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THE MARITIME MEDICAL NEWS

A MONTHLY JOURNAL DEVOTED TO
MEDICINE & SURGERY

VOL. XX.

HALIFAX, NOVA SCOTIA, APRIL, 1908.

No. 4.

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THE MARITIME MEDICAL NEWS is a monthly magazine devoted to the interests of the medical profession. Communications of general and local professional interest will be gladly received from friends everywhere. Manuscript for publication should be legibly written in ink (or typewritten, if possible) on *one side only* of white paper. All manuscripts and correspondence relative to letter press should be addressed to The Editors, MARITIME MEDICAL NEWS, P. O. Box 341 Halifax, N. S.

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THE MARITIME MEDICAL NEWS

VOL. XX., APRIL, 1908, No. 4

Inoculation We are indebted to Dr. A. S. Kendall, M.P.P., for the following interesting advertisement, taken from the *Gazette*, Halifax, of August 1, 1775.

"The happy effects of inoculating for small-pox is too well known to need any arguments to persuade a reasonable person to prefer inoculation to taking this disorder in the natural way. The subscriber, G. Greaves, has made himself fully acquainted with every improvement lately adopted by the most eminent practitioners of this age in said disorder, therefore all such as choose to put themselves under the care of said subscriber are desired to apply as soon as possible. The charge to each patient is ten shillings, being for inoculation, medicines and attendance through the whole course of the disease.

"GEORGE GREAVES.

"Aug. 1, 1775.

"G. Greaves has a very commodious house well situated in the north suburbs which he has furnished with candles and beds for taking in private patients for inoculation and a nurse to attend, etc."

♦ ♦ ♦

Clinical Study of Tuberculosis. G. E. Bushnell and C. A. Treuholtz have made use of Arneith's method of leucocyte count to obtain prognosis in tuberculosis as to the conditions of the lung lesions, and contribute their findings to the *Medical Record* of March 21. In case

a good reaction leucocytosis is present, and in favorable cases the production of leucocytosis keeps pace with their destruction, and the leucocyte count is normal. The loss of the older neutrophiles is an indication of the amount of circulating bacteria and their toxins. This enables us to decide whether absorption of toxins is great and harmful or small and of little importance. In the observations made by the authors the count has not been at variance with the course of the disease. The index of the normal individual is between sixty and seventy. The authors give thirteen illustrative cases

♦ ♦ ♦

Home Treatment of Pulmonary Tuberculosis. O. H. Brown, Saint Louis, explains the pathology and symptoms of tuberculosis according to the modern ideas of Wright and his followers in the *Journal of the American Med. Ass.* of March 21. The toxin produced by the bacilli enters the blood and produces a definite physiologic reaction which is responsible for the symptoms of tuberculosis. According to the modern conceptions of treatment we should endeavour to increase the immunity factors of the blood in order to eradicate the disease from the body. Hence the toxin must be prevented from entering the body at too frequent intervals and overwhelming the protective elements, but should be allowed only in such quantities and at such times as will properly

stimulate, instead of decreasing the protective reaction. Wright and his assistants have found that exercise of an infected part produces as definite changes in the blood as follow injections of tubercle poison, whereas this will not occur if the infected part is kept quiet—therefore the value of rest in the treatment, only interrupted by sufficient work to cause inoculation into the blood of a small amount of poison at not too frequent intervals. It is impossible to put the lungs at rest, but it is possible to reduce the depth and frequency of the respirations to a minimum. Tuberculous patients usually feel better after a few days rest, and over-exertion aggravates their troubles. In any but the last stages of the disease, however, they do not usually feel the need of staying in bed and the rationale of the rest treatment must be explained to them. Much depends on the mental attitude of the patient and a careful, conscientious, intelligent nurse is an absolute necessity. Obstinate, self-willed and fidgety patients are least likely to make progress. Climate is discussed, atmospheric impurities irritating to the respiratory tract are bad for consumptives and should be avoided. Humidity is of less importance, and, with excessive temperature, can be compensated for by care in clothing, etc. The worst days for consumptives are the hot, humid days of summer. These cause deep laboured respiration, which is likely to bring about an aggravation of the symptoms. Brown condemns high altitudes for this reason, and holds the sea level or a few hundred feet above it as preferable. Care should be taken to guard against the effects of sudden extreme changes of temperature. Hot climates are to be avoided by most con-

sumptives as well high altitudes. In any case it is inadvisable to take a patient away from home comforts and care without giving anything to take their places. Sanatorium treatment is better than home treatment because it affords more complete control of the patient than can be had at home. The strictly enforced rest is what gives the results; it is not enough to recommend it, there must be someone who can see it secured. This should be insisted on in the home treatment, and if the patient is not so far convalescent as to show no signs of toxæmia from the exercise of going about, he should be visited at his home, and the frequency of the visits depends on the patient. If he is cheerful and follows directions and is confident in getting better, once every week or two will do; if despondent, more frequent visits and encouragement will be required. As regards diet, anything that disagrees with the patient should be avoided. Brown finds several lunches of light nutritious food between the regular meals advantageous. There are no drugs that will do enough good to compensate for the possible harm, but complications may call for remedies, and there are no contraindications to calomel or cascara for constipation, sodium bicarbonate for hyperacidity, and other suitable drugs under proper conditions. Brown thinks that the stomach should be spared the irritation of drugs, and he thinks the influence of placebos is pernicious. It is important that active life be resumed very cautiously by the consumptive convalescent. Summing up, Brown classes regulation of rest and exercise as the first thing in the treatment; second, good air; and third, good food, and plenty of it.

Epithelioma. Among papers contributed to the recent meeting of the Medical Society of the State of New York, reviewed in the *New York Medical Journal* of February 29, was one entitled "A Study of Four Hundred Cases of Epithelioma." In this paper Dr. L. D. Buckley referred to the many statements regarding the cause of epithelioma, and said that none was universally adopted. He spoke of the striking resemblance that these lesions had to syphilitic ulcers, and said that because of this similarity many were improperly diagnosed and erroneously treated. He believed the prognosis to be directly dependent upon the wisdom with which the lesion was treated from the time of its inception.

He did not consider heredity to be an important factor, and declared that epitheliomata might disappear spontaneously or under proper local applications. He found them to be more frequent in males, and especially between the ages of thirty-five and fifty-five. He made a pathological classification of epitheliomata, as those originating from the basement layer of the skin and those developing from the prickle cells. In those developing from the basement layer of the skin the progress was seen to be slower, and they might show evidences of spontaneous healing. They did not give rise to metastases, and were amenable to treatment, notably with the X-ray. They occurred most often on the face.

The second form of epithelioma, growing from the more superficial layers, showed mitotic figures and epithelial pearls microscopically. This variety did give rise to metastases, was more rapid in its growth, and was apt to occur at a mucocutaneous junction. Bland ointments

had apparently cured lesions similar to the epitheliomata of the second variety. He cautioned the general practitioner against the indiscriminate use of silver nitrate. He referred to the constant changing of treatment in the past thirty-five years, but said that the results depended upon the stage of the disease and the completeness of its removal. He still thought that the knife offered the best and surest method of removal. Patients treated with arsenic paste often recovered, but the process was slow and painful, and this form of treatment had largely been superseded by the X-ray. Curetting, combined with other methods, such as cauterization, was recommended, but it had to be thoroughly done. The escharotic which the speaker preferred in connection with the curette was pyrogallic acid. He believed that the X-ray presented the greatest advantage in the treatment of certain cases of epithelioma. But, as this agent had been used in this connection only for the past five years, too much confidence must not be placed in it yet.

❖ ❖ ❖

Pubotomy and Artificial Delivery. Fehling (*Munchener Medizinische Wochenschrift*) gives as indications for pubotomy: (1) All contractions of the pelvis in primiparæ. (2) In multiparæ who refuse to have Cæsarean section performed, or where difficulties arise during labour from the size of the child or position of the skull, which demand an enlargement of the pelvis in the interests of the life of the child.

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Subphrenic Abscess. D. N. Eisendrath reports five cases of subphrenic abscess following appendicitis, in the *Journal of the American Medical Association*

of March 7, and discusses the pathology, symptoms, diagnosis, etc. The intraperitoneal form is much the most common, is usually on the right side, but six left-sided cases have been reported, one of these in the present paper. Subphrenic abscess may follow appendicitis when there has been no suppuration about the appendix, and it is often impossible to trace any purulent tract between the abscess and the appendix. It rarely occurs as the result of a general suppurative peritonitis. In the majority of cases the appendix is retrocaecal, and a persistence of the embryonal position of the appendix, due to non-rotation of the caecum and bringing it in close contact with the right lobe of the liver, also favors the formation of subphrenic abscess. In the acute form, the pain, nausea and other signs of an acute infection, are not always marked; the persistence of a high temperature, with or without accompanying signs of septic infection, is the most characteristic symptom. In some cases physical signs will be of the greatest aid and exploratory puncture is a valuable aid to diagnosis. It may also occur in a subacute form, the symptoms manifesting themselves first a week or more after the operation or attack, or in a chronic form with indefinite symptoms for weeks or months, or with the sudden late appearance of acute septic symptoms from an obscure deep-seated focus. If a patient who gives a history of probable appendical trouble or who has been operated on for appendicitis, has a continuous rise of temperature accompanied by other signs of septic intoxication, one should always search carefully for subphrenic abscess. The downward displacement of the liver, the presence of an area of dulness with a convex upper

border, continuous with the liver dulness, and the finding of foetid pus by exploratory puncture, are very characteristic. The principal condition to be differentiated is empyema, and sometimes this may be impossible, except from the history and the character of the pus. The prognosis in non-operative cases is not good. With early diagnosis and operation, Eisendrath estimates that the percentage of recoveries should exceed 75 per cent., but such early diagnosis is only possible when the physician or surgeon keeps in mind the relative frequency of this complication. A simple incision, when there is external bulging in the epigastrium, along the costal arch on in the lumbar region, will empty the abscess, but if suppuration continues or septic symptoms reappear, a more extensive operation may be necessary. Eisendrath describes the anatomic conditions and claims, as the ideal method of extrapleural operation, that devised by Elsberg as modified by himself, in which the tenth rib is resected between the anterior and posterior axillary lines, the pleural reflection pushed upward, and an exploring needle inserted through the diaphragm, which lies in the wound, and an incision made alongside the needle. If the ninth rib is resected also, the costophrenic sinus will certainly be opened unless the resection is strictly between the anterior and posterior axillary lines, and great care is taken in pushing back the periosteum of the ninth rib. If the abscess is high up under the diaphragm, it can only be reached by the transpleural route. In this case, if it is possible, the diaphragmatic pleura should be sutured to the costal pleura. If this is impossible, the general pleural cavity can be walled off with gauze

or a more extensive resection of the ninth and tenth ribs be made. The former is unsatisfactory on account of the danger of leakage; the latter is warmly recommended by McDill. After a four-inch partial resection of the ninth and tenth ribs in the mid-axillary line, an assistant presses the thoracic wall inward against the diaphragm, to which it is sutured, while an incision is made through the diaphragm into the subphrenic abscess.

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Heart Disease.

Wachenfeld, of Bad Nauheim, Germany, in an article entitled "Some New Facts Regarding Heart Disease," appearing in the *Medical Record* of March 7, discards the old notions of compensatory work, hypertrophy and dilatation, as unfounded on facts shown to exist in the circulatory mechanism. Hypertrophied muscle has undergone pronounced degenerative changes and could not increase the work of the heart. The poorly nourished muscle would tend to relaxation. Pressure cannot be negative in any part of the circulation as would occur if dilatation was produced. The increase in area of dulness of the heart is due to changes in position, not dilatation. Our present views of the mechanism of valvular disease are defective. The lesion develops slowly. Blood cannot regurgitate through diseased valves in quantity great enough to influence intraventricular pressure. Should it do so the volume of circulation must be reduced. Valvular lesions are always the result of infective processes of the endocardium. Supposed lack of compensation is only a new disease grafted on an old one. Indurated valvular excrescences can never undergo any

change. The myocardial changes are the important point. The lymphatics are the carriers of cell nourishment and the improvement of their work by diet, hydrotherapeutics, and rest will improve the condition. Thus rest in bed, digitalis, and thermal baths act well on the diseased heart, and exercise is contraindicated.

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Chemical Regulation of Function.

The New York Medical Journal of March 21, reviews as follows a paper entitled "The Modern Conception Regarding Chemical Regulation of Function," which was read at the last meeting of the Medical Society of the State of New York, by Dr. Graham Lusk, who observed in his paper that there was much in the nervous system below the threshold of consciousness. The cause of death in animals after the excision of the adrenals was the removal of their internal secretion from the system and not the shock incident to the operation. The active principle of this secretion was a ferment, because it could not be heated to boiling without destroying its activity. In tuberculosis of the adrenals the thymus, spleen, etc., might become secondarily enlarged, thus demonstrating a very complicated and involved problem in physiology at present unexplainable. He referred to the great number and general uselessness of the theories brought forward by fanciful observers anxious of recognition.

He stated that solid substances introduced into intestine which had been cut off from its nerve supply would still cause secretion due to the mechanical stimulation of the plexuses of Neisser. When food was taken into the mouth there were im-

pulses which traveled along the vagi and thus produced a reflex secretion. A secondary secretion might take place even if both vagi were cut if partly digested food was placed in the stomach. He believed that the secretion of the gastric juice depended upon a substance absorbed from the region of the pylorus and taken into the blood. This stimulated the gastric secretion. Hydrochloric acid was stimulating to the duodenal mucosa, causing a secretion of the pancreatic juice, and he cited experimental work of Popeelski proving that fact. As to the formation of the pancreatic juice, the acid gastric juice from the stomach activated a prosecretion there. This prosecretion was absorbed into the blood and then caused the secretion of pancreatic juice. Nerve reflexes were not necessary, simply the chemical stimulant being absorbed into the blood stream. If portal blood was diverted from the liver, the symptoms of toxæmia resulted, and this was shown to be due to the fact that certain toxins and deleterious substances were rendered innocuous in the liver.

Experiments had shown that if an extract was made of a rabbit's foetus and injected into the blood of a virgin rabbit, the mammæ would develop. Also in the human species it was pointed out, if one kidney was extirpated, the blood pressure was raised and hypertrophy of the left ventricle occurred, which went to prove that ordinarily certain substances were excreted by the kidneys in a definite amount; one kidney could not excrete as well as two, so part of these substances were retained, and by their presence caused a rise in blood pressure.

In fevers, the xanthine bases were present in amounts corresponding to

the height of the fever; therefore, the administration of xanthine free milk in febrile patients was declared to have scientific justification.

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**Passive
Hyperæmia.**

B. M. Bernheim, describes, in the *Journal of the American Medical Association* of March 14, the Bier method of using hyperæmia by cupping for therapeutic purposes. Cups of all sizes to fit every part where the method may be desired to be applied have been devised, and the suction is produced by means of a rubber bulb. The applications, for example, in a case of carbuncle, previously opened, last five minutes, the pressure being carefully regulated; then the cup is removed and the exudate gently sponged away with a piece of gauze, after which the process is repeated after two minutes' rest, and this alternate cupping and resting is kept up for from thirty to sixty minutes, when the part is cleaned and a simple wet dressing applied. The patient is again treated the following day; if a crust has formed, as over a sinus, it is carefully removed with a blunt instrument and the cupping repeated as before. The pus will usually be found to decrease each day and the granulations to become healthier, firmer and less likely to bleed. The improvement continues each day, the exudate decreases and the case progresses towards recovery. In regulating the pressure, a bluish-red tint should always signify the limit; too much pressure, even though exerted without pain, may induce hyperæmia amounting to stagnation, obviously not the end desired. Experience shows that the first few days of the treatment are most important; therefore, during that time the cupping should be

done as above directed; later, as the condition improves, the length and frequency of the treatments may be reduced. Squeezing and massaging of the parts to get out the remaining pus is not allowable, neither is curetting. It is best also to avoid the use of the probe or of splints, and the patient should be advised to use the affected member. Frequently patients present themselves early in the infection (as in beginning carbuncle, ischio-rectal abscess, and bubo) before suppuration has appeared, only the usual redness, swelling, tenderness and infiltration being present. Such cases should be treated as described, but without incision, as resolution sometimes occurs without the use of the knife. While, however, incision is demanded, a cut from 1 to 1.5 cm. long should be made and the cup applied at once. In cases of bone tuberculosis, sequestra are sometimes drawn out; at other times they do not come away and are best left undisturbed, as Bier has observed that they sometimes unite with the healthy bone. The formation of cold abscesses is not to be dreaded, but looked on as a normal process in the course of the disease. They should be promptly recognized and followed by the usual incision and cupping. Curetting, probing or iodoform injections increase the chances of infection, and immobilization is not advised. In acute mastitis, to avoid pain, the diameter of the cup should be at least 1 cm. greater than that of the breast, and when the breast is engorged with milk and much pus is also present, and very little comes away, a small cup should be applied over the nipple, and incision made after the treatment, simply to draw off the pus and milk. This is only neces-

sary in the presence of pus, and will hardly be needed more than two or three times. While recognizing that there are cases unsuited to this treatment, Bernheim claims for it certain advantages, viz.: 1. Relief of pain, which is one of its most striking features. 2. Rapidity of cure, the disease being materially shortened. 3. Preservation of function. The tuberculous joints are not immobilized, healing taking place with motion very frequently. The wide radial incisions are avoided in mastitis; hence a minimum of the scar tissue that often interferes with the function of the gland. 4. Discarding of the drain, itself a distinct advance. 5. Simplicity. The physician, as well as the surgeon, can use the method successfully.

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Menstrual Fever and Menstrual Sepsis. Riebold (*Deutsche Medizinische Wochenschrift*) observed two thousand patients within the last two years as to the temperature at the menstrual period. He concludes that in many cases there is a rise of temperature during menstruation that cannot be accounted for as from any other cause. The fever occurs generally on the third or fourth day, though it may come earlier or even after the flow has ceased. The fever and the leucocytosis attending menstruation are due to the absorption by the uterus of toxic or infective materials. During the menstrual period the contained blood and mucus in the uterine cavity forms a very good culture-medium, and at this time the normal protective of the vaginal mucus is absent. The author believes that the menstrual period is of great importance in the pathogenesis of febrile disorders. Toxins similar to those producing the fever may cause many skin and nervous affections

which occur during menstruation, such as erythema, urticaria, herpes zoster and neuralgias. They also cause rheumatism in the form of true polyarthritides and heart rheumatism due to infection arising in the genital tract.

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Human and Bovine Tuberculosis. J. S. Fowler contributes a resumé of the Report of the Royal Commission on Human and Bovine Tuberculosis, to the *Edinburgh Medical Journal* for March. The exact reference to the Commission was to inquire and report: (1) Whether the disease in animals and man is one and the same; (2) Whether animals and man can be reciprocally infected with it; and (3) Under what conditions, if at all, the transmission of the disease from animals to man takes place, and what are the circumstances favourable or unfavourable to such transmission. In the seven years which have elapsed since the commission was appointed, interest in the tuberculosis problem, so far from fading, has spread among all classes, and the observations and conclusions of the commission are of great importance in their bearing upon one of the practical questions of the day. The commission has not answered the first question referred to it, but it is able to give an affirmative reply to the second. The principal points drawn attention to in the conclusion of the report are: (1) That a certain amount of tuberculosis, especially in children, is directly due to infection with the bovine bacillus. (2) That tuberculous milk is clearly a cause of tuberculosis, and fatal tuberculosis, in man. (3) That a very large proportion of tuberculosis contracted by ingestion is due to bovine bacilli. (4) That more

stringent measures are required to prevent the sale or consumption of milk from tuberculous cows.

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Expert Testimony in Insanity. Wm. Hirsch, of Cornell University, an eminent alienist, made an address recently before the Boston Society of Medical Jurisprudence, on "Expert Testimony and Insanity." Dr. Hirsch was one of the experts retained by the prosecution in the recent Thaw trial. He said, according to the *Medical Bulletin* of September last, that "if a man deliberately kills another, then tells why he did it, I cannot see why anyone should say that the slayer did not know the nature and quality of the act performed. Yet we have the spectacle, the phenomenon, of two sets of alienists disagreeing. In European countries experts are never retained; they are appointed by the court. There should be in this country, as in Europe, a partial responsibility recognized, and separate courts for the insane. There are more paranoiacs out of the insane asylums than in them. They are subject to punishment and reward in insane asylums that will deter them from crime. An honest district attorney, like the one we have, will not go out after a man's life when he is in this plight, but will appeal under the law that says that no man who is incapable of understanding the risk he is running should be put on trial for his life. Paranoiacs who deliberately shoot down people who are enemies are not to be allowed free on the community." Dr. Hirsch continued to the effect that individuals who committed crimes during attacks of psychical epilepsy were invariably overwhelmed with horror when, on recovering their consciousness and

reason, they were informed of the acts they had committed, instead of boasting of their crime and setting themselves up as heroes or modern knights.



Chemical Control of the Body. The unjustifiability of the attitude of certain of the critics of the medical profession, is shown up by Professor E. H. Starling, of London, in the *Journal of the American Medical Association* of March 14. He points out that recent investigations have proved that administration of drugs for the cure of disease is only imitating, perhaps imperfectly, the methods employed by Nature, and that a large share of the coordinations of the activities of different organs of the body is due to the production and circulation of chemical substances, strictly analogous to the drugs employed in the treatment of disease. As an illustration of this fact, he refers to secretin, the chemical substance that excites the pancreatic secretion when the food passes into the duodenum. This body can be regarded as the type of a whole group of chemical messengers, which, formed in one organ, travel in the blood stream to other organs of the body and effect correlation between the activities of the organs of origin and the organs on which they exert their specific effect. To these chemical messengers have been given the name "hormone." The chemical agents acting on the organism have been divided by Ehrlich into two classes, which may be designated briefly as the toxins and the drugs. There is one marked distinction between the two groups: The toxins cause the formation in the organism of antibodies, tending to procure immunity, while in the case of the

drugs, though with some, as with morphia, a limited degree of tolerance may be produced, there is no evidence of the production at any time of antitoxic substances in the treated animal. The hormones, acting constantly as chemical messengers from one organ to another by way of the blood, can not produce antibodies that would abolish their function, and must necessarily, therefore, belong to the class of drug substances. Their action must also, in all probability, be ranked with the purely chemical processes which determine the formation of absorption compounds and distinguish the interaction of one colloid with another, as well as of toxins with the animal cell or with their corresponding antitoxin. Starling goes on to show how other functions are correlated by these chemical messengers, instancing the stimulation of the respiratory centre by carbon dioxide in the blood, the action of adrenalin on the blood pressure, in which we know both the source and nature of the chemical messenger and the exact nature of the effect it produces. Our knowledge of other hormones is as yet incomplete, but Starling gives the facts indicating their existence as shown in the effects of the internal secretions of the pituitary, thyroid and sexual glands in which the relations existing between the activity of certain organs and the development and functions of others are most clearly manifest, though the chemical nature of the hormone has not yet been revealed. An enormous field for experimental research has been opened up, and in working out the problems, we may look for increasing power over the functions of the body.

EDITORIAL.

The Spangler Trial.

(Early in April an action brought against one Spangler, an Osteopath, who practises in Saint John, for infringement of the Medical Act, was dismissed on the ground that the accused had not been practicing medicine.)

It is a little difficult to refer to this matter and its outcome with that equanimity and philosophic calm that is supposed to be essential in discussing the decision of those wise men, our judges. This practitioner of manual pressure and friction, has been adjudged not to have practiced medicine because he prescribed no drugs and made no diagnosis!

Evidently, the astute judicial personage who has delivered himself of this astonishing opinion, 'thinks "medicine" and the practice of it mean, necessarily, the giving of some form of "physic," though, no doubt, he would feel insulted should one hint that he must, in consequence, be quite ignorant of both Greek and Latin. The founder of his religion and his church has been, most appropriately styled "The Great Physician." Yet out of multitudinous occasions, He only once or twice used anything that could even remotely, be called a "medicine," and He, certainly, did not make it a practice to explain to the fortunate ones just what their particular disease was. On the face of it, this ruling would appear to be greatly to the profit of the druggist, and, if we desire in the future to legally collect our fees, we will do well to explain to the incipient consumptive, the bearer of organic heart-lesion, and above all, to the raving maniac and drivelling imbecile, their exact pathological condition. Indeed, those eminent lienists, heretofore reckoned

by our simple selves among the chief ornaments of the profession, and whose main reliance is far otherwise than in drugs, will hereafter, no doubt, out of respect to the dictum of our modern Solomon, cease to consider themselves physicians and humbly take rank with the innocent and guileless "osteopath." In midwifery, also, it will no longer do to stand watchfully by in simple and straightforward cases, and let benign Nature do its own work. If we even go to the usual length of manual interference, it will not do! We are not physicians! Hereafter, therefore, if we wish to retain our standing, the price of chloroform and ergot should boom, and we must never forget to inform the lady, when, in the intervals of uterine agony she obtains a chance to hear us, that she is possessed of a gravid womb about to empty itself, and that the process is called labour.

The seeming obtuseness of the legal mind, upon occasion, to the fundamentals of the medical profession is indeed astounding. It is true that to an intellect sufficiently uninformed and dull, the old-fashioned term "physic" in the New Brunswick Medical Act may be misleading, but one would think a little ordinary mother-wit, even without the aid of the classics, or the usual normal amount of grey matter within the cranium, would serve to throw a feeble gleam upon the pathway of those who guide as to legal decisions.

But, after all, this density on the part of the lawyer, though monumental at times, as in this instance, is not, we think, the chief or prevailing cause of such miscarriages of justice. Almost universal in the lay mind is

the notion that the profession is a "close corporation" and that all such prosecutions as the one adverted to, are for the sole benefit of "the doctors," and the outcome of envy and spite.

We, ourselves, are partially responsible for these superstitions, in that we make no effort at popular enlightenment along these lines, and secondly, and most significant, the profession, itself, almost invariably initiates and carries forward these trials.

Medical Acts, as we understand them, are as much the "law of the land" as any other contents of the statute-book, and their violation should be as much the concern of one citizen as of another. In future therefore, it would seem to be most expedient, in view of the unreason-

ing and unreasonable prejudice referred to, that these prosecutions be taken up and carried forward wholly by laymen, the medical profession taking no part whatever, except when forced to occupy the witness-box in common with other deponents.

In such event it might be found practicable to induce the legal fraternity to take an independent standpoint—to clear their minds of some of the vulgar errors of their environment—to forget for a moment professional and class-jealousy—and to assist other good citizens in clearing the country of impudent and arrant humbugs who prey upon the credulity of the ignorant and deplete the purses of the wealthy hypochondriacs.



ANÆSTHESIA BY THE H. M. C. METHOD.

By S. N. MILLER, M. D.,

Middletown, N. S.

(Read before the Annapolis-Kings Medical Society, January 22, 1908.)

WHEN Dr. Morton gave ether in the Massachusetts General Hospital, Oct. 16th, 1846, for Dr. Warren, who was then senior surgeon of the hospital, for the removal of a tumour from a young woman's neck, general anæsthesia, hitherto a dream, became a reality, and soon spread throughout the civilized world, and marked one of the greatest events in the history of surgery. It relieved the patient of much of the horrors of the operating room, of being strapped to the table, or held down by strong men while the operation went on, and the surgeon of the danger and inconvenience of operating while the patient was struggling, and of the fatal shock that so frequently followed. Though one of the greatest boons to both patient and surgeon, yet it has its drawbacks. Many are afraid of it—more so than of the knife—and are sure they will die from the effects of the anæsthetic, if not from the operation, and many an operation is deferred by the patient until too late to do any good, from this fear of the anæsthetic. Others who have taken it once, and do not fear fatal results from it, dread the terrible feeling of oppression, smothering sensation, noises in the ears, &c., and really suffer as much from the anæsthetic as from a minor operation. This has been my personal experience. I have taken it three times for extraction of teeth, and the sensation to me was something dreadful. I find it so with many others. I once asked a man, an opium eater, from whom I was about to

remove the whole right parietal bone, to take it, and he told me he had taken it some six times or more, and that he would sooner stand the operation without it than take it again, so he took a big dose of opium, and assisted by my friend Dr. E. N. Payzant, of Wolfville, I proceeded with the operation.

No anæsthetist feels easy and safe while giving ether or chloroform, or even the much safer mixture, A. C. E., unless he is sure of his patient's condition, and then he feels as though he were leading his patient down to the very "Valley of the shadow of death" and gives a sigh of relief when his patient has fully recovered.

To-day we have an anæsthetic which entirely does away with the objections of anæsthesia by inhalations, and so far has proven itself much safer, given as an *aid* to general anæsthesia by chloroform, or given as a general anæsthetic, by the aid of a few drops of chloroform, if you will; or it can be given without the aid of any other anæsthetic, and has proven itself perfectly safe and satisfactory. I refer to the Abbott formula No. 1, as follows:

℞ Chemically pure Hyoscine Hydrobromide gr. 1-190
" " Morphine " " 1-4
" " Cactin " " 1-67

This must not be confounded with the scopolamine preparations that have been on the market, and from the use of which a number of deaths have been reported. From the H. M. C. (Abbott's) so far we have no deaths reported. The preparation must be from C. P. drugs, and giv-

en with a reasonable amount of care, when no danger need be feared. It has only been in use a short time, but it is now being used by many of the leading surgeons of America.

Dr. Garcia, of St. Louis, Prof. of Abdominal and Pelvic Surgery, used it in fifty-five major operations during the past year, and in all cases he reports that it was perfectly satisfactory. In most cases he used it as an *aid* to general anæsthesia. He gave one tablet one hour previous to operation, and one immediately before, followed if necessary by a few drops of chloroform for an operation of one hour's duration. He finds the advantage of the H. M. C. tablets: The avoidance of the shock of a patient upon entering the operating room, and the continuance of sleep for hours after, which prevents pain and restlessness that usually follow an operation.

A correspondent of *Clinical Medicine* reports a series of operations he witnessed under the use of the H. M. C. alone. One was a case of appendicitis. The patient had two injections of one tablet each, two hours apart. Shortly after the second tablet was given, one of the attendants nervously came to the surgeon, and told him the patient's respirations had dropped to six per minute. The surgeon leisurely got up, and remarked that the patient was about ready for the operation, and without concern proceeded to operate. No nausea, no unrest, no bronchitis or nephritis, but perfect anæsthesia for hours, allowing plenty of time for careful work, with hours of perfect rest after the operation. "Surely," he says, "this is getting to perfection."

Dr. W. J. Bardley, of Cedar Rapids, Iowa, who has used the combination in a large number of cases, reports eighteen cases of abdominal

and pelvic surgery, operations lasting from fifteen minutes to two hours and a half, and says his experience has been eminently satisfactory. He says: "If the danger can be eliminated, the advantage of this anæsthesia is obvious. First, the unpleasant and often terrible experience of patients undergoing the first stage of ether, or chloroform anæsthesia. These are entirely done away with, for when chloroform is necessary, the patient is so thoroughly insensible that she does not know she is taking it. Second there is no vomiting during the operation, no filling up with mucus, or swallowing of the tongue, so called; and usually no (and never but little) vomiting after the operation. Instead of the usual vomiting of six to twelve hours after ether, the patient who has had this combination, *sleeps* most of the time of six or twelve hours. His technic is as follows: First, preparation of patient for operation in his own room. Two hours before operation he gives by hypodermic one full tablet. One hour later a like dose is given. One half hour before the operation, the patient is quietly moved to the anæsthetic room, when his eyes are covered with a towel, he is told to go to sleep. One half hour later he is taken to the operating room, where final preparations for operation are gone through with. If the patient is sleeping no chloroform is given. If not sleeping a few whiffs of chloroform are administered. This may require ten drops to three drachms. No chloroform is given after this, unless there are muscular contractions. In one case two double doses of H. M. C. were given by mistake of the nurse, but no ill effects followed. The respiration slowed to twelve per minute, and she slept for eighteen hours after the operation.

In another case a double dose was given intentionally. The patient was a large blacksmith. Reduction of Pott's fracture of left leg, and application of plaster cast. The patient was pale and faint with pain. He administered a double dose, sent for ambulance, and he was taken to the hospital. An hour elapsed before reduction was made. This was accomplished with ease. Muscles thoroughly relaxed. No chloroform. After dressing, patient was put to bed, to awake from a dream an hour and a half later, that he had broken his leg, which he verified by seeing it in a cast.

The foregoing gives us a glimpse of the work done by the H. M. C. tablet (Abbott) in surgical cases. My own experience has been necessarily limited, first using them in the autumn of the last year, but so far very satisfactory.

My first case was one of gallstone. Patient aged 48. Had several attacks during last year, lasting from twenty-four to forty eight hours each. Saw her shortly after the attack began, and gave her a full tablet hypodermically, and left another to be given an hour later, dissolved in a teaspoonful of hot water, if necessary. After a little she slept from the first one, and did not have to use the second.

Second case for the same trouble in a lady 56 years old. For this patient I had used the morphine-atropine tablet, and sometimes had to repeat several times before she got comfortable. When the pain would leave, or the calculus would roll into the bowel, she would go into a rather deeper sleep than I cared to see her. In this case I tried the H. M. C. tablet, and left another to be given her in an hour if necessary. She did not have to take the second at that time, but used it later in another at-

tack. The hyoscine in the tablet seems to have a much greater relaxing power than the atropine in the morphine - atropine tablet. These tablets can be given dissolved in a teaspoonful of hot water by the mouth, and act almost as quickly as by hypodermic.

Case third. Labour. Mother aged 27. Second childbirth. First labour lasted forty-eight hours. Under chloroform for eighteen hours off and on, and was delivered with a instruments of a 4 lb. child. Present labour began at 5 a. m. Was called at 8 a. m. Found pains of a teasing, irregular character, and doing no good. Could not get her to bear down to them. She was nervous, and had all the experience of the first birth looming up before her. At 9 a. m. I gave her a half of a full tablet. In a few moments pains were more regular and the os dilated better, and she would bear down to her pains instead of trying to get away from them. At 11 a. m. I gave her the balance of the tablet. Labour progressing fairly well. At 3 p. m. I gave half of a tablet, and at 4 put on instruments and delivered. She was conscious of what was going on, and said after it was over that she felt fine, and had not suffered any since I gave the first half tablet, though she was delivered of a 12¼ lb. boy.

Case Fourth. Labour. Primipora. Saw her at 12 noon. Had strong pains, which made her cry out and flinch and try to get away from them. Os not dilated enough to enter the tip of the finger. Very rigid. I tried to teach her how to bear down with each pain, but she would try all she could to get away from them. At 2 p. m. I gave her a full tablet hypodermically, and darkened the room, and ordered the nurse out, and to allow no person to go into the room,

and I went to sleep in an adjoining room. Before leaving her, I told her to go to sleep and she would wake fresh and have no trouble. At six p. m. I was called, she was making some fuss. Found the os dilating nicely, labour progressing as well as could be desired, and the nurse delighted to think the patient had so much rest, and still labour going on. At 7 p. m. I saw it was going to be an instrumental case. I gave her another full tablet, and told her to go to sleep. Between pains she would get into a pretty deep sleep, only to arouse a little when pains came on. At 9 p. m. I put on instruments and delivered. There was a slight laceration for which I took a couple of stitches without further anæsthesia, changed her bed, and fixed her all up and left her sleeping as sweetly as one lying down to pleasant dreams. At my next visit the nurse told me the patient had slept all night, only arousing occasionally for a drink, or to change position, and would then go to sleep again. In the morning she was fresh, and did not remember of having much or any suffering after the first injection. Her recovery was rapid and complete.

Case Five. Multipara. Called at 8 a. m. Water was broken. Os very slightly dilated and rigid, pains not doing much good. She was the mother of three children, and every birth had lasted for upwards of twenty-four hours, and delivered with instruments. As she told me that history, I concluded to visit some other patients some nine miles away, and gave her a full tablet of H. M. C. telling her I would return at 4 p. m. When I returned I found that labour had progressed fairly well, the os pretty well dilated, and that she had slept considerable of the time during my absence. I gave her half a tablet, and in a short time put on

forceps and delivered. No pain, no laceration, parts relaxed, and the delivery was easy. She made a good recovery.

Case Six. Primipara. Aged 35. Waters broke at 5 a. m. Saw her at 5 p. m. Pains irregular, not doing much good. Gave her 1-120 of a gr. of strychnia, and hyoscyamine 1-150 to soften the parts and to get up regular pains. I repeated this for four doses; one every hour. As she was having good pains, and the parts were rigid, I then wanted to give her a little chloroform to soften them up some, but this she refused, saying, she had taken it to get teeth extracted and she nearly died, and would not take it again. I then gave her a full tablet of H. M. C. which caused parts to soften, the os to dilate, and her to rest and sleep between pains. Three hours later I gave her a half tablet, and in half an hour I gave a few drops of chloroform, to which she made no objection, as she was too sleepy to think or object, and dilated and applied long forceps and delivered. When the head was delivered I found the cord around the neck, this I quickly slipped over the head, and completed the delivery. In this case the cord was shorter than usual, which may account for the head not engaging. The child was in a state of asphyxia, and gave us no little trouble to resuscitate. Whether this was due to the tablet and a half which I had given her, together with the hyoscyamine that she took in the earlier stage of labour, I am not prepared to say. I have had similar cases where neither had been given. However, I would not use strychnia and hyoscyamine in cases where I expected to use the tablets, as children in utero are very sensitive to narcotics. When baby cried lustily, and was washed and dressed, we put it in with the mother, who then asked

if it was born, saying she had not suffered much if any, since the first injection.

Case Seven. Threatened abortion, three months. Some show. Pains regular, and the woman happy to think she was likely to get rid of it. I persuaded her to let me give a hypodermic to strengthen her pains, and told her to go to sleep for a little while when she would wake up fresh, and soon end it. She soon went to sleep, and I went home. A few days later she met me on the street and gave me down the banks for stopping her pains. I laughed at her and told her I thought it was a pity to lose such good stock.

Case Eight. Threatened abortion at four months. Had pain, and show, and it looked as if a young coon was going to be launched on the world—too tender to be of any use. The mother, a coloured woman, said, "It is going to come sir, sure." I gave her a full tablet, cleared out the room and told her to go to sleep, which she did, and I heard no more from her until the eighth month, when I was sent for again. This time it was to be born for sure, repeated the tablet, and told her if she did not sleep alone, she would surely die. That fixed her, and she is going on to full term.

Case Nine. Right inguinal hernia. Patient a married woman four months pregnant. Hernia had been down twelve hours, and she kept trying to get it back but could not. It was very painful, and she would not let me use very much taxis. To make matters worse she had been vomiting for the past six hours, and had not had an operation of the bowels for two days. It looked as if I was up against an operation. I gave her a full tablet, and went home to my office. I returned in an hour, and found her dozey, and I could handle

the tumour without causing her pain. Gentle taxis soon reduced it.

Case Ten. Delirium Tremens. Man had not slept for three days and three nights. When he closed his eyes he saw a greater menagerie than he ever knew before was in the world. I gave him a full tablet, left four more with his wife, to repeat every four hours until he slept, and then at twelve hours. Also gave 1-60 gr. strychnia every hour for four hours when awake, and plenty of hot broths well seasoned with cayenne. He slept after the second tablet, and made a good and speedy recovery.

Case Eleven. Lagrippe with congestion of left lung, temp. 103, in a man aged eighty years. He was delirious, could not get sense enough into him to take anything by the mouth. Had not slept for thirty-six hours, and seemed sore when touched. I hesitated in this case, but remembered reading of a similar case of pleuro-pneumonia in an old man where it was given; the man rested, the lung trouble cleared up, the patient got better, so I resolved to try. It made my patient sleep, and he awoke free from delirium, and only complained of pains in all the muscles, and difficulty in breathing. We had him where he would take medicine, and we could treat him, and he went on to a good recovery.

Case Thirteen. Child six years old. Cramps in the stomach. Gave about a third of a tablet, and followed it in twelve hours with an anthelmintic, believing the trouble caused by worms, which was verified when the medicine operated. Saw no bad effect from giving it to so young a patient. It soon stopped the pain and vomiting, and after the worm powder operated, was all right again.

Case Fourteen. A strong, stout, deaf mute, aged 20, who had fallen from the trunk of a tree he was cut-

ting. He put his hand out to save himself, and fell full force on it, and dislocated the arm forwards between the radius and ulna. When I looked at it he clenched his fist, and his father cautioned me that he was liable to strike, and if he did, I may as well be kicked from a horse. I told him his son would be harmless before I touched him. Being deaf he made a grand subject for the tablet, he could not be disturbed by people talking, and after I had given him a full tablet, I covered his eyes, and would not allow any one to touch him. In an hour I repeated with half a tablet, and in a few moments began to examine the joint, but as there was some slight contraction of muscles, I gave him about twenty drops of chloroform, not more than that amount, and he went off without the least movement. He was perfectly relaxed, and I easily slipped the bones to their places. I am sure in this patient we would have had trouble to have given him a general anæsthetic, without first putting him prettily well under with the H. M. C.

I have used it in other cases, but the above will show the general way in which I have used it.

My conclusions so far as I have used it, are about as follows: I would not hesitate to use it in all cases where an *anodyne*, or a *hypnotic* is indicated. I would not hesitate to use it in a patient over six years, or one of eighty under certain conditions, but the doses should be small, and repeated if necessary in an hour or more. From eighteen to seventy I would not hesitate to use one full tablet and repeat in an hour if necessary. For complete anæsthesia, I would give one full tablet an hour and a half before operating, and half a tablet an hour later, and in half an hour if the patient was not asleep I

would follow with a few drops of chloroform. I would consider this the better way, unless the operation was going to last more than an hour, then I would give two full tablets as above instead of the one and a half, follow with the chloroform in half an hour after the last tablet if the patient was not asleep, or if there were any muscular contractions.

In all cases of accidents, I would use it upon first seeing my patient, as by the time you are ready to attend to the trouble your patient is well under its influence and is not suffering, will take chloroform without excitement, if you decide on using chloroform to complete anæsthesia instead of the tablets.

I would use it in confinement cases where there was rigidity of the parts, the woman suffering much, and would work away from her pains, and labour was likely to continue more than a few hours. I think it hastens labour, by softening the parts, making her pain more bearable, and enabling her to help herself.

I would use it as an *anodyne* and *hypnotic* in all cases where the morphine-atropine tablet was indicated, unless there was some special indication for the atropine in tablet mentioned.

I would consider it too slow for most office work, as the tablet requires time—an hour at least.

I have used it in the young and old, black and white, and I have yet to see any danger from it with a fair amount of caution.

In giving it, the room must be darkened, or the eyes covered with a cloth, and the patient allowed to be absolutely quiet. No noise or talking or people moving about the room permitted, or the injection will be a failure as an anæsthetic.

SUBPHRENIC ABSCESS.

By J. D. MacIntyre,

Montague, P. E. I.

(Read at meeting of Prince Edward Island Medical Society, February 19th, 1908.)

THE patient, a male, aged 35, had been suffering from malaise and dyspeptic symptoms for one week. He took suddenly ill while driving in a sleigh. He was seized by sudden severe pain the epigastric region which lasted a few minutes, followed by severe cramps of muscles of forearms and legs. These soon lessened, but the severe pain returned after he had gone half a mile. It somewhat abated, and he reached a house where he lay down and a doctor was summoned. Before the doctor arrived, however, he had another attack of the spasm, which was followed by agonizing cramp of the muscle of limbs, causing fingers and knees to be flexed to the utmost. The doctor administered a half grain of morphia in two doses.

I saw the patient half an hour later. He was very weak and only spoke in a whisper. The skin was wet with beads of perspiration, and was almost of a purple tinge, while nails and lips were purple, and expression was that of profound collapse. Every few moments a spasm would still strike him and cause his hands and knees to draw up. His abdomen was rigid and of the checkerboard variety, with great tenderness over the area above the level of the umbilicus, somewhat more pronounced on the right side in the region of the gall bladder. He complained of great pain which he referred to the region of the umbilicus, and also of pain in the right shoulder around the lower surface of the scapula.

During the past ten years I have seen many persons suffering severe

pain, but notwithstanding the two doses of morphia administered half an hour before my arrival, only on two other occasions have I seen persons display such suffering. It was intense, excruciating, unbearable. His temperature was subnormal and pulse 60. A diagnosis of probable gall stone colic was made.

After remaining a couple of hours he was sufficiently relieved to be removed to his home—a journey of six miles, more than five of which, was on ice. The journey gave him considerable pain, and every jolt of the sleigh caused him to wince. He had severe pain during the night, but hot poultices relieved him so that it was never afterwards necessary to give him morphia.

The next day he was feeling much better, but there was marked cyanosis still present which I may add was more or less pronounced during the whole course of his sickness. He still complained of pain in his right shoulder and across him. The tenderness was marked along the lower border of his ribs, both to the right and left of middle line, the most tender spot being now a little to the left of the middle line. Rigidity was not now very pronounced. Temperature 97°, pulse 55 and of fair tension, though cyanosis was still marked.

On the next day, the third of his sickness, the symptoms had somewhat abated. No pain was complained of except that in the right shoulder. Tenderness was less marked than on the day previous. Breathing from the first was somewhat ac-

celerated, but when asked if he seemed short of breath, replied that he was not.

On the fourth day he felt much better and got up, and remained up for several hours. On this day his pulse was 48 and temperature 98° .

I neglected to say that on the second day he felt as though his bowels would move. I gave him a dose of salts, which he vomited. I then gave his six grains of calomel and a dram of compound jalap powder. This he also vomited. I then used enemata which were not satisfactory. During the vomiting he ejected large quantities of bile, but he never vomited except when physic was taken. On the third day his bowels moved freely, and no more vomiting occurred.

On the fifth day his pulse was 80 and temperature $101\frac{1}{2}^{\circ}$. He did not feel so well and complained of pain at night which he could not locate definitely, though it was referred to abdominal region. He also still complained of the pain in shoulder, and of pain in back in lower part of lumbar region. Both shoulder and back were very sensitive to pressure. His temperature kept up during the remainder of his sickness, ranging between 99° to 100° in the morning, and 100° to $101\frac{1}{2}^{\circ}$ in the evening; pulse from 80 to 96. I only once found pulse 100 and temperature as high as $101\ 4-5^{\circ}$. Tympanites was never present. For the first week after temperature rose above normal he complained of great pain in turning, but none while at rest; but for the last ten days of his illness he had neither ache nor pain. Nor was he sensitive to pressure over any part of the abdomen. Two days before his death, while palpating him deeply over the abdomen, and on enquiring whether it hurt him,

I remember his answer: "No," said he, "I don't think that hurts me any more than it would were I in perfect health."

About a week before death his nose bled for two mornings in succession, and four rose spots were noticed on lower part of abdomen, which faded away in three days time. There was no tympanites, spleen was not palpable, his bowels were inclined to constipation, and he had never had a headache. Five days before his death the only thing noted abnormal about the abdomen was that there was dulness of a finger's breadth below the costal margin of right side and the margin of the liver was indistinctly palpable.

On examining the back, dulness was present on the right side reaching as high as the inferior angle of the scapula behind. In the axillary line it reached the level of the seventh rib. There was none in front nor could any change of dulness be detected by change of position.

When asked about his general condition, he said that he was feeling much better than he had been. He had never had any headaches; no delirium at night; no chills nor profuse sweats; nor had he up to this time ever coughed. Consequently it was supposed that the pleurisy evidently present was serous and that perhaps it was sufficient to account for his continued fever of mild type. It was proposed to aspirate to get a sample, but he begged that if it were not absolutely necessary that he might be spared the pain of the procedure. I told him that I would watch its progress and if he continued to improve as he now seemed to be doing, and if the fluid did not rise any higher, I would not aspirate. Though he cannot be said to have improved, his symptoms did not

grow worse and the fluid seemed to recede somewhat.

On the day of his death, being the twenty-second day of his illness, I visited him. I found him as usual. Temperature 101° , pulse 96. He asked me what his pulse was. I told him that it was a little higher than usual. He replied he had counted it that morning, and that it was 76. The fluid in chest seemed to have receded about two inches. He told me that he had coughed that morning for the first time since he got sick and that he had brought up a spit or two of dirty-looking stuff. I had not left him half an hour when I was sent for, and found him sitting up in bed coughing almost incessantly, and expectorating pus of horrible odor. It reminded me most of the odor of rotten eggs. This continued for about two hours. In this time he expectorated about fourteen ounces of pus. The character of the sputum then changed to that of red currant juice, but the odor remained the same. Dysnoea became marked, cyanosis deepened, and pulse became almost imperceptible. The pulse improved greatly for a few hours under stimulants, but dysnoea continued. The dulness increased from below up in chest. I then aspirated him and drew off from chest six ounces of serous fluid, slightly turbid, but having nothing of the character or odor of the pus expectorated.

He died in about twelve hours after the first appearance of cough. There was no pain during these hours and consciousness remained clear to the last.

POST MORTEM.—On percussion a small area of dulness about the size of a hen's egg was found in epigastrium, extending from the middle line to the left. On opening here there were bands of adhesions, and

between edge of liver and stomach a small pocket of pus, containing about a drachm, was found.

This small pocket of pus lay in the adhesions and was quite superficial, being almost in contact with the anterior abdominal wall. It had no sinus leading from it and seemed to be the starting point of a secondary abscess. On opening fully I found that adhesions extended from the region of right kidney over part of transverse colon, pyloric end of stomach below, up to and across the edge of liver, hiding the gall bladder and gluing the upper surface of the liver to the diaphragm. After separating this surface from diaphragm for about six or eight inches, I came to a collection of pus. On removing the liver I found on the upper surface of right lobe six to eight inches from the costal margin, a roughened surface circular in form and three inches in diameter, which with a similar roughened surface on the corresponding part of the diaphragm had formed an abscess cavity, the adhesions before spoken of completing the cavity. The abscess did not invade the liver substance, nor did it even penetrate its capsule, but had formed on the serous surfaces between liver and diaphragm. There was no sinus leading from this abscess cavity towards abdomen.

On opening the thorax about two ounces of fluid still remained in the right pleural cavity; also about two ounces fluid in the pericardium. The right lung was inflamed, the lower lobe solid and glued to the diaphragm. Both were removed together and about the centre of the circular roughened surface on the inferior surface of the diaphragm was a perforation which admitted a probe to enter the right lung. On

separation of the lung from the diaphragm the small gangrenous opening could be seen entering the lung. No abscess cavity existed on superior surface of the diaphragm. The adhesions were so firm that when the diaphragm was punctured the lung itself gave way without forming any sac in the pleural cavity. This sinus led directly from the abscess on superior surface of liver to a small bronchus.

The lower lobe of right lung and the lower parts of middle and upper lobes displayed all the signs of putrid pneumonia.

In summing up, I wish to draw attention to the absence of the signs of pus formation. There were no chills or sweatings during the whole course of illness. Temperature and pulse were subnormal until the fifth day. The great amount of adhesions present towards the close without rigidity or tenderness for last ten days is notable. I also wish to draw attention to the locations of the referred pain in this case. There were three points: the right shoulder, the lumbar regions, and the umbilicus. We know that pain in the liver is almost always referred to the right shoulder; pain in the peritoneum is

referred to the umbilicus, and it would seem that the pain in the diaphragm was referred to the point of attachment of that muscle to the lumbar vertebrae. These referred pains seem to point to the liver, the diaphragm and a peritoneal surface. If we can take the continued fever to indicate pus formation, the whole lesson could spell nothing else than Subphrenic Abscess.

It seems quite unnecessary to dilate on the lung conditions. He expectorated pure pus for two hours. Then it became blood stained. The lower lobe was probably filled with pus when the lung ruptured. He coughed this up, part was expectorated and part fell back into the lower parts of the other lobes, where it set up a pneumonia. I had no means of making a bacteriological examination of the pus, but I have little doubt that if it were examined, the ubiquitous colon bacillus would have been found as the causative factor. But why it should set up its tent in that particular locality I am unable to divine. This seemed to be the primary focus. There was no stomach, bowel or other abdominal condition on which it seemed to depend.



ECLAMPSIA: ITS ETIOLOGY AND TREATMENT.

BY ARTHUR S. BURNS, M.D., C.M.

Bridgetown, N. S.

(Read before the Annapolis-Kings Medical Society, January 22, 1908.)

ECLAMPSIA, as the derivation of the word signifies (*Ek*, forth, and *lamptein*, to shine), is the shining light of pregnancy, labor, and the puerperium, more especially of the stage of labor. Indeed, the light is often so dazzling that it quite dazes the beholder—the accoucheur. It is a disease ranking high among diseases in mortality with its maternal of thirty per cent. and fetal mortality of fifty per cent. approximately. Its group of symptoms generally comes as a surprise to the accoucheur, his first intimation of its existence often coming after his first call to a woman in convulsions, a woman whom he has not known previously to be pregnant, owing to our carelessness at present in the care and instruction of pregnant women—of which more anon. So we see great reason for being thoroughly equipped at all times with intimate knowledge of the disease and with necessary armentarium, particularly when we consider that twenty-four to forty-eight hours show either victory or defeat.

To-day I shall confine my remarks for the most part to the two divisions of the subject, Etiology and Treatment, and shall endeavour to bring before you the latest investigations and theorizings.

PREDISPOSING CAUSES.—Primiparæ are more frequently the victims than multiparæ, forming about seventy-five per cent., and especially those illegitimately pregnant. Average age of all cases from recent statistics of a large number is 27.2 years. Weather acts as a predisposing cause, most

cases coming in the spring and fall months of the year. It affects chiefly through its hygroscopic changes, *i.e.*, presence of large amounts of moisture in the air, rather than by rise and fall of temperature. The surface of the body is chilled, peripheral vessels contracted, perspiration checked, and consequently greater strain is thrown on the internal organs, chiefly the kidneys.

EXCITING CAUSES.—Eclampsia has been aptly defined “the disease of the theories.” Nearly every year some student and investigator brings forth a new theory to be almost as suddenly rebutted by another equally studious. The little bacillus has endeavoured to establish his priority, but his claims as yet meet with little acceptance. The other theories advanced for its causation as (1) a change in the maternal blood, in which presence of ammonium carbonate, a decomposition product of urea, seems the chief feature in producing convulsions; (2) that eclampsia is due to a disorder of the nervous system, (3) transfusion of fetal blood through the placenta into the maternal blood, where it is coagulated and causes thrombosis; (4) toxic material comes from corpus luteum.

All these theories are possessed of elements of truth, but all require an antecedent cause for their explanation. The whole tendency at present is to consider this antecedent cause to be a toxin and eclampsia to be the result of a toxæmia. This seems to be a natural deduction when one considers that the urine

of the eclamptic patient is less toxic than that of the normal patient and that examination of the blood shows an accumulation of toxins. In fact, the urine of an eclamptic patient is scarcely toxic at all.

Whence originates these toxins is now the question. The most interesting theory and the one that at present offers most is the syncytial theory. What is the syncytium? The syncytium is the superficial layer of the chorionic villi, and is a continuous layer of protoplasm without cell walls in which numerous nuclei are imbedded. A few words as to the development of syncytium may now be in place. Knowledge of embryology, as of most subjects with which one is not daily associated, passes away from one's grasp as "pass the swift ships," and neglected a few years leaves one very hazy on the subject; so I shall recall a few points in the development of the fetal membranes. You all remember the three membranes of the fetus, viz., Chorion, Allantois, and Amnion from without inwards, with the Chorion nearest the Decidua of uterus and Amnion nearest to fetus. The Chorion in early stage of development does not completely surround ovum but later covers it on all sides. It consists of two layers called the ectoderm and mesoderm, the ectoderm layer being the superficial one. The allantois is the blood vessel carrying layer for vessels to and from fetus and placenta, and completely lines chorion on its inner side towards the fetus. Soon after ovum sinks into uterine mucosa, the chorion throws out protuberances over all its superficial surface called villi, consisting necessarily of ectoderm. These villi disappear except on the side towards the placenta where they become larger and project into

blood sinuses of maternal placenta. The allantois sends prolongations of its vessels, arteries and veins, into the villi. It is believed from recent observations that the ectoderm of these villi differentiates into two layers, a superficial one in which the cell wall disappears leaving a continuous layer of protoplasm with numerous nuclei, and an inner layer with cell boundaries. The former continuous layer of protoplasm is the syncytium; the latter is Langhlan's layer of cells. So we see that the syncytium is one of the epithelial layers of the chorionic villi; it is of fetal origin (neoplasms have been found in men and children of which syncytial tissue entered into their composition, showing its fetal origin of necessity); it is derived from the primitive ectoderm and mesoderm. As we said before, these villi covered by syncytium dip into the decidua serotina and are bathed in maternal blood, the syncytium acting as a filter and carrier of nourishment, excretory organ, etc., the absence of cell walls perhaps favouring the processes. The further function of these villi is not thoroughly understood.

THE SYNCYTIAL THEORY. — These syncytial elements in the maternal blood determine the formation of a toxin which is called syncytiotoxin. The blood of the mother forms in its serum antibodies called antisyncytiotoxins. This antisyncytiotoxin neutralizes or tends to neutralize the syncytio toxins. So far it seems fairly well decided that syncytium is the active factor in causation of eclampsia, but just how it works is the question for further investigation. Some writers think the antibodies prevent proliferation of these fetal cells or chorionic elements and so deportation, holding that these elements or portions of

villi act as emboli producing occlusion of vessels in other parts of the body, more especially the liver. There is certainly considerable evidence of embolic or thrombotic processes in the liver in eclamptic patients coming to autopsy. W. M. Jordan claims that the peripheral zones of liver are affected. All place great importance on the part the liver plays in eclampsia. Liver functions and pregnancy seem to be closely connected. There is a close connection between pregnancy and gallstones, it being claimed by Naunyn that over 90 per cent. of women who have gallstones have borne children. Intraabdominal pressure of an enlarged uterus may, however, play chief part in causation of gallstones. In 1886, Jürgens pointed to possible hepatic origin of eclampsia. Many writers have commented on the almost certain occurrence of hepatic changes, and look upon their non-occurrence as the exception. Ewing in 1905 wrote that hæmorrhages into the liver substance occurred in ninety-five per cent. of all cases of eclampsia.

Ewing thinks eclampsia, toxæmia of pregnancy, and acute yellow atrophy of the liver in pregnant patients are all due to the same cause. W. M. Jordan says they are not. "While eclampsia affects" he says, "the more peripheral zones of liver lobules, pernicious vomiting and acute yellow atrophy affect the mid-zonal areas." Jordan says tendency is for eclamptic patients to get well after delivery, but not so with pernicious vomiting and acute yellow atrophy.

Dr. Zella White makes the following summary in a paper recently read before the South Dakota Medical Association. "Kidney of pregnancy and eclampsia are caused by the same toxin, which toxin is the result of a hepato—toxæmia or of

placental origin with greatest evidence in favour of the latter. There are most constant pathologic changes in the liver and kidneys, the more characteristic being in the former. Examination of the urine cannot alone be relied on, the condition of the kidney being only a symptom."

The liver in eclampsia fatal cases that have come to autopsy is generally pale and hæmorrhagic areas are present.

Evans says in 1906 in the *British Medical Journal*, that the toxæmia exerts its deleterious influence on the liver, kidneys, and general nervous system. "It is generally accepted that the liver plays an important role, the kidneys only secondarily, and that there may be a great deal of toxæmia before kidneys are affected at all."

Kervilly of Paris, found he was able to distinguish the livers from eclamptic women by the abundance of fat in the "Star" endothelial cells in the liver. He examined sixteen livers and found it so in all. He remarks that this may be the only distinctive histologic lesion in eclampsia.

Veit and Opitz believe the syncytio-toxin is produced by the syncytium being dissolved in the blood of the mother. In eclampsia, there is an absence or relative absence of anti-syncytio-toxins to neutralize the toxins.

Leipmann in 1905 held the theory that eclampsia is an auto-intoxication from a toxin found in the albumen molecule and released in the placenta through faulty action of the syncytium on the albuminous bodies of the maternal blood. This toxin is normally neutralized by antibodies; when not neutralized poisoning takes place. A certain amount of this poison is cared for by the liver and kidneys; if excessive, it cannot be

cared for, and generally poisoning manifesting itself as eclampsia results.

In opposition to Veit and Opitz, who hold that syncytial elements pass into maternal blood, Ascoli holds that such is not the case, but that there is only a passage of syncytiotoxin, produced by over-activity of the syncytium, thus looking on the syncytium as more or less a gland with a disturbed secretion.

Reed, in the *North Western Lancet* recently says: "(1) High tension in blood vessels is immediate cause; (2) the cause of high tension is coagula in the blood; (3) remote cause of coagula is retardation or stagnation of blood in the uterine or neighboring veins favoured by the anatomy of the parts; (4) a special ferment or toxin which, with the preceding causes the coagulability of the blood; (5) this toxin exists in the placenta."

To sum up all, it seems evident that the syncytium plays an important role, if not the chief part in the etiology of eclampsia, whether we consider that it produces its effect by (1) a ferment, (2) deportation of syncytial tissue causing thrombosis, (3) dissolving of syncytial tissue in the maternal blood to produce a syncytio-toxin, (4) over-production of syncytic-lysis, the syncytium being looked on as a gland, or (5) a coagulation of the blood produced by a certain ferment or toxin.

DIFFERENTIAL DIAGNOSIS.—This is sometimes difficult. From hysteria and epilepsy diagnosis is usually easy, though difficult cases may occur, and one should bear them in mind. I want to call more particular attention to uræmia and tuberculous meningitis.

Tuberculous meningitis. It is well known that tuberculous processes are aggravated by pregnancy. Latent catarrhal affections rouse up to a pro-

gressive course and tuberculous meningitis and miliary tuberculosis are liable to develop as pregnancy advances. Onset of tuberculous meningitis simulates eclampsia. It may set in with chills, headache, spasmodic contractions of the muscles of eyes, face, and limbs but no albumen in the urine. Look for tuberculous focus in the lungs and for incomplete paralysis of nerves at the base of the brain to differentiate. Oedema of face is an important sign in eclampsia generally, and reduction in the amount of urine. In eclampsia, the patient arouses at times and is comparatively conscious. In meningitis, the stupor continues a progressive course. Onset of eclampsia is briefer and more stormy, and convulsions subside at times. Visual disturbances come on suddenly.

Uræmia. Uræmia and eclampsia present approximately the same clinical picture, both being, probably, the work of same and similar poisons, but likely with different origin

TREATMENT OF ECLAMPSIA.—Treatment is considered under two heads, preventive and curative. Under prophylaxis or prevention of eclampsia, great importance attaches to the care and supervision of the pregnant woman. We too often see the patient for the first time in the throes of labor, not having known her previously to be pregnant, and, perhaps, to us the eclamptic condition may be the first intimation of pregnancy. The laity should have gradually and thoroughly instilled into them the necessity for pregnancy to be under the care of the physician from the early months. No doubt, in this way eclampsia would become much more uncommon. "Eternal vigilance is the price of liberty." "An ounce of prevention is worth a

pound of cure." The attendant should pay particular regard to any evidence of toxæmia. Urine should be examined monthly in the early months, and weekly or oftener in the last two months. In the examination of the urine, pay particular attention to the daily amount excreted, percentage of urea and albumen, presence and character of the sediment. We look too much for the abnormal constituents of the urine; instead, we should see whether the normal constituents are varying from normal amounts. Also, remember not to attach too much importance to the examination of the urine since eclampsia may be present to a serious degree without kidneys being affected or showing albumen.

Keep bowels and skin of pregnant woman active. This is important. See that patient does not eat food that favors constipation. Let her drink large amounts of water. If laxatives are necessary, let them be mild and not purging. Considering the influence of the weather, patient should wear suitable clothing adapted to the weather. Temperature of living rooms should be more equable, especially, when the weather is very raw without. Prevent an excess of moisture in the house by starting the fires early in the fall and not letting them go out till late in the spring.

CURATIVE TREATMENT.—If examination of the urine at any time shows fall in urea to 1.5 per cent., diet should be regulated. Let diet consist of milk, fish, white meats, etc. Give a dose of calomel and soda aa gr. 10 occasionally. Give warm baths twice or thrice a week to stimulate the skin. Be careful of diuretics. If little or no improvement, put patient at rest in bed. Let diet be of milk alone, if possible. Daily lavage of bowels with long rectal tube promotes elimination of bowels. Promote diuresis

by sodium tartrate. Diuretics having a very particular action on the kidneys are to be avoided, owing to their adding injury to an organ already injured in most cases. If kidneys show little or no damage, diuretics promote efficient elimination of toxins. Sweating procedures are useful, but troublesome in private practice. They are not absolutely harmless, as they disturb the patient considerably, and thus encourage convulsions in a system with reflex arcs very sensitive to impulses. When patient has progressed to the stage that one or more convulsions have occurred, absolute rest and quiet is necessary. Some even advocate that all interference with patient even to vaginal examination and giving of rectal enemata call for an anæsthetic. Make as few vaginal examinations as possible.

During convulsions we were formerly taught to give chloroform, but recently the teaching is "do not give chloroform during convulsions." It produces harm by cutting off supply of oxygen, which patient needs. Give it before convulsions come on as a preventative.

Veratum viride, formerly given in large doses to lessen arterial tension, and thus promote perspiration, is used with care. It is a heart depressant, and condition of heart should be ascertained before giving it.

Opium in form of hypodermic injection of morphine was looked on as a necessity till the last few years, but owing to its checking elimination, prolonging coma, and its unfavourable influence on the child, it is growing more and more into disuse, and tends to be discarded.

Venesection is at times of great value, especially in plethoric cases; it should never be resorted to in anæmic cases.

There are even objections to introduction of normal saline solution, subcutaneously or otherwise. It has been shown that with its use the quantity of urine excreted is lessened. Blood of eclamptics contain an increase in sodium chloride, so clear, sterilized water is now recommended instead of saline solution. Do not use salines when arterial tension is high, œdema marked, and kidney function much impaired.

Rectal injections of chloral hydrate, gr. 30 or of sodium bromide, gr. 15, are warmly recommended.

Bumm remarks that treatment of eclampsia is still empiric-symptomatic, and that the physician is powerless in the severer forms, in which autopsy shows extensive necrosis in the liver and kidneys. He says severity is to be judged more by the coma that follows the first convulsion than by the number of the convulsions. He says there has been a reaction of late years against narcotics in eclampsia, as they have a mortality of thirty per cent. at least with their use—just about the same as if nothing had been done. The narcotic merely arrests one symptom, but by no means cures the eclampsia. It aggravates the condition when injected during coma, and may weaken the heart's action and thus favour pulmonary œdema. He says there is no sense in giving a paralyzing poison to a woman already suffering from a paralyzing poison. At the commencement of eclampsia there is less objection, while the consciousness is unimpaired, and the nervous system still responds to stimuli, and that in these conditions morphine acts best if given by the rectum. Drugs to stimulate the kidneys to act, fail of their effect. He says, hot packs around the waist on a level with the kidneys combined with repeated massage of

the kidneys, are liable to be more effectual.

Esch says, "old primiparæ with abundant albumen and casts should be delivered earlier than others in the same conditions."

As to operative treatment, most writers favour immediate delivery, though tendency seems strong to conservative treatment if patient is not very comatose, pulse is not of high tension, and urine not much diminished. In these milder forms, operation or delivery depends largely on whether you consider most the mother's or the child's condition. General treatment up to the thirty-sixth week is in the interests of the child. After this time, except in severe cases, be guided by the condition of the child. The mortality of eclamptic children is very high.

In severe cases with deep coma, high tension pulse, and oliguria with blood, deliver at once. As to dilatation of the os, Bossi and hydrostatic dilators are not used as much as formerly, because they are slow in action and it unnecessarily prolongs anæsthetic, which is necessary in all interference. The best method for general use, but by no means the easiest, is manual dilatation. Now, the child may be delivered by forceps or version. In more difficult cases, such as a long and rigidly contracted cervix, in which internal os is not occupied by presenting part, incise the cervix, preferably in front or behind.

CÆSAREAN SECTION.—It profits little or nothing. It seems that with it mortality remains about the same, both for mother and child. Büttner claims that vaginal cesarean section in his hands has lessened mortality from thirty per cent. to twenty per cent.

Other operative mesures are renal decapsulation and lumbar puncture.

Renal decapsulation is obviously indicated only when the kidneys are seriously damaged. Poland, in 1907 operated. Patient improved, but died a few days afterwards of pulmonary œdema. Oliguria, urine containing blood and albumen, red corpuscles, tube casts, and renal epithelium indicate operation of decapsulation in puerperal eclampsia. Some statistics are somewhat favourable.

LUMBAR PUNCTURE.—Thies, in fifteen cases, had only scant satisfaction. Cases were always severe ones. After delivery was instituted, and even with subcutaneous injections of saline, the result was unfavourable. Number of convulsions preceding puncture was four o twenty-five,

urinary secretion being markedly disturbed in twelve cases, temperature 101 to 107 degrees. Fluid was drawn off slowly. It was invariably clear and contained but few leucocytes. In several cases, after withdrawing of fluid; symptoms or irritations, vomiting, twitching of muscles, irregularity of pulse and respirations were observed. Amount of fluid withdrawn varied from twenty to thirty c. cm. Pressure in spinal canal showed considerable variation, the prognosis being most favourable for recovery with low pressure, 150 to 200 mm. Effect on urinary secretion of all was unfavourable, none being benefited.

Parathyroidin has been used, but with doubtful value as yet.



SOCIETY MEETINGS.

HALIFAX AND N. S. BRANCH BRITISH MEDICAL ASSOCIATION.

MINUTES OF MEETINGS.

HALIFAX, N. S., FEBRUARY 19th.—The 9th regular meeting of the Branch was held on this date at the City Hall. The President occupied the chair, and there was an attendance of twenty-one members. The minutes having been read and communications disposed of, the President called upon Dr. H. K. McDonald, who presented an interesting paper upon the subject of "Tubercular Disease of the Hip-Joint." The paper was a lengthy one, dealing clearly with the affection under the various headings: Pathology, Symptoms, Diagnosis, Prognosis and Treatment. A fuller publication will be made in a subsequent issue of the NEWS, but following are extracts:

Pathology.—The disease generally first manifests itself in small foci around the head of the femur. Sometimes begins at the epiphyseal rim of the acetabulum. Primary disease of the synovial membranes is very rare.

Symptoms.—Early symptoms vary with the severity of the affection. Those usually first noted are:—pain, stiffness of the joint with limp, change of contour and atrophy. The disease may, however, exist long before pain attracts attention. A characteristic sign is a shooting pain in the knee, due to the distribution of the obturator nerve. Reflex spasm is an indication of an inflamed joint, and in a child is strongly indicative of tuberculosis. Changes in contour of the limb are due in the first stage to the attitude assumed; if left un-

treated, abscess-formation with dislocation and other deformities results.

Diagnosis.—Generally easy when early examination is made, each of the other possible conditions having some distinguishing feature.

Prognosis.—Good when treatment is adopted early and persisted in. We often abandon treatment too soon, and so encourage relapses.

Treatment.—Both local and general, each case suggesting variations suitable to existing conditions. As all motion favours dissemination of the disease, a good rule is to keep the joint immobilized, and the extent of the disease will determine whether this alone with extension will suffice. Extension is strongly indicated where opposing surfaces which are diseased tend to be pressed together by muscular spasm and cause pain; specially valuable in second stage. In later stages where pain is very acute the actual cautery is often of great value. No force should be used to return a dislocated limb to its position.

The Doctor here made reference to the value of surgical measures in treatment of this condition, and quoted at some length Mr. Watson Cheyne in his treatment, by operative methods, of the disease in its various stages. Unopened abscesses must always be treated at once, as they serve as a starting-point of fresh infection.

The Doctor referred to Bier's congestive treatment as impracticable in this condition. He mentioned also Wright's experiments with the use of

tuberculin, and remarked upon cases in which it had apparently rendered much assistance.

This ended Dr. Dr. McDonald's paper, and Dr. D. A. Campbell moved that discussion of it be deferred until after the reading of Dr. Farish's paper.

Dr. G. W. T. Farish, of Yarmouth, whose name was also on the programme for this meeting, then read a short and very practical paper entitled "Difficulties in Diagnosis of Abdominal Conditions," in which he pointed out many of the hardships often encountered in the endeavour to establish a definite diagnosis in such cases, the deplorable lack of methods by which accuracy may be attained to, and the results of consequent mistakes, often disastrous alike to patient and physician. The paper was interesting and instructive, and will appear later in these columns.

A helpful discussion on both papers followed, most of the members contributing.

Dr. Stewart corroborated the opinion expressed as to the value of the actual cautery in certain cases—the cautery was once much employed, and he thought its use at the present time too much neglected. He referred also to the promising value of tuberculin in tubercular conditions.

A motion for adjournment closed this very successful meeting.

MARCH 4TH, 1908.—The tenth regular meeting of the Branch convened at 8.40 p. m. on this date at the City Hall by the President, and with a good attendance of members.

Dr. M. A. B. Smith presented a clinical report of a case which had been in hospital under treatment for obstinate vomiting. Treatment had persistently failed to afford relief. There had been some doubt as to

diagnosis between carcinoma and stricture from simple ulcer. The case had gone on to death, and autopsy revealed a growth of considerable extent involving pylorus and pancreas, almost completely occluding the lumen of the former. There had been some hæmorrhages previous to death. The lungs at autopsy were found to be extensively tuberculous, though symptoms from this quarter had been few in life. The case illustrated the extreme difficulty of being sure of a diagnosis. It still remains for the pathologist to pronounce upon the condition present. Doctor Smith promised to make a further report later on. The diseased stomach and pancreas were exhibited.

Doctors H. A. March, of Bridgewater, and W. H. McDonald, of Rose Bay, were present on this occasion to read papers. The President in the name of the Branch, welcomed both gentlemen and expressed his pleasure in having them with us. He would now call upon Dr. March. Dr. March responded, reading a brief but very interesting paper upon "The Medical Profession—the Relation of its Members to One Another and to the Public, and Vice-Versa." He had ventured a degression from the hard scientific road in presenting a paper of this character, and hoped the members would be at least entertained, if not instructed by it.

After prefatory remarks relating to the devotion to duty of men, both in the past and at the present time in all ranks of the profession, the noble work done in all countries along the many lines of research, and the general advance which, under such leadership; had been made up-to-date, the Doctor went on to speak of some of the faults and failings, regrettable conduct, etc., which are so largely in

evidence in professional ranks, which in the past have retarded the progress of the profession, still do so, and always tend to lowering its dignity in the public eye. One great fault is a lack of co-operation among the members. We make ourselves too common; there is too much selfishness, and a deplorable lack of self-denial toward each other. The result of all such is to give the charlatan and others of crooked methods, opportunities to step in. The profession lacks protection from abuse. Most other trades and callings are fully self-defended, while this, the most noble, the most Christ-like, is the least protected of any. The great leaders of the past have but paved the way to greater achievements, and he would appeal to every medical man, however humble, to awake to his responsibility to defend the honour and glory of our great work. As a remedy for such conditions, the Doctor emphasized the necessity of educating both the profession and the people to the recognition of their opportunities and privileges, referring to the great ignorance of the latter, and the responsibilities in this connection resting upon the former. He thought over-crowding of the profession a fruitful cause of abuse among the members, and that measures should be adopted to prevent this. All the machinery of the protection of the public health he would assign to the control of the governing body. The public press, he suggested, should be more freely used as a means of disseminating the principles of good living among the people and teaching them the advantages of measures instituted by medical science for their welfare. In response to the education of the masses, he contended that financial support

necessary to the carrying on of the work would be cheerfully forthcoming as resulting benefits became apparent. Referring again to the need of a fuller cultivation of the true spirit of fraternity among medical men, Doctor Marsh closed his paper with a fitting quotation from the writings of John Ruskin, regarding the use which men make of their lives.

Doctors Woodbury and Carruthers moved that discussion be deferred until after the reading of Dr. McDonald's paper. Carried.

Dr. W. H. McDonald then favoured the Branch with an able paper on "Empyema."

Empyema he defined as a collection of pus in the pleural cavity, usually secondary to some infectious condition, and the organisms most commonly found associated with it being the staphylococcus, pneumococcus, streptococcus and colon bacillus.

Success in treatment depends upon early diagnosis. Cases should never be allowed to grow old. The condition usually comes on during the course of some other disease. Pallor and weakness are common, but cough is not a constant symptom. Absence of vocal fremitus is a valuable physical sign. One not often mentioned is a peculiar boggy feel over the effusion. Position of the heart is altered. Exact diagnosis may be impossible without use of the needle.

Treatment should be such as for any abscess. Simple aspiration cannot be relied upon to clear out pus—the cavity should be thoroughly cleansed.

Many authorities advise resection of a rib at once. This, Doctor McDonald regarded as serious, causing much shock to an already exhausted

patient. He regarded aspiration treatment of special advantage over resection in tubercular cases. The Doctor then reviewed the results of treatment in eight different cases which had come under his observation. In non-tubercular cases operated on, the results had been generally satisfactory, while in the tubercular they shewed distinctly against major operation and in favour of simple drainage.

An interesting and helpful discussion on both papers was participated in by nearly all present.

Doctors Buckley, Rankine, Corsno doubt of the value of early diagnosis in empyema. One early taken in hand offers much less difficulty for cure than otherwise, particularly in children. Quoted Erishsen as authority for the opinion that openings are best made more to the front—the reason he gives being, that owing to the mode of expansion of the lung, first from above downwards, then from behind forwards, any opening made low down behind produces a valvular action which inhibits expan-

sion. He was inclined to blame the needle for many errors in diagnosis—pus may be clotted, and not enter it, and a wrong conclusion may thus be made. As to tubercular cases, he could from experience corroborate Doctor McDonald's remarks.

Other gentlemen referring to the use of the needle, mentioned thickened pus as a cause of failure to succeed with it.

Dr. Mader.—Operation under local anæsthesia is a new and promising method. He favoured the mid-axillary line. Many cases in children, especially those following pneumonia, get well themselves.

Doctors Buckley, Rankine, Cors-ton, MacAulay, Carruthers and V. N. McKay, also contributed to the discussion, after which a vote of thanks to the readers of the papers was put and carried unanimously.

Drs. March and MacDonald responded briefly and closed the discussion. A motion to adjourn then carried, and brought a most helpful meeting to an end.

ST. JOHN MEDICAL SOCIETY.

FEBRUARY 5TH.—Dr. T. H. Lunney, President in the chair.

Dr. Thos. Walker read from a paper by Dr. Bramwell, on the subject "Temperature in Health and Disease."

The physiology of temperature was first considered, then the variations from normal and their causes.

In the differential diagnosis of conditions where rise of temperature is noted, the following procedure was suggested. Ascertain the leading

symptoms, their dates of recurrence and modes of development.

If contagious disease is suspected, ascertain sensibility of exposure, look for rash, examine throat and blood, and isolate.

If local inflammation is expected, examine the various organs and discharges. If malaria, examine the blood; if sepsis, look for wound or injury; if there are nervous symptoms and no other cause is to be found, examine that system.

Hyperpyrexia — the indications for and the means of treatment—was then discussed.

Dr. MacLaren spoke of the great importance of taking temperatures frequently (e. g. every four hours). Often the morning and evening temperatures will be normal, and yet variations be found between. He mentioned the fact that exposure to the sun increases temperature in all febrile conditions.

Dr. Skinner cited a case of cerebral hæmorrhage with temperature 108.6 shortly before death; also, a perforated gastric ulcer giving rise to one of 108.4.

Dr. T. D. Walker spoke of the efficiency of external applications of guaiacol and the use of quinine internally where the indications pointed to reduction of the hyperpyrexia.

Dr. McIntosh then gave an interesting address on the "Spontaneous Disappearance of Disease," reciting cases where, without treatment of any sort, various malignant diseases had apparently cured themselves. Doctor McIntosh referred particularly to cases of senile cataract, where he had seen the characteristic striæ disappear.

Dr. Crawford said he had never seen such a case, although he had noticed many where the disease seemed to be stationary.

Doctor MacLaren thought the diagnosis of malignant cases was not complete until reports were had as to microscopical findings, as many cases formerly considered malignant, were now known to be benign. Even in malignant disease a few cases do recover spontaneously, probably all sarcomata.

Dr. G. A. B. Addy mentioned a case of malignant disease of the

breast which had recovered with practically no treatment.

Dr. Corbet reported spontaneous recovery in a case which the microscope had proven to be carcinoma of the uterus.

Dr. James Christie and Dr. Walker also mentioned cases.

FEBRUARY 19TH.—Dr. Skinner exhibited a case of pseudo-hypertrophic paralysis in a boy aged ten. The disease was first noticed when he began to walk, in his difficulty in standing upright and in climbing stairs. Patient walks raised on his toes. His equilibrium is very uncertain. He stands erect by climbing up his own legs. The calf muscles and infraspinati are hypertrophied, the muscles of the arm atrophied. When lifted by the arms the shoulders rise up to the neck before the body rises. The chest and abdomen protrude, and the head and shoulders are thrown back. Dr. Skinner exhibited the lungs from a baby eight months old which had entered hospital with catarrhal pneumonia. Temperature remained elevated for three weeks, but no fluid was found. At post-mortem lungs showed marked miliary tuberculosis with caseation. Tubercles were also found in kidneys and spleen, none in the liver.

Dr. Gray spoke of three cases of pseudo-hypertrophic paralysis he had seen, and Dr. Christie told of three cases in his own practice.

Dr. Warwick reported a case of malignant endocarditis, and showed the heart removed at post-mortem; also a specimen of vesicular mole.

MARCH 4TH.—The Society met at the General Public Hospital, where Dr. MacLaren exhibited the following cases:

Two children (brother and sister) with right-sided empyemata — post operative.

Child with excised elbow for chronic tuberculosis.

Appendicitis two days after operation; also appendix removed.

A case of urethral fever following passing of sounds.

Two cases of fractured leg.

One fractured thigh requiring thirty lbs. extension.

A case where a bunion had been corrected by removal of a V-shaped piece.

A case of lupus of the nose curetted and skin grafted.

A young girl with resected elbow for old-standing tuberculosis.

Also the following pathological specimens:—

A cystic goitre of fifteen years standing.

An appendix with pelvis full of pus but not yet perforated.

A fœtus removed while curetting a patient for severe uterine hamorrhage.

A gall-bladder removed for obstruction by gallstones.

Dr. McIntosh exhibited a brain with abscess in temporo sphenoidal lobe, and gave a history of the course of the disease.

Dr. MacLaren gave a demonstration of catheterization of the ureters in the female bladder.

Dr. W. A. Ferguson, of Moncton, was elected a member of the Society.

MARCH 18TH.—Dr. J. B. Travers read a paper before the Society on "The Causation of Insanity," basing his remarks largely on cases at the Provincial Hospital.

The following causes were discussed: (1) Heredity. (2) Environment. (3) Traumatism. (4) Pregnancy and Parturition. (5) Sickness. (6) Intoxication.

Dr. Walker asked the speaker's opinion of alcohol (apart from heredity) as a cause. He thought the laity were apt to consider it the chief cause.

Dr. James Christie condemned the smoking of cigarettes. He did not consider alcohol a very frequent cause.

Dr. G. A. B. Addy thought the fact that cigarettes never cause tobacco amaurosis, showed they are not as injurious as other forms of tobacco.

Dr. Travers said in reply that the use and abuse of alcohol is regarded as a potent factor, but going hand in hand with heredity it accounts for from fifty to sixty per cent. of all cases. Tobacco was seldom, if ever, given as a cause, and his own personal views were that cigarettes were not as harmful to the adult as people are apt to think.

Dr. G. A. B. Addy made some remarks on the "Contagion of Pneumonia," illustrating his remarks by the history of a series of four cases in one family, all developing within thirty-six hours. One case died. Another developed empyema. Dr. Addy stated that the bacteriology of pneumonia is still incomplete. Empyema may be caused by the pneumococcus or some other organism; if pneumococcic the prognosis is good.

PERSONALS.

Dr. J. R. Corston has gone to Baltimore, to take up work at Johns Hopkins hospital for six weeks.

Dr. W. H. Eagar has been ap-

pointed a visiting physician to the Victoria General hospital.

Dr. John Stewart has returned from a trip to Toronto.

CORRESPONDENCE

VIENNA, AUSTRIA,
14th March, 1908.

DEAR EDITOR,—Perhaps the readers of the MARITIME MEDICAL NEWS would like to hear something of the post-graduate work here in Vienna. After three months residence one begins to form accurate impressions of the facilities offered to the students.

The hospitals are so large and the work so abundant that it takes some time to find out all there is to be seen.

To the Medico planning a trip here, the first and most essential thing is a knowledge of German, especially if he intends taking a long course, or for the matter of that a short one, for unless he understands the language he is at a great disadvantage; all post-graduates here will tell you the same thing. It is perhaps not so necessary in the eye, ear, nose or throat work as in medicine or surgery, as the American and English have come so much here for this class of work that quite a few of the professors and assistants speak English, and will give private classes if required. However, for the general work, unless one takes these private classes from one of the assistants who speak English, and pays a great deal for it, he must attend the courses in German. I found on first coming here that whilst I could speak German moderately well, it was perhaps a month or six weeks before I could follow with ease the lectures, and even yet, one meets a teacher who talks rapidly, or whose German is not clear, and one has great difficulty in following.

The American medical men, who average about one hundred and fifty in number, formed about two years ago, a society known as the American Medical Association of Vienna,

and established head-quarters at the Café Klinik, Spittelgasse, opposite the Allgemeines Krankenhaus (General Hospital); here physicians from all countries register in the Association and become members on payment of 10 kronen (about \$2).

There is no regular post-graduate school, but the Association has an Orientation Committee, who keep a list of courses posted, and these courses are limited to five or ten medical men, and are given mostly by the assistants in each klinik, the admission being regulated by the date of registration.

The Allgemeines Krankenhaus contains nearly 4,000 beds; it is an old building or series of buildings, divided into hofs or sections, and I think anyone who has ever followed the work here will agree with me, a perfect maze; one can very readily get lost, and it is a considerable time before the student learns his way and location of the various kliniks and ambulatoriums.

Here one meets with an enormous amount of clinical material of all kinds. Let me take first the surgical work, and using the term broadly, include gynecology and orthopedic surgery.

Perhaps the best known of the surgeons is Professor von Eiselsberg, a man of about forty-seven years of age, and a first-class operator. Just here let me say, when a man reaches a professorship, or hofrathship, he does very little operating. He generally has a staff of four or five assistants, all taking turn at a daily round of perhaps half a dozen major operations. In all the surgical kliniks and operating rooms, the student is welcome, no fee is charged, and he is provided with a gown and allowed to come as close to the operating table as he likes. It gives one a splendid

opportunity of following their methods, and from 8 a. m. to 1 or perhaps 2 p. m. one can see pretty nearly every kind of surgery in the various klinicks. Of the assistants in the Eiselsberg klinick, Drs. Harberer, Clairmont and Raimzi all do excellent work.

The second klinick of Hofrath Hochenegg has of late come markedly to the front. The professor is a remarkable surgeon, and has in his two assistants, Drs. Albrecht and Hans Lorenz, two of the finest surgeons in Wien, both young men in the thirties. And Lorenz especially is without doubt a genius, and one of the most rapid workers I have ever seen. To see him do a removal of a large goitre in eighteen or twenty minutes is a joy, and in his intestinal and stomach work, he is making quite a reputation. Kocher, of Bern, in his new edition, commends his methods and their results in this class of work. In one week in the Hochenegg klinick recently, I saw a complete extirpation of the bladder for cancer enucleation of the pituitary body, also a part removal of the larynx for cancer, besides numerous goitres, large and small, several intestinal and stomach operations: it illustrates the enormous amount of surgery done here.

The klinicks of Professor Schauta and Crobak for obstetrics and gynaecology are world-wide in their reputation. The birth rate last year was over 10,000, so that the material is abundant. I had the pleasure of a course from assistant Doctor Adler in operative obstetrics, and during this course have seen numerous "kaiser schnitts," (Cæsarian sections), both abdominal and vaginal, the latter originated by Dürhseen, and modified by Schauta, and used in all cases of eclampsia with undilated os, easy of performance, simply consisting of

slitting through the anterior lip of the cervix uteri and carrying the incision to the lower uterine segment, so that the operator can enter the uterus with his hand, do a version, and deliver. The operation of pubiotomy now universally used in Europe, instead of symphotomy originated by Gilli, of Florence, and carried to perfection in the Schauta klinick, is a simple one, almost devoid of danger if carefully done, and in the forty-one cases up to the last one which I saw a few days ago, there has been no mortality for the mother, and but one of the forty-one children died.

Here in the Schauta klinick are a corps of assistants, the youngest of them getting in his turn, his "kaiser schnitt" or pubiotomy, and all forms of gynaecological operation. Certainly these men have a great opportunity, but to off-set this, they may go on for twenty years doing magnificent work, and yet not reach a professorship, which in Europe means a tremendous lot. The Hofrath is looked up and bowed down to as if he were not made of mortal flesh. The assistants are paid a small salary by the Government, and supplement this by giving classes to students and post-graduates; as a rule they do not do private practice.

In this klinick Drs. Chrispofelli and Adler are both first-class surgeons. The latter gives an excellent course on operative obstetrics, and no matter what time of day or night the operation is held, he makes a point of sending for the students and keeps the case, if possible, till all the class are present. I have met very much kindness from him, and have done some private cadaver work with him. He is a born teacher, and should have a fine career. In the orthopedic klinick of Professor Lorenz, who has become so famous, one sees a great

variety of work, conservatism being the ruling factor, but every known variety of orthopedic operations being done here.

Also here from all parts of Europe and even America, come cases of congenital dislocation for treatment. The professor is a mechanical genius and his assistants are thoroughly trained in this matter. I have had courses here from Assit. Dr. Werndorf, who is a rising man, and stands out prominently from the others in this klinik. He has a charming personality and devotes a great deal of time to his classes. I would like to recommend anyone coming to Wien to get in touch with Werndorf, as it will well repay him. I am indebted to him for a history of the Lorenz klinik, which I intend to forward to the *Halifax Herald* for publication in its Children's Hospital column.

At the Elizabeth Spittal on the other side of the city, and the new Rothschild Spittal, Wertheim at the former in his gynecological work, and Zukerkandl, in his genito-urinary work at the latter, both offer to the post-graduate, splendid opportunities. The two hospitals are new and modern in every way. I forgot to mention that at the Allgemeines Krankenhaus all the operating rooms are modern, that is, have been modernised. Later I will have a few words to say on their methods and technic. Zuckerkandl is the genito-urinary genius of Wien.

Wertheim has published the best statistics for cancer of the uterus extant, and his operation is used all over the world. I have spent much time at the Elizabeth Spittal, and it repays one a hundredfold. Professor Wertheim, who is about forty-five years of age leaves most of the operating to his first assistant, Dr. Wyball. He is present each morning, however, and now and then does a

special operation for his historic cancer operation. A few of us organized a course here of operations on the cavader given us by Dr. Wyball. We performed each one of the Wertheim operations under his direction, and it was a most valuable experience. Everywhere in Europe the vaginal section is most popular, and many American surgeons are adopting it for the various fixations of the uterus, shortening of the round ligaments, cancer occurring in the corpus of the uterus, and in fact wherever the work can be as well done as by the abdominal route. To see Wyball make a small incision in the anterior vaginal wall of a little more than a centimetre puncture with a trochar an enormous ovarian cyst, draw the collapsed cyst out through this opening, tie off the pedicle which shows freely in the vagina, and close up again, certainly appeals to one's surgical instincts and is most artistic, if I may use the word. All the surgeons I have met, or rather gynecologists, prefer the vaginal route for three reasons; the patient is not scared, no danger of hernia, and the chances of infection are less. Wyball, who I would say, is not yet thirty years of age, ranks in my mind, with Hans Lorenz as an operator; both he and Professor Wertheim welcome the stranger, and go to no end of trouble explaining their methods to any visiting colleague. Here is the one operating room in Vienna where I have not seen gloves used. Wertheim believes in using gloves for ex-amination and in septic cases, &c., but considers if the hands are safeguarded in this way that the gloves are not necessary in the general work. However, he is alone here as far as I can see, and from my standpoint after limited experience, I would say that it is impossible for the general practitioner doing surgery to

safeguard his hands, and the gloves are safest for the patient. They use cotton gloves a great deal in Europe; I like them very much, as they are easily changed during the operation, and have the great advantage that the ligature does not slip with them like the rubber gloves. At Eiselsberg klinik they use the rubber glove and cotton gloves outside, which is an excellent method, as the blood cannot soak through to the operator's hands, as with the cotton alone.

To the internalist, Wien is overflowing with opportunities. The pathological work done here by Professor Ghon, who is easily one of the best men in Europe, is renowned. The professor is a young man on the sunny side of fifty, a charming man to a stranger, and beloved by all the visiting students. He has his class each day, night and morning, and to see him do a post-mortem puts to shame anything I have ever seen or hope to see. The history of each case is read and discussed by the professor, and the viscera of every interesting case of the day are prepared and shown up; following this illustrative microscopical slides are presented to half the class, whilst the other half notices the microscopical appearances. The amount of material is enormous, and the student in a single course covers an immense amount of work.

In the medical wards of the Krankenhaus the student is ever welcome. The names of Van Noorden, Neusser and Kovacs, are known to all students of medicine the world over, and their assistants in the various kliniks furnish abundant instruction and carry on any course either private or association that the visiting physician requires.

Professor Fuchs' course in neurology is very popular with both physicians and surgeons, and he discusses

in the most interesting manner the differential diagnosis of the various psychosis and neurosis; he has an unlimited amount of material. In the medical work I have been impressed by the thoroughness of the work done; everything is under one roof, and all sides of examination and treatment are readily available much to the advantage of the patient.

A few words to sum up, and that rather from a surgical aspect. On one's first visit to the Allgemeine Krankenhaus, one is apt to think that it is old and shabby, but after a short time one becomes rapidly convinced that the work is thorough and good, and the longer one stays, the more is this feeling intensified and the determination to isolate if possible, from all the many branches of work, some one subject which one can reasonably hope he can at least have a moderate knowledge of, and become in time proficient in. One shudders to think of the amount of work required, and all he must be familiar with, if he would be proficient in all.

In the treatment of cancer, the X-ray has been found wanting. The thorough, complete and radical resection with enucleation of all glands that can be reached is universal, as illustrated by the Wertheim operation for cancer of the uterus and the Lorenz operation for cancer of the breast. The immediate mortality is greater, but the average period of life is prolonged.

The incision in all operations I have seen is large, silk is used almost universally in the form of the interrupted suture. The Wiener surgeon is highly excitable, so much so that I think in some cases the patient suffers; he is thorough in his work, but oftentimes he seems to flare up at assistants and nurses without the slightest reason; they, the assistants do not mind it in the least, and take

it all as a matter of course, and in a few moments they are all laughing together again. However, I think sometimes it puts the operator off his work and militates against the patient.

One of the most interesting features of surgical study here, is their method of preparation of the patient for operation. In a great many of the kliniks the patient is not shaved or prepared till on the operating table, and very often just before an operation, is examined by numbers of students; however, when the shaving is done, the skin is thoroughly scrubbed with soap and water, then with bi-chloride solution, then alcohol, and again bi-chloride. This is almost universal. However, some surgeons paint the field of operation with iodine, and it has given good results; in fact, I have followed in the wards most of the operative cases I have seen for the last three months, and I have seen less pus and less infection than ever before. Might it be possible that we carry our methods of preparation beyond a reasonable limit, and give the patient a lot of unnecessary worry and annoyance, which after all is not necessary; this is heresy, I know, but I have thought a great deal of it.

The transverse (Farnesball) incision is much used in abdominal work, especially by the gynæcologists, and certainly gives one a splendid view of the pelvic viscera, and more room to work in, and leaves very little scar; in fact, when the skin is united with clamps there is none at all or hardly any.

Billroth, who did so much to make the Allgemeine Krankenhaus famous, has left his impress in the form of anæsthetic used. Just here I would like to say that we in Canada are very much better anæsthetists than the Viennese. I don't like their

way of giving an anæsthetic at all. They are far from careful. I may be wrong, but I have been impressed in this way.

I cannot close this imperfect and hurriedly written letter without referring to Professor Tandler of the Anatomical Institute. He is Professor of Anatomy in the University of Vienna, and has without doubt done more to raise the controversy and discussion in Europe regarding surgical and gynæcological anatomy than any man for some time. He has daily classes from 8 a. m. to 9 a. m., and from 2 to 3 p.m., for the post graduates, and they are most popular. He speaks splendid German, clear and distinct, and is a teacher to his finger tips. On payment of 20 kroner (\$4.00) a month, one can have an unlimited supply of material and dissect all day under Tandler's direction. He is ever interested in any anatomical point and loves discussion of it. He has written a book on retro-positions of the uterus and their cause, from the standpoint of the anatomist, which has caused a tremendous sensation; he condemns most of the prevalent operations for shortening the normal ligaments and other favourite gynæcological operations; it has caused a tremendous amount of discussion.

Just a word as to your own pet subject. No doubt you have seen in the literature, the splendid work being done by Professor Zinger, of the Skin klinik here; he and his assistants are making a special study of syphilis, and have isolated a bacillus and produced the disease in monkeys. It is a great advance; the material in this klinik is abundant and it is most interesting.

With kind regards,

Faithfully yours,

EDW. D. FARRELL.

BOOK REVIEWS.

TREATMENT OF INTERNAL DISEASES:

By Dr. Norbert Ortner, Univ. Vienna.
Edited by Nathaniel B. Potter, M. D., of
Boston. Translated by Frederic H.
Bartlett, M. D., from the Fourth German
Edition. J. B. LIPPINCOTT COMPANY, Phil-
adelphia and London, 1908.

This book is an English translation from the fourth German edition, a fact sufficient in itself to justify its publication. A careful perusal of its contents warrants that in value it is equal to, if not superior, to corresponding works on this most important subject. The scope of the book is indicated in its title. "The author initiates the reader into as much of the pathological physiology of the diseases discussed as bears upon their rational treatment. He very properly emphasises throughout the volume, the importance of the mechanical, dietetic, climatic, hydrotherapeutic and other extra-medicinal methods, with judicious reasons for those selected, and follows these with a discussion of the applicability of certain drugs, their respective advantages, disadvantages and limitations, adds useful prescriptions from his own experience and that of others, and leaves the reader better armed to meet etiological indications and the various contingencies which arise and require symptomatic treatment." The foregoing observation of the editor we most cordially endorse.

There is nothing in the work suggestive of therapeutic nihilism. The comments of the Editor give us side by side the most advanced ideas of German and English authorities, touching the treatment of internal diseases.

The translation is in the main excellent, and the press work and general appearance of the volume extremely good. The contents of this volume are worthy of most careful study, and it should be on the book-shelf of every scientific medical practitioner.



MINOR MEDICINE: A Treatise on the Nature and Treatment of Common Ailments; By Walter Essex Wynter, M. D., B. S. (Lond.) F. R. C. P., F. R. C. S.
Price \$1.75. TORONTO: D. T. McAVISH & Co.; LONDON: SIDNEY APPLETON, 1908.

Dr. Wynter has taken for his text the words of the prophet Zechariah: "For who hath despised the day of small things," and has written upon it a most useful work.

It can be especially recommended to recent graduates who have not had an opportunity to gain a practical acquaintance with minor maladies, and about which most of the text books are silent. Under the old apprentice system ample opportunity was afforded for becoming acquainted with the treatment of minor disorders for which no provision is made under the modern system of medical education. This book is an attempt to supply what is urgently required, a practical presentation of the subject in small compass and in a readable manner. It will be of interest not only to recent graduates, but general practitioners of many years standing will find in its pages many fresh and useful suggestions for treatment. The treatment of many minor surgical conditions is included. On the whole this book will certainly obtain a wide circulation by reason of its thorough practical character.

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short, the value of salol in rheumatic conditions is so well understood and appreciated that further comment is unnecessary. The statements of Professors Hare and Guttman are so well known and to the point and have been verified so often, that we are not surprised that the wide-awake manufacturers placed "Antikamnia and Salol Tablets" on the market. Each of these tablets contains two and one-half grains of antikamnia and two and one-half grains of salol. The proper proportion of the ingredients is evidenced by the popularity of the tablets in all rheumatic conditions, and particularly in that condition of muscular soreness which accompanies and follows the grip.



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* Contribution to "Symposium on Rheumatism," read before Toronto Clinical Society.

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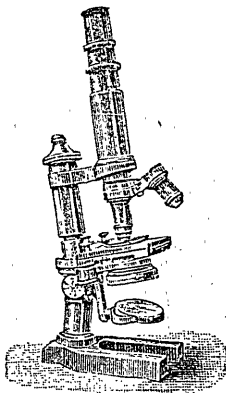
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Examination of the blood immediately after a severe hæmorrhage usually shows no apparent change in its number of corpuscles, for the portion lost withdrew the blood as a whole, and the portion remaining in the body, while decreased in volume will be found to contain a normal ratio of the fluid and cells. Shortly after a hæmorrhage, however, the tissues of the body give up large quantities of fluid to restore the necessary volume of the blood and a condition of true hydremia ensues. Examination of the blood three or four hours after a severe hæmorrhage, therefore, shows a very marked oligocythemia. Reconstruction must now take place and the response to the bodily demand is sometimes remarkably prompt, but in most instances it is a hard up-hill fight. This is to be expected, for the disproportion between the cells and the fluid elements of the blood, and the essential depression of all vital functions, makes recuperation a difficult process at best.

Much can be done, however, to assist the body in its efforts to restore normal conditions. The first and most essential requirement is absolute rest in a prone position. In some instances, it may be necessary for a few days to have the couch or bed tilted so that the patient's head shall be lower than the feet. Sudden movements or a sudden rising to an upright posture must be strictly interdicted, as these are always liable to produce a fatal syncope. Following severe hæmorrhage, the blood pressure is always lowered, and even if a certain degree of tension is apparently restored, it is very unstable, and may be lost instantly with all of the resulting dangers on the heart and central nervous system.

Another precaution to be taken is to frequently change the patient's

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posture from one side to the other. The hydremic state of the blood, and the loss of blood tension predisposes to gravitation œdema in the lungs and other organs, and the simple procedure of changing the patient's position often avoids annoying and serious complications.

Considerable quantities of water are always necessary after hæmorrhage, but it should never be given in large amounts at any one time. Two or three tablespoonfuls at a time by the mouth every few minutes is much more beneficial than to allow a patient to drink to satiation. Excessive thirst is always soon controlled by small enemas (one pint) of saline solution, as warm as can be borne, repeated every three or four hours. These also serve admirably to very materially raise arterial tension. It is no uncommon thing to

observe complete anuria for even twenty-four hours after severe hæmorrhages, but the warm saline enemas soon correct this condition.

Feeding is one of the most important details in post-hæmorrhagic treatment. Liquid food should be used in preference to solids for obvious reasons, and may consist of milk, beef extracts, white of eggs, etc. Small quantities should be given at short intervals, as it must be remembered that the digestive function is always more or less depressed and can only do a portion of its usual work. A good reliable hematic is early necessary, one that can materially hasten hematosis without endangering the digestive and assimilative functions in any way, shape,

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