Pages Missing

Dominion Medical Monthly

And Ontario Medical Journal

Vol. XXVII. TORONTO, NOVEMBER, 1906. No. 5.

Original Articles.

ABDOMINAL OPERATION FOR THE RELIEF OF UTERINE RETROVERSION.

By J. B. Eagleson, M.D., Seattle, Wash.

Hippocrates used posture for reducing uterine displacements by fixing the body to a ladder which was held with head down while the uterus was replaced by manipulation. "He further advised that when the uterus did not remain in its proper place, but goes from side to side, it occasions pain. When the patient is in bed on her back the uterus remains in place, but if she rises it slips down. Rest, astringent fomentations, and the raising the foot of the bed, are steps to be employed in the treatment. Then we should take a pomegranite, its shape being chosen to suit the parts, and we should divide it down through the umbilicus into two halves. Then warm it in lukewarm wine, after this thrust it as far as possible (into the vagina) and then bind the patient with a large sling bandage, which restrains it below and prevents it from slipping out, and so it can fulfil its office."

Thus we have described the first astringent pessary worn for uterine support, and from that time down through the centuries the pathology and treatment of this very common disorder of woman improved but little.

S. D. Gross, one of the ablest surgeons that America has pro-

*Read at annual meeting of British Columbia Medical Association, in August, 1906.

duced, in the fourth edition of his system of surgery published in 1866 states that the "treatment of retroversion must obviously be of an antiphlogistic character, consisting of rest in the recumbent position, light diet, astringent and cooling injections into the vagina and rectum, and the application of leeches to the hypogastric and sacro-lumbar regions. When the uterus has become firmly adherent to the surrounding parts, the disease may be regarded as irremediable, though considerable relief may follow the use of a pessary."

In those days the various inflammations of the appendages and pelvic peritoneum went under the general term of cellulitis, which came about as near being the correct pathologic term as the word hematocele for the collection of blood in the pelvis from a ruptured ectopic pregnancy.

Before the advent of abdominal surgery the pathology of pelvic disorders was in a very chaotic state, together with most all diseases of the abdominal organs. Since the modern development of abdominal work we are rapidly revising our pathology at the operating table instead of in the post-mortem room. In other words, we are beginning to have a living pathology instead of a dead pathology.

The result has been that the treatment of uterine retro-displacements has changed from a medical and palliative one, to a surgical and radical one, much to the comfort and health of our patients.

I do not mean by this that the day of the hot douche, tampon and pessary is past, for many cases are relieved and possibly some cured by these methods, and I believe that in many cases we get better and more prompt results in our operative work by a preliminary course of palliative treatment.

In a simple uncomplicated retro-displacement which is well retained by a pessary the woman should be permitted to choose between the permanent use of such a support and a radical cure, since no operation is absolutely devoid of all risk. In such cases all lacerations and inflammatory conditions of the cervix should be overcome and a well fitting pessary inserted and the patient given full instructions for the care of herself, with a warning to report at intervals for the inspection and alteration in size or shape of the support, in case the same should become necessary.

In complicated cases, or when the patient herself chooses to accept an operation, we are at once embarrassed by the multitude of operative procedures which have been devised for the sure cure of this displacement.

Goffe divides them into two classes: First, those which utilize the ligaments of the uterus, and, secondly, those which fasten the fundus or body of the uterus directly to some sustaining tissue. The first class are shortening the round ligaments by pulling them out of the inguinal canals, the Alexander-Adams method, with modifications, and the intropelvic shortening of the round ligaments by folding them on themselves and stitching them in that position. This may be done through an abdominal incision, as per Wylie, Mann, Dudley, Webster and others, or through a vaginal incision, as per Duhrssen, Mackenrodt, Byford, Goffe, Bovee and others, or by the plan of attaching the round ligaments to the abdominal wall, as per Noble, Ferguson, Simpson, Gilliam, Barrett and others. In the second class are: Suspending the fundus uteri from the anterior abdominal wall, as per Olshausen, Tait, etc., suspending the fundus uteri from the abdominal peritoneum, ventrosuspension of Kelly, stitching the fundus to the anterior vaginal wall, vaginal fixation of Schucking and Duhrssen, and shortening the utero-sacral ligaments, either through the abdominal or vaginal incision as practiced by Goffe and Bovee. Out of this list one must choose a method according to his best judgment and with a knowledge of his own skill, thinking always of the ultimate result on the patient.

Before any operation is undertaken a correct diagnosis should be arrived at, if possible, for upon a correct knowledge of the pathologic condition in each case depends the success to be attained by the procedure. We must remember that but very few cases of retro-displacements are simple; in fact, I have almost come to believe that none are, for "co-existent with the displacement, we may have adhesions of many kinds, inflammations, pustubes, cystomata, fibroids of the uterus, varicose conditions of the uterine veins, and numerous other complications. Many of these may bear the relation to the retro-displacement of cause or effect, and any operation which does not at the same time relieve these complications will not only fail to cure, but may leave the patient more uncomfortable than before."

Fixation methods either by the abdominal or vaginal route are mentioned only to be condemned, for it means the change from one pathologic condition to what is probably a worse one, and is never justifiable except in women with a severe prolapse, and that only after the child-bearing period.

The Alexander-Adams operation has probably been the most

popular of all operations, but it is limited to the few cases of simple retro-displacement in which there are no complications. To overcome this objection Goldsphon advocated and practiced enlarging the internal inguinal ring and through this opening attacking any pelvic lesions which might be present. This method has, however, been pretty generally condemned on account of the greater liability to hernia following the operation, which according to Goffe, results in from 5 to 15 per cent. of all cases after the simple Alexander operation. What would be more mortifying to an operator than to have a patient upon whom he had operated for the relief of a simple displacement of the uterus return to him in the course of a year or two with a single or double hernia through the Alexander incisions?

The very latest advocate of the Alexander operation, Reuben Peterson, in the July issue of Surgery, Gynecology and Obstetrics, gives the following resumé of its disadvantages, viz.:

1. "The operation is limited in its scope, since it must be reserved for perfectly movable, non-adherent uteri. This is a serious disadvantage, since besides limiting the operation to a comparatively few cases, it opens the way to failure should adhesions be overlooked prior to the operation. Every operator must admit such mistakes in diagnosis. Fine adhesions about the appendages and posterior part of the uterus and rectum sometimes escape the most expert examiner. They do not prevent the reposition of the uterus, but they exert a strain in the opposite direction when the uterus is held forward by the shortened ligaments. Pain and discomfort are the result and not relief of the symptoms.

2. Each ligament has to be shortened by a separate incision in the inguinal region. Hence there is a double chance for suppuration. Because of the location of the incision and its liability to contamination, there is more of a tendency to suppuration after Alexander's operation than after other procedures. This has been testified to by many operators and has been borne out by my own experience.

3. Alexander's operation cannot be used as an adjunct to other intropelvic work, since it would necessitate three skin incisions, which for obvious reasons, cannot be considered."

To obviate the last disadvantage, Dr. Peterson recommends using either a vertical or transverse skin incision close above the pubes, through which he not only opens the abdomen by a median incision, for the pelvic work, but also draws the skin wound to either side and

performs the Alexander operation secondarily, thus virtually making three wounds in the abdominal wall through the one skin incision. This method certainly makes a very complicated operation and in no way overcomes the danger of post-operative hernia.

Goffe has advocated making a preliminary vaginal incision to free the uterus and to relieve pelvic conditions.

The main argument in favor of the Alexander operation is that it does not complicate future pregnancies. In performing the operation, however, one is liable to meet with certain unforeseen complications.

Adhesions are sometimes encountered in the inguinal canal, which effectually prevent the drawing out of the cord. The cord is sometimes so delicate that it is unable, when separated from its attachments, to resist the strain and breaks. The rupture sometimes occurs at the horn of the uterus. In few cases the cord has been found not to run through the inguinal canal. All of these complications make it necessary to resort to some other procedure to complete the operation.

The vaginal operations for shortening the round and utero-sacral ligaments, as advocated by Duhrssen, Mackenrodt, Goffe, Bovee and others, is very difficult to perform by one who does not possess the highest skill in vaginal work. While its advocates claim that they are able to relieve all pelvic complications by this route preliminary to the main operation, there are still many disadvantages, as well as unforeseen dangers. Even in a case without any complications the vaginal vault has to be seriously mutilated and the bladder attachment separated from the uterus, the pelvic peritoneum torn off the face of the uterus and out into the broad ligaments which cannot be repaired from the vaginal opening, and thus leaves a raw surface which is liable to cause new adhesions as well as a permanent fixation of the uterus.

Suppose we have a case in which there are firm adhesions between uterus, tubes, broad ligaments and perhaps bowel, with a possible involvement of the appendix, which is rather frequent, and you have a condition that would tax the ingenuity of the most skilful vaginal route advocate. Add to the above a perforation of the bowel by an old abscess, so that when the adhesion was freed between tube and bowel an opening was left in the latter, which occurred in a case of mine a few months ago, or a severe intra-abdominal hemorrhage, and the probabilities are that not even the

most expert would recognize the condition, and the patient would either have to undergo an immediate abdominal operation or die from septic peritonitis or internal hemorrhage. No man has a perfect tactile sense or eyes on the ends of his fingers, hence where we have to deal with dense adhesions there is always danger of leaving some unrevealed accident buried in the pelvis. This brings us to the consideration of dealing with retro-displacements of the uterus, by the abdominal route, which, to my mind, is not only the most logical, but at the same time the best surgical door to the pelvic cavity. By it we can use our eyes as well as fingers, and absolutely know the conditions with which we have to deal, and if any part of the operation is left undone, or is wrongly done, it is the fault of the surgeon and not of the method.

"Koeberle, from observing that the uterus was influenced in its position in the pelvis by the attachment of the tumor pedicles in the abdominal incision after laparotomies, conceived the idea of fixing a portion of the uterus, or its appendages, in the abdominal incision as an operation of election for retro-displacements, consequently he was the first to execute such an operation, on March 27, 1869, when he stitched the pedicle of an excised ovary in the lower angle of an abdominal incision. Sims, February 22, 1875, cured a patient with persistent, painful retro-flexion by practically the same operation as that employed by Koeberle. Schrader reported, in 1879, a similar operation."

"On February 20, 1880, Lawson Tait, in closing an abdominal wound after removing the appendages in a case complicated with retroversion, allowed the sutures employed for closing the abdominal incision to include the fundus of the uterus and thus deliberately accomplished a ventral fixation. He reported this case, and another done in April, 1880, as cured in 1883. Sanger reported that Hennig performed this operation in 1881."

This operation has practically been abandoned on account of the difficulties which follow during pregnancy, and should never be resorted to except in cases of severe prolapse in women who have passed the menopause.

The operation of ventro-suspension which has had more ardent advocates than any other until recent years, was originated by Kelly, of Baltimore, in 1885, and will always be inseparably connected with his name.

It has been described so frequently in medical literature that it

is not necessary to mention its technique. Its object is not to fix the uterus to the abdominal wall, but to form suspension ligaments which will hold the fundus forward in its normal position.

The principal arguments in its favor are the ease with which it is performed and that in the majority of cases the results are good. It seldom interferes with the after pregnancies.

The arguments against it are numerous. It produces an abnormal adhesion, a pathologic condition which would be considered a menace to health in any other place in the abdominal cavity. A number of cases have been reported where it has caused intestinal obstruction or severe disturbance with the normal bowel function. The fact that, with the usual technique, two small bands result, makes the danger of incarceration of the bowel or omentum all the more liable. Even with the best of care, a firm fixation sometimes occur. Sometimes the bands stretch out so long that the fundus is again permitted to fall back into the hollow of the sacrum. The bands are practically devoid of muscular tissue, so that when once stretched out by a pregnant uterus they never retract to their original length.

The operation has been modified by the late Geo. F. Fowler, by suspending the uterus to the urachus; and by Martin, of Chicago, who uses a strip of peritoneum from the edge of the abdominal wound, which is passed through a small slit under the peritoneum on the fundus of the uterus. He thus obviates the use of any non-absorbent sutures.

The intra-abdominal shortening of the round ligaments was first suggested by Wylie, of New York, which he did by simply folding the ligament on itself once and stitching it together. This has been modified by Mann, who formed two folds, and by Webster, who made a single fold, and then passed this through the broad ligament and stitched it to the posterior wall of the uterus. Many of these operations give excellent results, but they all have the fault of using the good end of the ligament for folding and leave all the strain upon the very weakest part of the ligament, at the internal abdominal ring.

They do not interfere with pregnancy. Ashton, of Philadelphia, in bad cases recommends the combination of the ventro-suspension and the Wylie operation.

In order to secure the service of the strong end of the broad ligament, Gilliam, Ferguson, Grandin and others advocate the

suspension of the uterus to the anterior abdominal wall by the use of the round ligaments, which are either stitched to the peritoneum or are brought out through a punctured wound made through the rectus muscle and sometimes the fascia.

This method gives excellent results, but is open to the criticism of simply hanging the uterus up by the ears, and leaves a narrow space through between the ligaments which is liable to invite a loop of intestines or a portion of the omentum to become incarcerated. One case was reported some time ago in which about one-third of the omentum got caught in this manner and had to be amputated.

One year ago, C. W. Barrett, of Chicago, reported an operation for retro-displacement, which is simple and yet effectual, and does not present many of the disadvantages of the other methods. It has been slightly modified by C. H. Mayo, so that the present technique is very simple.

After opening the abdomen by the usual supra-pubic median incision, and taking care of any pelvic or other conditions that may be necessary, a large curved Kelly clamp is passed under the aponeurosis of the rectus and external oblique muscles, over the rectus, and out to a point immediately over the internal abdominal ring, where, by raising the handles, the tip of the forceps is made to perforate the abdominal wall behind the exit of the round ligament. By raising the same side of the abdominal wall by a retractor, the point of the forceps can be made to pass inwards and backwards under the round ligament and between the two layers of its peritoneal covering until it reaches a point about 2½ inches from the angle of the uterus, where the forceps blades are opened and made to grasp the round ligament, which can be done either with or without opening the peritoneum at this point. The forceps are now withdrawn, bringing with it the round ligament, which is held firmly until the other one is treated in the same manner. Frequently the loops are long enough so that they can be brought out in the median line and stitched together. If this can not be done without too much tension the loop is sewed to the underside of the aponeurosis with catgut. The abdomen is then closed in the usual manner.

"Tracing the round ligament we now have it running from the uterus to its normal exit, the internal ring, and under the aponeurosis to the lower angle of the abdominal incision, close to the symphysis pubis, to the underside of which aponeurosis it is attached about

one inch from median line or to the middle, if long enough. The ligament now retraces its steps to the internal ring, from whence it follows its normal course to the labium majus."

The ligament thus uses the normal structures for a pulley where it leaves the abdomen, and there are no loops or openings of any kind for strangulation of the bowel. The uterus is now supported by the very best part of the round ligament, where it has the capacity for evolution during pregnancy and involution afterwards.

I have seen but one criticism of this operation and that is in case of infection of the wound the suppuration might travel out along the round ligaments in their new course and thus lead to deep abscesses, but of this I think there is very little danger. Its originator claims the following advantages for this operation, all of which I think are very justly made, viz.:

1. It may be employed where there are intra-abdominal complications of any extent, and through the best possible opening for dealing with them.

2. It is easy of execution through even a very small opening.

3. It creates the least possible pathology, forming no new ligament.

4. It utilizes the very best part of the round ligament, acting through the internal ring.

5. It has shown the highest efficiency in holding the uterus forward and yet allowing the normal range of movement.

In case it may be deemed necessary to supplement it by a shortening of the sacro-uterine ligaments, this can easily be done at the same operation.

BIOGRAPHY.

Ancient Gynecology. McKay, 1901.
System of Surgery. Gross, 1868.
System of Gynecology. Bovee, 1906.
Reubin Peterson, in *Surgery Gynecology and Obstetrics*. July, 1906.
A Treatise of Gynecology. Martin, 1903.
Practice of Gynecology. Ashton, 1905.
C. W. Barrett, in *Surgery, Gynecology and Obstetrics*. November, 1905.

DIRECTIONS FOR NURSE AND HOUSE PHYSICIAN, BURNSIDE LYING-IN HOSPITAL, TORONTO.

DIRECTIONS FOR NURSE.—PATIENT ON ADMISSION.

Have the patient undressed at once, and her cast-off clothing placed in a receptacle, from which it is to be taken for fumigation.

Let her then take a warm tub-bath, after which she is to be dressed in hospital clothing.

Then make a record of her pulse, temperature and respiration.

Take pulse and temperature morning and evening while "waiting," and record everything abnormal.

PREPARATION AFTER ONSET OF LABOR.

Give soapsuds enema.

Give warm bath.

Let patient then put on a nightgown and remain in bed until examined.

Prepare delivery room and table.

Have at hand sterile towels, gauze sponges, absorbent cotton balls, thread for cord, three basins for solutions of sterile water, mercury bichloride, and lysol or cresoline, scissors, and two clamps.

Place small portable table near bed and operator.

FURTHER PREPARATION OF EXTERNAL GENITALIA.

After patient is placed on operating table:

Put Kelly's pad under buttocks.

Cut short all hair at sides of vulva, and all hairs above long enough to reach the vulva.

Give a vaginal douche of green soapsuds at about 110 degs. F.

Scrub the lower abdomen, pubes, vulva, perineum, buttocks and thighs, using green soap; then wash with warm sterile water, then with bichloride solution.

During the scrubbing process, wash from before backwards, *i.e.*, towards the anus.

Then place a bichloride guard over the vulva.

If labor is advancing too rapidly to allow all these procedures, omit the douche, but, if possible, cut short the hairs at side of vulva, and wash vulva and adjacent parts.

Then remove the Kelly pad, and place under back, buttocks, and thighs a fresh sterilized draw-sheet, and an absorbent gauze pad under the buttocks.

In prolonged labor give a second rectal enema in twelve hours after the first.

If there is any operative interference, wash the external genitalia again, and put on the Snively stocking-drawers.

The patient's legs are then to be held or fastened with leg-straps, as directed by the operator.

Catheterize only when directed by the obstetrician, the house physician, or head nurse.

Management of Patient After Labor.

Wash the external parts first with warm sterile water, then with bichloride solution, then cover with bichloride pad retained in place by T-bandage, or fastened to binder when applied.

Change vulvar pad as often as necessary, *i.e.*, before it becomes saturated with blood, sometimes every hour, for a few hours; after one day, every four to eight hours for a week.

When changing pads, wash the parts with a bichloride solution for seven days, and with soap-water after seven days.

Give a cathartic on the evening of the day after labor.

Note the height of the fundus uteri, and keep the daily involution line.

Prop up on pillows the head and shoulders for a few minutes, twelve hours after labor, and afterwards three times a day for seven days. Allow patient to sit up and void urine on and after second day, if she desires, unless there has been a perineorrhaphy, in which case the nurse will be instructed by the attending obstetrician. Allow her to sit up in bed on and after the fifty day, if she desires. Do not allow her to get out of bed earlier than the tenth day, and not then if the fundus is still above the pubes, unless by order of attending obstetrician.

Eclampsia Before, During, or After Labor.

Remove false teeth, if present.

Prevent patient from injuring herself; use several pillows as buffers.

Prevent her from biting her tongue, by covering an ordinary clothes-pin or large spoon handle with gauze, and holding it between the teeth during convulsion.

Darken room if possible, and keep the patient very quiet.

If there is much blood or mucus in mouth and throat, turn

patient on her side, with head in a position to allow liquids to run out of the mouth.

Hemorrhage Before or During Labor.

Keep patient absolutely quiet; elevate the foot of the bed.

The New-born Babe.

Weigh the baby at once, anoint with albolene, examine the cord for bleeding, the head for meningocele, etc., the back for spina bifida, etc., the limbs for talipes and other deformities, the whole body for birth-marks, etc.; notice if babe turns blue, and examine for imperforate anus.

Bathe the babe as soon as convenient, and thereafter every day; apply dry dressing with boric acid over cord, remove this dressing and apply a new one after each bath.

If babe weighs less than five pounds, anoint with albolene and wrap in flannel or cotton wool, or both, taking care to keep it very warm until ordered by the attending obstetrician to wash and dress it.

Let babe nurse every six hours during first day, every four hours during second day, and every two hours for twenty minutes during third day, and thereafter, except at night, when he should nurse at half-past ten, half-past four, and in morning, half-past eight.

Take the temperature twice every day.

Weigh baby before each daily bath.

Directions for House Physician.

Examine each patient on day of admission, especially as to condition of heart, lungs and kidneys, and also general health and record.

If there is any nasal or vaginal discharge, have a bacteriological examination made, and record the results.

Examine by abdominal palpation for position and presentation; also make external measurements by pelvimeter; record results as to both palpation and pelvimetry.

Examine specimen of urine furnished by nurse on day after admission, and every seventh day thereafter up to time of labor, and daily if there is headache, nausea, anasarca, or any other abnormal condition.

Preparation of Attending Obstetrician and Resident Physician.

Cut the nails short; wash hands and arms in hot water, using green soap and nail-brush; cleanse well under and around

nails; rinse in sterile water and then in a one per cent. solution of lysol or cresoline. Keep one of these solutions in a sterile basin on the small table beside the operator, and rinse hands from time to time. Put on operating-gown. The attending obstetrician may, and the intern must, wear rubber gloves in making vaginal examinations, which shall be as few as possible.

MANAGEMENT OF PATIENT IN LATTER PART OF LABOR.

Let the patient lie on her left side during the last expulsive pains, and let her turn on her back while the child is being expelled, or immediately after its delivery.

Keep one hand on fundus, press gently or irritate slightly with finger-tips, without using force.

After separation and passage into vagina, or after thirty minutes, endeavor to express placenta by pressure on fundus.

If placenta is retained, send for attending obstetrician, but in case of emergency, such as serious hemorrhage, introduce gloved hand and extract.

In all other cases of retained placenta, place a bichloride guard over vulva, and wait until an attending obstetrician arrives, but at the same time watch for hemorrhage.

Tie cord after pulsation has nearly ceased, or in five minutes.

Examine placenta carefully, measure and weigh.

Report all injuries and tears of the soft parts to an attending obstetrician, who shall treat or instruct as to treatment.

MANAGEMENT OF PATIENT AFTER LABOR.

See that directions for the nurses are properly carried out.

See that patient gets a cathartic on the evening of the day after labor.

Watch carefully the uterus for involution.

Keep patient in bed not less than nine full days.

DIRECTION FOR CASES OF EMERGENCY.

Eclampsia.

Use mouth-wedge at once.

Give hypodermic of morphine at once, half-grain, also another hypodermic, quarter-grain, in half an hour, and a third hypodermic in one hour if convulsions are not controlled in the meantime.

See that patient is kept very quiet, and protected from cold and drafts.

If the patient becomes conscious, give calomel, 3 grains, as soon as possible, and magnesium sulphate, 2 drachms, every half-hour.

If not effectual within two hours, order 1, 2, 3 enema (Epsom salts 1 ounce, glycerine 2 ounces, water 3 ounces), and also continue salts by the mouth until bowels are well moved.

After bowels are evacuated, administer high enema of salt solution, one pint every hour until three pints are injected, or use colon irrigation, if directed by attending obstetrician.

Apply hot packs on kidneys.

Hemorrhage Before or During Labor.

Keep patient absolutely quiet.

Elevate foot of bed.

Give hypodermic of morphine, quarter-grain.

Repeat hypodermic of morphine, quarter-grain, in fifteen to thirty minutes if necessary.

Give adrenalin 1-1000 solution, M. 10 by mouth or M. 5 hypodermically. If serious bleeding continues, and membranes are unruptured, plug the vagina, keep pressure over fundus uteri, and give three salt solution enemata, one pint each, at intervals of one hour.

Hemorrhage After Labor.

Massage fundus uteri so as to express clots.

If uterus cannot be well contracted, and hemorrhage is alarming, introduce the gloved hand into uterus, clear out clots, and irritate uterine walls with finger-tips, and massage externally.

If the uterus is well contracted, and serious hemorrhage continues, look for bleeding-points in lacerations of perineum, vulva, pelvic floor, other parts of vagina, and cervix.

Use of Forceps.

No house physician shall use the forceps without the permission of an attending obstetrician.

Do not apply the forceps until the cervix, vagina, vulva, and perineum are dilated and softened.

After dilation, apply the forceps within three hours in primiparæ, and within two hours in multiparæ, if nature has not completed delivery.

In using traction on handle attached to traction-rods, pull intermittently, and if considerable force is required, occupy not less than twenty to thirty minutes in delivering the head, taking the time from a watch or clock.

As soon as the head commences to press on the pelvic floor, remove leg-holder and allow extension of the thighs, etc., allow legs and thighs to hang over the end of the labor-table.

The Use of Anesthetics.

No house physician shall administer an anesthetic without the permission of an attending obstetrician.

In all serious operations, and in all operations on patients in a serious condition from disease or other cause, an official anesthetist shall administer the anesthetic.

The term "attending obstetrician" refers to the individual members of the visiting Burnside staff, and to all physicians who have charge of patients in the private wards.

All obstetricians in charge of private patients are requested to observe these rules.

Examine every male child on the seventh day after birth, to ascertain the condition of the prepuce. If found adherent, "strip" the glands, and secure, if possible, a prepuce freely movable. If this cannot be done after using the prepuce-forceps, and a probe or director, report to an attending obstetrician, who shall see that circumcision is done if required.

During labor and the puerperium, record, or let nurse record, as far as possible, the following: Length of first stage, length of second stage, length of time before expulsive pressure is used over the fundus of the uterus, length of time of such pressure, total length of third stage, time of washing of vulva, time of application of abdominal binder, time of putting patient in bed, time of first weighing baby, time of first washing baby.

In forceps delivery, record when forceps are applied, when head is extracted, when body is expelled or extracted.

In all other operative procedures record length of time of operation.

Remarks.

When Solon gave laws to the Athenians, he was asked, "Are these the best laws you can frame?" He answered, "No; but they are the best laws that the Athenians can keep."

We have endeavored to profit by Solon's wisdom, and have tried not to frame rules that are too elaborate. The tenure of office of our nurses and house physicians is very short, and the frequent changes make the training of the staff somewhat difficult. We find that a printed set of rules, which are to a large extent similar to those used in other maternities, especially in the United States, is very serviceable in many respects. We have made our rules simple, and we hope they will prove useful for our young graduates.

We have considered for several years that it is difficult or impossible to keep the Kelly pad perfectly sterile, and we use it only to a limited extent. We, therefore, remove the Kelly

pad after preparing the patient for labor, and place under the patient a clean draw-sheet and an absorbent gauze pad.

For many years we used no vaginal douche before or after labor in normal cases. Recently, however, we commenced the administration of the antepartal douche, as was the custom years ago in the Burnside. We do not use a douche of any kind after labor, unless there is some special indication for it.

Our rule as to the vulvar pad after labor is to change it as *often as necessary,* instead of every four or six hours, as was once our custom. Our aim is to change the pad before it has become saturated with blood, *i.e.,* before the bed-clothing has become soiled. Frequent changes, sometimes every hour, are generally required during the first twenty-four hours after the completion of labor.

We administer a cathartic earlier than we did a few years ago, with benefit, we think, to our patients. The height of the fundus is noted daily, and the involution line has been carefully kept on our ordinary charts for the last six years, according to the custom of Queen Charlotte's Hospital, London, England. The head and shoulders are propped up on pillows for a few minutes three times a day, to favor free vaginal drainage.

In cleansing the hands of the obstetrician, and the genitalia and adjacent parts of the patient, we have discarded alcohol, for two reasons. Its use involves considerable expense and some inconvenience, especially for the general practitioner who does not, as a rule, carry alcohol in his obstetrical satchel. So far as our observations show, we get along as well without it.

As to antiseptics, we still use the bichloride of mercury to a large extent. We have used lysol for some years, and are now using cresoline to a limited extent. Professor Amyot, of Toronto University, conducted a series of experiments for us last winter, and found that the germicidal powers of lysol and cresoline were strong. They are both commercial preparations, somewhat similar in nature, being saponified cresol mixtures.

In fixing a time limit after the Dublin fashion, we do not mean that in all cases the operator should wait for two or three hours after complete dilatation before applying the forceps, but we do mean that he should never wait longer.

Our chief aim in making rules as to certain time records is to secure uniformity in methods of procedure. For instance, we don't want a muscular and strenuous house physician to pull the head over the pelvic floor and through the vulva in five minutes. We don't want him to guess as to time, but use his watch, or the clock on the wall beside him, so as to know what progress he is making in a given time.—*A. H. W.*

Clinical Department.

A Case of Intestinal Obstruction. FRANK S. HOUGH, M.D., Sibley, Iowa, in *J.A.M.A.*

I have made no extensive examination of the literature of intestinal obstruction, but from the nature of this case I believe that it is a rare one.

History.—Mrs. A., aged 30, married one year, was operated on by me two years ago for destructive disease of the appendages. Nine years ago she suffered from pus tubes and general pelvic inflammation. Both ovaries were mere sacs filled with soft necrotic material, and all the other evidences of long-continued inflammations were present. She was a physical wreck. For about a year she suffered severely from the artificially-induced menopause; after that she commenced to put on flesh and became, apparently, the picture of health.

Present Illness.—On the evening of May 9, she partook liberally of sauerkraut. She returned home and retired with a feeling of well being. Some hours later, after midnight, her husband saw that she seemed ill, as she was groaning and rolling about though still asleep. He aroused her and she said that she had a great abdominal pain; the abdomen was found to be swollen. Soon she commenced to vomit and the pain increased in severity. I was summoned some time later and was loth to diagnose obstruction because one classical symptom, the element of shock (as registered by pulse, temperature and skin) was wanting. The patient vomited incessantly for sixteen hours.

Treatment.—I made many unsuccessful attempts to pass a long colon tube, but at last my efforts were rewarded by such an immense discharge of gas and feces that I thought, and told the family, that things were now all right. The pain and vomiting stopped for an hour and then the same symptoms returned and I found that I had only emptied the colon and that the small intestine was still enormously distended. I suspected volvulus near the lower end of the cecum.

Operation.—An eight-inch incision was made through the right rectus and was followed by evisceration of practically all the ileum, which was greatly distended and cyanotic. Not having a Paul's tube or other similar contrivance, multiple incisions were made in the bowel which allowed of evacuation of contents. The emptied bowel was sutured and returned. The cecum was located and an

effort was made to elevate it and the adjacent ileum, but it could not be done. The constriction could be felt, however, and a distended black loop of bowel was fished up. A white glistening cord was apparently tied around it. This cord was round, about three inches in length and the size of one's little finger, resembling somewhat a thick fibrous appendix. The herniated loop could not be extricated until the cord was exsected. By the application of hot wet compresses the strangulated bowel changed in color from black to rosy red, and no portion of the bowel was removed as its mesentery seemed all right and it had resumed a contracted natural appearance.

Result.—The patient did not vomit after the operation and on the second day she commenced to pass large quantities of liquid feces. The abdomen flattened and became normally tympanitic. Her recovery was rapid. She required cascara and epsom salts almost daily for two or three weeks before the bowels regained a normal condition.

The condition was of the nature of an intra-abdominal strangulated hernia. This cord was attached at one end to the bowel wall furthest from the mesenteric attachment, and to the adjoining mesentery near the bowel, so that a ring existed whose circumference was cord, bowel and mesentery. The diameter of this ring was one and one-half inches. This old adhesion was about six inches proximal to ileocecal valve, and on inspection another one almost identical in appearance was found a few inches proximal to that which was exsected to prevent subsequent trouble. These bands were undoubtedly the vestiges of her peritoneal inflammations years ago, and were there when I operated on her pelvic organs two years ago, but no search was made in this region at that time. She might have carried them around with her for years without suffering any inconvenience had not an unaccustomed dinner, and perhaps more especially the sauerkraut, excited violent peristalsis, and the ileum being thrown into violent action became strangulated by this band.

Strangulated herniæ through the omentum, diaphragm and gether and cause obstruction, and adhesions do the same by crossing the intestine. Such a case as this seems to me to be very rare. Had operation been delayed longer her chances would have been small, and my delay was due to the fact that I was unable to reconcile an unaffected pulse of 75, warm extremities, natural skin and no apparent depreciation of strength with volvulus or other form of obstruction, in spite of the distension, pain and vomiting.

Society Reports.

CANADIAN MEDICAL ASSOCIATION—REPORT OF SPECIAL COMMITTEE ON RE-ORGANIZATION.

CONSTITUTION.

Article I. Title.—This society shall be known as the Canadian Medical Association.

Article II. Objects.—The objects for which the Association is established are the promotion of the medical and allied sciences, and the maintenance of the honor and the interests of the medical profession by the aid of all or any of the following:

(*a*) Periodical meetings of the members of the Association, and of the medical profession generally, in different parts of the country.

(*b*) By the publication of such information as may be thought desirable in the form of a periodical journal which shall be the Journal of the Association.

(*c*) By the occasional publication of transactions or other papers.

(*d*) By the grant of sums of money out of the funds of the Association for the promotion of the medical and allied sciences in such manner as may from time to time be determined.

(*e*) And such other lawful things as are incidental or conducive to the attainment of the above objects.

Article III. Membership.—The Association shall be composed of ordinary and honorary members. Ordinary members must be regular practitioners in some province of the Dominion of Canada. Honorary members must be persons who have distinguished themselves and risen to pre-eminence in medicine, the allied sciences, in literature or in statesmanship.

Article IV. Affiliated Societies or Associations and Branch Associations.—All provincial, inter-provincial, county, city or district medical societies or branch associations at present existing in the Dominion of Canada, or which hereafter may be organized in the Dominion of Canada, may, by special resolution of said Medical Society or Association, become branches of or affiliated with the Canadian Medical Association, by subscribing to its constitution, by-laws and code of ethics.

Article V. Executive Council.—The Executive Council shall be the business body of this Association. It shall consist of delegates elected by the affiliated societies or associations or branches, by the Dominion and Provincial Boards of Health, and by the Canadian Medical Association as hereinafter provided for in the by-laws. It shall elect all the officers of the Association, except the president, by ballot, and transact all the general business of the Association. The president and general secretary shall be members of the Executive Council, and they shall act in the capacity of president and secretary of the same.

Article V. Sections.—Sections may be provided for by the Executive Council, or as hereinafter provided for in the by-laws.

Article VII. Meetings.—The meetings of the Association shall be held annually, at such time and place as may be determined by the Executive Council. Special meetings of the Executive Council shall be called by the president upon a written requisition stating the objects of such meetings and signed by twenty members of the Executive Council.

Article VIII. Officers.—Sec. 1.—The general officers of this Association shall be a president, a vice-president for each of the provinces of the Dominion of Canada, a local secretary for each of the provinces of the Dominion of Canada, a general secretary and a treasurer. The president shall be nominated by the Council and elected by the Association in general session.

Sec. 2.—The offices of general secretary and treasurer may be held by one and the same person.

Sec. 3.—These officers, excepting the president, shall be elected annually by the Executive Council to serve for one year or until their successors are elected and installed in office.

Sec. 4.—The treasurer shall give a bond to the Finance Committee for the safe-keeping of all funds in his possession and for their proper use and disposal.

Article IX. Finance Committee.—The Executive Council shall annually appoint five of its members as a Finance Committee, which shall also be a Publishing Committee, and whose duties will hereinafter be provided for in the by-laws.

Article X. Funds.—Funds for the purposes of the Association shall be raised by an equal annual assessment of $5.00 upon each ordinary member; from the Association's publications, and in any other manner approved of by the Finance Committee. These funds, from whatever source derived, are to be transferred to the treasurer, by him deposited in some responsible banking institution, and only paid out by him on the order of

the general secretary and the Finance Committee, through its chairman.

Article XI. Amendments.—No amendments to any of the foregoing articles or sections thereof shall be made, unless due notice has been given in writing to the general secretary at the previous annual meeting. Any such notice of motion must be laid by that officer before the Executive Council and sanctioned by a three-fourths vote of that body before it is adopted as a part of the constitution.

BY-LAWS.

Article I. Membership. Section 1. Membership. How Obtained.—A member in good standing of an affiliated medical society or association may become a member of the Canadian Medical Association by presenting to the general secretary: (1) A certificate of membership in good standing in an affiliated or branch society or association, signed by the president and secretary thereof; (2) written application for membership on the approved form; (3) payment of the annual subscription. In the absence of membership in a local association or branch a candidate may be elected to membership by the Council on the nomination of two members from personal knowledge.

Section 2. Membership. How Retained.—So long as a member conforms to the by-laws of the Canadian Medical Association, he retains his membership therein.

Any member who fails to conform to the by-laws and whose subscription shall not have been paid on or before the 31st December of the current Association year shall, without prejudice to his liability to the Association, be suspended from all privileges of membership, and at the end of the succeeding year, if the arrears be still unpaid, he shall *ipso facto*, cease to be a member. No member shall (except in case of his death or expulsion, or of his ceasing to be a member under the previous provisions of this article) cease to be a member without having given previous notice in writing on or before the 1st December in the current year to the secretary of the Association, of his intention in that behalf, and having paid all arrears of subscription (if any) due by him.

Section 3. Membership. How Restored.—Any delinquent member having once failed to comply with the sections of this article, unless absent from the country, shall have his name erased from the register of members of the Canadian Medical Association, and shall not be restored to membership until all his dues have been paid, and satisfactory evidence produced

that he retains his membership in an affiliated society or association, if admitted through such channel.

Article II. Registration of Members.— No member shall take part in the proceedings of the Association, nor in the proceedings of any of the sections thereof until he has properly registered his name and paid his annual dues for that and previous years.

Article III. Guests and Visitors.—Sec. 1.—Medical practitioners residing outside of Canada and other men of science of good standing may be received by invitation of the Canadian Medical Association, the Executive Council, the president, or any one of the sections or at the discretion of any of these on a letter of introduction from an absent member of the Association. They may, after proper introduction, be allowed to participate in the discussions of a purely scientific nature.

Sec. 2.—Medical students may be admitted to either the general meetings or to the meetings of any of the sections thereof, but shall not be allowed to take part in any of the proceedings. They shall be vouched for as such students by some member of the Association to either the general secretary or treasurer.

Article IV. Honorary Members.—Honorary members shall be elected unanimously by the Executive Council.

Executive Council.

Article I.— Qualifications for representatives on Executive Council.—Sec. 1.—No one shall serve as a member of the Executive Council who has not been a member of the Canadian Medical Association for at least two years.

Sec. 2.—Members of the Executive Council shall be elected for one year.

Sec. 3.—Every affiliated Medical Society or Association shall be entitled to elect one delegate to serve on the Executive Council for its membership from fifteen to fifty; two delegates for its membership from fifty-one to one hundred and fifty; three delegates for its membership from one hundred and fifty-one to three hundred; and thereafter one delegate for every hundred of a membership above three hundred; provided that no one delegate shall represent more than one affiliated society or association to which he may belong.

Sec. 4.—At the first general session of each and every annual meeting of the Canadian Medical Association, fifteen members thereof, who shall be present at that session, shall be elected by

ballot to act on the Executive Council for one year; provided that any one already elected a delegate by an affiliated society or association shall not be at that meeting elected a member of the Executive Council. The president of the Association shall name three tellers to conduct this ballot. The fifteen having the greatest number of votes shall be declared elected.

Sec. 5.—Every three years the Executive Council shall appoint a committee of five to examine the registers of membership of all affiliated societies or associations and so apportion the number of delegates entitled to be elected by each society.

Sec. 6—Every delegate from an affiliated society or association shall be required before acting on the Executive Council, to have entered his name on the annual register of the Canadian Medical Association, paid his annual subscription to the Association and deposited a certificate with the general secretary of the Association, duly signed by the president and secretary of the affiliated society or association, from which he has been elected a delegate.

Article II. Order of Business.—Sec. 1.—The following shall be the order of business in the Executive Council, which can only be changed or departed from by a unanimous vote of that body:

I. Calling the meeting to order by the president.
II. Reading the minutes of the previous session.
III. Reports of officers.
IV. Reports of committees.
V. Unfinished business.
VI. New business.

Sec. 2.—The Rules of Order which govern the proceedings of the House of Commons of Canada shall be the guide for conducting the sessions of the Executive Council.

Sec. 3.—Ten members of the Executive Council shall constitute a quorum for the transaction of business.

Sec 4.—It shall be the privilege of chairmen of committees and members of the Executive Council to report to the Executive Council, and they shall have the right to discuss their own reports.

Article III. Meetings of the Executive Council.—Sec. 1.—The meetings of the Executive Council shall be held on the dates of the annual meeting of the Canadian Medical Association, but not until after the first general meeting of the Association, and then not at the time of any general meeting of the Association.

Sec. 2.—As provided for in the constitution, the President of the Association shall be the President of the Executive Council and the General Secretary shall be the Secretary of the Executive Council.

Article IV. Nominations, Elections and Installation of Officers.—Sec. 1.—Nominations. Any five members of the Association may hand to the general secretary, in writing, the name of any member of the Association whom they may wish to nominate for any office, except in the case of the Finance Committee, which shall in all cases be elected by and from the members of the Executive Council, or any member of the Executive Council may nominate any member of the Association for any office.

Sec. 2.—All elections shall be by ballot and a majority of the votes cast shall be necessary to elect a candidate. Should there be more than two nominees for any position, the one having the lowest number of votes shall be dropped and a new ballot proceeded with. This procedure shall be continued until one of the nominees receives a majority of all votes cast, when he shall be declared elected.

Sec. 3.—The election of officers shall take place at any meeting of the Executive Council, and the exact time for same shall be fixed by the Executive Council.

Sec. 4.—The president shall appoint three tellers to conduct the ballot.

Sec. 5.—The Executive Council shall annually decide on the number of general addresses to be given at succeeding annual meeting and shall elect the readers to deliver same. In default thereof on the part of the Executive Council, this duty shall be discharged by the president.

Sec. 6.—Installation.—The president-elect shall be installed by the retiring president, at the first general session of the annual meeting of the Association succeeding the one at which he was elected.

OFFICERS AND COMMITTEES.

Article I. Duties of Officers.—Sec. 1.—President. The president shall preside at general meetings of the Association and at meetings of the Executive Council. He shall deliver the annual presidential address at either the first or second general session of the annual meeting, held under his presidency, as he may decide. In the absence of the president, the vice-president for the province in which the meeting is held shall perform the duties, or, in his absence, the meeting shall

select a vice-president. The president shall appoint annually a Committee of Arrangements, consisting of five members, who shall reside in the place at which the Association is to hold its annual meeting. He shall also name the chairman of this Committee.

Sec. 2.—The president shall be an *ex-officio* member of all committees.

Sec. 3.—In case of the death or resignation of the president the vice-president for the province in which the annual meeting is to be held, shall become the president.

Article II. Vice-Presidents.—The vice-presidents shall assist the president in the discharge of his duties at his request.

Article III. General Secretary.—Sec. 1.—The general secretary shall also be the secretary of the Executive Council of the Association. He shall give due notice of the time and place of all annual and special meetings, by publishing the same in the official journal of the Association, or if necessary in the opinion of the Finance Committee, by postal card to each member. He shall keep the minutes of the General Sessions of the annual meetings of the Association, and the minutes of each meeting of the Executive Council, in separate books, and shall provide minute books for the secretaries of the different sections which he shall see are properly attested by both chairmen and secretaries thereof. He shall notify members of committees of their duties in connection therewith. Where necessary or deemed advisable by the president, he shall conduct correspondence with other organized medical associations or societies, domestic or foreign. He shall preserve the archives, the published transactions, essays, books, journals, papers and addresses of the Association. He shall see that the official programme of each annual meeting is properly published and shall perform such other duties as may be required of him by the president or Finance Committee.

Sec. 2.—The general secretary shall be *ex-officio* a member of all committees.

Sec. 3.—For his services the general secretary shall receive a salary which shall be fixed by the Finance Committee.

Sec. 4.—The general secretary may also be elected to the office of treasurer.

Sec. 5.—All his legitimate travelling expenses to and from the annual meeting and other places ordered by the Finance Committee shall be paid for him out of the funds of the Association.

Article IV. Local Secretaries.—The local secretaries shall assist the general secretary at the annual and special meetings and shall perform the duties of corresponding secretaries for the respective provinces they are elected to represent; these duties shall be performed under the direction of the general secretary.

Article V. Treasurer.—Sec. 1.—The treasurer shall receive and collect the annual fees and demands of the Association from the members. He shall be the custodian of all moneys, securities and deeds belonging to the Association, and shall only pay out moneys on an order drawn by the general secretary and approved by the Finance Committee, whose chairman shall also sign all such orders.

Sec. 2.—The treasurer shall give to the Finance Committee a suitable bond for the faithful discharge of his duties, and shall receive for his services a salary to be fixed by the Finance Committee.

Sec. 3.—The treasurer may also be elected to the position of general secretary.

Sec. 4.—When the offices of general secretary and treasurer are filled by one and the same person, it shall be the duty of the Finance Committee to appoint a collector of dues and subscriptions at each annual meeting, who shall be responsible to the Finance Committee.

Article VI.—All the officers shall discharge the duties of their respective positions until the completion of the business and scientific proceedings of each meeting.

Finance Committees.

Article I. Appointment and Duties of the Finance Committee.—Sec. 1.—The Finance Committee as set forth in the constitution, shall consist of five members annually appointed or elected from the members of the Executive Council. This Finance Committee shall have charge of all the properties of the Association, and of all the financial affairs of the Association. It shall elect its own chairman. The chairman may then appoint any sub-committees that may be necessary or desirable in connection with the finances of the Association. This Committee shall have charge of the publication of the official journal of the Association, and of all published proceedings, transactions, memoirs, addresses, essays, papers, programmes, etc. of the Association. It shall have power to omit, in part or in whole, any paper or address that may be referred to it for publication in the official journal of the Association, by the general

meeting, the Executive Council or any of the sections. It shall appoint an editor and a managing editor of the official journal, who may be one and the same person if by them deemed advisable, and shall define the respective duties and responsibilities of each. They shall also appoint such assistants as may be deemed necessary for the proper conduct of this official journal, and shall determine their salaries and the terms and conditions of their employment. The Finance Committee shall have the accounts of the treasurer audited annually or oftener if desirable, and shall make an annual report on the same to the Executive Council. The Finance Committee may meet when and where they may determine, and the chairman shall call a meeting on the request of three members in writing, and three members of the Finance Committee shall constitute a quorum for the transaction of the business of the Finance Committee.

Sec. 2.—The president and general secretary shall be *ex-officio* members of the Finance Committee and the general secretary shall act as the secretary of the Finance Committee.

Sec. 3.—Any donations recommended by the Executive Council shall be paid only with the approval of the Finance Committee.

COMMITTEES.

Article I. Classification of Committees.—Sec. 1.—There shall be (*a*) Standing; (*b*) Special and (*c*) Reference Committees.

Sec. 2.—Standing Committees. The Standing Committees shall be the following: A Finance Committee, a Committee of Arrangements.

Sec. 3.—The Finance Committee shall be appointed by the Executive Council and its members shall always be appointed or elected from amongst the members of the Executive Council.

Sec. 4.—The Committee of Arrangements shall be appointed by the president. They shall be residents in the place in which the annual meeting is to be held, and the chairman thereof shall be named by the president.

Sec. 5.—The Committee of Arrangements shall be required to undertake to provide for transportation; a hall or halls for meeting purposes; a hall for Executive Council meetings; halls for section work; rooms for committees; rooms for general secretary, and other secretaries; room for registration; room or rooms or halls for exhibition purposes.

Sec. 6.—The general secretary shall act in an advisory capacity to the Committee of Arrangements.

Sec. 7.—The Committee of Arrangements shall have power to add to its numbers and shall name all the Reference Committees as well as the chairmen thereof.

Article II. Special Committees.—Special Committees may from time to time be appointed by the Executive Council; they may be named by the president on the authority of the Executive Council. They shall perform the duties for which they were called into existence and shall in all cases report direct to the Executive Council as hereinbefore provided.

Article III. Reference Committees.—Sec. 1.—The Executive Council shall at its first meeting appoint all the Reference Committees and name the chairmen thereof. Their titles shall be as follows: (1) A Committee on Sections and Section Work; (2) A Committee on Medical Legislation; (3) A Committee on Medical Education; (4) A Committee on Hygiene and Public Health; (5) A Committee on Amendments to the Constitution and By-laws; (6) A Committee on Reports of Officers; (7) A Committee on Credentials; (8) A Committee on Necrology.

Sec 2.—The general secretary shall notify each member of these committees so appointed of his duties.

Sec. 3.—Committee on Sections and Section Work. The Committee on Sections and Section Work shall secure papers for the sections. It shall report to the president or to the Executive Council when required.

Sec. 4.—Committee on Legislation. To the Committee on Legislation shall be referred all matters pertaining to local and federal Medical Acts. It shall report to the president or the Executive Council when required.

Sec. 5.—Committee on Medical Education. To the Committee on Medical Education shall be referred all matters pertaining to medical colleges and medical education. It shall report to the president and Executive Council when required.

Sec. 6.—Committee on Hygiene and Public Health. To the Committee on Hygiene and Public Health shall be referred all matters relating to hygiene, public health, etc. It shall report to the president or to the Executive Council when required.

Sec. 7.—Committee on Amendments to the Constitution and By-laws. To the Committee on Amendments to the Constitution and By-laws shall be referred all matters relating to the subject, before action thereon by the Executive Council. It shall report to the Executive Council when required.

Sec 8.—Committee on Reports of Officers. To the Com-

mittee on Reports of Officers shall be referred the president's address, the report of the general secretary and the report of the Finance Committee before submission to the Executive Council.

Sec. 9.—Committee on Credentials. To the Committee on Credentials shall be referred all questions regarding the registration and credentials of delegates, before submission to the Executive Council.

Sec. 10.—Committee on Necrology. To the Committee on Necrology shall be assigned the duty of collecting, as far as possible, the obituaries of members dying since the last annual meeting. These shall be duly filed by the general secretary. The committee shall report on the call of the president at the last general session of each annual meeting.

Sec. 11.—Three members shall constitute a quorum of any Reference Committee, and all reports shall be made as hereinbefore provided.

SCIENTIFIC WORK.

Article I. General Meetings.—Sec. 1.—Date of meetings. The date of each annual meeting shall be fixed by the president on the advice of the Committee of Arrangements.

Sec. 2.—Time of meetings. The general meetings or sessions shall be held at 10.30 a.m. and 7.30 p.m. of the first day of any annual session and at 7.30 p.m. on the subsequent days. The president shall preside at all general meetings, and in his absence, or at his request, one of the vice-presidents.

Sec. 3.—The president shall deliver his annual address at one of the general meetings of the first day, as he may determine. The time of the deliverance of all other general addresses shall be arranged for by the Committee of Arrangements.

Sec. 4.—The order of business of the first general session of each annual meeting shall be as follows:

1. Calling the meeting to order by the president.
2. Prayer; by some one designated by the president.
3. Addresses of welcome and response.
4. The report of the Committee of Arrangements.
5. Reading the minutes of the last general session.
6. The report of the general secretary of the last annual meeting.
7. Election of the Association's members to the Executive Council.
8. Presidential or other addresses, if decided on by the president and Committee of Arrangements.

Sec. 5.—The order of business for all subsequent general sessions shall be the same as that for the Executive Council.

Sec. 6.—All addresses delivered at any annual meeting shall immediately become the property of the Association, to be published or not, in whole or in part, as deemed advisable, in the official journal of the Association. They must, as soon as they have been delivered, be handed to the general secretary, who shall refer them to the Finance Committee. Any other arrangement for their publication must have the consent of the author or of the reader of same and of the Finance Committee.

Article II. Sections and Section Work.—The sections to be held at any annual meeting shall be determined by the Executive Council. In default of their so determining the duty shall be discharged by the Committee of Arrangements, who shall also appoint or elect the chairman thereof and the vice-chairman and secretaries. These section officers shall serve for such meetings only, but any of them, if deemed advisable by the Committee of Arrangements, may be appointed for the following meeting in proper course.

Sec. 2.—Duties of the officers of sections. The chairman shall preside at each meeting of any section, or in his absence or at his request, the vice-chairman shall preside. The secretary of each section shall keep a correct account of the transactions, and shall record them in a special section minute book provided by the general secretary. The chairman and secretary of each section must verify and sign the minutes.

Sec. 3.—Each section shall hold its first annual meeting at 2 p.m. on the first day of each annual meeting; and each subsequent day of the annual meeting at 9 a.m. and 2 p.m. until the programme of that section is completed. No section shall hold a meeting that will in any way conflict with a general meeting of this Association.

Sec. 4.—Honorary members of this Association shall have the privilege of presenting papers before any section and taking part in any of the scientific discussions.

Sec. 5.—All papers, essays, photographs, diagrams, etc., presented in any section, shall become the property of the Association, to be published in the official journal of the Association or not as determined by the Finance Committee, and they shall not be otherwise published except with the consent of the author and of the Finance Committee.

Sec. 6.—Each author of a paper read before any section shall, as soon as it has been read, hand it with any accompany-

ing diagrams, photographs, etc., to the secretary of the section before which it has been presented, who shall endorse thereon the fact that it has been read in that section, and shall then hand it to the general secretary to lay before the Finance Committee for publication, in whole or in part, or otherwise disposed of as may be deemed advisable by that Committee.

Sec. 7.—The order of procedure in any section shall be:

1. Calling the section to order.
2. Remarks by the chairman.
3. Reading minutes of previous meeting.
4. Reading of papers and discussions thereon.
5. Nomination of honorary members of the Association.

Sec. 8.—No paper shall be "Read by Title," except by unanimous vote of the section before which it was to have been read.

Sec. 9.—No business of any description shall be introduced at any meeting of any section except as hereinbefore provided.

AMENDMENTS.

Article I.—The Executive Council at any annual meeting may instruct the Finance Committee to make or to have made any changes in the articles of incorporation which may appear desirable, or which may be made necessary by any change or amendment in the constitution and by-laws of the Canadian Medical Association.

Article II. Amendments to By-laws.—No amendment to by-laws shall be made except on a three-fourths vote of the Executive Council; provided that no amendment shall be acted on until the day of meeting following that on which the amendment was introduced.

The Canadian Medical Protective Association

ORGANIZED AT WINNIPEG, 1901

Under the Auspices of the Canadian Medical Association

THE objects of this Association are to unite the profession of the Dominion for mutual help and protection against unjust, improper or harassing cases of malpractice brought against a member who is not guilty of wrong-doing, and who frequently suffers owing to want of assistance at the right time; and rather than submit to exposure in the courts, and thus gain unenviable notoriety, he is forced to endure black-mailing.

The Association affords a ready channel where even those who feel that they are perfectly safe (which no one is) can for a small fee enrol themselves and so assist a professional brother in distress.

Experience has abundantly shown how useful the Association has been since its organization.

The Association has not lost a single case that it has agreed to defend.

The annual fee is only $2.50 at present, payable in January of each year.

The Association expects and hopes for the united support of the profession.

We have a bright and useful future if the profession will unite and join our ranks.

EXECUTIVE.

President—R. W. POWELL, M.D., Ottawa.
Vice-President—J. O. CAMARIND, M.D., Sherbrooke.
Secretary-Treasurer—J. A. GRANT, Jr., M.D., Ottawa.

SOLICITOR

F. H. CHRYSLER, K.C., Ottawa.

Send fees to the Secretary-Treasurer by Express Order, Money Order, Postal Note or **Registered letter. If cheques are sent please add commission.**

PROVINCIAL EXECUTIVES.

ONTARIO—E. E. King, Toronto; I. Olmsted, Hamilton; D. H. Arnott, London; J. C. Connell, Kingston; J. D. Courtenay, Ottawa.

QUEBEC—F. Buller, Montreal; E. P. Lachapelle, Montreal; J. E. Dube, Montreal; H. R. Ross, Quebec; Russell Thomas, Lennoxville.

NEW BRUNSWICK—T. D. Walker, St. John; A. B. Atherton, Fredericton; Murray MacLaren, St. John.

NOVA SCOTIA—John Stewart, Halifax; J. W. T. Patton, Truro; H. Kendall, Sydney.

PRINCE EDWARD ISLAND—S. R. Jenkins, Charlottetown.

MANITOBA—Harvey Smith, Winnipeg; J. A. MacArthur, Winnipeg; J. Hardy, Morden.

NORTH-WEST TERRITORIES—J. D. Lafferty, Calgary; M. Seymour, Regina.

BRITISH COLUMBIA—S. J. Tunstall, Vancouver; O. M. Jones, Victoria; A. P. McLennan, Nelson.

Dominion Medical Monthly

And Ontario Medical Journal

EDITORS:

GRAHAM CHAMBERS, B.A., M.B. WALTER McKEOWN, B.A., M.D.

ASSOCIATE EDITOR:

T. B. RICHARDSON, M.D.

MANAGING EDITOR:

GEORGE ELLIOTT, M.D.

Published on the 15th of each month. Address all Communications and make all Cheques, Post Office Orders and Postal Notes payable to the Publisher, GEORGE ELLIOTT, 203 Beverley St., Toronto, Canada.

VOL. XXVII. TORONTO, NOVEMBER, 1906. No. 5.

COMMENT FROM MONTH TO MONTH.

In order to inform our readers in the matter of reciprocity between the General Medical Council of England and the medical councils of the various Provinces of Canada, a short report of the meeting of the College of Physicians and Surgeons of the Province of Quebec, held on September 26th, will prove interesting. But, before taking that up, a draft of the British Medical Act (1886) Amendment Bill, promoted by General Laurie, and having the support of Sir Walter Foster, Sir John Tuke, Mr. Rothschild, Sir Howard Vincent, Mr. Middlemore, and Sir Mancherjee Bhownaggree, will come in quite appropriately. The memorandum of this amendment was as follows: In order to facilitate the admission of the colonially trained and registered medical men to practice in Great Britain and hold appointments in the Imperial Service, the Act of 1886 provided for reciprocity between the mother country and

such of the self-governing colonies as might comply with certain conditions, but that Act expressly stipulated that when any colony had a provincial and a federal organization such reciprocal arrangements should be entered into with the federal government and not the provincial. In the case of Canada, the British North America Act of 1867, enacted by the Imperial Parliament, expressly provides that education shall be entirely under control of the provincial and not the federal government, so that it is impossible to bring the Act of 1886 into force in Canada. It is impracticable to amend the British North America Act of 1867, and to transfer the control of education to the federal authorities, and, therefore, it is the object of this bill to amend the Medical Act of 1886, without in any way interfering with the principle, and to enable reciprocal arrangements to be entered into either with the federal or provincial governments.

Subsequent to the memorandum, there follows: A Bil to Amend the Medical Act, 1886, A.D. 1904. Be it enacted by the King's Most Gracious Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same as follows: For the purpose of the Medical Act, 1886, where any part of a British possession is under a central and also under a local legislature, His Majesty may, if he thinks fit, by order-in-council, declare that the part which is under the local legislature shall be deemed a separate British possession. This act may be cited as the Medical Act (1886), Amendment Act, 1904. Up to the meeting of the Quebec College of Physicians and Surgeons, Nova Scotia was the single province which had moved in the direction of and established reciprocity with the home country. Quebec now follows suit at its September meeting, although at the previous meeting in July slight discussion of the matter had taken place. It has been brought about th is in the Province of Quebec: Dr. Donald Macalister, president of the General Medical Council of Great Britain, addressed a letter some months ago to a practitioner in the Province, not a member of the Medical Council, and, as it lets in a

great deal of light on the subject, it is here reproduced as it appeared in the October number of the *Montreal Medical Journal*: "I agree with you entirely that reciprocity with Great Britain and interprovincial reciprocity are entirely separate questions and should be dealt with separately. The former under the new law can be dealt with at once, without waiting for any reconstruction of the Medical Administration of Quebec. The one thing essential for a successful application to the King in council, is, that Quebec is prepared to allow duly qualified British practitioners to register and practise in Quebec without further examination. In other words, that possession of a registered British diploma shall admit to the Quebec register in the same way as if the holder had a degree from McGill or Laval. If this assurance is conveyed to the Privy Council by the "Provincial Government," along with their application to have the British Medical Act, Part II., 1886, applied to the Province, I am prepared to advise the Privy Council that the application should be granted. There is no need to wait for a Central Examining Board; there is none such in the Australian States, or Italy, or India, which already enjoy reciprocity. Supposing the Privy Council grant the application, the next step lies with the General Medical Council. It has to decide what Quebec diplomas shall admit to the British register. In accordance with precedent it will probably decide that any medical degrees granted in the Province which are registered in the Provincial register shall be registrable here. In no case hitherto, where a country or province (e.g., New South Wales or India) has been admitted to reciprocity has the Council discriminated between the several local universities, and accepted some while it refused others. But it is, of course, just possible that the Council might refuse to recognize a four-years' course—though if that is the rule throughout the Province, and there is no higher standard available, the result would be to render the reciprocity granted by the King in Council a nullity. Such a result would not, I think, be contemplated for a moment by the Council; and, if it were, the Privy Council has power to prevent such a fiasco, and could, without more ado, order the Medical Council to register Quebec degrees.

In my opinion this is the course that would be taken, and justifiably so; and the knowledge of its possibility and probability which the Medical Council possesses should remove any hesitation on your part as to whether the Council would act reasonably or not. It appears to me that the fact that the Quebec College of Physicians is primarily a registering and supervising body, and not an examining body, makes the procedure simpler and easier because it is on the lines of all existing precedents. For this reason I should much prefer that Quebec should be the first Province to apply. The examining-board provinces would raise other questions of a novel kind for which our past experience would be less useful."

The College of Physicians and Surgeons of Quebec, at its 26th of September meeting, adopted the following resolution: That the College of Physicians and Surgeons of the Province of Quebec beg the Legislature of the Province of Quebec at its coming meeting to send a request to His Majesty's Privy Council demanding the application of the Medical Act of 1886 and the Amendments of 1905 to the Province of Quebec. The following resolution was also adopted with the subjoined proviso: That upon a favourable answer from the Privy Council, the College of Physicians and Surgeons of the Province of Quebec enter upon the necessary negotiations with the General Medical Council of Great Britain, in order to assure the establishment of reciprocity between Great Britain and the Province of Quebec: Provided that those who, having obtained the British license and are demanding the license of the College of the Province of Quebec, shall prior to their British registration have fulfilled all the requirements of our Medical Act in regard to the obtaining of our license. The design of this proviso is to prevent irregulars in the Province of Quebec going to Great Britain and coming back with British registration and so demanding and even compelling their registration in the Province of Quebec.

There is a significant red insert in the Calendar of the Medical Faculty of McGill University for the session, 1906-1907. It reads as follows: "It is proposed by the University to establish a five-years' course for the degree of Doctor of Medicine and Master of Surgery, beginning in the autumn of 1907. Full details will appear in the Calendar of 1907-1908." At the recent meeting of the College of Physicians and Surgeons of Quebec above mentioned, there was adopted a resolution providing for the amending of the by-laws so that a five-years' course could be exacted of all candidates for the provincial registration. The Quebec Legislature at its coming session will be asked to ratify this by-law.

Science Notes.

Something About Cereal Breakfast Foods.

There is no part of the world except the Arctic regions where cereals are not extensively cultivated. From the oats and rye of the North to the rice of the hot countries, grains of some kind are staple foods.

An idea of the importance of cereal foods in the diet may be gathered from the following data, gathered by Dr. Charles D. Woo ls and Prof. Harry Snyder for the Department of Agriculture, based upon the results obtained in dietary studies with a large number of American families. Vegetable foods, including flour, bread, and other cereal products, furnished 55 per cent. of the total food, 39 per cent. of the protein, 8 per cent. of the fat, and 95 per cent. of the carbohydrates of the diet. The amounts which cereal foods alone supplied were 22 per cent. of the total food, 31 per cent. of the protein, 7 per cent. of the fat, and 55 per cent. of the total carbohydrates —that is, about three-quarters of the vegetable protein, one-half of the carbohydrates, and seven-eighths of the vegetable fat were supplied by the cereals. Oats, rice, and wheat breakfast foods together furnished about 2 per cent. of the total food and protein, 1 per cent. of the total fat, and 4 per cent. of the carbohydrates of the ordinary mixed diet, as shown by the statistics cited. These percentage values are not high in themselves, but it must be remembered that they represent large quantities when we consider the food consumed by a family in a year.

The reasons for such an extensive use of cereal foods are not hard to find. Besides being cheaply and easily grown, the grains contain unusually good proportions of the necessary food ingredients with a very small proportion of refuse. They are also readily prepared for the table and are palatable and digestible. Owing to their dryness they are compact and easily preserved without deterioration.

The grain as it grows on the stalk is surrounded by a hull or husk, which is so indigestible that it is removed before the seed is used for food. Each grain has an outer skin or bran layer, which may or may not be removed in milling. It is nearly always taken

off from rice and buckwheat, sometimes from wheat, corn, and rye, and almost never from the other grains unless the outer sections are ground off as in pearled barley. Grains simply hulled or husked and slightly crushed are called groats or grits; more finely crushed they are termed meal, and when ground into a fine powder and sifted they are known as flour.

Grains in the raw state are not usually considered pleasant to the taste and are thought to be difficult of digestion, and, therefore, cereals are almost always cooked before eating. The simplest and doubtless the oldest way of cooking them was by parching. This was frequently all that was done to the oats which the Scotch Highlanders took as their only provisions in their border forays, or to the corn the American Indians used for a similar purpose. But other ways of cooking make the grain more palatable, and it is usually mixed with water or other liquid and either baked as bread and cakes or boiled or steamed as pudding or porridge. It is the use of cereals as porridge that is of special interest, as cereal breakfast foods are most commonly used in America for porridge making or as a substitute for porridge. When used in this form they are perhaps not as convenient to eat as bread, do not keep so well, and require long cooking, but in spite of these disadvantages porridge is much used the world over, and grains have been thus cooked since earliest times. Many varieties of porridge are found. Sometimes the cereals are simply boiled in water, sometimes with milk, or with meat or kale, as in Scotch brose. Welsh budrum is made from oats which have been allowed to ferment and are then cooked, and the Arabs have a similar dish, kouskous, made from fermented wheat. In the old-fashioned bag puddings of England, of which Christmas plum puddings are the direct descendants, suet and fruit were mixed with wheat or barley and all steamed together in a bag. The simpler kinds of porridge are, however, the most common, and it is from them that modern cereal breakfast foods have been developed.

The number and variety of cereal breakfast foods at present on the market are large, but the majority of them fall readily into one of three groups. The first includes those which are prepared by simply grinding the grain, the second those which have been steamed or otherwise partially cooked and then ground or rolled, and the third those preparations which have been acted upon by malt, which induces a greater or less chemical change in the starch present.

No class of foods is more extensively or ingeniously advertised than the cereal breakfast foods. The claims sometimes made for them are astonishing. Some of them are said to contain several times as much nourishment as the same weight of beef; others are lauded as especially valuable as brain food or nerve tonics, and very many are claimed to be particularly well suited for persons of weak digestion. Many of these claims are obviously preposterous, others are doubtless true, and still others contain an ingenious mixture of fact and fancy. Realizing that accurate information in regard to breakfast foods was needed, investigators at several agricultural experiment stations have recently studied their composition and food value, and it is now possible to make a number of definite and reliable statements about them.—*Scientific American.*

The Need and the Testing of Pure Drugs.

It is, perhaps, not commonly realized that the druggist, by reason of necessity, occupies a position of trust toward the entire community. The helpless, the sick, the physically weak, yea, even the dying, rely upon him absolutely for safety, accuracy, and skill in the preparation of the physician's order. It would be idle to deny that cases have been known in which pharmacists betrayed their trust, but such, happily, were few in number, and pertained mostly to the atrocious crime of drug-substitution. This offence is as contemptible, deliberate, and cowardly as a stab in the dark, for in most cases it constitutes a criminal act difficult to prove and against which the victim has no redress whatsoever. Even the atmosphere of the sickroom has been contaminated with the spirit of commercialism and individual greed that seems to have so thoroughly infected our so-called modern civilization. While the integrity of the average pharmacist is all that could be desired, yet he is liable to dispense prescriptions that are not what they purport to be, in consequence of the use of drugs that are either partly or wholly inert. Most druggists have neither the time nor the facilities for making a careful investigation of the physiological action of the many drugs that compose their stock. But that work of late is being done for them, on a large scale, and will eventually revolutionize the drug trade.

Years ago, many manufacturers merely complied with the direc-

tions of the United States Pharmacopœia, providing for the selection of the drug by more or less superficial means and its exhaustion by a given menstruum (solvent) to the production of a stated yield. But a leading firm of manufacturing chemists went a step further and attempted to gain some insight into the value of the more powerful drugs by estimating their content of active constituents. This work was attended with much expense and also great difficulty because of the lack of satisfactory methods of procedure. Nevertheless they persevered, and as a result were soon able to arrive at comparative results, which showed to their astonishment that different lots of such drugs as quinine, belladonna, hyoscyamus, nux vomica, and others varied widely in the proportion of the active constituents they contained; that in fact it was the exception rather than the rule to find successive lots of any given drug to be possessed of uniform activity.

The extent to which a drug is contaminated depends, of course, largely upon its commercial value and the ease with which it may be simulated. Drugs like opium and crocus, for instance, are frequently adulterated and fraud is also widely practised in connection with the "manufacture" of powdered chemicals, resinoid or inspissated substances. Although time has wrought an improvement in that respect since cascara sagrada was first introduced to the medical world, that drug is still the object of shameless substitution. Questionable preparations of it are at fault, either because the bark employed in making them is not genuine or has not been properly cured and extracted. Bark less than two years old contains an active ferment that gives rise to unpleasant after-effects and must, therefore, be considered impure. Other plants are often mixed with strophanthus; there are about thirty varieties of this plant, of which only six contain strophantin, the active principle.

The senna of commerce is frequently adulterated and unsophisticated buyers are sometimes supplied with Tinnevelly senna in place of it, although the latter contains only two-thirds as much of the active principle, i.e., the principle upon which the therapeutic effect of the drug depends. The sennas of Tripoli and Mecca are also of an inferior character. Much of the Chinese rhubarb that is marketed is unfit for use because it is decayed or worm-eaten. Sometimes the cheaper European sorts are powdered, colored yellow with turmeric, and passed off as the genuine article from the flowery kingdom. Asafœtida is contaminated with gum resin of an inferior

quality or mixed with foreign substances, such as red clay, barley flour, etc.; in some instances the impurities have been known to reach 30 per cent. Belladonna and white bryonia are sophisticated with the root of a plant designated botanically as *Medicago sativa* and genuine calumba root with what is known as false calumba. Artificial substances are often employed to adulterate Japan camphor.

The quality of coca and that of the cinchona bark of commerce varies greatly, which accounts for the fact that the therapeutic effect of some of these drugs is so slight that they may almost be regarded as worthless. Dill and anise are used as the adulterants of conium. False jalaps are not uncommon in the market and sophisticated manna has been described by several authorities. The scammony of Smyrna is frequently displaced by a substitute manufactured in the south of France and the large or false senega of the trade palmed off for the much higher priced true senega. Much of the musk upon the market must be regarded with suspicion, as the high price of the odoriferous articles invites imitation. The leaves of *Uva ursi* are often intermixed with the inert leaves of other umbelliferous plants.

The foregoing constitutes a powerful argument why physicians and druggists should avoid questionable medicinal products and give preference to medicaments that are entirely reliable, even though they may be a trifle higher in price. Only the larger laboratories in the country possess the necessary facilities and capital to manufacture a full line of first-class pharmaceuticals. They are imbued with a sense of responsibility and are aware of the fact that their reputation depends upon the nature of the goods they market. Abundant means enable them to engage experts, who exercise great care in the selection of crude drugs and reject all materials that do not come up to the standard. Moreover, the gathering of the drug plants is under the direct supervision of men who are thoroughly posted in regard to the pharmacological features of the plant they are looking for. Before the remedy is placed upon the market, it is standardized, that is to say, subjected to tests that determine its therapeutic value and insure uniformity. Having decided upon a standard, the drug is extracted by the proper menstruum, in the most approved manner, assayed chemically, and "standardized" by concentration or dilution as required.

But there are certain powerful drugs, such as the heart tonics,

digitalis, strophanthus, and convallaria; the powerful arterial sedative aconite, ergot, cannabis indica, squill, and others equally important that cannot be assayed by chemical processes.

Happily, the method of physiological assay is now available, and practical use is made of the fact that certain of these drugs will produce characteristic physiological effects upon certain animals. For instance, good ergot blackens the comb of the cock, while an inferior specimen fails of effect. The therapeutic value of the heart tonics is measured by means of delicate apparatus which accurately determines the effect of graduated doses upon the cardiac mechanism of frogs. These amphibians are also employed to determine the maximum and minimum dosage of standard preparations of strophanthus.

The medical man is groping in the dark when he prescribes a preparation of unknown strength, the first dose of which may prove ineffective, or possibly poisonous. Under such circumstances he is virtually compelled to make a physiological test upon his patient. Gradually the dose must be increased or diminished until he finds that a definite amount produces the effect desired. But should the prescription be refilled with a preparation from another manufacturer, or by another apothecary, the correct dose must again be determined experimentally as before. When drugs are standardized by chemical assay or physiological test, however, the physician escapes the humiliation of palpable impotence in the face of danger and there is no occasion for needless experiment at the bedside, where so frequently prompt drug action saves lives.—HUGO ERISCHEN, in *Scientific American.*

IN light narcosis the pupils may dilate reflexly from operative manipulations. This, of course, is not to be confused with the sudden extreme dilatation that occurs when the narcosis has been carried too far.—*American Journal of Surgery.*

AFTER all, the localization of bone tenderness is not only the most useful sign in determining the site of a fracture, but, even in the absence of other signs, it is often, in itself, diagnostic of the presence of a fracture. As instances, may be cited green-stick fracture of the clavicle, and fracture of the metacarpal and metatarsal bones.—*American Journal of Surgery.*

Physician's Library.

WE have received the second Volume Report of the Wellcome Research Laboratories, of Gordon Memorial College, Khartoum, Soudan. It is double the size of the first Report, and contains reports and observations of striking value. Fine illustrations add to its importance.

International Clinics, Vol. III. Sixteenth Series.

This volume contains many beautiful illustrations and 298 pages of very valuable text. The present volume deals with Treatment, Medicine, Surgery, Obstetrics and Gynecology, Rhinology, Otology and Pathology. There is one colored plate, eighteen plates and eight figures, all splendidly keeping up the high standard this excellent production has attained.

Diseases of the Prostate Gland and Adnexa, A non-surgical treatise on the: By GEORGE WHITFIELD OVERALL, A.B., M.D., Chicago. Rowe Publishing Co., Chicago.

In inspecting this interesting little work, our attention is called to three new and original treatments of troubles of the prostate gland: 1. An instrument especially commended in diagnosis and treatment, simple and inexpensive; 2. an instrument which is especially desired for mechanical vibrating massage apparatus; 3. a thorough delineation of the author's method of applying the electro-cautery.

SEVERE localized pain after traumatism, especially in children, may be due to subperiosteal fracture, e.g., near the head of the humerus or the femur. Extreme localized tenderness is the chief sign; abnormal mobility and deformity are absent, and crepitus may not be elicited.—*American Journal of Surgery.*

News Items.

VIRDEN, Man., has a new hospital.

SELKIRK, Man., is to have a new hospital.

THE Leper Station in British Columbia is to be improved.

TYPHOID fever is prevalent in several different centres in Ontario.

ST. MICHAEL'S HOSPITAL, Toronto, is being enlarged to have 300 beds.

THE UNDERGRADUATES' SOCIETY and the McGill Medical Society will amalgamate.

DR. DANIEL CLARK, Toronto, has been elected an honorary member of the American Psychological Society.

DR. FRANK P. COWAN, Toronto, died recently in this city, aged 40 years. He was a graduate of Trinity, 1889.

DR. MILVIN is the new president of the St. John, N.B., Medical Society.

DR. ALEX. CAMPBELL, Superintendent of the Winnipeg General Hospital, has recovered from an attack of appendicitis.

QUEEN'S University is said to be after $25,000 from the Ontario Government for its medical department.

ONTARIO is deporting all insane who have only been in the province two years.

MR. G. F. CLIFF, Carleton Place, Ont., who formerly represented the DOMINION MEDICAL MONTHLY in the Great West, has received his M.D.C.M. at Queen's University.

THE Canadian Northern Railway proposes to establish hospitals at Port Arthur, Rainy River and Winnipeg.

DR. F. G. FINLEY, Montreal, is spoken of as successor to the late Dr. James Stewart as professor of medicine at McGill.

DR. C. B. COUGHLIN, Peterboro', Ont., has been appointed superintendent of the Deaf and Dumb Institute at Belleville, Ont.

CONTRACTS for additions to cost $27,000 have been let in connection with the consumption institution at Weston, near Toronto.

THE Department of Agriculture, Saskatchewan, is taking vigorous steps to control typhoid fever and tuberculosis in that province.

DR. F. J. SHEPHERD, Montreal, received the honorary degree of Doctor of Laws at the dedication ceremonies of Harvard University.

DR. WM. A. BALL, Toronto, died suddenly on the 3rd of November, aged 38 years. He was a graduate of Toronto and Trinity, 1904.

GRACE, St. Michael's and the Western hospitals, Toronto, want $50,000 each from the Toronto City Council. All hope they will be successful in getting it.

THE 25th graduating exercises at the Training School of the Toronto General Hospital has just been held. In all 441 nurses have received diplomas from this institution.

FROM the opening of the Alexandra (contagious diseases) Hospital, Montreal, on the 9th of July, to the 30th of September, there were: Diphtheria 37, deaths 3; scarlet fever 20, no deaths; measles 8, no deaths; erysipelas 1, and 1 death.

WINNIPEG MEDICAL SOCIETY has elected the following officers: President, Dr. E. W. Montgomery; 1st vice-president, Dr. J. R. Davidson; 2nd vice-president, Dr. N. J. McLean; secretary-treasurer, Dr. C. H. Vrooman; councillors, Drs. McKenty, H. MacKay, Galloway, and Todd.

DR. FOWLER and wife, of Wingham, Ont., have gone to California for the winter, and may remain there.

DR. J. W. S. MCCULLOUGH, of Alliston, has been appointed Chairman of the new Board of Health of Ontario.

DR. W. SLOAN, who has been out in the Klondike for nine years returned last week to his home in Blyth, Ont.

DR. J. L. TURNBULL, formerly of Goderich, is now taking up special work in New York hospital, before locating.

DR. R. E. MCKECHNIE, Vancouver, and Dr. R. Eden Walker, New Westminster, have arrived home after two months east.

DR. A. D. MCINTYRE, Petrolia, has arrived to assume his duties as general superintendent of the hospital at Kingston, Ont.

DR. H J. BROWNING, of Exeter, Ont., has left on a trip through the North-west, and if he finds a suitable place he may locate in one of the western towns.

DR. J. L. ROBINSON is spending a few days at his old home in St. Marys prior to his leaving for Vancouver, where he has been appointed medical superintendent of the new Vancouver General Hospital. Graduating from McGill in 1904, Dr. Robinson entered the Montreal General Hospital, where hespent two years as Senior Resident Surgeon, subsequently he was appointed Assistant Superintendent of Montreal's new Contagious Hospital, which position he recently resigned to accept the superintendency in Vancouver.

Obituaries.

JAMES STEWART, M.D.

Dr. James Stewart, Professor of Medicine and of Clinical Medicine in the Medical Department of McGill University, Montreal, died in that city on the evening of the 6th of October. The cause of death was cerebral hemorrhage. The late Dr. Stewart was born in Ontario in 1847. He was educated at the Ottawa Grammar School and McGill University, from which latter institution he was graduated in 1869 as M.D., C.M. He immediately pursued his medical studies further at Berlin, Edinburgh and Vienna, and obtained the degrees at Edinburgh of L.R.C.P. and L.R.C.S. Returning to Canada, he entered for a few years upon practice in Ontario, but soon removed to Montreal, where from 1883 to 1891 he was professor of materia medica and therapeutics in the University of McGill. Since 1891 he has held the chair of medicine and of clinical medicine. On the opening of the Royal Victoria Hospital he was appointed physician-in-chief, which position he held up to the time of his death.

Publishers' Department

COUGHS AND THEIR TREATMENT.

By Alex. DeSoto, M.D., and C. W. Compton, M.D., of Wayside Mission Hospital, Seattle, Wash.

An intractable cough!

What condition so persistently tries the patience of every physician?

Careful examination has been made, the diet regulated, and one of the innumerable prescriptions for that ailment selected, but still the cough continues.

Then more investigation, and more careful prescribing; but still after weeks that familiar cough re-echoes through your waiting room, and you wish Mrs. Smith would change her doctor.

No such good fortune attends you, and that cough haunts you as dismal thoughts of phthisis do your patient, until you are almost determined to advise a change of climate.

It is not the object of this paper to go into details regarding the only too well-known disadvantages of most of our familiar cough mixtures. Down to that household standby, "cod liver oil in every form," they have proven, in the vast majority of instances, discouraging failures.

The above-mentioned remedy, which the patient considers proof positive of the doctor having made a diagnosis of consumption, may invariably be depended upon to disarrange the digestion at least.

Cod liver oil, once begun, must frequently be continued throughout the entire winter season.

Nor can it be shown that the ingestion of fats and oils into the system, to become oxidized when coming into contact with the oxygen in the lungs, ever does more than raise the local temperature of combustion.

Although this may prevent cold in comparatively healthy lung

tissue, its therapeutic (?) effect on the inflamed pulmonary structure may be described as positively harmful.

Cough is a symptom, varying in tensity and character according to its cause.

Nor is that cause always situated within the respiratory organs themselves.

Cough is essentially a reflex act depending upon an irritation of the respiratory centre.

These sources of irritation may be sub-divided as follows:

Dropping of mucous from the posterior nares in chronic catarrh.

Polypo, enlarged uvula or tonsils, defective closure of the glottis, irritations within the larynx from whatsoever cause, malignant or otherwise.

Bronchitis, pneumonia and pleurisy.

Gastric when due to derangements of the stomach.

Cardiac disease, irritations of auditory canal, and organic diseases within the abdominal cavity.

From the foregoing causes it may be readily estimated that to arrive at the exact nature of any given case may not always be an easy matter. Nevertheless, we must relieve the patient without risk of disturbing either digestive or circulatory systems. Any remedy which will attain this object in a goodly number of cases is indeed a godsend to patient and physician, and in every sense an ideal remedy.

Not until our attention was called to Glyco-Heroin (Smith) did we become acquainted with a remedy which we have used with a most unvarying success in coughs of every description, and in patients of all ages and conditions, without the slightest unfavorable effect.

The points which recommend Glyco-Heroin (Smith) are:

1. Palatability.

2. Economy (three to four ounces being ample for a cure of the average case).

3. Its immediate action, soothing the most trying cases.

4. Its absolute freedom from unpleasant or unfavorable effects.

5. It is not only a palliative but a curative agent.

6. The hyoscyamus it contains reaches those trying cases of dry cough due to other causes than simple catarrhal irritation of the respiratory tract.

We are convinced that Glyco-Heroin (Smith) has no competi-