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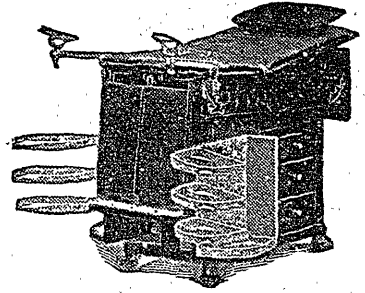

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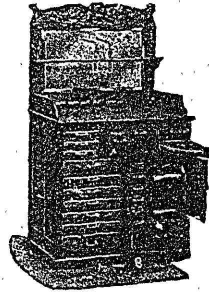

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1902.

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1902.

Maritime Medical Association.

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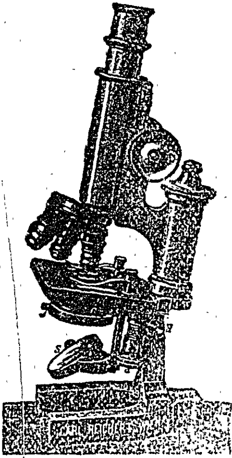

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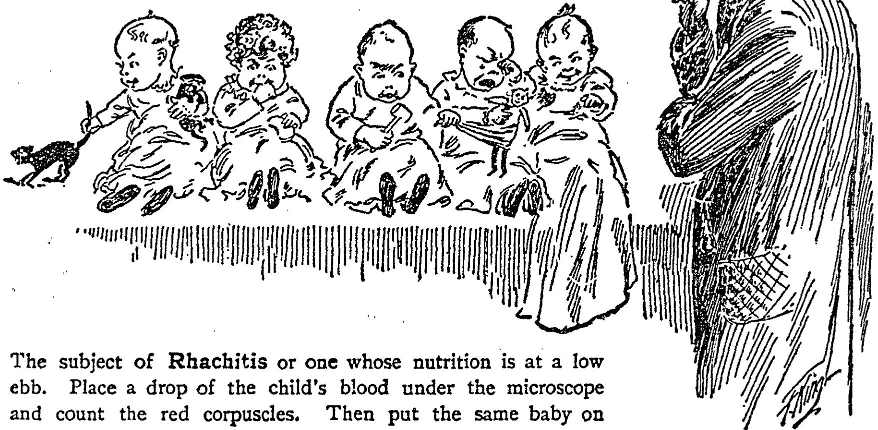

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VOL. XIV. HALIFAX, N. S., JUNE, 1902. No. 6.

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ACTUE STENOSIS OF LARYNX.*

By O. J. McCULLY, M. D., M. R. C. S., (London) St. John, N. B.

Of the many sad sights which we in the practice of medicine are called upon to witness, there is none more harrowing than to stand helplessly by and see a strong healthy child choked to death by what we have seen fit to call *membranous croup.* As we have stood by the bed-side of one of these little sufferers helpless, or only adding to the child's torture by smothering it with steam or the administration of emetics which produced no effect, our conception of the good we can do in the practice of our profession has been very materially lessened.

But now, thanks to the introduction of antitoxin and the perfection of intubation by O'Dwyer, our efforts are attended with as brilliant results as in any department of medicine or surgery. It is with a view, if possible, to simplify the diagnosis of these cases of acute stenosis of the larynx and give a few practical observations on the treatment that I read this paper. The student, when he consults a number of text-books with a view of differentiation of the different forms of acute stenosis of the larynx, is met with a multiplicity of names, and a complex classification based on such slight differences that instead of being helped he is only perplexed.

We propose to put all diseases which produce acute stenosis of the

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larynx of children under there heads: Laryngismus; Catarrhal Laryngitis; and Laryngeal Diphtheria.

You will notice that no mention is made of membranous croup; this is done intentionally, for we believe that all membranous inflammations of the larynx, except those due to traumatism, should be treated as diphtheria.

This judgment is founded on the fact that statistics collected from a microscopical examination of the membrane in several thousands of cases has revealed the Klebs-Loeffler bacillus in 95 per cent.

The argument against the identity of *laryngeal diphtheria* and *membranous croup*, based on the fact that there is little or no swelling of the cervical glands and no marked systemic effects as in diphtheria, is answered by the fact that the lymphatics in connection with the larynx where the membrane is deposited are very very few indeed. Again, close observers who have seen a great number of cases at their inception have in a great percentage of cases seen a small deposit on the lower part of the tonsil which might easily be overlooked by less careful observers.

Grant that five per cent. of the membranous deposits in the larynx are not truly diphtheritic, the clinical history of the five per cent. non-diphtheritic and the ninety-five per cent. diphtheritic are the same, and we have no time for making microscopical examinations; even if we were ever so capable, it is our duty to act at once. Our responsibility, and perhaps it is as great in these cases as any in the whole range of the profession, lies not in making a certain diagnosis as it does in giving the right treatment. We are not called to the child to use it as a means for perfecting our clinical education; we are called to save its life.

We now know that antitoxin can be injected with perfect safety. There were recently collected statistics of 30,000 injections of antitoxin for prophylaxis in the city of New York without a single untoward result. What harm is done if in five per cent. of the cases the antitoxin is wasted? The cost of a few thousand units of antitoxin should not weigh against a human life.

We have also in our classification of acute stenosis of the larynx left out the name *spasmodic laryngitis* or *false croup*. We include this under the head of catarrhal laryngitis, because all cases of false

croup have the early symptoms of catarrhal laryngitis and the spasm is a symptom only which may or may not supervene. We will now say a few words in the differential diagnosis of the different forms of acute stenosis of the larynx.

1. In *laryngismus* we have a slight snoring sound which accompanies each inspiration. When more severe it results in holding the breath such as one sees in children before a severe crying spell.

2. Found only in rickety, ill-nourished and anæmic children under two years of age.

3. It is generally excited by some emotional disturbance.

4. No fever, no coryza, no cough.

5. Occurs at any time in 24 hours. On account of the absence of rickets in this country the disease is very rare indeed and need scarcely ever be entertained. The important point in the diagnosis is to be able to determine between a case of *catarrhal laryngitis* attended with spasm and *diphtheritic laryugitis.* In the former we have:

1. Age, 2 to 7.
2. Fever none; or slight.
3. Little or no constitutional disturbance.
4. Attack comes on suddenly.
5. Attack comes on at night.
6. The application of a hot sponge to the throat, or rubbing with hot oil, or the successful administration of an emetic will relieve the attack.
7. Attacks do not generally last more than an hour or two.
8. These children generally have adenoids or enlarged tonsils.

Diphtheritic Laryngitis:

1. Occurs at all ages.
2. Attended with fever and constitutional disturbance.
3. Generally there is slight ulceration of the tonsils.
4. Attacks come on gradually.
5. Voice gradually becomes higher pitched and stridulous respiration more marked.
6. Dyspnœa gradually and steadily increases.
7. Dyspnœa attended with slight exacerbations, but always returning with increased severity.

8. It is not relieved by any of the means which are successful in spasmodic croup. The gradual steady increase in the dyspnœa is the symptom of the most importance, and by careful enquiry and careful observation on this point we can generally determine whether we have to deal with a case of diphtheritic laryngitis or catarrhal laryngitis with spasm.

Treatment.—We will confine our treatment to that of laryngeal diphtheria only. Give 2000 units of antitoxin—no less, at once. Do not delay as the beneficial effects of antitoxin are in direct ratio to the promptness with which it is administered. If the child does not improve in eight hours in breathing, in pulse and in color, repeat the dose. If at the expiration of another eight hours you do not get marked improvement in the above mentioned conditions repeat the dose. This much antitoxin in my experienceh as been sufficient. If the case has not been seen till several days have elapsed since the inception of the disease, more doses can be given. Some practitioners have given as much as 20,000 units. Such a large quantity can be given with perfect impunity.

But now despite the fact that you have given antitoxin in generous doses and at sufficiently short intervals, the patient grows more restless, wants to be taken in the nurse's arms, then to be laid in the bed only in a few moments to be taken up again; the cough becomes more high pitched, the voice reduced almost to a whisper, cold perspiration stands out on the forehead, the face becomes pale or livid, and on exposing the chest the episternal notch, supraclavicular and infraclavicular spaces and also the intercostal spaces are seen to sink in during each inspiration.

The child is suffering the indescribable torture of a lingering death by suffocation and unless speedy relief is given by some surgical or mechanical means death is almost certain.

Nearly all text-books, the English in a more eminent degree, tell you now is the time to make your choice as to whether you will intubate or perform tracheotomy.

There is no question what to do; there is no choice to make—*intubate.* To perform tracheotomy would be as monstrous, cruel and unscientific as it would be to perform Cæsarian section in a case of

simple inertia of the uterus where there was not the slighest mechanical obstruction to the delivery of the child.

Intubuation should be done in four or five seconds at the most, and in experienced hands no more shock is produced than by depressing the tongue with a spoon handle to inspect the fauces. While tracheotomy should not be thought of at all, it may not be out of place to state in detail the advantages of intubation as compared with it.

1. Intubation can be done earlier, as parents if they consent to tracheotomy at all, will not do so till the child is in extremis.

2. Parents will always consent to intubation.

3. Intubation is painless and does not exhaust to any extent.

4. Percentage of recovery in intubation is far greater than tracheotomy.

5. Coughing is more effectual.

6. No anæsthetic is needed, and a skilled assistant, if not at hand, can be dispensed with.

7. Respiration passes through the natural channels and there is therefore less danger of lung complications.

The objection that the false membrane may become detached and pushed into the trachea is not a real one, because if the string is left attached, the tube can easily be withdrawn and the detached membrane will be coughed up.

These cases of so-called detached membrane will be found on examination to be in almost all cases to be shock due to bungling, forcible and prolonged intubation.

When to Intubate.—When you have constant restlessness with a progressive, unremitting dyspnœa produced by obstruction in the larnyx, and a well marked sinking in of the yielding parts of the chest, viz.: the episternal notch, the supra and infraclavicular spaces and the intercostal spaces. It is cruel to wait till you have alarming cyanosis.

How to Intubate.—We will not detain you to speak of the position of the child and nurse as that can be learned from any text-book. Nor will we give you the details of the act of intubation as given in any of these text-books, but will say in passing that the original description as given by O'Dwyer is a classic in itself and has never been

equalled by any subsequent writer, and it would have been far better if other authors had copied his directions verbatim.

O'Dwyer lays great stress on the operator doing the operation so often that he has not to think what he is doing at all; in fact the whole operation should be automatic. This can never be acquired by operating on struggling children dying of suffocation.

Cadavers, especially those of small children, are not always at hand. The difficulty, however, can easily be overcome by securing a cat or a small sized dog as these larynges are about the size of a child's one or two years old.

As intubation is very difficult to perform without practice, and the beneficial effects which follow its successful performance are perhaps not equalled by any operation in the whole range of surgery, I may be excused if I go into details which may appear trivial. Trivial as they may appear, however, if followed out carefully and faithfully, anyone can become an expert intubator. Having secured a cat or small dog and having chloroformed it, with a pair of bone forceps cut through the ramus of the lower jaw, and then cut the ligaments and muscles till you fully expose the larynx. Next cut a hole in each ear and suspend the cat by rabbit-wire to two nails in the wall. This brings the larynx into the same position as a child sitting erect in the nurse's arms.

Now practice intubation and extubation with the eyes open; not once or twice, but hundreds of times. Then repeat the same with the eyes closed. The advantage of the continuous practice is that there are so many things to be thought of and so many movements to be made with both hands, that when you come to operate in the living, struggling child, you do not want to think about them at all; you must do them automatically. After two days' practice the larynx will get so dry and rigid that a new one must be procured.

Now the dissection must not be too extensive, sufficient only to introduce the finger and to bring the tube into the same plane as the larynx, before being detached.

Let the number of intubations and extubations, guided only by touch, be numbered by the hundreds or better still by the thousands. Now when you come to intubate the living child you have refreshed your memory in all the anatomy you need to know, in fact all you

need remember is that the larynx is in front of the œsophagus and that the epiglottis is at the base of the tongue. Most of the descriptions given in the text-books are rediculous. Without recommending any practice on the cadaver or on lower animals, they gravely tell you to introduce your finger into the larynx and feel for the epiglottis and hook it up. You might as well try to feel for the historic needle in a hay-stack and that moving in a cyclone as to feel for the epiglottis in the swollen distorted throat of a struggling child a year old. All you have to do is push your finger down the child's throat; of course it goes into the œsophagus. Then bend your finger slightly and pull it forward, exerting downward pressure till you come to the base of the tongue, which you pull forwards. You have hooked up the epiglottis, whether you have felt it or not. With your thousand or more previous intubations the introduction of the tube is accomplished the first time in a few seconds.

Extubation is a far more difficult operation than intubation, but there is seldom any necessity for it, for the thread should always be left attached to the tube, so that if the lumen of the tube should become blocked by a detached piece of membrane it can instantly be withdrawn by the nurse or attendant. If the child should bite the thread in two, the tube can be removed by placing the child across the knees, and then forcibly grasping the trachea immediately below the larynx with the thumb and forefinger and raising the whole larynx upward. The tube will, in this way, fall out of the child's mouth. Although I have performed intubations several scores of times, I have never had to extubate in the regulation manner.

Now, gentlemen, if I have convinced you that clinically you should deal with all cases of membranous croup as diphtheria, and if I have given such directions that the physician who cannot call in some one who has practiced intubation, can acquire the skill to do it himself, I feel fully justified for thus trespassing on your time.

MEDICAL ETHICS.*

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Last autumn I suggested that we devote some consideration to the question of lodge and contract practice. The secretary in making up the roster made the subject broader and seems to have got me down to open an ethical discussion.

My observations in the past have led me to the conclusion that there are two classes who have the most to say upon ethics. (1.) Those who, not receiving the amount of practice they think they are entitled to, attribute the fact to lack of ethics in others, and (2) those who, having broken every rule in ethics and outraged professional decency, apparently with personal profit, seem to consider themselves the guardians of the code. I trust I do not belong to either of these classes, and I reluctantly take up the subject.

The Golden Rule, I take it, bears in it the whole code and will apply in every case. There are a thousand unwritten ways to be ethical and a thousand undefinable ways of being unethical. Even though much must be left to the silent tribunal of each man's conscience, there are many points that can be clearly defined. It is necessary to have certain external rules of the game understood by all in order to make the play fair. There are certain covert acts that are inexcusable and can be clearly condemned. The secret and indefinable methods are the most obnoxious, just as the sneak thief is more to be despised than the highway robber.

When I find the patients of a particular practitioner in my absence hovering around some one I am attending, and telling my patient they would not have me to a cat (even with its nine lives); or when I hear of a particular practitioner ostensibly mistaking the house and calling on my patients; or that he calls at a house where some one is sick and claims that he got a telephone message to go there—when I hear of these and other like suspicious circumstances of frequent occurence, I conclude this practitioner is not wholly innocent in the premises.

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Take another instance: he is called to supersede another practitioner in a case. He asks to see the medicine the former doctor was giving. He assumes the countenance of a Solomon as he smells and tastes of it. With an air of virtuous forbearance and Christian charity he says decidedly, but with a certain misgiving faintly struggling up to the surface in spite of his good resolution: "I think you are mistaken, Dr. So-and-so is a very good doctor." When assured that it really is so—as if convinced unwillingly—he sadly pours the medicine into the sink.

This man, even though you bray him in a mortar with a pestle, yet would not his meanness depart from him. From all such we fervently pray "Good Lord deliver us." Rather let us have the man who openly says the other doctors are fools and ignoramuses.

Let us not be too ready, however, to attribute success in every case to dishonest methods. Given certain qualities of head and heart combined with industry, eminence is often legitimately reached.

I will now refer to certain definite points affecting the welfare of the profession.

(1.) Advertising.

This happily is growing less and has almost disappeared. We still, however, see sporadic cases. Incidentally I may say I see nothing in a doctor announcing that his practice is limited to certain things.

(2.) Directly maligning another physician or criticizing his treatment is not to be allowed. Sometimes it is necessary to disagree, but the difference should be softened as much as possible to the public.

(3.) Insinuating that he could have prevented a fatal result if called earlier to the patient of another is inexcusable. It is cruel to the people who have lost a relative and may fill them with vain regrets that all had not been done. The doctor who would do this for selfish purposes is unworthy of a place in the profession.

(4.) If called to the case of another, one's duty is with the *present* and *future*—not with the *past*.

(5.) Exaggerating the seriousness of a case to gain eclat when it gets well. Of course no patient likes to think he has sent for a physician unnecessarily and one should not make too light of any case.

(6.) Canvassing for positions held by medical men ought not to be tolerated. In this connection I may mention insurance companies

have a disagreeable habit which seems to be growing of getting doctors to take out insurance for the sake of an examinership. In a year or two they get other doctors for the same reason. Thus the doctor finds he has been gold-bricked. A good rule would be not to take such a position while they already had sufficient.

(7.) It ought not to be necessary to say that doing or saying anything tending to lessen the emoluments of any medical man in any public position is against the interest of the profession and should be condemned.

(8.) It goes without saying that asking nurses or others to intercede to get a case is abominable.

(9.) Another point I wish to refer to is the habit some have of charging very low fees to those well able to pay, or neglecting to render bills for long periods, sometimes for years. This is distinctly against the interests of the profession. We in Halifax need more prompt business methods. Bills should be rendered at least quarterly. Unreasonably large bills to people in moderate circumstances are to be deplored as injurious to the profession.

(10.) There should be more investigation as to the cases treated at the Dispensary and Hospital. Of course there are the Lord's poor, the devil's poor and the poor devils. People who would consider it a disgrace to go to the poor house or receive charity in other ways, think it no shame to systematically receive free treatment and medicine. When laboring men get hurt, the idea seems to be to send them to the Hospital. In many instances a moderate fee could be paid to a private physician. One thing ought to be accepted, viz: That those getting free treatment ought not to object to clinical teaching on their cases.

(11.) Our relations with drug stores ought to be considered carefully. Percentages are out of the question. Those that parade patent medicine advertisements ought not to be patronized. Counter prescribing is too prevalent. Opticians with apparatus for measuring refractrion, including ophthalmometer, *deus ex machina,* seem to me quite out of place. Such things should be in the hands of the profession.

(12.) Our relations with specialists (including operative surgeons) are not quite satisfactory. Their direct relations with the public tend to break the connection of the family physician who I think ought to be familiar with the details of all treatment.

(13.) As regards *lodge* and *contract* practice. I have probably

had as much experience in this class of practice as any one here.

In 1885 there was not much, but now it has grown to what I would call alarming proportions. We have the I. O. F., the A. O. F., I. O. O. F., both English and American, the S. O. E., tramway and railway. The Noble Order of Red Men has not yet reached here. I roughly estimate that there are 2500 heads of families that get treatment in this way. A large number of these get medicine included. The rates are from $1. to $2.50 per year. When one considers that there are only about 8,000 heads of families it becomes apparent what a large percentage of the people get treatment at inadequate rates. They are also now beginning to include women and children in the same category.

There are some advantages in this kind of practice :

(*a.*) If an interesting case develops one can closely watch without being suspected of selfish motives.

(*b.*) In many cases persons join different orders and thus the profession gets multiple fees.

(*c.*) A spirit of provision for sickness is engendered.

(*d.*) The well, paying for the sick, is a good example of bearing one another's burdens and ought to be encouraged.

(*e.*) The pay is prompt and definite.

The disadvantages, however, far outweigh the advantages. The lodge doctor is on quite a different footing from the private practitioner. The services of the one are *demanded*, while those of the other are *asked*. One is treated cavalierly, the other respectfully. One is spoken of as "only a lodge doctor," the other is referred to as the best in the vicinity. In club practice the doctor is suspected of a tendency to slight his work. This attitude of the patient is not conducive to pleasant relations. In private practice the principle of selection secures confidence. When medicine is furnished the doctor has an additional incubus. He is judged to some extent by the amount of medicine he uses. Many members are well able to pay good fees, yet get treatment for a dollar a year. Thus the profession is robbed. True, many do not take advantage of it, but the fact that so it is cheap makes them despise the doctor and they are apt to say so to his injury. Very few employ the lodge doctor in their families. Many young doctors fondly hope they are going to get a large connection by means of them, but the general experience is they are doomed to disappointment.

In speaking of this matter to the late Dr. Slayter, he said: "Yes," but "introduces them in the wrong way." Sometimes the doctor is called for a very trifling ailment. I have seen the head of the house ill with la grippe, while the family, though quite as ill, had no treatment or took the same medicine. Some do get treatment for their families from the club doctor, but never pay him. If he insists on pay, the patient "joins the opposition" in the lodge. Others do not employ him at all, because they have no confidence or do not like him. But they hate him more because they have to pay that dollar for nothing. Dislikes and trival faults are frequently aired in the lodge and the doctor is abused and often injured in his relations with those who would ordinarily be his friends. Club practice has a tendency to break into the relations of the family physician in many cases. These clubs are a tempting bait for the young practitioner. There are always cranks in the clubs who are not pleased with the old doctor. They interview the young doctor who feels flattered. A little canvassing does the rest. But the new incumbent finds that he cannot satisfy these same gentlemen and his turn comes later. If I had a special interest in a young man I should advise him to avoid clubs entirely. For his final success, if it came at all, would be in spite of them. Many who would scorn to canvass for private patients think it no shame to solicit votes for a position as club doctor. On the whole, the profession is degraded by the practice. In England it has been established for a long time, but now there is a revolt all along the line. Many think it should be ended, all think it should be at least mended. In the B. M. J. we see every week how the battle of the clubs goes. A very important step was taken by the General Medical Council when they forbade doctors to serve any club that canvassed for members. I would like to see a general movement among us to do away with club practice. In some orders the fakir-in-chief gets $10,000 a year, while the doctors are sweated for a pittance to build the concern up. Years ago I offered to give them up if no one else would take them. Now I have given them up and shall do what I can to induce others to forego them. Finally I wish to say that I have set down naught in malice. I have been a sinner against the code in some respects, but I have taken frequent opportunities of speaking well of the brethern. Seldom have I spoken against any. When I have done so it has been by way of retaliation, but I am

aware that even this, according to highest ethical standards, cannot be defended.

To my brother practitioners I would say—we have a glorious herittage of knowledge—we are members of a profession that has some of the most illustrious names—a profession which has stood high in public estimation for its discoveries and for its beneficent work in the struggle against pain, disease and death. Surely it is unworthy of us to lower ourselves by internecine bickerings, fraternal strife and jealousies. We must respect ourselves and each other if we would maintain the respect of the public. It is the more necessary to preserve cordial relations when we consider that we have the prejudice of ignorant and foolish friends to combat, and also the apathy of the great public who only faintly apprehend the truths we have discovered The patent medicine advertisements are choking out reading matter in the daily papers and magazines until one has to chase around South African fashion to find what one wants.

In England I noted a beautiful courtesy among members of the profession. It seemed to me, at the same time, that the profession held a much higher place in public esteem than here. From all I can hear, in the United States the profession does not practice the amenities among themselves to a very great extent, and commercialism is rampant. At the same time, the profession stands lower in public estimation. Let us, as a part of the British Empire, but through propinquity prone to take up American customs, strive to remember our heritage and hand it down with even greater lustre to our successors.

Selected Articles.

PRACTICAL POINTS IN THE TREATMENT OF EMPYEMA THORACIS.*

By RUSSELL S. FOWLER, M. D., Adjunct-Surgeon to the Brooklyn Hospital; Assistant-Surgeon to the Methodist-Episcopal Hospital; Assistant-Surgeon to the German Hospital; etc.

In the treatment of empyema, the question as to whether an *anesthetic* shall be administered and, if so, what that anesthetic shall be, requires first consideration. This point must be determined in the individual case by the condition of the patient and the procedure which is to be enployed. For thoracentesis no anesthetic is necessary, or, at most, one may inject one or two drops of a ½-per cent. solution of cocaine or freeze the point of puncture with ethyl chloride. For pleurotomy alone, local anesthesia will suffice. For pleurotomy with resection of a small portion of one rib, local anesthesia will usually suffice. For pleurotomy with resection of a large portion of one rib, or of several ribs, general anesthesia will usually be necessary. For Estlander's, Schede's or Fowler's operation, a general anesthetic will be necessary. Chloroform has been heretofore considered the anesthetic of choice. The condition of the heart muscle must also be taken into account, however, as well as the lungs, and it is the author's opinion that ether is far safer in those cases in which an anesthetic is imperative. In the first place a general anesthetic is to be avoided if possible; in the second, a minimum amount of the chosen anesthetic is to be administered. Having had two cases die under the operation as a result of the administration of chloroform early in my hospital experience, it has become my routine practice to operate on all cases, except those involving extensive resection of ribs and dissection of adhesions, under local anesthesia. To those patients who require a general anesthetic, ether mixed with oxygen has been administered, irrespective of their age. In fact it has been my practice for some time past, to give ether in preference to chloroform to children,

and I have found that the latter anesthetic in admixture with oxygen has proven quite as satisfactory as far as the operation is concerned and has given far less anxiety as regards the patient. It is not denied that in the hands of a skilled anesthetist, chloroform is as safe as ether, and in some instances and for some reasons more to be desired as the anesthetic of choice; but unfortunately skilled anesthetists are rare and surely not to be obtained in a hospital service, which requires a man to serve as anesthetist for six months at most, and in some instances for but three. In one case of resection of the pleura and disection of numerous adhesions at which I assisted Dr. George R. Fowler, practically complete analgesia was obtained by means of intra-spinal cocainization.

It has been stated (*Progressive Medicine*, 1901, Vol. I., page 80) that local anesthesia is apt to prove unsatisfactory in children. In my own experience, this has not been true. In children weakened by empyema, the administration of a general anesthetic is a direct menace to their well-being. At first, I operated on these cases under chloroform, and two died; later, a weak solution of cocaine was used, and still more recently no anesthetic whatever has been employed except in secondary operations requiring the resection of more than one rib or the dissection of the thickened visceral pleura. It has been my experience that children suffering from empyema are apathetic; they lie quietly in the position in which they are placed, and, while they make some outcry at the first cut of the knife, they are too weak to move to any extent or to offer active resistance. The operation can be performed in such a short time, and if deftly done, with snch a slight amount of pain, that the administration of a general anesthetic seems unnecessary. Of course, one can only judge by one's own experience, and to me it seems best that these little patients should be exposed to as little risk as possible. The children that have not been anesthetized have done better than those to whom an anesthetic has been administered. It is to be noted that the surgeons who have an anesthetic administered, stop that anesthetic as soon as the pleural cavity has been opened. In children, if an anesthetic must be administered, ether with oxygen is used, and it has been found that by the drop method, using Dr. George R. Fowler's inhaler, anesthesia is rapidly accomplished, and a surprising small amount of ether used.

Thoracentesis may be used either as a diagnostic, palliative, or curative measure. As a diagnostic aid, it should always be employed, as it locates the pus absolutely, The statement has been made that thoracentesis is perfectly safe if carefully performed (*Progressive Medicine*, 1901, Vol. I., p. 80). My experience does not agree with this. I have had two cases under my care, in one of which exploratory thoracentesis proved fatal, and in the second produced a desperate condition of the patient. Both of these cases had been ill for several weeks with symptoms of empyema, and both gave the physical signs of empyema. The house surgeon was instructed to introduce a needle into the chest to verify the diagnosis. In the first case, no sooner was the needle introduced, in fact before the piston of the syringe had been drawn up, than the patient gave a gasp and was dead. Autopsy showed a complete involvement of the effected lung with tubercle, but no sign of any injury by the needle. The pathologist reported the heart to be normal. In the second case, on the introduction of the needle the patient began to cough up small quantities of blood, and blood was withdrawn by the syringe. The patient at once collapsed, the respirations became shallow and the pulse imperceptible, and it was only by the most rigorous stimulation that she rallied. Experience of this kind, however, must not deter us from employing thoracentesis. These cases are simply introduced here to demonstrate that even this comparatively simple procedure is not unattended by risk. Not only does thoracentesis locate the pus, but it shows its character, and hence we are able to form an estimate as to how extensive a procedure will be necessary, and it will also aid in the prognosis. If the fluid is thin pus with thin shreds of fibrin in it, of slight or no odor, particularly if there has been a history of pneumonia, then the case is probably one of the pneumococcus empyema. In tubercular cases the pus is thin and contains many whitish shreds of fibrin. Should the fluid be markedly purulent, the staphylococcus and streptococcus, particularly the former, will be found predominating. Should the staphylococcus and streptococcus be largely predominating, the pus will be thick and yellow, with twings of green, but with slight odor. Should putrefaction have occurred, the pus will be thick, greenish with yellow and brown admixed and of a strongly fetid odor. Much more could be written on the clinical aspect of the pus.

Thoracentesis may prove curative in exceptional cases. Should the nfection be due to the pneumococcus for the most part, a cure may

be expected by a thorough evacuation of all the fluid; always providing, however, that secondary infection by some more virulent organism does not take place. Several cases of typhoid empyema have been reported cured following the withdrawal of the fluid. In this last connection it is well to remember that several cases of typhoid empyema have been reported as recovering spontaneously, the pus being absorbed. It is only in exceptional cases that such a result is to be looked for, and thoracentesis must remain for the present as a diagnostic and palliative but not as a curative procedure.

As a palliative procedure, thoracentesis is frequently employed with most beneficial results. Cases in which the pleural tension is extreme should be aspirated without delay. This should also be done in the very septic and much weakened patients. The amount of fluid withdrawn and the rapidity of its withdrawal depend upon the condition of the patient. If the patient becomes faint or if coughing is set up, then proceed more slowly, or stop entirely. It is not necessary to withdraw the entire amount of fluid at one sitting. By proceeding in this way, we improve the desperate condition of the patient somewhat, decrease the amount of septic absorption and gain a few days in which, by forced elimination and stimulation, the patient's condition may be so much improved as to permit of a more radical procedure with a less degree of danger than before. It will be found that cases in which the pleural tension is great take an anesthetic better if preliminary paracentesis is performed. This should be done several hours before the operation.

Time to Operate.—These cases should be operated upon or at least thoracentesis should be performed as soon as the diagnosis is established. Every hour that septic fluid is allowed to remain in the pleural sac compressing the lung makes against a good final result. Empyema is essentially a surgical disease and internal medication is unavailing in its cure. These cases are apt to die suddenly, so they should have the benefit of surgical intervention at the earliest possible moment.

The *preparation of the patient* for operation must be done carefully. These cases are much debilitated by septic absorption and all unnecessary shock and exposure are to be avoided. It is better to prepare them in bed and only disinfect that portion of the chest which is in the immediate vicinity of the operation. Dry sterile compresses are applied to prevent reinfection. Care is taken that the disinfecting

fluids do not wet any portion of the patient save the area to be cleansed. In very delicate children, the legs and abdomen are to be enveloped in warm cotton. All parts of the body save the chest on the affected side are to be protected from chill. No scrubbing or further disinfection is to be done on the operating table.

The Position of the Patient.—This will depend on the operative procedure to be employed. It is essential, however, that the patient rest as little as possible on the sound side, as this still further embarrasses respiration; nor should it be left to the patient to support himself in the required position. All parts of the body should be at rest,and no muscular strain whatsoever put upon him. This is accomplished by the aid of soft pillows. The simpler operations can be performed with the patient flat on the back, with the affected side extending somewhat beyond the edge of the table. The affected side is further made prominent by a flat sand-bag, while the sound side is supported by soft pillows. The arms should be placed naturally above the head. If no anesthetic is given, everything is done to reassure the patient, and the operation conducted in a quiet and orderly manner. The operator sits on a low stool with his head on a level with the field of operation. In the more extensive procedure it may be necessary to turn the patient so that he rests more upon the sound side, but even in these cases much can be done with the patient in the dorsal position and the side projecting over the edge of the table. Especially is this true if artificial light is reflected directly into the cavity.

The Location of the Incision.—It is not necessary to reach the very bottom of the cavity in dealing with empyema, for what is the bottom of the cavity on the day of operation is the next day pushed up to the level of the seventh rib by the action of the diaphragm. Therefore, if pleurotomy is performed at the level of the sixth rib, one may hope for the best result.

Except in those cases in which simple pleurotomy is indicated, either because of the desperate condition of the patient, of by reason of the acuteness of the process, the character of the effusion and the likelihood of the rapid expansion of the lung, the opening in the chest wall should be sufficient to allow one to introduce the finger. The pus is allowed to escape slowly, the patient being turned toward the affected side to facilitate this. The escape of pus is aided by the patient's attempt at coughing, but this should be avoided as it causes

the fluid to escape too rapidly, thus forming a vapid vascularization of the affected lung and the adhesions and granulations covering it. This may result in quite marked hemorrhage. The finger is then introduced, and the size of the cavity noted, also the ascent of the diaphragm, the descent of the lung, and the amount of granulative tissue and adhesions. If masses of fibrin are present, these are hooked out with the finger aided by a broad bladed pair of forceps. Stick sponges may be gently used to clean the cavity of all masses of fibrin. The question as to whether adhesions should be broken up with the finger is one that must be decided by the individual operator. To break up adhesions through a small incision, and in the dark, as it were, may become a serious matter. The probabilities are that a lung which is bound down by adhesions tense and unresisting enough to require tearing with the fingers at the depth of a cavity and unaided by sight, will ultimately require a pleurectomy to free it, while on the other hand, if the adhesions are not dense, lung gymnastics will ultimately cause the lung to expand and consequently the forcible loosening of such adhesions with the finger is unnecessary. To say the least, such a procedure is fraught with danger.

As to washing out the cavity, that may be left till the next day. It is unnecessary to increase the shock by irrigation at the time of operation. It should not be necessary then, if the cavity has been completely cleansed of masses of fibrin, except in cases of primary putrid empyema or in those which through neglect of the ordinary rules of asepsis become infected secondarily.

Drainage.—It is presumed that the operation has completely emptied the pleural cavity of pus and masses of fibrous exudate. In very recent cases in children, in which the lung completely expands at the time of the operation, simply packing the wound with gauze may be sufficient. Such cases are rare. In most cases, it will be necessary to employ a rubber drainage tube. There are many ways of arranging this tube. The tube may be slender, fenestrated, curved on itself, the coils held in place by thick strands of catgut, thus forming a mat which rests on the floor of the cavity, the proximal end of the tube emerging from the opening; or it may be short and thick and simply serve to preserve an opening in the chest wall through which the secretion may escape. Various other methods of placing the tube are used, but the above represent the two extremes. Care must be taken that the tube does not press upon the lung or injury may result. The

tube may be retained in place by passing a large safety pin through its walls, but not through its lumen close to the chest wall. A piece of tape is passed through the pin, and fastened around the chest. The tube at its entrance into the chest wall is surrounded with gauze. If the pus be thin and no fibrous deposits are present, the coiled tube or a tube which lies at the bottom of the cavity during the ordinary movements of the patient may be employed. The dressing around the tube is fastened in place by a chest binder through which an aperture has been provided for the emergence of the tube. To the chest tube a long tube is connected, the distal end of which is submerged in a basin or bottle of bichlorid of mercury (1-1000) placed beside the bed. The respiratory movements of the affected lung or its fellows will cause the antiseptic solution to rise and fall in the tube and this will aid the pus to flow down the tube and into the solution, keeping the cavity thoroughly drained, and by keeping the chest dressing clean, allow of ready closure of the thoracic wound around the tube. The catgut on the coiled tube loosens in from three to six days and the tube may then be withdrawn, by gentle traction, and if the discharge is profuse be replaced by a short drainage tube. If the coiled tube has been properly arranged changing the chest dressing will not have been necessary until the tube is changed.

If the pus be thick or if fibrous deposits are present, a thick walled tube of larger calibre will be used, which will project but slightly into the cavity. Such a tube may be sewn into the wound by stitches including its wall, but not encroaching on its lumen, or may be fastened by tapes as described above. A copious gauze dressing is applied to receive the discharges. This dressing should be changed as frequently as soiled and each removal of dressing should be done with aseptic care. This large tube may be connected with a bottle as described above.

Position of the patient.—Such patients are not allowed to sit up for at least twenty-four hours. Indeed, they should resume the sitting position by degrees. They are, as a rule, emaciated by long illness. Their respiratory and circulatory apparatus has experienced a shock, and a sudden change in position may produce severe and even fatal syncope. Even during the first few hours however, the head and trunk may be gradually elevated to ensure more efficient drainage by causing deeper respirations. The patient is encouraged to lie on the diseased side as much as possible, and to assume such positions as will

provide the most efficient drainage in order to prevent stagnation of secretions.

Significance of fever.—Rise in temperature, if it occurs early in the first forty-eight hours following the operation, may be due to the supervening of pneumonia or the extension of latent or subsiding pneumonia. The history would lead us to expect such a complication. If pulmonary tuberculosis existed prior to the operation, an acute process may be grafted on the already existing chronic one. By far the most common cause of fever, however, will be stagnation of the secretions. This is to be avoided as outlined above. If, however, the thick pus refuses to flow from the tube, it will be necessary to employ irrigation of the cavity. An empyema should be kept as fresh and clean as we would keep an abscess occurring elsewhere. A well placed drain and a favorable position of the patient will usually accomplish this. Irrigation is only to be used in cases which refuse to drain by the ordinary methods. The temperature of the irrigating fluid should be 100° F. to avoid shock and a sufficient amount of the fluid, at least one quart, employed to thoroughly cleanse the cavity. Solutions of carbolic or bichloride of mercury are to be avoided. Normal saline solutions or boro-salicylic acid solution (Thiersch) may be employed. If masses of fibrinous exudate persist they are to be removed by long handled blunt forceps. This disintegration may be facilitated by the use of small quantities of neutralized peroxide of hydrogen injected through the tube.

In case several sacculations or cavities are present these can be drained through separate tubes or may be converted into one cavity. If drainage is properly provided for and if no complications such as pneumonia supervene, or if the case is not a tubercular one, the temperature soon reaches normal. The amount of shock will depend upon the previous condition of the patient, the acuteness of the process, and somewhat upon the rapidity with which the cavity has been emptied. It will be greater in those cases in which irrigation has been used. It is to be looked for in all cases and combated by the usual means. Hemorrhage may occasionally occur from an improperly ligated intercostal artery; rarely from the cavity itself, unless extensive adhesions have been disturbed either by manipulation or by too rapid emptying of the cavity. In the former case, the bleeding vessel must be sought for and ligated; in the latter if excessive, the temporary

closure of the opening in the chest will control the hemorrhage. This is effected by strapping a compress over the opening.

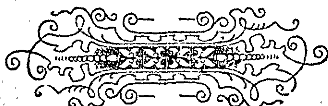
Lung gymnastics.—The patient is to be gotten out of bed and in the open air as soon as he is able to move about. He is early instructed in the use of the water bottles in order to expand the lung as quickly as possible. The longer expansion of the lungs is neglected, the more difficult it will become, as the adhesions will become more dense.

Duration of healing.—In acute cases, the lung expands readily as a rule, and the cavity quickly closes. In babies, the process may take from fourteen to twenty-one days. The longer the duration of the empyema, the longer will the cavity persist. In long standing cases, as those in which tubercular infection is superadded, an extremely long after-course is to be expected. In such cases, means other than gymnastics must be considered with a view of obliterating the cavity.

Secondary scoliosis.—As a result of the approximation of the ribs of the affected side, by reason of the lack of necessity for the muscular apparatus of that side to take part in the respiratory act, the dorsal portion of the spine becomes scoliosed with the concavity of the deformity toward the affected side. Compensatory curves in the cervical and dorsal region will follow in time. These deformities will disappear in case the lung can be subsequently made to expand.

Fistula following empyema—This is frequently met with in those cases in which a system of lung gymnastics has not been thoroughly carried out, in those cases in which the empyema has been present for a long time and many adhesions have formed, and in tubercular cases. Fistula may also be caused by a retained drainage tube. Here, as in operations upon the ribs alone, necrosis may cause the fistula to persist. Should the fistula persist eight weeks after an operation for empyema its cause must be ascertained. A thorough examination of the patient will reveal any tubercular disease. The general condition is to be improved as much as possible, lung gymnastics are continued, and cleansing and disinfection of the cavity with breaking up of adhesions with the finger or blunt curette done. Should the cavity still persist, several courses are open to us, with the view of obliterating the cavity. Either the chest wall can be sunk in by an extensive resection of the rib overlying it (*Estlander's* or *Schede's* operations) or the affected pleura can be resected, removing with it the dense adhesions and thus freeing the lung (*Fowler's* operations) or a combination of these methods may be employed. If a retained

drainage tube is the cause, removal of this will usually suffice for a cure. Operative methods should not be resorted to until it is seen that the cavity will not close by nature's aid alone. Nature tends to close such cavities by expansion of the lung on the diseased side, by expansion of the opposite lung, by the increased rise of the diaphragm upon the diseased side and by a narrowing of the intercostal spaces by a gradually encroaching of the ribs until finally they may even overlap. Not all cases can be cured even by extensive operations, and in obstinate cases several operations may be necessary. These cases make poor subjects for operation by reason of the long period of suppuration and the possible tubercular diathesis. *Brooklyn Medical Journal.*



Correspondence.

A HALIFAX DOCTOR ABROAD.

GRAND HOTEL, CURHAUS,
Davos Platz,
Switzerland.

DEAR SIR,—Possibly some personal impressions of this well known place may not be without interest for your readers.

Being in the city of Zurich I decided on making the journey here, and in addition to its medical interest, the visit has well repaid me.

The railway passes first along the border of the beautiful lake of Zurich and later skirts the margin of the smaller, but much grander, lake of Walenstadt, with its lofty rugged peaks arising abruptly from the water's edge.

At the little village of Landquart we take the narrow gauge railway and ascend a continuous grade, making the thirty miles in a little less than three hours, and gradually leaving a region of green grass and blossoming fruit trees for one of snow and stately spruces. Arriving in a snow-storm I soon found myself located in a most comfortable hotel and sat down to a dinner, including among other good things ripe strawberries.

The two villages of Davos Dorf and Davos Platz, now forming one community of about 8,000 people, are situated in a long valley about 5,000 feet above the level of the sea, and completely enclosed by mountains rising from two to three thousand feet above them.

Although it is usually thought that this was the starting point of the so-called open air cure for consumption, this is not strictly true. To a Dr. Breymer, of Gorbersdorf, in northern Germany belongs the credit of inaugurating the treatment, and it was not until about 1860 that Dr. Spengler proved the superiority of Davos—since become so famous. The special features claimed are high altitude, dryness, steady cold, absence of wind and a large amount of sunshine.

As to whether these are absolutely essential points, or whether as is being now claimed just as good results can be had without them, I

will not express an opinion. Naturally authorities here have only one view and I must say that it would seem reasonable that, although good results may be obtained elsewhere, they can hardly be as quickly, as surely and as markedly realized as in this or some place having similar conditions.

Davos may be said to consist of hotels, pensions (the continental synonym for boarding houses) and sanatoria. Of course there are the houses of the people, shops, churches, etc., but they are a secondary consideration. It is a bright attractive place, and in winter with the snow and bright sun and the crowds of visitors must be much more so.

The season extends from October to April and is now about finished. From three to five thousand people come here each season, and of these about two-thirds are estimated to come for the purpose of "taking the cure." The others are attracted chiefly by the winter sports which are to be had in perfection, including skating, sleigh-driving, curling, coasting and ski-running. Their presence is regarded by the doctors as a disadvantage, as patients are far too apt to be led away into taking too great exertion.

The first thing that strikes one on coming here is that sick and well are associated together in the hotels. For instance—of about sixty people at present in the hotel where I am, at least fifty are taking the "cure." This is especially true of Englishmen who for some reason avoid the sanatoria.* The explanation probably is that the hotels were originally built for the sick and not for the well as the name of this hotel indicates—"Curhaus" meaning "Cure House." Every hotel and pension is provided with extensive balconies on which the hours of "cure" are passed.

There are eight sanatoria proper; four in Davos Platz; two in Davos Dorf, and two about a mile away from the village. The two latter are supported, one by the city of Basle for Swiss patients; the other by the Dutch for the people of that nationality. In both of them patients are required to pay from two to five francs per day, if able. Of these institutions I have visited five, and was everywhere received most cordially. The original one is known as Dr. Turban's and is still conducted by him. The most recent and best equipped is the "Schatzalp." It has only been open about a year. It is built at a point on the side of a mountain of the same name 1,000 feet above the

* I find this the accepted spelling here and not *sanitaria*.

valley; accommodates one hundred and ten patients. It is modern and up-to-date in every respect, and with the Funicular Railway and winding carriage road up the mountain is said to have cost about one and a half million francs—so there must be money in the business yet. All of the institutions are constructed on the same general plan, being essentially hotels with long, wide verandahs, facing the south, and in many cases having private balconies connected with some of the rooms for special patients.

On these verandahs the institution furnishes wicker-work reclining chairs, with mattress—the patient has to provide his sleeping bag and blankets, and here it is that the most of his time is passed—no degree of cold being allowed to interfere with the regular hours of "cure." The day's routine is about as follows, each patient having, however, his particular card of instructions to guide him:

Rise about 7.30. Before rising take a glass of milk. Have rubbing, and (if able) shower bath. Then breakfast. Walk, (as much as allowed.) Glass of milk. Take the cure 11.30 to 1. Second breakfast or dinner. Take the cure 2.30 to 4, with absolute silence. At 4 o'clock a glass of milk. Then walk again as directed, or rest. 6 to 7 take the cure. At 7, evening meal. Then correspondence or amusement. 8.30 to 9.30 take the cure. Then take glass of milk and go to bed at 10 o'clock. This goes on day in and day out, for months.

As far as I can learn, cod liver oil, maltine and all medicines are abandoned. For cough all say codeine in some simple form of syrup is best. For sleep, sedatives only in extreme cases. For fever, occasionally antipyretics if rest in bed fails. All use baths given with hose and spray if patient can stand them, commenced warm and cooled down, given by male or female nurse, but one of the doctors always present; rubbing before and after. Hetol three times a week, injected into vein in bend of elbow, is praised by some, but they admit that it only does good in certain cases, and one doctor told me it did most good in nervous patients and was probably psychic mostly. Some still use tuberculin, but the whole drift of opinion is against use of medicine and in favor of reliance upon the cure alone. Food is plain, milk, eggs, meat, green vegetables, cooked fruits, etc.

As to results, of course it is very difficult to get an unbiased opinion. Everyone here is dependent more or less directly upon the presence of the patients in the town.

The sanatorias are owned by joint stock companies in which the

doctors, generally, are shareholders, as well as hotel keepers and other residents.

As far as I could judge by talking to doctors, druggists, patients, sanatoria managers and others, a good majority of patients who came here got well, or, at least, improved.

The usual period of stay is about six months, though they often return again for further period of cure.

The doctors recommend patients to remain during summer as well, but not many do, preferring to go away for a change and to return if necessary. As to new sanatorium cases, they are treated in hotels and pensions by the medical men of the place, and if they have strength of will enough to obey instructions, they possibly do just as well; but for the young and probably for most others, the institution would seem to have advantages not to had outside.

All patients are weighed once a month and a regular examination of chest is made at like interval. They take and record their own temperature from three to six times daily. Throat and nose conditions are carefully examined and treated.

It seems to be admitted that Davos is not likely to retain the preeminence which it has hitherto held in Europe, on account of the establishment of the "cure" in so many other places—but it has a a strong advantage in its reputation.

At present Germans form the largest number of patients. English probably come next. There are many Portugese and some Russians, but all nationalities are represented. My next door neighbour, now at table, is from New Zealand, and at one of the sanatoria I was asked about a young Haligonian who was here last winter.

As to the cases suitable for treatment, of course the earlier in the disease the patient comes, the greater the chances of cure. The stage of softening, however, is not considered to contraindicate hopeful treatment, and even the presence of cavities in one lung, provided the other one is in good condition.

Personally I may say that I feel more impressed with the hopefulness of good results from the treatment than I did before coming here. Also that the importance of early diagnosis is to be specially insisted on and the immediate use of and long continuance of the means enforced. Considering the results to be had in less favored places than this I would say, as in fact I have done already, that while they are not likely to be as good as if patients could be sent

here, or to some similarly circumstanced place, still this should not prevent our adopting the plan of treatment to the best of the means at our command.

The two public institutions here are just in line with the plan proposed in Nova Scotia. They each accommodate about eighty patients and I think are kept full.

The town regulations as to contagion are very strict. Every person who receives a stranger into his house—be it sanatorium, hotel or pension must notify the authorities, and if such person be sick he must again notify his departure, when an inspector is sent to disinfect the house with formalin. Frequent notices on streets, in German, French and English, warn against expectoration. Water supply is good, and drainage is well looked after. Modern water-closets and bath-rooms are provided and insisted on.

Hotels here are very good and charges very moderate, considering that everything, including fuel, has to be brought up the mountains.

At pensions the rate varies from five to twelve francs per day.

At sanatoria they charge from ten to fifteen francs. This includes medical services, baths, rubbing, and everything except washing. There is a public laundry with a disinfecting plant attached.

A subscription library provides all latest books. Town furnishes music, and everything is done to make time pass for the unwilling sojourners.

I go from here to Vienna where I expect to spend some time seeing the hospitals for which it is famous.

Yours,

May 9th, 1902. J. F. B.

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THE
MARITIME MEDICAL NEWS.
A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

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Editorial.

THE CANADIAN MEDICAL ACT, 1902.

In many respects, perhaps, the most noteworthy legislation passed by the Parliament of Canada during the recent session was the above named Act, which makes provision for a qualification in medicine enabling the holders thereof to practice in all the provinces of Canada.

Ever since Confederation strenuous efforts have been made to overcome the disabilities occasioned by the regulation of the study and the practice of medicine being subject to provincial control. At one period it was hoped that a scheme of inter-provincial reciprocity would be adopted, but like previous efforts it ended in failure. The collapse of the reciprocity movement inspired Dr. Roddick of Montreal to advocate a measure which had hitherto been regarded as impracticable.

Being assured by eminent constitutional lawyers that certain sections of the Confederation Act would permit the Dominion Parliament to regulate the practice of medicine, without trenching upon provincial rights, he set about to work out the details of a measure that would be acceptable to all parts of the country and to secure its adoption by the Commons and Senate of Canada.

Dr. Roddick has given much time and an infinite amount of labour to attain this object. He has visited all the provinces of Canada, many several times, with a view of dispelling objections and obtaining suggestions.

It is a well known fact that the chief reason which induced the

genial Doctor to enter upon a political life was the conviction that his presence in Parliament was essential to secure the adoption of the legislation which he had mapped out. His labours have been crowned with success, and a measure has been passed by Parliament without encountering serious opposition, which will be of inestimable value to the medical profession of Canada.

It is important to note that Dr. Roddick's bill cannot come into operation until it is endorsed by the medical boards of all the provinces, and legislation is obtained to recognize registration under its provisions as being equivalent to that obtained under provincial law. The refusal of one province to take this step will postpone the operation of the Act indefinitely. It is probable that the reason for this somewhat objectionable feature of the bill is that in no other way is it possible to secure recognition of a Canadian qualification by the Medical Council of Great Britain.

It is not likely that any opposition will be offered to the Act in the Maritime Provinces, and the necessary legislation can be obtained without difficulty. Hearty approval of the measure, by the various medical societies which meet next month, would strengthen the hands of the medical boards and materially lessen the risk of hostile opposition in the local legislatures.

The Act of course is not an ideal one,—too many conflicting interests had to be reconciled and provincial rights carefully guarded. Looked at in the light of these numerous difficulties, we regard the bill as being far in advance of any scheme hitherto proposed, and reflecting the highest credit upon Dr. Roddick who has been mainly instrumental in securing its adoption.

MEDICAL SOCIETY OF NOVA SCOTIA.

The programme in full of the approaching meeting at New Glasgow is as follows:

WEDNESDAY, July 2, 1902.

2 p. m.

Meeting called to order.
Registration.
Report of the Committee of Arrangements.
Reading of Minutes of last meeting, etc.

Reports of Committees.
Appointment of Nominating Committee.
Appointment of Members to serve on Provincial Medical Board (triennial election).

PAPERS.

1.—On Several Inconsistencies - - - - Dr. H. P. Clay, Pugwash.
2.—Insomnia, with Some Suggestions for Treatment, - - - - - - - - - - Dr. H. H. MacKay, New Glasgow.
3.—(Case reports.) - - - - - - - Dr. E. D. Farrell, Halifax.
a. Suprapubic Cystotomy.
b. Abscess of the Lung.
4.—Report on a Case of Cystitis, - - - Dr. H. P. Clay, Pugwash.
5.—A Short Report of Two Unusual Cases, - Dr. J. N. Mack, Halifax.

8 p. m. Evening Session.

PUBLIC MEETING.

1.—The Presidential Address, - Dr. John W. MacKay, New Glasgow.
2.—On Vaccination, - - - - - - - Dr. A. P. Reid, Middleton.
The reading of this paper will be followed by a discussion, in which Dr. Halliday, Gov't Bacteriologist; Dr. M. Chisholm, Dr. W. B. Moore, Dr. DeWitt, and others, will take part.
3.—Examination of Water, Chemical and Bacteriological, - - - - - - - - - - - - Dr. A. Halliday, Halifax.

THURSDAY, July 3.

9 a. m. Morning Session.

Report of the Nominating Committee.
1.—The Address in Surgery, - - - Prof. G. E. Armstrong, Montreal.
2.—A Case of Malignant Œdema: recovery, - Dr. M. Chisholm, Halifax.
3.—A Series of Laparotomies, - - - Dr. T. J. F. Murphy, Halifax
4.—The Treatment of Puerperal Sepsis, - Dr. Ernest Kendall, Sydney.

2 p. m. Afternoon Session.

1.—The Address in Medicine, - - - Prof. F. G. Finlay, Montreal.
2.—Mental Disturbances during the Puerperium, - - - - - - - - Dr. W. H. Hattie, Sup't N. S. Hospital.
3.—Gall Stone Disease, - - - - - - Dr. M. A. B. Smith, Halifax.

4.—Senile Peritoneal Tuberculosis, - - - - DR. ARTHUR BIRT, Berwick.
5.—Albuminuric Retinitis, - - - - DR. G. H. COX, New Glasgow.
6.—Some Indications for the Use of Arsenic and Sodium Benzoate, - - - - - - - - - - DR. E. KENNEDY, New Glasgow.

7 p. m. Evening Session.

1.—Note on the Treatment of Enuresis, - - DR. D. A. CAMPBELL, Halifax.
2.—Notes on Small-Pox, - - - - - - DR. W. B. MOORE, Kentville.
3.—On the Relation of the General Practitioner to the Physical Life and Development of our Youth, - DR. J. A. SPONAGLE, Middleton.
4.—On Phlegmasia Alba Dolens, - - - - DR. J. K. MUNRO, Lockeport.

9 P. M., BANQUET.

RAILWAY ARRANGEMENTS.

INTERCOLONIAL RAILWAY.

If ten or more delegates attend the meeting and purchase ten or more first class full fare one way tickets, and obtain at the starting point a Standard Certificate, they will be entitled on the presentation of such Certificate duly filled in and signed by the Secretary, to the Agent at New Glasgow, to free tickets for the return journey. "Certificates will be honoured up to and including three days after the close of the meeting."

DOMINION ATLANTIC RAILWAY:

Tickets can be obtained on the same conditions as on I. C. R.

CENTRAL RAILWAY CO., Ltd.:

Sells tickets to Windsor Junction on the Standard Certificate Plan, but does not issue tickets to points on the I. C. R.

THE MIDLAND RAILWAY CO., Ltd.:

Grant similar concessions on their line, to and from Truro.

INVERNESS & RICHMOND RAILWAY CO.

Grant similar rates to delegates, good going June 30 to July 3, returning up to and including July 5.

This meeting should be a record-breaker, not only in attendance, but in the benefits derived both socially and intellectually.

N. B.—Please read Notice at top of Standard Certificate.

MARITIME MEDICAL ASSOCIATION MEETING.

The association meets this year in the historic city of Charlottetown, situated on the Hillsborough River, in the Province of Prince Edward Island. The local committee will do all that is possible to make the meeting interesting and entertaining, and we trust that the attendance from the three provinces will be larger than on any previous occasion. The president, Dr. F. P. Taylor, will doubtless do all in his power as successor to the late lamented Dr. W. S. Muir, who presided so ably at Halifax last year. We hope the medical practitioners of the island province will show their appreciation of the benefits of mutual intercourse by attending in full force. Prince Edward Island at this season of the year is most attractive to visitors and tourists, and a drive through the rural districts will impart health and vigor to practitioners whose toil and labor entitles them to a holiday trip. Hotel accommodations are ample in the city; "Hotel Davis," "Queen Hotel," "Revere Hotel." "The Ocean House," the "Alexandra" and several others, prices ranging from $1 to $2 per day.

Men of Nova Scotia and New Brunswick—buckle on your travelling costumes and start for the island on the 8th of July. The steamer "Princess," from Pictou, and the steamer "Northumberland," from Point Duchene, are charming boats, with excellent commanders and attentive officers to cater to the wants and comforts of the travelling public.

Many old faces will be missed—many we shook hands with in the past have since passed over to the majority. This will serve as a reminder that an opportunity once lost can never be regained. Now we have the opportunity of going and renew and form acquaintances, as doubtless we will all never be able to meet at St. John next year. Some one will be missing whose vacant chair tells the old story. The battle of life must go on, and those who are left must realize that the great object of life is not to make money and hoard it up—for heirs to quarrel over. Take a well-earned recreation and enjoy a pleasant trip to the garden of the gulf—if not of all Canada. Come one and all and take your wives and daughters with you, and you will return to the active duties of life with better health and

vigor by spending a few days inhaling the healthy sea breezes on the shores of Prince Edward Island.

A portion of the programme has been already published (see May number.) Other papers promised and subjects of discussion are the following:

Presidential Address, - - - - - - F. P. TAYLOR, Charlottetown.
H. D. HAMILTON, Montreal, - - - - Laryngeal Cases in Practice.
J. J. McGEE, St. John, - - - The Mouth as an Index of Health.
JAMES ROSS, Halifax, Further Notes on Treatment of Prostatic Affections
J. A. MACKENZIE, Dartmouth, - - - - - - - - -
- - - The Mental Disturbances of Puberty and the Menopause.
H. D. WEAVER, Halifax, - - - - Therapeutics of the X-Rays.
F. F. KELLY, Charlottetown, - - - - - - - - Case Report.
T. A. STODDARD, Pueblo, Colorado, - - - - - - - - - -
- - - - Some of the Mistakes of Surgical Gynecology.
G. E. DEWITT, Wolfville, N. S., - - - - - - - - - -
- - Two Cases of Appendicitis Without Surgical Interference.
N. S. FRASER, St. John's Nfld. - - - Case of Rupture of the Uterus.
Discussions; Ethics, - - Opened by Dr. R. MACNEILL, Charlottetown.
Cancer; - - - - - - - Opened by P. CONROY, Charlottetown.

Among the Social events promised are the following:

"At Home" at Government House from 4 to 6 p. m. on July 9th.

A drive on the afternoon of July 10th

A "Smoking Concert" at the Orderly Rooms of the Drill Hall at 9 p. m. on Thursday evening.

The usual reduced fares on railways and steamers have been arranged.

THE MUIR MEMORIAL FUND.

In reference to the Muir Memorial Fund we have recently received a letter from Dr. E. A. Randall, Truro, from which we are pleased to quote the following:

"The Muir Memorial Fund has reached $1030.00 by $1.00 subscriptions, and still a few coming in every day, although I think the small amounts are nearly all in. I believe there are many of Dr. Will's friends who will wish to supplement this sum with larger subscriptions. From this time on there will be no limit as to amount

of subscriptions. If his friends among the medical profession in Halifax wish to give us a donation, we shall be glad to get it, either in a lump sum or individually just as they see fit."

Now that we are privileged to subscribe a larger amount than one dollar individually, we feel that the profession in this city particularly will gladly aid this worthy object. Any subscriptions to this fund can be forwarded to Dr. E. A. Kirkpatrick of this city, or to the editor of the NEWS.

EDITORIAL NOTES.

MAJOR G. C. JONES.—A few lines from Dr. G. C. Jones, at present with the Canadian Field Hospital, South Africa, contains the following: "Poor W. S. Muir—I was so shocked I have no heart to write anything for the Medical Society, now that he is gone."

THE LAURENTIAN SANATORIUM.—This well known institution at St. Agathe was unfortunately burned to the ground last month and one lady lost her life. While sympathizing with the director, Dr. A. J. Richer in such a calamity, we well know that the new buildings will be most modern in every particular and thus prove of even greater service in the treatment of tubercular cases.

Matters Personal and Impersonal.

A number of medical men of this province have entered into the holy bonds of matrimony this month, to whom the NEWS offers its sincere congratulations. Those noticed in the public press are the following:

June 2nd, Dr. Wm. H. Eager, of Barton, to Miss Constance Hill, of Dartmouth. (Miss Hill had been recently a very efficient nurse at the Victoria General Hospital.)

June 4th, Dr. Geo. G. Gandier, of Pictou, to Miss Annie L. Dickson formerly of St. John.

June 11th, Dr. H. H. MacKay, of New Glasgow, to Miss Christina Y. Miller, of St. John. (Miss Miller was formerly a capable nurse at the Aberdeen Hospital, New Glasgow.)

June 11th, Dr. L. B. W. Braine, of Hackett's Cove, to Miss Jessie E. Graham, of Bear River.

June 11th, Dr. C. H. Baltzer, of Middleton, to Miss Lyda E. Waterman, of North Brooklyn.

June 11th, Dr. T. M. O'Sullivan, of Glace Bay, to Miss Cassie MacLean, of Antigonish.

Dr. G. P. Girdwood has lately resigned his position as Professor of Chemistry on the Medical Faculty of McGill University. Dr. R. F. Ruttan, Professor of Practical Chemistry, and who so efficiently assisted Dr. Girdwood as lecturer for a number of years, has been appointed to the chair.

Dr. W. W. White, of St. John,—we omitted to state in our last issue—was elected in April in the mayoralty contest by a very large majority.

Dr. A. W. H. Lindsay, of this city, has lately returned from a pleasant trip to Baltimore and Boston. At the former city he attended the closing exercises of the Johns Hopkins University where his nephew received the degree of Doctor of Philosophy.

In Special Sessions on last Thursday before Justices Wyatt, McKean and Hinsdale, Clarence D. Bowman, a director of the Lewis A. Bates Company, and the manager of their drug store in No. 739 Sixth avenue, pleaded guilty to having violated section No. 364 of the Penal Code in using another preparation in place of essence of pepsin manufactured by Fairchild Brothers & Foster in filling prescriptions calling for the latter preparation. He was fined $50.

It appeared that on several occasions when physicians had prescribed Fairchild's Pepsin, Bowman had delivered the imitation mixture. Bowman said he was sorry for what he had done, but had no excuse to offer. In imposing sentence Justice Wyatt said that the offence was a most serious one, and that a heavier penalty would have been imposed had not the injured firm recommended leniency by reason of its being the defendant's first conviction.—*New York Press*, May 24th, 1902.

Society Meetings.

NOVA SCOTIA BRANCH BRITISH MEDICAL ASSOCIATION.

March 19th, 1902. Dr. T. W. Walsh, President in the chair.

Dr. Ross presented a case of leucoderma in a girl aged 16 years, several small patches being present on the face and neck, and also on one side of the face a thickened condition resembling the early stage of scleroderma. This latter condition had been treated by galvanism for some weeks at intervals of two or three days which resulted in diminishing the thickness very much.

Dr. Goodwin then read a paper on "Medical Ethics." (Published on page 194 of this issue.)

Dr. Cunningham complimented Dr. Goodwin on his paper. There was great improvement in the profession since his early days. Reference was made to the way doctors were treated when he was a beginner and he related some interesting examples. He considered much of the improvement due to such meetings as those of the branch of the British Medical Association.

Dr. Kirkpatrick said he would not treat of the relations of the specialists to one another and to the general practitioner, but thought that it would be well to discuss club practice which he thought might be done away with to a great extent. He also referred to the death of the late Dr. W. S. Muir who had done so much to elevate the tone of the profession.

Dr. G. M. Campbell endorsed what Dr. Goodwin said about club practice. However, he did not think many club patients could pay full fees. His club patients did not give him mbch trouble. He had not gained many families through club practice and did not care much for those he had gained.

Dr. C D. Murray referred to the advertisements of specialists, while advertising among the general practitioners was practically now unknown. The specialists, however, must be a law unto themselves. In reference to club practice he would prefer to see adopted the custom of the National Aid Society which allowed the employment of any doctor and paid him a stated fee per visit. He would be

willing to give up any clubs he held when he was assured they would not be taken by any other practitioner.

Dr. Mader advocated a scale of fees especially for confinements where he finds difficulty in collecting more than the minimum fee. He thought we were ahead of other cities ethically. Often the actions of physicians are misconstrued, and patients' and friends' stories are unreliable. He thought a word from this society would correct abuses of drug stores. It would be well for clubs to be held by men of less than three years' practice. Specialists are the greatest sinners ethically, as patients run from one to another with lies and then passions are aroused.

Dr Ross spoke of office practice and the difficulty of refusing patients of other men. He made it a rule to notify the other man when such cases occur.

Dr. Murphy said in France specialists were allowed to attend patients of a family doctor without letting him know. This was often reasonable. He was much opposed to medical men trying to cut down emoluments of other medical men holding public offices. These emoluments were already too low, and the positions were few.

Dr. Chisholm thought Dr. Ross did not go far enough in his requirements for a doctor who is called to the case of another man. Some men seem satisfied to send word to the practitioner that he is not wanted any more. This is neither etiquette nor ethics. He should meet him in consultation. In office cases judgment and charity should prevail. When a man begins practice he may not know much about ethics and may thus err. He can, however, always be guided by the Golden Rule. Referring to the question of the City Medical Officer, he (Dr. C.) considered his actions were justified but misunderstood. The Board of Health were endeavoring to create a second position, the salary of which would be increased later on.

The President thought the matter should be taken into particular consideration. The fee for examining for insurance companies was too small. The pay for I. C. R. employees was inadequate. Cases for specialists were often sent to Montreal and treated there at a regular rate.

Dr. Mader moved, and Dr. Goodwin seconded, that a committee be appointed to formulate a scheme to improve relations between the profession and clubs.

This was put and carried

The following were appointed: The President, Drs. Goodwin, Mader and Hogan.

Dr. C. D. Murray moved, and Dr. Mader seconded, that a committee be appointed to draw up a memorial to Dr. W. S. Muir. The following were appointed: The President, Drs. C. D. Murray, and G. M. Campbell. (See April number, page 142.)

ST. JOHN MEDICAL SOCIETY.

March 5th, 1902. Dr. James Christie in the chair.

A paper on "Simulated Blindness," was read by Dr. Crawford which will appear later in the NEWS.

March 12th. Dr. W. L. Ellis, President, in the chair.

Dr. Skinner reported three cases. (a) A patient complained of great pain about the rectum with formation of abscess and purulent infiltration of the surrounding parts. Examination of the rectum disclosed a foreign body—portion of the vertebra of a sheep. The case terminated fatally. (b) Spastic paraplegia. (c) Dupuytren's contraction of the palmar fascia.

March 19th. Dr. T. D. Walker presented (a) a case to the Society for diagnosis. The patient had a well marked, high pitched, musical murmur at the base of the heart. The murmur was thought to be due to some extra-cardiac condition. Dr. Walker also reported (b) the case of a patient who showed marked susceptibility to iodism from small doses of iodide of potash; and (c) internal strangulation of bowel occurring in an infant less than two months old. The strangulation was produced by a band (Meckel's diverticulum) two inches in length, attached to the ilium and the base of mesentery. The constriction was relieved by operation but the infant did not survive the shock.

A paper on "United States Immigration Laws" was read by Dr. Heiser. (This paper was published in our April number).

March 26. Dr. McIntosh exhibited a child with a swollen and everted condition of the conjunctiva of the lower lid which was considered to be lupus. There was a family history of lupus and the mother showed evidence of previous lupus.

Dr. McLaren showed a case of effective vaccination in a patient who had suffered severely from smallpox thirty years previously.

Dr. T. D. Walker presented a case of resection of the knee, performed on account of tubercular disease of that joint. The limb was strong and very serviceable.

Dr. Coleman, of Chicago, at one time a member of this Society, gave an address on the "General Uses of Electricity," with special reference to the sinusoidal current in diseases of the eye and ear.

April 2. Dr. Melvin, Vice-President in the chair.

Dr. MacAulay read a paper on "Hemorrhoids," in which the pathology, etiology, symptoms and treatment were discussed. Preference was given, in operative treatment, to ligation.

April 9. Dr. Ellis, President, in the chair.

Dr. Melvin exhibited a specimen of tubercle bacillus, showing the beaded appearance,

A paper on "Local Treatment in Diseases of the Upper Air Passages" was read by Dr McCully.

April 16. Dr. Ellis exhibited a case of a boy aged ten years with epispadias; and read reports of three cases, traumatic stricture of urethra, appendicitis and carcinoma of tongue.

April 30. Dr. McIntosh related a case of albuminuric retinitis occurring in a patient in the seventh month of pregnancy. The outlook was so serious with respect to the patient's vision that he submitted the question for the consideration of the Society as to the advisability in such a case of the induction of premature labour.

May 21. The President read an article from the *Scientific Monthly* on surgical instruments recovered from the ruins of Pompeii.

May 26. Annual meeting.

The Secretary's Report stated that there was a membership of forty and that thirty meetings had been held during the year.

The Treasurer and Librarian also submitted reports.

The following were elected officers for the ensuing year :—

President, - - -	Dr. Stewart Skinner.
Vice-President, - -	Dr. Gray.
Secretary, - - -	Dr. Shaughnessy.
Treasurer, - - -	Dr. J. Christie.
Librarian, - - -	Dr. Olding.
Curator of Museum -	Dr. W. A. Christie.

Book Reviews.

INTERNATIONAL CLINICS.—A quarterly of Illustrated Clinical Lectures and especially Prepared Articles by leading members of the medical profession throughout the world. Volume I, Twelfth Series, 1902. Published by J. B. Lippincott Company, Philadelphia. Canadian representative, Charles Roberts, 1524 Ontario Street, Montreal.

The present volume contains the usual number of excellent articles and illustrations. We only need refer to a few which we have had the good fortune to peruse carefully: "The Use of Opium in Daily Practice," by Arthur V. Meigs, M. D., Pennsylvania; "Habitual Constipation," by I. Boas, M. D., Berlin, the well-known authority on diseases of the stomach and intestines; "Methods of Investigating the Action of Drugs," by H. C. Wood, M. D., Philadelphia; "The Treatment of Acne," by Professor H. Hallopeau, Paris; "On the Significance of Basophilic Granules in Red Corpuscles, with Special Reference to their Occurrence in Chronic Lead Poisoning," by Chas. E. Simon, M. D., Baltimore. The Biographical Sketches of Drs. S. Wier Mitchell and John A. Wyeth are interesting sketches of these eminent gentlemen, and are illustrated by several fine plates. The Progress of Medicine during the year 1901, occupies some hundred pages, this part alone being well worth the price of the *Clinics*. The editors are to be commended for the material provided in the pages of this deserving publication, and the publishers for the excellent print and well executed plates and figures.

THE DIAGNOSIS OF SURGICAL DISEASES.—By Dr. G. Albert, late Director and Professor of the First Surgical Clinic at the University of Vienna. Authorized translation from the Eighth Enlarged and Revised Edition. By Robert F. Frank, A. M., M. D., with fifth-three illustrations. Cloth—Price $5. Publishers, D Appleton and Company, New York, 1902.

This work on the Diagnosis of Surgical Diseases by a well known Professor of Surgery of Vienna—Albert—will be read with much interest by many of the profession.

Similar works on medical diseases are numerous and widely read, but up to the present the efforts put forward in the direction of special literature on the diagnosis of surgical diseases has been greatly limited. There is, therefore, an excellent field for a reliable book of this character.

The translator in the preface states that "this volume presents to the practitioner and to the student the problems in diagnosis which confront them at the bedside. In order to achieve this object, theoretical classifications are not adhered to; instead diseases are grouped according to similarity of symptoms and points of general resemblance—considerations which in practice render their differentiation difficult * * * * by the presentation of a largenumber of cases, the value of this arrangement is further enhanced."

Some 407 pages are taken up with the subject of surgical diagnosis, and among a number of noticeable features which might be mentioned, one

particularly observes that the text is closely adhered to and that nothing unnecessary or foreign to the subject is introduced.

In the first chapter, which deals with causes of abnormal positions of the head, various rare diseases and accidents, as well as the more common ones, are discussed in an interesting manner.

The different regions of the body, with many of the diseases and injuries incidental to them, are then consecutively taken up. Numerous illustrative cases are briefly given and are of much service. The author observes in this conection that "the number of examples which show how the observation of small details lead to the finding of new symptoms, and thus to the proper interpretations of the symptoms already observed, could be multiplied indefinitely. The significance of many minor symptoms is frequently pointed out throughout the book, but on page 86, herpes labialis as a confirmatory sign refers probably to pneumonia, rather than typhus as given.

There are excellent articles on injuries and tumors of the thorax, while those on dislocation, fractures and inflammatory processes of the extremities are particularly good.

Albert cannot sufficently reprove the fault common to beginners of at once grasping, handling and pressing an injured patient without rhyme or reason. "I will show how a purposeful inspection reduces this handling to a minimum. Inspect as long as further information can be gained by the eye." This is advice which might be acted upon by others than beginners. It is anything but rare to observe unnecessary palpation and manipulation without any very definite idea of the object.

The work lacks somewhat in conciseness, but that is rather a characteristic of German writings and there are places where more detail might be given It can certainly be said that the book is an excellent one, and will be found to be of much service and value.

Notes.

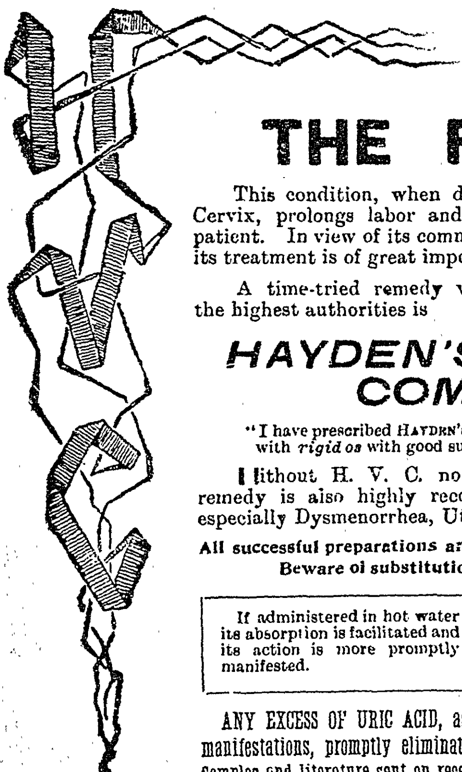
Sanmetto in Prostatitis, Enuresis, Catarrh of Bladder.—In prostatitis, enuresis, catarrh of bladder and all diseases of the genito-urinary system, Sanmetto has been indispensable to me.

Bellaire, Ohio. J. T. W Kerns, M. D.

Gastralgia—Its Treatment.—Gastralgia is for therapeutical purposes, divided into two groups by Prof. Saundby (N. Y Medical Journal.) The first group comprises those cases in which pain occurs independently of eating, and the second group, those cases in which the pain occurs after food is taken. The treatment of the first class consists of change of scene, a sea voyage or mountain air and abundant food at regular intervals. The palliative treatment consists of iron, quinine, arsenic, nux vomica and the mineral acids.

For the second class, the treatment is, rest in bed, milk and lime water in sufficient quantities—say an ounce every hour. A nutrient enema of one egg, beaten up in four ounces of milk, to be given every four hours. The amount of milk should be increased with improvement, and if milk fails, from two to four ounces of lightly cooked minced meat may be substituted.

For the relief of the pain in both cases, Saundby gives morphia or heroin, but in a recent clinical report, Professor Boone, College of Physicians and Surgeons, St. Louis, states that he finds one Antikamnia and Heroin Tablet (5 grains Antikamnia ; 1/12th grain Heroin Hydrochloride) given as required, not only relieves the pain, but prevents its recurrence, much more satisfactorily than either heroin or morphine alone. In other respects he concurs with Professor Saundby in his method of treatment.



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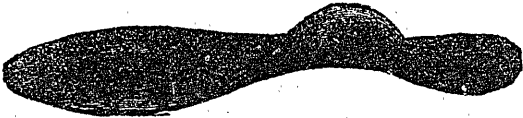

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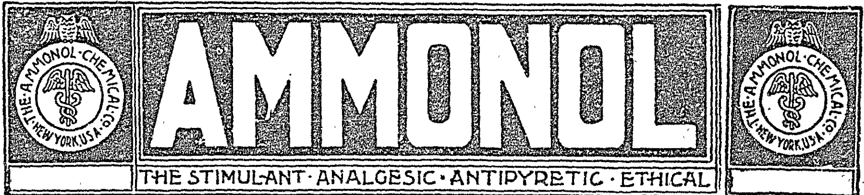

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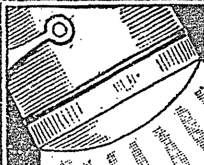

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