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A MONTHLY JOURNAL

OF

MEDICAL AND SURGICAL SCIENCE,  
CRITICISM AND NEWS.

EDITED BY

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CHARLES SHEARD, M.D., C.M., M.R.C.S., E.

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# THE CANADA LANCET.

A MONTHLY JOURNAL OF  
MEDICAL AND SURGICAL SCIENCE,  
CRITICISM AND NEWS.

## Original Communications.

### POST NASAL ADENOIDS.

BY J. D. THORBURN, M.B., L.R.C.P. AND S., EDIN.

Late Superintendent of Hospital for Consumption and Diseases of the Throat, Manchester, England.

*Mr. President and Gentlemen :—*

So much has been written upon post nasal adenoid vegetations, that it was with some feeling of diffidence I selected this subject for my paper, but it is one of such importance, especially to us Canadians, that I deemed it worthy to be brought before the Association. Post nasal adenoids were known to Hunter, but were first described by Wilhelm Meyer, Copenhagen, who gave a description of the aetiology, structure and the symptoms arising from their presence. Since that time many writers of greater or less worth have contributed much upon the same subject.

"Adenoid vegetations consist of a collection of hypertrophied lymphoid structures found as a rule in young children and infants, more rarely in adults, congenital in some, developed in infancy in others, and showing a tendency to disappear at puberty." The etiology of these true hypertrophic changes, in the lymphatic glands, is not well understood.

From a study of cases we are forced to admit, that scrofula, tuberculosis, syphilis, rheumatism and the various exanthemata are all predisposing causes. Many authorities deny, however, that the above mentioned dyscrasia influence the formation of the growths, and explain their presence as being due to inflammatory changes, resulting in a tendency to hypertrophy of the glandular and surrounding tissues lining the post nasal space.

"When, from any cause, we have partial occlusion of the nasal fossæ, so long as respiration is conducted through the nose, there is, of a physical necessity, a diminution in the barometric pressure,

behind the seat of stenosis. This inevitably results in more or less over filling of the blood vessels, which in its turn leads to hypernutrition."

The inflammatory changes of this region being increased by primary catarrhal changes, characterized by repeated attacks of acute rhinitis, hypertrophy of pre-existing elements is nowhere more conspicuously seen than the case of post nasal adenoids.

The *modus operandi* of the diminished barometric pressure behind the stenosis is as follows :— As you know when air passes behind an obstruction into a cavity, it becomes rarified ; this rarefaction of air has a suction power, which is influenced by each respiratory act, in such a manner as to cause a drawing upon, and then a more or less relaxation, of the tissues.

The bony structures cannot be influenced in a direct manner, therefore the soft parts are subjected to a greater suction-pump action, in order to compensate for the inability of the hard frame work. In time the blood vessels running through the yielding tissues become permanently dilated, and the increased blood supply leads in turn to hypernutrition and true hypertrophy.

The most common cause of the stenosis are (a) congenital osseous malformations, (b) small nostrils, (c) deflected septa, (d) septal spurs, (e) hypertrophic rhinitis, (f) simple engorgement of tissue covering more especially the inferior turbinated bones, (h) thickened septa, (i) then again adenoids are found associated with atrophic rhinitis and cleft palate.

Bosworth says "as a rule the seat of obstruction is situated near the anterior part of the nasal fossæ, and that in the case of deflected septa we often find the V shaped contraction of the superior maxilla." After the above explanation one can appreciate why the vault of the pharynx is the seat of adenoid vegetation, accepting the barometric theory as being the true one in the great majority of cases ; still there are other causes to account for the presence of adenoids which shall be mentioned later on.

Not being satisfied with the various classifications of adenoids as given by different authors, I have attempted a classification for myself, based upon clinical experience and have found it of some service, both as regards diagnosis and treatment, and hope it will prove of value to others.



First: Those resulting from nasal stenosis, which I again sub-divide into (a) soft, (b) firm, (c) mixed.

A.—The soft variety occurs in young children, subjects of a slight nasal stenosis. The dimensions of the growth and shape vary from day to day, at one time being small and flat, at another large, and sending down finger-like prolongations; these changes are no doubt owing to transitory œdema of the tissues.

Associated with these changes in size and shape, we find a corresponding increasing and decreasing nasal stenosis. From the appearance, structure and behaviour of the growths one would almost be justified in calling them a polypoid form of the disease. It is this variety that gives rise to the repeated attacks of acute rhinitis and otorrhœa in young children.

B.—Firm: These obtain in a totally different type of patient in contradistinction to class 1. They are found in healthy robust subjects, are slow in growth, firm in consistence, more regular in outline, showing a tendency to lateral and downward extension; do not vary in size from day to day. There is a marked nasal obstruction, and as a rule greatly enlarged tonsils. The best defined symptoms indicating their presence is facial deformity, noisy breathing and snoring, and if far advanced we find well marked pigeon breast.

C.—Mixed; Fill in the gap between one and two, both as regards the structure and symptoms.

Besides the above classes I wish to draw your attention to at least two other varieties which have certain peculiarities of their own, not so much in structure as in ætiology and symptoms. We find in a certain number of young adults well marked adenoids of large size, localized in the vault of the pharynx, firm in consistence; upon post rhinoscopic examination, the growth instead of presenting a greyish appearance presents rather that of a blueish red, the same as seen in passive inflammation of mucous tissue. Associated with this form are enlarged tonsils, showing on their surface indications of former inflammatory attacks. Now it has been proven beyond doubt by Lennox Browne and others that these attacks are due to rheumatism. This being the case with the buccal tonsils, it must of necessity be the same with the pharyngeal tonsil, which is similar in structure and functions.

The following history will go to prove my statement. H. J., æt. 15, school boy, healthy, but has a history of growing pains (rheumatism), and slight rheumatic attacks, father and mother both subject to rheumatism. Previous history. Except for above attacks and also a tendency to "ulcerated throat," he has enjoyed the best of health. Did not snore as a child, but does now. Present attack began with a severe cold, complained of rheumatic pains throughout the body; these lasted three days, when the throat became involved in a right sided tonsillitis, followed by same condition on the left side. Leaving there, the pharyngeal (Luschka) tonsil was attacked; this jumping from place to place lasted three weeks. After a tedious convalescence the patient recovered, but now has a permanently enlarged pharyngeal tonsil. This is one of many cases that have come under my notice.

The fifth and last variety is that of the chronically enlarged pharyngeal tonsil, the outcome of repeated attacks of inflammation caused by the presence of the vegetable parasite, *leptothrix buccalis*; and occurring chiefly in young adults. This parasite shows its presence in the form of small white or yellowish spots the size of millet seeds, covering a cheesy mass, which when pressed and squeezed between the fingers emit a very offensive odour. These masses are to be seen studded over all the nostrils and even on the base of the tongue. The patient is made aware of this presence from their taste, which is quite as bad as their odour.

These masses cause localized inflammation in the substance of the affected part, and in time a true hypertrophy of the same. The symptoms arising from their presence are more of those of a post pharyngeal catarrh than of obstruction. The patient also hawks up from time to time some of the cheesy masses. Race or climate has but little influence over the growth of adenoids. The only exception in this rule is in the Hebrew race who are prone to adenoid formation. Before describing the general symptoms of adenoids it would be well to refer to the functions of nasal respiration.

1st. Air passing through the nostrils is brought to the temperature of the body. 2nd. It is moistened and filtered. 3rd. Gaseous exchange takes place. Any interference of these functions would tend to lead to bronchitis, croup, asthma and other diseases of the respiratory tract.

*Symptoms.*—In the infant the inability to feed when not due to "tongue tie" is generally owing to the presence of adenoids. In older children we have the well marked adenoid expression of countenance due to the linea labialis extending downwards from the angle of the mouth until it becomes lost in the lower portion of the face. An open mouth, stupid expression, pinched nostrils, go to make up the picture. Snoring when asleep is a very prominent and distressing symptom; when there is no actual snoring the patient sleeping with his mouth open has his rest disturbed, and in the morning his lips are dry and parched. Inability to pronounce various letters, as the explosive labial, is another almost pathognomonic sign, as poat for boat.

Attacks of deafness are common; these may be due to a simple or a purulent cartarrh of the middle ear or to an indrawing of the drum head. The sense of smell and taste are impaired, headache is complained of, as well as blood escaping from the back of the mouth. Time will not permit me to enumerate the many other symptoms caused by these growths.

Examination of the mouth and throat shows almost certain indications of the presence of adenoids; higher up in the vault inspection we see enlarged buccal tonsils, and on the back of the pharynx oedematous solitary glands standing out from the surrounding tissue. The next thing we notice is the remarkably small space between the soft palate and post pharynx. If possible the next step in verifying the diagnosis is examination by means of the post rhinoscopic mirror, a difficult procedure when adenoids are present. If unable to see them, pass a guarded finger up behind the soft palate and ascertain by feeling their absence or presence. Upon withdrawal of the finger it is frequently found covered with a bloody mucus.

*Treatment.*—I will not say anything about the medical treatment as applied to the removal of the growths, inasmuch as I do not consider it worthy of attention. Surgical interference affords us the only means of getting rid of the disease. In children when the growths are soft my mode of treatment consists in scraping away the tissue with the finger-nail, no anæsthetic being required. In growths of firmer consistency one of the various forms of sharp spoons, forceps, or curets are to be

recommended, according to the locality of the growths and the temperament of the patient.

In my practice chloroform or ether are never used unless absolutely necessary, and that occurs in very few cases; cocaine has no anæsthetic effect upon the diseased tissue. The after treatment consists in insufflating boric acid through either nostril. I never use a nasal wash until some days after the operation, owing to the tendency of washing in to the eustachian tube some of the debris. Place the patient in bed and do not allow him to take of either too hot or too cold food. After the wound is healed remove the obstruction or exciting cause.

### OPERATION FOR THE RADICAL CURE OF HERNIA.\*

BY THOMAS R. DUPUIS, M.D., M.R.C.S., ENG.

Professor of Clinical Surgery in the Medical Faculty of Queen's University, Kingston.

(Continued from August Number).

The second case was that of an oblique inguinal hernia of about six months standing, in a young man 22 years of age. He had been ruptured by a heavy strain, and although the bowel was fully restrained by a truss, he found the wearing of a truss irksome, and naturally sought for some permanent relief. He consulted one of our most promising young M.D's., who recommended an operation of some kind, and brought him to me for my advice. I advised an operation by the direct method of cutting down and suturing the parts together in a proper manner. After the nature and probable results of the operation had been fully and honestly laid before the young man, he concluded to take the risk, and was anxious to have the operation performed.

After our patient had been anæsthetized and the parts shaved and well scrubbed with a strong antiseptic solution of  $HG Cl_2$ , I made an incision in the line of the canal, and proceeded layer by layer until the pillars of the ring were reached, the external ring was then enlarged upwards on the fore-finger until the two rings corresponded, and with the finger still in the ring, the edges of the conjoined tendon on the one side and of the

\* Read before the Ont. Med. Assoc'n, Toronto, June, '92.

upper margin of Poupart's ligament on the other, were refreshed by a probe pointed hernia knife. After all bleeding had been arrested and the wound effectively douched with a warm solution of  $HG Cl_2$  to aq. 4000, the work of suturing was proceeded with.

In this operation I used prepared cariboo tendon for sutures, and I believe that nothing can supersede it for either fine or coarse suturing where sutures are intended to remain.

The tendinous pillars were firmly drawn together by four sutures of good-sized splittings of the cariboo tendon, the fascia and skin were approximated by deep sutures of good-sized tendon, interrupted, and the skin closure completed by a continuous suture of fine tendon, covered by collodion and dusted with iodoform. A saturated compress of antiseptic gauze was placed upon the wound and overlaid with absorbent cotton, and a broad spica bandage completed the dressing.

The patient was placed in bed in a half-sitting posture, with pillows beneath his knees, morphine administered, the greatest quietness observed, and all such other measures carried out as would be considered requisite after a laparotomy. Healing was very soon effected, and the patient became so well in one fortnight that it was with difficulty I persuaded him to lie upon his back for six weeks—my prescribed time. No bad symptoms whatever followed the operation, and a few days ago I saw him going to his work—that of a tinsmith—feeling as well, he said, as he ever did in his life.

The third case was that of a young man about 24 years of age, who suffered from a complication of hernia, with imperfectly descended testicle. The testicle could be forcibly drawn down as far as the external ring, but was immediately retracted on being let loose, and remained in the upper part of the inguinal canal. The sac had been gradually elongated until the hernial protrusion passed in front of the testicle, distended the canal, and appeared as a spherical swelling over the front of external ring.

He had been advised from time to time to wear a truss, but, of course, on account of the testicle being situated beneath the pad of the truss, it was impossible for him to wear one. Suffering more or less pain constantly, and sometimes very acutely, in the testicle, and being unable to do any active duties, I proposed to him an operation

for removal of the irritable testicle, and the cure of his hernia, to which he readily consented.

The preliminaries and concomitants of the operation were the same as those of the last case.

In cutting down, I came upon the sac of the hernia before reaching the testicle, because the posterior part of the sac was adherent to the front and upper part of the tunica vaginalis testis, the hernia lying in front of the testicle as in "hernia into the funicular process," but reaching *below* the testicle instead of remaining *above* it, on account of the undescended state of the testicle. The sac was separated from the constituents of the cord and stitched through with fine catgut, close enough together to maintain the two layers in exact apposition; a stout piece of catgut was passed through the cord of the testicle to prevent its re-treating when severed, the tunica vaginalis was then opened, the cord securely ligated, the testicle cut away, and also the non-adherent portion of the tunica. The cord was held in place by the loop which had been passed through it, the sac was cut away beyond the line of stitches and returned, the edges of the canal refreshed, bleeding arrested, and three strong catgut ligatures passed through the pillars of the ring from side to side, and two of them at least passing through the stump of the cord in such a manner as to convert it into a plug to help fill up the vacancy which had been left by the removal of the testicle. The fascia and skin were approximated by deep, interrupted and superficial, continuous sutures, collodion and iodoform applied, and antiseptic gauze, absorbent cotton and a firm bandage over the whole. After-treatment, similar in all respects to the former case, even to the six weeks in bed, was carried out, and no rise of temperature or other bad symptom were ever present to cause the least anxiety. In none of the foregoing cases was a drainage-tube used; the wounds had been diligently douched and sponged with a warm solution of water containing  $HG Cl_2$ , the dressings were all antiseptic, union by the first intention was confidently expected, and we were not disappointed, and they seem to me worthy of being classed as safe, speedy, and permanent cures.

The fourth case is one at which I only assisted, but as it is another testimony in a favor of the safety of cutting down upon herniæ, I deem it worthy of being reported.

The subject was a middle-aged maiden lady who had suffered with her herniæ for perhaps 20 years. It had been an oblique inguinal herniæ and the sac had either distended the deep layer of superficial fascia, or caused its absorption by continued pressure, for the tumor, as large as a goose egg, lay in Scarpa's triangle and the neck passed over Poupart's ligament from the abdominal ring. The long continued irritation had caused consolidation of all the coverings of the herniæ and adhesion of the sac to the deep fascia of the front of the thigh; fortunately the intestines were not adherent and could be returned into the abdomen. When everything was in readiness the contents of the sac were pushed through the ring and retained there by the fingers of an assistant, the sac and coverings held up in a fold perpendicular to the thigh, and the knife at right angles to the line of the thigh, cutting from above downwards was made to remove the whole front of the empty tumor which had somewhat the appearance of a skull-cap. As soon as the cavity was open for inspection it was found that the anterior portion of the hernial sac had been cut away with the skin to which it was adherent, and that the posterior portion was adherent to the deep fascia of the front of the thigh. This deep portion was carefully dissected off from the underlying tissue, and the neck of the sac freed from its surrounding attachments up to the abdominal ring, thus leaving a tubular prolongation of peritoneum open at the lower end. The intestines were retained in their place by the fingers and soft antiseptic sponges, and the tube of peritoneum well pulled down so that it could be firmly closed by ligature. Two double ligatures of strong fine catgut were passed through it, their ends tied together on each side, and then passed around the whole neck a couple of times and firmly tied. The distal end of the peritoneal tube was then cut off close beyond the sutures, all bleeding arrested, the wound thoroughly douched with a warm antiseptic solution of  $\text{Hg Cl}_2$ —aq. 4000 the wound carefully sutured with prepared catgut and the whole dressed antiseptically with collodion, iodiform, gauze and bandages. A drainage tube was inserted in this case and the patient was kept exceedingly quiet, fed low and very carefully watched. I saw her but once and that was about a fortnight after the operation, and she was then recovering very nicely. Her attendant M. D., told me

that she had had no alarming symptoms; her pulse had been somewhat quickened and the temperature elevated for a few days, and nausea, I believe, annoyed her a few times. From the extent and peculiarity of the operation, and the nature of the parts so freely handled and cut open and sewn up, I had expected a much greater disturbance than there was. The lady was kept in her bed for about six weeks, when the wound being entirely healed she was allowed to go about. This operation did not make a radical cure, but it should not be forgotten that there was no attempt made to secure a radical cure; the object aimed at was to relieve the lady of the pain and discomfort caused by the large tumor in her groin and this has been done, and hernial protrusion now being limited (so I am told by her M. D.,) to a small swelling in the region of the internal abdominal ring and this is perfectly controlled by a light truss.

In conclusion, permit me to say that I have thrown together these rambling remarks, not for the purpose of giving instruction in, but to call attention to, this operation for the radical cure of hernia, believing it to be the very best in a large majority of cases; and to show also the safety with which surgical interference may take place in the parts involved in herniæ.

I thank you for your attention and express the hope that others may reflect upon and prove the efficiency of the *direct* operation for the radical cure of herniæ.

### Reports of Societies.

#### ONTARIO MEDICAL COUNCIL.

(Continued.)

#### REPORTS OF STANDING AND SPECIAL COMMITTEES.

Dr. Williams presented the report of the Executive Committee for the year as follows:

Your Committee beg leave to report that they held two meetings on the 17th March, and 6th April, at which meetings your Registrar was directed to ask the following members of the Council, and members of the profession, to accompany your Committee when interviewing the Attorney-General and the Government of Ontario, regarding the Bills which had been presented to the Local Legislature affecting the Medical Coun-

cil and the profession in this Province, namely, Drs. Bergin, Day, Orr, Britton, Moore, Geikie, Johnson, Thorburn, Aikins, Wright and Ruttan.

Your Committee believe this was necessary, after the representations made to them by Dr. A. McKay, M.L.A., of Ingersoll, Ontario, and the misapprehensions that appeared to exist in the minds of many of the profession, and particularly the promoters of the Bills brought before the Legislature.

The first meeting which was held on the 17th March, was for the purpose of presenting the case to the Premier and other members of the Government.

The second meeting was rendered necessary, because of the meeting of the Special Committee, to whom the Bills amending the Ontario Medical Act had been referred by the Legislature.

All of which is respectfully submitted.

J. ARTHUR WILLIAMS, M.D.

*Chairman, Ex. Com.*

13th June, 1892.

Dr. Williams moved, seconded by Dr. Bray, that the report be received. Carried.

Dr. Williams presented the report of the President as follows, and moved, seconded by Dr. Bray, that the report be received. Carried.

Your President begs leave to submit the following report :

1st. In accordance with the regulations of the Council, he attended and presided at the meeting of the Board of Examiners, as set forth in the report of that Board ; and he must express to you the conviction, that the Examiners use every possible care in the performance of their work.

2nd. It was impressed upon him at that meeting, and emphasized by some of the Examiners, that there is great irregularity in the distribution of the pay to the Examiners in comparison to the work performed.

3rd. That the remuneration given to the Examiners is entirely inadequate to the services performed, and for the time necessarily consumed.

4th. That when Dr. Pyne is present, as he should be as Registrar, he should also be the presiding Examiner in Toronto, and the Deputy Registrar for the time being, acting in the same capacity in Kingston. That there is then no good reason why the Examiner who prepared the paper should be present, as he is not allowed to give any explanations.

5th. That if not required to be present, less of his time will be consumed, and the Council will be saved the travelling and other expenses.

6th. That the oral examinations are a severe tax, for which there is not reasonable and proper compensation.

7th. That there were at the last examination, 226 primary students and 166 finals. That, accord-

ing to regulations, two Examiners must be present, and not more than eight students per hour, can be examined. This is a very severe tax upon the Examiners, and before the close of day the mental strain is such that justice can scarcely be performed by the Examiners, or hoped for by the students

8th. Your Examiners are very pronounced in their conviction that appeals ought not to be heard without the Examiner being present. That no case of appeal would be entertained in court, without both parties in the case were duly notified. That for the Council to re-examine on the application of a student, is an injustice to the Examiner, whose side is not heard, and therefore the Council or its sub-committee not having the student present cannot examine him orally, and it practically becomes a test for that student on written examination only.

9th. Your President would respectfully recommend, that this entire subject be referred to the Educational Committee with instructions to carefully examine the whole subject, and report to the Council during the present session.

Your President would further report, that because of the demand being made for the financial condition of the Council by the Legislature and other members of the profession, he asked the Treasurer to have a report prepared giving the financial condition of the Council year by year from its organization down to the present time. This report will be laid on the table at an early date.

All of which is respectfully submitted.

J. ARTHUR WILLIAMS,

*President.*

College Building, Toronto June 13th, 1892.

Dr. Williams.—The President's report is dealing largely with matters urged upon him by the profession. It is an educational matter ; and the President's recommendation is that the report be referred to the Education Committee with a view to the matter being carefully dealt with. I am quite satisfied myself it is possible to save hundreds of dollars in holding examinations, and have just as efficient Boards of Examiners as at the present time, and I think the whole matter should be carefully gone into by the Committee. I move, seconded by Dr. Bray, that the report be referred to that Committee. Carried.

Dr. Bray moves, seconded by Dr. Harris, that the Executive Committee's report be adopted.

Dr. Williams—Before this report is adopted I would like to make an explanation. In reading the report over you will observe that in addition to the Executive Committee there are a number of men in Toronto, and members of the Council as well, who were invited by the committee to be present and visit the Government with them.

This was done in this way, as I understand, there was a conference held in some informal way among the medical men who were in the House; and the outcome of that was that Dr. McKay, who was acting in our behalf in the Legislature, mainly, suggested as well as Dr. Pyne that we should bring together certain members, whom he named; I am not prepared to say whether those were named at the conference of the committee that was held at the House, or how; but it was suggested to us that we invite together certain persons that he named for the purpose of waiting upon the Government and presenting their case. As we felt at the time the matter was somewhat critical and we thought ourselves in duty bound to act in good faith with the members of the House who were acting in our behalf; and accepting that view we invited the medical men to assist us that had been specified by them. On the second occasion there was not so large a number invited; the invitations were confined here to Toronto men; and this was by decision of the first gentlemen when they were present, after consulting on the matter; it was decided then the invitations should be confined as far as practicable, to local men. At the same time we felt that we must comply with the gentlemen's wishes who were acting in our behalf in the House.

Dr. Rogers.—I think the principal involved is one worthy of the consideration of this Council. The principal is that the Executive Committee called a partial meeting of the Council, and not a full meeting of the Council, I do not find any power in the by-laws or in the Medical Act to empower them to do that. In the first place I do not say but what it was expedient; I do not say but the reason given by our late president is one well worthy of consideration; that he did what he should have done; that is, on the request of Dr. McKay, our mutual friend in the Local Legislature, it was agreed that certain members of this Council should be asked to help the Executive Committee before the Committee of the House of Assembly. I only wish to point out that such a course as that of calling a partial meeting of the Council is not authorized by either the Act or the by-laws of this Council.

Dr. Bray.—I do not wish to interrupt but I think Dr. Rogers is entirely astray. There was no meeting of the Council or partial meeting of the Council; there were some gentlemen, members of the Council, in their individual capacity and not as members of the Council.

Dr. Rogers.—I have said it was a partial meeting of the Council, and I said that it should have been a full meeting of the Council or a full meeting of the Executive Committee. I do not wish to be understood to be finding fault with the late president in any method he took, because I am satisfied all he did was in the interests of the pro-

cession; but I want to emphasize this fact, that it was an irregularity; that neither the Medical Act nor the by-laws empower the committee to do that. I do say if it was found necessary by the Executive Committee to have assistance from members of the Council then there was only one course open to them and that was to call a full meeting of the Council; that is always open. Each member of this Council has an equal right to attend the meetings with any other member. I have been informed by my friend, Dr. Bray, that this was not a partial meeting of the Council; if it was not a partial meeting of the Council I should like to know very much what it was. Certain members, for instance the names there are Dr. Day, Dr. Bray and Dr. Bergin and Dr. Rutan I believe were called here at the request of the president.

Dr. Bray.—I never was asked; I was not here at all.

Dr. Rogers.—I thought your name was read out. Certain names were given; those persons not only came here at the official request of the president, but they drew pay for this meeting; there is one serious matter comes in; had they come here as friends of the Council, well and good, had they come here as individual practitioners, well and good, but they were called together officially by the president of the Council which I say was contrary to the authority given by the Medical Act and by-laws of this Council; and they received pay for it. I say it was a partial meeting of the Council. I do not want to say it was not an expedient course to pursue. I do not want to say it was wrong; but I want to emphasize the fact it was not in accordance with the policy of the Council; and consequently it should not be left as a precedent of the future. This, if left unnoticed would be a precedent for the future, that partial meetings of the Council could be called by the Executive Committee.

Dr. Geikie.—I think a year or so ago Dr. Rogers was a member for he came up to attend a Legislative Committee; I think that was attended with a good deal of expense to the Council; and I never heard him say a word as to it not being perhaps wise. And I wish to point out that this report refers to a very essential work, a most important and indispensable work, for which very little was paid.

Dr. Campbell.—Dr. Rogers is quite wrong, both as to what was done and as to the power exercised on that occasion. The Executive Committee by the rules of this Council have to take cognizance of any action upon all such matters as may be delegated to it by the Council or upon such as may require immediate interference and attention between the adjournment of the Council and the next meeting. The Executive meeting found their immediate attention was required in a very seri-

ous matter that came before the Legislature during the recess of the Council; they were bound by the rules of this Council to take action upon it; and they did so; and as Dr. Williams says, following the suggestion made by their friends in the Legislature whose opinions they were bound to receive in carrying out the work they had in view, they called in the assistance of certain gentlemen connected with the medical profession throughout the Province of Ontario; some were members of the Council and some were not; and in carrying out the work of the Executive Committee any necessary expenses that were incurred were, of course, to be paid,—that is understood; where the Executive Committee does necessary work the expense involved in that work must be paid; and if gentlemen were called here to do work for this Council I do not suppose we are going to question that those gentlemen should have their expenses paid, whoever they may be.

Dr. Williams.—I would in one sense endorse what Dr. Rogers says, that no meeting of the Council should be called without every member being notified legally and properly; but I would just wish to point out that there was no meeting of the Council called, and that this meeting of members was not a meeting of the Council in any sense whatever; furthermore, that, in my judgment, the Executive Committee would be deserving of the severest censure that this Council could pass upon them if they had not acted in that matter and with the greatest promptitude as well. I think further that the very life of this Council was jeopardized in the Acts before the Legislature; and if this Executive Committee hadn't taken the matter up, and taken it up promptly and vigorously, I am not prepared to say that the Council would stand as well as it does to-day. I would say further that if the Executive Committee were taking it up at all, they couldn't do better than take the advice of the gentlemen who were acting in their behalf in the Legislature; I think if the Committee did not take that advice, and if anything had gone wrong, there is not a member in the Council who would have been quicker to censure them than the gentleman who now takes exception to our action at the present time. I believe if you turn up the Act and take the rule, as already referred to by Dr. Campbell, there is perfect authority to go into the matter and every matter that presents itself for urgency before the Council; and if you turn to the Statute itself and read Section 15, I think you will find there full provision is made for the Executive Committee acting in an emergency of that character (reads Section). I am quite satisfied, under the provision of the Statute, we had a perfect right to act, and we would have been deserving of the severest possible censure of the Council if we had not acted; and I believe we acted wisely and judiciously in taking the advice

of the gentlemen who were acting on our behalf in the House; and if we hadn't done so and anything had gone wrong, I am quite satisfied the Council would have been in a position, and justly in a position to censure us for having taken any other position.

Dr. Orr.—I wish to say one word with regard to some of the statements made before this Council. At the last session of the Local House there were three or four members of the Council resident in Toronto,—Drs. Johnson, Britton, Thorburn and myself,—present at the request of the President; and we spent a great deal of time in that Local House, watching closely any of the Acts that the opponents to the Medical Council might bring forward. An inference has been thrown out to-day that we were paid for the time we devoted in the interests of the Council and of the profession. And I would say that I believe Drs. Britton, Johnson, Thorburn and myself received nothing but the one day's pay and that for the day we were requested by the Registrar to appear before the Committee in the House.

Dr. Thorburn—And we spent a week there.

Dr. Britton—Drs. Johnson, Thorburn and Orr, and myself did a great deal of work. One whole week at least was taken from our practices in the interests of this Council at the Legislature, and in other ways for the purpose of advancing the interests of the Council; and for that work we received the sum of one day's pay. I would like this statement to go on record, because it has been stated in the public papers that we have been paid exorbitantly for what we have done.

Dr. Thorburn—I would like to add a rider to that statement; I am not aware I got one day's pay, and that instead of one week I was there one month; and I had daily converse with different members on this proposed legislature, sometimes nightly converse.

Dr. Bray moves that there be added to the motion to adopt the report that the thanks of this Council be, and are hereby tendered to the Executive Committee for their prompt action and good work.

Dr. Rogers—I will move to adjourn, and I will speak on that motion.

The president called for a vote on Dr. Rogers' motion for adjournment, and declared the motion lost.

Dr. Rogers—I would like to explain. I read Section 14 of the Act differently to Dr. Williams' reading. It says the Council shall appoint annually from among its members an Executive Committee. The bylaws of this Council state that the Executive Committee shall consist of three persons. It further says, "that the Executive Committee shall take cognizance of and action upon,"—they themselves shall—of such matters as may be delegated to it by the Council, or such

as may require immediate interference or attention between the adjournment of the Council and its next meeting—the clear words of the Act are that the Executive Committee shall do this, and that no other member of the Council shall do it. When I characterize this as a partial meeting of the Council, that is, my reading of the bylaw and the rules; not that I want to contradict the late president of this Council, for whom I have the highest respect, but I do say, and I maintain that the clear reading of the Act is that the Executive Committee shall do that; while in point of fact, instead of doing that, they called other members of the Council to their assistance.

Dr. Campbell—May I ask Dr. Rogers to explain his explanation, whether he considers the Executive Committee are authorized to take certain action, but they must do it themselves? If, for instance, this building should meet with a catastrophe that necessitated certain repairs to be made, and the Executive Committee thought it necessary to go to work and have those repairs made according to this line of reasoning, would the Executive Committee have to do the repairs themselves, or should they employ somebody to do it; and pay that somebody for it?

Dr. Harris—I think it is most ridiculous for Dr. Rogers to come here and to speak in the manner he has in regard to the ex-president and the Executive Committee. I think, and I believe every man in this room believes the Executive Committee did perfectly right in availing themselves of all the possible help they could, not only from members of the Council, but from outside members of the profession. It is a pity so much time should be taken up by Dr. Rogers in this manner. I think he must certainly feel the same as the others do.

On the motion to adopt being put, the President declared it carried.

Dr. Bray presented the report of the Treasurer and moved, seconded by Dr. Johnson that it be handed over to the Finance Committee. Carried.

On motion of Dr. Bray, seconded by Dr. Johnson, the Council adjourned to meet again at 2 o'clock p.m., Thursday, 16th June, 1892.

#### AFTERNOON SESSION.

Thursday, June 16th, 1892, 2 o'clock p.m.

Medical Council met in accordance with motion of adjournment. The President in the chair called the Council to order.

The Registrar called the roll. All present except Sir James Grant.

Minutes of last meeting read and confirmed.

#### NOTICES OF MOTION.

No. 1. Dr. Bergin to amend sub-section 5 section 5 of announcement of 1891-92, by the follow-

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ing, "which appeal shall only be considered by the Council if accompanied by a recommendation of the Board of Examiners, as set forth in sub-section 10 of said section 5."

No. 2. Dr. Williams, that the Treasurer be instructed to procure 2,500 copies of financial return of the Council and that a copy be sent to each registered medical practitioner.

#### PETITIONS.

Dr. Johnson presents the petition of Drs. Geo. B. Smith, Powell, Primrose and Atcheson, with regard to one Dr. William Anderson, of London, in the County of Middlesex, dated 16th June, 1892.

Moved by Dr. Johnson, seconded by Dr. Harris, that this be referred to the Committee of Discipline.

Dr. Williams—Before that matter is referred I think in justice to the Council we should have some further knowledge than we have got at the present time, as to the nature of the charges being laid against this man. They may be very grave, but so far as this Council knows from any information that has come before it, that supposition is not correct. We don't know that it is true; and before any steps are taken the Council should be satisfied that there are grave charges laid against this man. The Act of 1887 requires that this proceeding should be looked after with the greatest possible care, that no hardship may be inflicted on any man; and I certainly think that the Council should have some knowledge of the circumstances given to them before any very prominent step is taken against him.

Dr. Rogers—Sub-section 2 of section 3 of the Act of 1887 says "the Council may, and upon the application of any four registered medical practitioners, shall cause, etc." That leaves us without option in the matter.

Dr. Moore—I quite agree with the remarks that have fallen from Dr. Williams, that this Council should know something more of the charges that have been made, something more of the case we have before us, that no hardship may be done; I think we should not rush into those things blindly, and I think it would be wiser probably for the advertisements referred to be read.

At the request of the Council the Registrar reads advertisement, "The doctors are coming to Toronto. First three months free of charge. A staff of eminent physicians and surgeons will arrive in the city next Monday, Nov. 23rd, and permanently locate at their residence 272 Jarvis Street, near Gerrard, etc. Hours from 9 a.m. to 5 p.m. and 7 to 8 p.m."

"The doctors have arrived. First three months free of charge. The staff of eminent physicians and surgeons have arrived and are permanently located at their residence, etc."



The Registrar also read the report attached.

The President put the motion to refer the petition to the committee and declared it carried.

Dr. Harris presented report No. 1 of the Education Committee and moved, seconded by Dr. Rogers, that the report be received. Carried.

Dr. Bergin moves, seconded by Dr. Fulton, that the report be read. Carried.

Registrar reads report.

Moved by Dr. Harris, seconded by Dr. Rosebrugh, that the Council go into Committee of the Whole upon report No. 1 of the Education Committee. Carried.

Dr. Miller—I think it would be well to have it understood that the stenographer should report the proceedings in the Committee of the Whole.

Dr. Bergin in the chair.

Report read clause by clause.

Dr. Gilmour, M.P.P., was here introduced to the Council and requested to take a seat upon the platform.

Dr. Ruttan—(Speaking to first clause of report) I think this is a matter of very great importance and that we should be very careful of the individuals who are placed upon that Committee. We do not want any body there that is interested in this or that school. We want a fair representation from the profession in Ontario; and not school men in particular. And, furthermore, the Medical Association, as a whole, is a liberal profession. A medical man who is qualified to practice his profession in any one of the Provinces of Canada, should have a right to practice his profession in the whole Dominion of Canada. It is not like the legal profession, because in Lower Canada they have the French code of laws and a different code in Ontario; and therefore they require to serve a certain apprenticeship or study in these several Provinces in order to qualify themselves to practice within these Provinces, but it is not so with the practice of medicine; a medical man is a medical man wherever he may go. We have in this country the humiliating spectacle that each of the Provinces has a Board of its own, and no matter how well qualified a physician may be if he is living in the Province of Quebec he is liable to fine if he crosses the line to practice in Ontario; and it is the same with a physician living in Ontario who crosses to practice in Quebec; go further west and it is the same, out to British Columbia; no matter competent a physician may be; no matter how high his standing may be, he cannot go into British Columbia from Ontario and practice his profession without submitting himself to the humiliation of an examination; and that examination may, perhaps, be before examiners who were his own pupils in the schools in Ontario and Quebec. There should be something very different fixed with regard to this matter. There are just as competent medical men in Quebec as in On-

tario; and just as competent men in Ontario as in Quebec; there is not a whit difference between them; it is a mere sectional affair. The principal parties who are interested in this matter are the schools. On that account I object in committee to any man interested in any of these schools belonging to that committee, and I hope this matter will be taken seriously into consideration. For my own part, I feel very largely interested in it; and I think the profession as a whole is largely interested. We are driving our own men out of the country by this kind of legislation which I say is no benefit to the profession or the public, but that the principal parties interested in it, there is no doubt, are the schools.

Dr. Harris.—I wish to say one word to correct an impression Dr. Ruttan has got. The Committee is composed of the Education Committee, together with the President. There is only one man representing a school on that committee, and that is Dr. Thorburn. so far as I am concerned I represent a university; Dr. Moore represents a university, and Dr. Logan is also a representative of a university; the rest of the committee are territorial representatives.

Dr. Henry—I think it might be better for the chairman of the committee to give us some information on which he is recommending that this committee be sent down to meet the others. I do not know that there are any overtures made.

Dr. Philip—I having been connected with the Finance Committee, would like to have some information about this; it is obscure in the nomination—it states the president and members of the Executive Committee shall form a committee, etc.; and states the Registrar shall write to them, and ask them to meet this committee at the City of Ottawa on the 20th of September; I want to know from the chairman of the committee, when he gives his information, how this committee is to be paid. We have had committees of this Council in the past, and some of them very innocent looking at their establishment, but when it is all over and the bill is sent in, there is a great big bill to be paid by the Ontario Medical Council. I myself object to the committee being formed unless the financial aspect of the matter is understood. If there is a small committee I myself am in favor of having a committee to meet the committees from the other Provinces, on registration. I would not object to a small committee consisting of the President, and perhaps one or two members to meet this deputation; but unless there is a very clear explanation as to whether that committee is to receive remuneration, and if so, how they are to be paid, I shall object to that clause in committee.

Dr. Thorburn—I think Dr. Ruttan's idea is a very good one, that there should be reciprocity between the different provinces, in reference to the power to practice, and so on; that should not

be, however, like the handle of a jug, on one side; and we flatter ourselves, rightly or wrongly, that the standard we have established in Ontario stands prominent, not only in this Dominion, but perhaps, in the Anglo-Saxon world. And for us to give our rights to Quebec or the other provinces whose standards may be comparatively high (I don't know as yet that they are, in fact it is impossible for some of them to have an equal standard to us), I think would be folly; I think we should be very cautious in meeting delegates from other provinces until we can equalize our standard. In reference to Dr. Ruttan's remarks about school men, I think they are rather ungenerous; the school men have heretofore shown that they have a liberality not surpassed by the territorial men; they have always been anxious to do what is straight and fair; and as my friend the Dean from Trinity says, I am not a teaching man now; I have got beyond that, and I am merely an honorary man, and I can afford to be straight and square; I have no pecuniary interest, and I think we should hesitate before we come to terms of reciprocity with the other provinces; at the same time I have no objection that there should be a committee to meet these other parties, if so desired; the expense, of course, is a matter of very considerable importance; I do not think the profession have any right to expect men to go from different parts of the country to Ottawa, and attend meetings there, and lose their time for nothing; if it is worth having, it is worth paying for.

Dr. Geikie—I like the remarks of the chairman of the Finance Committee. We want to know what the thing is going to cost. I am a Scotchman, and I believe in knowing what we have to pay. It is very nice to have reciprocity, of course, but we have to be careful that we don't commit a *faux pas*; I think if a small and carefully selected committee could be constituted, with definite instructions—keep out the hateful school men if you like; although I am one of the school men, I would endorse what Dr. Thorburn has said; we have been aspersed as anxious to do all sorts of things, and I would like, as it has been brought up, to emphasize, that, perhaps, the school men have been amongst the most single-minded, and most straightforward men in promoting the interests of the profession—at least as much so as any in the Council; I don't say more so, but quite as much as if we had come from a territorial district. I sincerely hope we will have a small committee, and that the committee will receive definite instructions; and that it will not be landed in a large amount of expense for something that may accomplish no good. I know its promoters desire it should, but they may not accomplish, perhaps, as much as they expect.

Dr. Harris—In order to give the fullest information I would have to go over a great many

papers but, but I can give it to you in brief; yesterday in committee I read different communications from the different registrars from the different provinces; take for instance the Province of Quebec; Dr. Campbell writes, they have appointed a committee to confer with the committee of the Ontario Medical College, suggesting perhaps, the first meeting may take place in Toronto; that if another meeting was required it might take place in Montreal. We have also communications from Nova Scotia, Prince Edward Island and Manitoba; Manitoba is about the only province that seems to be very independent in the matter; I have a paper from Dr. Patterson, of Manitoba which states that they do not seek reciprocity, but are willing to grant it under certain conditions; that is if we brought our standard up to theirs they would grant it.

Dr. Day—They are perfectly right.

Dr. Harris—Quebec seems anxious to have it. I cannot give you any further information. There seems to be a general feeling, and I think the committee will bear me out in that, throughout the Dominion to have reciprocity with the other Provinces and Ontario. Dr. Philip has spoken about the cost of this committee to Ottawa; in reply to that I will first say, that so far as I am concerned I don't know whether I will be in Ottawa or not, but the feeling I have in the matter, is that the Canadian Medical Association will meet there on the 20th September, and Dr. Bray, a member of this committee, is President of the Association and he will certainly be there; there are other members, such as Dr. Moore, who will likely be there. I really do not wish to see the Council put to any expense in this matter at all. If this report is adopted as it stands, it undoubtedly will saddle the Council with the members' fees there, but I would suggest that it be adopted adding a rider to that in amendment.

Dr. Day—I would simply suggest, I will not move in amendment, that Dr. Logan lives in Ottawa, Dr. Bray will be there, Dr. Moore will be there and Dr. Rogers is living there and I think those gentlemen are quite competent to get the ideas of any representatives that may be there from other provinces, and report to this Council as the motion directs. If you take the report as it stands there it means a committee of ten, nine of the Education Committee, and the President of the Council.

Dr. Rosebrugh—The President and the Vice-President both; they are members of all committees.

Dr. Day—This resolution says the Education Committee and the President; that means, on the regular lines of payment, \$135 a day for whatever number of days they are there, and travelling expenses. I think we should be a little cautious; we have been going a little fast on expenses, and

I think if this first consultation with the other representatives could be had without any great amount of expense, it is all right, but I do not think this Council should be put to any expense in the matter; I do not think it is worth the money we would expend if we sent a large committee and paid them per diem. I do not think the information they would receive from it would be up to the value of the amount we would spend.

Dr. Bray—I was very much interested in the portion of the report referring to reciprocity. I have to be at the meeting in Ottawa; and Dr. Moore has to be there; Dr. Logan is there and some other members of the committee no doubt will be there. I would suggest that the committee should receive no pay at all; and let those members of the Education Committee who do not want to come, stay away; there will be enough members there I fancy; as Dr. Day has said, and I proposed in the Education Committee, the committee spoken of should be formed at no cost to this Council.

Dr. Harris—I was certainly under the impression that it would not cost anything, although it is not so stated in the report.

Dr. Day—I would suggest that the report be amended to read "that the committee be composed of the President, and such members of the Education Committee, and such other members of the Council as may be there at the time of the consultation.

Dr. Bergin (in the chair)—The gentlemen going to Ottawa are going to attend the Dominion Medical Association, and ought not to be paid their travelling expenses by this Council.

Dr. Bray—That is the reason why I proposed Ottawa, because there will be members from every Province there. It would be very expensive for the British Columbia Council to send a committee here, or for committees to be sent from Manitoba or Nova Scotia; as it is the men taking an interest in this matter will naturally be there; and it will not or should not cost any Province anything; and that was my object for having the meeting at Ottawa; I do not wish to receive, and will not receive a cent myself; and I am sure the other members of the Association will do the same as I do.

Clause of report adopted as amended.

On motion of Dr. Harris the committee rose, and the President resumed the chair.

Dr. Harris presented the report of the Committee of the Whole, adopting report as amended.

Dr. Harris moved, seconded by Dr. Rosebrugh, that the report as amended be adopted. Carried.

Dr. Miller presented a report of a scale of fees adopted by the medical practitioners in Hamilton for the Burlington and Home District, and moved, seconded by Dr. Campbell, that the report be

received and referred to the Committee on Rules and Legislation. Carried.

Moved by Dr. Moore, seconded by Dr. Rogers, that owing to the large amount of business coming before the Council, that a night session be held. Carried.

The Registrar read a communication from Dr. Prinrose, of Toronto, asking for an interpretation of certain clauses in the curriculum. Referred to the Education Committee.

Dr. Bray moved, seconded by Dr. Britton, that the Council now adjourn to meet again at 8.30 p.m., Thursday, 16th June. Carried.

#### EVENING SESSION.

Thursday, June 16th, 1892, 8 p.m.

Medical Council met in accordance with motion of adjournment, the President in the chair, called the meeting to order.

The Registrar called the roll. All present excepting Sir James Grant.

Minutes of last meeting read and confirmed.

#### NOTICES OF MOTION.

Dr. Rogers, *re* amendment to the Medical Act, 1874, in certain particulars.

Dr. Britton presented a petition of Dr. Geo. B. Smith and others, *re* Dr. S. E. McCully. Referred to Discipline Committee.

On motion of Dr. Moore, seconded by Dr. Harris, the Council adjourned to meet again at 10 a.m. Friday, 17th June, 1892.

#### FOURTH DAY.

Friday, June 17th, 1892, 10 a.m.

The Medical Council met in accordance with motion of adjournment. President in the chair. The Registrar called the roll, all present excepting Sir James Grant. Minutes of last meeting read.

#### NOTICES OF MOTION.

No. 1. Dr. Henry—That the re-arrangement of territorial divisions be referred to the Committee on Legislation.

No. 2. Dr. Rogers—That a circular be sent to every member of the College, together with a copy of the Medical Act, for 1891.

No. 3. Dr. Miller—That the Finance Committee be requested to furnish a statement showing—  
1st. The cost up to date of the building known as the Medical Registration office, at the corner of Bay and Richmond Sts.

2nd. The amount paid up to June 1st., 1892.

3rd. The amount of indebtedness on the 1st June, 1892, etc.

4th. The amount of revenue received from rent from year to year.

5th. The estimated amount of revenue provided all the offices in the building were rented.

Moved by Dr. Campbell, seconded by Dr. Johnson that leave be now granted to introduce a by-law to carry out the provisions of the Act passed in 1887 entitled "an Act to amend the Ontario Medical Act." Notice of which by-law has been given. That the said by-law be now introduced, be read a first time, and referred to a Committee of the Whole. Carried.

Dr. Bray in the chair.

The bill was read, clause by clause, and the second and third clauses adopted.

After the reading of the fourth section Dr. Campbell moved that the blanks be filled with the names of Dr. Day, of Trenton, Dr. Logan, of Ottawa and Dr. Bray, of Chatham, the present members of the Committee.

Dr. Rogers—I think it does not necessarily follow that we should have the same members on the Committee this year. I have no personal objection to any member of the committee, but I beg to move that Dr. Bergin's name be substituted for the name of Dr. Day. I do not mean anything of a character which may be taken as unpleasant, but I think, taking all things into consideration, that it would be advisable in appointing a new Committee this year to substitute Dr. Bergin's name for Dr. Day's.

Dr. Harris—If you have any reasons for suggesting that you had better give them.

Dr. Miller—Why not move a new committee altogether.

Dr. Williams—I think it is only reasonable that the names should be taken up one at a time, to allow the Council to pass upon them; that might be done and might result in a new committee or in the old committee; but if the names were brought up one at a time, the Council would have an opportunity of passing upon each. So far as the names proposed are concerned, my own feeling is, I would stand by the old man,—that is the chairman we had before, Dr. Day; in so distinguished a manner did he conduct himself before, that some of the legal men who appeared before the Committee did not hesitate to say to the members of this Council that he was equal to a Chief Justice. A man who gains such distinction as that before members of the legal profession who are in the habit of appearing in some of the most important courts in this country, I think we ought not to set aside, without some very important reason being given; and, as far as I am concerned, I will stand by our Chief Justice in that matter.

Dr. Campbell moved, seconded by Dr. Harris, that the first blank in the by-law be filled with the name of Dr. Day, of Trenton.

Dr. Thorburn—I would like to say a word in corroboration of what Dr. Williams said; he says Dr. Day got the name of Chief Justice of the medi-

cal profession; but I heard more than that,—that Dr. Day not only had the law but the physical force, and he was able to enforce both. I think that gives him a double claim to reappointment.

Dr. Rogers—I quite agree with the manner in which Dr. Day performed the duties of chairman of the Discipline Committee, but while I agree with that entirely, I think even Dr. Day will admit one thing, that he has now, I believe, accepted and acts in the very important and honorable position of Registrar of the county, and has left the practice of medicine altogether.

Dr. Day—No, I have not.

Dr. Rogers—If I have made an error I certainly wish to withdraw what I said altogether; but that is the impression given me, that Dr. Day has left the practice of medicine and given his time to the work of Registrar of the County and is now outside of the profession. I think to be the chairman of such an important committee whose duty it is to try a brother practitioner, he should be at least a practitioner himself.

Dr. Phillip—I submit that Dr. Rogers is out of order, in not speaking to the point. Dr. Day, there is no question, is a member of this Council so that he is capable of being put on the committee. I do not think we should occupy the time of this Council with such trifling things as that; and I ask the ruling of the chairman on that point.

Dr. Bray—I think Dr. Rogers is out of order but I will put the amendment, that the name of Dr. Bergin be substituted for that of Dr. Day.

Amendment lost.

On a vote being taken on the original motion it was declared carried.

Dr. Campbell moved, seconded by Dr. Philip, that the second blank be filled with the name of Dr. Bray of Chatham. Carried.

Dr. Campbell moved, seconded by Dr. Johnson, that the third blank be filled with the name of Dr. Logan, of Ottawa. Carried.

The chairman then proceeded with the reading of the balance of the report clause by clause.

The committee arose.

The president resumed the chair.

Dr. Bray presented the report of the Committee of the Whole. Adopted.

Dr. Campbell moved, seconded by Dr. Bray, that the by-law be read a third time, passed, numbered and signed by the President and sealed with the seal of the College of Physicians and Surgeons of Ontario. Carried.

#### REPORTS OF SPECIAL COMMITTEES.

Dr. Day presented the report of the Discipline Committee, the petition against Dr. Samuel E. McCully, and moved, seconded by Dr. Bray, that the report be received and filed. Carried.

Dr. Moore presented the report of the Printing

Committee and moved, seconded by Dr. Bray that the report be received. Carried.

Moved by Dr. Moore, seconded by Dr. Bray, that the report be adopted. Carried.

Dr. Hrrris presented the second report of the Education Committee, and moved, seconded by Dr. Ruttan, that the report be received. Carried.

Dr. Bray moved, seconded by Dr. Harris, that the Council go into Committee of the Whole.

Council in Committee of the Whole. Dr. Britton in the chair.

Dr. Harris moved, seconded by Dr. Ruttan, that the report be read clause by clause. Carried.

After the reading of the first clause Dr. Henry said, in regard to the second examination, we gave the privilege to the students two years ago to come up to that examination in September; I approve of that examination and I think it necessary to the interests of young men; but we gave them that privilege and they did not take advantage of it; and we found the cost of the examination was very extensive; and it was dropped. I have an amendment on that clause, "That the spring examinations be held annually on the second Tuesday in April, and a fall examination on the second Tuesday in September, provided a sufficient number of students make application to the Registrar two months previous, and that the fees for such examination be sufficient to cover all expenses, otherwise the said examination be not granted." The fact of having to make application to the Registrar two months previous to the time will put him in position to know whether there will be a sufficient number, and whether the money paid will cover expenses.

Dr. Williams—In that clause of the report there are several propositions, and if it is thought well to amend the clause at all, each proposition had better be taken by itself, because some persons might favor one proposition and not the whole; and if it is not carried *en bloc*, but it becomes necessary to take a vote, it had better be subdivided and taken item by item.

Dr. Day—I would suggest that so far as the fall examinations are concerned that in the amendment you simply move that after the words "fall examination," there be interlined "provided enough applications are made two months beforehand to warrant the Registrar in believing the examination will be self-sustaining."

Dr. Harris—It is proposed to change the fee from \$10 to \$20. You notice in the second clause of that report it reads "that in clause 4, section 4, the word ten be changed to twenty"; we thought this would be a fair compromise. There are a great many appeals laid before us, and many members of the committee thought it was not at all advisable to re-read papers or interfere with the examiners; we thought it would be a fair com-

promise to have fall examinations and give those students who failed at the spring examination an opportunity of going up and trying again; and the fee of \$20 we thought would be adequate for the examination. We do not recommend the examination shall be held in Toronto and Kingston both, but simply at Toronto, and that would lessen the expense.

Dr. Henry—Have you any guarantee that the students will come up to that fall examination? We expected before that they would put in an appearance, but they objected to the fee.

Dr. Britton—I asked the Registrar how many came up last time, and he stated that some hundred odd applied for a fall examination but that only some forty-three came up. I asked him "Could we reasonably expect twenty-five this time?" And he said, "Yes, more than twenty-five." I asked, "What it would cost for the examination?" And he said, "Some were about \$500 or 600, not very much more." I should think from that we have a fair guarantee that the expense will be covered by the fee of \$20 each.

Dr. Henry—Acting on this information I will withdraw my amendment.

Dr. Miller—If that amendment is withdrawn I beg leave to move another which provides that professional examinations be held in Toronto and Kingston, on the second Tuesday in each and every year, and also in Toronto on the second Tuesday in September, in each and every year; and that due notice of such examination shall be given by the Registrar. I think there should be some stability about this matter. I think one principle which has been adopted by this Council is a correct one, namely that there should not be an appeal by a student from his examiner to this Council. In order to show to the students that we have no desire to deal unjustly by them, that we are anxious that they shall have every opportunity of presenting themselves for examination, that there is no intention on the part of the Council to debar them from such privilege, and we provide that in each and every year, there shall be two examinations, not a supplemental examination, but two regularly appointed examinations in every year. It may be that some students, after their hard work during the winter, may be unable to present themselves in April, and it would, I think, be a hardship for a student situated in that way to be prevented from coming up for his examination for a year. Again, providing a student passes a fairly good examination on all subjects except one, it is not fair that he should be kept back a year, and more particularly when we prevent any appeal being had from the student to the Council, as to the mode of his examination. We say, instead of that, we will offer you the opportunity of coming up at a regularly appointed examination in September, in each and every year.

These are my views why we should have two examinations in each year.

Dr. Fulton—I will second that motion.

Dr. Philip—I think the policy recommended by the Education Committee for this year a good one; that is, to have an examination for this year in the fall. Having the fall examination at one place, say Toronto, and not at Kingston, would save a vast deal of expense and would not be an injustice to the students; if they wished a supplemental examination they could go from all points of the Province. I am in favor of a spring examination both in Toronto and Kingston, but I do not think the examination in the fall should be held in both places.

Dr. Williams—I fully accord with the remarks made by Dr. Philip; but while that is true, we know there is at least, about one half of this Council are of the opinion that one examination a year is enough. We have received this year the assent of at least all the Education Committee that this year it is better to have the two examinations; those of us who are in favor of having two examinations always, should not hesitate to accept that step, and when the next year comes let the next year stand upon its merits, but we had better accept the step, now that it is in our favor, and have the two examinations for this year.

Dr. Harris—I think the motion of Dr. Miller is all right in a way; but I believe the clause in the report is a better one at the present time; and Dr. Miller's motion is one that can very properly come up at the meeting of the Council in June, 1893. In our report we provide for an examination in the spring, both in Toronto and Kingston; and we make a special examination this fall; we do not call it a supplemental examination but a special examination and we charge a fee of \$20; in Dr. Miller's resolution he says nothing at all about the fee.

Dr. Miller—I understood your report further on dealt with the question of fees, and that was the reason I said nothing about it in my resolution, and the reason why I framed my resolution as I did. If a student comes up for examination who has failed, that clause will meet his case; he will have to pay a fee of \$20, while a student who presents himself at the September examination, and who did not come up in April, pays the \$10 fee as provided by the curriculum.

Dr. Bray—I quite agree with the views of Dr. Miller; I believe we should have two examinations a year, but at the same time, I doubt very much if we have power to legislate beyond a year; and I think if we have this examination this year, and the regular examination next year, it will be a step in the right direction. I quite agree with the remarks Dr. Williams has made; and I think it is better for those in favor of two examinations a year to accept this report of the committee now,

because I do not believe this Council has power to go beyond a year.

Dr. Miller.—In reply to Dr. Bray, I would say, why give any of our proceedings at all the character of stability? Why adopt a curriculum which we hope will continue to be in existence for years to come? I fail to see why we should adopt a temporary expedient, a temporary arrangement in a matter of this kind, when we ought, above all things, to make this as permanent as possible in order that the young men studying may know what they may depend upon; if it comes to be understood by the students and by their teachers that we adopt certain rules and regulations and that they only prevail for a few months following their enactment, then we will be giving to our rules and regulations and our curriculum, a character which I think should not attach to it; and for that reason I have moved the resolution which I have, because I believe the curriculum which my learned and esteemed friend on the right (Dr. Bergin) succeeded in passing last year is a curriculum which was intended to have a character of permanency about it, and this being a portion of it I should like it to be in the same position, not to imperil one part of the curriculum more than another.

Dr. Day—For the present year this is all right, as right as it can be; I am living in the faith of a permanent fall examination, but that is not a question necessary to speak upon just now; so far as this year is concerned, the fall examination is provided for. I think this supplemental examination should be self-sustaining, because I don't know that the Council is in a financial position to say we must have a fall examination, whether anybody comes up or not; I think we could not very well carry out that view. We talk about making this permanent. We have no power to say there shall be an examination at all after a year from now; next year we may change all this. Two years from now, at any rate, there will be a new Council, that all the permanency this Council could possibly give would be for 1893 and 1894; we could simply express an opinion that it ought to be permanent, in fact, there is no motion in that direction which we may pass now that may not be all upset before we get through this session. I think it is quite unnecessary to have these permanent examination views. We are saying they are permanent in each and every year, but we have no power to say that before we leave here to-morrow night the whole thing may not be changed. Therefore I think it is much better it should stand as the committee have left it.

Dr. Fowler—There is a financial question connected with this examination which I think has not been alluded to by any member of the Council. That is in regard to the fee. In the announcement which has been published for some time, the fee for these extra examinations has been

placed at \$10; and my impression is unless we make this fall examination a special one that we have no right to charge more than \$10 for it." In making it a special examination I think we can charge the \$20, but I question very much after our announcement that the fee for extra examinations shall be \$10, if we can change it except by making this a special examination.

Dr. Philip—In view of the explanation that is made by Dr. Fowler, if the proposer will allow me, I will withdraw my seconding of the resolution.

Dr. Rosebrugh—It says "each student shall pay \$20 for each subsequent examination." I agree it is perfectly right they should pay \$20 for the special examination this fall, but if one or two or three failed to pass that and came up next spring again in the regular way, I do not think they ought to be charged the \$20 for the spring examination.

Dr. Miller—I will move that clause of the report of the Education Committee be amended by providing that a professional examination be held in Toronto and Kingston on the second Tuesday in April, and in Toronto on the second Tuesday in September.

On motion, the first clause of the report was adopted.

Dr. Moore.—I move in amendment that section one, clause one, page twelve of the regulations, be amended by striking out the following words found in the fifth and sixth lines, "with the prescribed science course added and compulsory," leaving the clause to read "every one desirous of being registered as a matriculated medical student in the register of this College, except as hereinafter provided, must, on and after the first day of November, 1892, present to the Registrar of the College, the official certificate of having passed the pass university departmental matriculation examination, whereupon he or she shall be entitled to be so registered upon the payment of \$20, and giving proof of identity." I said yesterday, and the day before, that the way this section was worded, it was unintelligible. We had this up for discussion in the Education Committee last night, and in order that we might prove whether it was really intelligible or whether it was advisable to leave it in this form, it was moved that the opinion of the Deputy Minister of Education be obtained; and I obtained that opinion this morning. I went to the Deputy Minister's office this morning and took the announcement, together with this circular form of theirs, and laid the announcement open before him and asked him to read this, which he did. I then asked him his opinion as to what this "prescribed science course" really meant; and asked him to give his written opinion, which he gave as follows: "Toronto 17th June, 1892, Dr. V. H. Moore. In reply to your communication of to-day, I may say it would not be practicable to modify the require-

ments for matriculation in Arts so as to have the optional subjects to correspond with the compulsory additional subjects of science prescribed for matriculation in medicine. As you will notice, there is no science prescribed for university matriculation; a time paper for the July examination is arranged so as to present no difficulty to intending matriculates. It would not be possible to modify the present course of study so as to change the work in the high schools to suit the comparatively few students intending to take up medicine. I might suggest it would, perhaps, be better to have your requirements worded somewhat differently, say, "the departmental matriculation examination in Arts, and in addition, if not included, physics and chemistry."

I have also another letter from a gentleman whom a great many of you know, Mr. J. E. Hodgson, the High School Inspector, dated June 17th. "Referring to the subject of our conversation this morning, I have to say that unless the matriculation examination of the Medical Council is made to harmonize with the Arts matriculation in universities, the working of high schools will be materially interfered with by the necessity of providing extra classes for a relatively small number of pupils." This is the opinion of both the Deputy Minister and Mr. Hobson, the High School Inspector, who has had a great deal of experience. Therefore, it seems clear to me, as I said before, this is unintelligible to a certain extent; and it is unworkable; and if you leave it as it is, it is going to interfere with the workings of the high schools and collegiate institutes; and as the Minister informed me, a student in order to take this course would have to first matriculate in Arts, and then to take whatever we might fix upon as the science course at a subsequent date. It seems to me, under the circumstances, we ought to work on the lines of the Education Department, and on the lines of the University; and I therefore move this amendment, believing it is in the best interests of the profession, of the students, of the public, and of the high schools, and in the best interests of the educational institutes of the country. I feel if we press this we will have the very same difficulty arising that arose during the last year; the clause was so unintelligible, that the head masters of collegiate institutes and high schools could not understand it. I could not understand it. The professors in Queen's University could not understand it. I am lead to believe our Registrar could not understand it. Then why should we leave anything upon our record as to a portion of our matriculation examination that would not be intelligible and easily understood by every intending medical matriculate. I submit that the best way is to make it the "pass university departmental Arts examination."

Dr. Harris—We intended to have this matter

up in committee to-day, after having heard the views of the Minister, and then report on it. I have no objection to Dr. Moore adding that, because it is part of the same clause really that was intended to be left over.

Dr. Rogers—I submit this is out of order; this report simply specifies the date. We are now discussing only the report brought in by the Education Committee which says that the word "July" shall be changed to "November"; we are not discussing the terms of the matriculation; that has not come before the committee yet; we will report on that, but surely it is out of order before we have had a chance to report on it to discuss it here. Another thing is it was decided in the meeting of the Education Committee last night, and Dr. Moore was there, that we should ask the Deputy Minister of Education to come down to that committee and to give us information. In good faith we took that stand, and in good faith we left it; we did not report on it; and now Dr. Moore, without giving the committee a chance to consider it, brings forward an amendment which I say should be ruled out of order as it is not before the committee; and I ask the chairman's ruling upon it.

Dr. Geikie—It is a pity to waste time on technicalities.

Dr. Britton—I think as an addition to this clause, the amendment is in order.

(To be continued.)

### Selected Articles.

#### ON PREVALENT THERAPEUTIC INCONSISTENCIES IN MEDICAL PRACTICE, ILLUSTRATED IN CURRENT MEDICAL LITERATURE AND IN CLINICAL OBSERVATIONS.

To gain a correct knowledge of the morbid processes capable of taking place in the human body and the laws by which they are governed, on the one hand, and an equally correct knowledge of the action of remedial agents, on the other, are the two great leading objects of every thoughtful and conscientious physician. Without the first, he is incapable of seeing clearly what he needs to accomplish in the treatment of any given morbid condition or disease; and without the second, he is equally in doubt as to the particular remedy best adapted to the accomplishment of the changes desired; and in consequence he is obliged to prescribe empirically such remedies as are recommended by his teachers or authors.

For instance, if he regards any given case of fever as simply increase of heat or pyrexia as its

chief pathological element, without any definite knowledge as to whether such pyrexia has resulted from increased activity in the processes of heat production or a diminution of those of heat dissipation, he will have no guide as to which of the antipyretic remedies is best adapted to the case before him.

Or, if he has learned to discriminate correctly the special morbid processes by which the pyrexia is sustained, but has neglected to study the *modus operandi*, or mode of action of such remedial agents as are known to reduce animal temperature, he is equally in doubt and as liable to choose the wrong therapeutic agent as the right one.

The inadequacy of time hitherto devoted to study in the two directions just named, and the consequent incompleteness of knowledge concerning both morbid processes and the action of remedies, has caused our medical literature to be filled with the most confused and even contradictory statements concerning the application of remedies in the treatment of disease; and sometimes even attributing to the same remedy qualities so diverse as to be incapable of rational explanation.

Opium and alcohol furnish striking examples of the latter. Thus, in that well-known standard work, The National Dispensatory, we are informed that, "alcohol applied to the roots or stems of plants destroys their life. It is poisonous to every animal, producing local or general anæsthesia, according to the mode of the employment. Applied to the trunk of a nerve it paralyzes all its branches, and to the brain it impairs sensation and voluntary motion. \* \* Taken internally, in small quantities appropriately diluted, it excites a sense of warmth in the stomach, and, if the person is very susceptible, an almost instantaneous glow throughout the body, etc. \* \* In larger and intoxicating doses, alcohol occasions such symptoms for a shorter time, but speedily induces a state of impaired perception and motor power, which is followed by one of total insensibility and unconsciousness, in which the phenomena are those of congestion of the brain, and usually of the whole capillary vascular system, although the latter sometimes gives way to coldness and pallor." Yet, on the next page of the same work, the same substance is represented as "stimulating the exhausted nervous system and thereby exciting the distended capillary blood vessels to contract," and as under certain circumstances acting as food. And again that "in the form of distilled spirits, alcohol is the universal and familiar remedy for *debility of every kind*, whether it be due to exhaustion produced by shock or fatigue, or shown by syncope arising from a nervously feeble or an exhausted heart, to wasting chronic disease, or to the tissue destruction of acute febrile affections."

How any material substance can possess such properties as to be capable of diminishing the



sensibility of the whole nervous system, of impairing the oxidizing power of the blood-corpuscles, of lessening metabolic changes in all the living structures, and by contact absolutely poisonous or destructive to both vegetable and animal life; and yet be capable of "stimulating the exhausted nervous system," of becoming real food, and of exhibiting such ubiquitous tonic powers as to constitute a universal "remedy for debility of every kind," is certainly beyond the comprehension of an ordinary mind.

One of the most influential causes of confusion and failure in the application of remedies in the treatment of disease, is the long-continued custom of classifying or rather grouping of remedies in reference to their influence over some one prominent symptom of disease, instead of on their real mode of action in the system. For instance, we group together all remedies capable of efficiently reducing animal heat and call them antipyretics. Hence, we find under that name sponging, packing, and bathing with water, the exhibition of quinine, salicine, antipyrin, acetanilide, phenacetin, digitalis, etc.; and not unfrequently we see nearly all of them given in turn to the same patient during a single run of continued fever. Yet there is no fact within the domain of therapeutics better established than that antipyrin, phenacetin, and all the recently constructed coal-tar series of antipyretics, so modify the hemoglobin of the blood as to lessen its conversion into oxyhemoglobin, and, therefore, lessen the conveyance of the oxygen from the pulmonary to the systemic capillaries, and thereby diminish temperature by diminishing tissue metabolism and the sensibility of the cardiac, vaso-motor, and respiratory nerve centers.

In other words, they diminish the internal respiration by which oxygen is carried from the pulmonary to the systemic capillaries and carbon dioxide returned, and in the same proportion they diminish nerve sensibility and natural molecular and secretory action. Therefore, they reduce temperature principally by depressing all the processes by which heat is naturally evolved. On the other hand, the use of water by sponging, packing, or full baths, increases the activity of the nervous centers and of the natural secreting structures and actively reduces the temperature by increasing the processes of heat dissipation. Thus, while both series of remedies are called antipyretic, they produce their antipyretic effects by influencing the cardiac, vaso-motor, and respiratory functions in nearly opposite directions. And yet, we have often found the practitioner daily administering both kinds to the same fever patient for one or two weeks in succession.

Another cause of much inconsistent and even contradictory use of remedies in the treatment of diseases, is the failure to maintain a clear line of distinction between tonics, stimulants and asæsthe-

tics. Correctly speaking, a *tonic* is an agent that is capable of increasing the tonicity, strength and natural efficiency of some one or all of the structures of the body. A *stimulant* is one that simply increases the excitability and rapidity of action. An *anæsthetic* is one that directly diminishes both sensibility and action, either local or general, according to the method of its use. Within certain limits, it is evident that tonics and stimulants may co-operate in their action on the structures and functions of the living body at the same time; while the action of an anæsthetic is directly antagonistic to both. And still, some of the most familiar and extensively used anæsthetics are spoken of and used as stimulants and tonics both in and out of the profession, and often given alternately with the latter, to the same patient from day to day. Both in standard works on practical medicine and in the periodical medical literature, we find iron, quinine, mineral acids, cod-liver oil, wines, distilled spirits, ammonia, camphor, etc., enumerated as general tonics and stimulants, adapted for the promotion of strength and nutrition. And in referring to special cardiac tonics and stimulants, strychnine and alcohol almost always head the list, followed by digitalis, strophanthus, convallaria, cactus, musk, oxygen, etc. One eminent teacher and writer on practice of medicine says in regard to lobar pneumonia, the two chief sources of danger are "*heart-insufficiency and high temperature*," and he adds that "alcohol, judiciously used, is the most efficient means for overcoming" the first, and the sulphate of quinine in moderately antipyretic doses, the second. Another writer in the January number of *International Clinics*, 1892, formulates the treatment of catarrhal pneumonia in children under the following heads: 1. Fresh air. 2. Relief of pain. 3. Stimulation. 4. Treatment of complications. Under the first head he very properly insists on the most free and efficient ventilation of the sick room, that the patient may have constant access to *fresh air*. For relieving pain he condemns the use of opiates as dangerous in such cases, and relies on simple emollient poultices to the chest. For *stimulation*, he says: "We stimulate by the constant administration of alcohol; fifteen, twenty, twenty-five drops, or a teaspoonful of whiskey, according to age, every two hours." In several very recent numbers of the *British Medical Journal*, correspondents have detailed a number of cases of extreme depression and cyanosis in pneumonia treated with strychnine and oxygen inhalation, and at the same time giving brandy or whisky between the inhalations. Each inhalation revived and improved the aspect of the patient, only to be quickly replaced by the cyanosis and finally the death of the patient. One case came under my own observation, in the treatment of which the attending physician was diligently ad-

ministering oxygen by inhalation and brandy, both by the mouth and rectum. And very many times during the last ten or fifteen years I have seen patients in the second, third, and even the fourth week of typhoid fever, who were diligently taking day after day, antipyrin, acetanilide or phenacetin to reduce the temperature; strychnine and mineral acids to increase innervation or nerve sensibility; and wine, whisky, or brandy as supposed cardiac tonics. If we examine the results of the most reliable investigations concerning the action of the remedies mentioned as used in the cases to which I have just alluded, we quickly learn that the patients were actually using, coincidentally, remedies of decided antagonistic influence on the structures and functions of the human body. For instance, both carefully executed experiments on animals, and abundant clinical observation have shown that antipyrin and the group of antipyretics to which it belongs directly diminish the formation of oxyhemoglobin in the pulmonary capillaries and the conveyance of oxygen to the systemic capillaries, and thereby diminish metabolism, heat production and nerve force. Hence, there are many cases on record, in which their administration was followed by cyanosis and a dangerous degree of depression of the cardiac, vaso-motor and respiratory nerve functions: Still more numerous experiments on animals and almost unlimited clinical observation has shown that alcohol produces a similar effect on the hemoglobin and albuminous constituents of the blood, thereby lessening the tissue metabolism, but more directly diminishing at the same time the sensibility of the whole nervous system in a manner closely analogous to that of chloroform and ether. Therefore, instead of acting as either a stimulant or tonic, it constitutes a true anaesthetic, and has been often used as such, mixed with chloroform and ether. When introduced into the system in any manner, it not only diminishes the sensibility of the cerebral hemispheres and thereby suspends consciousness, but it also lessens the sensibility of the vaso-motor, respiratory and cardiac nerve ganglia, and in direct proportion to the amount used.

On the other hand, strychnine is conceded by all to be capable of directly increasing the sensibility and action of the cardiac, vaso-motor, respiratory and cerebro-spinal nerve structures; and, therefore, is in direct physiological and therapeutic antagonism with the antipyrin, alcohol and other anaesthetics. Consequently when a patient with typhoid fever is given from day to day antipyrin or phenacetin to control temperature, milk and eggs liberally mixed with alcohol for nourishment; and strychnine, mineral acids, and fresh air for tonics; the antipyrin and alcohol directly antagonize the influence of the strychnine and fresh air, both on the nervous centres and on the blood and tissue changes. If in such cases the antipyrin

and alcohol, and all other agents of similar action, were entirely omitted, and judicious applications of water to the surface substituted, the treatment would be harmonious and far more beneficial in its results, as I have seen demonstrated many times during the last half century.

In the cases of pneumonia to which I have alluded, the inconsistency of giving whisky or brandy, or any other alcoholic, freely, alternately with digitalis, strychnia, fresh air or oxygen, is still more apparent. The pneumonic engorgement of the lung has already much diminished the amount of oxyhemoglobin in the blood, and thereby checked both tissue metabolism and renal secretion, as well as dulled the nervous sensibilities, voluntary and involuntary. In such a condition, to set the doors and windows open for fresh air, or to give the patient oxygen inhalations, and at the same time liberally of alcoholics, perhaps twice in the twenty-four hours an antipyretic dose of antipyrin or phenacetin, or a hypodermic dose of morphine, would be much like plugging the larynx of a dog, and then trying to keep him alive by practising artificial respiration without removing the plug.

I am well aware that those who give alcohol in pneumonia, do it in obedience to the teaching that the chief danger in the disease is cardiac weakness and that alcohol is an efficient cardiac tonic. But why does the heart become weak or inefficient in pneumonia? Certainly not from fatty degeneration or any other structural change in the cardiac muscle; but its weakness is either from the diminished oxygenation and decarbonization of the blood through the obstructed parenchyma of the lung, or from the toxic effect of ptomaines or leucomaines, bacteriological or renal, or from all these combined. If it were possible, with the patient in such condition, to simply increase the action of the heart, it would only pump more blood into the already obstructed pulmonary capillaries and still further diminish the natural entrance of oxygen through the air cells of the lungs, and thereby increase the danger of inducing both respiratory cardiac paralysis. The rational indications for treatment, then, are, to lessen the pressure of blood and inflammatory products upon the pulmonary alveoli, and thereby allow the entrance of more oxygen and the exit of more carbon dioxide, and as far as possible to neutralize or eliminate the toxic ptomaines whether derived from the pneumococcus or from retained elements of urine or bile. Just in proportion as we accomplish these, we restore the natural sensibility and action of the nervous structures, increase the renal and hepatic secretions, and promote natural metabolism throughout the system.

But do not both common observation, whether at the bed-side or in the social circle, and the most accurate experimental work show, that alcohol is

a true anæsthetic, diminishing nerve sensibility, muscular force, and the efficiency of the blood in carrying oxygen from the pulmonary to the systemic capillaries in direct proportion to the quantity introduced into the system? If any one has doubts concerning the affirmation of this question, let him read carefully the experiments of Sidney Ringer and Prof. Martin on the action of alcohol on the isolated heart, and those of H. C. Wood, as given in his address on Anæsthesia before the International and Medical Congress in Berlin. If we add to the results obtained by these three, those obtained by R. Dubois in 1883, we have the most complete demonstration, not only that ether, chloroform and alcohol are true anæsthetics, each mutually intensifying the action of the others, but that each directly diminishes that sensibility and action of the vaso-motor, respiratory and cardiac nerve ganglia or centres, in direct proportion to the amount introduced into the blood, until either respiratory or cardiac paralysis ensues. And also that there is no stage in their action when the efficiency of the heart is increased. Then, why longer be so inconsistent in the use of language as to call either of them a stimulant or tonic? And why continue to give one of them liberally with one hand, while with the other you give to the same patient its most direct physiological antagonists, digitalis, strychnine, or oxygen? Or why cap the climax of inconsistency by giving a patient already dangerously depressed from anæsthetics, hypodermic injections of ether or alcohol as supposed restoratives, as has been done many times both in this country and in Europe? Indeed, it is only a few weeks since that a case was reported in the *British Medical Journal*, of a patient whose respiration and circulation had been suddenly suspended during the inhalation of the anæsthetic composed of ether, chloroform and alcohol combined, and, aside from the practice of artificial respiration, the most prominent remedy mentioned was hypodermic injections of ether. Of course, the patient did not recover. Many years since a man was brought into the hospital partially intoxicated by alcoholic drinks, with a dislocation of the head of the humerus. As he was somewhat boisterous the surgeon thought to quiet him and facilitate the reduction of the displaced bone by a cautious inhalation of chloroform. But he had inhaled only a very small quantity before both respiratory and cardiac action suddenly ceased, and all efforts to restore them failed. The amount of alcohol already in his blood and nerve tissues rendered the addition of only a very small quantity of chloroform, acting in the same direction, sufficient to overwhelm their functions. Another case came under my observation, illustrating the danger of giving in quick succession different remedies capable of modifying the functions of the nervous centres in the same direction. The patient was

wild and restless from delirium tremens. To quiet the delirium and induce sleep, the attending physician gave him chloral hydrate and potassium bromide every hour until three doses had been taken, forced a moderate amount of inhalation of chloroform, and finally gave half a grain of morphine, which was soon followed by sleep from which he never awoke. The amount given of any one of the four remedies used was not sufficient to endanger the life of the patient, but the co-operation of all certainly and speedily proved fatal.

Such cases show that it is quite as necessary that the physician should know accurately what remedies coincide and mutually intensify their action, as it is those that directly antagonize each other. And this suggests another item of extreme practical importance. It is to avoid giving a remedy to relieve some troublesome symptom without just appreciation of its liability to increase some of the most important pathological conditions involved in the case. For instance, in many cases of capillary bronchitis and of acute pneumonia, the patient becomes very restless from the oppressed breathing and harassing cough, and at the same time his urine is scant and his blood surcharged with renal and bacteriological toxic elements with excess of carbon dioxide and deficiency of oxygen. But his physician, overlooking these, thinks it necessary to give his patient rest, and for that purpose gives him a fair hypodermic dose of morphine, and perhaps an antipyretic dose of phenacetin to control the temperature. In a short time the patient becomes quiet, sleeps some, and expresses himself as much better, but is still drowsy, with a soft, frequent pulse, frequent and shallow respiration, and moist râles over nearly the whole chest. In from twelve to twenty-four hours, the somnolence, instead of disappearing, is increasing, the pulse is weaker, the respirations more frequent and less deep, the cutaneous surface is moist and dingy or of a leaden hue, and the physical signs of pulmonary œdema are hourly increasing. Now, if not before, the alcohol in the form of whisky or brandy, is given freely for the alleged purpose of sustaining the failing heart. But, nevertheless, in another twenty-four or thirty-six hours the patient is dead. While the morphine quieted the cough and restlessness, giving the patient an appearance of relief, in the same ratio it diminished the efforts to keep the bronchioles and alveoli free, consequently less oxygen reached the hemoglobin of the blood and carbon-dioxide accumulated still more rapidly, until vaso-motor paralysis and pulmonary œdema completed the fatal process. During the unusual prevalence of pneumonia and other acute pulmonary affections that have accompanied the influenza epidemics of the last three years, many cases have occurred to which the foregoing description would apply with almost literal accuracy.

Another of the most common therapeutic inconsistencies that mars the pages of our medical literature and leads to most important errors in practice, is the claim that the same medicine or therapeutic agent, may produce directly opposite effects on the living body by simply varying the dose. Examination will show that this claim is limited chiefly to the two important groups of medicinal agents properly called narcotics and anaesthetics. These are universally recognized as exerting their principal influence on the functions of some part or all of the nerve structures of the body, while some of them exert an equally direct influence on the constituents of the blood and through it upon the metabolism of the tissues generally. Concerning nearly all of the members of these two classes, and especially regarding the two representative articles, opium and alcohol, we are constantly assured that in small doses they are stimulating or tonic; in larger doses, anodyne or inebriating; in still larger doses, narcotizing or anaesthetic; and in still larger doses, paralyzing or destructive to life. Consequently the very general popular belief, and equally popular practice, is, that their use in small doses is cordial, restorative or tonic, and, therefore, beneficial, and injurious only when taken in larger doses. Unfortunately, however, no one has yet been able to define the limit or dividing line where the small or tonic dose ends and the larger or depressing dose begins. All admit that, even in small doses, these remedies diminish the amount of oxygen conveyed from the pulmonary to the systemic capillaries, and thereby diminish the molecular or metabolic tissue changes and the excretion of the products of natural tissue metamorphosis. Indeed, it is on this power to diminish the internal distribution of oxygen and its action on the tissues that one of their chief and most important uses is made to depend, both in health and disease. But while looking in this direction, and, perhaps, admiring the working of this fancifully so-called "savings bank for the tissues," it seems to be forgotten that all nerve sensibility and force depends upon the presence of blood containing the natural amount of oxygen; and that just in proportion as we diminish the proportion of oxygen in the blood distributed to the nerve structure, we diminish both nerve sensibility and muscular action. So true is this, that the simple exclusion of oxygen produces a more speedy suspension of all sensibility or profound anaesthesia than can be produced by the most active anaesthetics known.

Is it not, then, physiologically impossible that any agent should so far diminish the distribution of oxygen in the arterial blood as to diminish general tissue metabolism and not at the same time diminish the sensibility and action of the nerve structures, both voluntary and involuntary? And, if so, how can it be at the same time a cardiac tonic and general restorative?

A careful and thorough review of all the facts, social, clinical and experimental, bearing on this subject, will show that the very general belief in the stimulating or tonic properties of small and repeated doses of alcohol and opium is erroneous, being founded on a wrong interpretation of the primary symptoms produced.

Of course, no such review of the facts can be given within the proper limits of this paper, but I may trespass upon your patience long enough to suggest the more important conclusions to which it would lead. For instance, the temporary quickening of the pulse or heart beat, the sense of warmth and lightness or exhilaration, that pervades the system, and the greater volubility of speech and less restraint in action, which constitute the only foundation for the popular idea of stimulation, on closer physiological analysis will be found to be evidences of coincident diminution of nerve sensibility (anaesthesia), and retarded tissue metabolism. The nervous apparatus controlling the circulation of the blood embraces both cardiac accelerators and inhibitors, and every well-informed psychologist knows that the mental part of the brain furnishes both accelerators and inhibitors of mental action. Indeed, it is the possession of the latter that gives to the human species one of its most distinctive characteristics, namely, the power of self-control and the sense of propriety. Every true narcotic and anaesthetic makes its first recognizable impression simultaneously on the cerebral hemispheres and the vaso-motor and cardiac nerve structures, lessening their sensibility, partly by direct contact with the nerve cells, and partly from interference with the internal respiration. Such lessening sensibility in the cerebral convolutions, when slight, simply diminishes the mental consciousness of outward impressions, and lessens the balance between mental acceleration and inhibition. Hence they exhibit less consciousness of cold, or heat, or pain, and more mental exhilaration, with less reserve or self-restraint.

Precisely the same kind of influence is exerted on the nerves regulating the circulation, causing a very transient semblance of increased activity, but which is really lessened efficiency of circulation and molecular change. Now, if you duplicate the dose of the same agent, the patient's consciousness of impressions is still less, and while he is under the same impression that he could do a great deal, his mental exhilaration and lack of self-restraint has given place to mental incoherence and in-coördination of muscular action. Again duplicate the dose, and your patient soon lies profoundly unconscious, with every voluntary muscle paralyzed, with the cardiac and respiratory functions on the verge of final suspension.

To my mind, it is a clear demonstration that the action of the therapeutic agent was in exactly the same direction from the first and smallest dose

to the largest one. And that direction was one of depression, diminished efficiency and paralysis, from the beginning to the end.

This is fully corroborated not only by the experiments of Dubois, Sidney Ringer, Martin and Wood, to which I have before referred, and many others, but also by a great variety of facts to be gathered from the mortuary, vital and social statistics of every civilized people. Did time permit, I might point out many more important therapeutic inconsistencies that are to be found in the daily routine of medical practice, but those to which I have referred are sufficient for my present purpose. For the leading object I had in view in presenting this paper, was to urge upon your attention the importance of a more thorough study of the nature and true physiological action of the articles of our superabundant *materia medica*, in connection with an equally thorough study of the actual pathological processes that constitute disease.

I would in no wise diminish the activity and zeal that has been, and still is, displayed in studying the causes of disease, whether bacteriological, chemical or meteorological. But I would insist on an equal activity and perseverance in such investigations as will develop more accurate knowledge concerning the action of therapeutic agents in the living body, both in health and in disease. Every living structure has properties, or susceptibilities and affinities, that place it in definite relations to all other substances that may be brought in contact with it, whether as food, medicines or poisons.

And for gaining more exact knowledge of such relations, I would have every medical college laboratory, public hospital and dispensary, furnished with the necessary apparatus and means for such investigations, and with skilled workmen to use them.—N. S. Davis, Chicago, in *Jour. of Am. Med. Assoc.*

### TUBE-CASTS AND THEIR DIAGNOSTIC VALUE.

The study of renal tube-casts is not new. Since Henle, in 1842, first comprehended and announced their importance, their relation to renal diagnosis and pathology has been generally admitted.

The exhaustive essay of Barteis, in Ziemssen's *Cyclopedia*, is an excellent record of our knowledge of casts up to that time; but I think something more may now be added.

For some years past I have had occasion to study tube-casts frequently and consecutively for purposes of diagnosis, and, while doing so, have, insensibly perhaps, arrived at certain results and reached certain conclusions, which it is my purpose to set forth in this paper. I do not claim any new discoveries, but hope my paper will add

something of system and definiteness to the study of casts, and something of certainty to the diagnostic conclusions to be drawn therefrom.

Concerning the origin of tube-casts, I think they are clearly of two distinct kinds, each having a different origin, and each indicative of a different pathologic process. First, we have the mucous, or more properly mucin casts—and I do not think that casts of this variety have received the consideration to which their importance entitles them. Mucin casts I would divide into two groups: (a) Simple mucin casts, without crystalline or cellular elements; (b) Casts that include saline or cellular elements acquired during their formation in the kidney. This division has an important bearing on diagnosis, as I shall endeavor to show presently.

Secondly, we have the true fibrinous casts, or those that have long been recognized and variously classified by different writers; and these may be divided into four groups: (a) The hyaline or "structureless" casts, which contain no formative elements whatever. (b) Blood-bearing casts; (c) Cell-bearing casts; (d) Fatty casts.

This classification may be reduced to tabular form, for purposes of systematic study, as follows:

#### CLASSIFICATION OF TUBE CASTS.

##### Class I. Mucin Casts.

- (a) Simple mucin casts, entirely destitute of formative elements.
- (b) Mixed mucin casts, or those that include crystalline or cellular elements, acquired during their formation in the tube.

##### Class II. Fibrinous Casts.

- (a) Hyaline or structureless casts.
- (b) Blood-bearing casts.
- (c) Cell-bearing casts.
- (d) Fatty casts.

Of course, each group may be divided into sub-groups, but such wire-drawn distinctions serve no good practical purpose, while they are likely to confuse and perplex the student.

Turning now to the first class, the *mucin cast*, let us consider its origin and pathologic import. It is certainly not the product of an exudate, and is therefore not directly derived from the blood-vessels. This fact separates it at once and forever, as regards origin and pathology, from the fibrinous cast, a point to which I shall allude again presently.

It is undoubtedly true that the mucin cast is formed within the renal tubules, and from material furnished by the tubal epithelium, most likely by the epithelium of the convoluted tubes. Under certain circumstances, the epithelial cells seem to

undergo a change equivalent to the "mucoid degeneration" of Ziegler, the protoplasm of the cell being transformed into a mucoid substance, which is afterwards cast into the lumen of the tubule, there to aggregate itself with a similar product of neighboring cells, thus forming the simple "mucin cast," or the long, wavy string of mucin so often seen in urine. The mucin cast is the product of a catarrhal nephritis, a pathologic state to be sharply differentiated from exudative nephritis, with relation to origin, treatment and results.

I have contended for more than ten years that "catarrhal nephritis" ought to have a distinct recognition in our systematic nosology, simply because it is a distinct disease, frequently existing for years and having its own characteristic symptoms and course. The simple mucin cast is the characteristic morphologic product of this disease and establishes its differential diagnosis. Frequently, it is the only reliable indication of the existence thereof, since catarrhal nephritis is not generally accompanied by subjective symptoms of any marked significance.

Together with the mucin cast are frequently found tubal epithelium, leukocytes, and urinary salts, but these have no necessary relation to the pathologic condition indicated by the mucin cast; it alone establishes the diagnosis of catarrhal nephritis.

The "mixed" mucin cast is the "simple" mucin cast plus wherever crystalline or cellular elements may chance to be present. Clinical experience shows that the elements most likely to be present are leukocytes, or crystals of lithic acid or calcium oxalate. The presence of the first indicates that there exists a catarrhal condition of sufficient intensity to induce rapid multiplication of the nuclei of the epithelium, which by reason of the "mucoid" degeneration of the protoplasm of these cells are set "free" and are hence easily inclosed in the mucin cast during its formation.

It may be said that these leukocytes escape from the blood by diapedesis, but if that were true we should have hyaline (fibrinous) casts, instead of mucin casts, since we cannot conceive of a hyperemia sufficient to produce diapedesis without at the same time inviting exudation.

Of course, if hyaline casts are present, exudation is proved, and the diagnosis of exudative inflammation is thereby established. It is not at all unlikely that hyaline and mucin casts may be present together, which would show that the case was in a transition state from catarrhal to exudative nephritis, or *vice versa*, as I have seen in many instances; and it is in just such cases as these that familiarity with the appearance of tubecasts and their diagnostic pointings, is so neces-

sary, since it is impossible to establish a refined diagnosis from any other standpoint.

When the mucin cast includes crystals of lithic acid, oxalates, or phosphates, it is clearly correct to assume that these crystals were deposited in the renal tubules and that they point to a diathetic condition which determined their formation.

From a diagnostic point of view, it is important to note that the crystals are *within* the cast and not adherent to its *surface*; because it clearly warrants the conclusion that they were formed in the renal tubule, and not in the pelvis or bladder.

This being the case, we can readily account for the renal irritation that has led to the renal catarrh and consequent renal inadequacy, so common when these diathetic factors are present. The diagnostic value and the importance of recognizing the crystals and of determining their nature and location is thus clearly indicated.

In the year 1874 and again in 1879 and 1880, the late Dr. Mahomed drew attention to "high arterial tension" as a symptom prophetic of chronic interstitial nephritis, and described what he designated as the "pre-albuminuric stage" of chronic nephritis. His writings attracted wide and well-merited attention, but his unimely death occurred before he had completed his researches and experiments. It was his belief that high tension, or irritable heart, with contracted and resistant blood-vessels, preceded albuminuria, sometimes for months or even years. It was his further belief that the approach of renal cirrhosis might be predicted by carefully estimating the degree and constancy of cardio-vascular tension, by means of consecutive sphygmographic tracings.

A broader study of this subject has developed the fact that this peculiar condition is not certainly present, except in cases of well-marked lithemia, and that even then, as Dr. Granger Stewart has observed, some degree of cirrhosis usually precedes the symptom.

Increased or abnormal vascular tension, then, can hardly be regarded as a prophetic or prodromic symptom of renal cirrhosis, although its value as regards differential diagnosis cannot be denied.

I believe, however, that the presence of the mucin cast is of far greater diagnostic value than is high arterial tension under any circumstances.

In the first place, I am satisfied that the great, in fact, the overwhelming, majority of cases of interstitial nephritis are preceded by a long period of faulty digestion and mal-assimilation. This is certainly the case in the vicinity of Chicago, where my observations are chiefly made. This leads to overworked and irritated kidneys, as Dr. George Johnson first pointed out; but more than that, it leads to the development of renal catarrh, as Dr. Johnson did *not* point out.

Vitiated or abnormal urine produces a catarrhal irritation of the kidney, just as vitiated or abnormal ingesta produce a catarrhal irritation of the stomach. The next event is the appearance of the mucin cast long before any recognizable renal lesion occurs, and long before arterio-capillary tension is present in such degree as to be detected, except by the most expert and experienced sphygmographist. In fact, arterio-capillary tension, as a practical every-day symptom for the guidance of the ordinary practitioner, does not yet possess the value that Mahomed, as well as Gull and Sutton, predicted for it. Its recognition pre-supposes the possession of instruments and technical knowledge not generally possessed by those most likely to encounter the cases to which they are applicable. Moreover, as I have already said, the symptom in question does not usually precede the lesion of which it is an indication. Again, vascular tension does nothing more than suggest a possible diathetic antecedent; whereas it is all-important, if such a complication be present, that it be promptly recognized and appropriately treated.

I claim for the mucin cast a position of preëminent importance in the early diagnosis of interstitial nephritis; more than this, I claim that the appearance of the mucin cast is a prophecy of that change which is only too sure to follow chronic catarrhal nephritis.

Moreover, the cause or "diathesis" that preceded and led to the catarrhal kidney may generally be detected by the microscopic study of the urinary sediment that falls with the casts, and as this "diathesis" includes or rather is the essential pathologic factor in a given case, its early recognition is most important. All this can be done, has been done, is daily being done, by him who is most concerned in all our researches and experiments, namely, the general practitioner. What seems to me a consideration of no small importance is the fact that the recognition of the mucin cast and the crystals or granules of lithic acid are not matters of opinion or guess-work, or questions of comparative judgments, but simply questions of fact and of fact only; these substances are or are not present, and the conclusion is obvious. The degree of arterio-vascular tension in a given case is, however, a matter of comparative judgment at best, and in every case is a very variable factor, present to-day and absent to-morrow.

It is proper, although perhaps needless, to add that the foregoing statements are based on a long and cumulative experience, upon long and careful study of many cases, some of which are still under observation, and are in no proper sense theoretic or conjectural.

I will now ask your attention briefly to the second class, namely, the true *fibrinous casts*. The

presence of the fibrinous cast in urine is abundant proof that sufficient hyperemia exists, or has existed, in the kidney to produce exudation of the fibrin factors, and most probably diapedesis. It is proof, therefore, of the presence of "exudative" inflammation, instead of "catarrhal" inflammation, which I have just considered. I regard it as very essential that this distinction be kept in mind, since it has much to do with the question of treatment, and is all-important in its relation to prognosis. In both forms of disease albumin may be present—present at one time and absent at another. In the early stage of exudative (interstitial) nephritis, the quantity may be so small as to require very careful testing to prove its presence. In catarrhal nephritis the amount is always very slight, many times amounting to no more than a trace. As a diagnostic symptom, therefore, albuminuria has very little value, and no uniform value. Tube casts, however, have a positive as well as uniform diagnostic value, provided their interpretation is understood. One of the most important points settled by them is the question whether, in a given case, we are dealing with catarrhal or exudative inflammation.

The *hyaline cast*—the first variety of the second class—is the simplest and most innocent form produced by exudative nephritis. It is so small and so translucent that it frequently escapes detection, unless the examination happens to be made by an expert microscopist. Its diagnostic value depends mainly upon its frequency and upon its form or symmetry. If only an occasional hyaline cast is found it goes to show that exudation is very slight; that it is in its incipiency, or has well-nigh ceased—a question that can easily be decided by reference to other symptoms that do not come within the scope of this paper. If many are present, exudation is still going on actively. In my own examinations I lay great stress upon the form of the cast. If it is smooth and symmetrical, or free from "twists" or distortions, it seems to me to indicate that it was formed in a tube, not yet disturbed by the encroachments of pathologic connective tissue; but if the cast is not smooth and regular on its surface, and if it shows angularities, as though it had been violently bent or twisted, I am equally confident that the cirrhotic process has already made considerable progress. I regard this a very important diagnostic indication, and one that has helped me very greatly in seeking grounds upon which to found a reasonable prognosis. It will save repetition if I say now and here, that the same observations with reference to symmetry and form apply in equal degree to the varieties of casts that are yet to be mentioned.

*Blood-bearing casts* indicate a hyperemia sufficient to cause hæmorrhage into the renal tubules, although it may be very slight indeed. Hence,

blood casts are commonly regarded as proofs of acute nephritis, and of that only. In every such case, however, it should be borne in mind that while the blood cast may be the immediate result of an acute lesion, a long-standing chronic lesion may have preceded it, and careful search for other forms of casts should be made. In other words, a prognosis founded upon blood casts alone is quite likely to disappoint the expectations of physician and patient. In every case of apparent acute nephritis careful search should be made for casts indicative of pre-existing chronic disease, and it is not wise to prognosticate favorably until several consecutive examinations have failed to disclose the presence of the casts of chronic nephritis. I have rarely encountered cases of so-called "idiopathic" acute nephritis that were not preceded by undoubted chronic nephritis.

*Cell-bearing casts*, the "epithelial casts" of authors, are so common, and are generally so well understood that little need be said about them, except to emphasize some two or three points. Care should be taken to determine whether the cells adhere to the surface of the cast or are incorporated therein. In the former case they may not be the result of pathologic exuviation, but they may represent only cells wasted by wear and tear, whose escape has been anticipated slightly by the friction of the cast as it passes down the tubule. In the latter case they must have fallen off from purely pathologic causes. The shape or form of cell-casts is as significant as that of hyaline casts. Casts from a cirrhotic kidney are likely to be twisted and distorted; casts from a case of tubal nephritis are likely to be straight, symmetrical, and rather large. In either case the cells may be cloudy, granular, or filled with glistening droplets of fat, thus indicating with great precision the stage or condition of the case under examination, as the more advanced the process of fatty degeneration of the cells, the more advanced the destruction of the kidney in which they were produced.

*Fatty casts* are evidences of the completion of the destructive process of which the hyaline cast marks the beginning. They are more or less numerous as the case is more or less advanced in its ultimate pathologic history. They are more or less eroded and irregular as the tubule is more or less denuded of its epithelial lining, and otherwise roughened in its lumen. They are more or less twisted and distorted as the tubule is more or less pulled out of shape and symmetry by the encroachments and contractions of the pathologic connective tissue. Thus they indicate the stage as well as the form or type of the disease of which they are the product. With fatty casts may be mingled hyaline and epithelial casts; in fact, the three forms are frequently found together. The

stage of the disease in a given case would be pretty accurately indicated by the predominating type of casts; but it would be evident that some minor portion of one or both kidneys was either more or less advanced in the pathologic change than the chief portion of these organs.

I have not regarded the *waxy* or *amyloid* cast as entitled to a separate grouping, because it is only an accidental variety of fibrinous cast, presenting no inherent peculiarities of structure, and therefore indicating no pathologic changes in the kidney that are associated with its presence. Waxy casts are almost invariably hyaline or structureless; if they happen to contain the peculiar waxy or amyloid material implied by their name the iodine test will promptly demonstrate the fact, and thus establish the diagnosis of waxy kidney; but clinical experience shows that the amyloid disease can seldom be differentiated in this manner. In conclusion, permit me to add that I have long been persuaded that the course of a given case of acute or chronic nephritis, the type of the disease, the sequence and nature of the pathologic events taking place in the kidney, and the grounds for a reasonable positive prognosis, may be evolved from an intelligent and careful consecutive study of the tube-casts alone. Other factors, of course, enter into the diagnosis, and their value and importance I do not question, but I believe, with Formad, of Philadelphia, that the tube-cast conveys more actual and accurate information to the practised microscopist than any or all other symptoms or signs.—I. N. Danforth, A.M., M.D., in *Med. News*.

#### METHODS OF IRRIGATION AND ANTI-SEPSIS OF THE COLON AND RECTUM IN DYSENTERY.

In the earlier methods of rectal and colon treatment, water was thrown into the bowel, retained for a time and then expelled. Some of the most excellent results are reported from this plan and within recent date. But this cannot but be an imperfect way of cleansing the bowel, although it answers well enough for bringing an antiseptic fluid in contact with the wall of the bowel and with germ-breeding mucus. The objection to it is, the necessity of distending the inflamed coats of the bowel up to a point where injury may be done, if any considerable quantity of water is injected; its advantage is that by this distention the antiseptic fluid washes the inner wall more thoroughly than without it. The method is better fitted, therefore, for subacute cases or those tending to become chronic, than for the acute inflammation with necrosis of the mucous coat. Properly speaking, this method is not irrigation at all, and the only procedure deserving of this title is that in



which there is a *free and immediate escape* of the water thrown in; and even without argument, it is apparent that in this way only can the bowel be thoroughly emptied and made aseptic.

The mechanical difficulties are very much greater in the efforts to irrigate the colon than in the case of the rectum. To wash the *rectum*, a double, in-and-out, hard-rubber tube, passed into the rectum five to eight inches, through which flows a current of water from a fountain syringe, answers the purpose well. The only objection is the pain which attends the introduction of a hard, inflexible instrument through the irritable anus. Two soft-rubber tubes passed side by side, the larger one for the escape current, are more comfortable for the patient and better in every way; No. 17 English (29 French) is a good size for the smaller tube, the escape tube can be two sizes larger. A large-sized soft catheter will do very well for the entering current. The double-current soft-rubber tubes are not so successful; their soft and thin walls are pressed upon by the sphincter and escape of fluid is obstructed. Then again there is an advantage in having two separate tubes, as either can be pushed up or down as it is desired to wash different parts of the rectal wall; they are, therefore, to be preferred to any double-current tube. The disagreeable sensation of distending the anus passes away in a few moments and the patient gets so much relief from the operation that he ceases to object; preliminary cocaine application may be used if the suffering is great.

All that is needed, then, for this operation are a fountain or Davidson syringe, attached to a small rubber tube or large silk catheter, an escape tube of large size of soft-rubber, made long enough by the attachment of a long piece of tubing, so that the fluid escapes into a vessel on the floor. The hand holds and guides the tubes and changes their position from time to time.

The *colon* cannot be distended with water or irrigated with the same facility. That water can be made to pass through the sigmoid flexure there can be no doubt; but the passage of a tube through the flexure into the colon is a difficult task. If this is tried on the cadaver with the abdominal wall removed, one can see how difficult it is; the end of the instrument must describe a complete sharp curve on itself, as if it were about to tie itself into a knot. Even with the hand pressing on the passing instrument and guiding it, it is not easy to accomplish. It is clear from the experiments which I have made, that a partially flexible tube, like the old-fashioned stomach tube, should never be used, and that a small tube does not pass as readily as one which more nearly fills the bowel. Distending the rectum with water as the tube advances, does not favor the passage as much as leaving the bowel empty. The tube finds its way better along the mucus-covered mucous coat.

I speak now only of experiments on the cadaver, when the eye is watching the process; the contrary is the general opinion of physicians from efforts on the living patient. But the turning of the instrument on itself in a cavity filled with water, when the end strikes against the wall is very likely to happen and can easily be mistaken for the onward progress of the instrument. In the rectum the finger introduced discovers the error of direction, but higher up it is not possible to do so.

The conclusion of many trials must convince anyone that the attempt to make the instrument enter the descending colon as often fails as succeeds. The difficulties show that all colon irrigation must be done by one tube. I have tried the double-current stomach irrigator and have had constant failure—the closure of the lumen from twists of the tube or from outside pressure prevents the exit of the injected fluid; so that the only way in which this can be accomplished is to force half a pint or one pint of fluid into the colon and then allow it to escape at once through the same tube; in this way the colon and sigmoid can be thoroughly washed out.

What are the indications for the choice of colon or rectal irrigation? In all cases of so-called catarrhal dysentery where the stools are small, contain blood and mucus and in all cases, mild or severe, where the general or local symptoms are relieved by washing the rectum, no attempt need be made to do more than this. For even when the disease extends into the sigmoid flexure and colon, the curative influence is transmitted along the bowel wall upward, as gargling the throat benefits laryngeal inflammation. If the patient continues to have fever, delirium, great restlessness, or other symptoms of general infection, or if stools are large, thin, with a gangrenous odor, containing blood, mucus, and tissue-like shreds, then the attempt should be made to make the tube pass in the sigmoid for higher injection. If the patient is on his left side, with hips raised, a gentle current may pass from a raised fountain syringe into the colon, even if the point of the tube has not passed beyond the first curve of the "flexure." I need not add that there is a danger of perforating an ulcer, even without much force being used, so that the operation should be done with the greatest gentleness. In the great majority of cases of dysentery as we see it, rectal irrigation may, I hope, by continuing experience be proved to be all that we need to gain the desired end.

The *quantity* of water used depends upon the circumstances of each case; as a rule it should in and out of the bowel until it runs clear, and both in the case of the colon and rectum the amount thrown in should be equalled or almost equalled by the amount which escapes; if the egress is not free the operation must be stopped

until the trouble is remedied. There need be no limit to the quantity of water.

The frequency of irrigation is to be regulated by the number of stools, state of decomposition in the bowel, and other conditions; a good rule is to try to prevent the patient from having any stools at all; let his bowel be emptied only at your command through the inserted tube; at first once in three hours, later three times daily, as the outflowing fluid contains less blood and has less odor. Keep the rectum empty and clean, is the one rule.

At first wash the bowel once in three hours; later three times daily, and so on with diminishing frequency as there are less odor, less blood, and finally less mucus. When mucus is no longer seen in the form of thin flakes the patient may be said to be well; but for a few days one daily irrigation serves a good purpose. Relapses should at once be met by a return to local treatment.

As an irrigating fluid water may be used plain, hot or cold, or may contain in solution any of the numerous antiseptics. Extreme cold or very hot water may be injected, but both must have a more or less irritating effect, and their action, in the nature of things, is intermittent. If a continued current of cold or hot water could be kept on the inflamed surface, the case would be different. The surgeon would not apply great heat or cold for five minutes to an inflamed ulcer of the skin and then leave the ulcer alone for three or more hours. It may be practicable to keep water flowing in and out of the rectum for many hours, but few patients could bear such continued distention of the sphincter.

Almost every antiseptic has received warm recommendation. Fifty-three cases of acute dysentery were treated at the Military Hospital at Oran with a 1:5000 bichloride solution. After the first day the stools were fewer in number, and in three or four days the mucus disappeared; tenesmus and pain were soon lessened.

Lemoine treated fifty-four cases of dysentery with solutions of corrosive sublimate, 1:5000. Six ounces were injected into the rectum twice daily; later a solution of the strength of 1:3000 was injected twice daily. The fluid was not retained longer than ten minutes. Improvement followed immediately, and acute cases were cured in from one to three days. No systemic poisoning followed in any case.

Notwithstanding all this favorable testimony, the dangers of ulceration in the colon being set up by the remedy, and the grave doubts lately raised as to the value of corrosive sublimate as a germicide in just such conditions as exist in dysentery, deter one from using it at all. Under no circumstances should it be employed without an immediate outlet for the solution.

Tannin destroys bacterial life and renders ptomaines innocuous; it is recommended by Can-

tani for typhoid fever, and it may have as good an effect in dysentery for the same reason.

Salicylic acid, thymol, aseptol, sulpho-carbolate of zinc, alum, hydrochloric acid, carbolic acid, boric acid, the sulphites and hyposulphites have all been used and advised, but no sufficient number of cases have been treated by any one of these as to lead to its preference over all other remedies of the same class.

Boric acid and carbolic acid are the only antiseptics I have used frequently; the results have led me to think that the former, or both together, give all we want, and as I believe that a great part of the benefit comes from the cleansing and complete emptying of the rectum, the least irritating and least dangerous germicide ought to be preferred.—W. W. Johnston, M.D., in *Am. Jour. Med. Sci.*

## PRURITUS.

Pruritus may depend on any of the following causes:

1. Local irritation from rough clothing, parasites, unhealthy discharges (saccharine urine, leucorrhœa).

2. Inflammations of the skin; eczema, lichen, early psoriasis, pemphigus; slightly in roseola; sometimes severe after the local use of croton oil or tartar emetic. Desquamating syphilis may itch, but cutaneous affections of the lower layers of the cutis, as a rule, do not itch; and these comprehend most specific eruptions and leprosy.

3. Reflex irritation from the uterus or stomach in urticaria, pregnancy, intestinal worms, or from the kidneys.

4. The presence of certain substances in the blood, such as biliary acids and copaiba.

5. Undiscovered causes, as in true prurigo and strophulus. Kaposi speaks of pruritus cutaneous universalis as a true idiopathic neurosis.

Duhring has described *pruritus hiemalis* due to the effect of cold, and most apt to be felt by pruriginous persons who put on loosely knit underclothing.

Many persons are attacked with pruritus on putting woollens next to the skin, especially Scotch wool.

The uric acid diathesis, gout, and plethora are sometimes causes of pruritus. Certain articles of diet, such as shell-fish, lobsters, beer, coffee, mushrooms, and tomatoes, are thought to cause pruritus in some persons.

Albuminuria may be accompanied by itching due to irritation of the peripheral nerves or of the sensory centres by toxic substances in the blood. Depression of the spirits and various emotional disturbances may give rise to pruritus. Opium causes pruritus, and Hardaway says that the same

symptom is due to the inordinate use of tea, and to oatmeal. A rural tradition ascribes a form of itching to the use of buckwheat. The "Prairie itch," or "Texas," or "Kansas" scratches, is in some cases a form of eczema, in others scabies.

Nasal pruritus is thought to indicate the presence of worms in the intestinal canal in children, or it may precede an asthmatic paroxysm in adults. Pruritus ani in children is due to ascarides, or to phimosis; in adults it accompanies the disorders incident to a sedentary life, hæmorrhoids, fissure, fistula, constipation, enlarged prostate, etc.

Pruritus pudendi may be due to diabetes, vesical calculus, leucorrhœa, varix of the labia; or it may be due to the irritation by the menstrual fluid, and is then only present during its flow. Pruritus of the legs, if not pruritus hiemalis, is generally due to plethora or uræmia. Limited to the feet, pruritus is caused by the accumulation of epithelium, not removed by ordinary ablution. Pruritus senilis, not due to pediculi or to diabetes, is probably caused by atrophy of the papillæ of the skin.

The internal treatment of pruritus should be guarded very largely by the condition of the patient and by the cause of the itching.

The external treatment must necessarily depend very much upon the local conditions present in each individual case, but some of the following formulæ will be found very useful:

R—Camphoræ,  
Chloralis hydrat., . . . . . āā ʒ j-ij.

Rub together until liquefied; then add slowly, with friction:

Ung. aquæ rosæ, . . . . . ʒ j.

M.—S. Ointment. —*Bulkley.*

R—Hydrargyri chlorid. corros., . . gr. j.  
Pulv. aluminis, . . . . . gr. xx.  
Amyli, . . . . . ʒ jss.  
Aquæ, . . . . . ʒ vj.

M.—S. Apply locally. —*Goodell.*

R—Acidi carbolicæ, . . . . . ʒ j.  
Potassæ fusæ, . . . . . ʒ ss.  
Aquæ, . . . . . ʒ x.

M.—S. Lotion. —*J. C. Wilson.*

R—Naphthol, . . . . . gr. cccxxv.  
Saponis viridis, . . . . . ʒ xijss.  
Cretæ preparat., . . . . . ʒ ijss.  
Adipis, . . . . . ʒ cxxv.

M.—S. Apply to parts, and then powder with starch.

R—Sodii biberatis, . . . . . ʒ ss.  
Morphinæ sulphatis, . . . . gr. vj.  
Aquæ rosæ, . . . . . ʒ viij.

M.—S. Lotion; apply twice daily.

—*Meigs.*

R—Ol. staphisagriæ, . . . . . ʒ j.  
Adipis, . . . . . ʒ j.

M.—S. Apply once or twice daily.

—*Balmanuo Squire.*

R—Aquæ laureocerasi, . . . . . ʒ j.  
Acidi nitrici dilut., . . . . . ʒ ss.  
Acidi hydrocyanici dilut., . . ʒ iv.  
Glycerini, . . . . . ʒ j.  
Lactis amygdalæ, . . . . . ʒ xij.

M.—Ft. lotio. For pruritus vulvæ.

—*Greenhalgh.*

R—Acidi hydrocyanici dilut., . . ʒ ss-j.  
Infusi althææ, . . . . . ʒ v-vij.

M.—S. Lotion.

—*Fox.*

R—Potassii cyanidi, . . . . . gr. xv.  
Aquæ laureocerasi, . . . . . ʒ viij.

M.—S. Lotion.

—*Anderson.*

R—Liquor carbonis detergentis, . ʒ ss.  
Glycerini, . . . . . ʒ j.  
Aquæ, . . . . . ad ʒ x.

M.—S. Lotion.

—*Sparks.*

R—Acidi benzoici, . . . . . gr. cx.  
Ol. caryophylli, . . . . . gtt. xl.  
Alcohol, . . . . . ʒ ijss.

Solve, et adde:

Cerati simp., . . . . . ʒ viij.  
Bals. Peruvianæ, . . . . . ʒ j.

M.—Ft. unguent. Especially good for scabies.

—*Potter.*

R—Acidi hydrocyanici dilut., . . ʒ ij.  
Sodii boratis, . . . . . ʒ j.  
Aquæ rosæ, . . . . . ʒ viij.

M.—S. Lotion.

—*Fox.*

R—Potassii cyanidi, . . . . . gr. vj.  
Pulv. cocci, . . . . . gr. j.  
Ung. aquæ rosæ, . . . . . ʒ j.

M.—S. Ointment.

—*Anderson.*

R—Cretæ preparat., . . . . . ʒ j.  
Coal tar, . . . . . ʒ j-ij.  
Ol. lini., . . . . . ʒ ijss.

M.—Ft. unguent.

—*Potter.*

R—Zinci oxidi, . . . . . ʒ jss.  
Potassæ bromidi, . . . . . ʒ ijss.  
Ext. cannabis indicæ, . . . . ʒ ss.  
Glycerini amyli, . . . . . ʒ vijss.

M.—S. Wash vulva with very hot flax-seed tea, and apply above.

—*Ménière.*

R.—Acidi carbolici, . . . . . ʒ iv.  
 Glycerini, . . . . . ʒ j.  
 Aquæ, . . . . . q. s. ad. Oj.  
 Ol. menthæ pip., . . . . . ʒ jss.  
 M.—S. Use as a spray, with atomizer.

—Hardaway.

R.—Thymolis, . . . . . ʒ ij.  
 Liq. potassæ, . . . . . ʒ j.  
 Glycerini, . . . . . ʒ iij.  
 Aquæ, . . . . . ʒ vij.  
 M.—S. Lotion.

—Crocker.

—W. F. Waugh, in *Times and Register*.

OUR MISTAKES.

(Concluded from p. 375.)

It is curious to observe how often our cases run in pairs or groups. With the last case fresh in my mind I was called to see a gentleman in the north. On going into his room his wife said, "Do not bother him by many questions." On asking him to tell me of his complaint briefly, he, pointing to the inside of his thigh, said, "I can tell you in three words, 'It is pain there.'" I asked for vaseline, examined the rectum, and found a malignant mass in the pelvis—a sad solution of a case which had misled two excellent practitioners to suppose he suffered from disease of the pelvis of the kidney. These cases show how narrowly we sometimes miss a diagnosis, and show how important it is to take note of these slight and faint hints if we are to save ourselves from failure. We must, however, take heed lest a great success in diagnosis and treatment unduly impresses itself on our minds and we begin to seek for the same thing, and do the same thing in every case. It is easy to yield to this temptation, and we need to guard ourselves. I have again and again seen even great men plant their favorite diagnosis on the most unlikely cases. Two or three patients of a really great physician came to me a few years ago, each stating they had irritation of the ureter, until at last I was able to say, "Oh! I see you have consulted Dr. So-and-so." In each of these cases the true ailment proved to be lateral flexion of the uterus. Not that I have escaped this mental infection, as I am free to admit I may probably have treated irritated ureter for lateral flexion. Nothing short of a large view and a well-balanced mind can save us from this kind of thing.

An illustration of another kind of mistake which sometimes occurs as the result of a paucity of experience and a good deal of science may be here introduced. It also illustrates the so-called *nimia diligentia* in treating a case by everything but the

right thing. I was called to see a favorite child of wealthy people in Yorkshire, said to be suffering from inflammation of the brain. I found a strong plethoric child, with flushed face and suffused and congested eyes. He was suffering from pain in the head, restlessness and great irritability, together with anorexia and a coated tongue. He was in a darkened room, two nurses were in attendance, and an apparatus for circulating iced water over the head was in active operation. The temperature was taken at frequent intervals, and repeated doses of aconite were being administered. The expression of the child's countenance and his evidently clear intellect did not convey the idea of meningitis to my mind, and I asked when his bowels had acted. No one quite knew, and it was clear they had not acted for a day or two. I gave my opinion to the medical attendant that it was a case of disordered secretions, and insisted on giving three grains of calomel, followed by a dose of senna. We met again in a few hours, and found the patient sitting up in bed quite cheerful and comfortable, after a free purgation, and he was soon quite well. I do not mean to cast any reflection on what is called scientific medicines but I think an old-fashioned doctor would probably have purged at the outset and saved all this bother. Let us never forget the marvels achieved by our old friend calomel.

To omit the abdomen as the most fruitful field of all sorts of mistakes, would be to omit the character of Hamlet from the play. The many different organs contained in it, ministering to functions so different as digestion, excretion, assimilation, and reproduction, give rise to such enormous varieties of physical signs and symptoms that it would be strange indeed if we did not often fail to make an accurate diagnosis and use appropriate treatment here. Added to this is the ever-varying condition of the abdominal walls, due to distension and emptiness of the hollow viscera, the engorgement of the solid organs, and the amount of abdominal fat which often comes and goes with remarkable rapidity. These difficulties, from complication of organs and their changeable condition, can hardly be said to exist in the head or chest, but they are somewhat compensated for by the ease with which the abdomen can be manipulated.

To mention a few of our chief difficulties is all that can be accomplished in a short address. First, there are those connected with abdominal aneurysm, on which a book might be written, and an amusing one, for I shall never forget, when preparing an article on this subject, the extraordinary hits and misses in diagnosis which turned up in looking through the scattered literature of the subject. Existing aneurysms had been diagnosed as renal, hepatic, ovarian, and uterine tumors, and conversely nearly every variety of abdominal tumor, and often "no tumor at all" has been

diagnosed as aneurysms. My well-known case of aneurysm of the abdominal aorta was at one time treated for lumbago, and was subsequently said to be a fecal accumulation, by a man of great experience. The pelvic department of the abdomen is even more dangerous ground than the abdomen proper. It is here that confusion still reigns, as evidenced by the number of so-called exploratory incisions now made in that region. A good book on the diagnosis of pelvic disease is still wanted, but I doubt if the data for it have yet been obtained. The almost infinite variety of conditions brought about by pregnancy and menstruation almost defy classification, and thus general rules are almost out of the question. For instance, ovarian tumors, simple as their diagnosis generally is, often deceive the most experienced, and we must not rely on general rules even here, or the opened abdomen may possibly stagger our nerves and try our resources. Twice over I have been misled by trusting too much to a resonant note in the flank, and a dull abdominal dome, where I discovered our mistake to be due to the fact that the intestines were bound down by adhesions in the lumbar region so closely as to give resonance there in ordinary ascites. Then, again, there are mistakes attaching themselves to pregnancy, about which some experienced accoucheur might give a highly interesting discourse. I recollect a startling case where a patient was about to be admitted to an institution for the removal of an ovarian tumor; but her own doctor thought he would like to do the operation himself, and sent her to me to confirm the diagnosis. Labor pains came on while she was in my waiting-room, and she had just time to reach home in a cab before she was confined. Then, again, there are those trying cases of women who marry late in life, and, being possessed by a longing to have a child, arrive at the menopause and begin to swell visibly. Beware of such women. If you say they are not pregnant they will not believe you, because "they feel a movement which cannot be mistaken." If you for a moment favor their wishes, and incautiously admit it may be so with them, you have staked your reputation on a broken reed, and a day of reckoning lies in store for you some few months hence, "when it does not and will not come off." To be called in under such circumstances is one of the most trying and delicate tasks for a consultant. By a word or a look he may shatter his friend's reputation throughout a wide circle; and yet the truth must be told, either abruptly or—far better—by a gradual un-deceiving of the patient's mind.

Far more serious difficulties surround us when we are face to face with ectopic or tubal gestation. A certain diagnosis in many of these cases is impossible without the exploratory incision, and even then the complications may prevent a satisfactory diagnosis—nay, more, I have seen a case of this

kind so complicated that a post mortem examination failed to reveal the true state of the case. These are cases of the third order, in which a faulty diagnosis casts no blame on us. Let me give a history of a case illustrating the extreme difficulty or impossibility of arriving at a certain diagnosis. I do so the more readily because I believe the case is unique.

Some years ago the late Mr. John Hope and I saw a patient suffering from intolerable pain in the testes. Both testicles were enlarged, the left as large as a goose's egg, the right slightly smaller. As the enlargement and sufferings increased, especially on the left side, we decided to remove that testicle. On doing so we found a healthy testicle encased in dense concentric layers of suet-like fat about an inch thick. The relief obtained made the patient urgent to have the right testicle removed too, which was done with complete relief. Some months afterwards this man came to me again in a deplorable condition. His body was emaciated, but the abdomen had become enormously enlarged and extremely painful. The abdominal swelling was uniform and dough-like on palpation and absolutely dull on percussion, without any evidence of fluctuation. His chief symptom was a mucous diarrhoea over which remedies had but slight control. He died of exhaustion. On making a post mortem examination, we found the enlargement was entirely due to the presence of hundreds of fatty tumors scattered throughout the folds of the peritoneum. The mesentery was a mass of them. They varied from the size of a pea to that of an orange, and each was composed of concentric layers of suet-like fat similar to that found around the testicles. The smallest were concentric as distinctly as the largest. The most remarkable developments were in the appendices epiploicæ, each of which extended into the abdomen like a large bunch of grapes studded with fatty nodules. We might, if we had had a similar experience, have divined from the testicular encasements the real cause of the abdominal enlargement; but, lacking this, I think it was impossible to make a sure diagnosis. But I must draw this part of my subject to a close, or I should like to have alluded to the difficulties which surround the medical men who is called to see a patient in the initial stage of any of the acute febrile diseases, especially of infectious diseases. If he speaks of his suspicion too soon he may find he has given needless alarm; if he hesitates too long he may be blamed for not speaking soon enough. A wary outlook, an expectant state of mind, and a knowledge of human nature are all needed to save him from a false position. Lastly, the mistakes which occur in the treatment of disease may be divided into those arising from a false diagnosis and those in which the wrong remedy is used wherever diagnosis is correct. I need not say that for the most

part a false diagnosis is the cause of most of our mistakes, and this has already been dealt with. With regard to the first application of the treatment when the diagnosis is correct I may say this is often owing to the want of a true appreciation of the temperament and constitution of the patient, whereby we are led to give what is good enough for the disease, but bad for the patient. Let us ever remember, therefore, that we are treating patients as well as diseases, and what may, rigidly speaking, be the right thing for the disease is often the wrong thing for the patient. Take the case of tonics, such as iron and quinine. I know of nothing which has destroyed the confidence of patients, both in medical men and medicines, more frequently than the administration of these remedies to debilitated, anæmic, and phthisical patients when they were quite unable to bear them. How often do we see a patient in the early stage of phthisis suffering from the miseries of dyspepsia added to those of his disease. And yet we find such a patient is being treated by cod-liver oil, or iron and quinine phosphates, which only add still further to his misery. Or, again, take the case of anæmia in which the fault lies in a weak and irritable gastric membrane. Nine out of ten of such patients become considerably worse when treated by ferruginous tonics. Or, again, take the case of a patient recovering from an attack of gastric catarrh: to select the exact moment when that membrane will be able to bear a tonic, and decide what tonic to give it, is one of our most difficult problems. In early phthisis, in anæmia, in the exhaustion of gastric catarrh, I rarely venture on any so-called tonic medicine, and prefer to give aids to digestion and sedative correctives until I am well assured the stomach will tolerate such remedies as iron, quinine, or cod-liver oil. I cannot help thinking these misapplications of the right remedy for the disease in unsuitable cases is the secret source of that sceptical attitude which many able men have assumed towards the beneficial action of medicines. In early life they expected too much, and blamed the medicine when really it was its application which was at fault, and so they have lost faith. I, for my part, have an undying, nay, an increasingly vital faith, in the virtue of medicines, and I hope to live to see the day when mankind at large will accord to rational scientific medication the place it undoubtedly deserves to hold in its esteem. Many hints which I could give as the result of thirty years careful study of the action of medicines crowd upon my mind, but I must not trespass further, except to say that much depends upon the method of combining our remedies. I believe in combinations; without them we cannot put limitations to the action of our drugs, and we cannot guide them to the right spot. One medicine, so to speak, conditions another, and some are complementary to each other.

Take digitalis as an example. Do we wish to act upon a weak heart in an anæmic subject we combine it with iron. Do we wish it to act upon the heart where all the organs are engorged from re-gurgitation in a plethoric subject, we give it combined with mercury and purgatives; or, do we wish to relieve pulmonary congestion arising from the same cause, we combine it with ether and ammonia; or, do we wish it to act on a sluggish kidney, we add some suitable diuretic. We thus, as it were, condition and conduct our remedy to do its work in the right direction. To do otherwise would lead to serious mistakes, and might shake our faith in the power of this mighty drug.—W. Murray, M.D., in *Lancet*.

A CASE OF SPASMODIC TORTICOLLIS TREATED BY AVULSION OF THE CENTRAL END OF THE SPINAL ACCESSORY NERVE.—A lady aged twenty-eight was brought to me in August, 1885, by the late Dr. Troutbeck, for very troublesome spasm of the left sterno-mastoid muscle. She first experienced trouble in the neck eight years before, soon after the death of a near relative; the jerking of the head had persisted ever since, gradually getting worse. The patient was a tall, thin girl, and delicate looking. There was no history of fits; she had had facial neuralgia, but not severe migraine. The spasm appeared to be entirely limited to the left sterno-mastoid muscle, and was so severe and constant as entirely to preclude the patient from mixing in society, and at night it was some time before she could get to sleep. Dr. Angel Money applied the constant current to the muscle on nine occasions, but with no benefit; indeed, the spasms appeared to be increased in severity. So on Sept. 10th, 1885, with Mr. Hudson's assistance, I exposed the spinal accessory nerve by means of an incision along the anterior border of the upper part of the sterno-mastoid muscle, intending to stretch it and excise a considerable portion. In stretching it from the central end I felt the nerve gradually give way, and I pulled out a long, slender nerve from the jugular foramen and excised four inches and a half of it. No special symptoms were noticed from the tearing of the nerve roots. The wound healed without complication, and the patient returned home on Sept. 23rd. She called on me on Sept. 8th, 1886. She was then in much better general health, her head was held erect, and was quite steady. She could turn it freely to the left and about half the distance to the right, and she was gaining power in it. The left sterno-mastoid muscle had completely atrophied, and the cervical portion of the left trapezius muscle was markedly smaller than the right. The patient was able to mix again in society, and was very pleased with the result of the operation. A year later (October

1887) Dr. Troutbeck saw her, and reported to me that she was "quite well, except for occasional fatigue felt in the neck; no jerks." The satisfactory result of this operation was, in my opinion, chiefly due to the fact that the spasm was limited to the one muscle—the sterno-mastoid. I have on two subsequent occasions intentionally removed the central end of the spinal accessory nerve in the same way for spastic torticollis. The operation is quite a simple one, the delicate roots of the nerve rupture and a long tapering filament is drawn out from the spinal canal. These two cases were treated last year and it is too early to pronounce with certainty upon the result of the operation in them.—A. Pearce Gould in *Lancet*.

ON HOT BATHS.—Dr. Benjamin Howard has been drawing attention to the method of bathing adopted by the Japanese. The general opinion is that a frequent repetition of the hot bath has a debilitating effect. The *warm* undoubtedly is, but whether a very hot bath would have such an effect if continuously used has not been put to the test in this country. It would be worth trying by people who suffer from rheumatism or who cannot take a cold bath. Dr. Howard writes: "In hygienic matters the Japanese have everywhere a habit which may have a lesson for us. In their nightly bath and morning wash the water is never cold, never warm, but always as hot as it can be borne. To foreigners this habit seems very surprising, but the most inveterate Englishman, if he stays in the country long enough, abandons his cold tub in its favor. The cold-taking, which it is suspected must follow it, is found not to occur if the water has been hot enough. This heat is maintained by a little furnace beneath the bath. In the bath the bather or bathers take a prolonged soaking, the washing proper being done on the bath-room floor; then follows a second and final soaking, drying with towel, and a lounge in bathing wrapper. This habit seems to promote softness and suppleness of the skin, and by persons inclined to rheumatism is soon found to be altogether preferable to the cold bath in every particular. The poorest of the Japanese hear of a cold bath with amazement, and would be sure the man who used it must be a barbarian. With respect to the superiority of the hot bath over the cold, I have come to find that in my own case certainly the Japanese are right."—*Popular Medical Monthly*.

THE TREATMENT OF EPILEPSY.—Dr. Guy Hinsdale has shown from his clinical observations that potassium bromate shares with the bromides the power of controlling epileptic seizures, but it is an irritant intestinal poison, lowering the pulse and depressing the heart to such a degree that in most instances it had to be abandoned. Magnesium

bromide exerted an undoubted power in controlling the attacks, both as to frequency and severity; there was, however, apparently a greater liability to facial eruption than in the case of potassium or sodium bromide, and Fowler's solution of arsenic was usually given in addition. Hydrobromic acid was fairly successful; it is not likely to cause acne nor muscular depression, and, in some cases, it is usefully added to lessened doses of alkaline bromides. Certainly, in some instances, it does aid digestion or at least has no tendency to impair that function. The use of nitro-glycerin has not been sufficiently encouraging to insure its continuance. In some cases, when the improvement was most striking at first, the attacks soon returned, and the remedy had to be abandoned. Nitrite of potassium proved too depressing and produced marked cardiac irritability. Antifebrin succeeded in keeping the attacks, in one case in which the bromides had failed, down to such a number that life was saved, but usually only temporary improvement was noted, and in a few weeks it was necessary to return to the bromides. Sulphonal was used in several cases with more or less unsatisfactory results, and appears to answer admirably as a substitute when the bromides have to be discontinued on account of bromism or other disagreeable complications. He has used sodium bichlorate, lithium bichlorate, tincture of cannabis indica, tincture of digitalis, ammoniated copper, and antipyrin, but none of these remedies maintained themselves. He has fallen back, then, upon the bromides of sodium, potassium, and lithium, employing most frequently the sodium salt, which is well borne for long periods, when arsenic is used occasionally to check cutaneous disturbances.—*International Medical Magazine—Am. Jour. Med. Sci.*

THE EXCISION OF STRUMOUS CICATRICES OF THE NECK.—In a paper read before the French Congress of Surgery, *Le Progrès Médical*, Calot reports signal success in removing the unsightly and often pigmented cicatrices resulting from the spontaneous opening of suppurating lymphatic glands of the neck. With a bistoury he removes the entire extent of altered skin, encroaching one or two millimetres upon the normal integument. The edges of the wound are then freed from the underlying tissue and brought together with fine sutures, so as to make a linear closure of the exposed surface, no drainage being required. The result in all of thirteen cases thus treated has been eminently satisfactory, showing only a fine linear scar in place of the former ugly, irregular cicatrix.—*Am. Jour. Med. Sci.*

A new building is in course of erection for the School of Medicine of the University of Buffalo.—*Med. News*.

# THE CANADA LANCET.

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## POLEMIC MEDICINE.

The *odium medicum* is an old thing, and has been from time immemorial at once the bane and the cause of progress of the healing art, as well as the cause of many a gibe from the laity. It exists both as between individuals of the same school, and between the different schools, and must always exist, seeing that opinions must differ in a subject which deals, as that most brilliant literary member of our profession, Dr. O. W. Holmes, says, "not in certainties nor in demonstrations, but chiefly in probabilities." It has been left to the theologians to develop a branch in their curricula, entitled Polemic Theology. Perhaps the medical fraternity, being so occupied in study more important, are kept too ignorant of polemic medicine, and do not know enough of the views and systems taught by other schools than that in which each has been brought up. The "regular" practitioner, in proportion as he is an honest and capable man, can see in the homœopathic practitioner, with whom he refuses to consult, only a knave or a fool. His judgment is not usually based on calm review of the authorities worshipped by his opponent, and in that far cannot be said to be scientifically sound. And it would take so little reading of homœopathic manuals to satisfy a scientifically trained medical man of their utter fallacy, that any practitioner can easily form an independent judgment if he chooses. Dr. G. M. Gould, of Philadelphia, offers a prize of \$100 for the best essay of not more than 15,000 words,

type written, placed in his hands by January 2nd, 1893, on "The Ridiculous Pretensions of Modern Homœopathic Practice." A jury of physicians will read the essays, and the best will be printed for distribution among the laity, the main condition being that the essay "in simplicity and directness should be adapted to the commonest lay understanding." Giving Dr. Gould credit for the best intentions, we venture to say that the scheme is too much like fighting the devil with fire. Homœopathic practice, as judged by the perusal of their materia medica in both text-books and drug lists of commercial concerns, stands very much nearer the laity than does scientific practice, is very much more easily "understood (*sic*) of the people," and lends itself far more readily to *ad captandum* argument, and grossly misleading quasi-scientific analogy.

It is all very well to laugh, as does O. W. Holmes, that "if a billionth of a grain of sugar won't begin to sweeten my cup of tea or coffee, I don't feel afraid that a billionth of a grain of anything would poison me,—no, not even if it were snake venom." The answer given in explanation of the claim for increased potency due to increased trituration or dilution, is the false analogy, to any mind with even a blink of pathological and chemical training, utterly indefensible, of the better effect of manure upon soil, the more finely divided it is and the more minutely its portions are brought into contact with the microscopic rootlets, as if a solid when once in a state of solution, could be more finely divided by further dilution. The farmer to whom this analogy was presented would at once think that he saw the point, side with the homœopathic argument, and consider himself as good a man as his doctor, and so he would be if his doctor advanced such an argument. The text-book from which the above amazing explanation (*sic*) is taken is a limbo and chaos of incontinent attack upon men of such eminence as Virchow and Wunderlich, instead of a continuous and logical setting forth of homœopathic tenets. Of inflammation the author says: "Hence in homœopathy, there is neither a specific fever nor a specific inflammation, since all substances, proved on the human body, are capable of producing both fever and inflammation, though each one is different from the other according to the kind of irritation present. . . . To pre-



sent a picture of inflammation in general, even for a single organ, belongs, hence, to the realms of impossibilities, though of this physiological medicine has no idea." It seems a waste of ink to reproduce such pathology as that. The laity cannot be made to see the fallacies of homœopathic practice, since they are fallacies due to ignorance, and to prove them one would need first to instruct his layman in physiology, chemistry, anatomy, and all the subjects of a liberal medical education. How could one set to work to show up the ignorance of the Toronto practitioner, who, to cure ring-worm of the scalp, prescribed some of his glo, bules and quite neglected local measures? And while the public continue to look on disease as many homœopathic practitioners and writers do, as an occult entity, rather than as a condition of the tissues and fluids, a something to be exorcised and banished by the use of remedies, often most disgusting, the action of which is not sought to be understood but is looked on rather with superstitious awe, how can we expect them to side with scientific rather than with occult medicine?

The text-book on homœopathy, to which we refer, says for instance that arnica if sufficiently attenuated will always cause tearing toothache in the left upper molars. That malaria, if accompanied by cold feet and legs, should always be treated by arsenic, but if not, by ipecac; since "in the proving of ipecac there is no complaint of cold feet or soles, whether sitting up or in bed." That "nux vomica and many other drugs cannot be given during the night, because they aggravate just those very phenomena of disease which they should relieve, and which when given during the day they do relieve and cure." That "humid asthma," and other lung diseases, are cured completely by the administration of dried lung of the fox in trituration of one grain of lung in 100 grains of sugar of milk, given in one grain doses every hour, the *rationale* being that the *pulmonic acid* (!) of the human lung being deficient, as evidenced by the disease existing, it can be best replaced by giving the above dose of the lung of an animal fabled to always have strong lungs. How show the mediæval ignorance and folly of such therapeutics to the average lay mind, when the laity persist in ideas which made it possible recently, for instance, for a mother in the country, near Toronto, with all its medical schools, to empty the bottle of expectant

torant mixture prepared for her son by the doctor, and substitute a decoction of sheep-dung, the boy being induced thus in ignorance to take the disgusting mixture, which he would otherwise have refused, and the cough hitherto intractable to "doctors stuff" yielding promptly to the mother's treatment, as the mother fondly and firmly believed! Probably the majority of homœopathic practitioners would repudiate now such therapeutics, and claim a more rational system. But if they practice scientific medicine, as in proportion to their success in serious cases they must, why, if honest, do they persist in arrogating to themselves the trade mark and title of homœopathy, unless it be to injure so far as they can the honest man who practices under his true colors, and to deceive the public into thinking that they have some new and better way of evading death, while the "allopath," that title of offence to the class purposely so dubbed by the rival school, still gropes in the darkness of ages past and gone?

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#### THE ONTARIO MEDICAL COUNCIL.

That there is a widespread dissatisfaction among certain members of the profession, regarding the more recent acts of the Council cannot be ignored, though such feeling is much to be deplored. It must be admitted that our Council has done good work for the medical fraternity of Ontario. If we consider the protection that is afforded to regular and educated physicians, the steady elevation of the standard of requirements in medical knowledge, necessary before a candidate receives the *imprimatur* of the Council, so that our licentiates take and hold a respectable, nay, even honorable position, as regards their training, in any part of the world, and as compared with licentiates or graduates from any medical learning anywhere, and the certainly not extravagant or expensive manner in which this has been accomplished, surely it must be granted that the Council has done much good work.

Mistakes have no doubt been made; no body of men is infallible, but we cannot but think that, looking at the status of the profession in Ontario to-day, and comparing it with what it was at the time of inception of the Council, the work of that body has been, on the whole, such as must commend itself to

every reasonable member of the profession. There seems to be a feeling of annoyance among some that they shall annually pay the sum of \$2 towards the maintenance of the Council, which has become so obnoxious to them, and for the defraying of such necessary expenses for the conducting of examinations, registrar's salary, etc. Surely the amount is not too great for a man to pay yearly, for the support of body upon the integrity and business capacity of which, the very existence of his profession depends. If the members of the Council, individually or collectively have been either incapable, or guilty of dereliction of duty, then let the fiery cross be sent round, and let them, individually or collectively, be returned to their homes and other good men and true sent to fill their places, but do not let us in the present age complain that the impost is too much. How much does it cost a man per annum to belong to the Masonic order? Just about three times as much as to belong to the medical brotherhood by which he earns his living, and which *must*—if we do not wish to be overrun by quacks and charlatans, and if we wish our rising generation of medical men to be properly educated, and take their place in the ranks of the educated men of the world—which *must* be supported. No medical man will attempt to compare the importance to the medical profession of one or other of these institutions being maintained, and yet how many doctors—they are nearly all enthusiastic Masons, and all the better for it—pay without a murmur the amount considered necessary for the proper running of the honorable and respected Masonic machine, from the Grand Lodge down.

The Masonic body has been instanced, but the annual dues of many other secret organizations might be given to show that \$2 per year is a sum, small indeed to pay for the maintenance of the honor and dignity of the grand and noble profession. The druggists pay \$4 for their protection, which it must be admitted is not nearly so complete or certain in its working as ours. The lawyers pay about \$18, and we do not hear any revolutionary murmur in the camp. They either pay or quit the game.

The majority of the aggrieved ones, however, and it may be said to the honor of that majority, resent, not the amount to be paid, but the threat by which the "dun" is accompanied; viz., that the names of all who do not pay shall be expunged

from the register, rendering them legally unqualified to practice in Ontario, though they received their degrees and licences to practice for life many years ago. They regard the punishment as altogether out of keeping with the delinquency—that of failing to pay a trifling sum annually.

They enquire—Is not a power like this, given, in equity, if not in law *ultra vires*? Could the collection of the dues not have been secured in a fairer and less irritating manner?

The answer to the above, appears to us, who have taken some pains to get at the true inwardness of the doings of the Council as regards its financial operations, more especially as to the collection of dues, seems plain. When the annual due was \$1, many men, we fully believe from forgetfulness and the habit of procrastination, did not pay. It was not that they wished to evade the law, or get out of paying their just dues; they would have been indignant, and rightly so, if any one had seriously imputed to them the desire to sneak out of paying what they owed to the profession, \$1 per year, and yet *they did not pay*. This same habit of procrastination in the payment of small debts is not singular to those owed to the Council; would it were so.

So, many of the registered members *did not pay*. How could they be made to pay? By ordinary suit in the Division Court of the district where the delinquent lived. This proceeding was found to cost nearly as much as it came to, so that it was a sadly losing game for the Council. (See President Williams' address, CANADA LANCET, July, '92.

So far as irritation and annoyance is concerned, it cannot surely annoy a man who intends to pay his dues, to have certain penalties attached to his non-payment of them. It is not fair that some should pay, and some go scot free. Yet this was exactly what was happening under the old *régime*, in spite of the powers vested in the Council, for it did not pay to collect by an ordinary suit at law the dues owing the Council, and necessary for its proper maintenance. If any due is necessary, and if \$2 in a year is not too much, both of which propositions seem clear, what difference can it make to an honest man who intends to pay, what penalty is attached to his non-payment, even were that penalty—death by hanging!

## DRUNKENNESS AS A DISEASE.

The constancy with which the various so-called cures for inebriety are foisted upon the public and the frequent disappointment of those who pin their faith to the utility of drugs as in inherited or acquired disturbance of the higher nervous system, indicates how much yet remains to be done in the way of educating public opinion up to the proper comprehension of the complicated process, involved in the "cure" of a condition arising from such different and even conflicting causes. The *Medical Press and Circular*, speaking on the subject, remarks, "The treatment of chronic inebriety by restraint, is just now upon its trial, but although it yields a certain proportion of successes, it has not yet falsified the adage that *qui a bu, boira*."

In America, the so-called "Gold Cure," is attracting a great amount of attention, and certainly seems to do good in a large per cent. of cases treated, though controversy exists as to what extent it may be due to "moral effect." Keely, the originator of the treatment, claims that 95% of his patients are cured of all taste or desire for alcoholic stimulants, but admits, that if the "graduate" deliberately sets about cultivating the taste for it, he may become as badly off as before. But speaking of the treatment by restraint, or sequestration, we find it is only useful in cases where the habit has been acquired by self-indulgence, with no element of heredity in the case.

This is, however, not condemnatory of the system of self-sequestration, which is all that the law has seen fit to authorize. The most regrettable cases, and, at the same time, the most hopeful ones, are those persons who have fallen victims to the habit, owing to a want of prudence in the use of alcoholic stimulants. The average healthy man only resorts to liquor for social reasons, or to whip up his system when jaded and fatigued from overwork or worry, the temporary relief, so obtained, however, draws upon a store of latent nerve force, which, from constant depletion, weakens the will power, necessarily dependent, as a manifestation of nervous change or action, upon a thoroughly healthy condition of the nerve store, or latent accumulation of psychic energy; until at last the fatal day arrives, when the unfortunate victim finds himself the irresponsible slave of a

new growth of nerve-cells, whose ancestors in the economy, so to speak, have handed down to them an inability to perform their functions properly without alcohol, just as the want of oxygen in the circulation causes an "air craving," in the cells of the respiratory centre. In such cases there existed no lack of self-control or will power at first, and until the habit became a disease or rather an intrinsic nerve condition, this will power could have been exerted with good effect. It is in such cases that restraint, for a longer or shorter period, as the case may call for, is of great utility in bringing about a cure. But, on the other hand, in the poor unfortunate born into the world, a child of his ancestor's middle life, and formed habits of indulgence in sack, Madeira, or other stimulants so fashionable in other days, morally weak from the beginning, predestined, we might almost say, to ruin, if brought into contact with drink, we find that sequestration lamentably fails, and that the only hope lies in his never touching the drug, and being taught when a child wherein his danger lies. A great many such cases are unfortunately seen among the mentally gifted; how many do we all know of, who seemed to have success, power, riches, happiness at their command, who suddenly faltered in the race of life, struggled hopelessly for a time, and sank back into a drunkard's grave. Others, again, become affected at certain periods with the "drink crave," having little or no desire for it in the interval. Such cases resemble the disease to which the French psychologists have given the expressive name of *folie circulaire*, which is characterized by periodical outbreaks of mania, the patient being lucid in the interval, but requiring restraint during the attack. In many cases of this rhythmic "drink crave," the condition may be looked upon as an alternative manifestation, to epilepsy, insanity, or other nervous diseases, which upon investigation may be found to mar the patient's family history, so that we clearly see the hopelessness of drug treatment in such a condition of affairs, there being an inherited lack of nutrition of the higher nerve centres, the unfortunate victim being really a moral idiot. In conclusion, thinking men must agree, that great caution is to be exercised in the acceptance of any one cure for all classes of inebriates, remembering, that although many who have acquired the habit may be treated with success, those belonging to

the other categories are unfortunately doomed to outbreaks, so long as the stimulant is manufactured, and may be obtained by them.

### CANADIAN MEDICAL ASSOCIATION.

The twenty-fifth annual meeting of the Canadian Medical Association will be held in Ottawa on Wednesday, Thursday and Friday, 21st, 22nd and 23rd September, under the Presidency of Dr. John L. Bray, of Chatham, Ont. Arrangements have been made with the G. T. and C. P. Railways whereby members may obtain return tickets for one fare and a third. Members and delegates must procure certificates from the station agent at place of departure.

Judging from the number of members and delegates who have signified their intention of being present, the meeting to be held in Ottawa will in all probability be a very successful one.

Members desirous of contributing papers will kindly communicate with the General Secretary (Dr. Brickett, 123 Stanley Street, Montreal) at as early a date as possible. Appended is a partial list of papers:

Address in Medicine: "The Treatment of Pulmonary Tuberculosis"—Dr. J. E. Graham, Toronto. To be discussed by Dr. Prevost, Ottawa.

Address in Surgery: "Observations on the Progress of Surgery in our own Day"—Dr. Donald MacLean, Detroit, Mich. To be discussed by Dr. V. H. Moore, Brockville.

Address in Obstetrics: To be discussed by Dr. Harrison, Selkirk.

Gastro-Enterostomy—Dr. L. McFarlane, Toronto.

Chronic Bright's—Dr. McPhedran, Toronto.

Intussusception and its Treatment by Operation—Dr. F. J. Shepherd, Montreal.

Treatment of Abortion—Dr. K. N. Fenwick, Kingston.

The Management of Goitre—Dr. Dupuis, Kingston.

Uric Acid in Children—Dr. A. D. Blackader, Montreal.

Diseases of the Naso-Pharynx associated with Ocular Affections—Dr. Buller, Montreal.

Prostatectomy—Dr. Geo. E. Armstrong, Mon-

Appendicitis—Dr. H. P. Wright, Ottawa.

Biological Analysis of Some Canadian Water Supplies—Dr. Wyatt Johnston.

Unrepaired Laceration of the Cervix the most Common Cause of Epithelioma of the Cervix Uteri—Dr. Laphorn Smith, Montreal.

Case Illustrative of the Influence of Diseases of the Female Generative Organs upon the Visual Apparatus—Dr. Ryerson, Toronto.

(1) Two Early Deaths from Gonorrhœa; (2) Enterectomy for the Cure of Fæcal Fistula—Dr. H. H. Chown, Winnipeg.

An Epidemic of Morbilli Hæmorrhagici—Dr. C. J. Edgar, Sherbrooke.

Hemorrhage in the New-born—Dr. F. A. L. Lockhart, Montreal.

(1) Administration of Chloroform and the Dangers incident thereto; (2) (a) Phlebitis of the Left Femoral Vein caused by an Embolism coming on three weeks after Hysterectomy. (b) Aneurism of the Abdominal Aorta—Dr. J. D. Balfour, London.

.....—Dr. A. E. Prægor, Nanaimo.

(1) Notes on Eye Lesions consequent on Nasal Affections; (2) Traumatism of the Labyrinth—Dr. Geo. Baptie, Ottawa.

Papers have also been promised by Sir James Grant (Ottawa), Dr. Mullin (Hamilton), Dr. Geo. McDonald (Calgary), and Dr. Johnston-Alloway (Montreal).

A special general meeting of the Association of Medical Officers of the Militia of Canada will be held during the session of the C.M.A.

### GOLDEN RULES OF SURGICAL PRACTICE.—Continued—(Times and Reg.):

GENITAL-PENIS.—Never sanction a lengthened or adherent prepuce—circumcise.

Never despise any skin in stitching up scrotal wounds—the worst flap will heal.

[Warm a wound of the scrotum before uniting it with sutures.]

Always slit the urethra downwards in amputation of the penis, and stitch the angles outward.

Always keep a catheter in position continuously in injuries to the penis, if the urethra is divided.

Do not tap a hydrocele without examining the position of the testicle with the light.

Do not strap a testicle without shaving the scrotum.

Do not give a decided prognosis of a solid slow-growing tumor of the testicle in which hydrocele co-exists, before you have tapped the hydrocele and examined the gland carefully. It may be non-malignant. If any doubt exists after this advise a free incision.

GONORRHEA.—Never forget to warn your

patient about his eyes in treating a "first" attack of gonorrhœa.

In giving a "first" case of gonorrhœa copaiba, always warn your patient of the possibility of the eruption.

Never neglect, in treating gonorrhœal rheumatism to cure the discharge as speedily as possible.

In examining the cause of a knee synovitis of a young man never omit to examine the penis for gonorrhœa or gleet.

In inquiring into a history of syphilis do not hastily judge of the statement of the patient that a rash was syphilitic; inquire about copaiba.

Never use an injection if there is much pain, scalding, or inflammation, unless it be cocaine.

Never forget many gleans are due to slight contractions of the canal, and may be cured by a steel bougie.

**HAND AND FOOT.**—Do not forget that it is wiser, in cases of supposed needle in hand or foot, when the patient is not suffering much inconvenience, not to cut down unless the end of the needle is felt.

Never estimate the amount of flat foot when your patient is *sitting*, because the weight is taken off the arch.

Do not forget that the foot may be amputated for supposed strumous disease of the tarsus when, on examination, the affection might have been proved to be limited to one of the tarsal bones, and the patient might have been cured by a less extensive mutilation.

Do not despise or neglect corns, bunions, or ulcers of the leg in the aged, or diabetic. They often start gangrene.

(To be continued.)

**GONORRHEAL CEREBRO-SPINAL MENINGITIS.**—Dr. Stiénoü (*Jour de Méd de Bruxelles,—Med. Rec.*), relates a case of cerebro-spinal meningitis in a young man, which, according to the author's views, was due to the location in the cerebro-spinal meninges of gonococci from a urethritis which was found present, just as the germs of epidemic cerebro-spinal meningitis, typhoid fever, erysipelas, acute rheumatism, etc., are capable of vegetating in this region and developing their effects. The occasional production of arthritis, peri- and endocarditis, periostitis and neuritis, from the presence of this microorganism, plead in favor of the author's

hypothesis and permit the conclusion that while meningeal manifestations from gonorrhœal infection are very rare, they are by no means impossible.

In connection with this subject the following will be of interest: In the Johns Hopkins Hospital Bulletin for May, Dr. W. T. Howard, Jr., reports the case of an infant operated upon for imperforate anus in which the rectal wound suppurated. The child died in the second month, of purulent ependymitis, meningitis, and encephalitis, and a bacteriological examination of the pus from the inflammatory area showed the presence of a micrococcus and of the *Bacillus coli communis*. The child had atresia of the pulmonary orifice of the heart and patency of the foramen ovale and of the ductus arteriosus, and the reporter thought the feebleness of the circulation had favored the mixed infection by means of the suppurating rectal wound. He calls attention to Netter's bacteriological examination of twenty-five cases of simple meningitis, in which the *Diplococcus pneumoniae* was found present in fifteen; the *Streptococcus pyogenes* in four; an intra-cellular diplococcus in two; a short, active bacillus, the bacillus of Friedländer, and a slender, small bacillus, respectively, in the three remaining cases. Monti also found the *Diplococcus pneumoniae* in the pus of four cases of meningitis; and the frequency of the presence of pneumococcus is explained by the fact that meningitis is so often secondary to pneumonia and otitis media. Besides these microorganisms, Dr. H. M. Biggs, reported, at a recent meeting of the Section in General Medicine of the New York Academy of Medicine, a case of meningitis in which he had found the bacillus of anthrax, although there had been no local focus of that disease on the body. It is interesting to note the varieties of microorganisms that may cause meningitis.

**NEW TREATMENT OF ASTHMA.**—Dr. B. O. Kinnear (*N. Y. Med. Jour.*), holds that asthma is a nervous disease, the circular bronchial muscles being chiefly affected. The pneumogastric nerves and their congestive centres are mainly responsible for the asthmatic paroxysms. By excluding the blood from these centres, their function is rendered normal; consequently the muscles about the bronchi expand, and the swelling of the mucous membrane subsides. This

result is obtained by ice applied over the spine in such a way, that, the circulation being naturally distributed over the body, the congestion of the centres is at once lessened in the acute attack. He maintains that ice over the spine dilates the arteries throughout the body, distributing the blood to organs and tissues where there has been an insufficient supply. The ice is applied in bags extending from the 4th cervical to the 3rd lumbar vertebra daily, in time varying from three-quarters of an hour to four hours. Six cases are reported. *Case I*, is that of a woman 60 years of age, who was a sufferer from asthma for 16 years. Ice was applied in a full length bag, and used four hours a day, an hour at a time. The patient was practically well in six weeks. *Case II*, that of a boy with hereditary asthma. Application of ice bag at once relieved the paroxysm. The results in the other cases show, that the asthmatic attacks may be subdued or controlled by the application of ice to the spine, and that if the patient is not too old, or the disease of too long duration, cures may result.

DELEGATES TO THE DOMINION MEDICAL ASSOCIATION.—The following are delegates from the Ontario Medical Association to the Dominion Medical Meeting, in Ottawa, Sept. 20th: Drs. R. W. Hillary, President; Drs. Chas. O'Reilly, J. E. Graham and D. J. Gibb Wishart.

WOMEN'S MEDICAL COLLEGE, TORONTO.—The following appointments have been made in the staff of the Women's Medical College here:—Dr. G. Gordon, Lecturer in Sanitary Sciences; Dr. F. Cane, Mental Diseases; Dr. S. Boyle, Histology; Dr. J. Gray, Assistant in Anatomy.

TO LANCE A SWOLLEN TONSIL.—Christopher Heath says (*Internat. Clin.*):—Do not try to get round the anterior pillar of the fauces, but go straight back through the soft palate, and no effort on your part can possibly bring the knife into any relation at all with the carotid vessels. Open the upper part of the tonsil.

TURPENTINE IN TYPHOID FEVER.—Dr. H. C. Wood (*Therap. Gaz.*), believes that turpentine is

of great service in healing intestinal ulcers, which, after the fever, so often cause diarrhoea and intestinal indigestion. Again, the remedy is of great service when we have tympanites with dryness of the tongue, developing in the end of the second week of the disease. Wood, believing that turpentine acts locally, that in all cases of typhoid fever ulceration exists, that properly administered the drug is incapable of doing harm, is in the habit of giving towards the close of the second week of typhoid fever turpentine, without looking for special indications, and, as the result of an experience of considerably over a quarter of a century, he believes the practice to be a good one, and that the use of turpentine does distinctly tend to lessen the severity of the local lesions in enteric fever. In closing this brief paper, attention is called to the powers of glycerin in disguising the taste of turpentine; the following formula is given:

R.—Ol. terebinthinæ . . . f ʒ viii.  
Glycerinæ . . . . . f ʒ i.  
Mucil. acaciæ . . . . . f ʒ iss.  
Aque menthæ piperitæ, q.s. ad f ʒ viii.—M.

Sig.—Tablespoonful every four hours during the day. Shake well.

MAGNESIUM SULPHATE IN CATARRHAL INFLAMMATION OF THE DIGESTIVE TRACT.—Dr. S. Bradbury (*N. Y. Med. Rec.*), has had considerable experience with this remedy in inflammation of the mucous, areolar and muscular coats of the bowel, and thinks very highly of its efficacy in such conditions. The dose administered must be a large one. He says: "I have found, in a large experience in using this salt, that small doses do more harm than good. The smallest dose for an infant should not be less than a heaping teaspoonful, and a great spoonful may be given without harm. The truth is, the greater the dose the less it gripes. In my case above, I took half a pint of clear salt dissolved in water without the slightest griping when operating. This medicine does good in the case mentioned, evidently by producing a copious discharge from the lining of the digestive tract, without having any but the slightest effect upon the muscular coat. It is totally unlike ordinary cathartics, it simply causes the excretion of fluids from the digestive mucous

membranes, hence the safety in giving large doses, as the intestinal muscles are not acted upon by them."

ACROLOZONE, "HARVEY'S."—Manufactured in this city, is a somewhat similar, but much more staple preparation than hydrogen peroxide. It is a powerful antiseptic and can be used with greater freedom than the peroxide, owing to its being un-irritating. It is of particular value as a wet dressing for ulcerated surfaces, serviceable in cases of chronic suppuration, and simply invaluable in diphtheria. It is also being administered in teaspoonful doses, in certain cases of dyspepsia.

CORRECTION.—In our last issue, in the proceedings of the Ontario Medical Council, at p. 375, we stated that Dr. Moore moved a resolution relative to the Finance Committee. It should have read "Dr. Millar moves," etc.

### Books and Pamphlets.

A TEXT-BOOK OF THE PRACTICE OF MEDICINE, for the use of Students and Practitioners. By R. C. M. Payne, M.D., Professor of General Medicine and Diseases of the Chest, in the New York Polyclinic, etc. Wm. Wood & Co. N.Y., 1892.

This new volume, which is by no means one of the compend or quiz sort of text-book, is a very compendious treatise upon the large and important subject undertaken. One may make its scope plainer to Canadian readers by saying that it seems to occupy the same place in medicine as does Walsham in surgery, and while it seems incorrect to call it a text-book for the use of practitioners, it would appear very well suited to the purpose of the student. Even on the latter, however, it is probable that the effect of the exclusive use of such brief treatises in student days is not good, as tending not to develop the habit of reading in more extensive works; a habit which will not be well formed in the busier journal-reading days of practice, if the foundation be not laid before those days begin. The classification of diseases is modern and refreshing, rheumatism, articular and muscular, being classed where they belong, among the acute infectious disorders. Diseases of the heart and respiratory system alone

occupy rather more than one-third of the book, a circumstance due, perhaps, to the natural insistence of a specialist upon his own subject. The paper is excellent, and the typography very good, but the lack of proper paragraphing, and arrangement of the subject on the page so that the untrained eye and mind of the student may be aided in reducing order from chaos, is very apparent. It strikes one as unscholarly to see Latin and English incongruously mixed, as thus: "Fl. ext. ergot," where "ext. ergotæ fl." is meant; or thus, "I have usually given it in ten-grain doses ter die for about six weeks"; or thus, in a prescription, "Pulv. potass. iodidi, Fowler's solution, aquæ q.s. ad." etc.

A TEXT-BOOK OF NURSING; for the use of Training Schools, Families, and Private Students; compiled by Sarah S. Weeks-Shaw. Second edition, revised and enlarged. Illustrated, pp. 391. New York: D. Appleton & Co. Toronto: Carveth & Co., 1892.

This new edition is up to date, as regards the new procedures in surgery—those of the last half dozen years—and with which every trained and competent nurse should be familiar. A chapter on Gynæcology has been inserted, and it will be a welcome addition to the book. The book presupposes a certain knowledge of anatomy and physiology, it having been found impossible to incorporate these. The work is well written, and well printed, the illustrations are good, and, taken as a whole, the work is perhaps the best we have seen on the subject.

ESSENTIALS OF DIAGNOSIS; Arranged in the Form of Questions and Answers, prepared especially for Students of Medicine. By Solomon Solis-Cohen, M.D., and Augustus A. Eshner, M.D., with fifty-five illustrations, some colored, and a frontispiece. Philadelphia; W. B. Saunders, Toronto: Carveth & Co.

This is one of Saunders' well known series. The price is \$1.50; pp. 382. The general scope of such work is well known. While they must be harmful to the student if read to the exclusion of standard works, they certainly fill a place in the student's room,—that of the old-fashioned note book. The present volume is well up with the most modern ideas regarding diagnosis. The differential diagnosis of diseases will be of much use to the student.