tie-beam" connecting the piers of the plantar arch. The highest point of the arch corresponds to the joint between the astragalus and scaphoid; it is also the weakest part, and its chief supporting ligament, the calcaneo-scaphoid, is composed chiefly of elastic fibres, which allow the arch to yield slightly, enabling it to withstand the effect of shocks, and contributing to the springy action of the foot, so necessary to activity.

In standing, the weight of the body is received chiefly upon that part of the arch extending from the heel to the great toe, while the outer end of the transverse arch comes to the ground at a part external to a line passing through the internal pillars of the longitudinal arch. Thus the weight of the body is transmitted to a tripod in such a manner that its greater part is supported by the two inner feet. The three points of contact of this tripod with the ground are at the tubercles of the os calcis and the heads of the first and fifth metatarsal bones. In order to maintain proper stability in the foot, it is necessary that the line of transmission of the body's weight should come to the ground somewhere within the triangle

formed by joining the feet of the tripod ; otherwise there is a tendency to turn over to that side which receives the weight.

In a foot normally adjusted, this tendency to roll over toward the inner border is prevented by the action of four muscles especially—the tibialis posticus, the flexor longus digitorum, the flexor longus hallucis, and the tibialis anticus, three of which pass behind the inner malleolus as over a pulley to their insertion. The muscles which afford most support to the arch are the two peronei at the outer side, and the two tibiales on the inner side, some support being given also by the long flexors of the toes.

Flat-foot² is a deformity characterized by a marked pronation of the foot with obliteration of its arch. There is also abduction of the front part of the foot, and partial dislocation of the bones at the mid-tarsal joint.



Fig. 1. Congenital Flat-Foot.

The less marked cases are generally disregarded, but when the structures at the inner margin of the foot are placed constantly in a condition of strain, and those on the outer side are crowded together, there is often much pain, especially after standing or walking.

When it is remembered that the weight of the body is normally transmitted to the earth in such a manner as to fall more upon the inner portion of the foot, tending to produce pronation, it will be seen that abduction increases this tendency, and is a position of weakness, while adduction moves the points of support more directly under the weight of the body, and is a position of strength. Adduction implies muscular activity, the ligaments being then well supported, and the foot well under muscular control, while in abduction the ligaments are left to bear most of the weight.

The turning outward of the foot in walking or standing produces greater strain upon the arch, while the in-turning of the foot affords it greater protection. It is characteristic of the walk of those who have weak or flat feet that they roll over on the foot in walking, rather than rise upon the anterior portion of the foot, as do those who have a graceful and elastic gait.

The more common causes of flat-foot may be easily summarized. Marked cases are seldom seen at birth (*vide* Fig. 1), but those of moderate degree are very common, especially among girls. In taking the foot in the hand in these mild cases, it will be found that the foot may be easily abducted so as to cause the axis of the anterior portion of the foot to form an obtuse angle with that of the os calcis, and three bony points are made.



Fig. 2. Paralytic Flat-Foot.

to stand out with prominence at the inner margin, viz., the inner malleolus, the head of the astragalus, and the tubercle of the scaphoid.

The acquired variety is much more common (Fig. 3), but is probably to be regarded, in the majority of cases, as the development of a predisposition. Rickets, paralysis (Figs. 2 and 3), traumatism, and all forms of disease or habits of life which produce a relaxed and flabby condition of tissues, may cause weakening or breaking down of the arch. Flat-foot is a very common accompaniment of lateral curvature of the spine, and both, no doubt, are due to the same causes. In general, it may be said that flat-foot is a result of a disproportion between the body weight and the apparatus for sustaining it.³

Traumatism may occasionally be a cause of this deformity. When, after Pott's fracture, the foot is found in marked pronation owing to a defect in adjusting the fragments of the fibula, then the weight-bearing foot is moved outward, and the weight is transmitted to the ground along a line that may pass entirely inward of the points of support. Falls from a height may produce fracture of some of the bones of the tarsus or rupture ligaments, breaking down the arch.

Rational treatment must be based upon what has been shown to be the pathological anatomy of this condition. The deformity may be summarized as consisting of one or all of the following three elements, viz.,

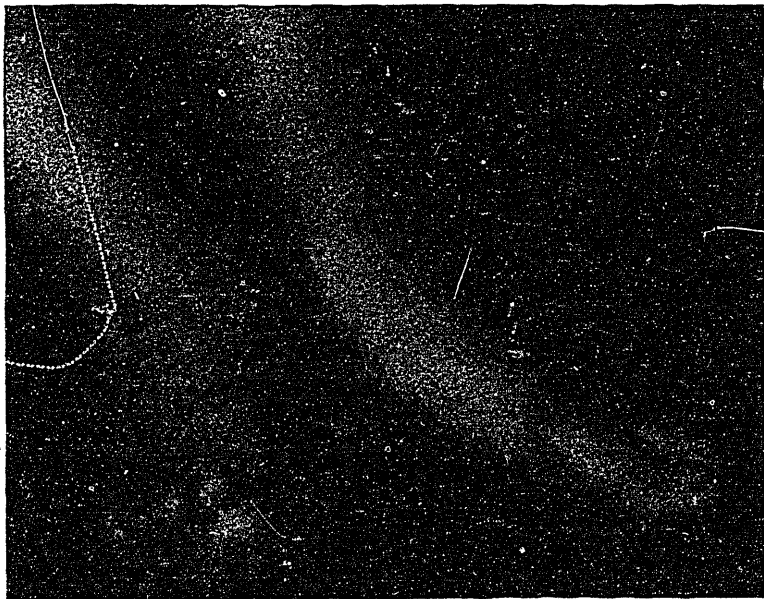
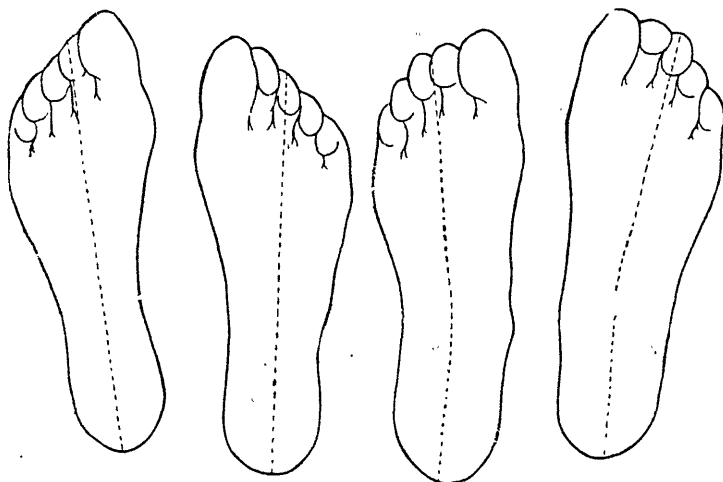


Fig. 3. Acquired Flat-Foot.

abnormal lowering of the arches, pronation, valgus. Any effort to establish a cure of the affection must aim at correcting the mechanical defect. While the arch remains broken down, and the weight of the body is permitted to fall upon the ligamentous internal and plantar supports, there cannot be the elasticity of step which is afforded by a healthy foot. Each of the other elements just named tends to exaggerate the defect in the arch, the valgus by removing outward the anterior limbs of the normal tripod of support, and pronation by removing the entire foot outside of the point at which the line of transmission of the weight of the body would reach the ground.

For the sake of presenting it tersely, the treatment may be presented under three heads.

(1) Forcible restoration of the foot to a normal position, or, rather, its over-correction. It has been pointed out that the attitude under consideration is one of weakness, whereas the opposite conditions, when present in normal degree, are positions of strength. Various methods of replacement have been employed. Ogston,⁴ of Aberdeen, has excised the head of the astragalus and procured ankylosis at the mid-tarsal joint, while at the same time he corrected the valgus by shortening the internal border, and also maintained during healing a properly elevated arch. Besides being an operation of considerable magnitude, this has the disadvantage of destroying the mid-tarsal joint, and the elasticity of the foot so greatly



Normal feet.

Slight valgus.

dependent upon its presence and integrity. Probably the best method of replacement is with the hand or the Thomas wrench while the patient is under anæsthesia, aiding, if necessary, by tenotomy of the peronei or other obstructing bands. In this way the correction should be so greatly overdone that the position of the foot will be changed from one of valgus, pronation, and flattened arch, to one of varus, supination, and exaggerated arch. The foot now should be encased in gypsum or other retentive dressing, having first protected it by a thick layer of absorbent cotton, and it should be retained in this for three or four weeks.

(2) After removal of the plaster, the most important part of the treatment is commenced—that which may appropriately be called *developmental*.⁵ Regularly, morning and evening, the foot should have vigorous massage and voluntary exercise for a period of half an hour. The masseur

should mould the foot into a position of adduction, supination, and of increase in curvature of the arch, while, at the same time, energetic kneading and rubbing is given, especially of the parts at the inner and plantar aspects of the foot and of the calf of the leg. Also voluntary efforts should be made by the patient to place the foot to the fullest degree in the same position of adduction and supination. A number of valuable exercises may be employed while in the erect position, among which raising the heel from the ground, turning the toes strongly inwards, and walking on the outer margin of the foot are the best. The bicycle may be employed as an excellent means of development of the inner and plantar structures. The weight of the body is removed from the feet, and in using the pedal properly a regular systematic exercise may be secured for those parts whose strengthening is most desired. In ordinary walking the toes should not be directed outward, but should be placed directly forward, affording in this way muscular support to the ligamentous power which sustains the arch.

(3) Mechanical support may be employed also to aid in keeping the rectified foot in position. As in all cases when orthopædic appliances are required, simplicity in construction and employment is a strong recommendation. Various forms of unyielding plates have been recommended, and have been employed with a measure of success; but there is one standing objection to their employment, viz., that the constant pressure on the structures at the inner margin of the foot and in the plantar region tends to produce atrophy of the very parts which it is our chief object to develop. It may be accepted as a principle that there is a standpoint viewed from which the application of all splints, braces, and orthopædic supports is wrong. Their use, however, may be the only mode of treatment available, or may be the one which is least objectionable. As the employment of a support in tuberculous disease of the spine or hip is generally the best treatment, and as it is sometimes justifiable in the treatment of roto-lateral curvature of the spine, so the use of rigid plates may in certain cases be the best means to employ in the mechanical treatment of flat-foot. A much better method; however, is a modification of that employed by the late Hugh Owen Thomas, of Liverpool. The shoe ought to be so constructed as to have the sole and heel at the inner margin elevated and projected inward, in order to increase the degree of supination of the foot. By this means the points of support are placed more nearly under the line of transmitted weight, and the condition of constant strain is relieved. The boot may be still further improved by making it upon a last curved inward from the instep, *i.e.*, made to correspond to a foot held in a position of varus. At the same time the arch of the last should be high, so that the shoe may give a support to the long arch

of the foot. This shoe, when compared with that which I have recommended for employment after the correction of ordinary club-foot,⁶ will be seen to embody exactly the same principles. It aids in maintaining the rectification in each of the three chief elements which constitute flat-foot, viz., pronation by elevation at the inner margin of the sole, valgus by the curving inward at the medio-tarsal joint, and direct support of the arch.

The application of these principles of treatment will vary according to the circumstances and conditions of the patient. There can be little question that the second—the plan of developing the weakened structures—is the most important factor in correction, especially as it finds ready employment in a large class of cases who greatly need treatment, viz., youths from five or six years upward, particularly girls. In these cases very great improvement or even a cure may be effected. In those whose age and circumstances render them less suitable for this treatment more dependence must be placed upon the mechanical treatment.

A careful study of each case, the removal of preventable causes, and a patient application of rational principles of treatment will afford much relief, or will cure the great majority of a class of cases whose management hitherto has not been found generally satisfactory.

(1) Quain's Anat., 9th ed., p. 132. McClellan's Anat., vol. 11, p. 327. Dane, Boston Med. and Surg. Journ., Oct. 27, Nov. 3 and 10, 1892. Cunningham, page 331, vol. 1.

(2) Orthopædic Surgery, Bradford & Lovett, p. 227. Whitman, New York Med. Journ., Feb. 27, 1892.

(3) Whitman, New York Med. Journ., Feb. 27, 1892.

(4) Lancet, Jan. 26, 1884.

(5) Roth, New York Med. Journ., June 16, 1888.

(6) McKenzie, Transact. Amer. Orth. Assoc., vol. 5, p. 203.

HISTORY OF A CASE OF RECURRENT NASAL FIBROMA.*

BY PRICE-BROWN, M.B.,

TORONTO.

MR. PRESIDENT AND GENTLEMEN,—I must request your forbearance with me for taking up your valuable time with the report of a single case. We all know how little weight can be attached to individual histories; and that it is only by accumulated evidence that we can be guided to a proper estimate of the value of clinical research. If this is true in reference to general practice, it is equally true of the wide range of subjects pertaining to our own special field.

Still, there are lesions in which the individual histories are so few, and the few so widely spread, over time as well as territory, that it would seem to behoove every observer to chronicle each instance as it occurs, with the hope of adding a fraction, however minute, to the information already possessed. This, I am inclined to think, is true of nasal fibroma, and, as the case I have to report presents several interesting features, I trust you will bear with me while I briefly detail its history.

On November 30, 1894, Mr. A. V. P., aged 22 years, stenographer, consulted me about a growth located in the posterior half of the right nasal passage. He was a hæmophilia. Had had no specific disease. Family history good. Both parents living and healthy. No relatives, so far as he could remember, had been afflicted with malignancy or tuberculosis.

Five years ago, he discovered a somewhat hard, dark-colored growth in the right nasal passage, just within the choana. His voice at the time was nasal, and it was almost impossible to breathe through the right naris. He consulted a specialist, who snared off a piece. This produced profuse hæmorrhage, which, however, soon ceased. At different sittings during the next few weeks, the snaring operation was repeated six or seven times. Each time the bleeding was severe.

As the tumor seemed to grow almost as rapidly as it was snared away, a microscopical examination was made, and the disease was pronounced

*Read before the Laryngological Section of the American Medical Association at Baltimore, May 1895.

to be sarcoma. On further consultation with general surgeons, it was advised that a portion of the right maxilla be removed and a silver plate inserted, the case being considered one of malignant disease.

This, however, his people declined to consent to, and he was sent to Boston and placed under the care of Drs. Packard and Macdonald, of the Homœopathic Hospital. He remained there two months, and during that time had several operations performed under ether. The nature of these he could not tell, except that they were intra-nasal, attended by exhausting hæmorrhages, and that the nostril, after each operation, was tightly plugged.

At the expiration of the period mentioned he was well enough to return home. The doctors told him that they had removed the whole of the tumor, with the possible exception of a little piece at the back end of the passage, upon which they did not think it advisable to operate at the time.

During the following summer he had, for months, slight daily hæmorrhages; but he spent the season in the country, and they eventually ceased. For the next three years he had so little nasal trouble that he did not think professional advice necessary. About a year ago, however, occlusion of the posterior end of the right nasal passage commenced to return; crusts would form which he found it difficult to void; and slight hæmorrhages would also sometimes occur. In November, the physician he consulted referred him to me.

Examination. The entrance to the right nasal passage was somewhat narrow, but immediately behind it was a wide, open cavity for about one-half the normal depth of the passage. There seemed to be complete absence of the inferior turbinated bone, probably removed by surgical operation in Boston, as already related. About an inch and a quarter from the anterior naris, the passage was completely filled by a bright, reddish growth, springing from the septum, the vault above and the middle turbinated. The attachment on the septal side extended down to the bottom of the inferior meatus.

The uvula was very long.

Posteriorly, the tumor filled the whole of the nasal cavity. It extended behind the septum, which it seemed to have pressed to the left. On the right it was attached all the way down to the floor of the naris, and lay immediately anterior to and continuous with the Eustachian tube. This tube occupied a plane considerably posterior to the left Eustachian, no doubt owing to the pressure of the tumor.

In other respects the health of the patient was of an ordinary character, with the exception already mentioned, that he was a hæmophilia. He told me that the extraction of a tooth would be followed by bleeding for hours, as also would the slightest cut or scratch.

The question of best method of operating in this case was difficult to decide. In so extensively sessile a growth with base convex from side to side snaring would be impossible, except in small fragments, and by following out Ingals' method of galvano-cautery notches, prior to adjusting the snare. His hæmorrhagic tendency also seemed to contraindicate treatment by this plan. Curetting, cutting away by knife or scissors, also seemed out of the question, on the same ground; as well as owing to the obscurity of the situation. Post-nasally, but a small portion of the growth could have been reached.

Directly surgical operation by excision of the superior maxillary and palatal bones did not seem to be required, as I did not believe these bones of themselves to be seriously involved. There was no external deformity; and the only displacement in the pharynx was a pressure downward of the right side of the soft palate.

Electrolysis I thought of, but, having had no personal experience of its effects in deep nasal work, I finally decided to endeavor to dissect it out, little by little, with the galvano-cautery knife.

On December 1st, I performed uvulotomy to facilitate post-nasal observation.

Two days later, after applying a 20 per cent. solution of cocaine, I made the first galvano-cautery incision, through the anterior naris, into the lower part of the tumor, at its union with the septum, continuing the burning until the hæmorrhage became somewhat severe. An astringent spray soon controlled the bleeding.

Several days later I repeated the operation in the same way, but at the outer margin of the growth, at the site of junction of the former inferior turbinated with the maxillary bone. The hæmorrhage this time was very severe, and I found it necessary to plug with kite-tailed tampons of absorbent cotton, packed solidly within the nasal cavity. This stopped the flow, and twenty-four hours later, upon removing them, there was no recurrence.

After an interval of a week I made the third attempt at galvano-cautery work, incising the central portion between the other two cuts. The electrode was of a bright red heat, and it had only been applied a few seconds when arterial blood commenced to jet forcibly out. The flow was so rapid that with difficulty I caught a glimpse of a large pulsating artery, laid bare and opened by the cautery. It seemed to run across between the septum and the external wall. Having had such a satisfactory result from the previous packing, I again resorted to it.

The patient lay down in my office, and for a few moments the bleeding was checked. Then it commenced again, escaping by the posterior naris, and soon became alarming. Dr. Reeve kindly came to my assistance,

and, after removing the plugs, I packed the cavity from behind by the use of Bellocq's cannula, having first soaked the sponges with a combination of tannic and sulphuric acids. This effectually stopped the bleeding, but the patient was almost pulseless by the time it was accomplished, and two hours later, when being assisted to a carriage, fainted.

This loss of blood confined him to bed for a week, and two others elapsed before he was well enough to proceed with operations again.

On looking up the literature of fibrous tumors of the air passages, I found that Kaarsberg, of Copenhagen, in 1894, recommended electrolytic treatment of fibrous tumors of the naso-pharynx, giving the history of four cases, the treatment being supplemented by the use of the galvano-cautery and scissors; and I decided to try it in this case of fibroma of the nose.

After applying a 20 per cent. solution of cocaine as in the cautery work, I used long needles, isolated by rubber tubing, and inserted through the anterior naris into the growth at a distance of about half an inch from each other. These were attached to a twelve-cell Leclanchè battery. The séances were about five minutes each, and given on alternate days.

Notwithstanding the anæsthetic effect of the cocaine the shock was very painful, even more so than that of the galvano-cautery. The effect upon the tumor was of a deadening nature, making the surface paler, and producing exudation. The shrinkage, however, was hardly perceptible. After using it through the anterior naris three times, I changed the direction of the electric current by passing a single straight needle into the tumor from the front, and a long curved needle through the mouth and naso-pharynx and into the growth from behind. This seemed to produce a more satisfactory effect. The central portion, both anteriorly and posteriorly, lost much of its vivid hue, though the shrinkage produced by four séances was still almost *nil*.

Hoping by this time that the electrolysis would have the effect of limiting the severity of future hæmorrhages, I again returned to the use of the galvano-cautery.

From January 18th to March 15th I operated with it at sixteen different sittings, each time applying the cautery as extensively as I thought I could do with safety. Sometimes there was no hæmorrhage; at others it was only slight; never severe enough to require plugging. Little by little the growth was destroyed. The first half of the operations were performed entirely through the anterior naris, the vision of the parts being obtained through the anterior rhinal speculum. The latter half also were done through the anterior naris, while the operations were guided by the use of the posterior rhinal mirror.

To complete the work, as the pharyngeal tonsil was somewhat protu-

berant, I removed it with Gottslein's curettes as a precautionary measure. The bleeding from the cuts was severe, but was checked without plugging.

In the cautery work the part found the most difficult to accomplish, and requiring the greatest care in manipulation, was the destruction of the part of the fibroid attached to the anterior margin of the Eustachian tube.

The supplementary treatment consisted of daily cleansings with alkaline sprays, followed immediately by removal of crusts, sloughs, etc., with the aid of cotton holders, and finishing with spray of albolene.

Twice over I had sections of the tumor examined by a competent microscopist. He pronounced it a dense, close-grained fibroma.

With regard to the physical condition of the patient, the course of treatment was very satisfactory. With the exception of the time lost as the result of the excessive hæmorrhage, he never lost a day from his professional duties. The operations were always done in the evening. Sometimes he would be restless and suffer pain during the following night ; but he could always take a light breakfast, and would go down to his office the morning afterwards. During the latter half of the treatment, notwithstanding the amount of cocaine used, he improved in weight as well as in color and spirits, and, I am glad to say, without acquiring the slightest craving for the drug so frequently used.

One notable feature in the history of the treatment was the extent to which the palate resumed its natural functions. At first, being pressed out of position, it had no control over sprays thrown into the nose, and would allow them to trickle over and drop into the larynx, with paroxysmal coughing as a result. Latterly this accident would never occur, and the nose might be filled with fluid without any escaping into the lower pharynx. In fact, the control over the velum acquired by the patient aided very materially in the treatment of the case, and during this period he appeared before the Toronto Medical Society, so that the members could examine the tumor while still in the process of removal.

I have called this a case of recurrent nasal fibroma, believing that the original attack, from which the present one must have developed, was really fibroma instead of sarcoma. That the former may degenerate into the latter is, I believe, a recognized pathological fact, but that a malignant growth should be the parent of a benign one is certainly open to question.

What the future of the case may be it is impossible to say. At present there is no indication of any tendency to return. A new mucous membrane has reformed. The throat is moist, and the voice normally resonant. Still, that it has been completely and finally eradicated seems almost beyond hope. The case, though interesting, is too recent to base a correct conclusion upon, and I shall watch the future history with more than ordinary solicitude.

SOME REMARKS ON PNEUMONIA, WITH A REPORT OF AN INTERESTING CASE.*

BY REGINALD BRAY, M.D.,
CHATHAM.

IN appearing before you to day to make some remarks on pneumonia, and to give you a report of an interesting case in practice, I feel rather out of place, because I see about me so many men who are older in years and in time of service; men who, if they would, could probably relate some very interesting cases and experiences; men of tact and originality, of pluck and perseverance; but men who are modest, retiring, and not fond of appearing in public, or forcing themselves and their cases upon a gathering such as we have here to-day; and as more of these men who have interesting cases do not often give expression in public to their views, owing to the active and busy life which they lead, and feeling that when they do take a holiday they would rather hear than be heard, this must be my only plea in craving your kindly indulgence and attention for a few minutes.

Pneumonia. By this we mean inflammation of the lung tissue, characterized usually by sudden onset, fever, cough, expectoration, and dyspnoea, by the physical signs of pulmonary consolidation, namely, engorgement, hepatization, and resolution.

Symptoms. The invasion is, in almost all cases, preceded by a chill or rigor, generally single, and of a severe character, more so perhaps than in any other disease. After the rigor we have fever, and then the symptoms which point to the lung affection, and enable us to make a diagnosis, which are pain (generally, though not always, present so early) in the side, dyspnoea, and a dry, tight cough. These symptoms gradually increase in severity, and are accompanied by accelerated pulse, thirst, and prostration, the dusky face, anxious expression, and hurried respiration, and when we find a patient in this condition our diagnosis should be complete.

Physical signs. We all know that the earliest physical signs are usually to be found in from thirty-six to forty-eight hours. The first abnormal

* Read before the Ontario Medical Association, Toronto, June, 1895.

sign—physical sign, I mean—which we find is an impairment of the respiratory movements on the affected side. This is owing partly to the pain, and partly to the diminished elasticity of the lung tissue. Percussion at this time is not markedly altered. The vocal fremitus is increased, and now we come to the most important sign, crepitation, which consists of a series of fine, dry crackling sounds, and which is due to the air trying to force its way through the air vesicles. The rate is almost always limited to respiration, and is intensified by deep inspiration and coughing. During the stage of hepatization the fine crepitation ceases, the diminished expansion of the lung is retarded, the vocal fremitus may or may not be altered, the percussion sound becomes diminished in tone, there is increased resistance and bronchial breathing. When a case passes the crisis successfully, we have resolution taking placē. This process usually commences in the part of the lung least affected, and the earliest and best sign is the return of crepitation, but crepitation of an altered character, not fine in quality, but rather larger, coarser, and liquid in character; the bronchial breathing loses its ringing metallic quality, the percussion dullness gradually disappears, and the respiratory movements become normal in character. These changes gradually show themselves in a few hours after the crisis.

History of case. The history of the case which I want to bring before you is as follows:

R. M.; foreman in a paint shop; complained on Friday, March 22, 1895, of a slight cough, with some pain in the chest on waking, but he got up, dressed, and went to work as usual. Feeling poorly during the morning, he took a teaspoonful of turpentine, but shortly after taking it he felt rather queer, so went home about 11 a.m. Having a patient in the house at the time, I called in about 2 p.m., when I saw the patient whose history I am now relating. He felt a little out of sorts, but had no fever, and pulse was good; the only thing he complained of was a soreness over the lower part of the abdomen. I advised him to lay off work, but he did not do so, going back to the shop at 2.30 p.m. During the afternoon this soreness became very much worse, so much so that he quit work at 5 o'clock. I was sent for about 7 p.m., and when I arrived I found the following condition: Temperature, 104°; pulse, 112; respiration, 26. A good deal of pain in right side was complained of, but no physical signs of pneumonia. I gave him antikamnia, grs. 2; quinia sulph., grs. 3, to be taken every four hours. I also ordered 8 grs. of Dover's powder when the pain was severe, and linimentum chloroformi to be applied to the chest, rest in bed, moderate warmth, and milk diet, and said I would call in the morning. I did so about 9 o'clock, and found temperature 102½°, pulse 104, respiration 26. Pain in side much

more severe, but not much cough. Bowels moved during the night, and urine was about normal in quantity. He continued in this condition all day, and I continued the same treatment. On Sunday, the 24th, the temperature was 102° , pulse 100, respiration 24. Pain in side still very severe, cough tight, tongue thickly coated, and rusty sputa present. He also complained of a great deal of pain and tenderness over the pit of the stomach and upper part of abdomen. I continued the same general treatment, also ordered patient put in cotton-wool jacket after the liniment had been applied, and hot dry cloths over stomach and abdomen. He continued much in this condition until Tuesday, the 26th, when the left lung became affected, the temperature rose to 104° , pulse 118, respiration 28-32. I ordered stimulants, and decreased the quantity of antikamnia and quinine to 1 and $1\frac{1}{2}$ grains respectively. All day Tuesday, and Wednesday until 4 p.m., his condition was as above described. At 4 p.m. the temperature became subnormal, pulse dropped to 108, respiration 26. He had a short sleep, and at 10 p.m. was quite comfortable. During the night he took a turn for the worse, and became delirious, talking almost incessantly and throwing himself from side to side in the bed. When I saw him in the morning early, I stopped the antikamnia and quinine, as the temperature was subnormal, and gave a little more whiskey, owing to diminished heart's action, and gave also strychn. nitrate, gr. 1-60, every three hours. This condition lasted all day Friday and Saturday; and, hoping to quiet him, I ordered pot. brom., 2 dr. ; chloral hydrate, 1 dr. ; aquæ ad., 4 oz., a teaspoonful every three or four hours. This had no quieting effect whatever. On Sunday afternoon, the 31st, his condition was so critical at 4 o'clock that I called in Drs. F. and B. in consultation; they agreed that the outlook was bad, but could suggest nothing except an increase in the dose of the strychn. nitrate. On Sunday evening I stopped the whiskey and increased the strength of the bromide and chloral mixture, but he continued to grow weaker and wilder every hour, even going so far as to jump out of bed and make for any one who might be near. This condition continued all day Monday. On Monday evening, the 1st of April, I saw him about 11 o'clock, and his condition was as follows: Temperature subnormal, 96.3° pulse 120, respiration 22, bowels not moved for two days. I ordered a double dose of the bromide and chloral mixture, to be repeated in one hour; counter-irritation to the feet, cold cloths to the head, body sponged with tepid water and whiskey, and told the family that unless he got sleep before morning he could not recover. The nurse followed my directions faithfully, and about 1.30 a.m. he quieted down, stopped his rambling speech, pulse became stronger and slower, and he went into a doze. He slept (not soundly) for about thirty minutes, when he woke. The nurse gave him some milk, and in a few minutes another dose of the mixture.

Very shortly he went to sleep again, so that by 8 a.m. on Tuesday he had slept two and a half hours. This was the first sleep for five days and nights. When I saw him at 9 o'clock his temperature was subnormal, pulse 96, respiration 20, mind perfectly clear, bowels moved with an injection, and general condition was much improved. I ordered $\text{r}\frac{1}{2}$ table-spoonfuls of whiskey in a glass of milk, to be taken every fifteen minutes; also continued the strychn. nitrate, grs. 1-60, every three hours. From that time on his condition continued to improve, and after two days his pulse was stronger and slower, tongue quite clean, no headache, but a great desire for sleep. Decreased the stimulants, and ordered beef tea, broths, etc., to be given him in small quantities, but frequently. On the tenth day I allowed him to sit up in bed, and on the seventeenth day to sit outdoors. He has been on the mend ever since, and now, May 7, is back at work, better than before he was taken down. I might add that I examined his urine at different periods, but could find nothing abnormal either in quantity or constituents. To me the interesting feature of the case was the marked delirium, continuing for five days and nights without a break, coming on after the temperature became subnormal. I cannot account for the change for the better occurring so suddenly, but would be pleased if any one present can give me a solution of the difficulty.

Progress of Medicine.

THERAPEUTICS

IN CHARGE OF

GRAHAM CHAMBERS, B.A., M.B. Tor.,

Professor of Analytical Chemistry and Toxicology, Ontario College of Pharmacy; Lecturer
in Organic Chemistry and Toxicology, Woman's Medical College;

AND

WILLIAM LEHMANN, M.B. Tor.,

Physician to the Home for Incurables and House of Providence.

KONIG-MAAS'S METHOD OF RESTORING PERSONS APPARENTLY DEAD FROM CHLOROFORM.

The following is a description of the method as practised at the Göttingen clinic: The operator, standing on the left of the patient and facing him, places the ball of the thumb of the opened right hand upon the patient's chest, between the place of the apex beat and the sternum. He then repeatedly presses in the thoracic wall with a quick, strong movement, at the rate of about one hundred times per minute. The results by this method have been very satisfactory.

HEPATIC COLIC.

The Paris correspondent of the *Medical Press and Circular* states that Ferrand made the following statement in his lecture:

(1) The gallstone is formed of a hard and chalky substance called cholesterine and divers coloring matters. Chemically, it is ranked among the alcohols, while physically it is a stone of varied form and dimensions. The first question that imposes itself is, Have we at our disposition therapeutic agents capable of acting directly on the calculus, either to dissolve it or break it up? The ancients would answer in the affirmative, for they had a series of medicines which they called lithotritics, because they attributed to them the power of dissolving the calculi. But it is well known to-day that these agents possess at most a preventive action on the

formation of these bodies. The writer made some very conclusive experiments in that direction with chloroform, ether, turpentine, and glycerin, and the results in each case were negative.

(2) If, however, we are disarmed against the gallstone in the first element of the malady, is the case the same with the other elements? As soon as the calculus has got stuck in the duct, the course of the bile is arrested, and accumulates above the obstacle, distends the gall-bladder and the biliary canals, producing, as a consequence, turgescence of the whole organ and more or less congestion of the liver, which, not yet disturbed in its intimate structure, continues to secrete the bile, although in less quantity than in the normal condition. But as soon as the tension increases in the biliary ducts, the calculus is pushed forward by the current and falls, not infrequently, into the intestine. The fact of the expulsion of the stone by tension of the bile forms the basis of expulsive medication. We have consequently to seek those agents which, by increasing the biliary secretion, can facilitate the expulsion of the foreign body, and the substances corresponding to this indication have received the name of cholagogues, in the first rank of which may be placed glycerin. Among others may be mentioned olive oil, administered in large doses. Chauffard advises ten ounces to be taken, but Willemin considers such massive doses unnecessary. In what way the oil acts is as yet an open question. Stewart thinks that it is converted into glycerin and saponifying matter in the intestine, while Willemin believes that the substance does not undergo this change, but by some reflex action arrests the spasm of the biliary ducts and the pain caused by the spasm.

Salicylate of sodium is a cholagogue which produces an abundant biliary flux. In many painful cases, where the kidneys were sound, the author obtained good results from this agent. The same may be said of chloroform and ether, both of which can give by reflex action a considerable increase in the biliary secretion. Calomel, so frequently employed as a purgative in hepatic colic, deserves special mention. This salt not only acts in an indirect way on the liver in provoking an increased secretion, but also as a direct stimulant on the hepatic cell. Mercury salts—more, perhaps, than any of the other metallic salts—are arrested in the liver, producing by accumulation the stimulating action which gives to calomel the properties of a cholagogue so universally admitted.

A few alkaloids, recently discovered, supposed to be beneficial in such a case, are podophyllin, euonymin, iridin, baptisin. Of the four, the first two only can be counted as evacuators. Benzoate of sodium and lithine have been also recommended.

(3) The third indication resides in the painful spasm of the hepatic colic, and the treatment must be directed to that symptom. Naturally,

opium and its preparations take the first rank in this direction, and more especially morphine combined with atropine in subcutaneous injections. Belladonna does not diminish the biliary secretion, and provokes the contraction of the organic muscles, and by this means favors the expulsion of the calculus. Chloroform and ether have been given internally with much benefit, while external warm applications are found by the patient to be very soothing. Enemas of cold water have been used very freely, in order to stimulate the peristaltic action of the intestine, but enemas of senna tea, followed by enemas of valerian root, or some other anti-spasmodic agent, are to be preferred.

(4) There is yet a fourth indication. To treat the congestion incident to hepatic colic, recourse should be had to emollients, poultices, or warm fomentations, and, when these are not well borne or do not succeed, friction with chloroform or opium liniments may be tried. If the inflammation does not yield to this anodyne treatment, leeches, followed by blistering, and small doses of calomel, should be ordered. To resume :

First Indication.—No means at our disposal.

Second Indication.—Glycerin, olive oil, salicylate of sodium.

Third Indication.—Injections of morphine, associated with atropine, chloroform, or ether internally ; poultices or warm fomentations.

Fourth Indication.—Poultices, frictions with sedative liniments, leeches, blisters, calomel in small doses, intestinal antiseptics.—*Therapeutic Gazette.*

TREATMENT OF THE ITCH.

Friction is not easily endured by children, as it irritates their delicate skin. M. Feulard (*Rev. Int. de Méd. et de Chir. Prat.*, December, 1894) prescribes the following to replace it :

(1) Applications to the regions which are generally the seat of the disease with the following pomade :

R. Adepis, ℥vi.
Balsamo Peruvianæ, ℥v.
Naphthol, ℥i.

(2) The following day this should be washed off with soap and dusted with almond meal.

(3) This treatment is continued for two or three days, the cutaneous irritation being calmed by the following ointment :

R. Vaseline, ℥i.
Zinc oxid., ℥i.

—*Therapeutic Gazette.*

SURGERY

IN CHARGE OF

L. M. SWEETNAM, M.D. Tor.,

Lecturer on Therapeutics in the Woman's Medical College; Surgeon to the Outdoor Clinic, Toronto General Hospital; Surgeon to St. Michael's Hospital;

AND

A. PRIMROSE, M.B., C.M. Edin.,

Surgeon to the Hospital for Sick Children, etc.

SURGICAL PHOTOGRAPHY.

Modern photography has not taken the place that it deserves in surgical practice as an aid in the recording and registration of cases. In the old wet-plate days the making of a negative was a matter of much labor; and to do it satisfactorily presupposed no small amount of experience and skill on the part of the operator. Nowadays, with dry plates and films of extreme rapidity; with ateliers everywhere where the mechanical parts of the process can be done; with electricity and flash lights which render skylights unnecessary, and make us independent of the sun; and with the expense incidental to the process reduced to a trifling sum, it is a marvel to us that a camera is not an adjunct to every operating room and surgical clinic. What verbal picture can reproduce a lesion, a deformity, a tumor, like a photograph? What record in words can have the effect of a photograph before and after operation? What description can tell so much as accurately as does the sensitive plate? A photographic record, as it can now be made, would be invaluable to the surgeon for recording and keeping track of his cases, as well as for his more strictly scientific work.

It is perfectly possible to do so with an inexpensive camera and lens and a few plateholders. All the rest of the work, developing, printing, toning, and mounting, is now done so cheaply that it hardly pays the amateur, unless he desires to do the work, to undertake it himself. He focuses his camera and exposes his plate, and he obtains a record far more valuable than one in words could be, more especially since the personal equation is entirely eliminated from his description.

For the best kind of work, of course, elaborate apparatus and great technical skill is required; but ordinary photography any amateur can accomplish. How great is the advantage of the surgeon who is a

draughtsman ; yet what draughtsman does work that can begin to compare in accuracy and rapidity with the very smallest and roughest blue print ?

We firmly believe that the time will come when the camera will be as necessary and universal an adjunct to the work of the careful surgeon as his case book is ; and when, light painting being so easy, verbal descriptions of external lesions will be looked upon as insufficient and misleading. —*International Journal of Surgery.*

ANTIPYRIN IN SURGERY.

In the *Philadelphia Medical News* of December 15, Dr. Roswell Park again calls attention to the value of antipyrin as a styptic. He has made frequent use of it since 1885, and does not hesitate to pronounce it the most valuable styptic we have, and an antiseptic as well, comparing "very favorably in this respect with most of the aniline or coal-tar derivatives that we use in medicine." He employs it most frequently in a five per cent. solution, in sterilized water, as a spray, and does not hesitate to use it in the peritoneal cavity, or upon the surface of the brain. He says : " I have found that antipyrin has power, not sufficient to contract vessels of any size that spurt, but to almost instantly blanch and check oozing from any surface from which blood is escaping just fast enough to be an annoyance." " It may be injected into a cavity, as in bone ; it may be applied on compresses to the oozing surface, or it may be sprayed as mentioned ; but, no matter how applied, under circumstances indicated within the limits given, it will seldom, if ever, be found to disappoint." He has found it, bacteriologically and in practice, antiseptic, and it is practically unirritating. It is especially valuable in operations within the nose, mouth, urethra, and bladder.

The remarkable analgesic properties of antipyrin, locally applied in inflammation of mucous membranes, have been pointed out by Hinkel (*New York Medical Journal* for October 28, 1888), Vigneron (*Concours Med.*, August 11, 1894), and others. We shall be glad to have reports from other surgeons who have used it, and especially pleased to know if it can be used without harm about the eyes. If so, it will prove a great boon to the ophthalmologist in some operations upon the eye and its appendages, which are often rendered very tedious and difficult by the presence of even a small quantity of blood.—Editorial in *The Railway Surgeon.*

A CASE OF TETANUS, WITH DEMONSTRATION OF BACILLI, TREATED WITH TETANUS ANTITOXIN.

A case is reported (*New York Medical Record*, 1895, xlvii., 5) by W. Gilmour Thompson. The patient was a boy, aged 13, who, three weeks before admission to hospital, had been injured by stepping on an iron fence spike, which penetrated his shoe, making a wound in the ball of the right foot. Symptoms of tetanus appeared five days prior to admission, and sixteen days after the injury. The diagnosis was confirmed by finding specific bacilli in scrapings taken from tissue about the hole in the boy's foot. On the thirteenth day of the disease injections of anti-toxin were begun, and continued daily, the dose varying from a half to one c.c. daily for five days. Recovery was complete.

ASEPSIS VS. ANTISEPSIS.

The Lancet, in its article "The Annus Medicus, 1894," refers to the general tendency at the present time in the treatment of operation wounds to aim at asepsis, as opposed to antiseptis. This is very evident to those who are working in the field of surgery, and the time will be welcomed when it will be considered safe to operate without the necessity of bringing irritating antiseptic materials in direct contact with fresh wounds. Methods of sterilization of instruments and dressing, etc., must, however, be more efficient and trustworthy before we can, with safety to our patients, omit in all cases such safeguards as irrigation with carbolic acid or perchloride of mercury.

The article referred to also calls attention to the fact that intravenous injections of saline solutions is steadily growing in appreciation, but chiefly in regard to cases where the fall of blood pressure is due to an excessive loss of blood, and not merely to collapse.

Editorials.

THE AMALGAMATED JOURNALS.

THE lion and the lamb have lain down together. All our nice ideas about welcoming a new subscription journal from the ranks of the purely and solely advertising sheets, as expressed in an editorial in February, have been dissipated, and the *Dominion Medical Monthly* has reverted to a purely advertising journal, and absorbed its competitor, the *Ontario Medical Journal*.

The little advertisement referred to in February has been remodelled, and the post-office authorities might explain why a free circulation journal (in Ontario, British Columbia, and the Northwest Territories) is allowed the same privileges as subscription journals.

Things are still done in style, and the *edition de luxe* is sent to advertisers only, while the *edition de ordinaire* is scattered broadcast amongst the profession, and by most of them relegated to the waste-paper basket.

Whether the *Ontario Medical Journal* had the power to assign its contract for council printing to a tenderer who was below them in price or not, we are not sure, but it appears as if it had.

Time will show how this new deal will turn out, but the profession and the best class of advertisers are averse to purely advertising sheets and possibly some of them have not been made aware of all the peculiarities of the case, and maybe some are still under the delusion that an American edition is published. *Verbum sap.*

THE PATRONS' MEDICAL BILL.

WE have received a copy of the *Seaforth Sun*, which contains a sensible article on the most remarkable of modern productions—the Patrons' Medical Bill—which was so ignominiously crushed when it came before Parliament. It will be remembered that only one member outside the Patron party voted for it. This wise legislator was Mr. Murdo Y. McLean, of Seaforth, South Huron riding. The *Sun*, in the

article referred to, disapproves of Mr. McLean's course, and supports the attitude of the immense majority who voted against the proposed bill.

We note with pleasure that the profession of Ontario are practically a unit on this question, and have shown a determination to bitterly oppose a movement which would necessarily lead to degradation and dishonor. To us, as physicians, there is no question in provincial politics which is at all comparable with an infamous effort to destroy everything like honesty, respectability, and decency in our profession. We acknowledge that the profession of medicine is not perfect, but are glad to add that a majority of its members desire to see it go forward rather than backward.

It is very important that physicians, in discussing this question, should endeavor to enlist the sympathies of the public. As a matter of fact, our interests are one. As our standards become higher, our doctors become better morally, and in every other way; and the public, especially the sick poor, receive the benefit. It is not in the interest of the public that our status should be degraded in any way. It is not in the interest of the public that women in labor should be left in the hands of uneducated midwives. It is not in the interest of the public that any difficulties should be thrown in the way of punishing conduct that is "infamous or disgraceful."

THE MEDICAL COUNCIL AND THE PUBLIC.

THE lay newspapers (very good papers they are, by the way) of Huron county appear to be taking a good deal of interest in medical politics. We have received a *Huron Expositor*, July 26, containing a letter from the able and worthy representative for that district in the council, Dr. Graham, of Brussels; and, in addition, an editorial in reply to the same.

From this editorial we quote briefly as follows: "The Medical Council, if it is, what is claimed for it, a body composed for the protection of the people . . . should be, in some way, as directly under the control of the people as possible. We say that the people, either directly, or through their chosen representatives, should have some voice in the composition of that body; it should also be subject to the control of the people, either directly, or through their representatives in the government; its legislative acts should be submitted to, and should receive the approval of, the government before they become operative."

We have no objection to raise against the principles involved in these sentences. They are substantially correct. We might add: The Council was organized in the interests of the profession as well as the public. We have no doubt the government, representing the public, established the

Council with these objects in view—the interest of the people being the first or chief consideration. The government had not simply “some voice in the composition of that body”—it had the whole voice. The government can amend or annul the Act governing the Council at any time. We can scarcely see how the interests of the people can suffer unless parliament wilfully betrays its trust. At the last session of the Ontario Legislature a determined effort was made to pass radical amendments to the Act referred to—not in the interests of the public, but in the interests of, and with the assistance of, notorious and dishonest charlatans.

After all, there is not much difference of opinion between the *Expositor* and ourselves. We agree on the general principles involved, we differ on details. We know of no better system for the governance of the medical profession than our own. We believe it is becoming more popular with both the profession and the public,—as is evidenced by the decisive vote of last session in parliament. Its continued popularity largely depends on the acts of the Council and the profession. Any attempts in the direction of a prohibitive standard, or efforts to favor physicians in any way at the expense of the public, will be not only resented, but will be certainly defeated. Certain expressions of opinion on such matters have to some extent alarmed the public, but the actions of the Council at its last session did much to remove such fears. The *Expositor* will find out, after all, that it is to a large extent a matter of details (but not “quibbling about words”). Let it carefully study the course of the honest and conscientious local member in the Council, Dr. Graham, and we think it will discover that he is ever actuated by a desire to ennoble the profession of medicine, to endeavor to increase its efficiency, and thereby to make it more useful to those who are sick—whether they are rich or poor.

THE JAMES CASE.

THE circumstances surrounding the death of Miss James show that when a respectable doctor takes charge of such a patient he assumes grave responsibilities, with, sometimes, serious risks. After the death of Miss James, we learned from the newspapers that the detectives worked up the following chain of circumstances: A young woman went to Dr. Lehman's house for treatment. He at once provided a quiet boarding house for the stranger. The woman owning the house was to take care of her. The doctor made several visits. The patient grew worse. Another doctor had to be called in. An operation was performed. The patient died five or six days after the operation. The lover told some person that the doctor ought to have done his work better, as he “got forty dollars for

the job." The post-mortem examination showed that death was caused by septicæmia, pregnancy had existed, the contents of the uterus had been removed, and the cervix had been lacerated. A few embellishments skillfully added, with sensational headlines, and numerous and various mysterious phrases, made a pretty clear case.

The evidence at the inquest brought out the following facts: A young woman who had been teaching school in the west was passing through to her home east of Toronto. Feeling ill, she went to a doctor—the first she could find—Dr. Lehman. She told the doctor that she was too ill to continue her journey, and would like to be directed to a boarding house. He did not make a positive diagnosis, but suspected appendicitis or typhoid fever. He found a boarding house, kept by a woman in whom he had confidence, where he had before sent patients, both male and female—none for accouchement, however. In a few days he discovered pregnancy, and, the symptoms being serious, he sent for Dr. E.E. King in consultation. As there were severe rigors, an offensive discharge, high temperature, and rapid pulse, they decided to empty the uterus. Chloroform was administered, the cervix dilated with great difficulty by fingers and steel dilators, and a putrid foetus, which must have been dead two or three weeks, was delivered. Appropriate treatment was carried out, but patient died about six days after. She had been in the house altogether about eleven days. Two days before her death she paid, without solicitation, on account, forty dollars, thirty-five to the doctor for himself and consultant, and five dollars to landlady. Dr. Lehman and the landlady were extremely frank in giving evidence. The pathologists showed that septicæmia must have existed some time (before Dr. Lehman saw her). All the direct and all the collateral evidence went to show that Dr. Lehman was absolutely guiltless of anything criminal, immoral, or unprofessional in the slightest degree. The jury did exactly the right thing by embodying in the verdict a clause completely exonerating Dr. Lehman from all blame.

THE MONTREAL MEDICAL JOURNAL.

WE are exceedingly pleased to see our contemporary, the *Montreal Medical Journal*, appear in a new and enlarged form. The change is a great improvement, and will undoubtedly be appreciated by its patrons. The price has been advanced, but the advantages anticipated will more than recompense the subscriber for the extra dollar. We wish the *Journal* every possible success.

THE DOCTOR IN FICTION.

THE doctor or surgeon often appears in fiction. In former times he, not infrequently, was represented as an ignorant and bumptious character. As the profession has advanced in the gradual process of evolution, aided by increased knowledge of science, the doctor has advanced to a higher plane; he has sometimes been painted in colors that are rather flattering to our guild—sometimes, *otherwise*.

Ouida has given us a story in the *Illustrated London News*, entitled "Toxin"—perhaps in imitation of Grant Allen in "The Devil's Die"—in which she tells us about a wicked English surgeon, named Damer, who, after saving the life of an Italian prince, stayed with him until a beautiful woman appeared on the scene, and captured the affections of both surgeon and prince. The prince happened to be attacked with diphtheria, and the surgeon put an end to the sufferings of his rival by administering a dose of the "venom of the toxin," under the name of antitoxic serum. The *British Medical Journal* says: "The story is as silly as Ouida's productions usually are, but with that we have no concern. What we do protest against is that a scoundrel like Damer should be presented as the type of a scientific surgeon. There can be no doubt as to the purpose of Ouida's story; it is an attack—feeble and futile, it is true, but most malignant in intention—on the medical profession. . . . When she speaks of the 'hills created by modern science,' and of the time being near at hand 'when there will be no kings but those of science, and beneath their feet the nations will grovel in terror and writhe in death,' she merely talks nonsense; but when she represents the search after scientific truth as naturally leading to crime, she utters an infamous falsehood."

Among the many good Scotch novels which have lately appeared is one by Ian MacLaren, entitled "Beside the Bonnie Briar Bush," which contains a series of pretty stories, including one under the title of "General Practitioner," or a "Doctor of the Old School," giving a description of the life of Dr. MacLure in the Parish of Drumtochty. It is a most beautiful and touching story, giving various details of MacLure's life work, which are extremely interesting. He paints MacLure as a hero of the highest and noblest type, who lived and died for his patients, whom he loved—who were wife, and family, and all the world to him. The tone of Ouida's story is bad, debasing; the tone of MacLaren's story is good, ennobling. We prefer MacLaren, and appreciate the compliment he pays to our profession in making his brightest and noblest character a physician. To our readers we may say: If you read the book, you will do so, we believe, with pleasure and profit—but not with *dry* eyes.

BACTERIOLOGICAL CONVENTION.

ON the 21st and 22nd of June there were held in the building of the New York Medical Academy a series of meetings, the results of which, in the field of bacteriology, will probably be most far-reaching and useful. A convention of bacteriologists from all parts of America was called last year by the American Public Health Association, in order to consult with regard to many questions which are of prime importance in bacteriological work. The primary object of the convention was to determine to what extent and by what means uniform methods of work might be followed in the study of the bacteria of water, but the results will probably be much more wide-reaching, affecting bacteriology in all of its applications. So far as we know, this is the first convention of the kind that has been held, and the necessity for such a meeting and for future reassemblings of the workers engaged in bacteriological research was amply demonstrated at an early stage of the proceedings.

Any one who has given even slight attention to the subject must have been struck with the lack of uniformity of results in the study of the same organisms by different men, and, indeed, by the same men at different times. This, to the ordinary observer, seems the more unaccountable since text-books in bacteriology lay down with a degree of precision methods to be followed in laboratory work. Attendance at a single session of this convention showed where the trouble lay. It would appear, too, that a great part of the difficulties in the way of the worker can be removed with comparatively little trouble.

To Dr. Smart, of the Surgeon-General's Department, Washington, together with Professor Adami, of McGill College, Montreal; Mr. George W. Fuller, of the Lawrence Experiment Station, Mass.; and Dr. Wyatt G. Johnston, of the Board of Health, Montreal, belongs the credit of having called the meeting and arranged the programme. The chair was occupied by Prof. Welsh, of Johns Hopkins University. The papers read were all of merit, and will be published at the proper time. We do not propose to give even an abstract of any of them, but may sum up the results in a word.

All of our present media, and many of our methods, are unsatisfactory in some respects. It will be necessary for purposes of comparison that media and methods be exactly the same in all laboratories, and that variations be accurately controlled. As things are at present, these conditions are far from being fulfilled. For example, one worker secures the reaction of his media by means of *one* chemical, another by *another*; one uses titration methods in fixing reaction, another works in a much rougher way. Again, the materials used may differ greatly in composition; for example,

one laboratory uses Sargent's peptone, another Witte's, and analysis proves that they differ from one another. Many examples could be adduced to show the necessity of change in our ways. It would seem that media prepared synthetically, chemically pure materials being used, must come into vogue before long. Mr. McKenzie's paper recorded some very interesting work in this direction.

The chief practical result of the meeting was the appointment of a committee of eight leading men to answer certain questions and suggest ways of overcoming the difficulties spoken of. Their work will be looked for with considerable impatience by bacteriologists—in America, at least.

THE BUFFALO MEDICAL JOURNAL.

THE jubilee number of the *Buffalo Medical Journal*, published this month, reflects much credit on both publishers and editors. As we informed our readers in our issue for April, this journal is fifty years old, having been established in 1845 by the late Austin Flint, M.D. It was the first journal established between New York and Cincinnati or St. Louis, and proved a success in all respects in a very short time. The jubilee number contains a very interesting special article, written by Dr. William Warren Potter, giving the history of the journal for the fifty years, involving, as a matter of course, a history of the medical profession and medical colleges of Buffalo during that period. Again we extend to Dr. Potter our sincere congratulations, and best wishes for continued success in the future.

KENT COUNTY MEDICAL ASSOCIATION.

A MEETING of this association was held at the Garner House, Chatham, July 10, 1895, of which an excellent report appeared in the *Chatham Daily Planet*. Dr. Bray, the representative of Division I. in the Ontario Medical Council, gave a brief report of the proceedings of the June meeting of that body, which was apparently well received by those in attendance. He dwelt especially on the collection of the annual assessment, which is, at least, one of the most interesting subjects for general practitioners to consider, and was very fully discussed in the Council. Dr. Bray also referred to discussions on various matters of finance, the expenses connected with salaries, the building, and the work of the Discipline Committee.

We will not here attempt to discuss any portions of Dr. Bray's address to his constituents. He expressed his views in the Council on all subjects that came up for consideration, and they are recorded in the Council's Hansard. We simply desire to call attention to the fact that Dr. Bray took the earliest possible opportunity to explain to his constituents the exact position of many vexed questions, from his point of view, at a time when there was considerable excitement in medical politics in this province. His course in thus acting was a wise one in every respect, and worthy of imitation by his brother members. We are glad to know that the increased interest taken in the Council's proceedings is likely to be permanent and intelligent in character. Those members of the Council who endeavor to explain to the professional public all matters of interest to physicians, calmly and dispassionately, without any appeal to passion or prejudice, are likely to accomplish much good.

THE CANADIAN MEDICAL ASSOCIATION.

THE provisional programme for the next meeting, to be held August 28, 29, 30, has been sent to the members by the secretary, Dr. Starr. It will be seen by it that the meeting will be held in the Convocation Hall of Queen's University. We learn from Dr. Starr's circular the following points: A member should purchase a ticket for Kingston from the station agent at the place of departure, and get from him a standard certificate (which is a receipt for one full single fare). When registering at the meeting leave the certificate with the treasurer, and it will be returned, signed by the secretary, on the morning of August 30. This certificate, when presented to the station agent at Kingston, will entitle the bearer to a ticket to his destination (1) for one-third of the single fare, if there are 50 or more holding standard certificates; (2) free of charge, if there are 300 or more holding such certificates. These rates refer to delegates and their wives. Arrangements have been made with the hotels for special hotel accommodation. Rates per day: Frontenac and British American, each, \$2.00; City, \$1.50.

The Ontario Medical Council.

(Concluded from la

Tuesday, June 25.

NO MEDICAL TARIFF.

Dr. Williams introduced the question of medical tariff. He said that he simply wished to learn what opinion the council held upon the matter. He thought personally that in view of the rumpus the Patrons had kicked up in the country it would be well to allow the matter to stand for a year or two until things quieted down.

Dr. Harris advised that no action should be taken.

Dr. Henry thought there should be a legal tariff which would protect medical men in the courts.

Dr. Rogers said that since the tariff had been abolished medical men in his part had suffered. He told of a case where a medical man had put in a bill for \$60, which was reasonable. The judge allowed him but \$15, and in delivering judgment took occasion to ridicule the medical profession in general. If the council would frame a tariff which would be sanctioned by the Local Legislature, it would be binding upon the courts. At present, when a doctor put in a bill and the case went to the courts, it was a sorry spectacle to see two or three medical men swearing on one side that the bill was a reasonable one, and, on the other, two or three swearing quite the contrary. Sir Oliver Mowat had written to him saying that the most vulnerable point of the whole matter was that the council wanted to fix the tariff. He said that if a tariff was framed and revised by some independent body, he thought it would be an easy matter to pass it through the legislature.

Dr. McLaughlin said that the government could do nothing in the way of passing the tariff. It just depended upon how the members felt on the matter. A great deal of trouble had been made throughout the country by the Patrons. He thought that matters should be allowed to stand.

Dr. Henry wanted to know if the profession intended to submit, and allow the Patrons to regulate their tariff. He did not fear the issue, and would like to see the council take a firm stand, and ask the government to grant them a reasonable tariff.

Dr. Roome said that medical men had, like all others, to be governed by public opinion. Public opinion at present was against a tariff. The people had an idea that the doctors had joined together to form a monopoly, and this feeling would have to quiet down before anything could be done.

Dr. Thornton thought that it would be foolish for the council to frame a tariff, since there was no unanimity of opinion among medical men themselves. Some wanted a tariff, others did not. The matter was heretofore allowed to drop upon the advice of Dr. Campbell, who pointed out that until medical men could agree to some basis there was no use weakening their case in the public mind.

Dr. McLaughlin pointed out that the by-law appointing the Discipline Committee was not legal. On consulting Mr. Osler, it was found that there was a clerical error, and a new by-law was drawn up, which was passed by the council.

Dr. Henry presented the report of the Committee on Complaints, which recommended that no action should be taken in the case of Mr. E. A. Foster against Dr. A. J. Johnson, the council having no power to deal with the matter; that the cases against Drs. W. E. Olmstead, of Caledonia; H. O. Martin, Toronto; J. H. Danter, Toronto; and C. Parsons, Coe Hill, who have been accused of unprofessional conduct, be referred to the Discipline Committee; that we have carefully considered the nineteen appeals from students, of whom fourteen were final men, and were plucked on medical and surgical anatomy at the last examinations, and, in view of the unusual character of the questions asked, we recommend that the council grant registration to H. E. Wallace, W. E. McKechnie, and Alexander McKay. These gentlemen passed with credit on all other subjects.

The report was adopted.

ADJOURNED MEETING.

The following notices of motion were given:

By Dr. Campbell: "That a committee be appointed to watch legislation in the Provincial Legislature, and to advise the Executive Committee on such matters, and to report at the next session of the council; such committee to consist of Drs. Thorburn, Williams, Barrick, Roome, and Emory."

By Dr. Sangster: "That a committee of four members, viz., Drs. McLaughlin, Williams, Barrick, and Campbell, be appointed to consider the whole matter of discipline, committee trials, and public prosecutions, as to their cost, effect, and mode of procedure, with a view to simplification and economy, without interfering with their efficiency, and to confer with the Attorney-General, if thought advisable, as to the feasibility of assimilating

our modes of procedure with those obtaining in the Law Society; also that pending the report of this committee next year, and the action of this council thereon, all Discipline Committee trials and public prosecutions be in the meanwhile suspended."

By Dr. McLaughlin: "Whereas, since the beginning of June, 1887, up to the present meeting of the council, members whilst in attendance on meetings of this council and committees thereof have appropriated to themselves as hotel expenses the moneys of the College of Physicians and Surgeons of Ontario; whereas such appropriation has been made without the authority of law; therefore, resolved, that the registrar be instructed to prepare and lay before this council forthwith a detailed statement of all appropriations thus received by each member of the council in office between the periods above mentioned."

Several communications were read. One was from Mr. B. B. Osler, on the subject of the fees payable by the registered members of the college, in which he pointed out that other similar organized bodies charging an annual fee made it a condition of continuing membership that the annual fee should be paid, and that this was not looked upon as a hardship, but as a necessity. He suggested to the council the following alternatives: To do away with fees altogether, to go back to the old Division Court method of collection, or to pass the by-law removing the suspension of the payment of fees in such form as to the council may seem best. A letter was read from Mr. O. F. Rice, manager of the Yonge street branch of the Imperial Bank, pointing out the necessity for the continuance of a general assessment in view of the present position of the loans of the council, and notifying the president that unless such an assessment were maintained he would be obliged to call upon the members of the corporation to individually guarantee its loans.

It was moved that the Executive Committee for the coming year consist of the president, the vice-president, and Dr. Campbell.

The council then went into committee of the whole on the report of the Printing Committee, but could not find the report, which had in some way been misplaced. The committee accordingly rose without having done any business, and the council adjourned, to meet at eight o'clock in the evening. A motion to the effect that the matriculation fee be fixed at \$50 was referred to the Education Committee.

EVENING SESSION.

Dr. Campbell moved his resolution, of which notice had been given by him during the afternoon, with regard to a committee to watch legislation.

Dr. Williams paid a tribute to the usefulness of last year's committee. He suggested the addition of the name of Dr. Sangster, those forming the committee being Drs. Barrick, Emory, Roome, Sangster, Thorburn, and Williams.

A motion by Dr. Barrick dealing with the duties of the Finance Committee and the treasurer was referred to the Committee on Rules and Regulations.

A report of the Committee on Complaints was presented by the chairman, Dr. Henley, in which the petitions of two students, Albert Dowling and S. H. McCammos, for reconsideration of their cases, were refused.

The council then adjourned.

Wednesday, June 26, 10 a.m.

The president called the attention of the members to the fact that the present session had already been very much prolonged, and asked them to bear that fact in mind in their discussion of the matters that would come before them, in order that the business of the council might be expedited.

Dr. Sangster moved his resolution for a committee to consider the question of trials and discipline, with a view to their simplification, of which he had given notice on Tuesday. In doing so, he said that, undoubtedly, these trials had been, and were still, a severe tax upon the resources of the council. Their cost was somewhere between two and three thousand dollars a year, and it was an open question whether the good resulting from them was commensurate with the money expended. He thought the present system was too elaborate, complicated, costly, and clumsy, and, if the committee which he proposed would take the matter into consideration, they would evolve some plan by which the cost of these trials might be reduced. He also suggested that the committee should consider the subject of restricting the sale and advertising the sale of quack nostrums.

Dr. Britton proposed, in amendment, that the matter be referred to the Discipline Committee. The amendment was finally carried by 17 to 12, and the council adjourned until two o'clock.

AFTERNOON SESSION.

Dr. Thorburn, chairman of the Committee on Finance, read the report of his committee. The treasurer's report showed receipts amounting to \$45,201.69, including a balance on hand, June 12th, 1894, of \$315.37. The expenditure for the year was \$44,186.06, and the balance on hand on the 11th instant was \$1,015.63. The cost of maintenance of the building was \$4,021.84. The more important recommendations contained in the report were the following :

"In order that the council may receive a continuance of the accommodation from the bank, we recommend the reimposing of the annual assessment. By the collection of outstanding liabilities we can meet all claims, but the prompt payment of the annual fee is an absolute necessity to enable us to meet satisfactorily accrued and accruing obligations."

"That the salary of the prosecutor be \$600 per year, and that all expenses for prosecuting irregular practitioners be paid by him, except in cases of appeal, and that the latter, before proceeding, must receive the approval of the president and registrar."

"We would also suggest the expediency of holding all examinations in Toronto, thereby reducing the expenditure by \$350."

The report referred to the demand made by the bank for personal guarantees for further loans if the annual fee was suspended, and to the assurance given by the committee that it was quite possible the council would reimpose the annual fee and collect past dues. The report continued: "Previous to the erection of our building, we found it almost impossible to secure suitable premises for holding the meetings of the council, and more especially for our spring and fall examinations; therefore the council decided to erect the present building, which is so admirably adapted for the purposes of the council that we think it desirable to inform the council that the resources and means of the profession and council are sufficient to enable us to retain the building; but if, upon further consideration, it be found advisable to dispose of the building, it should be done at such time as in the best judgment of those qualified to advise us upon the subject will secure the best price. The committee have carefully considered the question of disposing of the building, and are of the opinion that, if necessary to do so, the present time is inopportune. We are encouraged to hope that in the near future there will be a substantial increase in the value of property, especially in this locality."

Included in the report was the financial statement of assets and liabilities. It showed assets of \$126,535.62, which included the building at \$100,000, and unpaid assessments amounting to \$22,000. The liabilities amounted to \$72,500, of which \$60,000 was a mortgage on the building. The balance in favor of the college was \$54,035.62.

THE PRINTING CONTRACT.

The report of the Printing Committee had precedence for consideration by the council, and occasioned a lengthy debate. It recommended that the printing of the annual announcement of the college be awarded to the *Ontario Medical Journal* at \$360. Dr. Sangster moved in amendment that the printing be awarded to the *Dominion Medical Journal*, Dr. Beattie Nesbitt's name being substituted for that of Dr. Orr in the report. This excited a heated controversy, in which the claims of the two journals were vigorously upheld by their friends. Dr. Britton moved a second amendment that the contract be awarded by tender, and given to the lowest bidder, whoever he might be. The discussion lasted through the greater portion of the afternoon, and was taken part in by almost all the members of the council. Both amendments were finally defeated, and the report was passed as originally drafted.

A short report of the Committee on Rules and Regulations was adopted without discussion.

A DISCUSSION ON FINANCE.

Dr. Thorburn moved that the council go into committee on the report of the Finance Committee. Dr. Armour started to make a general statement on the report, but was ruled out of order, and the report was taken up clause by clause. When the clause providing for the assessment of members was reached, Dr. Armour at once objected to it. He claimed that there was no necessity for the imposition of fees in order to obtain sufficient revenue for the purposes of the college, and he quoted from a statement which he had compiled, and which showed that, irrespective of an assessment, a revenue could be obtained amounting to \$13,400 from various sources. The estimated expenditure he placed at \$9,900, which would leave a surplus of \$3,500 to be applied toward paying the expenses of the building. He considered that the authority to assess the tax granted in 1874 was unconstitutional. It had been withdrawn by the legislature, and he did not think that it could be shown that there was any moral or legal liability resting upon any one to pay what was certainly an illegal tax. He thought there could be no question as to the legality of imposing this tax now, but there should be shown the most urgent necessity for it before it was imposed, and especially it should not be imposed for the purpose of obtaining money with which to maintain the present building. He moved that the clause be struck out.

Dr. Thorburn briefly supported the clause, pointing out that the present financial position of the council made the imposition of such a tax absolutely necessary. The debate was continued by Drs. Brock and Bray, in favor of the report, and Dr. Thornton, in favor of Dr. Armour's amendment.

EVENING SESSION.

At the evening session of the council Dr. McLaughlin moved the resolution of which he had given notice the day before, instructing the registrar to submit a detailed statement of all appropriations received by members of the council as hotel expenses since June, 1887.

Dr. Campbell opposed the motion on account of the assumption contained in it that the council had been acting illegally in this matter.

A short discussion ensued, the sentiment of the meeting evidently being that the motion was one of censure on former councils, and practically amounted to charging them with a misappropriation of funds. Dr. McLaughlin offered to withdraw his motion, but his opponents would not at first permit him to do so.

On motion of Dr. Bray, seconded by Dr. Rosebrugh, a report was read from the Committee on Complaints correcting a statement that had

appeared in the press to the effect that Dr. Olmstead, of Caledonia, was charged with unprofessional conduct. What had been referred to the committee was merely a report from the prosecutor in connection with some circulars, which had not in any way reflected upon Dr. Olmstead.

THE FINANCE REPORT.

The consideration of the Finance Committee's report was then resumed in committee of the whole, the discussion being taken up on similar lines to that of the afternoon. Dr. Roome supported the proposed assessment, on the ground that the money was necessary to the college, and was not a hardship upon any one.

Dr. Sangster pointed out the great importance of the question, and the danger of a wrong decision. He and those with him in this matter opposed the tax because it was unjust, taxing one branch of the profession and leaving another, equally protected, to go scot free. It was also an unnecessary tax.

Dr. Williams replied, reiterating the statement that the debt, being statutory, was a just one, and should be paid. The statute was in the hands of the council, and it was their duty to administer it. Dr. McLaughlin assailed the tax, saying that it was not right that the expenditure should be controlled by a body of which almost half were not responsible to the profession. Dr. Campbell argued that the tax had been endorsed by the profession, and Dr. Moore maintained that the tax was perfectly legal. The discussion was continued by Dr. Barrick, who argued that the money was necessary in order to meet the obligations of the college, and by Dr. Britton, who disagreed with the estimate of expenses submitted by Dr. Armour. He did not think it adequate, and he urged the unadvisability of selling the building at present. He was willing to pay the tax, and hoped it would be enforced, so that no member would be exempted from it. Dr. Henry strongly supported the tax, as being necessary in order to meet the financial requirements of the council. After some further discussion the clause was carried without division. The clause regarding the prosecutor's salary was carried. This means the reappointment of Mr. Thomas Wasson with an increase of \$200 per annum. The clause providing that all examinations he held in Toronto was struck out. The other clauses of the report passed with little discussion, and the report was adopted, an amendment to strike out the "assessment clause" being defeated by 22 to 5. An amendment to the effect that the building be offered for sale by tender was also defeated by 21 to 6.

Thursday, June 27, 10 a.m.

Dr. Thorburn gave notice of a motion that hereafter tenders for printing and supplies be asked for before any contracts involving the expenditure of money be made. Dr. Sangster gave notice of a motion to amend

the by-law fixing the salaries of the registrar and treasurer. Dr. Barrick gave notice of a motion that in future copies of the estimates be placed in the hands of each member of the council. Dr. Barrick gave notice of a motion that the report of the Printing Committee be reconsidered.

It was recommended that no action be taken to extend the winter sessions from six to eight months, in lieu of the summer sessions, till all the teaching bodies had been heard from.

At the afternoon session Dr. Barrick moved that the report of the Printing Committee be reconsidered. The motion was lost. The second part of the educational report was then received. The council then went into committee of the whole to deal with the latter clauses of the first half of the educational report. There was a protracted discussion over the clause dealing with changes in the matriculation, which read as follows :

“It is recommended that the existing requirements for registration of matriculation, as set forth in clause one, section one, of the regulations for 1894-5, as per annual announcement, shall cease to be accepted on and after November 1st, 1897, and that instead of the said clause the following shall be substituted :

“Every one desirous of being registered as a matriculated medical student in the register of this college, except as is hereinafter provided, must, on and after November 1st, 1897, present to the registrar of the college the official certificate of having passed the departmental pass arts matriculation examination with not less than second-class honors in each of the following subjects : English, physics, chemistry, botany, and zoology, or, in lieu thereof, an official certificate of having passed the departmental pass arts examination, and, in addition thereto, a certificate of having passed, not sooner than in the ensuing year, the arts examination held at the end of the first year of the university course by a recognized university ; the second and third clauses of said section to remain in force.”

Dr. Britton, in presenting the report, stated that the members of various educational establishments had expressed approval of the higher standard, and that it was on that ground that it should be considered, and not on the ground that it would operate to the exclusion of candidates. He carefully explained the various points of the proposed change in the curriculum.

Dr. Campbell thought that the opinion of the Education Committee was deserving of great consideration, but there was no doubt that an impression was abroad that the raising of the standard was solely for the purpose of closing the doors of the profession still tighter. Indiscreet expressions with regard to overcrowding had been made, and it was unadvisable to go faster than public opinion. He moved that the clause be

struck out, and the following inserted: "That it is not expedient at present to make any changes in the matriculation." The remarks of Dr. Campbell were endorsed by Dr. Shaw. He stated that they were practically adding a year to the course, and that the change was too radical.

Dr. Sangster thought the question of elevating the matriculation standard was one of the most important to be considered. Many interests had to be considered, and the report was necessarily somewhat in the nature of a compromise.

The amendment was lost, and the clause adopted by a large majority.

The clause of the report stating that any action of the council dealing with the question of lodge practice would be *ultra vires* was carried after a brief discussion, as also was the clause recommending that the registration fee be not raised from \$20 to \$50.

The following changes were recommended in the Board of Examiners: H. Howitt, Guelph, *vice* A. A. Macdonald; A. B. Welford, Woodstock, *vice* W. Burt; H. T. Williams, London, *vice* W. J. Mitchell; C. V. Emory, *vice* D. O. R. Jones; D. J. Sinclair, *vice* C. E. Jarvis.

When the council resumed, the report, as amended in committee of the whole, was passed.

The report of the Discipline Committee was introduced by Dr. Bray, recommending an investigation by the committee into the conduct of Dr. C. Parsons, of Coe Hill; Dr. H. O. Martin and Dr. J. F. Danter, of Toronto. The report was adopted.

THE ANNUAL TAX.

A by-law to reimpose the yearly assessment of \$2 was introduced by Dr. Rogers. He spoke at some length, pointing out that no other adequate means could be employed for the raising of the necessary revenue.

EVENING SESSION.

At half-past eight the council resumed business. A resolution was moved by Dr. Thorburn that tenders should be called for in cases of supplies required, and that the lowest tender be accepted, all other things being equal. The motion carried.

Dr. Roome introduced a motion to the effect that the college building be placed in the hands of the Property Committee, to be sold when a satisfactory sale can be effected. After a short discussion the chairman ruled the motion out of order, as amending a clause in the Finance Committee's report, which had already been adopted.

Dr. Rogers then resumed his address on the by-law relating to the annual assessment. He continued his explanations with regard to the amendment to the Medical Act and the causes which led to it.

He contended that there was nothing in the least offensive in the amendment. With regard to the provisions of the new by-law, he pointed out that under its provisions a name could not be removed from the register for nearly eighteen months, and that should a defaulter in dues be suspended he could at once obtain reinstatement by payment of dues. The real cause of trouble was that in forwarding a copy of the amendment to all the medical practitioners the substitution clause relating to reinstatement was omitted through a printer's error, and, in consequence, great misapprehension arose. He read a letter from the solicitor of the council in 1890, showing the great difficulty and expense experienced in collecting arrears in fees from practitioners, and recommending that no suits be entered in future. The council was face to face with a very serious financial condition, and nothing but the reimposition of the assessment would be of any help.

Dr. Cameron did not think that so gloomy a view of the financial position of the council should be taken, or that there was any necessity for the imposition of the proposed tax. The outstanding indebtedness of the council was not as great as in 1891. He thought it was hardly the province of the present council to levy a tax for 1893 and 1894, when another council was administering the affairs. With regard to the collection of outstanding accounts, he thought Dr. Rogers had changed his opinions in 1893 and 1894. He at that time expressed the opinion that nothing should be done to coerce the profession. He (the speaker) believed that the passing of the by-law would be taken as a declaration of war by nine-tenths of the medical profession.

Dr. Thornton said that an inspection of the finances showed something radically wrong.

Dr. McLaughlin spoke of the extraordinary powers vested in the council, and the great danger of their misapplication.

Dr. Logan objected to strictures which had been passed on the homœopathists. Should the homœopathists be compelled to separate themselves from the council, he hoped that body would assist them to obtain powers from the legislature to form a Homœopathic Council on the same lines as the present council.

Dr. Sangster congratulated Dr. Rogers on his many-sidedness. The address delivered by that gentleman had been so long and rambling that it was difficult to pick out any one point to deal with. He thought the council should have honestly admitted that they had been led into a disastrous speculation, and should have appealed to the generosity of the profession to help them out of their difficulty. The profession generally were willing to condone the errors that had been made, but if any coercive legislation were attempted there would be a revolt, and the legislature would again be appealed to.

The adjournment of the debate on the by-law was then moved by Dr. Williams and carried.

The report of the sub-committee dealing with salaries was next considered in committee of the whole. Under its provisions the members of the council and the Discipline Committee will receive an allowance of \$12.50 a day and mileage of four cents a mile; members of committees who sit while the council is not in session, \$8 a day and the same mileage; Board of Examiners during oral examinations, \$12.50 a day and four cents mileage. The scale of fees for examining papers to remain unchanged.

Friday, June 28.

MORNING SESSION.

A short discussion took place on Dr. Roome's motion for the sale of the building, which ended in its withdrawal.

Dr. Williams resumed the discussion on Dr. Rogers' assessment by-law. He said that surely the principle of this matter had already been sufficiently discussed. In order to get down to a practical consideration of the by-law, he moved the previous question, which was carried, and the council went into committee of the whole. A number of clauses were carried without much discussion, but a debate arose as to the best means to be devised to collect the assessment. Dr. Barrick and others spoke in favor of endeavoring to collect the money, at least during the next twelve months, by voluntary action of the medical men, and not by coercion. Nothing could be gained by the enforcement of a penal clause, and it was above everything else advisable that the various parties in the council should sink their differences and try to effect the collection of the fee without friction among the members of the profession.

Dr. McLaughlin commended the words that had been spoken concerning the necessity for peace, but he objected to the idea that he and others who had refused to pay the tax had no right to sit in the council. They had as much right as a citizen would have to complain of road improvements, for instance, which he thought were badly constructed.

Dr. McLaughlin, continuing, said he was sorry that words had been uttered in the council which would have a bad effect. It had, for instance, been said that men who did not pay the tax were dishonest. There were 1,200 men on the list of delinquents, and the word must apply to them all.

Dr. Rogers denied this. He pointed out that many of those who were on the delinquent list were there through carelessness or ignorance. It was only a very small minority who refused to pay the tax, and he did not think it fair that the great majority of the profession should pay their

just debt and that others, who chose to refuse to pay a liability which had been legally imposed, should be allowed to exercise all those privileges for which others had paid.

Dr. Sangster referred to some expressions used by Dr. Bray during the discussion, in which he had instituted a comparison between those members of the council who had paid their tax and those who had refused to pay it as offensive and in bad taste. He upheld strongly the right of himself and others to sit in the council and express their views on this matter, which were shared by many members of the profession throughout the province and in their own constituencies. He informed the council that the number of those who agreed with him on this and other matters was 1,307

Dr. Bray replied to Dr. Sangster's strictures on his conduct by commencing to read a letter signed by Dr. Sangster, and published in the *Ontario Medical Journal* some time ago, with the evident object of drawing attention to the language used in it. He was stopped by the raising of a point of order as to whether the letter had anything to do with the subject under discussion.

The council then adjourned.

AFTERNOON SESSION.

The afternoon session opened with a discussion on finances, and a committee of three members was appointed to interview the manager of the bank and see if he would accommodate the council with an advance of money sufficient to meet the expenses of the present session. The committee immediately left for the bank, and, pending their return, the council adjourned for half an hour.

The committee returned, and reported that an advance of \$4,000 would be made by the bank, on condition that the penal clause was inserted in the by-law, providing for the enforcing of the annual assessment. No increase over the present liability of \$7,000 could be obtained except on this condition. The report was adopted, and the council resumed consideration of the by-law in committee of the whole.

Dr. Williams moved an amendment to the clause in the by-law which provided that non-payment of the annual fee should be followed by suspension until it was paid. His motion was that the operation of the clause should be suspended until June 1st, 1896, and that it should then come into force, in case the bank liabilities of the council were not by that time paid. This was a compromise motion, and was carried through committee without discussion. On motion of Dr. Williams, an additional clause was inserted in the by-law, instructing the registrar to forward to each medical practitioner a copy of the by-law, together with a circular

letter explaining that the fee had been reimposed, and calling his attention to the clause by which the operation of the penal clause was suspended until next June. The by-law was then read, and reported with amendments to the council.

On a motion for the adoption of the by-law being put, Dr. McLaughlin moved an amendment striking out the first clause, thus practically killing the by-law. The ayes and nays were taken, only the territorial and homœopathic members being allowed to vote. The amendment was lost on a vote of 18 to 4, those who voted for it being Drs. Armour, McLaughlin, Sangster, and Thornton.

Dr. Armour introduced an amendment striking out the portion of the by-law which brought the penal clause into effect. This was lost on division by 17 to 5, the minority being composed of the four members already named with the addition of Dr. Reddick. The by-law was then passed and read a third time.

Dr. Harris, the president; Dr. Rogers, the vice-president; and Dr. Campbell, were appointed as the executive of the council for the present year.

This concluded the business of the annual meeting, and the council adjourned at five o'clock.

Meetings of Medical Societies.

ONTARIO MEDICAL ASSOCIATION.

(Concluded from last issue.)

REMARKS ON APPENDICITIS, WITH REPORT OF A CASE OF RECOVERY IN A PREGNANT WOMAN AFTER RUPTURE OF THE ABSCESS INTO THE GENERAL PERITONEAL CAVITY.

Dr. T. K. Holmes, of Chatham, read a paper with this title. He said that the treatment of this disease during this past few years was passing from the hands of the physician to the surgeon's hands. Murphy, of Chicago, operates on every case. White, of Philadelphia, declines to operate where general septic peritonitis with paralysis has supervened, and in many cases of first attack. Treves has somewhat similar views. The essayist said that of forty-nine of his cases, eight had died from rupture of the abscess into the peritoneal cavity; four from general septic peritonitis; sixteen had been operated on, with one death four months after the operation. Twenty-one recovered without operation, but five of these still have some tenderness at McBurney's point, and were, doubtless, still in danger. He thought it might be fairly estimated that of the twenty-one cases of apparent recovery, not more than one would have died had they all been operated upon; and it was about as certain that of the twelve who died without operation, eight could have been saved by timely interference. This would have made the mortality about ten per cent., instead of twenty-five. The surgeon who operated on every case escaped a great deal of perplexity and disappointment, as every one would admit who had had an apparently favorable case suddenly die from rupture of the abscess into the general peritoneal cavity, or from the development of septic peritonitis. The essayist then gave the history of the case, the events of which are summarized in the title.

Dr. Atherton said that such cases as Dr. Holmes had reported were very rare, especially in the pregnant. Some authorities had recommended that where appendicitis occurred late in pregnancy, that pregnancy should

be terminated at the time of operation. If all cases were operated upon, there would be a larger percentage of recoveries; but as many cases recovered without operation, and there was danger when done by the inexperienced, most medical men would hesitate before attempting it.

Dr. Howitt said it was difficult to diagnose appendicitis in its early stage from typhlitis. In typhlitis an operation was seldom or never required. If symptoms of pus were present, operation should be done at once. In his practice intestinal paralysis was a rare occurrence.

Dr. Jeffries, of Lindsay, said that he had probably had one hundred cases of appendicitis, the majority getting well.

Dr. A. McKinnon, of Guelph, thought Dr. Holmes was teaching one thing and practising another when he had operated on a case of suppurative appendicitis, and stated that it was useless to do so, as they were hopeless. To every patient it should be explained (if suppurative appendicitis be diagnosed) that he will die if left alone. Bold operation, and pure cleansing of the peritoneal cavity, with drainage, might save the patient. The difficulty was to decide when to operate, not when not to operate. He referred to a case he had been called to see where the patient had awakened one morning with pain in the abdomen and vomiting. The pulse was normal. Twenty-four hours after the pulse was 120, temperature 103°, and the abdomen distended. On opening a large abscess was found which had opened with the peritoneal cavity. The operation was done just in time to save the patient's life.

Dr. Holmes, in replying, said that he repudiated the idea of preaching one doctrine and practising another. By suppurative appendicitis, he meant a condition in which the whole peritoneal cavity had undergone an inflammatory process with pus formation. In such a case he did not believe there was any use in operating.

On motion of Dr. Holmes, seconded by Dr. McKinnon, Dr. J. J. Cassidy's paper, "Metallic Sutures in Fracture of the Patella," was read by title.

Dr. Mitchell, of Enniskillen, reported a case of

SEPTICÆMIC POISON RESULTING FROM A SMALL WOUND.

The left femoral vein became thrombosed, and extensive cellulitis set in, followed by suppuration. The leg was enormously swollen, and covered with a number of blebs ecchymotic spots. Free incision was made, and milk, whiskey, iron, and quinine given plentifully. At the end of the third week the patient had a peculiar nervous attack, nearly all the muscles of the body taking on tonic and clonic spasms, which seizures lasted about a week. Recovery followed.

WEDNESDAY EVENING.

Dr. T. F. McMahan read a paper on

CALOMEL FUMIGATION IN THE TREATMENT OF LARYNGEAL DIPHTHERIA.

He referred to the frightful mortality under the old methods of treatment, even intubation or tracheotomy saving but 20 to 30 per cent. of cases in average epidemics. He thought it yet too soon to fix the value of the anti-toxin treatment, and described at length a method first used by Dr. Cortsin, of Brooklyn, in which calomel was burned under a tent, and the fumes inhaled by the patient. Dr. Cortsin, in his first paper, reported 30 cases, 25 of which recovered. Later, Dr. Maddren reported 505 cases (in the practice of 76 physicians), of which 54.5 per cent. recovered. The experience of Dr. Andrew Eadie, of Toronto, was then related. He gave a history of 11 cases, with 9 recoveries, 6 without intubation, and 3 with it. Dr. McMahan had 9 cases of severe type, 5 recovered and 4 died. None of the deaths were due to laryngeal stenosis.

Dr. Sheard's experience at the Isolation Hospital was next related. Sixty-two cases were treated with calomel and 43 recovered, not one of which was intubated. The death rate from laryngeal diphtheria previous to the use of calomel treatment was about 70 per cent. in spite of intubation. In 82 cases in Toronto treated with calomel there were 57 recoveries, or about 70 per cent.

Dr. McMahan was quite sure that he had seen cases recover which would inevitably have proved fatal under any other plan of treatment, and he thought a practitioner was no longer justified in neglecting its use in laryngeal diphtheria. It often rendered intubation unnecessary. The method of using and dosage were then described at length, and the general management of the cases touched upon.

Dr. W. J. Wilson, of Richmond Hill, opened the discussion on diphtheria. It was, he said, a disease of childhood, when glandular activity is greatest and nasal secretions are copious and likely to be retained. Secretions of enlarged tonsils and gastric catarrh were predisposing, the former often being the point of attack. The pseudo-membrane consisted of necrotic epithelial cells laden with Klebs-Loeffler and other bacilli, the former not penetrating the tissues as the latter do, but exerting their malevolent influence through the system absorbing their toxins. Glandular enlargement was most marked when the nasal chambers were involved, by reason of their increased vascularity and lymph supply. The poison often produces a hyaloid degeneration of the capillaries, a manifestation of which is nose bleeding, a dangerous symptom; albuminuria may also be present. The heart muscle also suffers, and operations should not be delayed till dilatation takes place. The essayist discussed the various

therapeutic measures in common use. If antitoxin would stop the formation of toxins in the blood, it would be useful in addition to the local treatment. Other forms of treatment should not be neglected, even when antitoxin was being used. The doctor described minutely the method of treatment by calomel fumigation in laryngeal cases. The child is to be covered by a tent. From fifteen to sixty grains of pure calomel are heated over a lamp and vaporized slowly; repeated every two or three hours: Sometimes in a severe case as much as 5,000 grains have been used. The child's skin should be covered to prevent a deposit of the drug on the skin. The mouth and teeth should be cleansed after each fumigation, and if the gums be spongy an astringent wash should be used. The doctor discussed the comparative merits of intubation and tracheotomy.

THE PRESENT POSITION OF ANTITOXIN IN THE TREATMENT OF DIPHTHERIA

was the subject of an address by Dr. Chas. Sheard, of Toronto. It dealt with the use of the new remedy in the Isolation Hospital, Toronto. A bacteriological examination was made in every case, not only at the time of admission, but also from time to time during the illness. The doctor then quoted statistics covering the months of February, March, April, and May. In concluding, he said he had yet to be convinced of the real value of antitoxin in diphtheria. It was to be remembered that many cases were of mixed infection, streptococci being present upon whose toxin the serum would have little or no effect.

Dr. Fotheringham referred to two throat cases (two brothers) he had seen, both of which at first seemed recovering from what had been diagnosed, and what seemed simple tonsillitis. The younger boy went on to recovery, but the other developed an attack of true diphtheria of the laryngeal type, as shown by a bacteriological examination. The doctor's theory was that, at first, it was a case of mixed infection, the diphtheria germ getting the upper hand of the others and true diphtheria developing, which in its earliest stage was much less malignant than it turned out to be later.

Dr. Holmes, of Chatham, said that the late Dr. Tye and he had kept a record of their cases of diphtheria for several years, and had found the death rate to be about twenty-five per cent. Last year, in an epidemic in the town, the mortality was about the same. Since the era of antitoxin he and his partner had used it in twenty cases, not one of which had died. The experience of the other Chatham physicians corresponded with this.

Dr. McPhedran pointed out that a large number of acute clinical observers on the continent had reported favorably on the new treatment. Even in conservative England reports were very favorable. The treatment was especially successful in early cases. It would require several

epidemics before its value could be definitely settled. No doubt it would be proved that only in those cases in which pure cultures were obtained would the serum be a success. From the hospital reports he considered the dosage had been insufficient. The speaker then referred to his own experience, which was favorable to the antitoxin.

Dr. Wilson, in reply, said antiseptics were valuable, and should be used right through; if they did not kill the germs, they would lessen their vitality. He thought, until the antitoxin had been tried by many different observers the world over, they could not come to a definite conclusion as to the value of the remedy.

Dr. H. A. Macallum, of London, read a paper on "The Physiological and Therapeutic Action of Iron, with a Discussion of its Newer Pharmaceutical Compounds."

LARYNGEAL AND TRACHEAL TUBERCULOSIS: THE IMPORTANCE OF THEIR EARLY RECOGNITION AND TREATMENT.

Dr. W. F. Chappell, of New York, read with this a little paper. The essayist, after referring to the difficulty of relieving this disease, spoke of the necessity there was for early diagnosis to ensure success in the treatment. He pointed out the two varieties—the acute, which was usually primary, and the chronic, or secondary. He detailed the symptoms, objective and subjective, in the diagnosis. The progressive character of the pain and the excessive secretion of frothy mucus, in pulmonary cases, were diagnostic. Hoarseness was another important sign. The characteristic local conditions distinguishable with the laryngoscope were described. The infiltrations were most common in the inter-arytenoid space. (A water color was passed around illustrating the condition.) The various forms of treatment were then gone fully into. That upon which most emphasis was laid was one used first by the reader—the submucous injections of creasote. The doctor then described the technique, and showed the instruments used and the mixture. His conclusions were that (1) every case of pulmonary tuberculosis should be carefully watched for laryngeal symptoms; (2) in profuse pulmonary expectoration a spray of creasote should be used; (3) no case should be abandoned to cocaine and other sedatives until all the other methods have been tried; (4) tubercular infiltrations and ulcerations may be arrested; (5) rest, nourishment, and creasote internally should be used as a constitutional treatment; (6) if the disease is arrested, the patient should be placed under the most favorable climatic influences.

Dr. Ryerson said he was pleased to hear of the new treatment for this most obstinate complaint. As to curettement, he thought it should only be done by skilled hands.

Dr. Palmer said he had had no experience in that special form of treatment, but it was something to which the profession should pay the utmost heed.

Dr. Price-Brown said these cases were not diagnosed early enough. When they came into the hands of the specialist, they were often too far advanced to receive much help. He had tried curettement and the galvano-cautery.

Dr. D. J. Wilson asked as to the action of creasote, administered in this way, whether it acted merely locally or constitutionally as well.

Dr. A. Primrose, of Toronto, presented a series of stereopticon views of sections through the body in various planes, showing the relations of the organs in the various regions.

Dr. A. K. Sturgeon, of Petrolea, read a paper on "Hydrotherapy in the Treatment of Exanthematous Fevers."

Dr. Playter contributed a paper (read by title) on

HOME AND FOREIGN CLIMATES IN CONSUMPTION,

mostly extracts from a book on consumption now in the printers' hands, in which he contends, and quotes authorities to prove, that, in the present state of our want of knowledge of the effects upon the human functions of the various atmospheric conditions, change of climate is an empirical remedy having no theoretical foundation, and that acclimatization is a process, the possible injurious effects of which will often outweigh any benefit derived. In hardly one case in a hundred is such a change desirable, although change of locality is often essential.

A warm climate sometimes gives more comfort and prolongs life in advanced cases; and occasionally, in the early stage, a young man indifferent about his health may be sent to an elevated climate.

Theory and practice have taught us that what the consumptive needs, first, last, and always, is more pure air, or more oxygen, and this in its best, most invigorating form. This cannot be best supplied by a warm nor by a thin atmosphere. The consumptive, whether from heredity or habit, is an imperfect breather. In the development of the soil for the tubercle bacillus, imperfect respiration plays the chief part; all other causes are but remote and contributive to this one—an imperfect respiratory function which clogs the entire organism with the débris of imperfect tissue metabolism, from want of oxygen.

In the decomposition of this accumulated effete matter, not only are inorganic substances formed which constitute food for the bacilli, but possibly also organic toxines, which transform simple saprophytic bacilli into poisonous or virulent pathogenic organisms or infections; the analogue of which we sometimes have in the transformation of the bacillus coli communis by intestinal toxins.

In the rarefied air of high mountains, with the climbing, there is great and forced expansion of the lung membrane. The subject actually gasps widely for breath in order to compensate for the thinness of the air. The whole function of respiration is aroused and improved, and the body purified and invigorated. But altitude is not necessary. This function can be more readily improved at the lower levels with the "richer" air of Canada by suitable lung gymnastics, if the patient will only persevere in the exercises; and more safely, too, in hæmorrhagic cases, in which there is considerable risk in going somewhat suddenly to a much elevated climate.

Dr. Playter refers to the benefits of compressed air, and of the dense air at sea, where the mortality from consumption has been (is) shown to be sixteen times less than on land; a result not attributable alone to the purity of the sea air.

The purer air of great elevations is an important condition. Yet we have in many parts of Canada a practically pure, highly ozonous atmosphere, at all seasons; while over our snow-covered expanses during several months of the year is air probably as germless as on sea or high mountain. The colder the air breathed the more oxygen it contains, and the more, too, it expands in the air chambers on becoming warmed to the lung temperature. Consumptives in Canada, in nearly all cases, have acquired the predisposition by means of indoor occupation or a habit of housing in close, overheated rooms, and they may be, the most susceptible of them, gradually habituated back again to an outdoor life, even in the coldest season, by proper attention to the skin, suitable clothing, and, especially, the cool bath. The sudden changes in temperature in Canada, although trying, are invigorating, and often less marked and sudden than on high altitudes. At Davos, the thermometer has shown a "drop" of 150° F. (from 166° to 16°) between the midday sunshine and the following night.

Dr. Playter contends that we have in Ontario and Quebec some of the best localities for consumptives on this planet. Muskoka has a reputation as a good one. It is sufficiently elevated, has a dry, pure, and invigorating atmosphere, and a large proportion of sunny days. The ideal place, the doctor thinks, is on the Gatineau Mountains, a few miles from Ottawa, in about the same latitude as Muskoka. With a pure and highly-bracing air, and a large number of sunny days, it has a southeastern aspect, and protection on the northwest by a much more elevated wooded ridge; and is hence suitable for all seasons. It has a delightful outlook, with a view of about 4,000 square miles of beautiful country—the Ottawa, Rideau and Gatineau rivers, their valleys, windings, and waterfalls, and the beautiful capital of the Dominion at the meeting of the three waters.

SOME UNUSUAL CASES IN PRACTICE.

This was a paper by Dr. George Acheson, Galt. The first case was that of double cephalhæmatoma, with enlarged thyroid occurring in a second confinement after forceps delivery, with recovery. The second was a case of leucoma in a woman, occurring on the inner side of the lower jaw and floor of the mouth, resulting, probably, from the irritation of a badly-fitting tooth plate. The third was a case of retro-pharyngeal abscess, complicating capillary bronchitis in an infant five months old. The patient was at death's door before the diagnosis was made, but after the condition was recognized and the abscess opened recovery soon followed. The fourth was the occurrence of an atheromatous congenital cyst in the neck, developed in connection with the fourth branchial cleft. Dissection of the whole cyst was performed after evacuation had failed. The next case related was one of complete and persistent loss of sight in one eye, following an attack of dacryocystitis with stenosis of the nasal duct. The last was a case of membranous colitis in a girl aged three and a half years, cured by attention to diet, washing out the bowels with a solution of copper sulphate, gr. ii. to the ounce, or distilled hamamelis half strength, and perchloride of mercury and syr. phos. co. internally.

Dr. Machell spoke of the diagnosis of the cases of cephalhæmatoma. Most of them got well if left alone. Regarding colitis, he had found they were likely to recur upon the least indiscretion. They were very difficult to treat to get an entire cure. They required constant daily attention. Copious injections of warm soft water, borated, often acted beneficially.

Dr. Peters said, in regard to post-pharyngeal abscesses, the opening should be made very free. He referred to a case of leucoma on the inside of the cheek which he had operated upon. The man had been a tobacco chewer, which may have had something to do with the causation.

Dr. J. H. Burns introduced Mr. Warring Kennedy, Mayor of Toronto, who made a short address to the members of the association.

NEPHRECTOMY.

Dr. L. McFarlane then read a paper on nephrectomy. He related the history of a case. The patient, aged 30, who had had gonorrhœa a few months previous, some four months before operation felt pain in left lumbar region, which disappeared and extended to the right, and then to the mesogastric and hypogastric regions over the tumor. Evening temperature rose to 102°. The tumor was tender, and painful at nights. Could be felt per rectum, and fluctuated. The urine was acid, and contained albumen and pus. An opening was made, and a large quantity of pus evacuated. The sinus failing to heal, the kidney was removed. A renal calculus was found in the ureter. The patient made a good recovery.

CHRONIC SEMINAL VESICULITIS.*

This was the title of a paper by Dr. Edmund E. King, of Toronto.

Dr. Peters said he did not see how the deep urethral injections spoken of by Dr. King could reach the seat of disease.

Dr. B. Spencer related the history of a case he had under his charge, where he had tried the line of treatment laid down by the reader of the paper with success.

ANTITOXIN IN THE TREATMENT OF DIPHTHERIA, WITH CLINICAL NOTES OF CASES.†

This paper was presented by Dr. J. D. Edgar, of Hamilton.

Dr. Stowe-Gullen related some observations she had made in some of the diphtheria hospitals while abroad. It was necessary for the best results that the cases should be seen early. In France, the mortality had been large until the introduction of antitoxin. She then described the method of injection. She pointed out that the children there were much hardier than those in America.

Dr. G. A. Bingham read the history of two cases of

MOVABLE BODY IN THE KNEE-JOINT.

In the first the body was removed under cocaine anæsthesia. The synovial membrane was stitched up with fine catgut, and the superficial wound with silkworm gut. Perfect recovery followed. In the second case the body was removed under chloroform. Suppuration followed, probably accounted for by the cachectic condition (perhaps specific) of the patient. The reader of the paper then gave Barwell's views as to the pathology in these cases, and stated that in his experience this condition was most often found in those with some cachexia. Where there was a gouty, rheumatic, tubercular, or syphilitic tendency, he would pursue a course of constitutional treatment before operating. The points to be specially observed in operating were: Rigid asepsis; refraining opening sac until the body is isolated and controlled; the smallest possible opening in the sac; closure of deep wound by independent absorbable sutures; fixation of limb after operation; voluntary decision of patient after due consideration of possible dangers.

Dr. Shepherd, of Montreal, said he thought many of these cases were congenital. He did not think cachexia had anything to do with them. He had never seen a case in a woman. He had met with a number of these cases, but had never had any serious results. Suppuration was usually indicative nowadays of some fault in the technique.

* See page 495, July issue.

† Will appear in THE CANADIAN PRACTITIONER.

Dr. H. T. Macheli read the history of a case of "Infantile Scurvy."

The patient was eleven months old. He said the first symptom noticed was an inability to use the legs and feet as well as usual. Pain was noticed about the hip-joint. The baby had not lost flesh. It had been weaned five months, and had been fed on oatmeal gruel. About a week before the doctor saw the patient the mother had noticed a reddish blush on the right ear about one inch in diameter, and a few petechiæ between the knees and ankles. In a week symptoms were exaggerated, and the gums of the upper four incisors were swollen and purple. A shiny appearance was noticed on the skin of the lower part of the thighs and legs. Upon a diet of grape juice the child began to improve, and in five days the swelling and tenderness of the legs disappeared, and the gums were perfectly normal two days later.

Dr. Shepherd said this disease was not confined to the poor, but in the children of the rich as well. He had seen a good many cases. Under suitable diet the cases did well.

Dr. Gibson, of Belleville, read the history of a case of

EXTRA-UTERINE GESTATION.

Prior to the operation the woman had suffered from peritonitic attacks. When seen by the essayist in consultation the temperature was $99\frac{1}{2}^{\circ}$; pulse, 125. Patient was in distress from flatulence. The tumor filled the pelvis, and was tender and fluctuated. There had been no flow, nor passage of decidua, and the breasts were not enlarged. The uterine canal was patent. Aspiration was done twice, with some improvement. On subsequent examination movements were observed suggestive of foetal life. On opening, the sac was found to be free, but, being friable, it ruptured, the contents escaping into abdominal cavity. On removal of the foetus there was tremendous hæmorrhage, which was with difficulty stopped. Recovery followed.

MENTAL ABERRATION FOLLOWING REMOVAL OF OVARIAN CYST.

This was the title of Dr. Gibson's second paper. He related the history of the cystic trouble, the main points in the diagnosis, and the various steps in the operation. Adhesions were very numerous. A good recovery followed; but it was noted on the sixth, seventh, and eighth days that the patient was at times talking foolishly. On the tenth day she became quite unmanageable, and, in spite of the nurse's efforts to restrain her, she got out of bed alternately screaming and muttering. Recovery followed in a few days.

Dr. Oldright detailed the history of two cases he had *seen* operated upon.

Dr. J. F. W. Ross reported having had several cases of mental aberration following removal of simple ovarian tumor. In one case the patient not only became insane, but died. He thought it might be attributed to the use of iodoform or long-continued suppuration of the pedicle.

Dr. J. F. W. Ross then read a paper on

EXPERIMENTAL SURGERY ON MAN AND WOMAN; A CRITICISM OF OPERATIONS DONE AND THE RESULTS ATTAINED.*

He said that since the introduction of antiseptics much of the surgery had been experimental in its nature. Owing to the ability of the surgeon to perform major operations, many unnecessary operations would be done. He pointed out that statistics of reports of cases as found in medical journals were very unreliable. Many coeliotomies done for relief of pelvic conditions would be better left undone. He preferred as a guide to the modern young woman one of the old-fashioned practitioners and the common-sense mother, by whom pelvic massage, one of the most revolting of modern medical procedures, would be tabooed. The uterus and the ovaries would be kept in the pelvis, and would not be permitted to migrate to the brain.

Oophorectomy for fibroids he had found to be a successful procedure; it had taken the place of hysterectomy. Hysterorrhaphy and nephrorrhaphy he considers useless, and perhaps harmful. For cancer of the pylorus in patients much emaciated, where life could only be prolonged a short time, he would not advise removal or intestinal anastomosis. The doctor considers that it would be just as sensible to take out the bladder or rectum as to remove the uterus for the relief of pus tubes. He holds that it is easy to remove adherent ovaries and tubes and adherent uterus through the vagina, and that it is much easier to remove healthy ovaries and tubes through the vagina than through an abdominal opening. The doctor uses the term so-called gynæcological surgery, and says that practitioners will soon be afraid to recommend a consultation with a specialist. After decrying the constant operations for appendicitis, the doctor, in conclusion, said that he felt satisfied that within the next ten years the waters of the great surgical flood that has swept over this continent and the continent of Europe will fall and regain their normal level.

Dr. Oldright said he would join issue with Dr. Ross in regard to operations on the breast and intestines. Where operation would give a couple of years' pleasant life, instead of a miserable existence, he thought it wise to operate.

Dr. Cronyn, of Buffalo, said he had watched the transitions of views on many surgical questions, and he felt sure that conservative surgery would

*See page 566.

take the place of experimental surgery in years to come. For twenty-six years he had done every possible operation. He had never had a case of sepsis. He always kept his hands clean, and cleaned his instruments himself.

Dr. Shepherd said he agreed that many members of the profession were suffering *pruritus operandi*. In olden times a surgeon had to have something more than technical skill; now any man who had learned the technique thought he could operate, even though he could not diagnose the case or knew not when to operate. The speaker did not think diagnosing was nearly so accurate now as it was years ago. Now surgical technique was in excess, and surgical judgment deficient. He did not quite agree with Dr. Ross in refusing to operate on the stomach. He had operated several times, and the patients were considerably relieved; and frequently died from some other affection.

In regard to mental aberration following operations on the ovaries or uterus, he fancied the anæsthesia or iodoform had something to do with it, together with some hereditary mental taint.

The association then adjourned to the Royal Canadian Yacht Club, where the out-of-town members were entertained to luncheon by their city brethren. Toasts to the Queen and the Ontario Medical Association were drunk; and the guests drank the health of the hosts. A most enjoyable cruise in the steam yacht, *Cleopatra*, was then taken before resuming business.

THURSDAY AFTERNOON.

Dr. J. Campbell, of Seaforth, read the first paper. Subject:

PHLEGMASIA DOLENS.

It consisted of the report of two very interesting cases. We quote the doctor's conclusions regarding the cases:

(1) The swelling of the legs in both cases began at the periphery. The first lost power of the limb; the second did not. (2) Both veins and lymphatics were involved in both cases, the veins being inflamed, the lymphatics being obstructed. (3) The phlebitis was produced by the precipitation of the fibrin by the action of the septic agent, which had been either developed in the blood or had made its way into the fluid. (4) The predisposing cause in the first case, besides the hypernotic state of the blood in all pregnant women, was the varicose veins. (5) In the second case, besides the condition of the blood and a moderate varicose condition of the veins, the doctor believed that the loss of blood at the confinement was the great cause of the trouble, weakening an overtaxed nervous system. (6) The modes of death were different, the first dying from pyæmia; the second from thrombosis, producing asphyxia, from arresting

circulation in the lungs. (7) The pathology of this interesting disease was still somewhat obscure, and much as yet to be found in reference to it.

Dr. A. H. Wright said he agreed with Dr. Campbell that the first patient died from septicæmia. The second case was more like an ordinary case of phlegmasia dolens. As to the prevention of phlegmasia dolens, Dr. Wright said the same precautions should be taken as are taken to prevent septicæmia. As to treatment, he was strongly opposed to big doses of quinine, antipyrin, or phenacetin.

Dr. Harrison related the history of a case in a man, following an attack of typhoid fever.

Dr. Adam Wright said that he had tried this form of treatment in a few cases, with satisfactory results.

Dr. Graham also commended the treatment. He had tried it in a number of bad cases, but was not satisfied with its effects in them so well as in the milder cases. One thing the treatment had taught them: that purgatives could be given with comparative immunity. For high and continuous temperature, he still had more faith in the cold baths. These tended to increase the elimination of urine, and hence of large quantities of the poison.

Dr. Harrison referred to Dr. Doyle's treatment of giving 10 or 15 grain doses of calomel and copious rectal injections, by which good results had been attained in the treatment of typhoid.

Dr. Saunders doubted if these mild cases of fever which ended early on free purgation were really typhoidal. The trouble, he said, with these different forms of treatment was that often statistics were unreliable, because epidemics varied so much in character. Instead of antiseptics, he had, like Dr. Graham, more faith in external applications of cold.

Dr. McKinnon said the matter of elimination could not be ignored. In mild cases, it acted, with him, satisfactorily. In a case cited, he spoke of the drop in temperature, the improvement of the mental condition, and of the circulation.

Dr. Thistle pointed out that in the forty-two cases reported the diagnoses had been made by able men, and should not be questioned. The elimination of the poison by the liver he considered greater than by the kidneys.

Dr. Bethune said he had practised in the country 38 years, and had thousands of cases. He held that many of the cases reported as cured by the antiseptic and eliminative treatment, and said to be terminated early by the treatment, were not the genuine typhoid at all, but a malarial or bilious type of fever.

THE ANTISEPTIC AND ELIMINATIVE TREATMENT IN TYPHOID FEVER.*

This subject was presented by Dr. W. B. Thistle, of Toronto.

* Will appear in THE CANADIAN PRACTITIONER

A paper on "Science in Medicine" was read by Dr. F. Oakley, Toronto.
Dr. D. Marr read a paper on

THE TREATMENT OF PULMONARY TUBERCULOSIS.

After treating of the idiosyncrasies of the disease, the doctor said that "the generally accepted doctrine is that the primary etiological factor of tuberculosis is bacilliary. Then why does it not develop in all catarrhal inflammation of the respiratory tract?" In the doctor's opinion there exists a something, either inherited or acquired, which prevents the lodgment and growth of the bacillus of tubercle in individual cases. He then dealt with the treatment of the disease, which, he said, should have two principal objects, first, the strengthening of the tissues of the body for fighting the invasion; secondly, the neutralization and destruction of the toxic substances already generated. After treating of climatology and the physical signs of the disease, the speaker gave his course of treatment. He gives creasote at the onset in the following combination:

R. Morson's creasote..... mm 128.
O*i.* Ment. Pip..... ʒss.
Spt. Chloroform..... ʒii.
Tr. Gent. Co..... ʒi.
Tr. Nuc. Vom..... ʒiiss.
Spt. Frument. ad..... ʒviii.
Sig. ʒi., three, four, or five times a day in water.

The doctor lays pressure on the fact that the creasote and Spt. Frument. should be the best obtainable.

For the cough the doctor gives the following spray:

R. Menthol..... gr. v.
Thymol.... gr. i.
Eucalyptol..... aa mm x.
Gaultheria.... aa mm x.
Phenol..... gr. iii.
Ol. Petrol. Alb., q.s. ad..... ʒi.

He claims that hæmoptysis has never been an alarming symptom under administration of the following:

Acid Sulp. Dil., Ext. Ergot. Fld., Acid Gallic, and Tr. Cinnamon.

Dr. E. H. Stafford, of Toronto, presented a paper, entitled

NOTES ON PARESIS.

The doctor said it was not until a few years ago that general paralysis or paresis was recognized by alienists as a distinct nervous disease, and for this reason the statistics of to-day, which show it to be so greatly on the

increase, may be, to a certain extent, misleading. As the earlier stadia of the affection, before admission to an asylum becomes necessary, often pass unrecognized by the general practitioner, a clearer understanding of the clinical signs of these stages has become a desideratum, and it is to this end that the present paper was read, attention being called incidentally to the helplessness of the student of psychiatry, through lacking a systematic pathological basis for the classification of mental diseases.

SPECIAL FORMS OF ULCERATION OF THE CORNEA.

The above paper, by Dr. G. S. Ryerson, M.P.P., was read by title. It dealt with the round ulcer and its chronicity; the funnel-shaped ulcer, its painfulness and tendency to perforation; the ring ulcer, surrounding the whole cornea, causing that structure to slough off; to the undermining characteristic of the rodent ulcer; and to the serpenty ulcer of Salmisch, which is often attended by hypopyon.

In cases attended by pain and irritation atropine should be used, but eserine was more beneficial in cases where there was much sloughing. The eserine should not be used in too strong solutions, one-quarter to one-eighth of a grain to the ounce being a proper strength. Special reference was made to the use of hot water in the form of a spray. The sheet anchor, however, in all serious forms of ulceration, was the actual cautery, more especially in those of primary origin.

Papers by Drs. Reeve, Sweetnam, Davison, and Teskey were read by title.

Dr. D. Campbell Meyers read a paper on

A CASE OF TRAUMATIC NEURASTHENIA,

and exhibited the patient. About a year ago the patient, a farmer of thirty years of age, was knocked down by a restive colt. He remained unconscious for a few moments, and on recovery he found that there was a super-parietal wound on the left side, with hæmorrhage, and that blood was also flowing from the left ear. The external injuries had disappeared soon, but muscular asthenia set in, accompanied by deafness of the left ear. The doctor diagnosed the case as traumatic neurasthenia, and the treatment consisted of central galvanization at first, followed by static electricity. Sodium, bromide, arsenic, ergot, and strychnine, were administered, with sulfonal for the insomnia. The patient has improved splendidly under the treatment, and is now practically a cured man.

The officers for the coming year are: President, Dr. Grasétt, Toronto; vice-presidents, Drs. McKinnon, Guelph; Gibson, Belleville; Wilson, Richmond Hill; McCallum, London; general secretary, John N. E. Brown, Toronto; assistant secretary, Chas. A. Temple, Toronto; treasurer, G. H. Carveth, Toronto. Windsor was chosen as the place for meeting next year.

Book Reviews.

TRANSACTIONS OF THE SOUTHERN SURGICAL AND GYNÆCOLOGICAL ASSOCIATION. Volume VII., seventh session, held at Charleston, S.C., November 13, 14, and 15, 1894. Published by the Association.

This volume of transactions is quite equal to those which preceded it. We have several times had occasion to refer to the remarkably good work done by this very vigorous society. We have much pleasure in extracting the following from the able address of the president, Dr. Cornelius Kollock, of Cheraw, S.C.: "Its (the association's) founders are earnest men, but there is one among them especially earnest, having its welfare much at heart, a hard and willing worker, an excellent operator, well known to the medical men of the South and of the North, striving for the advancement of the South, Southern in sympathy, yet catholic in spirit. This man is Dr. W. E. B. Davis, of Birmingham, Alabama, the secretary of the association." We believe this distinguished surgeon and worthy officer well deserves these words of praise. We rejoice in the prosperity of this excellent society, which worthily represents the exponents of surgery and gynæcology in the "sunny South."

THE AMERICAN ACADEMY OF RAILWAY SURGEONS. Official report of the first meeting, held at Chicago, Ill., November 9 and 10, 1894. Edited by Dr. R. Harvey Reed, Columbus, Ohio.

This little volume is replete with subjects of great interest to the profession. The first part of the volume gives a history of the organization of the Academy, etc., etc., which is historically interesting. The good work of the Academy is apparent by a perusal of the papers and discussions. We must refer to a very elaborate résumé of the question, "The best methods for approximately determining the amount of damages sustained by traumatism, from a monetary standpoint," by Dr. R. S. Harnden, surgeon, Erie Railway Co., of Waverley, N.Y. The paper shows very exhaustive research, and a careful consideration of the minor details which go to make up a personal damage. It also places the adjudication in the "law" and "claims" department of the railway, and rightly considers that the medical department should be exempt from interfering with damage adjustments. We hope the Academy will continue to prosper, and do as good work as the present report indicates. Dr. R. Harvey Reed, of Columbus, Ohio, the secretary, has spared no pains in making the volume complete and attractive.

THE DYSPEPSIA OF PHTHISIS. Its varieties and treatment. Including a description of certain forms of dyspepsia associated with the tubercular diathesis. By W. Soltan Fenwick, M.D., B.S. Lond., M.R.C.P. Lond., Assistant Physician to the Evelina Hospital for Sick Children, etc. London: H. K. Lewis, 136 Gower street, W.C., 1894.

Physicians will readily see the advantage of a work on this subject, which plays such an important part in the history of pulmonary tuberculosis. Ample proof will be found in this book to show the frequency of dyspepsia in phthisical patients, both prior to and during the disease itself.

The opening chapters are devoted to the pathology and morbid anatomy of the stomach and intestine in phthisical patients. Such frequent occurring conditions as dilatation of the stomach, chronic catarrh, irregularities of the mucous membrane, interstitial inflammation, receive due notice. The great rarity of tuberculous ulceration of the stomach, contrasted with that of the intestine, is attributed both to the antiseptic action of the gastric juice, and to the small quantity of lymphoid tissue in the wall of the stomach. The author, having described these pathological conditions, takes up the clinical side of the question, and describes in a very lucid manner the dyspepsia of strumous children, the dyspepsia which frequently precedes the development of pulmonary tuberculosis, initial dyspepsia of phthisis, and the dyspepsia of advanced phthisis. The author pays such particular attention to the dyspepsia which frequently precedes phthisis that alarm may be taken lest an intractable dyspepsia be a precursor of phthisis. However, we must remember that only a few of the great number of dyspeptics are attacked by pulmonary tuberculosis. The volume is neatly gotten up, and printed on good paper.

The following Books and Pamphlets have been received :

LECTURES ON THE SURGICAL DISORDERS OF THE URINARY ORGANS. By Reginald Harrison, F.R.C.S., member of the Council, and lately one of the Hunterian Professors of Pathology and Surgery, Royal College of Surgeons of England, etc., etc. Fourth edition. London: J. & A. Churchill, 11 New Burleigh street.

Medical Items.

DR. A. EDWARD AWDE, of Toronto, was married on June 22.

DR. and MRS. J. E. GRAHAM are spending a few weeks at Pigeon Cove, Mass.

DR. GEORGE H. CARVETH and family spent their holidays in Muskoka—at Clevelands.

DR. CHARLES CARTER, of French River, is spending a week at his home in this city.

DR. WILLIAM OLDRIGHT, who is spending the summer in Europe, attended the meeting of the British Medical Association in London.

THE American Orthopædic Association will hold its ninth annual meeting at Chicago, September 17, 18, and 19, 1895, under the presidency of Dr. John Ridlon, of Chicago.

THE American Laryngological Association held its seventeenth annual meeting in Rochester, June 17, 18, and 19, 1895, under the presidency of Dr. John O. Roe. Dr. Wm. H. Daly, of Pittsburg, was elected president for the ensuing year.

AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNÆCOLOGISTS.—The eighth annual meeting of this association will be held at the Auditorium Hotel, Chicago, September 24, 25, and 26, 1895, under the presidency of Dr. J. Henry Carstens, Detroit.

AN ECONOMIST.—“If you insist on knowing the truth, madam,” said the doctor, “your husband will not live twenty-four hours longer.” “Good gracious!” ejaculated the broken-hearted but economical wife, “and yet you have sent in medicine enough for five days.”—*Fliegende Blätter*.

THE American Electro-Therapeutic Association will hold its fifth annual meeting at the College of Physicians and Surgeons of Ontario, in Toronto, Canada, on Tuesday, Wednesday, and Thursday, September 3, 4, and 5, 1895. A most cordial invitation is extended to the medical profession to attend the sessions, all of which are open. For information as to traveling facilities, address Dr. Charles R. Dickson, 159 Bloor street east, Toronto, chairman Committee of Arrangements. Dr. Emil Heuel, secretary, 352 Willis avenue, New York City.

OBITUARY.

PROFESSOR WILLIAM C. WILLIAMSON, F.R.S., Emeritus Professor of Botany in Owens College, Manchester, died June 23, at the age of 78.

DR. HORACE P. REDNER, of Lonsdale, county of Hastings, Ontario, died May 15, at the age of 50 years. He was born in Belleville, and received his degree of M.D. from McGill in 1864.

JOHN DAVIDSON MCCONNELL, M.B.—The many friends of Dr. McConnell were shocked by the announcement of his sudden death in England, August 1st. He was attending the session of the Supreme Court of the Independent Order of Foresters, and appeared to be in good health. He left the session about 4.30 in the afternoon, and about fifteen minutes later was found dead in the lavatory. He was born at Markham in 1844, and received his medical education at the Toronto School of Medicine, graduating at the University of Toronto in 1869. He practised in Thornhill until 1882, when he moved to Toronto. In addition to his work as a physician he took an interest in politics, and was for a time an alderman. He was prominent in various societies, including that of Masonry. He was active, energetic, and enthusiastic in every work he undertook, and was especially loyal to his *alma mater*—the University of Toronto. In addition to his widow, two daughters and one son, he left a large number of warm friends in various parts of Canada.