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# THE CANADIAN PRACTITIONER

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## Original Communications.

ADDRESS OF THE PRESIDENT OF THE CANADIAN  
MEDICAL ASSOCIATION.\*

BY JAMES THORBURN, M.D.,

TORONTO.

I DESIRE, in the first place, to thank you for the honor you have conferred upon me in making me the president of this great association. I consider it the highest honor in the gift of the profession of the Dominion of Canada. When I think of the eminence of my predecessors, I have great apprehension of my ability to meet your expectations; but, gentlemen, relying on your kind assistance and loyal support, I will fulfil the duties of my office to the best of my skill.

During the past year many bright men have gone the way of all living. Medical science has lost her most valued son in Pasteur. Although many names are prominent in connection with the recent great advances that

\*Delivered at the annual meeting at Montreal, August 26, 1896.

have been made in medicine, that of Pasteur will always be pre-eminent. He may fairly be credited with having put the germ theory of disease beyond all dispute. Protective inoculation, apart from Jenner's, work, was first understood and successfully applied by him. The surgery of the present day owes its success very largely to him. Lister was stimulated to carry out his early experiments upon suppuration and infection in consequence of following Pasteur's researches upon fermentation, including ammoniacal fermentation of urine in the bladder. More recent therapy owes much to him. His success in the handling of patients who were presumably inoculated with rabies is well known, and there can be little doubt that the serum therapy of to-day comes indirectly from Pasteur's labors. It may be that the results of the work of Pasteur, and a host of others in the lines indicated, are not yet thoroughly understood or appreciated by the profession generally; but the knowledge that we have recently obtained respecting both the diagnosis and treatment of such diseases as hydrophobia, anthrax, tetanus, diphtheria, tuberculosis Asiatic cholera, typhoid fever, and septicæmia has already been productive of good results, and is likely to do much more in the future. Some are still skeptical as to the good that has been accomplished through modern serum therapy, but the ordinary conservatism of our profession has some influence now, as it so frequently had in the past, in preventing us from accepting new theories. One of the most remarkable instances of extreme conservatism that we know of was the opposition that Jenner encountered when he gave to the world the result of his experience in his work in connection with vaccination.

At the present time the number of those opposed to vaccination is very small indeed. The centenary of the vaccination of James Phipps, by Jenner, has recently been celebrated over the civilized world, and well might it be. By the discovery of vaccination, and its subsequent use, more lives have been saved than all the wars devised by the wickedness of man have destroyed; and I think it would be in keeping with the custom of our profession if some resolution were passed by this association expressive of our gratitude for this wonderful discovery.

In considering the different events of the past year, it becomes my melancholy duty to refer to the deaths of some of our ablest and most highly respected members. Drs. Fenwick and Saunders, of Kingston, and Dr. McFarlane, of Toronto, were well known to most of you as highly successful medical practitioners, and worthy and honorable men in all respects. They have gone from our midst, and it is difficult for us who are left to realize the sad fact that we will never more see their kindly faces at our meetings. It is a somewhat remarkable coincidence that these three honored members of our association died from septic poison, received while in

the discharge of their duties, and their deaths must ever remain as witnesses of the self-sacrifice and devotion of our noble calling. No soldier, leading a forlorn hope, died a braver death. The duty of the military man is to destroy life and weaken the enemy ; that of the medical man is to relieve pain and prolong life. May their honored names forever remain green in our memories !

An important subject for us to consider, gentlemen, is a common registration for the Dominion, or interprovincial reciprocity. The various provinces of our Dominion have regulations as to their medical curricula, which, while generally satisfactory from a local point of view, are widely divergent. This condition of affairs has been unavoidable. The wide extent of our country, with a sparse population, especially in certain localities, has made it difficult to maintain a uniformly high standard of medical education both in the preliminary and regular medical courses. I think, however, the time has arrived when the obstacles in the way may be overcome by mutual concessions on the part of the different provincial medical authorities.

The importance of obtaining a common standard for the whole Dominion cannot be questioned. As it is now, the physician's license does not extend beyond his own province, and, furthermore, I have every reason to know that, with a common Canadian standard, we could have reciprocal registration with the motherland, as already provided for by the Imperial Statutes, 1888, and then we would have uniformity of registration, not only in the Dominion, but throughout the Empire, of which we are all so proud, and whose banner, wherever it waves, is the emblem of civil and religious liberty.

Speaking as a member of the Ontario Medical Council, I may say we have always endeavored to maintain a high standard of preliminary and medical education. I have no doubt that our council would give careful consideration to any scheme unanimously recommended by the Canadian Medical Association.

The want of uniformity of registration in the different provinces is not only detrimental to our common progress and national unity, but has a tendency to drive away many good and valuable men from our land. As the law stands now, we are simply localized practitioners, liable to be prosecuted if we venture to practise beyond our immediate province. The making of a curriculum suited to the whole Dominion is not an easy matter. After having considered the question with some care, and having consulted with some of the most prominent teachers and practitioners in the various provinces, I would suggest that throughout the Dominion a four years' course of eight or nine months each be devoted to lectures, hospital, and laboratory work. I would not have the number of didactic

lectures increased, but the number delivered daily decreased, and would recommend that no lecture should occupy more than forty-five minutes. As it is at present, nearly the whole day is spent by the student in attending lectures, leaving little or no time for the important branches of observation and research. The five years' course, with winter sessions of six months, and one summer session of three months, is, in my opinion, not equal to a four years' course with sessions of eight or nine months. We all know from personal experience that the six months' term is practically but a five months' session; for allowance must be made for the two weeks' holiday at Christmas, and the last two weeks in March, which are taken up in examinations, etc. The long interval between the cessation of lectures in March and their commencement in October, over six months, is practically a barren period to most of the students. In the longer session of eight months, the student could divide his time to better advantage between attending lectures and taking part in practical work at the bedside, laboratory, etc. In addition, it would afford him some time for social life, which, in those days of rush and hurry, is sadly neglected, frequently to the detriment of many well-informed medical men, and in consequence of which they frequently fail to attain that success in life to which their professional knowledge entitles them. We should not only be educated men, but also men of gentle deportment and good manners. I hope, gentlemen, that the committee appointed at our last annual meeting on reciprocal registration will be able to report favorably for the eight months' session, as I am thoroughly convinced that such a course would be better both for the student and teacher.

Another subject of very considerable importance is the relationship of medical men to life insurance. Heretofore no special reference has been made to this subject. It has a most practical bearing on the success of every medical man. It is a well-known fact that many physicians can diagnose a disease with almost a positive certainty, but from lack of special training as to the probable expectation of life are often at a loss to state, with any approximate degree of certainty, what that may be in any individual case.

It has been said, and truly so, that the medical examiner is the watchman at the gate of entrance to life insurance. His office is a most sacred one, and from the fact that so much confidence is placed in him it is his duty to shield his company from every appearance of imposition. Examining for life insurance is so important, and the amount paid in medical fees so enormous, that in common fairness and honesty physicians should fit themselves most thoroughly for this branch of their profession. This has been recognized by the University of Vermont, which provides a course of lectures in life insurance medical examinations. The services

which every first-class insurance company is seeking are those of the educated, scientific, and skilled physician. The companies require the very best services that can be obtained. In our own Dominion the moneyed interest involved in life insurance is enormous. The obligation of the regular life institutions alone to policy-holders amounts to about three hundred and twenty millions of dollars, and in this I do not include the numerous benefits of friendly and assessment societies. These figures are being augmented each year by about twelve millions of dollars, and in the past twenty years alone they have been increased by about fourfold. The profession receives from the companies for medical examination fees yearly a sum not less than \$150,000, and if we turn to the land immediately to the south of us the figures quoted appear but insignificant. The thirty-three companies reporting to the New York insurance department are responsible to policy-holders in the enormous sum of six billions of dollars, and pay for medical examination fees a sum not less than two millions of dollars, which does not include the compensation of medical officers and directors, but simply the fees for examination of applicants.

Such an important part has the physician played in his relation to life insurance that in the United States there was formed some five or six years ago a medical directors' association, and some two or three years later a similar association was organized in England. In the former organization the chief medical officers of some of our more prominent Canadian life insurance companies are members. The objects of these associations are to obtain increased information and greater unity of opinion regarding medical subjects connected with life insurance. The American societies consist only of the life insurance medical directors, but in the English society both the medical directors, and all physicians who are legally qualified, are eligible for membership. The plan of the British association appears to be the better, for, while there are many questions which more particularly concern the executive phase of the medical department of the business, the real utility of these organizations is, and should be, the discussion of all medical subjects in relation to insurance, and the securing, as much as possible, of uniformity of opinion and practice. This can only be done by a conference, not simply of medical directors, but of both directors and examiners.

The question of professional secrecy is one which is ever and anon brought prominently before the profession and the public. In some countries, for example, France, and in some of the states of the North American Union, the physician is not allowed to divulge information received from his patient in a professional capacity, unless it involves conspiracy against the state or murder. Legal decisions in Britain and her colonies, as well as in some parts of the United States, are not satisfactory

or definite, and much is left to the decision of the judge and jury. No one questions the sacredness of married life, and the divulging of information obtained by a physician in his professional capacity would certainly be considered as contrary to all good morals and unbecoming the conduct of a physician and gentleman. It is to be regretted and severely deprecated that some medical men are overfond of retailing their professional experiences—some from the mere love of gossip, others from a desire to advertise themselves as something unusual. All such conduct is inexcusable, and I am glad that it is condemned by the majority of the profession, as well as by the more thinking public. It is when a medical man is brought into a court of law that his position is somewhat altered. As I have already intimated, in some countries all professional information is considered sacred, and must not be divulged voluntarily, nor can the physician be compelled to reveal it. From a careful study of cases in Great Britain and other English-speaking countries, I learn the decision of judges in general is to make it compulsory on a medical man to tell under oath, like any other witness, all that he may know, whether his knowledge has been obtained in a medical capacity or otherwise. If, however, the knowledge involves the witness, he need not incriminate himself. I think this ruling is of doubtful expediency; its tendency is to disturb the mutual confidence that exists between the patient and the physician—that honorable, sacred feeling so healthful to both parties. There are, I must confess, so many circumstances connected with individual cases that a fixed rule is not always possible. Speech is silver, but silence is golden.

In view of the wonderful discoveries of modern days, especially in reference to mechanical appliances, one should hesitate before pronouncing emphatically against the possibility of almost any discovery. The uses of electricity are so varied and well established that we should not ignore any statement as to its results without investigation. It was only the other day that a message was sent around the civilized world in a space of time not greater than I am occupying in speaking to you now. Electricity has also been recognized as a very important therapeutical agent in the treatment of diseases. One of the most recent discoveries, known as the Roentgen X rays, is the skiagraphing or photographing of the shadows of internal parts through dense structures, muscles, and bones. This must prove of great assistance in the diagnosing of many diseases hitherto obscure, and must also prove of great service to the surgeon in locating the presence of bullets, needles, and other substances that have entered the body, as well as indicating the presence of disease, for example, in cases of injuries to the vertebræ, stone in the gall bladder, kidney, and vesical bladder, the position of the fœtus in utero—in fact, gentlemen, I have no doubt but that the uses of the instrument will become most frequent as improvements are made upon it.

I have watched the growth and development of this association with the deepest interest. I had the privilege and pleasure of being present at its first meeting, held in Quebec in 1867. Has it received the support from the various parts of the Dominion to which it is entitled? I do not know that I can say, unreservedly, yes; but I certainly can say that it has ever and always received the most loyal and cordial support of the profession of Montreal. I have no hesitation in telling the honorable and zealous body of physicians and surgeons of this city that our members from the East and from the West, from the Atlantic and the Pacific, highly appreciate the work you have done in the interests of our national medical society, and I think that I may take the liberty of offering you the congratulations of the medical profession from the various provinces of our great Dominion on the honor that has been conferred on Montreal by the unanimous decision of the council of the British Medical Association to hold its next annual meeting in your fair and prosperous city. I also have much pleasure in tendering our congratulations to your distinguished townsman, Dr. Thomas G. Rodick, the president-elect.

Many subjects of a scientific nature in the various department of medicine will be brought before you, and I know that they will receive your most careful consideration, and I ask you one and all to put forth the most strenuous efforts to make this meeting a pronounced success.

In conclusion, gentlemen, allow me to express the hope that the Canadian Medical Association will continue to extend its usefulness and maintain its high reputation; and, in addition, that we may ere long have a common standard of medical education in Canada, with reciprocity between our different provinces, and also reciprocity between our Dominion and the mother country.



ABDOMINAL AND PELVIC OPERATIONS FOR THE RELIEF  
OF CONDITIONS INCIDENT TO THE  
PUERPERAL STATE.\*

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BY JAMES F. W. ROSS, M.D.,

Surgeon to Toronto General Hospital, St. John's Hospital for Women, and St. Michael's Hospital,  
TORONTO.

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THE subject under discussion is apt to be of interest to the general practitioner, and deals with questions that are liable to occupy any day a few hours of his life. It is not my intention to give you a very learned dissertation upon the various conditions of which I intend to speak, but a summary of my experience, and on this account I must ask you to bear with many imperfections.

FIBROID TUMORS AND PREGNANCY

Of all the curious tumors that grow grafted anywhere on the human being fibroid tumors are among the most curious. I have met with these tumors in all the various positions in the pelvis in conjunction with pregnancy in its early weeks and on up to term. The degree of the gravity of the case varies according to the situation of the tumor. When such a tumor is found in a young married woman who has never borne a child the prophylactic treatment to be adopted to prevent pregnancy is the removal of the ovaries and tubes; thus pregnancy will not occur, and early miscarriages, premature labor, and labor at full term, with all their accompanying dangers, will be avoided. But cases are met with that seem to stay the hand of the surgeon.

I on one occasion delivered a lady, the wife of a physician, with great difficulty of her first child. There was a large fibroid tumor situated on the fundus of the uterus at the time of this confinement. After a very prolonged illness she convalesced. In spite of every precaution there was septic infection. A gradual diminution in the size of the tumor followed. At the time of her second confinement the tumor had almost entirely disappeared. She was then delivered without difficulty. In this case the operation of oophorectomy would have saved the patient from a

\*The address in Midwifery, read at the twenty-ninth annual meeting of the Canadian Medical Association held at Montreal.

dangerous illness, but would have cheated the world of another human being.

Another lady was seen in consultation during a miscarriage. The hæmorrhage was terribly severe, and a great deal of difficulty was experienced in removing the placenta. She made a good recovery, and becoming again pregnant a short time after consulted her attending physician and asked him to produce abortion. We consulted about the matter and decided to leave nature alone. She has since been delivered of a living child and made an easy recovery.

Another case may well be related in this connection, as it is one of considerable interest. A lady from South Africa married late in life. She was thirty-eight or forty years of age and had been married two years. I found a large abdominal tumor with two abdominal nodules and one pelvic nodule, and between them what I considered a pregnant uterus. She was pregnant about three months. The fibroid tumor had been growing with great rapidity, and two of the nodules were each as large as a child's head. Having performed Porro's operation on two previous occasions I decided in this case, with the consent of the patient, to adopt more conservative measures, and, with every antiseptic and aseptic precaution, I induced abortion. The placenta was removed, with the patient under chloroform, without any great difficulty. The uterus was then packed with iodoform gauze, and an excellent recovery followed. She was advised to return when stronger to have the tumor removed, but did not do so. Several years after I learned the sequel. She was persuaded to place herself in the hands of some of the quack curers, and, while rubbing salve on her back and filling her vagina with inert suppositories, the tumor, as a consequence of the stimulation afforded by the involution of the uterus following miscarriage, began to disappear. The patent medicine people scored a great victory, but were unable to give the true scientific explanation of the reduction in size of the tumor. The patient became again pregnant and was delivered of a living child.

In the light of this experience one must carefully weigh the question before deciding on the performance of Porro's operation or of oophorectomy in young women suffering from fibroid tumors. All cases of abortion and labor are not as easily terminated as the above-mentioned cases would lead one to suppose.

I was recently called to see a patient by Dr. Miller, of our city. He stated that she had been delivered by himself, with a great deal of difficulty, of a dead child, owing to the presence of a tumor in the pelvis that was obstructing delivery. The patient barely escaped with her life, and as she was now pregnant again he desired to have my opinion regarding the desirability of inducing abortion. On examination I found a

fibroid tumor the size of a child's head in the right lower abdomen, another of the same size in the left lower abdomen, and a third tumor of equal size blocking up the pelvis. Between these tumors was evidently a pregnant uterus; the pregnancy had advanced to about the fourth month. I advised the induction of labor; this was carried out by means of a sterilized bougie, and the *fœtus* in due time was delivered. The placenta remained in utero for twelve hours, until after my return from the country, as I was out of town. There had been in the interval no attempt on the part of the uterus to expel the placenta. After Dr. Miller had administered the chloroform I proceeded to remove the placenta. The knees were well drawn up into the lithotomy position and the interior of the uterus explored. It felt like a collapsed india-rubber bag that was being pressed together by three large balls, one to the right, another to the left, and another below. Even after the introduction of the hand into the vagina it was impossible to reach the fundus. By means of a pair of long placental forceps the placenta was picked away piece by piece. The operation consumed three hours. Several times I felt like desisting. The curette was used, but to little purpose. Forceps of different kinds were used, but the placenta remained very adherent and broke away in small pieces. The tumors were rotated in different directions in an effort to reach the point of attachment of the placenta with the finger. At last the two upper tumors were rotated one by one towards the front of the abdomen while the hand was inside the vagina, and in this way the fingers inside the uterus almost reached the fundus. The sulcus behind was not explorable with the finger. At last I decided that the two upper sulci were emptied of placenta, and trusted to luck for the emptiness of the posterior one. The uterus was then washed out with an antiseptic solution and packed with iodoform gauze. The patient made an excellent recovery. I had no idea that the removal of the placenta could be as difficult an operation. A complete hysterectomy would have been an easy task compared with the removal of the placenta in this case.

You will see that there are almost insurmountable difficulties to be met with in endeavoring to deliver as early as the fourth month *per vias naturales*. But parturition at a later date is a much more dangerous affair. The death of the child is liable to occur, and many of the mothers succumb.

In looking through the literature on this subject it is painful to read the accounts of the treatment adopted in many cases. Women who have been attended by their physicians for days, in the hope that some fortunate circumstance may perhaps assist in the delivery, are placed in the hands of the abdominal surgeon when too far gone to withstand the shock of any delivery through the anterior abdominal wall. I am satisfied that

there is less shock from the delivery through the anterior incision than there is when the foetus is pulled by main force down through the parturient canal, when the tissues are terribly bruised, and the placenta, that is adherent over the surface of the tumor, is in all probability but partially removed. Even when there is no great difficulty in the act of delivery itself the patients are in greater danger than those who have no fibroid tumor present in the uterus at the time of pregnancy. I saw one case die after nine weeks of septic inflammation. She had a small fibroid tumor in the uterine wall that became inflamed on the ninth or tenth day after delivery, and suppurated. I have seen large fibroid tumors suppurate on two occasions after delivery, and in these two patients the convalescence was very much prolonged. The discharge from the fibroid down through the uterus produced in each case excoriation of the external genitals and vagina, and when brought to the hospital they were in what one would call a filthy condition, not from any fault of their own, but as a consequence of the foul discharge.

The early emptying of the uterus has, in my hands, been satisfactory. But, owing to religious and moral feelings, some mothers may refuse to sacrifice the foetus in utero for the sake of saving their own lives. When this is so, pregnancy must be permitted to proceed. When pregnancy has advanced to the later months, craniotomy, embryotomy, or difficult forceps delivery should not be thought of for a moment. If the patient can be delivered by the production of a premature labor that can be terminated without great instrumental force, and with a fair chance of saving the child, it may perhaps be tolerated; but if, under other circumstances, craniotomy or embryotomy or difficult forceps delivery are under consideration on the one hand, while delivery through an abdominal incision is under consideration on the other, the indication to my mind must always be in favor of an abdominal operation.

There is no reason why such patients should be allowed to become almost collapsed before these questions are taken up and carefully considered. There must always be weeks of waiting before the onset of labor, and it is in this interval that the attending physician must exert himself to place his patient in a position of safety. Plans can be matured and arrangements made with deliberation and without hurry. The fact that occasionally patients are safely delivered by the efforts of nature, or by the use of forceps after days of suffering, is no argument that such a delivery is the one that is most desirable. Though some are thus safely delivered many will die. That they recover after such terrible bruising of the parts and after suppuration of the tumor is more the exception than the general rule.

At the time of abdominal delivery another question will arise. Shall we

remove the child alone by Cæsarean section? Shall we remove the child by Cæsarean section, and also the ovaries, to prevent subsequent fecundation? Or shall we remove partially, or entirely, the uterus with ovaries and tubes? I would now prefer total extirpation of the uterus, having perfected the technique of total hysterectomy. The presence of the fibroid after the uterus has been emptied must always be a menace to the patient whether the ovaries and tubes are present or not.

Fibroid tumors are met with in the vagina growing from the cervix uteri. One reads of what appears to be a brilliant result of an operation performed by one who, perhaps, considers himself a very brilliant operator. As a consequence of his audacity, such an operator will attack a fibroid tumor whether it is situated in the cervix of a pregnant uterus or growing from its wall into the abdominal cavity. The tumor is removed and the pregnancy is allowed to go on to full term, if nature permits it. In many cases nature objects, and the woman miscarries and dies. The accounts of such operations would be better unpublished. Of fifteen cases of removal of fibroid tumors during pregnancy five died, a mortality of  $33\frac{1}{3}$  per cent. Why such operations should be undertaken in these modern days I cannot understand.

It has occasionally happened that these fibroid tumors, growing from the cervix, contrary to the expectation of those in attendance, have been drawn up during the progress of delivery, and the fœtus has been permitted to pass into the vaginal canal. Enuclation of such a fibroid at the time of labor must greatly increase the danger to the patient, and should not be undertaken when abdominal delivery can be carried out with so little risk.

#### OVARIAN CYST AND PREGNANCY.

After delivery the abdomen may not diminish in size, and the doctor is somewhat puzzled. On careful examination he finds the uterus reduced and empty, and a mass lying to either one side or the other in the abdominal cavity. The patient has completed her pregnancy, and been successfully delivered, while carrying an ovarian tumor. It is fortunate for some of them that the ovarian tumor is not discovered until after delivery. With the modern craze to do abdominal surgery, ovarian cysts have very short shrift. From my own observations I am satisfied that it is safer to leave such ovarian cysts untouched until after delivery has been accomplished, unless the life of the patient is seriously threatened by their presence. It is not often that the life of the patient is seriously threatened by the presence of such an ovarian cyst.

It is sometimes a matter of marvel to find an abdomen enormously distended and the patient but slightly inconvenienced. We have all seen ovarian cysts containing many gallons of fluid. Patients may live for

months in this distended condition. The breathing becomes embarrassed, the feet become swollen, but yet they are able to live.

It is, no doubt, very pleasant and very gratifying to find that the pregnant uterus behaves itself after an ovarian cyst has been removed from its side. But such pleasant surprises are frequently turned into mournful regrets when the woman, who was suffering but little, miscarries on the third or fourth day after operation and dies. The ovarian cyst is not like the fibroid tumor, prone to inflame after delivery. A pregnant uterus may be very much irritated by an abdominal operation, but an ovarian cyst is very little affected by a uterine delivery.

I always regret the termination of one case of ovarian cyst accompanying pregnancy. The patient was a strong, healthy woman. Three of us saw her in consultation. We diagnosed the condition present. She had a large ovarian cyst, and was in about the sixth month of pregnancy. Operation was decided on, and in the endeavor to remove the ovarian tumor the surgeon who was operating nicked the uterine wall with a scalpel. The uterus was considerably handled, in order to keep it out of the operator's way. I thought at the time that the uterus should be emptied, but this was not done. Subsequent to the operation the patient miscarried and died.

When life is seriously threatened nature will endeavor to empty the uterus, just as she does in the case of uræmic poisoning and of great emaciation induced by the persistent vomiting of advanced pregnancy. If nature, under such circumstances, fails to bring on labor, she can surely be assisted, and labor can be artificially induced without any very great amount of risk. The tumor can then be dealt with at a later date.

I have on four occasions operated on women a few weeks after confinement. In one case the operation was done for the relief of an enormous ventral hernia, and on two occasions for the removal of ovarian cysts. The infants were brought to the mothers three or four times a day to nurse, and they were fed at night-time. In one case the milk entirely disappeared after a few days. In the others the flow was diminished for a time, but again became abundant. The patients all made excellent recoveries. It is unnecessary to wean the children, and endanger their lives in the middle of a hot summer, before submitting the mothers to an abdominal or less serious operation.

The greedy surgeon can surely wait for his abdominal operation until after the obstetrician has delivered the woman. Some men, rather prominent in the profession, tell us in a general way that it is easy to open the abdomen, to remove the cysts, and allow the pregnancy to proceed to term. This may be all very well for the surgeon, but is it best for the patient? In the presence of an ovarian cyst with a twisted pedicle,

whether accompanied or not by pregnancy, all must admit that abdominal operation is generally demanded. But ovarian cysts do not become twisted more frequently in cases in which pregnancy exists than in cases in which the uterus is empty.

If puncture of an ovarian cyst is considered necessary it should be set aside for the induction of premature labor or ovariectomy, because puncture should never be performed unless the cyst is impacted in the pelvis and seriously obstructs the progress of labor. There are three methods of procedure when a cyst is impacted—first, abdominal section on the mother; secondly, mutilation of the child; and, thirdly, puncture of the cyst. Some cysts can, of course, be tapped from the vagina and the difficulty can be removed, but now and then a cyst will be met with in which there is either colloid material, or fibroid material, or dermoid material that will not readily disappear after puncture.

On one occasion I assisted to tap through the vagina such a colloid tumor of the ovary pressed down in the pelvis, and the patient made a complete recovery. The operation can easily be carried out, and then the opening can be made large enough to permit of the flow of thick material. Mutilation of the child should certainly not be undertaken. If abdominal section on the mother is performed, in such a case it will be necessary to remove the uterine contents before the tumor can be reached. The removal of the entire uterus can scarcely be justifiable in such a case; the other ovary, if healthy, may permit of future pregnancy. It must be remembered that occasionally a distended Fallopian tube may interfere with the progress of labor.

#### HYDRAMNIOS SIMULATING OVARIAN CYST WITH PREGNANCY.

There is a condition of the pregnant uterus that frequently simulates the presence of an ovarian cyst with a pregnant uterus, namely, hydramnios. It is an uncommon condition. Three cases have come under my observation. I do not here refer to cases in which the amniotic fluid is large in quantity, but to cases in which it is so great in amount as to give rise to definite symptoms. One case I saw was under the care of a surgeon of note. The case was diagnosed as one of ovarian cyst, and an abdominal operation was decided on. Just before undertaking the operation a further examination was instituted. A sound was passed into the uterus, the membranes were ruptured, and a free gush of amniotic fluid at once demonstrated the erroneousness of the diagnosis. Notwithstanding this fact a supravaginal hysterectomy was performed. I considered the operation an unnecessary mutilation, and, as a consequence, made a careful search through the literature of the subject to endeavor to find something to justify such a procedure, but without success.

In these cases the diagnosis is sometimes difficult. Ballottement is not easy to obtain. In some cases the abdominal walls are so tender that the patients can scarcely bear the weight of the bedclothes. In others, where the filling with fluid has been very acute, the temperature is elevated, and the disease has an inflammatory appearance; the pulse becomes accelerated.

Of McClintock's thirty-three cases four died after labor. Other authors, however, Caseaux, Leischman, and Charpentier, considered that the performance of puncture of the membranes through the vagina was followed by good results to the mother.

I bring this subject before you owing chiefly to a personal experience. I was asked to see a patient who was supposed to be suffering from an ovarian tumor accompanying pregnancy. Operation had been decided on. After carefully examining the patient, I was forced to differ from my confrères, for to me the case appeared to be one of hydramnios. There was something puzzling about it. The cyst was monolocular, and the uterus was apparently absent. A line of demarcation could be made out down the front of the tumor separating two pyriform masses with soft walls, but, notwithstanding this fact, the fluctuation wave could be felt distinctly from side to side and from below upwards. Bringing to mind the previous experience already related above, I strongly advised a preliminary puncture of the membranes from below. This was done, and an immense quantity of fluid escaped from the uterus. The patient was readily delivered next morning of twins, and made an uninterrupted recovery. There was no ovarian tumor present. The twins were, as is frequently the case, stillborn. The depression between the placenta and the foetus and the presence of a second foetus produced a peculiar condition of the uterus noted in front.

The main point in the differential diagnosis between ovarian cyst and pregnancy and hydramnios was the universality in the wave of fluctuation demonstrating the fact that the tumor was monolocular. In any such cases in which there is a reasonable doubt puncture of the membranes from below should be carried out before any attempt is made to remove the cyst by cœliotomy.

#### PELVIC CONTRACTIONS AND PREGNANCY.

The subject of craniotomy versus Cæsarean section has been discussed so much that there is nothing new to add. Neither operation is likely to meet with what should be its full measure of success, because the patient is only attended to when almost in a moribund condition from her prolonged sufferings. To perform craniotomy before this period has been reached is, from the very fact that the foetus will in all probability be alive as the patient is not exhausted, loathsome in the extreme. As Barnes



says: "In the whole range of the practice of medicine there arises no situation of equal solemnity." When the child is dead there can be no particular objection to the operation of craniotomy, and it is not likely to be of much use, because, whether craniotomy be performed or Cæsarean section be carried out, the mother is in many cases already beyond hope of recovery. To my mind, this should be one of the strongest arguments in favor of Cæsarean section, an operation that aims at saving the life of both mother and child.

I have several times been called in consultation to see cases in which the operation of craniotomy had either been instituted or carried out, and have been obliged to stand by and see the patients gradually sink from shock. When called in to see such women the pulse generally ranges between 130 and 140, and they are completely exhausted. They generally die within twenty-four or thirty-six hours after delivery. There is no reason why Cæsarean section should not be performed on a strong woman before exhaustion has set in from prolonged labor, with as much success as the abdominal surgeon performs hysterectomy or Porro's operation. The pregnant condition should not increase the rate of mortality.

In the minds of all thinking men a final decision has no doubt been arrived at, and nothing can be gained by any further discussion of the subject. But, notwithstanding all that can be urged, craniotomy will still be performed by a few. Craniotomy and Cæsarean section, if done early, are equally safe to the mother, but not equally safe to the child. If performed late they are equally dangerous to the mother, but not equally dangerous to the child. Therefore, whether performed early or late, the position as regards the mother is but little altered, while the child has everything to gain from Cæsarean section and everything to lose from craniotomy. The choice between the two procedures must depend to some extent on the religious and moral feelings of the parent and the humane scruples of the practitioner. To thrust a perforator into the brain of a living child must always be a revolting procedure. Above all, let me urge in cases of difficult labor or pelvic contractions early consultation with other practitioners, because the early moments are the golden moments, and the lives of two human beings hang in the balance.

#### PREGNANCY AND INTRA-ABDOMINAL DISEASE.

If an inguinal or femoral hernia becomes strangulated in a pregnant woman and cannot be reduced by taxis operation is imperatively demanded. In such a case the question of emptying the uterus cannot for a moment be entertained. The uterus is not handled, the abdomen is scarcely opened, the incision is not in the median line, and the patient is therefore not likely to miscarry. But there are other cases in which the ques-

tion of emptying the uterus at the time of performance of abdominal operation must be carefully considered.

Some months ago I was called to see a patient who, three years before, had been operated on for the removal of an ectopic gestation. I found her six or seven months pregnant. On the day previous she had been taken suddenly ill with an acute abdominal pain. The doctor in attendance thought that the acute pain must have some connection with the previous operation, and that the uterus had perhaps ruptured at the cornu where the tube had been removed. Vomiting set in and was persistent and stercoraceous. We advised immediate removal for operation. She refused, and thus a delay of two days occurred. The patient, then feeling much worse, consented to an abdominal operation. She was removed to the hospital, where the abdomen was opened, but by this time she was scarcely in a condition to withstand any serious shock. A coil of intestine was found strangulated beneath a band and released. The uterus was enlarged to about the sixth or seventh month of pregnancy. The released intestine was very dark in color, but still glossy. The patient improved until midnight, when she began to miscarry. The uterus was emptied, but she began to sink and died at 6 a.m. For a few hours after the relief of the strangulation her condition improved and vomiting ceased. I am satisfied that the extra physical strain and loss of blood incident to the emptying of the uterus militated greatly against her recovery.

In this case it is perhaps not likely that she would have recovered, even if the uterus had been emptied at the time of the operation. There had been too much delay. But still the question must present itself to us in certain cases that if called upon to operate for intestinal obstruction by bands, volvulus, intussusception, perforated appendix, ovarian cyst, with twisted pedicle, on a woman in a pregnant condition, whose uterus contains a fœtus at about the fifth to the eighth month, is it wiser to leave such a uterus to empty itself subsequent to operation, or to empty it at the time of operation by means of Cæsarean section? I believe that if the patient's condition warrants a somewhat more prolonged operation than that necessary to relieve the exact condition for which abdominal section has been performed, her best interests will be served by rapid, careful, and a thorough evacuation of the uterus by the abdominal route. She will then have nothing to contend with after the usual shock of operation and danger of peritonitis is passed.

#### RUPTURE AND PERFORATION OF THE PREGNANT UTERUS.

In connection with this subject I beg to call your attention to the close similarity of the symptoms accompanying three conditions that are commonly met with and that may require abdominal section. The first of

these is gonorrhœal endometritis and salpingitis ; the second is ruptured ectopic gestation ; and the third attempted abortion with perforation of, or intraperitoneal escape from, a pregnant or a non-pregnant uterus.

There is such an endeavor to conceal the truth in these cases in which abortion has been attempted that we are very liable to be led astray, and to diagnose either of the other conditions mentioned in this connection. We are thus liable to be induced to open the abdomen.

The diagnosis of gonorrhœal endometritis is surrounded with difficulties. The exact facts of the case are either unknown or untold. An eminent authority has said that he would not believe a woman on her oath when it suits her purpose to conceal the truth. Neither married nor unmarried women are to be relied on. After they have endeavored to procure an abortion on themselves, or after an attempt has been made to procure abortion on them by others, it is difficult to wring the truth from them. Even the husbands are not made aware of the true cause of the illness. We are frequently asked by such patients to conceal the facts from the husband. In the section from which I draw my patients this instrumental interference with pregnant uterus is becoming more prevalent. Catheters, crochet needles, pen handles, knitting needles, intrauterine injections, are among the various popular means of producing miscarriage. I am satisfied that a perforation of the uterus is frequently occasioned, and that occasionally fluids are forced through the Fallopian tubes into the peritoneal cavity. These perforations usually occur on the left side, because they use the instrument in the right hand. The thickening is usually found on the left side. The injection of fluid is most dangerous in a case in which pregnancy does not exist. The patients suspect they are pregnant because they have gone two or three days over the usual period.

I have carefully prepared a table setting forth the differential diagnosis between acute gonorrhœal endometritis and salpingitis, ectopic gestation and attempted abortion. From a careful scrutiny of this table it can be seen that it is an easy matter to be led into error. Such errors may either precipitate a fatal termination or lead to a fatal procrastination. I have often been puzzled in attempting to unravel cases of attempted abortion. Some of the modern women are wise enough to anticipate the questions of the physician, and to give evasive answers.

	ACUTE GONORRHEAL ENDOMETRITIS.	ECTOPIC GESTATION.	UNEMPLOYED ABORTION.
Previous health.	Good.	Perhaps history of previous attack of inflammation and sterility.	Good. Very likely had children fast if married.
History of discharge. Menses.	Matterly discharge, perhaps swelling of labia. Menstruation profuse, commencing perhaps at an irregular time, and lasting for ten days to three weeks. No period missed. Discharge not offensive.	No matterly discharge. A period missed, then irregular discharges of blood, more or less profuse. Discharge not offensive.	Leucorrhœa. No swelling of labia. A period missed, perhaps only one or two days. Then discharge of blood lasting indefinite time as instrument is often introduced at frequent intervals in desire to bring something away. Patient towards last becomes more desperate and uses more force. Discharge often offensive.
Pain.	Gradually growing worse.	Spasmodic. At times very acute. Spreads over a considerable portion of time. Sometimes only one sudden severe pain.	Sudden pain, perhaps followed by spasmodic pains, over a considerable period of time.
Collapse.	Not collapsed.	Often collapsed at time of rupture and at each successive hemorrhage.	A partial condition of collapse. If from escape of irritating fluid injected into uterus through Fallopian tubes, definite collapse found, but it does not recur.
Temperature. Pulse.	Elevated. Often simulates typhoid. Not rapid, unless general peritonitis present.	Not very high. Varies. Knees with each hæmorrhage into peritoneum. Goes up suddenly and comes down quickly.	Very high. Stimulates typhoid. Very rapid, hard, inflammatory. Remains up.
Rigor. Appearance—Face.	No rigors as a rule. Not much altered.	No rigors at this period. Pale. Pupils generally dilated.	Rigors present. Anxious. Often slight delirium. Flushed, as if in high fever.
" —Skin.	No perspiration at first. Dry skin.	Sallowish. Intermittent perspiration. At times bathed in perspiration.	Intermittent perspirations, coming chiefly after chill.
" —Abdomen.	Distended, if peritonitis general. Muscles tense, tender.	Slight puffing. Perhaps resistance from intraperitoneal clot. Shifting dullness, as clot shifts with patient's change of position. Not very tender.	Slight puffing at this stage. Vermicular action of intestines can frequently be seen. Distinctly localized tenderness simulating, if on the right side, appendicitis.
" —Breasts.	No enlargement. No change.	Perhaps enlarged and changed. Often had a period of sterility.	Perhaps enlarged and changed. Often still nursing last child.
Position.	On back. Feet drawn up. Does not care to move much.	Restless. Turns from side to side.	Assumes any position. Perhaps dragging pain if lies on one side.
Vomiting.	At first not persistent unless general peritonitis.	Not a marked symptom.	Irregular vomiting after taking food. Not persistent. Vomiting may have been present before as a consequence of pregnancy.
Onset of symptoms.	Definite history usually given. No apparent reserve, as patient frequently has no idea of cause of trouble.	Definite history given. No reserve. Onset usually definite. No particular anxiety at non-appearance of menses.	No definite history given. Evasive answers. Contradictory statements. Though history tallies closely with that of ectopic gestation it lacks definiteness. Occasionally, if carefully questioned, shows that she was anxious at non-appearance of menses.
Digital examination.	Mating of parts on each side of uterus. Uterus somewhat fixed.	Mass on one side of uterus and behind. Clot may occasionally be felt breaking down under finger. Boggy feeling. Uterus perhaps slightly enlarged.	Mass usually on left side of uterus. I think from use of right hand in passing instrument, thus perforating fundus at left side. No boggy feeling. No clot felt.
Bladder. Rectum.	Frequent history of irritability of bladder. Sometimes gonorrhœal proctitis and rectal tenesmus, with passage of blood-stained mucus.	Irritability of bladder, not a marked symptom. Often constipation and sometimes rectal tenesmus. No blood with any mucus passed.	Irritability of bladder not a marked symptom. Often septic diarrhœa.
Health of husband.	Often has had inflammation of kidneys or bladder (so-called).	More a desire to have bowels moved with ability to defæcate.	Good.

When unable to make the symptoms fit in accurately with those of ruptured extrauterine pregnancy or gonorrhœal endometritis, I usually conclude that, in spite of all denials, there is something that is being held back, and that, in all probability, some intrauterine interference has taken place. In such cases it is wise to stay the hand and refrain from advising an immediate cœliotomy. Within another twenty-four hours some little incident may crop up that will finally settle the diagnosis. At more than one consultation I have been able to obtain the information during the absence of the family physician from the room. They will sometimes tell the consultant what they are ashamed to tell the family physician. On one occasion I fortunately taxed the husband with having had an attack of gonorrhœa, and with having infected his wife, when, to save himself, he broke the seal of secrecy and admitted that his wife had on several occasions used an instrument to bring on miscarriage. The symptoms of this case pointed strongly to a diagnosis of ruptured extrauterine pregnancy, and I was about to advise an early abdominal section. The patient herself had denied everything.

In these cases death occurs in one or two ways—either from general peritonitis that is rapidly fatal, or from a condition of septicæmia, with high fever, rigors, and a rapid pulse. In the case of acute general peritonitis it seems impossible to accomplish anything by operation. I have operated on a few such cases, but have failed to save life. I have never yet removed the entire uterus and appendages for the relief of the second condition of septicæmia. As a rule, they will be too far advanced to benefit from any operative procedure. The physician in attendance is misled for several days, and valuable time is lost.

I desire now to draw your attention to what I consider is an unique procedure for the treatment of rupture of the pregnant uterus. A patient suffering from rupture of the uterus is usually collapsed, and can ill afford to stand the shock of a long-continued operation. There are two indications: First, to remove the blood from the interior of the abdominal cavity; and, secondly, to drain the uterine cavity and the site of the laceration.

I was called to see a patient with rupture of the uterus following miscarriage at the fourth month. In examination through the vagina the finger could be passed through the posterior uterine wall into the abdominal cavity, and the intestines could be felt. Twenty-four hours after the rupture took place I opened the abdomen, washed out blood from under the liver and spleen and from among the intestines, and then examined the uterus. A large rent was found extending from the left cornu down into the base of the broad ligament on the right side. The patient was in a shocked condition, and I considered it advisable to complete the operation as speedily as possible. The edges of the tear were too ragged and friable to permit of stitching. I decided that there would

be, in all probability, some sloughing of these edges. Having frequently performed hysterectomy and drained down through the vaginal vault after removal of the cervix with a rope of iodoform gauze, I concluded that this would be good treatment in the present instance, and, therefore, passed up a pair of forceps through the vagina, opened the blades, and caught a rope of iodoform gauze and drew it down through the laceration on the posterior surface of the uterus. After sufficient had been drawn down the upper end of the gauze was cut off level with the peritoneal surface of the uterus, thus leaving a plug of gauze filling up the uterine tear, the uterine cavity, and the vagina. A drainage tube was then placed in the cul-de-sac of Douglas from the front. In this manner the interior of the uterus and also the peritoneal cavity were drained. The bleeding from the tear in the uterine wall had ceased. Before the operation was performed the pulse was gradually rising until it had reached 120, and distension of the abdomen was setting in. At the time of operation the intestines were partially distended and the peritoneum looked reddened and angry and the omentum was thick and œdematous, conditions that indicated the first stage of peritonitis. The patient made an uninterrupted recovery.

On two occasions I have been called in to operate on women with rupture of the pregnant uterus at full term. In each instance the patient has been found in a dying condition. Since the experience related above I am satisfied that a case of rupture of the uterus can be rapidly dealt with in the manner I have indicated. Time will thus be saved and shock diminished. Careful stitching of the ragged edges will often be impossible, and, I believe, will always be an unnecessary procedure. Unless these patients are *inarticulo mortis*, in the light of my experience I believe operation should be performed. In skilled hands but a few minutes will be consumed in its performance.

Because a patient occasionally recovers after rupture of the uterus and extravasation of the placenta or the child into the folds of the broad ligament, or into the abdominal cavity, we have no right to argue against operation in these days of modern aseptic surgery, when the abdomen can be opened with so little risk. From my own experience I find that the peritoneum, in many cases, does not tolerate the presence of blood, even when it has escaped in only a comparatively small quantity. Some cases of ectopic gestation, in which the sac has ruptured and a small quantity of blood has been poured out into the abdominal cavity, are shocked out of all proportion to the amount of blood lost. I believe that this excessive shock will also be noted in many of the cases of ruptured uterus. There is a great similarity of symptoms in cases of intraperitoneal hæmorrhage.

At some future meeting I will endeavor to finish the subject, as my address has already passed the normal limits.

## HÆMORRHAGIC PANCREATITIS.\*

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I AM indebted to the kindness of my friend, Dr. H. T. Machell, of Toronto, for the privilege of reporting this interesting case. The history is from notes by the father, who is himself a physician.

Douglas G., aged nine months, had been a healthy babe, weighing 10½ lbs. at birth, and developed well until his illness. During the first three months he had a great deal of colic, the motions often containing curds. The bowels, although the motions were never constipated, always required some stimulus to excite them to act. A glycerine suppository was generally used. The motions were soft and yellow. In the ninth month they became more liquid, and contained a great many small yellow fatty-looking particles. The mother's milk was examined, and found to contain a great amount of fat. He had always been a placid child, but in the ninth month he became fretful, and his general condition failed slightly. The mother having become pregnant, it was decided to wean the child; and milk prepared with peptogenic milk-powder was given, but he refused everything but the breast. In those days he took not more than eight ounces of milk, and the attempt to feed him was abandoned, as vomiting had occurred. During the following night sudden profuse vomiting occurred, and all nourishment was stopped for some hours. He was purged with calomel, followed by castor oil. His motions were slightly green, and contained many solid particles. There was no elevation of temperature nor thirst.

Next day (November 14, 1895) he was better. He vomited occasionally, and had a severe attack of colic; calomel was repeated, and a small dose of paregoric given. He was not nursed. He slept fairly well. The temperature was slightly subnormal.

Next morning (November 15) he passed a large soft yellow motion, and appeared well. He sat up and played with toys. He did not want the breast until nearly noon, when he took it greedily, and again in three hours. Later he vomited again profusely, was prostrate, and inclined

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to lie quietly. In the evening he became fretful, and had a severe attack of colic lasting an hour, with tenderness over the epigastrium. Paregoric was given to relieve the pain, and calomel, followed by repeated doses of fluid magnesia to move the bowels, but without effect. He appeared to have no pain and showed signs of prostration.

The following morning (November 16) he was weak and listless. Attempts to give nourishment were followed by vomiting. He had an attack of pain, but not so severe as on the preceding day. Towards evening he grew rapidly worse. All efforts to move the bowels failed. When I saw him with Dr. Machell, the medical attendant, he was in great distress and very pallid. The temperature was slightly elevated; pulse weak and rapid. He was constantly moaning and tossing about, and from time to time straining considerably. The thirst was very great. In his napkin there was a small, green motion, chiefly mucus, with traces of faecal matter. This was the only motion that day, although he had had repeated doses of strong purgatives. The abdomen was slightly distended, and examination of it revealed nothing unusual, except in the region of the ascending colon, where there was an elongated mass about the size of the middle finger, and extending from the costal margin to a point nearly as low as the iliac crest. It was firm, moved with respiration, and was dull on percussion. The abdomen elsewhere was tympanitic. The resemblance of this sausage-like mass to that in intussusception, the failure to move the bowels even with strong purgatives, the straining and vomiting, seemed to render operation advisable, as the only hope of giving relief. In this opinion the father acquiesced, and Dr. George A. Peters operated. On opening the abdomen the mass was found to be an accessory lobe of the liver. The intestines were everywhere healthy, and there was no exudate in the peritoneal cavity. The incision did not admit of examination of the other abdominal organs. Death occurred next morning.

The probability of the illness being hæmorrhagic pancreatitis was suggested, and this was confirmed by the autopsy, in which only a partial examination of the abdomen was permitted. The middle third of the pancreas and its immediate surroundings were found deeply infiltrated with blood, but neither the head nor the tail were affected. There was no extensive clot. All other abdominal organs were healthy.

As the autopsy was not done until forty hours after death, the pancreas had become so much disorganized by post-mortem change that nothing could be determined from the histological examination, further than that the tissue was infiltrated with blood. There were cells among the stroma, but they were not recognizable. The pancreas undergoes such rapid changes after death that an early inspection is necessary to render the histological examination of value. The disintegration of the pancreas will, doubtless, be especially rapid in children.



A bacteriological examination was made by Mr. J. J. Mackenzie, B.A., bacteriologist to the Provincial Board of Health. The only organism present was a bacillus resembling the proteus group in growth and characters. Inoculation on rabbits and guinea pigs showed that it possessed a very low degree of virulence. The bacillus colli communis could not be found, though carefully sought for.

This case presents a fairly typical picture of acute pancreatitis—as typical as could well occur in an infant. The pancreatic disease probably began on the 15th, two days before death, the history preceding that day being that of gastro-intestinal indigestion only. On the 15th he had a severe attack of colic, followed by marked prostration; this recurred again next day, and in the evening became extreme. There was some vomiting, and for the last forty-eight hours the bowels could not be made to act, even with strong purgatives. There was extreme distress during the last night, with low fever, great thirst, weak pulse, and, finally, collapse.

The age is unusual for the disease to occur; there are no cases recorded of the disease in infants. Of all the cases reported the youngest is about 20 years, and the majority are about 45; some have been of advanced age. The majority of cases occur in males who have been more or less intemperate and have become very fat.

In most cases there is a history of gastro-intestinal derangement extending over varying periods, often for years, and, while the cause of the disease is still uncertain, the general opinion is that it has its starting point in inflammation of the stomach and duodenum, from which the infecting agents gain access to the pancreas by the duct or otherwise. Against this view, however, is the fact that in the majority of cases bacteriological examinations of the pancreas have been negative. In this case only a bacillus of very mild infective character was found.

Few organs in the body are less liable to disease than the pancreas. Owing to its position it is seldom injured, and constitutional infections and disturbances rarely derange its functions materially or injure its tissue. The organ itself is not sensitive, nor is the constitution acutely disturbed by derangements of its function. Recent observations have shown that many, if not all, gland structures furnish to the economy an "internal secretion," in addition to the more manifest functions which they may possess. In the case of the pancreas the arrest of the supply of pancreatic fluid, as well as of that of its "internal secretion," could produce only a gradual disturbance of health. It is probable, therefore, that to the implication of neighboring structures, especially the retro-peritoneal ganglia, and consequent dilatation of the abdominal vessels from vaso-motor paresis, is to be attributed the fulminant symptoms ending in collapse, and even sudden death in many of these cases. In the reports of these cases

we read such records as "found dead in bed," or "in a chair as if asleep."

In his Middleton-Goldsmith lecture on "Acute Pancreatitis," the most thorough exposition on the subject that has yet appeared, Fitz classifies the fifty-four classes which he collected into three classes: (1) hæmorrhagic, (2) suppurative, and (3) gangrenous pancreatitis. In the main, all the cases since reported may be placed under one of these heads. The case of the infant here detailed may, I think, fairly be designated hæmorrhagic pancreatitis, for, although, owing to unavoidable circumstances, the results of histological examinations do not clearly demonstrate the existence of inflammatory exudate, the symptoms were sufficient to justify such a conclusion.

In addition to the foregoing, Fitz also detailed a class of hæmorrhagic cases in which only extravasation of blood was found post-mortem, and in which there was a history of sudden death from shock, and no symptoms indicating an inflammatory process.

Various explanations have been offered to account for the hæmorrhage. The pancreas has been compared to the brain in the laxness of its tissue and the ease with which vessels will yield to pressure, but even in the brain rupture never takes place in a healthy vessel. Weakening of the vessel wall from some pathologic process must take place before it will dilate or rupture from internal pressure.

Klebs has suggested the possibility of degeneration of the wall of the vessel by the action of the pancreatic secretion. Fat necrosis has been assigned as a cause in those cases in which the necrosis occurs.

As in many cases of pancreatitis there is a great deposit of fat in the tissues, Sticker believes that repeated and increasingly extensive ruptures take place at the root of the mesentery similiar to those occurring in the abdominal wall of very fat people and in pregnancy; that these repeated lacerations interfere with the nutrition of the part, so that ultimately a more extensive rupture occurs, with free hæmorrhage.

The causes of hæmorrhage are probably various, and all these opinions may be true. Thorough examinations of the small vessels of the gland have not yet been made, and at least until that is done in a series of cases the question must remain in doubt.

Disseminated fat necrosis has been very frequently found in association with pancreatitis. It did not occur in this case. It has usually been found in cases in which there was an inordinately large deposit of fat, but it does not occur even in all such cases. Its causation, as well as its relationship to the hæmorrhage, is doubtful. But there is no doubt that either process may occur in absence of the other.

The diagnosis is of great importance, and presents grave, often insuperable, difficulties. As the disease has become better known in recent years, a correct diagnosis has occasionally been made. The clinical history is that of epigastric pain, gradually developed or sudden and severe, it may be agonizing; tenderness; generally some fullness in the upper zone of the abdomen; nausea and moderate vomiting; usually constipation that may resist the strongest purgatives, but there has been diarrhœa in a few cases; marked prostration occurs early; low fever; weak pulse, and, finally, collapse. Death has usually occurred within four or five days. If the patient survives a rapid recovery may result, or suppuration or gangrene may follow. The necrosed mass has been discharged *en masse* into the bowel with ultimate recovery. In a case under my care at present the formation of a large cyst followed the pancreatitis.

The affections with which this disease is most likely to be confounded are perforative peritonitis, especially of the stomach and abdomen, and acute intestinal obstruction. With these may sometimes be included irritant poisoning and hepatic and pancreatic calculi.

In the case here detailed acute obstruction would not have been considered possible but for the malformation of the liver. The vomiting was not extreme, nor did the vomit contain bile, much less become feculent. There was no marked swelling of the abdomen.

Perforation was not deemed possible, because there was no history of gastric or intestinal disease. There was no marked distension of the abdomen or evidence of the presence of gas in the peritoneal cavity; nor was there any initial shock followed by reaction with marked elevation of temperature.

The age excluded the possibility of hepatic or pancreatic colic.

It was not possible to make a positive diagnosis, but, with the exclusion by the operation of acute obstruction of the bowel, the extreme distress evidently due to a lesion somewhere in the abdomen, the moderate distension of the bowels, the failure of strong purgatives to move them, the slight elevation of temperature, and the great prostration, seemed a sufficient ground to justify a probable diagnosis of acute pancreatitis, notwithstanding the age of the patient.

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## Selected Articles.

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### OUTLOOK FOR THORACIC SURGERY BY A TRAP-DOOR OPENING INTO THE CHEST.

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By J. McFADDEN GASTON, M.D.,

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INVESTIGATIONS based upon clinical operations and experiments on inferior animals have led to important advances in thoracic surgery during the past decade. It is true that progressive surgery was inaugurated a quarter of a century ago, and bold measures have been adopted in the various processes for reaching the thoracic cavity, but the most effective surgical interferences in disorders of the thorax is of comparatively recent date. Aspiration for the removal of serous or purulent collections in the pleura was followed in a few years by simple drainage through an incision between the ribs and subsequently by drainage through a counter opening. Then came the removal of a portion of one rib to obviate the pressure upon the drainage tube, and for the escape of the purulent collection, while air must necessarily enter the chest.

The collapse of the lungs from the entrance of air in traumatism of the thorax is not followed by the same results as the presence of pus. A space unoccupied by the lungs remains, and an abscess of the pleura persists notwithstanding complete drainage. Under such circumstances excision of a portion of several ribs has been resorted to with a view to obliterate the cavity by approximation of the ribs. Another process has been used by cutting through the ribs anteriorly and posteriorly and removing an angular segment so as to allow the intervening portion of the rib to be pushed inward, and thus lessen materially the cavity within resulting from abscess. Other modifications for the removal of the soft structure of the thoracic wall as well as the ribs have been practised for the obliteration of the space left by a protracted empyema.

There is quite a divergence of views as to the indications for the different procedures, and it becomes a matter of moment to determine in

advance upon the exact pathological condition of the thoracic viscera and the mediastinum.

In order to open the posterior mediastinum a plan was recommended by Quenu and Hartman four years ago for making a vertical incision fifteen centimetres long over the angles of the ribs between the spinal border of the scapula and the vertebral column about four fingers' breadth from the spine, the middle of the incision corresponding to the spine of the scapula or to a point a little below it. On reaching the Trapezius it is possible, by retracting its interior border upwards and inwards, to avoid sacrificing more than a few of its fibres. The ribs are resected for about two centimetres. This small resection of the ribs suffices to permit the hand to penetrate the posterior mediastinum by stripping off the pleura. The opening made in the thoracic wall extends from the interior border of the second rib to the superior border of the sixth. By retraction of the rib it is possible to explore the hilum of the lungs, the aorta, and that portion of the œsophagus which extends along the root of the bronchus to the diaphragm. If the pleura, instead of being stripped off, is incised, the upper lobe of the lung, and even the summit of the thoracic cavity, are easily accessible, much more so, think the writers, than by resection of the ribs below the clavicle.

Looking to a practical outcome of this work, experiments have been undertaken by Wills and Willard on dogs and on guinea pigs to illustrate the tolerance of these animals for various operations upon the thorax. Barring the difference in susceptibility to traumatism between these animals and the human race, the results of these experiments tend to encourage a resort to similar measures in the operations upon mankind.

It should not deter the surgeon from using the knife in certain pathological conditions because of unfavorable showing by experimentation upon the normal structure of animals. It has been proved by clinical results that a tolerance or immunity is imparted to the structures of the body by previous and existing inflammatory processes, so that an operation would be borne well under such circumstances which would not be tolerated in a normal state of tissue. As we are called upon most frequently to operate upon the thoracic viscera after a lapse of some time when changes have ensued in the condition of the tissue, it may be inferred that such modifications have taken place as to lessen the disturbance or shock from an operation.

Observation of the result of diseases and injuries involving the mediastinum demonstrates that operative procedures may now be carried into various portions of the chest with a fair prospect of affording relief to some pathological conditions heretofore regarded as beyond the reach of surgery. Experimentation on animals, though insufficient as a test, has still

shown the feasibility of surgical interference in this comparatively unexplored region. If animals can survive traumatism of the mediastinum from the front and rear of the thorax, as verified by experiments of Lemoyne Wills, of Los Angeles, Cal. ; Dr. Forest Willard, of Philadelphia ; Levy, of Berlin ; and Zakharevitch, of Russia, it is evident that operations may be undertaken for the relief of mediastinal tumors, hydatids, and other morbid developments of this space walled in by folds of the pleura in the central portion of the thorax of man. We cannot as yet give a satisfactory solution of this question, but it is demonstrated by clinical observa-

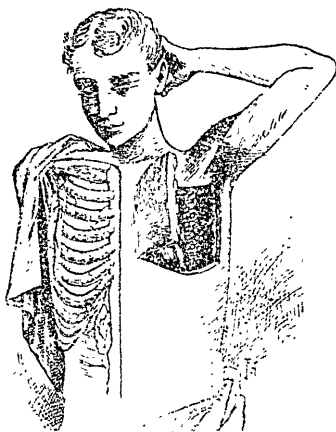


Illustration of right side, from Cloquet. That of left designed by author and executed by artist, Frank L. Henry.

The accompanying figure illustrates the distribution of the blood vessels on the anterior wall of the right side of the chest in a very satisfactory manner. The trunk of the internal mammary artery descending along the costal cartilages is seen to be out of danger even when the cuts are made transversely as indicated by the dotted lines. The long thoracic artery which appears on the posterior lateral aspect of the chest wall lies behind the longitudinal incision from the mid-axillary point, as indicated by the perpendicular dotted line. The only division of blood vessels likely to require ligation is the distal portion of the intercostal arteries when the ribs are severed, and being small at this portion of their distribution their ligation will not be attended with any difficulty.

The opening represented on the left side of the chest shows the lungs and the pericardium with the flap elevated by cutting through the ribs and turned partially back by bending the costal cartilages.

This trap-door admits of access to all parts of the corresponding cavity, and may be used on either side.

tion upon the human subject that these structures of the chest, like other parts of the physical organism, are more tolerant of surgical interference than when in their normal condition.

At a banquet of the Medical Association of Georgia on April 20th of 1893, in Americus, I am credited with the remark that "Ere long we shall be able to study the movements of the heart and lungs through trap-door openings through the walls of the chest."



So far as I was informed then no such operation had been undertaken, but the advantages of such a procedure are apparent to me, and in my review of the literature on thoracic surgery for Sajous' Annual in the following year, 1894, the following remark will be found : " My prediction in April, 1893, has been realized in the 'trap-door' of the chest made by Delorme, of Paris."

The flap is formed as follows : An incision representing the sides of a rectangle is made in the region between the third and sixth ribs. The base of the flap thus formed is directed posteriorly and above, and its upper and lower margin run parallel with the ribs, and extends from the axillary border of the scapula to within two fingers' breadth of the sternum. At the anterior margin of this flap the ribs and intercostal muscles are severed, while at the posterior margin only the ribs are divided to a limited extent. The flap is then loosened at its upper and lower margin and thrown back. This operation has been employed by Delorme in a tuberculous abscess of the chest wall which perforated into the thoracic cavity.

Operations have been performed by Lawson, of Hull, England, and Jennings, of London, cutting across the interspace between the first and second ribs nearly to the edge of the axillary fold. From each end of this incision a division of the soft parts and a second and third ribs is effected with knife and saw. This flap is then turned down so as to expose the upper portion of the lung and afterwards closed up. An operation has been devised by Postemski for opening up a trap-door on the same principle of utilizing the intercostal space for the hinge of the flap made in the side of the chest, and yet necessitates dividing the ribs anteriorly and posteriorly. Each of the different modes of access may be advantageous under certain conditions, and hence should not be condemned ; but after studying the principle involved another plan has seemed to the author as more satisfactory for exploring the thoracic cavity. I read a paper before the meeting of the American Surgical Association at Detroit upon " An Improved Method of Exploring the Thoracic Cavity," and gave also a demonstration of a process of dissection of cadaver on the occasion. The incisions are most conveniently made after raising the arm of the subject above the head on the side of the operation. Directly in the mid-axillary line a cut is carried perpendicularly from the third to the seventh rib—from the upper and lower extremities of this incision cuts are made transversely forward to the costal cartilages without going through the pleura. Any small vessels which may bleed should be seized with the forceps and then the bone forceps should be used for dividing the ribs, when scissors with a blunt point within may be used for dividing the pleura in each line of incision. At this stage the formation

of the flap consisting of skin, intercostal muscles, ribs and pleura may be lifted up and bent over upon the sternum by the yielding of the costal cartilages which serve as hinges to the trap-door.

If any vessels held by the forceps should bleed when released, they should be ligated with catgut or kangaroo tendon before closing the wound. If the nature of the case should not require so large an opening as to necessitate an incision in the axillary line extending from the third to the seventh rib, it should be made shorter ; and, on the other hand, if more space is demanded the cut should be made longer, reaching down to the eighth rib. When it is known in advance to what extent the structures are involved, the dissection should of course correspond to the area implicated, and in like manner, if there is evidence of traumatism which demands relief, the exposure of the region injured should be such as to facilitate the surgical procedure which may be indicated.

The principle of this method of entering the chest for exploration and for treatment of diseases and injuries of the thoracic viscera appeals to the surgeon as applicable to a great variety of cases, and has advantages over any other procedure which has been brought to the attention of the profession in this country or in other regions of the world.

While the operation has not been tested upon a living subject, the cadaveric demonstration made before the members of the American Surgical Association at Detroit elicited the most favorable expression from those who joined in the discussion, and some declared their purpose to put it into execution whenever opportunity afforded. If we analyze the elements which enter into this modification of the process for opening the chest, and compare it with others, it will appear that it is more simple in its execution and more effectual in securing the desired results of access to all parts of the thoracic cavity. When the part to be examined can be located from the symptoms, or from external procedures, of course the opening is to be made on that side. But in case of doubt the trap-door may be made on the left side, as giving a wider field of observation over the most important viscera of the chest, including the mediastinum.

The distribution of the blood vessels supplying the thorax is such that little hæmorrhage can result from the incision, and only the distal portion of the intercostal arteries will be encountered in a perpendicular axillary incision in which line the third, fourth, fifth, and six ribs are divided. The long thoracic artery lies behind this cut, and the internal mammary lies in front of the line of the chondral attachments of the ribs to which only the transverse cuts extend. With caution in carrying the knife along the upper margins of the third and seventh ribs there will be no risk of injuring the intercostal muscles, and the same will hold elsewhere.

—*Moody's Magazine of Medicine.*

## DIPHThERIA AND ANTITOXIN TREATMENT.

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THE following extracts bearing on the treatment of diphtheria by antitoxin, and sequences of the same, being of present importance, are published without comment :

### A POSSIBLE EXPLANATION OF SUDDEN DEATH AFTER THE ADMINISTRATION OF DIPHThERIA ANTITOXIN.

Dr. C. B. Fitzpatrick suggests that the cause of death of a male infant, aged twenty-one months, who died suddenly while in perfect health, in consequence of an injection of this substance, may have been due to the carbolic acid which is known to have been present. This is present to the amount of 5 per cent., and the dose administered contained between three-fourths and four-fifths of a grain. The patient in question received about five times the safe dose, and, inasmuch as the minimal fatal dose is unknown, perhaps a fatal dose.—*The Medical Record.*

### THE USE OF ANTITOXIN IN THE TREATMENT OF DIPHThERIA IN PRIVATE PRACTICE.

The report of the American Pædiatric Society based upon its collective investigation presents for analysis the results in 3,384 cases, which occurred in the practice of 613 physicians. In addition two series of cases, one treated in the tenements of New York, and the other a partial report from the inspectors of the Health Department of Chicago, are included. The report may be summarized as follows: More than six hundred of these physicians have pronounced themselves as strongly in favor of the serum treatment. The localities from which reports have been received are so widely separated that no peculiarity of local conditions can account for the favorable record. Doubtful cases, which have recovered, have been excluded, while doubtful cases, which were fatal, have been included. No new cases of sudden death immediately after injection have been returned. The number of cases injected reasonably early, in which the serum did not appear to influence favorably the progress of the disease, was but nineteen; nine of these were of doubtful diagnosis, four cases complicated measles, three were malignant, and in two cases the serum was of uncertain strength and of doubtful value. In three cases the patients

appeared to have been made worse; of these, in but one may the result be fairly attributed to the injection. The general mortality was 12.3 per cent.; excluding the cases moribund at the time of the injection or dying within twenty-four hours, it was 8.8 per cent. The most striking improvement was seen in the cases injected during the first three days; here the mortality was 7.3 per cent.—excluding cases as above, 4.8 per cent. The mortality of cases injected on or after the fourth day was 27 per cent. Of the laryngeal cases (membranous croup) one-half recovered without operation; in a large proportion of cases the symptoms of stenosis were severe. Of the cases upon which intubation was performed the mortality was 25.9 per cent., or less than one-half as great as has ever been reported under any other method of treatment. Broncho-pneumonia occurred in 5.9 per cent. In contrast to the two or three instances in which the serum is believed to have acted unfavorably upon the heart may be cited a large number in which there was distinct improvement in its action after the serum was injected. There is little, if any, evidence to show that nephritis was caused in any case by the injection of serum. The effect upon the nervous system is less marked than upon any other part of the body, paralytic *sequelæ* being recorded in 9.7 per cent. of the cases. The most concentrated strength of an absolutely reliable preparation should be administered as early as possible on a clinical diagnosis, not waiting for a bacteriological culture. However late the first observation is made, an injection should be given unless the progress of the case is favorable and satisfactory. The dosage for a child over two years old should be, in all laryngeal cases with stenosis and in all other severe cases, 1,500 to 2,000 units for the first injection, to be repeated in from eighteen to twenty-four hours if there is no improvement. A third dose after a similar interval may be necessary. For severe cases in children under two years and for mild cases over that age, the initial dose should be 1,000 units, to be repeated as above if necessary; a second dose is not usually required. The dosage should be always estimated in antitoxin units, and not in the amount of serum.—*Pædiatrics.*

#### SUDDEN DEATH AFTER A PREVENTIVE INJECTION OF BEHRING'S ANTITOXIN.

Dr. R. Paltauf, noting the previously reported cases of Maizard, Quinon, and Alfoldi, claims that these were not definite, in that thorough examinations were not made. It is admitted that local and general erythematæ, exanthematæ, even marked fever, may arise, and occasionally joint symptoms, but denies that a fatal case has resulted or that permanent injury has been done. The beneficial influence of the serum upon diphtheria is incontestable, and the assumption that death is due to its action only

prevents its use, through the anxiety of the laity, to which these reports give rise. Instances of sudden death in children are not uncommon, and may be attributed to causes not found save after especial examination. Among these may be cited acute interstitial myocarditis, the lymphatic-chlorotic constitution of rachitis.—*Wiener klinische Wochenschrift*.

#### DEATH FOLLOWING ANTIDIPHTHERITIC SERUM.

M. Variat reports a single observation. A child of eighteen months suffered from a slight pharyngeal diphtheria, followed by croup. After intubation five drachms of serum were administered. Death resulted in forty-eight hours; the temperature was 105° F. On necropsy nothing was found to indicate the cause of death. The pharynx and larynx were entirely free from membrane, and appeared healthy.—*La Semaine Médicale*.

#### THE CAUSE OF SUDDEN DEATH FROM ANTITOXIN INJECTIONS.

Drs. A. Seibert and F. Schwyzer, from laboratory experiments, conclude that: (1) Antitoxic serum does not seem capable of causing threatening symptoms and speedy death even when brought quickly into the blood current in very large doses. (2) That carbolic acid used as preservative must be in such a weak solution as to be unable to cause the characteristic carbolic convulsions. (3) Even very small quantities of air will cause severe disturbances and ultimate cessation of breathing, and to this cause the authors attribute the sudden deaths reported.—*Medical Record*.

#### DIPHTHERIA AND ANTITOXIN.

The Metropolitan Asylums Board of London has recently issued a statistical report on the use of antitoxin in diphtheria, as observed in six fever hospitals during 1895.

The statistics are based on a comparison with cases treated during 1894, when no antitoxin was used, this year being chosen on account of the fact that the mortality was exceptionally low at that time.

The tables show a general decrease in mortality of 7.1 per cent. in favor of 1895. The reduction is more striking if age and the day of the disease on which the antitoxin was administered are taken into account.

In the first quinquennium of life the results are most striking, and here the mortality is reduced 13.2 per cent. in 1895, lower than it was in 1894.

The necessity of administering the antitoxin early is forcibly shown by the statistics bearing on the relation between date of administration and mortality, as it is shown that those cases in which the antitoxin was

administered on the first and second days show a mortality of 4.6 per cent. and 14.8 per cent., respectively, in 1895, as against 22.5 per cent. and 14.8 per cent. in 1894.

The mortality in laryngeal cases is also shown to be greatly reduced, the percentage in 1895 being 49.3, as compared to 70.4 in 1894.

The complications of the disease were apparently not influenced by the antitoxin, as cases showing complications were rather more numerous in 1895 than in 1894. That this was not due to the antitoxin is shown by comparing an equal number of cases in 1894 and 1895 not treated by antitoxin, when it is seen that the 1895 cases show a higher percentage of complications.

The authors summarize the results of their inquiry in the following conclusions :

(1) There is a great reduction in the mortality of cases brought under the antitoxin treatment on the first and second days of the disease.

(2) That in this series of hospitals the combined general mortality is below that of any other year.

(3) That there is a particularly remarkable lowering of mortality in the laryngeal cases.

(4) That there is a uniform improvement in tracheotomy results.

(5) That there is a beneficial effect produced upon the clinical course of the disease.

They consider the value of the antitoxin to be demonstrated from the study of this large number (2,182) of cases ; and lay particular stress upon beginning the treatment as early as possible.—*Metropolitan Asylums Board. Report of the Medical Superintendents upon the Use of Antitoxic Serum in Diphtheria. American Journal of the Medical Sciences.*

#### EFFECT OF THE ANTITOXIN TREATMENT.

I have reserved to the end of my paper what is perhaps the most interesting question of all—namely, how far do the most recent statistics throw light on the effect of the antitoxin treatment. On this point I may say at once that the general conclusion reached in my former paper seems to me to be fully maintained, and that we may assert with confidence that the diphtheria mortality of the metropolis has received a considerable check which it is difficult to attribute to any other cause than the introduction of the serum treatment. Comparing together the average weekly number of deaths for the last five years, we find that after rising from 26.2 in 1891 to 36.2 in 1892 and 62.8 in 1893, it fell to 51.4 in 1894 and 44.5 in 1895. It is true that the opening months of 1895 promised a greater diminution than that exhibited by the figures for the whole year, and that the intensity of the rise last autumn seems to show that some other factor

than the antitoxin treatment must have been concerned in the diminished mortality at the end of 1894; but notwithstanding these facts, which are freely admitted, it would seem that the general run even of these figures suggests a conclusion favorable to the efficacy of the treatment. This conclusion becomes strengthened if, in the place of the actual number of deaths, we consider what is of course a truer test of the matter at issue—namely, the case mortality, or relation of deaths to notifications. Under this head the main facts are as follows: The number of cases notified during 1893 was 13,694; of deaths during the same year, 3,264; giving a case mortality of 23.8 per cent. In 1894 the corresponding figures were 11,190 and 2,674; the case mortality stood, therefore, at 23.9. In 1895, however, while the notifications rose to 11,229, the number of fatal cases fell to 2,289, and the case mortality was therefore only 20.4 per cent., the lowest rate for a whole year yet recorded. The numbers for the first half of the present year are respectively 6,193 cases notified, and 1,239 deaths, which work out to a case mortality of 20.2 per cent. In view of the fact that, quite irrespective of the number of cases, the case mortality of the last half of the year is invariably below that of the first, it may fairly be anticipated that by the end of 1896 the year's case mortality will for the first time on record have sunk below 20 per cent. This diminution in case mortality, which appears to be still in progress, represents the annual saving of some hundreds of lives, and I may be allowed, in conclusion, once more to repeat that it is difficult to see what cause can have been at work during the last two years in producing so marked a result, unless it be the treatment by antitoxin.—*F. A. Dixey, M.A., M.D., in British Medical Journal, August 22, 1896.*

# Progress of Medicine.

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## MEDICINE

IN CHARGE OF

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### BILOCULAR STOMACH.

M. Carel, Lyons, reports a double pouched stomach, caused by the cicatrix of a former ulcer. The cardiac pouch was large, the pyloric small. The patient died of digestive troubles and had interstitial nephritis.—*Lyons Médicale.* J.A.A.

### TREATMENT OF OBESITY.

A sarcastic physician gave the following advice to an obese patient on being consulted with reference to the treatment of his obesity: "Eat three francs' worth a day; but earn the francs and you shall get thin."—*Lyons Médicale.* J.A.A.

### ASEPTOL: A NEW ALBUMEN DETECTING REAGENT.

M. Barral has found that aseptol, a mixture of equal parts of sulphuric acid at 60°C. and pure phenol, will show the presence of albumen in urine containing as small a quantity as three or four milligrams to the litre. Its only drawback is that it precipitates mucus and peptones.—*Lyons Médicale.* J.A.A.

### DIABETIC BLOOD.

MM. Lépine and Lyonnet claim that the green color of the red corpuscles of diabetic patients obtained by Dr. Bremer, and published in *The New York Medical Journal*, with his eosin-methyl-blue stain is due to the diminished alkalinity or actual acid reaction of the blood in diabetes. They have found it in leukæmia. Dr. Bremer looks on the test



as pathognomonic of diabetes. He has found the blood of diabetic patients whose glycosuria had been suppressed by diet, and such drugs as antipyrine, etc., to still show it. Artificially sugared blood does not show it, neither does the blood of an animal in which diabetes is produced by phlorizine show it, but blood treated with true diabetic urine does.

It is something still unknown that Dr. Bremer claims produces the green coloration.—*Lyons Médicale*. J.A.A.

#### SIMPLE APPARATUS FOR THE QUANTITATIVE ANALYSIS OF UREA.

Dr. Linossier showed to the Medical Society of Lyons the following very simple apparatus that he has used for several years for the quantitative examination of urea in urine.

It consists of a 100 c.c. large-necked bottle marked on the side to indicate the 35 c.c. height.

A rubber cork is perforated to allow to pass through it a stoppered brass tube.

A piece of thick glass tubing, corked at one end, and large enough to contain 5 or 6 c.c. to drop into the bottle.

Besides this there is required :

A graduated pipette capable of holding 2.5 c.c. of urine.

A graduate with a capacity of from 35 to 50 c.c.

The method of operating is as follows :

Pour into the bottle 35 c.c. of a hypobromite of soda solution after the following formula :

Soapmaker's lye .....	100 c.c.
Water .....	200 c.c.
Bromine .....	5 c.c.

Into the corked tube let run 2.5 c.c. of urine. Drop the tube into the bottle in such a way as not to allow the urine to mix with the hypobromite of soda.

With the stopper in the brass tube open, the cork is securely introduced.

Close the tap and invert the bottle.

The reagent and the urine in contact with one another react and nitrogen is liberated; the reaction is aided by shaking the bottle gently.

As soon as the liberation of gas is complete (this requires but a few seconds), and without it being necessary to wait for the subsidence of the foam, the apparatus is inverted over the graduate and the tap opened. The nitrogen drives out part of the liquid (a quantity equal to its own bulk).

The liquid in the graduate is read off; each c.c. corresponds to one grain of urea to a litre of the urine examined.

The whole operation requires but a couple of minutes. The persistent foam which forms in albuminous urine does not interfere with the result. Care should be taken during the manipulation to hold the bottle by the neck, so as not to heat the contained gas with the hand.

For this apparatus to work properly it is necessary that the stoppered brass tube be made just as figured.

The tube itself ought to be large enough, so that when the bottle is inverted the air in the tube on the bottle side of the tap will be easily displaced by the liquid. The part external to the tap should be reduced to the minimum in length, so that none of the displaced liquid will remain in it.

Again, the opening in the tap should be small enough not to allow any air to gain entrance into the bottle when the pressure inside becomes neutral.

The calculation is after the data furnished by Yvon, and due allowance has been made for incomplete decomposition of the urea, and of the decomposition of other nitrogenous substances, for temperature and pressure, etc.

The results obtained are more than sufficiently accurate for ordinary chemical research.—*Lyons Médicale.*

J.A.A.

# OBSTETRICS

IN CHARGE OF

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## VERATRUM VIRIDE FOR PUERPERAL ECLAMPSIA.

Dr. Jones, of New York, speaks as follows with reference to the administration of veratrum viride in puerperal eclampsia (*N. Y. Med. Record*):

We come now to the consideration of the treatment of eclampsia by veratrum viride. In the July, 1859, number of the *Southern Medical and Surgical Journal*, Dr. Baker, of Eufaula, Ala., strongly advocated the use of this drug in puerperal convulsions, and reported one case of his own and several from the practice of colleagues in which it had been used with prompt success.

Norwood's tincture was used, first in doses of fifteen drops, followed by doses of ten drops every two hours as long as required, the aim being to reduce the pulse in frequency to fifty or sixty a minute, and to diminish arterial pressure. Dr. Baker especially noted the tolerance to large doses exhibited by patients suffering from eclampsia, and the consequent absence of dangerous symptoms, unless the *very* large doses originally recommended by Norwood had been used; still, he recommended that the initial dose of ten to fifteen drops should be followed by frequent doses of five drops, as being equally efficacious and less liable to produce disagreeable symptoms. He spoke of being frightened at first by the depression which sometimes followed very large doses, but declared that the patients always recovered.

Since Dr. Baker's paper many observers have lent the weight of their approval to this treatment. In the Transactions of the American Gynecological Society for 1887, Jewett says: "Experience seems to justify the statement that no convulsions will occur while the patient is sufficiently

under the influence of veratrum to hold the pulse below 60." Dr. T. G. Davis, of Bridgeton, N.J., has reported six cases successfully treated by the use hypodermically of six minims of Norwood's tincture and one-third grain of morphine combined, the rejection repeated as required, the aim being, of course, to reduce the pulse in frequency and tension. There seems little doubt that in this way all may be attained that is achieved by the blood-letting, without the disadvantages of the latter method. Dr. Reamy, of Cincinnati, reported to the American Gynæcological Society at Baltimore in May, 1895, six cases of puerperal eclampsia successfully treated by veratrum viride, with or without morphine. Dr. Reamy had given as much as twenty-five minims hypodermically, and believed that morphine controlled its unpleasant effects. Love, of Orange, N.J., has also strongly advocated the use of veratrum viride in large doses in this disease, and claims never to have been obliged to have recourse to radical measures for the induction or acceleration of labor in eclampsia, and to have carried his cases safely through. He has employed large doses, even a teaspoonful frequently repeated. These large doses, when given per os, generally produce vomiting, and probably are not entirely absorbed, while, when doses of more than fifteen minims have been used hypodermically, especially without the controlling influence of morphine, distressing symptoms have sometimes been met with. These symptoms have, however, seldom if ever led to disastrous results. It would seem, therefore, generally best to combine a moderate amount of morphine with the veratrum, and to use the latter drug hypodermically in small doses (of five minims), as being more certain in effect and permitting quicker repetition. When given in this way one need not hesitate to repeat the injection in half an hour, while if given by the mouth it would not be safe to repeat the dose until a much longer time had elapsed.

#### PUERPERAL PULMONARY THROMBOSIS.

Lackie (*Edinburgh Medical Journal*, 1896, No. 493) reports the case of a healthy, stout primipara, who had, during pregnancy, an anasarca of the lower limbs without albuminuria. Labor was not tedious, was spontaneous, and attended by a very little loss of blood. The patient did well, and was lifted to a couch on the eleventh day. On the twelfth day the patient walked a short distance in her room, struggled for breath, and died. Efforts were made promptly and vigorously to resuscitate her, but without avail. On post-mortem examination no abnormality was found, except pulmonary thrombosis and right heart distended with clot.

Reported cases of this complication show that it occurs most often before the fourteenth day after birth. It usually follows exertion, and is sometimes not fatal when thrombosis is but partial, in many cases accom-

panied by peripheral thrombosis also. Beyond immediate stimulation with ammonia and ether nothing can be done for serious pulmonary thrombosis. When a puerperal patient becomes easily faint and breathless she must be kept upon her back, all exertion absolutely avoided, and her nourishment carefully administered. Mental exertion and shock are also potent factors in causing this complication.

The editor adds to the above a brief report of the following case: A young primipara had been greatly depressed during her illegitimate pregnancy; her death had been foretold by a fortune-teller, whom she believed. She had a long, hard labor, the fœtus in breech presentation, and a marked tendency to uterine relaxation and hæmorrhage was successfully controlled. Sixteen hours after labor she was seized with dyspnœa, syncope, and fatal coma. Auscultation of heart-sounds showed overfilling of the right heart; post-mortem examination was not obtained. Treatment was absolutely unavailing. The patient's symptoms were all those of pulmonary thrombosis and heart-clot.—*American Journal of the Medical Sciences.*

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#### VERSION WITH THE PATIENT IN THE PRONE POSITION.

Mensinga (*Centralblatt für Gynakologie*, 1896, No. 23) does version, placing the patient upon her abdomen, and has had good results. He thinks this method has the following advantages: The outlet of the pelvis is directed above with the patient prone, giving the operator much more room for the insertion of the hand. The operator's hand and arm are in the position of pronation, giving a better use of the muscles and tactile sense. This posture widens and opens the uterus and vagina; the contraction-ring disappears in these cases. Risk of bruising the soft parts is less with the patient in this position. The patient has a pillow under the chest, her head turned to one side, while the operator may sit beside her, using either hand for version. By this posture two dangers are minimized: tearing the uterus from the vagina and air-embolism. Patients suffer less pain in this posture. Two illustrative cases are reported in detail.—*American Journal of the Medical Sciences.*

# SURGERY

IN CHARGE OF

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AND

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## EPITHELIAL SOWING. A NEW METHOD OF SKIN GRAFTING.

F. von Mangoldt, of Dresden (*La Sem. Méd.*), has conceived a method of skin-grafting to which he has given the name of "epithelial sowing," which, for easy execution and certain other advantages, merits careful consideration.

The epithelium is obtained by simply scraping a healthy cutaneous surface. For this purpose he prefers the external or internal surface of the arm. The chosen spot is carefully shaved and disinfected, and then, with a sharp sterilized razor, held perpendicularly to the skin, the epidermis is scraped away until the papillary layer is reached. In this way a magma is obtained, composed of epithelial cells and extravasated blood, which is spread upon the surface to be treated, and thoroughly pressed in with a spatula. This sowing is very simple in case of a fresh wound, provided the blood has ceased oozing; but in case of an old or infected wound, it is necessary to remove the granulations and thoroughly disinfect it.

In order to make sure that the epithelial elements adhere closely to the wound, it is advised to scarify it with a small and very sharp bistoury before spreading the scrapings upon it. The spot from which the epithelium has been borrowed is dusted with dermatol, covered with sterilized gauze, and bandaged.

The grafted area is covered with strips of protective, over which an aseptic dressing is placed. The region from which the epidermis has been removed resumes its normal appearance in a few days.

The transplanted area during the days immediately following the operation looks as if covered with a pseudo-membrane; it loses its primitive

brick-red color and becomes yellowish gray, a change due to coagulation of the fibrin. At the fifth or seventh day the fibrin begins to disappear, and the color changes to blush rose, the first sign of the proliferation of the epidermic elements. Toward the middle or the end of the third week the surface is completely covered with epithelium. After the fifth day the dressing is changed every two days and the wound gently irrigated with a sterile warm normal salt solution. After the tenth day boric acid is dusted on. The new epithelial layer is at first thin and glossy, later it thickens, and begins to desquamate. This desquamation, probably due to the absence of the glands normally present in the skin, should be combated with ointments of fat or oil. Not the least of the advantages of this method is the fact that no jackets of necrotic tissue are closed in by new skin, as sometimes happens in grafting by the Thiersch method.—*New York Polyclinic.*

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#### TURPENTINE IN SURGICAL TUBERCULOSIS.

I. Snardi, of Turin, employs turpentine in the form of an ointment (made with an equal quantity of vaseline) in the treatment of cutaneous tuberculosis, fistulæ abscesses, after having scraped the fistulæ and evacuated the abscess cavity by the aid of a trocar. The injection of turpentine brings about an inflammatory reaction, accompanied by a very marked rise of temperature, but without any grave effects being manifested. At the end of four or five days the abscess cavities are opened up and stuffed with gauze, sterilized and soaked in the turpentine and vaseline mixture. The author has used this in eighteen cases, nearly all children, and has obtained in every case a complete cure, which he has been able to verify some time after.—*Gazette des Hopitaux.*

W. McK.

# PÆDIATRICS AND ORTHOPÆDICS

IN CHARGE OF

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## CARBOLIC ACID POISONING IN THE NEWBORN.

The Vienna *Medical Press* reports a case of fatal poisoning in an infant the result of an application of a carbolic acid dressing after circumcision. A 3 per cent. solution had been applied on cotton at the time of operation. The same day the urine presented a dark appearance, and next day the dressing was removed by a nurse. Death followed forty-eight hours after the operation.

Another case occurred in a child of four months as a result of the use of dressings saturated with a 1 per cent. solution applied to the skin, although there was no wound or abrasion to increase absorption. The day following the application the little patient was pale, cold, covered with sweat, and the urine dark and scanty. The removal of the dressings was followed by the disappearance of all these alarming symptoms.

As a result of these two cases the *Press* concludes that carbolic acid should be used *never* with the newborn, even in very weak solutions.—  
*Gazette des Hopitaux.* W. McK.

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## INFLUENCE OF DENTITION IN CHILDREN.

The question of the rôle dentition plays in infantile pathology is still much discussed. Certain clinicians consider it as a cause of a great number of sicknesses in infants; others, on the contrary, believe it has no pathological effect. M. Arnstein discusses this question in a paper read before the society. With convulsions, for example, he admits that they may be produced reflexly under the influence of the new appearing teeth. Convulsions, however, from this cause are very rare. In eighty-two cases of



convulsions observed by the author during five years, in six only could he attribute it to teeth dentition. On the other hand, he has often observed in children at the time of the appearance of the teeth an increased excitability of the central nervous system, followed by general irritability, pain, crying, and restless sleep. Often with dentition is met affections of the lips and gums, and thrust so often as to appear in the relation of cause and effect. Dentition is not here the determining cause, but only predisposes to the development of these parasites. He concludes (1) that dentition is essentially physiological, and the great majority of cases is not accompanied by any pathological disturbance; (2) however, frequently severe pathological conditions, notably reflex nervous phenomena and affections of the mouth, must be attributed to difficult dentition; (3) diseases of the chest, abdomen, and brain probably never depend upon dentition.—*Gazette des Hopitaux*.

W. MCK.

# GYNÆCOLOGY

IN CHARGE OF

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## PREVENTION OF THIRST FOLLOWING CÆLIOTOMY.

Dr. Wm. H. Humiston, in *Columbus Medical Journal*, says that the method of preventing thirst following cœliotomy that he first published in July, 1895, in the *American Journal of Obstetrics*, has continued to give the same uniform results that the twelve cases which were then reported gave promise.

For the past two years the following has been my method, *adopted* because it was so efficient in overcoming the intense and distressing thirst which follows cœliotomy, and *continued* because the thirst *is allayed* and the quantity of urine almost quadruply increased, together with a remarkable increase in the total amount of urinary solids excreted.

The method: "The patient should have the usual preparation for cœliotomy; *i.e.*, diet, daily baths, cathartics, etc. For three days prior to operation order the patient to drink one pint of hot water an hour before each meal and on retiring, thus drinking two quarts of water each twenty-four hours, the last pint to be taken three hours before the time set for operating. Do not omit to give the water the day previous to the operation, while the patient is restricted to a limited amount of liquid nourishment, and the bowels are being unloaded. We thus restore to the system the large loss of fluid occasioned by the free catharsis, and we have the great satisfaction of seeing our patient pass through the trying ordeal of the first thirty-six hours after the operation in comparative comfort, with no thirst, a moist tongue, and an active renal function, represented by an excretion of from twenty-eight to fifty fluid ounces of urine during the first twenty-four hours, catheterization being seldom necessary."

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## INFLUENCE OF HOT AND TEPID BATHS UPON THE MENSES.

Matwieff publishes a series of observations which demonstrate that saline or mud baths, at 25°, 27°, or 28°C., have a favorable influence on

menstruation from the point of view of pain, the quantity of blood lost, and the duration of the flow. Mirouoff, who made a number of observations to verify this, is in a position to state that alkaline baths, at 27° or 28°, taken during the menstrual period by patients suffering from gynæcological troubles, act as an excellent sedative; the quantity of blood lost is not affected, or perhaps slightly diminished. After these results he wished to know the influence of hot baths in the same conditions, for these are what would be, more than anything else, recommended in gynæcological cases. In affections of the uterine appendages the menses are often increased in frequency, as also quantity of blood lost. Patients are afraid to use hot baths during this period for fear of increasing the flow, or, perhaps, bringing on severe hæmorrhage. His conclusions on this account are interesting. He finds, as a result of twenty observations, that hot baths, taken during menstruation, do not increase the quantity of blood lost; on the contrary, they often diminish it. At the same time, they soothe the pain accompanying inflammatory affections of the genitals. They are, therefore, of real benefit, not only between the periods, but during the flow.—*Gazette des Hôpitaux*.

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#### NEW METHOD OF EXAMINATION.

M. Sée, at the Academy of Medicine, announced a new method, which he had used especially for examination of tumor in the abdomen.

He terms it hydrostatic examination, that is, examination in water of the organs contained in the abdominal cavity.

When the abdominal wall is plunged into water a sudden relaxation takes place. This allows him to make out much more easily the subjacent parts, and has given to him very valuable results.—*Gazette des Hôpitaux*.

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#### AN EXTRA-UTERINE PREGNANCY OF TWELVE YEARS' STANDING.

During the proceedings of the Medical Society of Lyons, Dr. Denis showed an extrauterine fœtus that had been twelve years in the abdomen. It had neither calcified nor saponified.

During the pregnancy amenorrhœa had been complete, there had been no false labor at end of pregnancy, the child died at the tenth month, menstruation reappeared, and the patient's health became comparatively good again.

Functional trouble of the bladder and intestine decided the surgeon to operate. At the operation a cyst was found adhering to the neighboring organs. The wall of the cyst was one centimetre thick. The fœtus was extracted with difficulty, some of the bones being strongly adherent to the sac.—*Lyons Médicale*.

# HYGIENE AND PUBLIC HEALTH

IN CHARGE OF

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AND

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## FOODS AND THEIR ADULTERATION.

Dr. E. M. Bruce, in *The Clinique*, says: Some time ago I was in one of our large department stores, and while waiting for my parcel a lady came up and asked if the eggs they had were strictly fresh. He somewhat curtly replied: "Lady, they are strictly eggs, and that's all I know about them." The walls and counters of the store were emblazoned with banners bearing the legends of strict purity of the foodstuffs of all sorts; and I thought at the time that the eggs were probably the only things that were not adulterated. If they were not strictly fresh they were probably strictly pure.

The majority of our food products are more or less adulterated; we pay for butter and get some mixture of fats and oils that may taste very good, but is not butter. The "strictly pure Vermont maple sugar" is probably made down on South Water street from glucose and extracts of hickory bark. And the honey!—no flower was ever robbed of its sweets by vandal bee to furnish the honey we get, but we are robbed who pay for pure clover honey and get mostly glycerine, so the poet's metaphor is kept up. The pure fruit jams and jellies are, of course, mostly gelatine and glucose. The manufacturer points to the seeds in the jams as a passport of purity for the small seeding fruits, but a little reflection and investigation will show that hay and white clover will furnish any amount of seeds to take the place of the raspberries and strawberries that are present only in the pictures upon the outside of the packages.

Some years ago a manufacturer applied to me in my capacity as a chemist to furnish him with some thickener for water that would not ferment and not be at all harmful to the human economy. His idea was, I think, to add his thickener to water to give it the consistency of syrup, and sweeten the stuff with saccharine.

This was intended for a complete swindle. At that time I could not furnish him the required article. It could be and perhaps is done now.

Not all of the food adulterations or falsifications are begun with a desire to swindle. It was an honest, earnest effort on the part of Mège-Mouries, the French chemist, to give to the poor and to the sailor men an article of food which should be wholesome and palatable and keep better than ordinary butter; and while working at the Imperial farm at Vincennes he initiated the process which he supposed took place in the bovine economy when cows were underfed and the butter furnished was derived from their own fat. The very best quality of recently killed bullock's fat was finely cut up in a machine in order to break up the membranes. This was put in a steam-heated tank with water, a small amount of bicarbonate of potash, and two stomachs of sheep or pigs.

The temperature was raised to 45° C., and in a couple of hours, under the action of the pepsin in the stomachs, the membranes were dissolved and the fat rose to the top of the mixture. This fat was drawn off into another tank the temperature of which was slightly higher, and 2 per cent. of salt added. After a short time the fat became clear, took on a yellow color, and had somewhat the taste and odor of fresh butter. This fat was then drawn off and cooled. It was then cut in pieces, wrapped in linen, and placed in a hydraulic press at a temperature of 25°C. By the pressure the fat was separated into two portions, stearine and a fluid portion which has been termed oleomargarine. The stearine went to the candlemakers and the oleomargarine was used in the place of butter. With certain modifications, this is the process now in use for the manufacture of oleomargarine. If it is sold as "oleo" there is no objection whatever to it. It is a better article of food than much of the butter made, and it keeps very much better.

There has been and still is a large number of people who think that the "oleo" stock is made from any old scraps of fat or grease that may be found around. But this is not true; a first grade of oleo can only be made by using the very best fat. If it be at all fermented it cannot be used. The product is as wholesome and as good a food, so far as any experiments have shown, as butter, and the average oleo product reaches us in a better condition than the average make of butter.

#### ANTI-TUBERCLE ORDINANCES.

American cities, one after another, are taking measures to protect themselves from tubercle in milk by scientific dairy inspection, and by permitting milk to be sold only under certificates of health. Besides the city of New York, we note among recent accessions to the number the cities of Minneapolis, Allegheny, Pittsfield (Mass.), Lynn, Malone (N.Y.), San Francisco, and Alameda, Cal.—*Sanitary Era*.

## SOME EFFECTS ON THE GENITO-URINARY ORGANS BY BICYCLE RIDING.

The above is the title of a paper by C. E. Colwell in *The Clinique*. The writer found albumen in the urine in a number of cases following fast bicycle riding.

He also considers much injury has been done to the prostate from defective saddles.

He considers that those suffering from disease of the kidneys, pelvic inflammations, bladder or prostate diseases, should keep off the wheel.

## NEGLECT OF THE TEETH IN COUNTRY DISTRICTS.

It is not generally known to the public, but it is an indisputable fact, that in no part of the Dominion is there more neglect of the human teeth, and more ignorance of their functional importance, than in the country districts of the Province of Quebec, and no less among the English than the French population. Physicians in Ontario, as a rule, avoid interference in the diseases of the teeth, excepting where there is no dentist within their limits, but in Quebec we have known, upon several occasions, young successors to medical men receive as one of the legacies of practice of their predecessor large jars or bottles full of extracted teeth, 90 per cent. of which a dentist would have saved! We have had many opportunities to observe the serious extent of the various diseases of the teeth in the eastern townships especially, and to learn from intelligent country physicians who do not make a business of extracting these organs that the constitutional and especially the nervous affections due directly to diseased teeth are alarmingly on the increase. A large number of the affections of the eye and ears are traced to abnormal conditions in the mouth, and which get no radical cure excepting through proper dental treatment by experienced dentists. Digestion is impaired on account of the absence of the teeth. Beauty not only loses one of its chief charms, but strength loses one of its important aids. Sandow once said that he never knew a man of great strength who was a victim of dyspepsia, or who had bad teeth. There is no more common cause of headache, neuralgia, diarrhoea, and various other disorders than diseased conditions of the teeth, and it is astonishing to reflect that in the mouth, the portal of life and health, many people will tolerate filthy conditions which they would not endure in any other part of the body. A whole train of obscure nervous and sympathetic affections owe their exciting cause to diseased teeth. There may be no decay or pain frequently, but the ears, the eyes, the stomach, the head, etc., suffer. The teeth are not merely mechanical mills to grind food, requiring only mechanical treatment by mechanically educated men. They are as important and necessary to the mouth as the

fingers to the hand ; and even were it not so, the suffering following their neglect, and the decline of general health due to their loss or disease, should impel people to pay them more attention. It has been said that it is a wise dentist who knows his own teeth, and it is a fact that no one can faithfully examine his own or discover the beginnings of decay. The sufferings endured by hundreds of neglected children, due to the silly superstition that the loss of temporary teeth, which should last seven years, is no functional loss, is something appalling in Canada, especially in country districts. Our farmers' families, especially, are martyrs to the effects of bad teeth, and frequently bad dentistry. They wait "until the tooth aches," and foolishly expect then that the dentist can perform a miracle upon an organ which, by the death of the "nerve," has lost its chief nutrition, or they let the physician extract it. It is questionable if the care of the teeth of cattle would not become popular if it could be proved that it would add to their market value, and yet the care of the human teeth, which contribute so much to the health of the entire body, is overlooked ! No doubt some of the prejudice entertained by country residents against dentists is due to the quacking and imposture of uneducated practitioners, who go about seeking teeth to extract and patients to swindle. But there are plenty of honest and skilful dentists ; and it would be as unreasonable to condemn a whole profession for the iniquity of one, or even a whole practice because of an occasional failure, as to condemn the entire practice of medicine because there are quacks in it, or because death occurred where recovery was expected.—*Editorial in Dominion Dental Journal.*

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#### THE REGION OF THE GREAT LAKES.

For those patients living far inland, who need a moist, cool, and equable climate, and with whom the long and expensive journey to the seacoast is not to be considered, there is fortunately in this country a happy alternative. The vast bodies of fresh water constituting our "Great Lakes" supply those at hand with a seashore climate and seashore life, the importance of which can hardly be overestimated. Although differing in some particulars, it may be said that the climate of the Great Lakes in summer resembles closely that of a seashore. There is the same high proportion of moisture in the air, the same coolness, the same increase of ozone, and the same comparative freedom from dust particles and from bacteria. The chief difference lies in the somewhat lessened equability, since, although the Great Lakes are much less subject to sudden and extreme changes of temperature than are inland regions, they still possess hardly so equable and even a climate as does the seacoast. They supply, moreover, all the water sports and diversions that make seashore life in summer so attractive.

The thousands of miles of coast line of these lakes are thronged with summer resorts of all sorts, big and little, fashionable and primitive. We can only attempt in these pages to mention some of the better known ones, but one of the great advantages of this region is that it abounds in quiet, unpretentious, but comfortable resorts where, at very moderate expense, patients can obtain a summer outing and lay by a store of strength and vitality by living the unconventional, healthful, out-of-door life of the lakeshore.

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#### DOCTORS AS PUBLIC SERVANTS.

It has been decided by the Supreme Court of Illinois that the health authorities have no right to require physicians to report contagious diseases or births without remuneration. While the physician is morally bound to warn the community of danger when this can be done at a not unreasonable expenditure of time and labor, it is unjust to compel him to do so, and even to force him, under pain of imprisonment or a fine, to pay the postage on such notification. Of course, the State cannot afford to pay a large fee for such service, and neither would the physician demand it, but it would seem as though a compromise might be effected whereby the physician would receive twenty-five cents for each notification of a case of infectious disease or a birth. Such a plan is, or was, in existence in Connecticut, and we believe worked satisfactorily to both the State and its medical benefactors.—*New York Medical Record.*

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#### NEW YORK EPILEPTIC COLONY.

There are now sixty-six patients in the Craig Epileptic Colony, at Mt. Morris, N. Y. Governor Morton has signed the appropriation bill for this colony, which sets apart about \$75,000 for improvements of all kinds on the premises. The institution was opened on January 20th. It is thought that by May 1st the number of patients will reach one hundred.

The reception of private patients in this institution is entirely secondary, and only to be entertained after all the dependent epileptics of the State have been provided for.



## Editorials.

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### DR. SANGSTER'S LETTER.

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WE infer from the letter published in this issue that Dr. Sangster thinks our editorial in the August number was not logical. We desire to say that he is quite right in that respect, and we certainly hope no one thought we were trying to be logical. In the main we were simply putting Dr. Sangster against himself, and we can scarcely conceive of anything less logical than that. His foolish letter, and his subsequent quibbling, had placed him in such an absurdly awkward position that we could not resist the temptation of extracting a little humor from the situation. Dr. Sangster apparently took the matter very seriously, and has become somewhat coarse in his reply. When he goes into the "cuttlefish" business we must decline to follow him; we cannot come down to that level. As to the question of universities and schoolmen, we have but little now to say. If Dr. Sangster really thinks that he has not been offensive to both, he does not know what ordinary courtesy means.

In order that we may not be misunderstood, we desire to explain our position in this connection. Dr. Sangster has taken a prominent part in medical matters for some years. Many of his contentions were correct, and when we agreed with him we gladly supported him. He was a prominent member of a party which contained many influential and conscientious men. He and his party went to the Local Legislature with certain requests, and got practically all they asked for. Important changes were made in the Medical Act, whereby he and other men in his party became members of the council. His position was thus changed; he was no longer a free lance, but a member of the highest medical body in our province—the medical parliament of Ontario—with grave responsibilities. His duty was to be loyal to the council. He found himself in a minority, however, and grew restive. As a consequence, apparently, he wrote a letter a few weeks ago, in which he practically urged the profession to open rebellion against the body of which he was a trusted member. That letter, as we have before indicated, was utterly unjustifiable in every

respect. We have nothing to withdraw from our first comments ; but, at the same time, we have no desire to be drawn into a discussion of irrelevant issues—especially those which are personal in their nature.

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### THE PRESIDENT'S ADDRESS.

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THE address of the president of the Canadian Medical Association, Dr. Thorburn, which we publish in this issue, was exceedingly well received. He was one of the fathers of the association, having been present at its first meeting in Quebec, 1867 ; and his long experience as a prominent member of the medical profession of Canada, a teacher in one of our most prosperous medical colleges, a member of the Medical Council of Ontario, a railway surgeon, a hospital surgeon, a member of various medical societies in Canada and the United States, a medical director of an important life insurance company, enabled him to speak with considerable authority on many important subjects.

He made a new departure, as far as the association is concerned, in referring to the relationship of medical men to life insurance, and gave many interesting details in connection with the subject. It was a source of regret to some that he was unable to devote more time in elaborating some of the matters to which he made only brief mention.

One of the most important matters which he discussed is the question of inter-provincial registration, which has occupied the minds of prominent physicians in all parts of Canada for some time. Dr. Thorburn has definite views on the subject, which he expressed in clear and concise language. The committee which has had the subject under consideration for two years framed several clauses of their report on the lines laid down in his address. His opinions are very important in consequence of the position he holds in the Ontario Medical Council, which at present demands a course of five years. In assuming the attitude he does he shows a disposition to respect the views of all the other provinces, and such a conciliatory spirit is greatly needed in the settlement of the question of general registration for the Dominion.

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### PARTYISM IN THE MEDICAL COUNCIL.

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WE have before alluded to the fact that partyism is somewhat conspicuous in the Ontario Medical Council. We presume, from Dr. Sangster's letter in the August issue of the *Canadian Medical Review*, that there are, in his opinion, three parties, viz., the majority, the defence men, and the independents. If we accept this as correct—and it is certainly not far wrong—we may ask whether such a condition of affairs is

desirable. It will probably be generally conceded that partyism is not essentially bad ; but we think, at the same time, most will admit that the exhibition of personal animus between the members of the opposing parties does not add to the dignity or usefulness of any deliberative assembly. Who are responsible for the bear-garden exhibitions which have become too frequent lately in the Medical Council? Would it be wrong to suggest that the member who revels in letter-writing can claim a fair share of the responsibility?

Dr. Sangster, in his August letter, occupies five pages of the *Review* in demonstrating the singular fact that the majority rules in the council. Well, this has frequently happened before in public and semi-public bodies ; and we must confess that it will be difficult to devise any means which will prevent its frequent recurrence in the future. The doctor gives no evidence that he is able to furnish any solution of the difficulty. In fact—and we hope he will forgive us for saying so—his letter is rather weak, and not at all up to his average standard.

However, he has another grievance. The majority frequently holds a "caucus." We will suppose this is true, although we have no definite information on the subject apart from Dr. Sangster's statement. The question thus arises, Is it a crime for three, or thirteen, or more members of the council to meet at any time or place they choose for the purposes of deliberation or discussion? We will not now undertake to answer the question ; but, in any case, we can scarcely see how anyone is going to prevent such a meeting. Has the minority, or any portion of it, ever held a caucus? The doctor is not contented with a calm statement of the facts, and fair criticism of the same ; but goes on to add a few additional words, synonyms probably, such as "ring," "secret junto," "inner circle," "solid phalanx," "unholy league," "cabal," "conspiracy," "faction," "thing," "outrage on decency," "conclave." Does he thus carry out his threat of giving us something "decided," "startling," and "spicy," after the "renewal of hostilities"? If so, the flavor of the spice is rather insipid, and not seriously dangerous. It does not, however, tend to elevate the tone of his communication, but smacks rather of the old schoolboy trick of making faces and calling names.

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#### MEETING OF THE CANADIAN MEDICAL ASSOCIATION.

THE annual meeting of the Canadian Medical Association for the year 1896 was held in Montreal, August 26, 27, and 28. The hopes of those who expected to see one of the most successful meetings the society has known were fully realized. The president and his able staff of officers had worked with commendable zeal for many months, and

the arrangements made and the programme presented were highly creditable to them. The local committee are entitled to the highest praise for the efforts they made to assist the officers of the association in making the meeting a pronounced success. The profession of Montreal fully sustained their well-earned reputation for hospitality, and entertained the visiting members in truly royal fashion.

The various sessions were held in St. George's Church schoolroom, and the three large hospitals of the city—General, Hotel-Dieu, and Royal Victoria. The "clinics" in the hospitals were very interesting, and contributed materially to the success of the meeting. The papers read were above the average in point of merit, and the accompanying discussions were in many cases able and spirited. The president, Dr. Thorburn, of Toronto, won golden opinions for his admirable tact and dignified bearing in conducting the proceedings. It was feared that much valuable time would be lost in travelling between the regular place of meeting and the different hospitals, but the excellent arrangements made by the local committee with the street car company prevented any appreciable waste in this respect. It was the largest meeting the association has known, the numbers present being 168. The largest meeting previous to this was that held in Montreal five years ago, when there were present 135.

The banquet tendered by the profession of Montreal to the visitors was a most enjoyable one in all respects. The idea has gone abroad that the Montrealers know how to give a first-class dinner. They have thus acquired a reputation which handicaps them to some extent, because they cannot possibly improve on what they have done in the past. We have only to say they fully sustained their reputation in 1896, and we can give them no higher praise.

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#### THE "X" RAY.

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**M**ANY conflicting reports of changes in the skin, occasioned by the "X" ray, have appeared in medical journals. We have seen it clearly demonstrated that the ray has an effect upon the skin, but only after frequent and long exposure to its influence. The appearance of the skin strongly resembles severe sunburn, with the accompanying pain, swelling, blistering, and discoloration. The congestion in the hand is very marked, and the hand hanging in the usual dependent position occasions great pain. We have under observation at present a case in which the long exposure to the "X" ray has produced these symptoms, other exciting causes being positively excluded. The face showed the same series of changes as the hands. A full report of the case will be given later on.

A large number of unreliable houses are sending out literature descriptive of portable "X" ray apparatus, cheap, that will do wonders. We warn our readers against these concerns, and advise any physician who contemplates investigation with "X" rays to correspond with some house of undoubted reputation before investing. Reliable apparatus is procurable, and none but the best will give satisfactory results.

### DIPLOMAS FOR ALL.

IT is some years since the diploma mills of the United States made Canada a stamping ground. During the past two months the druggists of Toronto, and, quite possibly, those through the Dominion, have received a circular with copy of diploma enclosed, offering to grant them an M.D. degree, with power to practise medicine, surgery, etc., in five of the States of the Union—all for the sum of ten dollars: no examination necessary. The State Government of Wisconsin, in granting a charter to such a concern as the Wisconsin Eclectic Medical College, is, in reality, a party to a gross fraud. We are satisfied that, on perusal of the following circular, diploma, etc. (which we reprint in full), it will be evident to all that the State authorities have granted a charter to a concern that is abusing its privileges and degrading the laws of Wisconsin:

"Always give your FULL ADDRESS every time you write, no matter how often it may be."

FRED. RUTLAND, M.D., PRES'T.

CHARLES PODMORE, M.D., TREAS.

A. NEVE RUTLAND, M.D., SEC'Y.

Incorporated under the Laws of the State of Wisconsin.

## WISCONSIN - ECLECTIC - MEDICAL - COLLEGE, OF MILWAUKEE, WIS.

Correspondence Department: 1001 West Congress Street,

Chicago, Illinois, August 18th, 1896.

Mr. . . . ., Toronto.

DEAR SIR,—If you have any aspirations to a profession which runs side by side with pharmacy, and desire to have the append of M.D. to your name, then you are politely requested to read the contents of the enclosed prospectus. The plan as outlined therein gives to the pharmacist an open door to the practice of medicine as a physician. In these days, when the pharmacist is required by law to be as highly educated, as well read, as well versed in the various branches of medical science, and to pass as rigid an examination, and in some countries more rigid than is required of the physician, is there, we ask, any reason why the pharmacist should not avail himself of the opportunity (while he has it), and take yet another step on the ladder of life, and become M.D.? The average pharmacist's knowledge of materia medica, therapeutics, anatomy, physiology, science and practice of medicine, obstetrics and surgery, is usually just as good as the average physician, indeed, many much better, for there are

thousands of practising physicians who never had a single question asked them on the subject, while every pharmacist has been through the fires of inquisitorial examination. The Wisconsin Eclectic Medical College does not wish to make any false statements, nor does it want to deceive. The diploma, if you obtain one, will give you no legal rights in Canada, but it will be of enormous value to you from the prestige alone. The pharmacist who can display an M.D. diploma beside his Ph.G. certificate is the man who is going to do the trade. A reduced size (facsimile) copy of our diploma accompanies this, and gives some idea of what it is like. The regular fee is \$35, but as in Canada it will not be of value, therefore the College has decided to put down the fee to a very low sum—\$10. If you would like one—and please remember they are good, lawful, and valid in Wisconsin, Kansas, Idaho, Wyoming, Michigan, and Indiana—send your name in full (very clearly written), and also the name of your nearest express office, and the College will send you a diploma C.O.D., you to have the right of examination before making payment of the fees.

The diploma is gotten up in the highest style of art, is 18x23 inches in size, and its appearance will do credit to the office of any physician in the world. Please think this matter over, and let us hear from you at as early a date as possible, as this offer is good only for thirty days from date.

FRED RUTLAND, Ph.D., M.D.

#### COPY OF CHARTER.

United States of America, the State of Wisconsin, Department of State.

To all to whom these presents shall come :

I, Henry Casson, Secretary of State of the State of Wisconsin, do hereby certify that there has been this day filed in this department an instrument in writing, purporting to be Articles of Association with a view of forming a corporation to be known as Wisconsin Eclectic Medical College at Milwaukee, without capital stock, the business and purpose of which shall be to conduct a medical college, etc., and verified as a true copy by the affidavit of Fred Rutland, M.D., and Ann Neve Rutland, M.D., who appear in said instrument as two of the signers of said articles ; therefore, the State of Wisconsin does hereby grant unto the said Wisconsin Eclectic Medical College at Milwaukee the powers and privileges conferred by Chapter 86 of the Revised Statutes of the State of Wisconsin and all acts amendatory thereto, for the purposes above stated and in accordance with their said Articles of Association.

In witness whereof, I have hereunto set my hand and affixed my official seal, at the Capitol, in the City of Madison, the thirty-first day of December, in the year of our Lord one thousand eight hundred and ninety-five.

HENRY CASSON, Secretary of State.

Seal.

#### COPY OF DIPLOMA.

Collegium Medicum Eclecticum, Wisconsinense, Milwakiæ. Omnibus has Literas Perlecturis.

SALUTEM.—Quum in omnibus Academicis rite legitimeque constitutis, aut hic aut ubique, gentium, usus laudabilis et antiquus esset ut ii qui vel

litteris vel artibus ingenuis vel quibus libet studis liberalibus non minus diligenter quam feliciter, operam dederunt, se interea recte atque honeste gerentes, adornarentur aliquo eximio honore et ad meritam dignitatem attollerentur, et quum nos, per leges Civitatis Nostræ potestatem amplissimam insigniendi decorandique titulis Academicis eos bene merentes teneamus. Hac auctoritate præditi ususque antique haud immemores, judicavimus, atque, concilio convocato decrevimus. Richard Henry Armour egregium studis optimis deditum de cujus moribus probis atque profectu satis compertum, exploratumque habemus, dignum atque idoneumque honoretur altissimo dignitatis gradu; quare, uno animo creavimus et fecimus Medicinæ Doctorem eique omnia jura et privilegia ad illum gradum ubivis gentium pertinentia dedimus et concessimus.

In cujus rei testimonium nos hisce litteris Collegii Sigillo munitis nomina nostra subscripsimus.

Datum Ex Ædibus Collegii, hodie Secundo mensis Februarii Annoque Domini nostri Millesimo octingentesimo nonagesimo sexto, et Reipublicæ Americanæ centesimo vicesimo.

Ordo Medicum Collegii Medici Eclectici Wisconsinensis.

FRED RUTLAND, Ph.D., M.D., Decanus.

CHARLES PADMORE, M.D., Thesauri Custos.

ROSA DEMPSTER, M.D., Secretarius.

JULES GORDON, M.D., Prof. Anatomy.

WILLIAM NEWTON, M.D., Prof. Mat. Med. Phcy.

HORATIO MYERS, M.D., Vice Decanus.

Seal.

The prospectus points out that there is no need to attend the College, Degree granted without attendance. The letter states that the degree is of no value in Canada, but that it is equal to the best in the States mentioned. One would infer from the prospectus that attendance is required, but again it says that "it is possible for students to graduate without attendance," and "arrange for their examination before a notary public of their town, and if the examiners of this College can be satisfied they can be legally and lawfully graduated, receiving the diploma of the College conferring the degree of doctor of medicine without attendance at the College." We hope that no druggist will be duped by this circular. The medical authorities in Wisconsin should lose no time in having such an institution wiped out, and should endeavor to have more careful supervision given to medical legislation in the State.

## Correspondence.

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### DR. SANGSTER REPLIES.

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To the Editor of THE CANADIAN PRACTITIONER :

SIR,—I am compelled, very reluctantly, to ask for more space in your journal, as I cannot permit to pass without contradiction your averment that I have been, or that I intend to be, discourteous to "those who teach in our medical schools." I esteem these gentlemen very highly, and I have more than once publicly testified to their ability and high character. With the single exception of yourself, and of you only in this instance, I have never had occasion to complain of or to advert to any one of them individually. Would it be too much to ask the editor of THE PRACTITIONER to instance any specified acts of discourtesy to these gentlemen to which he thinks he has cause to object, instead of simply and profusely "swearing at large"? The acts which emanate from the school men in their corporate capacity are legitimately open to criticism, and to these I have, time and again, addressed myself specifically, and, I hope, in a reasonable manner. That you pretend not to know this is, probably, only another proof that there are none so obtuse as those who will not understand, and is quite in line with your attempt to ignore the fact that the whole of my last letter to your journal is a very specific, and reasonable, and moderate critique on the act of a school man who had grossly misrepresented my published utterances, and who now shows both an inability to justify his misstatements and a disinclination to withdraw them.

I regret that I cannot find any evidence in your last editorial effort that you have, as yet, profitably "pondered upon" what you are pleased to term my "interesting and instructive lecture upon your province as a medical journalist." In point of fact, this article is as full of misrepresentations as the one already complained of, and by stooping in it to the added use of *garbled* extracts and petty attempts at personal vilification you have taken a further long step downwards towards the plane formerly occupied by your exemplar and prototype—the *ci-devant Ontario Medical*



*Journal.* Let us hope that the mantle of its editor, which, it is only too evident, has fallen on your shoulders, may not prove to be, before you have done with it, a veritable shirt of Nessus. *Facilis descensus Averni.*

Permit me to remind you, sir, that the cuttlefish does not shine as a logician, and that even a copious discharge of printer's ink is not in itself either convincing or satisfactory. I am quite content to leave your editorial and my letter in your last issue to the judgment of your readers. You greatly underestimate their intelligence if you fancy that they will not very generally perceive the fact that when asked to defend or to retract certain inaccuracies and distortions in one of your editorials you try to evade or obscure the issue, and that, practically, your only response is a shrewishly spiteful attempt to scratch my face by saying that my letter, or one part of it, is "simply a wail of despair from an unfortunate and injured man, who has been compelled to pay a debt." I would, were it in my power, have that extract from your article printed in caps, or italics, as a notable example of what a respectable journal can sometimes condescend to. It is generally conceded that the *argumentum ad hominem* is the weakest weapon in the armory of dialectics, and when it is dipped in the venom of personal malevolence it commonly more deeply wounds the hand that uses it than the mark at which it is aimed. You have at times tried to pose as an independent journalist, and more than once in the past you have resented the assertion that, prior to the establishment of the *Canadian Medical Review*, the public press was the only unobstructed avenue of access to the profession open to a medical man in Ontario. Yet you must be well aware that just as soon as ordinary correspondents find that, if you do admit their letters to your columns, you hold yourself at liberty to traverse them unfairly, to garble their contents, and to condescend to the use, editorially, of means which are eschewed in all honorable controversy, you absolutely close THE PRACTITIONER to all communications that do not happen to march with your personal ideas and your private or corporate interests, and that, furthermore, by so doing you confess your journal to be what it really is—simply and solely the organ of a competing medical school.

I can afford to smile at your insinuation that my written utterances are both obscure and insincere. You cannot persuade a score of medical men in the province that I ever leave anyone of ordinary intelligence in doubt as to what I mean, or that I ever speak or write otherwise than *ex animo*. Oddly enough, the leading editorial in your last issue brings out the startling fact that possibly, in this case, by arguments more forcible than syllogisms, you have been driven to apologize to a business opponent, and humbly admit that you yourself do sometimes say what you do not.

mean and mean what you do not say. How true it is that "people who live in glass houses should not throw stones"!

JOHN H. SANGSTER.

Port Perry, Sept. 4th, 1896.

[The statements in the last portion of this letter are not correct, as Dr. Sangster may learn by a careful perusal of the two editorials to which he refers.—ED.]

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### INQUEST AND MEDICAL EVIDENCE.

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To the Editor of THE CANADIAN PRACTITIONER:

DEAR SIR,—Permit me through your columns to draw your attention, as well as that of the profession generally, to some of the facts in connection with the recent street railway accident which occurred at the junction of Queen street and Spadina avenue. As is usual in such cases, all the doctors in the neighborhood were summoned; and, in this case, three responded and remained with the unfortunate lady and attended to her until her death, which occurred about twenty minutes after the accident. The police took charge of the body and notified a coroner, who issued a warrant for an inquest. Instead of conducting the inquest himself he handed that part over to a second coroner, but coroner number one delegated himself to make the post-mortem examination, and gave the medical evidence at the inquest. The second coroner is said to have stated that he had nothing to do with appointing a physician to make the post-mortem, that the case was really not his at all, but that he was simply doing the work for his confrère. It would seem therefore that the coroner, who issued the warrant for the inquest, and who was in reality the actual conducting coroner, appointed himself to make the post-mortem and act as chief crown witness, while at the same time he is an official of the Street Railway Company. Now, sir, does this not smack of unfairness to the rest of the profession, and is it not also a case of most outrageous injustice to the public generally? It may be all very well to pass over the case of the friendless old lady lightly; but supposing the next time you are the victim and your friends bring suit against the Street Railway Company on behalf of your family, who have lost their only means of support, will it be comforting to know that the coroner, or chief medical witness, or both, are paid officials of the Street Railway Company? It is a well-observed rule that the physician who last saw a case in life or the attending physician conducts the post-mortem. Whether this custom is right or wrong I will not discuss, but in the absence of an official pathologist it seems only fair.

ONE OF THE PHYSICIANS.

Toronto, Sept. 10th, 1896.

# Meetings of Medical Societies.

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## CANADIAN MEDICAL ASSOCIATION.

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THE regular annual meeting of the above association was held in St. George's schoolhouse, Montreal, August 26th, 27th, and 28th.

Dr. James Thorburn, of Toronto, filled the chair in a most able manner.

Dr. T. G. Roddick, M.P., in a short speech, welcomed the visitors.

The committee on Inter-Provincial Registration, after a preliminary discussion of the question, selected a sub-committee, made up of representatives of all the councils of the Dominion except the Northwest Territories and British Columbia, to draft a scheme whereby this much-discussed matter might be settled.

Dr. C. F. Martin, of Montreal, read a paper entitled "Certain Observations on the Relation between Leucæmia and Pseudo-Leucæmia."

The association then adjourned to the General Hospital, where several clinics were given.

Dr. F. J. Shepherd presented a young woman upon whom he had operated for gastric ulcer, relating the history of the case and the technique of the operation.

The second patient was a man who had received a fracture of the skull, accompanied by depression of the fractured portion and immense hæmorrhage. Besides trephining a large area, he was obliged to ligature the common carotid artery, having discovered a rupture of the meningeal artery at the foramen spinosum.

A boy was then shown who had received an injury about the middle of the forehead from a bursting emery stone, the inner table being more damaged than the outer. The fractured portion was removed.

A thirteen-year-old girl was shown, in whom he had done excision of the ankle for tuberculous disease. The result was good.

The next patient had undergone operation for cancer of the bulbous portion of the urethra, everything being removed down to the prostate gland. Patient was doing well.

Clinics were also given by Dr. Blackader and Dr. Hutchinson.

Dr. F. J. Shepherd presented a young woman with a cervical rib, and also an interesting case of urticaria, the condition being easily induced by drawing the finger across the skin of the patient. The doctor also presented a case of psoriasis.

Dr. C. W. Wilson gave a clinic on flat-foot. He described the method of making Whiteman's plates, and explained the *rationale* of their action.

A child was then presented, a sufferer from tubercular disease of the cervical vertebræ. Before the present treatment of splint and jury mast she had suffered from meningitis and pachymeningitis.

A case of fracture of the neck of the femur was also given.

Dr. George C. Campbell presented a patient who was convalescing from scurvy.

Luncheon was provided for the members. A street car excursion about the city, lasting an hour, was then taken.

On reassembling, Dr. H. H. Meek, of London, read a report of

THREE CASES OF ABDOMINAL SECTION FOR CONDITIONS COMPARATIVELY RARE.

The first was for fibro-cystic tumor of the uterus, removed with appendages, after having been observed a year, the stump being fixed with a *serre-nœud* wire and pins. A good recovery. The second case was one of solid sarcomatous tumor of the ovary. A smooth recovery was checked, at the end of five days, for a few days by trouble from a stitch abscess. The third case was one of volvulus of the splenic flexure of the transverse colon, due, as was discovered, to a half twist of the bowel upon itself, apparently caused by old inflammatory adhesion bands in its mesentery. After a good recovery, unaccountably the patient succumbed from an attack of acute mania.

Dr. Proudfoot showed a baby two months old with an imperforate external meatus. He purposes relieving the condition.

Dr. R. Ferguson, of London, read a paper on

OPHTHALMIA NEONATORUM.

The paper referred first to the widespread prevalence of the disease. The main element in its causation was the gonococcus. The important point in the treatment was prophylactic; and this consisted in disinfection of the vagina, where a discharge was present. The second point was to follow the plan of Credé—to cleanse the infant's eyelids and then instil two or three drops of a one or two per cent. solution of silver nitrate. If the disease be established, thorough cleansing by frequent flushing with a mild antiseptic solution and the application of cold water in the early stages was recommended. After discussing the complications the reader discussed the question of preventive legislation, and moved, in closing, a

resolution that this association should call the attention of the various Provincial Boards of Health to this matter, and recommend that ophthalmia neonatorum be placed on the list of contagious diseases, and be subjected to the same restriction. This carried.

Dr. T. T. S. Harrison, of Selkirk, read a paper on some observations on the

#### HEREDITY OF CANCER.

In this paper the reader referred to many cases of cancer which had come under his notice during his long experience. Its occurrence in members of a family in one generation after another seemed to impress him that either cancer was hereditary, or, more possibly, the tendency to this form of disease was transmitted.

Prof. Wesley Mills complimented the reader on his paper, and pointed out the importance of the study of heredity, a most interesting subject. He advised that practitioners should take notes of cases where heredity was suspected.

Dr. Thorburn, President, then delivered his annual address.\*

#### THURSDAY MORNING.

The association met in McGill Medical Building.

Prof. G. P. Girdwood gave a demonstration of the "X" rays.

#### CLERGYMAN'S SORE THROAT,

was the subject of a paper by Dr. Price-Brown, of Toronto. This name was an improper one, because it gave no idea of any definite pathological condition. By old writers it was confined to a chronic follicular pharyngitis. The tendency now was to discard the term. Most chronic throat diseases to which clergymen were subject were dependent on nasal or naso-pharyngeal disease. When this was treated, generally the throat would get better. The doctor cited the history of a series of cases, which fully bore out his statement.

Dr. George Wilkins, of Montreal, read the address in medicine, his subject being

#### THE MODERN TREATMENT OF SOME DISEASES AS THE RESULT OF EXPERIMENTAL INVESTIGATION.

The essayist first dealt with the work of Jenner and Sir Joseph Lister in stimulating original research in the fields of medicine and surgery. Pasteur's work was also a wonderful example of development as a result of close observation. The relation between vaccination and modern serum therapy was then discussed. The principle depended upon the fact that the blood serum of animals, highly immunized by artificial means to any bacterial disease, possesses the property of protecting other animals against the same disease, and that this protection is afforded whether the serum is

\* See page 629.

administered before, simultaneously with, or after the injection, provided in the latter case that the disease has not advanced too far before the protective injection is made. The treatment of diphtheria, tuberculosis, typhoid fever, pneumonia, pyæmia, septicæmia, and tetanus was then discussed in the light of the most recent experiments. The influence of the discovery of the function of various blood-elaborating glands in the treatment of diseases by various extracts was then treated in an exhaustive way.

#### ETIOLOGY AND TREATMENT OF ACNE VULGARIS.

This was the title of a paper by A. K. Robinson, of New York. This paper dealt with the causes of the disease, maintaining that they were mainly local, and not due to constitutional disturbances of the stomach, uterus, etc. So, in treating the condition, the local treatment was of greatest importance. The keratosis and the comedones should be removed; the skin and follicles should be disinfected; the frequent accompanying seborrhœal condition should receive attention; the physiological function of the expulsion of the sebum should be assisted by adding tonicity to the glands. In addition, any disorders of the general system should be looked after and prophylactic measures should be attended to, especially during puberty.

A telegram was received from Dr. John Coventry, president of the Ontario Medical Association, expressing his inability to be present, and conveying a fraternal greeting to the Dominion association.

Prof. Wesley Mills presented a pigeon from which the whole brain had been removed; a rabbit, from which the motor centre for the limbs on both sides had been removed; a cat, from which the right motor area had been removed; a cat from which both sides, at different dates, had been removed; and a puppy, from which the right motor area had been removed. From these experiments he deduced the idea of the greater importance of the motor centres in the higher animals. He discussed the localization theory at some length.

Dr. Wm. Osler drew attention to the wonderful precision with which surgeons could now cut down upon brain lesions. He reported some cases.

Dr. W. B. Thistle then read a paper on

THE ANTISEPTIC AND ELIMINATIVE TREATMENT OF TYPHOID FEVER, in which he still upheld the theory he has advocated. He drew attention to the *rationale* of the treatment, basing it upon physiological and pathological grounds. The results in Toronto General Hospital, where the method had been but indifferently carried out, and in his own practice, proved it to be the most satisfactory form of treatment. He said that many men had misconceptions of what he had meant to convey by the

term eliminative, and one author had stated that the treatment was not based on correct views of the pathology of the disease. Dr. Thistle vindicated his position by referring to the most recent researches which have been made.

Dr. Wm. Osler claimed that the theory was a very good one, but the practice was fraught with danger. His preference was for the cold bath treatment, through the influence of which the toxins were eliminated by the skin and kidneys.

The association then adjourned to Hotel-Dieu, where Sir William Hingston is high priest. Sir William, in his gracious manner, welcomed the members, gave a résumé of the progress of surgery since he first began practice nearly forty years ago, impressing some very valuable hints for young practitioners, and presented some surgical cases. A substantial luncheon was then provided for the guests.

Dr. D. Campbell Meyers, of Toronto, presented a patient with hereditary cerebellar ataxia, and read the history of the case.

Dr. Stewart, of Halifax, read a paper reviewing the work of Lister, his old teacher, particularly his work in the experimental pathology of inflammation.

Dr. F. LeM. Grasset, Toronto, one of Lister's pupils, followed by a few appreciative remarks on his labors in the advancement of medical science, and commendatory of the spirit in which the great master worked.

Dr. D. Marcil, of St. Eustace, Que., read a paper on

#### THYROIDECTOMY.

A paper on

#### ORAL SURGERY

was presented by G. Lenox Curtis, of New York, which advocated the teaching of this branch of study in medical colleges.

Dr. F. Buller, of Montreal, reported some cases of foreign bodies in the eye, in which the electro-magnet was used successfully. This was discussed by Drs. R. A. Reeve, of Toronto; G. L. Curtis, of New York; and R. Philp, of Hamilton.

In the evening a splendid banquet was held at the Windsor Hotel.

#### FRIDAY MORNING.

Dr. J. F. W. Ross, of Toronto, gave the address on "Midwifery."\*

Dr. J. C. Webster, of Edinburgh, read a paper on

#### THE PLACE OF PESSARIES IN GYNÆCOLOGICAL TREATMENT.

The paper drew attention to the fast disappearance of the use of these instruments as a better knowledge of accompanying pathological conditions

\* See page 636.

was being acquired, which conditions, when treated, did away with the necessity for supports. Those cases in which supports were of use were described.

Dr. Laphorn Smith, of Montreal, read a paper of one hundred and ten operations for retro-displacement of the uterus, of which forty-two were Alexander's operations of shortening the round ligaments, and sixty-eight ventrofixations or suspensio-uteri operations. The results of both operations had, on the whole, been very satisfactory.

Dr. Playter prepared a paper on "Cold Air in the Treatment of Consumption," which was read by title.

The report of the Committee on Inter-Provincial Registration was presented and adopted, as follows :

"Your committee beg leave to report that, having examined the present requirements of the licensing boards of the several provinces, with a view to obtaining by mutual concession a uniform standard of matriculation, education, and examination, would recommend the following :

"I. *Matriculation.*—The schedule of subjects shall comprise : (1) English language and writing from dictation ; (2) arithmetic, including vulgar and decimal fractions and the extraction of the square root ; (3) algebra, to the end of the simple equations ; (4) geometry, Euclid, books, 1, 2, and 3, with easy deductions ; (5) Latin, grammar, translation from specified authors, or of easy passages ; (6) elementary mechanics of solids and fluids, comprising the elements of statics, dynamics, hydrostatics, and elementary chemistry ; (7) history, England and Canada, with questions in modern geography ; (8) and any one of the three following subjects : French, Greek, and German—the requirements being the same as in Latin.

"Fifty per cent. of the marks in every subject shall be necessary for a pass, and 75 per cent. for honors.

"In lieu of the above will be accepted a degree in arts of any university in Her Majesty's dominions, or from any college or university that may hereafter be recognized, but no matriculation in arts in any university will be recognized.

"II. *Professional Education.*—The curriculum of professional studies shall begin after the passing of the matriculation examination, and shall comprise a graded course in the regular branches of four yearly sessions of not less than eight months of actual attendance on lectures in each year, the subjects to be anatomy, physiology, chemistry, materia medica, therapeutics, practical anatomy, histology, practical chemistry, pharmacy, surgery and clinical surgery, medicine and clinical medicine, including diseases of the eye, ear, throat, and nose, mental diseases, diseases of women and children, medical jurisprudence, toxicology, hygiene, pathology, including bacteriology.



"That at least twenty-four months out of the graded four years, of eight months each, be required for attending on hospital practice, to begin with the second year of study. That proof of attendance on not less than six cases of obstetrics be required.

"III. *Examination.*—(a) All candidates for registration, in the various provinces, in addition to having fulfilled the foregoing requirements, shall be required to undergo examination before examiners to be appointed in each of the provinces by their respective councils, or by means of assessors, as in the Province of Quebec, or by delegating their authority to one central body, as has been done in Manitoba. Each examination shall comprise all the subjects of professional study, shall be both written and oral, and 50 per cent. of the marks shall be required in every subject for a pass. (b) The committee make these resolutions merely as suggestions for the consideration of the councils of the several provinces as a mutual basis of agreement, and that each be requested to report thereon to the next annual meeting of the association, and also to send one or more delegates to represent them at that meeting.

"In order that the councils may be enabled to consider the question with a full knowledge of the facts, it is decided that each registrar should send to every member of every council in Canada a copy of the statutes and of the regulations in connection with the council that he represents."

The following nominations were reported: President, Dr. V. H. Moore, of Brockville, Ont.; vice-presidents, Dr. James Conroy, Prince Edward Island; Dr. J. F. Black, Nova Scotia; Dr. T. Walker, New Brunswick; Dr. Beausoleil, Quebec; Dr. W. W. Dickson, Ontario; Dr. R. S. Thornton, Manitoba; Dr. E. H. C. Rouleau, Northwest Territories; and Dr. Hannington, British Columbia. Local secretaries, Dr. H. D. Johnston, Prince Edward Island; Dr. A. J. Maden, Nova Scotia; Dr. G. A. Addy, New Brunswick; Dr. J. G. McCarthy, Quebec; Dr. W. G. Anglin, Ontario; Dr. W. H. Smith, Manitoba; Dr. George Macdonald, Northwest Territories; and Dr. A. W. Reed, British Columbia; Drs. F. N. G. Starr, of Toronto, and H. B. Small, of Ottawa, to be re-elected general secretary and general treasurer respectively.

At 12.30 the members repaired to the Royal Victoria Hospital, where clinical demonstrations were held. The visitors were afterwards entertained to luncheon.

#### FRIDAY AFTERNOON.

The first paper presented was by Dr. J. E. Graham, of Toronto, entitled, "The Influence of Mitral Lesions on the Existence of Pulmonary Tuberculosis." \*

\*Will appear in THE PRACTITIONER.

Dr. W. Tobin, Halifax, read a paper on "Militia Medical Reorganization."

Dr. Thos. Roddick commended the scheme. In his experience, at the time of the Riel rebellion, militia medical affairs were in a very poor state; some arrangement was badly needed.

Short papers were also read by Dr. J. B. McConnell, Montreal, on "Tetany following Scarlatina"; Dr. F. J. Shepherd on "Excision of the Scapula"; Dr. H. L. Reddy on "Streptococcic Infection—Injection of Anti-Streptococcic Serum—Recovery"; Dr. Martigny on "Electric Baths in Dyspepsia"; Dr. H. D. Hamilton, of Montreal, on "Non-Malignant Tumors of the Tonsil," with report of a case.

Montreal was chosen as the place of the next meeting.

## Book Reviews.

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**PRACTICAL POINTS IN NURSING.** For nurses in private practice. By Emily A. M. Stoney, graduate of the Training School for Nurses, Lawrence, Massachusetts; Superintendent of Training School for Nurses, Carney Hospital, South Boston, Massachusetts. Philadelphia: W. B. Saunders, 925 Walnut street.

The skilled nurse is an important creation of modern times. Her usefulness and efficiency depend, to a large extent, on the character of the training she receives in hospitals where systematic courses of instruction are given. Text-books are, of course, valuable as aids to those who wish to excel. In this book the author has attempted to explain in popular language and in the shortest possible form the entire range of private nursing as distinguished from hospital nursing, and to instruct the nurse "how best to meet the various emergencies when distant from medical or surgical aid, or when thrown on her own resources, studiously refraining, however, from advising the nurse to act upon her own responsibility or to assume personal treatment of the patient, except under circumstances of great urgency." We have only to say that she has succeeded well and supplied a book which will be found very useful to both nurses and general practitioners.

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**ANATOMY, DESCRIPTIVE AND SURGICAL.** By Henry Gray, F.R.S., Lecturer on Anatomy at St. George's Hospital, London. New and thoroughly revised American edition, much enlarged in text, and in engravings, both colored and black. In one imperial octavo volume of 1239 pages, with 772 large and elaborate engravings on wood. Price of edition with illustrations in colors: Cloth, \$7; leather, \$8. Price of edition with illustrations in black: Cloth, \$6; leather, \$7. Lea Brothers & Co., Publishers, New York and Philadelphia.

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**DEFORMITIES: A TREATISE ON ORTHOPÆDIC SURGERY,** intended for Practitioners and Advanced Students. By A. H. Tubby, M.S. Lond., F.R.C.S., Assistant Surgeon to and in charge of the Orthopædic Department in Westminster Hospital; Surgeon to the National Orthopædic Hospital; Surgeon to Out-Patients, Evelina Hospital for Sick Children; Joint Honorary Secretary British Orthopædic Society; Late Senior Demonstrator of Physiology, Guy's Hospital. Illustrated with fifteen plates and 302 figures, of which 200 are original, and by notes of 100 cases. Cloth 8vo. Price, \$5.50. The MacMillan Co., 66 Fifth Avenue, New York.

## Medical Items.

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DR. W. L. COULTHARD (Tor., '94) has gone to Rossland, B.C.

DR. GEORGE A. PETERS, of Toronto, returned from England on September 7.

DR. CAMERON, of Toronto, expected to leave England for Canada on September 15.

DRS. NEVITT and Wishart, of Toronto, returned from England about the middle of August.

DR. FRED WINNETT, of Toronto, has removed from Wilton avenue to 525 Sherbourne street.

IT IS stated that 20,000 persons die each year in India alone from the direct effects of venomous snake bites.

DR. W. H. B. AIKINS, of Toronto, started on a trip to Winnipeg and British Columbia early in September.

DR. J. FRANK MCCONNELL (Tor., '95), of Toronto, is acting as *locum tenens* for Dr. Darby, who is off on a holiday.

DR. THOMAS MCCRAE (Tor., '95), one of the General Hospital residents, is now at Johns Hopkins Hospital, Baltimore.

DR. E. M. HEWISH (Tor., '83), of Philadelphia, after spending a couple of weeks in Toronto, left for home on September 2.

DR. JOHN SHEAHAN (Tor., '95), one of last year's residents in the Toronto General Hospital, has settled in St. Catharines.

DR. W. J. CHAPMAN (Tor., '95), one of last year's resident physicians in the Toronto General Hospital, is practising in Thedford, Ont.

DR. J. T. DUNCAN expected to sail from England on September 9 and resume practice in Toronto in the latter part of the same month.

DR. ALLEN BAINES, of Toronto, after a vacation of six weeks, returned to his home on September 4. He spent about four weeks in England.

DR. ARTHUR A. SMALL (Tor., '95), one of last year's resident staff in the Toronto General Hospital, has gone to England to take a post-graduate course.

DR. JOHN H. PACKARD, of Philadelphia, has resigned from the surgical staff of the Pennsylvania Hospital, and is succeeded by Dr. Wm. Barton Hopkins.

THE third annual meeting of the American Academy of Railway Surgeons will be held in Chicago, Ill., at the Auditorium on Wednesday, Thursday, and Friday, September 23, 24, and 25, 1896.

DR. SHEARD, the Medical Health Officer of Toronto, says that in a number of instances patients suffering from typhoid fever in this city contracted the disease in other localities during their holidays.

DR. A. MCDIARMID, formerly Professor of Obstetrics and Gynecology in Manitoba Medical College, has removed to Chicago, and is now Professor of Obstetrics in the Post-Graduate Medical School and Hospital in that city.

PROF. WILLIAM MCEWAN, the distinguished surgeon from Glasgow, passed through Canada on his way to California in the latter part of August. We understand that he is now giving a short course of lectures in Stanford University, San Francisco.

DR. JAMES F. W. ROSS, of Toronto, left home in the latter part of August for the Pacific coast. After a short stay in Victoria and Vancouver, he expected to return to northern Manitoba in time for the fall shooting, after which he will come east and reach his home about September 26.

DR. TEMPLE had a vacation of about ten weeks, the first holiday of any length that he has had since he commenced practice in Toronto. He spent the greater part of the time in England and Scotland, but was on the continent about two weeks. He returned to Toronto on September 7.

IT is reported by the daily press that a prominent merchant of Boston has donated \$100,000 to endow a chair of comparative pathology in the medical school of Harvard University. The value of the gift is augmented by the fact that this will be the first establishment of a professorship of comparative pathology in any of the great universities of America.

RESOLUTIONS ON LOVE.—Whereas Dr. I. N. Love has found it incumbent on him to sever his connection with the Marion-Sims College of Medicine, the members of the faculty of that institution embrace this occasion to express their appreciation of his past services, and to extend to him their hope that in all his future connections he will find both pleasure and profit.—*Ex.*

SELF-RESPECT MORE VALUABLE THAN POSITION.—Dr. James G. Kiernan, of Chicago, informs us that after an editorial service of nearly ten years upon the *Medical Standard* he has now severed his connection with that journal, because of insistence “by the publishers upon intruding nostrum advertisements, and the conversion of the journal into a ‘write-up’ organ for nostrums and allied performances.”—*Ex.*

EDWIN LORD WEEKS, in “From the Black Sea Through Persia and India,” states: “Wherever a medical officer reported on the condition of his men just returned from active service in Burmah or elsewhere, it appeared that the best soldiers, morally and physically, those who were always exempt from such maladies as dysentery, fever, cholera, and rheumatism, were the opium eaters; they were able to go longer without food or stimulants and to do more work.”

A POCKET FULL OF SPOONS.—A physician recently appeared at a meeting of his medical association in this condition. He stated that he had accumulated them at the houses of his patients and measured their capacity, which he found different in every case, ranging from two-thirds to three times the standard capacity. One teaspoon held exactly five times as much as another. He had brought them to serve as a warning to his colleagues in ordering their medicines.—*Journal of the American Medical Association.*

BILL NYE ON APPENDICITIS.—In one of the late Bill Nye's recent effusions he makes the following reference in regard to appendicitis. In speaking of this disease, he says: "A case of appendicitis required an operation some weeks ago, and the surgeon had never tried it before. When he had removed the inflamed appendix, on account of some typographical errors that he found in it, he began to put back the other organs, but after three or four days, and an apparent healing of the wound 'by first intention,' he found an odd-looking organ behind the lounge that had evidently been left out. The other doctors have worried him a good deal about it, and at the funeral of the patient tried to get the clergyman to make an allusion to it in the sermon. A doctor can't be too careful in that way. I once knew a young surgeon to operate for appendicitis on a large, roomy man, and had it not been for a timely autopsy he would not have known to this day that a good twenty-cent cigar dropped out of the physician's pocket during the operation and was sewed up in the patient's annex. Had it not been for the post-mortem the cigar would have been a dead loss."—*Journ. Mat. Med.*

ANECDOTE OF DR. LEIDY.—Dr. William Hunt, the famous surgeon, tells the following anecdote concerning the venerable doctor: The only instance I ever knew of Dr. Leidy's departure from strict truth was, to a medical man's way of looking at it, a very amusing one. Some years ago he came to my house in quite an enthusiastic mood, and said: "Dr. Hunt, do you know that they are moving the bodies from a very old burying-ground down town to make way for improvements?" "Yes," I said. "Well," he went on, "two bodies turned into adipocere are there (this is an ammoniacal soap and the bodies are commonly called petrified bodies). They have been buried for nearly a hundred years; nobody claims them, and they would be rare and instructive additions to our collections." "All right; I shall be delighted." So Leidy went down to secure the prize. When he spoke to the superintendent, that gentleman put on airs, talked of violating graves, etc., so the discomfited doctor was about to withdraw. Just then the superintendent touched him significantly on the elbow and said: "I tell you what I do, I give bodies up to the order of relatives." The doctor took the hint, went home, hired a furniture wagon, and armed the driver with an order reading: "Please deliver to bearer the bodies of my grandfather and grandmother." This brought the coveted prizes, and the virtuous caretaker was not forgotten.

AMERICAN PUBLIC HEALTH ASSOCIATION, 1896.—The American Public Health Association will convene at the city of Buffalo, N. Y., Tuesday, Sep-

tember 15, at 10 o'clock a.m., and continue for four days. The sessions of the association will be held at the Ellicott Square. In the building are the hall for the place of meeting, rooms for committees, restaurant, telegraph facilities, club room—in short, every comfort and convenience that would contribute to the success of the meeting. The Executive Committee have selected the following topics for consideration: (1) "The Pollution of Water Supplies"; (2) "The Disposal of Garbage and Refuse"; (3) "Animal Diseases and Animal Food"; (4) "The Nomenclature of Diseases and Forms of Statistics"; (5) "Protective Inoculations in Infectious Diseases"; (6) "National Health Legislation"; (7) "The Cause and Prevention of Diphtheria"; (8) "Causes and Prevention of Infant Mortality"; (9) "Car Sanitation"; (10) "The Prevention of the Spread of Yellow Fever"; (11) "Steamship and Steamboat Sanitation"; (12) "The Transportation and Disposal of the Dead"; (13) "The Use of Alcoholic Drinks from a Sanitary Standpoint"; (14) "The Centennial of Vaccination"; (15) "The Relation of Forestry to Public Health"; (16) "Transportation of Diseased Tissues by Mail"; (17) "River Conservancy Boards of Supervision." Upon all the above subjects special committees have been appointed. Papers will be received upon other sanitary and hygienic subjects also. The local committee have also made ample provision for the entertainment of members and ladies attending.

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THE BLACKSMITH AND THE PHYSICIAN.—A certain man was hanged, and he died, and he left two sons—honest men. Now, one of these sons was a blacksmith, but the other became a physician. And after their father had been taken from them these brothers made their homes in other lands. And the blacksmith would have prospered, but it befell that someone asked him how his father died. And the blacksmith, looking angrily upon him, answered: "He was hung." For the blacksmith was an honest man. Howbeit presently, when a horse was missing, men gathered and seized and hanged the blacksmith, saying: "This man must take after his father." So the blacksmith did take after his father. And, at the same time, in his own city, one inquired of the physician by what means his father died. And the physician covered his face and wept. But while he wept he considered, saying within himself: "If I say he was hanged then shall I shock this man, and give him pain. Nevertheless I must tell the truth." He said, therefore: "My father died of heart failure." And again he wept, the questioner weeping with him. Then, this being told, men said: "Doubtless, since his father died of heart failure this good physician and loving son has made a study of kindred diseases." So they resorted unto him. And the physician became a specialist, and he looked at them who came in, and coughed once and sneezed twice, and demanded \$100. And they gave gladly. For the physician was an honest man.—*Indian Medical Record.*

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A CASE OF SOMNAMBULISM.—On awaking one morning recently, a Dutch farmer, of Heerenneen (Drenthe), perceived with astonishment that his wife was no longer in bed beside him. In one corner of the room lay her shoes, and in another her clothing, but of the good dame herself not a trace could he find

anywhere about the premises. Greatly alarmed, he called in the aid of the police, and all day long there was a most energetic search for the missing housewife, but without avail. At length, towards evening, a peasant came forward and said that shortly after daybreak he had seen a woman in her night clothes wandering about near the village of Bonenknype. At the time he was inclined to think it was an apparition, for in the uncertain light the figure had a most unearthly look, but perhaps, after all, he was mistaken. Upon hearing this tale, the farmer at once started off in the direction indicated, and finally succeeded in finding his wife at the house of her sister, which is distant three leagues from Heerenneen. The wanderer had arrived there at about seven o'clock in a dazed condition and half dead with cold. She had no recollection of leaving her home and could give no account of the journey she had undertaken in such extremely light marching order. Before reaching her sister's place she had to cross a score or more of narrow bridges, some of them mere planks, and was likewise obliged to jump several formidable ditches. The fact that under these circumstances she escaped an accident is looked upon by the simple peasantry as well-nigh miraculous, but seems to bear out the general supposition that people in a state of somnambulism are able to perform gymnastic feats which they could not attempt in their waking moments.—*Indian Medical Record.*

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SUICIDE AND ACCIDENT INSURANCE POLICIES.—A short time ago the question of liability for payment of £1,000 in a case of drowning came before the Scottish Court of Session. The case entirely depended on probabilities. A seafaring man, who had for some time been employed on shore, threw up his place, alleging that his health was not in a good state. He consulted a doctor about himself, and was told that he was run down and required a holiday. He went up to a place in the Highlands, and the same afternoon walked twelve miles to a loch, where, after taking a very light meal, he rowed about in a boat from 6 p.m. to 8.30 p.m., when he was last seen. This was in the month of April. Next morning the boat was found, with his clothes left in it, but his body was never discovered. The chief question, of course, was: Had he committed suicide, or had he been drowned while bathing? A great point on the side of the defenders was made of the finding of the clothes, while three medical witnesses for the company gave it as their opinion that, although they knew of no exactly similar case, a suicide might very reasonably be suspected of removing them, as their acts before the actual deed were often very unreasonable. On the other hand, anyone who bathed after sunset from a boat on a rough night did not seem to be very rational. The court decided that probabilities were against suicide, and gave the relatives the benefit of the doubt. Shortly afterwards a striking confirmation of the truth of the evidence of the medical witnesses was supplied by the details of the suicide by drowning in a well-known case in England. As this is now common property, it may be mentioned that the lady who drowned herself took off almost all her clothes before entering a shallow pond. In this she showed a much clearer appreciation of the part played by clothing when a person is in the water than the medical witness called for the relatives in the first case. Clothing undoubtedly



impedes the power of swimming, but it hinders the sinking of the body very considerably, while it is of great service in preventing the danger of shock from cold. It was given in evidence in the case first mentioned that if a man wished to drown himself he would not take off his clothes. This proposition does not seem to be quite correct, for with clothes on one is more likely to float longer, and not to suffer so much from a "cold-stroke." The reason of this is plain. All clothes, especially if woollen, are when wet very impervious to air, and the imprisoned air under them can only escape gradually. The case is an interesting one both from a legal and from a medical standpoint, but as the verdict is possibly to be appealed against we cannot enter further into it at present.

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#### OBITUARY.

WILLIAM T. HARRIS, M.D., C.M.—We have to announce, with very deep regret, the death of Mr. W. T. Harris, which took place at his home in Brantford, on the evening of August 26th, at the age of 44. He had been slightly (as it was thought) indisposed for a few days, but went out driving on the day of his death. At ten o'clock of that evening, while resting on a couch, he had an apoplectic seizure, and died in a few minutes. He was well known as one of the ablest physicians in that portion of Ontario, and held many prominent positions in medical, political, and military organizations. He was a Conservative in politics, and was at one time president of the South Brant Conservative Association. He was one of the oldest officers in the Dufferin Rifles. He was for many years the representative of Trinity University in the Ontario Medical Council, and in 1895 was president of that body. He was highly esteemed by his large circle of warm friends.