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The Canadian Practitioner and Review

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EDMUND E. KING, M.D.

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Original Communications.

SOME POINTS IN THE DIAGNOSIS AND TREATMENT OF ACCIDENTAL HEMORRHAGE.*

By ADAM H. WRIGHT, B.A., M.D., M.R.C.S., Eng.
Professor of Obstetrics in the University of Toronto, Canada.

(From American Journal of Obstetrics, November, 1906.)

Accidental hemorrhage is one of the most complex subjects in obstetrics, and one of the causes of its complexity is the word hemorrhage. In medicine and surgery we consider certain hemorrhages, such, for instance, as one in the brain or pancreas, dangerous because of the resulting clots which act as foreign bodies, and by irritating pressure, produce serious effects. In obstetrics most practitioners consider that the serious condition in all forms of what is technically known as accidental hemorrhage, is loss of blood.

My aim in this paper is to refer simply to certain points in connection with accidental hemorrhage, without any attempt to treat the subject in a complete or systematic manner. In a paper on the concealed variety read at the meeting of the British Medical Association last August, I reported a case of the concealed form. I may say that four cases of concealed accidental hemorrhage have come under my observation.

As these cases are exceedingly rare, I take the liberty of repeating one report of great interest, because I had the opportunity of watching the patient carefully from the onset of the serious symptoms until the time of her complete recovery.

*Read at the nineteenth annual meeting of the American Association of Obstetricians and Gynecologists, held at Cincinnati, September 20-22, 1906.

Patient, aged 29, II-para, when seven months advanced in pregnancy was suddenly seized with abdominal pain while driving. Went home (only a short distance) as soon as possible. Went upstairs intending to go to bed, collapsed while undressing. I saw her in about twenty minutes and found her cold and weak, pale, with rapid pulse, and suffering intensely from "tearing" pains over the abdomen. Gave her large doses of morphine and ordinary treatment for shock. The symptoms, although very alarming for about two hours, subsided. Concealed hemorrhage suspected at first, but doubted on following day. Four days afterward an uneventful labor resulted in the expulsion of a dead fetus. The placenta showed evidence of being nearly half detached. The shock was evidently due to the tearing pains caused by the sudden impingement on the uterine wall, and not at all to the loss of blood, which did not amount to more than a pint (I think less than a pint). The clot thus produced, although comparatively small, had acted as a foreign body, and produced a surgical traumatism which nearly caused the death of the patient.

In considering the whole subject of accidental hemorrhage, several differences of opinion are prevalent, both as to diagnosis and treatment. The following procedures are conspicuous in this regard: rupture of the membranes, plugging the vagina, accouchement forcé, and Cesarean section. In this paper vaginal Cesarean section will not be considered as a variety of accouchement forcé. Why is there so much divergence of opinion? In the first place, probably because the internal concealed variety is absolutely different from the external hemorrhage as to symptoms and results, and requires entirely different treatment.

Again, all accidental hemorrhages are at first internal and concealed, and present a great variety of symptoms, such multiplicity depending on the suddenness of the gush, the amount of blood poured out, and the length of time of concealment. The blood streaming from the ruptured vessels may flow freely from the uterus at once, or may be bottled up for a varying time.

In a certain proportion of cases of accidental hemorrhage there is little or no shock, because there is little or no obstruction to the flow of blood. The important condition here is loss of blood resulting in collapse, with no tearing or agonizing pains.

What is shock? We have no time now to discuss such an important subject in detail, but we recognize the fact that the surgeons of to-day are giving us valuable instruction as to this

condition. Obstetricians have said much about shock as produced by accidental hemorrhage during the last sixty years. Many of their statements have been rather vague, but they generally indicate that shock, in connection with accidental hemorrhage, is a condition produced by loss of blood. It will simplify the matter somewhat from the standpoint of this paper to leave out of the question what is known as post-operative shock. I shall, however, give a definite meaning to the two words, shock and collapse, although it will be admitted that any distinction between these two conditions must be to a certain extent artificial.

Shock will be considered a condition which is produced more or less suddenly by a serious traumatism, or surgical injury, similar, for instance, to that produced by the wheel of a railroad car passing over and crushing a limb.

Collapse will be considered a condition caused by extreme exhaustion, especially that induced by severe hemorrhage, and depending on the amount of blood lost. It is, of course, difficult in many cases to differentiate between these two conditions. It may be that we have shock from traumatism and collapse from hemorrhage to an equal degree in certain cases of concealed hemorrhage.

In the majority of cases of concealed hemorrhage, however, shock and not loss of blood is probably the prominent symptom or condition. The muscle of the uterine wall is generally strong enough to resist the impact of the *new body* without appreciably stretching, while the nerves suffer from the sudden pressure to such an extent that a severe storm arises, causing agonizing pain, intense shock, and tetanic spasm of the uterine musculature, with a cervix "as hard as iron."

There is another entirely different class of cases where the uterine wall is not strong enough to offer much resistance, and as a consequence the uterine cavity enlarges greatly, allowing an escape of blood from the uterine vessels sufficient to destroy life. I have not seen, nor have I met a physician who has seen, such distention of the uterus, but we must accept the evidence of such careful observers as Oldham of Guy's Hospital, and others who have recorded such cases.

It should not be difficult to recognize such a condition because the patient would steadily grow worse, the abdomen would become enlarged, the temperature would be lowered, but the pulse rate would grow more rapid.

Diagnosis.—No attempt will be made to deal fully with the important subject of diagnosis. We may consider that, in many

cases of the concealed, combined internal and external, and the ordinary external varieties, diagnosis is often difficult or impossible for a time at least. The diagnosis of the concealed form is often impossible until after delivery.

In my paper of last August I referred to a very admirable discussion on accidental hemorrhage at the meeting of the British Medical Association two years ago. I can hardly agree, however, with the opinions there expressed respecting the diagnosis of the concealed form.

Sir Arthur McCann expressed the opinion that in many cases the diagnosis is impossible until after the expulsion of the placenta; but he adds: "However, once the symptoms of anemia are well marked, and are accompanied with much pain and tension or localized swelling, there is usually not much trouble about the diagnosis."

Jellett, who expresses the latest views from Dublin, tells us the symptoms of concealed hemorrhage fall under two heads: (1) "Those due to loss of blood"; (2) "those due to the accumulation of blood in the uterus." He adds that "the most prominent symptom in the second grade consists in the gradual enlargement of the uterus." Similar views are generally entertained in the United States and Canada. Whitridge Williams tells us: "The appearance of acute anemia with manifestations of shock in a patient in the later months of pregnancy should always suggest the concealed uterine hemorrhage."

While it must be admitted that acute anemia and uterine distention are sometimes present, it seems certain that in a case such as I have described, there is no acute anemia or marked distention of the uterus. Therefore, these two symptoms to which so much prominence is given by many, if not by most authors, should receive less consideration in such cases.

What, then, are the symptoms of concealed accidental hemorrhage? They are probably in the majority of cases pain and shock. Pain generally comes on suddenly—so suddenly sometimes that it resembles the "solar-plexus punch" that "knocks out" the prize fighter. The pain is so entirely different from the ordinary labor pain that the patient and her friends generally realize that something serious has happened. The pain is continuous instead of being intermittent, amounts to extreme agony and is accompanied by tetanic contraction of the uterine walls, including both body and neck. These symptoms should lead us to suspect that concealed hemorrhage is the possible or probable cause of the patient's condition.

Of course, one may be mistaken, as the following case will show: Mrs. A., aged 25, II-para. In the eighth month of pregnancy was suddenly seized with extreme continuous pain, accompanied by tetanic uterine contraction, July 24th of this year. When I saw the patient I suspected concealed accidental hemorrhage. Morphine was injected and the woman was at once sent to a private hospital, where she received a second dose of morphine and suitable treatment for shock. On the following day there was some local tenderness over the abdomen, with slight elevatic : of temperature, and catarrhal appendicitis was then suspected. In addition to the administration of morphine, the patient received calomel and castor oil, and recovered in about eight days (no signs of labor appearing in the meantime), and was sent home. On the last day of August labor commenced. She returned to the private hospital and, after a somewhat tedious labor, a healthy child was born September 1st. The patient made a good recovery. Careful examination of the placenta revealed no trace of " old clot."

Although one may make a mistake in diagnosis in such cases, the prompt and appropriate treatment of pain and shock, or in other words, the treatment of symptoms according to the methods of many able obstetricians of fifty or sixty years ago appears to be correct.

Treatment.—In the paper on the concealed variety, reference was made to Goodell's extremely valuable and interesting paper on the same subject. This distinguished obstetrician described in a very graphic way the symptoms, but he did not, in my opinion, properly differentiate between shock from traumatism and collapse from loss of blood; and as a consequence, his advice in such cases, " to deliver the woman as soon as possible," impelled men to carry out very radical forms of delivery with disastrous results.

The following is a synopsis of the treatment I have recommended when traumatic shock is the chief factor:

1. Administer morphine by hypodermic injection, half a grain at once, a quarter of a grain in half an hour after, and another quarter after another half hour, or less, if required; that is, one grain within an hour. Atropine may be given as well, if thought advisable.

2. Lower the patient's head and elevate the foot of the bed.

3. Keep up the body temperature by the external application of artificial heat.

4. Give a high enema of salt solution. Subcutaneous or intravenous injections may sometimes be advisable.

5. Give small doses of strychnine (not more than two doses, of one-thirtieth of a grain each, by hypodermic injection).

The latter recommendation is given with some confidence, notwithstanding the adverse views of certain surgeons. I believe at the same time that large doses of this medicine are exceedingly dangerous in certain cases of either shock or collapse.

In the discussion which followed the reading of my paper at the Toronto meeting, it was stated, "that the same results could be obtained in many different ways. In Dublin the practice was to plug the vagina; in Edinburgh to rupture the membranes."

I had no opportunity to reply, but I desire now to call attention to the fact that in one of the cases reported (which is also reported to-day), the clot resulting from the outpour of blood was entirely post placental, the whole margin of the placenta being adherent to the uterine wall. Neither the vaginal plug nor the puncture of the membranes could in this case mitigate the serious symptoms of pain and shock.

The combined internal and external accidental hemorrhage, whether occurring before or during labor, is more easily diagnosticated than the purely concealed form; but in certain cases, the diagnosis is sufficiently difficult to cause much perplexity. When, for instance, a quart of blood is retained internally and only two ounces escape externally, we have a condition closely similar to the concealed variety, with intense pain and shock. Under such circumstances it seems reasonable to suppose that the pain and shock are still the prominent symptoms, and should receive very prompt treatment. After complete or partial recovery from pain and shock it would seem well to carry out the so-called Dublin treatment, to which further reference will be made, or perform a vaginal Cesarean section. A report of a case with similar conditions and symptoms will be given later.

In what is known as the external accidental hemorrhage there is little or no shock, but there may be collapse from loss of blood. It is probably in such cases that the greatest difference of opinion prevails, especially as to two procedures, rupture of the membranes, and the introduction of the vaginal tampon. The puncture of the membranes and the use of the plug are very old procedures in the treatment of accidental hemorrhage.

We are told that one hundred and thirty years ago there was a great difference of opinion on this question, and at that time

Leroux, of Dijon, was a strong advocate of "rupture of the membranes," and the "administration of ergot of rye to check the flooding."

The discussions as to these two methods during the first and second thirds of the last century were interesting, and were equal in many respects, and perhaps better in some respects, than the discussions of the last forty years. It would appear from the discussion last August in Toronto that we have not made much progress in a century and a half as to the proper

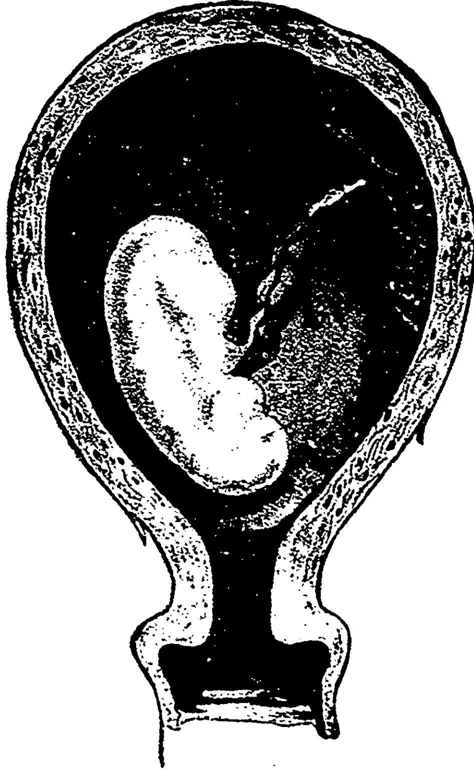

Fig. 1.—Pregnant uterus, seven months, membranes intact, uterine wall tetanically contracted cervix hard as iron, showing a post-placental clot between a portion of the placenta and the uterine wall.

estimate of these two procedures. There can be little or no doubt, however, that each method is good in its proper place.

All things considered, the vaginal plug appears to be more generally useful, and safer, for the various kinds of accidental hemorrhage than any other procedure. And yet, a candidate at a final examination, who expressed such an opinion before a board of examiners in London, England, ten years ago, would

probably have been plucked because of such dangerous heterodoxy. That terrible danger of converting an external into an internal hemorrhage was ever present for many years in the minds of the orthodox.

About twenty-five years ago, Speigelberg and Smyly reintroduced the use of the plug, and England and Scotland were for a time horrified. The results at the Rotunda have been so remarkably good that the whole world has been forced to modify its opinions respecting the procedure. No one pretends, however, that such introduction of a plug is always safe; but it is understood that the proper application of an abdominal binder greatly minimizes the dangers.

It is difficult to understand, at the same time, how plugging could accomplish much good in concealed accidental hemorrhage, although we are told that in three cases of this form of hemorrhage occurring at the Rotunda, a plug was used with good effect. I do not know how the diagnosis was reached in these cases, nor when the plug was introduced; but I should suppose that such introduction would be absurd while the patient was suffering, perhaps dying, from shock.

If I should again meet a case similar to that which I have reported in which severe pain came on four days before the onset of labor, I should now be inclined to interfere after the patient had rallied, say on the day after the advent of the acute symptoms. After such a severe nerve storm as I have described, with its prolonged condition of uterine tetanic spasm, a fetus is, so far as I know, always dead.

Although I believe that the statement made by Goodell, that in such cases the rule should be imperative "to deliver the woman as soon as possible," has done a large amount of harm, by encouraging the operation of accouchement forcé, even while the cervix is "as hard as iron," yet I believe that the patient can hardly be considered safe until the uterus is emptied. I think, therefore, when all symptoms of shock have disappeared, it might be well to introduce a bougie into the uterus, according to the Krause method (being careful not to rupture the membranes), and at the same time introduce a plug into the vagina. This can be done best by using some form of Sim's speculum, introducing a gum elastic or rubber bougie, about 12, English size, as far as possible, and packing the vault of the vagina with antiseptic gauze. I prefer 5 per cent. iodoform gauze.

It seems remarkable that rupture of the membranes in cases of accidental hemorrhage should have had so many advocates during the last one hundred and fifty years. While one of the oldest, it is one of the crudest, and one of the most objectionable

obstetrical operations when performed before the onset of labor. There is no doubt, however, that the procedure is an excellent one in its proper place, but its scope as compared with that of the introduction of the vaginal plug is much more restricted. In the case of concealed accidental hemorrhage before the onset of labor, and especially before the effacement of the cervical canal, it is, I think, never justifiable. In the case of the combined internal and external accidental hemorrhage before labor, one cannot speak so positively, but it seems probable that in such cases the operation is unjustifiable. If, however, labor has commenced and the external hemorrhage is serious, the rupture of the membranes will frequently, or perhaps generally, produce a good result by diminishing or frequently stopping the flooding. The puncture of the membranes may produce good results even if done before the onset of labor if there is

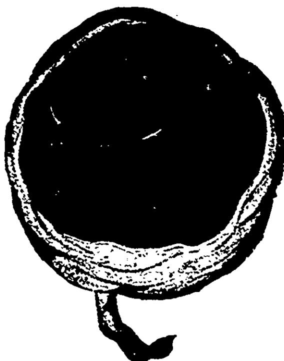

FIG. 2.—Placenta from Fig. 1 after delivery, showing on the maternal surface the saucer-shaped cavity occupied by the clot.

effacement of the cervical canal. I have not, however, had sufficient experience with this procedure to give a definite opinion in that regard.

It would not be profitable to spend much time discussing accouchement forcé. Its mortality rate, when the patient is suffering from shock, and the uterus is tetanically contracted, is, in my opinion, exactly 100 per cent. I know of no operation in obstetrics or surgery respecting which one can speak more definitely. A certain amount of force may, however, be used when the os is dilatable. For instance, we may have ruptured the membranes before the os is dilated; there may still be considerable hemorrhage, making an early emptying of the uterus desirable. In such a case manual dilatation of the os, with version or forceps delivery, may be advisable. It is doubtful, however, whether the manual dilatation, under such circumstances, should be designated accouchement forcé.

I should like to discuss the operation of vaginal or abdominal Cesarean section, but I have had no experience in connection with either operation for accidental hemorrhage. In the case of either concealed, or combined internal and external accidental hemorrhage, with the patient suffering from shock and a cervix as "hard as iron," any operation would probably be unjustifiable. The shock should be properly treated; and if, in spite of such treatment, the symptoms of shock grow worse instead of better, the patient is probably going to die. If, on the other hand, the patient recovers from the shock, it is certain that in some cases, if not in the majority, serious operation is not advisable. It might happen, however, that internal hemorrhage was taking place into a uterus whose walls were stretching rapidly, and the loss of blood was the chief factor. If, in such an emergency, it was not possible to dilate the os, and deliver soon enough to save life, some form of Cesarean section might be deemed advisable. Vaginal section, in one of its varieties, seems the best radical operation in sight; but I am inclined to think its field is exceedingly limited. It seems to me entirely unsuited for such a case as I have reported to-day, especially when there is doubt as to the diagnosis; but it may be indicated in cases where labor is imminent, or present, especially where loss of blood, whether internally or externally, or both, is the serious factor.

I shall now submit to the Fellows of the Association a case reported something like ninety years ago: "A lady of weakly constitution and delicate habit was attacked in the later months of pregnancy with a slight discharge of blood from the vagina, not amounting altogether to half an ounce, accompanied with alarming symptoms of exhaustion and debility. The os uteri was scarcely dilated to the size of a sixpence, and was in such a state of rigidity as precluded the possibility of affording any manual assistance. The lady in consequence died, and, on examination after death, it was found that the separation of the centre of the placenta from the parietes of the uterus had taken place, whilst its edges were completely adherent, forming a kind of cul-de-sac into which blood had been poured, to the amount of a pint and a half, which had become coagulated within the cavity thus formed."

What would you do in such a case as this? Did this woman die from shock, or from loss of blood, or from a combination of the two? I have never met a case where the loss of a pint and a half of blood without other complication caused death; but I must admit that such a hemorrhage is a serious matter.

I think, however, that the rigidity of the os was due to that peculiar nerve storm which is present in such cases, and that the patient died from shock. Under such circumstances, my chief aim would be to first treat the shock, as indicated elsewhere in this paper. As to operative procedures I should like to get your opinions.

The main points of this paper are as follows:

1. Making a diagnosis in many cases of concealed accidental hemorrhage is generally difficult, sometimes impossible, before delivery.

2. The so-called important symptoms—anemia and distention of the uterus—are not present in a large proportion of such cases.

3. The serious condition in most cases is shock from traumatism, and not collapse from loss of blood.

4. The diagnosis of the combined internal and external accidental hemorrhage is more readily made, but the amount and effect of the blood within the uterus are often difficult to ascertain.

5. Even in such cases, shock from traumatism is sometimes the predominating element; on the other hand, collapse from loss of blood, whether retained within the uterus or flowing externally, is sometimes the important factor.

6. In all cases where shock from traumatism is the main condition, or the predominating element, the most urgent requirement is proper treatment of such shock, and not emptying the uterus.

7. In a large proportion of cases of the combined internal and external hemorrhage, the introduction of the vaginal plug, with the application of an abdominal binder, appears to be a very safe and effectual plan of treatment.

8. In a small proportion of cases, especially during labor, puncture of the membranes is beneficial.

9. Any form of accouchement forcé, which includes forcible dilatation of a rigid cervix is never justifiable.

10. The best operative procedure would appear to be some form of vaginal section; but its field is limited, and not accurately defined.

30 Gerrard Street East.

PHLEGMONOUS GASTRITIS—REPORT OF A CASE.*

By CHARLES J. WAGNER, M.B., Toronto.
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This rare disease was described as early as 1656 by Bevel. In our own time cases have been recorded by various observers under many different names. Of these the more noteworthy are: Inflammation of the submucosa (Rokitansky), gastritis submucosa (Dittrich, Klebs and others), phlegmon ventriculi, suppurative interstitial gastritis, submucous suppurative phlegmon, and phlegmonous gastritis. The term phlegmonous gastritis is that most in favor with English writers, although perhaps not so descriptive as others.

Etiology.—The disease is due to the development within the gastric wall of pyogenic organisms. Of these the streptococcus pyogenes is the organism most frequently found. The disease occurs in both sexes and at all ages. Males are much more commonly affected than females in the ratio of four to one. Alcoholism predisposes to the disease, one-fourth of the cases occurring in persons addicted to the excessive use of alcohol. This undoubtedly explains to some extent the more frequent occurrence in males.

The disease may be primary or secondary. The primary cases occur in apparently healthy individuals or follow traumatism, ulcer or growth. The secondary cases occur in the course of such acute infectious fevers as pyemia, septicemia, typhoid fever and variola.

Mayo Robson and Moynihan, who have collected histories of 85 cases, state that in all cases of primary and probably in all cases of secondary disease there is a superficial denudation of the mucous membrane which permits of the entrance of the organism.[1] It appears to me that this statement would be difficult to prove or disprove, as we know that the most minute abrasion may suffice for the entrance of bacteria into the tissues, whereas, in these cases, secondary ulceration due to sloughing is very frequently found. Again in the infectious fevers, secondary infections of the blood by pyogenic organisms not infrequently occur, and it would be unreasonable to hold that in cases of phlegmonous gastritis secondary to such diseases hematogenous infection might not occur.

Pathological Anatomy.—The condition may occur as a diffuse cellulitis affecting the whole of the stomach submucosa, or it may be be localized to form one or more large or small abscesses. The diffuse form is probably that more frequently met with. Cases of this type show enormously thickened

* Paper read before The Pathological Society of Toronto.

stomach walls, particularly towards the pyloric end, with pus diffused throughout the submucosa. When compressed between the fingers, pus wells up from the cut surface.

The mucosa may appear normal, or may be greatly congested, even hemorrhagic. Large ulcers due to sloughing may be present. Occasionally there are many minute perforations through the mucous membrane out of which pus oozes when the stomach is compressed.

The microscope shows necrosis and purulent infiltration of the submucosa, and leucocytic infiltration and edema of the mucosa, muscularis and peritoneum.

In both forms general peritonitis is almost invariably present at autopsy. There may be thrombosis of vessels of the stomach, liver or lungs. Occasionally there is an acute pleuritis.

Clinical Symptoms.—The disease is frequently ushered in by a chill. Pain in the region of the stomach, vomiting of partially digested food or bile-stained fluid, accompanied by a moderate rise of temperature and increased frequency of pulse, are frequently the only symptoms for the first day or two, and being very similar to the initial symptoms of such conditions as, so-called, acute indigestion, gastric fever, etc., are not particularly alarming.

The symptoms, however, instead of ameliorating, become worse: the pain in stomach region becomes intense, the vomiting frequent and most distressing. There is great thirst. The temperature may be high and the pulse is rapid and thready. The expression is pinched and anxious, and, altogether, the symptoms are suggestive of sepsis, with localization in the stomach region. Physical examination usually reveals nothing excepting tenderness in the stomach region, if seen early, or general abdominal tenderness and distention, if seen during the period of general peritonitis. In a few of the localized cases a tumor may be felt. Auscultation occasionally reveals a friction sound behind the left costal cartilages or just below them. The bowels are usually constipated.

In the later stages of the disease, symptoms of general peritonitis almost invariably supervene. The vomiting may cease for a short period before death. Death is seldom deferred more than fourteen days, and frequently occurs on, or about, the fourth.

The symptoms of individual cases may differ somewhat widely from the above. The temperature may remain normal, as in a case reported by Asverus,[2] or it may be subnormal. Although constipation is the rule there may be diarrhea. The abdominal pain may be absent throughout, or, as in a case

reported by Habershon, of a nurse who suffered with malaise and intense aching of back and limbs for fourteen days before abdominal pain and vomiting developed, it may be greatly delayed.[3] In rare instances pus has been vomited, and sometimes in large quantities, as the result of the bursting of a large localized abscess. These localized abscesses occasionally rupture into the peritoneal cavity.

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Diagnosis.—The symptom complex is not characteristic. A positive diagnosis may rarely, if ever, be made. Some of the conditions most difficult to differentiate from phlegmonous gastritis are perigastritis following ulcer, purulent cholelithiasis, acute pancreatitis, peritonitis, hepatic abscess and poisoning by caustics.

The previous history may reveal alcoholism, traumatism, ulcer or carcinoma, or, as in Kelynack's case a stricture of the esophagus.[4]

However, in any case where epigastric pain and frequent vomiting are accompanied by grave general symptoms suggestive of sepsis the possibility of phlegmonous gastritis must be considered.

Prognosis.—The prognosis is extremely grave. Only a few cases are known to have recovered, and these were of the localized variety.

Treatment.—Little more can be done than to allay the more distressing symptoms: opium to relieve the pain and saline enemata to relieve the distressing thirst. Hot fomentations applied to the abdomen may be grateful to the patient.

Case.—F. G., a brewer, aged 30. Had previously been addicted to alcohol, otherwise normal.

April 8th, 1905. Felt chilly and unwell.

April 10th. Still very unwell, with nausea, but still able to work.

April 11th. Too ill to work.

April 12th. On this day I saw the patient for the first time, when I found the following symptoms present: Pain and ten-

derness in the region of the stomach, sharply localized; anorexia; frequent vomiting of bile-stained fluid; furred tongue; great thirst; the pulse was running at about 100, full and strong; temp., 101 deg. F.

April 13th. No change.

April 14th. Decided change for the worse. Expression drawn and anxious. Pulse smaller and more rapid. Pain most intense and vomiting very distressing.

Over the entire body with the exception of the face were large and small patches of the most intense erythema, sharply defined from the normal intervening skin. This rash closely resembled that of a marked case of scarlatina, differing only in that the skin was not uniformly affected. It was also most intense upon the mucous membrane of the soft palate and pharynx.

Believing that the rash was the expression of an intense sepsis, I had the patient removed to St. Michael's Hospital because of the inadequate nursing at home, and because I thought it possible that surgical measures might later be necessary.

When the patient arrived at the hospital there was some doubt expressed as to the nature of the rash, and for safety the patient was isolated. Shortly after, my attention was directed to a friction sound over the stomach just below the cartileges on the left side, by Dr. Graham Chambers, who had been asked to see the case. This disappeared within an hour, and could not again be heard. The day following admission, the pain became diffuse over the abdomen, tympanites developed, and the diagnosis of general peritonitis could be positively made.

The tongue, which at first had been heavily furred, became clean, red and glazed.

The patient became gradually weaker, and died from collapse on the tenth day of his illness. Consciousness remained until the end.

Autopsy.—The erythema, so intense before death, was still plainly visible. Over the rash areas the epidermis was peeling off in large patches.

In the thorax both pleural cavities were obliterated by fibrous adhesions. A small calcareous fibrous scar was found immediately beneath the pleura at the apex of the right lung.

The lungs were both congested. On separating the base of the left lung from the diaphragm, pus was found in the interstices of the adhesions.

The lung tissue at the base was intensely congested, but not consolidated.

In the abdominal cavity we found an acute fibrino-purulent peritonitis, most intense upon the anterior surface of the stomach. No perforation could be found.

The stomach appeared large and felt very heavy, as though there were considerable substance within its cavity. When opened, it was found entirely empty, the unusual weight being due to its immensely thickened walls, which were in places one-half of an inch in thickness. The cut surface was very pale, and when squeezed creamy pus welled up from the submucosa. The interior of the organ presented a mottled appearance, the mottling being due to patches of intense congestion of the mucosa. There were several large superficial ulcers, which I believe were the result of sloughing.

Under the microscope the stomach wall presented the following appearances:

The mucosa was greatly congested and infiltrated with leucocytes.

The submucosa was necrotic, the few cells not entirely disintegrated could be recognized as a polymorphonuclear leucocytes. The muscularis and subperitoneal tissue were infiltrated with leucocytes and serous fluid.

Stained for bacteria, streptococci and bacilli were found.

Cultures from the stomach wall were examined by Dr. Brefney O'Reilly, who isolated two organisms, a proteus and the colon bacillus, the streptococcus so evident in the stained section having evidently died out in the culture.

At a meeting of the American Medical Congress, in May, 1900, Kennicut, of New York, showed a specimen from a very similar case. A streptococcus and a bacillus, which he believed was probably the colon bacillus, were found in the stomach wall. This case was discussed by Welch and others. As in my case, a friction sound had been heard over the stomach. This friction sound is due to the roughening of the peritoneal surface of the stomach upon the development of peritonitis. Its early disappearance in my case I ascribe to the exudation of pus upon the peritoneal surface acting as a lubricant.

The rash which was such a prominent feature in my case would appear to be unique in connection with this disease, and beyond the suggestion of sepsis can have no diagnostic significance.

REFERENCES.

1. Mayo Robson and Moynihan. Text book on diseases of Stomach.
2. Asverus, S. Zeitschrift für Med. Natur: Jena, 1866, Bd. II. s. 476-482.
3. Habershon, S.O. Guy's Hosp. Reports, London, 1865, p, 115.
4. T. N. Kelynack. Lancet, March 14th, 1896.

PUBIOTOMY: CASE REPORT.

By DAVID JAMES EVANS, M.D.
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E. M., aged 24, III-para, was admitted to the Montreal Maternity, September 8th, 1906. Her two previous pregnancies had been terminated at term by craniotomy. The last had taken place a year ago. This was followed by prolonged sepsis, and she was admitted to the General Hospital, where she spent nearly a year. There she underwent an abdominal operation, one tube being removed.

The last menstrual period began January 1st, 1906. Patient first noticed fetal movements in May, 1906. There had been persistent nausea and vomiting throughout the pregnancy, and moderate severe frontal headaches. There had been edema noticed at times, but no disturbance of vision. The bowels had moved regularly with cathartics. The patient stated that she had learned to walk at twenty-four months of age, and that she was married in 1903. Her previous pregnancies had gone to term, the children being lost as above stated. There was no history of any previous disease. The kidneys were normal.

On examination the fundus uteri was found to be two fingerbreadths below the ensiform cartilage. The abdomen was in the condition of a full term pregnancy. There was a scar of an incision in the middle line half way between the symphysis and the umbilicus. The child was presenting in R.S.A., the presenting part being well above the brim. The fetal heart was heard from 144 to 156 on the right flank at the level of the umbilicus.

The pelvic measurements were Sp. 26.5 c.m.; Cr. 28 c.m.; Troch. 32 c.m.; Conj. Diag. 9 c.m.; the true conjugate was estimated at 8.5 c.m. The pubic arch was very wide, and the transverse diameter of the outlet was 12.75 c.m. A diagnosis of flat rachitic pelvis was made.

She had been seen in the Out-Door Department on August 29th, 1906, and her measurements having been taken at that time, she was advised to come into the Hospital when the pains began, and it was the intention, if the condition warranted it, to deliver her by means of abdominal Cesarean section. In accordance with this plan she was put to bed when admitted, as she was having irregular abdominal pains, and small doses of morphia were given to secure rest.

On the night of September 10th, patient began to have fre-

quent and severe pains. My attention was called to her on the morning of September 11th, when I had her removed to the labor room and prepared for examination. The position of the fetus was found unchanged by external examination, the fetal heart being heard in the same position, and at the same rapidity. On vaginal examination the parts were found relaxed. The vagina was short and there was nothing unusual about the vaginal discharge. The sacral cavity was markedly accentuated from above downwards, and decreased laterally. *The promontory could easily be reached by the finger.* The os was found three-quarters dilated, and the left hand of the fetus prolapsed into the vagina. The fetal breech was felt above the internal os in R.S.A. position.

No record could be obtained as to when the membranes had ruptured. Under the circumstances I decided that to deliver the patient by the abdominal route would necessitate a Porro operation, so I decided to attempt delivery by means of pubiotomy.

The patient having been prepared for operation in the usual method, she was catheterized in the dorsal position, and the catheter was allowed to remain in the urethra as a guide. A short incision was made parallel to the upper border of the left ramus of the pubes, down to the bone. The finger was inserted behind the symphysis, stripping off the bladder, and a Bumm-Stockel needle was then passed carefully down behind the symphysis, guided by the internal finger, and brought out midway on the left labium majus. A Gigli saw was then attached to the needle and drawn back through the wound. The bone was sawn through exceedingly easily, but it did not separate with any sudden snap. Just as the bone had been sawn through there was a gush of blood, which was readily checked by pressure from gauze packed into the wound and over the pubes. The legs were now flexed and held in position by assistants.

Dr. Little, who was assisting me, undertook the delivery. The right foot of the child was seized and brought down, and the body as far as the umbilicus delivered without difficulty. The right arm was found to be displaced upwards, and around the child's neck, and it was removed without much difficulty, but the child could not be turned to allow the biparietal diameter to come down on the left side, as is directed in such cases. Some considerable force was necessary to bring the head down into the pelvis: as it passed the brim the pelvic bones separated to the extent of 2 c.m.

The child was deeply asphyxiated on delivery, but was re-

suscitated with hot and cold baths and insufflation. After the birth of the placenta, which was expressed without difficulty, the patient was examined internally. A deep tear was found extending high up into the uterine segment on the left side. As it did not bleed it was decided not to suture. The skin incision was then closed with four silk-worm sutures, the lower wound being covered with iodoform collodion. The pelvis was surrounded by a broad strip of adhesive plaster, and sand bags applied along either side. A small band was placed about the knees of the patient to keep them together. After operation the patient's pulse was very weak, but soon after being put to bed it became about 116 per minute. She was given a saline solution of 700 c.c

About three-quarters of an hour afterwards the patient showed evidence of collapse, the lips and finger nails becoming deeply cyanosed. There was no definite sign of hemorrhage, nor was there marked abdominal tenderness, though the pulse rose to 144 per minute. Under prompt treatment she rallied.

The child was a male and weighed 2,600 grammes. The Bi. P. diameter was 8.75 c.m.; Bi. T. 8 c.m.; O. M. and the O. F. 11.5 c.m. The further history of the child was uneventful. It weighed when it left the hospital, 2,670 grammes. The mother was unable to nurse the child, and it was fed on a cream and whey preparation.

The recovery of the patient was on the whole uneventful. The highest temperature recorded was 101.5, which was reached on the fifth day. As a rule the temperature remained below 100. The patient required to be catheterized but twice, when she regained complete control of the bladder. She complained of considerable pain over the right sacro-iliac-synchondrosis throughout.

The incision was dressed on the sixth day and everything was found in good condition. There was marked swelling and induration of the left labium. On the eleventh day dressings were removed, the wound was dressed, and the sutures removed. A quantity of peculiar blood-stained fluid escaped from the outer edge of the wound at this time, and more could be expressed by pressure. This sinus was somewhat enlarged by a probe, a sterile gauze drain was inserted, and the wound was dressed every day or two until this discharge ceased.

The patient was a very sensitive and rather complaining type of woman, and very apprehensive about beginning movements of her limbs. She sat up for the first time on the

thirtieth day and was discharged on the forty-seventh day. She was detained longer than necessary in the hospital in order to permit of certain examinations being made. On discharge the pelvic examination showed the cervix lacerated on the left side. The uterus was well involuted, not tender, and in good position. The adnexa were free. The Diag. Conj. twice measured 9.25 c.m., showing a slight permanent increase. The left ramus of the pubes was markedly thickened in its entire extent, but there was no definite callous noticed at the line of division. The genitalia were practically in the same condition as when the patient was admitted. The patient could stand on either leg without difficulty, and there was no evidence of undue movement in the pelvis.

This operation was first suggested by Gigli, in 1894, his object being to retain all the advantages, and do away with some of the dangerous features of the operation of symphysiotomy. He proposed that the pubic bone should be sawn through to one side of the symphysis by means of a fine wire saw which he had designed for the purpose, since known as the Gigli saw. The operation was first performed by Bonardi, of Lugano, in May, 1897. The operation was first introduced into Germany by Döderlein in 1904, who largely improved the technique. Since then the operation has been done in practically all the German clinics, and in France. The operation has been steadily growing in favor and the results have on the whole been very satisfactory. It has been performed many times in the United States, and once in Canada by Laurendeau, of St. Gabriel de Brandon, who reports a case in *La Union Medicale du Canada*. Jan., 1906.

As has been suggested by Gigli the operation consists in making a large vertical incision to one side of the symphysis pubis, and then sawing through the bone from the outside. Döderlein's modification has made the operation practically a subcutaneous one. The operation performed in the case here reported is practically that of Döderlein.

Bill, in a recent paper on this subject to which I am much indebted, claims the following advantages of the operation over Cesarean section:

(1) The fact that the peritoneal cavity is not opened, and that the field of operation does not connect with the generative tract, allows of its being done in cases in which there is infection already present, or where there is a suspicion of infection on account of examination under doubtful asepsis.

(2) The greater simplicity allows of its being done in a

private house, and the fact that it may be done subcutaneously greatly lessens the danger of infection.

(3) The operation includes nothing which might interfere with future labors. The uterine wall is not incised, and this decreases the danger of weakening it.

The complications which attend the operation are, according to reports hitherto published, hematomata of the labia, and at the site of the operation; lacerations of the bladder and of the vagina wall, which in some cases connect with the field of operation; and thrombosis of the veins of the leg.

Bill has been able to collect records of 157 cases in which the operation has been performed, with eight deaths. There is no doubt that many other operations have been performed which have not been recorded. In but one of these fatal cases could the death be said to have resulted from the operation, and the cause of death in this was thrombosis and embolism. Several of the other cases died of sepsis, but in each one of them sepsis was present at the time of operation. One case died of chloroform during the operation, and another of typhoid fever twenty-five days after operation. The results for the child have not been so uniformly good as for the mother, but on the whole could be said to be very satisfactory.

The increase in the true conjugate which may be obtained depends upon the degree of separation of the cut ends of the bone. A separation of 6 c.m. between the cut ends of the bones will give an increase in the true conjugate of 2 c.m. This degree of separation of the cut ends of the bones has as yet not been recorded. The maximum of separation Döderlein records is 5 c.m., which was not attended with any injury to the soft parts. The operation is limited in flat rachitic pelves to 7 c.m. C. V., and in general contraction to 7½ c.m. C. V.

The enlargement as a result of the operation is an asymmetrical one. The pelvic diameter on the side opposite to the incision is as a rule most markedly increased.

Bill reports having been unable to record a single case where the bony surfaces did not unite after the operation; as a rule there is no mobility and in no case is there any record of the patient being affected as a result of the operation. Some observers have reported the presence of callus in considerable quantity after the operation. Van des Vale and Kannegiesser have reported cases in which pubiotomy had been performed, and at a subsequent labor there had been spontaneous delivery, the enlargement of the pelvis evidently being permanent.

My own opinion is that the operation has a distinct, though limited, field, and on the whole I am satisfied with the tech-

nique of the operation as performed in this case. The hemorrhage, which may be moderately severe, was, in nearly every case recorded, easily checked by pressure, and arises chiefly from the crura cavernosus clitoridis, and usually comes at the moment of the separation of the bone. The saw should be used through as wide an arch as possible to avoid bending, and so breaking it, and it should not be removed until perfectly satisfied that the bones have been completely severed. Drainage if required at all should be done from the upper wound.

J. C. Cameron, M.D.—Dr. Evans is to be congratulated on the result of his operation. It certainly seems to have been an ideal case for pubiotomy. The estimate which was made beforehand of the pubic dimensions was very accurate; the Conj.-Vera, estimated at 8.5 c.m., was found to be 8.6 c.m. by actual measurement when the patient was examined for discharge. After listening to the report of this case the first question which we should probably ask ourselves is, whether the result was better than it would have been had C. Section been performed, and if so, in what respects. In my opinion that woman left hospital in far better condition than she would have done had C. S. been done, and moreover the child was living and in good condition. The C. Section operation would have been a Porro; the patient would have been mutilated even if she had recovered, and the child would probably have perished on account of the time lost in dealing with the adhesions.

The chief value of pubiotomy seems to be the narrowing of the field for C. Section, especially for the *relative* indication. Of course there can be no question of pitting it against C. Section for the *absolute* indication. In minor degrees of pelvis contraction at the brim, pubiotomy will be of the greatest service; but the smaller the C. V. becomes, the more dangerous will the operation be for the child. Here in this case we have a pelvis with C. V. of 8.6; the child was born asphyxiated and was resuscitated with difficulty; if the C. V. had been 1 c.m. less or had it been 7 c.m., which is usually regarded as the lowest limit, there can be very little doubt that the child would have perished, and what gain would there have been over the results of previous deliveries where craniotomy was done? It would seem, therefore, that pubiotomy is to be preferred in cases of slight or moderate contraction of the brim.

With regard to the method of performing the operation, there are several practical points which this paper brings up. First, with regard to the amount of enlargement of the C. V. obtained by means of the operation. It has been the clinical

experience in Germany, confirmed by Roentgen ray photographs, that the closer the incision is made to the symphysis, and the more nearly parallel it is to the middle line, the greater will be the widening of the cut ends and consequently the *greater the gain in the C. V.* Conversely when the incision is made three or four fingerbreadths from the symphysis or in a line oblique to the central line of the joint, the gain will be correspondingly less. If I had occasion to operate on a case where the C. V. was below 8 c.m., I should take great care to make the incision as near as possible to the symphysis, and parallel to the middle line.

With regard to the subcutaneous method, I very much question *whether it is altogether an advantage. There is always* considerable effusion of blood after the bone is sawn through, and it must go somewhere. If it is not allowed to escape, it will form a hematoma more or less extensive in the labia or elsewhere; but if it is allowed to escape through a small opening, such a hematoma is not so likely to form, and the hemorrhage need never be severe, for it can be checked promptly by packing some moist gauze into the wound. Our experience here with symphysiotomy has been that the best results are obtained by one small incision down upon the top of the symphysis, through which the finger can be passed, the knife guided during the cutting, and the operation done almost subcutaneously. It seems to me that the same technique applied to pubiotomy should give equally satisfactory results. Another point which struck me in this case was made before discharge from hospital, the uterus was found to be in good position, and the soft parts involuted and in excellent condition. In our symphysiotomy cases, although the patient seemed to be in good shape when discharged from hospital, prolapse and subsequent trouble developed. The good success in this case was attributable, largely, I think, to the fact that the patient was kept so long in bed, and that involution had a chance to be well established. In the earlier days, there was great haste in getting patients up and out of hospital; experience has proved that to have been a mistake in symphysiotomy. I think that it would be equally a mistake in pubiotomy. This case is extremely interesting from many points of view, and I think we may safely conclude that in pubiotomy we have an operation which has a definite field, and that it limits considerably C. Section for the relative indication, especially in flat pelves where the flattening is only slight or moderate; but where the flattening is extreme, pubiotomy is too dangerous for the child and C. Section is to be preferred.—*Mont. Med. Jour.*

Selected Articles

PREDISPOSITION TO DISEASE, OR "MORBID IMMINENCE."*

By P. LONDE, M.D.,
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Diseases, even of sudden onset, do not "break out" without a period of preparation, so to speak, of days, weeks, months, or, it may be, years. This preparatory period may be very protracted in chronic diseases, but it exists also for acute diseases, though it is then of shorter duration. In passing from health to disease we go through a whole series of præ-morbid stages, and a moment arrives when we find ourselves in a state of morbid imminence—the predestined victim of the first accidental cause that may present itself. During this preparatory process there is no disease, properly so called; localization, at any rate, is still undetermined, and even its nature may remain uncertain. The change in health may not be manifested by any objective, or even subjective, sign, and if there be any prodromata, they are usually very vague.

We must, however, make a distinction between specific and non-specific diseases. For instance, from the moment when the incubation of measles commences, the nature of the disease is established; it will run a definite course, although its form is subject to variations. The evolution of certain other specific diseases, it is true, cannot be forecast with the same precision as in measles; nevertheless the nature of the disease cannot change the moment the particular microbe has taken possession of the organism. Each microbe has its own peculiar mode of preparing the soil on which it will multiply if left undisturbed by any preventive treatment. The period of morbid imminence or predisposition, however, dates back anterior to infection. Even the receptivity of the subject may vary according to the state of the digestive organs and of the nervous system. Disease always surprises the individual under cover of some nervous depression or digestive disturbance—indeed, these two factors are inseparable. The object of this article is, indeed, to demonstrate this fact in respect of non-specific diseases.

That disease gains a footing under cover of these nervous and digestive factors is a statement that can hardly be questioned,

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whatever be the particular form that it assumes—bronchitis, pulmonary congestion, pleurisy, pneumonia, broncho-pneumonia, enteritis, appendicitis, rheumatism, gout, cerebral hæmorrhage, and so on. Diseases such as erysipelas, tuberculosis, and typhoid fever, though markedly less specific than the eruptive fevers, are due to exhaustion of an over-worked organism quite as much as to the virulence of the specific microbe. The intrinsic cause dominates here, whereas in the truly specific maladies it cannot be said to exist.

The community of origin of so many very different diseases explains how it is that the physician prescribes repose and diet under so many and apparently opposite conditions. It enables us to understand the morbid equivalents that follow each other in the same subject, apart from diathesis, and it facilitates the treatment of the class of patients, so common in urban practice, who, though they do not conform to any particular pathological state, suffer from functional disturbances, respiratory, vascular, digestive, or nervous, premonitory troubles of a morbid state which will ultimately become defined and localized if rest and diet do not intervene in time.

It follows that the state of morbid imminence is not always latent. It may be manifested by a series of premonitory symptoms which only become prodromal when they group themselves in a characteristic manner. Headache, giddiness, noises in the ears, sleeplessness, diarrhœa, cough, epistaxis, etc., form a prodromal syndrome suggestive of incipient typhoid fever; yet any one of these symptoms separately is commonplace, and may be associated with any sort of affection—infection, auto-intoxication, etc.

There are two categories of symptoms of morbid imminence; some are common to a great many patients, others are peculiar to certain subjects previously suffering from a lesion or a functional disturbance of some standing. We will first of all discuss the common symptoms.

Nervous manifestations are perhaps the earliest of the precursory signs of a morbid state, especially in nervous subjects whose organic consciousness is comparatively highly developed. Side by side with the nervous subjects, by way of contrast, we must place those whose internal sensations are blurred, as in the aged and in alcoholics. It is in the latter especially that the state of morbid imminence remains latent. All forms of pain furnish a valuable indication, the significance of which is in proportion to its previous absence. Pain is a warning; it tells us that the normal equilibrium is disturbed—in short, it is a useful if

troublesome symptom. The subject who suffers is better able to defend himself. This is a general law, applicable just as well to a whitlow as to pneumonia, enteritis or what not. Headache constrains us to rest the whole organism, particularly the abdomen, because it impels us to diet ourselves, and although it is often the sign of intoxication or general auto-intoxication, it is not unfrequently the outcome of some sympathetic abdominal trouble. Pain in the head, when unilateral, is often on the same side as the abdominal lesion. Right supra-orbital neuralgia may be associated with hepatic affections (*biliary lithiasis*), while on the left side it is associated with disturbance of the stomach or sigmoid flexure.

Among the various kinds of backache, lumbar pain is the most important. We get it under many conditions—spinal meningitis, nephritis, lumbago, enteritis, Addison's disease, fevers, etc. Moreover, like headache, apart from any special indication, it signifies general fatigue, morbid imminence. The same may be said of undue sensitiveness to cold.

In addition to these early sensory troubles, there is a motor trouble that attacks patients long before the outbreak of actual disease—viz., asthenia with associated fatigue. In the psychical domain, somnolence and insomnia, irritability or depression, and especially anxiety, are not less characteristic signs of approaching illness. Some subjects on the eve of an attack of pneumonia, typhoid fever, or other affection, have a sort of presentiment that they are going to be ill. Others are seized with restless activity that makes them try and do several things at a time, as if they knew that this activity was about to be cut short, at any rate for the time being.

Alteration of the facies is a sign that may be associated with asthenia. The eyes become "hollow," and the features are drawn. The "seedy look" is but a rough sketch of the abdominal or influenzal facies. Internal suffering, even if unperceived, is reflected in the face, and even in the look. At the same time the complexion changes, becoming pale or yellow.

After all, these nervous disturbances are but the counterpart of what is going on in the digestive tract. There is arrest or vitiation of the digestive functions, and of the glands in connection therewith. Often the arrest is preceded by pre-morbid activity. Boulimia, for instance, may be met with on the eve of an attack of disease (influenza, articular rheumatism, enteritis, hepatic colic, etc.), especially in the new-born. In the same way an exaggerated flow of bile may precede acholia or temporary hypocholia. This stage is followed by anorexia, with furred tongue, constipation, and abdominal distension. These symp-

toms are defensive acts, just as is the vomiting that may follow. In order to check this pre-morbid auto-intoxication, the organism suspends nutrition and arrests digestion. This is a sort of providential inhibition, because, as disassimilation is not being carried out normally for want of the necessary vital energy, assimilation is inhibited by mechanical control. It is then that the virulence of chance microbes comes into play, taking advantage of the diminished organic resistance. These phenomena are evident at the apertures of entrance to the respiratory and digestive passages for coryza, sore throat, and stomatitis are due to infections of internal origin.

These are doubtless morbid manifestations that may remain isolated, but very often they merely herald some more deeply-seated affection, the localization and nature whereof may not stand in any direct relationship to the initial infections. Thus the cough of broncho-tracheitis may prelude enteritis, pericarditis or nephritis, just as much as a broncho-pneumonia; similarly a sore throat may proclaim the imminence of an outburst of rheumatism, just as much as of influenza or typhoid fever; or digestive disturbances may precede pleurisy, or catarrhal jaundice, or an attack of gout.

Consequent upon the digestive and nervous troubles, the general health suffers, and we get constitutional signs—plethora or anæmia, gain or loss of weight, pallor or congestion. Arterial pressure is modified in the sense that the standard of pressure is seen not to be the same under identical or analogous conditions in a series of subjects—in the subjects of arteriosclerosis, for instance. In the latter a rise of pressure is essentially a sign of morbid imminence heralding an attack of cardiac hypertension (angina pectoris) or pulmonary (pulmonary œdema) or nasal or cerebral hæmorrhage. Arterial hypertension, like most of these precursory signs, is a defensive reaction, and the same may be said of hyperthermia, which is only an exaggeration of a natural process—in fact, it is in a certain measure a nervous reaction of which the intensity varies quite as much in relation to the individual as to the cause. In acute diseases, cardiac and renal determinations are usually secondary, and it will be sufficient if we point out the early signs that may present themselves—disturbances of cardiac rhythm and modifications in the urine. Tachycardia, bradycardia, and arhythmia are in some instances premonitory or concomitant symptoms of distant accidents in the digestive area, the kidneys, or the brain.

The urine is the secretion that has been studied most closely in the evolution of disease. Now, in the majority of acute diseases, the results are approximately the same. During the ter-

minal crisis the total excretion is increased, a phenomenon which is a natural corollary of the retention of waste during the attack. The important point to bear in mind in this connection is that the accumulation of waste matter precedes the disease proper, and that the auto-intoxication that results therefrom is the real cause of the disease. In this way we sometimes see a prefebrile discharge of urea, an effort on the part of the organism to avert the threatened infection. Many ill-defined temporary indispositions, characterized by complete inhibition of the digestive functions, accompanied by the asthenia which is its consequence, and the anxiety that is caused by suspension of organic life in any department, are manifested by an increased excretion of urea. What is true of nitrogenous waste holds good in respect of chlorides, and if, in pneumonia or influenza for example, the urine is comparatively poor in chlorides, this is due to the supplementary discharge in the expectoration, which is often rich in saline constituents. It may fairly be assumed that the phenomena which characterize the transition of disease into convalescence are the converse of those which prepare the way for the morbid process. Considered as the ultimate result of a pre-existing auto-intoxication, the disease tends to create a supplementary emunctory or to provoke a phase of extra activity on the part of a normal emunctory.

This view is confirmed by the study of the peculiar symptoms which certain subjects, already the victims of some taint, present during the period of morbid imminence. Persons, for instance, who have a periodical or permanent discharge, remark a modification in this discharge which warns them of the danger. Thenceforth the symptoms will vary according to circumstances, such symptoms being peculiar to this or that category of patients. These special symptoms consist in the exaggeration, suppression, or diminution of an abnormal emunctory already existing, called into existence by a previous malady. Bronchial catarrh, for instance, dries up at the approach of an attack of pneumonia; eczema retrocedes under the influence of asthma; and fistula ceases to discharge in presence of tuberculosis of the lungs or pleura. In the same way we see the fœtidity of the expectoration or the urine increase on the eve of a fresh outburst of bronchitis or pyelitis, while, on the other hand, a hæmorrhoidal, nasal, uterine, or intestinal hæmorrhage may conjure the morbid evolution at its onset or prevent its appearance altogether.

In this way impending attacks of uræmia or cerebral hæmorrhage, typhoid fever, gout, or hepatic colic may be averted or deferred or arrested. By way of illustration we may mention the case of a young girl with angioma of the upper lip who was

never ill, although pale and delicate, simply because she had periodical epistaxis. Preventive recourse to spring-bleeding or the use of setons is understandable, indeed recommendable, because it is unquestionable that a supplementary emunctory by hæmorrhage or suppuration turns aside the morbid proclivity from the deeply-seated organs and dispenses with the necessity for a disease, the object of the latter being precisely the establishment of a supplementary emunctory. This theory is especially applicable to rheumatism. In this case it is the serous membranes of the joints that receive the discharge of the poisons which the organism is endeavoring to get rid of. Salicylate of soda, owing to its action on the liver, checks the formation of these poisons, which, in respect of acute articular rheumatism, appear to be elaborated in the stomach. Disease, then, calls into being an additional eliminatory function intended to get rid of accumulated toxic products accumulated during the stage of morbid imminence.

Just as there are lesions and functional disturbances which ward off other accidents, so also there are diseases which create a state peculiarly favorable to the development of other maladies, thus constituting a series of morbid stages. The chronic enteritis of the new-born is the first stage of rickets; scarlatina places the kidney in a state of morbid imminence, just as acute rheumatism makes us apprehensive of the heart. A child who has suffered from bronchitis will be specially prone to an attack of broncho-pneumonia in the course of an attack of measles or whooping-cough. The gravity of a previous infection, as in cholelithiasis, will be increased in presence of any inter-current infection. It would be easy to multiply such instances, but this is unnecessary except for the purpose of pointing out that repose and diet are always the necessary conditions of the preventive treatment of complications of diseases. The same means that enable us to avert diseases enable us to prevent their getting worse.

OBSERVATIONS ON THE ETIOLOGY AND TREATMENT OF ECZEMA.*

By GRAHAM CHAMBERS, M.D., Toronto.

Although eczema is so common, and in practice a consideration of the disease is such an everyday occurrence, all, I believe, are of the opinion that we know comparatively little about its etiology, and in its treatment our therapy is directed in a somewhat emperical manner. The negative character of our knowledge concerning its etiology has so impressed dermatologists that it is sometimes made use of in defining the disease. "Eczema is a term commonly applied to any wet or scaly inflammation of the skin, of the cause or nature of which the observer is ignorant," writes one author. To account for this dearth of knowledge there are several reasons, one of the principal of which being the probable composite character of the affection which, in the parlance of physicians, is designated eczema. We recognize certain varieties of eczema which do not appear to bear a close relationship to one another. Thus, for instance, the eczema of old, emaciated persons with degenerated skins is surely not the same disease as the eczema of infants, usually well nourished and frequently excessively fat; nor is the vesicular variety, which so frequently occurs on the hands and feet, likely to be the same affection as the dry, chronic, papular type.

In studying the etiology of eczema and the relationship which the various varieties bear to one another, one might have expected valuable information from histological examination of the lesions. This has not proved to be the case, as the microscopic appearances of sections of the lesions of the various types, as well as of the different forms of traumatic eczemas are more or less alike. Biochemical methods may prove of greater value in this regard. At the present, when we are almost wholly in the dark with regard to the relationship of these varieties, it would be well to drop the term "eczema" as a name of a simple disease. If we retain it, let the term "eczemas" be a group designation for all the varieties, including those of traumatic as well as those of non-traumatic or unknown origin. This would indicate a pathological but not necessarily an etiological relationship, a condition in keeping with our present knowledge of the eruptions.

The consideration of eczema as a disease characterized by various types of eruption of manifold origin has had no doubt

* Read at meeting of British Medical Association, Toronto, August, 1906.

a great deal to do with the diversity of opinion, both as regards its etiology and treatment. With regard to the etiology of eczema, one can obtain from writings on the subject very few definite statements on which there is unanimity. Hereditary influence is held by some writers to be an important etiological factor, while it is wholly disregarded by others. Some physicians look upon the eruptions as manifestations of constitutional disturbances. If this opinion were limited to the primary lesions of infantile eczema and to some of the eruptions observed in persons with strong so-called arthritic diathesis I would agree with them. Others believe that external irritation by bacterial growth, soaps, hard water, cold winds, actinic rays, etc., is the main if not the exclusive causative factor of eczema. There are several observations and considerations in favor of this view—such as the existence of traumatic eczemas, aggravation of the eruptions by scratching and other forms of irritation, the curing of many eczematous eruptions by local medication alone, etc. Still, there is insufficient evidence for one to form a definite conclusion with regard to local irritation as an etiological factor in every variety of eczema. There are others, again, who hold the opinion that nervous disturbances are important factors in the origin of the disease. Thus the profession is divided into three or four schools with regard to this subject.

Treatment of Eczema.

According to my experience, combined constitutional and local treatment gives the best results.

The local treatment is most important in the majority of cases. In following this out we should keep in mind the pathological condition, and make our therapy as rational as possible. We should particularly remember that the eruption is a dermatitis; that the mucous layer is oedematous, and owing to vesication, exfoliation of corneous layer and fissuring is more or less exposed to external irritation. If one examines an acute eczema on the hand with a magnifying glass or binocular miscroscope the unprotected condition of the mucous layer can readily be observed. In vesicular eczema the fibrinous exudate protects, to a certain degree, this layer. It also appears to act as a hydroscopic and emollient agent, for if it is removed by washing, shortly after the affected part feels dry and readily fissures. There is another character of the exudate which has a disadvantageous influence in treatment. I refer to its acting as a pabulum for the growth of germs. This is a most important consideration in treatment. Taking into consideration these char-

acters, as well as the inferences to be drawn as to the aggravation of the eruption by irritation, the indications for treatment of any case of eczema in which the mucous layer is exposed are as follows:

1. To reduce the inflammation of the skin.
2. To soothe and protect the skin, and particularly the mucous layer.
3. To adopt measures to bring about normal keratinization of the epidermis.

In the early stages of acute eczema the second indication should be our main guide in the local treatment. The question is, What is the best method of soothing and protecting the skin? In this connection there is much difference of opinion with regard to the value of aqueous preparations. Some authors advise against washing an eczema. At the same time they state that calamine lotion and other aqueous preparations are very useful in treatment. This appears somewhat inconsistent.

There is no doubt that washing an acute eczema is usually harmful. What is the reason? The following appears to me a probable explanation. When an acute eczema is washed with water the fibrinous exudate on the surface of the skin is removed. As soon as the skin dries it becomes less pliant, and readily fissures, which tends to increase the subjective symptoms. If this is the explanation, then aqueous preparations when used should be applied continuously. Again, in selecting the local application, the one which is most soothing to the mucous layer. Theoretically, a normal saline solution should be soothing; and, according to my experience, if it is applied continuously, this is the case. During the last two years I have frequently used with success this preparation in the treatment of eczema. In making the application cheese-cloth in eight to ten ply is moistened with the solution and applied to the patches. To prevent drying the moist dressing is covered with oiled silk. The dressing should be changed twice a day. In cases in which the eczema is impetiginous I add boric acid in sufficient quantities to the normal saline solution to make about one in sixty. At each change of dressing it is well to wash the affected parts with the solution. As soon as the skin, by its color, smoothness, the absence of crusts, etc., shows diminished inflammation and improved keratinization I discontinue the dressing and apply a soothing ointment such as Lassar's paste. Subsequently a mildly stimulating ointment may be required.—Abstract *Brit. Med. Jour.*

Progress of Medical Science.

MEDICINE.

IN CHARGE OF W. H. B. AIKINS, H. J. HAMILTON, C. J. COPP, F. A. CLARKSON AND BREFNEY O'REILLY.

Abdominal Reflex in Typhoid.

J. D. Rollestan (*Brain*, cxiii., p. 99), in an article based on observations made on 60 patients, supposed, on admission to the hospital, to be suffering from enteric fever, discusses the disappearance of the superficial abdominal reflex in the infra-umbilical zone, in those cases in which the diagnosis was confirmed.

In 45 of the series a positive diagnosis of typhoid fever was made. In all of these the reflex was either greatly diminished or in the majority entirely lost; the response in the supra-umbilical region is usually also diminished; no constant relation between this and the tendon reflexes could be determined. The remaining 15 cases proved to be suffering from other diseases. In only 3 of these was there a disturbance of the abdominal reflex. Thus, from its absence in patients under 50 years, being confined to certain nervous affections and acute abdominal conditions, notably appendicitis and typhoid fever, the absence of this reflex in a given case of continued pyorexia in any person below 50 is of considerable diagnostic importance.

Its disappearance is comparatively transient, and the return of a lost reflex is a valuable indication of commencing convalescence, and frequently corresponds with lysis and other clinical signs of recovery.

The Parathyroids.

In the November issue of the *Medical Review of Reviews* we note that Dr. W. N. Berkeley, of the Presbyterian Hospital, as a result of his experiments with parathyroidectomized rabbits, advances the hypothesis that in all probability atrophy or insufficiency of the parathyroid glands is the causative lesion in paralysis agitans.

He supports this by the similarity of the symptoms produced in rabbits, after removal of the glands, to those of paralysis agitans in the human subject; also by the finding at autopsy in a woman, the subject of this disease, parathyroids,

small in size and two in number, and showing in section cirrhotic changes and arterio-sclerosis in a marked degree.

He has also, in a series of 11 cases, produced favorable results by the administration of a standardized extract of parathyroid glands, in doses of 1-20 grain.

A New Test for Blood.

Schlesinger and Holt recommend (*Medical Review*) the following for practical detection of occult blood in both gastric contents and in the feces.

In the latter case a portion of the stool, about the size of a pea, is mixed in a test tube with water and boiled for a few moments. The reagent consists of a concentrated solution of benzidin in glacial acetic acid; 10 drops of this are added to 3 c.c. of a 3 per cent. peroxide of hydrogen solution; to this mixture 3 drops of the feces emulsion is added, and in the presence of blood a bluish green color appears.

Sahli's Desmoid Reaction.

In the *Johns Hopkins Bulletin* "Boggs" discusses this method as an aid in gastric diagnosis: A pill (.05 gm. methylene blue, .1 gm. iodoform, ext. glycyrrhizin, q.s. ad. pill 4 mm. in diameter) enclosed in centre of a square piece of thin rubidium, tied at the neck with turns of No. "00" raw soft catgut; the edges of the rubber must not cohere, and the pill must sink in water and be air-tight. This is given with lunch, and urine collected at periods of five hours, and is examined for methylene blue and iodine. If they are present within eighteen hours the test is positive (that is, the gut has been digested in the stomach). The reaction is based on the hypothesis that raw catgut is soluble in gastric secretion and indigestible in those of the pancreas. The test is almost one for helcoid, as in cases which show negative the helcoid is absent.

Action of Violet Leaf Preparations.

W. A. Potts (lecturer on pharmacology, Univ. Birmingham), in the *Medical Magazine* of November, 1906, takes up the discussion of the action of preparations from violet leaves. Outside the body he finds that the liquor violæ glucosidæ does not coagulate albumen or affect the clotting of blood; it has no influence on protozoa, bacteria or on fermentations; it has no digestive action, and therefore what action it has on carcinoma differs from that of trypsin, nor does it dissolve cholesterin.

It is found to paralyze the end-plates of motor nerves and to partially anesthetize the cornea on local application; also in the web of a frog's foot under its influence slowing of the blood current, oscillation and stasis in the finer capillaries is seen; its maximum effect is at its height in about five minutes, after which the circulation is gradually restored; no permanent traces of its action remains.

It has a marked depressant effect on the heart and consequent fall in blood pressure, but there seems to be an absence of cumulative action. Potts also finds that although he is unable to trace the ultimate disposition of the drug after administration it seems to be decomposed after absorption into substances which have disinfectant properties, and finally that it is a hemostatic. Taken by mouth it is unpleasant and frequently deranges digestion. Consequently he suggests the hypodermic injection of half a drachm twice daily. He also advises local fomentations prepared from the leaves. Its chief indications seem to be for the relief of pain and offensive discharges.

Spinal Sensory Areas.

A comprehensive article on localization of spinal cord lesions, originally published in St. Bartholomew's Hospital Reports, p. 37, Vol. xli., appears in the November number of the *Medical Review*. It is a compilation of the most recent researches into the subject, considered from a clinical point of view. The article is profusely illustrated by clear diagrams, the majority of which have been directly drawn from actual cases. Short notes on many of these add greatly to the interest, and the conclusions reached are of utmost value, both to the surgeon and neurologist.

Histo-Pathology of Drug Eruptions.

In the November number of *Interstate Medical Journal* appears an article dealing with the pathology of skin eruptions due especially to the salts of idoine and bromine, written by Engman and Mook, of the St. Louis Skin and Cancer Hospital. The material of the St. Louis Almshouse was at their disposal, with its numerous cases of epilepsy, chronic nervous affections, etc., in which the administration of iodides and bromides could be studied with the greatest facility. As a result of their work the following conclusions were reached: (1) That the old theory that the glands of the skin took an active part in the pro-

duction of the various lesions was fallacious; (2) the local phenomena are prone to occur at points of previous inflammation as acne lesions, etc.; (3) that the lesions, from the papule to the severe anthracoid eruption, consist merely of the various stages of inflammation, up to abscess formation (the pus in these abscesses is almot invariably sterile, and in iodide eruptions iodine can be readily found); (4) the stages are as follows, firstly, an increase of peri-vascular connective tissue cells, followed by an exudation of lymphoid cells; thirdly, leucocytes with granular appearance of collagen and vacuolation of fixed cells, and finally, the formation of an abscess (the first two may be found in iodide eruptions even in apparently normal skin); (5) the degenerative changes are probably due to a local disturbance of the equilibrium between the iodine combined in the serum and the tissues. The products of this disturbance act as toxines and intensifies the local pehnomena; the particular type of eruption present is due mainly to the character of the individual's reaction to the inflammatory charges thus produced.

Tubercular Peritonitis.

In the *Echo Médical du Nord* there is an important article by Le Fort on the therapy of tubercular peritonitis. He divides it into six varieties: 1. Acute miliary tuberculosis of the peritoneum, characterized by attacks of abdominal pain, vomiting, constipation, sometimes retention of urine, fever, swelling, and a little ascites.

2. Tubercular peritonitis of a septic form. In this class, which is more frequent, there occurs a slow but progressive increase in the size of the belly, without notable reaction. Digestion is imperfect, no appetite, vomiting somewhat frequent, irregular defecation; diarrhea alternating with constipation; emaciation and progressive loss of strength.

3. Fibro-caseous peritonitis. Irregular enlargement of the belly; liquid localized here and there.

4. Chronic peritonitis, "d'emblée," begins acutely, with terrifying symptoms and then stops, and assumes a chronic course, interrupted now and then by acute spells, ending in cachexia and death.

5. Fibrous ascitic peritonitis and fibrous dry peritonitis. In the former, the ascites, forming quickly, is absorbed. In the latter, without liquid, there occurs a true peritoneal cirrhosis.

6. Tubercular pelvic peritonitis and perityphlitis. Patho-

genic indications. Both the tuberculous and the abdominal lesion must receive attention. A cure is possible without treatment, especially in the fibro-ascitic form. This, however, is rare and most patients succumb to this terrible disease.

In the treatment of the general condition, we must pay special attention to alimentation, remembering the particular susceptibility of the intestine already more or less affected.

As for the abdominal lesion, tubercular peritonitis is to-day recognized as within the domain of surgery, and the treatment is laparotomy. Although we do not know how laparotomy can act on the tubercular lesions of the peritoneum, there is no doubt about its beneficial results. These results are seen more clearly in the ascetic than in the dry forms; in the caseous than in the fibrous; in the chronic than in the acute. Simple laparotomy is all that is necessary, with the object only of opening and closing the abdomen. (Le Fort then gives a detailed account of the operation, which it is not nescessary to repeat here.)—Translated from *Giornale Internazionale delle Scienze Mediche,* by HARLEY SMITH.

Temperature Taking in the Groin in Children.

A. H. Parks (*Journal A. M. A.*, September 29), points out the advantages of taking the temperature of infants in the closed groin. The oral method is hardly practicable, and there are some dangers in the rectal method in the exposure and possibility of breakage of the instrument, as well as some other inconveniences and objections. He has made comparisons of temperatures taken by the different methods, rectal and inguinal, in 175 children, ranging between four months and five years in age, under identical conditions, and found that the average difference between the temperature of the closed inguinal fold and the rectum is 0.34 F. (0.18 C.), while the normal temperature in the former in the child is 98.5 F. The great facility of the inguinal method was very noticeable, as the natural close apposition of the thigh to the body retained the instrument in place, and the retention of the thermometer in the groin was accomplished without any crying or uneasiness on the part of the child. In extremely emaciated cases it may be better to use the internal method, but when it is possible to use the external method the groin possesses decided advantages over the axilla. The usual variation between the groin temperature and that of the rectum (1-3 of a degree) is so small as to be practically disregarded for clinical purposes, and the absence of many of the objectionable

features of the rectal method and the ease and reliability of the groin method give the latter several points of advantage. These should recommend it not only in hospital but more especially in home practice among children.

Grocco's Sign.

Drs. Thayer and Fabyan drew attention to the following points at the October meeting of the Johns Hopkins Hospital Medical Society. In 30 out of 32 cases of pleural effusion a paravertebral triangle of dulness at the base of the opposite chest was clearly demonstrated. This triangle is an area of relative dulness, the vertical side of which is represented by the line of the apophyses of the vertebrae, the apex reaching a point slightly above the level of flatness of the effusion, the base by the lower limit of pulmonary resonance on the healthy side for a distance of 2 to 7 c.m. from the spine, the hypotheneuse by a line connecting these two points; this triangular dulness disappears when the patient lies on the affected side; over this area the respiratory murmur is frequently suppressed; egophomy may be present. They find it to be a constant sign in pleural effusions and to be present even in those which are encapsulated, the cause to be due to the fluid passing anteriorly over the bodies of the vertebrae and acting as a mute in suppressing the vibrations; also partly due to its displacing the contents of the posterior mediastinum.

Roentgenography of Stomach.

A short article by Max Einhorn and L. G. Cole appears in *Medical Record* of October 13th, describing a method of taking roentgenography of the stomach. It consists of administering to the patient a pint of milk, to which one ounce of subnitrate of bismuth is added, on an empty stomach. A skiagraph is immediately secured, with the subject in an erect posture; usually an exposure of ten to fifteen seconds is sufficient.

The advantages are that no instruments are introduced into the organ, and that on the day following, by a second exposure, an investigation of the color can be procured.

A second plate is usually taken immediately after the first exposure, with the patient in the prone position. In both instances he is instructed to hold his breath. The article contains several excellent illustrations.

OBSTETRICS AND GYNECOLOGY.

IN CHARGE OF ADAM H. WRIGHT, K. C. McILWRAITH, FRED. FENTON AND HELEN MacMURCHY.

Myomectomy During Pregnancy.

Mr. Alban Doran, in the *British Medical Journal,* tells us that myomectomy has often been performed during pregnancy with the most satisfactory results; gestation is as a rule uninterrupted, and when labor sets in the expulsive powers of the uterus seem to be but little impaired. This has been noted even in patients where the wound in the uterine walls at the operation was of considerable length, breadth and depth.

Mr. Doran reported a case of a woman aged 35, three months advanced in pregnancy. He found evidence of a morbid growth connected with the posterior part of the lower segment of the uterus, most likely a fibroid, likely to prejudice labor. The operation was performed, the section of the abdominal wall was prolonged to one inch above the umbilicus, and the uterus was then drawn out and examined. Two subserous pedunculated growths springing from the inferior posterior uterine segment were removed with considerable difficulty. The patient made a good recovery, went on to full term and had normal labor, giving birth to a living child.

Dr. Jos. Stewart, of Leeds, recently operated on a woman aged 35, in the sixth month of her first pregnancy, and enucleated a large sessile fibroid attached to the left of the fundus, rotating the gravid uterus somewhat toward the right. A large gap was left not easily closed. The patient went on to full term and had a normal labor which ended spontaneously in six hours and a half. The contractions of the uterus were normal so far as Dr. Stewart could make out. He could discover no indications representing the spot from which the tumor had been enucleated.

Lacerations of the Cervix Uteri.

There is a great difference of opinion as to the proper treatment of lacerations of the cervix occurring during labor. Dr. Striker Coles, of Jefferson Medical College, tells us (*Surgery and Gynecology*) the cervix just after labor is greatly elongated, being from two to three inches long. Lacerations are more usually to be found on one or both sides, rarely in the anterior

or posterior lips. During the first twenty-four hours following labor the cervix retracts from one to one and a half inches, which lessens the tear to about one-third of its original length. If the raw surfaces are left open, nature, to prevent the entrance of bacteria, throws out a wall of lymph, and the surrounding tear becomes infiltrated and the wound heals by granulation and cicatrization. Also lacerations of an inch or more should be closed immediately after labor. An exception may be made in badly neglected cases, when from pressure or violence the tissue of the cervix has been devitalized and is likely to become necrotic.

The method employed in most cases was to pack the uterus with iodoform gauze, which was removed after the closure, or left in for thirty-six to forty-eight hours. The cervix was grasped with tenaculum forceps through both lips, or in later operations by simply holding the cervix with the index finger placed in the tear, and the thumb and middle finger on either side. A curved needle armed with ten-day chromacized cat-gut is guided along inside of the thumb to the uppermost part of the tear and carried down to, but not through, the mucous membrane. The needle is then guided by the index finger across the tear to the opposite side and the middle finger protects the point at its exit when it is grasped by the needle holder. The suture is then tied and examined to see that it is placed high enough, and should there be an opening above, another is placed higher up. Two sutures are usually enough, as the lower suture must be one-quarter of an inch above the lower border of the cervix, and the sutures must be placed one-half inch apart. When the cervix is torn on both sides, each side must be closed. The sutures will not become loose when the cervix retracts, as the diminution is in length and not in thickness.

Dickinson, on the other hand, tells us in the *New York Medical Journal,* that just after delivery the cervix is swollen, distended and stretched beyond recognition, that there is laceration, that accuracy in coaptation is less, because exact identification of the uterus is out of the question; bleeding also obscures the work of immediate suture. The great edema of the cervix, especially the anterior lip, makes us very uncertain how much tension to put on a stitch in order that it may hold well for a day or two. He has seen these stitches lying as loose loops three days after their introduction. Nature repairs very many cervical injuries. He gives, however, the following rules for exceptional circumstances:

(*a*) Suture immediately when laceration appears to be the cause of post-partem hemorrhage.

(*b*) Sew up all cervical tears in the first week in conjunction with the perineal operation, when the pelvic floor injury is of such a character that a few days' delay is desirable.

(*c*) Operate for very severe injuries to the cervix from the third to the tenth day after delivery.

Treatment of Puerperal Eclampsia.

We reported in our November issue a report of a case of vaginal Cesarean section in the treatment of puerperal convulsions by Dr. Hayde, of Buffalo. At the same time we expressed the opinion that this operation was a difficult one in ordinary private practice.

Dr. Foulkrod, of Jefferson Medical College, reports (*Surgery and Gynecology*) three cases of eclamspia recovering without delivery, and expresses the opinion that such treatment affords as good, and in some cases better, opportunity for both mother and child. In one case the patient had ordinary premonitary symptoms, including excessive headaches and disorders of the kidneys. June 13th, 1906, had severe nausea and vomiting at noon, three convulsions within three hours, with no intervening consciousness.

Treatment.—Hot pack for one hour, during which time the pulse tension rose considerably, while in the back was received a hypodermic of veratrum viride, 10 min.; the stomach was washed out with salt solution, 1 gal., and calomel, 10 grs., was introduced through the tube. The bowels were then irrigated. The coma became deeper, and three successive convulsions were checked by the use of chloroform. Blood pressure rising, five ounces of blood were withdrawn, and a pint and a half of salt solution introduced into the same vein. Morphine, 1-2 gr., and atropine, 1-100 gr., were given by hypodermic injection. Bowels again irrigated and patient catheterized without obtaining any urine. Vaginal examination revealed no inflammation or obliteration of the cervix. It was decided not to interfere. An enema of salt solution, 8 oz., and whiskey, 2 oz., was given every two hours, and water by the mouth through a pipette. Normal labor occurred nine days after; she was delivered of a still-born female child. Mother made a good recovery. Four cases somewhat similar, but in one the child was born alive and healthy.

The author explains that he gives a record of the expectant eliminative treatment of his three patients to illustrate the pos-

sibilities of such treatment in certain selected cases of eclampsia, keeping in mind that nature's method of delivering the child is safer if existing conditions can be relieved by suitable treatment.

Dr. Jellett, in speaking of such cases, tells us not to induce labor, but when it occurs he advises us to shorten it as much as possible. He also advises us not to do Cesarean section or accouchement forcé. Sir John Byers advises us to treat the convulsions with morphine, used subcutaneously, keep the patient on her side, purge freely, use salt infusions, allow no liquids. In a word, as Gooch advised long ago, "take care of the convulsions, and let the uterus take care of itself." If labor has not set in during the convulsions, do not produce premature action of the uterus. Many authorities on the Continent advise the emptying of the uterus as soon as possible in a case of convulsions. Formerly interference with the uterus generally meant accouchement forcé or Cesarean section. When the cervix is not effaced nor softened accouchement forcé is never justifiable. Some form of Cesarean section is probably advised in a limited proportion of cases. It seems probable that a good line of treatment is to introduce within the uterine cavity one or two flexible bougies, according to Krause's method. Such induction can generally be accomplished with little or no violence. In many cases such introduction brings on labor within twenty-four hours without the slightest injury. In a certain proportion of cases it does not induce labor. In ordinary cases, if one is very anxious to induce labor by Krause's method, it is better after the introduction of the bougie to plug tightly the vault of the vagina with iodoform gauze, but as this tampon is likely to cause a good deal of pain and irritation it is not advisable in cases of eclampsia. A. H. W.

Editorials.

THE CRICHTON CASE.

A great deal of interest has been manifested throughout the Province of Ontario respecting what is known as the Crichton case.

Dr. Alexander Crichton graduated, B.A., from the University of Toronto in 1883, and received his license to practice from the College of Physicians and Surgeons in 1892, and has been for some years a general practitioner in the Village of Castleton, in the County of East Northumberland. About three years ago he commenced sending out preparations for medicinal purposes, the ingredients of which he refused to make public. He advertised his medicines, and published testimonials from many prominent persons who had used them with alleged good results.

A formal charge being made against him, the Council gave instruction to its Discipline Committee to investigate the matter. After the first trial held in Cobourg the committee reported that, after hearing the evidence, it had not arrived at a conclusion. We understand that this practically meant suspension of judgment, with the hope that the accused would stop advertising.

We are told that Dr. Crichton practically defied the Council, and said that he was acting within his legal rights.

The Discipline Committee brought in a second report, July 3rd, 1906, in which it was stated that "the said Alexander Crichton did infamously, disgracefully, improperly and unprofessionally advertise and distribute advertising circulars claiming to have discovered a remedy which would cure la grippe and influenza in a few hours, and assist in curing a number of other diseases specifically mentioned in said circular, soliciting and requesting that all letters of inquiry in reference to said remedy be sent to him, the said Alexander Crichton, at Castleton, Ont., and that the said advertising pamphlets did appear and were distributed to some of the residents of the County of Northumberland and throughout the Province of Ontario."

Dr. Bray, the chairman of the committee, by way of explana-

tion, spoke as follows in the Council: "Gentlemen,—In this report you will see that we had two sessions, and the evidence was not very satisfactory at the first session, and we had a second meeting, and our report is as follows: 'That we find those charges proved. It is for the Council to deal with this case as they may deem fit.'"

It was then moved by Dr. Ryan, and seconded by Dr. Glasgow, that the report be adopted, and that the name of the said Alexander Crichton be erased from the said Register, and that the Registrar be and he is hereby directed to erase from the Register the name of the said Alexander Crichton.

After the discussion engaged in by the members of the Council, the solicitor for the Council, the accused Dr. Crichton and his solicitor, it was decided that Dr. Crichton's name would not be removed from the Register until he had an opportunity of appeal. This means that Dr. Crichton's name was never removed from the Register.

Dr. Crichton appealed to the Divisional Court against the action of the Council, and the trial, which extended over three days, was held in Toronto, December 13th, 14th and 15th. Mr. W. F. Kerr, of Cobourg, who appeared for Dr. Crichton, in the argument before the Court maintained that Dr. Crichton was not given a fair trial; that he was charged with advertising, but convicted of fraud on an attempt to deceive the public; that the members of the Council had not read all the evidence, but had relied upon the report of a committee; that no test of the preparation had ever been made, and that the Council undertook to find proven against his client certain things that, even if they were true, and he held that they were not, would not constitute infamous or disgraceful conduct.

We find the verdict of the court in the Toronto daily papers of December 17th, under the following headlines: In the *Globe*, "Medical Council Wronged Doctor," and in the *Mail and Empire*, "Medical Council is Called Down." The court allowed the appeal, and instructed that the appellant's name be restored (that is, if it had been erased), but did so without prejudice as to the question whether on subsequent enquiry there may appear sufficient cause for erasing his name.

Chancellor Boyd observed that the Medical Council does not seem to be invested with such extensive power of disciplining its members as is given to the Law Society by the Legislature. To the Benchers is entrusted power to enquire into the conduct of lawyers who are charged with professional misconduct, or with conduct unbecoming to the Law Society. So to a more limited extent in medicine, if anyone admitted to practise on certain explicit conditions, and is given an undertaking to observe them, that is, a promise not to advertise in any offensive way, by a breach of that engagement, if wilfully and deliberately made, such action might well be regarded as disgraceful conduct in a professional respect. As to the costs, the Chancellor did not consider that the proceeding had been frivolous or vexatious. The conduct of the appellant had been such as to provoke complaint and invite investigation. He has offended against the provisions of the Ontario code, which declares it to be derogatory to the dignity and prestige of the profession to resort to the practice of secrecy on the one hand and publicity on the other, which, though not in force when he registered, yet declares the professional standard, which he has disregarded to set up a trade standard for himself, so that, while in the result he might be right legally, he is wrong professionally.

Having regard to this and other considerations, the Chancellor did not think that the Council, who are discharging a quasi-public service, should be called upon to pay the costs of the investigation at Cobourg or this appeal in Toronto.

Mr. Justice Maybee, in his summary, made the following comments: Complaint was made throughout the trial that Dr. Crichton refused to make the formula of his medicine public. This was said to be against proper practice, but he was not charged with that, and was not convicted of it. The charge was for advertising. He was convicted of fraud, or something he was not charged with. The evidence is not sufficient to convict of charge, even had he been so charged, and the trial was not conducted with those safeguards that should be carefully observed upon a case of fraud with so serious consequences as the present one.

ACADEMY OF MEDICINE FOR TORONTO

At a meeting of the Toronto Medical Society, December 18th, Dr. Osler delivered an interesting address on the advisability of establishing an Academy of Medicine in Toronto. He said there were three recognized important factors in the evolution of medical thought: (1) Medical schools, (2) Medical societies, and (3) Medical journals. Medical societies evolve with the growth of a place, and as a city grows special societies are organized for the various schools of medical faith or teaching. After a time, under conditions of a still greater expansion to the city and its medical bodies, the fact greatly becomes patent to those societies when a fusion of two into one centrally organized institution, called an Academy of Medicine, would serve the purposes of each on a larger and better plan. In Toronto there are Clinical, Medical and Pathological Societies, each in itself doing good work, but under existing circumstances their horizon is necessarily limited in the field of medical knowledge, and their usefulness is confined within certain narrow boundaries.

The amalgamation of all these societies into an Academy of Medicine would increase the field of each, and would give much greater strength to the profession as a whole. Such an organization would be of great benefit to all medical men, but more especially to the younger men, who could have the advantage of an extensive library. It would stimulate work in the various branches, and give a firmer status to the profession. He thought the College of Physicians in Philadelphia was an institution that might well be taken as a model.

He himself would be willing to make one of five to subscribe $100 a year for five years, or one of a greater number to subscribe a lesser sum a year for a longer period.

By such a grand consolidation of all the medical societies, with a large and increasing number of members, not belonging to Toronto alone, but from Hamilton, Kingston, London and other towns, an Academy of Medicine in Toronto would have an importance as great as the Law Society or any other large representative organization, which virtually represents the whole

people for which it stands. Opposition from a few from each existing society must be expected. It is second nature with some people to resist change. A society which has taken years to grow may feel reluctant to lose its identity by becoming merged in another, even though it may stand on a larger and grand basis. But the old societies of London, England, whose antiquity and recognized high standing were both unquestionable, did not hesitate for the good of the profession and the enlarging of the medical field to become absorbed into an Academy of Medicine of London.

Dr. Osler advised his hearers to hold out the hand of good-fellowship to all reputable members of the profession with a view to soliciting their enthusiasm, co-operation and partnership. The all-important matter of organization, backed by an earnest and intelligent committee, who could appoint sub-committees to carry out the required work to bring all the different ideas into line, would, he hoped, mean the establishment of such an ideal institution in the near future.

The medical profession is not a tremendously lucrative one. What money is made is made with difficulty, and what money is spent is lost with ease. He hoped that united effort on the part of the profession, intelligent sympathy and help from many sources of the public, and valuable assistance from all the seniors of the profession would soon place this proposed academy in our midst, for all time, an institution which will help every physician who practises in Ontario, and will be an ever-present monument of the advancement, progress and efficiency of medical thought in the Dominion of Canada.

THE AMERICAN INTERNATIONAL CONGRESS ON TUBERCULOSIS.

We have received a letter from Dr. Clark Bell, the Secretary of the Council of the American International Congress on Tuberculosis, in which he says that the assertion made in our November issue on the statement of Professor Adami, "that no physician of repute in the United States has signified his

participation in the American International Tuberculosis Congress," will place the CANADIAN PRACTITIONER and its editors in an unenviable position. He considers that the article contains a gratitnous and uncalled for assault upon all the medical gentlemen from Canada, who, under the leadership of Dr. Barrick, of Toronto, made such a splendid success of the St. Louis meeting of 1904. He says that a very large number of medical men of the highest repute and standing in the United States are on the list of officers.

Dr. Bell also states that since 1903 the name of Professor Adami has not been published as in any manner connected with the American International Tuberculosis Congress. Dr. Bell also correctly states that the senior editor of this journal accepted the Secretaryship of the Committee of Organization from the St. Louis management at the request of Dr. Barrick.

PUBIOTOMY OR HEBOTOMY.

We are publishing in this issue an interesting report of a case in which the operation of pubiotomy was performed on a patient because of contracted pelvis by Dr. D. J. Evans, read at the Montreal Chirurgical Society. We also add the apt comments on the paper made by Dr. J. Chalmers Cameron.

The rise and fall of the operation known as symphyseotomy is a bit of interesting medical history which is well known to most of our readers. The operation is really an old one, but was reintroduced into France by Pinard in 1881. For a few years it was performed frequently in certain parts of America and Europe. Its popularity, however, was very short lived, and it has now become practically obsolete. Section of the pubic bone near the pubic spine was proposed by Gigli as a substitute for symphyseotomy in 1894. His object was to prevent injuries to the bladder, the bony pelvis, and septic infection. The indications for this new operation, which is at best limited as to scope, are similar to those for symphyseotomy, and are well explained by Dr. Cameron. It is well in this connection to consider the comparatively recent report of Tissier, of Paris,

who gave notes of the after histories of twenty women who had been delivered by symphyseotomy for six years ending in 1903. The patients were operated on at seven different hospitals, and four only out of twenty escaped without some undesirable sequelæ, the remaining sixteen being more or less damaged by the operation. One patient has been a chronic invalid for five years, eight suffered from phlebitis, ten had urinary trouble during months or years, and a number had difficulty in lifting and going up stairs.

That the new operation, pubiotomy, will become popular is doubted by many surgeons. The results of conservative Cesarean section are so remarkably good in the hands of even moderately skilled surgeons that it has become very popular. While it may be generally admitted that Cesarean section, either abdominal or vaginal, is the best suited for a large majority of cases of obstructed labor, whether caused by pelvic contractions or tumors, it may be that the operation of pubiotomy will be considered the best in a limited proportion of cases.

THE HISTORY OF ART IN THE UNIVERSITY OF TORONTO.

We are told by the *University of Toronto Monthly* that the University authorities made a grant last year for the purchase of the first instalment of a collection of art reproductions to be hung in the University buildings and to be used as part of the equipment for teaching the history of art. This grant has been renewed for the current year, and it is hoped it will be continued for many years to come.

The reproductions acquired this year comprise a number of examples of Grecian architecture and sculpture, such as those of the Parthenon, of the Temple of Poseidon at Pæstum, of the Venus of Milo, of the Laocoon, etc. There are a few examples of Roman art, such as the Pantheon and the Arch of Constantine. There is also an Italian collection of paintings numbering about one hundred. There are also in addition collections from the German, Netherlandish and French schools.

NOTES.

Prof. Osler's Visit.

As announced in our last issue, Prof. Wm. Osler visited Toronto to attend the celebration of his mother's 100th birthday, December 14th.

Dr. and Mrs. R. A. Reeve were "At Home" on the evening of December 15th, when a large number of the physicians of Toronto were invited to meet Dr. Osler. One of the interesting incidents of the evening was the meeting of two of Lord Lister's ex-house surgeons, Dr. John Stewart, of Halifax, and Dr. Fred. Grasett, of Toronto.

This calls to the writer's mind an occurrence at the British Medical Association banquet in Montreal in 1897. During the progress of the dinner an address was presented from the Dalhousie University, of Halifax, in which the faculty congratulated Lord Lister on his elevation to the peerage, and assured him of the high regard in which he was held by the medical profession, not only in Halifax, but throughout all Canada. Lord Lister, in replying, said he found it impossible to express his feelings at this additional token of regard from the medical profession. He confessed to being absolutely astounded at the repeated kindnesses shown him by his Canadian friends. He found on the address the name of one of his late house surgeons, Dr. John Stewart, of Halifax, and referred to him "as a man whom I not only admire, but may truly say reverence." While thus speaking, His Lordship was so much affected that words ceased to come readily, and speech soon failed entirely. (Dr. Stewart had expected to meet Lord Lister in Montreal, but had been prevented on account of the very severe illness of his brother.)

Dr. Osler was a very busy man during his visit to Toronto. It was singularly appropriate and very fortunate that he, one of Dr. Graham's oldest friends and a great physician, was here to unveil the portrait of one of Canada's greatest physicians. Dr. Osler left Toronto for Baltimore, December 19th, and expected to sail from New York, January 4th.

New Hospital at Goderich.

The new hospital, which will be called the Alexandra General Hospital, was formally opened in Goderich, December 1st. During the ceremonies the institution was handed over to the Board of Trustees by the Daughters of the Empire. The Daughters of the Empire are doing very useful work in many parts of Canada. The local chapter of this organization have been working in Goderich and vicinity for many years, and the new hospital is the result of their charitable endeavors. The institution was opened December 1st, in honor of the birthday of Her Majesty, Queen Alexandra.

Post-Graduate Society of Toronto.

The Post-Graduate Medical Society of Toronto, at its annual meeting, held in the General Hospital on the evening of December 5th, elected the following officers: Honorary President, Dr. J. N. E. Brown; President, Dr. K. W. Van Norman; First Vice-President, Dr. W. Gilbay; Second Vice-President, Dr. W. E. Brown; Sec.-Treas., Dr. A. H. Rolph.

Canadian Medical Association.

At the last meeting of the Canadian Medical Association, held in Toronto, August 21st, it was decided to hold the next annual meeting at Montreal. We learn from the *Montreal Medical Journal* that the members of the medical profession in Montreal met November 8th to make preliminary arrangements for the meeting of 1907. The President, Dr. A. McPhedran, Toronto, was in attendance and acted as chairman.

Dr. McPhedran delivered a short address, in which he outlined certain plans and methods which he recommended for adoption, and suggested that the meeting should be held early in the summer, that is, in the month of June, or later, say the latter part of August, or some time in September.

At the conclusion of his address the following committee was elected to carry out arrangements: Drs. Shepherd, Blackader, Lachapelle, England, Gardner, Roddick, Armstrong, Hamilton, Shirres, St. Jacques, Harwood, De Martigny, Garrow, Reddy, Boulet, Monod, Mercier, Villeneauve, Aubrey, Birkett, MacKenzie, and Sir Wm. Hingston.

Dr. Horatio C. Wood Made Professor Emeritus After Resigning.

Dr. Horatio C. Wood, for many years professor of therapeutics at the University of Pennsylvania, tendered his resignation to the Board of Trustees a few weeks ago. Continued ill health has made it impossible for him to take active charge of his work at the University. In accepting Dr. Wood's resignation, the trustees made him an emeritus professor of the subject he formerly taught.

Medical Directory.

Messrs. Theo. E. Gibson & Co., have taken charge of this publication, and advise us that the 1907 edition is now in press. This painstaking firm may be relied upon to produce a thoroughly reliable book.

Dr. L. S. McMurtry, of Louisville, Ky., read a paper on "Tuberculosis of the Peritoneum" before the Cleveland Academy of Medicine, November 16th. We are told by the *Buffalo Medical Journal* that the medical profession of Cleveland occupies a handsome building equipped with a voluminous library, reading rooms, auditorium and other conveniences, which makes the Buffalo medical accommodations by comparison look poor indeed.

At a meeting of the Board of Trustees of the Toronto General Hospital, held December 5th, the firm of Messrs. Darling & Pearson was chosen as architects of the proposed new hospital building.

Obituary.

DR. WALTER D. CLEMENT.

Dr. Clement died at his home, 62 Tranby Avenue, Toronto, on December 11th, aged 76. He began practice in Innerkip, County of Oxford, 52 years ago, and continued there until 1893, when he removed to Woodstock. After practising in that town ten years he came to Toronto in 1903.

Personals.

Dr. John A. Oille is practicing at Bing Inlet.

Dr. P. J. McCue (Tor. '04) is practicing at Crediton.

Dr. A. E. Stewart (Tor. '04) is practicing at McGregor.

Dr. A. R. Curtis (Tor. '05) is practicing at Grand Forks, N.D.

Dr. W. T. Hamilton (Tor. '01), is practicing at High River, Alta.

Dr. G. F. R. Richardson (Tor. '03) is practising at Burke's Falls.

Dr. J. L. Turnbull, formerly of Goderich, is now practicing in Listowel.

Dr. A. Primrose, of Toronto, went to Halifax for a short visit, December 26th.

Dr. J. D. Monteith, of Stratford, has gone to Europe for post-graduate work.

Dr. Lambert G. Stewart, a graduate of the University of Toronto, 1904, died October 21st.

Dr. W. B. Hendry, of Toronto, has been elected President of the University Lawn Tennis Club.

Dr. A. J. MacKenzie, of Toronto, is the First Vice-President of the Toronto Canadian Club.

Dr. Chas. O'Reilly, of Toronto, went to Montreal, December 10th, and remained there about ten days.

Dr. L. F. Millar, of Rosedale, Toronto, and family have gone to Southern California for the winter.

Dr. Cameron Wilson, of Norwood, Ont., was married to Miss Smith, of Oshawa, November 27th.

Dr. Louis G. McKibbon, of Spadina Avenue, returned from Great Britain, December 1st, to Toronto.

Dr. John Stewart, of Halifax, visited Toronto, December 12th, and was the guest of Dr. Primrose for about a week.

Mrs. Potter, wife of Dr. Wm. Williams Potter, of Buffalo, died November 28th, aged 68. The immediate cause of death was cerebral apoplexy.

Mr. J. R. R. Williams, son of Dr. Richard Watson Williams, of Allenford, Ont., died at the Lakeside Hospital, Cleveland, Ohio, December 12th.

Dr. Geo. H. Carlisle (Tor. '05), of Esterhazy, Sask., was married to Miss C. Thompson, of Cobourg, November 15th.

Dr. B. A. Cohoe (Tor. '01), formerly of Cornell University, is now on the staff of the Johns Hopkins University, Baltimore.

Dr. Hillier, of Bowmanville, has been elected Honorary President of the Conservative Association of the County of Durham.

Dr. Fred. Grasett, of Toronto, was elected by acclamation as representative of the Graduates in Medicine in the Trinity College Council.

Dr. Neil Macphater, President of the New York Canadian Club, visited Toronto during the last week of November, and attended the Dinner of the Toronto Canadian Club, November 28th.

Dr. F. H. Scott (Tor. '04), who has been engaged in post-graduate work in Europe for some time, has been awarded one of the two Royal Society research studentships at the University of London.

Dr. Geoffrey S. Beck, of Port Arthur, visited Toronto in the latter part of November. His many friends will be pleased to know that his health, which was in a precarious condition for some time, is now excellent.

At a meeting of the Hamilton Medical Association, held December 6th, the following officers were appointed for the coming year: President, Dr. Ingersoll Olmsted; Vice-President, Dr. D. G. Storms; Cor.-Secretary, Dr. Davey; Rec.-Sec., Dr. L. R. Hess; Treas., Dr. W. J. McNichol.

The physicians of the counties of Carleton, Lanark and Renfrew have formed a society called the Ottawa Valley Medical Association. At the first meeting, which was held in Arnprior, the following officers were elected: President, Dr. Preston; Vice-President, Dr. Lynch; Treasurer, Dr. Kelly; Secretary, Dr. McIntosh.

Prof. John W. Byers, Professor of Midwifery, Queen's College, Belfast, has been honored with a knighthood. We are told by the *British Medical Journal* that this is a matter of congratulation, not only to Sir John Byers, as he now is, and his friends, but also to the public. It is all the more satisfactory because it is not a "terminal symptom," as the recipient is in the prime of life, and has many years of useful work before him.

Book Reviews.

A Text-Book of Obstetrics. By Barton Cooke Hirst, M.D., Professor of Obstetrics in the University of Pennsylvania. Fifth revised edition. Octavo of 915 pages, with 753 illustrations, 39 of them in colors. Philadelphia and London: W. B. Saunders Company. 1906. Cloth, $5.00 net; half morocco, $6.00 net. Canadian agents: J. A. Carveth & Co., Toronto.

Hirst's "Text-Book of Obstetrics" is one of the best available among the many good books published in the United States in recent years. The author has been for many years one of America's best teachers and writers on the important subject of obstetrics. The book is well adapted for the wants of both student and practitioner.

Obstetrics for Nurses. By Joseph B. DeLee, M.D., Professor of Obstetrics in the North-western University Medical School, Chicago. Second revised edition. 12mo of 510 pages, fully illustrated. Philadelphia and London: W. B. Saunders Company. 1906. Cloth, $2.50 net. Canadian agents: J. A. Carveth & Co., Toronto.

This book was published originally for nurses, but it is valuable also for medical students and young practitioners. It is one of the best manuals for nurses that we have seen. The style is good, the matter is interesting, and the illustrations are excellent.

The American Illustrated Dictionary. All the terms used in Medicine, Surgery, Dentistry, Pharmacy, Chemistry and kindred branches. By W. A. Newman Dorland, M.D. Fourth revised edition. Octavo of 836 pages, with 293 illustrations, 119 of them in colors. Philadelphia and London: W. B. Saunders Company. 1906. Flexible morocco, $4.50 net; thumb indexed, $5.00 net. Canadian agents: J. A. Carveth & Co., Toronto.

This admirable work has achieved wonderful success, as shown by the necessity of publishing a fourth edition in a comparatively short time after the issue of the first edition. We find in this volume over 2,000 new words, over 100 new tables, and many additions to the pictorial features by the insertion of new plates, etc. The book is attractive in appearance, convenient in size, and altogether excellent in every way.

THE OPERATIVE TREATMENT OF PROLAPSE AND RETROVERSION OF THE UTERUS. By J. Inglis Parsons, M.D., M.R.C.P., M.R.C.S., Physician to the Chelsea Hospital for Women. London: John Bale, Sons & Danielson, Ltd., medical publishers, 83-91 Great Titchfield, Oxford St. W. 1906. Price, 3s. 6d. net.

This is an excellent little book prepared by the author after twenty years' work on the staff of the Chelsea Hospital for Women. The author describes only those methods and procedures which have been found in his experience to produce the best results. The description of the general causes of prolapse and retroversion will be found very interesting. The author also describes the operations, ventrosuspension, Alexander's operation, intraperitoneal shortening of the round ligaments, and at the same time discusses their relative values.

SURGERY: ITS PRINCIPLES AND PRACTICE. In five volumes. By 66 eminent surgeons. Edited by W. W. Keen, M.D., LL.D., Hon. F.R.C.S., Eng. and Edin., Professor of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College, Phila. Vol. I. Octavo of 983 pages, with 261 text-illustrations and 17 colored plates. Philadelphia and London: W. B. Saunders Company. 1906. Per volume: Cloth, $7.00 net; half morocco, $8.00 net. Canadian agents: J. A. Carveth & Co., Toronto.

We have received what promises to be a magnificent work on the science and art of surgery, edited by Wm. William Keen, M.D., LL.D., the well-known Professor of Surgery in Jefferson Medical College, Philadelphia.

There is probably no man in the United States better qualified to act as editor of an encyclopedia of surgery than Dr. Keen, of Philadelphia. The editor has associated with him 66 contributors, all of whom are well known to the surgical world. The contributors to Vol. I. are: Dr. Adami, of Montreal; Mr. Bland Sutton, of London, England; Dr. Crile. of Cleveland; Drs. De Costa, sen. and jun., of Philadelphia; Dr. Frazier, of Philadelphia; Dr. Freeman, of Denver City; Dr. Hektoen, of Chicago; Dr. Martin, of Philadelphia; Dr. Mumford, of Harvard Medical School; Dr. Nichols, of Harvard Medical School; Dr. Eugene Smith, of Buffalo, and Dr. Francis Carter Wood, of New York.

The first chapter contains an exceedingly interesting historical sketch of surgery from the time of Hippocrates, 470 B.C., down to the time of our great and honored Lister.

Among the other many valuable chapters the following are considered especially well worthy of note: Infection and Immunity, Inflammation, Gangrene, Process of Repair, Special Infections, Traumatic Fevers and Tumors.

The work altogether will comprise five volumes and over 4,000 pages. The other four volumes will follow as rapidly as they can be printed.

So far as we can judge from the first volume the editor has done admirable work, and has apparently accomplished the difficult act of preventing overlapping and repetitions. This volume is published in Saunders' best style.

It seems to us that this is a work that should be read by surgeons, physicians and general practitioners.

The Technic of Operations Upon the Intestines and Stomach. By Alfred H. Gould, M.D., of Boston, Massachusetts. Octavo volume, containing 190 beautiful original illustrations, some of them in colors. Philadelphia and London: W. B. Saunders Company. 1906. Cloth, $5.00 net; half morocco, $6.00 net. Canadian agents: J. A .Carevth & Co.

The author in this book has presented to the profession a valuable work on gastro-intestinal surgery. In the first chapter he gives an account of the repair of intestinal wounds, his conclusions being based on the results obtained by experiments on animals. He then takes up suture material, needles used, the different methods of tying knots, the special technic of sutures and gastric and intestinal clamps. Following an account of the anatomy of the intestines he describes very clearly the different operations upon the stomach and intestines. The text is concise and the book is well illustrated by practical illustrations made from operations done either upon animals or the human being.

Atlas and Text-Book of Human Anatomy.—Volume I. By Professor J. Sobotta, of Wurzburg. Edited, with additions, by J. Playfair McMurrich, A.M., Ph.D., Professor of Anatomy at the University of Michigan, Ann Arbor. Quarto volume of 258 pages, containing 320 illustrations, mostly all in colors. Philadelphia and London: W. B. Saunders Company, 1906. Cloth, $6.00 net; half morocco, $7.00 net.

The above is the most recent addition to the series of anatomical atlases. It is a manual more especially adapted to the

student, as an aid to his dissecting, and to the practitioner who wishes to review his subject in a not too comprehensive manner, and who is debarred by his practice from actual dissections.

One must not confound this volume with the familiar "Quiz-compends." The descriptions throughout are thorough, without being exhaustive, clear and eminently practical. It is said to be the first atlas in which multicolor lithography has been employed. The illustrations are without doubt most comprehensive. None have been omitted which could elucidate more readily the parts under discussion. They are, with a few exceptions, direct reproductions from original photographs, the colors are unusually true to nature, and the pearly tints of the fascial are especially beautiful.

In this the first volume of the series the bones, joints and their ligaments and the muscular system are in turn considered. A series of plates are also given, showing the arbitrary regions into which the body is divided for purposes of description.

Abdominal Operations. By B. G. A. Moynihan, M.S. (London), F.R.C.S., Senior Assistant Surgeon at Leeds General Infirmary, England. Second Revised Edition, greatly Enlarged. Octavo of 815 pages, with 305 original illustrations. Philadelphia and London: W. B. Saunders Company, 1906. Cloth, $7.00 net; Half Morocco, $7.00 net. J. A. Carveth & Co., Toronto, Canadian agents.

The second edition of this admirable work has just been published, with a large number of additions to the text, and many new illustrations. Besides the revising, two of the chapters have been entirely rewritten.

No Gynæcological operations have been described, but only those intraperitoneal operations which are common to both sexes, with the surgery of the kidney and bladder, which is partly intraperitoneal and partly extraperitoneal. The work is divided into five sections. The first deals with the general considerations of abdominal surgery; the second, operations upon the stomach; the third, operations upon the intestines; the fourth, operations upon the liver; and the fifth, operations upon the pancreas and spleen.

The book is well written and well illustrated, giving, in a complete, clear and concise way the technic of abdominal operations.

The work is one that the surgeon should read, and one which we heartily recommend.

PULMONARY PHTHISIS. Its Diagnosis, Prognosis and Treatment. By H. Hyslop Thomson, M.D., Visiting Physician to the Consumptive Sanatoriums of Scotland, Bridge of Weir, N.B.; formerly Medical Superintendent. London: John Bale, Sons & Danielson, Ltd., Oxford House, 83-91 Great Titchfield Street, Oxford Street W. 1906.

The above monograph is an excellent short and concise account of pulmonary phthisis, comprised in a volume of about two hundred pages, freely illustrated with specimen fever charts.

The first three sections into which it is divided take up the diagnosis, prognosis and treatment, the fourth, tuberculosis in childhood. The appendix consists of circulars issued by the Local Government Board of Scotland, and which contain much valuable information.

Special stress has been laid on prognosis and interpretation of the various local physical signs, and in the chapter on treatment the more recent methods employed are fully discussed, and reference is made to the advances made since Wright's opsonic theory has been introduced; the various tuberculins also receive attention.

The book throughout is essentially practical, as well as being most interesting reading.

Ignorance and superstition have always barked, like ill-conditioned curs, at the heels of advancing science, and they always will, "for 'tis their nature to." In the Dark Ages the scientific experimenter was looked upon as seeking knowledge from the powers of evil, and was lucky if he escaped being burnt. In modern days chloroform was denounced from the pulpit as "a decoy of Satan," which would "rob God of the deep earnest cries which arise in time of trouble for help." The abuse showered on Pasteur is believed to have helped to produce the disease of which he died. It might have been thought that so obviously beneficent an invention as spectacles would have escaped the anathemas of folly, yet these aids to vision were denounced as though they were inventions of the Devil. The story is told in Professor Gotch's contributions to the "Lectures on the Method of Science," recently issued from the Clarendon Press, and is so interesting in itself, and so illustrative of the nonsense which a man of education can utter under the inspiration of an antiscientific bias, that we make no excuse for quoting it:

"Tracts were written fulminating against the Royal Society

(formed in 1661), which was rightly regarded as the headquarters of the New Philosophy; attacks and rejoinders were as thick as leaves in June. Sprat found it desirable to write a history of the foundation and work of the Society in order to demonstrate that it did not exist for the purpose of upsetting Church and State, but that when fully understood the New Philosophy will be found to be a bulwark of Christianity, not its destroyer. In an article upon the Royal Society, included in the 'Quarrels of Authors,' the elder Disraeli gives an interesting account of this literary controversy. From this it appears that the zeal of the opponents often outran their discretion, for not only the aims, but many of the obvious practical results of scientific inquiry, were inveighed against. Crosse, the Vicar of Chew Magna in Somersetshire, anathematized the Royal Society as a Jesuitical conspiracy against both society and religion; he regarded the use of the newly-invented optick glasses as immoral, since they perverted the natural sight and made all things appear in an unnatural, and therefore false, light. It was easy, he said, to prove the deceitful and pernicious character of spectacles; for take two different pairs of spectacle glasses and use them both at the same time, you will not see so well as with one singly; therefore your microscopes and telescopes, which have more than one glass, are imposters. *Hostility went further than this; it was declared to be sinful* to assist the eyes, which were adapted to the capacity of the individual, whether good, bad, or indifferent. It was argued that society at large would become demoralized by the use of spectacles; they would give one man an unfair advantage over his fellow, and every man an unfair advantage over every woman, who could not be expected, on esthetic and intellectual grounds, to adopt the practice."—*B. M. J.* (Book Notices.)

Apropos of the wide use of effervescent beverages, it is admitted that carbonic acid gas in mineral waters greatly improves digestion, and that this is especially so in the case of Apollinaris, because its mineral constituents give additional help in that direction, so that Apollinaris is by far the best of the few naturally effervescent waters for mixing with whiskey, wine, fruit syrups or milk. The consumption of effervescent liquids is especially large in Great Britain and the United States.

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