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Original Communications.

THE GENERAL PUBLIC AND THE MEDICAL PROFESSION.*

—
BY ADAM H. WRIGHT, M.D.
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According to the constitution of this Association, I am now called on to deliver an address, setting forth the conditions of the profession in this province, with such suggestions as I deem it proper to make. In referring especially to the relations existing between the profession and the public in Ontario, I may say, in a general way, that they are pleasant and satisfactory. Our efforts, in a private way, and in a public way, are at least fairly well appreciated. The public are frequently kinder to our profession than we are to each other. In this respect history is simply repeating itself.

If we consider some of the triumphs of medicine during the century now closing, we will find that some of our heroes got little or no support from their professional brethren. One of the most important features of the early years of the century was the complete triumph of vaccination. Edward Jenner had perfect confidence in vaccination in 1770; but, after that, he labored quietly and persistently for thirty long years before he published his first treatise on the subject in 1800. We were told by Dr. Ward Cousins last year, that, although the new method spread rapidly over the whole civilized world, the acceptance of vaccination was due to the efforts of public-spirited men rather than to those of the members of the medical

* President's Address, delivered at meeting of Ontario Medical Association, June, 1900.

profession. Many of the doctors of that time considered vaccination as pure quackery, and even charged the vaccinator with flying in the face of heaven.

About the middle of the century Semmelweis made a great discovery in midwifery. In 1847 he enunciated the view that puerperal fever was caused by the introduction of putrescent substances from without, and used chlorine as a disinfectant. By his new method he reduced the mortality in one of the lying-in hospitals from 11.4 to 1.27 percent. Notwithstanding the proof he adduced, his views were bitterly opposed by the great mass of the profession. We have been told by Cullingworth, that he was ridiculed and despised, and finally died insane, the victim of continued persecution.

It is much more satisfactory to consider the work of another hero in the latter half of the century—that grand man of our own time—Lister, who has reached so high a niche in the temple of Fame. It is pleasant to think of those “gifts of nature which gave him a happy combination,

The patient thought, the steadfast will,
Resolve and foresight, strength and skill,

which he has laid upon the altar of suffering humanity” (Mr. Jno. Wood), and through them the great work he has accomplished. We all rejoice that Lord Lister has received his reward; that all peoples of all nations of the civilized world have united to do him honor.

We have heard much in recent years about the advances made in medicine, and the greatly improved status of the profession; and yet it is difficult for the student of to-day to fully realize the truth of such statements. The following advertisement taken from a newspaper of Shakespeare’s time will give us an idea of the position, social and otherwise, of a physician of that era:

WANTED.

In a family who have had bad health, a sober, steady person in the capacity of doctor, surgeon and man-midwife. He must occasionally act as butler and dress hair and wigs. He will be required sometimes to read prayers and preach a sermon every Sunday. A good salary will be given.

In those days the physician was generally depicted by writers (dramatists and others) as a cunning knave or an ignorant charlatan. What a contrast is presented in considering the position of our profession to-day. The painter makes the physician a hero. For instance, take Mr. Luke Fildes’ picture, “The Doctor,” which you have probably all seen. Mr. Mitchell Banks speaks about the original painting as follows: . . . “Of the

hundreds of medical men who must have stood before that picture I am sure there was not one whose pulses it did not quicken with pleasurable pride, or who left it without thinking that it already had been, and again would be, his privilege to fight against pain and suffering and death like his colleague on the canvas. For to us he is a real living man like ourselves. We have acted like him and felt like him.

“ Note where the scene of the picture is laid; not in some rich man’s mansion, where the doctor might reasonably expect a handsome fee for his trouble, but in the workingman’s cottage, where, most likely, the gratitude of the people and a consciousness of having done his duty by the poor will be his sole honorarium. With admirable skill the painter has pitched on the early hour of morning for the time. The light of the lamp in the room and the light of the dawn coming through the casement are struggling with each other. It is the cold, sad hour when human vitality is the lowest and when statistics tell us most men die. The sick child, worn with the raging fever, that commonly burns from eight in the evening till one or two in the morning, lies spent and exhausted. Till then the parents have been fighting on with their nursing, soothing, caressing, encouraging their little one. But now, they too are exhausted and depressed, and hoping against hope seems all that is left to them. And there sits their friend—the gentle doctor—watching with them, and still puzzling his brains to think what more he can devise to stay the lamp of life from flickering out. He is no courtly physician, no London specialist, that man, thank God. He is only a country doctor. But his somewhat rugged face tells of honesty and common-sense, self-reliance and gentleness. What more do you want? The men that look like that man, whatever be their business, or trade, or profession, whatever be their wealth or their social position, I say, of such men is the kingdom of heaven.”

Mr. Gladstone, some years before his death, spoke as follows about our profession: “ And speaking of the body of the profession it is impossible for us not to notice the change, it is impossible for us not to see how far more strongly now than of old, the medical man of to-day conforms to those general laws of common-sense and prudence which are, after all, universal laws of human life in every one of its departments. It is impossible not to see his greater and more sustained earnestness of purpose, that elevated sense of the professional dignity, that desire to make it subservient to humanity, that general exaltation of his aim in the exercise of his profession.”

This is a generous tribute to our profession from a personal point of view. From another distinguished British statesman we get kindly words as to the scientific side of the profession.

Mr. Mitchell Banks tells us that a few years ago the Marquis of Salisbury went down to Oxford to plead for the Radcliffe Infirmary and said : "I believe that if you respond munificently to the appeal that is made to you, you will do something more than place this Infirmary in a position of which it need not be ashamed ; you will be taking a long step towards introducing more closely the cultivation of one of the greatest of the sciences—the science of medicine—in this ancient university. I always think that science has scarcely received among us all the tribute it ought to receive among the sciences which rest upon observation. It is the most sober, the most absolute, the most positive among all the sciences. Again, there is no other science—which is but another name for a work of mercy—there is no other science that is so closely linked with the relief of human suffering as a remedy for human calamity in its most overwhelming form."

This, coming from a man who in his younger days was distinguished as a scientist, who in latter years kept himself fully in touch with every advancement in science, whose chief relaxation to-day is working in his chemical laboratory, is a magnificent tribute to our profession. Tell your parson, tell your lawyer, tell your funny friend when he gets off that old joke about doctors differing, that one of the most distinguished statesmen, who is at the same time one of the greatest scientists of the world, says positively that the science of medicine "is the most sober, the most absolute, the most positive among all the sciences."

The modern novelist delights to describe the doctor as Fildes has painted him. We all love such noble specimens of our order as George Ohnet's *Le Docteur Rameau* and Ian Maclaren's *Doctor MacLure*. I need go no further in this direction as I have given sufficient evidence to prove that where the doctor was despised two hundred years ago, he is respected and honored to-day.

If it be admitted that the public are, as a rule, well disposed to our profession, it may be well to consider what return we make to this same public for their kindly consideration. I will refer very briefly to this aspect of the question ; but I may say that we try to replace the gross quackery and charlatanism of past ages by careful methods of investigation and general honesty of purpose. We are earnestly trying to place medicine on a scientific basis. We are endeavoring to do our duty both to our patients and the general public. We are not all heroes ; but, as far as my experience and observation have served me, I have known very few physicians who have not done some kindly and generous acts in their professional career, and I have known many who have done numerous, generous and noble acts in a very quiet and unostentatious way. In fact, some

good souls appear to form a habit of doing such things without knowing it.

How do the members of the profession treat each other? Frequently, not very well, sometimes very ill—I am sorry to say. There is altogether too much mutual distrust and small-minded jealousy in our ranks. I often think that we are apt to become big in great things, and small in little things. Let me refer first to the town containing only two doctors—Smith and Jones. The two physicians, working together in a profession that we are pleased to designate as a noble one, should be on the most friendly terms. It is in the interest of themselves, their patients, and their profession that such should be the case. And yet how frequently do we find that they are deadly enemies. Such enmity is really a calamity for both Smith and Jones, and also for the science of medicine in that town. Sometimes, instead of open enmity, there is an armed neutrality; that is a little more respectable, but scarcely less objectionable.

This sad condition of things is so common that it appears to me that we ought to continue to put forth some strenuous efforts to improve matters. What are the causes? Smith and Jones are both good and honest practitioners, we will suppose. The success of each must depend largely on his reputation. This is a truism which both fully appreciate, and concerning which both are duly or unduly sensitive. The public are apt to put a relative valuation on our services. Smith and Jones may be equally good doctors, but a large portion of the community will refuse to think so, and a section will praise Smith at the expense of Jones. This is very unpleasant for Jones and he resents it. He hears that Smith has said something of an unfriendly nature about him. Some simple remark made by Smith is so terribly twisted and grossly exaggerated in the report given to Jones that the latter becomes very angry. If Jones asked Smith about the matter, in nine cases out of ten the trouble would probably be settled amicably. I have only to say professional jealousy is not confined to small towns. In this city—Good Toronto—we have quite a sufficiency of the commodity.

I have not time to discuss in detail the means we should adopt to banish jealousy from our ranks, but I may say, in a general way, that we should endeavor to see more of each other. There is no better way to do this than by attending the annual meetings of our Provincial and Dominion Medical Associations. A man like our able and genial friend, Dr. Harrison, of Selkirk, who always attends these meetings, is a broader and more generous man than Dr. Jones, of Selkirk (if there be such a man there) who never attends them. When we meet in groups of two or more we might be a little more charitable in speaking

of absent ones. I heard, a short time ago, a friend of mine speak to a small group of doctors in Toronto who were talking about a physician, whom I will call Jones, in terms not altogether complimentary, as follows: "Why is it that you fellows never have anything nice to say about Jones? He has at least nine good points for one bad. Why can't you sometimes refer to some of the nine instead of eternally harping about the one?" I think it would be well for us to act on my friend's advice, and cultivate more than we do that greatest of all virtues, charity, in criticising the characters and acts of our professional brethren. I have but little to say about our ethical codes which are intended to promote peace and brotherly love between us. They are well enough in a way and accomplish much good, but we must not rely too much on them, because there never was and never will be devised a code which will make a crooked man straight.

I do not wish, however, to be considered a pessimist in this connection. As a matter of fact I am not. I love and respect my profession and my friends in that profession. As I have frequently said to my student classes, our profession is a great and noble one in the sense that it gives us grand opportunities for good work in the interests of suffering humanity. If we work honestly and conscientiously, having regard to our duties to God and man, we will make the profession of medicine good, great and noble in the best sense of the words.

This country has produced many specimens of the better and higher type of physician. I will refer simply to one, James Elliot Graham, whom we hoped to have as our presiding officer at this meeting. He was the father of our Association in a sense, as he first conceived the idea of its establishment, and was one of the chief promoters of its organization. Dr. Graham was one of the greatest men and one of the most high-minded physicians that this country has produced. I think I can speak for the whole profession of Canada when I say that through his death this province and this Medical Association have suffered an irreparable loss.

There has been, I think, no time in the history of this Association when its members were doing more in the interests of the public than now. Our Public Health Committee had an interview with the Hon. G. W. Ross and the Hon. J. R. Stratton during the last session, and asked the Government to make some provision for the treatment of inebriates and dipsomaniacs. The Government had before that declined to do anything because of the expense, but when it was suggested that the probation system, as carried out in Massachusetts, was not expensive, the interviewing committee was asked to draft a bill to be introduced into Parliament. This was done, and

the proposed bill was presented to the Premier. The bill did not, however, come before the House, although I understand the members of the Government are favorably disposed towards an inexpensive scheme for benefiting this class of unfortunates. Dr. A. M. Rosebrugh, of Toronto, has for years taken a very active interest in the matter, and in his good work has been greatly assisted by Dr. Wm. Oldright. These gentlemen are very anxious to get all the help possible from the members of this Association in the promotion of their good work.

Another extremely important matter is that relating to the prevention and cure of consumption and other forms of tuberculosis. The results at the Gravenhurst sanatorium, and at other sanatoria in various parts of the world, have been very gratifying. Largely through the exertions of Dr. E. G. Barrick, of Toronto, an association has been formed with the object of bringing proper facilities for the treatment of the poor who are suffering from this disease in Ontario. Through the efforts of this committee an admirable Act was passed at the last session of the Ontario Legislature providing for the establishment of sanatoria for consumptives by municipalities. I earnestly hope that good results from the work of Dr. Barrick's association will appear in the near future. I hope the profession of Ontario will make some extra exertion to get the public interested in this subject. If the wealthy of our province can get some adequate conception of the enormous amount of good that can be accomplished by this crusade against the most terrible disease of civilization, they will not long withhold substantial assistance to Dr. Barrick and his noble band of co-workers, including, I am glad to say, a goodly number of charitable women. I can speak for you all, I think, when I wish them God-speed.

We will have this afternoon a discussion on the most important question that has ever come before the profession of Canada, *i.e.*, Inter-Provincial Medical Registration. Dr. Roddick has done a vast amount of good work in connection with the matter, as you know. I am very glad to be able to say that the profession in Ontario has commenced to realize the great importance of the new movement. I am very glad that Dr. Williams, and many other members, if not all the members of our Medical Council, are taking a very active interest in the matter. The largest of the provinces in our Dominion will have a great influence for good or evil in the settlement of the question. May I venture to hope that the representatives of Ontario will be broad and generous as well as just while carrying on negotiations with the representatives of the other provinces and the territories.

It is not a part of my duty to make the slightest reference

to any debatable points in connection with the question; but I may, perhaps, be allowed to refer to one phase respecting which there will be no difference of opinion. We all appreciate, now better than before, the fact that while we are physicians of Ontario we are citizens of Greater Britain, and we would like to have our professional status as broad as our citizenship. The little Englander of Canada is dead. We have buried him, and we are glad to have been at his funeral. *R. I. P.* These three letters represent Latin words. I don't give the words in full because I do not wish to put too much Latin into one address. Something—call it imperialism if you like—has heated our blood. We feel bigger than we did a few months ago. We are sometimes seized with a delirium which is very peculiar from a psychological point of view. Take, for instance, that cyclone of good-natured lunacy which struck Toronto last Wednesday night and raged furiously for something like thirty hours.

In connection with these remarkable phenomena we, the profession of Ontario, feel that we are getting too large to be bounded by the Ottawa River on the east and the Lake of the Woods on the west. We want our Medical Parliament to do all in its power to set in motion the machinery to give our graduates a Dominion degree which will carry with it a license to practise in any part of the great empire of Greater Britain.

CANADIAN RED CROSS COMMISSIONER.—From a cable recently received we learn that Dr. George Sterling Ryerson, who has been doing such noble work in South Africa, not only for the Canadian heroes but for the British troops as well, will sail from Cape Town, July 4th, for England on his way home. His work has been of late most arduous owing to his attachment to Headquarters Staff and his appointment as Acting British Red Cross Commissioner. He has performed his allotted task with signal ability and in a manner to elicit words of warmest praise from all ranks, from the drummer boy up to "Bobs."

THE TREATMENT OF SQUINT (STRABISMUS) FROM THE STANDPOINT OF THE FAMILY PHYSICIAN.*

BY J. T. DUNCAN, M.B., M.D., C.M.
Ophthalmologist to the Western Hospital, etc.

Mr. President, Ladies and Gentlemen,—The title of my paper is "The Treatment of Squint from the Standpoint of the Family Physician." Although, sir, I am now in special work, I have spent most of my life as a general practitioner, and, therefore, I desire to consider this question from that standpoint. You will pardon me, however, if I occasionally digress into the special domain, for by this means I hope to make my subject more clear.

Since my attention has been turned to this subject, Mr. President, I have looked up a number of treatises on medicine, but only in one or two of them do I find any attempt to deal clearly with the subject, although in most of them there are long articles on strabismus, suitable, however, mainly for a specialist.

Let me make it very clear, Mr. President, that it is only on early cases of strabismus, viz., strabismus in children, that I wish to speak to-day. My excuse for speaking on this subject is the enormous importance of it, an importance which is not fully recognized by all, for strabismus has two consequences: first, it produces "cross-eye," and second it may cause blindness, more or less complete.

Now, we know that a cross-eye is a handicap in any walk of life, but what shall be said for us if by neglecting the early treatment of a squint, partial blindness results?

Supposing a child, say, of three years, be brought to the attention of the family doctor. A squint has been noticed, perhaps it is constant, or it may be only occasional. In order to give proper advice we would first remember that strabismus has two great causes:

1. It is due to paralysis of one of the ocular muscles.
2. It is due to a faulty shape of the eye, no paralysis being present. Strabismus then is: (a) Paralytic. (b) Non-paralytic.

In determining whether we have before us one of the first, or one of the second class, we have to remember two things: first, that in a paralytic squint, the cause is usually very evident (such as a history of inflammatory conditions, syphilis, diphtheria, wounds, blows, etc.), and second, that paralytic squints

*Read at meeting of Ontario Medical Association.

are very rare, perhaps one case in ten being due to this cause. Cases of paralytic squint, then, we will not further discuss, but concentrate our attention on strabismus produced by badly shaped eyes, or non-paralytic squint.

The vast majority of squints in children are caused by the eye being misshapen. Either it is too flat (producing hyperopia), or it is too prominent (producing myopia), or it is astigmatic. I say the vast majority,—some authorities consider that 75 per cent. are thus caused.

Assuming, then, that we have before us a case of non-paralytic squint, what advice would be given? That would probably vary according to circumstances. For instance, if the child was weakly it would be put under tonics, with the expectation of recovery from the strabismus when its strength returned. Or the advice might simply be, "Wait a while, the child will outgrow it;" or it might be, "Have the eyes examined as soon as possible."

Now, in regard to the first line of action, it is quite possible that, in a weakly child, a comparatively slight cause may unbalance the eyes, and a proper course of general medicine may restore the balance. Such cases do occur. Even in them, however, the underlying cause is likely to be faulty refraction. But in the vigorous, healthy child, at the age we are speaking of (three years), squint is almost sure to be due to faulty refraction, and it is a dangerous waste of time to adopt a purely waiting policy. It is a dangerous waste of time for the reasons stated, which may be restated and added to thus :

1. That the vast majority of cases of squint in children are due to faulty shaped eyes—in other words to faulty refraction.

2. That if due to faulty refraction, the child will not outgrow it.

3. That, by waiting, a squint may become established so that an operation is required for its cure.

4. That the waiting may result in a partially blind eye.

5. That, if due to faulty refraction, there is a probability of cure by the use of proper glasses.

Even if convinced on most of these points, Mr. President, it is right for the family adviser to ask, what success may be expected even if proper glasses are applied? I answer, the experience of specialists is, that properly fitted glasses in many cases will cure the strabismus, prevent amblyopia (blindness) which would otherwise supervene, and render an operation unnecessary. Such being the case, the family medical adviser, would in all cases of strabismus in which the cause was not perfectly plain, unhesitatingly say the child's eyes must be examined as soon as possible.

This leads me, Mr. President, to the practical points of my paper. We can well understand that many a parent, if thus advised, would answer: "But I have neither the time nor the money to go to Toronto or Montreal." I answer it is not now necessary to do so. In all the cities of Canada are medical men who can attend to such cases just as well as those in a larger place. No family in Canada is out of reach of one of these places. Nor need time deter him. Three or four days should be sufficient to ascertain the refraction and prescribe proper glasses; then the patient could return home and be under the care of his own physician. For those who could not afford to pay for the examination, there are our hospitals—in large or small cities.

During the weeks that might ensue between the time when the case was first seen and when it went to be examined, the doctor would apply atropine, the prescription being:

R. Sulphate of atropine. 2 grains.
 Distilled water. $\frac{1}{2}$ fluid ounce.
 Dissolve.
 S. One drop in each eye once a day.

This treatment may be continued for many weeks, and usually without the smallest detriment.

Summing up, then, the treatment from the standpoint of the general practitioner:

1. In a child aged three years or over, he would in every case (with the exceptions noted) advise a thorough examination of the eyes, so as to ascertain the refraction.

2. He would advise that this be done as soon as possible, but if some weeks must elapse before this can be done, he would use atropine drops once, twice or three times a day in both eyes, ordering that the drops be left off for at least two weeks before the child goes to be examined.

3. If it be reported to him that the child needs to wear glasses, he would exercise his influence with the parents to see that they were worn.

4. In case of any hesitancy on the part of the parents to attend to the matter, he would free himself from responsibility by pointing out some of the dangers of delay:

1. The child may be permanently cross-eyed.

2. He may be partially blind.

3. An operation may be needed in after years.

4. The operation, although it may straighten the eye, will not cure the blindness.

NASAL AND POST-NASAL SYNECHIAE.*

BY J. PRICE-BROWN, M.D., TORONTO.

(Abstract.)

The presence of synechiæ within one or other of the nasal cavities is a pathological condition frequently met with by every rhinologist. During recent years many monographs, long or short, have been written upon it, among which I might mention those of Kyle, Moliné, Scheppegrell, Vansant, Watson, and White.

Many cases are the result of injudicious treatment. This may arise from unwise operations, lack of care in after treatment, or from one cause or other our inability to keep sufficient control over the future progress of the case.

A synechia may be described as a bony, cartilaginous, or fibrous band, unnaturally connecting together the opposite walls of a cavity. It occurs most frequently between the middle turbinal and the septum; next between the inferior turbinal and the septum. It may also occur between the lower turbinal and inferior meatus, the middle turbinal and the external wall, or between the two lower turbinal bodies. In the naso-pharynx the synechia is usually found connecting the lip of one or other of the eustachian tubes to some part of the pharyngeal vault.

Pathologically it is almost invariably either osseous or fibrous in character. The synechia can only be cartilaginous when situated in the extreme anterior region, where the septum lies directly opposite the superior or inferior lateral cartilages; and the condition in this region is so exceedingly rare as to be practically non-existent.

When osseous, it usually consists of solid union between the septum and the outer wall, either of the middle turbinated with the perpendicular plate of the ethmoid or the inferior turbinated with the vomer.

Almost all other synechiæ, wherever situated, are of a fibrous character, the result of inflammatory adhesion between two abraded surfaces.

The cause, in all cases, I believe to be either directly or indirectly traumatic. By directly traumatic, I mean direct physical injury of one form or other, either by the surgeon's knife, saw, or cautery, or whatever other instrument he may use in operating upon his case, or from direct accidental injury to the parts themselves.

By indirect traumatism I mean simple abrasion of the surfaces from forcible blowing, when the swollen tissues are either

* Read at meeting of Ontario Medical Society, Toronto, June 2nd, 1900.

almost or altogether in contact, or abrasion of the surfaces by continuity of contact, as in cases of chronic congestive hypertrophy of the middle and inferior turbinated bodies. In the latter condition the vitality and resistance of the mucosa is in some cases so materially impaired that the soggy tissues lose their contractile tonicity, and the membrane at the part of greatest pressure becomes so thin that intercapillary circulation is readily developed.

Perhaps of surgical instruments the electro or galvanocautery is the one of all others, the use of which within the nasal passages is most likely to be followed by the development of this condition. I do not want it to be understood that I side at all with the wholesale condemnation of the electrocautery, which is at present becoming the fashion with rhinologists. I fear that with us, as with other men, the pendulum is allowed to swing from one extreme to the other, and we have not yet learned to run the happy mean. I believe that when used with judicious care and precision, and in properly selected cases, there is no instrument more useful in our whole armamentarium. But that does not invalidate the fact of its effect in producing nasal synechia, owing largely to the edema which its use produces.

When operations are performed with other instruments, such as the knife, saw, scissors, chisel, etc., the mucous membrane of the opposite wall should not be injured at all, while subsequent edema of the part operated upon is less frequent, and hence the formation of synechia not so likely to follow.

The prolonged existence of turbinal hypertrophy is not an uncommon cause of fibroid or ligamentous synechia. Cases sometimes come under observation in which no history can be traced and in which direct traumatism is out of the question.

In the post-pharynx the pathology and etiology are very similar to what they are in the nasal chambers. There the synechia are always of a fibrous or ligamentous character, and the parts connected are one or other or both of the eustachian tubes to the upper or back part of the pharyngeal vault.

Careless or ineffectual removal of the adenoids may readily be a cause of eustachian synechia. When a single large central piece is removed the ragged edges are likely to drop down on to the lips of the eustachian tubes, and if from careless handling of instruments the bulbs have been bruised, synechia can readily form.

I believe, however, that in the naso-pharynx, the most frequent cause is indirect instead of direct traumatism, the very opposite of its occurrence within the nasal chambers. Perhaps in this variety there is only a single proximate cause; and that is excessive redundancy of pharyngeal tonsillar tissue.

Be this theory correct or not, I have on several occasions found direct ligaments binding the eustachian tube to the base of a shrunken pharyngeal tonsil; and in which no operation of any kind had previously been performed.

There is one other variety of naso-pharyngeal synechia I would like to mention, and that is a perfectly symmetrical bilateral synechia extending over the vault of the pharynx from lip to lip of the two eustachian tubes. I have seen several instances of this, and in two cases in which the synechia was accompanied by adenoid enlargement, I removed, as I thought, successfully, the entire synechia. Within a year, however, in each case, I had the opportunity to examine the patient again, to find although there was no return of adenoid tissue, there was complete redevelopment of the cicatricial band.

In treatment there is a diversity of methods from Scheppegrell's artistic sweep, with celluloid sound and silk and wire, down to Watson's simple friction.

I will simply speak, however, of the methods I have found the most useful. In the bony synechia, between the vomer and the inferior turbinated, I have found the saw to be the most useful instrument, choosing one with a strong, wide, cutting edge and narrow back, severing the part first at one side, and then sawing the chink a little wider at the other. The saw can also be used in middle turbinated osseous synechia though in this its limitations are more marked. To keep the parts open I have used cotton wool tampons soaked in albolene—I like them better than gauze—or thin rubber sheeting, made wide enough to completely cover the raw surface. By its own elasticity it will usually retain its position. It may readily be kept in place for three or four days, or a week without removal. To keep the parts free from discharges, albolene sprays have been used two or three times a day; and the patient has been directed to lie on the opposite side to the one operated upon to favor gravitation.

In removing fibrous synechia, I have found the knife, scissors, or hooked nasal knife the most useful, very rarely indeed using the cautery. When there is a simple, ligamentous band, it can be clipped out at each end by appropriate scissors. When the space is small and the synechia likewise, the simple sharp hook passed through it from behind forwards, will sever the parts and cause a chink.

Any hemorrhage that occurs at the time I always consider an advantage to the patient. These cases almost invariably require the insertion of tampons of one form or other. As I said before, I do not like gauze, but prefer absorbent cotton soaked in one of the hydro-carbon oils, and left *in situ* for several days without being disturbed, except to keep the passage above and below cleansed and open.

One point here I want to emphasize, and that is I do not use aqueous sprays at all in these cases; but hydro-carbon oils thrown through the atomizer by means of compressed air.

In removing post-nasal synechiæ between the eustachian tube and the vault, I have used the cautery blade passed up behind the palate, with success. Usually, however, I have employed a narrow Gottstein's curette and the finger-nail. Of course tampons are not required in this region.

MORPHIA IN THE TREATMENT OF PUERPERAL CONVULSIONS.*

BY DAVID HOIG, M.D., OSHAWA.

Mr. Chairman and Gentlemen,—The use of morphia in the treatment of puerperal convulsions has been long enough before the profession for its value to be appreciated and its limitations fairly well defined. There still seems to be, however, the greatest diversity of opinion as to the propriety of its use.

It has been my bad fortune to encounter during twenty years of practice an unusually large number of cases of this terrible malady, and my attention has been consequently strongly directed to everything bearing on its relief. My first experience with the use of morphia in its treatment dates back to the beginning of my practice and almost to my first obstetrical case. My consternation may be easily imagined at being thus saddled with the responsibility of an eclampsic attack of great severity, several miles from professional assistance, and with a very limited supply of drugs. The supreme necessity of controlling the convulsions almost forced me to use morphia, but I did it with fear and trembling, for I had been taught to distrust opium and all its works in cases complicated with uremia. The results were most gratifying, and my gratitude being proportionate to my previous anxiety, I became an enthusiastic advocate of the morphia treatment, and for a long time I had no reason to doubt its entire efficacy. But, after a time, I began to meet every now and then with a case in which morphia failed to control the convulsions. One of these was an undoubted uremic case of an aggravated type with complete suppression of urine, and no return to consciousness during the intervals of convulsions. Death ensued in about twenty-four hours after the birth of the child. This was the only case I have seen where albumen was present in the urine and the labor completed, in which morphia failed to control the convulsions.

* Read at meeting of Ontario Medical Association.

The other cases that I have seen when morphia failed now number five, three occurring in my own practice and two in that of others. These cases all presented one of two peculiarities. Three of them were non-uremic cases with no history of renal insufficiency—in the other two the convulsions preceded child-birth.

Three years ago I attended a woman in her fourth confinement, the previous labors having been entirely uneventful, as was also this one up to four hours after childbirth, when she was seized with convulsions. I injected a $\frac{1}{4}$ grain of morphia, and an hour and a half after another $\frac{1}{4}$ without any abatement of the convulsions. Five hours after—the interval having been employed in stimulating the skin and kidneys—the convulsions still continuing with increased severity, I injected $\frac{1}{2}$ of a grain, thinking my previous dose had not been enough. I was greatly mortified to find that this only aggravated the condition, and I abandoned morphia and resorted to rectal injections of chloral and bromide, with the happiest effects. I had secured a specimen of her water after the first convulsions and found it free from albumen, nor was there any reason to suspect its presence at any time during pregnancy. The other two cases of this group resembled this one in the essential features of the absence of albumen or any suspicion of renal insufficiency. These cases are classified by some of the German writers as “acute epilepsy or eclampsia convulsions.” In my experience morphia was entirely inoperative in their treatment.

Within a few months a young woman I was engaged to attend was seized with convulsions in her eighth month. Bromide and chloral were first tried, but without avail; $\frac{1}{4}$ grain of morphia was twice injected within two hours without the slightest effect in controlling the convulsions. The condition was now getting very serious—the temperature 104 and the pulse 150—and it was decided to deliver the child. This was done as rapidly as possible, and a severe hemorrhage was with difficulty controlled by pressure and ergot. After the birth of the child this patient had two severe convulsions at about four hours' interval; both were readily controlled by $\frac{1}{4}$ grain injections of morphia, and the second was the last. In this case morphia was perfectly useless before the birth of the child, and completely efficient afterwards.

These cases are too few in number to build up a theory on, but, occurring as they did all under my own observation, they have made a deep impression on me, and may serve to explain to some extent the conflicting experience of different observers. I have made it a practice for some years to examine the urine from time to time in cases I was responsible for, and have been surprised to note the comparative frequency with which

albumen is present and how seldom it is followed by convulsions. On the other hand the long-continued loss of so valuable a constituent of the blood is, I feel sure, responsible for so many of these sudden deaths from obscure causes following child-birth, and which are tabulated under a variety of heads. I recall a case in the country where the woman lost a large quantity of albumen for nearly three months before child-birth in spite of every effort to stop it. Indeed, I have often been disappointed in my efforts in this direction. She went to full time, however, and gave birth to twin children, but so unexpectedly that only a neighbor woman was present. Half an hour after I found her lying in apparent comfort, though with a rapid pulse; ten minutes later she was dead, without the occurrence of any accident, convulsion, hemorrhage, or the like, to account for it.

Quite recently I saw a case with a friend where convulsions had ensued shortly after labor. These were, after a time, completely controlled by morphia, and for several hours she lay quietly resting, when without warning of any kind she suddenly died. These were undoubtedly cases where the integrity of the heart muscle had been weakened by the long-continued drain on the system.

The conclusions that I have arrived at are :

1st. That while in morphia we possess a valuable, perhaps the most valuable, drug for the control of puerperal convulsions, I would not yet be inclined to rely on it in the worst types of the disease with complete suppression of urine and a comatose state between attacks, but would rather have recourse in such cases to every means to promote diaphoresis and the free action of the bowels.

2nd. That it is much less useful in non-albuminous cases than in those where albumen is present, and may even be harmful in such cases.

3rd. That it is of comparatively little value before delivery, chloroform being the drug of election at that time.

4th. That to be efficient it is necessary to use it in large doses, as much as half a grain being borne at such times without any harm resulting.

An excellent article by Dr. Wm. Krauss, of Memphis, on "Why I Use Pepto-Mangan "Gude" appears on page 399.

Society Reports.

ONTARIO MEDICAL ASSOCIATION.

The twentieth annual meeting of this Association was held in the Normal School buildings, Toronto, on Wednesday and Thursday, the 6th and 7th of June, 1900.

The meeting was called to order on the morning of the first day at 10.30 a.m., by Dr. Adam H. Wright, of this city, the 1st Vice-President, who stated that, owing to the death of their President since the last meeting, it would be necessary for the Association to elect his successor.

Dr. Wright then vacated the chair, which was voted to Dr. R. A. Pyne, who called for nominations for the position of President.

Dr. Adam H. Wright was unanimously elected President amidst much enthusiasm, and, after expressing his sincere thanks for the honor, called upon the Secretary to read the minutes of the last meeting. These were unanimously adopted.

The report of the Committee on Papers and Business followed. It was presented by the chairman of that committee, Dr. A. A. Macdonald. Adopted.

Dr. Allen Baines, the chairman of the Committee of Arrangements, presented a verbal report, setting forth the entertainment provided for the members of the Association during the progress of the meeting.

READING OF PAPERS AND DISCUSSIONS THEREON.

The Use of Morphia in Puerperal Eclampsia. (See page 359.)

Dr. David Hoig, Oshawa, read a paper on this subject, stating that his experience with eclampsia dated almost from his first obstetrical case in practice, and in this he was forced to use morphia from the severity of the convulsions, and with very gratifying results. He recited the history of eight cases, in three of which there was no history of any renal insufficiency. The case of a young woman in the eighth month of pregnancy was cited, in which the bromide and chloral treatment was first tried, but failed. He then used one-fourth of a grain of morphia, but this also failed. The temperature was 104 and the pulse 150. Delivery was effected. Severe hemorrhage followed, succeeded by two very severe convulsions, both of which were fully controlled by one-third grain injections of morphia. Dr. Hoig has always made it a practice to examine the urine from time to time and he has frequently noticed albumen present,

and no convulsions. He instanced another case where twins were born, no doctor being present. Ten minutes thereafter the woman was dead, without convulsions to account for it.

Dr. John Ferguson began the discussion of the paper, and congratulated Dr. Hoig on its practicability. It was now generally recognized that you may have puerperal convulsions even of severe type without the presence of albumen in the urine; and that you may have the occurrence of albumen for the first time known in the history of the patient, in fact abundance of albumen, without the occurrence of convulsions. You may also have a successful pregnancy in an old albuminuric, in chronic disease of the kidney without convulsions.

Dr. J. L. Bray, Chatham, speaking of the treatment, did not think that morphia alone was sufficient, as his experience with morphia has not been successful. Free elimination and chloroform has done more for him than morphia. He did not think that any one really knew the cause of these convulsions. Another thing that Dr. Bray had noticed in his experience was that when he had a case of convulsions appearing before labor commenced, the prognosis was generally unfavorable; but when the convulsions came on after delivery, his prognosis has been favorable. He would lay great stress upon free elimination. Give elaterium or croton oil. He further stated that in venesection he had found that often it was not possible to get the blood to flow at all freely. He mentioned one patient who had thirty-three convulsions after delivery and she got well.

Dr. E. Clouse, Toronto, stated that he had recently attended a case of confinement with advanced kidney disease. Saw her first about a month after pregnancy, with swollen limbs and characteristic pasty complexion, and passing large quantities of albumen, about 35 per cent. of the urine. On consultation with two other physicians she was permitted to proceed to her confinement and she got along very well indeed, without any convulsions, and gave birth to a well-developed female child. A point of interest in this case was that about four or five days after the child's birth there was a discharge from it, corresponding with the menstrual discharge.

Dr. K. C. McIlwraith, Toronto, stated he had seen five of these cases during the past year, one case in particular being mentioned where the urine was almost solid with albumen, accompanied by great ascites and anasarca; the labor was good and no convulsions whatever. In another case, the urine had been examined one day and no albumen found, but the next day she had a convulsion and albumen was found afterwards. Speaking of the treatment, he has found that small doses of morphia had usually no effect, but one-third grain in his experience, generally had controlled them.

Dr. Barrick took issue with Dr. Bray in regard to unfavorable prognosis where the convulsions came on before delivery. In half a dozen cases which he could then call to mind, only one of them died, where the convulsions appeared before delivery. He further stated that those who recovered had no trouble in succeeding pregnancies. Referring to bleeding, he mentioned a case where chloroform would not control the convulsions. Bleeding was resorted to, a half pint was drawn from the arm, the fits ceased immediately and did not again occur.

Dr. Harrison, Selkirk, stated that he had seen a great many cases of eclampsia, in an experience of fifty years, and his experience is exactly opposite to Dr. Bray's. When convulsions take place before delivery, you can deliver; and the chances were not so good when the convulsions came on after delivery. He has lost patients after and before delivery, but he has always regarded those coming on after delivery as the more dangerous. In properly selected cases he would bleed.

Dr. Hoig in reply: He quite agreed with Dr. McIlwraith that there was no use in giving small doses of morphia. He has had no experience in bleeding, but could readily believe that in properly selected cases it might be of value. He referred to the debilitated state the patient was left in after these attacks, and thought that the long loss of albumen was responsible for many of the sudden deaths that had occurred.

Discussion in Surgery—Appendicitis, Its Recognition and Operative Interference.

Dr. Luke Teskey opened this discussion. One of the most important conditions in the study of this disease is the recognition of many varieties or, perhaps better, degrees of inflammation which attack the appendix, and also various conditions which may be left by a severe attack. One may be prepared to find any degree, from the slightest chronic, catarrhal, appendicular colic to the most acute and rapid gangrene. He divided this affection into three classes: (1) Chronic catarrhal appendicitis; (2) acute circumscribed appendicitis; and (3) the fulminating, or gangrenous appendicitis.

Speaking of the first variety, it is not difficult to recognize, when there are repeated frequent slight attacks of pain in the appendiceal region, coming on after slight exposure to cold, or after slight exertion, or sometimes without any well-defined cause, lasting a few hours or an hour or two, with possibly slight rise of temperature, or no rise of temperature, and the patient able to go on with his work the next day. In many instances, the pain is not referred to the appendix, but frequently to the epigastric region. Other symptoms, sympto-

matic or general, such, for example, as symptoms of chronic indigestion, in effect, a loss of power in the digestive function throughout the alimentary tract, associated with marked loss of body weight, were very important. These sometimes caused this form of appendicular disease to be mistaken for a chronic tubercular affection of the abdominal viscera, and sometimes for chronic indigestion. In relating one or two cases brought before him of recent date, Dr. Teskey stated, that in these cases which were often looked upon as chronic indigestion, when an operation was performed for appendicitis, this simple catarrhal condition was found, without any foreign body in the organ, but with enlarged lymphatic glands in the vicinity of the appendix. These attacks never caused the patient to lay up in bed, at most only colicky pain existing but for a few hours. Invariably, the patient had lost, in these cases, in body weight. The symptoms had resembled tuberculosis. In these cases, there is little or no invasion in the abdominal cavity. After operation in these catarrhal conditions, the recovery of the patient was most complete and perfect, so much so that within two or three months they gained back their body weight and usual power of digestion and usual health and strength; and that is the essence of the complete proof of the beneficial effects in that particular class of cases. The most reliable means of diagnosis in such cases is careful palpation of the abdominal wall in the iliac region. In some you may be able to palpate the appendix, but you cannot always feel it, and even when you do feel it or think you feel it, you do not know whether it is the appendix or not.

In reference to the second class—acute circumscribed appendicitis—that is, the form of affection in which nature has succeeded in organising adhesion sufficient to incarcerate the disease to a limited area, this is perhaps the most frequent form. The attack begins with acute pain, perhaps most frequently epigastric pain; a rise of temperature; furred tongue; indigestion; the abdomen becomes more or less resistant over the right iliac region; and tumescence on palpation is found on the right side. The symptoms continue, with some tympanites, when on the second or third day, there is distinct tumescence to be felt in the appendicular region, and circumscribed suppuration has taken place. The recognition of this form of the disease depends largely upon the tendency of the symptoms to localise in the right iliac region. This form of appendicitis is not difficult to recognize after it has gone on for a short time. When the disease is low down in the pelvis, however, you may not succeed in discovering it by palpation, and you must then depend largely upon general symptoms. If you cannot find tumescence, you will be able to get a degree of resistance, whether low in the pelvis, or up towards the liver. This degree of

resistance, together with general symptoms, will lead you to a diagnosis.

The third class of cases is the acute fulminating or gangrenous appendicitis. Here reference is made to the greatest degree of intensity of inflammation, produced by the greatest degree of infection, which has created the inflammatory act, so that gangrene is invariably formed in some form or another. At times it may not be localised in the appendix but in the adjacent structures. To this class Dr. Teskey gives the name, acute fulminating or gangrenous appendicitis. Severe symptoms may be expected from the commencement onwards. Here the attack is so intense from the infection, or so virulent, that nature makes but an imperfect attempt to circumscribe the abscess. You will have great pain and acute rise of temperature; early tympanites; brown furred tongue; some resistance and rigidity of the abdomen; in fact, symptoms of septicæmia. The characters of this variety of appendicitis, because of the acuteness and the intensity of the symptoms, render it not so very difficult of diagnosis. Sometimes the amount of tympanites that exists causes the physician or the surgeon to overlook the localised condition. The patient almost invariably commences by vomiting, severe vomiting. Because of this, acute gastritis has been diagnosed. Palpation is interfered with from the intense tympanites which comes on. Very often the inscription on the death certificate is written, "Acute peritonitis." These acute forms can also only be recognized by the general symptoms, possibly by the previous history in connection with some difficulty in that region, and careful palpation before tympanites has come upon the patient. After that has come upon the patient you are more or less in the dark. Conditions which follow an acute attack: In a large number of instances, the result of an acute attack uninterfered with, is that various sinuses have been formed, imperfectly draining abscesses in the abdominal cavity, to various surfaces, perhaps most frequently to the intestinal surfaces. Discharge of pus through the intestinal tract may go on and recovery result, or a chronic discharge into some of the hollow organs of the body or to the surface of the body may result. When that chronic suppurative condition is imperfectly drained into some of the internal organs, it may be very difficult to diagnose the case in after years. Dr. Teskey here mentioned a case suffering for two years.

Operative Treatment.—Taking the first class of cases—simple appendicular colic—shall we operate or not? When we have made a diagnosis, Dr. Teskey has no hesitation in pronouncing in favor of operation in all such cases. His reason is this, that the death rate should be nothing. The recoveries should be 100 per cent. A limited incision is all that is essential—an

inch to an inch and a half at the very outside. There should be no death rate from that operation. And you have relieved the patient from a constantly occurring painful condition. This simple form of appendicitis in many instances leads onward to the more severe forms.

As to the second class of cases, shall we operate, and when shall we operate? This is the one in which discussion has been rampant. Calomel and opium have been used a multitude of times, and there is no doubt of the possibility of the patient getting well. The physician says we will not submit the patient to the operation, but we will trust to the process of nature, assisted by the specific remedies. That is the wrong practice. The physician who has taken that ground has taken a mistaken ground. In all instances he has jeopardised the life of his patient. If he can diagnose the condition within twenty-four hours, carefully feeling for the resistance, which one always finds in localised inflammatory conditions—it may not be easy to find it at first, but practice will soon get one to recognize the resistance, which is not usual and which indicates appendicitis—and as soon as he gets this located, and appendicitis exists, that is the moment for operation, and in all instances you should operate. If you do not operate and wait until abscess has formed, you can open the abscess, and the patient recovers. Very true. But what follows? The patient has absorbed a large amount of septic material into his system. Already there may be an abscess in the liver. Abscesses may be set going almost in any part of the body, and then there is a localised abscess, and the intestines and omentum are entangled and serious chronic trouble apt to follow, for many years in most instances. But if you operate immediately before all that, you have saved the patient and you have run no greater risk so far as the preservation of the patient's life is concerned.

And third, in the acute fulminating and gangrenous appendicitis, the only hope for life is an early operation.

Dr. George Bingham: Dr. Teskey's views in reference to the treatment and diagnosis of this subject correspond so closely with his, that he had scarcely anything to add thereto. In reference to classification of this disease into forms, there was a difficulty, for the simple reason that unfortunately any given case may be in class one to-day and in class two to-morrow. He was pleased to hear from Dr. Teskey that he does not claim to palpate the normal appendix. He referred to the vomiting which he thought occurred almost invariably. Examination per rectum had also been of use to him in the diagnosis. He dwelt on the importance of the interval operation, considering it to be the ideal operation, and thought that the fatality here

should be nil. In the case of the circumscribed variety he was exceedingly glad to hear that Dr. Teskey approved of an early operation.

Dr. H. A. Bruce: He agreed in the main with the observations of Dr. Bingham and with those of Dr. Teskey. He took a little exception to the classification. In the second class he would put the simple acute, and then under the heading of acute appendicitis (the particular variety which may be present in the case you may be dealing with) the name of perforation. He did not think we could say positively, before opening the abdomen, whether the appendix is in a gangrenous condition or not. Dr. Bruce made further reference to the diagnosis, particularly dwelling on that between appendicitis and tubercular disease of the same region.

Dr. George Peters: The creed set forth seems to be, appendicitis—operation. He could not quite agree to that. He thought most of the members present had seen cases of appendicitis get well and the patient remain healthy—perhaps only have a slight attack. He thought all had seen cases of more than one attack with recovery. Nor could he go so far as to say that every case of operation for appendicitis in the catarrhal stage would be followed by recovery, because one cannot always tell what condition the patient is in constitutionally as regards diabetes, Bright's, etc. Reference was made to the length of the incision advised by Dr. Teskey, and Dr. Peters thought there were many cases in which you cannot remove the appendix through an incision an inch and a half long, as, for instance, in a patient with much adipose tissue in the abdominal wall. In regard to the diagnosis, he thought in the great majority of cases it was an easy matter, but whilst a good many cases escaped diagnosis there were also a good many cases diagnosed as appendicitis that were not appendicitis at all. He did not believe you could feel the normal appendix, except in a very few cases, and then how can you tell that you are not feeling a fold of the intestine? If, however, it is diseased and thickened, you can feel it in a thin abdominal wall.

Dr. Wm. Oldright: With regard to operation or no operation, he was very strongly of the opinion that if a person has had a second attack of appendicitis we should operate. With regard to the cases operated on between the attacks the statistics are 98 per cent. of recoveries; and although we cannot say positively that the patient will recover, the mortality may be put down at nil. Dr. Bruce had referred to finding grape-seed bodies in the appendix. This reference he considered unfortunate. He had never seen grape-seeds in the appendix, and thought their occurrence there was very rare.

Dr. N. A. Powell spoke in regard to symptoms. In regard

to the location of the pain he thought not occasionally but uniformly the pain is referred to the epigastric region; then it becomes umbilical, and then reaches the appendiceal region. He was glad that the point had been brought up, a medical point of great importance—that intestinal indigestion is antecedent to the attacks of appendicitis; not gastric, but intestinal. Then one should not pin his faith too much upon a single symptom. He considered that nausea always and vomiting usually were present. Another symptom he would lay stress upon was that of rigidity of the right rectus. Dr. Powell thinks it useful to divide the attacks into periods of the first twenty-four hours, the second twenty-four, etc. If you get over three complete days, and if the case is not getting along well, you are likely to have to deal with pus. One and one-half-inch incision is too short in fat people. He further stated that Dr. Osler says there is no medical treatment of appendicitis.

Dr. Watson, Agincourt, spoke of the diagnosis and recited his experiences with appendicitis. He thought it important to watch the breathing and the pulse. Examination per rectum he had always found of benefit. Referring to the question of grape-seeds, in one of these cases an enema had brought away a large fecal mass in which was embedded between forty and fifty of these bodies, but of course he could not say that any of them had been lodged in the appendix.

Dr. Parfitt, Toronto, referred to the differential diagnosis of what might be called typhoid appendicitis, appendicitis and gall-stone colic, and the importance of examining the blood in appendicitis to ascertain the number of leucocytes.

Dr. A. A. Macdonald thought that by and by we would come to have the courage to operate at once on every case of appendicitis. He looked forward to the time when the physician would say to his patient, you must be operated on now within twelve hours.

Dr. John Ferguson: If the case is a very mild one, and doubtful if it is appendicitis, but some distress in that vicinity, and the patient well and about his business in two or three days, he would not counsel operation in that case. He would advise the patient to keep himself under his physician's watch and care, and should there be a return of symptoms he would then advise operation at once.

Dr. Teskey, in reply: With regard to waiting for the interval, if you are called so late to a case that it is already resolving, and the symptoms are abating, of course wait for the interval. Dr. Bruce thought perforation should be included in one class as a variety. Perforation is always associated in the second class when it goes on to extensive abscess. He never

removes a gangrenous appendix. He considers it a dangerous process to interfere with imperfect adhesions which nature seeks to form as a limitation to the process. Palpation in the rectum he has found of very little value. It may be of value where you find a chronic abscess low down in the pelvis. Early operation was considered justifiable because it would lessen the death rate, and that was everything—lessen the death rate.

Adjournment.

AFTERNOON SESSION.

PRESIDENT'S ADDRESS.

At the meeting of the general session on the afternoon of the first day, Dr. Adam Wright delivered a very interesting and able address upon "The General Public and the Medical Profession" (see page 345) which was very cordially received by the members of the Association present. He referred to the progress of the profession and the stand it held in the community at the present day. The opinions of Mr. Gladstone and the Marquis of Salisbury were given, both of whom were on record as having said very flattering things of the profession of medicine. Jealousies in the profession came in for his condemnation, and he thought it would be particularly happy for all if this was kept out of the profession as much as possible. The importance of attending the annual meetings of the Association was dwelt upon and emphasized, and a feeling reference was made to the death of the founder and recent president of the Association, Dr. J. E. Graham.

Dr. Wright was accorded a hearty and unanimous vote of thanks for his unusually interesting address, to which he replied appropriately.

Discussion in Medicine—The Future of Therapy.

Dr. Lewellys F. Barker contributed an erudite paper on this subject, which was easily seen to be written in choice and elegant diction. He was thankful to have the opportunity and pleasure to return to Toronto, after an absence of eleven years, and to be accorded the honor of reading the address in medicine before the Ontario Medical Association. Although the title of his paper would lead one to expect considerable information about what the future held in store for therapy, it proved more to be a masterly review of historical character down the long line of the centuries. The history of therapy was intimately linked with that of medicine, and the past was rapidly

reviewed until scientific study in the use of the microscope in histology, pathology and bacteriology was reached. The essayist dwelt upon organo-therapy, serum-therapy, climate-therapy, and all and everything that one could bring to bear upon the treatment of disease. The stupendous advantages being made in scientific medicine, and the vast amount of experimental and research work going on throughout the world now rendered it essentially necessary to emphasize the importance of a division of labor in the profession of medicine as well as in other walks of life.

Dr. Barker was accorded a very flattering vote of thanks on the conclusion of his exceedingly able review.

Dr. McPhedran congratulated Dr. Barker upon his unusually able address. It was, he said, exceptionally brilliant. It was very gratifying to have one of our own students come home and contribute such a paper. He thought that the therapist of the future would be the man skilled in science in all its bearings. He contrasted the position of internal therapists with the surgeons, and thought that the former were far behind the latter, although the surgeons must not forget that it was by the influence of therapy that made it possible for them to reach such a state of preferment.

Dr. J. L. Davison considered the paper of Dr. Barker's a mass of erudition, but would have liked had he referred to the action of drugs. Whilst we had been brought up on drugs and fed on drugs, it was difficult to understand how the belief in drugs was going to pass away. He further referred to the action which one disease has in curing another, and thought this feature together with how drugs acted, was still a very interesting side of the question. Referring to the question, What is disease? he stated disease to be a condition of unstable equilibrium, while health was a condition of stable equilibrium. Electro, hydro and other therapies were also alluded to.

Inter-Provincial Medical Registration.

Dr. J. A. Williams, Ingersoll, introduced this subject in a clever address. He detailed the history of the agitation for the reform of our laws so as to permit of legislation for this purpose, and then proceeded to deal with the details of the proposed bill now before the profession throughout the Dominion of Canada, and which Dr. Roddick, M.P., purposes introducing at the next meeting of the House of Commons.

Dr. Thorburn, in a brief speech, said that the proposal had his heartiest endorsement.

Dr. Britton thought the proposed bill as a whole a good one. He took exception to the appointment of one member of the Dominion Council by the Governor-General in Council. He

thought that feature objectionable as it might tend to make the body partly at least political.

Dr. Herod, Kingston, spoke at some length, in the main concurring in the proposals as set forth in the Draft Bill.

Dr. Roddick, M.P., went into the subject exhaustively and asked for the unanimous support of the Ontario Medical Association, as he believed that with the influence of such an important body behind him, it would go far towards bringing the matter to a successful issue. His burden was to get the legislation passed through Parliament now; any minor details could be arranged afterwards. The provisions of the bill are now so well known that any synopsis would be superfluous, although Dr. Roddick explained it very clearly to the meeting.

Dr. Williams made a brief reply. Adjournment.

EVENING SESSION.

The evening session was held at McConkey's, where one of the most enjoyable—if not the most enjoyable—banquet in the profession here was held. Dr. Allen Baines, the chairman of the Committee of Arrangements, was indefatigable in his efforts to make this function a pronounced success, and he must have slept happy and contented that night, because his efforts were crowned with supreme success. Dr. Wright presided. The usual toasts were drunk, and the following gentlemen made speeches: Drs. Sheard, Williams, Bray, Burt, Barwick, O'Reilly, Harrison, Bruce, Smith. Songs and music and an exceptionally fine and dainty menu were thoroughly enjoyed.

SECOND DAY—MORNING SESSION.

Acute Suppuration of Mastoid Cells—Chronic Suppuration of Maxillary Antrum and Anterior Ethmoidal Cells of Thirty Years' Duration.

Dr. P. G. Goldsmith, Belleville, read notes of these cases, and presented the patient in the latter case. In the first three cases which came under his notice during the past year were noted: The first was a man aged 50, who during a bad cold, felt something snap on blowing his nose. Immediate pain in the ear followed. On examination, perforation was found in the membrane, but in spite of proper treatment the mastoid became involved, and he was referred to Dr. James MacCallum,

Toronto, who concurred in the diagnosis, and agreed that operative procedures were advisable. This was done and the discharge stopped at once, and the patient made a good recovery.

In the second case, the patient died, but on *post-mortem* examination, the brain was not found involved.

In the third case recovery was noted.

The case of chronic suppuration of the antrum of Highmore occurred in a man aged 38. It began at the age of eight, after a severe attack of neuralgia of the face by a yellowish discharge from the right nostril, which has persisted ever since. The anterior ethmoidal cells were scraped, with a great deal of relief to the patient. Then the antrum was drained in the usual way. Complete relief was noted for a few weeks, but the discharge returned, and Dr. Goldsmith now purposes to curette the cavity.

Drs. L. L. Palmer and Price-Brown discussed these causes.

The Committee on Credentials here brought in their report, which was adopted. The following were elected members of the Association: C. J. Copp, Toronto; R. K. Anderson, Milton; W. D. Scott, Peterboro'; J. H. Watson, Toronto; John Grant, Woodville; A. L. Danard, Rocklyn; G. W. Clendennan, West Toronto Junction; Murray McFarlane, Toronto; W. Thompson, Toronto; John D. McNaughton, Glenallen; L. G. McKibbin, Toronto; W. C. Harriman, Hamilton; C. Lang, Owen Sound; C. S. McKee, Toronto; A. E. Perfect, Toronto Junction; G. D. Parfitt, Toronto; P. McG. Brown, Camlachie; J. D. Berry, Hastings; A. Carmichael, Sundridge and F. W. Young, Michipicoten Harbor.

Exploratory Incision in Obscure Brain Lesions.—Some Points in the Surgical Treatment of Meningocele.

Dr. L. W. Cockburn, Hamilton, reported two cases of obscure brain symptoms without any definite diagnosis, both occurring in young men. In the first no treatment being of any avail, an exploratory incision was advised and accepted. The dura and brain were both found healthy; the patient recovered completely from his symptoms thereafter. He considered this case as well as the second recorded to be one of cerebral neurasthenia. In the second case there was the history of a head injury in early life. Incision was also advised here but up to present time has not been accepted.

His remarks on meningocele referred to an operation on a child with resultant death thirteen days after the operation. He thought operation the proper method of treatment in these cases, and condemned the injection of any fluid such as Horton's.

Dr. J. T. Duncan, Toronto; Dr. McKinnon, Guelph; Dr. Peters, Dr. Ferguson and Dr. Lett spoke to this paper.

Removal of Tubercular Testicle, Vas Deferens and Vesiculae Seminales at One Sitting.

Dr. George A. Peters reported this case, exhibited the pathological specimen, described the difficulties of the operation and the final results.

Total Removal of Vas Deferens and Vesiculae Seminales for Tuberculosis.

Dr. J. Alexander Hutchison, Montreal, by invitation presented this paper. It reported the excision of the right organ for secondary tubercular affection. It may be primary or secondary, but usually the latter. The first operation of this sort was done in 1890, and the first excision on this continent was performed by Weir, of New York, in 1895. The essayist described three chief methods. The method which he had adopted, and which he would recommend, was that of Roux, of Rosanne, the perineal route. The subject upon whom he had operated was a young man aged 28, with a sinus in the right scrotum. It transpired that he had been operated on for left testicular trouble with recovery. Recovery was noted and the patient had returned to England in good health to resume his work.

Dr. Cockburn, Hamilton, and Dr. E. E. King discussed these two papers and their respective cases.

Dr. Hutchison closed the discussion.

A cordial vote of thanks was voted to Dr. Hutchison for his contribution to the meeting. This he acknowledged suitably.

Transplantation of Ureters into Rectum by Extra-Peritoneal Method—Further Report of Case with Exhibition of Patient.

Refer to reports of Canadian Medical Association, 1899, for notes of case. The boy is now six years of age, and is in a good healthy condition, able to play and run about with his playmates. He is able to go for eight hours through the night without soiling the bed, if he does not drink very much before he goes to bed. He retains it for two or three hours during the day. So far there has been no ascending infective trouble in the kidneys. The operation was performed extra-peritoneally, and for this Dr. Peters claims priority and originality.

Dr. W. Britton and Mr. Cameron discussed the case and congratulated Dr. Peters upon the results he had achieved.

Army Medical Arrangements for the War in South Africa.

Dr. J. T. Fotheringham, by means of interesting charts, was able to deliver an admirably instructing address upon this now very lively topic. The Medical Service was exhaustively gone into, and carefully and lucidly explained from the time the soldier was wounded in battle until he rested quietly and peacefully on board a hospital ship, the hospital at the base, or was invalided home.

Dr. Nattress followed, confining his remarks to first aids on the field of battle.

Dr. F. LeM. Grasset gave a highly interesting account of the bullet wounds, and what knowledge had been obtained in regard to this matter from South African experiences. He deplored the fact that Canadian surgeons had not been given a fair chance to participate as consulting surgeons, although this Dominion had supplied a very acceptable quota to the "sinews of war."

Dr. Peters also participated in the discussion.

Cancer of the Rectum—Illustrations by Lantern Slides.

Dr. E. E. King gave a very admirable exhibition on this subject. He presented two patients for examination by the members of the Association, described his cases fully and concluded with statistics on the subject. Reports of these cases have already been published in the Toronto journals.

Observations upon Blood Pressure.

Dr. R. D. Rudolf, Toronto, contributed one of the features of the meeting. By means of a lantern, slides were exhibited, showing blood pressure in dogs under different conditions, together with the effects of drugs, as chloroform, atropine, etc., upon the circulation and respiration. An interesting canvas picture was that referring to the new drug chloretone. The animal received a dose of .275 per kilo. of the body weight, and ten minutes after the administration of the drug, the animal was in the condition of anesthesia, with regular pulse and regular respiration. Another chart showed the animal some hours later. That animal never recovered; and in the act of dying the respirations became lowered; the pulse had gone on very small, and the point was indicated on the chart showing where the animal died. The temperature fall was marked; the lowest was 83.4F.

The Adaptation of Patient to Climate in Cases of Phthisis.

Dr. N. A. Powell addressed the meeting on this subject. He considered mistakes are being constantly made, although we

are all honestly seeking for guiding principles in this matter. In trying to adapt the patient who is stricken with pulmonary tuberculosis, or who shows a tendency towards that disease, we have to consider first the patient, then the form of the infection, and then the climates available. We have also, and very seriously, to consider the financial condition of the patient. We are satisfied that the very best results accrue from climatic treatment. Take these patients away from dust-laden and moisture-laden localities, put them upon dry soil, and keep them in the open air, and we will get for them prolonged and useful lives. The early cases promptly removed and systematically treated, give a very large proportion—extending up to 90 per cent. of recoveries. It is best to do this in the pre-tubercular stage, where we are not able to say by the physical examination that the lung is involved at all. There are certain clinical varieties which we meet with. First, the acute inflammatory type with high temperature and invasion of the lung tissue: they do badly anywhere. Then there are the class as characterized by early hemorrhages. Of these, cases were instanced from his own practice. The cases of early hemorrhage sent to moderate elevations are ones which give us excellent results. Reports with regard to them from Colorado are not as encouraging as those which come from more moderate elevations; 1,500 to 3,000 feet seems to be much better in the hemorrhagic class. Then we have the class of cases where the pleura is the point first involved; these do excellently in Muskoka. Speaking of the laryngeal cases, Dr. Powell did not think it advisable to send patients affected with this form of tuberculosis away from skilled laryngologists. We should never be content in sending a patient to a good locality. If there is a sanatorium there, he considers it advisable to make use of it. As to cases of fibroid phthisis, in our Rocky Mountain region and in our Muskoka region, we have places that will benefit them materially. He instanced cases now under his care that have made the best gain during the winter months. They will gain more in January, February and March than in any other three months in the year. As to the climate, we have practically only four varieties: the cool-moist and the cool-dry; the warm-moist and the warm-dry. Long ago we sent patients to Florida. They enjoyed it while there, but they came home and they died very speedily. There is a universal repugnance in the profession to-day towards sending patients to a moist-warm climate. As regards the cool-moist climate, on the Atlantic sea-board, in the Lake Ontario and the Lake Huron areas, we find, as we pass inland from these, that the cases of tuberculosis diminish. If we can take our patients to places of moderate

elevations between 700 and 3,000 feet, take them into localities where we can have nearly or quite 300 days of bright sunshine in the year, and where the rainfall is limited, and where the climatic changes are comparatively limited, we shall find ideal localities. In the mountain slopes of our North-West and in our Northern regions, we have an ideal climate. Dr. Powell concluded his address by emphasizing the necessity of placing these patients, when they are sent away from home, under the supervision of competent, skilful, and reliable physicians.

The Relation of the Profession to Sanatoria for Consumptives.

Dr. P. H. Bryce, in presenting this paper, dealt with the recent legislation passed by the local legislature in regard to sanatoria for consumptives, the work which is now being done throughout Ontario in regard to the prevention and treatment of this malady; and proposed to move a resolution at another stage of the proceedings in regard to the formation of a provincial Association for the prevention and treatment of tuberculosis.

Dr. John Ferguson, Dr. Wm. Oldright, Dr. Playter, Dr. Carveth and Dr. N. A. Powell spoke to this paper.

The meeting here divided into sections.

SURGICAL SECTION.

Extensive Necrosis of the Skull.

Dr. William Oldright presented the patient and photographs of the condition at different stages. A man aged 58, formerly syphilised, in whom the first appearance of the trouble was brought on about a year ago, after a slight injury, was exhibited to the members. The extent of the necrosis was a patch of four inches square, more or less. The dura could be seen in the opening.

Two Forms of Puerperal Infection.

Dr. K. C. McIlwraith, Toronto, described two cases of puerperal infection in both of which a large piece of placenta had been left behind in the uterus. The lochia was collected by means of Doderlein's tubes, and cultures made therefrom. The importance of this procedure was that the physician would know whether he was dealing with infection of a mild or more serious character.

Drs. Amyot, Kitchen (St. George), McNaughton (Glenallan), Machell, and McKinnon discussed the subject, after which Dr. McIlwraith replied.

The Removal of Septal Spurs—A Note upon the use of Carmalt-Jones' Spokeshave.

Dr. D. J. Gibb-Wishart spoke on the advantages of this instrument in the removal of spurs of the septum, pure and simple, exhibited the instrument and described its use.

Dr. Price-Brown hardly endorsed its use.

Intussusception in Children.

Dr. Primrose thought this was the most general cause of the intestinal obstruction in children. He also referred to tumors as a cause of the condition. The symptoms were carefully gone over and cases reported in which he had operated for the condition. He thought the trouble was much commoner in infants than was generally diagnosed.

Dr. McKeown spoke in regard to the medical treatment.

Drs. Bruce, Macdonald and Howitt discussed the paper and the cases, the latter gentleman referring to eight cases already reported in the literature, which he had had in practice, the children being all under one year, recovery noted in seven, and the chief symptoms dwelt upon. He was of the opinion that this occurred far oftener than was supposed.

"The Treatment of Squint from the Standpoint of the Family Physician" (page 353) and "Nasal and Post-Nasal Synechia," (page 356) by Drs. J. T. Duncan and Price-Brown respectively, were taken as read.

Dr. Henry Howitt presided over this section.

MEDICAL SECTION.

Dr. Lett, Guelph, was elected to the chair.

The Etiology of Acute Rheumatism.

Dr. H. B. Anderson contributed a paper on this subject. He said that chemical and nervous theories that had been advanced to explain this disease, had not received confirmation from subsequent research, and offered no sufficient nor satisfactory solution of its causation. Among those most competent to speak on the subject; practically all were agreed that it was of microbic origin. The curves formed by the statistics and the mortality of the disease, its occasional epidemic occurrence, the transmission of the disease from mother to child *in utero*, the clinical course of the disease, and its affiliation to the joint inflammation, at times complicating gonorrhoea, septicemia, pyemia, pneumonia, etc., as pointed out by different observers, were all confirmatory of this view. The pyogenic organisms had frequently been found associated with the lesions of rheumatism *post mortem*, but these were probably merely

secondary. Of all the organisms which have been described as the cause of the disease, he thought the bacillus described by Acholme in 1891 was the only one which had stood the test of subsequent research, and he thought that Acholme's work was deserving of more consideration than it had received in England and America. This is a large organism, strictly anaerobic, resembling the bacillus of anthrax, growing in ordinary media and easily stained by the aniline dyes. It was often associated with the pyogenic staphylococci and streptococci, though frequently found in pure culture in cases of acute rheumatism.

Dr. Anderson reported a case of acute rheumatism in which death occurred during the first week. At the autopsy, four hours *post mortem*, an acute endocarditis, pericarditis and double pleurisy was found. Both aerobic and anaerobic cultures were made from the various organs. In the aerobic cultures from the pleuræ, pericardium, endocardium, liver, spleen and kidneys, the staphylococcus pyogenes aureus and albus were found. In the anaerobic cultures from the pleuræ, pericardium and endocardium, a large bacillus, corresponding in every way to Acholme's bacillus was found, associated with the pyogenic organisms. A culture from the throat three days before death showed the staphylococcus aureus. Dr. Anderson showed microscopic specimens of this organism. The reason why the organism was not more frequently found was probably that death seldom occurred early in acute rheumatism. The organism was a strict anaerobic and so did not grow in cultures as ordinarily made, and it was frequently associated with the pus organisms, so that it was very difficult to separate it out in pure culture.

It had been suggested that Acholme's bacillus was the same as the *B. aerogenes capsulatus* described by Welch, but it gave rise to no gas formation either in culture media or on inoculation and was otherwise quite distinct. He thought the subject was one worthy of very careful consideration.

In discussing Dr. Anderson's paper, Dr. Bryce asked if the presence or excess of uric acid has had any effect in the growth.

Dr. Cassidy asked if the bacterium is hard to obtain. Dr. Anderson's statements were of great value. In reading, he had seen the statement that acute rheumatism may proceed from several causes: First, heredity; second, chemical lactic acid; third, uric acid; fourth, all three previous. How does lactic acid play a part? By supplying an acid medium for the micro-organisms.

Dr. H. H. Oldright reported two cases dwelling in the eyeball, one a case of adhesions, and asked if this location would bear out the germ theory.

Dr. Lett asked if you can recover the organisms before or earlier in the case.

Dr. Anderson, in reply, stated that the growth was better in the urine of arthritics. Anaerobic cultures were not made as a rule; hence, probably the bacillus would not have been found. This case died so soon after coming in that it was a good subject for examination. It has been found in the blood by Acholme.

Differential Diagnosis between Pneumonia and Pleurisy with Effusion.

Dr. H. H. Oldright presented a paper on this subject.

Dr. H. C. Parsons asked for physical signs and characters of expectoration in one case reported.

Dr. Rudolf recommended use of the needle. There was no risk in an adult with carefully sterilized needle.

Dr. Lindsay, Guelph, reported a case with a mishap. The needle failed for a number of times to reach the abscess, but it was finally found imbedded deeply in the lung. Removed portions of two ribs and evacuated. Absorption was increased and the man went down rapidly.

Reply: Foul smelling; chest was completely dull; needle pus organisms might be carried into the lung tissue.

An Unusual Case of Crossed Paralysis.

Dr. D. Campbell Meyers read a paper on this case. It occurred in a man aged 66, who has one child, a daughter, who enjoys good health. Last September the case came under his care, with left facial paralysis and a history of a recent paralysis of the right arm. The family history of the patient was good. Previous history unimportant. The eyes are good and there is no paralysis of the tongue. Dr. Meyers considered that there were two lesions present in the case, one cortical and the other peripheral. Under treatment the patient was fully recovered in five weeks.

Dr. Ferguson asked as to sensory lesions.

Dr. Cassidy spoke of a case of facial paralysis in a young man with recovery in ten days.

Dr. Ferguson spoke of the double lesion in Dr. Meyers' case. He thought the facial lesion was peripheral, the arm lesion was evidently cortical. He thought there may be vaso-motor changes sudden in onset, and the production of paralysis may be only temporary.

Dr. Meyers replied. He thought Dr. Ferguson's vaso-motor theories quite possible, but difficult to prove. Thought Dr. Cassidy's case a simple slight neuritis.

Erythema Bullosum.

Dr. Graham Chambers contributed this paper. He defined this condition to be that form of erythema multiform which exhibits in the highest degree the pathological change which is present in the latter disease. He looks upon the hyperemic spot, papula, tubercle, edematous nodule, vesicle and bulla, as lesions representing different degrees of the same pathological process. The forms of lesions are all inflammatory in origin, but there is always present in addition more or less angio-neurotic edema. Four cases were reported in all.

Dr. W. J. Wilson spoke of diagnosis between erythema bullosum and pemphigus. The latter sometimes follows vaccination, as it did in two of the cases reported by Dr. Chambers.

Dr. Bryce spoke regarding the confusing preliminary marks of smallpox, so important to recognize at present.

Dr. Chambers in reply: The classification of bullous eruptions is unsatisfactory. It is sometimes very difficult to differentiate them. Pemphigus is usually chronic; erythema bullosum usually acute. Symmetry of lesions, multiformity of lesions. Thinks Dr. Wilson's point well taken.

Beds: Their Proper Construction and Care from the Doctor's Standpoint.

Dr. Carveth read a paper with this title.

The paper was discussed by Drs. Machell, Anderson, W. J. Wilson, Chambers and Bryce.

The Artificial Feeding of Infants.

Dr. C. Sears McKee, Toronto, read a paper on this subject. He thought this subject was not given enough attention by the medical man, as a rule. Cow's milk, and that alone, modified, should be the only food in artificial feeding up to nine months. The various foods on the market were dealt with, and the modification of cow's milk given.

Dr. Machell agreed with Dr. McKee regarding milk for children—not patent foods. He gave a scheme for working out the proportions.

EVENING SESSION—GENERAL BUSINESS.

Dr. A. A. Macdonald in the chair.

REPORT OF NOMINATING COMMITTEE.

This was read by Dr. Macdonald, and was adopted.

President, Dr. A. McKinnon, Guelph; 1st Vice-President, Dr. R. A. Pyne, Toronto; 2nd Vice-President, Dr. W. H. Jeffs, Havelock; 3rd Vice-President, Dr. A. S. Fraser, Sarnia; 4th

Vice-President, Dr. H. H. Sinclair, Walkerton; General Secretary, Harold C. Parsons, Toronto; Assistant Secretary, George Elliott, Toronto; Treasurer, George H. Carveth, Toronto.

Next place of meeting, Toronto.

REPORT OF COMMITTEE ON PUBLIC HEALTH.

This was read by Dr. Gilbert Gordon, and adopted.

Under the heading of receiving the report of the Publication Committee, a discussion took place upon the desirability of having the proceedings printed in full. The matter was referred to the Publication Committee and the Committee on Papers and Business to report at the first day's meeting next year.

The Special Committee on Inter-Provincial Registration not reporting under this heading, a unanimous resolution was passed approving of the proposed bill of Dr. Roddick.

The Ontario Medical Library was voted \$75.

Dr. W. J. Wilson read the report of the Committee on Hospital Abuse, which was adopted.

The General Secretary's report and the Treasurer's report were here presented, received and adopted. The Treasurer's report showed cash on hand of \$48.30.

Dr. Bryce read a resolution favoring the formation of a Provincial Association for the prevention and treatment of tuberculosis, which was assented to by the Association.

Necrology report was read by Dr. Cassidy in the absence of the chairman, Dr. J. L. Bray. It included Drs. J. E. Graham; James B. Campbell, London; Samuel Hagel, Toronto; Joseph Allen, Osgoode Station, and Dr. Corbett, Orillia.

A vote of thanks was unanimously passed to the Hon. the Minister of Education for the use of the auditorium; also to Dr. Adam Wright for the efficient manner in which he had conducted the meeting. To this Dr. Wright made a suitable and appropriate reply.

The usual honoraria were ordered to be paid the secretaries.

Dr. Wright then installed President-elect, Dr. McKinnon, in office. Dr. McKinnon accorded gracious thanks for the honor which had come to him unexpected and unsought.

[We are indebted to Dr. George Elliott for the report of this meeting.—Ed.]

Editorials.

THE MEETING OF THE ONTARIO MEDICAL ASSOCIATION.

We are pleased to give in this issue a fairly complete report of the meeting of the Ontario Medical Association, held in Toronto, June 6th and 7th. The system in vogue in connection with the conduct of the meetings during the last few years is certainly a very good one. The great portion of the work is left in the hands of two committees: the Committee on Papers and Business, and the Committee on Arrangements.

According to the constitution of the Association it is the duty of the Committee on Papers and Business to undertake all business not coming within the duties of the other committees. To it are referred all papers to be read, and by it the programme is arranged. The committee has also to arrange all details as to the invitation of guests, and generally look after the conduct of the meeting. This year the President made a happy choice in making Dr. Albert Macdonald the chairman of this committee. He worked faithfully in the interests of the meeting, and to him and the members of his committee are due a great amount of credit for the successful results of their untiring efforts. The discussions on certain subjects, such as that of Appendicitis, the Future of Therapy, Inter-Provincial Registration, and Army Medical Arrangements in South Africa, were admirable—the best, we think, ever heard at any meeting of the Association.

The duty of the Committee on Arrangements is to provide a suitable place for holding the meetings, to attend to the reception of members and guests with a view to having all on the best possible social footing. The most important function in this connection is the annual banquet. The chairman of this committee was Dr. Allen Baines, who worked indefatigably in the interest of the meeting, but especially to make the banquet a success. It is putting it very mildly to say that it was a good banquet. It was much more than a good banquet, it was the best and most enjoyable banquet that was ever held

in Toronto. The menu was good—probably perfect would be a better word—the music was good, the songs (mostly patriotic) were inspiring, the speeches were short, crisp and good, the air was full of fun and frolic, everybody was happy, everybody said that Allen Baines was a genius. It is only fair to add that Dr. Baines received material assistance from Drs. Jas. F. W. Ross, Bruce Riordan, Chas. J. Hastings, and others.

It has occasionally happened that members have been to a certain extent disappointed with results in the past, but we have yet to find one member who was not perfectly satisfied with this meeting in every respect.

ISOLATION OF CONSUMPTIVES.

It is now generally conceded that tuberculosis is a preventable, curable, and infectious disease. The municipal authorities of many cities and towns are now considering the question of the isolation of its victims. The majority of the profession are not yet prepared to go so far as to recommend complete isolation. We will watch with much interest the results of two cities of the United States—Boston and Trenton—where the Boards of Health have assumed authority to isolate consumptives. It is thought that it may not be necessary to remove the patient to a hospital in order to secure satisfactory isolation, but we are told by the *Toronto World* that the Boston Board of Health has authority to remove the patient if the necessary isolation is not provided at his home. According to the regulations, a physician must report every case of tuberculosis coming under his care. On receipt of such report an inspector for the Board will visit the home of the patient. If the conditions there are not satisfactory, he will be removed to a public institution. If, however, the conditions are such as to satisfy the Board that proper precautions will be observed, the patient will be allowed to remain with his family.

We fully recognize the fact that the most important thing for the people of Canada to do is to build many suitable institutions for the reception and treatment, especially, of the sick poor suffering from tuberculosis. Much good has been accomplished at the Gravenhurst Sanatorium, but that excellent

institution can only accommodate a very limited number. The Anti-Consumptive League of Ontario is doing magnificent work in the direction indicated; and we hope its efforts will be appreciated and properly supported by the general public in the Province.

THE SUPERINTENDENT OF THE GUELPH GENERAL HOSPITAL.

We learn from the *Guelph Herald* that Miss L. J. Sheppard, Superintendent of the Guelph General Hospital, was presented by the medical staff with an address, a gold watch, and a handsome purse of gold, June 9th. She had completed her seventh year of service to the hospital, and her work had been so eminently satisfactory that the staff felt impelled to show their appreciation in a very pleasant way. Dr. Brock, before reading the address, referred to Miss Sheppard as a woman of ability and integrity, having at heart the good work connected with the hospital. Dr. McKinnon, in making the presentation, said that in his opinion there was nothing too good for the staff to put in the way of the lady superintendent. Dr. Howitt said she had the esteem, confidence, and hearty co-operation of every member of the medical staff. Dr. Lindsay said that her general administration and management of the hospital were as perfect as a human being could make them with the means at her disposal. Dr. Lowry thought that Miss Sheppard's worth, were it known to many of the large hospitals, would cause her to be very much sought for. Dr. Stewart said that she came from the Toronto General Hospital, where she was assistant lady superintendent, to Guelph, carrying with her credentials from the ablest medical men in Toronto. Her entry to the position was auspicious, and her career as superintendent was a complete success. Dr. Robinson said the high standard of efficiency in the hospital was directly due to Miss Sheppard's energy and ability. Dr. O'Reilly hoped she would live to wear the watch which was presented to her, so long that it would require a new case and a new set of wheels. Dr. Savage could not speak too highly of her never-failing patience and courtesy. We in Toronto who knew Miss Sheppard in our General

Hospital, are much pleased but not at all surprised at her success in Guelph. We desire to congratulate the staff of the Guelph General Hospital upon the generous method which they adopted to show their appreciation of Miss Sheppard's worth.

THE NATIONAL SANITARIUM ASSOCIATION.

We are glad to publish the following statements relating to the Muskoka Cottage Sanatorium for Consumptives: The Muskoka Sanatorium is provided with everything necessary for the comfort, convenience and benefit of its patients. No expense has been spared to make it one of the best institutions of the kind on this continent.

Two hundred and thirty patients have been admitted during the past two years, and 183 have been discharged. The resident physician reported that of the latter number 134 were apparently cured, had the disease arrested, or showed marked improvement. "This result," the resident physician adds, "would have been still more favorable if many of these patients, owing to want of means, had not been obliged to leave the Home sooner than they should have done."

The successful treatment of so many consumptives at Gravenhurst has been followed by applications for admittance on the recommendation of previous patients or their friends. Some of the patients have casually mentioned that their physicians did not seem to be aware of the good work done at the Muskoka Sanatorium, inasmuch as they had not referred to it in speaking to them of sanatoria.

In view of the large measure of success which has attended the treatment of consumptives at the Muskoka Home, we have deemed it advisable and proper to bring the matter specially under your notice, with the hope that if, on inquiry, our statements are found to be satisfactory, you may be pleased to recommend patients in the first stages of the disease, and who are able to pay the necessary expense of their maintenance, to avail themselves of the advantage afforded by the Muskoka Home for Consumptives.

The rate charged to patients, at the present time, is only

seven dollars per week, payable in advance, for board and lodging, ordinary medicines and medical attendance.

Any additional information that may be required can be obtained on application to the Medical Superintendent, at the Sanatorium, Gravenhurst.

CANADIAN MEDICAL ASSOCIATION.

The thirty-fourth annual meeting of the Canadian Medical Association will be held in Ottawa, September 12th to 14th, under the presidency of Dr. R. W. Powell. The following distinguished visitors are expected to be present: Mr. Edmund Owen, of London, England; Professor Shattuck, of Boston; Dr. Louis Gerster, of New York; Dr. Nicholas Senn, of Chicago; Dr. A. M. Hamilton, of New York, and others.

We have always thought that the right place to hold the meetings of the Canadian Medical Association was Ottawa, the capital of the Dominion. A certain amount of sentiment (for which we have much respect) creeps in, and through its influence we have decided that it would be better in the interests of the profession of the whole Dominion to continue the peripatetic system. This view appears to have been accepted by the majority of the members, and we therefore, for the present at least, cheerfully accept it, and hope that Winnipeg will be chosen as the place for the meeting in the year 1901.

We were much pleased to have Dr. Powell, of Ottawa, the president-elect of the Canadian Medical Association, at the meeting of the Ontario Medical Association. We are glad to know that he got many assurances from physicians of this province that Ontario would appear in force at the Ottawa meeting. We have every reason to believe that there will be a goodly representation from Toronto. The Dominion Association is certainly the one which should receive hearty support from all sections of Canada. We sincerely hope that the meeting at Ottawa will be in all respects a pronounced success. The members will receive information about railway rates in the provisional programme, which will be issued in August, by the Secretary, Dr. F. N. G. Starr, Toronto.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO.

LIST OF THE FINAL, INTERMEDIATE, AND PRIMARY RESULTS.

The following candidates have passed the examinations of the College of Physicians and Surgeons of Ontario:

Final Examinations.—D. H. Arnott, London; B. C. Bell, Chatham; J. Y. Baker, Summerstown; E. P. Bucke, London; W. G. Collison, Mitchell; Harriet Cockburn, Toronto; N. Colville, Leskard; G. L. Clarke, London; R. F. Carmichael, Strange; C. A. Campbell, Toronto; E. D. Carder, Toronto; G. W. Dowsley, Toronto; M. K. Dillane, Tottenham; J. Gow, Windsor; W. A. Hall, Kingston; H. G. Hargrave, Toronto; R. C. Hiscock, Kingston; A. C. Hendrick, Frankford; G. W. Howland, Toronto; Rowena Hume, Toronto; G. A. Holmes, Chatham; C. P. Johns, Kingston; E. A. Jones, Whitby; A. A. Knox, Toronto; W. A. Kerr, Seaforth; H. S. Kirby, Ottawa; T. M. Leask, Toronto; S. J. Morris, Crompton; W. A. MacDonald, Windsor; Margaret McCallum, Toronto; Helen MacMurchy, Toronto; A. J. MacKenzie, Lucknow; H. Mason, Toronto; James Moore, Brooklin; G. C. McGibbon, Arkona; G. H. McLaren, Hamilton; Kate McLaren, Toronto; Dorothea Orr, Whitby; J. H. Peters, Fergus; R. Y. Parry, Dunnville; W. G. Ratcliffe, St. Catharines; D. G. Revell, Tyrconnell; G. Ramsay, Toronto; W. O. Simpson, Toronto; A. T. Stanton, Pontypool; J. R. Stanley, Granton; H. R. Smith, Hamburg; Nellie S. Skimin, Hamilton; R. P. Vivian, Toronto; D. C. Wilson, Parkhill; C. J. Wagner, Toronto; H. C. Wrinch, Toronto; E. G. Weir, Toronto.

Intermediate Examinations.—B. C. Bell, Chatham; R. F. Carmichael, Strange; E. N. Coutts, Harwich; C. A. Campbell, Toronto; E. D. Carder, Toronto; H. C. Cameron, Rob Roy; S. E. Charlton, Galt; H. L. Collins, Kincardine; H. G. Downing, Woodstock; H. Dittrick, St. Catharines; C. C. Elliott, London; E. Flath, Drayton; J. W. Fitzgerald, Peterborough; W. A. Hall, Kingston; H. G. Hargrave, Toronto; R. C. Hiscock, Kingston; A. C. Hendrick, Trenton; G. W. Howland, Toronto; C. P. Johns, Kingston; A. A. Knox, Toronto; H. S. Kirby, Ottawa. James Moore, Brooklin; A. J. MacKenzie, Lucknow; F. W. Marlow, Blackstock; A. S. Morgan, Kerwood; F. E. MacLaughlin, Hamilton; J. A. McClintock, Manchester; Belle C. Oliver, Ingersoll; A. R. Perry, Mount Forest; R. Y. Parry, Dunnville; H. P. Ross, Exeter; E. S. Ryerson, Toronto; W. E. Robertson, Milton; E. J. Stubbs, Stratford; G. B. Snyder, Abingdon; P. L. Scott, Paris; W. O. Simpson, Toronto; C. L. Taylor, Wardsville; F. C. Trebilcock, Bowmanville; S. Thompson, Strathroy; E. G. Weir, Toronto; J. Webb, Hamilton.

Primary Examinations.—Passed with honors: E. J. Davey, Stony Creek; R. W. Irving, Ingersoll; O. Klotz, Ottawa; A. Moir, Dunnville; P. W. Saunders, Toronto.

Passed Primary: D. W. Allin, Bowmanville; G. M. Atken, Milverton; A. E. Archer, Freeman; E. A. Boyd, Jerseyville; A. Brown, Motherwell; J. Y. Baker, Summerstown; J. D. Chisholm, Toronto; Emma Connor, Chatterton; B. A. Cohoe, Grand Valley; F. A. Cleland, Meaford; J. L. Campbell, Ridgetown; F. J. Doherty, Eglinton; G. F. Dalton, Kingston; H. E. Day, Kingston; G. W. Fletcher, Blenheim; A. Fisher, Stratford; T. S. Genge, Halliford; J. W. P. Gray, Toronto; J. N. Gunn, Ailsa Craig; J. E. Godfrey, Meaford; G. W. Graham, Toronto; H. B. Hutton, Dungannon; J. L. Huffman, Aylmer; W. R. Hunter, Smith's Falls; V. E. Henderson, Toronto; H. G. Hargrave, Toronto; E. T. Hoidge, Toronto; J. R. Irwin, Port Hope; E. P. James, Galt; A. A. Knox, Toronto; H. S. Kirby, Ottawa; R. W. Leader, Plattsville; J. J. Mason, London; S. A. Moran, Trenton; A. Murdock, Brucefield; J. W. Merrill, Ottawa; W. R. Mitchell, Perth; N. T. MacLaurin, Toronto; K. MacKinnon, Guelph; A. H. Montgomery, Brantford; Elizabeth McMaster, St. Mary's; W. A. McCauley, Keene; A. D. McEachren, Glencoe; M. D. McKichan, Hamilton; A. F. McLaren, Lancaster; H. N. McCordick, Jura; D. McBane, St. Thomas; G. McNeill, London; J. M. Oswald, Janetville; H. R. Parent, Windsor; R. W. Rutherford, Chatham; G. W. Ross, Toronto; A. B. Rutherford, Owen Sound; H. E. Roaf, Toronto; W. O. Simpson, Toronto; L. L. Stauffer, Waterloo; F. Shortt, Elora; D. Smith, Embro; T. Turnbull, Stratford; S. Thompson, Strathroy; W. T. Wallace, Orangeville; A. B. Wright, Toronto; O. C. Withrow, Toronto; W. T. Yeo, Little Britain; W. D. Young, Toronto.

THE RESIDENT MEDICAL STAFF TORONTO GENERAL HOSPITAL.

The house staff of the Toronto General Hospital for the year 1900-1901 has been appointed as follows:

From Trinity University—Drs. W. A. Kerr, Seaforth; George A. McLaren, Hamilton; A. T. Stanton, Toronto; H. A. Smith, Toronto; E. Weir, Toronto; Drs. James Moore and W. H. Marshall, alternates.

From Toronto University—Drs. E. D. Carder, Toronto; J. Gow, Windsor; Goldwin H. Howland, Toronto; A. C. Kendrick, Frankfort; A. J. McKenzie, Lucknow; Drs. C. A. Campbell and A. Knox, alternates.

Personals.

Dr. Irving Cameron, of Toronto, will sail for England, July 7th.

Dr. Allen Baines sailed from New York for England, June 20th.

Dr. Bertram Spencer, of Toronto, went to England in the latter part of May.

Dr. Charles H. Doherty (Trin. '99) has been appointed Superintendent of the General Hospital, Nelson, B.C.

Dr. Charley Murray, of Toronto, who had his leg fractured by a bicycle accident some weeks ago, is recovering.

Drs. A. McPhedran, E. E. King, B. E. McKenzie, and H. P. H. Galloway attended the Congress of American Physicians in the latter part of May in Washington.

Dr. R. J. Dwyer, Superintendent of St. Michael's Hospital, Toronto, is at Johns Hopkins Hospital, Baltimore. He intends shortly to go to Europe for a few months.

Miss Snively, Superintendent of the Toronto General Hospital Training School for Nurses, has been elected honorary treasurer of the International Council of Nurses, the headquarters of which are in England.

Dr. T. H. Middlebro (Tor. '92), house surgeon Toronto General Hospital, '92-3, after '93 a practitioner of Owen Sound, has recently passed both the primary and final examinations for fellowship in the Royal College of Surgeons, England.

The tenth annual meeting of the American Electro-Therapeutic Association will be held on September 25th, 26th and 27th, 1900, at the Academy of Medicine, New York City, under the presidency of Dr. Walter H. White, of Boston.

The sixty-eighth annual meeting of the British Medical Association will be held in Ipswich, county town of Suffolk, on July 31st, August 1st, 2nd and 3rd. The President-elect is Dr. Elliston, of Ipswich. The address on Medicine will be delivered by Dr. Henry Pye-Smith; that on Surgery by Mr. Frederick Treves; that on Obstetrics by Dr. Smily, of Dublin.

Dr. T. G. Roddick, of Montreal, has visited Toronto three times during the month of June—first, on June 6th to attend the meeting of the Ontario Medical Association; second, June 16th, to confer with the Ontario Medical Council about Dominion registration; third, June 23rd, to attend a social function. He expects to sail from New York for England, July 11th.

Drs. B. L. Riordan, H. A. Bruce, C. R. Dickson, and Arthur Small, of Toronto, attended the meeting of the Association of American Railway Surgeons in Detroit. Among the other surgeons present from Canada were Drs. Radford of Galt, H. H. Oldright of St. Catharines, Jeffs of Havelock, and McCarthy of Niagara Falls. Dr. Bruce was elected one of the vice-presidents of the Association.

As a matter of course, Dr. Wm. Britton, of Toronto, the Vice-President of last year, was elected President of the Ontario Medical Council, at the recent meeting held in June. We are pleased to be able to say that his election was eminently satisfactory to the rank and file of the profession of Ontario, and also to the Senate of the University of Toronto, whose representative he has been for many years. Congratulations!

The election of Dr. Angus McKinnon to the Presidency of the Ontario Medical Association gave universal satisfaction to the members present. It was generally understood that the office should go to the west, and the names of Dr. J. L. Bray, of Chatham, and Dr. A. McKinnon, of Guelph, were those most frequently mentioned for the position. Many would have chosen Dr. Bray, but none objected to Dr. McKinnon, who is one of the most able and active members, and has been generally recognized as such for many years. There was also a general feeling that Guelph and its vicinity deserved some consideration from the Association. We heartily congratulate Dr. McKinnon, and hope he will have a successful meeting in 1901.

“An Appendix to the ‘International Directory of Laryngologists and Otologists,’ compiled by Mr. Richard Lake, is in course of preparation. In it will be found corrections of names and addresses already given, an additional list of names and addresses received since publication, and an obituary list.

“ . . . Considerable additions have been obtained for the foreign list, which will materially add to its value and completeness. The decision of the Editors of the *Journal of Laryngology, Rhinology, and Otology*, under whose auspices the Directory is published, to allow no name to be inserted in the British list for which sanction has not been given in writing, at once explains some omissions and criticisms. The Editors, whilst desirous of making the Directory as complete as possible, consider it best to adhere to this course. It is therefore hoped that all engaged in the practice of Laryngology, Rhinology, and Otology will assist as far as possible in making this useful work complete,” by sending in their names and addresses to the Editor, “International Directory of Laryngologists and Otologists,” 129 Shaftesbury Avenue, W.C.—*Journal of Laryngology, Rhinology, and Otology*, April, 1900.

Correspondence.

PROBATION AND TREATMENT OF INEBRIATES.

To the Editor of the CANADIAN PRACTITIONER AND REVIEW :

SIR,—In the May number of the PRACTITIONER you intimate that the columns of your journal will be open for a full discussion of the problem of what shall be done for the unfortunate inebriate. As a contribution to a solution of this important question, perhaps you will kindly allow me to report regarding a recent visit to the State of Massachusetts, to a large extent with this object in view. In making this visit I had in view, firstly, to ascertain at first hand the practical working of the probation system for the reformation of inebriates; secondly, to visit and inspect the State Institution for the care and treatment of dipsomaniacs; and, thirdly, to canvass the opinion of medical and other authorities regarding the provisions of the bill now under the consideration of the Ontario Government proposing to deal with this question.

As you are aware, a bill was drafted jointly by the Public Health Committee of the Ontario Medical Association and by the Prisoners' Aid Association of Canada, and was submitted to the Premier of Ontario and the Provincial Secretary during the session of the Ontario Legislature last March. This bill is based on the Massachusetts Probation System.

The probation system was adopted in the State of Massachusetts several years ago in dealing with youthful offenders under 16 years of age, and the results were so satisfactory that about five years ago the system was extended to cases of adult first offenders and to the more hopeful cases of inebriety. The results, it is claimed, have been most gratifying. In every criminal court throughout the State an officer, called a probation officer, is appointed by the court, who takes the supervision of cases placed on probation under suspended sentences. The probation officer makes friendly visits to the probationers, not in the capacity of an informer but in the capacity of a friendly visitor, and he does what he can to place the probationer on a higher plane of life and living. At the end of the probationary period the probationer appears in court, and if the report of the officer is favorable the person on probation may be discharged or the probation may be continued. If the report is unfavorable the probation may be continued or the person may be committed either to prison or to a House of Correction.

While in Boston I made it my business to look into the practical working of the probation system. I accompanied the probation officers while making their early interviews with prisoners in the police cells awaiting trial. I made the rounds with one of these officers outside to ascertain the truth or falsity of the statements made, and I followed the cases as they were afterwards dealt with in court. I also attended the weekly probation court held for the purpose of dealing with cases whose term of probation had expired. Besides this I interviewed the chief probation officer and several of his assistants, two of whom are ladies, regarding the working of the probation system. I also interviewed others who are in a position to judge regarding the results attained by the system of probation. As a result of this investigation and these inquiries my conclusions are as follows: That from 30 to 35 per cent. of those placed on probation for petty offences, and about 45 to 50 per cent. of those placed on probation for drunkenness, are either reformed or at least are not known to be again arrested. It is claimed that 80 per cent. of all those placed on probation are reformed but unfortunately the statistics are not compiled in such a manner as to demonstrate this. I found, however, that there is a consensus of opinion among those who are in a position to know, that the probation system in Massachusetts is giving great satisfaction. The Secretary of the Massachusetts Prison Association said to me, that although the statistics are not as complete as they might be, "We *know* that probation is doing a good work." I found, moreover, that there is now a bill before the State Assembly which, when adopted, will extend very materially the scope of the probation law.

I visited the State Institution for the Treatment of Dipso-maniacs, which is situated at Foxborough, about thirty miles from Boston. It is on a farm containing one hundred acres, most of which is under cultivation. The hospital is on the cottage plan, and there were 198 patients under treatment the day of my visit. Dr. Woodbury is the Superintendent and he has one medical assistant. The institution is thoroughly equipped, including gymnasium, baths, lecture hall, etc., etc., at a total cost of about \$200,000. The income is about \$48,000 a year, \$13,000 of which is from municipalities, \$11,000 from industries, \$2,500 from pay patients, and the balance made up by the State. Patients are admitted on the certificate of two licensed physicians, and the municipality where the patient is committed is liable for the payment of the expense of maintenance, the same as in the case of lunatics. In cases, however, where the patient has no "legal settlement," the expense is borne by the State. Besides farming, the principal industry is broom-making. Patients are committed for a period of two

years, but they may receive a conditional discharge (on parole or probation) any time after six months' detention. The average cost per patient is \$5.30 per week. This includes all expense as follows: provisions \$1.32, clothing, etc., \$1.77 wages \$2.21. The results of treatment (report for 1899) are as follows: Doing well 37.12 per cent., improved 13.77 per cent., unimproved 32.93 per cent., dead 1.19 per cent., could not be found 14.97. In reply to my question the Superintendent stated that the chief cause of relapse after discharge is lack of employment; a second cause is lack of supervision.

While in Boston I also visited the Washingtonian Home for Inebriates, which is under the charge of Dr. Ellsworth, and I had an interview with Dr. Temple, Surgeon to the Massachusetts Home for Intemperate Women. I submitted the provisions of the proposed Ontario bill for the treatment of inebriates to these specialists as well as to Dr. Woodbury, of Foxborough, and also to members of the Massachusetts Prison Association, and I was gratified to find the consensus of opinion was in its favor. Dr. Woodbury was very emphatic in his commendation of the idea of combining medical treatment with the probation system, and he assured me he was convinced that very great good would be accomplished by making provision for home treatment in addition to general hospital treatment in connection with the probation system and as provided for in the Ontario bill.

Yours truly,

A. M. ROSEBRUGH.

Confederation Life Building, Toronto, June 20th, 1900.

Selections.

Popular Superstitions Relative to Menstruation.

Laurent (*Chronique Medicale*) does not entirely disbelieve in certain ideas, popular amongst women in different countries, relating to menstruation. In the sugar refineries in the north of France the female hands are actually kept out of the premises when the sugar is being boiled and also when it is undergoing the process of cooling. The objection to women is that if one or more were menstruating the sugar would be blackened. A similar notion prevails in Cochin China in respect to the preparation of opium. Another doctrine, also common to Europe and Asia, is that the hands of a menstruating woman break objects of strength and toughness. Especially is this notion entertained in relation to stringed instruments. A performer on the double bass at a theatre in Paris declared that if his wife touched one cord of the instrument during her "period" it snapped at once. Two young women, excellent violinists, informed Laurent that they never played when menstruating, as the snapping of cords interfered greatly with the performance. One of these ladies admitted that she was extremely nervous and irritable at the period. Several much more credible phenomena have been reported, and clearly come under the head of neuroses. Young girls sometimes acquire an idea that their clothes stick to them at the period. Such a person gets nervous during the catamenia, and trying to pull off a tight glove fails, and then believes that it sticks to her. Since she thinks that the same must be the case with her clothes, she loses the power as well as the will to pull them off. Laurent observed this in two sisters. Their body linen did not stick to the skin through perspiration or any visible cause, but it could not be taken off during a "period" till a servant pushed her hand between it and the skin.—*Indian Lancet*.

Some "Signs" in Appendicitis.

In the course of a series of clinical lectures on the various forms of intra-abdominal suppuration, now in course of delivery at Westminster Hospital, Mr. Tubby called attention to the importance of certain "signs" in the diagnosis of appendicitis. In his opinion the most common sign is rigidity of the abdomen. As a rule the whole abdomen is distended and somewhat rigid or tympanitic; later on, at the second or third day, local rigidity and tenderness are more marked. If the rigidity

remain persistent it indicates acute general peritonitis. The tenderness, he observed, is best marked at McBurney's spot, and the reason that this is the point of greatest pain is that it is just at this part that the appendix arises from the cecum. Though we may have appendicitis without the sign of any tumor, a swelling is generally present on the second or third day in the right iliac fossa; with a long appendix hanging in the pelvis the tumor cannot be felt. The tumor may consist of intestine, peritoneum, exudation, and possibly pus, and therefore dullness is not persistent. Should, however, a tympanitic note remain persistent, the signification is that there is gas in an abscess cavity. The formation of pus, without its evacuation, causes the patient to rapidly waste, and the presence of indican in the urine is noticed. In acute appendicitis, with the formation of pus we have an excessive number of leucocytes in the blood, and this has been relied upon by some as one means for the differential diagnosis of appendicitis from typhoid.—*Medical Press and Circular*.

Pyloric Stenosis in Tuberculous Persons.

Patella at the Congress on Tuberculosis recently held in Naples said he had seen three cases of stenosis of the pylorus caused by fibrous peripyloritis developed in individuals who at least three years previously had presented symptoms of tuberculous lesions of the lung, which had passed into the phase of obsolescence. In two of the cases gastro-enterostomy had been performed by Colzi and De Pauli, with the result that the patients, who were in a state of extreme marasmus, regained weight and strength. In these cases, in addition to thickening of the pylorus there were found nodules of fibrous appearance: examination showed that these were not of tuberculous nature. The author affirms that the conditions found gave no ground for the belief that the peripyloritis was tuberculous; he thinks that they are examples of slow sclerosis dependent on tuberculous intoxication, the effect of which may, according to Potain and his school, become manifest in various parts, especially where (as at the pylorus) there is considerable movement. Whatever be the interpretation of the condition, he urges that in such cases surgical intervention should not be delayed.—*British Medical Journal*.

Treatment of Vaginismus.

Dr. Verchere, in *La Médecine Moderne*, says the first advice to give a woman suffering from vaginismus is to suppress all genital excitation, since absolute and prolonged rest of the organ may of itself alone bring about a cure. Iodoform is

recommended as a dressing, being anesthetic as well as anti-septic, and is usually efficacious. Various methods of treatment, from cold sitz baths to divulsion and cutting operations, are passed in review. The Sims' method is in a general way regarded as too radical. Two successes are reported from subcutaneous section of the anal sphincter. Medical treatment is of great importance. Much attention must be paid to subjects predisposed to hereditary insanity. Antispasmodic and tonic treatment is usually indicated, while hydrotherapy and arsenical treatment are not to be forgotten.—*Indian Medical Record.*

Puerperal Mastitis.

Brouha (*L'Obstétrique*) gives details of a healthy primipara who during at least the last three weeks of her pregnancy carried out most conscientiously the prophylactic treatment advised by Rubeska for the prevention of mammillary abrasions and cracks; twice daily she washed the areola and the nipple with warm water and soap, and followed this with a fomentation of the parts, sometimes with alcohol and sometimes with glycerine. The labor supervened at term; the child presented by the breech, but was delivered without interference; but there was some *post-partum* hemorrhage causing considerable anemia. The same night there was some fever and a feeling of tension in the breasts. The infant was only once put to one breast. A mastitis developed, although no lesion could be discovered in the breasts; recovery took place. The author finds it difficult to explain how microbes reached the gland tissue, as the infant had not been put to the breast when the first signs of mastitis appeared. He considers that some of the microbes which are normally found in the lactiferous ducts had forced their way through the epithelium and reached the lymphatics; he thinks that the mechanical and chemical means employed to prevent the occurrence of abrasions may have weakened the vitality of the epithelium, and so made easy the entrance of the microbes and perhaps also have increased the virulence of these microbes.—*British Medical Journal.*

Diabetic Coma.

M. Sternberg (*Zeit. f. klin. Med.*) after a careful discussion of the work done on the relation of organic fatty acids in the blood to diabetic coma, records the results obtained in a series of experiments in which he administered the various amido-butyric acids to animals. It appears that of the three amido-butyric acids the α and the γ acids were without poisonous or toxic influence, whereas the β -amido-butyric acid, when given in doses of about three grams, caused profound symptoms of

toxemia closely resembling those of diabetic coma in human subjects, there being a profound comatose condition, with strikingly deep slow inspiration and a rise of blood pressure. It is important to observe that β -amido-butyric acid is one of the few fatty organic acids of its series which produces such a comatose toxic reaction, and it is also a striking fact that the blood in cases of diabetic coma has frequently shown the presence of β -acids of the organic fatty series. The author does not conclude positively that β -amido-butyric acid is the identical acid met with in the blood in diabetic coma, but believes it is highly probable that this substance, or one closely allied to it, is the toxic agent, and that by studying minutely the chemistry of these β -acids in the laboratory and on animals it may be possible to discover chemical substances which may neutralize or render innocuous the toxic character of these acids thus afford us with an efficient remedy for administration in cases of diabetic coma.—*British Medical Journal*.

A Case of Death from Psychic Insult.

T. Pagenstecher, Elbelfeld, Germany. A manufacturer, with a good previous mental and physical history, had taken quite an interest in insurance matters and had been insured by an accident company for \$80,000. While in good health he accidentally cut his finger slightly and it became ink-stained. He believed immediately that he had blood-poisoning from the ink; felt pain in the arm and wanted it amputated. The next day there was delirium and great excitation, with delusions; but he could be aroused from his delirium to coherency, and all the time fearing death and praying for amputation. There was no fever nor any change in pulse. Thirty hours after the accident death came suddenly and unexpectedly. At the autopsy there was no evidence of infection, either bacterially or microscopically, and the internal organs were normal, except for a slight concentric hypertrophy of the left ventricle. This case is regarded as delirium nervosum Dupuytren, in which not the severity of the trauma but the psychic shock produced the effect. But there is no way to account for the death except through insufficiency of the heart. This case was considered in the courts, suits being brought against the insurance companies for non-payment. There were presented two witnesses who thought that suicide was committed with curare, supported by the negative results of the autopsy; another witness thought the case one of tetanus. Decision has not yet been rendered by the court.—*Medical Review*.

WHY I USE PEPTO-MANGAN "GUDE."—AN EXPERIMENTAL DEMONSTRATION.*

BY WM. KRAUSS, Ph.G., M.D., MEMPHIS.

Director of the Microscopic Laboratories, Memphis Medical College; Pathologist and Visiting Physician to St. Joseph's Hospital, etc.

Some five years ago I wrote a paper for the *Memphis Medical Monthly*, giving a résumé of the evolution of the iron compounds, and appended a report of cases giving blood counts, etc. The manufacturers of the preparation I preferred saw fit to reproduce the case reports in their pamphlets, but said nothing about the reasons that induced me to prefer their product.

At a recent joint meeting of physicians and pharmacists I was criticised for opposing the use of ready-made compounds, while still advocating the use of Pepto-Mangan "Gude," which is a proprietary preparation. I hesitated considerably about bringing the matter up again, because I dislike to build up a reputation as an endorser, and have never in any other instance written an article endorsing a proprietary preparation.

I hope, however, to show you this evening that there is no pharmacopeial preparation that meets the requirements of an ideal iron compound, and, until this is found, I intend to continue to use what has never disappointed me, and is not based upon mere faith. The work of Bunge is too well known to be now quoted, and I will only make a few experiments before you this evening and show the reasons for the faith that is in me. There may be other proprietary iron compounds, and doubtless there are, that will come up to the same requirements, but I see no advantage in swapping the devil for the witch.

It is not necessary to repeat all the tests with all the official iron preparations, because they are divisible into groups, all the salts of one group behaving very much alike toward the gastric and intestinal juices.

An ingenious theory recently put forward regarding the action of the mineral salts of iron is, that they decompose the substances in the intestinal tract which precipitate the food iron so that it may be absorbed. This is the only rational explanation of the fact that we do occasionally get results from them. On the other hand, it is far more rational to use an iron compound that can be, and is absorbed, for then we are reckoning with known quantities, instead of blundering along, giving more iron at a dose than is contained in the

* Read before the Memphis Medical Society.

entire body, and incidentally deranging the digestive functions by precipitating the gastric, pancreatic and intestinal juices, and producing constipation by reason of the very astringent nature of some of the iron salts.

Beginning with the organic double salts, of which the scale salts are representatives, we notice upon the addition of this gastric juice, that a precipitate is formed; the double salt is decomposed and ferric salt remains, which is insoluble, both in gastric and intestinal juice.

The tincture of ferric chlorid will precipitate some of the gastric constituents, though most of the iron will remain in solution in the hydrochloric acid; the iron still in solution will not be absorbed, because its non-diffusibility is taken advantage of in the manufacture of dialysed iron, the acid passing through the animal membrane; when the iron finally reaches the intestine, the alkalin carbonates promptly precipitate it. Ferrous sulfate behaves similarly. In both instances, as you see, the very insoluble ferric oxid is finally formed. If you have ever tried to remove iron stains from your water pitcher, you have some idea how insoluble it is.

The insoluble compounds, like reduced iron, or Vallet's mass, only serve to render inert the arsenic with which they are usually prescribed; if dissolved at all in the stomach, they are re-precipitated in the intestine.

Taking now Gude's preparation, we find it soluble, not only in all these reagents, but also in a mixture of them. Potassium ferrocyanid readily gives the iron reaction, excess of ammonia will separate it, redissolving the manganese, which is then recognized by the color of its sulfid; the alkalin copper solution gives the reaction for pepton, showing that it is what the label says. It mixes with arsenious acid, forming a perfect solution, thus giving us a most useful hematopoietic agent. The soluble alkaloids are perfectly soluble in it, as is also mercuric chlorid. Being a pepton, it is readily diffusible by osmosis.

The only disturbing agent in the intestinal tract is hydrogen sulfid; this will precipitate it, but presumably, much of the iron must have been absorbed before it encounters this gas; if not, appropriate agents should be used for its elimination.

Therapeutically, it does not nauseate, constipate, discolor the teeth, precipitate the digestive agents, nor become inert from contact with them. As to the clinical results I need not add anything to the many reports already on record.

Quinine Sulphate in Incomplete Abortion.

Schwab (*Rev. Med. Chir. des Mal. des Femmes*) points out that obstetricians are not agreed as to the best treatment of incomplete abortion, some leaving matters alone unless hemorrhage or sepsis appear, others proceeding at once to the clearing out of the uterus with finger or curette. He is of the opinion that, save in cases in which the medical men can keep the patient under constant supervision, in which antiseptic precautions have been carried out since the commencement of the abortion and in which the os is still closed, the uterus ought to be emptied at once. He admits, however, that the curette has its dangers, and that ergot is inconvenient, so he recommends quinine sulphate. He has used it with success in seven cases of incomplete abortion. It is quite safe; it does not set up a tetanic condition of the uterine muscle; it may be given in two doses of eight grains at an interval of ten minutes, and it usually causes emptying of the uterus in about four and a half hours.—*The Times Register*.

Bathing of the New-Born.

The question whether the new-born should be bathed or not has occupied the attention of the Prussian and German obstetricians during the last decade. Dohrn, in 1880 (*Archiv. f. Gynecologi*, 1880), formulated the following procedure: Having washed the umbilical cord with a 2.5 per cent. solution of carbolic acid, it is wrapped up in carbolized cotton and secured with adhesive plaster. The dressing is left on for seven days. The child is not bathed at all. Artemyeff (*Arch. f. Gyn.*, 1887) modified Dohrn's dressing—he does not apply the adhesive plaster. Lvov (*Jour. Akush. i Jensk. Bol.*, 1888) advised powdering the umbilical cord with one part of iodoform and ten of bismuth. The child is bathed. In 1892, however, Lvov changed his opinion, and suggested another method. After the first bath, the cord is wiped dry, wrapped in absorbent cotton saturated with glycerin and bandaged with gauze. The child is not bathed until the cord falls off. Doctor (*Arch. f. Gyn.*, 1894) has studied this question on 1,341 new-born children. His conclusion that children should not be bathed until the cord falls off is based on the fact that such children are less liable to febrile complications; their weight is more rapidly increased, and the cord falls off earlier than in children who are bathed daily. Keilman (*Deutsche med. Woch.*, 1895, No. 21) reported his observations made on 400 children and arrived at the same conclusion as Doctor, with the exception that in his cases he did not notice the difference in time of the drying up of the cord. Weinstein (*Jour. Akush. i Jensk. Bol.*, 1895, p. 846) also advised against bathing the new-born. He based his conclusions on the observation that

the cord in unbathed children falls off earlier. Knopp (*Monatschr. f. Geburtshülfe u. Gyn.*, 1897) warned against bathing the new-born, so as not to infect the vagina with gonorrhœa. Neuman (*Berliner klinische Woch.*, 1898, No. 1), in his report before the Berlin Medical Society, pronounced bathing of the new-born as absolutely harmful. Arthes (*Ibid.*, 1898), made his observations on 150 children and arrived at an opposite conclusion, as did also Czerwenka (*Wiener klin. Woch.*, 1898, No. 11.) Kovarski (*Pract.*, 1900, p. 102) has conducted careful observations on 420 children: half of the number were bathed, and the other half were not. With the exception of a large percentage of icterus among the bathed ones there were no other perceptible differences. After summarizing the pros and cons of the subject Kovarski concludes that no scientific proof has as yet been adduced as to the harmfulness of bathing, and that we can follow, without perturbation of spirit, the time-honored custom of bathing the new-born.—*Jour. Am. Med. Assoc.*

Methylene Blue in Malaria.

Smithwick in *Merck's Archives* for February, 1900, from the reports of others and his own observations, has reached the following conclusions in regard to this drug:

1. Methylene blue is a perfect succedaneum for quinine, and may be given whenever the latter drug is indicated in the treatment of malaria of every form and under all conditions, with the same confidence that has always attended the administration of quinine.

2. Patients need not be selected on account of idiosyncrasies, as no bad effects ever follow the use of methylene blue, if given intelligently.

3. It is the remedy to use in malaria with hematuric complications, as it acts in a twofold manner.

4. It is the remedy to be given in malaria occurring during the pregnant period, as it has no oxytocic effect and will cause a freer action of the kidneys, which is also beneficial.—*Therapeutic Gazette.*

A Creosote Wine.

According to *Les Nouveaux Remèdes* of February 8, 1900, the following prescription for a creosote wine may be employed:

Creosote, $\frac{1}{2}$ ounce;
Tincture of gentian, 1 ounce;
Alcohol, 8 ounces;
Sherry wine, enough to make a quart.

Two or three dessertspoonfuls of this mixture may be given a day in cases of pulmonary tuberculosis, provided the temperature is not very distinctly febrile.

Miscellaneous.

Abnormal Self-Consciousness in Children.

When the child's appetite is good and his temperature normal, most physicians are apt to think him safe in his mother's care and no longer dependent upon medical advice. Yet, if we counsel correct habits of diet, exercise, and sleep, we ought not to be considered as transgressing very far the legitimate bounds of medical practice if we essay occasionally a warning word about so bad a mental habit as self-consciousness. Such advice, when given to a reasonable mother may be in the best sense prophylactic. Few parents can be got to believe, for example, that "forwardness," disobedience, and rude conduct in a young child are sometimes a grave sign of mental deficiency. Gowers has noted them as one of the earliest indications of abnormal cerebral function. Instead of the youngster being prompted to rudeness and impertinence and laughed at for his supposed precocity, such performance should be viewed with anxiety, and should be gently but promptly suppressed. That small children should be "seen and not heard" is a maxim based on an enlightened psychology. The abnormal self-consciousness that prompts such outbreaks may easily develop into an incurable egomania, the growing brain tissue is, as Horace so well said long ago, *cereus in vitium flecti*. Even where it is not congenital, a morbid feeling of self can be awakened and nourished with alarming ease and speed. No child should be encouraged to repeat poetry before his mother's guests, or praised for his "pretty curls," or even have his first trousers made too much of. The less he thinks of himself the better. He may be judiciously commended for good conduct or for diligence in study, but never flattered for his cleverness or good looks, or for anything which he has not come by through self-forgetting endeavor. Both boys and girls should be taught to endure; to neglect trifling aches and pains, and to seek for a remedy rather than to cry over the trouble. Self-command and self-control are the noblest things a man can strive for, and he will never gain them unless he begins learning in infancy to fix his thought and will upon objects outside of himself. If such principles of education were more closely followed, hysteria and the "artistic temperament" might gradually disappear and the hosts of insane people now walking at large, because their disorders of consciousness are directly menacing to society, might be much diminished.—*Ex.*

The Broader View.

Sir James Paget was of penetrating mind, often expressing his convictions in quaint observations, showing his intimate acquaintance not only with his profession, but with human nature. "All habits are bad, even good ones," said he, the

paradox relating to the attempted cure of an inebriate, one of Sir James' patients. The patient plaintively appealed to the physician: "I am in the habit of drinking several Scotch whiskeys a day—you won't stop everything, will you? It's so difficult to break a habit."

The doctor further averred that "the worst man to bear a surgical operation is a drunkard; the next worst is a total abstainer."

There is much food for thought in Dr. Paget's philosophy. Physicians, as a rule, are not apt to take a wide view of their calling, being too engrossed in the material, mercantile bearings of their business. They are scientists rather than philosophers, regarding proximate causes and conditions with too great consideration, and consequently failing to detect the subtler, more powerful agencies with which scientific skill must contend. The highest achievements of medical art are tangibly related to psychological as well as pathological investigation. The most adept diagnostician may woefully err in discarding occult yet potent manifestations of disease. A deeper, more thoughtful study of mental characteristics and a profounder knowledge of the psychical relations upon which outward accidents often largely depend, would not infrequently suggest more rational procedures than those which are wont to commend themselves. Man is an extremely complex organism, defying complete analysis. It is the part of wisdom, no less than of professional science, to examine closely the remoter influences which may affect the conditions which confront us, enlarging the scope of our examination and ignoring nothing which may possibly conduce to ultimate success.—*Doctors' Magazine*.

Operations in Gloves.

M. Quénu spoke at the Société de Chirurgie on the aseptic advantages of wearing indiarubber gloves while operating. He said that it was impossible to sterilize the hands sufficiently, and the use of caoutchouc simplified singularly the question, for without that precaution the surgeon should in general renounce all septic interventions forty-eight hours, at least, before an aseptic operation. The same precaution of protecting the hands permitted the making of autopsies, but, as a rule, the operator should never enter an autopsy room, as it was never properly cleaned. M. Tuffier said that for his part he would never let a surgeon operate on him who had previously done a septic operation. As regarded indiarubber gloves he recognized their advantage in performing septic operations, but he preferred thread gloves for aseptic operations. But before everything he considered that the rapidity of the operation was an essential factor in the success of the intervention. To put on the caoutchouc gloves easily it was only necessary to fill them with water.—*Paris Cor. Med. Press and Circular*.