

THE CANADA LANCET

DILATED OESOPHAGUS.

(ILLUSTRATING DR. PETERS' PAPER.)

A. Upper portion, about the region of the cricoid cartilage. B. The widest part laid open. C. is placed just above the point where the oesophagus passes through the diaphragm. D. The hypertrophied crus of the diaphragm, divided and held apart by a glass rod. E. The gastrostomy wound, about two inches from pylorus.

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1. A CASE OF FUSIFORM DILATATION OF THE OESOPHAGUS WITHOUT INTRINSIC STENOSIS
2. A CASE OF OESOPHAGOTOMY FOR FOREIGN BODY.—RECOVERY.

By GEORGE A. PETERS, M. B., F. R. C. S. Eng.

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THE case from whom the specimen which is the basis of this article was removed, was a farmer aged 35 years, referred to me by Dr. S. T. Rutherford of Listowel, to whose careful observation and clinical acumen I am indebted for the following history. The family history is free from taint of cancer. There is, however, a history of some degree of neurosis, particularly on the mother's side. The personal history is that of a strong, hearty, well-developed and well-proportioned man, a farmer by occupation and a very hard-working man. He was always in the habit of eating rapidly, and then going immediately to work. Until the age of about 30 years he experienced no trouble in swallowing and the history of difficulty in deglutition which follows, dates from December, 1896, when he first came under Dr. Rutherford's care. For a short time previously, he had noticed that he had occasional attacks of regurgitation of food and liquid after meals. This condition persisted with fluctuations in intensity for four or five years, gradually, however, becoming more marked. He noticed that the food which regurgitated was not sour in taste but somewhat sweet, apparently due to the fact that it had been acted upon by the saliva, but had not come in contact with the gastric juice. The eructation was not exactly an act of vomiting, but a gulping, regurgitating act. It would sometimes be accompanied by marked hiccough. He observed that on some occasions after partaking of a solid meal, the ingestion of a cup full of fluid, such as milk or tea, would carry the whole meal onwards to the stomach and thus obviate the regurgitation. This, in fact, was his habit of eating for many months. On the contrary, on some occasions the swallowing of the liquid seemed to stimulate or excite the act of regurgitation, and the whole meal would then be rejected. The latter condition gradually became more marked, until finally he found it

impossible to cause the food by any method to reach the stomach. He was sometimes troubled very considerably with hiccough, and the whole history of the case would appear to point to a spasmodic element in the disability in regard to swallowing. Recognizing this element, Dr. Rutherford exhibited the bromides in full doses, and on the further advice of the late Dr. J. E. Graham, who suspected that there might be pressure of enlarged mediastinal glands on the oesophagus, he also had a full course of the iodides. The bromides, when given in full doses, gave more relief than any other drug, thus serving to substantiate the view that there was a spasmodic element in the causation. The patient noticed that while taking the bromides, his hiccough was less marked than under the iodide treatment.

During the last year and a half he gradually lost flesh to the total amount of some 50 or 60 lbs and had, of course, become correspondingly weak. Latterly his weakness had been such that he had found it necessary to give up work altogether, and when in that weak condition in September, 1900, he was prostrated by an attack of typhoid fever. This still further reduced his condition and swallowing became impossible, so that had rectal feeding not been resorted to, he would undoubtedly have died at that time. On the subsidence of the fever he was fed for a time by the stomach through a tube which his physician was able, after some manipulation, to pass. Dr. Rutherford at that time recognized a dilated oesophagus, capable of containing nearly a pint of fluid.

As soon as the fever abated, he was placed in the hospital, under the care of Dr. Howitt, of Guelph, who preformed a gastrostomy, making an opening near the pyloric end of the stomach, but making no attempt in the then weak condition of the patient, to ascertain the state of the oesophagus. The gastrostomy was followed by most gratifying success. He could take food by the fistulous opening and retain it well in the stomach. It seemed to digest perfectly, and in the course of some three or four months he increased in flesh up to his original weight.

After being fed through the gastrostomy opening for some six months, he began again to go down hill, and became nervous and extremely anxious to have something done to allow him to partake of food in the natural way. With this purpose in view, he, on Dr. Howitt's suggestion, placed himself under my care in the Toronto General Hospital.

On passing an oesophageal bougie no obstruction was found until the bulb had passed some 16 inches from the front teeth. Here the passage was abruptly interrupted, though the bulb was not grasped to any extent whatever. Occasionally, however, the bulb could be made to pass onwards to a distance of nineteen inches, apparently entering the stomach.

But I was never able to feel the bulb of the bougie by means of a sound passed through the gastrostomy wound. This must have been, as I found out later, due simply to the fact of accidentally missing the bulb, for it is quite clear that the two instruments must have been in the same cavity. The stomach was fairly large, and this probably accounted for the ease with which the two instruments missed one another.

Before operation my conception of the condition was that there was an hour-glass contraction of the stomach, the oesophagus communicating with the left compartment, while the gastrostomy wound communicated with the right. This view seemed to be substantiated by the fact that liquid coloured with methylene blue to the amount of more than a pint could be swallowed and yet could not be recovered through the gastrostomy wound. It turned out afterwards, of course, that the blue liquid swallowed remained in the oesophagus and never entered the stomach at all, as it would after a short interval be returned by an act of easy vomiting, or regurgitation.

In March, 1901, I made an opening parallel with the margin of the costal cartilages on the left side, through the rectus muscle, and entered the abdomen. By means of a sound passed through the gastrostomy wound, I very quickly found that my diagnosis of hour-glass contraction of the stomach was an error, and that the sac which contained the fluid was situated above the diaphragm. The oesophageal bougie passed by the mouth under an anaesthetic, could not be felt with the fingers in the abdomen outside the stomach. Accordingly a small opening was made in the stomach and the finger introduced. The stomach wall felt smooth, and it was only after a prolonged search that the oesophageal opening was found. It seemed to lie close to the aorta, rather to its right side, and was so small that only the tip of the index finger could be made to enter it. With the finger in that position the aorta seemed to be beating directly against its left side, and gave me the impression that the oesophagus passed through the same opening in the diaphragm as the aorta but to the right of that vessel. This was subsequently disproved so far as the common opening was concerned, by post mortem examination, as it was found that the right crus of the diaphragm passed between these two tubes in the normal manner, but that the oesophageal opening had been dragged quite to the right of the middle line by the weight of the oesophageal sac pouching into the right pleural cavity.

An oesophageal bougie was now passed by the mouth, but could not be felt to come in contact with the finger in the cardiac opening of the oesophagus. On withdrawing the finger from this opening, however, and exploring the neighborhood, the end of the bougie could be felt dis-

tinctly to the right of this opening through the stomach wall and the diaphragm. After considerable manipulation the bougie was directed towards the oesophageal opening, and passed on into the stomach. The bougie was now directed by the finger across the stomach cavity towards the gastrostomy wound and made to emerge there. A silk thread was tied to it, and to this in turn a length of small rubber tubing, which was thus withdrawn across the stomach through the cardiac opening and so upwards to the mouth. My intention was to endeavour to dilate the stricture by slow traction by means of this rubber tube, adopting to some extent the string-saw method of Abbe.

The operation wound in the stomach was now stitched up by a double row of Lembert sutures, the stomach dropped back, and the abdominal wound closed after disinfection, without drainage.

The operation was a prolonged and somewhat severe one, and the patient suffered greatly from shock. He died within eight hours of the operation, apparently from exhaustion and failure of the circulation.

POST MORTEM EXAMINATION.

On opening the chest wall the oesophagus was found lying pouched towards the right pleural cavity. It still contained some fluid, and looked as large as the sigmoid flexure of the colon. On removing the right lung, it was seen that the dilatation extended from the pharynx to the oesophageal opening in the diaphragm, being considerably larger below than above and terminating in an abrupt manner just above the diaphragm. The diameter of the dilated oesophagus at its upper end (Fig. 1 A) in the recent state was about two inches, while at a point an inch and a half above the diaphragm (Fig. 1 B) where the dilatation was greatest, the diameter was a little less than three inches. The coats were exceedingly muscular, but taking into consideration the great dilatation did not display a thickness that would indicate hypertrophy. The relation of the oesophagus to the opening in the diaphragm was of very peculiar interest. Even after death it was with difficulty that the little finger could be passed through this opening, and the stricture was clearly extra-oesophageal and due to the tight clasping pressure of the pillars of the diaphragm at this point. The inner lining of the oesophagus was perfectly soft and smooth here as well as throughout its whole length. There was no sign whatever of intrinsic stricture, either malignant or non-malignant. Nor was there any scarring. The pillars of the diaphragm, however, were exceedingly strongly developed. The left crus, supplemented by that portion of the right which crosses between the oesophageal and aortic openings was particularly strongly developed (Fig. 1 D.) and was not less than five-eighths

of an inch in thickness at a point opposite the oesophageal opening. It is quite clear that the tension during contraction of this portion of the diaphragm, particularly if of spasmodic character, would exert a very powerful influence in obliterating the lumen of the oesophagus. In fact, the action of the two crura of the diaphragm upon the oesophagus when in a state of contraction might be compared to the action of a dull, loose-jointed pair of scissors on a rubber tube, viz., to produce a sudden kinking of the oesophagus at the point where it passed between these two muscular bands. The whole diaphragm was an exceedingly strongly developed muscle, and, in fact, presented a body of muscular tissue far in excess of what must be looked upon as normal. One may, perhaps, even go farther than this, and point out that the obstruction was not, at all events in the later periods of life, merely spasmodic but of such a character that, even in a passive condition, these muscular bands were such as to produce a marked stenosis of the oesophageal opening (Fig. 1C). This was recognized, as above pointed out, during the operation, when it was found that it was with difficulty that the tip of the index finger could be inserted into it, and, moreover, also at post mortem examination, when it was found that the little finger could scarcely be passed through this opening. It is, to my mind, quite clear that the stricture in this case was due to the hypertrophied condition of the pillars of the diaphragm, with or without a degree of spasm in this muscle. Moreover, Professor J. J. Mackenzie found on examination of a section of the oesophagus at the point of constriction that there was no cicatricial tissue whatever, and that the circular muscular fibres seemed to be mechanically accumulated but not hypertrophied. The causative relation of the pillars of the diaphragm to the stenosis is further attested by the fact that after their division the index finger could with ease be passed from the oesophagus to the stomach, up to the second joint.

REMARKS.

The dynamics of swallowing in a case of this kind affords an interesting subject for speculation. Ordinarily in a case where a muscular effort is opposed by mechanical obstruction, hypertrophy of the muscle takes place, and thus the effect of the obstruction may be entirely overcome, but where the hypertrophy is unequal to the task, dilatation takes place, and when that stage has been reached the problem is an entirely different one, because the muscular contraction, taking the form in this instance of a peristaltic wave, is unable even at its height to entirely obliterate the lumen of the viscus. Accordingly, instead of forcing the column of food and liquid ahead of itself, the peristaltic wave now merely

travels upon the surface of this column which, at the moment of passage of the wave, is of course lessened in diameter. The result is, that the food and liquid instead of being forced strongly against the obstruction merely rush strongly backwards, or regurgitate, beneath the peristaltic wave and re-accumulate in the upper part of the dilatation.

Taking the instance before us, it is quite clear that this must have been the case, otherwise food must have entered the stomach, since there was really no absolute obstruction, as the tip of the finger or a bougie properly directed could at all times be passed through the opening from the oesophagus to the stomach. Practically, then, after a certain stage of dilatation has been reached, the condition appears to perpetuate itself, and the increasing weight of the column of food and liquid which may be contained in the dilated portion merely tends the more strongly to bring about a passive dilatation. Moreover, it must not be forgotten that there is a negative pressure in the thoracic cavity through which this portion of the oesophagus passes and this still further tends to favour the dilatation. Again, in the case above cited, it was perfectly evident that the presence of the heart and pericardium crowded the dilated oesophagus towards the right pleural cavity and caused a distinct curve of the tube in that direction. This again would still further increase the stenosis at the point of passage of the oesophagus through the diaphragm by tending to cause a sharp kink of the tube at that point.

The literature of the subject has been comprehensively reviewed in an article by Dr. H. Strauss, of Berlin, Germany, which formed the subject of a lecture and demonstration at the Nineteenth Congress of Internal Medicine at Berlin. Among the theories given to account for the condition may be mentioned the following:—

1. Congenital weakness of the oesophageal wall as urged by Strümpel.
2. Abnormal relaxation or elasticity of a Mehnart's oesophageal entromere.
3. Pressure of the aorta upon the lower portion of the oesophagus, leading to a slight degree of stagnation which, it is argued, sets up repeated irritations of the mucous membrane which lead to spasms of the cardiac region of the oesophagus.

4. Strümpel considered that in his case a bend of the oesophagus in its lower portion had impeded the passage of the oesophageal contents.

In the transactions of the Pathological Society of London, Vol. 39, p. 103, Handford reports a case of dilatation of the oesophagus without stricture. The history given is similar to that given above as regards the difficulty of swallowing and the regurgitation of food, but differs in regard to the cardiac symptoms and the mode of death. The seat of

obstruction in this case was exactly at the point where the oesophagus passes through the diaphragm, and it is noted that there was no intrinsic stricture of the oesophagus, since the opening would readily admit the finger. There was no induration or thickening which could point to a cicatricial condition or new growth. It is noted, however, that the aorta was dilated to some extent, and the cause of the obstruction is attributed to the pressure of the oesophagus against the unyielding central tendon of the diaphragm by the dilated aorta. The condition of the diaphragm itself is not noted, nor is there history of hiccough, as was present in my case, but it seems to me possible that the fault here may have been primarily in the diaphragm, since it is difficult to understand how simple dilatation of the aorta could produce such an effect upon the oesophageal opening through the diaphragm.

I have above given my reasons for holding the diaphragm responsible, in this case, for producing an extrinsic stenosis of the oesophagus, probably primarily as a spasmodic condition but subsequently passing on to an organic lesion due largely, if not altogether, to hypertrophy of the pillars of the diaphragm.

A CASE OF OESOPHAGOTOMY FOR FOREIGN BODY.—RECOVERY.

The case about to be described is that of a patient referred to me by Dr Allen Baines, who furnishes the following history:—

Mr. G. D., aged twenty-six, while swallowing a raw egg dislodged and swallowed a small vulcanite plate bearing one front tooth. This occurred on the 18th July, 1901. The plate lodged just below the level of the cricoid cartilage. The patient experienced great pain and was quite unable to swallow any solid food. A throat specialist, who was called in, made an attempt to withdraw the plate by means of a coin catcher. He was able to locate the plate but not to withdraw it. This was explained afterwards at the time of the operation by the fact that the two lateral horns of the plate, which was an inch and a half in length transversely and fortified at the points by gold tips, became entangled, as it were, in the mucous membrane and muscular coats of the oesophagus, so that any efforts made to draw the foreign body upwards merely resulted in imbedding it more firmly in the oesophageal walls. Moreover, the frequent contractions of the oesophagus in efforts to swallow, still further served to imbed the horns. The plate thus came to occupy an oblique position across the oesophagus in such a way that its concavity looked forward, and thus an oesophageal bougie passed readily downwards and failed to locate the foreign body. Had it not been for the

patient's sensation one might have thought that the plate had passed onwards to the stomach. Its continued presence, however, was detected by means of an X-ray photograph, which showed the plate lying slightly obliquely in the position indicated, at a short distance above the sternal notch.

It thus became evident that no less an operation than an open oesophagotomy would suffice to dislodge the body, and with that end in view Dr. Baines placed the patient in my charge. Accordingly on the 22nd July, assisted by Drs. Baines and Wishart, the following operation was undertaken.

The patient was placed in position, with the shoulders well raised and a sandbag under the neck so as to throw the head somewhat backwards and thus increase the area for operative measures. An incision about three inches long was made on the left side of the middle line, corresponding with the anterior margin of the sterno-mastoid muscle. The incision was rapidly deepened, largely by blunt dissection, until the anterior belly of the one-hyoid muscle was reached. This muscle, and the sterno-thyroid and sterno-hyoid muscles were drawn inwards. The lateral border of the trachea could then be felt, and on stretching the wound open the oesophagus could be located immediately behind this. Great assistance in locating the gullet was rendered by an oesophageal bougie with a large bulb, passed into its interior and pressed towards the wound. The foreign body, however, could not be felt. The gullet was separated from its connections to a considerable extent, both anteriorly and posteriorly, by blunt dissection, and in this way it was possible to bring its lateral wall almost to the level of the skin before making the opening. The remainder of the wound was then packed closely with iodoform gauze, so as to prevent any discharge which might escape when the oesophagus was opened, from infecting the deep portion of the wound. These two measures, viz.: the free dissection of the oesophagus from its surroundings and the packing of the wound, we regarded as very important measures in preserving asepsis of the wound. An incision was now made upon the bulb in the oesophagus, and the lateral margin of the wound was held by a pair of forceps on each side. The finger was then inserted, and the plate was felt to occupy the position already described, viz.: just below the level of the cricoid cartilage, and so firmly and deeply imbedded in the oesophageal wall that the finger could easily be passed in front of it. This accounted fully for the inability to feel it with the oesophageal bougie, or with forceps passed down from the mouth. A pair of curved forceps were then passed along the finger, and the body grasped and removed, though not without very considerable difficulty. Great care was

taken to catch all the mucous that escaped from the wound in sponges. The wound in the oesophagus was then closed accurately by means of a double row of catgut sutures, the outer row being in the form of Lembert sutures. Having sponged this portion of the wound dry, and disinfected with carbolic acid solution 1-20, the gauze was removed from the main body of the wound and the oesophagus allowed to fall back to its place. The whole wound was then sutured up with deep sutures, applied in such a way as to bring all the deep parts of the wound together and yet allow of their subsequent removal by passing the ends through the skin at each end of the wound and tying them over pledgets of gauze. The skin edges were approximated by a continuous horse-hair suture, and a dry dressing applied after dusting the wound freely with bismuth formic iodide.

The patient was given no food by the mouth for two days, and the wound healed kindly without any swelling or inflammation. In the meantime the patient was well sustained by rectal feeding.

The sutures were removed on the fifth day, when the wound appeared to be perfectly healed. A day or two afterwards, however, a small area of fluctuation was observed under the wound, and on making a minute opening in the scar a small quantity of purulent fluid escaped. This left a cavity, which however did not communicate with the oesophagus. The abscess discharged for about a week but ultimately closed, leaving but a slight scar.

The patient was allowed liquid food on the fifth day, and shortly afterwards solid food was permitted. He had some slight difficulty in swallowing at first, and a slight degree of hoarseness was present for a short time, but he has subsequently fully recovered the use of his voice, and of his powers of digestion. There is no evidence of any stricture having followed the operation.

A CASE OF GRAVE'S DISEASE TREATED BY THYROIDECTOMY

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MISS McK. æt. 30 years, entered my Clinic at the Toronto General Hospital on September 9th, 1901, with the following history:— Seven years ago she noticed an enlargement in the thyroid region to which she paid no attention. Two years later she lost her mother and had other family troubles and at that time the mass began to increase rapidly.

From that time her health began to fail. She lost flesh steadily and from 167 lbs. her weight at that time, she became reduced during the last four or five years until now she weighs 120 lbs. From a robust girl she became reduced to the condition of a partial invalid. Her eyes became prominent, the breathing embarrassed and the heart-action very rapid. She tired easily and at times suffered from dyspnoea and dysphagia. She was restless and irritable at all times. On examination I found an emaciated woman apparently 38 or 40 years of age with a haggard anxious expression, prominent eyes and a pulse rate of 120. She was excited and her breathing slightly stridulous at the time.

The notes from my case book are as follows:

Miss K. McK., aged 30, consulted me Sept. 5th, 01. Kindly referred by Dr. D. J. Gibb Wishart.

Family history—Father living age 72, very robust and well. Mother dead, age 60, tuberculosis of the lungs and bowels. Brothers, 1—none dead. Sisters, 7—one dead aged 9 years, from meningitis.

Personal history—Never a week in bed except from diphtheria, five weeks, at age of 18 years.

Present illness—Began five years ago, when nursing her mother through a long illness, with rapid heart, anaemia, irregular menstruation, etc.

Present condition—Tall, slight, pale, nervous, with goitre, prominent eyes. Temp. 98 $\frac{2}{3}$ °F. Pulse 112. (8 p.m.)

Weight—132. Most, 167 lbs. 5 years ago. Not much gain or loss in past two years

Digestive system—Tongue clean, tremulous. Appetite good. No dyspepsia or constipation.

Respiratory system—Normal.

Circulatory system—Small, rapid, not quite regular pulse. Blood not examined but she is distinctly anaemic.

Genito-urinary system—Menstruates at present every month. Has never been regular. Flow scanty and pale. No pain or leucorrhoea.

Nervous System—Headache rare. Is a good sleeper as a rule. But

(a) Fine tremor of hands, tongue, etc.

(b) Eyes prominent. Van Graefe's sign absent.

(c) Capillary unrest, not very plain objectively, creeping blush of skin of chest not prominent. She complains of flushes and heats, and cannot bear much clothing or bed clothes. (Compare the sense of internal heat from which some suffer in *paralysis agitans*.)

(d) *Myotatic irritability* distinctly plus. (Supinator, jaw, and knee-jerks. etc.)

(e) Goitre—large, firm, cystic, pulsating, both lobes and isthmus, left lobe the larger.

Diagnosis.—Grave's Disease.

I am much obliged to Dr. Bingham for the skill with which he operated—the details of the surgical side of the case he will describe to you. I may preface my brief remarks with a revision of the extremely chaotic state of the etiology of this disorder. Two views are held as to the functions of the thyroid gland. One is that the gland provides an anti-toxin to the results of destructive metabolism, or somehow removes or destroys deleterious substances, the result for instance of abnormal proteid digestion in the intestine, which otherwise do damage to the central nervous system.

The other is that the secretion is necessary directly for the proper nutrition, more particularly of the central nervous system. The first view may be called the catabolic, the second the anabolic view, of its action. In Allbutt's System, W. M. Ord expresses the belief that the thyroid condition is not at any rate the primary cause of the disease at all.

Trousseau, whose observations upon the obscure larval or non-typical forms of the disorder, were so valuable, "*formes frustes*" he called them, seems to have been the first to hold that the disease could exist without either exophthalmos, goitre, or marked frequency of pulse. I have certainly seen two or three cases of which this could be said, and one in particular in which actual mental aberration with homicidal impulses was the chief feature.

Theories differ also as to whether it is from over or under activity of the gland that the symptoms arise. "Hyper" or "hypo-thyroidation" some of our American confreres like to call it. If one contrasts the clinical picture of myxoedema or cretinism with that of Grave's Disease he will surely have difficulty in accepting under-activity of the organ as the under-

lying condition. On the other hand, one sees clinical reports of cases in which administration of thyroid Extract is said to have been of service. My own experience is entirely against its use. Still it may be that here again as so often in matters medical, the truth lies between, and that there are cases of both kinds. The interesting features in the progress of the case after operation are two. First, the accession of a severe attack of acute Grave's Disease on the day after the operation, in which pulse ran 140-170, and temperature 103° F. There was much shock the first day but this soon disappeared, and the temperature and other systemic disturbance was plainly not from the wound; belladonna, digitalis and potass bromide, with the icebag to the præcordium, soon caused the symptoms to subside.

The other feature referred to was an aphonia, of typically hysterical type, with occasional lapses into phonation particularly during the night, which still persisted when she left town seven weeks after the operation. The cords however lay in a typical cadaveric and not in the hysterical position, Dr. Wishart informs me, so that the recurrent laryngeal nerves though not divided in the operation may, have been so roughly handled as to produce the vocal cord paralysis. The girl went home practically well seven weeks after operation, and I have to heartily congratulate myself, and thank Dr. Bingham, for the eminently satisfactory outcome of an operation for a disease usually so serious and intractable.

The surgical side of the case is described by Dr. Bingham as follows:—

The thyroid gland was enlarged bi laterally, both lobes and especially the isthmus being involved. The whole mass was solid moveable and circumscribed. All the ordinary methods of treatment had been exhausted when she consulted Dr. Fotheringham, who advised operation. I agreed with this and operated on September 11th through an oblique incision from the left mastoid process to the sternum. The inferior thyroid arteries were tied off very close to the tumor and the whole mass removed except a small apparently healthy lobule, situated at the upper part of the right lobe. The anæsthetic (chloroform) was only fairly well borne and normal saline was introduced per rectum during the operation.

The mass extended well below the upper margin of the sternum and left clavicle and the cavity thus left was obliterated by "quilting" with several rows of catgut sutures. Drainage was introduced and the wound closed.

During her convalescence she developed several attacks of intense tachycardia with elevated temperature. The first of these attacks occurred on the evening of the 12th when at 6 o'clock, her temperature was

103.1°, pulse 170, respirations 46. The ice-pack was used over the heart and at 8.30 temperature was 100.3° pulse 157, respirations 31.

Stimulation was ordered as required, as well as a combination of morphine, atropine and digitalin used hypodermically for several days.

On the eleventh day temperature, pulse and respiration were normal and thereafter convalescence was uneventful and she was discharged on the nineteenth day after operation. Vocal phonation was lost entirely from the time of operation, a temporary condition not unusual in these cases, and early in the present month (October) she began a course of electrical treatment of the vocal cords by Dr. Wishart. On October 15th the doctor tells me she is beginning to phonate and he can detect some motion in the cords.

As to her present condition she tells me she has not felt so well in five years. She is gaining steadily in flesh and strength, restlessness and irritability are disappearing and tachycardia practically a thing of the past.

The following points in connection with the case appear to be of interest :

One source of danger in this operation is the anaesthetic. If we can dispense with the general anaesthetic we remove this danger. In this case, owing to the highly nervous condition of the patient, this appeared to be impracticable, but I am satisfied our efforts should be directed toward the use of local anaesthesia in every case possible.

Another source of worry to me in these cases has been the yawning cavity left behind the sternum and clavicle, inviting retention of secretions, burrowing of pus and mediastinal infection. This I think can be entirely overcome by a careful resort to the method of quilting used in this case. The aphonia often following complete thyroidectomy is not necessarily permanent but may result from (a) hysteria or (b) laryngitis, owing to the necessary traumatism inflicted during the operation.

The discussion of other methods of operation is not within the scope of this report. I may mention however that the partial operation, in cases of exophthalmic goitre such as the one I have reported, does not appear to have been attended with the success which was hoped for.

Turning to the post-operative treatment I cannot too strongly insist upon the imperative necessity for a careful and scientific attention to the patient. In this case the medical treatment was directed by Dr. Fotheringham and I was particularly impressed with the effect of the ice-pack to the heart, which appeared to relieve the patient so quickly.

A CASE OF PERFORATION OF THE BOWEL IN TYPHOID.
OPERATION, RECOVERY. FOLLOWED BY SUBPHRENIC
ABSCESS. OPERATION, RECOVERY.*

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G. A. S., M. B., aged 29. Dr. Rogers, of Ingersoll, has kindly furnished me with the following history of the case:

"Last summer he suffered slightly from gastric and intestinal dyspepsia. At the time of his illness he was attending three typhoid cases, one of which was very severe. During the ten days previous to the attack on October 17th, he had no appetite, aching pains generally, and chilly feelings, but no fever. He thought possibly he might have typhoid, but kept on his feet until October 17th, when he had a moderate chill. Temperature shot up to 103° F., and his pulse was 100. When I first saw him on the 19th he was suffering from a severe headache, muscular pains in various parts of the body, and a severe backache. Temperature 102½; pulse, 100; and respiration, 21. Examination of the urine revealed nothing abnormal. A blood examination gave the typical Widal reaction.

"On Oct. 20th, his temperature was 103; pulse, 110; respirations, 22, and his other symptoms were somewhat intensified. On the 21st he was removed to the Sanitarium at Ingersoll, and upon admission his pulse and temperature were as recorded. The case ran the usual typhoid course until the 26th, when a moderate hæmorrhage occurred. On the 27th a second hæmorrhage of less magnitude occurred, and on the morning of the 31st a third slight hæmorrhage. Temperature in the morning, 99.4-5, pulse 78, respirations 20. At 10.30 o'clock that evening his temperature was 98.1-5, respirations 20, and pulse 78. He was feeling first-class at the time, and was quite jubilant at the prospect of an early recovery. He went to sleep at eleven o'clock, but became restless at twelve, and tossed about until 2.30 in the morning, when he was seized with a severe pain in the region of the bladder. At this time his temperature was 99, respirations 20, and his pulse 76. The pain grew rapidly worse, and I was telephoned for, but as I was out in the country, Dr. Williams was obtained, and ordered 1-8 gr. morph. sulph. and 1-300 gr. atropia sulph., to be repeated in an hour if necessary. After the second hypodermic the pain was relieved.

"At 9.30 o'clock in the morning I saw him, and found quite a changed countenance from the preceding night. Temperature 104, respirations 26, and pulse 110. He had a very anxious expression, but said he felt pretty comfortable. There was not the slightest symptom at the time of

*This paper was read and the patient presented before the Toronto Clinical Society, Wednesday, March 5th, 1902.

collapse. At 12.30 Drs. Parke, Tait and Williams saw him with me, but no agreement could be arrived at as to whether or not perforation existed. Shortly after this I telephoned to Dr. Bruce to come up on the two o'clock train."

I may say here, that in telephoning, Dr. Rogers told me that he suspected a typhoid perforation.

I will give my notes as to the patient's condition when I saw him at 6.30 on the evening of November 1st. Temperature, 103 1-2, pulse 126, and respirations 22. The abdomen was hard all over and tender. There was no distension, but on the contrary he was quite flat. The liver dulness was somewhat lessened, but had not disappeared. His facial expression was anxious, and what one sees so commonly in peritonitis. A diagnosis of typhoid perforation was made, and the patient prepared for operation.

Shortly after nine o'clock he was brought into the operating-room, and was given chloroform by Dr. Tait. Dr. Rogers assisted me, and Drs. Williams, Parke and McWilliams were also present. The usual median incision was made, and the perforation was found very easily, about ten inches from the cæcum. It was very small, being only the size of the lead in a lead-pencil. Some lymph surrounded the perforation. There was marked general peritonitis, with about a pint of sero-purulent fluid in the peritoneal cavity.

A very interesting feature in connection with the appearance of the ileum was the fact that pieces of lymph, about the size of a half-dollar, were present on the surface of the bowel, at intervals of three inches, extending over the lower three or four feet, evidently Nature's effort to reinforce the ulceration and avert perforation. The ulcer was turned in by means of a double row of Lembert's sutures, and the peritoneal cavity flushed out with hot salt solution. Iodoform gauze was put into the abdomen at the site of the perforation, to act as a drain, and the abdomen was closed, with the exception of about an inch, to allow the passage of this gauze.

He was back in bed again at ten o'clock, the operation taking about thirty-five minutes. We considered from the symptoms that perforation had probably occurred about 2.30 o'clock, so that the operation was done 18½ hours afterwards. Immediately after the operation his pulse was 140, but in an hour's time it came down to 120. 1-20 gr. of strychnine was given hypodermically, immediately after the operation, and every two hours for four doses. Then 1-30 gr. every three hours. Eight ounces of hot salt solution was given by rectum every two hours for the first twenty-four hours after operation. He was also given a

nutrient enemā, consisting of six ounces of milk and half an ounce of whiskey every eight hours.

At twelve o'clock he had a slight movement, very offensive, much flatus being expelled. At one o'clock his temperature was 100, pulse 118, and respirations 25. At two o'clock he had another small movement, a great deal of flatus being expelled. At six o'clock on the morning of the 2nd his temperature was 100, pulse 110, and respirations 26. At four in the afternoon his temperature was 99 3-5, pulse 120, and respirations 26.

On the morning of November 3rd his temperature was 99 2-5, pulse 106, and respirations 26. In the evening the temperature was 100 2-5 pulse 108 and respirations 28. From this he continued to improve until the morning of the 5th, when his temperature was 98 3-5, pulse 88, and respirations 22. Calomel was given on the 5th, and he had a free movement on the 6th, and temperature was normal on the morning and evening of the 7th—pulse 86, and respirations 20. The temperature fluctuated from this on, but gradually rose until November 15th, when it reached 101 4-5, with a pulse of 104.

On November 16th I went up again to Ingersoll as there was pus coming from the original opening left for drainage, and it was thought not to be draining freely. The patient was given chloroform, and the sinus enlarged and found to lead to a cavity about the size of a hen's egg, which extended from the middle line outwards to the outer edge of the rectus muscle, the floor being formed of loops of bowel.

I made a counter opening here for drainage, wiped out the cavity with 1-40 carbolic acid solution, and put a drain in through the old opening, and also through the new one, on the right side of the rectus muscle. The temperature did not drop, however, as was expected after this procedure.

On the 20th of November he first complained of pain on the right side, in the region of the liver, and this gradually became more severe. A pleuritic friction rub was made out, and air did not seem to be entering the lower portion of the right lung. There was, too, at this time some tenderness over the gall bladder, and increased dulness. This gradually became more marked, and the line of liver dulness descended. On the 25th Dr. W. P. Caven was sent for and examined the patient, and thought that the gall bladder was infected with the typhoid bacillus, and on the 6th December I went up to Ingersoll again.

I will here give my notes of his condition on December 6th. His temperature the previous evening had been 102 1-5, pulse 130, and respiration 22; and now his temperature was 101 1-5, pulse 112, and

respiration 22 On examination, I found the liver about two inches below the ribs, increasing very greatly the extent of liver dullness. The right side was bulged out, making it appear as if the liver was greatly enlarged. At the lower edge there was a great deal of tenderness, and the skin was red and brawny.

I could make out deep fluctuation here. Dr. Rogers gave me a history of the gall-bladder having been markedly enlarged, and that only during the past couple of days had the swelling at the lower edge become diffused, and the outline of the gall-bladder disappeared. Chloroform was given by Dr. Walker and Dr. Rogers assisted me, (Dr. Tait being also present.) Owing to the above history, I made an incision in the right semilunaris and exposed the liver and gall-bladder. The gall-bladder was not enlarged, and appeared to be normal. On palpating the liver to the outer side of the gall-bladder, fluctuation could readily be made out. I made an incision into the liver, at this situation and after penetrating $\frac{1}{4}$ of an inch, evacuated about a quart of pus. On passing the finger through the opening in the liver, I found the margins of the liver were somewhat ragged, and my finger entered a large space behind the liver, filled with pus. On passing the finger still further, the ribs could be felt posteriorly. It was evident then that we were dealing with a large subphrenic abscess, which had secondarily invaded the liver.

An opening was made in the tenth intercostal space, and just to the outer edge of the erector spinæ muscle, and a quart or more of pus drained out through this. In making this incision the pleura was not opened into. The cavity was explored through the posterior opening after the evacuation of the pus, and proved to be of great dimensions, leaving a huge space between the liver and the diaphragm. Two drainage tubes were put in, and a large quantity of gauze. There was sufficient room between the ribs to allow of this being done. A drain of iodoform gauze was put down to the opening in the liver anteriorly, and surrounded by strips of iodoform gauze, shutting off the general peritoneal cavity. The wound anteriorly was closed, with the exception of about half an inch, through which the gauze passed. He was under the anæsthetic between thirty-five and forty minutes, and considering his weak state, stood the operation very well. His pulse at the finish was 150. Interstitial hot salt solution was given under each breast,—about a pint—and hypodermics of strychnia, etc., were freely used.

Dr. Rogers says that the collapse following was most marked, and during the night an interstitial saline was given, strychnia and brandy hypodermically and oxygen administered, and eight ounces of hot salt solution were given by bowel every two hours. The next day another

interstitial saline was given. His temperature was 99.4-5, and his pulse 160. At times his pulse was quite imperceptible, and even when felt it was so rapid as to prevent its being counted. The following day the temperature rose to normal, and the pulse came down to 110-120. After this the temperature never rose above 100, and kept between normal and 99-2/5, until he left the Sanatarium, on Jan. 7th, for home, the opening behind being completely closed. His pulse remained somewhat quick, however, varying from 80 to 110. After returning home he rapidly gained strength, and resumed his practice on Feb. 15th.

I wish now to express my admiration and appreciation for the exceptional skill and ability shown by Dr. Rogers in his treatment and management of the case. He deserves all the credit for the diagnosis of the perforation, and his prompt action undoubtedly saved a valuable and useful life.

The perforation occurred on the fourteenth day after the real onset of the disease, if we consider

the disease commenced when the chill occurred followed by a temperature of 103. I think it is generally stated that the most frequent time for perforation to occur is during the third week, the second week following very closely upon this. Osler says that perforation occurs in the majority of cases in small, deep ulcers, and that there may be two or even three, and that usually within the last foot of the ileum. In one case, only,

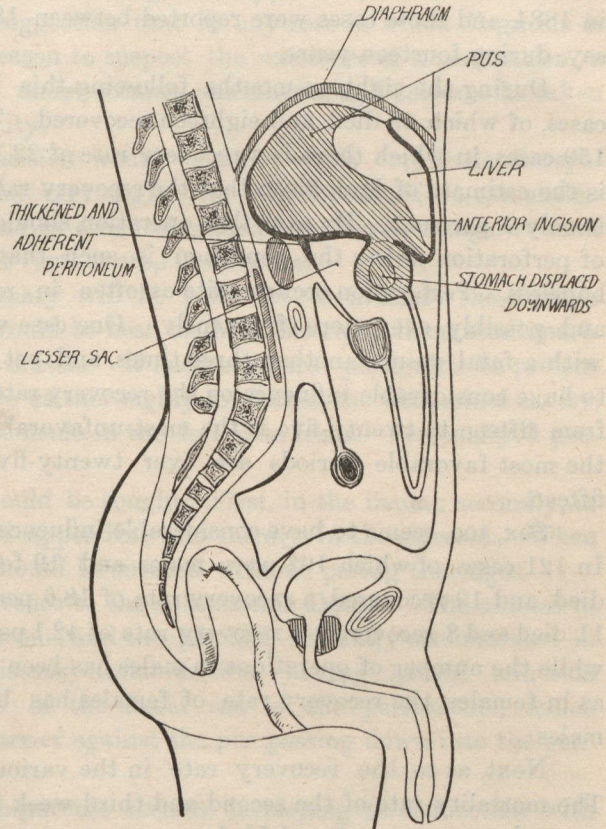


CHART SHOWING POSITION OF SUBPHRENIC ABSCESS.

was it distant eighteen inches. Peritonitis was present in almost every instance.

I am going to quote from an excellent paper by Dr. W. W. Keen, of Philadelphia, on "The Surgical Treatment of Perforation of the Bowel in Typhoid Fever," published in the Philadelphia Medical Journal, of Nov. 4, 1899.

In 1898, he collected 83 cases of operation, of which 67 died, and 16 recovered, a recovery rate of 19.3 per cent. The first operation was done in 1884, and these cases were reported between 1884 and 1898, that is to say, during fourteen years.

During the eighteen months following this he found reported 67 cases, of which 49 died, and eighteen recovered. This makes altogether 150 cases, in which there is a recovery rate of 22.7 per cent. In contrast is the estimate of Murchison that the recovery rate in unoperated cases is only 5 per cent. He says that operation should be done in every case of perforation unless the condition is such that recovery is evidently hopeless. Perforation occurs quite as often in mild cases as in severe, and possibly even more frequently. One case was operated on twice, with a fatal result, another three times, and yet recovered. Age seems to have considerable influence on the recovery rate. Analysis shows that from fifteen to twenty-five is the most unfavorable age to operate, while the most favorable periods are over twenty-five and especially under fifteen.

Sex, too, seems to have considerable influence on the mortality rate. In 121 cases, of which 102 were males and 19 females, 83 of the males died, and 19 recovered, a recovery rate of 18.6 per cent. Of the females, 11 died and 8 recovered, a recovery rate of 42.1 per cent. In other words, while the number of operations in males has been over five times as many as in females, the recovery rate of females has been over twice that of males.

Next, as to the recovery rate in the various weeks of the disease. The mortality rate of the second and third week is by far the worst, yet even these two weeks yielded a recovery rate of 16 per cent. In the fourth week this rate is doubled.

Next, as to the time for operation. He claims that the best time is during the second twelve hours after perforation, and even if perforation is diagnosed earlier and there is profound shock, he thinks that operation should not be done until this has passed off. In cases, however, where there is no shock, most surgeons will agree that the abdomen should be opened at the earliest moment. Cushing and Taylor take exception to this, and state that the shock is due to sepsis, and not to perforation, and that the

quicker the operation is done, the better for the patient. Cushing has proposed to operate in what he calls the "preperforative" stage. Keen urges that the surgeon be called in at the earliest moment, when any symptoms indicate possible perforation.

Next, as to the use of an anaesthetic. Cocain is recommended instead of a general anaesthetic. This was first used by Cushing in two cases. He says that local anaesthesia is a great step in advance, and that he will never use general narcosis again in typhoid.

Finney adds the suggestion that in any case in which diagnosis is obscure, and there is reason to suspect the existence of a perforation, a small incision be made under cocaine anaesthesia, and cultures be taken from the abdominal cavity.

The exploratory incision would be followed by very little disturbance to the patient, and very slight risk. Still more, if we can anticipate both shock and sepsis, by diagnosing the preperforative stage, we shall have made an important further step in advance.

A very brief summary will be sufficient to indicate the further technic. The incision would be best made in the right linea semilunaris or through the rectus muscle. If such a general peritonitis be present that this will not enable us thoroughly to cleanse the abdominal cavity, a second incision may be made in the left iliac fossa. Personally, I prefer a median incision.

The perforation should be sought: First, in the ileum; secondly, in the adjacent caecum and appendix; and thirdly, in the sigmoid. When found, the perforation should be sutured without paring the edges.

Just a word in reference to the sub-phrenic abscess. The abscess in this case was a posterior one, and the pus had evidently accumulated in the retro-peritoneal tissues, inflammation having caused adhesion of the opposing layers of the lesser sac of the peritoneum, which formed a very strong barrier against the pus passing down into the general peritoneal cavity.

In the case of a sub-phrenic abscess developing in connection with ulceration of the stomach and duodenum, pus is most commonly found within the lesser sac of the peritoneum. As regards the symptoms of a sub-phrenic abscess, there will be, in addition to the usual symptoms of a collection of pus, elevation of temperature, rigors, perspirations, etc., tenderness over the liver, and often a slight pleurisy, with increased liver dullness and bulging of the right side.

Then we have the "diaphragm phenomenon," which is the existence of a shallow depression which moves with respiration, across the intercostal space to the left side, as the diaphragm ascends and descends. On

palpation a collection of fluid may be felt. Greig Smith draws especial attention to the significance of a line or band of induration and resistance felt through the abdominal wall, moving with respiration. This band is due to the presence of adhesions which limit the abscess cavity below.

The patient was present and said he was enjoying excellent health and had gained 30 lbs. in weight since leaving the sanitarium.

THE VALUE OF GENERAL READING TO THE YOUNG PRACTITIONER.*

By H. S. HUTCHISON, M.B., Toronto General Hospital.

To be widely read is to have an accomplishment which holds a high place in the estimation of the world. That so few possess it must seem remarkable, when it is considered that of all the methods of self improvement, apart from one's life work, general reading stands as the most conspicuous for combining accessibility with both pleasure and usefulness.

For the young medical man, however, to consider general reading a mere accomplishment, by all means to be acquired by those who have abundance of time, but having no place in the day of a fairly busy doctor must be a grave mistake. For a knowledge of literature, slowly but surely, is coming to be a factor absolutely essential to success. Far from inflicting itself as a drudgery however, it offers him actual value of a most practical character, and is willing to afford him a pastime of the highest order.

In advocating a pastime to be universally acceptable to a body of men so vast, one not speaking from the actual experience of years, must, under ordinary circumstances, hesitate. When, however, the shrine of the Goddess of Letters is to be the place of common worship confidence may be assumed on the subject by the humblest. On the pleasures of reading, essays might be written. Here, it is only necessary to point out that the enjoyment of these pleasures combines perfect mental refreshment with bodily quiet and comfort, in a way acceptable to none more than the practitioner of medicine, fatigued with the rounds of a day. To adopt from the outset a recreation of necessarily in-door nature to the total exclusion of others more beneficial physically, would be a course far from sensible. There are few of the sports, however, which do not make calls on the time soon certain to be felt too great for even the commencing practitioner, and prosperity bringing with it as it must, more open

* Read before the Toronto Post-Graduate Society, Dec. 4, 1901.

air activity, can look in no more profitable direction for pastime than the the ever present book-shelf.

In respect of the actual practical value of general reading to the busy medical man, let us first look into the characteristics which make a writing great, be it novel, essay or poem. As an illustration may be used the novel, because the essence of what can be said in regard to it will be found to apply also to the others. In works of fiction we find a story running connectedly throughout, and at different junctures scenes of more than ordinary interest. In a novel of exceptional merit some of the success is due no doubt to the construction of the story, and the way in which the scenes are colored, but these do not form the true substance of the work at all. The true substance is the exhibition of human nature. This must be done in a way that will appeal to all, and must have for its characters genuine representations of actual men and women, acting, thinking, and speaking as people do, or have done.

The writer of such must be a person of no mean ability. His insight into human nature and human motives must be extraordinary. He must be a man of the world, having had wide experience of actual happenings, and must be a careful student of the past. Most of all, however, we are told, he must possess a *unifying principle*. This, attained to only by deep reflection on life, enables him to see, no matter in what sphere he may be placed, the very core of life in all its sides, the very first principles of human tragedy and comedy.

Now are not the powers which such an one displays the very ones which every young medical man who intends to build up a practice should strive to acquire? Coming into relationship with our fellowmen of the utmost intimacy possible, what class of men can require more, that this great human nature shall be an open book? The meeting half-way of delicate questions from embarrassed patients, the preservation of dignity in trying circumstances, the judicious handling of grave forecasts, are a few examples of occasions demanding of the physician a careful previous study of like situations. In other words, he too must possess a unifying principle, and nowhere can he acquire it more readily than in the works of the masters.

A decision of the utmost importance for a young man to make once and for all, is that as to whether conscience or selfish ambition shall have the right of way in his actions. For us young medical men this problem assumes most serious proportions, for grave indeed, for humanity at least, must be the consequences of the adoption by any of no definite constant course, and graver one of personal advantage entirely. To the help of all in this great determination, comes reading. Biographies pleasurable to

read, readily to be obtained, state actual facts of the lives of men of both modes of action. Essays place within the reach of all, the thought of great minds who have been confronted with the same question. One may read the life-story of a Mirabeau or a Talleyrand, and estimate for himself the measure of success which in these cases attended the annihilation of moral self. (It is significant that in other pages than those of British history must we seek to find lasting conspicuous figures of this type). Again, one may read the biography of the cruelly ambitious Napoleon and then that of the conscientious Cromwell, and finally in an essay by one of the world's greatest thinkers, see the motives, actions and success of these very two contrasted. These men all shine forth as having individually given one or other course the best trial possible to human soul. We may with but slight trouble learn of their every step. What folly then for any to map out his course without taking advantage of the fund of information which literature silently offers.

It is interesting to note that whichever course one may select, he will still find reading indispensable. Amongst others, the very characters above referred to found it so, and it is told of the great Napoleon that he never travelled any considerable distance in his coach without being literally surrounded by a fresh stock of works of value, which were eagerly devoured, and then, to allow of ordinary comfort, had to be thrown out of the window.

In still another direction, may reading be said to yield practical value to the physician. No matter how excellent a man may consider his methods of working to be, he must always acknowledge the possibility of better ones. If it be impossible to have the advantage of personally observing such, he may at least learn of them from the literature. In connection with work in medicine, there is plenty of biographical material to be procured containing information of this very nature, and the fact that it comes necessarily from the old world, where medicine is more classical, in no way detracts from its usefulness. A description of the marvellous capacity of work, and the great versatility, of some master must forever leave its impress on the memory to be a stimulus to higher attainment.

If any, on careful consideration, cannot see in such advantages sufficient inducement to give to literature systematic attention, let him now look at the necessity for doing so, which is coming to stare him in the face.

The position of the medical man has always been one commanding a more than ordinary amount of respect. Few men, even in public positions come in during their daily rounds, worthy as they may be, for display

toward them of deference from so many individuals, as the busy practitioner. Till the present age, the condition of the mass of the people with regard to education has been poor. Nowadays however, there is a change sweeping over all civilized communities. Well-read men abound everywhere. Merchants, financiers, and men in humble walks of life, are finding the advantages for their actual business of being men of knowledge. Their sons and daughters are early making strides into even scientific knowledge. Books are coming more and more within the reach of all. Technical schools abound where even the poor may make inroads into learning of all sorts. Minds formerly engrossed in small things are now, as a result of this change, and of the wider familiarity possible through the style of magazine now current, the freedom of the press and not a little through such modern inventions as the cinematographe, coming to comprehend life in all its sides. No matter to what extent civilization may advance, the acquired practical skill of the medical man must command at all times, consideration. In all but this practical knowledge, however, the laity is somewhat approaching the level of the professional man.

Is then the practice of medicine, heretofore giving to its adherents a position above the average in general society, in any danger of coming to be merely a high-class trade? Are the sacrifices made, the hardships gone through, even the sympathy displayed by the physician, in any risk of being set down as merely commodities to be exhibited as routine, and not in any way the true inclinations of one ennobled to some extent by having worked in the vast field of usefulness, and of grave responsibilities, which medicine presents? No; practically this is not what seems to be coming to pass at all. The masses are still prepared to respect, but are by their own advancement, raising the standards required of us. Woe to him, then that does not appreciate and hasten to profit by this necessity. He will be what Carlyle calls "the unable man" in the position of influence. If, however, he earnestly set about the acquiring of general information, he will, judged by the standards now fixed by the laity, be considered a worthy member of his profession, will help to maintain the rank of medicine with its sister professions of necessarily wide learning, and most of all, will approach the type of his British brother in medicine, as gentleman of culture.

Once having realized the value of general reading as a habit, it must be a weak character, who will not strive to adopt it. It may be urged that a busy practitioner, especially one settled in the country, has hardly time for medical reading, much less for that of any other nature. When however it is remembered that this other is recreation and that as years

roll by, it is one of the few pleasures likely to satisfy, and that true manliness is the direct result of reading and its accompanying thinking, objections must vanish. Practically it has been found that, with a definite system of even but fifteen minutes daily allotted time, in a year the fruits of our industry will be remarkable. There are, no doubt, some to whom literature, other than medical, has scant charm, but let them weigh its results and remember, that if they earnestly seek, they shall find.

RECURRENT GASTRITIS--GASTRO-ENTEROSTOMY.

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

D. M., aged 54, stone mason, fifteen years ago, was taken with severe pain under ribs of left side and vomited bile: after five weeks suffering recovered with the exception of pain, which continued intermittently, occasionally severe, until 1894, when he had an attack of diarrhœa, with pain in the left side, and passed tarry stools. Continued fairly well till March, 1899, when symptoms become distressing, pain severe, with attacks of dizziness and vomiting, each lasting about a week. These attacks increased in severity till in September, 1899, when he was forced to cease work, and became confined to bed, the pain being only controlled by large doses of morphia. Vomited large quantities of greenish fluid, and black masses resembling disintegrated blood. This would be followed by vomiting of particles resembling coffee grounds, A diagnosis of cancer of the stomach was made by six medical men, who gave him only a short time to live. I saw the patient about this time, and while not disagreeing with a diagnosis of cancer, could find no tumor nor thickening of the parts. Patient had been vomiting large blood clots, and was very much emaciated. Nitrate of silver pills were ordered. Drachm doses of milk were retained; patient gradually improved. In December he had a severe hemorrhage which left him very much exhausted, but he rallied rapidly, and in a few weeks enjoyed good health, though the pain continued. In August, 1900, he had another slight attack. May, 1901, I was again consulted: he had suffered severely from constipation, always feeling better after a thorough saline purge. An examination showed dilatation of the stomach. Upon a diagnosis of recurrent ulceration and pyloric stenosis, I recommended operative measures to which he agreed. On July 12th, Vancouver City Hospital, assisted by Drs. Jeffs, McKechnie, and McEwen, I opened the abdomen, finding the stomach unusually dark-colored, the walls very much thickened,

specially towards the pylorus, no cicatrices nor adhesions. All other organs were healthy. The jejunum was attached to the posterior wall of the stomach (Von Hacker's operation) by a Murphy button, reinforced with silk sutures. During the operation pulse ran as high as 210, twice respiration became suspended. After the operation the patient was very weak, but under the care of Drs. Jeffs and McKechnie, for whose skilful attention great credit is due, he made an uninterrupted recovery. He has since gained 45 lbs. and returned to work. The button passed on the fourteenth day.

In no department has surgery made such inroads as in the treatment of diseases of the stomach. Gradually the knife is displacing the pill,—and the end is not yet. Shall it soon be said that disorders of the stomach that do not yield to regulation of the diet, and to surgical means, yield only to the Great Harvester? The improved methods of diagnosis of obstructive conditions, and the application of the principle of drainage, to over distended cavities, have been the factors in the evolution of gastric surgery. The early recognition of malignant diseases is still the uncertain problem. We would hail with delight the seer who would offer us a greater degree of accuracy in this matter.

Early diagnosis is necessary if we hope to be as successful here as in other departments of abdominal surgery; and if our results are to reflect credit, radical operations must be done before the patient becomes exhausted. It is neither creditable to the physician, nor encouraging to the operator to find a patient weary with treatment for chronic dyspepsia present an irremediable malignancy.

Greater familiarity with the many excellent methods of gastro-enterostomy is gradually relegating the severer operation of pylorotomy to the back ground; in fact there is reason to doubt if there be any conditions that formerly called for pyloric extirpation, that cannot be more satisfactorily relieved by gastro-enterostomy.

The less serious, and manipulatory easier method, is yielding such excellent results that surgeons are becoming more and more disposed to give their patients its benefits in cases that only recently were admitted to be within the exclusive domain of the physician.

With reference to the gastric opening—so long as the structures are firm, the opening sufficiently removed from diseased parts, and located near the lower border of the stomach, there appears to be very little preference for the posterior surface, as the anterior anastomosis gives very satisfactory results, yet the anatomical relations appear to give preference to the former. If the drainage is as satisfactory as in the posterior method, the anterior method is to be preferred in many cases as infinitely

easier from the standpoint of both operator and patient. While posterior anastomosis entails a larger abdominal wound, greater exposure of the intestines and at times no small amount of manipulation with its corresponding amount of shock, the anterior operation is one of the easiest and quickest of all abdominal operations, and can be done with the minimum of anaesthesia or with cocain. In this method there is greater tension at the gastro-intestinal junction requiring additional supporting sutures at the upper border of the attachment. The part of the bowel to select should be that part of the jejunum as near to the duodenum as can be easily appropriated without undue traction or extensive disturbance of the parts. Emaciated and exhausted patients do not bear manipulations in the region of the solar plexus without experiencing considerable shock, infinitely more than in the same amount of manipulation of the pelvic organs. The recently introduced method of gastroplication effects nothing that cannot better be done by anastomosis and further, it is an unsurgical procedure, inasmuch as intra gastric fissures are left caused by the foldings of the stomach wall, in which particles of food are apt to be retained and undergo fermentation, thus to a great measure defeating the object of the procedure.

A CASE OF OTALGIA.

B. F. BUTLER M. D. London.

H—A lad of 15 years had suffered for a year from such a distressing pain in his right ear, that the family physician found it necessary to administer hypnotics in order to procure sleep. An examination of the ear was negative, and suspecting a dental origin, I examined the teeth, although in reply to a question, the patient was positive that his teeth were sound, as he had not experienced any trouble in connection with them. A small discolored spot, a little soft, was found on the 2nd lower molar on the right side, and a gentle tap on the tooth produced a little extra sensitiveness. Extraction of the tooth was followed by prompt recovery.

Diseased teeth are frequently responsible for otalgia, but in many cases the connection is quite evident, and the report of this case is merely to show the necessity for careful examination of the teeth, although the patient may not have been aware of any defect

DISEASES OF THE NOSE AND THROAT.

Conducted by D. J. GIBB WISHART, B.A., M.D., C.M., L.R.C.P.

THE EARLY APPEARANCE OF LARYNGEAL TUBERCULOSIS.

AN interesting contribution upon this live subject appears in the December number of the *Laryngoscope* in a paper read by Holbrook Curtis before the New York Academy of Medicine. The writer considers that the weight of evidence is in favor of the theory that there is a secondary sub-mucous infection either through the lymphatic and vascular system, or through the lymph spaces by infection of their endothelial lining membrane. He considers that the flaw in theory that the bacillus laden sputum causes the onset of the disease in the larynx by contact is that it does not explain the immunity from laryngeal tuberculosis of the majority of phthisical victims in the advanced stage of the disease while there are many cases in our clinical experience in which the pulmonary disease has not advanced to such a stage that sputum is an appreciable factor.

Dr. Curtis does not deny that the pharyngeal lymphatic ring may be the seat of a primary infection, but thinks that the tendency of tuberculosis of the tonsils is to become latent. Tubercle most frequently appears in the sub-mucous layers, more or less distant from the epithelium and often the mucous membrane is of a healthy type, until the swelling caused by the rapid invasion of the tuberculous infiltration lends credence to our suspicion of the existence of the dreaded disease. In several of the writers cases the presence of the bacilli was never discovered in the sputum until after the edematous and ulcerative stage had commenced, nor was the so-called characteristic pallor of the patients larynx or pharynx visible. In fact no physical sign gave warning of the approach of the disease except that the vocal cords were sluggish in response to vibratory movement and the morning temperature of the patient was sub-normal (1 to 2 degrees).

It is a mistake to look only for superficial erosions in suspected cases much more important is the close examination of the inter-arytenoid space and the crenated appearance of the fold. Before any edematous condition of the arytenoid tissues supervenes, we must watch carefully for the sub-mucous yellowish gray spots which appear sooner or later beneath the translucent membranes of this region and the aryepiglottic folds. It is in these cases early diagnosed that we may hope to obtain

brilliant results from the injection of guaiacol, carbolic acid or other antiseptics into the tissues.

Another indication of the possibility of a tuberculous infection in its initial stage is a simple persistent congestion of one cord with a slightly swollen appearance, the mucous membrane being markedly vascular over the entire cord.

In the early manifestations of laryngeal tuberculosis there is always a feeling of general languor and debility complained of, far in excess of that which the lung complication alone would cause. This exhaustion must be regarded as pathognomonic when it occurs with a sub-normal morning temperature and evidence of laryngeal disturbance and lack of mobility of the cords, which latter may arise either from a beginning muscular infiltration or from pressure upon the recurrent nerves exerted by an enlarged lymphatic gland, and in the latter case the disturbance of motion is generally unilateral. Following closely on these symptoms comes the consciousness of the possession of a larynx, which in turn ushers in the clumsy impression in swallowing and vocal fatigue in talking.

In the discussion which ensued Dr. Chappell spoke of observing a laryngorrhea, which in many cases had preceded any changes that could be observed with a laryngoscope, and deprecated curetting the larynx, which he looked upon as a very unwise and unfortunate practice. Dr. Quinlan was equally severe upon surgical interference, which seemed to him almost a relic of barbarism.

SOME OF THE BACTERIA FOUND IN THE NOSE.

IGLAUER, of Cincinnati, contributes to the November Laryngoscope an account of a series of experiments made by him last year in the Pathological Institute of Vienna.

The prime object of this work was to search for the diplococcus intracellularis meningitidis and for the influenza bacillus in the cadavers of persons who had not had either disease. Thirty-four cadavers were examined. The bodies had previously been kept in the cold cellar prior to the examination. The examination was made as soon after death as possible. After the brain had been removed in the usual manner a transverse cut was made through the base of the skull in such a way that it extended into the pharynx and exposed the posterior nares.

A sterile platinum loop was then introduced into the posterior nares, and with it mucus was removed from the nose. The first drop was used for smear preparations. The loop was reintroduced from one to three times, and the mucus thus collected was mixed with a few c.c. of sterile

bouillon. From this bouillon mixture three plates were immediately inoculated, *i. e.*, one agar plate, one serum agar plate, and one blood-agar plate.

The smear preparation was stained according to Gram and examined for bacteria.

After twenty-four to forty-eight hours the plates were removed from the incubator, and the colonies identified as nearly as possible. These observations differ from those previously reported, in that the cultures were taken from the posterior nares of the cavader.

A summary shows that the staphylococcus pyog. aur. was present in eleven of the twenty cases, the staph. pyog. alb. in six of the cases, the diplococcus pneumonia (Frankel-Weichselbaum) and the colon group were each represented eight times; the streptococcus pyog. in six of the cases; pseudo-diphtheria group, three times. The influenza bacillus, the subtilis and the B capsulatus group and the yeast plant were each found in one of the cases. The bacillus pyocyaneus was found in two of the cases. Besides these, eight unidentified forms were noted. Thus a total of nineteen varieties was found.

No experiments were made as to pathogenicity for animals.

The additional fourteen cases of the thirty-four showed some marked pulmonic lesion, and hence are given in a separate table.

(The pulmonic condition was not the cause of death in most of these cases. The weight of evidence is strongly to the effect that the normal nasal mucus contains bacteria. However, the flora of the nose cannot be as abundant, as we would suppose from the number of bacteria inspired; for the following reasons:

1. The surface over which the bacteria are scattered is rather large. From measurements I have made I find it to be about 154 sq. cm. in the nose, and 25 sq. cm. in the naso-pharynx.
2. A certain number of bacteria must reach the naso-pharynx, from which they are swallowed and digested.
3. The flow of mucus and serum, together with gravity, tends to carry away the germs.
4. The nasal mucus is not a good culture medium.
5. The organisms which have lodged in the nose are expelled by the ciliated epithelium with great rapidity.
6. A recent work seems to show that the nasal epithelium has bactericidal power.

The practical conclusions to be drawn are:

1. It is advisable to sterilize the vestibule of the nose before operating.

2. After operations the nostril on the operated side should be closed with a piece of cotton to act as a filter.

3. Plugging of the nasal cavity after operation is, as a rule, inadvisable, as it tends to retain the nasal secretions.

4. Nasal wounds do not heal by first intention, owing to the presence of bacteria. This also explains the occurrence of secondary hemorrhage.

5. Fever after operations and the few deaths recorded have probably been due to the presence of pathogenic micro-organisms in the nose.

FALSETTO VOICE—TREATMENT.

DR. ARTHUR B. DUEL presented a young man, a native of Bermuda, with a falsetto voice. These cases are not uncommon, yet very little has been written about them. A cure had been effected in this case largely by suggestion. By holding down the patient's larynx he could be induced to speak in a proper voice, but would at once break into a falsetto on relinquishing the hold on the larynx. He had been assured that his trouble could be quickly overcome by holding the larynx in a certain way and practicing a few scales. He had been very quickly cured, and now found it almost impossible to speak in his old voice. This brings out very clearly the fact that this form of functional neurosis can be easily cured by proper measures.—*Selected*.

STENOSIS FOLLOWING INTUBATION.

DR. J. A. KENEFICK presented a child that had come to the Manhattan Eye and Ear Hospital in June, and had been transferred to the Willard Parker Hospital for diphtheria. He had been discharged from there on October 12. While at that hospital he had been intubated twenty-eight or thirty times. Dr. Kenefick had then treated him with tubes, gradually increasing in size, beginning with the two-year old and finally using a specially made six-to-eight tube. On December 19th, he had been found without his tube, and had been without it ever since, though before that he had been able to go without it only for a short time. The boy's general condition had improved, and he could now phonate quite well. When he had first intubated, the feeling had been that of passing the tube through a mass of granulation tissue, but this had gradually become less distinct during the treatment.—*Selected*.

DEPARTMENT OF THERAPEUTICS.

Conducted by J. T. FOTHERINGHAM, M.D., C.M.

SODIUM CINNAMATE.

THE writer has found this drug apparently of great service during the past few months in a case of tuberculosis, of which the appended notes are taken from his case book. Twice a week or thereabouts it was injected hypodermically into the fleshy part of the thigh, the initial dose being 15 m. of 5 per cent. watery solution. It has never caused any local irritation or trouble. The dose was pushed up to 30 m. of a 10 per cent. solution, and is still being so used. The rationale of the treatment is that the very marked leucocytosis produced must favour the fibrosis going on in the local contest between the leucocytes and invading bacilli, and tend to wall off the cavity and turn it into a smooth walled, non-secreting innocuous space. Systematic careful observation of this patient showed as satisfactorily as can be shown short of actual post mortem inspection, that not only did the surrounding area of pneumonia subside, the sputum grow scanty and finally disappear, the cough almost disappear too, and the temperature become normal, but that the bacilli have almost entirely disappeared, and the apparent size of the cavity decreased from that of a walnut to that of a filbert. The local tuberculous process seems to have been arrested. We cannot of course ascribe all the improvement to the one drug. Creosote has been employed steadily in doses as large as 15 m. or so thrice daily. Ferrol, and other good food has been taken in as large a quantity as possible, and though she has steadily refused to leave home for sanitarium treatment and has therefore had nothing like the amount of open air that one would like, she has gained in weight.

The class of cases in which the drug seems to be useful is those in which the process is well localized, and only a single focus exists. One could not *a priori* expect much in large pneumonic or acute miliary forms; and probably its results would be less favourable in basal than in apical deposits. The writer thinks that it will be found a valuable assistance to other means of treatment, in all cases in which fibrosis is going on, particularly if as above stated the disease is not very widely disseminated in the lung.

The writer is hoping soon to have a series of cases from which some

useful generalization can be made, and will be glad to have any of his readers report cases from their practice.

Miss J. H. M., aet. 19. First seen Aug. 5, '01.

Fam. Hist. Four mother's brothers died of phthisis.

Personal Hist. History of malarial fever (*sic*) and bronchitis for one year at age of 12 years, followed by five hemorrhages from the chest.

Present Condition. Weight decreasing, 110 lbs. Cough, with free expectoration, containing *tubercle bacilli*.

Aug. 5th, '01. Temperature 101 F. Pulse 120, at noon to-day.

Physical Examination. Extensive right apical consolidation to level of 4th rib in front, same corresponding area behind, with small patch of prolonged breath sound over margin of left lung beneath 2nd, 3rd and 4th ribs in front.

Large and small râles (bronchitic) pretty widely heard, scatteringly over both lungs.

During September she had two fairly large hemorrhages with several smaller ones.

During October, November and December, weight ran up to 114 lbs. Her temperature remained normal most of the time, and general improvement occurred as above noted.

A few of the injections with blood count appended, are as follows:

Sept. 20. Sod. Cinnam. $\frac{1}{2}$ gr. Blood count 5 hrs. later showed R. b. c.—5,600,000. W. b. c.—11,000.

Oct. 27th. Sod. Cinnam. 1 gr. 5 hours afterwards w b. c. were 27,600.

Nov. 9th. Sod. Cinnam. 1 gr. W. b. c., 25,000.

Nov. 23rd. Sod. Cinnam. $2\frac{1}{2}$ gr. W. b. c., 24,000. R. b. c., 6,168,000

On Feb. 18th, 12.30 p. m. Temp. 97° F. Pulse 110. Resp. 24. Taken in my office, after a considerable walk. Weight 114 $\frac{1}{4}$ lbs.

Oneslide showed three bacilli. Sputum very scanty. Cough slight.

THE ARREST OF OBSTINATE HICCOUGH.

VARIOUS mechanical measures have been suggested for this rather uncommon, but very alarming and intractable condition. Laborde's method of stimulating the respiratory centre, by vigorous rhythmical traction upon the tongue, for instance, in suspended respiration in drowning accidents, or in the asphyxia of the new-born, has been found very useful. Noir (*Progrès Médicale*, January 6, 1900,) relates the case of a nervous girl, aet. 6, much exhausted by six hours of hiccough, immediately and permanently relieved by one minute of traction upon the

tongue. This would seem to have been steady, not rhythmical traction, and to the practitioner outside of France would suggest that the hiccough was hysterical. The same writer details a case of advanced diabetes, with terminal tuberculosis, relieved by Laborde's method in two minutes of a hiccough which had for several days resisted all other remedial measures.

Other mechanical means employed have been : (1) Galvanization of the phrenic nerve. (2) Erb's method of faradism to epigastrium. (3) Leloir's method of compression of the left phrenic nerve. (4) Nothnagel's method of forcible elevation of the leg and bone of the fingers.

ETHER-NARCOSIS.

TWENTY drops of oleum pini punilionis added to 200 grammes of ether, just before administering the latter, prevents the secretion of mucus. This gives but a slight piny odor to the ether, and makes the latter less objectionable to the patient. This mixture has been used in about five hundred cases, with great success. Even when bronchitis, phthisis, empyema, or senile emphysema existed, these conditions did not grow worse. Ernst Becker (*Centrall. f. Chir.*, June 1, 1901).

PHYSOSTIGMINE IN PARESIS OF INTESTINE.

PHYSTIGMINE in doses of from $\frac{1}{120}$ to $\frac{1}{80}$ grain for tympanites in different intestinal disorders has given excellent results. The drug is given by mouth three times daily. Von Noorden (*Berliner klin. Wochenschrift*, Oct. 21, 1901).

THE TREATMENT OF HIGH BLOOD-PRESSURE IN RENAL DISEASE.

CARTER, in a research on the conditions of blood pressure in renal disease (*Amer. Jour. of the Med. Sci.*, December, 1901) has been able to establish certain important practical conclusions as follows regarding treatment: (a) When the blood pressure is high, as in chronic nephritis, and accompanied by symptoms of uraemia, the best treatment is venesection to the extent of withdrawing 5 to 8 ounces of blood, following by saline infusion of 1,400 to 1,500 c.cm. of hot normal saline solution. (b) Sodium nitrite in full doses (3 grs. every four or five hours) should be given in combination with the above. (c) The combined treatment as above indicated is almost invariably marked by improvement. (d) The average mean blood pressure in chronic nephritis is 62

mm. of mercury higher than that of acute nephritis, (e) The blood pressure in acute nephritis is about the same as in health; and when the pressure rises to the extent of 60 mm. higher than in health, the presence of chronic nephritis, or other cause of increased blood pressure, may be suspected. (f) Symptoms of arterio-sclerosis are often clinically combined with high blood pressure, and the combined treatment (with venesection, saline transfusion, and administration of nitrites) is thus also indicated as specially valuable in averting threatened cerebral haemorrhage, which is a common sequel in arterio-sclerosis.—*B. M. J.*

PRESCRIPTIONS.

1. For recurrent migraine during the attack :

℞
 Tr. Gelsemii ʒii ss.
 Antipyrin ʒj.
 Sod. Brom. ʒij ss.
 Aq. Chlorof. ad ʒij. M.

Sig. A teaspoonful in a little water every hour till relieved.

If the attack be characterized by marked pallor a nitrite, say one grain of Sod. Nitrite, will help, or half min. doses of the Solution of Nitroglycerine.

The writer has recently controlled for four months a previously constantly recurring migraine in a broker of about 40 years of age by gr. $\frac{1}{30}$ nitroglycerine in pill after each meal.

2. For intestinal flatulency and putrefaction, either in adults or children, not of acute type, the writer finds much assistance from a mixture such as this (doses for adult):

℞. Resorcin ʒj ss.—ij.
 Hydrogen Peroxidi ʒiv—vj.
 Glyc. Pepsini (B.P.)..... ʒj.
 Ac. Phos. Dil ʒiii.
 Syr. Limon..... ʒi.
 Aquae ad ʒiv. M.

Sig. A dessert spoonful after food, three times a day.

Suitable diet must, of course be specified.

MENTHOL INHALATIONS FOR THE RELIEF OF COUGH.—Saenger (*Therapeutische Monatshefte*, Vol. XV, No. 7, 1901) offers a number of suggestions for the administration of menthol in vapor form to take the

place of opiates in the treatment of cough. A few crystals may be placed in a teaspoon and warmed over a candle flame for 10 to 20 seconds until menthol fumes are given off; this may be repeated as often as desired. As an alcoholic solution of menthol (40 to 50%) evaporates without heating it may be rubbed between the palms, and the hands carried to the nose; or the solution may be dropped on a chloroform mask. A more radical measure consists in intralaryngeal injections of olive oil containing menthol in solution; this may, according to Saenger, be carried out by lay attendants. No rule can be given for the number and duration of the inhalations; they must be regulated by the needs of the individual case. The treatment is advised in tuberculosis, chronic bronchitis and whooping-cough. It should not be employed in acute inflammatory diseases of the lungs and pleura, especially if hemoptysis has recently occurred; nor should it be used to allay the cough following an endolaryngeal surgical operation.—*American Medicine*.

TREATMENT OF LARYNGISMUS STRIDULUS.—The following is recommended by *Merck's Archives* in treatment of laryngismus stridulus occurring in children two years of age or older:

R.	Tinct. belladonnæ.....	m. xii	75
	Chloralis hydratis.....	gr. xx	1 30
	Potassii bromidi.....	ʒi	3 75
	Syrupi aurantii.....	ʒiv	15 00
	Aquæ destil.....	ʒii	60

M. Sig.: One teaspoonful every hour until difficult inspiration is relieved.

TREATMENT OF THE PAIN OF DENTAL CARIES.—Redier (*Journal des Praticiens*, March 9, 1901), recommends the following for relief of the pain of dental caries:

	Tincture of benzoin.....	1½	drams
	Tincture of opium } of each.....		
	Chloroform }	½	dram
Or,	Tincture of benzoin.....	1	dram
	Tincture of opium } of each.....		
	Chloroform }	½	dram
	Creasote (pure) }		

The second formula is applicable in rebellious cases, when sensibility is excessive. A small pledget of absorbent cotton is dipped into one of these solutions and inserted into the cavity. A second tampon saturated with a resinous substance is then inserted over the first. Contact with saliva causes precipitation of the resin in the meshes of the cotton and

thus forms a more or less impermeable dressing. The following formulas may be used for this purpose :

(1)

Benzion } equal parts
 Alcohol, 80% }
 Dissolve, let stand and then decant.

(2)

Camphor.....	30 grains
Mastic.....	75 grains
Balsam of Peru.....	30 grains
Sandarac.....	1 ounce
Ether 65% } of each.....	1½ ounces
Alcohol 90% }	

The first formula is commonly employed, the second gives good dressing suitable for broad, shallow cavities. Further treatment should be carried out by a dentist.—*American*.

SWEATING FEET.—Professor Kaposi recommends the following :

R Sodi salicyl, 30 grains.
 Kali permangan., 1 drachm.
 Bismuthi subnit., 12 drachms.
 Pulveris talci, q. s. ad 3 ounces.
 M. et ft. pulv.

Sig: Dust on feet and into stockings and shoes every morning.
 —*Sajous Cyclopaedia*.

ASTHMA.—Use either belladonna or lobelia. The reason why these drugs have not a greater reputation in this malady is, that they are not given in sufficiently large doses. Either must be administered in quantities sufficient to produce the physiological effects.—*Salter (The Lancet, London)*.

CORNS—Perhaps the best method for securing the partial removal of corns by the application of chemical substances is that recommended by Unna. A ring of glycerin-jelly is painted around the circumference of the corn so as to form a raised rampart. A piece of salicylic plaster-mull is then cut to the size and shape of the central depression, and applied to the surface of the corn. This is then covered with a layer of glycerin-jelly, and, before it sets, a pad of cotton-wood is applied to the surface. This process is repeated as often as is necessary, until the horny layer of the corn separates and is cast off.

If the point of a sharp, thin-bladed knife be introduced at the groove which runs around the margin of the corn, and be made to penetrate toward its central axis, by the exercise of a little manual dexterity the horny part of the corn can be easily made to separate from the parts

beneath. This method of removal is one which is much in favor with chiropodists.

Any method of treatment, however, to be curative must secure the removal of the entire corn together with the underlying bursa.

Having taken every precaution to render the operation aseptic, a spot is selected for the injection of the anæsthetic solution. At this point the skin is rendered insensitive by the application of ethyl-chloride, and 5 minims—more or less—of a 4-per-cent solution of eucaine is injected into the subcutaneous tissue beneath the corn. Having waited a few minutes, the superficial parts at the site of the incision are rendered insensitive by ethyl-chloride. Anæsthesia is now complete, the process itself being painless, and the operation may at once be commenced. Two hemielliptical incisions meeting at their extremities are made through the skin around the circumference of the growth, care being taken that they penetrate well into the subcutaneous tissue. Seizing the parts included in the incision with a pair of dissecting forceps, a wedge-shaped piece of tissue—including the corn, a layer of skin and subcutaneous tissue, and the bursa, if present, is dissected out. The oozing is pretty free, and it is sometimes necessary to torsion a small vessel; but the hæmorrhage is never severe. The edges of the wound are brought together by one or two fine sutures; an antiseptic dressing is applied, and the wound left to heal—primary union in a few days being the rule. The net result is the production of a layer of scar-tissue at the former site of the corn. It might be thought, perhaps, that the formation of a scar on an exposed position, where it was liable to be subjected to pressure and friction, would lead to untoward results; but such in practice is not the case.

The chief advantages to be derived from the complete excision of corns are that, as a method of treatment, it is safe, speedy and painless; while the results, as far as a cure is concerned, are permanent and effected at a minimum of time and trouble.—*Edinburgh Med. Jour. and Sajous Cyclopaedia*.

NASAL ECZEMA.—The syrup of iodide of iron, given to children afflicted with nasal eczema, and whose vitality is below par, will bring about better results than all the local applications in the list.—*Sajous Cyclopaedia*

ANTHELMINTIC ENEMATA.—Thread-worms and round-worms are both met with in the rectum, the former more frequently. Their presence in children is not infrequently the cause of prolapse. Strong solutions of

salt and water, or of quassia and water, will sometimes prove efficient. Or an enema composed of 1 to 4 drachms of spirit of turpentine mixed with the yolk of an egg, and added to 4 to 8 ounces of water, may be given repeatedly until the worms are destroyed. Two drachms of asafoetida or aloes in water also answer equally well.—*Maryland Medical Record*.

VERATRINE IN PRURITUS.—In the obstinate pruritus of women at the menopause Dr. Lutaud recommends the external application of veratrine, if the pruritus is localized. He orders an ointment of $2\frac{1}{2}$ grains of veratrine to an ounce of lard, to be applied morning and night. If the pruritus is general, he orders the drug internally; 1-180 grain in pill form once a day, gradually increased to six times a day, half an hour before meals or three hours after meals.—*Merck's Archives*.

HABITUAL CONSTIPATION—

℞ Sulphuris loti, $\text{f}\overline{\text{ss}}$ j.
 Potassi bitartratis, $\overline{\text{ss}}$ j.
 Pulv. sennæ, z iv.
 Syrupi rhei, $\text{f}\overline{\text{ss}}$ ij.
 Ext. cascarræ sagradæ fl., $\text{f}\overline{\text{ss}}$ ij.
 M. et ft. confectio.

Sig.: One teaspoonful at night to move the bowels.—*Journal of the American Medical Association*.

Pills for Use in Heart Troubles with Hepatic Congestion.

The *Gazette hebdomadaire de médecine et de chirurgie* gives the following:

℞ Powdered digitalis, }
 Powdered squill } of each, $\frac{3}{4}$ of a grain ;
 Scammony resin, }
 Calomel..... $\frac{15}{100}$ of a grain ;
 Excipient, enough to make 1 pill.

M.

Five may be taken daily after meals for three days. Or this :

℞ Powdered digitalis, }
 Powdered squill, } of each, $\frac{3}{4}$ of a grain ;
 Calomel, }
 Watery extract of ergot of rye, $1\frac{1}{2}$ grain ;
 Excipient, enough to make one pill.

M.

Five may be taken daily for three days, after meals.

MILITARY MEDICAL TOPICS AND NEWS.

Conducted by Lt.-Col. Nattress, P. M. O. M.D. No. 2.

RE-ORGANIZATION OF THE ARMY MEDICAL SERVICE.

The report of the Committee appointed by the Secretary of War and which was submitted in October last is not giving entire satisfaction judging from the comments we see. The chief features complained of are.—The institution of an Advisory Board which practically takes the place of the Director General who has always been the official head of the Medical Department and on the staff of the Commander-in-chief but who is not now even a member of that Board. His influence is impaired and the position vitiated.

The omission of a sanitary adviser from that board has been unfavorably commented upon.—Also again allowing some regiments to have their own regimental surgeons is looked upon as a retrograde step and one tending to split up the R. A. M. C. and form a sort of corps within a corps. Criticizing this feature a senior officer writes.—“To attach a medical officer to a regiment will impair his efficiency, by the example of the idle and stupid officer (*vide* South African war). It will cause two interests to spring up in the medical service, the regimental and departmental; as was the case formerly. It will destroy the doctor's independence as the sanitary adviser of the commanding officer, for if the doctor wants to live at peace and obtain his promotion he must be careful not to put forward a proposal to which the commanding officer objects. He ought to be as independent of the C. O. as the civil medical officer of health ought to be of slum landlords and jerry-builders. It is doubtful if any combatant officer can report fairly on a doctor for if the latter does his duty they must often be at loggerheads.—Strong objections are taken to the quiet shelving of ‘Old Netley’ Queen Victoria's favorite military hospital. The course of this army medical school for “Lieutenants on probation” or young graduates from the English Medical Schools is to consist of only a two months training in hygiene and bacteriology, the very essence and specialty of their life's work—namely military surgery and medicine are not mentioned, a correspondent says:—“The great training school that Sidney Herbert and Florence Nightingale toiled to create is being quietly shelved or allowed to die of inanition. Nothing is said of its reform and indeed the study time there is reduced to two months.”

The best features of the new scheme are:—(a) Increased pay, (b)

simplification of the entrance examination, (c) provisions for hospital study periodically during the first few years of service, (d) rewards for special study and qualification, and (e) reduction of clerical labor.

Service in the R. A. M. C. has been exceedingly unpopular and as a consequence the Corps is very much under strength. It is hoped that some of the good points referred to will enhance its popularity and increase the supply of desirable young graduates in medicine and surgery, but unfortunately it is feared the all important feature has been again overlooked namely the status of the Corps. It should occupy in the *Army List* a place next to the other two scientific corps—the Royal Engineers and Royal Artillery. This would once for all solve most of the social troubles which have made service in the British Army uncomfortable for doctors, and has induced professors in medical colleges, and leading practitioners to advise students not to choose the Army.

SURGEON GENERAL OF THE UNITED STATES ARMY.

The Surgeon General in the U. S. Army corresponds to the Director General in the English Army. Judging from a Bill recently introduced by Senator Proctor so far as the head of the Department is concerned the mover of the bill seems to have taken his cue from the report of Mr. Broderick's Committee in detracting from the dignity of the position. He proposes that the Surgeon General of the Army shall be filled by the detail of a medical officer of the army for four years who after the expiration of that time unless re-appointed shall return to the position and grade in the Medical Corps he would have held had he not been so detailed. The "Medical Record" says the majority of medical officers are opposed to Senator Proctor's bill believing that it not only diminishes the importance of the position and decreases its influence but also will have a bad effect in a political sense—reappointment for a second or a third term being a natural desire. It would seem rather an awkward position for the Surgeon General to occupy. He would scarcely be in a position to insist upon what he thought the best interests of the service and compliance with the same of medical officers over whom he was only in temporary control and later on under whom he might himself have to serve. Such anomalies do occur however in the service in other countries.

A QUICK RUN TO CAPE TOWN.

The British troopship *Victorian* with the second section of the Mounted Rifles under command of Col. Evans and No. 10 Canadian Field

Hospital made a record voyage from Halifax to Capetown, being only 23 days out. This is nearly a week faster than any previous transport. The Manhattan which carried the first section of the Mounted Rifles was 30 days on the passage.

THE ROYAL VICTORIA HOSPITAL.

Reference to historic Netley recalls my visit there during the summer of 1898 when I was detailed by the Militia Department for a short course at that military training school. The following is an extract from my diary of that date and which may be of some little interest:—

The Royal Victoria Hospital here is intensely interesting. It is beautifully situated on rising ground on the east bank of Southampton water, and is approachable by water—a pier being run out immediately in front of the hospital. I find, however, the Board of Trade will not allow the pier to be extended out far enough for transport ships to come along side and land the wounded—(something about interfering with the channel) hence patients are taken on to Southampton, landed there and put into cars and run out to Netley Station (about 15 minutes' trip). The ambulance waggons meet them there and take them to the hospital, a distance of about half a mile. The hospital will accommodate 1,100, but by putting up tents on the lawn, they have sometimes had as many as 2,000 patients. It is an immense three-storey structure, with a frontage of nearly a quarter of a mile. Along the front of each storey runs a corridor, mostly glass in front, with doors opening into the various wards as you pass along. The wards, which hold from 9 to 12 patients, are lighted by windows looking on to the corridors, supplemented by other windows opening directly out in the opposite wall.

* * * * *

In locating bullets the Roentgen or X-rays here find their most useful function, and they have a powerful and very complete apparatus. I saw a skyo-graph taken this morning of a hand of a chap just returned from Egypt, showing a starred fracture of the first metacarpal bone, with little or no displacement—an injury difficult to exactly diagnose without the use of this instrument.

Dr. Birkett and I are very much interested in the variety of cases shown us, and somewhat struck with the good results generally obtained here after operations. The building is well lighted and ventilated, and a walk through these long corridors (the longest in the world) this morning was both an instructive and interesting Sunday morning's work.

We met several of the professors and surgeons to whom we had letters of introduction, and they received us most kindly. We are off up to Salis-

bury to-morrow for the manoeuvres, but will return here for a few days for a further look round. I had intended staying here some time, but find there is no special course I can take; only a matter of following the cases in the hospital, of which there are now about 850. Bullet wounds are in our line just now, but here of course we see only the results of secondary operations and after-treatment—not operations on the field nor anything differing materially from any good surgical hospital, so will not remain more than a few days.

THE MOSQUITO.

It almost appears evident that the careful research of the Military Medical Officer in various parts of the Globe—in West Africa in the Barbadoes in British Central Africa, in South Africa and in the East is about to reveal to the medical world the contagiousness of various diseases through the medium of the mosquito.—Malaria, Black water, Yellow fever, Dengue, Filaria Sanguinis Hominis etc. The destruction of the Mosquito is evidently quite as essential as the raid upon rats.

TELEGRAMS.

By arrangement with His Majesty's Government telegrams to friends in South Africa will be delivered in the field at 49 cents a word.

TREATMENT OF WHOOPING COUGH BY IRRIGATION OF THE NARES.

W. Lattey, according to *British Medical Journal*, states that the irrigation of the nares in pertussis should be more frequently employed. The child should be rolled up in a shawl with the arms confined, and placed face downward across the nurse's lap. Tepid water should first be used with a soft India rubber tube attached to the syringe. This should be followed by some antiseptic solution. The same treatment should be carried out with both sides.—*Journal American Medical Association*.

CURRENT MEDICAL LITERATURE.

Conducted by A. J. MacKENZIE B. A., M. B.

FIBROMYOMATOUS TUMORS OF THE VAGINA.

IN the February number of the American Journal of Obstetrics this subject is discussed by Richard R. Smith, M.D. and an analysis is made of 100 published cases and one case occurring in his own practice and hitherto unpublished. From his own examination of the cases cited he derives the following conclusions :

Fibroma (myoma and fibromyoma) of the vagina is a rare disease. It occurs more frequently in women between 30 and 40, but has been observed at ages ranging from 20 to 70. The cases observed in infants are open to some doubt as to diagnosis.

It occurs independently of civil condition. No proof can be deduced to show that it affects fertility. It may obstruct labor when large. When the growth is small it rarely affects coitus, and may not do so even though the growth be large. There is some evidence that in some cases menstruation may be increased. The tumors when small, rarely produce symptoms of consequence; when large they prove the source of considerable suffering and even danger. The symptoms when present are pain, hemorrhage, discharge, obstruction to the bladder and, rarely, to the bowel.

No exact division of the cases into fibroma, myoma, and fibromyoma can yet be made. The term fibromyoma will probably cover most of them, but pure fibroids have been observed. Pure myomata may also exist. The tumors grow from anterior and posterior wall in proportions of about 2 to 1. They may be sessile or polyfous. They vary very greatly in size. They are single with very rare exceptions. They are as a rule of very slow growth. They are prone to oedema, necrosis, and ulceration. Treatment is essentially surgical.

IS THERE A FOURTH DISEASE?

IN the February number of the Practitioner, Dr. Claude B. Ker, Medical Superintendent of the Edinburgh Hospital for Infectious Diseases, discusses the Fourth Disease, the term by which Dr. Duker, in July, 1900, classified certain cases appearing in epidemics, which could not readily be classed as measles, scarlatina, or rubella. The writer first gives an admirable differential diagnosis between these three diseases,

which are so frequently confounded, and then sums up the evidence adduced by Dr. Dukes which rests on two epidemics in schools; in one, two diseases were epidemic, one of which undoubtedly was scarlatina, the other resembled rubella, while in the second epidemic the disease was scarlatinaform. The symptoms were an incubation of 9 to 21 days, an absence of premonitory symptoms, slight sore throat and malaise before the appearance of the rash, an eruption brighter than that of scarlatina, the throat swollen, the conjunctiva pink, the glands enlarged, desquamation slight or profuse, the tongue furred but does not peel, the temperature 101 degrees, the pulse not unduly accelerated; the disease affords no protection against scarlatina or rubella, does not last longer than 21 days and there are no sequelae.

The writer thinks that too much force is laid on the fact that immunity was not conferred by the disease, as in many cases we have second attacks of all these maladies, and believes the symptoms in the first outbreak compatible with rubella, and in the second with scarlatina. The evidence of his own experience coincides with that of Dr. Washbourn of the London Fever Hospital and of Dr. Caiger of the South Western, in the failure to find any epidemic corresponding to that described by Dr. Dukes, and on the whole believes that for the present the case may be considered "not proven."

CHRONIC PROGRESSIVE DEAFNESS.

IN the Medical Press and Circular for February 5th, Mayo Collier discusses the causation and treatment of that form of deafness which occurs insidiously, without pain or discomfort in the ears, and becomes apparent to the individual only when a marked impairment of hearing has taken place. The cause he finds in catarrhal conditions, often slight, and episodal rather than continuous, of the naso-pharynx, which by obstruction of the Eustachian tube interferes with the passage of air into the tympanic cavity, and produce there a diminished extra-vascular tension, with the result that the intra-vascular pressure asserts itself by dilating the vessels and tissues generally, and the drum head is driven in to accommodate the cavity to its lessened contents.

The appearance in this condition is an angular rather than a concave drumhead, with redness and striation in the region of the handle and head of the malleus. The extra pressure from the outside hampers the movements of the tympanic membrane, the joints of the ossicles are stiffened and their movements retarded, and the dilatation of the vessels and tissues interferes in time with the function of the parts. This is

enough to produce progressive deafness, though there may never be pain or discomfort.

The treatment is that of the catarrhal condition, with daily exercise of the drumhead by the Politzer bag and Seigle's aspirator, and the writer believes that many such cases may be improved or cured if the condition be recognized in time.

ON FLOATING KIDNEY AS A CAUSE OF OBSTRUCTIVE JAUNDICE AND HEPATIC COLIC.

J. HUTCHINSON, Jr., F.R.C.S., in the Practitioner for February, discusses this most interesting among the varied symptoms due to floating kidney. The subject is not a new one, cases having been described as early as 1884, and recently several surgeons, among others Sir Frederick Treves, have reported cases where biliary obstruction was cured by nephropexy. Owing to the comparative rarity of such cases, many surgeons have doubted a causal relation between the conditions, and suggested that it was merely a coincidence, but the writer is firmly convinced of the connection, though he differs from others as to the manner in which the obstruction is brought about. Two of his own cases are reported in the article.

The explanation offered by Dr. Weisker was that the floating kidney made traction on the so-called hepato-renal band of peritoneum, which is described as connected with the gastro-hepatic omentum; our author points out that the gastro-hepatic omentum does not reach outwards as far as the first bend of the duodenum, and so is free of the kidney. Other explanations offered are direct obstructive pressure on the ducts, which is improbable, and the existence of pathological bands of peritoneum due to adhesions which doubtless may and often do exist, but some cause must have induced their formation.

The true explanation Hutchinson finds in the relation of the right kidney to the second part of the duodenum which rests on it, the pelvis of the kidney being on the same level and a little to the outside of the orifice of the common bile duct, so that it is improbable that the right kidney ever floats forwards and inwards without to some extent affecting the position of the duodenum, and this is what occurs in displacement by corset pressure. The writer cites the evidence of dissections, and gives illustrations in support of this view. He says: "We have then the following factors to explain the occurrence of obstructive jaundice with floating kidney: (1) Downward displacement of the third part of the duodenum, with stretching of the common bile duct; (2) displace-

ment of the gall-bladder with sharp kinking of the cystic duct; (3) torsion of the vertical part of the duodenum and perhaps even of the bile duct." The close connection of the solar and renal plexuses is invoked to explain the vomiting, etc., due to floating kidney, but it is not unlikely that displacement and dragging on the duodenum may sometimes be the cause.

Medical treatment can do nothing for cases where biliousness and indigestion are due to floating kidney, and diagnoses of gall-stone may in cases be revised in the light of a concomitant nephroptosis; the only rational and satisfactory treatment in such cases will be nephropexy.

LARYNGEAL TUBERCULOSIS.

THE Journal of Laryngology, Rhinology, and Otology for February publishes three lectures delivered by Dr. R. Lake, at the London Post-Graduate College on the subject of Laryngeal Tuberculosis. An admirable and most comprehensive description of this affection in its clinical manifestations and therapeutical indications is given; a few of the most salient points brought out are as follows: The predisposing causes are—previous inflammatory conditions of the laryngeal mucosa, chronic laryngitis resulting usually in "pachydermia laryngis", chiefly situated in the posterior commissure, which is in the route of sputa being discharged from the lungs, the age being most frequently affected is from 20 to 40, males are affected about three times as often as females, in-door, dusty, and sedentary occupations favor its development, syphilis increases the tendency by decreasing vitality, while disease of the naso-pharynx reduces the protective power of this region.

Under symptomatology, the writer, while admitting the possibility of primary tubercular infection of the larynx, calls attention to the frequency with which it is associated with pulmonary lesions, and the difficulty of certainly determining that there was no antecedent lesion of the lung. Hence symptoms of a systemic character are masked by those of the larger lesions. In this connection we must avoid classing all laryngeal affections concomitant with pulmonary tuberculosis as tubercular. The special symptoms associated with the disease include alteration of the voice varying from slight hoarseness to a complete aphonia, and this interference may be either purely mechanical, purely neurotic, or due to absolute implication of the larynx in the morbid process. Among mechanical causes may be cited adhesion of tenacious mucus to the cords themselves, obstruction by means of pachydermatous thickening in the intra-arytenoid region, loss of muscular tone in the internal tensors of

the cords, or paralysis due to causes acting on the trunk of the recurrent laryngeal nerve. A vocal symptom peculiar to this disease is, in cases where there is a chronic affection of the cords, a sudden change of pitch, say from bass to tenor takes place due to one swollen cord becoming caught or engaged against the other. Dysphonia, dysphagia, reflex pain, and sore throat frequently are present, the latter symptom is rarely present except in ulceration of the arytenoids or epiglottis; if the former, the pain occurs in swallowing fluids, if the latter, in swallowing solids.

When examined by the mirror, one usually notices an anaemia of the oro-pharynx, part of the systemic anaemia of the disease. The most characteristic conditions seen in patients who complain much of their throats are a swelling, usually bilateral and pyriform in shape, of the arytenoids; also the so-called "turban-shaped" epiglottis, and ulceration on its dorsal aspect, and general shallow ulceration of the whole larynx, with or without characteristic swelling. Besides this pyriform swelling the arytenoids show a red color becoming paler later, with ulceration, and they may become so oedematous as to obscure the rest of the larynx. Ulceration of the epiglottis is rarely on the anterior surface, in this it differs from syphilis, and when the substance of the organ becomes involved, it becomes thickened and frequently assumes a horizontal position from the passage of food over it. The posterior commissure is frequently the site of swelling and of characteristic cauliflower-like growth. Rarely an abscess cavity is formed discharging pus, or the ulceration attacks a vessel and haemorrhage is seen. The true vocal cords may show a variety of conditions from inflammation due to coughing etc. hyperplasia, abrasion, ulceration with the erosion of the edge, extending to complete destruction of the structure. A perichondritis may develop and some writers describe this as affecting the crico arytenoid joint. Associated lesions may be found in the mouth, ear, nose, or trachea.

The parts most frequently attacked are in the posterior half; as this is the channel along which sputa impinges upon the vocal cords, on account of their striking together, and generally the parts where the epithelium is not provided with cilia.

Treatment. While systemic treatment is of course imperative, we need only mention the different methods of special treatment, and these may be classified as medical and surgical. Under medical we have pigments or paints applied to the larynx; it may be necessary to precede these with an application of cocaine, 10 per cent. The best drugs are Lactic acid and formalin, which the writer uses as follows: formalin 7 per cent. lactic acid 50 per cent. glycerine 20 per cent. water to 100 per cent. Insufflations may be used more easily for home treatment, among the

powders most useful are iodoform, chinosol, paraform, combined with orthoform for its anaesthetic properties. For all tubercular trouble below the cords, and for the cords themselves, Dr. Lake finds the intra-tracheal injection most useful; he uses about an ounce of a preparation containing 3 per cent. of naphthalin and $\frac{1}{2}$ per cent. of oil of cinnamon. As to choice of remedies he says "Where there is swelling of the arytenoids and epiglottis, with or without ulceration of the false cords and of the interarytenoid region, one should confine one's treatment entirely to friction of the parts with one or other of the pigments suggested. But if the ulceration is deep or if the swelling of the false cords is of that form which we have described as pointing to perichondritis, paints should only be used as an adjunct to operative treatment; and the same may be said of cases exhibiting severe dysphagia, when the surface is intact, and where the patient's temperature chart is fairly regular, and where the highest point reached during the 24 hours is not greater than 100.5 F."

The most important contra-indications for operation are to be found in the general condition, advanced progressive pulmonary tuberculosis, high fever, wasting, great nervousness, or general miliary tuberculosis. The author admits that in this resort to operation he is not supported by his British colleagues, but claims the highest foreign authority. For the epiglottis, scraping or cutting out small ulcers is indicated, but if the body or fibro-cartilage is involved, removal by the galvanocautery is advised. For swelling of the arytenoids of an oedematous character, scarification or multiple puncture is indicated, for deep swelling when the cartilage is involved, complete removal with the cutting forceps. In the inter-arytenoid fold, ulceration should always be removed by the curette. The vocal cords rarely require much operative procedure, except picking off granulations, or curetting a particularly sluggish ulcer. Tracheotomy is occasionally required for the immediate relief of symptoms, but should never be adopted as a curative measure.

The prognosis in these cases can only be directed toward the possibility of cure of the laryngeal condition and here the writer's experience supports him in affirming that the patient's comfort may be vastly increased, and that laryngeal symptoms may be abated, until the cure or fatal result of the pulmonary affection.

THE RUSSELL TREATMENT.

THE Post-graduate for February contains the report of the committee appointed by that journal to review the experiments of Dr. John F. Russell, in the treatment of tuberculosis in the Post-graduate Hospital, New York, during the year 1901. The whole object of the method of

treatment is to improve nutrition, and Dr. Russell's purpose is to demonstrate the curability of uncomplicated pulmonary tuberculosis, by dispensary methods in classes where for various reasons, sanatorium treatment is not available. The report is most encouraging, 50 per cent. having been discharged apparently cured, and of the others all gained in weight.

TREATMENT OF FEBRILE DELIRIUM TREMENS BY THE COLD BATH.

IT is well known that febrile delirium tremens has an extremely grave prognosis, at least 50 per cent. dying. It has been supposed that some toxic infection is the cause of this condition, and it has therefore been suggested that we might treat the pyrexia symptom, as is done in other cases, by the direct application of cold. Salvant has recently collected a series of such cases (Thèse de Paris, 1901) in which he employed this form of treatment with remarkable success. The following is his method: In the first place every case in which the temperature rises above 39° C. ought to be so treated. The temperature of the baths may be 18° provided the cardio-vascular system of the patient will stand it. Should this not be the case, or if any tendency to collapse be manifested, the initial temperature may be 28°, or 25° and then gradually lowered. So soon as the patient has been immersed it is well to give warm and stimulating drinks, while at the same time the head is doused continuously with water taken from the bath. The bath ought to last from five to ten minutes, and should the pulse remain good, it may be prolonged from fifteen to twenty at most, but baths of this duration should be reserved for cases in which the temperature has exceeded 40°. According to some it is a good plan to give frequent baths, even as many as three every hour rather than to prolong each individual bath. It should be continued till the temperature comes down and the delirium disappears. It is laid down as a most important rule that these baths should be carried out under the personal supervision of the medical man himself who should carefully watch the pulse, for it must be recognized that the sedative effect does not show itself until the patient is almost reduced to a condition of collapse. On being removed from the bath he must be put into a warm bed and abundance of hot and stimulating, but not alcoholic drink given. These favor diuresis and renal elimination. After the attack it still remains to treat the patient during convalescence which in itself requires considerable care. In those cases where the temperature does not exceed 38° C. tepid baths may be used. The contra-indications for cold baths are grave cardiac disease, endo-pericarditis, myocarditis,

and in all cases that are incapable of reaction. Thus, old people and the subjects of arteriosclerosis, or interstitial nephritis are not good subjects for this method of treatment. (*British Medical Journal, Feb. 5th.*)

A NEW METHOD OF CLOSING VESICO-VAGINAL FISTULA.

THE Philadelphia Medical Journal, Feb. 15th., has an article by Dr. A. Laphorn Smith, of Montreal, describing a new and improved method of closing a vesico-vaginal fistula, with report of a case. Briefly the procedure was as follows: After careful disinfection the bladder was separated from the uterus and vagina, the laceration in the uterus was closed by Emmet's method with chromicised cat-gut; the edges of the tear in the bladder wall were brought together, the margins being freshened in the separation; and the muscular walls were brought together by an over and over chromicised cat-gut suture going back fully an eighth of an inch on each side, but without penetration of the mucus membrane, in this way a strong ridge was made; next the slit in the vagina was closed by an interrupted silk worm gut passed through the vagina then through the muscular wall of the bladder, but half an inch to the left, so that the bladder was displaced sideways, and the line of the two rows of sutures was separated by an interval, thus opposing a valve to the escape of the contents. A catheter-à demeure was placed in the urethra; the stitches were removed on the tenth day, and the result was an uneventful and permanent cure.

The surgeon emphasises the importance of the avoidance of penetration of the bladder membrane, thus avoiding the possibility of the formation of calculi on the sutures; the inclusion of enough of tissue in the suture to ensure the presence of a thick ridge, and the displacement of the two lines of sutures, as an additional safeguard against leakage.

NAKED-EYE DIAGNOSIS OF STOMACH DISPLACEMENTS.

IN the New York Medical Journal, Feb. 15th., Dr. Knapp calls attention to the possibility of locating the stomach curve and the lines of other organs, by the naked eye. The patient's abdomen is bared, the examiner stands either at the side or shoulder of the patient so as to look down towards him, the eye is then brought on a level with the surface of the body and the abdominal respiration is watched with one eye or both, when the curvatures of the stomach will be seen distinctly as fine lines under the skin, moving with the respiration. These may be marked with ink and their position verified by percussion. The same method may be applied to the location of the enlarged spleen or other organ.

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EDITORIAL.

OPERATION FOR MITRAL STENOSIS.

APPARENTLY the end is not yet. Sir Lauder Brimton contributes to THE LANCET a preliminary note on the possibility of treating mitral stenosis by surgical methods. The condition is so distressing and so little amenable to medical treatment that he thinks dividing the constriction should be considered as a possible surgical procedure to afford relief. While appreciating the dangers attending such an operation, the risk of a shortened life might well be balanced against the continuance of a condition worse than death. Sir Lauder very properly says that no one would be justified in attempting this operation on a fellow creature without first experimenting on animals. He accordingly procured a license to make the necessary experiments out so far he has not been able to carry them out. The distinguished author would probably have been wise to have deferred writing until he had put himself in possession of some clinical or experimental data to commend his suggestions to the profession.

Is not the argument that a certain condition is irremediable by medical treatment too frequently put forth as a reason for undertaking certain surgical measures often immediately hazardous and offering scarcely the faintest chance of giving relief? Surgical interference should have more to commend it than that the patient's condition is distressing, or even hopeless, under medical treatment. There should be a well grounded hope at least of relieving the condition for which the operation is undertaken. The surgeon should not be asked to play the role of executioner—even in desperate cases. We hope something good may come of Sir Lauder's suggestion, but we believe an excellent rule has been violated by going into print before having something definite to say.

CHRONIC PENTOSURIA.

This is an obscure condition wherein a substance appears in the urine which reacts with Fehling's test and with phenyl-hydrazin in much

the same manner as glucose, consequently giving rise to a possibility of mistaking pentosuria for glycosuria. It differs from the latter, however, in not responding to the fermentation test. Neither does the administration of glucose to patients suffering from the condition, cause any increase of the substance in the urine nor yet produce a glycosuria, so that it evidently bears no relation to diabetes. No alteration in the condition can be produced by variations in diet. The etiology of pentosuria is not understood as only a few cases have been studied and reported. Bial & Blumenthal, who have reported a case say that in normal tissue metabolism a certain amount of pentose is formed from the nuclein of the tissues, but this is rapidly oxidized and does not appear in the blood or urine. Under other circumstances not yet understood this process of complete oxidation fails and the pentosuria appears. The chief practical importance attaching to it is the liability to mistake it for glycosuria, its true clinical significance being as yet unknown.

EDITORIAL NOTES.

DR. R. S. A. KNOPF, of New York, the specialist in tuberculosis, has written a very kind letter in appreciation of the two excellent Tuberculosis numbers of THE CANADA LANCET. The congratulatory letters now received from all parts of the country show that the improvements in this publication are much appreciated by the profession. Not one half of the projected improvements have yet been made, because time is required to work out the details of the scheme now in hand. New departments and new features will be added from month to month, until THE CANADA LANCET is the equal of any medical monthly in the world. There is no reason why this country, with its excellent colleges and its high standard of professional training, should not have a journal which will truly represent the medical profession. THE CANADA LANCET now circulates in every province in Canada, two hundred new subscribers having recently been added from Manitoba, the North-West and British Columbia. It hopes, by a consistent and broad-minded editorial policy, to retain the good-will and respect of every member of the Canadian profession, no matter what his college affiliations or his special line of work. It asks no more than to be judged by the standard it maintains.

June 4th and 5th have been fixed as the dates of the next meeting of The Ontario Medical Association in Toronto. Dr. J. T. Fotheringham has been chosen as chairman of the Committee on Papers and Business, and has associated with him a number of active workers. This committee

is hard at work arranging for a programme, which we understand will present many new and interesting features. The time has certainly come for this association to make a move forward and to deal more vigorously with many matters pertaining to the interests of the medical profession of the Province. The fact that the officers are at work early procuring papers and arranging the programme augurs well for the success of the meeting, as little can be expected where these matters are deferred to the last minute. The active co-operation of the profession in general will infuse new life into an organization that has done excellent work, but that has not yet realized the full extent of the possibilities before it.

It is proposed to build an addition to the hospital at Woodstock, Ont., to cost \$3,500.

The County of Huron recently made a grant of \$1,000 towards the erection of a hospital in Goderich, Ont.

The heirs of the Chipman estate at St. Stephen, N.B., have presented to the town the Chipman grounds and residence, the latter having been remodelled and fully equipped as a hospital. Accommodation is provided for twenty patients.

The Medical Faculty of Toronto University contemplate the erection at an early date of a new building in Queen's Park at a cost of \$125,000. A deputation from the Faculty waited on the Ontario Government recently in order to make financial arrangements. It is stated that the buildings will be ready for occupation by January, 1903.

The common-sense, logical German has little use for the mental and moral vagaries of the followers of Mrs. Eddy. The Emperor has turned his attention to the matter and the authorities are beginning to deal vigorously with the Christian Scientists. It is stated they will be prohibited from practicing their methods within the domains of the fatherland.

The Huron County (Ont.) Medical Association met in Clinton on March 4th. The papers read were as follows: President's address—"Progress of Medicine," Dr. Dunsmore, Stratford; a case of Cerebellar Tumor, Dr. Graham, Clinton; Surgical Rules to be observed in Practice, Dr. J. A. Robertson, Stratford. Others present were: Dr. Armstrong, Mitchell; Dr. Bethune, Seaforth; and Drs. Shaw, Gunn and Thompson of Clinton.

The American Medico-Psychological Association will meet at the Windsor Hotel, Montreal, on June 17, 18, 19 and 20. The Committee of Arrangements are: T. J. W. Burgess, M.D., Medical Superintendent, Protestant Hospital for the Insane, Montreal; George Villeneuve, M.D., Medical Superintendent St. Jean de Dieu Asylum for the Insane, Longue

Pointe; A. Vallee, M.D., Medical Superintendent, Quebec Asylum for the Insane, Quebec; Jas. V. Anglin, M.D., Assistant Medical Superintendent, Protestant Hospital for the Insane, Montreal; E. Philippe Chagnon, M.D., Physician to Notre Dame Hospital, Montreal; Jas. Perrigo, M.D., Past President Montreal Medico-Chirurgical Society, Montreal. The annual address will be delivered by Dr. Wyatt Johnston, Lecturer on Medical Jurisprudence, McGill University Law Faculty, Assistant Professor of Hygiene, the Medical Faculty, Pathologist to Montreal General Hospital. His subject will be "The Medico-Legal Appreciation of Trauma in its Relation to Abnormal Mental Conditions." There will be some eighteen other papers.

The modes by which those who have commercial or proprietary preparations to dispose of, seek to engage the interest of the profession, and make capital of their endorsement, are so constantly in evidence at the present as to deceive no one; but we believe that the standard of the profession in Canada is too high to permit our physicians, unwittingly or intentionally, to be made the dupes of this class of dealers. Such being the case, the manager of a concern devoted to the cure (*sic.*) of drug habits, makes, we believe, a most egregious blunder, as well as offers a most shameful insult to the profession he addresses, when in a pamphlet recently and widely circulated in the form of a personal communication to the doctors of Ontario, he offers a "commission of five dollars" to any physician referring a patient to him at the full fee. "Shade of Hippocrates!" what are we coming to, when one who has necessarily had some association with the profession, presumes to suggest such an arrangement? We imagine it will take a still longer list of Chief Justices and Principals of theological colleges to satisfy those he addresses of his "professional standing and personal integrity," and that proverbially poor though we may be, he will have to increase the generous donation offered before he induces any to prostitute professional standing to his advantage.

We publish elsewhere a letter from Dr. Rosebrugh, secretary of the Prisoners' Aid Association of Canada, in which he makes an appeal for the active support and co-operation of the medical profession in influencing the Provincial Legislature to make statutory provision for the care of inebriates. Resolutions adopted from year to year by our various medical associations show that the necessity for legislation is generally recognized by the profession, but these resolutions have not been followed up by sufficiently strong pressure on individual members of the legislature and the government to convince them of the urgency of the need or even that we are in earnest in reference to the matter. Session after session it has been expected that something would be done, but no move has yet been

made. The request of an appropriation of \$5,000 in order to begin the work contemplated by the Bill is surely a reasonable one, and we believe the expenditure will be generally approved of. The present lack of provision for properly dealing with pauper inebriates is a disgrace to the Province. Let the medical profession give their vigorous support to Dr. Rosebrugh and his associates, and legislation in keeping with the spirit of the times, in the management of inebriates, will soon be forthcoming.

A deputation representing the universities and medical schools of Ontario recently waited on the Ontario Government in opposition to the Bill introduced by Dr. Jessop to amend The Ontario Medical Act by excluding from representation on the Council of the College of Physicians and Surgeons of Ontario the homœopathic practitioners and the various universities and teaching bodies.

The main objections to the Bill are stated in a memorandum submitted to the Honourable, the Minister of Education by the University of Toronto as follows :

(1) It excludes from the body entrusted with fixing and determining the standard of medical education and prescribing the curriculum of studies those, who by reason of their avocation, as well as training and experience are, if not best fitted, at least specially qualified for performing these duties.

(2) It hands over to a practically irresponsible body the entire and absolute control of medical education, and creates a close corporation or guild.

(3) It imposes on the universities and colleges engaged in the work of medical education the obligation of following the curriculum of studies prescribed by the Council without having any voice in framing of it.

(4) It violates the compact entered into with the universities and teaching bodies by which they were given representation on the Council in consideration of their giving up the right to confer degrees or diplomas in medicine and surgery, entitling the possessor of them, without further examination, to practise on obtaining his license or becoming registered."

The Council at present is composed of ten college and university appointees, five homœopathic representatives and seventeen territorial representatives of the regular body of registered practitioners.

It was pointed out that, while in a council of thirty-two members in Ontario, ten are college representatives, in the General Medical Council of the United Kingdom, with a membership of thirty, five are appointed by the Crown, twenty by the universities and colleges and only five are elected by the registered medical practitioners.

consulting physician should have the opportunity to make such further inquiries of the patient as may be necessary to satisfy him of the true character of the case. Both physicians should then retire to a private place for deliberation; and the one first in attendance should communicate the directions agreed upon to the patient or his friends, as well as any opinion which it may be thought proper to express. But no statement or discussion of it should take place before the patient or his friends, except in the presence of all the faculty attending, and by their common consent; and no opinions or prognostications should be delivered which are not the result of previous deliberation and concurrence." How closely this rule has of late been observed in practice leads many of us to question its existence. We are told that the first physician in attendance should communicate "any opinion which it may be thought proper to express. But no statement or discussion of it should take place before the patient or his friends, except in the presence of all the faculty attending and by their common consent; and no opinions or prognostications should be delivered which are not the result of previous deliberation and concurrence." Notwithstanding this we very frequently see opinions expressed by the consultant regarding the condition of prominent men, not verbally before the patient or his friends, but publicly in the lay press, which not only the patient and his friends but all who can read may learn and discuss. Imagine the mental distress experienced by Dr. A. B's patient, who is suffering from pernicious anæmia, when he reads in his morning paper that Mr. X. Y., a prominent citizen afflicted with the same disease, is said by an *eminent consultant* to be gradually sinking. Any physician who happens to be in attendance upon a patient who is incurably ill knows full well the extreme restlessness and lack of confidence evidenced by that patient when he sees in the paper that X. Y., suffering from the same disease as he, is said by the eminent consultant to be slowly but surely sinking.

I am willing to admit that the importunity of the eager reporter is in part responsible for a great deal of such information as is frequently given concerning prominent individuals. It is the business of the reporter to provide copy and it cannot be denied that news of this kind is of interest to the laity, but I contend that the attendant physician should impart the information after "previous deliberation and concurrence." Should the consultant be pressed by a reporter it would be easy for him to observe the rule and refer him to the attendant physician and thereby avoid being an accomplice in doing him an injustice. Certainly no information should be given without the knowledge and consent of the attendant physician. Is it for the public good that the morning papers

It was of course a disappointment to be told that the bill could not be introduced this session but on the other hand if the Government should act upon the recommendation and make a sufficiently ample grant to permit of a fair commencement to be made this year, on the principle that even a moderate beginning gives a fair guarantee for the future, we should be content for the present to rest meanwhile. The danger is however that the Government's ideas and our ideas regarding what would be an ample grant for the present purpose may differ widely. Hence the need of influence being brought to bear upon the Government through the members of the Legislature. As it is estimated that the practical working of the bill would involve an expenditure of \$10,000 yearly it would surely not be too much to ask for an appropriation of say \$5,000 to be used, to a certain extent experimentally, during the present year and to prepare the way for intelligent legislation later on.

We respectfully solicit the influence not only of the *Lancet* but also of every reader of the *Lancet* on behalf of this movement,

Yours truly,

A. M. ROSEBURGH,

Secretary.

Toronto, February 16th, 1902.

I have every sympathy with Dr. Roseburgh's long continued, and disinterested efforts on behalf of inebriates—a sadly too large class even in Ontario, of which Province we are so justly proud. I think such work is very well worth the small outlay for which he asks as a beginning—and sincerely trust that as he conducts it with so much zeal, it may result before very long, in great good being done to a class of persons whom we all would fain see reformed, for their own sakes, as well as for the satisfaction of their relatives and friends.

WALTER B. GEIKIE.

Toronto, Feb., 1902.

To the Editor of THE CANADA LANCET :

SIR,—Being a practitioner in a neighboring city I depend largely upon the daily papers for news from Toronto. During the past few months I have noticed articles in them which have led me to refer to the Code of Ethics of the Ontario Medical Association. Bearing upon the duties of physicians in regard to consultations I read and reproduce Article 4, clause 3: "In consultations the attending physician should be the first to propose the necessary questions to the sick; after which the

consulting physician should have the opportunity to make such further inquiries of the patient as may be necessary to satisfy him of the true character of the case. Both physicians should then retire to a private place for deliberation; and the one first in attendance should communicate the directions agreed upon to the patient or his friends, as well as any opinion which it may be thought proper to express. But no statement or discussion of it should take place before the patient or his friends, except in the presence of all the faculty attending, and by their common consent; and no opinions or prognostications should be delivered which are not the result of previous deliberation and concurrence." How closely this rule has of late been observed in practice leads many of us to question its existence. We are told that the first physician in attendance should communicate "any opinion which it may be thought proper to express. But no statement or discussion of it should take place before the patient or his friends, except in the presence of all the faculty attending and by their common consent; and no opinions or prognostications should be delivered which are not the result of previous deliberation and concurrence." Notwithstanding this we very frequently see opinions expressed by the consultant regarding the condition of prominent men, not verbally before the patient or his friends, but publicly in the lay press, which not only the patient and his friends but all who can read may learn and discuss. Imagine the mental distress experienced by Dr. A. B.'s patient, who is suffering from pernicious anæmia, when he reads in his morning paper that Mr. X. Y., a prominent citizen afflicted with the same disease, is said by an *eminent consultant* to be gradually sinking. Any physician who happens to be in attendance upon a patient who is incurably ill knows full well the extreme restlessness and lack of confidence evidenced by that patient when he sees in the paper that X. Y., suffering from the same disease as he, is said by the eminent consultant to be slowly but surely sinking.

I am willing to admit that the impertinence of the eager reporter is in part responsible for a great deal of such information as is frequently given concerning prominent individuals. It is the business of the reporter to provide copy and it cannot be denied that news of this kind is of interest to the laity, but I contend that the attendant physician should impart the information after "previous deliberation and concurrence." Should the consultant be pressed by a reporter it would be easy for him to observe the rule and refer him to the attendant physician and thereby avoid being an accomplice in doing him an injustice. Certainly no information should be given without the knowledge and consent of the attendant physician. Is it for the public good that the morning papers

should serve up for breakfast a synopsis on Addison's disease, acute cardiac dilatation, leukaemia, pernicious anaemia, exophthalmic goitre, angina pectoris or hepatic inadequacy? In the morning papers I have also sometimes seen a physician receive such an advertisement as the following: *Yesterday afternoon Dr. E. F. of Toronto, assisted by local physicians, operated upon Mr. C. D. for appendicitis. The patient is progressing favorably but is not lacking in the element of danger.* This interesting item of news was inserted as a local from a correspondent in an outlying town. Imagine the local correspondent making use of the carefully couched language of the shrewd prognosticator. I will not even make an insinuation as to who was directly or indirectly responsible for the information. It cannot be denied that many readers are interested in the welfare of friends who chance to be ill but it must be conceded that it is reprehensible for the consultant or operator to allow his name to appear conspicuously in such articles.

Also it is reprehensible for a physician to ignore Clause 4 of Article II. in the Code which reads as follows:—"Equally derogatory to professional character is it for a physician to hold a patent for a surgical instrument or medicine; or to dispense a secret nostrum, whether it be the composition or exclusive property of himself or of others. For if such nostrum be of real efficacy, any concealment regarding it is inconsistent with beneficence and professional liberality; and if mystery alone give it value and importance, such craft implies either disgraceful ignorance or fraudulent avarice. It is also reprehensible for physicians to give certificates attesting the efficacy of patent or secret proprietary medicines."

I am led to refer to this clause because of the appearance in the press of your city of an announcement to the effect that an establishment for the treatment of tuberculosis by a process known as the Ramage system is to be opened in the near future under the auspices of two physicians. Of this system I know nothing, but do know that it is a secret process. It may be patented or it may not. It matters little whether it is or not. The fact that it is not given to the profession for the public good stamps it at least as a commercial enterprise. I will not criticize the conduct of the physicians who *lend* their names to the project. Words fail me. Further, it might be uncharitable for me to do so. It is possible that the public, rich and poor alike, may be able to secure this marvellous cure. There may be well advertised bargain days during which those without means may be able to present themselves for treatment. Be that as it may. If the system is of value why withhold knowledge of it from the profession? Where would science be to-day if the commercial spirit had actuated those to whose efforts we are indebted for

vaccination, serum therapy and other advances in the medical and surgical world ?

I will not pass an opinion as to whether physicians flagrantly and repeatedly breaking Clause 3 of Article IV., or those who do not observe Clause 4 of Article II., are most guilty, but would prefer to leave that to be done by the Ontario Medical Association, of which they all are or have been members. Suffice it to say, in conclusion, that all are alike in one respect, and that is the insatiable desire for newspaper advertising.

Yours, etc.,

Hamilton, Ont., Feb. 28th, 1902.

PHYSICIAN.

THE ONTARIO HOSPITAL ASSOCIATION.

IN compliance with the request in the circular letter sent out to the hospitals of Ontario from the County of Carleton General Protestant Hospital of Ottawa, bearing date 7th January, 1902, and signed by Mr. E. B. Eddy and Mr. T. W. Kenny, a number of ladies and gentlemen met at the Queen's Hotel, Toronto, 18th February. The following were present:—Mr. E. C. Gurney, from Grace Hospital, Toronto; Dr. Spiers, Galt Hospital, Galt; R. E. Nelson, Guelph General Hospital, Guelph; Mrs. J. Bell and Mrs. Rathbun, Belleville General Hospital; Alex. Lumsden, M.P.P., Maternity Hospital, Ottawa; F. Haight, Berlin and Waterloo General Hospital; H. Malcolmson, Public General Hospital, Chatham; Dr. A. Robillard, Water Street General Hospital Ottawa; Dr. Herald, Kingston General Hospital; J. P. Featherstone, C. C. Roy, and G. L. Orme, County Carleton General Protestant Hospital, Ottawa; Dr. J. Ferguson, G. H. Carveth, and Price Brown, Western Hospital, Toronto; Dr. M. O'Connor, St. Michael's Hospital, Toronto; Dr. C. O'Reilly and A. F. Miller, Toronto General Hospital, Toronto; C. F. Maxwell, St. Thomas Hospital, St. Thomas; Dr. Edgar, Hamilton City Hospital, Hamilton; Robert McLaren, General and Marine Hospital, St. Catharines; Grant Ridout, Children's Hospital, Ottawa; James McLaughlin, General and Marine Hospital, Owen Sound; Dr. F. L. Howland, General Hospital, Huntsville; F. Cochrane, Mayor of Sudbury, St. Joseph's Hospital, Sudbury.

Mr. E. C. Gurney was unanimously asked to take the chair, and Mr. G. L. Orme to act as Secretary of the meeting.

The Chairman stated that the objects of the meeting were to consider in what way they could best promote the interest of the hospitals throughout the Province. He called upon Mr. J. P. Featherstone, of Ottawa, to address the meeting.

Mr. Featherstone then addressed the meeting at considerable length.

He pointed out that the Government grant to patients in the hospitals had fallen from 20c per diem to 18c per diem. This was due to the fact that while the total grant for many years had remained, the number of hospitals and patients had greatly increased. He pointed out that the cost of maintenance had increased from 40c to 80c or \$1.00 per day. This was owing to better and more expensive accommodation being required. He further pointed out that the Succession Duties Act which took a good slice of wealthy estates for charitable purposes, often prevented wealthy persons from making bequests to hospitals. Thus, while the Government grant had decreased nearly one-half, there were fewer private and voluntary donations and legacies. He went on to say that few municipalities did all that they ought to do, and some did nothing towards the maintenance of its indigent sick. He urged that steps be taken to secure a proper measure of county and city aid. He suggested that a Provincial Hospital Association be formed to further the welfare of the various hospitals.

The following resolutions were then put and unanimously adopted :

NAME.

The organization shall be known as the Ontario Hospital Association.

OBJECTS.

1st. To procure increased Government aid for the maintenance of indigent patients in the public hospitals of Ontario.

2nd. To take steps to secure a proper amount of county and civic aid.

3rd. To promote, by mutual suggestion and discussion, the interests of hospital work throughout the province.

MEETINGS.

The Association shall meet annually at Toronto at such time as may be decided best in the opinion of the Executive for the furtherance of the work of the Association.

OFFICERS.

The officers shall consist of a President, six Vice-Presidents, a Secretary-Treasurer and a Committee of eight, who shall constitute the Executive, and of which number five shall form a quorum.

MEMBERSHIP.

Each hospital in the Province receiving Government aid shall be entitled to be represented, and any member of its Board shall be entitled to membership in the Association, but that each hospital shall be entitled to one vote.

FEES FOR MEMBERSHIP.

1st. It was moved and adopted that the minimum fee from each hospital be five dollars, and

3rd. That the fee for individual membership one dollar.

ELECTION OF OFFICERS.

President—Edward C. Gurney, Esq., Toronto.

Vice-Presidents—C. O'Reilly, M.D., Toronto; J. P. Featherstone, Esq.

Ottawa; B. W. Robertson, Esq, Kingston; Adam Bucke, Esq, London; George Roach, Esq., Hamilton; H. Malcolmson, Esq., Chatham.

Secretary-Treasurer—John Ferguson, Esq., M.D., Toronto.

Committee—M. O'Connor, Esq., M.D., Toronto; Robert McLaren, Esq., St. Catharines; J. Strolford, Esq., Brantford; A. Robillard, Esq., M.D., Ottawa; James McLaughlin, Esq, Owen Sound; T. L. Kenny, Esq., Sarnia; Robert Melvin, Esq., Guelph; F. Cochrane, Esq., Sudbury.

INTERVIEW WITH GOVERNMENT.

Mr. A. Lumsden, M.P.P., announced that the Government would receive the members of the association as a deputation at 12 o'clock, on the 19th inst., in the Premier's room. It was then agreed that as many as possible should be present in the deputation.

The meeting then adjourned.

THE DEPUTATION.

According to appointment a deputation waited upon the Government and were received by Hon. G. W. Ross, Hon. J. R. Stratton, Hon. Jas. Gibson, and Hon. Mr. Latchford.

Mr. A. Lumsden, M.P.P., introduced the deputation. He stated that the deputation was a unique one. It did not come to seek any personal advantage or gain. It was entirely philanthropic and sought the good of the indigent sick in the province. He stated that many of the hospitals in the province, at the call of the circular letter, had sent representatives to Toronto, and that these had organized themselves into an influential Provincial Hospital Association. He then asked Mr. Edward Gurney, the president of the association, to address the members of the Government.

Mr. Gurney said that the deputation sought to place the needs of the hospitals before the Government. Hospitals had not been supported by the Government as the asylums had been. It was the duty of the well to care for and look after the indigent poor. In the matter of the Government grant to the hospitals there was a grievance, and the deputation asked to have that grievance remedied. The grant had fallen from 30 cents to 18 cents per diem. If the Government did not act and move liberally the time might come when the hospitals would be forced to refuse admission to the poor. The need was urgent and assistance should be granted at once. Hospitals were going back financially. Mr. Gurney then asked Mr. Featherstone to state his views on the objects of the deputation.

Mr. J. P. Featherstone went on to show that the Government grant was now 18 cents or less per day, whereas it was formerly 30

cents. On the other hand, the cost of maintenance had gone up from 40 cents or 50 cents a day to 80 cents or \$1.00 a day. Municipalities did not always do their duty in the matter of aid to the poor; but even where the municipalities did give aid, the Government grant of 18 cents was too small. The Succession Duties Act had interfered with bequests and donations, as persons would not give when the estate would be taxed. It was clear that in this way the income to hospitals was very much lessened. Notwithstanding the fact the income to the Government, for the Succession tax, had greatly increased, the total amount to the hospitals had not increased, while the number of patients entitled to assistance had greatly increased. The time had now come when it was necessary, if the hospitals hoped to keep up with medical and surgical advance, that the Government should restore the grant to its original amount of 30 cents per diem.

Mr. Ross and Mr. Stratton promised to give the matter careful consideration. They pointed out that the Succession Duties only provided about one-third of what was paid out in charities; and also that the tax might have the effect of making some contribute to these charities who would not otherwise do so.

The Secretary has since prepared a lengthy letter giving all the facts brought out before the Government by the deputation. A copy has been sent to each Minister.

TWO MANITOBA MEDICAL ASSOCIATIONS.

The Southern Medical Association of Manitoba met at Brandon Feb. 26th. Nearly sixty of the leading physicians of the province were present.

President McConnell of Morden, opened the meeting with a short address. The Secretary of the Association, who has been an indefatigable worker in bringing the organization to a successful issue, read a paper on the "Necessity of Organization in the Medical Profession." After some discussion the physicians from the northern part of the province decided to organize an Association.

The officers elected were Dr. L. M. More, Brandon, President; Dr. Little, Alexander, Secretary; Executive Council: Dr. Poole, Neepawa, Dr. Goodwin, Elkhorn, Dr. Thompson, Douglas, Drs. McDonald and McDiarmid, Brandon.

D. H. P. Elliot of Morden, read an excellent paper on "The Ethics of the Profession." Dr. James Patterson, Dominion Health Inspector, gave a paper on the "Differential Diagnosis of Smallpox," which was much

appreciated. The next paper was read by Dr. Macdonald, Health Officer of the city, on "Quarantine in Smallpox." In view of the prevalence of the disease in Canada these papers will be of use in directing the attention of the Association to this dread disease. "Christian Science" was ably discussed by Dr. J. R. Jones of Winnipeg, whose sarcasm and humor evoked considerable applause. Dr. Chown, ex-President of the Dominion Medical Association, next discussed "Gall Stones" in a very able manner. The last paper on Surgical Subjects was read by John Hardie, M.B., F.R.C.S. Its subject, "Delayed Union and Non-union of Fractures," was handled in an original manner and with thoughtful care. Dr. J. O. Todd, Professor of Surgery in Manitoba University, was present, and though invited to read a paper, very generously gave way to others, as the programme was lengthy. The meeting was disappointed but respected his good will in the matter. Dr. Gahan of Hartney, criticized the Manitoba Health Act in a short but forcible address.

The profession in Brandon tendered the visitors a banquet in St. Matthew's Hall. Blackett's orchestra was present and enlivened the proceedings with excellent music. Dr. More, the President of the newly formed Association, was in the chair. Mayor Fraser made an address of welcome on behalf of the city. Drs. McConnell, Hughes and Latimer replied. The toast to the King being honored was followed by the toast "Canadian Medical Association," which was replied to by Drs. Chown, Todd and Jones. Dr. McConnell proposed the toast of the new "Northern Medical Association." Drs. More, Macdonald, Matheson and Fraser replied.

OBITUARY.

DR. JAMES McLAREN.

DR. JAMES McLAREN died at Deer Park, Toronto, on March 7th, aged 78 years. The deceased was a graduate in Arts of Queen's College, Kingston. He studied medicine in the Old Rolph School, and was graduated from Toronto University in 1853. Owing to ill health he was forced to retire from active practice many years ago, after which he took up his residence in Deer Park, where he continued to live until the time of his death.

DR. GEORGE W. JACKES.

ON March 7th Dr. George W. Jackes, of Eglington, Ontario, was suddenly stricken with apoplexy, dying in less than an hour. The deceased was a son of the late Franklin Jackes, Esq., of Castlefield,

Eglington, and was born in 1851. He received his early education at the public school, Eglington, and later at Upper Canada College. He was a graduate in medicine of Toronto University, receiving his degree in 1870. For a while he practised at Unionville, but afterwards removed to his native village where he established a successful practice. Dr. Snider was a Liberal in politics, and in religion a Methodist. Though quiet and unostentatious, the deceased was always interested in anything of benefit to the community in which he lived, and his kindly manner and honourable character greatly endeared him to all his acquaintances.

His wife was Almira, daughter of Captain Snider, of Eglington, who, with two sons survives him.

JOSEPH ALEXANDER FYFE.

DR. JOSEPH ALEXANDER FYFE, one of the most prominent physicians, and one of the most highly esteemed citizens of Peterborough, died on February 14th at the age of 64 years. The deceased had been in failing health for some time, which prevented him from attending to his professional duties. His death was due to chronic Bright's disease.

Dr. Fyfe was a native of Peterborough County, where he was born January 26th, 1838. He received his early education in the Peterborough Grammar School. He studied medicine at the old Toronto School, and was graduated from Victoria University, afterwards studying in Bellevue Hospital, N.Y. During the American civil war Dr. Fyfe served as naval surgeon with the Northern forces for two years, and was present at the bombardment of Charleston, S.C. After returning to Canada, he practiced at Brampton, Hastings, and finally in Peterboro', where he worked up a large practice.

He was a county coroner for many years. He was a Liberal in politics, and in religion a member of the Methodist Church. In 1868 Dr. Fyfe married Miss Jessie Fletcher, of Woodstock, and she, with five children, survive him.

A large and impressive funeral service was held in the George St. Methodist church, at which the pastor and other leading citizens paid tribute to his memory, and testified to the sterling qualities of one who was beloved and honored alike as physician and citizen.

PERSONAL.

Dr. Guimont, of Quebec, has returned from taking special work at Philadelphia.

Dr. W. J. Anderson, of Smith's Falls, has been elected warden of the County of Lanark.

Dr. and Mrs. Walker, of Truro, N. S., have left on a four month's visit to Los Angeles, Cal.

The engagement of Dr. Rogers of Ingersoll to Miss Edith Hamdbidge of Aylmer has been announced.

Dr. McLellan, of 947 Talbot street, London, has gone to take a special course in the eye and ear hospitals in New York.

Dr. A. P. Kelly (Trinity, '98), formerly house surgeon, St. Michael's Hospital, Toronto, has begun practice in Orillia, Ont.

Drs. G. W. Howland and Geo. McLaren, of last year's staff in the Toronto General Hospital, are studying in London, Eng.

Dr. Ernest Hall, Victoria, B.C., who suffered from an attack of typhoid fever, we are pleased to learn, is able to be about again.

We are pleased to learn that Dr. Graham Chambers, of Toronto, who has suffered from a severe attack of appendicitis, is convalescent.

Dr. Wallace Scott, who has been engaged in practice at Cartwright, Ont., is at present taking post-graduate work in the Toronto Medical College.

Dr. H. B. Anderson, of Toronto, is spending a couple of months in New Ycrk, devoting his time to clinical medicine. He returns to Toronto about May 1st.

Dr. Harvey McNaught is visiting his parents in Toronto. He has recently received the appointment as superintendent of a sanitarium in southern California.

Dr. Charles E. Treble and Miss Treble, of Toronto, have left for Europe. Dr. Treble will put in some months in advanced work in London and continental hospitals.

Dr. W. Morrison, who has recently been engaged in practice in Pinkerton, has sold out to Dr. Tatham, M.B., Tor. '00, and has come to Toronto to engage in some post-graduate work.

Dr. G. H. Burnham has leased the residence formerly occupied by the late J. E. Graham, Bloor St. E., Toronto, and Dr. Geoffrey Boyd has purchased the property now occupied by Dr. Burnham.

Dr. Luther A. Allingham, (Trinity '90), who has been practising at Randsburg, California, died there on January 29th, at the age of 39 years. Dr. Allingham was a native of Peterboro' County, Ontario.

Dr. J. H. Allin, who has been practising at Bloomington, Wisconsin, has bought the practice of Dr. McKee of Petrolea, Ont. Dr. McKee leaves shortly to spend some time in post graduate work in Europe.

Dr. A. R. Perry, sometime of the resident medical staff, Toronto General Hospital, is visiting Dr. Stacey, of College street, Toronto. We understand that Dr. Perry intends opening an office in Winnipeg.

Dr. T. A. McCallum, of Dunnville, one of the best known physicians in the Niagara Peninsula, has been appointed superintendent of the Asylum for the Insane, London, Ont., in place of the late Dr. Buck.

Dr. Horace Norquay, of Dawson, a son of the late Hon. John Norquay of Winnipeg, was married recently. Dr. Norquay has a good practice, owns a drug store, and is an alderman in the City of the North.

Dr. R. W. Large (Trinity, '97), formerly on the resident medical staff of the Toronto General Hospital, and who has been practising in British Columbia, recently spent a couple of months in Toronto with his friends.

Dr. A. Dixon Wagner, one of the best known practitioners in the eastern part of Ontario, died at Cornwall on Feb. 13th, at the age of 53 years. The doctor was a graduate of McGill College and a prominent Mason.

Dr. J. W. Brien, of Essex Centre, who has been taking a post graduate course in New York, has resumed practice. Dr. R. F. Rorke, who had charge of Dr. Brien's practice during his absence, is visiting at his home, St. Thomas, Ont.

It was impossible for the Windsor, Ont. council to agree on the appointment of one of the candidates for the combined office of medical health officer and city physician at its last meeting, so the position was split in two, Dr. Richard Carney getting the office of city physician and Dr. J. A. Ashbaugh that of medical health officer.

The following physicians and surgeons have been appointed to the visiting staff of the National Sanitarium Association: Drs. W. B. Geikie, H. J. Hamilton, Gilbert Gordon, C. J. Hastings, W. Theo. Stuart, Allen Baines, J. T. Fotheringham, George A. Bingham, C. M. Foster, Beverley Milner, F. N. G. Starr, Wm. Oldright, F. T. McMahon, A. McPhedran, W. B. Thistle, R. J. Dwyer, G. A. Peters, G. Chambers, Andrew Gordon, Charles O'Reilly, D. W. McPherson, R. A. Stevenson, John Caven, J. J. Mackenzie, H. B. Anderson.

BOOK REVIEWS.

A PRACTICE OF OBSTETRICS

Edited by Charles Jellett, M. D., Professor of Obstetrics and Gynaecology in the Long Island College Hospital, New York. Second Edition, revised and enlarged. Illustrated with 445 engravings, 48 of which are in colors, and 36 colored plates. Lea Brothers & Co., New York and Philadelphia.

THE second edition of this work by the well known author assisted by eighteen contributors, the most of whom are prominent in the profession, is to hand. Important alterations have been made in the chapters dealing with the pathology of pregnancy and with obstetric surgery. Many new illustrations, mostly original, have been added.

The first edition was exhausted in two years and there is little doubt but that this one will be equally well received.

D. M. A.

THE DIAGNOSIS OF NERVOUS AND MENTAL DISEASES.

By Howell T. Pershing, M.Sc., M.D. Professor of Nervous and Mental Diseases in the University of Denver; Neurologist to St. Luke's Hospital; Consultant in Nervous and Mental Diseases to the Arapahoe County Hospital; Member of the American Neurological Association. Illustrated. 12mo. Published by P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia. 1904. Price, in cloth. \$1.25 net. Messrs. Chandler & Massey, Limited, Toronto and Montreal, Canadian Agents.

THIS work is not a text-book on nervous diseases, but is rather designed to afford the physician who is not a specialist assistance in neurological diagnosis. This is done by means of a series of tables containing the chief symptoms of the different diseases and these serve as a key which may be referred to in attempting to interpret a given case.

The first 70 pages deal with the examination of the patient and the general significance of symptoms and short chapters are devoted to the symptoms of hysteria, neuasthenia, etc.

This book will be found especially useful to practitioners and students who have difficulty in unravelling the intricate problems presented by many cases of nervous disease.

DISEASES OF THE DIGESTIVE ORGANS IN INFANCY AND CHILDHOOD.

With Chapters on the Diet and General Management of Children and Massage in Pediatrics. By Louis Starr, M.D., late Clinical Professor of Diseases of Children in the Hospital of the University of Pennsylvania; Consulting Pediatricist to the Maternity Hospital, Philadelphia, etc. Third edition, rewritten and enlarged. Illustrated. Published by P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia. 1901. Price \$3.00 net. Messrs. Chandler & Massey, Limited, Toronto and Montreal, Canadian Agents.

THE third edition of Dr. Starr's well known work on diseases of the digestive organs of children, deals in a thoroughly practical way with this most important branch of medicine. Much obsolete matter has

been omitted and new sections have been added on simple atrophy, infantile scurvy, rickets, lithæmia follicular tonsillitis, adenoids, proctitis and appendicitis. The general management and feeding of children receives especially full attention and the exact formulæ and specific directions for the modification of milk will be particularly appreciated by the young practitioner. Laboratory preparation of milk for infant feeding, while theoretically possessing many advantages, has not proved satisfactory in the author's experience.

The book is essentially practical, safe and up to-date in its teaching and altogether satisfactory. It is one of those works which one can refer to as an old and tried friend who never disappoints one's expectations.

CLINICAL HAEMATOLOGY.

A Practical Guide to the Examination of the Blood with Reference to Diagnosis. By John C. DaCosta, Jr., M.D., Assistant Demonstrator of Clinical Medicine, Jefferson Medical College; Hematologist to the German Hospital, etc. Containing 8 full-page colored plates, 3 charts, and 48 other illustrations. Octavo, 450 pages. Published by P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia. 1901. Price, \$5.00 net. Canadian Agents, Chandler & Massey, Limited, Toronto and Montreal.

HÆMATOLOGY has advanced so rapidly during recent years and the application of its methods is capable of throwing so much light on many diseases that a working knowledge of the subject is essential to every progressive practitioner. DaCosta's "Clinical Hæmatology" well represents the present status of our knowledge and describes fully in a clear, practical manner the technique of blood examinations in general and the limitations of their usefulness in practical medicine. The work is based on a careful research into the literature of the subject as well as on the author's own observations.

The plates representing stained blood specimens are accurate, and very beautifully executed. The work can be recommended as a full, practical and reliable exposition of hæmatology at the present day in its application to clinical work.

HIRST'S OBSTETRICS.

A Text Book of Obstetrics, by Barton Cooke Hirst, M. D., Professor of Obstetrics in the University of Pennsylvania. Third Edition. Thoroughly revised and enlarged. Royal Octavo. 873 Pages with 704 illustrations, many of them in colors. Philadelphia and London: W. B. Saunders & Co., 1901. Cloth \$5.00 net. Canadian Agents: J. A. Carveth & Co., Toronto.

In this edition the book has been thoroughly revised, and much new matter added to many of the chapters, notably those treating of diagnosis and pathology of pregnancy, pathology of labor, and obstetric operations.

The work is profusely illustrated throughout, fifty new illustrations being added, three of which are colored plates. Also frequent reference (in foot notes) is made to the author's own private cases which greatly adds to the interest of the subject in hand. In the chapter on the pathology of labor there is an excellent article on the treatment of eclampsia, which is brief, rational, easily carried out and should be effectual in most cases of this alarming condition, so often fatal to the mother or child, and occasion-to both. In the latter part of his closing chapter the author devotes some twelve pages to the diagnosis and treatment of the more common diseases of the new-born, of necessity a short resumé of the subject but none the less useful to the practitioner.

J. T. F.

AMERICAN TEXT BOOK OF PHYSIOLOGY.

Edited by William H. Howell, Ph.D., M.D., Professor of Physiology in the John Hopkins University, Baltimore. Second Edition. Revised. Philadelphia: W. B. Saunders & Company. J. A. Carveth & Co., Toronto, Canadian Agents. 1901.

This work has been rendered more convenient by its division into two volumes, each one containing about six hundred pages and being of such a size as to be easily held in the hand while reading.

The first volume deals with blood, lymph, circulation, secretion, chemistry of digestion and nutrition, movements of the alimentary canal, bladder and ureters, respiration, animal heat and the chemistry of the animal body.

The second volume contains the general physiology of muscle and nerve, the central nervous system, special senses, hearing, cutaneous and muscular sensibility, equilibrium, smell and taste, physiology of special muscular mechanisms, voice, speech and reproduction.

The book deals with physiology solely and contains little, if any, histology, it being assumed that a knowledge of that subject is already possessed by the student.

It is essentially a students' book and as such has much to commend it, being clear, concise and thoroughly up-to-date.

F. F.
