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THE

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A MONTHLY JOURNAL OF

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Original Communications.

ENTEROPTOSIS AND ITS RELATION TO FUNCTIONAL DISTURBANCES. *

By W. F. HAMILTON, M. D., Lecturer in Clinical Medicine, McGill University; Assistant Physician to the Royal Victoria Hospital, Montreal.

The condition described by the term Enteroptosis has been attracting an increasing degree of attention during the past few years. Some years before Glénard's monograph appeared, Virchow, Leube and others described the anomalous downward displacement of different abdominal organs, but in 1885, Glénard formulated his views upon this subject, accurately describing the condition of the abdominal viscera and the nervous phenomena connected therewith. Among the features prominent in this symptom-group which Treves is pleased to call "that medley of symptoms," are, downward displacement of the stomach, a movable right kidney, various digestive disturbances and often very typical neurasthenic symptoms. So sanguine was the pioneer observer among the French, and indeed among all writers, that he had discovered a solution to the difficult problem of many cases of neurasthenia, that he says at the close of one of his very early monographs upon the subject in a free translation as follows:—"I can affirm that the physician who will follow my directions and strive to verify my statements in such cases will find in his practice the satisfaction which a positive diagnosis gives to both physician and patient from which alone a proper prognosis can be made, and that satisfaction, the greatest of all, which directs the treatment and avoids for the patient the trials upon him of so many

* Read at meeting of Maritime Medical Association, Charlottetown, July, 1899.

remedies, while at the same time it secures him relief and prevents the physician himself from falling into therapeutic scepticism."

The next step of importance in the advancement of our knowledge on this subject is marked by the appearance of Ewald's writings in 1890, and those of Pick, Boas, Kumpf, and Hufschmidt in 1892. With Ewald many of the Germans took sides against the French school on several points to which we may refer later. The German school claims that Glénard had reference but to the intestines in his descriptions, while, associated with ptosis of these parts, displacement of other organs was common. By the German school, the application of this term is broadened and more comprehensive. Schwerdt believes he is justified in speaking of enteroptosis when at least two organs are found prolapsed.

It may be mentioned here, however, that Ewald's methods of investigation were more accurate than those of Glénard—for while it appears the latter did not employ any means of inflating the stomach or intestines, Ewald claimed that such was a necessity and thus by Glénard's method of diagnosis, mistakes were more likely to creep in.

Treves, in England, has contributed to the study of the symptomatology and treatment of this disease, while Osler was the first in America to include this subject in a text-book in 1892.

Glénard's disease or Enteroptosis or Splanchnoptosis, as it may be called, according to Stiller's suggestion, should be considered independently of those conditions of visceral displacement resulting from former inflammatory process, such as frequently occur about the genital organs of females and result in pulling down portions of intestine or an isolated organ. This view, however, is open to the criticism, that, upon the normal position of any one organ the position of the others largely depends, and it is possible to have very general ptosis result from such a cause associated with all those signs incident to the true disease. It is acknowledged, however, that in a large number of such instances the signs of the true disease are not prominent in the clinical picture and may be absent entirely.

Meinert urges that the prominent pendulous abdomen resulting from numerous pregnancies "has nothing whatever to do with Glénard's disease. Such an abdomen holds a dilated stomach, not a dislocated one." However conflicting these views may be concerning the classification of cases under this head, it may be accepted as safe teaching, at least for the present, that (1.) Enteroptosis may exist without subjective

signs, that (II.) the Enteroptosis of Glénard is associated with the most pronounced subjective signs, chiefly of a neurasthenic type, that (III.) in those cases where a pendulous abdomen is present the nervous features of the case are less pronounced than in thin subjects with greatly flattened belly walls, and that (IV.) Enteroptosis arising from inflammatory processes in the abdomen may be typically characteristic.—(Treves.)

The view of Mathieu is thus expressed, that Enteroptosis is of two varieties, (I.) the form which shows itself plainly from without by a pendulous abdomen and is rarely found associated with nervous manifestations The second form (II.) is that in which the abdomen is thin and flat and where the neurotic element is very prominent,—the internal variety.

The organs displaced in this disease may be all those found below the diaphragm. Most frequently, however, the colon and small intestines, the stomach, the right kidney and the liver are found in altered relations. It is not rare to find the left kidney also displaced ; the spleen very rarely is found away from its normal position while the pancreas has been once recorded as dragged down (Rokitansky, Treves.)

About the subject of the Etiology of Enteroptosis much interest centres and numerous theories have been advanced to account for its occurrence. Kuttner and Dyer affirm that no cases of congenital gastroptosis have been observed. Stiller (1896) says that Enteroptosis is a congenital anomaly. It occurs in those whose muscles are soft, whose bony organisation is delicate and upon them but a small deposit of fat may be found. There is usually found in such patients a floating tenth rib.

Enteroptosis is found in men as well as in women, although much less frequently. Two of the cases herewith reported were male patients, although the percentage of men is much smaller in a large series of cases as shown by Glénard, Meinert, Schwerdt and indeed by all observers. The French writer reports 404 cases, 306 of which were among women ; in Meinert's series, 88—90 per cent. were females, while in Schwerdt's series of 95 observations, 89 were in women. Pregnancies and tight lacing are the chief causes, according to Manges, for this great difference between the sexes.

In answering the question as to the etiology of the condition, Dr. Schwerdt, of Gotha, states that the essence of this disease is to be sought for in an atony of the whole nervous system which affects the muscles

of the whole body. As active causes of such a condition he enumerates heredity, unhealthful methods of living and working, all chronic diseases, the wearing of corsets and lack of care in the pregnant state and in childbed. He regards this disease as a *constitutional ailment.*

The abdominal organs are kept in place very largely by a certain degree of intra-abdominal pressure, and when this is greatly diminished, ptosis is the result. The corset contributes to this condition, among other ways (I.)by diminishing the tone of the body walls and suspensory ligaments of the organs, and (II.) by interfering with the mechanical and chemical functions of digestion thus impairing nutrition. The teaching of Schwerdt upon this point is more theoretical than that of Meinert, who regards the corset as a means of altering the relation of the parts chiefly by direct pressure.

There is doubtless no one cause or group of causes which will suffice to explain the occurrence of this disease or condition. We may conclude then that:—

1. The intra-abdominal pressure is altered.
2. Many causes contribute to this end.
3. The organs may be displaced by being pulled down.
4. In all probability a congenital predisposition exists in the conformity of thorax and the character of fibre entering into the supporting tissues of the organs.

The *diagnosis* of Enteroptosis, since the adoption of the method recommended by Ewald and others, is a matter of comparative simplicity. On the inspection, the contour of the abdomen may suggest a condition of Splanchnoptosis. The epigastrium is hollowed, the two lower quadrants of the abdomen, even with the patient in a recumbent position, are often quite prominent—while, as pointed out by Dr. J. C. Webster in a personal observation, the recti abdominis may be seen widely separated in thin subjects when attempting to assume an erect position. In a few cases I have seen the position of a displaced stomach indicated by the peristaltic waves extending from left to right. It is necessary, however, to distinguish between a displaced and dilated stomach. In brief, we may say that it is all important to determine:—

1st. the position of the lesser curvature of the stomach.

2nd. the relation of the greater curvature to the lesser.

In all cases where one can demonstrate the lesser curvature some degree of misplacement exists, and in proportion as the lesser curvature approaches the umbilicus or falls below it, so is the degree of displace-

ment. Dilatation, as the result of atony, is a usual accompaniment of gastroptosis and a transverse measurement of from four to five and a half inches might still be within normal limits, and would not indicate dilatation.

The hypogastrium may present a dull note from the close prolapse of the small intestine. A point upon which Glénard laid great stress is termed by him "la corde colique transverse,"—by this he described a small band which ran horizontally across the abdomen about two inches or so above the umbilicus. He regarded this transverse band as the "colon transversum." Upon this point there is much diversity of opinion. The German teachers, led by Ewald, claim that the French teaching is wrong and that the "corde colique transverse" was the pancreas. According to Frickhinger, who saw the intestine of a patient with Enteroptosis inflated by Ziemsen, it is regarded as the transverse colon, the hard cord, during the process, becoming changed into a cushion-like and elastic body. On the other hand Ewald cites a case reported by Krez in which an autopsy was done and the "corde colique transverse" was apparently the pancreas. In case No. 3 (Mrs. M.), the "corde colique transverse" was plainly felt and during a laparotomy done upon this patient, it was shown to be the pancreas.

Palpation of the abdomen usually reveals movable kidney, methods of examination for which are known to all. The liver, when displaced, is usually more prominent in the epigastrium and may be rotated upon its longest axis, the upper line of dulness falling much below normal. Another point upon which Glénard laid special stress, as one of diagnostic worth, and which is to be applied in all cases of Enteroptosis he described under the phrase "*l'epreuve de sangle.*" This test is applied by the examiner, standing behind the patient who also is in the erect position, and with both hands laid flatly over the lower zone of the abdomen, a firm but gentle pressure is made upwards. In the great majority of cases this affords considerable relief to the distressing dragging pain which is felt in the epigastrium and abdomen and which is one of the patient's chief complaints. At the same time the result of this test is an index to treatment.

As illustrative of many of the above points in diagnosis, the following cases may be briefly described. With two exceptions they are from personal observation, and by these two I am greatly indebted to Dr. James Bell and Dr. C. F. Martin.

Case No. 1, C., male, æt. 25, admitted June, 1899. Complaints were of pain in right side of abdomen, loss of weight, jaundice and of recurrent attacks of indigestion. In February, 1898, the patient had his first attack of severe colic, which was referred to the liver—and regarded as hepatic colic. During the past ten years he had frequent pain in the region of stomach, especially marked after walking, standing or riding. These attacks were brief and on two occasions were followed by jaundice. After the attack above referred to (February, 1898), the patient was comparatively well for about a year with the exception of slight "indigestion" and a dull heavy feeling at times.

In Januarry, 1899, another attack similar to the first occurred and since then, every two or three weeks, this has been repeated, although each attack was of a much milder type. The jaundice was associated with clay-colored or colorless stools and high colored urine and he remarked that on several occasions when the attack of abdominal pain was passing off, the urine, which had been scanty, became more copious and light colored. The loss of weight was about thirty-three pounds. The patient was of a constipated habit. Quietness in bed relieved both constipation and abdominal distress.

The patient is tall and slender, somewhat nervous in temperament; the abdomen is flat, the right kidney is freely movable and the stomach is displaced as shown in the drawing made from the gastrodiaphane; the corde colique transverse is faintly palpable. (See Fig. 1.)

Case No. 2. Mrs. G., æt. 66 (Hospital No. . .). Complaint of pain in stomach. The patient says that during the past twelve years she has been subject to abdominal pain coming on about two hours after food and lasting for three or four hours. These attacks have recurred at ntervals varying from three or four months to one or two weeks. Great care has been necessary with her diet in order to avoid an attack. She is the subject of flatulence and constipation during these attacks. The pain has been felt chiefly in the epigastrium but extends around the back on the right side. She had never been jaundiced before coming under observation and there is no history of over-indulgence in food or drink or past stomach disorder, but she has partaken freely of condiments.

Her condition was one of emaciation, muscles, small and flabby; mental state was irritable; the circulatory and respiratory systoms were negative. On examination of the abdomen one observed that it was thin-walled and very lax. There was the epigastric depression extending down to the um-

bilical level, below which fullness was manifest. The spleen and liver were not palpable, while both kidneys might be readily felt. Inflation of the stomach and illumination of the same were confirmatory and showed marked displacement downwards and to the right with no dilatation as shewn by the diagram (Fig. 2). The lesser curvature was just above the umbilicus. A test breakfast showed no hydrochloric acid and no lactic acid. The patient was under treatment for some days in the hospital upon a fairly liberal diet of gruel, sweetbreads, fish, toast and tea, somatose, and koumiss. Faradism was also applied to the stomach. While under observation a severe attack of abdominal pain supervened and on the following day the patient was markedly jaundiced with bile in the urine. The degree of jaundice diminished to deepen again only after another attack of pain.

This case illustrates the following points:—(I.) Marked digestive disturbances for years; (II.) Nervous irritability; (III.) Constipation; (IV.) Epigastric pain followed by jaundice.

Case No. 3. Mrs. M. A. M., æt. 36. (Hospital Nos. 1,024, 4,029.) This patient complained of "disease of the liver, kidney and bladder." For years she had suffered with pain in right hypochondrium; she had had no acute illness; she had borne two children, both of whom died in infancy; one year previous to her admission to the hospital she suffered from severe abdominal pain which was referred to the right flank and was attended by "swelling and tenderness over the part." This attack was but temporary and fully subsided. Since that time, however, she has had occasional vomiting and felt chilly sensations.

Present condition:—One was struck with the expression constantly present on this patient's face. It was one of anxiety and distress; she was of a dark complexion, thin and hollow-eyed, and I remember well when going about the wards for the first time after she came into the hospital. She presented the striking picture of a neuasthenic patient. Discovering neurasthenia written so plainly on the face of this patient, I immediately examined the digestive system and abdomen with the gratifying result herewith given in detail. Her tongue was flabby, teeth poor and appetite capricious. She was often troubled with flatulence, the bowels were constipated, the abdomen was flat and flaccid. Some general hyperæsthesia was present, but especially manifest over the right hypochondrium and hypogastrium; the epigastrium was flat and hollowed, the lower abdominal zone, if anything different, was comparatively prominent; on deep inspiratory movements one noticed in the

epigastrium and extending across this area, a wave passing from above downward to a point about two inches above the umbilicus and one could feel a rounded body quite superficially. The right kidney was readily palpable and moved freely on inspiration and could be pushed up under the ribs.

The usual method of locating the stomach was resorted to and it was found, as in the diagram (Fig. 3) markedly displaced. The pelvic organs were normal.

Case No. 4. Mrs. L. C., æt. 38. (Hospital No. 6,525.) Admitted June, 1897. Patient complained of gastric distress constantly present, constipation, aching back and palpitation of heart. The patient believes her present illness began three years before and during the past few months it had been greatly aggravated. Although always of highly neurotic nature, she had been specially so during the past three years. In March, 1897, her menstruation ceased. Gastric distress, flatulence, pyrosis and constipation describe her digestive disturbances.

Present condition :—The patient's nutrition was only fair as she showed signs of emaciation; her facial expression was troubled and she was decidedly neurotic. Anxious introspection characterised her mental state. Vasomotor instability manifested in visible flushing of her face and body, was a feature of her case. There were no stigmata of hysteria, The respiratory and circulatory organs showed no signs of disease. The generative organs were not diseased; she had a left inguinal hernia. The abdomen was very lax with tenderness on pressure about two inches below ensiform cartilage; the liver and spleen were not displaced. The right kidney was palpable and movable to a slight extent. The chief interest centres upon the stomach. A test breakfast was given but no contents could be gained thereafter. Gastric inflation revealed downward displacement of the stomach, the greater curvature presented three inches above the symphysis pubis, the lesser curvature was seven inches above this point, thus showing a transverse measurement of the stomach of four inches (Fig. 4).

Remarks:—These two cases, Nos. 3 and 4, illustrate in the most striking manner the neurasthenic symptoms associated with this condition of the abdominal organs; the facial aspect, the complaints, the introspection, the self-observation and the results of treatment were typical. In No. 3 treatment consisted first in nephrorraphy which availed nothing. The "corde colique transverse" was well marked in this case and was misleading, inasmuch as it was movable and associate d

with loss of flesh and the absence of free hydrochloric acid in the stomach contents after the test breakfast. It was strongly suggestive of malignant disease of the stomach, but an exploratory incision showed it to be the pancreas. The wound healed but the patient was not improved.

The treatment in Case No. 4 was more satisfactory, although no operation was done, under massage (general and local), suggestion and reassurance, tonics and mild aperients and the wearing of a bandage, much improvement was made and though she has not continued as well as ever, yet she is leading a fairly active life in comparative comfort.

Case No. 5. Mde St. D, æt. 48. (Hospital No. 6,504). Complaints were of pain in loins and a feeling of weight and distress in upper abdominal zone which was worse on the *left* side. The patient had borne thirteen children, and at the second pregnancy twins were born. Ever since this event the abdomen has been prominent and flabby. During the past twelve years flatulence had frequently troubled her; during the past five or six years vertical headaches and distress in upper part of abdomen were complained of. While always nervous she has become much more so during the past few years.

Examination of the abdomen showed it to be one of "*hangebauch*," the walls were very flaccid and pendulous, the recti abdominis were widely separated and between these muscles one could readily feel the prolapsed contents of the abdomen. On examination of the different organs of the abdomen one found the normal area of liver dulness a resonant one. This organ was movable and could, at times, be easily felt between the recti; again it was with difficulty made out, possibly becoming rotated upon its transverse and longest axis. The left kidney was felt on deep inspiration, while the spleen and the right kidney could not be felt. The stomach, on inflation, was dislocated downwards, while the measurement of the organ when distended with gas indicated some degree of dilation as well. The lesser curvature was three inches above the umbilicus, the greater four inches below this, giving the transverse measurement of the stomach as seven inches. (Fig. 5.)

This case illustrates a ptosis of the liver with gastroptosis occurring in a woman with a multiple of pregnancies and in whom the recti were widely separated, the stomach dilated and nervous symptoms manifestly exaggerated.

Case No. 6. Mrs. K., æt. 40. (Out patient.) Showed displaced stomach, freely movable and tender right kidney, with occasional vomiting; epigastric pain and tenderness with pulsating area on the left of

the middle line; some frequency of micturition. *L'Epreuve de Sangle* was most satisfactory in her case, and the wearing of an abdominal support was found very helpful. (Fig. 6.)

Returning now to the second part of our subject, we may say that the chief functional disturbances to which Enteroptosis is related are :—

1. Neurasthenia, including digestive disturbances.
2. Anæmia.
3. Constipation.
4. Jaundice.
5. Gastric dilatation.
6. Myxœdema, Scleroderma and Exophthalmic Goitre.

The theories concerning the symptoms associated in most instances with the altered position of the abdominal organs are numerous, but for convenience of consideration we may classify them under three headings :—

1st. There is the mechanical theory from Glénard.

2nd. What may be termed the neuro-mechanical theory of Meinert.

3rd. The neuro-intoxication theory of Schwerdt.

The first theory, although not purely a mechanical one, is chiefly such. It does not ask for any antecedent nervous cause, but it implies a weakness of the suspensory ligaments of the transverse colon, especially the colico-hepatic ligament. The descent, Glénard claims, begins at the hepatic flexure and the other events incident to the disease follow, viz :—The entero-stenosis due to a kinking of the colon at the point of prolapse, the *corde colique transverse,* the gastroptosis, the constipation, the auto-intoxication, the neurotic manifestations, etc.

The second theory, which we may characterise as the neuro-mechanical one, is advanced by Meinert; in short, Meinert attributes the symptoms associated with "dropping of the viscera" to the constant stimulation and irritation of the sympathetic nerves, as a result of pulling and stretching of these nerve fibres. This has its deteriorating effect upon the blood, through the blood-forming organs, and the general nervous system, and hence chlorosis, neurosis and all sorts of vasomotor disturbances.

The third theory is that of Schwerdt already alluded to in speaking of the etiology of the disease. The nervous system is primarily at fault—the fibre of the individual is *toneless;* the functions of the abdominal muscles, both parietal and visceral are not normal, intra-abdominal pressure is lessened—ptosis takes place. There is stasis in

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the blood and lymph vessels, the bowel contents decompose, the excretions are not carried off, absorption of poisonous products goes on and auto-intoxication results—dyspeptic manifestations, neurasthenia, headache, anæmia, lack of energy, palpitation, etc., etc. Polyuria follows as a consequence, while Graves' disease, scleroderma and myxœdema, are theoretically possible as results of visceral irritation and intoxication. However obscure the causes of the three diseases may be, few are ready to accept this as an explanation of their etiology.

When we consider the altered relation of the abdominal viscera in a condition of ptosis, the interference with the motor function of the intestine, the great tendency to constipation, the resulting distress and pain, it is not difficult to understand how a state of mental depression or nervousness and of general nerve weakness may result. In whatever relation these two conditions may really be, it is not hard to understand that enteroptosis may be a direct cause of the neurasthenia.

Chlorosis and enteroptosis are doubtless related in both respects.

Chlorosis on the one hand has been regarded as due to a neurosis, on the other as an intoxication, and it would seem that in the teaching of Meinert some ground for both these theories existed. The left-sided pain is common in chloro-anæmia, and Taylor refers this pain to distention of the colon in an organ displaced downwards. In one of our cases of marked enteroptosis the pain was constantly referred to the left side of the abdomen in the upper quadrant.

Jaundice in such cases may be due to :—

1. Passive congestion of a displaced liver and its results upon the bile passages.
2. To obstruction in the duodenum.
3. To direct pressure upon the bile ducts exerted by a floating kidney.
4. Other causes.

Constipation has already been explained.

Gastric dilatation was at one time thought to be due to obstruction to the duodenum and pylorus, caused by the floating kidney so commonly found associated with it; it is doubtful if such can be the cause. The position of the stomach and the lack of tone so common in such cases doubtless extends to the muscular wall of the stomach, and in these conditions one finds sufficient explanation for the dilated condition which is rarely pronounced.

The indications for the treatment of enteroptosis as originally recommended by Glénard, are as follows :—

1. The intestines must be elevated and kept in their new position.
2. The abdominal pressure must be increased.
3. The bowels must be regulated.
4. The secretions of the intestinal glands must be increased.
5. The digestion and nutrition must be regulated and stimulated.
6. The whole organism must be strengthened.

These indications, in many instances, are met by the *body binder* so applied as to exert upward pressure and thus support the prolapsed organs while it increases the intra-abdominal pressure. It may be made by ordinary grey cotton pinned firmly about the body.

Then mild purgatives are needed. Massage of the abdomen often does good in stimulating the movements of the bowel and giving tone to the abdominal muscles. The same may be said of electrical (Faradic) applications.

Then the use of alkalies and the choice of such a diet as is most nourishing and easily digested are of importance.

Recently both hot and cold baths have come into favor as giving general tone to the circulation, and Buxbaum recommended the cold Sitz bath as inducing favorable results, especially by reason of its action upon the intestinal circulation and secretion. He advises that they be taken daily for two—five minutes.

The chief advance in the treatment of the condition since 1886 has been in surgery, by which some brilliant results have been brought about. Recently reported cases have come from Treves, in England, who sutured the liver to the abdominal wall; Bernhardt, Ferrari, Terrier and Hartmann, in Europe, and Byron B. Davis, Stengel and Beyea, in America. Gastropexy and gastrorrhaphy have, in different cases, given good results; while in Stengel's case, operated on by Dr. Beyea, the gastro-hepatic omentum and gastro-phrenic ligament were shortened by a tuck made with multiple sutures, thus bringing the stomach up towards its normal place.

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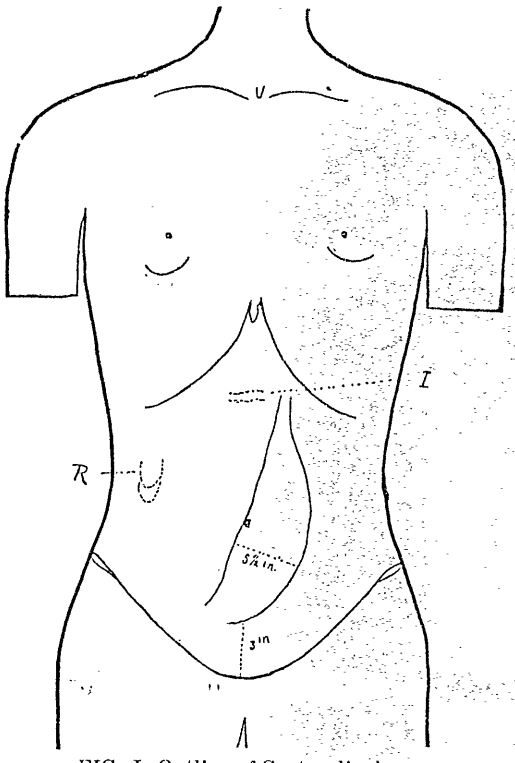


FIG. I. Outline of Gastro-diaphane.

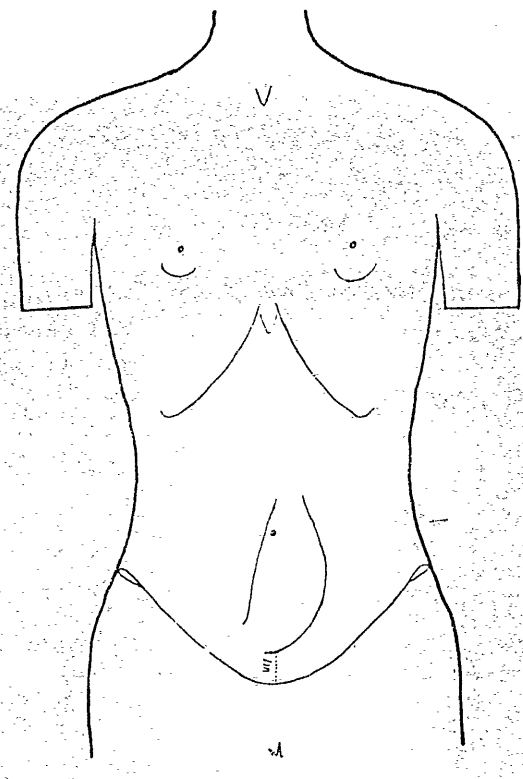


FIG. II. By Gastro-diaphane.

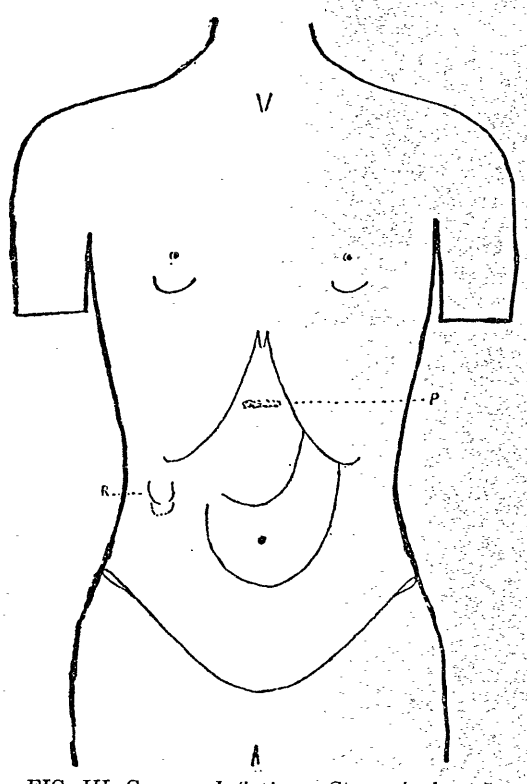


FIG. III. Gaseous Inflation. Stomach about 5 inches wide.

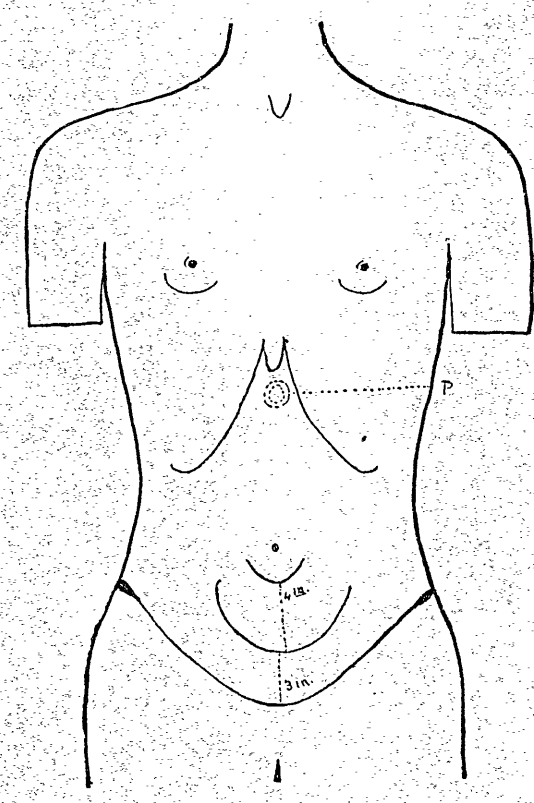


FIG. IV. Gaseous Inflation.

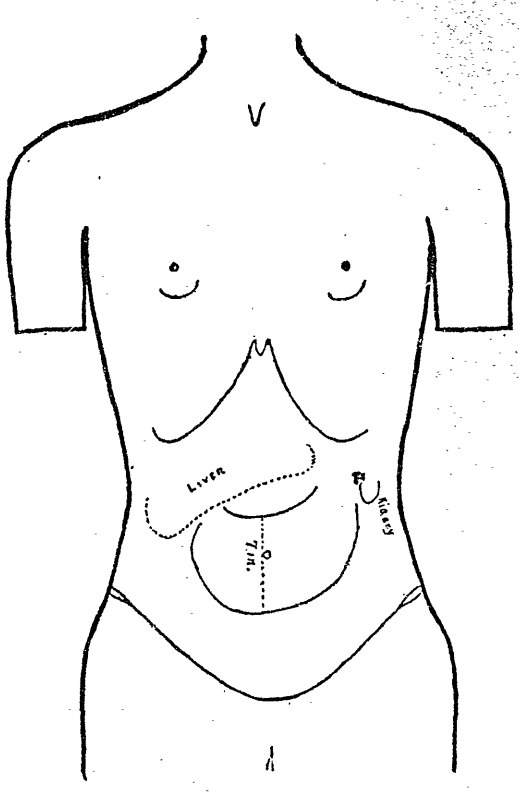
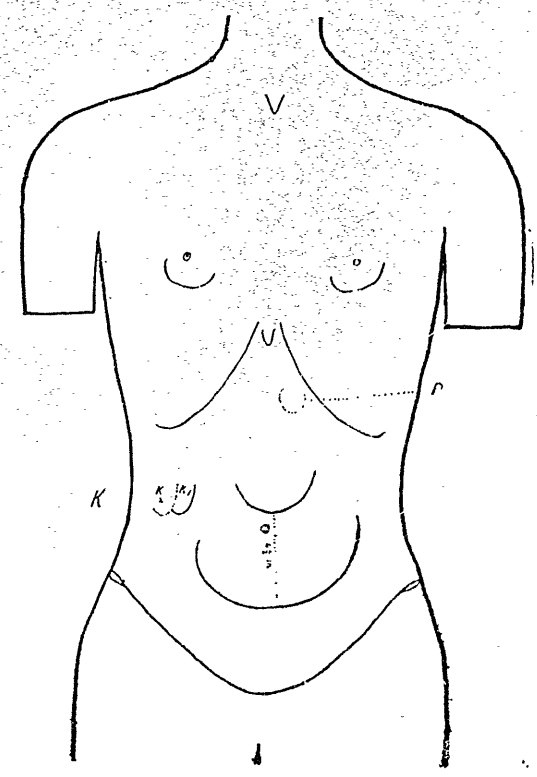


FIG. V. Gaseous Inflation.



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Clinical Reports.

NOTES OF TWO OBSTETRICAL CASES.*

By W. Rockwell, M. D., River Hebert, N. S.

The first case I wish to report is that of Mrs. W. M., aged 25 years. Her family history is good, both parents living and in good health. She herself is a stout, robust and well developed woman. Have attended her sisters in labor and never found anything out of the ordinary in their cases. Attended her in her first confinement in March, 1896. Labor was apparently normal and not more severe or prolonged than the average. A short time after third stage was completed the hemorrhage seemed quite profuse, and during first twenty-four hours she had three or four similar attacks. It was, however, controlled without any particular difficulty. Perhaps it would hardly be demonstrated post-partum hemorrhage, but very near the border line. After this everything progressed normally and she made a good recovery.

Her next labor was in August, 1897. My associate attended her in this labor, which was quite normal, remaining an hour after completion of third stage when he left her, not knowing of any previous history of a tendency to hemorrhage. One hour after this, as I was passing, I went in and found her quite prostrate from hemorrhage. I may say that in both labors she had had a dram of ergot after completion of third stage. I emptied the uterus of clots and used manipulation over the fundus with the hand. Stayed with her about eight hours, having to keep up pressure as the uterus would relax whenever my hand was removed. She made a slow recovery being very anæmic for three or four months but had no other complications. She, however, regained her former healthy condition.

Her next labor was in April 1899 and was in every way normal with no tendency whatever to post-partum hemorrhage. I stayed an hour and finding no tendency to hemorrhage went home and no further trouble ensued.

In this last labor, one month previous to her expected confinement, she was put on treatment as suggested by Dr. Atthill which consists in administering ergot and strychnia three times daily. The treatment is

* Read at meeting of Medical Society of Nova Scotia, Truro, July, 1899.

begun about the thirty-fourth week of utero-gestation and continued for three weeks; then a period of five days is passed without it when it is again begun and continued till labor sets in. In this particular case she was given:—

℞ Fld. ext. ergot ..... ʒi
Liq. strych. ..... ʒii
Aq. ..... q. s. ad. ʒiii ℳ.
Sig.—ʒi t. i. d. in water.

She was kept under this treatment steadily for five weeks with the exception of a period of five days beginning at the end of the third week of treatment. She then had an interval of three days without medicine followed by a week when it was again administered, this order being kept up to within one week of her confinement during which time she took no medicine. She expected to be sick the first week of March The above treatment was begun the first week in February and she was not confined till April 16th., her labor having been postponed by the treatment as I suppose. The author claims that it will do this. The labor was very satisfactory throughout and I am inclined to credit the treatment for the absence of hemorrhage.

Second Case.—Was first called to see Mrs. S. W., aged 22, on the morning of Sept. 29th., 1898, at 5 a. m. Did not know family, but as near as I could gather found a history of tuberculosis among her cousins but none in her own family. She herself was a slight delicate looking woman and this was the first time I had seen her. I examined her and found her in labor. The passage and passenger were, as near as I could tell, normal and the latter in the L. O. A. position. Os was between a twenty-five and fifty cent piece in size and quite soft, and to appearances dilatable. Pains were not so vigorous as one would ordinarily find at this stage. Gave an enema and cleared out the bowel with the hope that it would increase vigor of contractions. This, however, it did not do and at seven o'clock gave fifteen minims of fluid extract of ergot, there not being any progress thus far and the pains just about as they had been. At eight o'clock examined again and found no change only that pains did not seem so strong. Gave fifteen minims more of fluid extract of ergot There was now some show. Examined again at nine o'clock and found no change in parts and pains had left her. Stayed with her until 11.30 when no signs of pains returning, left and returned at 4 p. m. Found that pains had returned again at 2 p. m. and at 4.15 p. m. child was born. After second stage sat down with hand over uterus and found it well contract-

ed, not noticing up to this time anything out of the way, and was waiting to give a little rest previous to completion of third stage. Ten minutes after second stage was completed she called my attention to the fact that she was flowing very much, the uterus not having given any warning to my hand. I looked and found she was flowing freely. I at once delivered placenta which came away readily, and introduced two fingers into the vagina posterior to cervix and placed other hand over fundus, thus having the uterus between my two hands. This I was enabled readily to accomplish in this case as the woman was not stout. I thought by this procedure to control the hemorrhage. I had the nurse at the same time to give a dram of ergot. This was not sufficient, however, to control the hemorrhage, although I could keep the uterus from filling up and distending. I then used a very hot intra-uterine douche of hot water with a little creolin. This did not control it and in twenty minutes I gave a second dose of ergot. Getting no effect I came to the conclusion that ergot was doing no good if not positive harm. I then gave at intervals two intra-uterine hot douches, using acetic acid. I stayed with her holding uterus as above stated for four hours. She was unconscious from loss of blood before it was controlled. When I got it checked she began to vomit. Gave her whiskey and nourishment by the bowel and strychnia hypodermatically. Remained till 10 p. m. They sent me word next morning that she was doing fairly well. She made a very slow recovery devoid of anything to remark except the anæmia which persisted. She never regained but a measure of her former health and some three months later developed tuberculosis which ended fatally in May last. This case I may state was attended by my associate and I have the report from him.

A CASE OF PENETRATING GUNSHOT WOUND OF THE ABDOMEN WITH LESIONS OF INTESTINES SUCCESSFULLY TREATED BY IMMEDIATE OPERATION.*

By NORMAN E. MCKAY, M. D., M. R. C. S., (Eng.,) Professor of Surgery, Clinical and Operative Surgery, Halifax Medical College, Surgeon to the Victoria General Hospital, Halifax.

Perforated gunshot wounds of the abdominal wall with intestinal lesions are of interest because of their high mortality.

Paul Ziegler, writing on the treatment of these wounds, says that in the University of Munich they have treated seven gunshot wounds by immediate laparotomy with a mortality of 58 per cent. He advises immediate operation as the best and wisest course to pursue, as it is impossible to tell from the symptoms, in the majority of cases, whether or not perforation has taken place.

I do not know of any case of penetrating gunshot wound of the abdomen with perforation of the intestines treated by immediate operation having been reported in Canada.

The following case I had in my practice last year:—

R. H., aged 34, teamster, married, was admitted to the Victoria General Hospital on the night of August 8th, 1898, with a bullet wound of the abdomen and also one of the left side of the chest immediately below the axilla. The latter wound was not more than skin deep When the man was brought into the hospital, he was in a semi-stupid condition from liquor and morphine that had been injected to relieve pain, so that it was difficult to get from him any reliable data regarding the shooting accident.

He had been a hard drinker all his life time, and was drinking heavily during the five weeks immediately preceding the accident. The evening of the shooting, he and a chum forced an entrance into a small beer shop by the road-side, four miles out of the city. The patient is a very muscular and powerful man. When he entered the house he was met by the proprietor with a loaded revolver, who fired at him, the bullet entering the left side of the chest a little below the axilla. This stag-

* Read by title at the Annual Meeting of the Canadian Medical Association, Toronto, August 31st, 1899.

gered him somewhat, but he soon recovered himself and rushed at his assailant, who again fired at him. This shot took effect. The bullet entered the abdomen about three inches to the right of the umbilicus and on a level with it. The man fired at him the third time, but missed. The patient fell on the floor unconscious, in which condition he remained for some time, but he had recovered by the time the doctor arrived with the ambulance. He was suffering great pain, so much so that the doctor who saw him first had to give him $\frac{1}{4}$ gr. morphine hypodermically. The shooting took place about eleven in the evening, and he got to the hospital at 12.30, just an hour and a half after the accident. After some little time I managed to get out of him that his assailant was standing at a distance of about three feet right in front of him when the second shot was fired. Judging, therefore, from the relative position of the two and the distance they were apart when the shot was fired, I was satisfied that the bullet had perforated the intestines. Very little hæmorrhage went on internally, for the man had no appearance of shock when I first saw him or subsequently. The pistol used was a 32 calibre one.

Prognosis was of course unfavourable. I decided to operate at once, or not at all. I explained to the man as best I could to a person in his condition the serious nature of the accident, and strongly impressed upon him that the only thing to be done to save his life was an immediate operation, to which he consented.

The patient was prepared at once for operation in the usual way. (Parts washed and scrubbed well with soap and water, then with ether, and, lastly, with bichloride, 1 in 500.) Ether was the anæsthetic used. The abdominal cavity was opened by a vertical incision about five inches long, three-quarters of an inch to the inside of the bullet wound, so that the middle of the incision was opposite the wound. Upon opening the peritoneum, I came right down on the upper part of the ascending colon which was distended with gas. It looked all right. There was no blood in the peritoneal cavity, neither was there any evidence of extravasated fæces.

I now probed the wound in the abdominal wall to determine, if possible, the course the bullet took after it had entered the peritoneal cavity, and as far as I could make out it was antero-posteriorly. There was no wound of exit. I then searched for intestinal perforation, and found a wound in the colon near the hepatic flexure. I detected the perforation by the noise of gas escaping through it when I pressed the wall of the colon together, and in like manner the other three wounds

were located. There were two wounds in the colon, one of inlet and one of exit, and two wounds in a loop of the intestines which happened to be lodged behind the colon in the line of the bullet's course. The wounds were small and difficult to locate; there was no loss of substance; the intestinal walls were simply lacerated. The operation was performed at night with artificial light. The distended state of the intestines with gas was very favourable for locating the wounds, which I closed with a Lembert suture.

On satisfying myself that there was no other wound of the intestines, I lifted the wounded portion of the bowel from the abdominal cavity and douched them thoroughly with bichloride lotion, 1 in 8000, and then returned them and flushed the peritoneal cavity with normal saline solution, and after drying the parts thoroughly, the abdominal wound was closed with three rows of sutures, the peritoneum with continuous catgut, the muscles with interrupted sutures of catgut, and the integument with interrupted sutures of silkworm gut. A glass drainage tube was inserted in the wound for twenty-four hours.

He stood the operation well. For the first twelve hours after the operation the patient vomited considerably, but he complained of very little pain. His stomach kept irritable for three or four days, and for the first six days his temperature ranged between 99° F. in the morning and 101.8° F. in the evening. The next four days, however, his temperature and pulse were normal, and he felt well. All this time he was fed with liquid diet and his bowels were quite regular.

About the 19th of August, the tenth day after the operation, he complained of deep-seated pain in the region of the wound, and his temperature ran up to 101° F. and on the 21st, at 9.45 p. m., it was 102° and the pulse 88. The pain was much worse now, and it extended down the front of the right thigh to the knee in the course of the anterior crural nerve. It was so intense that he was unable to straighten his limb. He had no chill at any time during the progress of the case. From now till the first of September his temperature ranged from 100° to 103°, and his general condition continued much the same. It was quite plain now that the bullet was lodged in the vicinity of the roots of the anterior crural nerve. Two or three unsuccessful attempts were made to locate it with the X-rays. After he took the change for the worse his side was bathed with boracic lotion as hot as he could bear it, three times a day, and large gauze pads soaked in the hot lotion were kept continually on his side. About the 1st of September he began to improve, and continued improving steadily till he completely recovered. He was discharged well on the 24th of September. He has been attending to his usual work ever since, and has not been ill a day.

Selected Article.

EXPERIENCE, JUDGMENT AND LUCK.

ILLUSTRATED BY A COMBINATION OF GONORRHŒA AND PREGNANCY AND TWO UNUSAL ABORTIONS.

By NELSON W. WILSON, M. D., Buffalo, N. Y., Attending Obstetrician St. Mary's Infant Asylum and Maternity Hospital.

A recent writer in designating the qualities which should be possessed by a successful physician, named an unfailing nerve, exquisite good nature and ready resource. To these might have been added experience, judgment and luck. They do not teach any of these in medical colleges of today. One gets excellent instruction; one gets quizzed, and one gets the benefit of a teacher's experience, provided the teacher has that happy little trick—too rare unfortunately—of being able to give a parcel of raw material students the good of his experience. But experience comes with practice; judgment comes with experience and luck comes sometimes like a visitation of Providence, masquerading as experience, and very often giving judgment and experience, both, the very healthiest kind of help when a lift is most needed.

When a new doctor begins practice he takes the first lesson in experience—judgment follows as a matter of course. If the Lord is with him, and his patient has fighting powers, his judgment is apt to be good. In other words, he has luck. Three cases will illustrate the triple title of this article.

In the days of the first flush of college weaning, when the faculty had signed themselves down on my diploma, and the great state of New York, through the regents, had officially certified to my ability to practise medicine and surgery, and gave me a legal right to charge for my services, I was called to see a young woman who had come to Buffalo from the Queen's colony, across the river, full of shame, and a story of wrong. She had all the preliminary requirements for membership in a mothers' congress, save a marriage certificate and a ring. Being naturally sympathetic and anxious to show my interest in the fortune and misfortunes of my patients, I listened to her long story of how it happened.

Still as a sort of reward for my sympathy and services to be rendered I was informed that the gentleman who was at fault in the matter was willing and ready—nay, anxious—to pay all expenses of her illness. This and the fact that I was practising with all the earnestness, if not the ease, of a "real paid doctor, who carries a bag," enthused me. How I discovered that the young lady was also suffering with gonorrhœa is quite as long, and quite as sad as the story of her life. Truly, the gentleman, secure under the protecting folds of the red cross of St George, was lavish with his favors. I cannot truthfully say that he killed two birds with one stone, but it seemed figuratively speaking, to amount to that.

At any rate, I went to work. Twice a day I visited that woman for days and days; I irrigated her carefully and conscientiously, and happy was the day, when the discharge had ceased and she was rid of the trouble, with the other looming up in the near future.

I saw her, then, every few days after that for a few weeks, sympathising with her, cheering her and looking wise. And one morning I called and found that she was free from trouble and that her baby had been born in the early morning hours, without any discomfort to speak of, and that a neighboring physician had been called in after the birth of the baby and had taken charge of the case. While I was there he came in. He was an oldish man, with a supernatural wise look and ragged whiskers. *En passant*, always get to windward of a supernaturally wise-looking man who wears his whiskers ragged. He had assumed charge, and he had a snap lock on that case. He could not relinquish the care of that baby, nor that woman. He always "saw a labor case through," he said. And he did. Oh, yes, I would be recompensed for my share of the work.

He saw the case through and the gentleman in Canada paid forty good United States dollars to my friend with the supernaturally wise look and the ragged whiskers. I was to use a racing term among the "also rans." I felt for a long time like that "fore and aft" regiment Kipling wrote about, which was stalked and potted from out the dark by the heathenish, knife wielded Paythans.

This is experience.

"I've had four children, an' I'm not goin' to have any more, doctor, not if can help it, for th' old man's got a bad habit of drink, and the rent comin' due every thirty days, an' me doin' a full day's washin' every day

for six days out of seven, to keep the sheriff out of th' house. I'm near four months gone now, an' can you gimmie somethin' to help me."

That was the opening of she whom I call my judgment patient. I used, in answering her, the words of an old practitioner, who had given me the benefit of his years of wisdom, in many a comfortable hour's talk.

"You want to get rid of it?" I asked.

"I do," she said.

"If you will do as I say, I will guarantee that you wont have any trouble. You go home, and live as you have been living. Take care of yourself. Don't overwork and in five or six months you will be all right."

She came of a quick-witted race and she saw the point. She was good natured about it, too. Two weeks later, I was sent for. It was Sunday, at 11 o'clock in the morning. I found her in bed.

"It come," she said, pointing vaguely at the bed clothes. Turned back the coverings and there between her thighs, wrapped in a piece of sheet, lay a fœtus, probably four months, dead and dry, the clothes stained and hardened, the fœtus attached to the cord, which passed into the vagina.

"When?" I asked.

"Last night, about 8 o'clock," she answered. That dead fœtus had been there fifteen hours. Then I was stricken with a dash of judgment.

I covered up the little corpse and wrote a note to my old doctor friend, asking him to come. He came at once. While awaiting him I gathered the history. The previous Tuesday "after a hard day's washing" she had pains. They continued all Tuesday night and Wednesday. They eased up Thursday; Friday there were more, and still more Saturday. Saturday afternoon at 6 o'clock she went to bed and at 8 o'clock the fœtus had come away dead. It was attached. She waited an hour or so for the placenta. It not coming she had tugged on the cord, but could not budge it. All Saturday night and early Sunday morning she had at different times tugged at the cord and failing to get it clear, had sent for me. I had recently delivered a vi-para in the house where she lived. The case was perfectly normal and things went along with neatness and dispatch. This woman was present, and I presume she looked upon me as a sort of boy wonder.

When my old doctor friend came, I had her repeat the story to him. He saw the condition of affairs and after cutting away the fœtus, tried to clean out the uterus with his fingers. He could not and finally

curetted her. She was in anything but good shape. She recovered finally, however, under my old doctor friend's care. She probably would not had I plunged ahead on my own responsibility, and then there would have been all sorts of ugly aspects of the case. I consider that my judgment center was working full time when I sent for assistance and a man of years and irreproachable standing. He found things as I found them and he assumed charge. It was a charity case and that made me feel content at his compliment: "You showed great judgment in sending for me in a case like this."

The luck case came to me recently with this history. Six weeks previously she had a miscarriage. She was employed on a lake vessel, and believing that every thing had come away, continued her duties. She flowed considerably for a week. Then the flow lessened, for a few days only to begin again. This kept up for four weeks. She had lost considerable blood, evidently, for she was very weak. She went to a doctor in one of the cities at which the boat stopped, and "he put pincers in and took out the after-birth." That was two weeks previous to her visit to me, and she had been flowing most of the time since. She was very anæmic and weak. Her legs were œdematous and she was, as she expressed it, "not a bit of good for anything."

I found the cervix dilated sufficiently to admit my index finger, and I felt and removed a piece of placenta the size of a silver dollar. The uterus was thoroughly cleaned out and irrigated. Her urine was examined and found to be albuminous. She was instructed to rest, was put on Basham's mixture and strychnine and she sailed away in her boat on its next trip out, a few days later, her duties being assumed by another woman. When the vessel touched Buffalo on its return trip I saw her. She reported that there had not been any flowing whatever, her urine had cleared up, the œdema was about gone, and her lips were getting along toward the natural color. She was feeling better, too, and stronger.

If there is an element in this case more predominant than another, it is luck. Here was a woman who had every opportunity to enter upon a long and dangerous siege of sepsis. I don't pretend to figure out how she escaped. I only know she did, and I attribute it to luck.—*North American Medical Review.*

THE
MARITIME MEDICAL NEWS.

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Editorial.

WHERE ARE WE AT?

The stress of the life of to-day bears no less heavily upon the physician than upon those engaged in other than medical pursuits. The crowding of the profession, the multiplication of medical charities, the luxuriant development of quackery, and the dissemination by the lay press of enough of medical lore to instil into the lay mind the conceit that a little knowledge of medicine is sufficient and to encourage the tendency to self-prescription—all these tend to lessen the doctors' income and to make his very existence precarious. Ample evidence has been adduced to show that a large number of the members of our profession are unable to earn a decent living. Many are the instances of hardships endured by worthy confreres; few are the instances in which fortune deals lavishly with our co-workers. And yet, throughout the whole profession, as strongly in the struggling beginner as in the well established "old doctor," there breathes a spirit of altruism which puts aside self-seeking, and which always gives the first place to the good of humanity, no matter what the financial risk. An occasional exception serves to but demonstrate more effectually the general existence of this unselfish disposition. The establishment of medical charities is always encouraged, usually in a most active manner, by members of our profession, and this in spite of the assurance that such charities will be abused and that the income from practice will be reduced accordingly. To those who have been unfortunate, to the poor and needy, the doctor is always ready to be a friend—to give his services freely and gratuitously, and no class of men deal so leniently with well-to-do delinquents as do the members of the medical profession. And yet, the noisy quack, who never does anything except for gain, the ignorant, obtrusive, boastful, self-assured, not-very-truthful and always unscrupulous charlatan is

much more apt at enlisting the sympathies of the public than is the modest, conscientious regular practitioner of medicine.

The reason for this anomaly—for surely it is an anomaly—is not easily found. Possibly it may lie in that eternal gullibility which the illustrious Barnum considered to be the secret of his prosperity. But if the cause be obscure the fact is all too evident.

In one of the most progressive of Nova Scotian towns an active campaign is being conducted in the interests of the consumptive. An eminent and energetic clergyman is in the van, and, as he has earnest supporters in the doctors of the town, there can be no doubt of the success of the movement. Opposition comes from one source. An itinerant promulgator of strange doctrine, who, despite ability to attach M. D. to his name, does not come within the pale of the regular profession, evidently scents danger of diminution of his income in the success of the venture. He has contributed some letters to one of the newspapers which, for sheer incoherence and absolute meaninglessness, stand unique, and which ought to give people a fair idea of the mental calibre of the author. And yet people considered to be intelligent have passed over reputable physicians and have given this man their countenance and their patronage.

It really seems that we can do nothing but deplore the peculiarity of mind which takes sides with the irregular as against the regular in medicine. There does not appear to be any treatment. We can only trust that the condition is self-limited, and that sooner or later men may see the lack of fairness and of reason now commonly shewn towards the medical profession.

IMPLANTATION OF THE URETERS IN EXSTROPHY OF THE BLADDER.

This condition is such a distressing one that almost any risk in the way of operative treatment is as a rule agreed to even if the surgeon can only promise the possibility of a good result. Transplantation of the ureters has been experimentally done in animals years ago, but so frequently was the operation followed by ascending infection that death seemed to be always regarded as a consequence.

Now, that the operation has been revived, it has been satisfactorily proven that ascending infection has been the result of cicatricial contraction rather than the direct effect of the operation itself. Exstrophy is the most important malformation of the bladder and is by no means uncommon. Therefore, we are glad to refer to a case recently operated on in Canada by the method referred to and in whom an ultimate cure seems hopeful. This patient was exhibited at the recent meeting of the Canadian Medical Association. The report of the case with remarks as published by several Toronto contemporaries is as follows :

Dr. Geo. A. Peters, Toronto, exhibited the patient and fully described the two operations he had performed on this subject. In addition to the exstrophy of the bladder, the patient had also had procidentia recti, and was therefore a great source of trouble and annoyance, disgust and loathing to his friends. The resulting deformity from this condition would be such as would be produced by taking away the anterior wall of the abdomen, below the navel. There is then exposed to view the posterior wall of the bladder, with the mouths of the ureters filling in the space between the wide separated walls. In this case he has removed the exstrophy of the bladder altogether. The scrotum is present and the testicles are descended. The condition is a congenital one, and due to defective development in the uro-genital parts. At the age of $2\frac{1}{2}$ years the boy first came under the doctor's notice; he is now $4\frac{1}{2}$ years. All the organs and limbs were perfectly formed with this exception. On the broad, flattened and shortened penis, a groove descended down to the extremity thereof, the under skin of the urethra being exposed and also the mucous membrane of the posterior wall of the bladder. A rudimentary prostate could be seen, and at the lower part of the bladder wall the openings of the ureters could be detected. Around these there were excrescences, mucous in character. The surrounding skin showed very

little irritation, though it was constantly bathed in the escaping urine, though the escape of urine was not constant. When the surface was dried it would remain dry for 15 seconds to 1 minute. A fine probe was inserted into these openings of the ureters, passed almost directly backwards. Both kidneys were somewhat prolapsed as could readily be determined under chloroform. Generally speaking, in these cases, the testicles have not descended. There was an entire absence of the pubic smyphysis. With the finger in the rectum, one can draw forward and easily detect that there is no smyphysis pubis whatever. The projection of the prolapsed rectum came down to his knee. The mucous membrane of this was irritated and tenesmus was frequent and caused suffering. The procidentia could be easily returned and the sphincter had some contraction, but when the hand was removed it would return. This condition called for immediate relief. Dr. Peters here exhibited to the meeting the result of operative procedures, which certainly was very gratifying to the patient, the parents and also to the surgeon. A description of the operation for the exstrophy of the bladder followed. The operation was done extra-peritoneally, and this operation would seem to hold out hopes, but the mortality is high. The ureters were fixed into each side of the rectum and almost immediately the rectum manifested a tolerance for the urinary secretion. In 48 hours after the operation the bowels moved, and after that the child got along without any difficulty. It is now five weeks since the operation was done and the bladder has all gone. Now, his urine is passed into the rectum, and almost immediately it manifested a tolerance for the urine. He can go from three to five hours. That day he had gone from 8 a.m., then at 11 a.m., and again at 2.30 p.m., and at night he will go from four to five hours without passing anything from the bowel at all.

Dr. Cameron, Toronto, thought that this operation was bound to become the operation of the future. He instanced a case in which he had done this operation for a woman, in whom it had existed for 19 years. A good many of these operations have all proved failures.

Dr. Bell, Montreal, congratulated Dr. Peters upon the result of this case. He considered it a surgical triumph. The operation for the re-plantation of the ureters has been done for a good many things; and the question of the tolerance of the urine in the rectum is still a much discussed question. The results shown in this operation are good.

Dr. Shepherd, Montreal, thought that the operation was an ideal one and congratulated Dr. Peters upon the great success he had obtained in this case.

Dr. Peters, in reply: There is one point we must not lose sight of, that there is danger of death from ascending pyelo-nephritis. When the operation has been done in animals, that has been the cause of death. When contraction occurred, the ureter in the rectum would have a papilla. If we have a papilla projecting into the rectum, it minimizes the danger.

Society Meetings.

The annual meeting of the Nova Scotia Branch of the British Medical Association was held at the Halifax Hotel on the 18th instant.

The following officers were elected for the ensuing year:

President—Dr. E. A. Kirkpatrick.

Vice-President—Dr. G. C. Jones.

Treasurer—Dr. M. A. B. Smith.

Secretary—Dr. C. D. Murray.

Council—Surgeon-Col. McWatters, Drs. Chisholm, Walsh, Ross, Jones, Trenaman and McKay.

Representative on General Council—Surgeon-Gen. O'Dwyer.

The President elect, Dr. Kirkpatrick, on taking the chair, thanked the members for the honor conferred upon him in unanimously electing him to preside over the branch.

Obituary.

Dr. A. C. Page.—The announcement of the death of Dr. A. C. Page which occurred on the 23rd inst., at Truro, reached us as the News was going to press. Dr. Page was born in Truro in 1829, and was consequently 72 years of age. He graduated at Harvard University in 1856 and practised his profession for over thirty years. He was one of the first trustees appointed for the Truro public schools under the free school law of 1865, and had ever since been a commissioner of schools for Colchester. He had also held the offices of examiner at Dalhousie college; president of the Colchester Medical Association; president of the Nova Scotia Medical Association; president of the Provincial Medical Board. For many years, up to about one year ago he held the position of inspector of hospitals, asylums and poor farms, under the provincial government, which position he filled with marked ability and signal success. Owing to declining years he resigned and Dr. G. L. Sinclair was appointed. Dr. Page had also served as a surgeon to the 3rd Colchester and the 78th battalion volunteer militia, and was gazetted surgeon-major, September, 1882. In 1860 he married Miss Susan L. Blair.

Dr. Page was a good and public-spirited citizen, generous and warm hearted in his associations with the people, decided and firm in his convictions of duty and at the same time tolerant and respectful in his attitude towards those from whom he differed in opinion. He will be much missed in Truro and throughout Colchester county.

ABBEY'S EFFERVESCENT SALT.

A pleasant effervescing aperient, taking the place of nauseating mineral waters.

Recognized and prescribed by eminent members of the profession in Great Britain, Europe and Canada.

Matters Personal and Impersonal.

The marriage of Dr. R. J. Macdonald, Westville, and Miss Glennie, daughter of Walter MacDonald, Esq., Glendyer, Inverness County, took place early this month.

On the 10th. inst., at the "Pines," Miss Marie Louise, daughter of Dr. Thomas Trenaman, city medical officer, and Dr. Hugh L. Dickey, of Charlottetown, were united in marriage in the presence of a large gathering of relatives and friends of both parties. The "Pines" was handsomely decorated for the occasion, the drawing room, where the ceremony took place, being a veritable flower garden and presented a very pretty scene. A coincidence about the marriage was that the officiating clergyman, Rev. A. W. Nicholson, of New Glasgow, married the bride's father and mother, and also christened the bride.

The NEWS extends hearty good wishes to the happy couples.

Dr. G. Carleton Jones, who for two months was taking the practical course of the royal army medical corps at Aldershot, England, returned on the 17th. inst., after having passed a very creditable examination. Before leaving for home Dr. Jones volunteered his services as surgeon to the Canadian contingent. Dr. Charles A. Wilson, of Montreal, however, has been chosen to fill that capacity, on account of being senior in the service.

Dr. H. S. Jacques, Captain of No. 3 Company, 63rd rifles, who was to command the Nova Scotian section of the Canadian regiment in South Africa, is confined to his residence through illness and will therefore be unable to undertake the trip.

The demand for Park's Emulsion has necessitated Messrs. Hattie & Mylius erecting an electric motor to more thoroughly and rapidly assist in emulsifying their preparation.

Drs. M. T. McLean and S. E. Shaw, have recently been appointed house surgeons to the Victoria General Hospital.

Dr. T. C. Lockwood, of Lockeport, sailed early this month to take up post-graduate work in London.

PAMPHLETS RECEIVED.

CONCERNING IMMUNITY AND THE USE OF NORMAL NON-IMMUNIZED SERUMS.—By W. Thornton Parker, M. D., Westboro, Mass.

INVOLVEMENT OF THE EYE AND EAR IN CEREBRO-SPINAL MENINGITIS. —By William Cheatham, Louisville, Ky.

THE FAILURE OF ANTITOXIN IN THE TREATMENT OF DIPHTHERIA.— By J. Edward Herman, M. D., Brooklyn.

Matters Medical.

"WHY SHE LOVED HIM."

A man of modern science woo'd
A maiden of accepting mood,
Who, dreading less infection might
Do mischief to her chosen wight,
With sol. chlorid washed her hair,
And sponged her limbs and body fair.

She rinsed her mouth with listerin,
And held her snow white teeth between
A pad of antiseptic gauze,
Covering her nose as well as jaws,
Which formed a sort of respirator
Between her and her osculator.

But this reminds. I should have told
That these were things he'd taught of old,
With others which I may not tell, in
Regard to spots that germs might dwell in.
She was a wise professor's daughter,
And practiced all that had been taught her.

Now, this good medicine man, with pride
Clasping his antiseptic bride,
In disinfected murmur low,
Asked, "Why she loved her doctor so?"
And, nestling softly down, she sighed:
"You're such a dear old germicide."

—*Public Health.*

CATGUT STERILIZATION.—While personally entirely satisfied with the modifications of the formaline process for the preparation of gut as described at length in the *Recorder* for January, we feel that we can safely recommend the method of boiling in alcohol. Dowd devised a condenser for the alcohol, which is thus described by Copeland *(Med Age, Aug., 1899.)*

This condenser is made by encasing a coil of block-tin tubing in a cylinder of sheet copper. Two taps are inserted into the cylinder for the transmission of water in and out. The lower one is attached to a faucet of running water, and the upper one is fitted with a rubber tube

to provide for the essape of the water. The crude catgut, as received from the dealer, is wound on glass spools and put into absolute alcohol in such an open-mouthed jar or bottle as is convenient. The piece of block-tin tubing at the bottom of the condenser is fitted into a perforation in the cork of this bottle or jar. The jar is then placed in a water-bath and boiled for one hour. This device is simply a still which recondenses the alcohol.

Alcohol alone has great germicidal power. Catgut boiled in absolute alcohol for one hour is, I believe, rendered sterile aud increased in strength. Repeated boiling does not weaken the gut. My belief is based upon twelve years' experience with catgut, prepared after this method, without a single bad result that could possibly be attributed to the catgut. Some objection is made to the time and trouble required to prepare catgut after this method. No method could be quicker or easier after we have the apparatus; no more than five minutes is required to bring the alcohol to the boiling point.—*Western Clinical Recorder.*

SOME OF THE MINOR IMMORALITIES OF THE TOBACCO HABIT.—Dr. Matthew Woods, in the *Journal of the American Medical Association*, writes on this subject. If these are the *minor* immoralities we would like to enquire what the *major* ones could be. He says:—"The vulgarity and licentiousness of the Press, with its mercenary pandering to vice, corrupting as it does that very fountain of national strength, the home; the lubricity, the demoralising baseness of the degraded drama; disfigurement of hoardings by the cigarette soaked indecencies of the variety stage, making it difficult for our children to walk the streets without contamination; the growing fondness for certain social functions with their flimsy vaudeville adornments; the mockery of and attempted obliteration of personal puritanism, the crass things done by tobacco-biased young people, degradation of seats of learning by the introduction of smoking-rooms, those hotbeds of vice and agnosticism, of ballet dancing and brainless burlesque—imbecility and irreverence under the auspices of fashion; defilement of public buildings by foul receptacles provided for a people so base that it is necessary to ask them to please not spit on the floor; the negro minstrel methods of some of our churches, the effeminacy of religious periodicals with their venal advocacy of successful quackery and fraud; the prevalence of the gambling mania among women; levelling all ranks, dissipating time so much needed in more ennobling ways; mediæval grotesqueries, euchre and wine parties for the spiritual and physical benefit of the outcast and sick, made so by gambling and

drink!—what, unless completely engrossed in other things, could induce thoughtful men to silently submit to these but that indiscriminating drowsiness of conscience—'denying nothing, doubting everything'—so frequently induced by tobacco?"—*Health.*

A PROFESSIONAL CARD.—The following is said by the *Medical and Surgical Reporter,* to be clipped from an Arizona weekly of respectability:

"J. E ———, M. D., PHYSICIAN AND SURGEON."

Heath Officer, City of ——; for five years County Physician—County; Medical Director Department of Arizona, G. A. R.; Late Surgeon U. S. Army; for 20 years U. S. Examining Surgeon; the largest Medical Practitioner in Arizona, and charges fees in proportion to his size. His patrons will find it to their advantage to keep healthy.

Office and Dispensary, —— Street, Corner of ——.

COCAINE AND ITS ABUSE.—The cocaine habit is one of the alarming evils that is rapidly gaining in popularity in Kansas City, especially among the negroes and lower class. The police court sees daily evidences of this great evil, and an attempt to stop the sale of this drug should be on foot before the habit is stamped as a life-mark. It is surprising at the number of the colored population who are victims of this evil vice, which is more seductive than cigarettes or opium, or any other narcotic. One and the main reason is the great ease with which it is administered, no hypodermic needle being required, as they simply place a little of the drug in the palm of the hand and, by moistening it with a drop of water, use it as a snuff. Pleasurable sensations follow, succeeded in turn by intoxication, nausea and intense craving for more cocaine. As the desire and the capacity for the deadly drug increases, the indelible evidences of its use stamp themselves upon the face of the victim. The habit is quite frequently induced by patent medicines taken to cure catarrh, by the neurasthenic, or to cure nervousness by the hysterics and other unstable persons. These victims are daily being fined in the police courts, and many crimes are committed for the purpose of getting money with which to purchase this drug.—*Kansas City Medical Index—Lancet.*

THE TRAINED NURSE.—The science of treating and curing the ills of humanity has made greater advances in the last twenty years than in all the preceding years of the century. We are apt to look upon ourselves as being deserving of all the credit for this happy outcome of the

end of the century, regardless of the fact that many other agencies that are practically outside of the medical profession have contributed. Much of the advance in medical science has been in the department of hygiene, both personal and general, and especially in the more intelligent and scientific methods of nursing. The trained nurse, who but a few years ago was an unknown quantity, has certainly come to be the helpmate for the hard-working doctor. To be sure, without the medical profession the trained nurse would never have been in existence to-day. There was an evident need for her or she would not have been brought forward to fill the vacancy. She relieves the busy practitioner of much of the worry which would otherwise be his lot in treating his patients. Many of us can remember, and not very long ago either, when the doctor, even the city doctor, was obliged to be, to a great extent, his own nurse, and often in the minds of the laity the physician was judged largely on account of his nursing abilities. To be sure, the trained nurse ofttimes, and worthily so, has ambitions looking forward to usefulness in a more advanced direction. Her knowledge of medicine she improves; she learns anatomy, physiology and chemistry, and it is but natural that she should acquire a taste and laudable ambition to still further investigate into the mysteries of medical learning. This has resulted at times in arousing antagonism toward the medical attendant. In other words, the nurse is inclined to be too independent, and often dictates to the attending physician. In doing this she is treading on forbidden ground and is encroaching upon the rights and dignity of the physician. This is the tendency of the present-day system of education in the training schools, and it certainly cannot be systematically tolerated. It is an evil that physicians in general must meet. The intimate relations in which the physician and the nurse are thrown require that there be harmony between them. But there should never be any question as to the matter of authority. There is no question but that the faithful nurse is the best assistant and the best friend that the modern physician can have. Her intimate relationship with the patient places her in a peculiarly advantageous position to make or mar the physician in the estimation of the patient. The faithful trained nurse will always use her position to advance the interests of the attending physician, and we believe that she nearly always does. We cannot speak too highly of the nurse as an angel of mercy to the helpless patient, for such she has in the main proven herself to be since her advent upon the scene of human suffering.—*Western Medical Review.*

Therapeutic Suggestions.

PILLS FOR THE HEADACHE OF NEURASTHENICS.—The *Riforma Medica* gives the following formulæ:

1. ℞ Zinc phosphide ..... 0.23 grain.
   Reduced iron ..... 3 grains.
   Extract of nux vomica ..... 1.8 grain.

M. Divide into eight pills. Two or three to be taken daily.

2. ℞ Zinc valerianate .....
   Iron sulphate .....
   Extract of rhubarb ..... } each 18 grains.
   Asafœtida .....

M. Divide into twenty pills. One to be taken three times a day.—*N. Y. Medical Journal.*

FLATULENCE.—℞ Beta-naphthol ..... 2 grains.
Poplar charcoal ..... 8 grains.

To be taken immediately after meals to avoid dyspeptic fermentation.—*L' Union Medicale du Canada.*

INJECTION IN HEMORRHOIDS.—Internal piles suitable for the injection method may be injected with:

℞ Acid carbolic ..... ℥iss.
Acid salicylic ..... ℥ss.
Sodæ biboratis ..... ℥i.
Glycerini (steril.) ..... q. s. ad. ℥i.

M. ft. solutio.

Sig.—Two to four minims to be injected into the base of the hemorrhoid. If other injections are required they are made in from three to five days.—TUTTLE.

CHRONIC NEURALGIC HEADACHE.—A formula ascribed to Henry J. Kenyon by the *Journal of the American Medical Association* as an alterative to diseased nerves in chronic neuralgic headaches, etc., is:

℞ Zinci phosphidi ..... gr. $\frac{1}{10}$
Ext. cannabis Indicæ ..... gr. $\frac{1}{8}$
Ext. nucis vomicæ ..... gr. $\frac{1}{8}$
Sodii arseniatis ..... gr. $\frac{1}{4}$
Quinine sulphatis ..... gr. $\frac{1}{2}$
Ext. aconiti radicis ..... gr. $\frac{1}{10}$

M. ft. tab. No. 1.

Sig.—One such at 10 a. m., 4 and 9 p. m.—*Medical Bulletin.*

TREATMENT OF DYSPHAGIA AND COUGH IN TUBERCULOUS PATIENTS — In a very clear and candid article on this subject, read by Dr. Freudenthal before the German Medical Society of New York, after citing the uncertain and often unsatisfactory results following the curettage of ulcerations in the larynx, the author gives at some length his experience with orthoform and heroin. Of some twenty-nine cases in which he had curetted tuberculous ulcerations in the larynx, eighteen were improved, seven slowly improved, and four showed a temporary improvement. He regards the value of curettage as a still undetermined question in laryngology. Dissatisfied with his own experience he began in 1897 the use of orthoform insufflations among his tuberculous patients at the Montefiore Home. He used it alone and in various combinations, apparently getting the best results from the following emulsion:

℞	Menthol	10.0
	Oil of sweet almonds	30 0
	Yolk of egg (about two yolks)	30 0
	Orthoform	12.5
	Distilled water q. s. ad	100.0

Ft. emulsio.

The emulsion containing yolk of egg is found to be of value in preventing a separation of the orthoform and also to lessen the initial burning and irritation to which an insufflation of orthoform gives rise. He used intralaryngeal injections of this emulsion with the ordinary laryngeal syringe.

The other remedy which Freudenthal regards as so essential in tubercular affections of the larynx accompanied by cough is heroin, the morphine derivative. Heroin is quite devoid of the disagreeable aftereffects of the morphine and codeine salts, while its sedative action upon the cough is prompt and decided. He lays stress upon the demonstrated fact that heroin affects neither the heart nor the circulation, and is a safe remedy to use in patients who may have some heart lesion.—*(Monatsschrift fur Ohrenheilkunde,* vol. xxxiii, No. 3.)—*Medical Age.*

DELIRIUM TREMENS.—

℞	Potass. bromid.,	
	Sodii bromid aa	gr. xv.
	Chloral hydrat	gr. x.
	Tr. zingiberis	♏x.
	Tr. capsici	♏v.
	Spt. ammonii arom	ʒ j.
	Aquæ	ʒ ij.

M. Sig.: Dose, a dessertspoonful.— *Vanderbilt Clinic.*

HALIFAX MEDICAL COLLEGE,

HALIFAX, NOVA SCOTIA.

Thirty-First Session, 1899-1900

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