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Saskatchewan Medical Journal

VOL. 2.

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ONE DOLLAR A YEAR

NOTICES

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THE SASKATCHEWAN MEDICAL JOURNAL

VOL. 2

MARCH, 1910

No. 3

Original Memoirs

*UTERINE FIBROMYOMATA. THEIR PATHO- LOGICAL SIGNIFICANCE. DIAGNOSIS AND TREATMENT.

Clinical Lecture

By JAMES N. WEST, M.D.

Professor of Diseases of Women, New York Post-Graduate
Medical School and Hospital

This subject, as can be readily understood, is a very broad one, and many volumes have been written upon it. But what I will try to give you this morning is a simple statement of the facts regarding these tumors as we apprehend them to-day, and the practical deductions therefrom which you may utilize in your work.

In regard to the causation of fibromyomata, we still have to hold to the theory of Cohnheim, modified, perhaps, to a certain extent by the theory of Hanseman. Cohnheim's theory assumes that all tumors are due to the development of fetal rests, a collection of cells of embryonic type, sometimes displaced from those portions of the body in which they should have been located and undergoing a development characteristic of fetal tissues, due perhaps to some form of irritation, either actual, chemical or metabolic. These cells may lie dormant for years, only to assume activity as life advances, or the required irritant appears to stimulate their development. We have almost

overwhelming proof of the correctness of Cohnheim's theory in regard to many varieties of new growths. Its correctness in regard to the development of carcinoma has been questioned of recent years, the question being whether carcinoma is or is not primarily due to a microorganism. A great deal of work has been done on this subject, but so far a satisfactory and conclusive proof has not been adduced to show that carcinoma is due to a microorganism. Even if such proof should appear, it would not invalidate the theory of Cohnheim, but would remove carcinoma from its classification.

You know that in the development of the embryo the cells undergo multiplication with enormous rapidity. There comes a time, however, in the development of the being, when a balance is reached, and the number of cells developed equals the number of those displaced. The time when this balance is reached is puberty, and in proportion to the youth of the individual is the index of rapidity of cell multiplication. In a growing embryo the cells develop with almost incalculable rapidity. The fetal rests are endowed with this power of rapid reproduction. Thus, in fetal life the seed of the tumor is planted and remaining there latent until suddenly something in the form of irritation starts it into activity, and the cells begin to develop as they did in the fetus, overwhelming the tissues and producing a tumor. That is the theory of Cohnheim, and what is there to substantiate it?

In the first place there is the dermoid tumor, in which we may find any of the different tissues of the body; teeth, hair, bone, cartilage, in fact any tissue which exist in the organism may be found in the dermoid cyst, and we may find these tumors almost anywhere in the body. They may develop in a part normally entirely devoid of the tissues which they contain, and their development may begin quite suddenly. When they are removed, they are often found to contain highly specialized tissues of other parts of the body, frequently muscular tissue, glands, teeth, bones and even hair. We cannot imagine that tumors of such character could be caused by an invasion of microorganisms; we can only assume that they

are the result of fetal displacement, of fetal cells, in that part of the body.

The fibromyoma is a connective tissue growth differentiated entirely from all forms of carcinomatous or epithelial growths and due to the development of tissue from a different fetal layer, the mesoblast, and we find in general that all these connective tissue growths are developed from this source. The uterine fibromyoma, then, may be accounted for by the theory of Cohnheim or by the theory of Hansemann, that certain adult cells, may, for reasons unknown, undergo development of a fetal character, that is a development of a very rapid tempo, and thus form a tumor not necessarily from fetal rests. Considerable proof has been adduced to show that this is possibly the case.

Uterine fibromyomata are in themselves benign growths, which means that they are encapsulated, and there is no tendency for them to invade other tissues by contact, that they do not form metastases, and that they have no tendency to return after removal. In other words, they present to us all the characteristics of benign tumors.

The pathological significance of these tumors may be considered conveniently as arranged into three groups of disturbances: (1) those due to pressure from the growths; (2) those due to visceral changes; and (3) those due to tumor degenerations and infections.

Pressure symptoms due to large tumors may be readily inferred, when we remember the great size which they sometimes attain. I have several times seen them grow almost as if molded into the pelvis and rising above its brim to almost fill the abdominal cavity. In one case the bladder was forced to a level above the pubes, and the pressure of the urethra against the pubic bone was so great that catheterization of the bladder, the only means by which it had been emptied for some time, became no longer possible, and the immediate indication for operation was retention of urine. In another, intestinal obstruction, due to the adhesion of the small intestine to the front of the tumor and consequent pressure against the

anterior abdominal wall, was the immediate cause of operation.

Serious mechanical circulatory disturbances are most common in large tumors as well as respiratory disturbances and nutritional disturbances due to pressure. It is not uncommon, however, to find tumors of considerable size to which the abdominal viscera adapt themselves so that little or no mechanical disturbances occur, and if it were not for feeling a "lump" in the abdomen, the patient would be unaware of their presence.

The pathological significance of small fibromyomata is subject to great variations. Many women have fibroids without suffering any pain or inconvenience from them; they do not even know of their presence, unless the tumors have been discovered accidentally while some examination was made for other purposes. But certain small tumors do assume a very wide pathological significance; those tumors which produce visceral changes in organs distant from the site of the tumor, and those tumors which produce pressure symptoms upon neighboring organs and thereby give rise to pathological conditions in them. Thus, they may press upon the ureters and cause hydronephrosis. A tumor growing directly against the bladder may project and press against the pubes, or in one growing from the intermediary part of the cervix, the tumor may not be large but may cause great distress. Small tumors have sometimes indirectly important pathological significance, but most of those situated in the upper segment of the ureter and away from the endometrium have practically no pathological significance. Sterility and chronic invalidism may result from a small submucous fibromyoma.

In regard to the visceral changes produced, Shoemaker has made especial and interesting investigations. Professor Boldt, in a recent article on this subject, states that in 79 cases in which close observations were made, 47 per cent. showed some circulatory disturbances. Five out of thirty-four with circulatory disturbances died after operation (15 per cent.). He considers the degeneration of the heart muscle to be one of the chief factors in these deaths.

The mechanical changes in the heart, such as dilatation and hypertrophy, have a position subordinate to the myocardial changes. The practical deduction is that women with myomata should pay especial attention to diet and exercise.

All those pathological changes usual in such cases may follow the cardiac changes and thus result in far-reaching disturbances in other viscera. Kelly and Cullen have found that most of the cases showing heart lesions were those in which there had been much loss of blood, and considered the heart lesion to be due chiefly to disturbance of its nutrition. Such conditions usually disappear after a successful operation.

I saw recently in this hospital a case in which we recognized myocardial change before the operation, and although the operation was most skilfully performed and the patient bore it well, she died within a week from myocarditis or gradual failure of the heart. I relate this as an instance showing the very great importance of this visceral change. In regard to visceral changes due to pressure, these may be most extended and varied. There may be pressure upon the intestines, the bladder, the ureters, the rectum and even upon the iliac vessels, which produce their corresponding pathological conditions. Mechanical changes in the circulation may take place as a result of these pressure symptoms, such as dilatation and hypertrophy of the heart, and the establishment of new branches of circulation. Oftentimes the omentum will become adherent to a large fibrinous tumor and a new circulation will be established there. Enormous veins, like cords, may pass up through the omentum.

We will not attempt to go into the particular condition produced upon the viscera, because within the short time at our disposal we shall have to confine ourselves mainly to broad issues. Certain changes of the greatest pathological significance may take place in the tumors themselves. The most common is that of coagulation necrosis and cystic degeneration. A condition apparently favoring another degeneration of the most serious nature, that is, sarcomatous degeneration. The latter change occurs in about two per cent. of the cases

which come to the operating table. This change is readily comprehended since fibromyoma as well as sarcoma are connective tissue growths. A direct change into carcinoma I regard still as doubtful, for the latter is an epithelial growth and the possibility of its becoming grafted upon the fibroid is easily understood.

Infection may result in abscess formation in a tumor and lead to gangrene of it as well. Gangrene may occur also from circulatory disturbance, due to twisted pedicle or other forms of cutting off the blood supply of the tumor.

Let us consider for a moment the diagnosis of fibroid tumors. Perhaps the most important element in the diagnosis is the physical examination. The symptoms may vary very widely, as you may imagine, from the pathological conditions produced. We may, however, picture to ourselves a typical case of a woman with a uterus with fibromyomata scattered throughout its body, and then give some of the variations of that picture. Menstrual disturbances are somewhat characteristic, the usual one being increase in the duration and quantity of the flow (menorrhagia). This will be in direct proportion to the proximity of the tumor to the endometrium. Thus, a very small tumor situated just under the endometrium may set up a flow which will be almost constant, increasing in severity at the time of the period and diminishing in the intervals; whereas a tumor situated further away from the mucous membrane may cause only a moderate increase of the menstrual flow, and tumors situated under the peritoneum may not cause any increase at all. I have seen several very large subperitoneal fibroids, in which the flow was actually diminished. Hemorrhages between the periods, that is where the flow ceases entirely after the period, but sets in freely in the interval, are not characteristic of fibromyomata, but are strongly suggestive of malignant disease.

Discharges.—As a rule, moderate leucorrhœa will be present but without any especially disagreeable odor. In very large tumors there is sometimes an excessive odorless, serous

discharge, which demands the constant wearing of a napkin. The presence of a serous or sero-sanguinolent discharge with bad odor is always a sign strongly suggestive of carcinoma. The character of the discharge, then, is an important symptom, and may often guide you to a very great extent. Before a patient begins to have hemorrhages from carcinoma, she will always have a discharge of a serous, watery, foul-smelling fluid oozing from the uterus, which is almost pathognomonic of carcinoma, whereas with fibroid tumor the discharge is of a thick, whitish character and not offensive. In carcinoma in which ulcerative changes have taken place, there is necrosis of tissue, and this dead tissue has the characteristic smell of decomposing organic matter. This characteristic smell can never be mistaken after it has once been recognized. This odor comes, before the patient commences to bleed, because it is due to erosions which have already previously taken place, so that, as a rule, you can make a diagnosis of carcinoma before the patient has had irregular bleeding.

Pain.—Pain is not a characteristic of the majority of tumors of moderate size, yet a symptom of fairly constant occurrence is a feeling of bearing down in the pelvis and a moderate pain in the back. These symptoms become magnified at the time of the periods, but there is nothing to differentiate this pain from that of a retroversion or that of an old inflammatory remains in the pelvis, especially in the utero-sacral ligaments. The symptom of pain, however, has a very wide range of variation. When pain in connection with uterine fibromyoma is a very prominent element and subject to sharp exacerbations, it usually points to inflammatory complications.

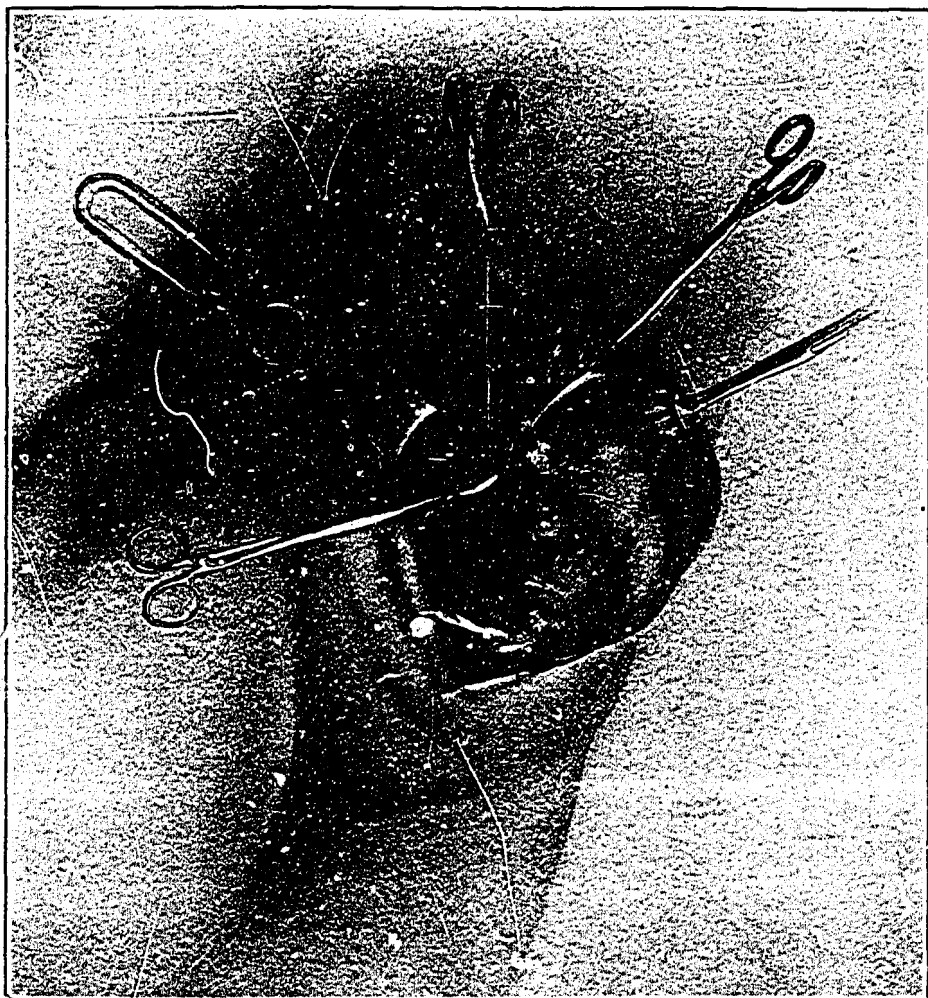
Bladder Symptoms.—These are quite common and usually consist in a desire for frequent micturition, due to the pressure of the tumor on the bladder. It is not infrequent that inability to consult the physician. Like the other symptoms, this one is subject to wide variations according to the size and situation of the tumor.

Menopause.—Atrophic changes and subsidence in tumors of moderate size not infrequently occur at the menopause, but, on the other hand, malignant changes are especially liable to occur; and Winter, of Berlin, regards irregular bleeding in a case of fibroid tumor after the menopause as a positive indication for operation on account of the probable beginning of malignancy indicated by it. If a patient with a fibroid tumor is approaching the menopause and the tumor is not too large, we try to carry her beyond that time with the hope that it will disappear. All cases of fibromyomata existing at the time of the menopause should be kept under most careful observation in order that operative relief may be given at the first sign of danger.

In regard to physical characteristics of these tumors, as stated at the beginning, it is perhaps the most important element in the diagnosis. Fibroid tumors grow round a centre in a globular form, no matter how many fibrous tumors there may be, they will assume more or less of a globular form. Then there is a certain density which is characteristic of the tumor, especially when it has an excessive amount of fibrous tissue. It differs from malignant growths in that it is considerably softer and yet it is much more dense than the tissue of the ordinary healthy uterus. The malignant disease for the most part has a hardness which may be likened to wood, while the fibrous tumor has to the touch a certain resilience.

The shape of the tumor is very important. The tumors grow around a centre and, therefore, assume a globular form, and all of them, even if there are a number of them in the abdomen; the different masses will maintain more or less this globular form and can all be traced to a common point of origin in the uterus, whereas malignant disease is characterized by firmness of growth, a nodular condition, and little angular projections firmly attached to the surrounding tissue.

The fibroid tumors are nearly always movable, even if very large. With proper manipulation they can be moved, as they are not attached firmly to their surroundings, whereas



malignant disease progresses by contact with the surrounding tissue. We often find malignant disease so firmly fixed that it resembles an object in frozen ground. It is attached to the bony framework and invades the surrounding cellular tissues.

The degeneration of fibroid tumors into malignant growths does not always present physical characteristics which enable us through the sense of touch and sight to make a diagnosis. A sarcoma is a fleshy growth of cells, like those of muscle, as a rule, except the osteosarcoma which, of course, has a bone cell and a growth of connective tissue. The sarcoma we have to deal with here is of the fleshy kind and resembles the myoma very much indeed. Unquestionably, it has been demonstrated that about two per cent. of these fibromyomata undergo sarcomatous degeneration.

It is impossible to determine beforehand by the symptoms what tumors are undergoing degeneration and which are simple fibromyomata, because oftentimes only the microscope can decide this question, but after extensive changes have taken place, the characteristics of malignancy which I have spoken of present themselves, that is, involvement of surrounding tissues and firm attachment to the tissues which contain the tumor and the nodular and uneven character of the growth. Of course, this degeneration into sarcoma is a very important element in deciding what cases we should operate on and what cases we should not.

Now we take up the question of operation. Ellice McDonald has shown that out of a series of 175 miscellaneous autopsies which he had examined, about 1 in every 5 had fibrous tumor, so we can understand that we should not operate upon every fibrous tumor we come in contact with. In the beginning I stated they are benign growths, and I know of no more benign process, which we can call pathological, than a small fibroid of the uterus. Therefore, there must be some discrimination as to what cases we should operate upon, and I have formulated these indications as follows:

Great size.	Causing visceral changes, exhaustion and inconvenience.
Rapid growth.	Indicating that the tumor may be malignant
Pressure upon ureter, bladder or rectum.	Interfering with the functions of these structures.
Hemorrhage.	Which cannot be controlled except by operation.
Interference with labor.	as in the case of a tumor so situated in a pregnant uterus as to make normal labor impossible.
Causing sterility.	As when a tumor causes repeated abortions, or prevents fecundation.
Gangrene or infection of the tumor.	Endangering the life of the patient, through toxemia or septicemia.

Various complications may exist in coincidence with the tumor which taken together with it, will prove sufficient indication for operation.

Gangrene is an important indication, and one which has, curiously enough, never occurred in my experience until recently, when two cases have come under my observation, in which operation had to be attempted immediately in order to save the life of the patients. Curiously enough, in both these cases the tumors were large, soft, myomatous masses. We often read in literature of gangrene of pedunculated fibroids, but it is quite rare that we read of gangrene of a sessile myomatous tumor. Both these cases had undergone gangrene, and this is one of the most important indications for operation.

This brings us to the subject of the operation itself, the questions when we shall operate and when not, and what kind of operation shall be performed. When shall we do hysterectomy and when myomectomy? By myomectomy we understand the removal of the tumor without removing the uterus. Certain tumors should always be removed, that is, pedunculated tumors. A pedunculated tumor in the abdomen is a source of danger to the patient; it is also a source of irritation. A pedunculated tumor in the uterine cavity is oftentimes a source of most extensive hemorrhage and it may, therefore, keep a patient ill from month to month. A tumor not larger than a walnut has been known to make a patient a chronic invalid

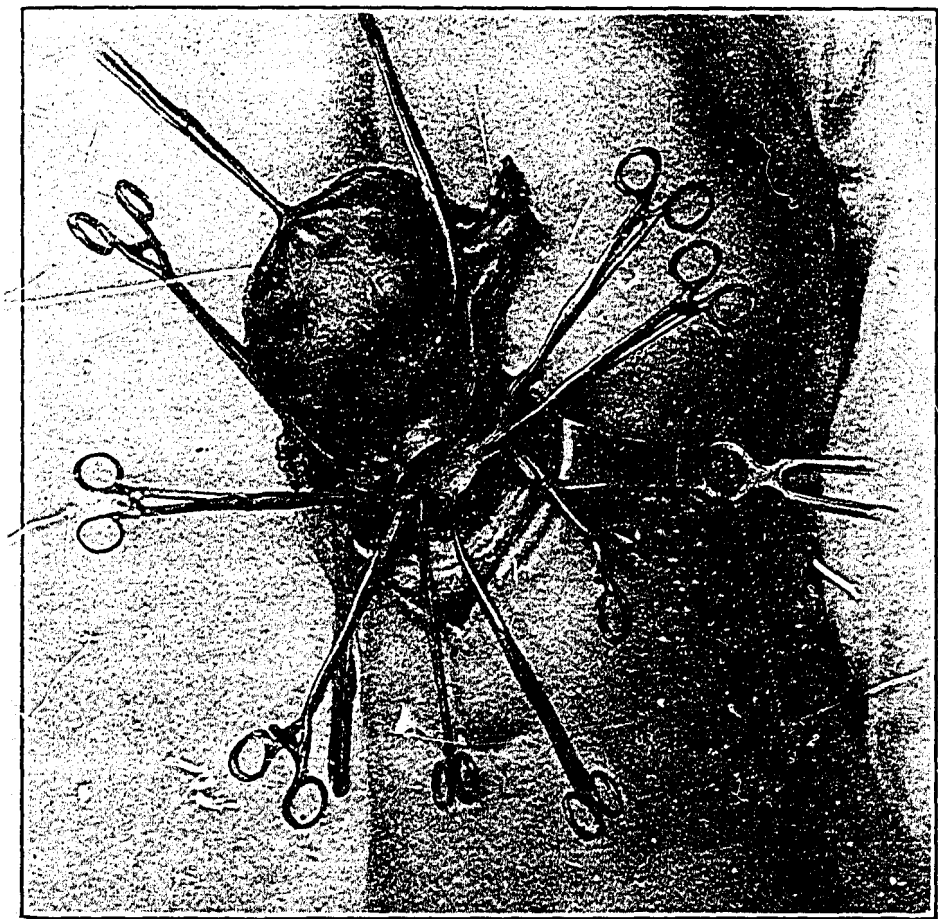


FIG. II.

[WEST]

during menstrual life or the child-bearing period. They should nearly always be removed, if only pedunculated, by myomectomy.

The removal of sessile or of those tumors which are situated in the walls of the uterus, is a question which may be determined largely by the extent and size of the tumors and by the patient's social condition and according to individual and particular cases. For instance, in a young woman for whom it is very desirable that she should bear a child and who has a tumor situated in the uterine wall which it is possible to remove, it oftentimes becomes a factor of the greatest importance to her happiness that the uterus should be retained, and then, if possible, myomectomy should be done. I had one such case in which I removed sixteen tumors from the uterus of a young woman who has since given birth to a healthy child. A short time ago I attended a young woman who was engaged to be married, and in this case I stretched a point and removed a larger tumor than I would usually care to do. I have done forty such cases with two deaths, whereas in this hospital I have operated upon sixty-six cases, performing hysterectomy, in a little over four years without a death. In the work of Drs. Kelly and Cullen, a recent work on fibromyomata, it is stated that the death rate was less than one per cent. in their more recent cases, showing an enormous improvement in technic in supravaginal hysterectomy.

I am guided as to the safety of the operation to a considerable extent by the number of tumors and their sizes. I do not feel it safe to remove individual tumors which have a diameter of more than $4\frac{1}{2}$ inches and which impinge upon the endometrium. In removing such tumors I have had several cases when the patients have barely escaped with their lives.

The late Dr. Mundé removed thirty-four tumors by the vaginal route, and the patient afterward bore a child.

The possibilities of myomectomy are dependent largely upon the size and situation of the tumor. Tumors of small size and away from the endometrium we may remove, almost without any regard to the number which are present, with comparative safety.

Dr. Kelly states that he considers a most serious danger to consist in hemorrhage, but I never had a case of hemorrhage from myomectomy.

All other cases—those which are not subject to myomectomy—should be subjected to hysterectomy. Shall this be complete or supravaginal? I think it very desirable in all cases, where it is possible, to use the supravaginal method. It is quick, sure and the loss of blood practically nothing, and the patient has preserved to her the cervix and the normal anatomical relations of the parts about it. With tubes and ovaries left behind, she does not suffer the severe symptoms by menopause artificially induced, which a woman must suffer when uterus and ovaries are removed. So when possible, I do a supravaginal hysterectomy and leave one or both of the ovaries behind, if there is some considerable time to pass before the menopause. Women who have passed the menopause, should have complete hysterectomy done, as a rule, because, usually operation done after the menopause is on account of the suspicion of malignant disease, and therefore, as a rule, it should be done as completely as possible. If here supravaginal hysterectomy is done, and the ovaries are left behind, there is a possibility of fresh danger through the formation of other tumors, *i.e.*, ovarian cysts. The ovaries are especially prone to develop cysts after the menopause, and after this time they are useless structures in a woman's organism.

In what cases should we do complete hysterectomy? I think in those cases where growth has been excessively rapid, and where upon examination of the tumor, when the abdomen is opened, we have any reason to suspect malignancy; also if there are degenerations of a character indicating malignancy, which may often be determined by inspection, also in cases of lacerated cervix where there is considerable adenomatous hyperplasia. All these cases indicate complete hysterectomy.

Then comes the question of how we shall perform these operations. Myomectomy is a very simple operation, if the tumor is pedunculated. One should ligate the pedicle securely and cut the tumor away. If the pedicle is large, it should be

transfixed and tied off in sections. I never use silk for these pedicles, but use a No. 3 catgut.

Sessile or Intramural Tumors.—If we have a tumor situated on or in the body of the uterus, we make an incision right through the capsule of the tumor—a short incision—when you will see the glistening fibres or the muscular tissue of the tumor, as the case may be; seize it with a double volsellum forceps and draw it out of the opening. The uterus will close behind it. Nothing is easier than shelling out the tumor. Sometimes you can take the dull end of a knife or pair of scissors, and shell it out. The important part is to secure hemostasis. Make a continuous suture of No. 1 or No. 2 catgut, beginning at the bottom of the place where the tumor had lain. In the first place I cut off any excess of tissue which had lain over the tumor (oftentimes the tumor is very much larger than the uterus, and it is necessary to cut away part of the uterine wall which had lain over it). In the case I quoted I opened the tumor which represented a mass about three or four times the size of the uterus, and when the incision was made into the capsule, a large excess of muscular tissue was left over the capsule. I took a pair of scissors and trimmed it down to the size of the uterus when of approximately normal size. But you have to avoid cutting away too much tissue, because it contracts very rapidly. Then there is the pocket where the tumor had been shelled out. I began at the very bottom with a continuous suture, approximated the tissues by over and over continuous sutures, until I came to the layer of muscular tissue which I wanted to bring together. Then I passed separate sutures through the muscular layer, using alternately No. 2 chromic and No. 2 plain through and through interrupted sutures, thus bringing the tissues together, as you would in Caesarean section. I have devised a special needle for suturing the uterine tissues, which Tiemann & Co. keep under the name of West's Myomectomy Needle. When the interrupted sutures have been tied, there is often a little puckering of the peritoneum. Then I take fine catgut No. 1 and, independent of all other sutures, simply bring together the peritoneum carefully with a little round-pointed needle, so that it nearly approxi-

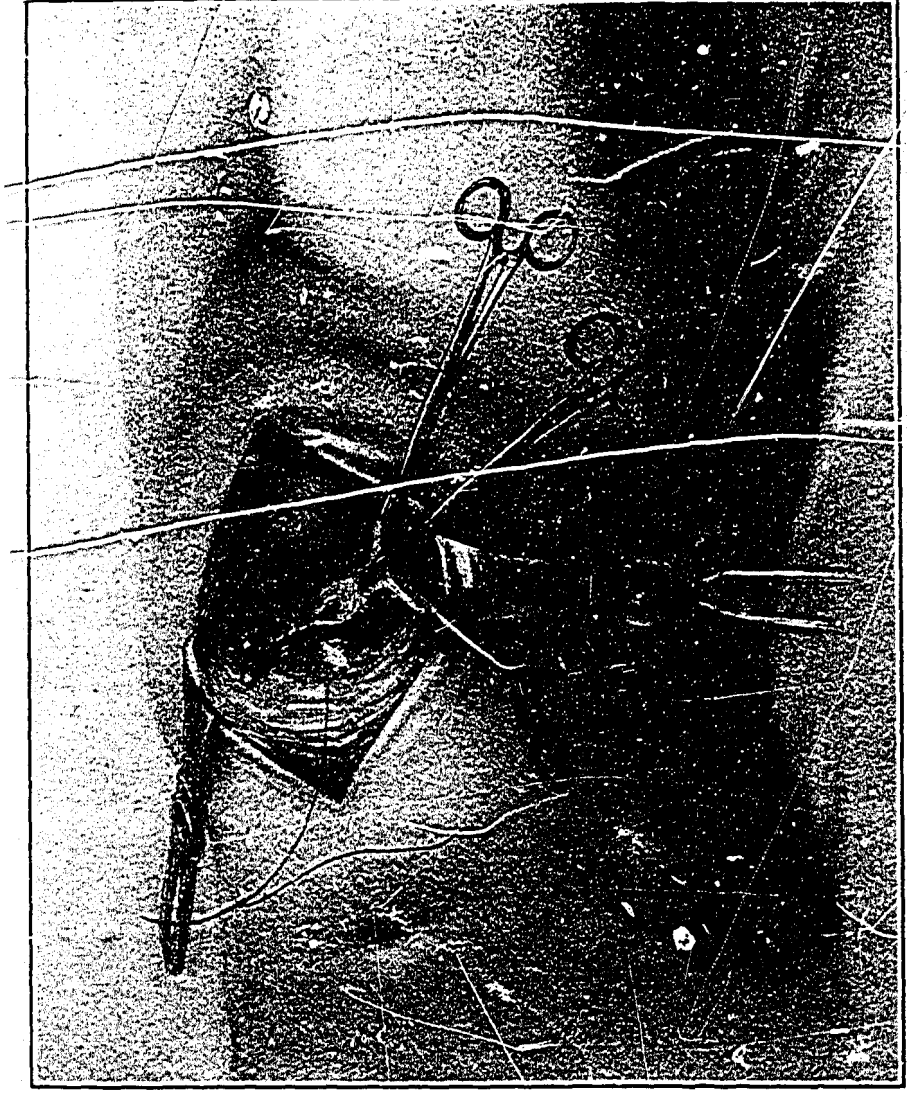
mated. In dealing with a tumor in this way, you may be sure that there will be no hemorrhage.

Before passing from the subject of myomectomy I wish to call your attention to a very valuable form of ligature for large pedicles or thick masses of tissue. It is called the Grad ligature and is described in the surgery of J. D. Bryant. It requires a large strong ligature, No. 3 or No. 4 catgut. We pass it around the pedicle twice so that the suture forms a loop and then we start as though about to tie, and pass the distal end of the suture under the loop. The purpose is that the loop will come down upon the knot, and then, as I draw upon it, the loop is guided down upon the knot. Then there is no yielding whatever, because it is held down by the loop, and you complete the tie as in an ordinary knot. If one passes the proximal end of the ligature, the loop will not slide down upon the knot.

What shall the technic be in hysterectomy? Kelly and Cullen have reported a death rate of less than one per cent., and I have, in taking my record of sixty-six successive cases in this hospital, no death. Therefore, the question of technic becomes of enormous importance.

The operation is best comprehended by reference to the illustrations. No. I represents the abdomen opened and the uterus drawn out of the wound and forward towards the pubes. The clamps are in place and the dotted line represents the line of incision through the broad ligament and the peritoneum just above the bladder. A corresponding incision is made behind, then the cellular tissue at the side of the uterus is loosened up and a long artery clamp applied to the uterine artery. The same procedure is carried out on the opposite side and the uterus is then cut away by an incision through the cervix from behind forward, turning the tumor out over the pubes.

Illustration No. III shows the method of dealing with the main vessels and suturing the peritoneum. The abdomen is usually closed with catgut sutures in layers, plain catgut No. 2 in the peritoneum and chromicized No. 2 in the fascia and the skin with plain No. 2 subcuticular suture.



(WEST)

FIG. III.

One great advantage of this method over many others is that the clamps may be very quickly placed and the tumor cut away practically without loss of blood. No ligatures are placed until the mass has been removed, thus allowing ample room to work. The tying-off of the vessels begins with the clamp which is most accessible, thus neatly simplifying the operation. The duration of the operation is usually from twenty-five or thirty minutes up to the point of closing the fascia. Hemorrhage and shock are absent. There is in the hospital the sixty-sixth successive case without a death.

The time at our disposal will not permit us to enter upon the subject of conservative treatment of uterine fibromyoma, nor the complications. Upon this subject I shall have to give you a lecture at another time.

* MUCOUS COLITIS

By F. J. ELLIS, M.D., C.M., Regina

MR. PRESIDENT AND GENTLEMEN,—

My paper deals with a condition which can hardly be classed among the prevalent diseases. Literature on the subject either in text books or medical journals is very limited. I choose this subject with the hope that I might acquire some more satisfactory line of treatment than the one I adopted in the case report, since many of you who are much longer in practice than I, have no doubt had to treat such a condition on more than one occasion.

The subject of my paper is Mucous Colitis, and defined as periodic discharges of masses of mucous or mucous-membranous shreds or casts of the bowel.

The cause of the trouble is not very well established. Many of the cases occur among those of a neurotic temperament and very frequently among women—75%. A great many of the cases have occurred among those who have suffered with dyspepsia and constipation. A chronically inflamed appendix has been responsible for the condition in some patients. Some

Read before the Regina Branch of the British Medical Association, March, 1910.

claim that the cause is bacterial in origin and refer to the bacillus coli communis as the probable offender. A stricture of rectum or colon may give rise to a discharge of mucous.

The mucous appears as masses or balls clear or whitish in color mixed with fecal matter of a liquid nature. Sometimes it is in the form of shreds and occasionally we find a complete cast of the bowel. There is usually no structural disease of the bowel, although a slight degree of inflammation may be present.

These patients will usually consult you for indigestion and inform you that they have had similar attacks on previous occasions. There is a feeling of weight in the abdomen, especially when standing. There is a distended condition of the bowels and a mild degree of pain on pressure which in time becomes very severe and is only relieved by the passage of the mucous. This is accomplished generally by an enema which if administered twice or three times daily keeps the patient fairly comfortable. An attack of this kind may last from two to three weeks and then all symptoms disappear.

The pain at times may be so severe as to indicate the onset of some acute inflammatory trouble and no doubt this does exist at times. Some cases show great distension of the colon, whereas in other cases it is markedly contracted. On percussion we notice dullness over certain areas. This is usually of a migratory character and may disappear altogether after an evacuation of the bowels. Many of these patients are very irritable. This may be a result of the condition or a potent factor in the etiology. Emaciation seems a natural result in most cases. In a few cases there is no loss in weight.

The disease is not looked upon as dangerous to life, yet a great many are invalids for a long time. The outcome is very trying for the patient and not encouraging to the physician.

Owing to the many factors in etiology the treatment must of necessity vary with different cases. It is well to search diligently for a cause and if such can be found to remove the same where possible. Those cases complaining of pain over the appendix would no doubt be benefited by an exploratory laparotomy at least. The tip of the appendix has been attached

to the abdominal wall and the colon flushed out by this means. Some surgeons have gone so far as to advocate the removal of the colon en masse. It is possible that the surgeon may yet, as in many other abdominal troubles, come to the rescue of the ever-willing but unsuccessful physician.

Medical treatment seems at the present time, however, the one more employed, and it certainly would be the only one where no definite lesion could be found.

Hygienic measures are very important. Exercise, forced or otherwise, together with a change of climate, will be productive of good results. The diet in practically all intestinal troubles is restricted. It may be necessary to do the same in this condition, yet those patients who suffer with constipation should be benefited by a copious diet. If constipation does exist it should be relieved. Occasional doses of castor oil will keep the bowels loose and assist in the removal of the mucous. Intestinal antiseptics such as Salol or Calomel may be beneficial to those cases which are bacterial in origin.

The irrigation of the colon once or twice daily with silver nitrate solution (1-5000) seems to act very well in reducing the amount of mucous and an enema even of plain water is a very good means of relieving the pain when it becomes severe.

Indigestion, whether gastric or intestinal, should receive appropriate treatment. Massage and electricity have been used with advantage.

I have much pleasure in giving you a short history of a case which I had.

Patient—Female, 25 years old; married three years; no children. Well nourished, appetite good. Never suffered with indigestion, not constipated when well, menstrual function normal.

I was called to see this patient in July, 1907. I found her in bed. She did not feel very ill, except when on her feet. On examination I found the abdomen distended. There was pain over the left hypogastric region, increasing gradually till the bowels moved, when, with the passage of a large amount of mucous shreds mixed with a small amount of fecal matter, the pain decreased. There was no temperature and pulse was normal. The appetite was fair. Patient was withholding food, thinking it was best to do so. I gave her two grs. of calomel and ordered an enema in morning. The bowels moved after the enema and the stool was largely mucous. This gave great relief. I ordered an enema night and morning. I gave

grs 5 of salol every 4 hours and ordered a light diet. She remained under treatment for two weeks. After the following week she went back to work. She had a similar attack about five years previous. I was called to see her again in February, 1908. I found her in bed with severe pain over McBurney's point. The temperature was 101° and pulse 95. I made a diagnosis of appendicitis but as pain was much less severe than on previous day I thought conditions were improving and did not urge operation. The bowels were constipated, but when they did move there was a small amount of mucous in the stool. I concluded it was a similar condition to that which she had had before, and probably secondary to the appendicitis.

I gave her calomel, followed by an enema, and placed an ice bag over the appendix. The bowels moved twice daily and on the third day the temperature and pulse were normal. She continued to pass a small amount of mucous. I ordered salol grs 5 every 4 hours and irrigated the colon with silver nitrate solution, (1-5000) night and morning. In about ten days the mucous ceased to appear in the stools and inside of two weeks she went back to work.

I believe it quite probable that an appendectomy would lead to a cessation of the trouble.

Notice to Medical Graduates of McGill University

Most of our readers will remember that the buildings occupied by the Medical Faculty of McGill University were destroyed by fire in 1907. The work of the medical school has been carried on since then in the hospitals and in the lecture rooms, saved from the fire, which had been repaired in a temporary fashion.

A site, just to the north of the former buildings, was given by Lord Strathcona for the erection of the new buildings which the Governors of McGill University determined to put up at once. These new buildings are almost ready for occupation. No care has been spared to make them perfectly suited for their purpose. Although they are not quite as large as the magnificent buildings of—for example—Harvard University, no medical school buildings in the world can surpass them in the beauty of their design nor in the convenience with which they have been laid out. Lord Strathcona, the Chancellor of McGill University, in addition to giving the site, has contributed no less than \$450,000 towards the cost of these new buildings.

It was felt that the occupation by the Medical Faculty of this magnificent new home should be commemorated in some striking way and it has been determined to hold a reunion of as many as possible of those who have graduated in medicine from McGill. The buildings are to be opened with a most interesting programme on the 6th and 7th of June, 1910. The members of the graduating classes of no less than 45 years have already signified their intention of participating in this reunion to the Registrar of the Medical Faculty. A series of class banquets, conversaciones and receptions has already been arranged and it is confidently expected that the opening of the new buildings and the reunion of McGill graduates will do much towards solidifying, increasing and renewing that strong spirit of loyalty towards their *Alma Mater* which has always been characteristic of McGill men.

LABORATORY METHODS FOR THE GENERAL PRACTITIONER

SECOND PAPER

As has been stated, the various manipulations to be described are not intended for advanced research work, but are to assist those who desire to carry on these examinations which are simple, yet accurate, and may be done with a small outlay of capital.

In the consideration of the apparatus, the most important instrument is the microscope. This instrument and the use of it is the subject of an article by Dr. Jackson L. Martin, the title, "The Microscope in Diagnosis," contains many good suggestions that we reproduce it in part.

The microscope as an aid to diagnosis in many cases, by bringing to light facts concerning the condition of various organs of the body in obscure conditions, as well as in discovering the specific micro-organism of disease, and thus leading to a diagnosis, is invaluable. Occasionally the anamnesis and physical examination tell us but little, while the exact condition is clearly revealed by the microscope. In other cases where the status presens is not made known, very valuable evidence may be given as to the condition.

What is learned by microscopical examination in the hands of an expert may be relied upon, while what we gather from the patient is often misleading or untrue.

The space of this article will not allow me to more than briefly mention a few of the numerous conditions in which the microscope may be used to advantage, both in cases where the cause is specific, and non-specific.

Bacteria, as the direct cause of many diseases is an acknowledged fact, and to make a positive diagnosis often requires but the recognition of the particular pathogenic micro-organism. As for example, in a case of suspected diphtheria, a swab from the throat may be taken, rubbed over the cover-

slip, stained with methylene blue, or other suitable stain, and examined under the microscope, best by the use of the one-twelfth-oil immersion objective. If the germ is present in sufficient numbers, the morphologic characteristic forms of the Klebs-Loeffler bacillus may be distinguished from among the numerous other forms which infest the throat, and a diagnosis of diphtheria immediately made. If the micro-organisms are few, it may be necessary to make a swab culture, on suitable media, which will cause a delay of one or two days before examination can be made. Thus, a disease, the early recognition of which is very important, may be pointed out from the less dangerous forms of throat diseases, and isolation, with the proper course of treatment pursued.

A similar advantage may be obtained by microscopic examination of the sputum in suspected cases of tuberculosis, where there is a cough, but no well-marked physical signs. Finding the bacillus tuberculosis, which is not always easy, and sometimes impossible, even where the disease is present, dispels all doubt and calls for a course of treatment different to the presence of a mere bronchitis or other bronchial or pulmonary trouble; and so with the finding of the diplococcus pneumoniae, the plasmodium malariae, the gonococcus of gonorrhoea, and many of the other diseases due to the presence of a specific micro-organism.

The microscopical examination of the urine may be the means of throwing much light upon the patient's condition, by the revelation of pus, crystals, blood, fat globules, bacteria, casts, etc. Organic changes in the kidney structure, such as are found in Bright's disease, may be made known through the casts, blood, renal epithelium, and other formed elements found in the sediment.

By sedimenting the urine and straining for tubercle bacilli, tuberculosis of the bladder, or kidney, may be discovered.

However, knowledge of a negative character is often valuable. as for example, the absence of the urinary products of

Bright's disease, even with symptoms, simulating, would necessitate its exclusion.

From the fecal discharges valuable data may be obtained, as for example, the presence of the Eberth bacillus of typhoid fever, or the spirillum of Asiatic cholera. In several different cases of dysentery, I have been enabled to find the amœba coli, which has always settled my diagnosis as to the particular form of enteric trouble present.

The microscope reveals to us a great deal through the blood, and may occasionally make the diagnosis for us alone; in other cases, throwing side lights on obscure conditions. Besides, as in urinary analysis, it gives us valuable information of a negative kind.

The red cells, and the white cells, with their various subdivisions, in the normal blood, sustain, in a general way, a certain relation to each other, as pertaining to numbers. In many diseased conditions, the haemoglobin of the red cells may be increased or diminished, or the red cells themselves, as regards size, or numbers, or both, may be changed, or the white cells as a whole, or of any particular kind, may be increased or diminished; or cells like myelocytes, which are rarely found in normal blood, may be found in large numbers, as in leukæmia, or nucleated red cells, many of large size, and called megaloblasts, may appear in relatively large numbers, as in pernicious anemia. The determination of a variation from the normal, or of an increase or a decrease as occurs in certain diseases, is often of great value in diagnosis, not only in enabling us to name the disease, but also in enabling us to detect variations in the condition of the patient during the progress of the disease.

The microscopical study of pathological blood is very interesting, but the subject being broad, only an allusion to its benefits can be made here.

Another wide field over which the microscope has control is the subject of pathology. In disease, certain tissues and organs of the body undergo changes. These changes may be only cellular, but are usually more extensive. By taking small

parts of the tissues and organs at the post-mortem, if one can be had, hardening them in alcohol and embedding in paraffin or celloidin, after which cut in thin sections, and then properly stained, one may examine under the microscope. By comparison with the normal it is possible to determine the nature of the morbid changes in the fundamental structures of our being. However, this examination of one after death to determine the diseased conditions, is not of so direct benefit, or encouragement to the patient, as what may be obtained from the examination of diseased tissues while one is living. This is possible in recognizing the atypical structure of neoplasms, where a small part of the tissue may be taken and examined, to determine whether it be of a benign or malignant character. Also uterine curettings may be examined for malignancy, tuberculosis, or to determine the nature of an endometritis. Every general practitioner has not the facilities, nor possibly can not take the time to work out for himself knowledge that the microscope can impart, but he should at least recognize its broad field of usefulness, and give his patient the benefit of the specialist, who devotes himself exclusively to clinical and pathological microscopy.

THE SASKATCHEWAN MEDICAL JOURNAL

HARRY MORELL, M.D., C.M., *Chairman of Publication Committee*

All communications relating to this publication should be sent to the
Saskatchewan Medical Journal, Regina, Saskatchewan, Canada.

Box 1109.

Editorial Notes

Our contemporary "The Maritime Medical News" March number contains the following:

The
Roddick Bill

We regret to inform our readers that an unavoidable difficulty has arisen, necessitating the abandonment of the introduction of the Bill at this Session of Parliament. We have been favored with a letter from Dr. Roddick, inclosing a copy of a telegram from British Columbia, running as follows:

"Executive of Medical Council of B. C. protest against
"introduction of Bill this session until completed Bill
"meets with approval of profession of this Province."

"(Signed) C. J. Fagan."

And so the hoped-for "Dominion Register" is again postponed, and competent men are still barred from practice in other provinces than their own until they have passed absolutely unnecessary examinations.

Dr. Roddick says: "I have now positively given up the fight for this session."

We have just received from Dr. Roddick a copy of the proposed amendments to the Canada Medical Act. This matter will be gone into thoroughly in our April issue.

Dr. Roddick will watch the progress of this Act and will not allow the bill nor any amendments of it to be pigeon-holed or tabled.

We feel sure that Dr. Roddick has the support and thanks of every active, progressive, medical practitioner in Canada in his efforts to give us relief from our intolerable position.

The Regina General Hospital affair as taken up in our last number has gone a step further and a petition signed by fourteen medical men of Regina was forwarded to the City Council, in the following terms:

Regina
General
Hospital

"That your petitioners are all agreed that in their opinion it would be in the best interests of the Regina General Hospital if the suggestions contained herein be adopted, and beg to suggest as follows:

(a) That no medical practitioner be appointed to the Regina General Hospital board of governors.

(b) That all matters of special interest to our profession be referred to a committee of three or more medical practitioners elected by the Regina medical profession annually as our representatives, whose duty it shall be to act as an advisory board of governors on matters of special interest to our profession."

(Signed)—

Harry Morell,

D. S. Johnstone,

G. J. Ball,

W. A. Harvey,

J. C. Black,

J. Cullem,

James McLeod,

W. R. Coles,

F. J. Ellis,

J. M. Shaw,

O. E. Rothwell,

A. S. Gorrell,

David Low,

H. M. Stephens,

The petition will be considered in the usual course by the Health and Relief Committee.

The following is from an editorial in the January issue of the "St. Paul Medical Journal." It is well worth repeating.

—EDITOR.

Cancer of the uterus is perhaps the most dreaded and most dreadful of the diseases of women and causes a very large number of deaths as well as an immense amount of suffering. Cancer of the uterus like all forms of cancer is a local disease in its early stages, is easily recognizable by proper methods of examination and is curable in a very large percentage of cases if

Diagnosis of
Uterine
Cancer

operated upon before it has extended to the surrounding tissues. Why then should cancer of the uterus cause so many deaths? Partly because physicians and midwives fail to appreciate the significance of the earliest and most important symptom—slight irregular uterine hemorrhage—in women past middle life, and partly because of the ignorance of women generally in regard to this dangerous and easily recognizable symptom. From the age of puberty women become accustomed to uterine bleeding and regard it as a normal function, which, of course, it is when taking place at regular intervals, and they frequently pay no attention to the slight hemorrhage occurring between the menstrual periods which is so commonly the first symptom of the most dreadful disease a woman can have. Physicians themselves are often too careless when consulted regarding this same symptom and are apt to make light of it and to refrain from making the very simple and easy examination which would at once disclose the presence of beginning cancer of the cervix. The patient is lulled into a feeling of security, the occasional hemorrhage continues to take place for months without other symptoms, until at last the physician is again consulted, the examination made and the disease recognized; too often, however, the favorable time for operation has passed and the patient is doomed. The importance of this subject has impressed itself so strongly upon those of our profession who see these cases most frequently, that medical associations in various parts of the world, especially in Germany and in England, are making concerted efforts to disseminate a knowledge of the facts concerning the early recognition of uterine cancer among physicians, midwives, nurses and, indeed, among women in general. The council of the British Medical Association has recently issued an important document, setting forth the early symptoms of uterine cancer, calling attention to the dangers of neglecting them and urging immediate examination of every woman who presents any of these symptoms. The document has been very carefully compiled and we cannot commend it too highly. We should be glad to see similar steps taken by the American Medical Association and the widest publicity given to

a similar appeal. Many lives would be saved if the importance of early diagnosis of cancer of the uterus were more generally recognized.

News Items

A meeting of the Regina Branch of the British Medical Association was held recently. Dr. F. J. Ellis, of Regina, presented a very interesting paper on Mucous Colitis, which appears elsewhere in this issue.

During the early part of March the citizens of Saskatoon voted down by a majority of 36 a bylaw to provide \$110,000 for hospital extension. This is the first money bylaw the people of Saskatoon have ever defeated, and the reason for such action seems to be the opinion that the request was somewhat excessive. The city two years ago built the first municipal hospital in Western Canada, at a cost of \$55,000, which has been very successful, being already on a self-sustaining basis. The grant asked for was for an additional two wings, steam heating plant, and isolation hospital, but it is evident from the vote it was considered too much.

At Carnduff, Sask., on March 10th, a largely attended and highly successful meeting was held. The gathering was addressed by Dr. Seymour, Provincial Health Commissioner, and Dr. Porter. A local branch of the anti-tuberculosis league was organized for Carnduff and district with the following officers: Hon. president, J. H. Riddell, M.L.A.; president, Dr. W. F. Lockhart; secretary-treasurer, M. R. Foults.

Over \$300 was subscribed towards the proposed Provincial Sanitarium.

The meeting of the Canadian Medical Association takes place in Toronto on the first, second, third and fourth of June. Arrangements are being looked after by a special committee for that purpose. Let us hope that Western Canada will be well represented.

Elsewhere in this issue is an announcement which will be interesting to the graduates of McGill University Medical Faculty. Those from the West contemplating attending the meeting of the Canadian Medical Association at Toronto on the 1st, 2nd, 3rd and 4th of June, should make arrangements to also attend the McGill reunion.

Book Notices

CLINICAL MEMORANDA FOR GENERAL PRACTITIONERS. By *Alex. Theodore Brand, M.D., C.M.*, and *John Robert Keith, M.D., C.M.* Bailliere, Tindall & Cox, London, England.

AIDS TO MICROSCOPIC DIAGNOSIS, By *Ernest Blake Knox, B.A., M.D.* (Dubl. Univ.). Bailliere, Tindall & Cox, London, England.

SYMPTOMS AND THEIR INTERPRETATION, By *James Mackenzie, M.D., M.R.C.P.* Physician to the West End Hospital for Nervous Diseases, London. Shaw & Sons, 7 & 9 Fetter Lane, E.C. D. T. McAinsh & Co., Toronto.

INTERNATIONAL CLINICS. Quarterly. Vol. I. Twentieth Series. These clinics are illustrated clinical lectures and especially prepared original articles on all subjects of medical and surgical science by leading members of the Medical Profession throughout the world. Edited by *Henry W. Cattell, A.M., M.D.*, Philadelphia. J. B. Lippincott Company, Philadelphia, London and Montreal.

This volume contains seven colored and about fifty other plates, with three hundred pages of text.

The articles are contributed by leading authorities, included are those by *Emil G. Beck*, on "The Diagnostic Value and Therapeutic Effects of the Bismuth Paste in Chronic Suppuration." *Dr. A. Laphorn Smith* of Montreal has an address on

"Progress of Gynaecology and Abdominal Surgery during the Last Twenty Years."

Other articles on the Serum diagnosis of Syphilis, and the latest summing up of the Tuberculins are contained in this issue which we think is the best that we have seen for some time.

PREPARATORY AND AFTER TREATMENT IN OPERATIVE CASES. By *Herman A. Haubold, M.D.*, Clinical Professor in Surgery and Demonstrator of Operative Surgery, New York University and Bellevue Hospital Medical College, New York; Visiting Surgeon Harlem and New York Red Cross Hospitals, New York, etc. New York: D. Appleton & Co.; Toronto: D. T. McAinsh & Co. Illustrated, price \$6.00.

In thirty-four chapters the author has covered the field of the "Preparatory and After Treatment in Operative Cases," very thoroughly. The illustrations of which there are about four hundred and thirty are good. They deal with the essentials of preparation for operation, the patient, instruments, dressings, materials, solutions, assistants, and the operating room. Then the treatment of the wound is taken up, suturing, drainage, dressings, hemorrhage, post-operative complications, and feeding. (Warbasse).

Taking up the whole volume it is an extremely useful work, and it ought to prove popular with those who are removed from the large medical centres, and also with the general practitioner.

MORELL.

Personals

Dr. J. E. Knipfal, of Broderick, Sask., was in Regina recently.

Dr. Hugh Gillis, of Bethune, Sask., has just completed his splendid new residence. The Doctor is the President of the local Liberal Association of this district.

Dr. Brydone-Jack has received the appointment of Health Director to the Vancouver public schools.

Dr. J. W. Mahan, of Fillmore, was in Regina during the early part of the month.

Obituary

NEWELL—At Sarnia, Ont., on February 11th, J. Newell, M.D., after a lingering illness. The Doctor was a graduate of Trinity University, 1888.

TELFER—At Montreal, Que., William Telfer, M.D., C.M., McGill University, in the 46th year of his age.

SINKLER, WHARTON.—At Philadelphia, Pa., March 16, Dr. Wharton Sinkler in his sixty-fifth year. Dr. Sinkler was one of the foremost neurologists in America. At the time of his death he was physician to the Orthopaedic Hospital, Philadelphia, neurologist to the State Asylum, a trustee of the University of Pennsylvania, a member of the Board of Managers of the Episcopal Hospital, and many other positions of trust. Many are his contributions to medical science.

Letters to the Editor

To Editor, Saskatchewan Medical Journal:

SIR,—

I have watched with interest your attempts to "wring" from the Council of the College of Physicians and Surgeons of Saskatchewan a report of their proceedings and a detailed statement of receipts and expenditures. Also a correct register of every person licensed to practice in this province, as required by law.

In your February number you make the statement that a movement is on foot "whereby the medical organizations of Moose Jaw, Saskatoon, and Regina would, or are making, or intend to take concerted action, and demand a statement of proceedings.

May I ask if any action has taken place, as above, and to what purpose? Kindly publish this letter, and state if any one is sufficiently interested they may have my name and address from you. In the meantime, I am,

Faithfully yours.

MEDICUS.

It is our intention to obtain the information desired, and it will be inserted with other correspondence, and other letters received, in a later issue. (Editor).

Answers to Correspondents

J. T. S., Minnesota.—The fee for registration is \$50.00 and also an annual fee of \$2.00.

Subscriber.—The article on Laboratory Methods will be continued regularly. The cause of delay is caused by not receiving some electroplates which are being made.

Alberta.—Apply to the Registrar of the Faculty of Medicine, University of Toronto, Toronto, Ont.

T.H.—Write to The Acting Registrar, College of P. & S., Sask., Regina; he will give you all information regarding registration.

R. H.—Dr. Henry is the President; address, Yorkton, Sask.

Items of General Interest.

Recently in London (Eng.), at the City Coroner's Court, Mr. F. Danford Thomas held an inquiry into the death of Henry Cross, aged 32, horsekeeper, in the employ of Robert Benjamin Pettit, who died at St. Bartholomew's Hospital, from glanders. Dr. C. R. Hoskin stated that when they diagnosed the case as being one of glanders, they adopted the new method of Vaccine treatment, but without avail.

The timely administration of Ergoaplol (Smith) in any one of the several varieties of dysmenorrhea always serves to at once relieve distress and promote functional activity of the uterus and its appendages. When used during the menstrual visitation, the anodyne and restorative action of the preparation is notably pronounced.

A disastrous fire destroyed over one million dollars worth of medical stores at the United States Army Depot in New York City recently.

S. M. J. Saliba, M.D.C.M., University of Edinburgh, late Surgeon to His Majesty, King Edward's forces in South Africa, Late Physician to St. George's Hospital, Beyrouth, Syria, Turkey, Asia, says:

"I have found Waterbury's Metabolized Cod Liver Oil Compound always to be relied upon in every instance where such a product is indicated. In Tuberculosis I have had most beneficial results, and I compliment you upon your valuable preparation and wish you abundance of success.

We note that Mr. R. L. Gibson has issued a list of recent additions to "D. & F." capsules. One especially will appeal to the practitioner, that is No. 328, which contains Ergotine and Apiol. We advise any doctor who has never used the ophthalmic capsules to send for a sample, which will be gladly sent. Address the house at, 88 Wellington West, Toronto.

Dr. Orr, of Toronto, one of the governors of the Toronto General Hospital, resigned to make a place for Mr. J. C. Eaton who had donated a quarter of a million dollars to this institution.

The "Young-Thomas" washing powder has been used to very great advantage in hospitals as well as in private houses. For the cleaning of operating-room, ward, lavatories, etc., it is unexcelled.

We do not believe in substituting. For instance look at "Lixterine." It is the first of its kind. Other preparations intended to take its place have come and gone, why should you "switch?" Use the original, you can depend on it.

Tyree's Antiseptic Powder has been subjected to many critical tests and has always remained up to its full standard of purity and usefulness. Mr. Tyree will be pleased to send a working sample to any physician in Western Canada.

The Paris correspondent of the Times has telegraphed his paper on March 13 the following: Particulars are given to-day with regard to the organization of the international congress for the study of cancer, which is to be held in Paris under the patronage of the President of the Republic in the first week of October. The president of the congress will be Professor Czerny, who is co-president, with Professor Fibiger, of the International Association. The other members of the presidential bureau will be Professors Pierre Marie, Roswell Park, George Meyer, von Hausemann, Boucharde (of the Institute), Barrier, and Pierre Delbet; Doctors Ledoux-Lebard and Henri de Rothschild, and Professor Gabriel Petit. The reports presented by the members of the congress will summarize the progress which has been realized in the study of cancer since 1906. The proceedings will be public.