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## Original Articles

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### \*HEADACHES AND HETEROPHORIA.

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No one symptom in the whole range of clinical medicine causes more annoyance to the patient and is a greater source of worry to the practitioner than persistent headache. Almost every organ of the body, in turn, is accused of being the offender, but the liver and the uterus have to take the greater part of the blame, and are maltreated and punished accordingly, very often with little benefit to the patient. After months of treatment of these unfortunate organs, he or she is sent to the ophthalmologist, if in the meantime the patient has not taken the matter into his or her own hands and consulted an optometrist, who successfully sells several pairs of glasses. As is well known, astigmatism and other refractive errors are frequent causes of headaches, but muscular imbalance plays a prominent part in causation. It may be said axiomatically that refractive headache is mostly frontal; uterine headache, bregmatic; and heterophoric headache, occipital.

In heterophoria the headache is accompanied by other symptoms of a reflex or neurotic character, presenting a symptom-complex which may simulate grave organic disease: such as pain between the shoulder blades, nausea, vomiting and dizziness, confusion of vision, confusion of mind, and fear of accident in crowded thoroughfares. Use of the eyes on railroad trains, street cars, or in shopping, render these symptoms acute. Restlessness is commonly marked, especially in children. Stevens and others have held that migraine, chorea and epilepsy result from heterophoria, and there is good

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\*Read at meeting of Ontario Medical Association.

reason to believe that these opinions are, in some cases, well founded.

The following cases well illustrate the conditions produced by heterophoria: A boy aged eleven years was brought to me by his father, in February last, complaining of almost constant headache, and of confusion of vision and mind. He said that he lost the line when reading in his book and on the blackboard so that he was always making mistakes, and was considered a very dull boy, and was quite discouraged in consequence. He was very restless in school, and was constantly reprimanded for not sitting still. The pain he complained of was at the back of his head. He had an occasional twitching of the alae nasi, and his parents noticed that when he chewed his head was jerked upwards, backwards and to the right. Examination showed hyperopia and right hyperphoria,  $4^{\circ}$ . After wearing his correction for a time without relief of the symptoms, partial tenotomy of the right superior rectus was done. A month later jerking of the head had greatly diminished, and at present has almost disappeared. His headache is relieved and he is able to follow the lines in his book without difficulty.

*Case II.*—This case illustrates the benefit to be derived from partial tenotomy of the external recti in exophoria, both for near and distance. Mr. S., manager, aged 36, had constant headache referred to the occiput, confusion in reading and difficulty in fixing his eyes. He always came home from the theatre with a headache. Examination showed a small amount of hyperopic astigmatism, which was corrected under homatropin, but without much benefit. A partial tenotomy of both external recti was made with most gratifying results.

*Case III.*—The following is an illustration of the relief of epilepsy by the treatment of the hyperphoria. W. M., aged 30, came to consult me March 10th, 1905. He gave a history of suffering from severe headaches from which he got some relief by bending his head as far backwards as possible. For a year or more he had had slight epileptic attacks with loss of consciousness. They were not severe and were unattended by protrusion or biting of the tongue. They probably lasted but a minute or so, and in half an hour he had recovered except for a feeling of listlessness and drowsiness. Examination showed a myopia of 4 D., with hyperphoria right of 6 degrees. After correction I partially divided the right superior rectus. A test showed that there was still 2 degrees of hyperphoria. In spite of this he steadily improved and the attacks ceased. I kept track of him for two years, during which time he continued well, but have not heard from him since.

What is the proper course to pursue, operation or prisms? Obviously the first consideration should be the correction of the refraction. I believe many cases of slight heterophoria correct themselves when the irritation of incorrect or of no glasses is removed. In other cases where there is little or no refractive trouble hyperphoria, even as little as 2 degrees, will give rise to annoyance, and must be corrected by prisms. This is especially true of hyperphoria. It may be necessary to do tenotomy in some of these cases. I think that where after wearing a prism, singly or combined with a spherical glass, and exercise with a prism of five degrees or thereabouts, for some time without relief of the symptoms, a partial tenotomy is indicated. I would recommend a partial tenotomy in all cases of hyperphoria or exophoria of three degrees or upwards, but I would be chary about operating on the internal rectus. I would prefer a small advancement of the opposing muscle. It is serious matter to weaken any one's accommodation, and the case should be studied with great care. Finally, let me deprecate promiscuous operating for heterophoria. Choose your cases carefully, and do not divide the tendons unless you are convinced that nothing else will do the work as well.

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### TORSION OF THE PEDICLE OF AN OVARIAN CYST.\*

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BY E. R. SECORD, M.D., BRANTFORD.

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It is my desire to present the following notes of a case of torsion of the pedicle of an ovarian cyst, because they illustrate in an exceptionally clear manner the sequence of events when such an occurrence happens.

Mrs. K., aged 37, the mother of four children, was confined on Nov. 4th, 1910. She was attended by my friend, Dr. Addison, of St. George, and he has kindly contributed the following description of the early events in the case.

Her labor was quite normal. She was visited on Nov. 6th and 11th, and on these occasions pulse, temperature and lochia were all that could be desired. She was permitted to get up on the 14th. Dr. Addison was called to see her at 11 o'clock p.m. on this date, and on arrival was told that she had been out of bed in the afternoon, and towards evening she picked up one of the children who

\*Read at meeting of Ontario Medical Association.

required some assistance. She immediately felt sharp pain in the right lower quadrant of the abdomen, and had to be helped to bed. At the time of the doctor's visit her pulse was 120, and temperature 101 F. Her abdomen was slightly distended, and very tender, especially in the right iliac region. The uterus was quite movable, but drawn to the right, while in the right fornix, above and behind, could be felt an indistinct tender mass. Believing the case to be one of salpingitis, with commencing peritonitis, small doses of morphia were given, and hot boracic vaginal douches ordered.

There was no improvement on the 15th, and I saw her for the first time on the 16th, when the picture was that of a moderately sharp attack of pelvic peritonitis—abdomen distended, very tender, but not markedly rigid. An indistinct tender mass occupied the right fornix. There had been no movement of the bowels since the onset of the attack—calomel and rectal enemata both proving ineffectual. Ice bags were applied to the abdomen and the hot douches continued. During the next three days the distension increased, absolute constipation continued, the temperature dropped to normal, the pulse became more rapid, the patient more restless, and continuous hiccough with occasional vomiting supervened. In short, the picture of abdominal inflammation had given place to one of acute obstruction. An interesting feature at this time was the entire absence of visible paristaltic movements—a symptom I place great reliance on in the diagnosis of mechanical obstruction of the bowels, nor could any be elicited by flicking the abdominal wall. A very occasional gurgling could be detected by the ear placed over the abdomen. The pelvic mass was larger but extremely hard to map out, owing to the distension. An aspirating needle was introduced into this without result.

Feeling that the patient was dying from obstruction of the bowels of the paralytic type, possibly due to a peritonitis, I advised laparotomy. This was hurriedly done without removing the patient from her bed. Through a short incision in the right rectus below the umbilicus, a coil of distended small intestine was withdrawn, incised, and a tube introduced. There was no free abdominal fluid, though the peritoneum was intensely injected. Owing to the extremely bad condition of the patient I made no further exploration. For twenty-four hours her condition was critical, but gas and fluid feces were finally passed from the artificial anus, assistance being given by turpentine stupes, and gentle abdominal massage.

The distension gradually subsided, some bowel contents being

now passed per rectum, and what appeared to be a localized aseptic collection on the left side of the abdomen became revealed. The abdominal wall over this collection was quite flaccid, and within certain limits the fluid moved with movements of the patient, though definitely localized on the left side, reaching from pelvis to ribs. Gradually this collection became more distinct, and I was considering the advisability of section to determine its nature, when on Dec. 9th she was seized with a severe chill, and the temperature rose to 104 deg. F. This soon dropped to normal, but went to about the same level on the following day. The pulse rate was increased to about 130, and the facial expression was bad, breath foul, and in short every evidence of a severe toxemia.

On Dec. 11th I opened the abdomen by a median incision, great care being taken to avoid soiling of the wound by the discharge from the artificial anus. On incising the parietal peritoneum, a dark red ecchymotic membrane was found everywhere adherent. I punctured this with a trocar and drew off a large quantity of hemorrhagic fluid, then introduced a finger into the cavity and proved it to be an intra-abdominal cyst. I then carefully separated the adhesions upward and laterally, separating adherent omentum, large intestine, and numerous coils of small intestine, and was finally able to deliver part of the cyst wall through the incision. I was then able to work down behind the cyst into the pelvis, and finally to follow the cyst wall to its pedicle, which sprang from the right ovary, was about the size of an ordinary lead pencil, and contained the most clearly defined example of axial rotation, from the patient's right to left. The wall of the cyst was ecchymotic, and in many places very soft, being punctured and torn in numerous spots while separating the adhesions. In other words the cyst wall was undergoing necrosis. Feeling that herein was the complete explanation of the symptoms, I ligated the pedicle, removed the cyst, mopped out the abdominal cavity, closed the incision without drainage, and had the satisfaction of seeing the patient make a complete and uneventful recovery.

After some weeks the skin around the artificial anus was becoming pretty raw and excoriated, and as considerable fecal matter was being passed per rectum, I decided on closing the artificial opening, which was accordingly done on Jan. 4th. The adherent bowel being carefully separated, the loop of ilium was drawn outside the abdomen, the opening closed with a two layer suture, the loop returned, and the abdominal wall closed in layers. Again an uneventful recovery ensued.

Torsion of the pedicle of an ovarian cyst is not a very rare con-

dition. Rokitansky is quoted as saying that it develops in 12% of all cases, but from the expressed opinions of Canadian and American authors I would be inclined to think this above the average.

It has occurred during pregnancy, and this is set down by some writers as a factor in determining this accident, but so far as I have been able to review the literature, its occurrence during the puerperium is rare.

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## HOSPITALS FOR INEBRIATES.

BY A. M. ROSEBRUGH, M.D., TORONTO.

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*In Great Britain* there are three classes of institutions for the treatment of inebriates, as follows:

1. The "Retreats."
2. The "Certified" Reformatories, and
3. The "State" Reformatories.

1. The "Retreats" are private hospitals under government inspection. There are twenty-two of these institutions in England.

2. The "Certified" Reformatories are established by counties or union of counties, but the expense of maintenance is borne wholly by the Government. They receive cases committed to them by the courts, and they are under Government inspection.

3. The "State" Reformatories are Government institutions for the segregation of imbecile and unmanageable drunkards, transferred from the "Certified" Reformatories. On account of the encouragement given by the Government through the "Inebriates" Act of 1898, the number of Certified Reformatories has increased from three to eleven, and during that period over 3,000 patients have been received from the courts. The twenty-two "Retreats" receive on an average 500 cases a year.

*Australia* is profiting by the example of Great Britain in the public care of inebriates.

*In New South Wales* reformatory efforts were commenced by the Government in 1907. Institutions for this purpose have been established in connection with jails.

*In Victoria* an Institution for Inebriates was founded in 1907. At Lara a mansion has been purchased by the Government for the reformation of inebriates. The land attached covers one square mile.

*In New South Wales* a portion of Darlinghurst Jail has been set apart for the reception of habitual inebriates on indeterminate sentences.

*Germany* has no State Hospitals for Inebriates, but private hospitals are assisted by the German Imperial Insurance System. There are about fifty private institutions for inebriates in Germany. They receive aid from local poor commissioners as well as from insurance companies.

*Denmark* has five private Institutions for the Reformation of Inebriates, and which receive Government aid.

*Hungary* subsidizes a private Inebriate Hospital near Budapest.

*Switzerland* has eleven "Colonies" for the treatment of alcoholic cases. They receive aid from the Government monopoly in alcohol. Switzerland leads the world in the scientific study of alcoholism, and a large percentage of cures are reported.

*United States.*—Although there are at present but two State Hospitals in the United States for the treatment of inebriates, steps are being taken in a number of the States with a view to their establishment.

*In Massachusetts* a hospital at Foxborough for the medical treatment of inebriates has been in operation for a number of years, and at Knoxville, Iowa, a hospital has been in operation for two or three years.

Two years ago the Legislature of Minnesota adopted a bill providing for the establishment of a hospital or reformatory, and at the last session of the New York Legislature a bill was adopted authorizing the establishment of a farm colony by the city of New York.

*Farm Colonies.*—At Cleveland, Ohio, there is a farm colony located on a very extensive tract of land for the reformation of inebriates. There is also a farm colony at Bridgewater, Massachusetts, with ample grounds, which is used for the detention, on indeterminate sentences, of vagrants, as well as for the defective and apparently hopeless criminal drunkards.

#### A NEW DEPARTURE.

Massachusetts is making a new departure in its provision for the care and cure of its inebriates. A second farm colony is being established on a large tract of land such as will permit of three classes of inebriates, widely separated, receiving distinct and separate care and treatment, as follows: (1) A hospital and grounds for men. (2) A hospital and grounds for women. (3) A detention colony for observation and care of inoffensive but seemingly hopeless chronic inebriates.

## THE SITUATION IN ONTARIO.

When the late Sir Oliver Mowat became Premier of Ontario he was strongly impressed with the great need of provision being made for the reformation of drunkards, and he proposed establishing an institution for their reformation at Hamilton. Much to his regret, however, he was obliged to abandon the project, as he found that public opinion did not seem to him to be sufficiently ripe to justify incurring the necessary expense; for which reason the proposed institution was changed to an Asylum for the Insane.

In 1891 the Prison Reform Commission appointed by the Ontario Government reported very strongly in favor of the establishment of at least one reformatory in Ontario for the reformation of drunkards. When, however, the attention of Sir Oliver was called to this recommendation, he stated that his Government would be pleased to co-operate in the establishment of one or more reformatories in the Province, but that the initiative could not be undertaken by the Government. However, as this offer was never put in such a form by the Government as could be made use of as an incentive to voluntary effort either on the part of the municipalities or private individuals, nothing came of the offer.

## THE SITUATION IN TORONTO—A HOSPITAL REQUIRED.

The Ontario Society for the Reformation of Inebriates was organized in Toronto five years ago. The object of the Society is:

(1) To promote the reformation of indigent inebriates in Ontario: (a) By making use of the public hospitals of the Province for the purpose; and (b) by combining therewith the Massachusetts Probation System.

(2) The second object of the Society is to promote the reformation of inebriates in Toronto as follows: A medical officer and a probation officer attend the Police Court and offer medical treatment and a helping hand to inebriate prisoners found desirous of such help. The medical treatment is given by the medical officer either in the home, at the office of the physician, or in a ward of one of the public hospitals of the city. The probation officer acts the part of a friendly visitor, assists in finding employment when necessary, and helps to a better life. By means of these combined efforts no little good has been accomplished. The work is heavily handicapped, however, from the lack of proper hospital accommodation. The public hospitals are frequently overcrowded, and moreover lack facilities for the up-to-date scientific treatment of inebriates. A small hospital—a "Cottage Hospital"—is urgently required in Toronto for this purpose. It is true that the City



Council is committed to the scheme of establishing a farm colony within, say, 10 miles of the city for the detention and proper treatment of inebriates, but two or three years may elapse before this boon can be realized. Moreover, a reception hospital in the city will be required in connection with the proposed farm colony. Under the circumstances the Executive Committee of the Society consider the time ripe for grappling with the problem. It is proposed to ask the Ontario Government for one-third the amount required, the City Council one-third and the benevolent public one-third. In this project may we not count upon the sympathetic co-operation of the medical profession?

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### \*INFECTIOUS AND CONTAGIOUS DISEASES.

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The upper air and digestive tracts are coming more and more to be considered as the port of entrance to the general system for many of the infections and contagions. The following list of diseases—some of them generally, and some of them occasionally—have as ports of entry the mouth and nose:

1. Diphtheria, with or without streptococcus complications.
2. Streptococcus infections—so called pseudo-diphtheria.
3. Influenza.
4. Pneumonia—the pneumococcus being present in the mouths of nearly all persons, adhering to the mucous membranes, and expelled by coughing and by cilia.
5. Otitis media.
6. General sinusitis.
7. Cerebro-spinal meningitis—in which it is commonly conceded that the nasal mucous contains specific organisms.
8. Intestinal and pulmonary anthrax.
9. Glanders—where usually the disease is first manifest in the nose, in the form of ulcerations on the mucous membranes.
10. Bubonic plague.
11. Leprosy.
12. Spirilla infections.
13. Spirocheta pallida.
14. Chancroids.

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\*Read at meeting of Ontario Medical Association.

15. Tuberculosis.
16. Mostly all bacterial diseases, protozoa infections, fungi, etc.
17. Staphylococcus infections of the lungs and middle ear.
18. Pyorrhœa.
19. Milk infections—although directly considered, they are somewhat outside of the realm of the laryngologist; indirectly, they are within it, through secondary manifestations and complications.
20. Scarlet fever.
21. Measles.
22. Follicular tonsillitis.
23. Alveolar abscess.
24. Cerebral meningitis—the infection here entering by way of the tonsils, etc., into the general system.
- 24a. Acute rheumatism with its tonsillar manifestations may be superinduced by diseased tonsils, as certainly relief from many attacks has been obtained by their removal when diseased.
25. Phlebitis, erysipelas, pericarditis, peritonitis, by tortuous extension.
26. Serpiginous ulcer of the cornea.
27. Enteritis.
28. Septicemia.
29. Headaches resulting from sinus infections.
30. Mental phenomena.

The many complications that may result from the above diseases and conditions will occur to most of us, and proportionately add to the importance of these organs, and point to a means of preventing or augmenting the percentage of the diseases with which we have to deal, either as general practitioners or as practitioners of any of the various specialties.

Of the above mentioned infections, if we except the tubercle bacilli and the germs of suppuration, bacterial evidence seems to indicate that no germs are carried by the air or can be carried by dust and retain their virulence. Coughing, sneezing, and talking cause showers of droplets that are laden with infection—at least for the distance to which they are carried. Smallpox is still by many believed to be air borne, but even here the fact that during epidemics the disease is less prevalent the farther the radius from the isolation depots. Careful investigation shows the propagation to be largely due to direct contact through intermediaries of various kinds.

In the Pasteur Hospital in Paris, each patient is cared for in a separate room opening into a common hall. The doors are fre-

quently opened and left open. In the first thirty months of this hospital's existence, beginning in 1900, 2,000 patients were received, of whom 524 had smallpox, 163 erysipelas, 92 scarlet fever, 166 non-diphtheretic sore throats. The same nurses cared for patients with the different diseases, taking surgical precautions before going from one patient to another. The only evidence of transfer of infection among the 2,000 was the development of four cases of smallpox and two of erysipelas.

At the children's hospital in Paris, partitions separate the beds in the same wards. Asepsis is practiced, and all kinds of contagious diseases are treated, including typhoid and pneumonia. Out of 5,017 cases treated, only seven cross infections developed—six of measles and one of diphtheria. This would seem to indicate that there is not much evidence that the bacteria of these diseases are air borne to any considerable extent for any great distance. There is evidence that tubercular and pus germs are air borne; not much evidence that smallpox, measles, whooping cough, typhoid, etc., are transmitted in this way.

But whether disease germs entering the general system are conveyed by air or by direct contact, it is worth the time of the rhinologist to have his attention directed to the fact that they are within the scope of his work, in order that he may protect his patients by devising means of prevention for diseases entering the body through the nose and mouth. The means of lessening the chances of infection are in the hands of all of us, and as the subject receives more thought better and more numerous means will be devised.

Syphilis, tuberculosis, influenza—in our own time—and other diseases, show a partial or complete immunity—at least greater resistance develops in races and individuals—from the virulence of these diseases, as a result of being infected from time to time and from generation to generation, so that it may be more advantageous to the race that the individual be not entirely protected from gentle or light infections. The virulent infections, however, can transmit nothing to the race where the infected are killed, nor can the gentle one transmit anything favorable to an individual, of slight resistance, where the same ending results.

The external air passing through the nasal cavities undergoes changes of temperature, moisture, and freedom from suspended foreign substances before reaching the lungs. The spaces between the septum and external walls of the nose must not be too wide or too narrow—as we find by the discomfort produced by atrophic and hypertrophic cases, as well as in other conditions. Closure may be

manifested only in the recumbent position or in certain atmospheric conditions interfering with proper modifications of the air referred to above and predisposing to mouth breathing and changes in the mucous membranes and other tissues, thereby interfering with the natural resistance and predisposing to bronchitis, pneumonia, etc.

No work that I am conversant with has been done to mathematically prove that nasal abnormalities predispose their possessors to cerebro-spinal meningitis or other infections, but it is known in a general way that influenza and other infections are more severe and more likely to be followed by complications—and proportionately more frequent in cases where sinus trouble or other abnormalities are present. Diphtheria and scarlet fever are known to be proportionately more severe where adenoids and tonsils are enlarged or diseased. Coryza attacks the individual with a deflected septum or an occluding ecchondrosis much more readily than where conditions are normal. Of course if coryza is superinduced by the above conditions, and if tonsillitis is superinduced by abnormal tonsils, we know that pneumonia, peritonsillar abscess, rheumatism, Bright's disease, peritonitis, etc., etc., are also invited by neglect of these and other conditions.

In a general way, rhinologists know the above to be facts. From the evidence of statistics, however, we have little proof. The best opportunity of getting evidence of the relative frequency—say of acute colds in those affected with nasal abnormalities—lies with the general practitioner, as he sees more of them, but he is not so awakened to the diagnosis of nasal conditions or to their effect as to endeavor to gather statistics of value. When I graduated I did not practically know, by inspection, an ecchondrosis from a deflected septum or from a swollen turbinate; and very few general practitioners know a nearly normal nose when seen, so that evidence from that source, generally speaking, would not be as reliable as we could wish. The rhinologist does not see as many cases of acute coryza—although he sees the sequelae—but when he does, he might gather figures, and in the aggregate he might get some statistics of value. It would seem to be undoubtedly true that many illnesses could be prevented were nasal and pharyngeal secretions kept from decomposing in the upper air and digestive tracts, whether the patient be well or sick. For instance, it may be that the nasopharyngeal catarrh of typhoid fever plays a part in inducing the pneumonia of typhoid. In any case, these patients are more comfortable after a mouth and throat cleansing.

The above reference to the general practitioner is not intended as an adverse criticism. It is impossible that any man can

thoroughly cover the entire field of medicine; even the specialist may find it difficult to keep abreast with the progress made in his own department. Indeed, the general practitioner, within human capacity fulfills the demands required of him more conscientiously than the modern specialist—whether he be a rhinologist, a neurologist, or what not—who launches into his chosen department with no more practical knowledge of general diseases than that demanded for the passing of undergraduate examinations. For the patient to obtain the best that modern medicine can give is, in many instances, an expensive performance, but the public are of course ignorant of the many modern devices of laboratory diagnosis and indirect laboratory treatment, and in many cases only need to be directed and informed by the practitioner before making use of them.

Incidentally, I may say that the neglect of the doctor to inform patients and the neglect of patients to make use of the means of obtaining the best that can be given by modern medicine is partly responsible for their resort to fads for relief of real ailments, and the antagonism shown by the ignorant for laboratory methods. Those of the public who cannot afford to pay for the fullest investigation of their ailments are liberally provided for by the enlightened wealthy and our profession.

We who are doing nose and throat work are continually seeing patients whose stomachs are incapable of performing the work that health demands. Frequently pus from the sinuses or nasopharyngeal catarrh is behind the stomach disturbance; again, the stomach disturbance is responsible for augmenting the unhealthy condition of the upper air tract, both resulting from recurring infections of the nose and throat due to neglect, and perhaps to easily removable causes. Yet there are general practitioners who object to the rhinologist's administering even rhubarb and soda to a referred patient. It is for the best interest of the patient that the rhinologist should, in many of these cases, handle the case as a whole. The subjective throat symptoms are the important ones to the patient. The indications of improvement are manifested in the throat. The patient, though a millionaire, can and will find something pleasanter to do than to spend hours in the waiting rooms of the different practitioners of medicine.

The rhinologist must go past the point where his place in medicine is the removing of echondroses of the nasal septum, cauterizing the turbinates, or making a minor diagnosis for some one, who, in the nature of things, is a less competent man to treat and note the results of treatment. The general practitioner should understand this in cases that he refers to the rhinologist.

A patient of mine who had been relieved of a long standing digestive trouble through moderately intelligent attention to her infected sinuses, laughingly told me that a medical friend had advised her to go to a fifth general practitioner as no nose man could treat stomachs. Generally speaking, when the rhinologist, with his general knowledge behind him, has corrected evident local causes producing general disturbances, the patient should then, in the nature of things, do better in the hands of a man to whose work any special ailment points, whether he be a general practitioner or some one else.

Pneumococci in the upper air passages are undoubtedly the cause of the spread of pneumonia, especially in wards where most patients' resistance is lowered. Influenza, coryza, tonsillitis, cerebro-spinal meningitis spread by contact, and patients so afflicted should be isolated. The infective power continues after the patient is entirely well. In diphtheria, this has been proven. Why should not the same hold true of other infectious diseases? Patients with virulent infections should be isolated, and patients with lowered resistance should not be in such close proximity to any infection as to render their contracting of it likely. Many people are immune or are too resistant to contract ordinary infections.

Infection carriers should be more carefully investigated; also there are cases where bacterial examination is the only way in which a diagnosis can be made. This should be resorted to in the milder forms of certain diseases, where the looked for clinical symptoms are absent. The sick need more careful supervision, to the end that all serious infections be isolated. This is true of even acute colds, where possible—and with certain intelligent families it is possible. It is not for the infected laity to decide whether they have had certain diseases; the danger is not only to the sick, but to those who come in contact with them. Physicians themselves should be more careful in making calls on the infected, owing to the danger of carrying the infection.

As it would seem to be advantageous to the individual in order that his resistance might be increased, that he be infected lightly, but from time to time, and as surgical asepsis is impracticable for every one every day and all the time, we must be satisfied with reasonable cleanliness, except in acute cases, where, as nearly as possible, asepsis and isolation should be maintained.

The general practitioner should educate his families to the importance of infection and the possibility of carrying it. It is difficult to educate the older people; perhaps the young can be impressed with its importance in school, but teachers in the schools

cannot teach hygiene if they do not know it themselves. A good way to appeal to the adult is through his pocketbook, by showing him how financial loss results from neglect of precaution. Then he will understand and become scientific.

In hospital wards where laboratory tests show infection without symptoms, screens can be used, if no better method is available. Physicians could have circulars printed, dealing with infectious diseases, and distribute them to their patients, as they will learn more by that method than by word of mouth. Circulars might present statistics, showing economic loss. When coughing, a handkerchief should be held before the mouth. Fresh air and good breathing are important.

Much can be done while waiting for perfection. Normal resistance takes care of ordinary infections. Virulent infections need to be isolated, and persons with lowered resistance should be kept away from any infections.

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## Medicine

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GRAHAM CHAMBERS, R. J. DWYER, GOLDWIN HOWLAND,  
GEO. W. ROSS, WM. D. YOUNG.

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**Etiology of Constipation.** (Am. Proctologic Society.) By  
HORACE HEATH, M.D., OF DENVER, COL.

Dr. Heath mentioned two groups—miscellaneous and mechanical. Under miscellaneous, the author regarded heredity as unimportant, but attention was called to the faulty instruction of children in certain families. He stated that the constipation of infancy was due to undeveloped muscles; and of old age, to inactivity and atonicity.

Under mechanical causes he considered—diet, sedentary life, abnormal positions, angulations, colop<sup>t</sup>osis, and hypertrophy of the rectal valves.

The predisposing diseases mentioned were colitis, stricture, proctitis, fissure, hemorrhoids, fistula, polypi, enlarged prostate, and malignant growths.

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**Physiology of Constipation.** (Am. Proctologic Society.) By  
SAMUEL T. EARLE, M.D. OF BALTIMORE, Md.

In reviewing the physiology of constipation in the symposium read before the American Proctologic Society, June, 1911, Earle calls attention to the sensibility of the alimentary canal in connection with its bearing on constipation. It has been shown that the stomach and intestines are quite insensitive to tactile and thermal stimuli, but that the esophagus and anal canal are sensitive. The whole of the alimentary canal is, however, sensitive to distension, which produces at first discomfort and subsequently pain. The rectum appears to be more sensitive than the rest of the intestines to distension, so that a large fecal mass produces more discomfort when lodged in the rectum than in any other situation. As a result of this, the normal accumulation of feces in the pelvic colon is unaccompanied by any discomfort, whereas, the entry of feces into the rectum at once produces a sensation, which acts as a warning that defecation is necessary. The discomfort produced by the presence of a large mass of feces in the rectum is partly due to the pressure



it exerts on the upper extremity of the sensitive anal canal. Prolonged retention of feces in the rectum leads to a blunting of its sensibility, so that comparatively little local discomfort is present in most cases of confirmed constipation. But in acute cases or cases of recent origin, in which the rectum is distended with feces much discomfort and occasionally severe pain is experienced. On the other hand, even a very large accumulation in the pelvic colon produces little or no discomfort in the intestine itself.

A large fecal accumulation in the rectum presses directly upon the anterior primary divisions of the third, fourth and fifth sacral nerve routes, as they emerge from the sacral foramina. It may therefore lead to neuralgic pain referred to the sacrococcygeal region. It is liable to cause suffering more from its constant presence than its severity; it is often as severe when the patient lies down as when he takes exercise, but some relief follows flexion of the lumbar spine. The muscles of the buttocks and back of the thigh, which receive a small part of their sensory and motor supply from the third sacral nerve route, may be the seat of similar pain. Neuralgic pain or parasthesia, in the form of tingling or a sensation of heat or cold may occur, in the course of the sciatic nerve, in the back of the thigh, and occasionally the sensation of cramp in the calf is produced. Pain is also occasionally felt in the hip-joint, it receives part of its nerve supply from the third sacral nerve. The roots which supply the muscles of the front of the thigh, are situated out of reach of the distended rectum, so that in the exceptional cases in which pain is produced by constipation in this situation, it must be due to pressure exerted by a fecal mass in the iliac colon on the anterior crural nerve; and is accordingly only observed on the left side.

That these neuralgic pains are probably due to the direct presence of a large and hard mass of feces, on the sacral nerve-routes is shown by their instantaneous disappearance on completely evacuating the rectum by enemata, a form of treatment which was already advocated for sciatica by Columnius of Naples at the end of the eighteenth century.

Possibly the erections and seminal emissions, and the frequency of micturition and nocturnal incontinence, which occasionally result from large fecal accumulations in the rectum, are due to direct irritation of the third and fourth sacral nerves, and are not reflex in nature. The spasm of the sphincter ani and levator ani muscles, which has already been described as an occasional complication of the fecal impaction in the rectum, which occurs in constipation, may perhaps be in part due to pressure on the fourth sacral nerve routes.

Neuralgia of the testicles in men and dysmenorrhea in women are sometimes increased by the direct pressure in the rectum on the nervous supply of the testicles and uterus respectively.—*Arthur F. Hertz, on Constipation.*

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**Bacteriology and Urinary Findings of Constipation.** (American Proctologic Society.) By JOHN L. JELKS, M.D., OF MEMPHIS, TENN.

The author advances no new theories but expresses his views of the importance of both chemical and microscopical investigation in connection with clinical proctology, and the value of these examinations in cases of atonic constipation.

He refers to the importance of either finding, or eliminating, the presence of intestinal parasites, that are known to produce lesions in the intestinal coats and ports of entry of bacteria or their toxins. He expresses the belief that the destruction wrought to the sub-mucous structures, the infiltration of plastic material and the contracting, distorting, scarred portion of the bowel, as also the consequent destruction of, and interference with the secreting glands, their ducts and the nerve supply may become important factors in the atonic condition of some patients.

The author believes it is important to make microscopic examinations in all cases of this character—both of the crude and washed specimens, and of scrapings from the intestinal wall or from any lesion found in it. He also examines the urine chemically, and microscopically, believing this important, owing to the relationship and association of diabetes, kidney insufficiency and diseases of the kidney with cases of atonic constipation.

These examinations of the urine aid in determining the proper course of treatment, especially is this true when indicanuria, casts and sometimes traces of albumen, indicate the vicarious overwork of the tired and irritated kidneys, as also the intestinal fermentation and coprostatic auto-intoxication, which results in some cases.

The author refers to the importance also of examination of the stomach contents after test meals have been given, as these may furnish in some cases a clue to etiologic factors.

Blood examinations he finds quite important in determining the amount of opsonic resistance as also for finding infections in the blood, which matters by lowering the vitality may become factors in the atonic conditions which were being discussed.

## Surgery

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WALTER MCKEOWN, HERBERT A. BRUCE, W. J. O. MALLOCH,  
WALLACE A. SCOTT, GEORGE EWART WILSON.

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**The Surgical Treatment of Chronic Constipation.** (American Proctologic Society.) By LOUIS J. HIRSCHMAN, M.D., OF DETROIT, MICH.

Constipation is divided into two great classes, the one class being due to a lack of functional activity, i.e., dietetic error, improper habit, neural or trophic influences. The other class, which some of us have been pleased to designate as obstipation includes all cases whose impaired activity is due to mechanical interference with the normal peristaltic movements and expulsive function of the bowel.

Obstipation or obstructive constipation may be caused by:

- (1) The presence of any foreign body, occlusion, contracture, hypertrophy or accumulation in the intestinal canal.
- (2) Displacements, acute angulations, distensions, neoplasms, adhesions or compressions of the bowel.
- (3) Developmental defects and congenital deviations from normal.

Inasmuch as the surgical treatment of constipation, due to easily recognized local conditions, is obvious, they are dismissed with mere mention. Coloptotic constipation represents such a large percentage of cases of mechanical constipation that its discussion involves the most important field of surgery in the treatment of constipation. All patients with ptotic colons are not constipated, nor do all constipated patients suffer from coloptosis. There must be in addition to ptosis of the cecum, transverse or sigmoidal colons, a condition of functional inactivity due to atony of the bowel muscle. •

Suspensions of ptotic colons by means of fixation by adhesions to the abdominal wall are unnatural and interfere with peristalsis. Restoration should be accomplished by shortening the natural support—the mesentery. Lateral anastomoses between the most dependent loops of ptotic bowel is sometimes indicated. Above all, massage, both abdominal and internal rectal, is of primary importance in restoring function, and should be used along with either dietary or hygienic measures to restore bowel function.

**Some Observations Upon the Surgical Anatomy and Mechanism of the Colon.** (American Proctologic Society.) By GRANVILLE S. HANES, M.D., OF LOUISVILLE, KY.

Until comparatively recent years diseases of the colon and sigmoid, and the surgical anatomy of each, received but scant attention. Recently, however, much valuable information upon this subject has been developed. Robert Coleman Kemp in his work on Diseases of the Stomach and Intestines says that Dr. J. M. Mathews was the first to call attention to sigmoiditis and diverticulitis of the sigmoid.

The entire length of the large bowel in situ is found to be much shorter than when it is dissected from its attachments. An ordinary thirty-inch colon tube has sufficient length to extend around the lumen of the large bowel to the cecum. While this has not been done in the living individual it has been done in the cadaver, and radiographs of the same are on record.

It is almost universally believed that ordinary flexible colon tubes can be manipulated in such a way as to traverse the entire course of the large bowel around to the cecum. It has been proven by a number of investigators that such an achievement is impossible in the normal bowel. The average length of the sigmoid is about eighteen inches, and this being a floating portion of the large gut it is almost impossible for an instrument to pass beyond the middle half of the sigmoid. Should such be possible and the tube enter the descending colon it would be a physical impossibility for it to pass either the acute angle at the splenic flexure or the hepatic flexure. The failure of instruments to pass high into the bowel has been demonstrated by X-ray pictures.

Dr. Hanes demonstrated the difficulty in passing any instrument through the hepatic and splenic flexures by introducing a thirty-inch, No. 20, French, soft rubber catheter into the caput coli in an old appendicostomy case. He failed by any kind of manipulation to pass the catheter through these flexures. The tube was allowed to remain in the head of the colon for twenty-four hours with the hope that peristalsis would carry it around, but this failed. After manipulating the second time three hours later four inches of the catheter appeared through the anal opening.

He forced bismuth solution into the head of the colon till the wall of the gut was thoroughly distended, and then Dr. E. Bruce made a skiograph. No regurgitation into the ileum occurred. This experiment was repeated a number of times with the results as above given. If the ileo-cecal valve allows no reflow into the ileum,

then exceedingly large amounts of water injected into the bowel are retained in the large gut, and not a part of the amount passed into the small bowel as is supposed by some.

In an old appendicostomy case, with the patient on the left side, coal oil was poured into a colon tube that had been introduced three inches into the rectum. In six and a half minutes the oil was flowing out of the appendicostomy opening. The amount employed was thirty ounces. This clearly demonstrates that liquids will easily pass around the entire colon without flowing through a tube. The point is also made that coal oil is much less irritating to the mucosa than plain water or ordinary aqueous solutions.

The capacity of the large bowel in situ was measured by temporarily closing the opening of an appendicostomy case and allowing coal oil to flow into the rectum as long as the patient could tolerate it. At a later date the same experiment was made by allowing oil to flow into the head of the colon. About the same amount of oil was received in each case. After making the same experiments in other cases it was decided that the average large bowel had a capacity, varying between fifty and sixty-four ounces.

The capacity of the rectum was ascertained by inverting the patient and placing a colpeurynter at the junction of the sigmoid and rectum, just within the sigmoid. The colpeurynter was then distended with air until no fluid could pass into the sigmoid. Coal oil was allowed to flow into the rectum till no more could be received. It was then drawn off with a catheter, and the average amount was found to be between fourteen and seventeen ounces.

He insists that the inverted position (Hanes) is much to be preferred by both patient and operator when any kind of illuminating instruments are to be employed in the rectum or sigmoid.

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THE FOUR GLASS TEST.—*Glass 1.* The anterior urethra is washed out carefully until the water returns clear. This gives us the contents of the anterior urethra. *Glass 2.* If a soft catheter is introduced and some of the bladder contents are drawn off into glass two, this gives us the bladder urine. *Glass 3.* The catheter is now withdrawn and the patient passes a small quantity of urine into glass three. This gives the debris washed from the posterior urethra. *Glass 4.* The prostate and vesicles are then carefully massaged and stripped, and the remaining urine is passed into glass four; this gives us any pus that may have been expressed from the prostate by massage.

## THERAPEUTIC NOTES.

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### HEMOPTYSIS.

C. J. Wiggers (*Arch. Int. Med.*) considers that early in the course of hemoptysis when there is occasional cough and no alteration in the breathing, the prompt relief of the bleeding should be brought about by those drugs which reduce the pressure within the pulmonary circuit; that cardiac depressants, such as chloroform and pituitary extracts, must be resorted to. In his opinion pituitary extract is the drug that possesses the ability to meet the indications.

### VOMITING OF PREGNANCY.

J. H. Martin (*B. M. J.*) doubts the efficacy of drugging in hyperemesis gravidarum. He prefers dieting—gastric lavage, dieting and elimination. For several days he puts his patients on peptonized milk and milk and soda; then light diet. They are not allowed up until they have been on the light diet for two or three days. He gives a powder thrice daily, which powder consists of one grain of mercury-with-chalk powder and three grains of sodium bicarbonate. Where there is chronic constipation, he has found magnesium sulphate in hot water, every second morning, the best aperient. The septic condition of the mouth he treats with one in eighty phenol solution, used frequently always immediately before and immediately after food. The following are important points in the treatment: 1. Bowels to be moved at least once per day. 2. Prevention of oral sepsis. 3. Good, plain, well-cooked food, daintily served at regular hours. 4. Kidneys and skin to be kept active. 5. Gentle exercise in the open air daily if the weather is at all suitable, and a good supply of fresh air night and day.

### TRACHOMA.

G. M. Harston (*B. M. J.*) has effected a cure in forty out of fifty cases of trachoma, in from five to eighteen applications of carbon-dioxide snow.

### PULMONARY TUBERCULOSIS.

H. Vallow (*B. M. J.*) believes that cases of pulmonary tuberculosis in the early stages are best treated with injections of a one per cent. solution of pure phenol in sterilized water. He gives 0.1 to 0.2 c.c. between the shoulders once each week.

## DIAGNOSTIC NOTES.

PERICARDITIS.—W. E. Winter (*Clinical Journal*) says that the absence of the abdominal respiratory movement may be important evidence of pericarditis. In one of his cases in which there was no evidence of pericarditis, appendicitis was diagnosed. This loss of abdominal movement may precede by a few days or longer, and outlast the other signs of pericarditis. X-ray examination has confirmed the immobility of the diaphragm. The restriction of movement is more marked in fibrinous pericarditis.

LIVER DISEASES.—Frey (*Zeit. f. klin. Med.*) finds first in diseases of the liver that urobilinuria appears frequently; second, that the appearance of laevulose is a useful diagnostic accessory in liver diseases. In the diseases of the liver the latter occurs in fifty per cent., especially in the cirrheses. The excretion of urea is of no value in diagnosis. Galactose is of no less diagnostic assistance. In the cirrheses, the amino-acids are regularly increased.

MALIGNANT DISEASE.—Fiehs and Lintz (*J. A. M. A.*) state that methylene blue is decolorized by the urine of patients suffering with malignant disease. It is also true sometimes in rheumatism, nephritis and meningitis. They state that thus far in their work it has been positive in every well-established case of malignancy. The technic is given as follows: Three to five drops of Loeffler's methylene blue is added to a test-tubeful of fresh urine—sufficient to give it a blue color. The urine is then shaken and allowed to stand at room temperature from twelve to twenty-four hours. A control fresh specimen of normal urine similarly treated is made. At the end of said time the blue color of the urine disappears. The control specimen on the other hand remains unchanged, retaining its uniform blue color.

TABES.—A correspondent to *The Lancet*, London, England, calls attention to pruritus and its occasional relationship to tabes, especially in the early cases. Milian, the first to call attention to this, found a casual relationship in six out of 25 cases. Three were anal, one anal and periorbital, one thoracico-lumbar, and one epigastric. Milian found it always an early symptom.

TUBERCULOSIS.—C. L. Wheaton (*J. A. M. A.*) directs attention to a new sign in diagnosing pulmonary tuberculosis. When the skin is pulled away from the fascia over the affected area, it was freely moveable and not adherent to the muscle-fascia. On the affected side the skin can be drawn from the chest wall with ease, while the skin is also thinner on that side.

## Reviews

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*International Clinics.* A Quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles. Volume II. Twenty-first Series. 1911. Philadelphia, London and Montreal: J. B. Lippincott Company.

Articles in this issue appear on Medicine, Surgery, Obstetrics and Gynecology, Neurology, Laryngology, Ophthalmology, Pathology and a Post-graduate Course on Wounds. There is one colored plate, many plates and numerous figures. One Canadian contributes an article, "Some Advances in Obstetrics in the last Twenty-five Years," Dr. A. Laphorne Smith, Montreal. In this article Dr. Smith describes his method of placing the preliminary perineal stitch, as recently set forth in a communication to the *New York Medical Record*. Dr. Smith originally brought this before the American Gynecological Association many years ago. He has been employing it now for ten years, since which time he has seen no "milk fever." Our readers will find *International Clinics* a periodical of the utmost value. Its price is \$8.00 the year, issued in quarterly volumes. Those who wish to obtain this volume can do so from Mr. Charles Roberts, 608 Lindsay Building, Montreal, the agent for Lippincott's in Canada.

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*Diagnostic and Therapeutic Technic.* A Manual of Practical Procedures Employed in Diagnosis and Treatment. By ALBERT S. MORROW, A.B., M.D., Adjunct Professor of Surgery in the New York Polyclinic; Attending Surgeon to the Workhouse Hospital, and to the New York City Home for the Aged and Infirm. With 815 illustrations, mostly original. Philadelphia and London: W. B. Saunders Company. Canadian Agents: The J. F. Hartz Co., Toronto.

We consider this to be one of the best books we have seen issued for some time. As the title announces, the writer has here brought together and arranged in a readily accessible manner a large number of procedures employed in diagnosis and treatment. There will be found a general description of diagnostic and therapeutic methods, as well as a description of those measures employed in the diagnosis and treatment of diseases affecting special regions and organs of the body. That there is a good field for a work of this character we are assured, and the author is to be congratulated in having brought all this valuable material under two covers. The illustrations are exceedingly ample—815—and they are splendidly executed. We heartily commend this book to all.



# Dominion Medical Monthly

And Ontario Medical Journal

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## COMMENT FROM MONTH TO MONTH.

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**The British National Insurance Bill** brings strongly before the medical profession again the whole question of contract practice and the evils attaching thereto. This scheme, modelled after the German system, but going considerably further, is compulsory in its nature, and affects wage earners, men, women and young persons earning less than fifteen dollars per week. Its object is to assist these self-same wage earners during sickness and old age. To provide a fund for this purpose it is proposed that the workingman will contribute fourpence per week, the working woman threepence, the employer threepence for each employee and the State twopence for each working person.

In return for these contributions the bill will provide for the following:

1. Free medical relief with no taint of charity. The medical men attached to the friendly charities are to be better paid—an increase to \$1.50 from \$1.00 per patient, and wherever possible the chemist will do the dispensing and the doctor will only prescribe.

2. The benefit of thirty shillings in maternity cases, with the proviso that women are not to return to work for four weeks.

3. Special help in cases of tuberculosis.
4. Sick allowance of ten shillings a week for three months, and a permanent disablement allowance of five shillings a week to age of 70 years, when the patient will be transferred to the old age pension fund.
5. Women to receive seven shillings and sixpence for the first three months and thereafter on the same scale as men.
6. Young persons under sixteen years of age will not receive sick pay allowance, but will receive medical treatment and the use of sanatoria.

At the same time that the British Government is promoting this elaborate scheme the Germans are considering the revision and extension of the German system; and it was due to the apparent success of this scheme in Germany that led Mr. Lloyd-George to father the measure in the British House of Commons. In some quarters it has been hinted that its introduction is on the grounds of political expediency.

The profession in the three kingdoms is up in arms in opposition to the medical provisions of the scheme, and is well backed up by the General Medical Council, the Royal College of Physicians of London, King Edward VII Hospital Fund for London, Dublin University (Trinity College), the Royal College of Surgeons of Edinburgh, and the British Medical Association, a body which contains between one-half and two-thirds of the entire British profession. To this latter organization, since the bill loomed upon the horizon, several thousand of physicians have been added to its membership.

In France, Germany, the United States and Canada, the progress of the measure through the House of Commons has been watched with eager interest, and the medical press have kept their readers in touch with the entire situation. It will be of interest to all to know that the bodies above-mentioned, in Great Britain and Ireland, have shown a determined and worthy unanimity in opposing the provisions of this bill, and have even gone so far as to pledge themselves to decline to work under the measure as at first drafted. They have demanded, before doing so: (1) An income limit of ten dollars a week for those entitled to medical benefit. (2) Free choice of doctor by patient, subject to the patient's consent. (3) Absence of friendly society control. (4) The preference of the majority in local districts to decide method of remuneration. (5) Medical remuneration to be what the profession considers adequate, having due regard to the duties to be performed and other conditions of service. (6) Adequate medical

representation on the various bodies administering the act, with statutory recognition of local medical committees.

The latter, one vital feature, has been conceded, as by a vote of 387 to 15, the administration of medical benefits under the bill has been placed under the local Health Committees. In the opinion of *The Lancet* this is regarded as a triumph.

The evils of contract or lodge practice have so long been harped upon by the medical press and by a majority of the profession, and that without any visible assuagement, but with augmentation, that it is a question whether anything can or will now be done by the medical profession as a whole to offset those evils. When, therefore, the powers that be, those with the hand on the helm of the ship of state, commence an exploitation of the entire medical profession in the interests of the public and in the interests of political emergencies and contingencies, it is but the entering of the thin end of the wedge, which, whilst it would curtail the liberty and independence of the medical profession, would at the same time be in accord with the socialistic and public health tendencies of the day. It is the approach of those days, when, as Sir Lauder Brunton himself long ago remarked—those days when the medical profession would be engaged more in preventing disease than in curing the ill's flesh is heir to.

One prime cause of alarm is seen in those provisions of the bill which will undoubtedly tend to very materially decrease the incomes of physicians. The anxiety in which this is viewed by the profession in the mother country, as well as the equally anxious interest manifested by the profession of other countries, is not suppositious. It is all too real. This is by reason of the fact that the patient earning fifteen dollars per week is snatched from the hand of the practitioner. But we have not to go very far afield to find instances of this right in our own Canadian cities, where patients earning under fifteen dollars per week, paying four or five dollars per week for their board, are admitted into hospitals, and denied the right to select their own medical attendant. This cuts materially into the income of many physicians and materially decreases that income. If it is unfair to do the first, surely it is equally unfair to allow the latter to obtain.

If state medicine of the character proposed in this bill is to obtain, then it is high time that the state should pay for the services rendered by physicians in charity, either in hospital or out of it. Physicians should not be expected or called upon to give of their time and their talents any more than any other class in the community.

When the state commandeers the medical profession it would seem right to do it *in toto* and upon adequate remuneration.

What is adequate remuneration?

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**Mistakes** is a title for an address which sounds refreshing, for it is new. How few have been the papers published on this line we all know. Yet this was the title of the address in Medicine recently delivered before the British Medical Association by Byrom Bramwell. It requires courage to speak about mistakes, and he is a brave man who publishes them to the world. But we profit by mistakes, both our own and others.

Long ago we remember someone suggesting it would be a profitable night at a medical society meeting to recount mistakes, but we never remember knowing or hearing that any such *melange* was served up, for it would certainly prove a profitable, if a laughable, medley.

Now, however, that a distinguished member of the profession has had the courage to take on "Mistakes" as a title for the Address in Medicine before that august body, the British Medical Association, we may expect that "Mistakes" will come into fashion for symposia at the coming meetings of our medical societies. And, indeed, a medical society might very easily spend a night to less amusement, interest and advantage.

But there are mistakes and mistakes, some which are excusable, others inexcusable. Those whose results are unimportant may be passed by, but not so with those which may entail very disastrous consequences. Mistakes teach us this: We can learn a great deal from our mistakes. If this is so it is a wonder such a vast amount of clinical material should have been wasted and so often been disregarded. Now that the example has been set, others will pattern after it.

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**The Physiological Effects of Aeroplane Flying**, since we have arrived at the day when an aviator may any time alight at our doors, is an appealing subject to medical men. The Paris correspondent of *The Lancet* had an opportunity of examining Aviator Beaumont when he came down from his machine after winning the prize for the European circuit.

Others have made interesting observations and have recorded them. The effects of rising to great heights in the air are similar to those seen in mountain-climbers, such as giddiness, nausea,

headache. Owing to the rapid transition from a lower level to a higher, the blood pressure does not steady itself, as in mountain-climbing. Variations are seen here, too, in individuals, as in mountain-climbing. All the observations tend to show that the blood pressure is increased but slightly, owing to the free access of air. The temperament of the individual will have a special influence upon the blood pressure. Nervous fatigue and nervous tension will lower it. In the case of Beaumont referred to, he was said to be remarkably calm, his pulse scarcely reaching 85, but he had his moments of cardiac palpitation. Naturally of a calm disposition, his added experience and long practice in flying would have considerable to do with any excitation. It has not yet been established that aeroplane flying causes any particular illness. The most constant phenomenon observed is the increase in blood pressure.

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**The Maritime Medical Association** has passed into history. This was accomplished at its recent annual meeting in Halifax, and it was done by unanimous vote, we are told, without discussion and without regret. The object in dissolution is, of course, apparent. It is a part of the policy of the Maritime medical profession, following upon the discontinuance of publication of the *Maritime Medical News*, to do all they can to promote the interests of the Canadian Medical Association, and of course the official organ of the national medical body. This action will put a damper on the proposed formation of a somewhat similar medical society for Western Canada, the sometime mooted organization, which would be in close touch with the medical life and progress of the West.

The passing of the only interprovincial medical society in Canada leaves the road open to a closer affiliation of the provincial societies with the parent Association. But to round off the reorganization of the profession throughout the Dominion, as contemplated through the new Constitution and By-Laws of the Canadian Medical Association, it will first be necessary for each provincial medical society to establish affiliation by effecting the required and necessary resolutions, and then to proceed to affiliate with them the county and city societies in existence, or hereafter to be established.

So far as the Province of Ontario is concerned it would appear advisable to proceed to the establishment of territorial medical societies in affiliation with the Ontario Medical Association, which

societies would serve the dual purpose of incorporation with the Ontario College of Physicians and Surgeons, and at the same time be in affiliation with the Ontario Medical Association, and through that provincial medium, in affiliation with the Canadian Medical Association.

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**The History of the Present Cholera Epidemic** being seasonable at the present time, owing to some distant manifestations, will as well prove interesting. It took its origin in India in 1902. Hindoo pilgrims, journeying to Mecca, carried it to Hebjaz. In 1903 it was in Damascus; in Bagdad in 1904. From this point it crossed into Persia, reaching the mouth of the Volga. It then spread in the Caucasus to the extent of three thousand cases. In 1905 there were six hundred cases in Poland. Then it appeared in Eastern Prussia and places in Germany—three hundred cases. In 1907, from Southern Russia to St. Petersburg, it counted its victims to the extent of thirteen thousand. By 1908 this had reached thirty thousand cases. In 1909 there were different foci of infection in Russia; it appeared in Holland, particularly Rotterdam—sixty cases. Belgium, nine cases. Ships spread it from the latter point. Every winter it died out to appear in the following spring. It is reported that in 1910 there were a total of 281,259 cases, with 131,433 deaths, in the southern provinces of Russia especially.

From Brindisi it was carried into Southern Italy. One hundred and thirty-seven localities were infected. There were in all 11,700 cases, with 768 deaths. The disease made great ravages in Turkey.

The incubation period is six days, but the dejecta of persons exposed should be examined for some time thereafter. By rigid attention to this detail Holland was able to reduce the number of fatal cases to four. Generally contracted through drinking contaminated water, it must not be lost sight of that fruit and vegetables ingested may be the cause of the disease, especially where those have been grown from soil watered with contaminated water. Even microbes may be carried into houses on the shoes through the medium of contaminated mud.

Immigrants, sailors and similar persons should naturally be subjected to strict supervision landing on American shores, as these carry the disease, the epidemic proceeding up-stream against the current. Careful attention to waste matter, disinfection of

same, exclusion of flies, are preventive measures. In fact all measures look towards the prevention of contamination through the alimentary tract.

The letter published in our September issue from the Director-General of Public Health, Ottawa, to Quarantine Officers, the Commissioner of Customs, Ship Owners, Agents, and others concerned, tells how well our Canadian shores are protected from an invasion of this Asiatic disease.

No case of cholera has developed in the United States, nor has any case arrived at quarantine since July 28th.

Since August 12th, thirty-seven cholera suspects have been detained at Grosse Isle. They were removed from the Allan liner, "Lake Erie," and are said to be Italian immigrants bound for the Canadian west.

About the middle of August there were in the Quarantine Station of the Port of New York seventeen cases.

## News Items

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DR. WATSON CHEYNE was in Toronto in August.

DR. J. N. ELLIOTT BROWN has returned from Europe.

DR. GEORGE W. ROSS, Toronto, has returned from England.

DR. D. KING SMITH, Toronto, has returned from England.

DR. CHAS. A. HODGETTS and Major Drum are in England.

DR. G. STERLING RYERSON, Toronto, has returned from England.

DR. JEPSON, Durham, England, paid a short visit to Toronto in August.

DR. GOOD, Winnipeg, has been operated on successfully at the Mayo Hospital.

THERE are to be no public drinking cups after the first of October in New York.

DR. WILLIAM WARWICK has resigned as Pathologist at the General Hospital, St. John, N.B.

A RECENT Toronto graduate requires locum tenens work for four to six months. Apply to us.

DR. ALEXANDER HUGH FERGUSON, Chicago, who has been seriously ill, is reported recovering.

THE *Canadian Journal of Medicine and Surgery* for September is a finely illustrated number.

OTTAWA physician wishes to purchase practice and property near Ottawa. Vendors apply to us.

MONTREAL had 8,749 cases of contagious diseases in 1910. In 1907 the number reported was 4,271.



THE death is announced of Dr. Frank P. Foster, for many years Editor of the *New York Medical Journal*.

DR. A. S. MONRO, Vancouver, Secretary of the British Columbia Medical Society, has returned from abroad.

DR. J. H. LEEMING, Bacteriologist to the city of Winnipeg, is working temporarily in Paris and London.

DR. GEORGE K. McNAUGHTON, Cumberland, B.C., has been doing extra work in Chicago and Rochester, Minn.

DR. ERNEST HALL, formerly of Toronto, Vancouver and Victoria, has taken up his residence in southern California.

"KING COOK," for many years janitor of the medical department of McGill University, died recently in that city.

DR. EDMUND E. KING, Toronto, has returned from a month's holidays at his summer residence in Hastings County.

THE first annual meeting of the Canadian Public Health Association will be held in Montreal the 21st-23rd November.

DR. BRUCE, London, England, has been appointed Superintendent of the Tuberculosis Sanitarium at London, Ontario.

THE Toronto Academy of Medicine has moved into its new quarters, Queen's Park and north corner of Grosvenor Street.

DR. A. B. ATHERTON, Fredericton, N.B., formerly of Toronto, is a candidate for parliamentary honors in the pending elections.

PROFESSOR J. GEORGE ADAMI, Montreal, has gone to Rome to represent the Dominion Government at the Tuberculosis Conference.

THE Laboratory of the Ontario Board of Health is now established in its new quarters, Queen's Park and Grosvenor Street, Toronto.

IN Montreal in 1910 there were 10,221 deaths and 16,616 births.

A **SPLENDID** medical practice and property is for sale in the county of Wentworth. Particulars will be given by applying to this office.

THE Bill Poster's Association of Canada is granting the Canadian Association for the Prevention of Tuberculosis, \$25,000 of advertising space throughout Canada.

THE Ontario Board of Health had an extremely interesting exhibit at the Canadian National Exhibition, particularly as regards infant mortality, tuberculosis and milk.

DR. GEO. D. PORTER, Toronto, Secretary of the Canadian Association for the Prevention of Tuberculosis, has returned from his summer home, "Treasure Island," in Muskoka.

TUBERCULOSIS seems to be increasing in Montreal. In 1907 there were 919 cases; 1908, 1,000; 1909, 1,114; 1910, 1,336.

A **THREE** thousand medical practice and property, unopposed, is for sale fifty odd miles north from Toronto. The property is good and the price is right. A small cash payment will be accepted. Apply to us.

DR. DUNCAN GRAHAM, formerly of Pittsburg, has returned from Germany and been appointed Lecturer in Bacteriology in the medical department of the University of Toronto, succeeding Dr. Fitzgerald, who has gone to California.

DR. HIBBERT WINSLOW HILL, Director of the Division of Epidemiology of the Minnesota State Board of Health, has received the diploma of Public Health from the University of Toronto, by examination. This is the first degree of that character issued by Toronto University.

## Publishers' Department

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SYMPTOMATIC OR COMPLICATING ANEMIA is that form or condition of blood poverty which results from various constitutional infections and diatheses. Prominent among such causes are, Syphilis, Rheumatism, Paludal Poisoning, Tuberculosis, Carcinoma, etc. In many instances, such an anemia is due to some obscure, latent metabolic perversion, or a slow but persistent intestinal auto-intoxication of gastro-intestinal origin. While it is an axiomatic principle that successful therapy depends upon the removal of the causative factor, it is more than often wise and eminently judicious to adopt direct hematinic treatment while the underlying cause is being sought for and combated. Pepto-Mangan (Gude) being bland, non-irritant and readily tolerable, can almost always be given, with distinct advantage to appetite, digestion, nutrition and general well-being, while causative therapy is under way. Neither constipation nor digestive disturbance results from its steady use, and a general hematic gain is practically a certainty, if its use is persisted in.

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PROMPT RELIEF IN SCIATIC PAIN.—In reporting his experience in the treatment of sciatica, Fred E. Davis, M.D., writes as follows in *Annals of Gynecology*: "I have been giving antikamnia and codeine tablets a thorough trial in the treatment of sciatica and I must say that my success has been phenomenal indeed. I have also induced two other physicians to give them a trial and their success equals or surpasses my own. I meet with many cases of sciatica and before adopting antikamnia and codeine tablets I used a great deal of opium and morphine to relieve the pain. Since then, I have not given either. One of my patients had been confined to bed for three weeks during her last attack of sciatica. I prescribed one antikamnia and codeine tablet every four hours, and in forty-eight hours she was up and about and has not felt the pain since."

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SUMMER CLOTHING FOR MEN.—During the long spell of magnificent weather that has been such a notable feature of this Coronation year the question of how to dress comfortably must often have perplexed the professional man confined to city life, and therefore to some extent forced to observe the conventions. Of late years there has certainly been a far less rigid

adherence to these conventions than, say, 20 or 30 years ago; but the legal and medical professions, at any rate, have been on the whole conservative in this respect. With regard to headgear, the ordinary silk hat of the town dweller has long been criticized; but it must be admitted that in spite of many attempts to displace it in popular favor it remains the *sine qua non* for certain society functions, though not now so indispensable for many others where a short time ago it was quite compulsory. We do not understand why the white tall hat has fallen out of use; it was lighter to wear, cooler to look at, and, so long as there was no black band to suggest that the wearer was in mourning for the last remnants of his respectability, its appearance was cheerful. Straw hats, that now form so large a proportion of the summer headgear of our town population, are certainly cool and light; the soft panama variety looks more comfortable, but not only is it much more expensive, but from a medical point of view it has a drawback. Whatever type of hat is worn the lining should be soft and elastic, so that there is no constriction anywhere round the brow; yet the panama offers so large a surface of attack for sudden wind that it must be tight to the forehead. The air-space above the head should be ventilated. Air itself is a bad conductor of heat, and if a deep layer of air is interposed between the head and the head covering, this forms the best protection against the effects of sun, provided, of course, that the air layer is kept cool by free ventilation. Although the tall hat to some extent retains its vogue, the double-breasted frock-coat has almost disappeared for daily use; but we still seem to cling to funeral black as the appropriate hue for city life. Our climate is so variable that we cannot always assume that a fine warm morning will be followed by a hot day; therefore we cannot always at the beginning of the day dress appropriately for the ensuing eight hours or so. Woolen stuff for material, and a loose fit, will secure comfort, and protection from extremes both of heat and cold. Light colored garments are naturally cooler than dark ones, as they reflect instead of absorb the sun's rays; but a permeable texture is of much more importance than color; it is necessary for health and comfort that free passage should be allowed for evaporation from the skin, inasmuch as this is the most effective physiological means of cooling the body. Dwellers in tropical countries generally wear white cotton clothing, very light in texture, being careful, however, to protect the head from the sun's direct rays by some form of turban, and the abdomen from chill by several folds of material, forming a cummerbund. With our variable climate we must be cautious, even in the hottest weather, how far we imitate the habits of people