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Original Communications.

SOME CASES OF INTESTINAL OBSTRUCTION AND STRANGULATED HERNIA AND THEIR TREATMENT.*

BY A. T. HOBBS, M.D.,
Asylum for Insane, London, Ont.

Since the summer of 1896 several cases of intestinal obstruction and strangulated hernia have come under my observation from among the insane patients, the employees or their families.

The seven cases that will be detailed represent four varieties of obstruction usually met with, and are as follows: a volvulus, an intussusception, fecal accumulation, and adhesive bands and three cases of strangulated hernia.

It may be said that a correct diagnosis, during the early stages of obstruction, was rendered difficult in those occurring among the insane, owing to their insensitive condition and delusional reasoning and that we had to depend almost entirely upon a physical examination.

CASE 1.—*Intussusception.*—At noon on September 29th, 1896, I was called to see the seven months' old son of one of our attendants. I found him well nourished and quite a sturdy little fellow. According to the mother's statement the child had had a fair-sized stool that morning, which, however, was succeeded by an attack of vomiting together with evidences of pain and restlessness and followed later on with mucus and bloody discharges from the rectum. Being in a hurry to get back to some operative work I had in hand I made a cursory examination noticing only a slight bloody mucus discharge

* Read before the London Medical Association, on Monday evening, April 9th, 1900.

from anus in the little patient, with straining and restlessness and a refusal to nurse, and an occasional outburst of crying. Temperature I found was normal and pulse somewhat rapid. I gave a mild sedative and ordered a small enema of water and left instructions for the father to report to me in three or four hours. He did so, stating child was no better. He was told to bring the baby to the operating room. When stripped and laid upon the table the little fellow vomited a quantity of thin fluid and at same time there issued from the anus bloody mucus. Rectal examination was negative, the abdomen seemed soft and not distended, and no evidences of tumor could be seen. Palpation of abdomen, however, disclosed a sausage-shaped tumor to the right of the umbilicus. A diagnosis of intussusception was made. Operation revealed the tumor to be 10 inches of the ilium, which, with its mesentery, had travelled through the ilio-cecal valve into the ascending and transverse colon. There was also partial inversion of the cecum The appendix was 3½ inches long. Slight adhesions had formed at the point where the ilium had passed through the ilio-cecal value. The vessels of the involved mesentery were swollen and of a dark color. Steady pressure on the apex of tumor with gentle traction on ilium aided by warm towels and pads reduced the intussusception. The abdominal wound was closed by through and through silk-worm gut sutures. Throughout the night the little patient was restless. The temperature rose to 103° and the pulse ranged as high as 180. Within twenty-four hours the temperature dropped to normal During convalescence, which was uninterrupted, the baby nursed at his mother's breast. The variety of intussusception in this case was that of ileo-colic, which, according to Treves, is somewhat rare, occurring only in 8 per cent. of all cases.

CASE 2.—*Femoral Hernia (Strangulation).* — A female patient, aged 54, resident of one of the asylum cottages, was reported sick on June 16th, 1897. It was found that she had had occasional attacks of vomiting during the previous three days and was thought, by the attendant in charge, to be an ordinary attack of biliousness. Examination, however, of patient showed a small hard lump on right thigh immediately below the middle of Poupart's ligament. Diagnosis of strangulated femoral hernia was made and operation was proceeded with. A knuckle of the small intestine made up the tumor. Constriction was caused by very slight band at neck of ring, and not by Gimbernat's ligament, and stretching of the neck was easily accomplished. The involved intestine was very dark in color and apparently the circulation was stagnant; also no peristaltic movement could be observed. It was thought

advisable to try and revivify the injured part before returning it into the abdomen. This was done by covering the coil of bowel with gauze and pouring in a steady stream of warm salt solution for fully half an hour. The color and appearance distinctly improved and it was then returned into the abdomen. The patient being somewhat feeble, the abdominal cavity was filled with salt solution through the crural opening, after which the edges were sutured, overlapping one another, by kangaroo tendon and the wound closed. Recovery was good and there has been no return of the hernia.

CASE 3.—*Inguinal Hernia (Strangulation).*—On the evening of January 11th, 1899, an outside employee of the asylum came to me complaining of severe pain and sickness of the stomach. I found him pale and skin cold and clammy; pulse fast and somewhat weak; abdominal pain was intense. He drew my attention to the fact that he had a hernia which he could not reduce. On examination I found a right inguinal hernia of a large size, tense and tender. He stated that he had suffered for several hours and tried several times to put it back but failed. I had him carried to the operating room, and failing reduction by manipulation, proceeded to operate. The contents of the incarcerated sac was a coil of small intestine, which at this time was distended and very red. Remembering my experience in the previous case, I kept up a steady stream of hot salt solution on the bowel for fifteen or twenty minutes after freeing the constriction at neck of sac. Returning the now revivified bowel, I closed the wound by the Bassini method. He is now well and minus a hernia.

CASE 4.—*Volvulus of Intestine.*—A chronic epileptic patient of miserable physique was brought to the operating room from the refractory wards on March 7th, 1899. The doctor in charge stated that on the previous day the patient had refused his meals and was pale and feverish. This morning he showed a rapidly increasing swelling of the abdomen and was exceedingly tympanitic. Ordinary measures failed to reduce it. Obstruction of the bowel from some cause was diagnosed. Great care had to be exercised in making the abdominal incision. When the peritoneal cavity was opened a huge coil of intestine rolled out. On examination it was found that the descending colon was twisted three times on itself in the form of a volvulus two or three inches below the splenic flexure. The colon above and below the constriction must have been four inches in diameter and very thin and of a bright red color. At the point of the twist the bowel was irretrievably injured. For an inch in length, four-fifths of its circumference, there remained only a sodden peritoneal wall. The extreme distention below injury was no doubt due to paresis caused by this injury. A

rectal tube was passed up into distended bowel and the flatus drawn off. The injured section was brought up to wound and supported there with gauze packing above and below. In twenty-four hours he became again very tympanitic. On removing the dressing from over the knuckle of bowel in wound it was seen that the injured section was black and gangrenous, awaiting only time to slough away. It was immediately punctured and the tympanitis soon disappeared. Feces began to pass by the fistula. In a few days all gauze packing was removed, the artificial anus being completely shut off from the peritoneal cavity. On flushing out the bowel through the fistula there came away with the feces, pieces of china, prune stones, buttons, sections of rubber sheeting, etc., that the patient had swallowed from time to time. We tried to rally the patient, who, after operation, was very weak, so as to get him in shape for a second operation for repair of the bowel. This could not be done as he gradually failed and died on 11th April, 1899, or thirty-five days after the initial operation.

CASE 5.—*Intestinal Adhesions Caused by Appendicitis.*—A female patient, aged 60, complained of some abdominal pain on February 1st, 1900. She could not locate pain, but on examination a tenderness was noted to the left of the umbilicus. She had a temperature of 100°, and a pulse rate of 90. General treatment being adopted, the severity of the symptoms apparently subsided. She had several free movements of the bowels during the next few days, and felt quite comfortable. On February 10th she again complained of pain in the abdomen, which, on pressure, revealed tenderness close to the left of the umbilicus; the abdominal walls were soft, and no dulness was exhibited anywhere on percussion. Temperature to-day was 98°, but pulse rate was 100 and somewhat weak in character. Purgatives given to-day had no effect. February 11th she became slightly distended and vomited a little. Still no movement of the bowels. She, however, passed a little gas. February 12th, vomited occasionally throughout the day whenever she took a little liquid diet. The abdomen was a little more distended, pulse weaker, and temperature subnormal. Enemas were given, together with eight drops of tr. belladonna every six hours, but with no effect. February 13th—In addition to occasional vomiting, hiccoughing had now set in. Distention of abdomen increased, while edema of walls was very marked, and patient was weakening fast. Operation was decided on as a last resort. On entering the peritoneal cavity, coils of distended intestine appeared in the wound. The color was of a bright red. On inserting the hand into the pelvic cavity a quantity of foul-smelling pus welled up. After sponging out pus, the contents of the abdominal cavity were

thoroughly exposed. Two or three coils of ilium were found adherent to the floor of the pelvic cavity, and the cecum with its appendix, suspended over its rim well into true pelvis. The appendix on being brought up was found to contain an ordinary black pin, the major part being within the lumen of the appendix, with head towards the blind end. About half an inch of the point had pierced the appendix and was outside it near the cecum. The appendix was removed and the adherent intestine separated from floor of pelvis. About two and a half feet of the ilium was bound down and contracted in a number of places to the size of one's finger. This section of the bowel when separated, was found to be badly injured, and would have to be removed *en masse*, as there was no possibility of its recovery. However, the patient died before the operation could be completed.

CASE 6.—*Fecal Accumulation.*—On Sunday, February 11th, 1900, my attention was drawn to a chronic insane female patient, aged 33, with a distended abdomen. Palpation revealed a hard mass in the peritoneal cavity the shape of an enlarged bowel. Percussion produced marked dulness Temperature and pulse normal. Absolutely no other symptoms present. The patient was known to be an enormous eater. Digital examination of rectum disclosed a hard fecal mass. With difficulty the mass was scooped out with finger and spoon. A quantity of oil was administered internally, and oil enemas were introduced, resulting in the removal of a very large fecal accumulation. She was kept in bed on a milk diet and ordinary treatment. A slight diarrhea kept up for several days. The patient failed steadily, and died on February 20th, 1900. *Post-mortem* showed the descending colon to be very much dilated and of a deep red color, with several small spots of ulceration on peritoneal coat over sigmoid flexure. There was evidently paresis of the descending colon and rectum, together with a condition of intense colitis. Treves ("Intestinal Obstruction," page 276) aptly describes these cases in these terms: "This weakness would appear in some cases to be congenital. It is more often acquired. It is illustrated by the constipation which may attend certain injuries and affections of the brain and spinal cord. It is concerned possibly to some extent with the constipation of the insane and neurotic."

CASE 7.—*Inguinal Hernia (Strangulation).*—On March 27th, 1900, a female patient at one of the cottages, aged 70, was reported sick. Examination showed a hard swelling in right inguinal region. She gave a history of hernia. She had been sick for twenty-four hours, but had not complained until that morning. She had had an occasional attack of vomiting. She was at once transferred to the infirmary, and operation was

proceeded with inside of two hours. The sac contents proved to be a section of omentum bound to canal at outer edge of internal ring and knuckle of small intestine. The appearance of bowel was dark and circulation turbid. Removal of the omentum bound in canal, and incising the ring above and below, released the hernia. Before returning the injured intestine, it was bathed some time with hot salt solution and a quantity of solution poured into abdomen through the internal ring. The wound was closed by the Bassini method. During the operation injections of strychnine and rectal salt enemas had to be introduced to prevent collapse. To day, April 9th, twelve days after operation, she is doing well, and has practically recovered.

Selected Article.

TREATMENT OF NON-MALIGNANT GASTRIC AND DUODENAL ULCERS.*

In so far as treatment is concerned, two things should be prominent in one's mind: first, to relieve immediate symptoms; second, to cure the ulcer. In hematemesis one cannot insist too strongly on rest in bed, and that the patient must not get up for any reason whatever. No food should be taken by the mouth, and in fact no liquid should enter the esophagus. The lips may be bathed in water. If hemorrhage continues, some preparation of ergot should be used, perhaps followed by morphine in gr. ¼ doses. An ice or cold-water bag should be applied to the stomach. In case of collapse, transfusion should be made with decinormal salt solution. During this period the patient should be fed by the bowel Six ounces of peptonized milk should be given every three or four hours. At the end of three days a little liquid may be given by the mouth, *i.e.*, milk, lime water, beef tea, or the peptonoid. At the end of the week the patient should be put on a regular diet, and kept in bed. The bowels should be moved by laxatives, such as Apenta water. Warm applications should be made continuously to the epigastrium. After two weeks the patient may be allowed to get up, but food likely to distend the stomach should be avoided. The stomach should never be washed out or the tube used in gastric ulcer: profuse hemorrhage may occur with all its attendant dangers. There is, I am sure, much harm done sometimes by unskilful washing out of the stomach. Large pieces of mucous membrane may be caught in the eye of the tube and torn out. Bits of mucous membrane are so frequently found in the wash-water as to lead to the supposition that they were torn off by the tube. In fact, at *post-mortem* examination I have seen in a single case numerous erosions of the stomach caused by lavage. Operative measures have been frequently restored to, and especially during the last few years.

But, as will be seen, it is difficult to make a fair comparison between the medical and surgical results that have been reported thus far. When Weir and Foote published their paper, there appeared to be no reason to prefer surgical to medical methods, for the surgical mortality in their seventy-eight collected cases was set at 71.51 per cent. Apparently

* Abstract of paper by Dr T. E. Satterthwaite, in *New York Medical Record.*

the surgical outlook is now better, for Tinker reports that one hundred and thirty-one cases he has collected since the former date show a surgical mortality of only 35.71 per cent., while individual surgeons are now known to have reported still better results. Thus, Haberkant's show a surgical mortality in gastro-enterostomies of only twenty-five per cent. Further, of Tinker's cases thirty-seven operated on during the first twelve hours showed a mortality of only sixteen per cent.; in pyloroplasty of 13.2 per cent. The French surgeon, Doyen, in his book puts his mortality after gastro-enterostomies at ten per cent., while W. S. Mayo, of Minnesota, reports that he had only one death in fifteen gastro-enterostomies, a mortality of 6.6 per cent. Accepting these statistics it is plain that the dangers from surgical interference are becoming gradually less and less in certain classes of operations, so that the counsel of the surgeon may be well invoked by the medical practitioner in these cases. In fact, in suspected cases of gastric ulcer the physician and surgeon should work together, mutually aiding one another in diagnosis and in deciding the question as to whether an operation is advisable or not.

For on the medical side of the case it must be recognized that the mortality from medical treatment is probably quite small. Weir and Foote once put it at twenty per cent. On the other hand, a recent writer puts it at only five per cent.; while Leube, of stomach fame, has stated publicly that in five hundred and fifty-six of his cases he has lost only twenty-two per cent. by death, and four per cent. represents his failure to cure.

It would not be proper to let the opportunity pass of emphasizing the statement, that a surgical operation is the only possible resort in some cases, if life is to be saved.

But all is said and done, and although, therefore, surgery seems likely to gain new laurels in the treatment of gastric ulcer, especially in complicated cases or if the operations be done very early, medical practitioners will still be content in uncomplicated cases to employ established medical methods, and will have a good share of success.

The most dangerous complication is peritonitis, and it is extremely important to be able to recognize this condition at the earliest possible moment. Palpation ought to show a little tenderness over the ulcer. Peritonitis sets in with a chill, a rise of temperature to 100° or 102° F. The patient lies with the knees drawn up, and has the characteristic facies. The pulse is rapid and small. It is now that surgical relief is to be sought at the earliest possible moment.

Subphrenic abscess is another complication that is also very important from a surgical point of view. It may be dependent

on or independent of gastric or duodenal ulcer, but it is most frequently caused by perforating ulcer of the stomach or duodenum. Other causes are ulcerated appendix, abscess of the liver or kidneys, or various intraperitoneal troubles; it may also be due to extraperitoneal influences. I have described such a case as a sequel to empyema. Subphrenic abscesses are apt to be so large as to push down the stomach and the spleen on the left side and the liver on the right, raising the diaphragm up to the level of the third or fourth rib; they may even perforate the diaphragm, causing empyema, or burst through the lungs into a bronchus and so discharge their contents. In a large number of cases these abscesses contain gas, owing in part to communication with the stomach, or to the decomposition of their contents. At first the signs will be gas in a sac containing liquid associated with a perforated ulcer of the stomach or duodenum, together with pain in the epigastrium, possibly a gastric tumor, and the signs of local peritonitis. The differential diagnosis must be made from empyema, simple abscess of the liver or spleen, or pneumothorax. Theoretically the upper level of the diaphragm should in subphrenic abscess be concave, with the concavity upward so that the upper limit of the abscess should correspond to this upward curve of the diaphragm. On the other hand, in simple empyema the curve of the diaphragm should be downward. In these cases of subphrenic abscess, according to Penrose and Dickson, including the thirty-four cases collected by Weir with fifteen cures, Nowak estimates his cures at fifty-five per cent. The treatment should be incision with or without exsection of the rib and drainage. I should be disposed from my experience to recommend thorough drainage as originally recommended by Chassaignac If the diagnosis of a subphrenic abscess is made, a surgical operation should be considered at once.

There is no difference in anatomical characters between the ulcer of the stomach and the duodenum; in fact, the non-malignant ulcer that has been described, with its sharply cut edges and rounded contour, may be found as well in the duodenum and esophagus as in the stomach: for the gastric juices can under appropriate conditions act in all these localities. In fact, the causes of the one ulcer are equally well those of the other, except perhaps that burns have a special tendency to be associated with duodenal ulcers (in from twelve per cent. to four per cent. of burns). As in the stomach, these ulcers are usually found in a middle period of life, but there is this difference, that in men they are three times as frequent as in women. Duodenal ulcers are usually found near the pylorus on the inner or posterior walls of the bowel. In a large number of

cases there will be no symptoms; in about 12.5 per cent. ulcers of the duodenum and stomach will be associated together. In one hundred and fifty-one cases of duodenal ulcer collected by Perry and Shaw there were no noticeable symptoms. So far, however, as we are able to decide, symptoms of pain come on later than in gastric ulcer. If it occurs in from four to five hours after eating, duodenal ulcer is probable. There is also more or less pain to be expected over the right lower border of the liver. This pain radiates and may go through to the back. There is no tumor, but there may be a painful spot. If the patient takes no solid food, the pain may stop. As in gastric ulcer, hemorrhage is an important sign. If the food is first vomited without blood, and blood follows, the indications are that the difficulty is below the pylorus. There will also be obscure dyspeptic symptoms. The prognosis is more unfavorable than in gastric ulcer, because the disease is less easy of reach.

ONTARIO MEDICAL ASSOCIATION.

The meeting for this year will be held June 6th and 7th under the chairmanship of Dr. Adam H. Wright. The provisional programmes will be sent out in a few days. The general discussions are likely to be very interesting. Dr. Lewellyn Barker, of Baltimore, who will open the discussion in Medicine, has chosen as his subject, "The Future of Therapy." Drs. Third, of Kingston, McPhedran and Davison, of Toronto, will take part in the discussion.

Dr. Teskey, of Toronto, will lead in Surgery. Subject: "Appendicitis, Its Recognition and Operative Interference." Discussion by Drs. Prevost, of Ottawa, Ingersoll Olmsted, of Hamilton, and Ross and Bruce, of Toronto.

Dr. Garrett, of Kingston, will lead in Obstetrics. Subject: "Puerperal Infection." Discussion by Drs. Powell, of Ottawa, Wright and Temple, of Toronto.

"Dominion Registration," Drs. Williams, of Ingersoll, Roddick, of Montreal, Herald, of Kingston, and Armour, of St. Catharines.

"The Army Medical Arrangements for the War in South Africa." Drs. Fotheringham, Nattress, Grasett, Peters and Ryerson, of Toronto.

A number of papers will be read by Dr. Hutchison, of Montreal, and others, on surgical and medical subjects. We have every reason to suppose that the meeting will be a very ood one.

Society Reports.

TORONTO CLINICAL SOCIETY.

STATED MEETING, APRIL 4TH, 1900.

The President, Dr. Bingham, occupied the chair.

Fellows present: Drs. Aikins, Anderson, Fenton, Hamilton, Badgerow, King, Rudolf, McIlwraith, Small, Trow, Bruce, Cameron, Parsons, Pepler, Dwyer, Orr, Elliott.

Visitors: Drs. Spence and Dean, of the Toronto General Hospital.

Nomination for Fellowship: Dr. J. H. McConnell, by Drs. Bingham and Elliott.

Nomination of Officers: President, Dr. W. H. B. Aikins; Vice-President, Dr. George A. Peters; Corresponding Secretary, Dr. A. A. Small; Recording Secretary, Dr. George Elliott; Treasurer, Dr. W. W. Pepler; Executive Committee, Drs. Hamilton, Parsons, King, Bruce, Rudolf, McIlwraith, Dwyer, Anderson, Badgerow, Fotheringham, Fenton, Silverthorn and Trow. Five of these to be elected at the next meeting in May.

Cancer of Rectum and Prostate.

Dr. E. E. King presented a patient, a man aged 59, upon whom he had operated for carcinoma of the rectum. Patient had always been healthy. In 1897, two years before seen by the surgeon, he noticed a condition of irritation around the anus, with the passage of slimy material and some blood. Had a severe hemorrhage in August, 1899; on the following day he had another severe hemorrhage. Patient came under Dr. King's care September 26th, 1899; and on the 11th of October he excised the tumor presented. The mass extended from the sphincter, which it involved, three and one-half inches, including the whole of the circumference of the bowel, and there were enlarged inguinal glands, an interesting fact, because it is exceedingly rare that these glands are involved. Only five months have elapsed since the operation, and he has gained somewhere in the neighborhood of twenty pounds. The operation performed was a modified Kraske. An incision was made over the coccynx, which was removed, and the surgeon was thus able to get above the mass and draw down the gut without opening the peritoneum. The patient was examined by the Fellows.

Dr. King reported a second case, aged 56 at the time of operation. Bowel movements had been slimy and contaminated

with blood for eighteen months prior to the time of entering the Toronto General Hospital in 1894. Had been operated on then by a confrere, and presumably a portion of the growth excised. This did not unite, and there was an ulcerated condition in December of 1894, when he came under Dr. King's care. Suspecting syphilis, he was placed on iodide and watched carefully for a month, the ulcerated surface being cauterized. This treatment proved futile. Colotomy was then performed, the growth excised, and there was recurrence at the edge. In 1895 had third excision of the recurrence. After six months another recurrence took place at the junction of the skin and mucous membrane. This was the last recurrence. About June of 1898 it was decided to close up the colotomy. He has gained since that operation about forty pounds, and has comparatively good health. He has fair control over his movements, and has fifteen to thirty minutes' notification that the bowels are about to evacuate. He can also retain the ordinary solid movements for ten minutes or so.

The third case reported by Dr. King showed that the family history was entirely free, except that the mother had had a tumor in her neck, which was said to have been removed by a plaster, the patient subsequently living until she was seventy-five years of age. In 1895 this patient had a very severe pain over the iliac region and lower part of the spine and left side generally. She went into the General Hospital, and operation was performed which was said to be the removal of the growth. It recurred within a year, and when seen by Dr. King she had a very severe cancer of the rectum. In this case the peritoneum was opened and the growth taken away very freely. Recurrence took place, and this patient is now dying.

Case No. 4 was peculiarly unique. Patient was thirty-eight years of age. Mother and father living, healthy; brothers and sisters healthy. Maternal grandfather had a cancer of the lip removed some years before his death by plaster. At seven years of age she was injured by being hit in the hip with a large stone. Severe pain developed in forty-eight hours; and between that time and the next ten or twelve years she was in bed and out of bed at intervals of six months, and developed a severe form of hip disease. Photos of this case were here presented. The abscess formations and the fistulæ closed, until she was taken down with an attack of typhoid fever, when these broke out again, and she came to St. Michael's Hospital in 1894. At that time she had a large mass involving the left side of the anus, perineum, and the labia majora, extending into the buttock almost as far as the greater trochanter. Its extent was about seven or eight inches long by six inches wide. It was impossible to pass the finger above the

diseased area. The mass was cut through into perfectly healthy tissue and dissected up through the fat and down to the muscles, exposing the greater and lesser notches, opening the peritoneum and removing about two-thirds of the area. The bowel was brought down and stretched and covered about three-fourths of the whole surface. Dr. King did four operations on this patient, and so far as the removal of the cancer is concerned feels that one is not saying too much when he claims it to be a successful removal of the cancer. The patient almost succumbed during the operation. as she is suffering from chronic Bright's disease. The patient has gained eighteen to twenty pounds. Dr. King then dealt with the statistics on this subject.

Dr. Bingham stated, in discussing the paper, that the original Kraske operation was intended for conditions where the mass was high up in the bowel—it was then able to continue the functions of the sphincter. Of course if there was any involvement of the sphincter, it should be removed. He further spoke of twisting of the bowel in these cases to effect a final cure.

Bullet Wound of Orbit.

Dr. H. A. Bruce stated he was unable to produce his patient, as he did not care to tax his strength in coming from the hospital. A boy of fifteen years of age had been practising with a 38-calibre revolver at a target, while sitting on a log in the country. Two shots had been discharged, when he examined the revolver, holding it in both hands, looking down the muzzle pointing towards him. That is all he remembers. On regaining consciousness, he walked two miles to town to consult a doctor. An unsuccessful attempt having been made to locate the bullet, the lad came down to the city. The bullet had passed through the eyelashes of the lower lid near the external canthus. The X-ray apparatus at the General Hospital was pressed into service, but it was quite impossible to outline clearly the bones of the skull, although the bones of the extremities could be seen clearly. Chloroform was administered, and with a probe through the opening in the lower lid, entering the orbit, and passing along the outer wall of the orbit (the bone being quite bare of periosteum), the bullet was located about one and one-third inches in, and could be easily moved by the probe. The external opening was slightly increased. With a pair of artery forceps the bullet was gotten hold of easily and extracted. It was lying just behind the eyeball about the middle of the orbit, probably against the optic neve. It had grazed the orbital surface of the malar bone and the orbital surface of the greater wing of the sphenoid. There are one or two points of interest as regards the

symptoms. The boy could move his eyes, but on looking downward had pain. The inferior rectus was pressed upon during contraction and caused the pain. He could see to the right of the middle line, but could not see to the left of the middle line. The bullet having been removed, it does not now cause him pain to look down. The bullet was considerably deformed.

Dr. Fenton spoke of a similar case of bullet wound, shot from a small-calibre rifle at short range This bullet entered the nose, there being no external wound, passed through the lachrymal bone, entered the orbit through the great wing of the sphenoid, then through the tempero-sphenoidal lobe, finally lodging in the occipital fossa.

A Case of Addison's Disease.

Dr. R. J. Dwyer read at considerable length notes of a case of this disease, which presented all the classical features of the disease. It occurred in a young man aged 38, born in England, a machinist by trade, but on the sea for a good deal of his life. He was admitted to St. Michael's Hospital December 22nd, 1899. As regards his family history, the father is living, but the mother is dead. She was sick six years with spinal trouble before her death, which suggests tubercular disease. In reference to personal history, he weighed 146 lbs. on admission, but used to weigh 160 lbs. Five years ago he was in Australia; malaria on return to England, in bed nine weeks. Was always subject to headaches. Drank heavily for several years, also smoked. Present illness began with nausea and vomiting in the morning; he would feel better during the day. Headache principally in the morning, which would disappear when out in the open air. Breathlessness and fluttering of the heart appeared. Shortly after Christmas, 1898, his wife first noticed any change in color. Skin became dark, principally the face and hands. This contrasted with the body, which was quite white. He continued his work until June, when he had to give up on account of weakness, which increased. After he discontinued work was able to go about for two months before coming into the hospital, in December. Sometimes he would have attacks of diarrhea, alternating with constipation. He was very languid and drowsy during the day and restless at night. Temperature subnormal; pulse varied from 72 to 100. The yellowish-brown color was very marked on the neck. The conjunctivæ presented marked contrast, being comparatively pale. The discoloration was mostly marked on the face, back of the neck, perineal sulcus, scrotum and penis, which was quite black. The mouth presented an interesting condition. The presence of very black pigmenta-

tion on the inner surface of the gums, and also and still more striking, on the under surface of the tongue, was an interesting feature. The whole under-surface of the tongue was absolutely black. Respirations ran at twenty. The patient died on the 29th of December, apparently from syncope. At the *post-mortem* examination tuberculous areas were found in the lungs, liver, and a solitary tubercular ulcer in the small intestine, situate about three or four inches from the ileo-cecal valve. There was some enlargement of the spleen. The right supra-renal capsule was very hard and dense, and the appearance of the normal gland was destroyed; it was apparently converted into a hard fibrous mass. The left one was increased in size. Sections of each were made, and gaseous deposits found abundantly.

Dr. Parsons, who made the sections, stated there was most extensive tuberculosis present.

GEORGE ELLIOTT,
Recording Secretary.

STATED MEETING, MAY 2ND.

The President, Dr. George A. Bingham, occupied the chair.

Fellows Present: Drs. Peters, Thistle, Trow, Britton, Small, Orr, Anderson, Silverthorn, Rudolf, Lehman, Boyd, Meyers, Fotheringham, Pepler, Chambers, Hamilton, Badgerow, Wright, Dwyer, Nattress, Fenton, McDonagh, Bruce, Parsons and Elliott.

Visitors: Drs. Theo. Coleman, J. T. Clerke and A. Y. Scott.

Election of Officers: President, Dr. W. H. B. Aikins; Vice-President, Dr. Geo. A. Peters; Corresponding Secretary, Dr. A. A. Small; Recording Secretary, Dr. George Elliott; Treasurer, Dr. W. H. Pepler; Executive Committee, Drs. Anderson, Hamilton, Dwyer, Silverthorn and Parsons.

Tubercular Testicle, Vas Deferens and Vesicula Seminalis removed by operation.—Gonorrheal Vesicula Seminalis removed by operation.

Dr. George A. Peters presented these specimens, described the conditions present, the operations and the results. From the first patient was exhibited a testicle, a vesicula seminalis and corresponding vas deferens; from the other both vesiculæ seminales. The first was undoubtedly tubercular, the second not tubercular. In the second the man denied the history of gonorrhea, although no other source of the condition could be

deduced. The surgeon described the symptoms present, the difficulties of the operation, and the final results which were good in both cases.

Dr. Bingham, speaking in the discussion, dwelt on the difficulty of operating, and instanced a case of absence of the vagina in a young girl of seventeen years upon whom he had operated that day as an illustration thereof.

Traumatic Origin of Cancer.

Dr. Wm. Britton introduced this subject. Between two and three years ago a commercial traveller was returning to his home in this city carrying in either hand a heavy valise. As he was nearing his house he slipped, but recovered himself before falling to the ground. He entered his house suffering from a certain amount of shock, and declined to partake of any supper. He stayed at home for a few days and returned to his business but did not feel himself. Early in January (he was injured about the middle of December) he started for a trip to the Maritime Provinces. He returned about the middle of February and consulted a physician of this city. An exploratory incision was deemed advisable, and it was then found that the man was suffering from extensive cancer of the liver. The incision was closed and in a few days thereafter the man died. He carried an accident insurance policy for $5,000, and the company declining to pay the policy, action was brought to recover same. The case excited considerable interest amongst the medical men retained to give expert evidence. Dr. Britton stated he had come to a decided conclusion that the injury did not cause the cancer, but the others, on the other side, were just as positive that the injury did cause the cancer. Dr. Britton discussed at considerable length the causes of cancer of the liver and the bearing this accident had on the disease in this case.

Dr. H. B. Anderson, who performed the *post-mortem* examination, stated that he found a solitary mass in the head of the pancreas, and innumerable nodules throughout the liver. The only part of the liver free from the disease was that part of the organ most closely in relationship to the surface where the alleged injury was said to occur. He also stated that instances of primary cancer in the liver were exceedingly rare, but thought he had seen one case; and if it were likely to be due to injury we would expect cancer of the liver to be more primary and more frequent, as the liver is an organ exposed to injury. He thought the likelihood of cancer of the head of the pancreas being due to injury was exceedingly limited; and in this case the fact that the part of the liver in direct relation to the site of the injury was entirely free from any

disease, precluded the possibility of the disease being here due to traumatism.

Dr. George A. Peters discussed the case from the other standpoint, and showed how a lawyer might be able to pin the medical expert down to a traumatism as a cause of the condition present.

Dr. Nattress, the medical referee of the insurance company, gave the precise dates of the injury, medical attendance, operation and death. He also stated that a provincial physician had diagnosed the man's condition as one of cancer of the liver months before the supposed injury.

Dr. Theo. Coleman, who had charge of the medical evidence for the prosecuting attorney, here read general observations upon the origin of cancer and the present-day theories of the cause of the disease.

The result of the case was a non suit.

Vote of thanks: Dr. George A. Peters moved, seconded by Dr. Herbert Bruce, that the retiring president be accorded a hearty vote of thanks for his efficient services during the past year.

Dr. W. Britton, in the chair, presented this to Dr. Bingham, who made a suitable reply in acknowledgment.

One of the most successful years in the history of the Society closed with the usual refreshments.

GEORGE ELLIOTT,
Recording Secretary.

HAMILTON MEDICAL SOCIETY.

The regular meeting of the Hamilton Medical Society was held at the Royal Hotel on April 4th, at 9 p.m.

Members present: Dr. White, chairman; Drs. Baugh, Cockburn, W. J. Langrill, Crawford, Dickson, McEdwards, McGillivray, Inksetter, Gibson, Gillrie, R. W. White, Wallace, McNichol, Kittson, Dillabaugh, Mullin, Morton, O'Reiley.

Minutes of previous meeting were read and confirmed.

Dr. O'Reiley presented two cases from practice: Case 1. Compound fracture of patella: 3,000 lbs. of iron fell on leg and broke patella into several fragments. Under an anesthetic they were united by wire sutures. When removed on the fourteenth day suppuration was found in joint; continuous irrigation with plain, sterilized water, and piece of necrosed bone afterwards removed; patient made good recovery.

Case 2. Fracture of tibia and fibula, both high up; union was delayed, finally good result. Dr. Dickson, in Case 1, thought a sterile suture was necessary. In his experience, the

sutures were not always removed. *Re* Case 2, he wished to ask how long should such a fracture be kept in plaster before resorting to more radical measures.

Dr. O'Reiley said that in this case of consultation of staff, they had decided that six weeks would be sufficient time for plaster.

Dr. Cockburn agreed with writer on continuous irrigation in separation of joints. He thought that modern surgical technic would justify cutting down, and immediately suture in simple cases.

Dr. Baugh referred to aluminium wire.

Dr. Wallace referred to use of kangaroo tendon. He also referred to the case of the Prince of Wales when the conservative methods had been adhered to, notwithstanding adverse continental criticisms, and with good results.

Paper II. Dr. White read a paper on occipito-postero presentations. Diagnosis and management important owing to danger to child and injury to mother. Diagnosis often difficult owing to compression of head in pelvis masking sutures, and often presenting large scalp tumors. In such cases position of child's ear and information gathered from abdomen, assists us in making the diagnosis. When diagnosis was made sufficiently early we divide cases into two classes: First, Roomy pelvis, flexion good, head readily engaged, strong contractions. In these cases the only treatment necessary is to maintain flexion by external pressure. Keep fœtus compact, delivery natural, but slow. Second, In other cases disproportion between head and pelvis, weak pains, projection of promontory of sacrum, small quantities of amniotic fluid, difficult labor, especially in primipara. In such cases various methods of treatment are advised:

(1) Prophylatic knee clust position. (2) Manual rotation of head forwards under anesthetic, with or without forceps, internal and external manipulation. (3) Pedalic version advised in multipara, and for inexperienced operators. (4) Temporizing and interference only when natural efforts seem to be failing. (5) High forceps delivery found to be most valuable.

B. When diagnosis is made out later, in the second stage we find two classes of cases: First, easy cases; when head is well flexed descends to pelvic floor, when rotation voluntary takes place and head is born; secondly, smaller groove, very difficult, head impacted. In these the following methods are used: (1) Flexion by manipulation. (2) Rotation with forceps. (3) Apply forceps and pull—apply to sides of pelvis, trunk or child's head.

If above methods fail afterwards resort to symphyseotomy, cecarian section or craniotomy. Some rare cases of occipito-

postero may be converted into face presentations, and delivery effected in that way very easy.

In all cases when the diagnosis is made the accoucheur needs the benefit of all reading and experience to bring the labor to a happy conclusion with safety to the child and to the mother.

Dr. Wallace thought that his experience gave a larger average than usually quoted. He preferred to apply forceps to the sides of pelvis.

Dr. Gillrie referred to the necessity of immediate attention to the torn perineum.

Other members discussed the paper and congratulated the writer.

Corresponding secretary read a letter from Dr. Ross, of Toronto, in reply to an invitation from the society, offering to read a paper at the next meeting of our society.

Drs. Wallace and McGillivray moved that the secretary write Dr. Ross thanking him for his offer, and accepting the same for our next meeting, and requesting him to discuss the subject of Gallstone Surgery.

Drs. Mullin and O'Reiley moved that the names of the writers and the papers read before this society be excluded from the daily papers.

Paper for next meeting by Dr. Ross.

Meeting then adjourned.

J. H. MULLIN,
Secretary.

HAMILTON, April 4th, 1900.

Editorials.

THE PROVINCIAL UNIVERSITY AND MEDICAL EDUCATION.

We notice in the April issue of the *Canada Lancet* an excellent editorial which is especially important, because it gives expression to the opinion held by at least a portion of the staff of Trinity Medical College. In speaking of the position of Trinity it mentions three alternatives—either affiliation, federation, or amalgamation. From the article we extract the following reference to the latter alternative:

"As to the third alternative, amalgamation, we do not hesitate to say that it is in our opinion the best solution of the existing difficulty; and, more than that, that it is the one thing needed to firmly establish the teaching of medicine in Ontario on a permanent and satisfactory basis. . . . The institutions concerned would profit by the concentration of energy and the lessening of expense which would follow. The beneficial effects of rivalry with other institutions would still be felt in their relations with colleges outside the city, while the divisions that have lain beneath the surface and spoiled the bloom of the friendships that should exist, and have existed in hospitals, medical societies and general practice, would cease.

"The undoubted advantages of Toronto as a centre for medical teaching could then be realized to the fullest extent, with an institution supported by a united profession and under the control of, and fostered by, the Provincial University. The post-graduate courses, for which so many have at present to expatriate themselves, would become possible at home. We look upon the present period as a crisis in educational matters, one of the gravest that has occurred in the Province in many years, big with possibilities of either good or evil to the profession, to the public, and to the progress of medicine. It is the duty of all concerned to lay aside self-interest, personal opinions and partisan views, and approach the question in the broadest spirit of conciliation, fairness, good-will, and mutual respect, looking only to the main point—a permanent settlement of the question of medical education in Toronto and in the Province."

We heartily endorse the whole article, which is evidently

written in a friendly spirit. Coming so soon after, as it seems to most of us, an unfriendly effort to abolish the medical faculty of the University of Toronto, we note with pleasure the evidence that better counsels will in the future prevail among the authorities of Trinity Medical College. Many of us have felt for thirteen years that a union of our forces in Toronto would be in all respects beneficial. The University of Toronto made friendly advances to Trinity in 1887, and offered to make that institution a part of its medical faculty. As that offer was rejected, we have always felt since that nothing further could be done until Trinity viewed matters in a different light.

We regret exceedingly that Trinity took a course in connection with the introduction and promotion of the McKay Bill that caused considerable irritation in Toronto University circles. But we hope that the authorities of our Provincial University are big enough and broad enough to consider any new questions that may arise in a fair and judicial spirit. Trinity, as a rival not always friendly, has been to some extent a source of embarrassment both to Toronto University and the Government. Would it not be possible, under changed circumstances, to make her a source of strength to the Provincial University?

We are told that some members of the Trinity staff are in sympathy with the views expressed by Drs. Anderson and Fotheringham, some are lukewarm, and a few are opposed—the numbers of each class not being given.

From a University of Toronto standpoint we are given to understand that some are in favor of the establishment of closer relations between the two Faculties, some are opposed to any such proposition, while many, perhaps the majority, will give the matter careful consideration before deciding as to their actions.

We have in view especially two things—the interests of our great Provincial University and the interests of higher medical education in Ontario. We are unreservedly opposed to anything like an abolition of the Toronto Medical Faculty; but we believe, at the same time, that a fusion of the Faculties of Toronto and Trinity would greatly strengthen the University, and produce a stronger medical college than any which has heretofore existed in this province.

THE DUTY OF THE HOUR.

We have reached a crisis in a very important movement that has been in progress for some time, and we wish to appeal to every one of ourselves—to every medical man—to do his duty, to do his best towards saving thousands every year of our fellow citizens, our friends, our kin, and, it may be, of our own households, from being destroyed, from dying prematurely. In using the word "thousands" we are not indulging at all in hyperbole. We have received to-day the report of returns from the Division Registrars for the last three months, and we find that in that period 557 persons have died of "tuberculosis" (consumption)—we quote the words of the report; in the same period last year we find deaths from "tuberculosis," 634. Picking up the reports of the Registrar-General we find the deaths from "consumption" for the year 1898, 3,291, and from tuberculosis 2,315 in 1899, considerably more than double the deaths from smallpox, scarlatina, diphtheria, measles, whooping-cough, typhoid and "malaria" put together; and we must remember that no system of reporting is so accurate but that we may count upon a larger number of deaths than reported.

Our next point is that, on the authority of physicians of careful observation and judgment, it is certain that more than half of these cases are acquired, and others might be prevented, or saved, by early and judicious courses of treatment. So that we are quite within the mark in saying that the saving of life annually by our efforts in this matter ought to go beyond the thousand limit. Our appeal to our profession now is to help, at this critical juncture, the putting into operation of the provisions of Hon. Mr. Stratton's bill, recently passed by the Legislature, having for its object the formation of sanatoria by the various municipalities, or groups of municipalities, and that of providing provincial assistance conditionally thereon. In our Hygienic Department will be found a slight sketch of this Act, and of events connected with it, as well as of other movements in the struggle against tuberculosis. We ask members of the profession to wake up aldermen, councillors and influential people generally to the necessity for these institutions; not

merely to give our opinion when asked, but to work the subject up and to set others working at it.

It is not many years ago that Mr. Ross knocked out of the Ontario Statutes the clause providing for a "separate" smallpox ward in every general hospital! To-day people would be horrified at such a combination. So we grow; but it would certainly be safer, as was pointed out at a recent conference, for a person, well protected by vaccination, to share a room with a smallpox patient than with a consumptive. And, yet, how little is the danger in this latter class of cases appreciated and guarded against. Let each patriotic medical practitioner go on working at this matter until there is some proper place in which poor consumptives (the consumptive poor) of his municipality can be placed and kindly cared for in such a manner as to give them the best chance for life, and to save them from being a constant menace to the lives of their friends.

W. O.

THE MEDICAL CARE OF CHRONIC INEBRIATES.

In writing for medical readers we do not consider it necessary to take up time proving that these unfortunates exist, and that many of them and their friends need a helping hand. The practitioner has the fact of their existence thrust upon him from time to time in the shape of the perplexing problem: What can I do to save this man from this constant recurrence; from going down, down, down in the social and financial scale? to save his family from the concurrent shame and loss?

The general question has, for a long time, been merely answered by a helpless shrug of the shoulders. An attempt to give the more wealthy victims, (the wealthy victim of alcoholism and those dependent upon him), means of deliverance was embodied in what is now Chap. — R. S. O., but beyond this the general attitude has been as described. This, surely, is not a logical way of dealing with the question. There either is a problem to be solved or there is not. The springing up of gold-cure establishments, *et hoc genus omne*, seems to indicate that there is; and we think *few* in our profession will say there is not. It is evidently, then, incumbent on the *many* to help

to solve the difficulty in some way or other. We shall be glad to open our columns to a discussion of the subject. Meanwhile we would ask our readers to give an attentive consideration to the schemes outlined and the news items given in this or future issues. The subject is one of great importance to many suffering persons, and certainly calls for attentive consideration by the medical and other professions within whose purview certain branches of it fall.

W. O.

THE CANADIAN NURSES ASSOCIATION.

A bill has been introduced into the House of Commons which, if passed, is likely to materially affect the position of the great body of trained nurses in Canada. The first clause reads as follows:

"Mesdames M. E. Rogers, E. Tait, H. M. Dunlop, A. Colquhoun, Ida E. Dodd, F. Clements, and H. S. Hill, together with such persons as become members of the Association, are hereby incorporated under the name of 'The Canadian Nurses Association.'"

From the other clauses we learn that the head office will be in Montreal, the Association may hold property not to exceed twenty thousand dollars, and the revenues arising from every source of income will be appropriated solely to the accomplishment of the objects of the Association.

There is unfortunately a vagueness about the wording of the proposed bill which prevents the majority of physicians and nurses from getting any clear idea in reference to the "object of the Association." We have been told that the chief object is to guide the public in the selection of nurses, and to raise the standard of nursing generally. The members of the Association are to have, exclusively, the right to designate themselves as members by using after their names the letters M.C.N.A. or other similar title.

It will probably be admitted by all that the organization of a strong association of trained nurses in Canada would be very desirable; but there is not a general inclination to support this bill in its present shape. After making careful inquiries we can find no one in this part of Canada who knows anything

about these seven mesdames of Montreal who are applying for the Act of incorporation. In a conversation with a well-known superintendent of a nurse-training school the following remark was made: "I know nothing about the proposed association, and am not therefore prepared to support it in any way. What would the physicians of Toronto think of the establishment of a Canadian medical association, with extensive powers, by seven physicians of Montreal whose names were absolutely unknown to doctors outside of that city?"

The fact that the bill was introduced by Dr. T. G. Roddick is sufficient evidence that nothing wrong is intended. At some future time the subject may be fully discussed, but at the time of writing there is every reason to suppose that the bill will be withdrawn for this session at least. At the same time it seems likely that there will be established in the near future an association of Canadian trained nurses.

(NOTE.—Since this article was written, Dr. Roddick, after a conference with Mr. John Ross Robertson, who had been in correspondence with several lady superintendents of hospitals, withdrew the bill.)

THE PHYSICIAN AND THE INSURANCE COMPANY.

We publish in this issue a letter from Dr. Anthony Freeland, of Ottawa, which voices the opinion of a large number of physicians throughout Canada. Many life insurance companies, as well as other corporate bodies, show very little consideration for physicians. In Dr. Freeland's case, the cross-examination to which he was subjected was very objectionable; and the request that he should, after answering questions of such a confidential nature with reference to his patients, go out and look for a notary to make oath as to the correctness of his answers, was still more aggravating.

Since receiving Dr. Freeland's letter we have consulted both physicians and insurance men, but cannot hear of any very satisfactory solution of the difficulties connected with the questions raised. Fortunately a large number of such companies treat the members of our profession fairly in all respects.

Where others decline to treat us in the same fair way we are to a certain extent helpless, because, in the interests of our patients who must have our reports, we often have to submit to the indignities to which we are subjected. We fear that the frequency of contracts, with very small fees, entered into between various corporate bodies and physicians has had much to do with bringing about the conditions complained of.

THE STRUGGLE WITH THE TUBERCLE BACILLUS.

If we had time it would be interesting to trace the growth of our knowledge regarding the nature and peculiarities of the *bacillus tuberculosis*, but not very flattering to note our slowness in following up the clues, and more particularly in taking decisive rational action against the foe.

In 1868 the inoculation of guinea-pigs by KLENCHE and VILLEMIN proved the communicability of tubercle. Passing by a number of observers our attention is more particularly arrested by the discoveries of Koch; and of the first papers read amongst ourselves, two which we remember as asserting strongly and decisively the infectious character of the disease, were those of the late Dr. J. E. Graham, before the Ontario Medical Association, and of Dr. Whittaker, of Cincinnati, before the Canadian Medical Association. Next Whittaker published his tubercle-dotted map showing how the seed had spread in certain houses and localities. The results of tuberculin tests and *post-mortem* examinations in herds of cattle in Ontario and elsewhere are well known.

THEN CAME THE ESTABLISHMENT OF INSTITUTIONS IN GERMANY and elsewhere for early treatment looking towards aiding the human organism in the struggle with its unwelcome host, enlisting the best possible conditions on the side of the patient, whilst at the same time dealing promptly with the *b. t.* and destroying it as it is cast forth from the patient.

IN ONTARIO THE NATIONAL SANITARIUM ASSOCIATION was organized and a building erected, which has been branching out into a group of buildings in Gravenhurst. This association has been making efforts in other directions. With it the names of Mr. Gage, Dr. N. A. Powell, the late Dr. J. E. Graham,

Mr. Massey and others are associated. By others it was felt that a more extensive movement was necessary so as to take up the cases of persons and their friends who are not able to pay charges necessary to maintain sanatoria such as those at Gravenhurst.

THE "TORONTO CITIZENS' SANATORIUM COMMITTEE" was formed as a result of this, some of the promoters being Drs. E. G. Barrick, A. A Macdonald, P. H. Bryce, A. H. Wright, W. H. B. Aikins, J. S. King, James Thorburn, W. Oldright, Prof. Clark, Messrs. Crawford, M.P.P., Mayor Shaw, D. W. Alexander, Rev. A. Burns, Ald. Davies, Principal McMurchy, Rev. Dr. Withrow, Mrs. Boultbee, Mrs. Brereton, Mrs. Lillie, and many others. Dr. Playter was originally connected with this committee, but later embarked in another project of a private sanatorium. Later, the Rev. C. S. Eby took a warm interest in the whole subject, and conceived the idea of a more extensive movement. ASSOCIATIONS FOR THE PREVENTION AND TREATMENT OF CONSUMPTION and other forms of Tuberculosis are being organized with the idea of eventually forming a Canadian Association of a similar character to the association in England, with which the Prince of Wales is connected, and affiliating the local associations to the Canadian one. The interest of the general public culminated in a grand meeting composed of a number of deputations from various parts of the Province, and from various societies, to wait upon the Government.

We would like to give in this issue a report of that meeting on account of its personnel, and the cogency of the arguments, but space prevents us. This meeting was held on the 9th March, and immediately thereafter the Hon. Mr. Stratton gave one of the proofs of his prompt aptitude for taking hold of public questions of importance, and bringing them rapidly into shape, by preparing a bill which passed through all its stages and became law on the 26th April.

"AN ACT RESPECTING MUNICIPAL SANATORIA FOR CONSUMPTIVES" PROVIDES: 1. For the establishment of sanatoria by municipalities.

2. For joint action by two or more municipalities.

3. That the plans, estimates, and the provisional by-law or agreement, and the proposed site (which may be anywhere

within the Province) shall be submitted to the Provincial Secretary, who shall submit the same to the Provincial Board of Health for report. Upon receiving the report of the Board of Health the Provincial Secretary may approve of the plans, estimates, provisional by-law or agreement as the case may be, and the site; subject, however, to such modifications and alterations as he may think best.

Provided, that if a proposed site be not within the municipality or one of the municipalities proposing to establish the sanatorium, the Provincial Secretary shall, before approving of such site, transmit by post to the head of the municipality in which the proposed site is situate, notice of the application for approval, for such remarks thereon as such municipality may desire to submit.

4. That the council of the municipality, or municipalities concerned, may from time to time pass by-laws to raise the moneys proposed to be paid or contributed by such municipality in respect of the original cost of the sanatorium, or of the cost of extensions, alterations and additions, and to issue debentures therefor.

5. For by-laws for establishment of sanatoria; and

6. For the appointment of a board of trustees determining the terms and conditions of admission, and in the case of joint action by municipalities the apportionment of cost to each.

7. For defining the powers and duties of trustees; and

8. The organization of the board. The trustees shall elect yearly one of their number to be chairman of the board, to hold office for one year and thereafter until his successor as chairman is elected. A vice-chairman may also be similarly elected.

9. For trustees acquiring, expropriating and holding lands for the purposes of a sanatorium; and

10. Controlling and managing the sanatoria.

11. For inspection and management by the Lieutenant-Governor in Council.

12. For a grant from province towards establishment, such grant being one-fifth of the cost, but not to exceed $4,000.

13. For payment by the Province of $1.50 per week for each patient.

14. That the municipality or municipalities shall levy such moneys as may be required to meet the balance of the cost of maintenance, operations and repairs of the sanatorium.

15. That nothing in the Act shall prevent the municipality or municipalities establishing a sanatorium from closing the same at any time or times, either temporarily or permanently.

16. That if a sanatorium be closed for a period of nine consecutive months the Legislature may make provision for the sale or other disposition of the sanatorium and the properties and effects thereof and for the application of the proceeds, and may make such other provisions relating thereto as to it may seem just.

17. For exemption from taxation.

18. For accepting donations.

THE INAUGURAL MEETING OF THE TORONTO ASSOCIATION FOR THE PREVENTION AND TREATMENT OF TUBERCULOSIS—(we wish it could be shortened into "Anti-Tuberculosis Association")—was held in Association Hall on the 8th inst. The chair was occupied, in the unavoidable absence of the Lieut.-Governor, by Rev. Prof. Clark, who expressed his sympathy and dwelt upon the pressing necessity for the Association and its work. The President, Dr. E. G. Barrick, gave the history of the events leading up to the present stage, and made a strong presentation of the pressing need for such measures as the Association intends to carry out to stop the destruction of life now going on. Dr. A. H. Wright was next called upon to supply the place of Sir James Grant, and made a short, forcible speech, emphasizing the points that tuberculosis is communicable, preventable and in its early stages curable; that we can and should adopt and carry out the means for its prevention and cure amongst both poor and rich. Miss Jessie Alexander next gave a thrilling rendering of the scenes in which Dr. Wm. McClure, Drumsheugh and Sir George restored joy to the cot of Tammas Mitchell. Other speakers were Thos. Crawford, M.P.P., Rev. Principal Caven, President Loudon and Dr. Sheard—the latter speaking most encouragingly, which we hope may augur a like treatment in the councils of the municipality. Rev. C. S. Eby, the Secretary and organizer of the Association, appealed to the humanity and generosity of the public, and by means of contribution cards and envelopes

facilitated the giving of practical expression to the same. The annual membership fee is $1.00, and life-membership $20. We trust that all heads of families will become at least ordinary members, and the many of those who have been blessed with means will aid in larger degree this most commendable work. Rev. Dr. Eby is an enthusiastic, resourceful and persistent worker.

Mrs. and Miss Skeath-Smith, Miss Maud Swan and Miss Williams varied the proceedings with music, Mrs. Brereton having arranged this to add to the attraction of the evening.

THE PROVINCIAL BOARD OF HEALTH, at its meeting on the 9th and 10th inst., advanced its firing line by having put in force the following:

1. That hereafter all houses and rooms, whether in hotels or otherwise, in which tubercular persons have been, shall be disinfected, and the health authorities shall see to this. R.S.O., cap. 248, sec. 101.

2. That persons must not make false statements as to the existence of such cases. Sec. 102.

3. That in government institutions persons suffering from tuberculosis shall be kept from infecting others.

4. That with the above aims in view, health officers shall be urged to require notification of cases of tuberculosis, as empowered by the Public Health Act.

5. That the Stratton Act be distributed to health officers, medical men, clergymen, and the public generally, by means of a circular appealing to them to use their influence to have the municipal authorities avail themselves of its provisions where necessary in the interests of humanity and for the saving of life.

W. O.

THE RED CROSS SOCIETY.—This society has evidently done a large amount of good work in South Africa. One of the most active members of the order in that country is Dr. G. Sterling Ryerson, of Toronto, the second officer in command. His services, especially at Kimberley, were very highly appreciated by Lord Methuen and others among the chief officers He established a Canadian hospital in the masonic temple of that town, and also furnished large quantities of supplies to

other hospitals. After visiting many other hospitals in that country of distances nearly as big as our own in this country, he returned to "civilization and beds" in Cape Town, March 23rd, but left again for the north, March 27th. After stopping off at Towe's River, DeAar, and Naauwport, he went on to Bloemfontein, where he remained for some time.

SURGICAL HINTS.

If you deem it necessary to open the skull in an emergency, don't hesitate because no trephine is at hand. A good chisel and mallet, or a small hammer, in careful hands, will often do just as well. The best surgeon is often the one who can best and most readily make use of quickly improvised instruments and apparatus.

Many bad cases of head injury appear to end fatally, owing to failure of the respiratory centres. In these cases the proper treatment consists in the persistent use of artificial respiration, with alternate heat and cold to the chest and abdomen. These measures may tide the patient over a dangerous period and bring about an ultimate recovery.

In order to relieve the pain and irritation caused by the removal of dressings adhering to a wound, pour some peroxide of hydrogen over the adherent part of the dressing. This will rapidly soften the coagulated discharges, and the dressing will come off readily. This method saves the time employed in prolonged soaking with ordinary solutions, and relieves the apprehension so usually shown by patients at each fresh dressing.

In order to prepare leather for making moulded splints, it should be softened. Soaking in water will do, but it takes a day or two before the leather is soft enough. If you wish to save time, place the leather in water containing a tumblerful of vinegar or dilute acetic acid to each quart, and it will soften in a few hours. In order to obtain a really good fit, it is best to take a plaster cast of the limb to be encased, and mould the leather over the cast.—*Intern. Med. Jour.*

Progress of Medical Science.

MEDICINE.

IN CHARGE OF W. H. B. AIKINS, J. FERGUSON, T. McMAHON, H. J. HAMILTON, AND INGERSOLL OLMSTED.

Appendicitis and Intestinal Obstruction.

Aviragnet and Bernard have recently observed two cases of perforating appendicitis coexisting with intestinal obstruction. The first was that of a woman, forty years old, who entered the hospital with symptoms of intestinal obstruction, probably due to a cancer (meteorism, constipation, fecal vomiting, etc.). After a few days this patient was suddenly seized with violent abdominal pain, and died in collapse. At the autopsy a cancer was found in the left angle of the colon, and an acute peritonitis caused by a perforation of the appendix. Peritonitis and appendicitis had been overlooked during life because these lesions were hidden by the symptoms of intestinal obstruction.

The second patient was a woman of forty-nine years, who was admitted to the hospital for symptoms similar to those of subacute appendicitis. Very rapidly there appeared the signs of intestinal obstruction, necessitating a laparotomy. On opening the abdomen, there was found an acute peritonitis, caused by perforation of the appendix. There was also intestinal obstruction. The distention of the intestine was so great that it was necessary to make an artificial anus in order to be able to close the abdomen. The patient died the evening of the operation. Not being allowed to have an autopsy, this observation remains incomplete; but the course of the symptoms makes it probable that in this case the appendicitis preceded the obstruction.

These two cases show that appendicitis and peritonitis may be developed insidiously, and that their symptoms may pass unobserved owing to the existence of intestinal obstruction.

Hayem states that perforations of the stomach and intestines often produce peritonitis which may be easily overlooked. It can, however, be discovered by examination of the blood. Peritoneal inflammations, indeed, always accompany hyper-leucocytosis and increase of the fibrin of the blood. Parmentier has had opportunity to verify the correctness of these observations. On examining the blood of a man in a state of collapse, who was supposed to be suffering from peritonitis, there was found an abundant fibrinous reticulum, as well as an increase of

leucocytes. Operation revealed a peritonitis, wl ich would certainly have been undiscovered if the blood had not been examined.—Translated from *Giornale Internazionale delle Scienze Mediche* by HARLEY SMITH.

Trophic Troub'es Caused by Radiography.

At the Société Nationale de Médecine de Lyon, M. Destot spoke of the trophic disturbances du' to X-rays, and opposed the use of the latter for therapeutic purposes in dermatology. He quoted cases in which the rays had caused serious disturbances. He referred especially to a case of lupus treated by the rays, where the latter not only caused no improvement, but gave rise to ulceration which w as not cured after five months. These results could be avoided by interposing a thin sheet of aluminum, or by employing the static machine. M. Leclerc related the case of a patient with an old fracture of the patella who was radiographed fifteen months ago. After three weeks an ulcer developed, which was slow in healing. It was a question here of nervous lesions, central or peripheral. M. Monoyer asked whether the cause was physical or nervous. It seemed to be nervous. Among the inconveniences attending the use of the rays in therapeutics was the difficulty of limiting their action to a definite zone. M. Horand asked M. Destot if it were not possible in the X-rays to separate the caloric from the chemical rays, as experiments had been made in that direction in Germany for the treatment of diseases of the skin, especially lupus. As for heat, M. Horand said, it can exert a good influence on affections of the skin. Thus it is that the air, under a high pressure, and at a temperature of 200°, can improve lupus, tuberculous and cutaneous lesions, when it is projected with special apparatus and by a trained hand. M. Destot replied that Druser in his treatment by light separates the light rays from the caloric rays. The latter are checked by crystal lenses through which passes a stream of fresh water. As regards the X-rays, M. Destot has shown that their ill effects can be prevented by a sheet of aluminum.—Translated from *Lyon Médical* by HARLEY SMITH.

PATHOLOGY AND BACTERIOLOGY.

IN CHARGE OF J. CAVEN, W. GOLDIE, AND J. AMYOT.

Birch-Hirschfeld's Recent Contribution to Phthisiology.

Birch-Hirschfeld, the distinguished pathologist, of Leipzig, whose death occurred toward the close of the past year, was never publicly known to be especially identified with the study of tuberculosis during most of his career as an author and teacher; yet within a year before his death he published a paper which was not only his own masterpiece, but which embodies what is probably the greatest advance in our knowledge of this subject since Koch's discovery of the bacillus and tuberculin. In reading this paper we perceive that the deceased scientist had been for years at work upon the solution of an important problem in tuberculosis, and that he finally solved it to his own satisfaction, and fortunately lived to publish his results.

This paper appeared in the *Festschrift* on the celebration of the centennial anniversary of the Leipzig Medical Clinic (Vol. LXIV. of the *Deutsches Archiv fur klinische Medicin*), and discusses the site and mode of development of the primary lesion of pulmonary tuberculosis ("Ueber den sitz und Entwicklung der primären Lungentuberkulose"). The work is based upon the most careful *post-mortem* study of the earliest demonstrable lesions of pulmonary tuberculosis (which were naturally found only by accident in subjects otherwise healthy, having died by violence or acute disease), together with special studies upon the anatomy of the bronchial system. Many years were required to secure autopsy material enough to warrant the author's deductions.

Before the publication of this paper we had hardly any definite notion that a single primary focus of disease could be predicated of this affection. The author has proved that the primary lesion of pulmonary consumption is a tuberculous ulceration of a medium-sized bronchus, many secondary phenomena being, as a rule, quickly joined to this primary manifestation. A second great discovery is the fact that the ramification area of the so-called "posterior apex bronchus" constitutes a relatively dead expanse of lung tissue, in that its function of interchanging gases is so feebly performed that germs which are once inhaled within its limits are with difficulty exhaled.

Birch-Hirschfeld's work appears to give the fullest confirmation to the inhalation theory of Cornet, and to give a death-

blow to the scrofula theory of consumption as put forth by a number of recent authors of extreme views.

Our present author finds that pulmonary phthisis may in a very small percentage of cases begin interstitially, and in these cases must, therefore, be of hematogenous origin. Practically, however, pulmonary phthisis is an inhalation disease.

The author never was satisfied, he tells us, with the assumption of pathologists, that the primary focus in the lungs originates in the same manner as the consecutive lesions, which, to begin with, are not of uniform character. Experimental inhalation-tuberculosis in animals could not be hastily regarded as paralleling the natural disease in man. To solve this problem there was no other course to pursue but to watch patiently in the autopsy room for cadavers with but an isolated tuberculous focus within the lungs. The technique of the autopsy room also needed bettering, and the author devised a manual of procedure, which included palpation of the lungs, for the detection of minute nodes of disease, and then slitting up the bronchial tree until the palpated node could be exposed. Being much dissatisfied with our crude knowledge of the bronchial tree in health, he conducted the most exhaustive researches upon the practical anatomy of this structure, making casts of plaster and metal, and giving a name and individuality to every considerable branch. This work had indeed been done by others, Aeby, for example: but our author began to study anew without building upon their foundation, while his results were often at variance with those of his predecessors. The author's autopsy material was limited to twenty-eight cases of primary inhalation-tuberculosis, consisting invariably of tuberculous ulceration in a medium-sized bronchus. In three other cases of primary lesion the interstitial tissue was the site of the earliest mischief, and while these exceptional cases might possibly be looked upon as due to the penetration of inhaled bacilli, the author, with true candor, regards them as of hematogenous origin, seeking always to avoid forced interpretation. If this percentage holds good, not much over 10 per cent. of pulmonary phthisis originates otherwise than from inhalation.

Once the bronchus is implicated primarily, occlusion of its lumen results with consecutive atelectasis and sclerosis of that portion of the lung to which it is tributary. Before occlusion is complete, however, bits of infectious tissue are first exhaled into larger bronchi, to be in turn inhaled into sound portions of lung tissue with resulting aspiration-pneumonia of tuberculous character. Doubtless the opposite lung may become infected in this manner.

In an ordinary clinical case of so-called "incipient phthisis,"

the autopsy findings are so heterogenous that nothing definite is to be learned from them, so numerous and varied are the modes of secondary infection. The author's cases are uniformly robust people, surprised by deaths like drowning, puerperal sepsis, and the like—cases which would almost certainly have become examples of latent phthisis had the patients survived. We may here interject the statement that the author's material does not include mere obsolete foci of presumably tuberculous disease, mere scars or pleural adhesions about the apices, for without histological or bacteriological evidences of tubercle, such residual lesions would signify nothing.

The author is also enabled by the results of his study to give us the best and simplest explanation extant of the occurrence of early hemoptysis. When the ulcerous process perforates the bronchial wall, it may encounter a peribronchial vessel of varying calibre. Free hemorrhage does not invariably occur, as one of the author's cases showed a peribronchial hematoma. It is thus readily seen why hemoptysis may or may not occur, and why it may be extensive or only slight.

The autopsy material shows most clearly that it is possible for the bacillus to cause primary tuberculous bronchitis in one side of the chest, while in the other side it may be absorbed without bronchial lesion and cause a caseous bronchial lymphadenitis. This latter lesion is not uncommon in children, for, as the author shows, the chest up to the age of puberty expands uniformly, and the fatal "dead expanse" of the posterior apex bronchus is not in evidence until adolescence arrives.

The last section of the paper is devoted to adducing every sort of evidence to maintain the fact that that portion of the apex which is supplied by the posterior apex bronchus is, from its relationship to the immobile spine and central ends of the ribs, practically without function, and that primary tuberculous foci occur with such regularity in the territory of this bronchus that this latter structure and its entire area of ramification may be regarded as the great physical basis of ordinary pulmonary consumption. It is because of this "dead expanse" of lung that such a vast number of people are attacked with pulmonary tuberculosis, and the healthy adult lung has, perhaps, not much more natural immunity to this first invasion than the lung which accompanies the consumptive thorax; but it is infinitely more likely to repel the attack successfully. The presence of a robust organism and large chest appears to be the principal factor in preventing the secondary dissemination of the primary disease, as in this type of individual the initial lesion is rendered harmless by encapsulation and retrograde changes.

While some element of hypothesis is inseparable from a paper of this kind, the substratum of fact here present is very large, while no other conclusions may be logically drawn than those of the author himself.—*Med. Rev. of Reviews.*

Williamson's Test in Diabetes.

Lucibelli (*Gazz. degli Osped.*) had made clinical and experimental examination of the above test, and finds it extremely delicate and trustworthy. By its means it is quite possible to detect sugar when no evidence is given by examination of the urine. The test consists in the admixture of a drop of blood with a warm alkaline solution of methyl blue (1 in 6000). If sugar is present the solution becomes greenish or dirty pale yellow (almost the color of normal urine). The author's experiments showed that in diabetes mellitus and in alimentary glycosuria Williamson's reaction could be observed even when the urine gave no reaction. In experimentally induced glycosuria (by floridzin) Williamson's test gave positive results much earlier and later than could be showed in the urine. In other words, it is more delicate, earlier, and more lasting than the usual urine tests A calorimetric table could be compelled by observing the degrees of discolorization corresponding to the amount of sugar. The reaction is manifest and complete in all the various forms of glycemia.—*British Medical Journal.*

Lymph-Gland Infection in Cancer of the Lip.

Dowd (Charles N.). "The Submaxillary Part of the Operation for Epithelioma of the Lip." *Medical Record*, December 23rd, 1899. The writer of this paper very rightly considers that it is just as important to explore the submaxillary region through an open incision in all operations for cancer of the lip, as it is to open the axilla in the removal of cancer of the breast. Yet it is still a common practice to remove a lip cancer and not touch the submental and submaxillary regions. The explanation of this would appear to be (1) that many cases have been cured by simple removal of the lip; (2) that there is a general belief that the submaxillary and submental glands can be felt if they are infected. In reply to the first, the observations of Fricke and of Gussenbauer may be quoted. Fricke examined the subsequent histories of 114 cases: of these cases three only showed local recurrence, whilst metastases occurred in 32 per cent. In three-fourths of the total number of cases, the metastases were in the neck, in the jaw, or under the jaw. Gussenbauer found evidences of lymph-gland infection in twenty-nine out of thirty-two cases of lip cancer. Palpation sometimes fails to detect enlarged glands because of the omission to make counterpressure within the mouth. It is,

moreover, not infrequently impossible to detect enlargement of the glands except through an exploratory incision, and hence an incision is advisable in all cases. Three situations should be particularly examined—(1) the region above the anterior part of the submaxillary gland; (2) the space under the chin between the two anterior bellies of the digastric muscles; (3) the region about the posterior part of the submaxillary gland. —J. E. PLATT.

G. W.

OBSTETRICS AND GYNECOLOGY.

IN CHARGE OF ADAM H. WRIGHT, JAMES F. W. ROSS, ALBERT A. MACDONALD, H. C. SCADDING AND K. C. McILWRAITH.

Intra-Uterine Douches.

In the March number of the *Gynecological and Obstetrical Journal* is an article on "When shall the uterus be douched?" The answer given is, in septic infection and hemorrhage. With this we are in accord, but cannot agree with the author in recommending, in the former case, that the douche curette be used. He claims that in this way an anesthetic is rarely necessary, but we prefer to give an anesthetic, and thoroughly explore the uterus with the fingers, or hand if necessary. We agree with him in the belief that it is not wise to give repeated intra-uterine douches. Except in some cases of sapremia, the repetition of the douche is useless. K. C. M.

Vienna Clinic.

In the March number of *Obstetrics* there is given a very interesting account by Landesmann of the conduct of labor in Schanta's clinic in Vienna. In hyperemesis gravidarum first place is given to the taking of food in the horizontal position, which position is maintained for an hour after eating. Orexin is also mentioned among the remedies, but no account is given of its efficacy.

It is stated that rigid os during labor is incised. We sincerely hope that this does not mean that every rigid os that is met with is incised. Surely this must be only as the very last resource.

In the various degrees of contraction in flat pelvis, version and forceps are spoken of as indifferent measures.

In *ante-partum* hemorrhage from detachment of the placenta the treatment is accouchement forcé. This is in itself a dangerous operation, and not sufficiently rapid to save a large percentage of serious cases. The Rotunda plan, which we prefer, is as follows: In concealed hemorrhage, Porro's operation, or

possibly accouchement forcé. In external hemorrhage, plugging of the vagina until strong labor pains come on. The success reported from the use of this method warrants our preference Eclampsia is treated by morphia and chloral. The latter has been abandoned at the Rotunda on account of its depressing effect on the heart. At the Burnside we use morphia for the convulsions, and calomel and magnesium sulphate for the elimination of the poison.

We are glad to find that in puerperal infection the advice is given, "Do not scrape out the uterine cavity." K. C. M.

French Theses.

Another interesting article in the same number of *Obstetrics* is a summary of recent French theses on obstetrical subjects. We notice especially one by Helouin, on the "Hepato-toxemia of Pregnancy." The author believes hepatic insufficiency to be the cause of albuminuria and eclampsia, and treats these troubles by rest, milk diet and purgation. Of these, we consider the last-mentioned as most important. The theory of the hepatic origin of eclampsia has been taught for years by Dr. A. H. Wright and others.

It is worthy of note, however, that the affection is peculiar to pregnancy, that it ceases with the death of the fetus *in utero*, and generally on the birth of the child. These facts would seem to indicate that though the liver may be the maternal organ that suffers most, the primary cause is some poison having its origin in fetal metabolism. K. C. M.

LARYNGOLOGY AND RHINOLOGY.

IN CHARGE OF J. PRICE-BROWN.

Emphysema of Orbital Wall of Anterior Ethmoid Cells Caused by Blowing the Nose.

Dundas Grant (*Jour. Lar., Rhin. and Otol.*, March, 1900). A man, aged 28, while blowing his nose without a handkerchief, felt something give way in his eye. On examination the swollen tissues crackled as in emphysema. As the patient had been kicked in the nose two months previously, it was supposed that the orbital wall of the ethmoid cells might have broken.

Atrophic Rhinitis with General Systemic Infection.

Permewan (*Liverpool Med.-Chir. Jour.*, July, 1899). A man, aged 45, had suffered from fever for some weeks without

evident cause. Daily temperature from 100° to 103°. For over twenty years he had been troubled with nasal discharge, which at times was very offensive. He was found to have fetid atrophic rhinitis. After cleansing and disinfecting the nasal cavities, the temperature became almost normal and never rose again. He improved in health, and the breath remained free from taint.

Sarcoma of Nasal Passages.

Wurdemann (*The Laryngoscope*, October, 1899). A few months after nasal polypi had been removed from a woman by forceps, Wurdemann found fibrocystic growths in both nostrils. There was pain in the head with a strong tendency to hemorrhage. The growths were removed at different sittings. The recurrence of hard tumors necessitated also the removal of the superior turbinal on one side. Microscopic examination showed the growth to be lympho-sarcoma. The author concluded that this was an instance of malignancy, having been produced by rough treatment. After final removal by himself there had been no recurrence in nine years.

Aural Complications of Ozena.

Lacroix (*Jour. Lar., Rhin. and Otol.*, March, 1900), contrary to antiquated opinion, shows that the propagation of ozena from the pharynx to the middle ear is very frequent. He believes that the same lesions affecting the mucosa of the nasal passages may be found in the ear.

In illustration of this view he reports the case of a girl suffering from ozena, in whom an attack of acute otitis media occurred. He performed a paracentesis. The secretion presented the characteristic odor, and contained little crusts like those of nasal ozena. On further examination he discovered that out of forty-two cases of ozena, thirty had a certain degree of otitis media, with deafness, tinnitus, etc., confirming the belief that aural ozena was the cause.

Adenoids in Early Infancy.

Jauquet (*Jour. Méd. de Bruxelles*, 1899). Report of a case of removal of adenoids in an infant a few months old. The removal was accomplished by curettes and the finger nail. Hemorrhage was controlled by inflation by Politzer's bag with bent tube behind the palate. Treatment was followed by retropharyngeal abscess.

Delstanche believes in infants the operation should be done as early as possible, but by means of an instrument, as the space is usually too small to admit of finger.

On the Operation for Adenoid Vegetations.

Alfred Decker (*Jour. Lar., Rhin. and Otol.*, April, 1900). Amongst 1,087 children Decker found 138 mouth-breathers, and in 114 of these adenoids were the cause of mouth-breathing. On an average amongst 1,000 patients he found 127 in whom adenoid growths required removal. He usually employs superficial chloroform anesthesia, in the sitting position. He abandoned Gollstein's curette because on one occasion a mass of adenoids fell into the larynx, causing alarming symptoms. [Taking into consideration the position and the anesthetic, one would be surprised if such an accident did not sometimes occur!—*Abstractor.*] He now uses scissors curved to fit the vault, and constructed to catch the detached tissue.

Treatment of Diseases of the Sphenoidal Sinus.

Hermann Cordes (*Monatschrift für Ohrenheilkunde*, May, 1899). The author holds that chronic sphenoidal empyema is generally secondary to some other disease of the nose or naso-pharynx, especially ozena. In this he differs from Grünwald and Michel. To get a good view of the sinus he recommends Cholewa's method. A slender elevator is introduced between the middle turbinal and septum, and the former is simply pressed outward and fractured. Under cocaine this procedure is not painful. Bleeding is slight, and the turbinal is retained and preserves its function. In most cases this manœuvre gives sufficient access to the anterior surface of the sphenoid; but, if necessary, part or the whole of the middle turbinal may be removed by snare or forceps. This is rarely necessary. To freely open the sinus he recommends an instrument on the plan of Krause's double chisel, for removing spurs from the septum.

Case of Fatal Sphenoidal Suppurations.

Samuel Lodge (*Laryngoscope*, March, 1900). The patient, aged 31, when admitted to the Halifax Infirmary, had complained of constant pain in right ear and right side of face for six months. There was also swelling on same side, and copious discharge of pus from right nostril. Had syphilis nine years previously.

The patient lived for three weeks after admission. There was constant fever. Iodides were given in large doses. Exploration of antrum excluded it from the disease. Finally cancer developed and patient died.

Owing to the excessive discharge no absolute diagnosis during life could be made. *Post-mortem* examination revealed necrosis of posterior wall of sphenoidal sinus, with free openings from it into cranial cavity and also into nose. The sinus was full of thick muco-pus. The base of the brain was also

bathed in thick greenish pus, which extended backwards over pons and medulla, and forward in neighborhood of pituitary body.

Papillomatous Condition of Tongue.

Ball (*Jour. Lar., Rhin. and Otol.*, March, 1900). A healthy country girl, aged 20, has for two years complained of a growth on the tongue. The situation is to right of middle of dorsum, the growth being half an inch wide, and extending from near the tip to the circumvallate papillæ. The tumor is made up of small nodular masses. The surface redder than the rest of the tongue.

Mr. Butlin had seen several such cases. He had tried cutting the papillomatous growths off with scissors; but this was always followed by severe hemorrhage. Latterly he had removed them by deep incisions, bringing the edges of the wound together by silk sutures. He proposed similar treatment in this case.

Cysts of the Tonsils.

Mounier (*Arch. Intern. de Lar.*, May-June, 1899). The author has seen five cases of the ordinary retention cyst of the tonsil. In each case the caseous contents proved, on microscopical and culture examination, to be absolutely free from micro-organisms —something difficult to reconcile with the prevailing theory, that these cysts have their origin in the occlusion by inflammation of the mouth of an ordinary lacuna.

Mounier adds that this asepsis further proves the innocuous character of the numerous micro-organisms, which are normally found in the tonsil, as they all failed to penetrate the cysts referred to.

Case of Tabes with Almost Complete Laryngoplegia.

Sir Felix Simon (*Jour. Lar., Rhin. and Otol.*, March, 1900). This case was shown to the Laryngological Society of London on account of its extreme rarity. It occurred in a carman, aged 40, who had recently been treated for secondary syphilis. Present throat symptoms began fourteen months ago. There was complete paralysis of all voluntary movement of vocal cords, their position being the cadaveric one, with the posterior ends a little nearer than is usual under such circumstances, the distance between them being about three millimetres. In neither inspiration, expiration nor phonation was there the slightest movement. Still the patient could speak in a rough, loud voice.

On touching the epiglottis with a probe, no reflex movement was produced; but on touching the interarytenoid fold, the right ventricular band, or the left ventricular band, reflex

closure was produced, the last-named being attended by slight cough.

The case was evidently one of complete bilateral recurrent paralysis. The tabetic symptoms concurrent with the laryngeal were extreme general emaciation, arteries thickened and tortuous, double ptosis, reflex iridoplegia, slight weakness of right half of face, extreme inco-ordination, entire loss of sense of passive movement in lower limbs, complete incontinence of sphincters, deep reflexes absent. At same time there was no difficulty in swallowing.

Epidemic of Simple Angina Due to Streptococcus.

Le Damany (*La Presse Medicale*, November 15th, 1899) gives an account of an epidemic of this disease, lasting for six months in the town of Rennes. In a population of 70,000, several thousand were attacked.

Clinically, the cases fell into two groups:

1. Cases in which angina was the only or most serious lesion
2. Cases in which angina was accompanied by more serious lesions.

In some cases there were skin eruptions, erythema, papillæ, etc. Glands were affected slightly. Only one case died.

Some Consequences of Singers' Nodes.

Rosenburg (*Laryngoscope*, October, 1899). The writer believes that the occurrence of nodes has some relation to a gland of the vocal cord described by Fränkel. He believes that in a large proportion of cases the node is caused by occlusion of the mouth of this gland. The consequent dilatation of the gland duct through increased secretion may produce both enlargement of the gland and hyperplasia of the cord. He gives the history of two cases, which he instances in support of this view.

Extensive Mediastinal Emphysema in a Fatal Case of Laryngeal Diphtheria.

Ewart and Roderick (*Lancet*, December 30th, 1899). Child, aged 5, suffering from diphtheria, was threatened with suffocation. Tracheotomy was performed, and immediately afterwards 4,000 units of antitoxin injected. Next day emphysema developed. This increased, and patient died in three days.

Necropsy twenty-four hours later showed great subcutaneous emphysema of neck, face and eyelids, the aspect being similar to that met with in acute renal dropsy. Only shreds of membrane were found around the larynx.

The remark is made that after relief of larynx by tracheotomy, a membranous tracheitis may still remain.

Obituary.

JOSEPH ALLAN, Lic. Fac. Phys. and Surg. (Glasg.).

Dr. Joseph Allan died at his home in Osgoode Station, March 11th, 1900, aged 77. He qualified for practice in Glasgow, having passed his final examination in 1843. He soon afterwards came to Canada, and practised in Metcalfe, then in Almonte, also for a time in Fenelon Falls and Harriston. About nine years ago he went to Osgoode Station, where, on account of failing health, he did not engage in practice to any extent. He was highly respected in the Ottawa district.

ALEX. N. BARKER, M.D.

Dr. Barker, of Fenwick, county of Welland, was instantly killed, March 25th. While driving his horses ran away, and when crossing the railway track his buggy was struck by a C. P. R. express train. He graduated M.D. Queen's College, Kingston, in 1893. After graduating he commenced practice in Fenwick, and we are told that he was considered one of the most successful practitioners in the district.

CLARENCE R. CHURCH, M.D.

Dr. Clarence Church was for long one of the best-known and highly-respected physicians of Ottawa. He was a son of Dr. Basil R. Church, who represented Leeds and Grenville in the Canadian Parliament in 1854-8, and was born in Merrickville in 1846. He received his preliminary education in Upper Canada College, and his medical training at McGill, where he graduated M.D. in 1868. After practising five years in Ashton, Ont., he removed to Ottawa when he soon acquired a large practice. About five years ago he met with an accident in Ottawa by stepping into a drain, from the effects of which he never fully recovered. In the latter part of March he is said to have shown symptoms of heart failure (cause unknown to us). After a few days he appeared to rally, but the improvement was only temporary. From April 12th he steadily sank until the morning of April 20th, when he died. He was prominent in masonry, being a thirty-third degree member of the Scottish Rite, and also a Knight Templar. He took a prominent part in the establishment of St. Luke's Hospital, Ottawa, and was elected President of the Ottawa Branch of the British Medical Association in 1896.

WM. FRANCIS PETERS, M.D.

Dr. W. F. Peters, of Collingwood, died at his late residence, May 15th, aged 50. He attended lectures at Trinity Medical College, and graduated M.D. Trinity and M.B. Toronto in 1881.

ALBERT P. CORNELL, M.D.

Dr. A. P. Cornell, of Gravenhurst, died April 11th, aged 50. He graduated M.D. at Kingston in 1882, and had a good practice for several years in Gravenhurst. During the last two years, however, illness interfered more or less with active work.

JAMES M. CLEMINSON, M.D.

We have lost a bright and clever young physician through the death of Dr. Cleminson, of Warkworth, which occurred April 28th, after an illness of only three days, from appendicitis, aged 35. He graduated M.D. Trinity University in 1886, and shortly afterwards settled in Warkworth, where he became very popular and successful in practice. We notice in the Colborne *Express* many expressions of sorrow from correspondents living in Warkworth and several of the neighboring towns.

DR. PETER ST. JEAN.

Dr. St. Jean, of Ottawa, died May 6th, 1900, aged 67. He was well known as a public man, having represented Ottawa in the Dominion Parliament from 1874 to 1878. He was afterwards mayor of Ottawa for two years. He had been in poor health for some time.

RICHARD KING, M.D.

Dr. Richard King, of Peterboro', died March 27th, aged 58. He was born in Longford, Ireland, and came to Peterboro' when quite a young lad. He received his medical education in McGill, where he graduated M.D. in 1867. He practised in Baillieboro' until 1879, when he removed to Peterboro', and was then engaged in practice until a short time before his death. He had for many years a very large and laborious practice, and was highly respected by all classes in Peterboro' and vicinity.

Personals.

Dr. Sheard paid a short visit to New York in April.

Dr. Adam Wright, Toronto, spent Easter week in Atlantic City.

Professor Osler, of Baltimore, paid a flying visit to Toronto, May 1st.

Dr. Donald Campbell Meyers, Toronto, was married to Miss Burson, March 24th.

Dr. W. H. B. Aikins, of Toronto, visited New York during the last week of April.

Dr. T. B. Richardson, 10 Carlton Street, Toronto, was married to Miss Butland, March 3rd.

Professor Mills, of McGill University, Montreal, is at present in Leipzig, doing special research work.

Dr. Jas. F. W. Ross left Toronto, May 14th, with a party for a fortnight's outing in northern Muskoka.

Dr. George Sterling Ryerson, while in South Africa, rendered important services as a consulting oculist.

Dr. Chas. D. Parfitt (Trin., '94) has commenced practice in Toronto, and is associated in his work with Dr. W. P. Caven.

Dr. Arthur Jukes Johnson, of Toronto, is now recovering from an attack of acute rheumatism of about three weeks' duration.

Drs. McPhedran and King, of Toronto, attended the Congress of American Physicians and Surgeons in Washington, May 1st to 3rd.

Dr. Crawford Scadding, of Toronto, left his home, May 13th, to pay a visit to New York, Philadelphia, Washington and Baltimore.

Dr. Llewellyn Barker (Tor., '90), of Baltimore, has been appointed Professor of Anatomy of the University of Chicago, at a salary of $5,000. He will take charge of the department 1st of October next.

The annual banquet of the Toronto Clinical Society was held in the Albany Club, April 18th, under the chairmanship of Dr. G. A. Bingham, President.

Dr. C. H. Brereton (Trin., '96), one of the house surgeons in Toronto General Hospital, 1896-97, has recently recovered from a severe appendicitis requiring operation.

Miss M. E. Snively, Lady Superintendent of the Training School for Nurses, Toronto General Hospital, left Toronto, April 26th, to attend the annual meeting of American Association of Superintendents of Nursing Schools, in New York City.

Dr. Herman M. Robertson, Secretary of the Victoria (B.C.) Medical Society, writes to the *Dominion Medical Monthly*, saying that Drs. Ernest Hall and Joseph Gibb, after signing an agreement not to engage in contract lodge practice, promptly violated it, and are now doing the combined lodge work of this city, and, in consequence, have been expelled from membership in the Victoria Medical Society.

Dr. Thos. S. Cullen (Tor., '90), of Baltimore, has been appointed Associate Professor of Gynecology in Johns Hopkins Hospital. The many friends of Drs. Barker and Cullen living in Toronto and other parts of Ontario are more than pleased with the success which has followed their years of patient work in Baltimore since they left the Toronto General Hospital in 1891, after spending one year there as resident assistants.

A despatch from Baltimore, Md, says: Dr. Thomas Cullen, formerly of Toronto, where he took his medical degree, has been appointed associate professor of gynecology at Johns Hopkins University. Dr. Cullen recently declined a call to the chair of gynecology in Yale University. Dr. Cullen graduated in Toronto, 1890, and was one of the house surgeons at the Toronto General Hospital until May, 1891, after which he took a post-graduate course at Johns Hopkins University, Baltimore, in company with Dr. Llewellyn Barker, a contemporary on the house staff in Toronto, who is now associate professor in pathology at that university and who has just returned from Manila, where he has been investigating for the United States Government.

House physicians and surgeons of the Toronto General Hospital who have held positions at the Johns Hopkins University and Hospital are as follows:

Dr. Llewellyn F. Barker, associate professor of pathology, pathologist to hospital.

Dr. Thomas Cullen, associate professor of gynecology.

Dr. Harold Parsons, first assistant resident physician, and first assistant resident surgeon.

Dr. Thomas B. Futcher, resident physician to hospital, associate in medicine (J.H.U.).

Dr. Thomas McCrae, director of clinical laboratory, instructor in medicine (J.H.U.).

Dr. Charles D. Parfitt, research in tuberculosis, first assistant resident physician.

Dr. John McCrae, assistant resident physician.

Other Toronto graduates who have held appointments at Johns Hopkins Hospital are: Theodore Coleman, first assistant resident surgeon; Norman B. Gwyn, first assistant resident physician and clinical bacteriologist to the hospital.—*Evening News.*

Correspondence.

To the Editor of THE CANADIAN PRACTITIONER AND REVIEW:

DEAR SIR,—A lady called on me after the death of her little child, whom I had attended, to have a certificate of death from a life insurance company filled in. Among the questions asked on the insurance blank were: "Is there any tendency to consumption or other hereditary disease in the family?" "When and for what have you attended deceased prior to last illness? Give the immediate and remote cause of death," etc. These questions are quite proper to be asked by the company's examiner before the acceptance of a person's application, but to ask them of the family physician after his patient's death is a piece of gross impertinence.

The insurance companies have the additional effrontery to require him to go to a notary's office, and take an oath that the information supplied is true. I also find that no fee is allowed by the companies to the physician, who thus betrays his patient.

In the case related above I refused to fill out the document further than to give the information required by the "Death Return" issued by the Registrar-General of Ontario. I would like to know, Mr. Editor, your opinion in the matter. If you agree with me, the attention of the Committee on Ethics of the Medical Council ought to be drawn to the matter.

ANTHONY FREELAND, M.D.

OTTAWA, ONT., April 19th, 1900.

Book Reviews.

The International Text-Book of Surgery, by British and American Authors. Edited by J. COLLINS WARREN, M.D., LL.D., Professor of Surgery in Harvard Medical School, Surgeon to the Massachusetts General Hospital; and A. PEARCE GOULD, M.S., F.R.C.S., Surgeon to Middlesex Hospital, Lecturer on Practical Surgery and Teacher of Operative Surgery Middlesex Hospital Medical School, Member of the Court of Examiners of the Royal College of Surgeons, England. Philadelphia: W. B. Saunders; Toronto: J. A. Carveth & Co. 1900. Vol. I. (16mo, 947 pages, 458 engravings, plain and colored, and 9 colored full-page plates.) Cloth, $5.00; sheep or half morocco, $6.00.

This work is one of those pleasing evidences of co-operation and good feeling between the two English-speaking nations, a co-operation which has frequently taken place between the members of our profession north and south of the Great Lakes, citizens, respectively, of the British Empire and of the United States of America, but which has in this work extended to embrace our fellow-subjects of the Empress Queen on the other side of the Atlantic, one of those evidences of good feeling of which so many proofs have in the last two or three years been given in various spheres of life.

The work consists of two volumes. The contributors to Vol. I. reside in the great English metropolis, and the subjects of which they treat are: Golding Bird and Guy Billingham Smith, Surgery of the Spine; J. S. A. Burns, Anesthesia (in conjunction with Gay and Pfuff, of Boston); Watson Cheyne, Diseases of the Bones; Mahon's Injuries of the Joints, including dislocations; W. G. Spencer, Gangrene; Bland Sutton, Tumors. In Great Britain we also have Rushton Paden, of Liverpool, Orthopedics; and nearer home we are glad to see that the Greater Britain is still further represented by I. H. Cameron, of Toronto, in a chapter on Surgical Tuberculosis. Turning now to our friends of the Great Republic, the "Hub" supplies us with articles by E. H. Bradford and H. A. Lothrop on certain other portions of orthopedic surgery; H. L. Russell, on Surgery of the Heart and Blood Vessels; R. C. Cabot, on the Surgical Pathology of the Blood; Grust, on Bacteriology; G. W. Gay and F. Pfuff, Anesthesia (in conjunction with Burns, of London, as already mentioned); G. H. Marks, Surgery of Muscles, Tendons and Bruises; Maurice H. Richardson, on Peripheral Nerves; whilst J. Collins Warren, the American editor, writes four chapters on Hyperemia, Inflammation, Local Infection

and its Terminations: Suppuration, Abscess, Ulcer Sinus, Fistula; Erysipelas, Hospital Gangrene, Tetanus, and Dislocations of the Hip, respectively. In New York G. R. Fowler writes on Wounds, etc.; McBurney, on the Technic (so the American *will* spell it) of Aseptic Surgery, and has associated with him Howard D. Collins and Frank Oustler; whilst Lewis S. Pilcher and James P. Warbosse give us a chapter on Fractures. From Philadelphia John Chalmers Da Costa contributes the chapter on Minor Surgery; and Dr. Forest Willard, a chapter on Diseases of the Joints. From Baltimore S. McLane Tiffany gives an article on Cranial Surgery. From Chicago Weller Van Hook sends a chapter on Constitutional Reactions to Wounds and their Infections, and another embracing Hydrophobia, Anthrax, Glanders, Actinomycosis, Madura-Foot, Snake Bite and Insect Bite; and John B. Hamilton, of Chicago, wrote the article on Surgery of the Lymphatic System. It is a mournful coincidence that the concluding chapter of Vol. I. was written by one whose life-work here is now concluded.

In our review we have not taken the book up in the order of its chapters or subjects, but have rather grouped the fields for which the materials have been contributed, and named the laborers in these fields and their contributions.

Nobody need fear that his views will be narrowed by reading this work, nor complain of want of variety. It is printed on good paper, with good clear type and illustrations, and is a useful addition to surgical literature.

The Principles of Treatment and their Applications in Practical Medicine. By J. MITCHELL BRUCE, M.A., M.D., F.R.C.P., Physician and Lecturer on Medicine, Charing Cross Hospital; Consulting Physician to the Hospital for Consumption, Brompton; Examiner in Medicine, University of Cambridge. Adapted to the United States Pharmacopeia, by E. QUIN THORNTON, M.D., Demonstrator of Therapeutics, Pharmacy and Materia Medica, Jefferson Medical College, Philadelphia. Lea Brothers & Co., Philadelphia and New York. 1900.

This work consists of about six hundred pages. In Britain it was published a short time ago as No. 8 of Pentland's excellent Medical Series. It would be difficult to accord the present work higher than to say that it is one of the very best of the series. The work is divided into two parts. The first three hundred pages are devoted to the principles of treatment, and the second three hundred pages to illustrations of the principles of treatment. The first half of the work discusses

treatment from the various standpoints of etiology, pathology, clinical characters, clinical course, the personal factor and the proper relation of treatment to a disease. Under these headings sound advice is given in a pleasing and lucid manner. It is interesting to watch how much the author makes the etiology, the pathology and the clinical features of disease contribute towards sound and rational methods of treatment. The second half of the work deals with the management of special diseases. It is to this portion of the work that most will turn their attention. The suggestions throughout this portion of the work on the management of such important topics as inflammation of the heart, valvular disease of the heart, acute Bright's disease, chronic Bright's disease, gravel, acute and chronic bronchitis, asthma, pleurisy, pneumonia, phthisis, diarrhea, typhoid fever, indigestion, etc., etc., cannot be too highly commended. At the end of each chapter there is an epitome on diet, clothing, climate, medicine, exercise, etc. Very carefully prepared selections of prescriptions are given, with indications as to the stages when they should be employed. Those who studied fifteen and twenty years ago will remember what a favorite Fothergill's "Hand-book of Treatment" was. We have in the work before us from the pen of Dr. Bruce all the good features brought up to date, on a highly scientific and rational plan. After having read the work, one can hardly imagine how he could have gotten along without it. A feature of the book that merits more than a passing word is the attention that is given to what nature can do, and does do, to cure disease; and to what an extent we should aid these efforts, and how to give this aid, and when. So far as the make-up of the book is concerned, the well-known publishers have done their full duty. We can conscientiously recommend the work. Every page of it will yield, both pleasure and instruction to the reader.

A Text-Book on the Practice of Medicine. By JAMES M. ANDERS, M.D., Ph.D., LL.D., Professor of the Practice of Medicine and of Clinical Medicine in the Medico-Chirurgical College, Philadelphia, etc. Illustrated. Third edition. Revised. Philadelphia: W. B. Saunders, 925 Walnut Street. 1899. Canadian agents, J. A. Carveth & Co., Toronto. Cloth, $5.50 net; sheep or half morocco, $6.50 net.

Dr. James C. Wilson, the able and genial Professor of the Practice of Medicine and Clinical Medicine, Jefferson Medical College, Philadelphia, who will be remembered as one of the guests at the meeting of the Ontario Medical Association in 1899, expresses the following opinion with reference to this

admirable work: "It is an excellent book—concise, comprehensive, thorough, and up to date. It is a credit to you; but, more than that, it is a credit to the profession of Philadelphia —to us." We have no hesitation in saying that we quite agree with Dr. Wilson. The general plan of the book is good. The author has given much that is original, as, for instance, a large number of diagnostic tables; and also has gleaned enough from medical literature to bring the book well up to date. We can recommend the book both to students and practitioners of medicine.

Diseases of the Tongue. Revised and enlarged edition. By HENRY T. BUTLIN, F.R.C.S., D.C.L., Surgeon to St. Bartholomew's Hospital; formerly Erasmus Wilson Professor of Pathology and Hunterian Professor of Surgery at the Royal College of Surgeons; and WALTER G. SPENCER, M.S., M.B. (Lond.), F.R.C.S., Surgeon to the Westminster Hospital, and in charge of the Department for Diseases of the Nose and Throat; formerly Erasmus Wilson Professor of Pathology at the Royal College of Surgeons. Eight chromo plates and numerous engravings; 488 pages; size, 5½ x 9. Cloth, $3.25 net. New York: Cassell & Co., Limited.

The author, in his preface to this revised edition, says "Various additions have been made, such as the chapter on the Anatomy of the Tongue. On many points relating to clinical occurrences, particularly on the manner in which cancer first appears on the tongue, and on questions of operative surgery for malignant disease, the experience I have acquired during the last fifteen years enables me to speak with far greater authority than I ventured to do in 1885."

Tuberculosis—Its Nature, Prevention and Treatment. With Special Reference to the Open-air Treatment of Phthisis. By ALFRED HILLIER, B.A., M.D., C.M., Fellow of the Royal Medico-Chirurgical Society, London; Member of the Council of the Medical Graduates College; Member of the Council of the National Association for the Prevention of Consumption and other forms of Tuberculosis; Hon. Sec. to the London Open-air Sanatorium. With thirty-one illustrations and three colored plates; 256 pages; size, 5 x 7½. Cloth, $1.25 net. New York: Cassell & Co., Limited.

The author in his preface says: "Tuberculosis offers many aspects for study. These have been considered under different headings and in many different volumes; but no one book in English, so far as I am aware, is devoted to the subject as a

whole. For this reason I venture to believe that a concise manual, dealing with all the hydra heads of tuberculosis in one volume, will form a work of reference of some interest and value to practitioners of medicine and medical students. It is for them that this work is primarily intended. Tuberculosis is the Nemesis of overcrowding, of squalor, of departure from the conditions of a healthy animal life. Immunity from tuberculosis is a large portion of the reward which a community may hope to derive from good sanitation, from light, from air, from all that is sound in the progress of civilization, and all that is conducive to the material and moral welfare of the masses. It is thus a social as well as a medical problem."

The American Year-Book of Medicine and Surgery. Being a yearly digest of scientific progress and authoritative opinion in all branches of medicine and surgery, drawn from journals, monographs, and text-books of the leading American and foreign authors and investigators. Under the general editorial charge of GEORGE M. GOULD, M.D., in two volumes. Vol. I. Surgery. Philadelphia: W. B. Saunders. 1900. Canadian Agents: J. A. Carveth & Co., Toronto, Ont. Price, $3.00 per vol., cloth; $3.75 per vol., half morocco.

The Year Book for 1900 is issued in two volumes in order to make it less tiresome to hold, and for the convenience of specialists. Vol. I. contains General Surgery, Obstetrics, Gynecology, Orthopedic Surgery, Ophthalmology, Otology, Rhinology, Laryngology and Anatomy. The portion of the volume devoted to Surgery is particularly good. It covers 220 pages and reviews papers written and work done in Asepsis and Antisepsis, Cysts and Tumors, Anesthetics, Surgery of the Esophagus, Stomach, Intestines, Peritoneum, Hernia, etc.

The work of this part is simply invaluable to Surgeons, as indicating what is being done in other parts of the world. To Obstetrics seventy-five pages are devoted under the charge of Barton Hirst and Dorland. To Gynecology eighty-five pages. Kelly's article in the *Johns Hopkins Bulletin*, and Baldy's in the *Philadelphia Medical Journal*, on "Perineorrhaphy," are fully reviewed and illustrated by three handsome plates.

This volume is really an excellent *résumé* of the best work done in the subjects referred to.

Selections.

CAUSES, DIAGNOSIS, AND TREATMENT OF CYSTITIS.

In the *Medical News* of April 7th, 1900, appears a complete and comprehensive article with above title by Dr. Ramon Guiteras, a recognized authority on diseases of the genito-urinary tract. We print herewith portion of this paper on "Treatment of Cystitis Due to Tuberculosis."

"In the treatment of tubercular cystitis, the practitioner encounters a condition that taxes all the resources at his command, and he errs, as a rule, on the side of too much, rather than too little, treatment. In other words, it often happens that the more you treat the patient locally for his cystitis, the worse the condition becomes. It is, therefore, necessary to proceed cautiously in the treatment of this form of bladder inflammation, and, above all, it is important to improve the general condition of the patient as much as possible. If we were to treat patients suffering from tubercular cystitis along the same lines as pulmonary cases, namely, by sending them away to lead an open-air life under conditions that would improve their nutrition to the utmost, the condition would be much more rapidly improved or cured than by anything that could be done by the ablest specialist of the period.

"Numerous remedies have been recommended by different authorities for the treatment of this form of cystitis, and, naturally, every practitioner who encounters this rebellious trouble grasps at anything that offers the probability of a cure. Guyon at one time advocated the use of intravesical injections of bichloride of mercury, 1 to 10,000, and since then many have been following his advice, but such a solution will rarely cure this disease, while it usually produces an irritation that is almost unbearable.

"Nitrate of silver and permanganate of potassium have the same effect. Boric acid and boro-glycerine irritate less, but do not seem to possess the power to ameliorate the disease. Recently iodoform injections have been advocated, and the procedure would seem to be founded on a logical basis. Three or four ounces of a five per cent. solution of iodoform in liquid vaseline are injected into the bladder every two or three days, the patient being instructed to watch the stream when he urinates, and stop the flow just as soon as the oil appears. This forms a permanent iodoform dressing of the bladder-wall, and

in the hands of some of the French surgeons is said to have met with gratifying results.

"Personally, I have had better results with borolyptol in this class of cases than with any other remedy which I have employed. This seems to have a powerful germicidal effect, while the fact that it does not irritate the bladder renders it pleasant to the patient. It is used in the strength of from 1 in 8 to 1 in 16 in irrigations, by the hydrostatic method. After a few irrigations at the office, the patient will be able to use it every night at home. I have one patient now under observation who suffered for a number of years from a most aggravating frequency of urination accompanied by pain, dependent upon a tubercle cystitis. Under this treatment the urine has cleared up, the tubercle bacilli have disappeared, and the patient can hold his urine from seven to nine hours at night, and from four to six hours during the day.

"Internally, in connection with any local treatment, an antispasmodic and an internal antiseptic should be used as a palliative measure; it is wonderful how much relief may be given to the patient by this means, even although pus remain in the urine and the tubercle bacilli still be found. One patient has been coming to me for three months, who was entirely relieved of his disagreeable subjective symptoms by a mixture containing 10 minims of the tincture of belladonna, 15 grains of benzoate of soda, and oil of gaultheria up to one drachm, t.i.d., although not until he was put on the borolyptol irrigation did the pus and tubercle bacilli in the urine diminish to any marked degree. The effect of the palliative internal medication is worthy of notice, in view of the fact that he had suffered for fourteen years, and had been under the care of many different physicians without relief, having most probably been over-treated by too much instrumentation and too frequent or too irritating irrigations."

Appendicular Pleurisy.

Under this title Professor Dieulafoy calls attention to the frequency of pleural infection in connection with appendicitis, a frequency which appears to be more marked than is generally suspected. He ascribes the complication to direct infection of the pleura through the lymphatics, and this view concords with what is known of the essentially ineffective nature of the appendicular lesion. It usually makes its appearance between the eighth and fifteenth day after the onset of the appendicitis, it is as apt to occur in the mild as in the severe cases, and it is usually the right pleura which is the seat of the secondary infection, the initial symptoms of the pleurisy being masked

by hepatophrenic symptoms, this being the path by which the infection travels. Perforation, with consequent pneumothorax, is a not infrequent result, with corresponding aggravation of the constitutional symptoms. The possibility of this grave complication will strengthen the hands of those who are for immediate operation in all well-marked cases of appendicitis, since the removal of the focus of infection in the appendix not only spares the patient the risks associated with its presence in the abdominal cavity, but also saves him from the further risk of secondary infections elsewhere.—*Medical Press and Circular.*

Lobar Pneumonia.

A very interesting series of statistics regarding 500 cases of lobar pneumonia treated in ten years in the wards of the Mount Sinai Hospital has been prepared for the Hospital Reports by Dr. Alfred Meyer, attending physician to the hospital. The youngest patient was four months old, and died, and the oldest was seventy-seven years, and recovered. The total deaths were 94, a mortality of 18.88 per cent. Omitting 23 cases that died within forty hours after admission, the mortality for the series is only 14.20 per cent. There was a very high mortality under twelve months (67.34 per cent.), an almost uninterrupted fall in the mortality up to thirty years of age, and then a rise for every decade up to seventy years, which latter gave a mortality of 50 per cent. The mortality was nearly three times greater between thirty-one and forty than between twenty-one and thirty, and nearly twice as great between forty-one and fifty as between thirty-one and forty. The mortality in female cases was 23.68 per cent., and in male cases 16.66 per cent., a proportion agreeing almost exactly with that given by Juergensen in Ziemssen's Encyclopedia. Out of 263 cases there were 63 lyses and 200 crises. Of 200 crises, 79 fell on even days and 121 on odd days. All cases were considered as having defervesced by crisis in which the temperature fell from 103° or over to normal within forty-eight hours. In the 263 cases with complete histories the average duration (from the beginning of the disease to the cessation of fever) was thirteen days. As to site, the figures agree with those of other authors in showing a more frequent involvement of the right lung than of the left. The left lower lobe was the most frequent seat of disease, occurring in 26.62 per cent. of the cases. Pneumonia involving the right lung were more fatal than those involving the left, in the proportion of 13.50 to 8.18. There was not one fatal case of left upper pneumonia, though there were 36 in this site out of 325 cases. This does not support Juergensen's view that the prognosis is better when a lower lobe is involved. Pulmonary edema was both the most frequent and the most fatal compli-

cation. It occurred in 5.8 per cent. of the cases. There was pleurisy with effusion in 5 per cent., and pericarditis in 2.2 per cent. The cases occurring in summer appear to have been more benign than those of other seasons, for, though they represent 16.16 per cent. of the morbidity, they give only 8.51 per cent. of the deaths.—*Boston Med. and Surg. Journal.*

Creosote in Phthisis.

Creosote in *phthisis* is the subject of a recent paper by Dr. I. H. Hance, of Lakewood, N.J. He holds that its chief beneficial action comes from its antifermentative power in the stomach and bowels, and not in any antitubercular power it possesses; that too large doses are injurious instead of beneficial, and should be avoided. If given in proper amounts it improves the patient's appetite and digestion, so that in this way it brings about a condition of general improvement. The author states that creosote is to-day the most widely used drug in the treatment of phthisis pulmonalis, and he advises the use of only pure beechwood creosote, and for a long period of time. It should be begun with quite small doses once or twice a day, well diluted, and on a full stomach. He advises against its combination with other drugs, particularly cod-liver oil. The urine should be watched during its administration.

Creosote and whiskey, equal parts, mixed in half a tumbler of water or milk, is well tolerated by the stomach. Capsules packed lightly with bismuth carbonate will permit the depositing of 3 or 4 drops of creosote in them before being capped. Then the physician can use two capsules for doses of 6 or 8 drops instead of crowding the full dose into one capsule, and can readily explain to a patient how this is done, and its economy. See that the capsule is swallowed with a considerable amount of fluid. These capsules can be prepared more satisfactorily by the pharmacist. Mixed with a little glycerin and tincture of gentian, creosote can readily be given. Six to eight drops taken after each meal is the limit. Begin with 1 or 2 drops and increase 1 drop every third or fourth day until the maximum dose is reached.

Creosote carbonate has been much used by the author in the past five years; it is well tolerated by the stomach and has given satisfactory results. The doses, up to twenty-five drops, after each meal, should be given in milk or soft gelatin capsules. One objection is that this drug is expensive. Pills of creosote, or creosote carbonate capsules, made by the wholesale, become old and hard and have been known to pass undissolved through the alimentary canal.

When creosote is tolerated it is indicated in any form of tubercular affection of the lungs, but more particularly in afe-

brile cases, in first and second stage cases, where the expectoration is free, the cough distressing, or much bronchitis exists. In febrile cases it often is valuable, but must be administered more cautiously.—*Merck's Archives.*

Labor Complications after Vaginal Fixation.

Rühl (*Cent. f. Gyn.*, 1899, No. 51) calls attention to the severe labor complications which may follow both vaginal fixation of the uterus and ventri-fixation. The predisposition is greatest in the vaginal operation when the top of the uterine body is fixed to the anterior vaginal wall; and in the abdominal operation, when the fundus itself is immovably fixed close above the symphysis. The obstruction to labor may be so serious that although the pelvis be of normal dimensions, Cesarean section may be required. In passing he calls attention to the fact that Cesarean section, when performed for this cause, has been attended with a very high mortality, amounting to 50 per cent. In a normal pregnancy at the fortieth week the long axis of the uterus lies exactly at right angles to the plane of the pelvic inlet. In the pathological conditions under consideration the fundus is fixed much lower than it should be, whilst the cervix is drawn up and retroposed, with the result that the uterine axis may make an angle of only about 40° with the plane of the inlet. When the uterine contractions occur under these conditions, the tendency is for the presenting part of the child to be driven backwards against the sacrum, instead of downwards and backwards in the pelvic axis. The cervix may be drawn so far up and back as to lie above the level of the sacral promontory, and the true pelvis may be bridged over by the anterior wall of the uterus and vagina in such a way as to leave between the anterior lip of the cervix and the sacrum no room for the passage of the child or for the manipulations necessary for artificial delivery. In these cases the author advocates an anterior utero-vaginal section, consisting of an incision passing through the anterior lip of the cervix, the anterior uterine wall, and vagina. Special care is needed to avoid injury to the bladder. As much natural dilatation of the cervix as possible should be obtained before making the incision.—*British Medical Journal.*

Old Specula.—The *Bulletin d' Oculistique* relates a story answering the query, "What becomes of the old speculum?" A physician happening to enter the kitchen in a country hotel saw a brightly polished bivalve hanging among the cooking utensils, and upon inquiry learned that it was used by the cook for moulding sausages. The proprietor had bought it at an auction of second-hand household effects.—*Med. Record.*