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## INDEX TO VOLUME X.

<b>Book Reviews.</b>	<b>PAGE</b>	<b>PAGE</b>	<b>PAGE</b>
A Compend of Human Physiology. By Albert P. Brubaker, A.M., M.D. ....	81	Atlas and Epitome of Obstetric Diagnosis and Treatment. By Dr. O. Shaeffer ..	229
A Hand-Book of Pathological Anatomy and Histology. By Francis Delafield, M.D., LL.D. ....	382	Atlas and Epitome of Ophthalmoscopy and Ophthalmoscopic Diagnosis. By Prof. Dr. O. Haab. ....	159
A Laboratory Course in Bacteriology. By Frederick P. Gorham, A.M. ....	466	Atlas and Epitome of Special Pathological Histology. By Docent Dr. Hermann Durck. ....	468
A Manual of Diseases of the Nose and Throat. By Cornelius Coakley, A.M., M.D. ....	472	Atlas and Epitome of the Nervous System and its Diseases. By Professor Dr. Chr. Jakob. ....	386
A Manual of Surgical Treatment. By W. Watson Cheyne, C.B., M.B., F.R.C.S., F.R.S. ....	385	A Treatise on Orthopedic Surgery. By Royal Whitman, M.D. ....	306
A Manual of the Practice of Medicine. By George Roe Lockwood, M.D. ....	470	A Treatise on Surgery by American Authors. Edited by Roswell Park, M.D. ....	456
Anatomy, Descriptive and Surgical. By Henry Gray, F.R.S. ....	464	Captain Ravenshaw. ....	469
Annual Report for the Year 1900. E. Merck, Darmstadt, Germany. ....	81	Circumstance. By S. Weir Mitchell, M.D. ....	472
A Practical Treatise on Diseases of the Skin. By John V. Shoemaker, M.D., LL.D. ....	457	Clinical Pathology of the Blood. By James Ewing, A.M., M.D. ....	77
A Reference Hand-Book of the Medical Sciences. Edited by Albert H. Buck, M.D. ....	70	Cliniques Medicales Iconographiques. Par M.M. P. Haushalter, G. Etienne, L. Spillman, Ch. Thiry. ....	223
A Reference Hand-Book of the Medical Sciences. Edited by Albert H. Buck, M.D. ....	458	Diseases of the Intestines. By Dr. I. Boas. ....	381
A Syllabus of New Remedies and Therapeutic Measures. By J. W. Wainwright, M.D. ....	157	Diseases of the Nose and Throat. By D. Braden Kyle, M.D. ....	284
A System of Physiologic Therapeutics. Edited by Solomon Solis Cohen, A.M., M.D. ....	73, 150	Doom Castle: A Romance. By Neil Munro D'Bi and I. By Irving Bacheller. ....	231 471
A Text-Book of Diseases of Women. By Charles B. Penrose, Ph.D. ....	465	Dose-Book and Manual of Prescription-Writing. By E. Q. Thornton, M.D. ....	467
A Text-Book of Pharmacology. By Torald Sollmann, M.D. ....	458	Elements of Practical Medicine. By Alfred H. Carter, M.D., M.Sc. ....	472
A Text-Book of the Practice of Medicine. By Dr. Herman Eichhorst. ....	75	Encyclopedia Medica. Edited by Chalmers Watson, M.B., M.R.C.P.E. ....	77, 386
A Text-Book of the Practice of Medicine. By James M. Anders, M.D., Ph.D., LL.D. ....	388	Essentials of Refraction and of Diseases of the Eye. By Edward Jackson, A.M., M.D. ....	250
A Text-Book on Obstetrics. By Barton Cooke Hirst, M.D. ....	408	Essentials of the Diseases of Children. By William M. Powell, M.D. ....	82
Atlas and Epitome of Bacteriology. By Professor Dr. K. B. Lehmann. ....	461	Etidorhpa, or the End of Earth. By John Uri Lloyd. ....	230
Atlas and Epitome of Labor and Operative Obstetrics. By Dr. O. Shaeffer. ....	81	Favorite Prescriptions of Distinguished Practitioners. Edited by D. W. Palmer, A.M., M.D. ....	80
		Golden Rules of Aural and Nasal Practice. By P. R. W. de Santi, F.R.C.S. ....	160
		Golden Rules of Hygiene. By F. J. Waldo, M.A., M.D. (Cantab.), D.P.H. ....	229
		Human Physiology. By Joseph Howard Raymond, A.M., M.D. ....	462

# INDEX TO VOLUME X.

iii

	PAGE		PAGE
International Clinics. Edited by Henry W. Cattell, M.D., Philadelphia .....	224, 400	The Diseases of the Respiratory Organs, Acute and Chronic. By William F. Waugh, A.M., M.D. ....	384
La Cure Pratique de la Tuberculosis. Par Dr. P. Pujade .....	388	The Helmet of Navarre. By Bertha Runkle .....	75
Materia Medica, Pharmacy, Pharmacology and Therapeutics. By W. Hale White, M.D., F.R.C.P. ....	469	The Hygiene of Transmissible Diseases: their Causation, Modes of Dissemination and Methods of Prevention. By A. C. Abbott, M.D. ....	228
Matière Médicale Zoologique. Histoire des Drogues d'Origine Animale. Par H. Beaugregard .....	310	The Making of a Marchioness. By Frances Hodgson Burnett .....	388
Mistress Nell. By George C. Hazelton, Jun. ....	82	The Observations of Henry. By Jerome K. Jerome .....	230
Modern Obstetrics: General and Operative. By W. A. Newman Dorland, A.M., M.D. ....	459	The Pathology and Treatment of Sexual Impotence. By Victor G. Veeki, M.D. ....	471
Murray: Thyroid Gland .....	405	The Physician's Visiting List .....	471
Nervous and Mental Diseases. By Archibald Church, M.D. ....	383	The Practical Household Physician. By Henry Hartshorne .....	78
Nothnagel's Encyclopedia of Practical Medicine. Edited by Alfred Stengel, M.D. ....	455	The Practice of Obstetrics. Edited by Chas. Jewett, M.D. ....	462
Operative Surgery. By Joseph D. Bryant. Pathologie Générale et Experimentale les Processus Gendraux. Par MM. A. Chantemesse et W. W. Podwysotsky. ....	311	The Principles and Practice of Medicine. By William Osler, M.D. ....	378
Practical Dietetics: Food Value of Meat. By W. R. C. Latsón, M.D. ....	467	The Principles of Hygiene. By D. H. Bergey, A.M., M.D. ....	464
Principles of Surgery. By N. Senn, Ph.D., LL.D. ....	76	The Ready Reference Hand-Book of Diseases of the Skin. By Geo. Tnos. Jackman, M.D. ....	470
Progressive Medicine. Edited by Hobart Amory Hare, M.D., assisted by H. R. M. Landis, M.D. ....	154, 350	Topographic Atlas of Medico-Surgical Diagnosis. By Dr. E. Ponfick .....	74
Practical Surgery. By Nicholas Senn, M.D., Ph.D., LL.D. ....	222	Uterine Fibromyomata: Their Pathology, Diagnosis and Treatment. By E. Stanmore Bishop, F.R.C.S. (Eng.) .....	158
Pro Patria. By Max Pemberton .....	227	<b>Correspondence.</b>	
Purulent Nasal Discharges, their Diagnosis and Treatment. By Herbert Tiley, M.D., B.S. (Lond.), F.R.C.S. (Eng.) .....	228	New Ideas in Medicine .....	72
Queen Victoria: Her Life and Reign. By J. Castell Hopkins .....	80	Pure Milk .....	67
Sajous' Annual and Analytical Cyclopedia of Practical Medicine .....	158	Upon Professor Koch and Matters of Priority .....	373
Sexual Hygiene. By the editorial staff of The Alkaloidal Clinic .....	228	<b>Editorials.</b>	
Surgical Technic. By Fr. Von Esuarch, M.D. ....	379	An "Absent" Treatment for Christian Scientists .....	447
Text-Book of Bacteriology. By George M. Sternberg, M.D., LL.D. ....	463	A Plea for Union between Canadian Physicians .....	56
Text-Book of Nervous Diseases. By Chas. L. Dana, A.M., M.D. ....	406	Are Bovine and Human Tuberculoscs Identical? .....	293
Text-Book of Physiology Edited by E. A. Shafer, LL.D., F.R.S. ....	154	A Warm Weather Diet .....	145
The Acute Contagious Diseases of Childhood. By Marcus P. Hatfield, A.M., M.D. ....	79	Canadian Medical Association .....	59
The American Illustrated Medical Dictionary. By W. A. Newman Dorland, A.M., M.D. ....	312	"Consistencie's a Jewell" .....	449
The Canadian Year Book for 1901 .....	231	Did Dr. Adami Forestall Koch's Latest Discovery? .....	357
The Crisis. By Winston Churchill .....	160	Editorial Notes .....	60, 158, 217, 391, 365, 460
The Diagnostics of Internal Medicine. By Glentworth Reeve Butler, A.M., M.D. ....	387	Ethics Among Coroners—A Threatened Monopoly in Inquests .....	58
		Expert Medical Evidence in Courts of Law. Is a Druggist Justified in Diverting a Sale of a Proprietary Medicine? .....	361
		Language is Only the Instrument of Science. Liquid Aliments in Disease .....	214
		On the Pathology of Cancer Lesions .....	442
		Oxaluria .....	298
		Personals .....	65, 221, 305, 370
		Poisoning by Canned Salmon .....	439

2637

	PAGE		PAGE
Poisoning by Strychnine.....	53	The Early Recognition and Treatment of	
President McKinley's Death.....	300	Pulmonary Tuberculosis. By Alexan-	
Prompt Detection of the Cause of Typhoid		der McPhedran, M.B., Toronto.....	90
Fever in Potable Water.....	143	The Old Ship's Medicine Chest. By Ezra	
The Etiology of Noma.....	216	Hurlburt Stafford, M.D.....	190
The Indian Medicine Man.....	303	The Outdoor Treatment of Sick People. By	
The Winnipeg Meeting of the Canadian		Geo. H. Carveth, M.D.....	193
Medical Association.....	147, 296	"The Passing of the Surgeon" in Toronto.	
		By F. N. G. Starr, M.B. (Tor.), Toronto	313
		The Recent Christian Science Trial. By Jas.	
		H. Richardson, M.D., M.R.C.S. (Eng.),	
		Toronto.....	403
		The Relation of Nasal Obstruction to Ob-	
		scure Cases of Asthma. By Arthur W.	
		Maybury, M.D., Toronto.....	196
		The Sanatorium Treatment of Tuberculosis.	
		By Arthur J. Richer, M.D., Montreal.	266
		<b>Pharmacology and Therapeutics.</b>	
		Cocaine Muriate in Whooping Cough.....	119
		Indolent Varicose Ulcer of the Leg.....	116
		Sleeplessness in Heart Disease and Its	
		Treatment.....	201
		The Treatment of Gonorrhœa with Ichthar-	
		gan.....	118
		<b>Proceedings of Societies.</b>	
		Annual Meeting of the College of Phy-	
		sicians and Surgeons of Ontario.....	42
		Canadian Medical Association.....	274
		Exhibits of Drugs, Surgical Appliances, etc.	39
		Maritime Medical Association.....	209
		Meeting of the Executive Health Officers of	
		Ontario.....	45
		Ontario Medical Association.....	18
		<b>Public Health and Hygiene.</b>	
		Report on Tuberculosis by the Committee	
		on Contagious Diseases of the Provincial	
		Board of Health of Ontario.....	416
		<b>Selected Articles.</b>	
		Alkaloidal Medication.....	429
		Chronic Gastritis—Report of a Case.....	434
		First Aid to the Prostrated.....	204
		Linen Underwear.....	120
		Medicine as a Profession.....	200
		Peroxide of Hydrogen, Materia Medica and	
		Therapeutics.....	52
		Prof. Schweitzer profoundly Impressed with	
		Parke, Davis & Co.'s Plant.....	438
		Quaint Remedies and Ideas.....	207
		Skin Grafting.....	51
		Stypticin.....	422
		Summer Diarrheas in Children.....	47
		Tannaform as a Preventive of Hyperidrosis	
		and Sore Feet.....	50
		The American Pediatric Society.....	120
		The Treatment of Some Cases Frequently	
		Met with in Medical Practice. By C.	
		W. Canan, M.D., H.S., Ph.D., Orkney	
		Springs, Va.....	352
		Toronto Orthopedic Hospital.....	430
		Treatment of Bright's Disease.....	432

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## *Original Contributions.*

### ON THE USE OF NITROUS OXIDE AND ETHER AS AN ANESTHETIC.

BY L. COYTEUX PRÉVOST, M.D.

Gynecologist to St. Luke's Hospital, Ottawa.

I CONSIDER bad all anesthetization which kills the patient and, in the meantime, destroys at a stroke the reputation of a surgeon. Am I conciliating enough? Is this proposition satisfactory to all? I am sure it is.

Now that I possess the intimate conviction of having, at last, my opinion shared by everybody, I shall humbly venture to add that we are justified in calling anesthetization defective also, when the poor patient finally loses consciousness only after fifteen or twenty minutes of anguish and struggle against the threat of imminent smothering, or when sensibility suddenly returns, accompanied with disorderly movements at the first contact of the knife. Detestable again the anesthesia, when the surgeon operates, a prey to the most uncomfortable anxiety, with his eyes riveted as often upon the undecided manœuvres of the anesthetist as upon the field of operation; that he is, at every moment, compelled to discontinue his work, waiting with folded arms until the patient, half awake, is again put to sleep.

At last, unsatisfactory again is anesthesia, when the after-effects of the operation have acquired an exceptional character of gravity by the fact of an objectionable anesthetic, or owing to the imperfect manner in which it has been administered.

Therefore, I could not help being overpowered by the greatest stupefaction when lately, at a meeting of a medical association, I heard an honorable confrere making without a frown the following declaration:

"The practice of anesthesia is the easiest and the simplest thing in the world.

"Anybody whoever can properly administer an anesthetic, and it is not necessary to possess so much intelligence and experience to do it.

"I have yet, personally, never seen anybody die from anesthesia.

"It is ridiculous to pretend that special education is required to be a good anesthetist. One should, then, as well exact similar qualifications to treat a case of pneumonia, a meningitis or typhoid fever."

Tell me, gentlemen, do you not think life a little too short to stop and answer those pseudo-arguments?

After all, everybody is the master of his own opinion, and has the right to suit his taste.

As far as I am concerned, I contend that the practice of anesthesia is an extremely important operation, and anybody who undertakes it is laboring under an immense responsibility. It is in the hands of the anesthetist that the patient confides his life, and on his ability as much as the surgeon's rests the immediate or ultimate success of the surgical operation.

To treat this subject inconsiderately, as it is done in some places, is, to my mind, nothing less than criminal. Almost every day, medical reviews contain the relation of fatal accidents occurring during anesthesia, and what if they related the innumerable "starts" after which hazard and good luck, as much as the skillfulness of the attendants permitted to resuscitate individuals who had the narrowest escape with their life. And then, what anxiety, what appalling fright! An inexperienced anesthetist had undertaken the administration of an anesthetic agent upon whose properties he has but the most superficial knowledge. Little conversant with the warnings which the character of the pulse, the respiration, the condition of the pupil, generally give to the educated anesthetist; possessing insufficient experience to constantly remain sheltered against the surprises of an accident, he continues his operation without the least apprehension, automatically as it were, when, all of a sudden, the patient ceases to breathe. The face becomes livid, the tissues flabby, inelastic; the pulse is imperceptible. Quick, hurry, artificial respiration; the patient is going to die, if he has not already breathed his last.

Everybody then hustles about. The surgeon himself—for, after all, he is the general commanding the action, and therefore

entrusted with the greatest responsibility—the surgeon, washed, scrubbed, purified, antisepticized, rushes to the arms of the moribund, and during three, five, ten minutes, conscientiously pumps the air into the inert lungs of the victim, while the assistants bring into play all the other accessories reputed successful in re-animating life. At last! Oh, what a sigh of relief is emitted from everyone's breast, and accompanies, with a touching unanimity, the feeble groan which for the patient is the forerunner of the resurrection! He is saved! But what a fright, O Lord!

The operator resumes his work, which he shall continue to the end, but not without being unpleasantly caressed from time to time by a chill of goose-flesh all along his nervous system.

These cases, gentlemen, remain unpublished, and do you think they are very uncommon? As far as I am concerned, it has been my misfortune to witness them, outside of my operating room, though, I hasten and am proud to say. I have seen them out of the city where, at times, I have occasion to be called to perform operations at the house of the patient. In those conditions, you are as well aware of it as I am, we are not, as in the hospital, surrounded by our usual assistants. It is generally the family physician who obligingly offers his services to act as anesthetist. Certainly, some of them are very clever, although it is always easy to notice quite an explicable lack of experience; but, how many others there are who, feeling the paramount importance of the functions which they are going to discharge, bring with a visible emotion and almost trembling near the mouth of the patient the cone containing the mysterious agent which will plunge the unfortunate being in a condition so similar to death, even when anesthesia is perfectly regular. It is easy for the operator, if he gives a stealthy glance upon the features of his confrere, entangled in the fulfilment of functions to which he is not accustomed, to detect on the latter the anxiety which tortures his mind, and the knowledge of this fact is far from being of such a nature as to promote the calmness so necessary to the surgeon at the beginning and in the course of a serious operation.

And, anesthesia at the dentist's. Let us say a word about it. It is, if I am not mistaken, comparatively the most frequent source of the accidents we generally hear of. I do not wonder at it, and the only thing which surprises me is that they are not of more frequent occurrence.

Every physician has, at least once or twice a year, occasion to send a patient to the dentist to have teeth removed under anesthetics. Naturally it is he, the family physician, who, at the client's earnest request, is asked to administer the chloroform. These rare opportunities to handle an anesthetic constitute, in the majority of cases, the entire amount of experience which the physician possesses upon the subject.

At times, we happen to read in some of the periodicals the following terrific news: "Mr. — died yesterday in the dentist's chair while being under the influence of chloroform."

But what we do not read is the more frequent fact of a patient anesthetized by the family physician, and upon whom the dentist, forceps in hand, is awaiting the propitious moment to begin his surgical functions. With the extraction of the first tooth the patient emits a scream, wakes up, and struggles with the feeble strength left to him, against the pain and the actions of the dentist, who thinks best never to stop once his work is commenced. The improvised anesthetist witnesses immovable the scene which is taking place, and penetrated, I am sure, by the intimate conviction that, although there is no death to record, his anesthetization has been all the same an utter failure on the whole line. This, however, will not deter his beginning again a few months later, and perhaps with the same result. Neither he, his client, nor the dentist have realized the dangers they have escaped, because really, if no one could detect the signs of complete anesthesia, how could they have been made aware of the precursory symptoms of fatal accidents? All these are well-known facts, and I do not think that I may be accused of exaggerating.

How is it, therefore, that we have not already recognized the necessity of possessing, in every city, at least one or two medical men thoroughly educated on that subject, and to whom would be confided the duty of administering anesthetics in surgical operations? Everybody would derive benefit from it; the client, the operator, and the anesthetist himself, who would find in the patronage extended to him by every practitioner a remunerative compensation for the hours which he would take away from the practice of his profession, and also a precious competence which experience alone can acquire.

If some take umbrage at this specialization—and why? may I ask you—if it is deemed useless, unreasonable, in the name of humanity and the profession, let us take some means at least to protect our patients against these dreadful surprises, of which the operating room is too often the scene. Let us put an end to our confiding, in our hospitals, the administration of anesthetics to the youngest and most inexperienced. Let us make a rule never to allow the medical student to act as anesthetist until he has acquired a special and prolonged experience, after having passed, if it is necessary, an examination upon this subject, compelling him, at least, to observe during a determinate period the anesthetist in charge, whom he would see at work, and who would be entrusted with the education of the younger ones.

And to guard ourselves against the uneasiness and the misfortunes to which we are exposed in our private practice, would it not be proper to follow the wise advice given by Dr. Böldt, of



New York? This eminent surgeon, whose friend I am proud to be, after a series of unfortunate accidents which had befallen him during anesthesia, said in the course of a communication made in 1887 to the Society of Medical Jurisprudence of New York:

"On careful consideration of the subject, it has seemed to me that it would be advisable to have a medical college rule, making it a necessary requirement for every candidate for the degree of Doctor of Medicine, to receive a certain amount of practical training in the administration of anesthetics before such degree is conferred, so as not to trust to good luck for the obtaining of first experience at such great risk as is the case in the vast majority of instances at the present time; and secondly, to prevent hospitals from entrusting this most responsible position, next to the operator himself, to the most inexperienced gentleman of the house staff, until he shall have received sufficient experience."

There are a great many hospitals which employ a physician whose exclusive or special duty is the administration of anesthetics. All hospitals, in my humble opinion, should follow that example. We owe this moral obligation to those who place their existence in our hands, and such a procedure would be, for the surgeon himself, an invaluable source of security and satisfaction.

The argument which we sometimes receive from those who refuse to accept the righteousness of this proposition, makes me smile. They never have, they say, followed this practice, and still never have they met with any accidents. Do they want to wait until they have a fatal case to record before they put a term to their imprudence? What is to them, then, the bitter experience of others on this subject?

All that I have just said must lead you to believe—and you are right—that I do not accept without reserve the well-spread opinion that complications arising during anesthesia are generally due to idiosyncrasy of the patient rather than to a defective administration of the anesthetics. It is a well-known fact that when anesthetics are trusted in the hands of an educated and careful surgeon, the mortality from their use is reduced to the minimum, and there is no doubt that many deaths have been caused through the want of proper knowledge and experience.

I have more than one reason to believe that these accidents would have been avoided in a great number of cases, had a more competent anesthetist been placed at the head of the patient. I am far from pretending that anesthetization in skilled hands is always deprived of risk and dangers. Certainly not, but we must all the more surround ourselves with every precaution, and endeavor to put on our side as many chances as possible.

A good and satisfactory anesthesia must, to my mind, possess the following qualities: (1.) Offer the least risk possible for the

patient; (2) be rapid; (3) complete; (4) permanent; (5) followed by as few disagreeable post-operative effects as possible.

In order to obtain the realization of these conditions, we must pay attention to the qualifications of the anesthetist and to the nature and mode of administration of the anesthetic employed. The person who administers the anesthetic should be prudent, educated, and experienced. He must take into consideration the age, temperament, condition of health of the patient; the nature and approximate duration of the operation to be performed. He should be thoroughly conversant with the chemical, physiological, and toxicological properties of the anesthetic agent which he is going to use. He should, before all, exclusively mind his business, without for a single moment allowing his attention to be diverted by the manœuvres of the operator, however interesting the latter may be. His hands, eyes, and mind should be on his duty alone, exercising constant watch upon the pulse, respiration, the condition of the pupil, continually keeping in mind the significance of phenomena which might happen into the field of his observation.

In the choice of the anesthetic, the surgeon must be guided by his general knowledge and his personal experience, and employ the agent which, in his judgment, offers the least risk to the patient, and the administration of which is accompanied with the least unpleasantness, and followed by the least disagreeable after-effects.

It is not my intention to enter into these interminable discussions concerning the relative value of ether, chloroform, A C E mixture, etc., etc. I simply desire to offer for your consideration the results of my personal experience during the last two years, at the hospital as well as in my private practice. I hasten to declare that, faithful to the principles I have enunciated, it has been my good fortune to have been assisted in all my operations by the same anesthetist, Dr. C. W. Gorrell, of Ottawa, to whom I am happy to pay the largest tribute of congratulations upon his consummate ability and his thorough competence.

The agent we have employed is ether. After using it alone at first, we have lately associated with it the nitrous oxide, given at the beginning of anesthesia, by the means of Clover's inhaler. So far, I consider this mode of anesthetization as absolutely ideal, as much for the rapidity with which the patient becomes anesthetized as for the freedom from all unpleasant sensations during the process of anesthetization, and the diminution of after-symptoms so frequent after operations.

Here is, in a few words, the method of anesthesia which we have recourse to:

The apparatus which we have been using for the administration of nitrous oxide and ether is the Hewitt's inhaler. This

consists of a Clover inhaler with the rubber bag replaced by a large bag with valvular attachments. One end of this bag has a stop-cock, through which the nitrous oxide is allowed to enter from the gas cylinder into the bag. At the other end, the bag is connected with the Clover inhaler by a series of valves and conducting tubes. The two main valves we may call the inspiratory and the expiratory valves, the latter being double, that is, covering two openings. The inspiratory valve is next to the gas bag. The valves being opened, allow the gas to pass directly from the bag to the lungs, the expiration passing through the expiratory valve to the open air. When the expiratory valve is rotated, it partly closes the aperture for the exit of expiration to the open air, and partly opens a valve leading to the gas bag. When the expiratory valve is completely closed, the valve leading to the gas bag is fully opened, making what is to all purposes a Clover inhaler, using the nitrous oxide gas.

The gas bag is filled with nitrous oxide. One ounce of ether is placed in the cylinder of Clover inhaler, the indicator turned to zero.

The patient is warned that some disagreeable sensations may be felt at first, but that unconsciousness will come on after a few breaths.

The mouth-piece is then fitted to the face of the patient, who is instructed to breathe easily a few times, to prove that the valves are working. The valves connecting the nitrous oxide bag with the Clover is now opened, and the patient told to breathe deeply. After four or five respirations, the indicator of the Clover is turned one-eighth from zero to 1, and the expiratory valve is closed about 1-4. If patient bears ether well, the indicator may be turned rapidly to 1-2-3, or full. The expiratory valve is slowly closed. When anesthesia is complete, the gas bag is removed and the ordinary Clover bag substituted.

Within the last two years, we have been using this mixed method almost exclusively, and perhaps it will be of some interest to you to know the results we have obtained with regard to the time required to induce complete anesthesia:

NITROUS OXIDE AND ETHER, 307 CASES.

Anesthesia in.....1	minute.....24	times.....	7.8	per cent.
" .....	1½	" .....	55	" .....
" .....	2	" .....	94	" .....
" .....	2½	" .....	47	" .....
" .....	3	" .....	44	" .....
" .....	3½	" .....	9	" .....
" .....	4	" .....	19	" .....
" .....	4½	" .....	1	" .....
" .....	5	" .....	14	" .....
" .....	less than 2	" .....	79	" .....
" .....	" " 3	" .....	220	" .....
Longest time (5 minutes).....	14	" .....	4.5	" .....

At first sight, it might seem strange that in 14 cases, anesthesia was not complete until after five minutes, and in the face of the fact that we claim an unusual rapidity of action for this mode of anesthesia.

The only explanation I can offer is that sometimes it is difficult to get the mask of the inhaler to fit accurately the faces of certain individuals, especially men with moustache and whiskers. In these cases I believe it advantageous to wet the beard before applying the cone, in order to secure better adaptation and prevent the respiration from taking place through the dry hairs.

Let us now compare the above figures with the results following the administration of ether alone.

ETHER ALONE, 132 CASES.

Anesthesia in . . . . .	1 minute . . . . .	0 . . . . .	
" . . . . .	1½ " . . . . .	0 . . . . .	
" . . . . .	2 " . . . . .	7 times . . . . .	5.3 per cent.
" . . . . .	2½ " . . . . .	7 " . . . . .	5.3 "
" . . . . .	3 " . . . . .	21 " . . . . .	15.2 "
" . . . . .	3½ " . . . . .	12 " . . . . .	9 "
" . . . . .	4 " . . . . .	28 " . . . . .	22.7 "
" . . . . .	4½ " . . . . .	6 " . . . . .	4.5 "
" . . . . .	5 " . . . . .	14 " . . . . .	10.6 "
" . . . . .	5½ " . . . . .	1 " . . . . .	.7 "
" . . . . .	6 " . . . . .	12 " . . . . .	9 "
" . . . . .	7 " . . . . .	9 " . . . . .	6.8 "
" . . . . .	8 " . . . . .	5 " . . . . .	3.8 "
" . . . . .	10 " . . . . .	9 " . . . . .	6.9 "
" . . . . .	14 " . . . . .	1 " . . . . .	.7 "

Thus, never with ether alone, have we succeeded in inducing complete anesthesia in less than two minutes, a result which we have obtained in 25 per cent. of our cases in making use of nitric oxide. On the other hand, with the mixed method, the time required never exceeded five minutes, whereas this time has been reached or exceeded with ether alone in 37 out of 132 cases, that is, in 28 per cent. I need not dwell any longer upon the advantages to the surgeon of this shortening of time in the process of anesthetization. To the patient, these advantages are: The rapidity with which she or he becomes anesthetized, the freedom from all unpleasant feelings, such as smothering sensation, irritation of the throat by the vapor of ether, etc.

As regards the quantity of ether employed by the use of one or the other mode of anesthetization, it was not our experience to perceive any difference at all, the amount of ether being practically the same in both cases, a fact which is obviously evident when we consider that, in the mixed method, the ether is allowed to be inhaled almost at the beginning of anesthetization.

Now, gentlemen, what has been our experience concerning the effect of ether alone, or with nitrous oxide upon the kidneys? Does it confirm the opinion so universally entertained that ether

is apt to produce renal irritation, albuminuria, very frequently nephritis, and sometimes total suppression of urine. I said it already, it is not my intention to enter into this everlasting controversy, aiming at the proclamation of the advantages of one anesthetic agent over another. Upon that question, as with regard to all opinions which haunt the human mind, "*tot scnsus, tot capita.*" Some profess a religious faith in chloroform; they are not only entirely convinced of its numerous advantages, but they are, besides, so deeply impressed with the idea that ether has been guilty of so many misdeeds that, according to them, this agent should be unmercifully banished from the class of anesthetics. Others swear by ether exclusively; another group is composed of the admirers of the A C E mixture.

Here, as well as in everything, I deem that the wisest are those who conform themselves to the indications offered by the patient, the nature and complications of the disease, and also to the more or less experience they have acquired with the anesthetic of their choice.

Chloroform especially has had, and has still, its detractors. Ether, on the other hand, is not in want of enemies. One of the greatest faults which are found with it is its harmful action upon the renal functions. This subject periodically returns at almost every meeting of our medical associations. I do not want to make any citations, but I have present in my memory the names of eminent surgeons who have in turn related cases of albuminuria, nephritis, and suppression of urine, which they attributed without the least restriction to the irritant influence of ether upon the kidneys.

I have, indeed, the utmost respect for the authority of these great names, and I reluctantly resist the impulsion of bowing to their judgment and their experience. However, may I be allowed to humbly ask one question? A patient is being prepared to undergo a major operation. Urine is analyzed before anesthesia and is found normal. Ether is given, the operation takes place, and 24 hours or more afterwards there is albumen in the urine or the functions of the kidneys are disturbed, even entirely suppressed. Will you, please, tell me to which of the following causes the pathological disorders should be attributed:

1. The irritant action of ether upon the kidneys.
2. The shock caused by the disturbance produced in the renal circulation through manipulations of organs having, with the vascular system of the kidneys, a close relation by the means of the nervous plexuses by which they are connected.
3. The elimination, through the kidneys, of infectious agents which have been brought into greater activity and virulence by the fact of the surgical traumatism, and which the organism is endeavoring to get rid of by all its emunctories.

4. The congestion of the kidneys produced by possible exposure to cold on the operating table.

I offer for your consideration these various propositions, to which I have neither the intention nor the desire of finding a solution. Dr. Mann, at the meeting of the American Gynecological Society, May, 1898, announced that he had found albumen in 50 per cent. of his cases anesthetized with ether.

These data differ a great deal from the results of my own investigations. I make it a duty to examine, in every case, the urine of my patients before and after anesthesia, and although I am well aware that the absence of albumen is not always a criterion of the integrity of the renal parenchyma, still I will beg the permission to state the results of my observation.

I hasten to say that the quantity of albumen found in my cases has been almost the same after anesthesia by ether alone, or associated with nitrous oxide, the slight difference being in favor of the latter.

Out of 434 observations, albumen was found 26 times, that is, in six per cent. of the cases. In the immense majority of these cases the urine, after operation, contained but insignificant traces of albumen, which generally disappeared within 24 to 48 hours.

## ALBUMINURIA AFTER ANESTHESIA.

OPERATIONS.	AMOUNT OF ETHER.	TIME OF ANESTHESIA.		REMARKS.
		H.	M.	
Removal of intra-uter. polyp.	2 ounces.		20	Traces. None after 24 hours.
Laparotomy.	4½ "	1	20	Traces. None after 24 hours.
Schroder and nephrorrhaphy.	4 "	1	35	Traces. None after 24 hours.
Curetting.	2 "		20	Traces. None after 24 hours.
Laparotomy (pyosalpinx).	4 "		50	Traces.
Radical cure (hernia).	5 "	1	20	Traces. Disappeared on 4th day.
Schroder; colporrhaphy, laparotomy and oophorectomy.	6 "	1	35	Albumen; disappeared in 12 hours. Returned on the 7th day. None on the 19th day.
Ventro-fixation.	3 "		30	Traces. None after 24 hours.
Laparotomy (pelvic abscess).	5 "	1	15	½ gr. to litre after operation. ½ gr. 24 hours after operation. ½ gr. on the 4th day. None on the 7th day.
Fistula in ano.	3 "		35	Traces. None after 24 hours.
Vag. hysterectomy.	3½ "		40	½ gr. to litre the first 3 days. Diminished gradually. None on the 8th day.
Laparotomy.	3½ "		40	Traces. None after 24 hours.
Ampt. of the breast (cancer).	3 "		45	Traces. None after 24 hours.

## ALBUMINURIA AFTER ANESTHESIA.—(Continued.)

OPERATIONS.	AMOUNT OF ETHER.	TIME OF ANESTHESIA.		REMARKS.
		H	M	
Laparotomy (ectopic gestation).	½ ounces.	1	15	½ gr. to litre after operation. None after 24 hours. Returned on the 10th day. 1 gr. per litre. On the 11th day: ½ gr. per litre. " " 14th " ½ gr. " " 17th " 1-16 gr. per litre. " " 19th " ½ gr. " " 25th " none.
Abd. hysterectomy.	7 "	2		½ gr. per litre after operation. 1-16 gr. 24 hours after operation. None after 48 hours. Returned on the 38th day. ½ gr. per litre. Disappeared gradually in 3 days.
Nephrorrhaphy.	3 "		50	1½ gr. per litre after operation. ½ gr. " " 24 hours after. Traces on the 7th day. " one on the 8th day.
Laparotomy (intra-lig. cyst).	3 "	1	10	Albumen, ½ gr. to litre. None on the 3rd day.
Laparotomy (ectopic gest.).	6½ "	1	45	Albumen present. None after 48 hours.
Colpotomy (pelvic abscess).	2½ "		20	Same patient as above. Colpotomy done 10 days after first operation. No albumen before anesthesia; traces after. None after 24 hours.
Laparotomy (removal of pad).	2½ "		30	Abdominal hysterectomy the day before. Gauze pad forgotten in abdomen. Abdomen reopened the next day. No albumen before anesthesia. Traces 24 hours after. None after 48 hours.
Laparotomy (intes. occlusion).	5½ "	1	40	Traces. None after 48 hours.
Appendectomy.	4 "	1		Traces. None after 48 hours.
Curetting.	2 "		30	Traces. None after 24 hours.
Curetting.	2 "		35	Traces. None after 24 hours.
Nephrorrhaphy.	5 "	1	35	Traces. None after 24 hours.
Schroder. Colporrhaphy, laparotomy (ventro-fixation).	8½ "	2	10	Traces. None after 24 hours.

In casting a glance on the above table, you shall easily convince yourselves that the appearance of albumen has very little relation with the quantity of ether inhaled, or the duration of anesthesia, the albumen being detected in urine as well after the use of two ounces of ether and a 20-minute anesthesia as after the administration of six ounces of ether and an anesthesia of two hours' duration. The quantity of albumen has always been very small; never have I observed total suppression of urine. Once only, following abdominal hysterectomy, the quantity fell to five ounces in 24 hours. This considerable diminution of urinary secretion was accompanied with no alarming subjective symptoms

whatever, and under the influence of hot applications and injections of salt solution in the rectum, the physiological functions of the kidney soon became normal. Therefore, although I deem prudent not to indulge in false security, I am compelled to confess that my personal experience renders very slight, to my mind, this exaggerated fear of the injurious effect of ether upon the kidneys.

Furthermore, I shall now cite a few cases in which the examination of urine detected the existence of albumen before anesthesia, and you shall see for yourselves that anesthesia has in no wise aggravated the condition of the patient, notwithstanding the quantity of ether administered and the long duration of anesthesia in certain cases.

CASES IN WHICH URINE CONTAINED ALBUMEN BEFORE ANESTHESIA.

OPERATIONS.	AMOUNT OF ETHER.	TIME OF ANESTHESIA.		REMARKS.
		H.	M.	
Hemorrhoids and appendectomy.	6 ounces.	1	25	Albumen before operation. None on the 4th day after.
Opening and drainage of abscess in abd. walls.	3½ "		30	1 gr. per litre before operation. 1 gr. " " after ½ gr. " " 24 hrs after operation. ½ gr. " " on the fifth day. Gradually diminished. None on the 10th day.
Examination (tuber. kidney).	1 "		15	Before operation: pus cells, blood cells; albumen: 1½ gr. per litre. 24 hours after: 1½ gr. " " 48 " " 1½ gr. " " 3rd day " 1½ gr. " " 4th " " 1 gr. " " 6th " " ½ gr. " " 7th " " 1 gr. " " 8th " " ½ gr. " " 9th " " ½ gr. " " Still some albumen when discharged.
Removal of hemorrhoids.	3 "		35	Albumen before operation. Not increased after. None on the 4th day.
Appendectomy.	4 "		50	Albumen before operation. Not increased after.
Amput. of thigh.	4 "		50	Albumen before operation. None 24 hours after.
Schroder.	3½ "		50	Albumen: ½ gr. per litre before. ½ gr. " " after. Quantity of albumen oscillated between one-eighth and one-fourth during her stay in the hospital. Still one-eighth when discharged on the 18th day.
Curetting and cauterization (cancer of cervix).	4 "		50	Before operation, albumen: ½ gr. After " " ½ gr. Same quantity when discharged on the 5th day.
Vag. hysterec. (cancer).	5 "		45	Albumen before operation. None 48 hours after.
Cauterization (cancer).	2½ "		25	Albumen before. None 24 hours after operation.
Bassini (strangul. hernia).	6 "	1	35	Albumen before. Traces 24 hours after. None 36 hours after.



CASES IN WHICH URINE CONTAINED ALBUMEN BEFORE ANESTHESIA.  
(Continued.)

OPERATIONS.	AMOUNT OF ETHER.	TIME OF ANESTHESIA.	REMARKS
Abdom. hysterect.	7 ounces.	H. M. 1 40	Albumen, blood cells and casts before. Diminution of urinary secretion for the first 24 hours after operation. Albumen not increased. Still albumen and casts when discharged on the 28th day.
Explor. laparot. (cancer of uterus and bowels).	3½ "	1	Blood and albumen before operation. Urinary secretion normal after operation. Same quantity of blood and albumen.
Appendic. abscess (operation).	1 "	25	½ gr. per litre before operation. ½ gr. " " 12 hours after. ½ gr. " " 24 " " None 48 hours after operation. ½ gr. on the 4th day. None on the 5th and following days.

This last case is, I believe, extremely interesting. I performed the opening and the drainage of the appendicular abscess in presence of several medical gentlemen, who had done me the honor of witnessing the operation. I drew their attention to the fact that the urine of the patient contained 4 1-2 grains of albumen per litre before anesthesia, and they could ascertain for themselves the next day the almost complete disappearance of albumen, in spite of the inhalation of ether used to anesthetize the patient.

A few words concerning the vomiting which follows the mixed anesthesia by nitrous oxide and ether, and I am done with that part of my subject. Vomiting has been obviously as frequent after anesthetization with nitrous oxide and ether as with ether alone, and I will unite in the same statistic the results of my observations.

Out of 439 cases of ether, administered alone or associated with nitrous oxide, 279 patients vomited after anesthesia, that is, 63.3 per cent.

I grant you that, at first view, there is nothing in these figures that we should boast of. But let me tell you that the vomiting recorded in the observations occurred, in the majority of cases, with the awakening of the patient, and before entire consciousness had returned. It has been extremely rare that patients continued to vomit when completely out of the anesthesia, or within the 24 hours following the operation.

This vomiting occurred with the immediate return of consciousness. Far from being objectionable, I deem it eminently salutary. It permits the bronchial tubes to get rid of the mucus they contained and, immediately afterwards, the patient usually falls back in a quiet sleep, out of which he awakes without the least nausea. If, by exception, the vomiting shows a tendency to

return, it is almost instantly relieved by a sinapism to the epigastrium. I showed you above that the appearance of albumen in urine has not always offered a direct relation between the duration of anesthesia and the quantity of ether administered. It is, I believe, interesting to draw your attention to the fact that we have observed the same thing with regard to post-operative vomiting, and I can point out from amongst the long operations which were accompanied by no vomiting whatever, the following cases:

OPERATIONS.	ETHER.	DURATION OF ANESTHESIA.		VOMITING.
		H.	M.	
Abdominal hysterectomy.	6 ounces.	1	45	None.
Laparotomy.	5½ "	1	30	"
Laparotomy.	4½ "	1	25	"
Laparotomy.	5 "	1	35	"
Abdominal hysterectomy.	5 "	1	40	"
Laparotomy.	5 "	1	20	"
Bassini (rad. cure).	6 "	1	25	"
Appendectomy.	5½ "	1	5	"
Laparotomy.	5 "	1	45	"

With regard to medullary cocainization, spinal anesthesia, cocain analgesia, intro-spinal cocainization, subarachnoidean injections of cocain, cocainization of the spinal cord, medullary narcosis—the simple enumeration of the various denominations given to this new mode of anesthesia would constitute a whole article in itself—I have very little to say. Besides having had my name connected with the fact that I was the first to use it in Canada, my personal experience upon the subject would bring out nothing that you have not already read a little everywhere in medical literature. The technique of this small operation, the quantity of cocain to be injected, the results of cocainization of the spinal cord, are now facts universally known. My own experience is the same as what has been written by different observers within the last two years.

I certainly do not deny the fact that the surgeon may sometimes be placed in circumstances such that the fact of being familiar with this new method of anesthetization would become very handy, and besides, the surgical arsenal cannot be too complete and one would be wrong not to keep in some corner of his memory the knowledge of a special means of action, which might be of valuable assistance to him in unforeseen emergencies.

I have nothing to say against this mode of anesthesia, the unpleasant after-symptoms, and even the fatal results attributed

to it; all I want to declare is, that as long as the old and well-tried anesthetization by the means of anesthetic agents handled by competent men continue to give the same satisfaction as we have been gratified with in the past, I do not, in the least, feel inclined to abandon it for any other, until the superiority of the latter has been clearly demonstrated, which is certainly not the case, so far, with medullary narcosis.

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### SOME PRACTICAL FEATURES IN THE TREATMENT OF CONSUMPTION.

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BY EDWARD PLAYTER, M.D.,

Medical Superintendent Highfields Sanatorium.

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THE friends of most phthisical patients who consult me say that the family physician gave but little hope of recovery; this even in the early stage of the case. True the chances are against a patient in an advanced stage if he, or she, has to be treated at home, and the means to do so are not ample for obtaining every necessary. The progress of most cases, however, is so slow that the physician is afforded every opportunity for checking its progress, and hence for successful treatment in favorable circumstances. In the rapid progress of a case of pneumonia or acute fever it is quite different. And with many high authorities now, I am fully convinced that the disease in any stage can usually be cured, if there be no special complications, both lungs not extensively involved, and there be not much prostration from marked failure of the assimilative and circulatory organs, especially the heart, so that the patient cannot take much food or walk about or up a flight of stairs without great exhaustion, etc.

As we all know, there is no one specific, nor will there ever be, other than the supply of an excess of oxygen to make up for the want of it during that period, long or shorter, of gradual "decline" into the pre-bacillary stage, as well as later.

In view of this usual gradual "decline," of the fact that most, if not all, so-called "disease germs" are originally saprophytes, and that the formation of tubercle is a benign process,—large quantities remaining for years in an animal body, until from some cause they break down, it seems most reasonable to regard the cause of this disease as an auto-intoxication. As such I have always treated it: the bacilli as *post hoc* and of secondary consideration. Already we see articles on the "passing of the bacillus," and everywhere it is beginning to lose its hold as *the* cause of the disease.

Again, and in support of the above theory, all these patients have in the beginning an inherited or acquired want of full respi-

ratory capacity—as from small lungs, measles, bronchitis, the effects of pneumonia, very sedentary stooping occupations, etc. This means a limited supply of oxygen in the blood and system generally; the immediate cause of the auto-intoxication. This theory I have advanced and explained in my book.

Directly in support of this is our one universal panacea, the “out-door” life—practically an increased respiratory function: To increase it more, patients are sent to great elevations to force them to distend the air-chambers or cells of the lungs—to improve, attenuate and restore the respiratory membrane; or they are induced to practise certain lung exercises or gymnastics. I much prefer the latter, in or near that section of country in which the patient has become acclimated. Except in rare cases, change of climate is a great mistake.

It is gratifying to find the practice of special lung-expansion recently becoming more general. Not long ago a medical journal stated that it would have been more so had it not been so much in the hands of “irregulars,”—a weak, indeed cowardly, reason.

Never have I observed any increase of hemorrhages from it, but the reverse, as one would expect, with care in the beginning, especially in hemorrhagic cases.

Half a century ago now, permit me to relate here, when in my “teens,” I was said to be in a “decline,” chiefly from over-study, want of out-door exercise, and an indiscreet diet. After many months of treatment—drug-swallowing—by two or three of the ablest physicians in this county, a book, written by a New York “M.D.,” chanced into my hands, rationally explaining the value of the erect posture and deep breathing. The book was published, apparently, for the purpose of selling a very simple “inhaler,”—a short tube with a valve. I have the book still, and value it highly: did not buy the inhaler, but forthwith seized upon the “idea,” the function of respiration being so simply (and correctly) explained, and used my nostrils and puckered lips as an “inhaler,” and exhaler. I improved so satisfactorily that during all my practice of about forty years I have invariably employed this super-respiration as *the* remedy in phthisis.

Of “drafts,” most people are yet too much afraid. Here at Highfields Sanatorium, with deep bay windows and three-windowed tower recesses, in the cold winds of last April and May, I proved this to my satisfaction, by insisting on patients, well covered, sleeping all night between two FULLY OPEN windows, with really cold wind blowing freely over them. One excitable woman called me a “tyrant,” after I had told her she must so sleep or give up the bed to one who would do so. In not one instance did a patient suffer any evil effects, but invariably, from the first night, coughed less and slept better. I had tried this treatment on myself, will the reader observe, in the course of typhoid fever in No-

vember weather, as well as in weak lungs, and felt fully justified in the course with these patients, who appeared to be, and were said to be, hopelessly diseased.

Habitual DEEP breathing, then, night and day, of pure outdoor air, is the first remedy.

As further evidence of the need and value of oxygen as a direct remedy for tuberculosis, ozonized air has been found in the Manchester Hospital for Consumptives to give better results than any other special remedy of many tried there. We have imported for Highfields Sanatorium an ozonizing apparatus, like those used at Manchester, and expect to have the necessary cell batteries for working it put in at once, and so try this multiple of oxygen.

Of the value of sunlight and sun-baths, I need not write.

Respecting feeding, I have a positive fear of "stuffing,"—dare not attempt it. Early cases with little fever, in which considerable exercise can be taken, may improve in spite of being stuffed. One of the advantages of sanatorium treatment is that the patient's assimilative powers can be closely watched and studied, that they may not receive more than can be thoroughly disposed of. Increase of weight is not at all a positive indication of improvement. The disease will progress with increase of weight, and *vice versa*. I never aim to increase fat or flesh—rather tone and strength; and the majority of my patients lose weight for a time, with improvement in all other symptoms.

As a nutrient, I have given bovine a good deal, and been greatly pleased with it. I also frequently give a preparation of sterilized, evaporated ox-blood, with Malaga wine, glycerine, and other preservatives, as an excellent substitute.

The judicious use of the tempered bath, for promoting a healthy, vigorous skin, thus assisting the respiratory function, is of great value, and it would seem that a tuberculous patient could hardly be successfully treated without it.

Cod liver oil and creasote I administer most commonly at bedtime, in the form of inunctions. This, followed in the morning by a good wash with warm water and soap, and then a cool or cold "rub" with sponge, towel, or hand, as a tonic.

Most phthical patients considerably advanced in the disease need rest rather than active exercise; although passive exercises are often useful and promote sleep, when given a little before bedtime.

Inhalents—antiseptic, sedative, astringent, etc., are usually best for controlling cough and improving the mucous membrane of the air passages.

Night sweats and chills soon subside with abundance of oxygen; and nausea and diarrhea, usually with a judicious diet; even, if necessary, of Wampole's malted milk, alone for a time, or concentrated beef-juice. For hemorrhages, absolute quiet, cool air and, if severe, opium, are usually sufficient.

## Proceedings of Societies.

### ONTARIO MEDICAL ASSOCIATION.

THE twenty-first annual meeting of the Ontario Medical Association was held in the Education Department, Toronto, on the 19th and 20th of June, 1901, the President, Dr. Angus McKinnon, of Guelph, in the chair. The secretary read the minutes of the last session of last year, which were adopted.

The report of the Committee on Papers was presented by Dr. Machell of Toronto, and the report of the Committee on Arrangements by Dr. Bruce L. Riordan.

*Three Recent Gall-Stone Cases.*—By Dr. Wm. Oldright, Toronto. These cases had occurred recently in his practice. They present features of interest to the profession. The first case occurred in a woman about fifty-five years of age. He was rather surprised to be called upon to see her in a hurry, to find symptoms of gall-stone obstruction. The late Dr. Little had seen the patient, and had endeavored to obtain purgation without effect. Powerful cathartics were unavailing. About nine months previously she had a similar attack, but Dr. Oldright had heard nothing about it until this attack. The symptoms were somewhat elevated temperature, about 100 to 101, constant vomiting, obstruction, and, of course, intense pain. He supplemented Dr. Little's catharsis but without any effect. On examination he could map out a distinct tumor, and told her that she had a distended gall-bladder, and advised her to go into the hospital, which she did that night. She was operated upon in the afternoon, and he removed some gall-stones, and endeavored to establish patency of the duct. He could feel no stones left behind, but there was some stenosis of the duct. There was a great deal of inflammatory action in this case. The gall-bladder was stitched into the abdominal wall and drainage established in the usual method; bile flowed freely. The patient made a good recovery. The second case was one Dr. Oldright saw in consultation with Dr. McLean, of Woodbridge. She was sixty-five years old. The prognosis was certainly death without operation, and provided there was no malignant trouble she would probably recover. In this case one could imagine the difficulty there would have been had it been his first case of operation, as he could not locate the gall-bladder.

He came to the conclusion that it was not a case for further interference. Within twenty-four hours she succumbed to the shock and probably to some hemorrhage. There was no doubt after passing the finger in that it was malignant. If this woman had been operated on some years before, Dr. Oldright thought that malignancy would not have occurred, and her life would have been saved. The third case occurred in a woman forty years of age. Upon her the surgeon operated last February. Here was a case in which there had been gall-stone symptoms, obstruction, for about eighteen months. She consented to an operation. The obstruction was in the cystic duct. He opened the gall-bladder and took out the stones, which he exhibited to his audience. The operation occupied about forty minutes. The patient made an uneventful recovery, and left the hospital thirteen days after the operation.

Dr. Garrett, of Kingston, said that operative interference in gall-bladder surgery has only recently been brought into prominence. Early diagnosis is very important. We should operate at once when we make a diagnosis. He referred to a case which had been diagnosed as catarrh of the stomach, upon which he had operated and had extracted 170 stones from the gall-bladder.

Dr. T. Shaw Webster, Toronto, asked Dr. Oldright if there are not some cases where it would be better to wait for a little while, in cases where there is a strong probability that the condition will disappear in a short time.

Dr. Oldright, in reply: As soon as we are satisfied of gall-stone obstruction—as soon as acute symptoms have subsided—we should operate, and not allow repeated attacks to go on until malignant disease is established.

*Excision of Upper Jaw for Sarcoma, with Exhibition of Patient and Specimen.*—Dr. Herbert A. Bruce, Toronto, presented this paper, whilst Dr. G. Silverthorne exhibited the specimen. Dr. Bruce also presented the patient, a woman thirty-four years of age, from whom he had removed the upper jaw for sarcoma. The patient had been sent to him by Dr. Bowles, of Woodhill. The history of the patient is briefly as follows: During the last week of January of this year she felt for the first time a slight swelling over the alveolus of the left jaw, which she thought to be a gum-boil. She consulted Dr. Bowles at the end of March, and Dr. Bruce saw her about the middle of April—that is, less than three months after the first symptoms. Dr. Bruce operated upon her on the 29th of April, exactly three months after the first symptom she had. On examination he found a very hard swelling just behind the second bicuspid tooth, and extending backwards to the full extent of the jaw. Internally it had not extended to the middle line, and bulged externally to the extent of half an inch beyond what would be the line of the

teeth. It extended backwards towards the antrum, but the latter did not seem to be implicated externally. The growth in the roof of the mouth was covered by a mucous membrane. On looking into the nose a polypoid mass was seen, and the patient had some difficulty in breathing through the left nostril. The cheek on the affected side was slightly more prominent, and it moved freely over the growth. No prominence of the eye on the affected side was noted. A small portion of the growth was removed under cocaine, and Dr. Silverthorne reported to Dr. Bruce that it was sarcoma. The patient left the hospital on the 18th of May, and made an uninterrupted recovery.

Dr. Silverthorne presented the specimen to the members of the Association. It was the size of a large-sized orange, containing spindle cells, with a cartilaginous basis.

Dr. Bruce stated that the history of the patient showed that a polypus had been removed about eight years ago, and he thought that it must have been a simple polypus.

*Ectopic Gestation.*—By R. W. Garrett, M.D., Kingston. He extended his thanks to the Committee on Papers for placing under his care a subject of such great magnitude. The subject is one of vital importance to every practitioner, for at any time he might be called upon to differentiate the condition from others with which it might be confounded. The responsibility of a life was in his hands, and demanded accurate diagnosis, medical acumen, and judgment and ability, to conduct the case to a favorable termination. He entered at considerable length as to the causation and earlier changes consequent upon ectopic gestation, and stated that every physician is expected to make a correct diagnosis of tubal pregnancy on the occurrence of rupture, and in a fairly large proportion of cases to make a diagnosis before the occurrence of rupture. Theoretically, the arrest of a fructified ovum may occur first in the ovary; second, in the abdominal cavity between the ovary and tube; third, within the tube, and fourth, between the tube and the uterus. He would direct the attention of his audience to but one kind only—arrest within the tube, or tubal pregnancy, as all other varieties are but merely developments of this kind, owing to secondary invasion of the Fallopian tube. These he divided into three groups—first, tubo-abdominal, or simply abdominal pregnancy, in which there is a secondary invasion of the abdomen; second, tubo-ligamentary, in which there is a secondary invasion of the broad ligament and sub-peritoneal tissues, and third, that subdivision of the tubo-uterine in which there is rupture into or secondary invasion of the uterus. At considerable length he discussed the etiology, then the symptoms, pointing out the difficulties that lie in the road to making a diagnosis, owing to the absence of many, if not of all, the classical symptoms generally enumerated. Having dealt with these in a masterly



manner, he recited a very interesting case in illustration of his contention of the difficulties of diagnosis.

Dr. J. F. W. Ross followed Dr. Garrett in the discussion regarding the diagnosis as the most important point of all, and especially the diagnosis before rupture. He thought that we ought to be able to diagnose these cases before rupture had taken place. What are the symptoms? Generally four or five symptoms. He referred to the pain that is indefinite, not severe, not acute, but a feeling as if something were wrong. He referred to several cases recently seen in practice.

Dr. Powell referred to a case where Dr. Ross had diagnosed the condition before rupture had occurred.

Dr. Oldright mentioned a double rupture of both tubes.

Dr. A. A. Macdonald complimented Dr. Garrett on the careful manner in which he entered into his subject, and thought it was one of the greatest importance to the general practitioner. He remembered the time when it was stated that no one could make the diagnosis before rupture. He referred to a case which came into Bellevue Hospital, comparatively recently—a case of twins, in which one child was delivered in the natural way and the other child ectopic.

Dr. T. S. Webster said that the subject was one that he had taken a great deal of interest in, and has had to deal with four of these cases.

Dr. Prevost, Ottawa, showed a specimen, and said that sometimes, in spite of the most accurate diagnosis, we make mistakes. He described the case, the specimen of which he presented.

Dr. A. F. McKenzie, Monkton, referred to a case seen in his practice, which went on to full term and was delivered of a large child, and no trouble. He further spoke of the difficulty in making the diagnosis in these cases.

Dr. Machell thought the interest centered in the diagnosis.

Dr. McKinnon, the President, stated that he had not had much experience with these cases before rupture, but had had a little experience after rupture. He thought frequently there might be danger in making a mistake. He also cited a case occurring in a young married woman with a little child five or six years old.

Dr. Garrett closed the discussion, and thanked the members for their generous treatment of his paper. He considered that discussions of this character were of the greatest moment. Rupture is generally about the third month, and interstitial pregnancy can go on to much longer term than tubal pregnancy, and in this form we generally have external rupture.

*AFTERNOON SESSION.*

*President's Address.*—Dr. McKinnon delivered a very able address on the opening of the afternoon session. He considered that it was great honor to be elected President of this, the largest and most influential medical association in the Dominion of Canada. Having referred to the success of the meeting so far, he proceeded to contrast the state of medicine at the beginning of the last century with that of the present, and compared the vast advantages we to-day possess over those of one hundred years ago. Anesthesia, antiseptics, asepsis, vaccination, the antitoxine treatment for diphtheria, the discovery of bacillus of tuberculosis, were mentioned, and he looked for the dawn, in no far distant day, of that grand and glorious day when we can say to the world that tuberculosis and cancer can both be cured. He deplored the growth in the employment of new proprietary remedies, and thought that harm was being done to the medical profession by manufacturing firms making up pills for neuralgia, for malaria, etc. He considered that the literature and drugs sent out to medical men by these manufacturing houses had become an intolerable nuisance. The electric belt man, the Christian Scientist, the advertising cancer-curer, the osteopath, and many other such like fakes which hang on to the skirts of medicine, he scored most unmercifully, and regretted that the public press, both secular and religious, opened their columns freely to these fulsome, untruthful, and sometimes immoral advertisements, because they pay well. There was great danger to the public in permitting Christian Scientists, the "pray-for-hire-healers," and "Dowieites," impudently undertaking to cure infectious diseases such as diphtheria, scarlet fever, and small-pox, diseases which they are unable to recognize, and we think that we have come to a point where toleration and forbearance becomes criminal. The 2,500 medical men in Ontario should have influence enough to obtain from the Legislature an amendment to the Medical Act, that will put an end to this trifling with human life. He directed attention to the delay that occurs in securing admission to the asylums for people the subject of acute mania, and thought that it was high time the necessary steps in this department in the practice of medicine should be simplified.

*Pulmonary Tuberculosis: Its Treatment in Special Sanatoria.*—Dr. J. H. Elliott, medical superintendent of the Sanatorium at Gravenhurst, read this paper. Speaking generally, it may be said that from fifty to seventy per cent. of the incipient cases are restored to health, while from all classes from fifteen to thirty per cent. are reported cured or arrested, in sixty to seventy per cent. a marked improvement. The first thing noticeable after

entering the sanatorium in most cases is an improved appetite, a gradual gain in weight, and a decline in the evening temperature. With this improvement, night-sweats disappear without medication, cough and expectoration noticeably lessen, and the patient sleeps until morning. The principles generally adopted are: First, a continual life in the open air, with rest or exercise as indicated; second, a liberal, suitable diet; third, medicinal treatment according to indications, and to a great extent symptomatic; fourth, hydro-therapy; fifth, a strict medical supervision of the patient's daily life.

Speaking of the "rest-cure" in febrile cases, the object is to reduce muscular exertion to the least point consistent with the ingestion and proper assimilation of a good diet. Referring to medicinal treatment, with an hygienic life, pure medicines are required. The various tuberculins and serums are being used both in America and Europe with the prospects of yet securing a specific of those cases where mixed infection is absent. Constant supervision of the patient is the most important point in which the sanatorium treatment must necessarily differ from that adopted by the general practitioner. Living as he does with his patients, adopting their mode of life, having his meals in common with them, the physician is enabled to individualize the treatment, and though on broad lines the patients all receive the same treatment, each one has to be studied in detail, and the indications met accordingly. The chief point, under all circumstances, is that the patients, wherever they may be, live prudently, and be under the care of an intelligent and firm physician.

Dr. Price Brown referred to the advisability of sending patients for sanatorial treatment, and stated that we have for every disease places to send our patients—hospitals throughout the length and breadth of the land—except for tuberculosis. Having recently been at Asheville, N.C., he described the treatment which he had seen carried on in that institution.

Dr. John Hunter, Toronto, deprecated sending these patients long distances away from their homes, which was formerly the custom, but is not so now. He hoped to see the time when there would be a large number of these institutions established in this country.

Dr. Elliott, in replying, strongly emphasized the point that there should be no exercise when the evening temperature is above 99 degrees; it may be permitted in the morning, if it reaches one hundred or one hundred and a half, but not in the evening.

*Vaccinal Protection Against Small-pox.*—Dr. P. H. Bryce, Toronto, the Secretary of the Provincial Board of Health, presented this paper. In the introduction to his paper he expressed the belief that, although the practice of vaccination against small-pox has existed for a century, there never was a time since it was

formally accepted by the profession when there was so much expressed scepticism as there was to-day on the part of the laity with regard to its protective qualities, and never a time when the profession has been so indifferent as to impressing the necessity of its proper performance upon the public. In Ontario, between 1898 and 1899, there were but twenty-two recorded deaths from the disease. He made special reference to the art of vaccination and the quality of the lymph, and thought five separate insertions should be made in each case. The quality of the lymph was very important. He thought that a medical man going out from the college did not receive sufficient practical instruction on this most important subject.

Mr. I. H. Cameron discussed Dr. Bryce's paper, and stated as a matter of fact he had no hesitation whatever in seeing a case of small-pox himself, nor would he object to any member of his family seeing it, if he knew that they had sufficient protection through vaccination. He warned the profession against laxity in dealing with this most important subject.

Dr. Harrison, Selkirk, stated that he had had considerable experience with small-pox, and on account of that experience he entered a vigorous protest against the prevailing carelessness in the insisting of vaccination and re-vaccination in the laity as well as the profession, and that in many cases he had failed to secure successful vaccination.

Dr. Geikie considered that Jenner's discovery was one of the greatest and grandest achievements in medicine.

Dr. Price Brown referred to a case in the Toronto General Hospital in the year 1866.

Dr. Rudolf asked Dr. Bryce whether the instructions given along with lymph supplied by different firms were not partially to blame for the insufficient vaccination among the profession. He considered that no one should be guided by those instructions.

Dr. Bryce, in reply, thanked Mr. Cameron for taking up the discussion. He considered that the profession was lamentably ignorant of the nature of protection and protective qualities of vaccination itself.

Dr. D. J. Gibb-Wishart suggested that a resolution be passed by the Association expressing its approval of from three to five insertions, and advising manufacturers interested in the matter.

Dr. Thistle thought that they should not stipulate the number of marks, that it would not be wise, as many successful vaccinations had been obtained from one mark.

Dr. Stewart, of the Ontario Vaccine Farm, Palmerston, thought four or five marks better, so situated that there should be no coalescence.

Dr. McPhedran did not wonder that the younger members of the profession were weak as regards the diagnosis of small-pox,

when facilities for instruction in clinical work were absolutely nil. He had repeatedly asked to be permitted to take a class to the infectious diseases hospital, but had always been denied.

Dr. Noble, Philadelphia, thought as a surgeon that something else might have been said about the care of the vaccination wounds. The wounds should be protected so that there would be no chance of infection.

*Discussion on Empyema: Medical Aspect.*—This subject was introduced in a well-prepared paper by Dr. Ferguson, London, who said that the treatment of this condition was essentially surgical, and that the medical aspects of the disease were limited to a consideration of its pathogenesis and prophylaxis. He considered that the conditions of non-purulent or primary effusion were indispensable to an understanding of the pathogenesis of empyema. He gave a description of the pleura, and discussed the bacteriological aspect of purulent pleurisy, which he divided into four classes: First, those due to pneumococci; second, those due to streptococci (and staphylococci); third, those due to the bacilli of tuberculosis, and fourth, those caused by saprogenic organisms. In nine cases, extending over eleven years in his practice, three were diagnosed tubercular, three meta-pneumonic, two due to the streptococci, and one undetermined. The prognosis varies with the micro-organism present, the pneumococci being the most benign. It is the only variety of purulent empyema that may possibly yield to treatment by mere aspiration, especially in children. Tubercular empyema is usually mixed infection. The prognosis here will depend upon the general condition of the patient, and the character of the mixed infection. We therefore see the importance of a bacteriological examination, as in any other debilitating disease; supporting and tonic treatment is essential. With the advent of pus surgical means must be adopted.

*Surgical Aspect.*—Introduced by Dr. J. L. Turnbull, Goderich. When the presence of pus is determined, it should be evacuated at once, as there is always the danger of the abscess bursting into or through the chest wall, or even through the diaphragm, and producing peritonitis. Aspiration need not be described; remember not to remove the fluid too rapidly. In this, as in an ordinary abscess, it is not necessary to open at the most dependent point. The preferable way, and the one which Dr. Turnbull always uses when a diagnosis of pus is made, is to remove a portion of a rib; an inch and a half may be cut out, preferably with the saw, under strict antiseptic precaution. Dr. Turnbull advises washing out every day when pus is offensive, and drainage tube gradually shortened until it can be removed altogether. Where a cavity and sinus remains after this operation, the sinus may become closed, and a second empyema established. This requires an Estlander's operation, and one of the best ways is to carefully locate size and

boundaries of cavity with a probe, and after dissecting up a flap of skin be sure to remove enough bone. The hard fibrous tissue beneath the ribs, which is always present in quantity there, must be thoroughly removed. Dr. Turnbull advises mopping out with pure carbolic acid, then with alcohol to prevent poison, and then with sterilized wire, the part being carefully dried. He puts a drainage tube in the most dependent part.

Dr. J. C. Mitchell considered that these cases should be dealt with purely on the same principles as an ordinary abscess. He has seen more cases in adults than in children. He considers that a good many of them are tubercular.

Dr. Powell took exception to Dr. Mitchell styling empyema as being only ordinary abscess. He considered that it was something more, because lung was pressing on one side of it. He exhibited an instrument which he used in the operation.

Dr. John Hunter mentioned a case where air entered the cellular tissue of the skin, and universal empyema was set up.

Dr. Primrose considered it an important point to know whether the case was one of mixed infection. He does not think that we have taken all the advantage we might do of the researches that are made in the bacteriological laboratory.

Dr. Thistle said that one point had not been referred to which he considered of first importance in successful treatment—the time at which operation should take place. That is the crucial point in procuring success in these cases. The earlier the operation is done the speedier the cure, and in many of the cases which run into chronic empyemata, this result was due to the lateness of the operation.

Dr. McKeown said that there were three points of importance, to his mind: recognized that pus is present, that we want to get at it, and that we want to get the cavity closed up.

Dr. McPhedran considered that these cases should be diagnosed very early, and are easily treated, as a rule. One should be on his guard in a case of pneumonia when the temperature falls about the eighth day to near the normal; if it commenced to rise again it is suspicious of empyema.

Dr. Freel, Stouffville, considered that it was better to resect the rib with proper dressing and tube than to aspirate.

Dr. Rudolf: So far, it seems to be the opinion of this meeting that where pus is discovered in the pleural cavity it should be removed by operation. It appears that there is one exception to that, that is, where an empyema exists along with tuberculosis of the lungs. In this condition, where pus is found, it should not be at once removed without careful consideration.

Dr. Turnbull, in reply, considered that it was best that the rib should be removed in every case. He does not think it necessary

to wash out the cavity in every case, only where the discharge is offensive. The tube should be long enough to go into the cavity.

Dr. Ferguson, in reply: Early diagnosis, with the aid of the bacteriologist, will add much to the after treatment.

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EVENING SESSION.

*Open-air Treatment of Disease.*—By Dr. George H. Carveth, Toronto, who described his method of treating several forms of disease: First, in the house, with wide-open windows; second, in beds on the veranda; third, in beds under tents on the lawn. At first he experienced some difficulty in getting his patients to consent to be treated in this manner, but after they had become habituated to life in the open air they returned indoors reluctantly. Some of the cases that he has treated in this way are iritis, cases of fracture, cases of the radical cure of hernia, rheumatoid arthritis, tubercular diseases of the spine, typhoid fever, and a case of hysterectomy. His address was illustrated by lantern slide projections on the canvas, which proved very interesting to the members of the Association.

Dr. P. H. Bryce spoke of the value of treating small-pox patients in tents. The tents should be double-roofed, and double-floored, and double-walled, each tent provided with a stove. The patients lived in these when the thermometer was 20 degrees below zero, being quite comfortable. Nobody died, although many were seriously sick.

Dr. Freel, Stouffville, recited the history of the case of a clergyman, the victim of tuberculosis, who lived in his tent all winter when the thermometer was 20 degrees below zero, and the wind blowing a perfect gale, and he was very comfortable. In a few months' time he ceased sweating, and gained very rapidly in weight, to such an extent that delivering a sermon would not throw him into a perspiration, as it always did before he took up tent life on his lawn.

Dr. J. H. Elliott, Gravenhurst, saw no reason why out-door life should not be employed in the treatment of other diseases as well as tuberculosis. It is not specific, and the only reason it is used is to strengthen the organism to resist disease. It is practically returning to primitive life, and it is so comfortable and pleasant that you find it very difficult to get patients to return to the house.

Dr. John Hunter referred to the Orphans' Home, Toronto, where they keep about 200 children. These are admitted at about four years of age, and they are kept there until they are about fourteen. Their mortality in that institution is about three in one thousand. They are practically kept out of doors all the time, and comparisons between the children of the Orphans' Home

and the children of the well-to-do people of the city are greatly in the former's favor.

Dr. Webster: The trouble is not now so much to get patients to sleep out of doors as it is to get them to return to the house when they have once been out of doors.

Dr. G. S. Ryerson, speaking of his visit to South Africa, said that at Bloemfontein the typhoid fever patients did particularly well in tents. The mortality was much larger in buildings improvised and used as hospitals. He considered that it was well to have the roof of a tent of material of some dark color, such as green or brown, because the patient, lying on his back, begins to complain of the color of the roof.

*On the Use of Nitrous Oxide and Ether as an Anesthetic.*—This paper was prepared and read by Dr. L. Coyteux Prevost, of Ottawa, and it proved to be highly interesting, carefully prepared, and ably delivered. He considers that a good and satisfactory anesthetic must possess the following qualities: First, offer the least possible danger for the patient; second, be rapid; third, complete; fourth, permanent; fifth, followed by as few disagreeable post-operative effects as possible. He then proceeded to relate the results of his personal experience during the last two years at the Hospital in Ottawa, as well as in his private practice. Dr. Gorrell, of Ottawa, was his assistant in this work. The agent they employ is ether, which they lately have associated with nitrous oxide, which is given at the beginning of anesthesia by the means of Clover's inhaler. He considers this method as absolutely ideal, as much for the rapidity with which the patient becomes anesthetized as for the freedom from all unpleasant sensations during the process of anesthesia and the diminution of after symptoms so frequent after operations. The apparatus which they have been using for the nitrous oxide and ether is Hewitt's inhaler, which is a modification of a Clover inhaler, with the rubber bag replaced by a large bag with valvular attachments. Within the last two years they have used this method almost exclusively, and the results are as follows: Anesthesia in one minute, twenty-four times out of 307 cases recorded; in one and a half minutes, fifty-five times; in two minutes, ninety-four times; in two and a half minutes, forty-seven times; in three minutes, forty-four times; in three and a half minutes, nine times; in four minutes, nineteen times; in five minutes, fourteen times. Dr. Prevost then entered into his observations with regard to the effect of the anesthetics upon the kidneys, and stated that out of 434 observations albumen was found twenty-six times. He drew attention to the fact that post-operative vomiting was very rare. Dr. Prevost was the first surgeon in Canada to employ intra-spinal cocainization. He believes that so long as the old and well-tried anesthetic agents, handled by competent men, continue to give good satisfaction,



that it will not be wise to abandon them until medullary narcosis has been clearly demonstrated. Our readers will find Dr. Prevost's paper in full under our Original Contributions in this issue.

*The Complications and Degenerations of Fibroid Tumors of the Uterus, with Reference to the Treatment of these Growths.*—Dr. Charles T. Noble, Philadelphia, delivered an able and exhaustive paper under the above heading, an abstract of which will be published in a subsequent issue.

Drs. J. F. W. Ross, N. A. Powell, McKinnon, and Clouse discussed the paper, to which Dr. Noble replied.

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### SECOND DAY—MORNING SESSION.

*The Relation of Nasal Obstructions to Obscure Cases of Asthma.*—By Dr. Arthur W. Mayburry, Toronto. This paper was read by title. Patients suffering from nasal obstruction are frequently coming before the notice of the busy practitioner. Asthma has a complex etiology, and the close association of this disease with nasal trouble is sometimes very remarkable. Adenoid growths in the pharynx frequently cause asthma, and in recent years much stress has been laid on the nasal origin of this disease. The author quoted Bosworth, who goes so far as to assert that asthma in a large proportion of cases is attributed to some form of nasal obstruction, the bronchial spasm being caused through reflex sympathy conducted along the fifth nerve.

*On the Importance of an Early Recognition of Locomotor Ataxia—Do the Eye Symptoms Assist Us?*—Dr. J. T. Duncan, Toronto, read this paper, and emphasized the importance of being able to diagnose this disease in order that prompt treatment might be applied. To do this we must be able to recognize the pre-ataxic stage. What are these symptoms? Professor Osler gives them as pains, ocular symptoms, and loss of the knee-jerk. What are the ocular symptoms? Strabismus or squint, ptosis, or drooping of the eye-lid, the fixed pupil (the Argyll-Robertson pupil), inequality of the pupils, and optic atrophy.

*Notes on the Use of Adrenalin.*—By D. J. Gibb-Wishart, Toronto. This is the formula which Dr. Wishart has been using in his office practice; having made several hundred applications, chiefly to the mucous membrane of the nose: One in 1,000, the chloride being dissolved in normal salt solution containing 0.5 per cent. chloretone. A ten per cent. solution of the above solution, which is equivalent to one in 10,000, has been sufficient to contract the blood-vessels in the membranes in a few seconds, and the repetition of the same or the use of a stronger dilution will blanch these membranes. Especially is this seen to be marked in the nose, where the membranes will become tightly drawn over the turbinated bones, which show

up white through it. It has proven itself to be highly useful in rendering operations about the nose practically bloodless, it is not found to answer so well in the removal of adenoids or enlarged tonsils. Dr. Wishart mentioned two cases in particular where it acted very promptly. The bottle in which it is kept must be tightly corked; and the properties of the substance are not destroyed by heat. Since he has added chloretone he was perfectly satisfied as to the stability of the preparation for all practical purposes. In no instance has there been a tendency to increase in the amount of bleeding. Dr. Wishart considers that the drug is a valuable addition to our armamentarium.

Dr. Duncan's paper was discussed by Dr. Wishart, Dr. Trow, and Dr. Hunter, while Dr. Wishart's paper brought out a discussion from Dr. Trow, Dr. McPhedran, and Dr. Graham Chambers. Dr. Wishart and Dr. Duncan replied respectively.

*Discussion on Gastric Ulcer: Medical Aspect.*—This was introduced by Dr. R. D. Rudolf, Toronto. In opening the discussion, from a medical point of view, he gave a short historical sketch of the chief literature of the subject, and said during the last thirty years only one important symptom had been added to those mentioned by previous writers, viz., the very common occurrence of hyperchlorhydria. Avoiding the consideration of the well-known points on the subject, he propounded five questions in connection with gastric ulcer, which seemed to him to specially merit discussion. First, is there any relation between gastric ulcer and cancer? Trosseau believed that an actual antagonism existed between the two conditions, while Labert considered that nine per cent. of all gastric cancers so arose, and Rosenhein states that five or six per cent. of all gastric ulcers became carcinomatous. Clinically, the speaker had never seen a case of simple ulcer end in cancer, nor had he seen a case of cancer preceded by ulcer, though such cases undoubtedly occasionally occurred. Dr. Rudolf had seen pathological specimens that illustrated both. Second, can we diagnose the site of gastric ulcer? This question is becoming more important on account of operations. Ewald states that in 90 per cent. of cases it is impossible to tell whether the ulcer is in the stomach or duodenum, and that usually it is hard to diagnose the site in the stomach. Most gastric ulcers occur on the posterior wall, near the pyloric end. The site of the pain and tenderness, the time the pain occurs after food, the position in which the patient is freest from pain, and the presence or absence of gastric dilatation may help, but these are very uncertain facts to lean upon. Thus in Pinel's famous case, mentioned by Abercrombie, where the patient was known to have ulcers near the pylorus, and the pain used to occur *immediately* after taking food. The taking of food may not only mechanically irritate the ulcer, but by stimulating the acid secretion peri-

stalsis may cause pain without touching the ulcer. It must further be remembered that there are sometimes several ulcers present. Third question: Does ergot ever stop gastric hemorrhage? Most authorities recommend ergot without question, but we must remember that the hemorrhage tends to be self-limiting from the lowering of the blood pressure, and the forming of a clot, and ergot may interfere with this natural cure by raising the blood pressure. Turpentine and other local aseptics have no such objection, and calcium chloride increases the tendency to clotting. Fourth question: Are cases of apparently "cured" gastric ulcer "first class lives" for insurance? The speaker did not think that they were, because sudden perforation might occur after years of quiescence (he had seen two such cases). Ulcers were apt to relapse or to break out in new places. The severer the symptoms of ulcer had been at the time, especially the hemorrhage, and the shorter the period since its occurrence, the worse the "life" was. Fifth question: As regards operation, as soon as perforation into the peritoneal cavity be diagnosed, operation should be at once performed. As regards operation where no perforation exists, the question was not so easily settled. Severe, uncontrollable hemorrhage might occasionally call for surgical treatment, but the mortality from hemorrhage is surprisingly small, even if this is severe. Dr. Mayo Robson had recently recommended that "after a second bleeding, even during a course of the hemorrhage, if the patient can stand it, or as soon after as his condition will admit, the operation should be done." The speaker was glad to see that his old teacher, Dr. Byron Bramwell, challenged this advice (*The Lancet*, March 9th, 1900, p. 687). Operation for the less urgent symptoms of gastric ulcer would occasionally be necessary, but in this direction we should proceed with great caution. Dr. Moylihan, in a recent paper (*The Lancet*, April 27th, 1901) gave a summary of all the cases to date in which gastro-plasty or gastro-gastrostomy has been performed for "hour-glass stomach." They amounted to thirty-eight in all, and 9 of them were fatal, while in many complete relief of symptoms occurred.

*Pathology.*—This branch of the discussion was led by Dr. H. B. Anderson, Toronto. He said he would make no reference to ulceration resulting from the breaking down of tubercular foci, syphilitic gummata, or malignant growths, nor of ulceration occurring during the course of acute infective diseases, nor resulting from the action of corrosive poisons, but would limit the discussion to a consideration of the commonly designated, simple, round, perforating or peptic ulcer. From the similarity in all essential points, however, he included the corresponding ulcer at the lower end of the esophagus, and in the first part of the duodenum. From *post-mortem* statistics the frequency of gastric

ulcer was in about five per cent. of cases, cicatrices being found about three times as often as healed ulcers. From his own experience at autopsies in Toronto, he was sure that gastric ulcer did not occur in Ontario as frequently as indicated by the above figure.

The condition occurred most frequently in adults from 20 to 40 years of age, but was by no means rare at the extremes of life. The mortality was greater from 40 to 60 years of age, no doubt from the lessened reparative power at that period of life. Females were affected more frequently than males, in about the proportion of two to one.

The etiological import of other diseases, especially chlorosis, was dwelt upon. Injury was a factor in rare instances, a statement substantiated by certain experimental data. Occupation, race, climate, habits, all had an indirect influence in some cases, and arterial sclerosis, thrombosis, and embolism of the gastric vessels were occasional factors in the etiology of the condition.

All these factors were, however, of secondary importance, and were only active in the presence of an altered condition of the gastric secretion. The localities where this form of ulceration occurred—at the lower end of the esophagus, in the stomach, and the first part of the duodenum—situations exposed to the action of the gastric juice, as well as the not infrequent occurrence of *post-mortem* digestion of the walls of the stomach—were strongly suggestive of the importance of this factor, and this had received further direct proof from the discovery of the frequent occurrence of a hyperchlorhydria, associated with gastric ulcer from a chemical analysis of the stomach contents, obtained after test meals. The failure to find this condition in some cases was not proof that it had not existed at an earlier period in the diseases, for the hyperchlorhydria might afterwards have been lessened as the result of the greater or less degree of gastritis following in the wake of the ulcer. Ulceration did not occur unless there was a disproportion between the acidity of the gastric juice and the condition of the blood. Normally, auto-digestion of the walls of the stomach was prevented, not by a simple chemical reaction in which the acid was neutralized by the alkalinity of the blood and fluids in the tissues, but by the vital resistance of the living cells of the part. He did not think there was anything to uphold the bacterial origin of this form of ulcer urged by some authors.

The pathological anatomy of gastric ulcer and its various terminations were discussed and illustrated by specimens. Healing was the fortunate result in the majority of cases. At other times a fistulous communication was formed with the duodenum, colon, or the cutaneous surface, or a subphrenic abscess might result. Adhesion to the pancreas, liver, or to the omentum, frequently walled the trouble off. Not infrequently, however, peritoneal in-

fection from perforation occurred, and the symptoms might be so intense as to stimulate irritant poisoning. Gastrectasia, or hour-glass deformity, from cicatricial contraction at the pyloric orifice or in the centre of the organ, at times gave rise to serious results. A specimen, showing the development of a carcinoma at the base of an ulcer with a clinical history extending over many years, was presented.

*Surgical Aspect.*—Dr. Henry Howitt, Guelph, conducted this part of the discussion and said: Did it never strike you as being peculiar that the best remedies, nitrate of silver and so forth, are germ destroyers? He first took up the procedures for dealing with the ulcer or its results, in which perforation is not a factor. In all the operative procedures it was essential to prevent infection of the wound; stomach should be thoroughly washed with aseptic water, by means of siphon tube, immediately before the anesthetic is administered. It is not necessary to make the abdominal incision extensive; the length of the incision would depend upon the amount of contraction, and it is sutured in such a manner that when closed the line of union is at right angles to the original incision. This gives excellent results when properly done. Adhesions render this ideal operation impracticable. The first successful operation in Canada was performed in Toronto, 1894, by Dr. Atherton. Up to last September, in the neighborhood of 300 operations were reported, with a mortality of a little over 45 per cent. Dr. Howitt then referred to cases in his own practice. With regard to the treatment, Dr. Howitt said that as soon as we are satisfied that perforation has taken place, referring to acute cases, he believes it is good practice to give morphia hypodermically; and it further lessens the amount of the anesthetic in the opinion of many. Success largely depends on the shortness of time before operation; delay is dangerous. It is Dr. Howitt's practice to eviscerate the bowels; one or more small incisions in the prominent coils soon overcome the distension, and each one is closed before another is made. Attention is now turned to the stomach, and the part brought into the wound. The ulcer is incised and opening closed with two or three layers of sutures. When the trouble is in the posterior wall it may be impossible to excise it, in which case it can be generally inverted and closed by layers of sutures. The abdominal cavity should be thoroughly flushed with a stream of saline solution. When drainage is necessary the tubes or gauze should not be introduced through a large wound. The object should be to have primary union to take place in the incision.

Dr. McPhedran, referring to the treatment of simple ulcer, said that the treatment for this is one that is not carried out very effectively. If not successful after a month of rest in bed with medicinal treatment, he would advise operation.

Dr. J. F. W. Ross referred to a case of catarrh of the stomach in a woman of 59 pounds, and where he was satisfied before operation that he had to deal with a cancer of the stomach. She recovered and rapidly gained in weight until she reached 140 pounds.

Dr. Bruce referred to a case upon which he had operated.

Drs. Rudolf, Anderson, and Howitt replied.

*Vaginal Section, Exploratory and Operative.*—Dr. F. Shaw Webster read a paper with the above title, describing several operations performed in that way, one being for ectopic gestation. He reported good success in them from the vaginal route.

Dr. Noble thought the vaginal route all right for abscesses, but had a preference for the abdominal in pelvic operations.

Drs. Bruce, Macdonald, Oldright, Ferguson (London), W. J. Wilson, and Clouse discussed this paper, the discussion proving an interesting one, although the members were rather impatient for hot soup, it being past the hour for luncheon.

Dr. Webster replied, and defended his position ably.

Dr. Bruce L. Riordan now passed through the theatre announcing that luncheon was ready in the dining car, so there was an immediate bolt for the door, and all were soon enjoying themselves at a very fine spread provided by the Committee of Arrangements. Afterwards, bright and happy speeches were made by several of the members, the audience simply calling for their favorites, and no one being specially set down for any toasts. Amongst others who said some good things were Drs. Harrison, Dean Geikie, J. C. Mitchell, N. A. Powell, George Bingham, and the President.

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#### SECOND DAY—AFTERNOON SESSION.

*The Roentgen Rays in the Diagnosis of Urinary and Biliary Calculi.*—This paper, X-ray photos and specimens of calculi, which proved a very interesting demonstration, was presented by Dr. S. Cummings, of Hamilton.

Dr. McGillivray, Toronto, asked if the diagnosis is always positive.

Dr. Cummings replied that, if any errors, they are due to operator, not to X-ray itself.

There was a demonstration of skiagrams in an adjoining room.

*On the Relation of Hyperacidity of the Stomach to Biliary Attacks, Some Forms of Eczema, Muscular Rheumatism, and Gout.*—Dr. Graham Chambers, Toronto, stated that on several occasions he had examined the gastric contents of patients of apparently normal digestion, and found hydrochloric-superacidity, although in some of them there was a history of "bilious attacks," which were probably attacks of hyperacidity. He considers that

the gastric distress which is present in these cases is more or less due to the hyperesthesia of the mucous membrane of the stomach, as well as to the excessive acid contents. The commingling of these two neuroses, hyperchlorhydria and hyperesthesia gastrica, makes an investigation into the relations of the former to "bilious attacks," eczema, muscular rheumatism, and gout a very definite one, but he cannot but think that a general irritable condition of the gastric nerves must produce some changes in the sympathetic and cerebro-spinal centres, which will no doubt lead, or tend to lead, to diseases in other organs.

Dr. Chambers' attention was first called to this subject about two years ago, when he observed that the internal treatment, both dietetic and medicinal, which he was accustomed to give in cases of hyperchlorhydria, was approximately the same as that which he was using in some forms of acute eczema, and in both cases it gave very satisfactory results. In his experience "bilious attacks" are very frequent in cases of chronic hyperchlorhydria; he has also found that symptoms of indigestion are of frequent occurrence in eczema, and are usually of a character which indicates hyperchlorhydria. He has examined the gastric contents of six cases of eczema, with symptoms of dyspepsia, and in five of these there was an excess of HCl in the gastric contents. He gave notes of cases in illustration of his researches. "Acidity" is a common symptom in gouty subjects, and Dr. Chambers believes that a thorough investigation of the subject would prove the opinion that the "acidity" of the gastric contents is not due to organic acid at all, but that hydrochloric acid will be found to play an important part in it. With regard to muscular rheumatism, we know very little about the etiology of it. Clinically, we have found that muscular rheumatism and gout are in some way related, and in regard to relations of hyperchlorhydria and muscular rheumatism, Dr. Chambers has observed that they are frequently associated, but whether the muscular rheumatism is the result of the hyperchlorhydria, he is at the present time unable to say.

Dr. Bryce discussed the paper.

*Medical Treatment of Surgical Tuberculosis.*—By Dr. W. B. Thistle, Toronto. It is important to remember this fact, that there is no difference in the nature of the disease, whether considered surgically or medically, and especially is this so when we come to consider treatment. We hear on all sides that it is a curable disease, and complete cure often now happily results from medical treatment. Dr. Thistle has observed that tubercular cases requiring surgical treatment in the great majority receive little or no medical treatment. The subjects of surgical tuberculosis should have the fullest advantage of sunshine and fresh air, as well as those suffering from the disease in its medical aspect.

*Treatment of Post-Operative Peritonitis.*—By Walter McKeown, Toronto. The paper suggested that this condition should be treated by the use of decinormal salt solution, either subcutaneously or intravenously, and enemata of strong solutions of sulphate of magnesia. The toxins will dialyze; the antitoxins will not. If, then, the toxins can be eliminated with sufficient rapidity, the disease will limit itself as a result of the formation of antitoxin, together with the plugging of the peritoneal lymphatics. The blood is diluted by the addition of the salt solution, and this is drawn out into the rectum by means of a solution of higher osmotic pressure, carrying the toxins with it. He claims that, even with a condition of paralysis of the bowel, toxins will dialyze in this way. He suggests that if a patient were placed in a salt bath, the toxins would probably osmose directly through the skin. That osmosis does not take place from without through the skin does not prove that the reverse process will not occur. Osmosis is known to take place much more rapidly in one direction through the shell membrane of the egg than the other.

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#### SECOND DAY—EVENING SESSION.

Dr. R. A. Pyne, the first Vice-President, occupied the chair.

The Committee on Credentials recommended the following for membership, which was adopted: Dr. R. W. Garrett, Kingston; George Sherk, Cheapside; W. A. Scott, Courtright; Daniel Buchanan, Galt; L. C. Prevost, Ottawa; Milton Baker, Springfield; Donald McGillivray, Toronto; A. E. MacColl, Belleville; Arthur I. Brown, Holstein.

The following constituted the Nominating Committee: Drs. George A. Bingham, A. McPhedran, Burt, of Paris, Powell, of Toronto, Mitchell, of Enniskillen, Harrison, of Selkirk, and Macdonald, of Toronto; Drs. E. Clouse and Price Brown acting as scrutineers.

This Committee reported as follows, which on motion, was received and adopted:

President, Dr. N. A. Powell, Toronto; First Vice-President, Dr. R. Ferguson, London; second Vice-President, Dr. R. W. Garrett, Kingston; Third Vice-President, L. C. Prevost, Ottawa; Fourth Vice-President, R. L. Turnbull, Goderich; General Secretary, Harold C. Parsons, Toronto; Assistant, Dr. George Elliott, Toronto; Treasurer, Dr. A. R. Gordon, Toronto.

The report of the Committee on Public Health was presented by Dr. Rosebrugh, seconded by Dr. Wm. Oldright, and adopted.

That on tuberculosis, by Dr. W. B. Geikie, seconded by Dr. H. J. Hamilton, and adopted.

That on Hospital Abuse was presented by Dr. Webster in the



absence of the chairman, Dr. W. J. Wilson, seconded by Dr. W. A. Young, and adopted.

The Committee on Inter-Provincial Registration had nothing at the present time to report.

Treasurer's Report was presented by Dr. G. H. Carveth, and showed last year's receipts to have been \$370.30, and expenditure, \$334.66, leaving a balance of cash in bank of \$35.64. This was audited by Dr. R. D. Rudolf, and on motion adopted.

The Report on Necrology was presented by Dr. Geo. Bingham. It included the names of C. W. Covernton, Toronto; C. E. Martin, Toronto; J. D. Macdonald, a past president, Hamilton; J. E.



DR. N. A. POWELL  
Newly Elected President of the Ontario Medical Association.

Eakins, Belleville; Isaac Ryall, Hamilton; A. K. Sturgeon, Petrolia; Dixon, Pembroke; Mennie, Toronto; J. A. Watson, Toronto; T. H. Little, Toronto; Jonathan Robinson, Toronto; J. H. Parsons, Toronto; and Irving, St. Mary's.

The Ontario Medical Library was voted \$50 on motion by Dr. R. A. Reeve, seconded by Dr. H. T. Machell.

A notice of motion was given by Dr. Graham C. Ambers, and seconded by Dr. H. B. Anderson, that the business session at future meetings be held on the evening of the first day. This will be referred to the Committee on By-laws.

Resolution of regret *re* non-payment of the annual \$2.00 fee

of the Ontario Medical Council was introduced by Dr. Ferguson, of London, seconded by Dr. Gibson, of Belleville, that some members of the profession in Ontario had failed to pay their annual assessments, and that this Association regards the imposition of this fee as most reasonable, payment of which should meet with a cheerful response on the part of every member of the profession. This was carried unanimously, amid much applause, and without a dissenting voice.

Dr. Wishart, Toronto, chairman of the Special Committee to draw up a resolution *re* vaccination, reported:

*Resolved*,—That the Ontario Medical Association desires hereby to re-assert the opinion of the medical profession of this Province:

1. That the principles of Jennerian vaccination against small-pox, which have now been attested by the experience of over a century, are scientifically correct.

2. That in order to carry out the protection through vaccination against small-pox, it is necessary that the lymph used in the operation be of normal quality, and that this can be shown only by a proper amount of systemic reaction to the vaccine as determined by the character of the vesicles, and that the absence of a normal reaction as shown by the presence of vesicles is no positive evidence of the immunity of the person either against vaccinia or small-pox.

3. That this Association emphasizes the urgent necessity that the scarification of the skin be sufficiently extensive to secure such reaction, and to this end recommend that from three to five insertions, each of a quarter of an inch square, be made in each vaccination. This was carried.

*Medical Defence Union*.—On motion of Dr. J. F. W. Ross, seconded by Dr. A. Primrose, a committee was appointed to inquire into this matter, to report at the next meeting of the Association in 1902.

Votes of thanks were passed to the Minister of Education for the use of the building, and also to the President, Dr. McKinnon, for his exceedingly able address.

During the progress of the meeting, it was addressed by the Hon. the Minister of Education, Mr. Harcourt, who advised them strongly to keep up the standards of matriculation and the professional examinations.

Dr. N. A. Powell was then installed in the office of president, and after brief acknowledgment the 1901 meeting adjourned.

## EXHIBITS OF DRUGS, SURGICAL APPLIANCES, ETC.

*The New York Pharmacal Association—Arlington Chemical Company—Palisade Manufacturing Company. Canada Office, 88 Wellington Street West, Toronto.*

Exhibit of these companies proved a centre of much interest, demonstrating the high esteem in which their products are held by the profession. The New York Pharmacal Association showed the various preparations of "Lactopeptine," which have made the Company's name a household word in the medical world on both sides of the Atlantic. Pioneers in the field of digestives, "Lactopeptine" still heads the procession as the digestive *par excellence*.

The Arlington Chemical Company showed their "Liquid Peptonoids," which have established themselves as a most effective and reliable nutrient, where ordinary food cannot be taken. Particular attention was directed by representatives to the combination with "creasote," to the value of which in typhoid, tuberculosis, and gastric intestinal disorders we gladly bear testimony. This Company also exhibited their new preparation, "Phosphagon," a combination of phosphorus and the organic phosphorized compound. Composition of this "natural nerve material" is fully set forth in a most interesting treatise issued by the Company, which they will cheerfully send to all applicants for same.

"Hemaboloids," "Hemaboloids Arseniated," "Hemaboloid Tablets," and "Borolyptol" constituted exhibit of the Palisade Manufacturing Company. The first-named preparation and its recently added "arseniated" combination are rapidly growing in favor with the profession in Canada as a valuable agent in treatment of chlorosis, etc. This preparation is described as "a combination of the various iron-bearing nucleo-albumins of the vegetable kingdom, reinforced by bone-marrow extract and beef peptones, antiseptically treated with nuclein." Remarkable and overwhelming testimony is offered as to practical clinical results obtained in its use, and we would advise our confreres to take advantage of the extremely liberal offer of the Palisade Manufacturing Company to furnish samples, as well as copy of booklet, "Concerning Hemaboloids," to any physician in regular practice who may desire them. "Borolyptol" is too well known to the profession to call forth extended mention, and we are glad to learn that its merits are becoming fully appreciated on this side.

Exhibit was in charge of Dr. W. B. Nichols and Mr. L. G. Christie, the latter a veteran and acceptable missionary to the service in this field. Dr. Nichols made his bow to the Canadian profession on this occasion, and demonstrated his thorough fitness for the important work entrusted to him, viz., waiting upon the

profession generally in the interest of the preparations of the three companies above named.

*H. K. Wampole & Co., Philadelphia and Toronto.*

Another of the features of the exhibit of the Ontario Medical Association was the very elaborate display made by Messrs. Henry K. Wampole & Co., whose Canadian Laboratory is at Nos. 36, 38, and 40 Lombard Street, Toronto. While it would be impracticable to mention in detail each of the special and pharmaceutical preparations which this popular firm displayed at this meeting, yet there are several newer preparations whose salient points are of such value to the medical profession that we deem it advisable to further direct their attention to them. Probably the most important among these is Wampole's Milk Food, which by chemical analysis is shown to simulate more accurately and uniformly human milk than any other similar food. Briefly stated, chemically it is simply pure milk, largely deprived of its casein, partially predigested by the diastase of the malt, and its nutritive principles enhanced by the beef, and the extra percentage of soluble phosphates obtained from the inner cortical of the whole wheat grain. Practically, in preparing Wampole's Milk Food, the mother or nurse avoids all the disagreeable manipulations necessary when cream or milk is added, avoiding expense of same, as well as that for ice, and the complex apparatus needed in sterilizing, etc. The reports received from the medical profession bearing upon this food are of a most gratifying nature, and, we think, of such a character as to warrant, at least, a thorough trial.

Antiseptic Vaginal Cones of Beroglyceride Compound with Ichthyol are most appropriate for those diseases in which their use is indicated, offering an acceptable method for the treatment of vaginal ailments without inconvenience, pain or discomfort, and without necessary exposure, unavoidable in introduction of tampon or other local applications; giving prolonged contact of very efficient antiseptic and mild astringents, besides the medicinal activity of the Ichthyol.

The other specialties of Messrs. Wampole & Co., as exhibited, are well known by the profession in Canada, and we bespeak for them consideration.

*The Chandler & Massey, Limited, Toronto.*

Chandler & Massey, Limited, made a splendid display of a number of their lines. Their exhibit of ligatures, etc., attracted a great deal of attention, as did also their bedside tables and ward tables, special mention being made of the high-grade quality of the goods being turned out of their manufacturing departments. One of the most interesting features, however, of their exhibit, and which seemed to gain the attention of the physicians in attend-

ance, was the adjustable Fox Invalid Bed. Chandler & Massey have just recently acquired the patents in connection with this bed, and report that sales are being made as rapidly as the beds can be turned out of their machine shop.

A great many of the visitors could not resist the attractions of the very fine display of books, which is the latest department added to the Chandler business, and Mr. Watts, who had the exhibit in charge, reports a large number of sales of medical books. Their book-table certainly showed a good assortment of up-to-date medical literature, and a nice line of books for which Chandler & Massey are special Canadian agents.

*Parke, Davis & Co., Walkerville.*

A most attractive exhibit, which drew the attention of all of the physicians as they came in at the main door, was that of Parke, Davis & Co., of Detroit and Walkerville. It consisted of their different biological preparations, their anti-diphtheritic, anti-streptococic, anti-tetanic, and other serums in different sized vials and of varied dosage. The firm also exhibited a full line of vaccine tubes and ivory points. The exhibit was in charge of Mr. Grant, who was courtesy personified, and assisted in no small manner in adding to the enjoyment of the visitors.

*Frederick Stearns & Co.*

The exhibit of Biologic Products and Specialties from the laboratories of Frederick Stearns & Co. received much attention from members of the Association present. Their package of *Special Concentrated Diphtheria Antitoxin*, combining with each bulb a complete syringe for injection, was especially favorably commented upon.

Messrs. Stearns & Co. have recently erected a large addition to their laboratories for the Biologic Department, which is now one of the most modern and completely equipped in the world. Their exhibit of Pharmaceutical Specialties included Kasagra, which is recognized by the profession as the ideal tonic laxative. Stearns' Wine of Cod-Liver Oil, Liquid Hæmoferrum and Tri-palm, also the newer specialty, *Vibutero*, a concentrated and exceedingly palatable preparation of the two viburnums, in combination with saw palmetto, and other uterine tonics and sedatives. Stearns & Co. invite correspondence with physicians, and their scientific department is at the command of the profession at all times.

*J. H. Hartz & Co., of Detroit and Toronto.*

J. H. Hartz & Co., of Detroit and Toronto, had an exhibit which, judging from the crowd of physicians constantly around it, proved attractive. Besides his other goods, Mr. Hartz, who

was there himself, erected a large static machine, and demonstrated its value as a cathode ray generator.

*Tropon Preparations.*

Hupfeld, Ludecking & Co., of Montreal, was represented in the interests of Tropon in its different forms—Tropon and Iron, Tropon Chocolate, and Tropon Cocoa. This preparation is one which is rapidly surging its way to the front, and deservedly so, as it proves frequently of considerable value in the treatment of cases of marasmus in children, and anemia, anorexia, and similar conditions in the adult.

*J. A. Carveth & Co., Toronto.*

J. A. Carveth & Co. had a table on the left of the main entrance, and showed a full line of W. B. Saunders & Co.'s medical books. This exhibit was in charge of Mr. Carveth himself.

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**ANNUAL MEETING OF THE COLLEGE OF PHYSICIANS  
AND SURGEONS OF ONTARIO.**

*(Digest.)*

Our local medical legislature met in their council chamber, Tuesday, June 11, with Dr. Britton, President, in the chair. Dr. Britton, in opening his annual address, referred to the deaths of Dr. W. W. Dickson, Vice-President of the Council, Dr. Carlyle, Auditor, and Mr. B. B. Osler, Solicitor of the Council. He dealt with the question of the annual fee and the method of its collection, referring to recalcitrant members (280 in number), who still refuse to pay. In speaking of Dr. Roddick's scheme of Dominion registration, Dr. Britton said: "It is my strong conviction that representation by population, so modified as not to render the Dominion Council unwieldy or financially impossible, must be conceded before Ontario could, in justice to herself, take the first step towards unifying the profession throughout Canada."

On Wednesday the committee on examinations reported that owing to the large number of candidates presenting themselves for examination this year, it would not be possible to make the results known until July 22. As the Council has to pass these results, a difficulty presented itself, and the committee suggested that it be left to the executive committee to disclose the results, and deal with any complaints that might arise, a special meeting of the Council being called if necessary.

The application of Dr. Jordan, a soldier who served in South Africa, for registration, was referred to the committee on registration by the examination committee. The property committee reported that the building is in good condition, and that the Canada Life Assurance Company had agreed to re-

duce the interest on the mortgage to 3 1-2 per cent. on \$60,000, if the Council could not sell the building at a fair price, the Council to keep the building insured for \$25,000 for the benefit of the mortgagees. A letter was attached from an architect, recommending that by adding two floors of offices under a flat roof it would be possible to make the building a paying concern. Every effort had been made to dispose of the property. None of the offices in the building were vacant. The committee appointed to deal with infractions of the Medical Act reported that a number of cases were considered and investigated, and in some cases prosecutions were made. An opinion was appended from Mr. J. W. Curry, K.C., to the effect that under the Medical Act the registrar was in duty bound either to enforce the payment of the \$2 fee upon all practitioners or else leave it in abeyance altogether. The committee recommended that medical practitioners who were said to be shielding men in practice, who were not registered, should be brought before the discipline committee, or at least that the discipline committee should investigate these complaints.

On Thursday morning Dr. Roddick, of Montreal, addressed the Council on the subject of Dominion Registration. After dealing with the well-known features of this question, he added that at the next session of the House of Commons of Canada a committee would be appointed to hear delegates from any Province, and consider their suggestions.

A great deal of discussion took place on the case of Dr. Shepherd, who was accused of conduct infamous and disgraceful in a professional way. He was suspended by a vote of 24 to 6. Mr. Curry was present as counsel for the Council. Dr. Shepherd said he would appeal from the Council's decision.

On Friday morning the by-law providing for an imposition of a fee of \$2 a year on each member of the College was adopted.

The report of the finance committee showed that the estimated revenue for the coming year was \$25,136, and the estimated expenditure \$17,885. The salary of the treasurer, Dr. Aikins, was increased from \$400 to \$500.

Dr. Macdonald presented the report of the committee on Dominion registration. They recommended the adoption of the preamble of Dr. Roddick's bill; but suggested the following scheme of representation: The first 100, or fraction of 100, medical practitioners in each Province shall be entitled to one representative. The second 100 or fraction of 100 over 50 per cent. shall be entitled to one representative, and for each subsequent 600 one representative shall be allowed. One representative from each Province shall be appointed by the Governor-General in Council, and there shall also be three members elected by such practitioners in Canada as are now recognized by the laws of a Province as forming a particular and distinct school of the

practice of medicine, and are as such entitled to representation in the Medical Council of the Province. There shall be one representative for each university having a teaching faculty in medicine or a medical college in affiliation with it. The committee also recommended that such members of the Ontario Council as shall attend the meeting of the Canadian Medical Association at Winnipeg be a committee to confer with similar committees from other Provinces. The report was adopted.

The officers elected for the ensuing year are: President, Dr. L. Brock, Guelph; Vice-President, Dr. W. J. H. Emory, Toronto; Registrar, Dr. R. A. Pyne, Toronto; Treasurer, Dr. H. W. Aikins, Toronto; Auditor, Dr. J. C. Patton, Toronto.

At the concluding session of the Ontario Medical Council on Saturday morning, the report of the educational committee, read by Dr. W. H. Moorhouse, recommended the following board of examiners for 1901-1902, which was adopted: Dr. H. B. Anderson, Toronto, anatomy, descriptive; Dr. W. G. Anglin, Kingston, theory and practice of medicine; Dr. R. N. Horton, Brockville, midwifery, operative and other than operative, and puerperal diseases; Dr. A. Primrose, Toronto, physiology and histology; Dr. J. W. Edgar, Hamilton, surgery, operative and other than operative; Dr. W. Gunn, Clinton, medical and surgical anatomy; Dr. G. Chambers, Toronto, chemistry, theoretical, practical, and toxicology; Dr. J. W. Schooley, Welland, materia medica and pharmacy; Dr. J. H. McLellan, London, medical jurisprudence and sanitary science; Dr. R. Ferguson, London, assistant examiner to the examiner on surgery, diseases of women; Dr. A. Haig, Kingston, first assistant examiner to the examiner on medicine, diseases of children; Dr. G. H. Field, Cobourg, second assistant to the examiner on medicine, pathology, therapeutics, and bacteriology; Dr. E. T. Adams, Toronto, homeopathic examiner.

On motion of Dr. Britton, seconded by Dr. Emory, the special committee on Dominion Registration was instructed to favor the following addition to clause i, sect. 10, of Dr. Roddick's proposed Registration bill: "And provided always that the possession of a Canadian University degree alone, or a license to practise founded thereon, shall not entitle the holder to register under this Act." Dr. Britton explained that, according to Dr. Roddick's bill, the Dominion Council would have power to register anyone holding a license to practise in any Province, or holding a degree from any Canadian University. Dr. Britton's intention was that his amendment should not apply to those licensed to practise in any Province prior to the passage of Dr. Roddick's bill; but only to those presenting themselves for registration after that bill should pass.

The Council adjourned to meet again on the fourth Tuesday of June, 1902.



MEETING OF EXECUTIVE HEALTH OFFICERS OF  
ONTARIO.

BRANTFORD, JUNE 25TH AND 26TH, 1901.

THE matter of time and place of the 1901 meeting of the Executive Health Officers Association of Ontario was left in the hands of the Executive Committee, who, after consultation with the local health officials of Brantford, decided to hold the session on Tuesday and Wednesday, the 25th and 26th days of June, as being a time of year when medical health officers and members of boards of health were likely to be most at liberty to attend. A strong local committee of arrangements was formed, and there was a large attendance and enthusiastic reception by the public-spirited citizens of Brantford. The Executive Committee carried out the following general programme, most of the papers read being upon those subjects:

1. *Small-pox Outbreaks in Ontario.*—(1) Types of Smallpox. (2) Difficulties of diagnosis. Degrees of protection by vaccination. (3) Methods of dealing with outbreaks in cities, towns and townships, and unorganized districts. (4) Vaccination—As a problem in serum therapy. (5) What is normal vaccination? And to what are the protective qualities of vaccine due? (6) Dangers from vaccination. How existing? How far inevitable? How avoided?

2. *The natural history of Typhoid-Fever.*—(1) Typhoid outbreaks in Brantford during five years. (2) Relationships of Typhoid to ground water. (3) The spread of Typhoid through milk supplies. (4) Is the *Bacillus Coli* causative of Enteric Fever? (5) The immunity of towns when uncontaminated public waters are supplied.

3. *The regular medical inspection of school children and schools as a means of stamping out infectious disease.*—(1) Should schools be closed during an outbreak of contagious diseases?

4. *How far can the examination of swabs from diphtheritic throats be accepted as a reason for giving certificates of recovery in diphtheria?*—(1) Variations of types in Diphtheria and Scarlet Fever and the duties of physicians in the matter of duration of time before giving certificates of recovery, and in the isolation of mild cases.

5. *How are Sanatoria for Consumptives to be established and maintained?*—(1) Does the bill for county sanatoria meet local conditions? (2) Can a private company be expected to deal with the work of a whole Province or the whole Dominion? (3) How will physicians and health officers best promote public health

interests in dealing with the care and treatment of consumptives. (4) Meat production for transportation and export, and the relation of local or state inspection thereto. How can local populations be protected against poor meat, while the best quality is sold for export or to metropolitan markets?

6. *Has the Milk Inspection Act of 1900 proved adequate for prohibiting the sale of unwholesome milk and improving the quality of public supplies?*—(1) What are the important points in practice required to obtain a safe children's supply of milk? (2) How can health officers best assist in improving the milk products of dairies and creameries? (3) Can Dairymen's Associations have their products improved in wholesomeness, quality and value by systematized compulsory inspection by qualified health officers? (4) How should expenses be met in the inspection of factories where meat and dairy products for the export trade are prepared?

7. *Can rural sanitation in the matter of inspection of wells, the inspection of schools, the dealing with the outbreaks of contagious diseases, be improved by any alteration in our present health machinery?*—(1) Would the extension of the unit of local health organizations to ridings or county boundaries be conducive to greater efficiency and economy in the public health service?

8. *The progress of sewage purification works in Ontario.*—(1) Some of the practical advantages to towns in disposing of sewage on sewage farms.

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**Sir Frederick Treves.**—Mr. Frederick Treves has had the honor of knighthood conferred upon him by the King in person, who also invested him with the insignia of a Commander of the Royal Victorian Order. Recently he was appointed Honorary Sergeant-Surgeon to the King. He was awarded C.B. for his services as Consulting Surgeon in the South African War. But entirely apart from his services in the war, Mr. Treves has earned sufficient distinction as a surgeon and surgical writer to entitle him to the highest distinctions from his sovereign. His works on "Intestinal Obstruction," "Surgical Anatomy," "Operative Surgery," and the "System of Surgery," edited by him, have long been standard books in the profession.—*Jour. Amer. Med. Association.*

**A Very Serious Case.**—Late one evening a doctor received a note from a couple of fellow-practitioners, saying: "Pray, step across to the club; we are one short for a rubber." "Emily, dear," he then said to his wife, "I am called away again. It appears to be a very serious case, for there are two doctors already in attendance."

## Selected Articles.

### SUMMER DIARRHŒAS IN CHILDREN.

BY H. S. BAKETEL, M.D., MELROSE, MASS.

To the busy practitioner the proximity of summer brings little of joy or gladness. The average man looks forward to the hot months for pleasure, rest and recreation. The average physician, however, can only anticipate hard work and plenty of it, with difficult cases, aggravated by the heat and atmospheric changes.

Probably the greatest bugbear to haunt the dreams of the medical man is intestinal disturbance. From June to late September he is greeted on all sides by summer diarrheas, many of which are of the most baffling nature.

The mortality from intestinal diseases in children is very heavy, particularly in cities and large towns. Even in the country the physician signs more death certificates from these causes than he cares to.

I have been greatly interested in the diseases of children, and have followed certain definite lines of action with a considerable amount of pleasure. The summer diarrheas of which I am about to speak were met with in a fairly extensive country practice radiating about a town of 3,500 inhabitants.

The people were prosperous mechanics, farmers and artizans, with a comfortable sprinkling of business and professional men. The town was high and sandy, well drained by natural and artificial means. The cases reported were with rare exceptions seen in good homes, clean and sanitary, so that the element of filth was quite eliminated.

A careful study of the diarrheal cases in my record book for 1899 shows that there were three well-defined classes: Catarrhal enteritis, entero-colitis, and cholera infantum, named in the order of their frequency. I also saw cases of cholera morbus in older children, but as I am speaking particularly of young children, I will omit any discussion of that form of disturbance.

Catarrhal enteritis, or the so-called acute diarrhea, was met with almost daily. The similarity between the various cases was

so marked that I kept but few records other than the diagnosis, duration, and treatment.

The characteristic feature of this complaint is a marked looseness of the bowels, accompanied by fever, pain, and localized abdominal tenderness.

Twenty-nine cases showed these general features, and were therefore treated in much the same manner. The causes were mostly indigestible food and heat changes, six being of the latter variety. When seen, these symptoms were observed: Increase in temperature, ranging from 101 to 103 degrees, two cases showing 104 degrees; colicky pain near the umbilicus, and much tenderness over that point; yellowish-green stools, showing much indigested food and little fecal consistency; anorexia and great weakness. In 21 of the cases the yellowish-green stools gave way to the characteristic "rice water" evacuations, and in nearly every instance emaciation was noted after the second day. At the outset I swept the bowels clear of mucus and fermenting food by the administration of castor oil, to which was added laudanum for the prevention of griping, and sodium bicarbonate (15 gr.) to counteract the acidity of the bowels caused by fermentation. After the intestines had been thoroughly cleansed of all irritating substances, they were given an opportunity to rest. The diet was limited to milk and lime water, to which was added later chicken soup. The following prescription was very generally used, and each time proved successful:

R	Tinct. opii deod. ....	gtt. i.
	Bismuth subnit. ....	gr. v.
	Mist. cretæ. ....	ʒi.
	Peptenzyme ....	gtt. x. M.
Sig.	Every four hours.	

But one case became aggravated, necessitating acid treatment, and that one was not seen for three days after the onset of the disease. The average duration of the trouble was eight days. It was found exceedingly difficult to keep the patients in bed, as they ranged from two years up.

In looking at the second class, entero-colitis, of which 18 cases are noted, one is much impressed with the severity of the disease. Its causes are very like those of catarrhal enteritis, improper food and changes in atmospheric conditions, to which may be added uncleanness, impure air, and exposure to dampness. I believe improper food plays a most important part in the causation of entero-colitis. This belief was emphasized from the fact that seven cases occurred in three neighboring families who obtained their milk from a common source. It was only delivered three times a week, and although some care was taken with the milk, the severe diarrheas in the three families, who alone obtained their supply tri-weekly, leads me to suspect that the intervals between

milking and the actual consumption was so long that lactic acid fermentation had set in, thereby causing an inflammatory diarrhoea. The various cases of entero-colitis simulated each other with no great divergencies. The patients were in the period of first dentition to a large extent, 12 of the 18 cutting incisors. Two had no teeth, one was getting his anterior molars, and three possessed a full set of teeth. The symptoms of anorexia, feverishness, nausea, vomiting, with greenish, semi-fluid stools containing yellowish fecal flakes, the "mousy" smelling, "spinach-like" stools, are familiar to all practitioners. Each of the cases recovered after illnesses averaging 17 days. This was due in great measure, I believe, to insistence on proper hygienic conditions, combined with proper medication. In three cases where the drainage was not modern, the children were taken to neighboring houses, which were perfect from a sanitary standpoint. Fresh air, daily baths, and absolute rest were found to be absolutely essential in the treatment of this malady. The first few days I gave small doses of milk and peptenzyme, one tablespoonful every three hours. After the fifth day the amount of milk was increased, and the peptenzyme given in the same dose at 10 a.m. and at 2 and 7 p.m. This prescription gave the best satisfaction:

R. Tinct. opii camph..... ℥iii.  
 Tinct. catechu comp..... ℥iv.  
 Mist. cretæ..... ℥ix. M.

Sig. Teaspoonful every two hours.

The usual spice poultice on the abdomen was also found of service. My extreme good fortune in these cases was due in great measure to the excellent offices of peptenzyme.

Cholera infantum was met with 11 times, with 10 recoveries. The fatal case was not seen until the patient was *in extremis*. The symptoms are so well known that no description is necessary, and I will merely outline the plan of treatment. Immediately upon seeing the patient the colon was thoroughly washed out. Irrigation was continued every two hours until the food flakes and mucus had been thoroughly dislodged and a clear fluid shown. I then sought for the cause of the trouble—whether heat, exhaustion, thermic fever or ingestion of irritating food products, and treated the case accordingly. Food was rigidly prohibited, small doses of protonuclein being administered every two hours in bran-died water. This prescription was used:

R. Acid. sulph. aromat..... gtt. xxx.  
 Tinct. opii camph. .... ℥ viii.  
 Sprt. chlorof..... gtt. xlviij.  
 Syr. zing. q. s. ad..... ℥iii. M.

Sig. Teaspoonful every two hours.

Peptenzyme was freely given, often five drops every two hours, and in two severe cases the dose was doubled. Counter-irritation

over the bowels by a spice poultice was also invariably used to good advantage.

I believe the excellent success attending the cases was due in great measure to the liberal use of peptenzyme. I have found nothing which acts with such uniform success in diarrheas as this remedy. Its use is not necessarily confined to the sphere of pediatrics, as its influence is as potent among adults as among children. In previous experiences with summer complaints, in which peptenzyme was not used, the death rate was much larger, and I am convinced that its superiority over the average digestive ferments was the cause of the excellent showing made in the cases here reported.

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### TANNOFORM AS A PREVENTIVE OF HYPERIDROSIS AND SORE FEET.

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SURGEON-MAJOR F. MERZ, in order to ascertain the comparative value of tannoform in preventing and curing excessive and fetid perspiration of the feet (hyperidrosis and bromidrosis), used it in a great number of soldiers side by side with other treatment. Each company was divided into three portions; one division was treated for three nights in succession with tannoform powder, the second division was treated with the ordinary regimental foot-powder, and the third division was made to take a cold foot-bath only. In a week the feet of all soldiers, who in the meantime had attended to their exhausting drills and marches, were inspected, and the following instructive results were noted: Of those that were treated only with the ordinary foot-bath, 68 per cent. were found to suffer with hyperidrosis of various degrees of severity; of those treated with the regimental foot-powder, 52 per cent. were so affected, while of those treated with tannoform only 20 per cent. had hyperidrosis, and not one case was of the very severe variety (where the skin between the toes becomes macerated, etc.). The tannoform, mixed with two parts of talcum, was applied by rubbing it in well between the toes and over the foot. The writer is convinced that had the tannoform been applied more than three times the results would have been still better. He agrees with Dr. Karl Ullmann that the prophylactic treatment of hyperidrosis with tannoform must extend over a period of at least eight days; but then, he says, we may be certain, that *for weeks to come* those so treated—at least the greatest majority—will not suffer with sweating of the feet. The best time to apply the tannoform is on going to bed. A preliminary foot-bath before each application is desirable, but not absolutely necessary. The bad odor of the feet disappears just as surely as the sweat itself. In not a

single instance has the doctor noticed any disagreeable by-effects of any nature, and he considers the drug absolutely innocuous. Basing himself on his highly gratifying experience, the major, in his report to the chief physician of the army, made the following recommendation: "There is no doubt that in tannoform we possess an excellent, absolutely innocuous remedy for the prevention, to a great extent, of hyperidrosis and sore feet in the army; its systematic employment will contribute materially toward the marching ability of the soldiers."

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### SKIN GRAFTING.

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BY FRED. T. J. ADAMS, M.D., BRIDGEPORT, CONN.

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THE following case of skin-grafting may prove interesting. The patient, Bessie R., aged eighteen years, while carrying a lamp upstairs, fell. The lamp ignited her clothing, and before it could be taken off the patient was severely burned on the inside of both legs and thighs. A doctor, while passing, was called in, and applied carron oil. He was subsequently discharged and another doctor called, who treated the case first with various ointments, the names of which the patient could not recall.

I was called in during the illness of the attending physician, and after consultation with him I prescribed ichthyol. The recovery was not as rapid as I considered should be the case, and on dressing the patient one morning I discovered a number of blisters on the adjacent whole skin. These I raised, and tearing off as large flakes of the epidermis as possible, grafted them onto the granulating surface of the burn. In place of the usual rubber protective I applied dolomol-aristol, ten per cent., and smoothed the powder with a bit of cotton used as a powder duster. The following day the grafts had all taken, with two exceptions, and the process was continued every day for nearly two weeks until the whole surface had been covered by the grafts. The surface covered by grafts included the whole of the inner side of both legs, including the ankles, thighs, and also the vulva. One month from the time I began to use the epidermis for grafts my patient walked about and was discharged, cured.

I found the dolomol-aristol, ten per cent., far superior to any rubber protective, as it is thoroughly antiseptic and does not produce too much heat, a point always to be careful of in doing a skin graft. Since that case I have used the preparation a number of times on similar cases, and always with uniform success.—*N. Y. Lancet*, March, 1901.

## PEROXIDE OF HYDROGEN, MATERIA MEDICA AND THERAPEUTICS.

BY JOHN V. SHOEMAKER, A.M., M.D.,

Professor of Materia Medica in the Medico-Chirurgical College, of Philadelphia, Pa.

*Pharmacology.*—The usual strength of peroxide of hydrogen is called the fifteen volume solution, because each portion of the solution yields fifteen volumes of the oxygen. It is prepared by Charles Marchand, New York, for medical use, and is an active oxidizing and antiseptic agent. Glycozone is the trade name of a similar preparation, in which glycerine is the vehicle.

*Therapy.*—Though less powerful than many other antiseptics, the solution of hydrogen peroxide has a special place in surgery, gynecology, and obstetrics, on account of its powers of decomposing pus and destroying the microbes of suppuration. Being free from all irritating qualities, it can be poured over wounds, injected into sinuses or into the ear, or used as a spray in ulceration of the pharynx and of the larynx.

It produces a frothing up when it encounters pus, owing to the liberation of oxygen, and the cessation of this commotion indicates the removal of all pus. The surface of the wound or ulcer becomes blanched, but is not injured by the application.

Tubercular and mammary abscesses especially are well treated in this way. In ulcerative tonsillitis, fetid breath, and in some bronchial affections, a spray of dilute hydrogen peroxide is productive of benefit. A spray of this agent is likewise of utility in chronic nasal catarrh, ozena, and scarlatinal angina. It has been administered, well diluted, in gastric affections, and is said to be very useful in flatulent dyspepsia, heartburn, catarrh of the stomach and bowels, etc.

In diphtheria and croup its value has been established; a two volume solution is especially recommended in young children as a local application, and particularly after separation of the membranes, in order to remove the odor and disinfect the surface. Internally it is too quickly decomposed in the stomach to render much service as a source of oxygen to the blood. It might prove of value in gastric ulcer.

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**The Mayor of Cleveland**, forgetting that mediæval times are past has promulgated a decree that, while he is mayor, there shall be no compulsory vaccination in his city.—*Jour. Amer. Medical Association.*



# The Canadian Journal of Medicine and Surgery

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Doctors will confer a favor by sending news, reports and papers of interest from any section of the country. Individual experience and theories are also solicited. Contributors must kindly remember that all papers, reports, correspondence, etc., must be in our hands by the fifteenth of the month previous to publication.

Advertisements, to insure insertion in the issue of any month, should be sent not later than the tenth of the preceding month.

VOL. X.

TORONTO, JULY, 1901.

NO. I.

## Editorials.

### POISONING BY STRYCHNINE.

To a practitioner who is unaware that the patient he is called to see has taken a poisonous dose of strychnine, the first intimation of the truth may be revealed by the peculiar convulsions of the patient. These sudden and universal convulsions affecting the voluntary muscles have sometimes been so violent that the patient has been jerked off his bed. In severe cases the patient may

assume the position of opisthotonos, the body curving in the form of a bow, so that he rests upon his head and his heels. During the convulsion he suffers intensely and tries to obtain relief, gasping for air. After a brief period of time, lasting from half a minute to one or two minutes, an intermission follows a convulsion, and the patient is exhausted; but his intellect is clear. He can then speak and swallow, and he complains of thirst. Naturally such an array of striking symptoms points to poisoning by strychnine. Even if tetanus were suspected, the fact that the attack had begun in full intensity with tetanic spasms in other muscles than in those of the lower jaw, and that intermissions occurred between the convulsions, would point to strychnine poisoning.

Usually the first symptoms are milder in form, and consist of restlessness and anxiety, with stiffness of the neck, twitching of the muscles, pressure in the chest, and difficulty in breathing. The tetanic symptoms produced by strychnine, when once clearly established, progress rapidly either towards death or recovery, authorities agreeing that within two hours from the beginning of the symptoms, the patient either dies or recovers, according to the severity of the paroxysms and the strength of his constitution. "Death has taken place in a patient in ten minutes from the beginning of the first paroxysm" (Taylor's "Medical Jurisprudence").

Minutes being precious in the treatment of such a case, and as a would-be suicide rarely volunteers to give information, and a would-be murderer, should such be present, never, a practitioner should, at an early stage of his career, familiarize himself with the appearances of strychnine poisoning in animals, as exhibited in dogs (*vide* Butler's "*Materia Medica*," p. 485).

Melted lard has been used with advantage in several cases of strychnine poisoning, a favorable reference to this agent appearing in the "National Dispensatory." Lard acts as a mechanical absorbent of strychnine in the stomach, thus preventing its effect on the nerve centres, and keeping it in a harmless form until it can be removed by an emetic. Sweet oil and milk have been used with apparent success and also operate in a mechanical way. Animal charcoal and tannin have also been used for the same purpose, but tannin has the additional advantage of acting chemi-

cally, as it forms an insoluble tannate of strychnine in the patient's stomach. After the employment of any one of these agents an emetic should be promptly given. Mustard in warm water will probably suffice; but a modern practitioner should be prepared to use apomorphine hypodermically. The bowels should be evacuated, croton oil per rectum being an efficient agent.

One reason why mechanical remedies may be persevered with, even when spasmodic symptoms are well developed, is that all the strychnine taken by the patient is not absorbed from the stomach at once, but gradually, and some portions of a poisonous dose may not be absorbed at all. Thus in the White case, tried at the Brantford assizes, last May, Dr. Ellis, the analyst, swore that he had recovered 3-8 of a grain of strychnine from the contents of the stomach of the deceased, and that he expected to recover some more of the drug from the walls of the stomach. Evidently the convulsions from which the deceased suffered had been caused by the strychnine which was absorbed from the stomach, and exerted its special influence on his nerve centres; and, even if these convulsions had been temporarily controlled by chloroform, chloral, or bromide of potassium, the attendant might, with advantage to the patient, have used some one of the mechanical agents referred to above.

From this brief account, it appears that three most useful antidotes to strychnine poisoning, viz., lard, tannin (in the shape of tea), and mustard, are nearly always available, even in very humble homes.

The use of chloroform to control the convulsions of strychnine poisoning is not without danger. Authorities state that it has apparently controlled them, or, when unsuccessful in this way, has made the patient's death easier. Owing to its effect in reducing reflex excitability, bromide of potassium has been used in strychnine poisoning, "repeated doses of from eighty to two hundred and forty grains having been administered" ("National Dispensatory"). When bromide of potassium has been associated with chloral the effect has been better, and with smaller doses of each drug, than if either had been used alone. They may be given singly or combined by the mouth or the rectal route.

"Like many other motor depressants, amyl nitrite has been used in strychnine poisoning" (Butler's "Materia Medica").

When sudden spasm of the glottis occurs, a drop or two of the agent may be applied to the nasal mucous membrane of the patient.

Catheterism of the bladder should be performed to favor elimination of the poison, an anesthetic being employed to prevent a recurrence of the convulsions.

"Tobacco has been employed as an antidote successfully in four recorded cases. It is thought to have acted in part by hastening the elimination of the poison by the urine" ("National Dispensatory").

Other drugs to remember are physostigma, camphor, and atropine. In a recorded case ("National Dispensatory"), "one-sixth of a grain of atropine, every ten minutes for three doses, was employed hypodermically, and the patient recovered."

.J. J. C.

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#### A PLEA FOR UNION BETWEEN CANADIAN PHYSICIANS.

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WE were going to begin this editorial with "*On dit*"; but refrain, as it will be more intelligible to the general reader if written in plain English. We see it stated in *La Revue Medicale*, of Montreal (April 24th), that a Medical Congress is going to meet at Montreal this summer. This Congress is going to establish a permanent association among all French-speaking physicians practising on the American continent. Including practitioners from Louisiana and Canada, there would be over five hundred members. We do not think that there is much philosophy in attempting to found an association among physicians practising on this continent solely on a basis of sameness of language. Medical science is not limited by geographical or political boundaries; it knows no barriers except those erected against man's intellectual efforts. It is for the benefit of all men, and not for the glorification of any race. The French nation has produced so many medical luminaries, that it might be pardoned for wishing to unite physicians in a Congress in which the French tongue only should be spoken; but such a Congress should be convened on the banks of the Seine. A French-speaking Medical Congress, composed of physicians from Canada and all other parts of the American continent, with some celebrities from Europe, meeting at Montreal, would in no sense be representative of the medical profession of Canada. It

would indicate, in no uncertain terms, that the process known as scission is operative among the educated as well as the uneducated class in this country, and that the hatching of a hybrid Canadian race is as far off as it was one hundred years ago.

The French language has infinite charm, and is singularly happy in conveying thought, either from the professor's chair or the printed page; but, to the unimaginative physician, language is but the vehicle of thought; the thought itself is of greater importance than the language in which it is expressed.

And what shall we say of the Canadian Medical Association? Would it not be more friendly and patriotic for Canadian physicians, who speak English or French, to sink minor differences in the cause of their common country? A bi-lingual parliament meets at Ottawa to legislate for Canada, and weighty affairs of state are discussed in either the French or the English language. This practice is the outcome of a written Constitution; but it works well, for it reposes on a basis of mutual good-will. The same admirable feeling, the tie that binds a people in the bonds of anity, should be strong enough to hold together English-speaking and French-speaking physicians in a true Canadian association. The work of such an association could be done in sections, and the French members could read their papers and discuss them in their own language under the leadership of their own officials. This would be a patriotic course, and would prove that an educated class of men take an abiding interest in each other, and are prepared to meet on common ground, for the advantage of their profession and for the benefit of their country. It would also be a strengthening band on that silken tie that binds the two races together under the ægis of the British Empire.

If the English-speaking Canadian physician finds that a common Medical Association will not be supported in Canada, because French Canadian physicians place language on a higher level than patriotism, he may learn to solace himself in the company of his American cousins, and help to carry a few stones for the uplifting of the English-speaking Medical Association of North America.

J. J. C.

**ETHICS AMONG CORONERS.—A THREATENED MONOPOLY  
IN INQUESTS.**

A FEW weeks ago, in this city, a most unfortunate shooting accident took place, when a lad, in fooling with his little sister, having a revolver in his hand, shot and instantly killed her. The fatality took place on Sunday afternoon, and before long several coroners were notified, and more than one took up the matter for investigation. Coroner J. M. Cotton had the facts laid before him in the course of a very short time after the little girl died, and then carefully looked into the case. Knowing, however, that a warrant could not legally be filed at the police station until midnight on Sunday, the Doctor taking the further precaution to call up and consult by telephone Crown Attorney Dewart upon this point, Coroner Cotton did not send his warrant down to No. 1 Station till 12 o'clock that night; but to his surprise the sergeant in charge told him then that a warrant in the same case had been filed for registration several hours before by Coroner W. J. Greig (all but whom retired on learning that Dr. Cotton was looking into the circumstances). Dr. Cotton naturally felt aggrieved to find that another Coroner had deliberately "walked in" upon his case, knowing that he had the matter in charge. He reported the facts to the Attorney-General's Department, and also intends, we understand, to take up the matter with the Board of Police Commissioners to find out whether some constable did not overstep his duty, and, as has been suspected for a long time in the city, showed too great a feeling of anxiety to secure, as nearly as possible, all inquest cases for Dr. Greig, who is also one of the junior police surgeons. We hope that this matter shall be settled now, as there has been much comment for the past year or more upon the fact that a man who is almost the youngest appointed Coroner in Toronto should be able to, in nearly every instance, have his warrant filed in No. 1 Police Station prior to that of any of his seniors in office, who for that reason may be better fitted to conduct the more difficult cases than is Dr. Greig. We have heard several of our Coroners make open remarks as to how this can be arranged at the Police Station, some of the policemen having gone as far as to say, when asked

why it was that their surgeon should be shown the preference in inquests, that, if they did not do so, they would in some way or other suffer for it. We claim that anyone who holds an appointment of Police Surgeon should not be allowed to also hold a commission as Coroner. It does not seem fair that one man should have the dual office, and we hope that some action shall be taken at our next parliamentary session to introduce an amendment to the Act which shall settle this just cause of contention. Legislation in this direction is already upon the Statute Book, preventing any surgeon to a railroad from holding an inquest in any case of death in connection with such railroad. This also excludes any surgeon to any manufacturing industry from holding a similar inquest (Section VII., Act respecting Coroners, R.S.O. 1897). Why should this not apply to one holding an appointment as police surgeon? We trust, also, that Dr. Cotton will press his claim before Judge McDougall's Board, and have an investigation put upon foot to find out whether what looks like nothing short of favoritism does exist, and if so, to have it put a stop to, so that when a Coroner other than a police surgeon presents his warrant for registration it will not be refused just because Dr. Greig's was filed first. Most of the coroners in Toronto are gentlemen, and will not intentionally tread upon one another's toes. We cannot see why the same professional ethics does not exist between physicians as coroners as is the case in regular practice.

A. J. H.

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#### CANADIAN MEDICAL ASSOCIATION.

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From what we can learn, the Winnipeg meeting of this association promises to be one of the best ever held. The railways have granted a single fare for the return trip, with the additional privilege of a single fare from Winnipeg to any point in Manitoba, the North-West, British Columbia, or North Dakota after the meeting. This, of course, will make a large attendance certain.

The Address in Medicine, by Dr. J. R. Jones, Winnipeg, in Surgery, by Dr. O. M. Jones, F.R.C.S., Victoria, and in Gynecology, by Dr. Thomas S. Cullen, of Johns Hopkins, make a nucleus for the programme that will indeed be hard to beat.

In addition to these, the following have promised to contribute

to the programme: Drs. Gilbert Gordon, John Hunter, B. E. McKenzie, D. J. Gibb Wishart, G. Silverthorne, and G. H. Burnham, of Toronto; W. S. Muir, Truro, N.S.; Laphorne Smith, Montreal; A. Armstrong, Amnprior; I. C. Mitchell, Enniskillen; Prof. Russell, of the University of Wisconsin; H. M. Bracken, of St. Paul, Minn., F. I. Shepherd, Richer and Blackader, of Montreal, and L. H. Warner, of New York.

Judging from the foregoing list, which has been supplied to us by the Secretary, the scientific part of the programme will be almost equal to the social part, and, from what little birds tell us, visiting members may look forward to a rich treat.

The Secretary, Dr. F. N. G. Starr, Biological Building, Toronto, will be glad to furnish particulars to any intending to be present.

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#### EDITORIAL NOTES.

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**Meeting of Executive Health Officers of Ontario.**—Owing to the short time, which intervenes between the close of the proceedings and our going to press, we are unable to furnish our readers with a full report of the meeting of the Executive Health Officers of Ontario, which was held at Brantford on June 25th and 26th, 1901. The nature of the subjects discussed may be gathered from the announcement which appears at page 45.

**Appointment of a Lady Graduate to the Resident Staff of Toronto General Hospital.**—Miss Helen MacMurchy, M.D., has been appointed to the resident staff of Toronto General Hospital. Having already advocated in this journal (July, 1900) the advisability and propriety of conceding to Canadian lady graduates in medicine the same opportunities for professional training in hospitals as their male rivals, we have nothing to add, except that the practical working out of the experiment at Toronto General Hospital will be watched with a good deal of interest in medical circles.

**A Correction.**—On page 442 of the June issue of this journal, a paragraph appeared, entitled "A New Medicine Concern," in which it was stated that on the Board of Provisional Directors of the United States Ferrol Co., Limited, appeared the names of Dr.



Alexander McPhedran, Dr. J. L. Davison, and Dr. Geo. A. Bingham. We take great pleasure in now stating that this is not the case, and that these gentlemen are not in any way connected with the Company referred to. We inserted the paragraph as an item of news only, and regret very much indeed having published it without sufficiently investigating the facts.

**Toronto Correspondents of American Medical Journals.—**

We notice that the *New York Medical Journal* has a special correspondent in Toronto. The *Philadelphia Medical Journal* also has "our special correspondent" at Toronto. Evidently our cousins are beginning to think that there may be something in Canadian medical news worth the gathering. As an indication of an increasing importance, attached by our neighbors to the medical affairs of Canada, and of greater interest felt by American physicians in the fortunes of their brethren in this country, this new feature in the American medical journals is noteworthy.

**Lady Doctors Dine.—**The annual dinner of the Alumnae Association of Ontario Medical College for Women was a bright and successful function at the Temple Cafe last month. Dr. Jennie Gray acted as president, in the unavoidable absence of the president of the association, Dr. Ida Lynd. The toast-list was: "King and Country," proposed by Dr. Jean Cruickshank, and honored by singing "The Maple Leaf"; "Absent Graduates" was responded to by the reading of letters; "The Graduates," proposed by Dr. Helen MacMurchy, responded to by Dr. Doyle; "Undergraduates," responded to by Dr. Minerva Greenway; "The Women's College Hospital," responded to by Dr. Leila Skinner.

**Trinity Doctors at Dinner.—**The graduating dinner of the Trinity Medical College class of 1901 was held recently at the Temple Cafe. Dr. C. P. Lusk presided, and Dr. W. J. Brown was secretary of the committee. After the loyal toasts came "Our Alma Mater," proposed by Dr. W. J. Brown, responded to by Dean Geikie; "Medicine and Surgery," by Dr. Ralph T. McLaren, responded to by Dr. Bingham, Dr. Baines, and Dr. Anderson; "Undergraduates," proposed by Dr. W. R. Coles, responded to by Messrs. C. McDougall, B. O'Reilly, and R. Frankish; "Class of 1901," proposed by Dr. R. T. McLaren, responded to by the medallists, Dr. Marsnall, Dr. Ferguson, and Dr. Coleridge.

**The "Papyrus Ebers."**—One of the most interesting articles in the last number of the *CANADIAN JOURNAL OF MEDICINE AND SURGERY* was one entitled "A Medical Work Seven Thousand Years Old," a full translation just completed of the Ebers Papyrus, an Egyptian book devoted to the diseases of man and their cure. Regardless of any expense connected with the same, which must have been enormous, The Palisade Manufacturing Co., of Yonkers, N.Y., are prepared to present to their friends in the medical profession a fac-simile reproduction of the beginning of this, the earliest medical treatise extant, together with transcription into hieroglyphics and translation of a portion of the text. The firm named will be pleased to forward a copy to any physician on receipt of his professional card.

**Salol in the Treatment of Diabetes.**—Dr. Tesmacher (of Neuenahr), has experimented with salol in eight cases of diabetes, administering 1.30 gramme (almost 20 grains) three times a day to each patient. No effect was observed in three patients. In five others, who had the disease in a moderately severe form, the results were better. In spite of an anti-diabetic diet, the urine of these patients had always contained sugar in the proportion of from 0.6 to 1.5 per cent. After the administration of salol, only traces of sugar were discernible. Dr. Tesmacher observes, "that this action of salol is not lasting, and when the drug is no longer given, sugar reappears in the urine and, little by little, attains the same level as before it was given." This coincides with Fiquet's view on diabetes, to which reference was made in the April number of this journal (see p. 288).

**Malt Beer and Part Malt Beer.**—As a consequence of the poisoning in England from the consumption of beer contaminated with arsenic, a bill has passed its second reading in the Imperial House of Commons, on which the *Lancet* comments as follows: "Put shortly, the bill is intended to enable the consumer to know what he is not drinking. Beer is divided into two classes, somewhat on the logical process of dichotomy—namely, malt beer and part malt beer. Malt beer means that which is brewed from barley-malt, yeast, hops, and water. Part malt beer does not mean this. These are admirable provisions, in our mind, and we would fain see them extended to all classes of food. Substitutes are

generally harmless and often palatable, but the consumer should know what he is getting. If, for instance, he likes to use cotton seed oil for a salad, let him do so, but he should not have cotton seed oil palmed off on him under the impression that he is buying olive oil."

**Tetanus and Hypodermic Injections of Quinine.**—Dr. Desbrousses blames hypodermic injections of hydrochloride of quinine for causing several cases of tetanus among the patients treated for malaria at the military hospital of Majunga in 1895. These hypodermic injections of quinine had been frequently used, although always with great antiseptic and aseptic precautions. Orders were given that the quinine injections should be used as rarely as possible with the greatest antiseptic precautions, and only in the abdominal walls or the flanks of patients. No more cases of tetanus occurred afterwards. Without offering, to explain these phenomena, Dr. Desbrousses thinks "that tetanus was produced by an ascending neuritis due to irritation of one or several nerves by the hypodermic injections of quinine." No wound is free from the risk of tetanus. The introduction of a hypodermic needle, a slight graze of the skin, and the extraction of a tooth have been followed by severe tetanus. Besides, "the hypodermic method of administering quinine depresses the heart to a considerable degree" (Butler).

**Some Remarks on the Treatment of Gonorrhoea.**—Dr. Casper (writing in *Berlin. Klin. Wochenschrift*, 1900, No. 22, p. 482) says: "There is no medicine or treatment which can be said to cure gonorrhoea with certainty, and in a given time. The practitioner should, above all, endeavor to prevent complications." He obtained no advantage from the use of abortives; on the contrary, they aggravated the disease. In the acute stage, instruments should not be introduced into the urethra. *Local medical treatment should be begun from the first.* Casper used thalline sulphate with advantage in the acute stage in 1-2 per cent. injections. After the acute stage is over treatment, by the salts of silver may be employed with advantage; among these salts he gives the preference to the nitrate of silver. Posterior urethritis, in his opinion, requires special treatment. In 55 per cent. of the cases in which this lesion is observed, the prostate gland is affected.

Casper, however, found the gonococcus in only 5 per cent. of such cases; likewise, in 16 per cent. of the cases, changes in the prostate were perceptible on palpation. The treatment of sclerosifying chronic urethritis ought to be, in his opinion, both chemical and mechanical. The chronic prostatitis should be treated by massage. Casper warns his readers against a treatment which is either too timid or too severe, and which may expose patients to neurasthenia.

**Immediate Urethroplasty after Traumatic Rupture of the Urethra.**—Dr. Carlier (*Soc.-Cent.-Med. Nord.*) recommends an immediate operation in the greater number of urethral traumatism. He cites the case of a patient who had fallen astride of a solid body, the injury being followed by free urethral hemorrhage and slight ecchymosis of the perineum. Although a catheter was easily passed, Carlier was not content with the simple introduction of a self-retaining catheter, as certain authorities recommend; but performed external urethrotomy, and found a laceration of the urethra about 3-4 of an inch in length, and a complete crushing of the lower wall of the urethra. He immediately performed urethroplasty. He mentions a second case, in which, in spite of easy catheterisation, he found during his operation a complete circular laceration of the urethra, the two ends of the tube being separated for over an inch. The torn ends were sutured. He thinks that, after recognizing rupture of the urethra in a patient, the surgeon's duty is to perform external urethrotomy, followed by urethroplasty. In this opinion he differs from Delorme, of Paris, who performs external urethrotomy as a primary operation to provide for the escape of urine, and, after waiting a sufficient time for granulations to appear in the wound, performs urethroplasty as a secondary operation. Dr. Moty, who had seen some of Delorme's cases, declared, in discussing the paper, that in some cases of urethral traumatism, the self-retaining catheter could not be borne by the patient, on account of the extreme irritability of the urethra. In these cases a surgeon could not safely do a urethroplasty immediately after an external urethrotomy. The same objection applies when rupture of the urethra occurs in a case of urethritis.

**PERSONALS**

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DR. DWYER, of St. Michael's Hospital, has returned from England.

DR. ALEXANDER MCPHEDRAN, of Toronto, left for England on June 20th.

DR. HOLFORD WALKER last month was at the Tadenac Club, Georgian Bay.

DR. J. M. MACCALLUM spent the last three weeks on a visit to his brother in the States.

DR. BRUCE RIORDAN attended the meeting of Railroad Surgeons at Milwaukee, Wis., last month.

DR. J. M. COTTON spent ten days at St. Catharines last month, resting after his recent attack of typhoid.

DR. J. J. CASSIDY, of Toronto, was one of those who attended the Convention of Health Officers in Brantford last week.

DRS. G. A. PETERS, J. T. CLARK, FRED. FENTON, and J. E. ELLIOTT were among the medicos at camp at Niagara last month.

DR. BROCK, of Guelph, has succeeded Dr. Wm. Britton, of Toronto, as President of the Ontario Medical Council.

DR. A. W. MAYBERRY left two weeks ago to spend a few weeks at Baltimore, Md. On his return the Doctor will resume his specialty, the eye and ear.

DR. ALEX. PRIMROSE will deliver the Address in Surgery at the approaching meeting of the Maritime Medical Association, at Halifax, N.S.

DR. NOBLE, of Philadelphia, Pa., Dr. Prevost, of Ottawa, Dr. Elliott, of Gravenhurst, and Dr. R. W. Garrett, of Kingston, were among those in attendance at the Ontario Medical Association Convention, ten days ago.

DR. T. G. RODDICK, of Montreal, was in Toronto on the 13th ultimo, and addressed the Medical Council on the subject of Dominion Registration.

DR. FERDINAND FLEURY has been appointed Medical Superintendent of Notre Dame Hospital, Montreal, to succeed Dr. Ethier, who has gone to Europe.

DR. B. E. MCKENZIE attended the meeting of the American Orthopedic Association, held on 11th, 12th, and 13th of June, at Niagara Falls, N.Y. He reports the meeting as having been very successful under the general presidency of Dr. Arthur Gillette, of St. Paul, Minn.

THE trustees of the Hospital for Sick Children, Toronto, have made the following appointments to the resident staff for the ensuing year: Drs. Allen B. Rutherford, John D. Chisholm, W. H. Lowry, and Margaret Macallum. Dr. Macallum is one of the first women to be appointed on the resident staff of any hospital in Canada.

THE trustees of the Toronto Orthopedic Hospital have recently secured a new property at 104 West Bloor Street. Mr. F. H. Herbert, the architect, has for some weeks past been busily engaged upon the plans for remodelling and enlarging the building, and work will be begun immediately. When completed, the hospital will be able to accommodate about sixty patients.

THE following compose the different committees appointed for the ensuing year for the Ontario Medical Council: *Registration*—Drs. Campbell, McLaughlin, Robertson, Hanly, Powell, Sullivan, Stuart. *Rules and Regulations*—Drs. Hanley, Vernon, Lane, Barrick, Henry. *Finance*—Drs. Henderson, Griffin, Douglas, Glasgow, Bray. *Printing*—Drs. Barrick, Macdonald, Stuart, McLaughlin, Spankie. *Education*—Drs. Moorehouse, Roome, Sangster, Moore, Robertson, Luton, Macdonald, Williams, Geikie. *Property*—Drs. Thorburn, Campbell, Williams, Thornton, Roome. *Complaints*—Drs. Griffin, Thorburn, Spankie, Henry, Douglas.

## Correspondence.

*The Editor cannot hold himself responsible for any views expressed in this Department.*

### PURE MILK.

*To the Editor of THE CANADIAN JOURNAL OF MEDICINE AND SURGERY.*

DEAR SIR,—Most practitioners of large experience, especially those practising in cities, have found the problem of successfully nourishing infants who cannot be nursed by their mothers a very serious one. Years ago, when engaged in general practice, I first encountered this difficulty, and the experience arising out of the necessity of providing artificial nourishment for my own children served to emphasize it, and to direct my attention strongly to the great importance of pure milk; incidentally I discovered the difficulty, amounting almost to impossibility, of obtaining such milk. My first child was fed with one of the patent foods and lived only two months, succumbing to an attack of acute digestive trouble. A second one fed upon modified milk, the milk being obtained from an ordinary dairy, and modified at home, was brought up with almost no difficulty, but in the case of my youngest, now almost two and a half years of age, milk from the same dairy, modified in almost every conceivable way, failed to agree, and the outlook for the infant rapidly became serious.

When almost in despair I first learned about the celebrated dairy of the Dentonia Park Farm, and arranged for a daily supply of the milk. This was modified according to my best judgment, and immediately it was apparent that the food thus prepared agreed better than any we had yet tried. After considerable experimenting the best proportions of proteids, fat and sugar, for this individual infant were discovered, and we soon had the satisfaction of noting a marked improvement in digestion and assimilation, attended by a steady increase of weight. I have always felt that, had the child been limited to milk produced and handled as it is in the average dairy, she could not have survived.

At the time of which I write there was no Walker-Gordon Laboratory for the scientific modification of milk at Dentonia, but this has since been established and should, it seems to me, immensely simplify the problem of artificially feeding young infants as far as the neighborhood of Toronto is concerned. I have not the slightest idea to what extent the profession avail themselves of this laboratory, but I can hardly imagine any physi-

cian living within reach of it, if he has acquainted himself with the triumphs of modified milk in infant feeding, failing to use the laboratory when his patients can afford the slightly greater expense of this system of artificial feeding.

When it became known that a public dairy largely on the lines of that at Dentonia was to be established in Toronto with the object of supplying the citizens with milk handled in the most scientific way, it seemed to me that the news would be hailed with delight by all who appreciate the importance of pure food products, and that the law of survival of the fittest could not fail to bring to this particular dairy the patronage of practically the entire city. I have no knowledge of the extent of the trade done by the City Dairy Co., but in a purely incidental way have become acquainted with a good deal of unreasoning and unreasonable opposition to it, and in conversation with different persons when the subject of milk has happened to come up, have been surprised at hearing objections raised and fault found with the milk of this particular dairy by persons whom I expected enthusiastically to support it.

The two things complained of by friends with whom I have conversed, are the appearance and taste. Because the milk looks white\* even very intelligent people seem to take it for granted that it must be poor in cream, and the slightly different flavor imparted by the aerating process is also attributed to this small proportion of cream.

Now, Mr. Editor, it seems to me that to the medical profession belongs a share of the duty of educating the public on the subject of milk. People should be taught the elementary fact that the percentage of butterfat in milk cannot be determined by looking at it or tasting it, but must be found out in the laboratory. It should also be more generally appreciated that even rich-looking and good-tasting milk may contain disgusting and dangerous filth. There is as much difference in appearance and taste between absolutely pure, clean, unadulterated milk and the average farm product as between refined sugar and the coarse brown sugar which is now but little used. It is true that the flavor of refined sugar is very different from that of unrefined, but most of us prefer the former. Twice within the past week I have sat down to breakfast in the best hotel of an Eastern and a Western Ontario city respectively. On both occasions the cream supplied for my porridge and coffee was very attractive to the eye but as thin as ordinary milk, and I knew perfectly well that its rich, yellowish appearance came not from a high percentage of

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\* Since writing this it has been very interesting to note the gradual change to a richer color in the milk supplied by the City Dairy Co.—a change due to the fact that as spring advanced, the cows of the different farms supplying the milk were turned out to grass.



butter-fat, but was imparted to it before it came to the table by the addition of coloring matter. It is anything but a complimentary comment upon the general information of the public in regard to this common food product that they should swallow dyed milk with a relish born of the persuasion that it is cream surpassingly rich in butter-fat. What inducement can there be for dealers to supply clean, unadulterated and uncolored milk if the public demand that which conforms to an artificial and inferior standard? I have never owned a dollar's worth of City Dairy stock, nor has any hint or suggestion that I should "write it up" ever been made to me by any one. I will, therefore, hardly be accused of having any axe to grind. Moreover, I am genuinely sorry for the proprietors of those smaller concerns, which are so often forced out of business by gigantic and powerful combinations of capital. It must not be forgotten, however, that in the readjustments inseparable from reform and advancement, more or less disturbance of existing economic conditions and relations is inevitable, and that suffering and hardship have been the price of progress since the beginning. Public health is so precious that its safety must not be menaced by sentimental considerations; individual interests must always step aside if they conflict with the general welfare. There can be no doubt that the average quality of the milk consumed in Toronto is much better than it was a few years ago, and that the subjects of cleanliness and purity are more closely studied by dairymen to-day than formerly, owing to the increasing interest in the matter that the public is manifesting, but so far as the average methods of milk production and marketing are concerned, there is still room for almost infinite improvement. Believing as I do, Mr. Editor, that the difference between surrounding the production and handling of the milk of this city by modern scientific safeguards, and allowing indifferent happy-go-lucky methods to prevail, is equivalent to the saving of hundreds of lives, especially infant lives, it seems to me not outside the proper office of a medical journal to actively support efforts to improve the general supply, to advocate a wider interest in the subject, and especially to urge upon medical practitioners the duty of not neglecting their many opportunities for sowing the seeds of a more general knowledge of what constitutes good and pure milk. I would be glad to see this important subject receive a share of attention in your columns.

H. P. H. GALLOWAY.

Toronto, May 18th, 1901.

## NEW IDEAS IN MEDICINE.

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To the Editor of THE CANADIAN JOURNAL OF MEDICINE AND SURGERY:

DEAR SIR,—In the JOURNAL of June, page 442, you quoted from the *Toronto Journal of Osteopathy* as follows: "The English for bacteria," says Dr. Still, is 'buzzard.' " And you say, "Try again, Osteopathy, a buzzard is not remarkable for sense." This may be true, yet the buzzard performs as important a function for mankind in places as do bacteria. For instance, in Japan there are in all towns and cities special laws for protection of buzzards. They are the street-cleaners and removers of garbage from the Empire's back door. Each buzzard (or gang of buzzards) has his own thoroughfare, which he faithfully cleans, and without any inspector to supervise him. Morning and night (twice daily), rain or shine, while I lived in Tokio, my buzzard came to the kitchen door (which there is at the front of the house) and took away, with more or less chattering gossip, whatever refuse the cook had set out for him. He flew afar off with it, where his family could enjoy or bury its tidbits at pleasure. There was no garbage-man in Japan, excepting Mr. Buzzard. He had a monopoly of the business. And if he is "not remarkable for sense," he performed that important duty as regularly and thoroughly as bacteria have done theirs, and still must do it, on the ethnological pathways of mankind's progress.

ALBERT S. ASHMEAD, M.D.

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**Extermination of Birds.**—The extermination of birds is not alone the work of fashionable vanity, but of fashionable gluttony. The recent seizure in a New York cold storage warehouse of great numbers of dead birds during the close season illustrates the easy evasion of the law by those careless of consequences. In hotels, travellers often find upon the bills of fare the names of birds unknown to ornithologists and dictionary-makers. When asked what kinds of birds these represent, the waiters are permitted to answer only by smiles and silence, or by confessions of ignorance. In the cold storage house in New York were found so many birds that the legal fines would have run to millions of dollars. What would they amount to for the United States? As a result of such practices everywhere those butchers and dealers who obey the law are really punished for their honor, while the reckless are rewarded by great profits. We are fond of pointing out excellent spheres of work and usefulness for those who are greatly troubled by a few deaths of animals in scientific laboratories. Why should this stupid and ruinous war of extermination of birds with its great resultant suffering not arouse the energies of the S. P. C. A.?  
—*American Medicine.*

# The Physician's Library.

## BOOK REVIEWS.

1 *System of Physiologic Therapeutics*, a practical exposition of the methods, other than drug giving, useful in the treatment of the sick. Edited by SOLOMON SOLIS COHEN, A.M., M.D., Professor of Medicine and Therapeutics in the Philadelphia Polyclinic; Lecturer on Clinical Medicine at Jefferson Medical College; Physician to the Philadelphia and Rush Hospitals, etc. Vol. V., Electrotherapy, by GEO. W. JACOBI, M.D., Consulting Neurologist to the German Hospital, New York City, to the Infirmary for Women and Children, and to the Craig Colony for Epileptics, etc. (in two books). Book I., Electrophysics, Apparatus required for the therapeutic and diagnostic use of electricity. With 163 illustrations. Philadelphia: Blakiston's Son & Co., 1012 Walnut Street. 1901. Canadian Agents: The Chandler & Massey, Limited, Toronto and Montreal.

The title of this new series, "A System of Physiologic Therapeutics," would, if used alone, be rather obtuse, and would hardly, we think, convey a sufficiently clear idea of the ground which the editor intends to cover. The work is, however, well described as "a practical exposition of the methods, *other than drug giving*, useful in the treatment of the sick." There has never been published, as far as we know, anything in medical literature just similar, either in America or England, and from our perusal of the work so far, we feel that it will take but a short time to make a large number of friends, who in turn will be the source of a just and deserved revenue to the publishers. Volume I. is divided into two books, and deals with Electrotherapy. The first book devotes its pages to what the author calls Electrophysics. The publisher was fortunate in securing the services of Dr. G. W. Jacobi for the two opening volumes of this series, that gentleman occupying a very high status in Electrotherapeutics. He divides Book I. into two parts: (1) Electrophysics, and (2) Apparatus required for the therapeutic and diagnostic use of electricity. Under the first heading he considers Frictional (static) electricity, dynamic electricity, effects of the electric current, varieties of electro-motive force, and the methods of obtaining and altering

electro-motive force. Under Part II. Dr. Jacobi devotes his space to Galvanic Apparatus and its use, static machines, and finishes with an exceedingly interesting chapter on X-Rays, a chapter which will well repay anyone for the time devoted to its careful consideration.

Volumes III. and IV. of this series will be devoted to Climatology and Health Resorts; V. to Prophylaxis and Hygiene; VI. to Alimentary Therapeutics; VII. to Mechano-Therapy; VIII. to Mental Therapeutics, Rest and Suggestions; IX. to Hydrotherapy, Thermo-therapy and Baths, and Vol. X. to Pneumato-therapy and Inhalation.

*Topographic Atlas of Medico-Surgical Diagnosis.* By Dr. E. PONFICK, Director of the Pathological Institute, the University of Breslau. First volume. Jena: Gustav Fischer. 1901.

This work is to consist of five parts, each of which shall contain six lithographic plates, accompanied by explanatory text. Each plate forms an independent subdivision and represents some special diseased condition, with the secondary effects on the surrounding organs. The object of the whole work is not only to study the diseased organs themselves, but also to show the manner and the degree in which neighboring structures are affected by the primary condition.

Medical and surgical diagnostic measures are daily coming into closer relationship, as medical and operative therapy are being employed together in a constantly increasing number of diseases. This renders it of increased importance that we should be able to survey at a glance all the changes and displacements resulting from disease in any part of the body.

In some measure to accomplish this object Ponfick has resorted to a method long in use in anatomy, namely, that of making frozen sections in order to show the pathological changes and the displacements resulting therefrom in various diseases.

The first volume of his work has been received, and accomplishes the object he aimed at in an excellent manner. It contains six plates: (1) Pneumothorax sinister; (2) Endocarditis cum insufficiencia valvulae mitralis; (3) Carcinoma colloides peritonei; (4) Cirrhosis hepatis; Ascites, Icterus; (5) Carcinoma partis-pyloricæ ventriculi et gland. retroperitonealium; (6) Abscessus otiticus lobi temporalis dextri.

Each plate is most accurately drawn and colored, and presents in a striking manner the diseased conditions represented.

The whole Atlas, when completed, is to contain forty reproductions. The thoracic and abdominal cavities are represented by thirteen pictures each; and the cranial cavity by fourteen pictures. The whole work will form a valuable addition to any physician's library.

The Atlas is highly creditable to the publishing house of Gustav Fischer. In its production many difficulties, no doubt, had to be overcome, and the result is eminently satisfactory. The price of each volume is placed at 12 marks (\$3.00), or for the whole work, 60 marks (\$15.00). Single plates can be obtained at a cost of 3 marks each.

A. M'P.

*A Text-Book of the Practice of Medicine.* By DR. HERMAN EICHHORST, Professor of Special Pathology and Therapeutics and Director of the Medical Clinic in the University of Zurich. Translated and edited by AUGUSTUS A. ESHNER, M.D., Professor of Clinical Medicine in the Philadelphia Polyclinic. Two octavo volumes of over 600 pages each; over 150 illustrations. Philadelphia and London: W. B. Saunders & Co. 1901. Price per set: Cloth, \$6.00 net. Canadian Agents, J. A. Carveth & Co., Toronto.

Dr. Eshner has placed in our hands a translated work of the highest order. He has made additions and annotations where it seemed they would be most serviceable. The book has an appropriate chapter on Diseases of the Skin, Venereal Diseases, Impotence and Sterility in the Male, and Spermatorrhea. The work is in two volumes, which makes it handy for reference and a better library book.

It deals, naturally, with the established facts of medicine, carefully avoiding any methods which are not thoroughly tried treatments. Dr. Eichhorst's specialty as a pathologist and therapist has enabled him to give concisely his own practical experience in these two important branches. His position as Director of the Medical Clinic in the University of Zurich has provided him with clinical material which could not be excelled, and earnest consideration has been given to the subject of treatment. We anticipate many succeeding editions of this most valuable work on medicine.

The volumes are well bound and handsome in appearance.

A. J. H.

*The Helmet of Navarre.* By BERTHA RUNKLE. With illustrations by Andre Castaigne. Toronto: The Copp, Clark Company, Limited.

An exceedingly fascinating French historical romance, in the time of Henri Quatre of France and Navarre. Henry IV. was the most popular of all the kings of France. He was the founder of the Royal House of Bourbon, and is still regarded by the French People as the beau-ideal of a monarch, an heroic warrior, and a gallant Frenchman. He was a lineal descendant of Louis IX., and was born in 1553. His mother was the heiress

of the King of Navarre. The authoress selected this stormy period as the groundwork for this interesting story, when Henry III. and Henry of Navarre united their arms against the Duke of Mayenne, the Chief of the League who was aided with money by Philip II. of Spain. The War of the League arose out of an association of princes, prelates, and gentlemen of Picardy. The object of the League was at first simply the maintenance of the Catholic as the sole religion of the realm. Henry of Navarre, as a Huguenot, endeavored but failed to maintain peace and the integrity of France by his anti-Catholic means. The country was devastated by war. Fire and sword ravaged every town and village; every plain was a battle-field, every wood an ambuscade, and the whole land became a huge Golgotha. Henry, to mitigate this, consented in 1593 to profess Catholic religion as being that which the majority of his subjects preferred. At the same time he assured the Protestants of his favor and protection, and in 1598 five years later, by issuing the celebrated Edict of Nantes, he secured religious toleration for the Huguenots. Bertha Runkle has shown great tact in limiting the characters in her story, a feature which makes her work much more interesting, as I always thought Dumas in great error in this respect, although I should imagine she has been an ardent admirer of the great French writer. She holds her historical characters well in hand, and has compiled a story which is very creditable to her, and well worthy of careful perusal.

A. J. H.

*Principles of Surgery.* By N. SENN, Ph.D., LL.D., Professor of Surgery in Rush Medical College, in affiliation with the University of Chicago; Professorial Lecturer on Military Surgery in the University of Chicago; Attending Surgeon to the Presbyterian Hospital; Surgeon-in-Chief to St. Joseph's Hospital; Surgeon-General of Illinois; Late Lieutenant-Colonel of the United States Volunteers and Chief of the Operating-staff with the Army in the field during the Spanish-American War. Third Edition. Thoroughly revised, with 230 wood engravings, half-tones, and colored illustrations. Royal octavo. Pages, xiv.—700. Extra cloth, \$4.50 net; sheep or half-russia, \$5.50 net. Delivered. Philadelphia: F. A. Davis Company, Publishers, 1914-16 Cherry Street.

A medical library can hardly be considered complete without a copy of Senn's "Principles of Surgery." With this sentiment we are sure the author will fully agree.

In this, the third edition, two new chapters have been added. The one on Degeneration appropriately follows that on Regeneration. Commencing with "Atrophy," the simplest form of degeneration, the chapter goes on and considers "Cloudy Swelling," "Fatty Degeneration," "Mucoid, Colloid, and Waxy Degener-

ation," and "Amyloid Changes." It is extremely interesting, and following, as it does, its counterpart "Regeneration," it presents a striking picture to the student or practitioner of surgery.

The other new chapter deals with "Blastomycetic Dermatitis." The chapter is instructive, and should be read by every one, in that the disease is comparatively new, having been first recognized by Tokishige, a Japanese investigator, in 1893.

The book all the way through bristles with practical teaching for the busy practitioner. In fact, if one is thoroughly conversant with the principles of surgery—so lucidly brought out in this work,—he is much more competent to deal with his case than the one who is well posted in a great mass of technique only.

The publishers are to be congratulated on the bookmaking.

F. N. G. S.

*Encyclopedia Medica.* Under the general editorship of CHALMERS WATSON, M.B., M.R.C.P.E. Volume VII., Liver to Menopause. Edinburgh: William Green & Sons. 1901.

This volume compares favorably with its predecessors. The article on Pulmonary Tuberculosis is rather condensed, but very good, and of course gives due prominence to out-of-door life and to sanatoria. The article on malaria, by Rees, is brief, but clear and sufficiently comprehensive for the general practitioner. There is an interesting article on the History of Medicine by W. E. E. Willoughby. This is a new and desirable departure in works on general medicine. Physicians generally would be benefited greatly by a fuller knowledge of the history of the progress of medical sciences. The article on tuberculous meningitis by Still is a very good one, and it is needless to say to Canadian readers that the one on Epidemic Cerebro-Spinal Meningitis, by Osler, leaves nothing to be desired. The volume closes with an article on the Menopause, by Mrs. Garret Anderson, M.D., and is an excellent account of the subject, and contains valuable suggestions and advice. The volume is a credit to the book-makers, both in material and workmanship.

A. M'P.

*Clinical Pathology of the Blood.* A Treatise on the General Principles and Special Applications of Hematology. By JAMES EWING, A.M., M.D., Professor of Pathology in Cornell University Medical College, New York City. Illustrated with 30 Engravings and 14 Colored Plates, drawn by the author. Philadelphia and New York: Lea Brothers & Co. 1901.

Most of the articles and discussions on the blood appear in special journals, which seldom come into the hands of the busy practitioner. These articles appear, also, at irregular intervals and in such a variety of places that it is difficult or impossible for

any one outside a laboratory to keep up with the rapid advances in knowledge regarding the blood, both in health and in disease. Dr. Ewing has collected the latest reliable information, and presents it in compact form in his book, "Clinical Pathology of the Blood."

In the opening chapter he deals with the general physiology and pathology of the blood, and follows with the special pathology in chlorosis, the various forms of anemia, and leukemia. He then describes changes in the blood in acute infections, constitutional, nervous, and mental diseases, and in general diseases of the viscera, and ends with malaria, relapsing fever, and miscellaneous parasitic diseases.

The treatment in the various chapters is brief, readable, and to the point, very little space being given to useless historical discussion. The book is full of useful information for students and physicians, in general or special practice, while for those who make a special study of the blood it supplies a vast amount of valuable information that cannot be obtained elsewhere, except with considerable labor and difficulty.

A. E.

*The Practical Household Physician.* A Cyclopedia of Family Medicine, Surgery, Nursing, and Hygiene, for daily use in the preservation of health and care of the sick and injured. By HENRY HARTSHORNE, formerly Professor of Hygiene in the University of Pennsylvania, and Professor of Physiology and Diseases of Children in the Women's Medical College of Pennsylvania; author of "Our Homes," "Essentials of Practical Medicine," etc., etc.; editor of the American edition of "Reynolds' System of Medicine." Accurately and profusely illustrated. Toronto: J. L. Nichols & Co.

In glancing over the preface to this book, we find the following sentence: "No intention is herein implied to supersede the attendance of physicians or surgeons upon persons who are ill or seriously hurt. On the contrary, it is hoped that the readers of this book will be thereby better prepared to appreciate and assist the skilful efforts of medical practitioners to relieve suffering and save or prolong life." It will be seen, therefore, that neither the author nor the publishers, in getting out this work, have shown the desire, as has been too frequently the case in the past in such publications, to educate the public in medical lore, and thereby rob the physician of his right to earn what is almost always but a livelihood. The author, on the other hand, has succeeded in placing in the hands of the public at large a book which will enable patients to the better appreciate, and benefit from, the efforts put forth by his medical adviser, and in reality assist him in the accomplishment of convalescence.



*A Reference Hand-Book of the Medical Sciences*, embracing the entire range of scientific and practical medicine and allied science, by various writers. A new edition, completely revised and re-written. Edited by ALBERT H. BUCK, M.D., New York City. Volume II. illustrated by several chromolithographs and 765 half-tone and wood engravings. New York: Wm. Wood & Co. 1901.

The publishers of this medical work are to be congratulated upon getting out Volume II. so promptly, but a short time having elapsed since the first volume was placed in the hands of the profession. This volume is like its predecessor, in being alphabetically arranged, and comprises practically everything medical from Blastoderm to Chloralose. After perusing Volume II. we cannot but conclude that the doctor who possesses a complete set of the new edition of "Reference Hand-Book of the Medical Sciences" will, in it alone, have nothing short of a medical library. The work will be more than complete, at least judging from the first two volumes, and we think that it will be found difficult for any publisher to get out a work which will be more thorough and up-to-date in every respect than that of Dr. A. H. Buck, who is determined to leave nothing undone to have the fruit of his present labor unequalled in medical literature. Among the contributors to Volume II. we are pleased to find the names of two Canadian M.D.'s, Dr. L. F. Barker, now of Rush Medical College, Chicago, and Dr. Beaumont Small, of Ottawa. W. A. Y.

*The Acute Contagious Diseases of Childhood*. By MARCUS P. HATFIELD, A.M., M.D., Professor Emeritus of Diseases of Children, Northwestern University Medical School; Professor of Diseases of Children, Chicago Clinical School; Attending Physician, Wesley Hospital. Pages, 142. Price, \$1.00 net. Chicago: G. P. Englehard & Co., 358-362 Dearborn Street. 1901.

This compilation is devoted exclusively to the eight principal acute contagious diseases of childhood. The two sections that appear to us as being especially helpful are those dealing with scarlatina and variola. Herein the different varieties of those diseases are carefully discussed.

The volume closes with a very complete description of the now so prevalent disorder, La grippe. The author has paid particular attention to history, etiology, and pathology, and throughout has compiled the opinions of such eminent authorities as Moizard, Holt, Jaccoud, Kennan, Grandin, Bartie, Cohen, closing each subject with his own ideas. The work is replete with much that is new in bacteriological research by Burgess, Tessier, Bouchard, Pfeiffer and others, and in many ways will make a valuable addition to the physician's shelves devoted to pediatrics. We

might add in conclusion that the work of the publishers, G. P. Englehard & Co., of Chicago, is most attractive and well above the average.

W. H. P.

*Queen Victoria: Her Life and Reign.* A study of monarchical institutions in British countries and Her Majesty's imperial influence. By J. CASTELL HOPKINS, author of the "Life of Sir John Thompson," "Life and Work of Mr. Gladstone," "The Sword of Islam," etc., etc. With a preface by the Marquis of Dufferin and Ava, K.P., G.C.B., etc., late Governor-General of Canada and Viceroy of India. The Queen Publishers, Toronto and Brantford. 1901.

Mr. Hopkins presents his subject in a taking style, due, no doubt, to extensive research in English history and biography, coupled with an innate capacity for the felicitous expression of thought. In some passages he rises to eloquence. The perusal of the work has been a source of positive pleasure, and we feel under an obligation to its accomplished author. The volume is embellished with portraits of different members of the Royal Family of England, and also those of some European sovereigns.

Of interest to Canadians also will be the portraits of well-known statesmen of this country, such as Sir W. Laurier, Sir C. Tupper, etc. The account given of the royal obsequies is most graphic and touching. The paper and illustrations are poor.

J. J. C.

*Favorite Prescriptions of Distinguished Practitioners, with Notes on Treatment,* compiled from the published writings, or unpublished records of Drs. Fordyce, Barker, Roberts, Bartholow, Samuel D. Gross, Austin Flint, Alonzo Clark, A. L. Loomis, Wm. Goodell, Wm. Pepper, A. Jacobi, J. M. Fothergill, N. S. Davis, J. Marion Lewis, L. A. Duhring, E. O. Jane-way, J. M. DaCosta, J. Solis Cohen, and many others. Edited by D. W. PALMER, A.M., M.D. Seventh Edition. New York: E. B. Treat & Co., 241-243 West 23rd Street. 1901.

To choose from the mass of literature at the disposal of the busy practitioner, and attempt to bear in mind what all of the best known writers have found to be the happiest combinations and most successful therapeutic agencies for the treatment of the various diseases, would be a task well-nigh impossible. In this book of "favorite prescriptions," Dr. D. W. Palmer has culled from all of the medical journals, as well as the more recent works, the remedies and their combinations which physicians of the highest repute have found from experience to be most suitable in treatment. The work will be found to be in many cases most useful, and should be placed, not in a doctor's library shelves, but left on his desk for constant reference.

W. A. Y.

*Atlas and Epitome of Labor and Operative Obstetrics.* By DR. O. SHAEFFER, of Heidelberg. From the fifth revised German edition. Edited by J. CLIFTON EDGAR, M.D., Professor of Obstetrics and Clinical Midwifery, Cornell University Medical School. With 14 lithographic plates, in colors, and 139 other illustrations. Philadelphia and London: W. B. Saunders & Co. 1901. Cloth, \$3.00 net. Canadian Agents: J. A. Carveth & Co., Toronto.

We have taken occasion to remark before, when reviewing Saunders' Medical Hand Atlases, that, as a guide to the study of the subject, we know of no other series of works which will prove of such assistance as will the Hand Atlases published by W. B. Saunders & Co. The "Atlas and Epitome of Labor and Operative Obstetrics" is certainly no exception to the rule. It is full of beautifully executed plates, showing in the most natural, and consequently correct manner the different manipulations necessary to the successful conduct of obstetrics in its different phases.

W. A. Y.

*Annual Report for the Year 1900.* E. MERCK, Darmstadt, Germany. Published in March, 1901.

Merck's Report for 1900 is a considerable improvement upon that for 1899. We notice that the publisher has greatly improved his index of diseases, in that they are classified, thus greatly facilitating any work in this direction. The original communications contained in this Report have considerable merit, and the list of pharmaceutical preparations is most complete, altogether making the pamphlet one worth keeping on the desk for constant reference. A copy can be obtained by any physician on application to the firm.

*A Compend of Human Physiology.* Especially adapted for the use of medical students. By ALBERT P. BRUBAKER, A.M., M.D., Adjunct Professor of Physiology and Hygiene in the Jefferson Medical College, Philadelphia. Tenth Edition. Revised and Enlarged, with Illustrations, and a Table of Physiologic Constants. Philadelphia: P. Blakiston's Son & Co. 1900. Canadian Agents: Chandler & Massey Limited, 235 Yonge Street, Toronto.

This belongs to the series of "Quiz-Compend." It is not arranged in the form of questions and answers, but is a short and condensed account of the main facts in physiology. These works are intended to be an aid to students during their attendance on lectures. They should be used mainly as a help in reviewing the subject, but should never take the place of the ordinary text-books. Dr. Brubaker's Compend is very full and complete for a work of

this kind, and it is a valuable aid to students while reviewing their work for examinations in physiology. A. E.

*Mistress Nell.* By GEORGE C. HAZELTON, JUN. Toronto: The Copp, Clark Co., Limited. Cloth.

Truly "a merry tale of a merry time." The wit and witchery of *Nell*, the actress, the gay yet admirable Charles the King (her lover), the intrigue of the Frenchwoman, Portsmouth, the finely drawn Buckingham, with the minor characters, all combine to make play or novel, in whichever form the tale is told, a joyous one. This time it's surely "the cart before the horse," to use an expressive but rather inelegant simile—the play was first a success, then the novel was written. Henrietta Crossman has been delighting New Yorkers in her role of *Mistress Nell*, but let us hope that the inimitable Bernhardt may yet make us all laugh, as she only can, as *Mistress Nell*, in the *Masquerade of Beau Adair*. In the meantime, read this little story, amusing, short and tempting to the eye, because of its splendid typography. W. A. Y.

*Essentials of the Diseases of Children.* By WILLIAM M. POWELL, M.D. Third edition. Thoroughly revised by ALFRED HAND, JUN., M.D., Dispensing Physician and Pathologist to the Children's Hospital, Philadelphia. 12mo, 259 pages. Philadelphia and London: W. B. Saunders & Company. Price, \$1.00 net. Canadian Agents: J. A. Carveth & Co., Toronto, Ont.

Like former volumes of this series, Saunders' Question Compend on *Essentials of the Diseases of Children* consists of questions and answers as to the causes, symptoms, diagnosis, and treatment of the various diseases of children most commonly met with. For the student who is preparing for his "final," and for the physician even who has become a little rusty, Dr. Wm. Powell's little volume will be found a wonderful source of assistance.

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**The Canadian Agency of P. Blakiston's Son & Co., Philadelphia.**—The profession will be glad to know that P. Blakiston's Son & Co., of Philadelphia, Pa., the well-known publishers, have appointed the Chandler-Massey Limited, of Toronto and Montreal their agents for the Dominion. The Chandler-Massey Limited but recently established their book department, but it has already made wonderful strides under the good management, foresight, and business acumen of Arundel P. Watts. All Blakiston's books can be procured from Chandler-Massey at a moment's notice. In fact any book, no matter where or by whom it is published, can be ordered through this firm by letter, postal card or telephone.