

# The Canadian Journal of Medicine and Surgery

A JOURNAL PUBLISHED MONTHLY IN THE INTERESTS OF  
MEDICINE AND SURGERY

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VOL. XXI.

TORONTO, JUNE, 1907.

NO. 6.

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## *Original Contributions.*

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### THE DETECTION OF MENTAL DEFECT IN SCHOOL CHILDREN.

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BY C. K. CLARKE, M.D., LL.D.

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LAST June I took part in a Symposium on the Prognosis and Treatment of Dementia Precox at the meeting of the American Medico-Psychological Association, which was held at Boston. During this discussion I made the following remarks:

“Little is to be said about treatment, unless it may be suggested that a careful study of school children should regularly be made by those who are familiar with the disease and understand the gravity of the situation. Surely if ever the advisability of early treatment of disease is indicated, it is in dementia precox. Consultation with intelligent teachers would generally bring to surface those weaklings whose future is threatened by the development of dementia. Treatment might then be possible, and in many instances psychotherapeutics and other treatment of value suggested. It is not going beyond the truth to say that most of our public school systems are the very worst possible for the care and development of the D. P. classes. It would be better for the State, the weaklings and all concerned, if these children could be recognized early, and intelligent effort made to steer them clear of the dreadful fate that ordinarily stares them in the face. Possibly, in spite of any means taken, a large proportion of these classes would run to the terminal stages, but certainly the effort to avert this result should be made intelligently and persistently.”

These remarks must be the text from which I shall speak very briefly to-day.

When an alienist has been in harness for a few years he learns,

among other things, that the admissions to hospitals for insane contain a large proportion of young people, who have already reached the incurable stages of disease. Ordinarily, they will go from bad to worse, sinking into a condition of mental torpor that ranks them as ciphers, as far as the world is concerned. Under careful treatment a small percentage improve, and lead lives of limited usefulness, as long as preserved from over-strain, and a few are said to recover. I make the remark "said to recover" because my own experience has led me to believe that complete recovery is so rare that it can scarcely be said to occur. Now, what is dementia precox—in other words, precocious dementia? If we limit its definition carefully, we find that it is a form of mental disease appearing generally at the first developmental crisis, rapidly running a course culminating in dementia, as characterized by apathy, indifference, negativism, irrelevance and inability to make continued mental effort. These wrecks are the most striking evidences and proofs of what a bad heredity will do for those who are cursed with it, and who try to endure the strain imposed upon the organism by civilization. If it were the truth that as nature weeded out the weaklings, gradually, dementia precox was disappearing, there would be little reason for calling attention to the present state of affairs. Unfortunately, civilization and culture are not always under the control of the best of nature's laws, and certain conditions of society are decidedly artificial. We do not yet understand the best methods of brain development, nor have we learned to recognize all of the danger signals of over-strain.

The methods of making mental and physical analyses employed by the modern alienist are so exact, so painstaking, so plodding and so different from the delightful, "jump-at-conclusion" ways of many of his predecessors that it will not be long before he will be in a position to offer suggestions of immense value to the whole world. Perhaps we have too little patience with the so-called theoretical psychology, much of which is attractive, but not founded on fact; but, at all events, the day is not far distant when the theoretical psychologist will be forced to correlate his theories with the facts of psychiatry before he dare offer his wares to the admiring public. Experiences in abnormal psychology make plain the truths of the normal, and allow us to fix the standard, not for a class, but for the *individual*, something that the theorist nearly always overlooks.

It is here public school systems fail so frequently; they are constructed, as no doubt they must be, to a very great extent with regard to classes rather than individuals. Now to idealize on what public schools might be is seductive; but I am here merely to discuss, from my standpoint, a practical problem that must some time or another be faced.

In making an analysis of a mental case, we commence with the history from the time of birth, and, if possible, go back as many generations as authentic history will give us an account of. The whole development of the child is scanned as closely as it can be done, and rarely indeed in cases of dementia precox is the history without a hundred significant warnings of the tragedy to come—warnings so clear to those familiar with the ear marks of this protean disease that no competent observer could have overlooked them.

When I turn to my own school days and read the histories of the pupils, I stand aghast at the tragedies which occurred, and which possibly might have been averted had the teachers recognized the drifting of several frail barks to their inevitable doom beneath the Niagara of dementia.

These children did their best to stem the current, but no helping hand was stretched to save them from their doom, and their fate was never in doubt for one moment. The wrecks are now scattered about in various institutions for the insane.

The position occupied by such children in the school was somewhat striking—none were *average* in any sense of the word, but at once attracted attention by their departures from what might be called the normal. In some, mannerisms were clearly becoming apparent, the ego undergoing hypertrophy, and emotional disturbances making themselves manifest. Apathy and indifference were the characteristics in others, and those of the paranoid variety were introspective to a degree that brought upon them the accusation of stupidity. In every instance the true mental status was not suspected by the teacher, although some of the other pupils had formed shrewd guesses regarding the mental defect of their companions.

Let me detail very briefly one or two striking examples:

J. C. was a boy of bad heredity, and at an early age showed striking abnormalities in the way of sexual perversions. At school he did well until about thirteen or fourteen; indeed, in certain directions showed unusual ability, especially in mathematics. Then a gradual change took place: he became quiet; neglected work, and was the butt of the school. Teachers lost patience with him, but he showed absolute indifference to the many punishments which came in his direction. He startled the class now and again by flashes of brilliancy which were quite unlooked-for, but at once relapsed into indifference again. The jeers of his companions were taken in good part and without resentment, and among the pupils he acquired the reputation of being a good-natured fool.

He succeeded in mustering up enough energy to make a poor pass at a matriculation exam., and became the *hete noir* of a professor, who was exasperated beyond measure at the stupidity of his pupil, and yet from time to time the whole class was electrified

by spasmodic exhibitions of an ability that might, if gone on with, have left all of the other pupils in the rear. The case came before my attention, and from what I learned, without seeing the lad, the development of dementia paranoides was suspected.

A few weeks after this time the boy made what was supposed to be a most determined effort to commit suicide, and I was called upon to give an opinion on the mental status. The patient spoke to me freely and without hesitation, and the story told was a pathetic one. He had been fully alive to the false estimates made by his teachers, but had been so interested in watching, as he believed, the development of a new brain, that he had no time to worry over the trivialities of school life. "They called me stupid," he said, "but if I had cared to exert myself I could have passed them all."

A mysterious voice had been directing him, and he had been told by it that he had the same power as Christ, and his belief in that power had led to his making the so-called attempt at suicide. He reached complete dementia in a few months, and died in a year or so.

Here is a brief history of a case of the hebephrenic variety:

C. S. was always an eccentric child; even in the earliest days at school she attracted attention by her mannerisms and vanity. When she was ten or twelve her mannerisms were a common subject of remark. She walked with a silly strut; her hair was arranged in a manner so grotesque that it was always a subject of comment, particularly on the part of the village gossips, who saw evidences of the degeneracy of the modern days in this so-called new style. Even her voice, as is so often the case in D. P., gave evidence of the abnormal. This poor girl endeavored to stand the pace set at school, but in vain. By and bye the village gossips had more than enough material to keep their tongues wagging. Poor C. S. began to give evidences of what they called "dreadful wickedness"—what I was able to classify as well-defined mental defect.

She was removed to a hospital for the insane, and reached complete dementia almost at once. To see her now, after many years, a mere lump of hideous clay, is object lesson enough to inspire many a plea, far more eloquent than this, in favor of more careful study of school children, in search of the weaklings who may be helped.

Perhaps I should have said that I am not one of those who believe that our school systems are so developed that they cause over-strain in the average child. On the contrary, my impression is that the majority of children are capable of acquiring with ease and benefit, much more than is given them, and I strongly believe in the proper development of the brain, an organ that is of far greater importance than any other in the human economy. I merely maintain, that without an intelligent study of the individual, it is not possible to avoid the tragedies the alienist is called

on every day to witness. With all respect to those who have evolved our educational systems, enough attention has not been paid to the training of teachers, who should be given broader ideas, and more thorough knowledge of the requirements of actual life, and have some conception of the dangers of over-strain in abnormal and diseased children. The education of the masses is, of course, a laudable ambition on the part of any nation, but no greater error can be made than to attempt to make finished scholars of poor weaklings whose sole chance of a useful life lies in carefully guarding them from every species of mental strain.

Paton says: "The first duty of the educator should be to determine the latent capacity of the individual, and then adopt the training, as far as possible to meet the needs of the developing nervous system. To render it possible for an individual who is physically and mentally unfitted for the stress associated with the effort to undertake the acquirement of what is termed a liberal education, should be regarded as an offence against the public health and morality, no less culpable than if one were to place lives in an environment where they are exposed to an infectious disease."

Efforts to control the spread of exanthematous diseases are regarded as a necessity by all but a few faddists, and so sound is the common sense of the community in the control of such matters that we have become almost socialistic in some lines.

How different, though, when questions of sound mental health come up, and yet six or seven thousand chronic insane in the hospitals in Ontario testify to the fact that there is something wrong in our methods. Remember that fifteen per cent., some say twice that proportion, are cases of dementia precox, and the significance of my contention may be grasped. Consider that the first evidence of the coming mental breakdown were to be seen during the school days of these children, and the importance of the whole subject must at once strike you.

Now in my many years of experience it has been my lot to see a large number of children who were abnormal and diseased, and I have been surprised how little intelligent notice has been taken by teachers of their developing defects. In the majority of instances they have been regarded as nuisances; blamed and punished for their stupidity and apathy, and in every way possible made to suffer for so-called sins, for which they were in no way responsible. Often the whole class is made to mark time for one or two weaklings who should be weeded out. This has been an aggravation to teachers whose reputation depends far too frequently on the number of pupils who "pass", rather than on the solidity of the work taught.

I have no fault to find with the average teacher: as a rule he is far more sinned against than sinning. My contention is merely

for a more careful study of the individual pupil in the interest of the State and of everybody concerned.

How is this to be accomplished? At present I believe teachers are supposed to acquire some knowledge of normal psychology—delightful theory, but too often theory founded on arm chair speculation that would work out splendidly if we had to deal with standardized human beings. Those of us who study abnormal psychology soon realize that in our investigations the *individual* is the basis of study, and methods of treatment must be directed from that point of view. Now, no one expects teachers to have a knowledge of psychiatry or of psycho-therapeutics, and no one can expect them to decide off-hand on the proper course to be followed in the treatment of abnormal and diseased children, but I think it important that they should know something of the facts I have detailed to-day, and to report any suspicions they may have regarding the development of such conditions in any of the pupils. It is difficult to say just how the State must deal with the problem, which is even more difficult to handle than that of vaccination, because of the want of special knowledge, both on the part of the public and the physician in general practice. This physician has little or no opportunity to see much of mental defect and disease, and is apt to overlook even some of the most striking appearances. However, the problem must be met in due course, and its importance has already been recognized in some of the Continental cities. What, I suppose, will eventually be done is to have teachers co-operate with physicians who are familiar with mental-disease in all of its stages, and the proper course mapped out for the individual who is not equal to the strain of public school work.

In one direction this will, perhaps, entail immense cost to the State; in another a marked saving.

**A NEW METHOD OF DEALING WITH CLEFT PALATE.\***

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BY F. N. G. STARR, M.B., (TOR.),

Associate Professor of Clinical Surgery, University of Toronto; Associate-Surgeon, Hospital for Sick Children; Assistant-Surgeon, Toronto General Hospital.

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*Mr. President and Gentlemen—*

Those of us who have had much experience with cases of cleft palate have all met with more or less disappointment in our results. It has more than likely happened in the practice of all who have undertaken these cases that certain ones, though they looked promising at the time of operation, have broken down at some point in the line of closure, if not throughout. This experience has been mine upon more than one occasion. In looking about for causes, the following points presented themselves: (1) Tension along the line of suture. (2) Sucking of the stitches by the patient. (3) Infection from the mouth.

When searching for some means to overcome these difficulties I read a paper by Chas. H. Peck, of New York, in the *Annals of Surgery* for January, 1906, in which he made reference to a plan suggested by C. H. Mayo, namely, the introduction of a tape through the lateral incisions completely surrounding the flaps, and thus preventing tension. I tried this at the first opportunity, but though it took off the tension I am satisfied that in the three cases upon which it was used the risk of infection was increased, for after forty-eight hours it became most offensive, and by the end of a week the patients almost hated themselves. It therefore became necessary to find something better, and finally as a substitute for the tape I chose aluminum, sufficiently beaten out to make it pliable. I have no doubt that silver would answer the purpose equally well, but it is more expensive.

My technique varies somewhat from the Langenback operation, and I think saves time, which is an important point. The child is placed upon a table with a sandbag under the shoulders to throw the head well back, while the surgeon stands to the left of the patient. Hewitt's gag is placed in position, and the tongue drawn well forward by means of a silk suture. I make the first lateral incision well out to the alveolar margin of the hard palate, carrying it beyond the anterior extremity of the cleft, if the cleft does not extend through the alveolar margin. With the periosteal elevator the muco-periosteum is quickly denuded from this side, then with Lane's curved scissors the palate aponeurosis is snipped from the posterior margin of the hard palate, thus freeing the flap from its bony attachment. The flap should be freed anterior to

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\*Read at meeting of the Toronto Medical Society, May 2, 1907.

the left. This incision may then be packed with a piece of sea sponge, while one proceeds to the opposite side to deal with it in the same way. The first packing may now be removed, when one finds that all hemorrhage has ceased. The edges of the flap are then removed with a small tenotomy or cataract knife, making certain to cut as thin a slice as possible, at the same time taking the whole thickness of the flap margin. By the time denudation has been carried to the anterior angle on one side the sponge packing from the other may be removed, and denudation proceeded with on the other flap. While the raw edges are still oozing, and before there is time for mucous to glaze them over, I begin



(a) (b) (c) (d)  
FIG. I.

- (a) Aluminum prepared with flange to cover line of suture.  
 (b) Same, bent at an angle preparatory to passing small end through lateral incision.  
 (c) Appearance of splint when fastened in place.  
 (d) Piece of aluminum without flange, that may be used in small clefts.

suturing, commencing at the anterior angle and proceeding backward. Horsehair is used, and each suture is passed about one-eighth of an inch from the margin, and from one-eighth to one-quarter of an inch apart. These are left long until all have been passed, when they may be quickly tied. Lane's needles and needle-holder are used and greatly facilitate the work. I then take a piece of aluminum (Fig. 1.), bend it at an angle where I want it to fold over the outer side of the flap, and pass it through one lateral incision; then by passing a pair of forceps into the opposite lateral incision I grasp the free end and pull it down into the mouth cavity again, carry it across to the point at which it entered, and there cut off any excess. With a heavy needle one



may then easily penetrate the metal, at one or two points as required, and pass a horsehair suture through and tie it to prevent the free end scraping and irritating the tongue, or the free end may be turned up into the lateral incision again, and pinched with a pair of forceps (Fig. 2.) The operation takes from twenty-five to fifty minutes. The aluminum may be left in for eight or nine days, when it is removed by cutting it across close to the lateral incision, and the stitches are taken out. The lateral incisions then rapidly heal, and the patient may leave the hospital in from ten days to two weeks. The case, aged two years and four months, that I show to-night, was operated upon April 19th last. The cleft was of the soft palate, and about one-third of the hard. The aluminum splint and the stitches were removed on the 28th; you, therefore, see the case thirteen days after operation, and may judge for yourselves as to the efficiency of the method. This is

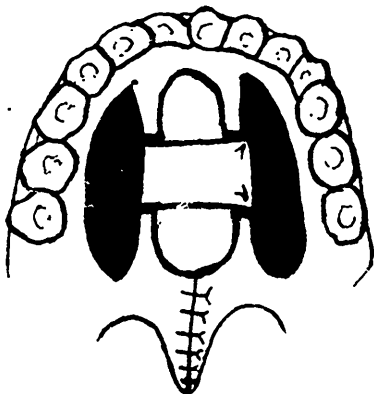


FIG. II.

To illustrate aluminum splint in place—covering line of suture and preventing tension.



FIG. III.

Pin through small opening.

the third case upon which the aluminum splint has been employed. The first one was in a child, aged 14, that had a very wide cleft which had been pronounced incurable, and it was advised that she wear an obturator. The cast of the mouth (see Fig. 3), was sent me a few days ago by Dr. Bennett, a dentist of St. Thomas. You will observe that union has taken place except at one pin point spot at about the junction of the hard and soft palate. This, of course, can readily be repaired.

The second case was a child of two years with a complete cleft in which union occurred throughout.

The advantages of the aluminum splint that occur to me are these: That it prevents tension, and prevents—till union of the edges has occurred—adhesion taking place between the muco-peri-

osteum and the bone of the hard palate. I am satisfied that some cases have gone bad because of this, in that while there may be no tension at the completion of operation, yet, when such union begins, tension upon the edges of the flap may be sufficient to separate them by tearing out the stitches. Then, too, it prevents the child sucking the stitches. To avoid infection the mouth is sprayed with a solution of boric acid and 10 per cent. rectified spirits, which may easily find its way under the splint, and remain in contact with the wound for some time. For this purpose, however, I shall in future have the opsonic index taken, and if it be low to the germs within the mouth an injection of vaccine will be administered a day or two before the operation, when there will be little or no possibility of infection. Thus, one has overcome all the causes that tend to prevent union.

112 College Street, Toronto.

## *Selections, Abstracts, Etc.*

### HOW CAN PROPHYLAXIS BY TREATMENT IN THE CASE OF THE VENEREAL DISEASES BEST BE OBTAINED?\*

BY JAMES PEDERSEN, M.D., NEW YORK.

Whatever the measure of prophylaxis to be expected from treatment, it stands to reason that the more thorough the treatment the better the prophylaxis. The solution of the question which forms my part of the evening's subject must, therefore, be worked out along two parallel lines, namely: How to obtain thorough treatment in the private office; and how to obtain thorough treatment in the public clinic. The latter is the point of chief concern. To focus the discussion upon this point and to hope that the discussion may be productive, it will be necessary to assume that every man and every woman, whether professional or lay, who has undertaken or who will undertake to influence the health and happiness of human beings, the physician, the philanthropist, the settlement workers, yes, and the faddist, whether he is ostensibly practising medicine or not, it will be necessary to assume that one and all accept as axioms: (1) That the venereal diseases are tangible entities; (2) that they constitute a formidable menace to the individual and the State; (3) that there is a crying need for prophylaxis; (4) that actual treatment, persistent and persevering, is a potent agent in prophylaxis; (5) that material medication, given or applied, plus obedience to the laws of general hygiene, constitute the only actual treatment; (6) that to impart instruction as to the serious nature of the venereal diseases is a social duty which all are under moral, legal, and ethical obligation to fulfill.

Assuming, then, that these axioms have been accepted universally, the question how best to obtain prophylaxis by treatment in the case of private office patients will never cause a moment's concern, and will therefore be eliminated from this discussion; while the same question as to public clinic patients will have been reduced to an enquiry into (A) dispensary facilities and (B) hospital facilities, necessary to thorough treatment and prophylaxis. To give all the weight possible to my paper, permit me to say that

\* Read before a meeting of the American Society of Sanitary and Moral Prophylaxis, February 14, 1907.

I have based it largely on the writings of Fournier, who, in a long experience, has given this subject much careful study and thought. I have aimed, however, to adapt his suggestions to American sentiments, and have ventured to incorporate my personal observations.

(A) *Dispensary Facilities.* To advance the success of prophylaxis by treatment, we need more dispensaries and better facilities in those already established, all with provisions for carrying out the restrictions against dispensary abuse. Another paper, this evening, has dealt with that specific point, therefore no further comment is desired here. I may be permitted to say, however, that at present, in my experience, combating the evil rests chiefly with the physician in the dispensary. He feels called upon in many cases to challenge the would-be patient, thus taking from the already limited time allotted to treatment and teaching.

To everyone thoughtfully interested, whether from a medical, a philanthropic, or a sociological point of view, it must be obvious that more dispensaries are needed, each located accessibly in a district not already provided for. These should be general dispensaries under private or public control. Special dispensaries, *i.e.*, for venereal diseases, would defeat their own object by the unavoidable offensive publicity they would soon attract.

For convenience, the facilities needed in each dispensary may be taken up categorically under separate heads.

*The Hour of the Clinic.*—There should be an afternoon clinic and an evening clinic, both for men and for women, at least three times weekly (the men and women on alternate days), but six times weekly when the attendance demands it. An early afternoon clinic would accommodate the unemployed, would not interfere with their morning search for work, and would ease the strain on the evening clinic. The evening clinic should begin preferably at 7, admit patients for one hour, but remain in operation until 10 o'clock, if necessary, the clinical staff doing duty in two divisions to avoid obliging any member to remain longer than an hour and a half. (It is understood that any patient under fifteen years of age should be referred to the medical clinic for children, where, if necessary, he or she could be seen in repeated consultation by a member of the staff in venereal diseases, whose duty it should be to instruct the guardian in the details of prophylaxis.)

*The Waiting-room.*—There should be a special waiting-room attached to the suite of rooms devoted to the venereal clinic, and the patients should be allowed to pass to it without detention in the general waiting-room.

*The Consultation-room.*—This should either be large enough to so accommodate an increasing staff of clinical assistants that each may be consulted at least semi-privately by the patient before

him, or there should be a series of small consultation-rooms. Of the value of privacy in the clinic consulting-room Fournier makes a strong point. It encourages the timid and diffident to seek advice, it lends to the dignity of the clinic, and it fosters careful treatment.

*The Staff.*—The staff should consist of a chief and as many clinical assistants as may be necessary in his judgment to complete the work of the clinic in an orderly and professional manner within the time limit. The clinical assistants should hold an official appointment from the institute of which the dispensary is a part or a branch, and their attendance should be made a matter of record and report. By way of return for their services, applicants for treatment at the clinic and able to pay should be referred to the private office of each clinical assistant in rotation, without favor, by the proper officer at the application desk. At least half the number of clinical assistants in the clinic for women should be women physicians, holding official appointments with the same responsibilities and privileges as the men physicians.

The routine work of duty in a clinic often becomes a drudgery to the recent graduate, especially when performed in the evening after a day's work at building up a private practice upon which he must depend for support. But if this or some similar system were not only introduced, but also carried out, by which the clinical assistant could feel that he was a factor in the personnel of the dispensary and of its parent institute; that his work had a value and a dignity in the opinion of the governing body, and that his growing experience received recognition in the form of patients referred to him for treatment at his office, then would his clinical duty be less a drudgery and more a pride, thus adding to the prestige of the institute that appointed him. A dispensary run on these lines, especially if equipped for giving careful, detailed, scientific treatment expeditiously, would attract desirable men who would learn as well as teach. Thus would be created a growing number of young practitioners with knowledge and skill in the treatment of the venereal diseases, and the office of each would become a subcentre for prophylaxis by treatment. Many a clinical patient challenged as to his right to attend, declares that the "private doctor" he went to did not know how to treat him. Granting that the patient expected too much of the physician, was there not an avoidable error on the part of that physician in having failed to instruct his patient as to the nature and prognosis of the disease? The vicious circle is obvious.

*Orderlies.*—They should be paid sufficient to attach them to the clinic and to inspire their personal interest. They should have the care of, and be responsible for the instruments, supplies, and equipment. Not more than ten hours a day should be expected of them. During the morning they could do duty in the medical

wards; between the afternoon and evening clinics they should be allowed an interval for recreation to fit them for the evening's work. A system of substitutes should be arranged to secure for them at least one night off a week when the clinic is held every night. An annual vacation should be similarly arranged. Possibly no one who has not had practical experience can appreciate the time saving value of an intelligent orderly who has remained not only to be trained, but also to practise the training. Furthermore, he has an undoubted influence in attracting patients through his able assistance in expediting the work of the clinic. It may not be too Utopian to add that eventually, by arrangement with the Mills Training School, its pupils could serve a specified time in the different clinics in rotation as a part of their training in venereal and genito-urinary diseases and their prophylaxis.

*Nurses.*—The present system of having undergraduate nurses in attendance at the gynæcological clinics needs no elaboration. There will remain only the detail of extending it to the venereal clinic proper, in both the attached and detached dispensaries controlled by the hospital of training.

*Equipment, Instruments and Supplies.*—These should be furnished and maintained by the hospital or institute of which the dispensary is a part or a branch, and should imitate those of a private office devoted to venereal diseases and genito-urinary surgery. The orderly in the men's clinic, the senior nurse in the women's clinic, should have the care of these, and be responsible for them. A well-appointed, well sustained clinic is obviously a greater power in prophylaxis by treatment than its opposite. An important detail of the equipment should be printed slips, stating the nature and danger of the venereal diseases, the rules to be observed during treatment, and the rules for prophylaxis. Such a slip, covering the three diseases, should be given to every patient.

(B) *Hospitals.*—The question of hospital isolation of venereal patients need not come up for discussion. The fact that any such plan would defeat its chief purpose, and the fact that hospital treatment is needed only in exceptional cases, should be a sufficient veto. We need concern ourselves only with the exceptional cases. Though few, they are already in excess of the available hospital accommodations. As far as I know, all the general hospitals, excepting those under the control of the city, refuse patients in the active stages of venereal disease. Among the private hospitals, those that admit such patients admit them under protest or only when an operative emergency is present or threatens.

The attention of boards of governors and other bodies in control of hospitals should be called to this deficiency and that, from the humanitarian point of view, there is need for relief, not only for the sake of the infected patient, but also for the sake of the immediate community and the State. The different bodies in

control of general hospitals should be appealed to most urgently; it is in their power to lend very substantial aid in the prophylaxis of venereal diseases.

In the *public* hospitals, one ward for men and one for women should be set apart somewhat removed from the general wards. The orderlies and the nurses, respectively, in these wards should be responsible to a member of the house staff, he, in return, to a specially appointed board. The venereal wards would not be regarded with curiosity after the first few weeks; they would soon be accepted as an integral part of the hospital, as at Bellevue Hospital to-day.

If the criticism be made that this would multiply the duties of the house staff and increase the cost of the hospital management, let it be noted that the house staff has been increased in some hospitals, and that it should be increased in all. Every house staff to-day has more work than is good, either for it or for the service. A periodic increase in every house staff to meet the ever-growing demands would be no more than consistent with the modern idea of progress.

In a *private* hospital a man patient could be practically isolated with a graduate from the Mills Training School, who would carry out all the detail necessary to safeguard the neighboring patients. This has been done in my own practice with satisfactory results and without unduly disturbing the accustomed discipline and routine of the private hospital. Still easier would this be in the case of a woman patient, whose special nurse would be detailed from the hospital's corps of women nurses.

The criticism that these suggestions as applied to dispensaries and public hospitals entail great expense may be anticipated. It is realized that to carry out any suggestion would require time, but while contemplating the greater, why not put into operation the lesser? Let the facilities in the dispensaries and hospitals already established be increased and improved at once. Let the expense be met by an annual legislative appropriation, forced, if necessary, by an aroused public sentiment. If the physicians here and abroad have found it necessary to warn the people against the ravaging danger of venereal disease, it is not too much to ask the people to aid in protecting themselves by providing themselves with immediately available defences in the form of more and improved centres of treatment and teaching, the potent aids in prophylaxis.—*N. Y. Med. Journal.*

20 East Forty-sixth Street

### THE NEW YORK WOMAN'S HOSPITAL.

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THIS hospital was reopened on December 5, 1906, in its new building on West 110th Street, facing the grounds of the Cathedral of St. John the Divine. Addresses were made by John E. Parsons, the president of the board of managers; Dr. D. B. St. John Roosa, Bishop Henry C. Potter and Gen. Horace Porter. Mr. Parsons gave a sketch of the history of the hospital, which was started in May, 1855, by Dr. J. Marion Sims in a private house on Madison Avenue, and, as a result of the indefatigable labors of Dr. Sims, was enabled some years later to put up the large buildings on Park Avenue on an entire block owned by it, which were occupied until the sale of the property to the New York Central Railroad Company necessitated their abandonment. He stated that notwithstanding the many generous gifts it had received, the new hospital started with a debt of \$200,000, and he expressed the hope that, in view of the great benefit which the institution had proved to the community, the city authorities might be induced to aid its finances.

Dr. Roosa paid an eloquent tribute to the original genius of Marion Sims, stating that his device of the silver wire suture was an achievement which was unquestionably to be classed as an epoch-making one. He then referred to the splendid results which were afterwards accomplished by Thomas Addis Emmet, T. Gaillard Thomas and Edmund R. Peaslee; which, with the brilliant successes of Sims, gave the New York Woman's Hospital a unique position and made its work the standard of excellence in gynecological procedures throughout the civilized world. Dr. Roosa also seconded heartily the suggestion of Mr. Parsons in regard to municipal aid and said that, to his mind, it was clearly the duty of the city and state to contribute to the support of this and similar philanthropic institutions. Bishop Potter said that fifteen years ago, when the site for the cathedral had just been selected, he dreamed that these beautiful and historic heights, rendered sacred by the blood of American patriots shed in the war of Independence, would one day be crowned with religious, philanthropic and educational institutions. To-day, much sooner than he could have thought of anticipating, that dream was realized, and there were now located here the rising cathedral, the National Academy of Design, Columbia University, the Teachers and Barnard Colleges, St. Luke's Hospital, St. Luke's Home, and, finally, the new Woman's Hospital.

The new building is constructed of granite and limestone, and so completely fire-proof that it is stated that it would be impossible for the flames of burning material in any one room



to communicate with inflammable material in another. No effort has been spared to render all the appointments of the operating rooms and the wards as complete as possible and thoroughly in accord with the most approved ideas of modern hospital construction. The capacity of the wards is one hundred and twenty-five beds and there are, in addition, a large number of private rooms, each of which has its own bath-room. The kitchen, a model of its kind, is next to the roof and is perfectly ventilated. There is a fine solarium, and one of the most attractive features of the building is a roof garden, inclosed in glass at this season, which is bright with palms, vines and pots of blooming flowers. The house staff will consist of six physicians, assisted by a corps of thirty nurses. The hospital as it stands represents an expenditure of more than \$1,000,000, and the actual cost of the building, which faces both on 109th and 110th Streets, was \$800,000.—*Medical Review of Reviews.*

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### ABSCESS: DRUG THERAPY.

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BY W. C. ABBOTT, M.D., CHICAGO, ILL.

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No pyogenetic microbe can live in the body saturated with sulphides till their odor is perceptible on the perspiration or breath.

Give calx sulphurata gr.  $\frac{1}{6}$  every half hour or quarter hour till saturation; then enough to sustain this effect. Must be true to quality.

It seems better to give the small and frequent doses of calx sulphurata (calcium sulphide) than large infrequent ones; either way will do.

In gonorrhœal infections the sulphide of arsenic seems to possess a control superior to that of calx sulphurata; try it further.

All abscesses do better if the blood-supply for repair is pure and nutritious; free from a surplus of toxins. Therefore eliminate!

Keep the bowels free and disinfected with calomel—a grain in the evening, a saline laxative next morning, and calcium sulphocarbonate as needed.

Fatty degeneration of morbid products is promoted by arsenic; give it in some form as may be best, to full toleration.

Nuclein reinforces the leucocytes and makes tonics "take hold"; give it up to a dram each day, best dropped on the tongue.

Quinine restrains sepsis and fever, and is one of the most appropriate tonics to be taken during suppuration.

Aconitine, gr. 1-134, with digitanin, gr. 1-67, form a useful combination for fever, restraining it in harmless limits; a dose every one or two hours.

Arsenic iodide is a powerful stimulant to remove debris; give gr. 1-67, not more than four times a day to an adult.

Atropine checks the discharge from an abscess as it does any mucous secretion; give enough to dry the mouth slightly.

Calcium salts check discharge and rebuild disintegrating cells; give small frequent doses; gr.  $\frac{1}{6}$  every half hour, lactophosphate best.

Calc iodata fulfils the two great indications—it stimulates absorption of debris and favors rebuilding; give four grains a day.

Baptisin is believed to directly improve the vitality of tissues threatened with death; give gr. 1-112 every hour or two.

Echinacea is gaining testimony daily as to its possession of the virtues of a systemic antiseptic; give a granule every half hour or hour.

Not only septic infections, but suppurations are checked quickly by echinacea, which has no perceptible action in health.

Relaxation of tissues may demand the use of berberine, gr. 1 to 5 each day, or oozing of blood call for hydrastine, a grain a day, divided.

Iron arsenate is the best chalybeate here; give gr. 1-67 every hour, or 1-6 an hour before each meal and at bedtime.

Iron iodide for glandular suppurations; give gr. 1-12 every hour to an adult, better than larger less frequent doses.

Iron phosphate will answer when the arsenate is not needed; give gr. 1-6 every half hour, always in solution if possible.

Lobelin will hasten the maturation of sluggish indurations that are disinclined to soften; a grain a day, divided.

In all cases reinforce the leucocytes by giving nuclein solution, standard, a dram a day, dropped on the tongue.

Neurolecithin is a remarkable reconstructive, not simply for nerve degeneration alone; a tablet four times a day.

A few granules of quassin given in water before meals stimulate the appetite and digestion in a way to aid reconstruction markedly.

Quinine arsenate is the best salt during most stages, the hypophosphite after the discharge has gone the desirable limit.

Quinine hydroferrocyanide is a capital remedy, and may be given up to two grains a day, divided into 1-6 gr. doses.

Sanguinarine stimulates or incites the vitality of the pharyngeal tissues and may do so to others; the idea has never been tested.

Strychnine is frequently needed; the arsenate, hypophosphite or nitrate; best in small doses quickly repeated to desirable tonicity.

There is something about populin that we can not quite grasp; it is no ordinary tonic, and we believe worth close clinical study.

The incitation of the vitality of various tissues to make them more resistant of noxious influences is an unknown book of therapy.

The action of the sulphides is beyond question, when a pure salt is given in sufficient doses and sustained at saturation.

The sulphides, nuclein and echinacea threaten to remove abscesses from the list of surgical diseases.

There will never be such perfect drugging that we can neglect to evacuate abscesses, and disinfect them; especially the first focus of trouble.

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### WRIGHT'S WORK ON OPSONINS AND VACCINE THERAPY.

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If the work of Wright fulfils the many expectations entertained by him and others, and if the numerous investigators repeating and elaborating Wright's experiments can continue to confirm his results, a powerful curative agency will be at the disposal of both physician and surgeon. This agency is not strictly a new one, but, granting that Wright's premises are correct, it brings a hitherto incalculable factor under direct observation and partial control.

There exists in the blood of every individual, to a greater or lesser degree, an element (Wright calls it "*opsonin*," to cook or prepare for consumption) which enters into combination with the bacteria and prepares them for phagocytosis. In order to gauge the power of this element, Wright has devised an ingenious method which enables one readily to compare the opsonic power of the patient with that of normal individuals; the resulting proportion is the "*opsonic index*." In disease the opsonic index is either higher or lower than the normal, usually higher if the resistance is good, lower if the body reaction is poor. If low, it is often possible to assist the body resistance by appropriate vaccine therapy.

The method of determining the opsonic index, in broad outline, is as follows: An emulsion (or "cream") of the leucocytes of a healthy individual is freshly obtained; likewise the mixed blood sera of several healthy people (called "pool"). Another requisite is an emulsion, of known concentration, of the variety of bacteria for which the patient's opsonic power is to be determined. Finally some of the patient's serum must be taken. Formidable as this list of requisites may appear, by following Wright's technic, the necessary paraphernalia (chiefly pipettes and capsules made of ordinary glass tubing) are readily prepared by each investigator. Like quantities of the patient's serum and the mixed serum of healthy individuals are now taken and each serum is mixed with the same amount of bacterial emulsion and

of normal leucocytes. These two resulting mixtures are incubated at 37 deg. C. for fifteen minutes, in order to allow the phagocytes to do their work, and then blood spreads on two slides are prepared and stained. Fifty or one hundred polymuclear leucocytes are counted; the number of bacteria contained within each leucocyte is determined, and an average obtained. The proportion of bacteria to the leucocyte in the patient's serum compared to that in the normal serum is the *opsonic index*. A surprising number of technical details and simple expedients has been devised by Wright in order to simplify and render accurate these manipulations.

Should the patient's index prove low, it will show that his resistance to the particular bacterial invasion is insufficient to successfully combat the infection. If this proves to be the case "vaccine therapy" may be tried. It has been known for a long time that injection of dead cultures of bacteria assists the body in elaborating elements which aid in overcoming the infective agent, but until Wright's method was announced no rapid or clinically practical means were at our disposal to ascertain the good or bad effects of the treatment. It is now possible to give the vaccine injection and, day by day, watch its influence on the opsonic power, thus enabling us to omit, increase or decrease the dose, as may seem indicated.

What the practical results will prove to be, it is as yet too early to say, but in any case the method has stimulated research along the lines indicated, and thrown a new light on many hitherto doubtful points.—*Amer. Journ. of Surgery.*

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### STOVAINE AS A LOCAL ANESTHETIC.\*

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MR. G. L. CHIENE read a communication on the "Use of Stovaine as a Spinal and Local Anesthetic." He said that the use of a general anesthetic was always a source of possible danger to the patient and now when the dangers due to the actual operative procedure had been reduced to a minimum the anesthetic might be regarded as the most dangerous factor in many operations. Bier first attempted the production of anesthesia by spinal injection. Cocaine was used, but as the after-results were often of a most unpleasant or even dangerous nature the method for a time fell into disuse. In February, 1904, Fourneau, a French chemist, first brought before the profession the hydrochlorate of amyleine, which he named Stovaine. This product, when injected into man, slowed the pulse and caused contraction of the pupil. Pallor was not induced but often flushing supervened. Dyspnea, oppression,

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\*Read before meeting of Edinburgh Medico-Chirurgical Society, Jan. 17, 1906.

uneasiness, or excitement was absent, and there was no tendency to syncope. It was certainly much less toxic than cocaine, and so could be given in larger doses if required. As after-result there was usually a slight rise of temperature which might last for some days. There was little tendency to sickness or vomiting, while headache and spinal neuralgia were rarely present. The general condition was good and the patient could enjoy an ordinary meal. Reclus, in July, 1904, gave the results of nine months' experience with Stovaine as a local anesthetic. He employed it in doses twice the strength of cocaine. Chaput maintained that many laparotomies could be performed under spinal anesthesia with Stovaine. In 100 cases, 45 operations were performed on the legs, 26 on the perineum, and 29 on the abdomen (hernias, hysterectomies, appendectomies, and ovariectomies). He stated that it was very useful in fractures and dislocations of the lower extremities. The height to which the anesthesia rose varied greatly with the dose, and his failures occurred only when small doses had been given. In his experience the after-results of Stovaine were much less severe than those of cocaine. The dose injected varied from four to eight centigrammes, and he did not care to employ it in patients over 65 years of age. Mr. Chiene had employed this drug on various occasions since October, 1904, combined with hemisine. In his experience a larger dose was required to produce spinal anesthesia than that recommended by foreign authorities. He used Tuffier's solution, 10 per cent. of Stovaine in sodium chloride solution. Sterilized solutions of the drug were supplied in *ampoules*. After injection into the spinal canal a sensation of pins and needles was felt in the legs and in about seven minutes the patient was unable to lift the limbs. At this time sensation to pain was lost though that to touch remained. Anesthesia commenced in the perineal region, then affected the toes and feet, and passed gradually up the limb. It passed off in the reverse order. The operations which he had performed under spinal anesthesia induced by Stovaine included inguinal hernias, transplantation of tendons, removal of tuberculous glands in the groin, operations for severe traumatic flat-foot, hemorrhoids, varicose veins of both legs, etc. Mr. Chiene was quite satisfied that with more experience both in technique and in the dosage of the drug failures would be exceptional. Lumbar puncture was now a routine method for diagnostic purposes in medicine and accidents were rarely heard of. It was too soon to compare the risks with those of general anesthetics, but it must be allowed that this method might be preferable in many cases. It was stated by some authors that gangrene of the skin occurred at the point of injection, but in Mr. Chiene's experience with the combination of drugs already mentioned, he

had not had a single case of gangrene of the cutaneous tissues.—  
*The Lancet*, Jan. 27, '06.

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### ABSTRACTS.

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**Serum Treatment of Dysentery.**—L. Vaillard and C. Dopter (*Bulletin de l'Académie de Médecine*, Paris) for years have been making a special study of dysentery and its treatment with a prepared serum. Shiga and Kruse used cultures alone to immunize the animals in making their serum, ignorant of the existence of a soluble dysenteric toxin. Vaillard and Dopter immunize their horses by inoculation on alternate weeks with progressive doses of living bacilli and of the soluble toxin. The toxin is obtained by filtering through porcelain a culture in Martin bouillon kept for twenty days at a temperature of 37 C. The injections are made under the skin at first and later in the veins. The serum of the horses acquires immunizing properties against the bacillus of dysentery and against its toxin. Ninety-six patients with dysentery have been treated with the serum. The number includes 50 with from 15 to 20 stools in twenty-four hours; 18 with from 30 to 80; 24 with from 80 to 150, and 4 with from 150 to 288 stools. All recovered except one patient in the last group. The serum has an almost immediate influence on the local and general symptoms of the dysentery, and recovery is complete in two or three days in the mild and in four or six days in the severest cases. Relapses were observed only twice, and in these instances they occurred the tenth day or third week after the last injection of serum, when its effect was exhausted. Some of the patients had been treated for weeks with calomel, lavage of the intestines, etc., without appreciable effect. The condition changed as soon as the serum was injected and the patients were cured in two or three days. The minimal dose is 20 c.c., injected under the skin, repeated once or twice in the severer cases. Its harmlessness has been amply established.

**New Glandular Function of the Connective Tissue Cells.**—J. Renant (*Bulletin de l'Académie de Médecine*, Paris) found nearly two years ago that the fixed cells of the connective tissue are endowed with a secretory activity which seems to confer glandular functions on them. Like the cells of the true glands, such as the parotid and pancreas, they elaborate in the heart of their cytoplasm a large number of granules possessing all the histologic and cytologic characters of the "pro-ferments." The granule grows to maturity in the centre of a vacuole. The cell does not throw off these granules as such, but acts like a true fer-

ment-producing gland, and redissolves its segregated granules before excreting the substance. He calls this the "rhagiocrinic function," coining the term from the Greek words for granule and select. Such a connective-tissue cell should henceforth be regarded as a true interstitial glandular cell. The cells in question are spherical, are able to migrate, and are the phagocytes *par excellence* of the connective tissue. Their "rhagiocrinic function" is in evidence in early life, and subsides when the organism has reached maturity. It is not lost, but remains latent until aroused by some irritation or other stimulus. The connective tissue thus forms an enormous gland whose elements can be aroused to glandular activity at any time. These elements pass through the stages of the round, migrating "rhagiocrines," then the fixed "rhagiocrines," then the branching, and then the anastomotic "rhagiocrines," growing more and more quiescent with age. The material secreted by the "rhagiocrines" has certainly some relation to the growth of the connective tissue, as the secretion lasts until the organism has reached maturity and is then suspended. A large number of these connective-tissue "rhagiocrines" still persist free in the fluids of the serous cavities, even in the adult. They migrate by their own ameboid movements, and are not dependent on the circulation. They retain their extremely active phagocytic properties long after they have settled down into quiescent fixed cells, incorporating blood corpuscles and foreign bodies with like avidity. The task now before us, he declares, is to learn the means of stimulating and controlling this "rhagiocrinic function." It may prove of far-reaching importance.

**The Glycosuria Caused by Saline Solution.**—Underhill and Closson (*Amer. Journ. of Physiol.*, Vol. xv., p. 321, 1906), as a result of experiments upon this question, conclude that the polyuria and glycosuria which follow the injection of sodium chloride into the venous circulation of the rabbit are, like phloridzin glycosuria, due to an increased permeability of the kidney, the amount of sugar in the blood being diminished. This permeability may be counteracted by the injection of calcium chloride together with the salt; the excretion of sugar is then diminished or arrested, the sugar content of the blood rises up to or above its normal figure, and the quantity of urine is lessened. If sodium chloride be injected into the cerebral arterial circulation, glycosuria is produced with a rise in the sugar in the blood and without polyuria. This phenomenon is referred to a poisoning effect on the brain, causing disturbance of respiratory processes, dyspnea, etc., such as follow the injection of magnesium sulphate under the skin and the administration of anesthetics and various drugs.—*B. M. J.*

# School Hygiene.

## MEDICAL INSPECTION OF SCHOOLS.

DR. ROBERTS, the recently-appointed Medical Inspector for the Public Schools of Hamilton, Ontario, has already made his first report to the Board of Education. This is an interesting document and shows clearly the need for such inspection. Dr. J. E. Laberge, the Medical Health Officer of Montreal, has submitted to the Health Committee of the Montreal City Council the detailed report of the Medical Inspectors of Schools in Montreal, from October 1st, 1906, to May 1st, 1907. This report shows that over twenty thousand children were in some way affected, as the following table will show:

Badly nourished.....	954
Inflammation of the glands.....	1,406
St. Vitus dance.....	30
Heart troubles.....	104
Lung troubles.....	89
Skin diseases.....	254
Deformity of vertebral column.....	127
Deformity of chest.....	88
Defects of vision.....	1,022
Deformity of limbs.....	154
Defects of hearing.....	256
Conjunctivitis.....	222
Trachoma.....	..
Difficulty in nasal breathing.....	832
Decayed teeth.....	9,478
Enlarged tonsils.....	2,453
Adencids.....	746
Diphtheria.....	5
Scarlet fever.....	4
Measles.....	26
Smallpox.....	..
Whooping-cough.....	19
Mumps.....	5
Chickenpox.....	5
Erysipelas.....	..
Vermin.....	1,472
Itch.....	46
Impetigo.....	27
Ringworm.....	97
Pemphigus.....	1
Paralysis.....	1
Headache from study.....	205
Children dismissed from school on account of infected houses.....	82
Children dismissed on account of uncleanness.....	45



## CONDITION OF THE SCHOOLS.

The following report shows what is the condition of the schools in regard to situation, ventilation, etc.:

Number of schools situated in a basement .....	3
Number of schools situated in a garret .....	1
Number of schools of bad appearance .....	3
Number of schools of poor and miserable appearance ....	3
Number of schools of poor and dirty appearance .....	1
Number of schools with damaged and decayed walls .....	1
Number of schools of good appearance .....	112
Number of schools ventilated by windows .....	53
Number of schools with insufficient ventilation .....	4
Number of schools with no ventilation at all .....	3
Number of schools well ventilated .....	64

It is shown that in many schools the chairs and tables are not adapted to the height of pupils. In five schools the floors are swept without being moistened. Then comes the astonishing report that there are three schools that only have their floors washed twice a year; one school has its floors washed once per annum; while yet another school has its floors washed every two years. Five schools have defective flooring. Quite a number of schools are reported to have defective lighting. Over twenty schools have classes that are overcrowded.

## DR. J. E. LABERGE ON SITUATION.

Reporting on the above condition of the schools, Dr. J. E. Laberge, in a special report, says:

"I have the honor to submit to you my report on the medical inspection of schools up to the 1st of April last. At that date the funds set aside for the service having been exhausted, we had to discontinue the service.

"One of the most important duties of the Health Department is to prevent the dissemination of contagious diseases. This report shows that the school is one of the places where contagion is spread most surely. By the medical inspection of schools you have in a great measure decreased this source of infection.

"The number of cases reported by our inspectors is considerable, and without the inspection such children would have continued to go to school and spread the contagion everywhere.

"In general, the physicians you appointed fulfilled their duties with zeal and much tact. Their relations with the principals of schools were always most cordial and kindly. The principals of schools finding the good that results from this service and the slight inconvenience it causes the scholars, desired it to be continued.

#### “DUTIES OF INSPECTORS.

“The duties of the medical inspectors consist in the daily inspection of each of the schools assigned them. When they find a child suffering from a transmissible disease requiring him to be sent home, they notify the principal, who alone has the right to send the children home.

“Since the beginning of the year we have made two general inspections of all the children in the schools, and all that was found wrong with any of them was noted, and the Health Department was notified accordingly.

“The result of this inspection is very evident, especially since the second one is over, which is the complement of the first.

“The reports received from the medical inspectors establish the fact that the cleanliness of the children has increased 50 per cent., and that the schools are now better ventilated and lighted.

“The number of children affected with diseases of the eye was 1,343; of the ear, 417; adenoid tumors and hypertrophy of the tonsils, 3,029. These figures show to what an extent disease was prevalent in the schools. Many of those affected were suitably treated, so that by this inspection you have prevented infirmities that would have become chronic and affected the patient even in adult life.

“Adenoid tumors are the cause of permanent lesions of the ears, and serious troubles of the respiratory organs. Even the brain is affected by such tumors. A number of children who appear unfit for work, indolent, more or less idiotic and sometimes vicious become docile, studious and even brilliant as soon as the nasal obstruction has disappeared. Unfortunately, in families, this affection passes unnoticed. They do not know how it injures the child who grows up with the infirmities which these tumors engender, the infirmity being often both physical and moral.

#### “DANGER FROM DECAYED TEETH.

“The cases of decayed teeth reported numbered 9,478. A great care should be given to that affection which is the cause of many troubles, especially those from bad digestion. Bad teeth are also a continuous focus of infection for the child's mouth. Surely the fact does not need any comment.

“Many of those children have not received all the benefits desirable from medical inspection, for, in a number of the schools, no notice was taken of those only slightly affected, in order not to create too much trouble in the establishments.

“By continuing the inspection another year, the work could be done more completely on account of the varied experience acquired.

“In most cases it is sufficient to draw the attention of parents

to any disease with which the children may be affected, when they at once take the measures necessary to effect a cure.

"We have received but few complaints from parents on account of their children having been sent home from school. The publication of the deplorable condition in which the scholars were found upon the first visit of the inspectors (October and November last) caused an uneasy feeling through the population. To-day there are but few who do not understand the importance of this service and the people would be pleased to see the inspection continued. They understand now that it is for the protection of the children, and they see its usefulness and necessity.

**"SPECTACLES NEEDED.**

"To complete this report I consider that I should direct your attention to the large number of poor children (875) requiring spectacles, who made a request for them in writing, accompanied by a certificate from the principal of their school attesting that their parents were too poor to purchase them.

"I would also draw your attention to the large number of children (1,188) suffering from pediculosis or scabies. If you would complete the medical inspection by a service by nurses, who would visit the school and attend to the children so neglected by their families, you would be filling an urgent want. These nurses could also treat light affections, such as bandaging of sores, treating certain eye diseases, etc. The truly remarkable results obtained in New York City by the attendance of these nurses, show that the few hundred dollars you devote to this purpose would be money well spent."

F. MACM.

# Laryngology, Rhinology

IN CHARGE OF  
PERRY G. GOLDSMITH, M.D.  
TORONTO.

and Otology

## OPERATIONS FOR DEVIATION OF THE NASAL SEPTUM, WITH SPECIAL REFERENCE TO THE SUB- MUCOUS RESECTION.

JOHN MACINTYRE, Surgeon for Diseases of the Nose and Throat, Glasgow Royal Infirmary, addressed the students of Anderson's College Medical School in December last on this subject.

He mentions the enthusiasm that seems to go with the so-called new (first performed by Heylen in 1847) operation, and expresses a fear that the importance of other operations may be overlooked. Winslow (Trans. A. L. A.) is quoted. "While some degree of septal deviation is so common that it may almost be regarded as a normal condition, a deviation becomes pathological only when it interferes with normal nasal function, producing consequences that can rationally be attributed to the deformity; according to Beaman Douglass this occurs in from 11 to 12 per cent. of the c.ses only. Some of the most marked deformities that I have ever seen caused no detectable disturbances. We should operate, therefore, only for the relief of definite symptoms, and not simply because of anatomic abnormalities." The same writer very properly remarks that the best treatment for deviated septa may consist in avoiding operation, and in this connection it would be well to remind you of an interesting remark by Sir Felix Semon, "that no operation should exceed in magnitude the importance of the symptoms."

Macintyre enumerates the various methods of correcting deviations and describes more particularly the Gleason, Moure, Asch and Killian's submucous resection. He points out that some simple measure may suffice to give breath way, such as removal of the anterior half of the inferior turbinal or sawing off the apex of the crest of the deflection. One man familiar with a certain operation may get brilliant results, while another, operating by the same method, only occasionally, may have poor results and unfairly condemn the operation.

Macintyre agreed with Dundas Grant in stating that there was yet room for eclecticism and, furthermore, we will be better able to compare methods and results ten years hence.

## INFLUENZA AS IT AFFECTS THE NOSE AND THROAT.

THE *Practitioner* for January, 1907, is devoted to a consideration of the various manifestations of influenza. Sinclair Thompson takes up the nose and throat affections.

No doubt, Thompson says, the infection of influenza does enter the system through the upper air passages, and while a nasopharyngeal catarrh is a usual accompaniment, it is not a necessary manifestation of the disease. The disease, as it affects the upper respiratory tract, is divided into two types, (1) inflammatory affections, (2) neuroses.

1. *Inflammatory Affections.*—Epistaxis may usher in the symptoms, together with all the symptoms of an ordinary acute rhinitis. Influenza cold seems to vary in different epidemics. Thompson's own experience points toward a more frequent involvement of the accessory sinuses of the nose than was the case fifteen years ago. Not infrequently this is mistaken for "supra-orbital neuralgia or face ache. Symptoms around the orbit may appear without pus being discovered in the nose. A case is cited in a boy eleven years of age who developed an intense edema without redness of the right eyelids and tenderness at the upper and inner angle of the orbit. No pus could be seen in the nose, but on incising the swelling, fluid pus escaped from the right frontal sinus containing the micrococcus catarrhalis in pure culture. A case is also mentioned showing the persistence of the pain, even after opening the frontal sinus and excluding antral infection. Ethmoidal retention was the probable explanation. Sphenoidal infection is accompanied by post-nasal discharge, pain referred to the occiput or deep between the eyes, and sometimes marked somnolence. Influenza infection may light up a previously quiescent sinusitis.

*Pharynx.*—A diffuse inflammatory condition of the nasopharynx and pharynx with or without lacunar tonsillitis, is not uncommon. False membrane and quinsies may also form.

*Larynx.*—Acute catarrhal inflammation is very common. Swelling of the ventricular bands, ary-epiglottic folds and particularly the arytenoids and epiglottis is not uncommon. Inflammation and abrasion of the vocal cords account for the painful hoarseness. Septic edematous laryngitis occurs in rare instances and is extremely fatal.

2. *Neuroses: Nose.*—Anosmia is very apt to be a sequel of influenza. Recovery generally takes place even after many months, but occasionally it is permanent. Cacostmia is due in most cases to antral empyema rather than to a true neurosis.

*Pharynx.*—Paralysis of the soft palate has been observed, and

some dysphagia may be due to weakness of the constrictors of the pharynx. A condition of hyperesthesia or anesthesia is not unusual.

*Larynx.*—Various laryngeal palsies may follow influenza laryngitis. Abductor paralysis is the most common. It is doubtless due to a peripheral neuritis and the diagnosis has to be made from the numerous other possible causes of a lesion of the recurrent laryngeal nerve. It may clear up rapidly or remain for years.

*Cough.*—A barking, inveterate cough referred by the patient to the wind-pipe is another legacy of influenza. These persistent coughs may be due to pus from the nasal sinuses trickling back into the throat. This auto-intoxication may induce many symptoms suggestive of phthisis: Loss of flesh, sweats, rise of temperature, dyspepsia, expectoration of pus, etc. Alteration of the breast sounds may be noticed, due to diminished expansion. Sputum examination and tracing the pus to its true origin determines an exact diagnosis.

*Treatment of Inflammatory Affections.*—The patient should remain in bed until the acute stage is passed. He can be kept very warm with the bedroom windows wide open. Tenderness and neuralgia is met by having the head wrapped up in a woollen shawl; hot fomentations are applied over the affected side, or the patient may lie with his face on a hot-water bottle. If the maxillary sinus is involved and there are any suspicious bicuspid or molar teeth on the same side, they should be removed. The pain can be met with phenacetin, caffeine, aspirin, and, if necessary, morphia. Thompson carefully avoids the use of sprays or lotions during the acute stage, since they may disseminate the infection and carry it to the ear. The following inhalation is used:

R Menthol .....  $\frac{1}{2}$  dr.  
Tinct. of eucalyptus ..... 3 oz.

A teaspoonful of this is put in a pint of steaming water, and the vapor inhaled up and down the nose every two or three hours. If necessary the maxillary sinus may be punctured through the inferior meatus. Packing the middle meatus each day with a five per cent. cocaine solution frequently relieves the frontal and sphenoidal sinuses. After the acute stage is passed, a simple alkaline lotion is used. Change of air may be necessary to bring about complete relief.

*Treatment of Neuroses.*—A guarded prognosis should be given as to the relief of anosmia. If the nose is healthy, it is best to refrain from local measures. General treatment, such as strychnia electricity, will do best for this, as well as the laryngeal palsies.

The obstinate paroxysmal cough responds best to sedative sprays and lozenges of menthol, heroin, codeia. "Stomach coughs" are helped by morphia and opium, or the following may be of value: A tablespoonful in water three times a day.

R Diluted hydrocyanic acid .....  $\frac{1}{2}$  dr.  
 Diluted nitric acid .....  $\frac{1}{2}$  dr.  
 Glycerine .....  $\frac{1}{2}$  oz.  
 Infusion quassia ..... 6 oz.

A tablespoonful in water three times a day.

### THE DIAGNOSIS AND TREATMENT OF INFECTIVE THROAT CONDITIONS.

MEREDITH YOUNG, Medical Superintendent Stockport Corporation Hospitals, in *The Practitioner* has a very instructive article dealing with some of the acute infections of the throat, which are in so many cases of grave importance. Scarlatinal sore throat is usually unmistakable. It may be confounded with simple and septic tonsillitis, measles, initial smallpox, diphtheria, secondary syphilis, etc. The following tabular form is of value in the diagnosis.

#### I. AS TO THE DEPOSIT OR EXUDATE.

	Color.	Consistence.	Ulceration.	Persistence.
1. Scarlet Fever.	Yellowish white or dirty and sloughing.	Very soft and easily broken up.	Distinctly present.	Disappears very slowly.
2. Septic tonsillitis.	Whitish or Yellowish.	Mucoid.	Very slight.	Disappears fairly rapidly.
3. Muscular tonsillitis.	As above.	As above.	Very rare.	As above.
4. Diphtheria	Whitish, may be brown or black owing to hemorrhage.	Tough and adherent.	Slight.	Rapid disappearance.
5. Syphilis.	Dirty.	Fairly tough; removal often followed by bleeding.	Almost invariably and frequently extensive; symmetrical, superficial and often kidney shaped.	Not long duration.
6. Thrush.	Dead white.	Soft and easily removable.	None.	Brief.

AS TO THE GENERAL CHARACTERISTICS.

	Distribution.	Color.	Symmetry.	Pain.	Glands.	Local Accompaniments.	Pyrexia.	Progress.
1. Scarlet Fever.	Palatal arches usually tonsils and sometimes pharynx and roof of mouth. Buccal mucosa usually normal. Does not involve larynx.	Vivid red.	Symmetrical	Considerable	Usually unaffected in early stages. Enlarged and may suppurate.	Strawberry tongue.	Marked.	Disappears slowly.
2. Simple Tonsillitis.	May extend over fauces palate and pharynx. Larynx not involved.	Deep red, and almost shining.	Generally bilateral.	Considerable	Gland at angle of jaw usually enlarged and painful at early date.	Furred tongue and foul breath.	Marked.	Disappears rapidly.
3. Septic Tonsillitis.	Rarely extends beyond base of palate. One or both tonsils affected.	Deep red often almost purple.	Usually though not always unilateral.	Very severe.	Slightly enlarged at early date but quickly subsides.	Thick furring of tongue.	Marked.	Usually slow. Follicular abscess
4. Diphtheria.	Extremely variable usually settles on tonsils first. Larynx.	Very faint reddening.	Asymmetrical.	Usually slight or absent.	Frequently enlarged but suppuration rare.	Typical odor. Frequent croupous symptoms or nasal discharge. Subsequent local paralyses.	Around 102°.	Rapid disappearance Few days only.
5. Syphilis.	Involves all fauces palate, pharynx and larynx.	Bright red.	Symmetrical	Little or none.	Seldom enlarged.	Ulceration. Mucous patches. Sui on tongue, etc.	None.	Persistent. Rapidly clears under treatment. Slow.
6. Follicular Tonsillitis.	Rarely extends beyond base of soft palate. One or both tonsils affected.	Bright red not so deep as 2 and 3.	Almost always bilateral.	Fair amount.	Slightly enlarged at early date but quickly subsides.	Thick furring of tongue.	Slight.	
7. Measles.	Palate appears to be chiefly but slightly affected.	Red blush. Tiny red papules.	Symmetrical	Slight or none.	Normal.	Koplick's spots.	Marked.	Rapidly subsides.
8. Thrush.	Variable.	Almost normal.	Asymmetrical.	None.	Normal.	Patches on tongue. Buccal mucosa.	None.	



In *septic tonsillitis* the onset is usually sudden, without vomiting, which ushers in scarlet fever; pulse rapid, increasing with temperature only. If a rash be present it is always erythematous and not punctiform, and rarely lasts more than a day.

*Follicular tonsillitis*, though perhaps most commonly confounded with diphtheria, is, as a matter of fact, an affection which ought to be more readily distinguished from it than anything else. The points in common are usually the low temperature, rarity of ulceration, fairly rapid disappearance of the local patches and the slight involvement of glands. They differ in four main points.

1. In follicular tonsillitis the patches are mucoid and are easily removable, sometimes by mere douching with weak salt or boracic solution, practically always by swabbing with cotton wool. In diphtheria the patches are tough and only removable, if at all, by firm and repeated swabbing.

2. In follicular tonsillitis the patches rapidly reappear after being cleared away, in fact may do so in half an hour.

3. The mucosa is a fairly bright red color in follicular tonsillitis, whereas, in diphtheria, it is only faintly, if at all, reddened.

4. Edges of exudate taper off gradually in tonsillitis, while in diphtheria there are distinct cleft-like edges which often curl up.

Young describes a case of diphtheria as "A prostrate, pallid, pulseless, placid, painless patient, with a putrid breath and a temperature about 102 deg." Bacteriological examination is not referred to, for, though frequently helpful, it is not, for the general practitioner at all events, of much immediate assistance. (The reviewer thinks this is not good doctrine, since one is so easily misled by the milder forms of diphtheria that the only positive means of diagnosis is by a bacteriological examination.) A form of septic sore throat due to milk is described. It may closely resemble diphtheria in both the clinical appearance of the throat and the constitutional depression. *Drain throats* are also alluded to, in which there is a septic pharyngitis due to the inhalation of drain or sewer gas.

*Treatment.*—As a general rule, a fairly brisk saline purge is a *sine qua non*, especially in septic tonsillitis. Young does not give a purgative during the first week of scarlet fever or diphtheria. A simple enema seems to avoid grave complications. Salicylates are given first place in simple, septic and follicular tonsillitis, but are to be avoided in diphtheria, because of depression and possible effects on the kidneys. In syphilis constitutional treatment is of most importance. In diphtheria antitoxine *early and in large doses*. Antitoxine is also of decided value in cleaning up post-scarlital rhinorrhoea (cases of mixed infection,

diphtheria and scarlet fever. G.). Salophen is of value when there is a rheumatic element, 10-15 grs. every three or four hours. Iron and strychnia are also indicated as general stimulants.

*Local.*—One must not neglect to consider the effect the infection may have on the nose and ear. Little good comes from applying remedies, unless the mucus or other covering of the diseased area is removed. Solutions of borax, boric acid, *very weak* sulphurous acid or liq. soda chlorinata and common salt solution are good solvents; preference is given to borax and sodi. bicarb. since they dissolve mucin (a 2 per cent. solution of sodi. sulphate is better. G.). For nasal or throat douching the Higginson syringe and the ball syringe are condemned. A douche may be considered much safer. As disinfectants, formamint, sublimin, hydrarg. perchlor., acetozone, boric acid and ichthyol are advised. A good solution is made by using the following—sodi bicarb., grs. xii; acid carbol. pure, grs.  $1\frac{1}{2}$ ; sodi chlor., gr. ii—dissolved in a tumbler of tepid water. Formamint as lozenges and spray is strongly advocated. Ichthyol is better in the severe septic cases—ichthyol, grs. 50, sodii chlor., grs. 25, water six ounces. In nasal douching it is of the greatest importance that the patient *keep his mouth widely open and breathe quickly in and out*. Cocaine or storanine are advised as applications after the stronger antiseptics, if the pain and suffering demand it. A 20 per cent. solution is mentioned, but surely this would be dangerous in many cases.

P. G. G.

# The Canadian Journal of Medicine and Surgery

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Advertisements, to insure insertion in the issue of any month, should be sent not later than the fifth of the preceding month. London, Eng. Reproductive, W. Hamilton Mill, Thanet House, 231 Strand, W.C. Agents for Germany, Saarbach's News Exchange, Mainz, Germany.

VOL. XXI.

TORONTO, JUNE, 1907.

No. 6.

## Editorials.

### A PSYCHIATRIC CLINIC FOR TORONTO.

In February, 1907, the first number of *The Bulletin* of the Toronto Hospital for the Insane, a journal devoted to the interests of psychiatry, was issued. Among other matters of importance referred to in its pages the proposed establishment of a psychiatric clinic upon a site near the Toronto General Hospital is mentioned. From an article published in *The Globe*, Toronto,

it appears that such a clinic will be established by the Government of Ontario, \$100,000 being mentioned as the sum to be spent on the construction and the fittings. It is intended, we learn, that this clinic is to occupy a separate building in connection with the new hospital, with accommodation for 100 patients, and it is to contain every modern requirement for the treatment of acute cases of insanity. There will, also, be laboratories with lecture rooms, and provision will be made for research work in pathology, physiology and psychology. Opportunities will, also, be given to physicians and medical students to study cases of mental disease. The new clinic is to stand in close relation to the medical faculty of the University of Toronto and the new hospital. It will, also, have a dispensing department. It is said that the Kraepelin Clinic, of Munich, Germany, will be used architecturally and for the equipment as a model for the clinic. Improvements in the methods of treating acute cases of insanity are said to have been introduced into other parts of Germany from the Munich clinic. Similar improvements in America are prognosticated from the operation of the Toronto clinic.

An important result of the establishment of the new clinic will be the closing of the old Toronto Asylum. Acute cases of insanity will be sent to the clinic, and on recovery they will be discharged as patients who have been treated in an hospital for mental diseases. Should they develop into chronic cases of insanity they will be sent to existing asylums, where the cottage accommodation system prevails.

The operations of the psychiatric clinic will enable its medical staff to make more striking exhibits of cures of insanity than has fallen to the lot of the medical staffs of the eight Provincial asylums; whether the total percentage of cures of insanity in Ontario will be higher than it has been remains to be proved.

From the standpoint of medical teaching and clinical study a psychiatric clinic should, and doubtless will, be welcomed by all who are interested in straightening the tangled threads and raveled skeins of mental disease. Is it a lesser stigma to have been an inmate of a psychiatric clinic than of an old-fashioned asylum? The question involves a sentimental consideration; but the stigma consists in having been reputed insane. Incarceration in a psychiatric clinic in place of an asylum, will not blot out that fact. Besides, the operations of a clinical hospital bring an insane patient's infirmity to the notice of more persons than if he were immured in some asylum situated in a country place.

Again, the clinic will not be as favorably situated as a country asylum for "the rest cure," owing to the noises of a great city.

The new department will afford to professors of psychiatry an arena for the display of skill in diagnosis and prognosis. Whatever results may attend the exercise of psychiatric therapy—improved mental conditions or the reverse—the professor must show that he understands and can expound the subject matter; for the diagnosis and prognosis of mental disease will ever be of absorbing interest to the friends of the patient, to physicians and students of medicine and to others interested in medico-legal questions. To understand a difficult case of mental disease is not, by any means, to possess a lever suitable for the removal of the difficulty; in fact, an exact comprehension of the difficulty frequently reveals, that it cannot be removed. As we said in an editorial, published in this journal, May, 1906, "To measure the professional skill employed in the treatment of the insane in the asylums of Ontario by the output of cures or the probational discharges of patients, improved or unimproved, would be a fallacious test. But that is just another way of saying that, in a large number of the insane of Ontario, the prognosis as to the recovery of sound mentality is unfavorable. By the exercise of admirable care and good hygiene, the lives of the insane are conserved; but that which makes life precious is rarely restored." F. S. Toogood, in *The Lancet*, September 15, 1906, states that out of more than 2,000 cases of alleged insanity treated during the past ten years at Lewisham Infirmiry, 50 per cent. recovered, 10 per cent. died, and only 39.5 per cent. were sent to asylums. Should there be an approach to such results at the Toronto Psychiatric Clinic the medical profession of Ontario would be delighted.

Some of the advantages likely to accrue from the treatment of incipient insanity at the Toronto Psychiatric Clinic are: (1) The benefit of the patients themselves; (2) the increased efficiency of the nursing profession; (3) the improved clinical training of medical students; (4) improvements in the scientific study and practical treatment of insanity, when the necessary work is done by physicians who are in touch with other active workers and teachers in science and medicine.

Too much credit cannot be given to our collaborator, Dr. D. C. Meyers, of Deer Park, for his work in this connection, as also to Dr. C. K. Clarke, medical superintendent of Toronto Hospital for the Insane.

J. J. C.

**THE PHYSICIAN'S DUTY IN REGARD TO CONSUMPTION.**

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IN a recent issue of *The Star*, Toronto, an editorial appears, founded on a dictum of Dr. J. H. Elliott, ex-Medical Superintendent of the Gravenhurst Sanitarium. Dr. Elliott is made to claim that, through ignorance or worse, the average medical practitioner of Ontario is not doing what he might towards stamping out consumption, because he fails to diagnose the cases of incipient consumption which he meets in general practice.

Dr. Elliott also states that seventy-five per cent. of all consumptives in the early stages of that disease can be cured by sanitarium methods, while only fifteen per cent. of moderately advanced cases, and only one per cent. of far-advanced cases are found to respond to treatment. Accepting as true Dr. Elliott's statements, it is also true that doctors, who cannot be rightly accused of carelessness, ignorance or something worse, fail to recognize marked lesions in the lungs of patients. We know of several cases in which mistaken diagnoses have been made by competent men, but will instance this one, taken from the writer's case book: "April 19, 1880. J. Q., *ætat.* 24; weight, 125 lbs.; height, 5 ft. 7¾ in.; measurement of chest on forced inspiration, 34½ in.; forced expiration, 31¼ in.; respiratory murmur good, except at apex of left lung, where some mucous râles were noticed. The patient is a law student, a hard worker and a light eater. The evidence in favor of phthisis is strong. Ordered him a very nutritious diet, with ½ oz. emuls. ol. morrhuæ t.i.d.; salt water morning bath; as much outside air as possible; advised him to get his weight accurately every week. Aug. 1, 1881—Saw J. Q.'s death in *The Globe*." It transpired that after getting the writer's opinion, J. Q. took out a life insurance policy. The examination was made by a very competent examiner, since dead. J. Q. subsequently went to a town in Michigan, where he resided until he died of consumption. Would Dr. Elliott say that this examiner in life insurance was careless, ignorant or deaf? His contemporaries would not give a verdict of guilty on any of these counts.

Examiners for life insurance companies generally strip their applicants, before examination—but there are others. A confrère of considerable auscultatory experience tells us, that carelessness in

diagnosing lung disease is the besetting sin of the average doctor, just as mendacity characterizes the lawyer and dogmatism the theologian. He suggests that doctors should eschew inane methods of examining their patients. So far as the ladies are concerned, he says, examining doctors will find no difficulty; the men will cheerfully expose the cuticle if the doctor so wills it. This witness is, if anything, a little more severe on doctors than Dr. Elliott; but it is well for the average practitioner to learn what his severest critics have to say against him.

It would certainly help to keep the doctor up to the mark, if backward people were to become solicitous about the condition of their lungs. When to have incipient phthisis spelled death in a few years, 'twas folly to be wise. Not so in our day, for medicine teaches, that phthisis in the early stages is curable. Hence the advisability of a patient consulting a doctor for a severe cold instead of taking some medicine. On the other hand, a doctor cannot use his senses of sight, hearing and feeling too much in diagnosing lung disease. And yet, with all care and scrupulosity, doubts will intrude. If a case of incipient lung disease is brought to a doctor's notice, it is not possible for him to be certain from clinical evidence alone, that the condition is tuberculous, unless tubercle bacilli are present in the sputum. In the early stages of consumption, the physical signs—slight dulness on percussion and moist sounds at the apex of one lung may be suggestive, in fact indicative, of phthisis; but, in such cases there may be no tubercle bacilli in the sputum.

And that circumstance raises a question of great moment. When should a case of consumption be reported to the health authority? In the writer's opinion, a case of consumption should be reported if tubercle bacilli are found in the patient's sputum. It is the business of the public health authority to provide for the destruction of the tubercular sputum—the source of tubercular infection.

Doctors know that sanitarium life is serviceable in incipient consumption; but sanatoria are few and consumptives are many. Would editors of papers who deplore the morbidity and mortality from "The great white plague" help to build, equip and manage more sanatoria in Ontario? The doctors will help to find the cases to fill a good many sanatoria.

Stricken people, however, have to play their parts, while life is left, and a long stay at a sanitarium does not suit a lean purse, or an exacting rôle. But the stimulative education of sanitarium life lops off whims and grafts right notions of healthy living in their stead. What a pity, say you, that some of these sanitarium notions—fresh air, good food, the solarium—were not taught at medical schools thirty years ago. Aye, some of them, or their congeners, were taught; but the seed fell by the wayside.

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### CONTACT-INFECTION AS A MEANS OF PROPAGATING TYPHOID FEVER.

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AUTHORITIES are agreed that typhoid fever is propagated by means of infected water, milk and shellfish; but it may also spread by contact-infection, derived from the excretions of a typhoid fever patient, or even from a convalescent. An outbreak of typhoid fever occurred recently in one of the female wards of the Lariboisière Hospital, Paris, and the circumstance was reported by Dr. Gandy at a meeting of the Faculty of the Hospitals. Three cases occurred simultaneously, eleven days after a case of typhoid fever had been admitted to this ward; then, in succession, and after two other typhoid cases had been admitted from outside places to the same ward, three fresh cases appeared in patients who had been domiciled in the hospital for some time. The facts pointing to some form of contact-infection in the three first cases were: They occurred simultaneously, eleven days after the admission of the case of typhoid fever; two of the patients occupied beds near the typhoid patient, who had been brought in from an outside place; the third case was the nurse, who waited on this same patient. The sudden occurrence of these three cases showed they were due to direct contagion originating in the ward. The water used in the hospital was not to blame, as nothing of a similar kind was observed within other wards of the Lariboisière. Several suggestions were offered during the ensuing debate on the paper. Dr. Rist insisted that a frequent mode of contact-infection was by fever thermometers and soiled basins. Dr. Achard thought that in hospitals a habitual mode of contact-infection was through the dejections of the patients, the urine-



bottles, and finally, from cultures of Eberth bacilli made in the hospital laboratory.

Dr. Widal said on this subject: "The propagation of typhoid epidemics occurs through drinking water; but cases in which typhoid fever is evidently communicated by contact-infection are observed in families and in hospitals. The inquiry made in Germany, at Koch's instigation, to ascertain the most reliable means of stamping out typhoid fever, showed that the patient, the persons who approach him, and the objects which touch him may serve to transmit the disease. Contagion is effected particularly by the hand, which touches the body of a typhoid patient or the objects which have been contaminated by fresh or dried fecal matters, or by the patient's urine. The infected hand serves afterwards as a vehicle to transport the germ through the intermediary of different kinds of food carried to the mouth. A relatively immediate contact is, therefore, necessary to open the way to contact-infection. This explains why contagion occurs in persons living in close contact with typhoid fever cases, particularly nurses. The hygiene of the hand ought to ceaselessly occupy the attention of nurses caring for typhoid patients. Not only should these nurses wash their hands, but they should disinfect them after touching the patient."

Dr. Hiss, while finding typhoid bacilli in the stools in 80 per cent. of the cases examined during the febrile stage, stated that the convalescent cases which he examined gave uniformly negative results, and this rapid disappearance of Eberth bacilli from the stools after convalescence was apparently confirmed by others. This is, however, by no means the invariable rule. Evidence collected by the Royal Institutions for Bacteriological Research in Germany shows the spread of typhoid fever by convalescents, whose excreta contain Eberth bacilli after ten weeks from the beginning of the illness or from the beginning of the last relapse.

Dr. Lentz, at Trier, discovered twenty-two typhoid bacilli carriers, to seven of whom other cases, often multiple, were traced. A. Besserer and J. Jaffe found typhoid bacilli in the stools of four persons, who had had typhoid three months, six months, four years and seven years previously. These and similar reports by other observers prove that typhoid bacilli persist in the stools after the recovery of patients, their persistence being due

either to chronic infection of the gall-bladder or to intestinal conditions, which produce stools offering a favorable medium for the growth of the Eberth bacilli.

The persistence of typhoid infection in the urine of typhoid cases is now recognized, as many investigators have worked in this field. All agree that, if they appear at all, they persist in the majority of cases into convalescence. Dr. Richardson's conservative statement is that they may persist for weeks, occasionally for months, rarely for years.

Typhoid bacilli may also persist for considerable periods in the sputa of patients having a complicating bronchitis or pneumonia. Seven weeks is the longest period recorded. Thus far no effective method of eliminating the typhoid bacilli from the intestinal tract seems to have been discovered. Urotropin has been used for sterilizing the urine of patients convalescing from typhoid fever, and the testimony is, in the main, in its favor.

Fortunately, the adult or older child convalescent, in many cases, passes the stools and urine in a water closet, so that in their cases, danger of infection through the hand is largely eliminated. With the infant it is different, since the diaper or vessel is handled and the infant cleaned by a nurse. In the absence of care, or through lack of knowledge, this may give opportunities for infection of the hands of the nurse, who may infect herself or others in the family whose food she prepares. An instructive case in which typhoid infection was produced in this way is reported by Dr. Southworth in *Annals of Pediatrics*, March, 1907.

J. J. C.

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#### EDITORIAL NOTES.

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**Aristochin Tasteless Quinine.**—Aristochin is a carbonic ether, a neutral compound, containing 96 per cent. of quinine. It is richer in quinine than the hydrochloride of quinine, which contains 81.7 per cent. A white, tasteless powder, insoluble in water, and saliva, soluble in the acid contents of the stomach. Dreser says that it is not precipitated from the acid contents of the stomach by the alkaline secretions of the intestines. It is ordinarily used in the same doses as quinine salts. It is administered to children in powders, containing doses of  $1\frac{1}{2}$  to  $4\frac{1}{2}$  grains, according to the patient's age; to be repeated three or four

times in twenty-four hours. It may be very conveniently given to young children in milk; taken in this way the little patients need not know that they are taking a medicine. Aristochin may be prescribed with advantage, instead of quinine, in the treatment of whooping cough. Binz commences with a small dose and increases it till the child is taking twice daily 3.8 grains for each year of age, or in infants  $\frac{1}{3}$  of a grain for each month. But, as a rule, a child does not require a higher dose than 22 grains daily, or an infant over  $1\frac{1}{2}$  grains. Under the influence of such doses, it is said, the attacks of coughing rapidly diminish in number and severity. Aristochin should certainly be welcomed by the attendants of sick children, who must have found the administration of quinine by the mouth an almost insuperable task. The hypodermic administration of quinine is painful and not quite free from the danger of infection, although this method has the sanction of Malafosse and Hertz. The rectal route for administering quinine to children is untrustworthy, as these patients cannot retain enemata except for a short time. An alcoholic or ethero-alcoholic solution of quinine applied to the skin with friction is of doubtful efficacy, owing to the fact that only a small quantity of quinine is absorbed by the skin under such conditions.

**The Diet of Infants.**—Some mothers seem to think that their babes are not thriving, or at least have not the appearance of thriving, unless they are "fine and fat." In some instances an irritable child, suffering from teething, is allowed a quart of undiluted milk a day and, for extras, a share of what is going at the table, viz., potatoes and meat gravy. During hot weather the intestinal canal of a babe may suffer from the irritating products of indigestion and diarrhoea may ensue. Prevention being easier than cure, it would be in the child's interest if its diet were simple and suitable to its age. Infants twelve months old do better on a pint and a half of milk (imperial measure), diluted with half a pint of barley water than on two pints of whole milk. Between six and nine months one pint of milk is usually sufficient, provided that barley water, to the extent of a third of its volume, be added. Between the third and fifth months equal parts of milk and barley water should be given. Infants under two months should get half a pint of milk and the milk should

be diluted with rather more than its volume of barley water. Barley water prepared from pearl barley is a useful demulcent and is slightly nutritious. Some practitioners advise plain sweetened water as a diluent of milk given to infants. The dilution of cow's milk is the important feature in the artificial feeding of infants. When an infant seems hungry, when it coughs, when its stools have too pronounced an odor, when it seems indisposed in any way, the fault commonly lies in the direction of overfeeding. Even if overfeeding be not the fault, when an infant is suffering from teething or other source of reflex irritation, its food supply ought to be reduced in quantity.

**The Untoward Effects Produced by the Salicylates on Children.**—In an article published by Langmead in the *London Lancet*, June 30, 1906, some conclusions are drawn as to the effects of large doses of the salicylate of sodium on children. (1) Salicylate of sodium sometimes causes in children the appearance of a clinical syndrome resembling diabetic coma (stupor, dyspnea, coma, acetonomia). (2) The toxic dose of the drug varies, appearing to depend (barring idiosyncrasy) on constipation in the patient. (3) Acetone may be found in the patient's urine and on his breath. The presence of acetone is one of the first symptoms of the untoward effects of the salicylate of sodium and is a real danger signal. (4) The treatment consists in reducing the acidity of the child's urine by the free administration of bicarbonate of sodium and the production of catharsis. Dr. Langmead thinks that the knowledge of these facts should not cause physicians to give up the administration of salicylate of sodium to children in suitable cases; but, on the contrary, should help to put them on their guard against the accident arising from its use, once the danger is known.

**A Few Ontario Statistics on Tuberculosis.**—The following figures quoted from a pamphlet issued by Charles A. Hodgetts, M.D., Chief Health Officer of Ontario, show that here as well as elsewhere, tuberculosis destroys life at an early age. "Note the following figures showing the deaths from tuberculosis in this Province. In 25 years (1880-1904), 64,928. In 1904 there were 2,877 deaths out of a total of 30,920 from all causes, or 1 person out of every 10 who died in that year died from tuber-

culosis. As a proof that no age is immune from the deadly effects of tuberculosis, note the returns for 1904:—

No. of Deaths.	Age.
7	1 year.
52	2 years.
26	3 “
9	4 “
17	5 “
51	5 to 9 years.
77	10 “ 14 “
276	15 “ 19 “
419	20 “ 24 “
411	25 “ 29 “
319	30 “ 34 “
270	35 “ 39 “
212	40 “ 44 “
162	45 “ 49 “
257	50 “ 59 “
176	60 “ 69 “
104	70 “ 79 “
13	80 and over.
21	Not stated.
<hr/> 2,877	<hr/> All ages.

Were the decedents from tuberculosis under 1 year and 2 years of age affected by hereditary or accidental tuberculosis? Hilton Fagge says it is impossible to draw the line in such cases, as naturally the children of an infected parent are more liable to accidental contamination. In the April number of this journal, p. 240, we quoted the opinion of Prof. Calmette, of Lille, who states that “the baby is contaminated with tuberculosis in the family circle by soiled objects put into his mouth by himself or others.” Admitting the full force of the evidence showing the contagious origin of tuberculosis, the existence of parental, grandparental or collateral tuberculosis should be mentioned on the return of death of any person dying of tuberculosis.

**Hemostasis in Hemophilia.**—At a meeting of the Surgical Society of Paris, March 6, 1907, Dr. Broca advocated the use of fresh human or animal serum, by intravenous or hypodermic injection, in cases of hemorrhage in hemophiliacs. To produce hemostasis in an adult, 10-20 cubic centimetres of fresh serum injected into a vein or 20-30 cubic centimetres injected under the skin are ordinarily sufficient. In children, doses of half these strengths suffice. To prevent hemorrhages similar doses may be used when cutting operations are required in bleeders. In

practice Dr. Broca said if one cannot wait twenty-four hours and practise an antiseptic bleeding from the carotid artery of a rabbit, in order to obtain some fresh animal serum, Roux's antidiphtheritic serum will answer. Dr. Broca added, that fresh samples of Roux's serum are placed on the market every month by the Pasteur Institute people. A surgeon, he said, should not in reliance on this serum, do an optional operation on a bleeder; but should not hesitate to use the serum if obliged to operate for appendicitis or strangulated hernia. At a subsequent meeting of the Paris Surgical Society, March 20, 1907, Dr. Broca reported the case of a lad aged 11 years, whose hemophilic antecedents were well known to him, and who had been brought to his office a few days previously to be treated for an obstinate hemorrhage, appearing after the fall of a milk tooth. In this case treatment was begun by plugging the tooth cavity with a tampon of gauze, wet with antidiphtheritic serum. Afterwards a hypodermic injection of 20 cubic centimetres of the same serum was administered. The hemorrhage stopped the same day and had not returned at the time the report was presented. As an offset to this optimistic report, Dr. Manuclaire reported to the same society, March 27, 1907, the case of a bleeder, who required incision of a double parotitis. Anticipating hemorrhage, several cubic centimetres of antidiphtheritic serum were injected the day before the incisions were made; but the opening of the parotid phlegmons caused a frightful hemorrhage, which carried off the patient in a few hours, in spite of the hypodermic injection of gelatinized serum.

**Local Treatment of the Puerperal Uterus.**—At a meeting of the Obstetrical Society of Paris, March 21, 1907, Dr. Jeannin read a paper on the changes in the bacterial flora of the puerperal uterus as influenced by local treatment. A tampon of sterilized cotton was applied to the puerperal endometrium and afterwards studies were made of the results obtained from the cultivation of the bacteria. The specimens examined were taken before and after curetment. In every case Dr. Jeannin discovered an extraordinarily rich bacterial content, both anaerobic and aerobic; the bacterium coli was always present. In no case had the local treatment employed caused the asepsis of the endometrium, although, in the course of twenty-four or forty-eight

hours the anaerobic bacteria were greatly reduced in number. From his researches Dr. Jeamin concluded that the disinfection of the puerperal endometrium should be much more vigorous than it usually is. He thought that more activity should be shown in securing drainage of the uterus instead of tamponing that organ with antiseptic gauze. Tamponade of the puerperal uterus was injurious, he thought, as it causes the retention of microbes in the uterus. He also thought that the obstetrician should do more to obtain efficient general treatment of the puerperal state (collargol, serum, etc.).

**Longevity of Canadians.**—In the obituary notices of the *Globe*, Toronto, April 15, 1907, nineteen deaths are recorded. One death at 90, one at 84, one at 83, one at 82, one at 76, one at 75, one at 74, one at 66, one at 65, one at 42, one at 40, one at 34. The age at death is given in thirteen instances; in six is not mentioned. Among the latter, five were deaths of females, two of whom were widows, two married and one unmarried, and one the death of a lad. Worthy of note in these records is the longevity of several of the decedents. The four greatest ages of female decedents aggregate 330 years; the four greatest ages of males 315 years. Another interesting point is that, even in death, the record of a lady's age was not given unless she was over sixty. Is Dr. Osler responsible for this "fine reserve"?

**Finsen's Disease.**—In a paper read before the Paris Academy of Medicine, March 26, 1907, Dr. Poncet, who had prepared a paper with the assistance of Dr. Leriche, stated that from a close study of the disease of which Finsen died and from the results of the necropsy, they thought that the celebrated inventor had been attacked by inflammatory tuberculosis. That disease, which is specially characterized by periviscerites and by chronic inflammations of the serous membranes, had puzzled Finsen's medical attendants, and even left in doubt the men who had performed the necropsy on his remains.

**Athletic Games Involving Loss of Life.**—Athletic sport is a fine thing and Canada is justly proud of her athletes. Still play is play; killing is not play. Recently at Cornwall, Ont., a hockey player was charged with manslaughter, because an opponent, whom he had struck on the head during a match, shortly after-

wards died of cerebral hemorrhage. That an assault had been made by the accused was proved at the trial; but the defence proved that the slain man had also received a vicious blow from another opponent; the outcome of the trial was an acquittal. Perhaps the blow given by the accused did not cause the death of the slain man. Perhaps, even if the slain man had worn an iron head piece, his brain would have been injured by the blows he received during the battle—dignified by the name of a hockey match, at which he met his death. One solution of the best method of controlling outbursts of savagery at athletic contests would be as follows: A player at a hockey, lacrosse, football or other athletic match who, during play, deliberately assaults another player with fist, foot or stick, should be dismissed by the referee and not allowed to play during the remainder of the match, a substitute not being allowed to take his place. The public who patronize these games are interested in an athletic performance and not in assault and battery.

J. J. C.

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#### PERSONALS.

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DR. MURRAY MCFARLANE has left for Europe, where he intends spending three months visiting the special hospitals of London, Paris and Vienna.

WE are pleased to announce that our collaborator, Dr. Andrew Eadie, has sufficiently recovered from his recent illness to be able to attend to a little work.



## News of the Month.

### THE NEW PRESIDENT OF TORONTO UNIVERSITY.

BY DR. QUILL.

FEW things can equal in importance the filling of the vacancy that has existed for some time in our Provincial seat of learning. It can easily rival the appointment of a Chief Justice or the granting of a charter to a transcontinental railway. Judges interpret the law to men; the pedagogue instructs men to be capable of it, and, although we are doing things in this land by the continent, yet no geographical measurements can suffice for university influences. If Rugby School could be worthy of a Dr. Arnold, what must the man not feel who takes his place as the master-mind of a great and growing family of colleges!

Hail Robert Alexander Falconer!

He is not a native of Ontario or an illustrious graduate of "Old Varsity." Had it been a Henry John Cody, a Charles William Gordon, or best of all, our classical hero—Maurice Hutton—his face would have some of the familiarity that belongs to King Sol. But everything is too big in Canada, to lose one second complaining that the President-elect belongs to the Province of Nova Scotia.

Shade of Sir Daniel Wilson!

We have been informed that the Governors of the University were seeking not for an intellectual mastodon, but for the "right man." Be it unto them according to their faith. In another few thousand years the world may come around to its old way of thinking, and some Plato may be intrusted with an academy. There may be things said to-day on behalf of some who were passed over, although they had every qualification, save that they lacked the "golden touch." Sir Daniel Wilson never looked to us as one with this modern esoteric gift. "Hence, accordingly," the institution was poor. But we believe that we shall think of him during those sacred times when only rare friends will be allowed to enter; think of how he stood before even the unruly convocation, like some statue of the gods, representing faith and truth in a world of chaos and conflict. He was of the spiritual "touch."

No doubt that it took a great deal of nerve to commit the trust to the young theological professor down by the sea. But

those of us who know him and have watched his rapid rise during the past decade do not doubt for one moment that his pulse will beat just as steadily in accepting the responsibility, and will reward the judgment of the Governors by rare success and authority. He will be President Falconer; that is certain, because he can!

Well done, Canada!

If we keep on with our victories we shall soon hold up our heads among the peoples of the earth. Dr. Falconer seems to have fairly won in a good field. Good fortune has always smiled upon him. He has not paid the price of greatness unless it be the sacrifice of that leisure which ordinary men enjoy for "sweet abandon" in good fellowship. This he must regret, as he is every inch a "first-class fellow." He has too good health to suggest that he had ever been an inmate of a mad house where "children read Homer at eight." Unless we are very much mistaken his maxim is rather that of the old Roman—who taught a boy nothing that he could not learn "standing."

To sum up, the new President is "all right." His bearing is quite easy and natural, yet is markedly distinguished. He is not an orator to move the blood, but speaks well and "right to the line." His style is hardly Canadian, lacking our unhappy accent. One would say that he was "well bred." So he is, for he was born in a Presbyterian Manse, where the honor of moderatorship now rests. He has tastes for diplomacy and has won a distinct reputation for shrewdness, tact and power in handling delicate and intricate subjects. Since the time he so impressed the great Scottish professor as to call forth his appreciative query to another Canadian, Have you any more Falconers in Canada? he has made his way fairly into fame and position. Above all this, he is no mean scholar. As a graduate therefore and thus with every interest in our alma mater, we would say—Welcome! Welcome to our President!

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#### QUEEN'S UNIVERSITY, NEW MEDICAL LABORATORY.

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CONVOCATION is one of the few occasions in the college year which emphasize the essential unity of spirit and of aim in a great university, and Convocation at Queen's University on April 24th was the first Convocation of that institution when degrees in all the Faculties were conferred at the same time. Grant Hall was filled to overflowing long before the graduates marched in and took their reserved seats. As co-education has long flourished at Queen's, the sweet girl graduates and their friends

formed a fair portion of the interested audience. The never too-respectful gallery advised them to "Hop along Sister Mary," and they hopped along. The graduating class of Queen's this year is exceptionally large. And they made a brave show as they marched in two abreast. Following the graduate body came his Honor the Lieutenant-Governor and Chancellor Sir Sandford Fleming, Principal Gordon and the professional staff, members of the Board and visiting friends of Queen's.

After an invocation prayer by Rev. Dr. Drummond, of Hamilton, the Chancellor called upon Hon. Justice Maclellan, Chairman of the Board, to unveil a brass memorial tablet. This brass contains the following inscription:

"This tablet is placed by order of the Trustees of Queen's University to commemorate the loyalty and liberality of the students who, of their own accord, in November, 1901, undertook to erect at their own cost a new hall in honor of George Munro Grant, who for twenty-five years was the famed and much-beloved Principal of the University, and whose lamented death on May 11th, 1902, gave the noble act of the students the solemnity of a memorial. The corner-stone was laid by the Chancellor of the University, Sir Sandford Fleming, December 6th, 1902, and the hall was formally opened and dedicated on November 9th, 1904."

Then followed the presentation of prizes and scholarships by the Chancellor, assisted by the heads of the Faculties. The conferring of degrees—or in college parlance, the laureation ceremony—took some time, the number of graduates was large, and there were five different degrees given—Master of Arts, Bachelor of Arts, Bachelor of Science, Doctor of Medicine and Bachelor of Divinity.

An unusual feature was the laureation of two blind students, A. T. Barnard, of Hamilton, receiving the M.A. degree, and Rixon Rafter, of Arthur, that of B.A.

The caping ceremony is picturesque. The candidates kneel before the Chancellor, while the hoods are draped over their shoulders and the Chancellor gravely taps each recipient on the head with a mortar-board and recites the stately formula that rewards the student for hard years of patient work and gives him his standing as Bachelor or Doctor or Master. These hoods are even as Joseph's coat of many colors. Some are red as scarlet; some are white as snow; some are canary-color; some are combinations of these, with facings of black or crimson; and the careful carelessness of draping that blazes forth all their possible glory is a trick revealed only to a few people like Deans and such like. But if you want the real thing in barbaric gorgeousness you should see the Chancellor in his robes and collars and stars of office and the purple magnificence of the Principal—

who makes the glory of all the Caesars look like a faded flower of year before last.

After the ceremony of lauration Prof. Goodwin presented Professor Willet G. Miller, Provincial Geologist, for the degree of LL.D., *honoris causa*. Prof. Miller, who was for seven years a professor at Queen's, expressed briefly his appreciation of the honor and his confidence in the future of Queen's, making special reference to the School of Mines.

Principal Gordon delivered the address to the graduates. As might have been expected from a Principal of Queen's, he made an earnest plea for "loyal devotion to truth." This theme he developed with eloquence and power and a fine fervor that revealed the animating spirit of the University, and its makers. He enjoined the graduates to set their faces like flint against falsehood and cowardice in word and deed—he pointed out how with the pursuit of truth mental horizons melt and enlarge forever; that truth cannot contradict truth and that, for a seeming contradiction, the solution is more truth. Finally he made an earnest appeal for their affectionate loyalty to their alma mater and its ideals.

The ceremony of laying the corner-stone of the new medical laboratories followed immediately, on a temporary platform prettily draped with bunting and flags. Principal Gordon made the invocation prayer. Dean Connell followed with an account of the circumstances which led to the erection of the building and the uses to which it was to be put. The Dean then handed the presentation trowel to the Chancellor, who requested his Honor the Lieutenant-Governor to lay the corner-stone. It is not necessary to inquire precisely how much manual labor this ceremony involved, but certainly the trowel and stone and mortar became acquainted. This trowel is an extremely handsome piece of work, executed in Kingston, bearing a short inscription, surmounted by the crests of the Province and the University, the whole surrounded by a wreath of maple leaves.

His Honor's address was brief, but it was marked by a fine regard for learning and a proper understanding of its worth, the debt of the community to Queen's and a strong expression of his personal interest in the truly national work of the University. Over fifty years ago he had been connected with the Royal College of Physicians and Surgeons in Edinburgh, and ever since then he had been deeply interested in the advancement of medicine. He dwelt upon the splendid progress made in the healing art in the last quarter century, though he slyly expressed some doubt as to the physician's real knowledge of the origin, nature and treatment of disease even at this late day. He mentioned the recent improvements in pathology and in *materia medica*, in bacteriology and biology. The remarkable progress

of Queen's, in spite of all difficulties, elicited the Lieutenant-Governor's hearty congratulations. To the Medical Faculty he paid a special tribute, saying that in Old World universities such as Aberdeen and Edinburgh, the Faculties of Medicine are their enduring strength and glory, and that they wield an enormous influence in forming the spirit and *esprit de corps* of the university. He was sure the added facilities in the new building would conduce to the advancement of medical science and the amelioration of human suffering.

In truth, Queen's is an inspiration to the visitor. Because, somehow, Queen's is different. Queen's is not endowed and supported by the Provincial Government like Toronto University, nor the recipient of splendid munificence from men like Lord Strathcona and Sir William Macdonald like McGill. Queen's is a monument to the many. Built up from insignificant beginnings, it is a singularly fine illustration of what energy and perseverance and faith and statesmanlike administration can do, even when every cent of the financial support is raised by individually small subscriptions. Unwearied personal effort by a few and warm and loyal support from the many have made Queen's what it is.

Taking the Scotch universities as a model, a small, a very small beginning was made in 1842. The struggle has been long, painful at times, difficult always. In 1868 the old Government grant was withdrawn, and in 1873 the effort for the first endowment fund was begun and was soon successful. The second endowment campaign, in 1881, resulted in additional accommodation, an increased staff and more students. The third endowment campaign was for the Queen's Jubilee Fund of \$250,000, which was also successful. In 1854 the Medical Faculty was established. After years of vicissitudes it gained new vigor in 1891, and from then it prospered. In 1870 co-educational work was begun, and in 1878 the full course was opened to women. The year 1891 also marked the gift of the Carruthers Science Hall and the establishment of a Faculty of Practical Science. Queen's is especially proud of the School of Mines, which has done important work in the present era of mining development in Northern Ontario.

The group of grey stone buildings has a particularly impressive appearance. They are all built of the light grey stone which abounds in Frontenac County, and yet there is nothing grim or forbidding. Rather, the aspect is cheerful and inviting. The style throughout is plain, solid and substantial, yet somehow the plain grey stone buildings, standing four-square to the winds, carry a poise, and, besides, something almost of grace and beauty

easy to discern, hard to define. A Presbyterian might say that the whole scheme typified the genius of the church which has done so much for Queen's.

But while the University of Queen's owes much to the Presbyterian Church, there is nothing limited or limiting in its field of action. There is a fine catholic temper permeating Queen's, which is too broad and too courageous for any creed. This, indeed, is of the very fibre of Queen's—and has been from the days of Snodgrass and Mackerras and Grant, to these days of Gordon and Watson and Schorrt and Cappon and Dyde and Dupuis. Queen's has never consented to hold a brief for any theorem; for its essential characteristics are independent thinking, freedom of discussion and a singularly consistent pursuit of truth for its own sake. Couple this with a fine, sturdy dignity, the rugged spirit of the Covenanters, and it would seem that you have the spirit of Queen's. It is fair to say that the University has remained true to its early ideals as set forth in its charter: "The education of youth in the principles of the Christian religion and instruction in the various branches of science and literature."

Queen's has done and is doing a magnificent work for Ontario and for Canada. What the State has done for it is as nothing compared with what Queen's has done for the State. Its work is truly national in character, and it is done by private means. Nowhere can be discovered a finer university spirit nor a graduate body more enthusiastically loyal to its alma mater. And this is at least one test of a university.

W. E. J.

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### A PSYCHIATRIC CLINIC.

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ONTARIO is a Province of surprises and occasionally the people are wakened up from their condition of self-satisfaction to find that the world has been making advances while they have been quietly and contentedly resting. This criticism has been applicable to psychiatry, and while it is true that a few restless spirits in the service have chafed under restraints imposed upon them by unsympathetic Governments and have done excellent work in spite of hamperings, the service as a whole has not been satisfactory. From the standpoint of the profession at large this has been particularly true, and there has been little correlation between general medicine and psychiatry. During the last year the waking up of a new spirit in Toronto Asylum has attracted widespread attention, and it was felt that we were on the verge of interesting developments. The vote on Toronto Asylum esti-

mates during last session denotes that a Provincial Secretary keen enough and broad-minded enough to rise to the situation has been found, and Mr. Hanna is to be congratulated on his progressive policy, which stands to put psychiatry in Ontario in the van in America. The intention to build a psychiatric clinic in the neighborhood of the new hospital is an admirable plan, and if it is equipped as it should be we may look for the most gratifying results. As we understand it this clinic is to have 100 beds for the reception of incipient and acute cases of insanity; it is to have extensive laboratories for clinical and pathological investigations, research work, etc. An ample medical and nursing staff will be attached and there will be a close relationship between the University, the new hospital and clinic. In other words, while the clinic is a Government institution, it will be working in harmony with these departments which are not strictly under Government control. All assistants for the Hospital for Insane service will necessarily be trained here. No doubt general practitioners will have opportunity to get in touch with the problems of psychiatry, and the mystery which has always surrounded this branch of medicine will fade away before the searchlights directed from many points of view. The General Hospital will have a new field in which its nurses may derive clinical experience, and medical students will have clinical advantages to be had nowhere else in America. Surely no branch of preventive medicine has greater reason for existence than psychiatry, and it seems to us Mr. Hanna has been well advised when counselled to make this advance. To take such a step must have required a great deal of courage, but the reform is one that commends itself to the profession at large and will redound greatly to the credit of the Government. There has been a feeling abroad that politics have played too prominent a part in institution affairs for many years, and while it is true that too many appointments have been made because of so-called political exigency, this step in advance will clear the way to a better state of things.

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#### DR. DONALD ARMOUR WINS THE JACKSONIAN PRIZE.

DR. DONALD ARMOUR, F.R.C.S., was recently awarded the Jacksonian prize for 1906 by the Royal College of Surgeons, England. In this competition, which is open, special importance is attached to personal observation and original work. It is the first time the prize has gone to a Canadian. Dr. Armour's essay was the "Diagnosis and Treatment of those Diseases and Morbid

Growths of the Vertebral Column, Spinal Cord and Canal, which are Amenable to Surgical Operation."

Dr. Armour, who is a son of the late Hon. Chief Justice Armour, is a graduate in Arts, 1891, and Medicine, 1894, of the University of Toronto. He is a lecturer in the Royal College of Surgeons, England, and is assistant surgeon of Queen's Square Hospital, London. In surgical circles the award won by Dr. Armour is considered a high honor.

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#### ITEMS OF INTEREST.

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**New University Fraternity.**—A chapter of the Alpha Omega Alpha Honorary Medical Fraternity, which is purely medical, and whose motto is "To be worthy to serve the suffering," has been established in the University of Toronto. This is the first chapter in Canada.

**What They Say in England.**—The Outlook, of London, says in a recent issue: "One could have better spared any educational buildings in the world than the part of McGill University burned down by two successive fires. They were to scientific education what the Hospital for Sick Children in Toronto is to surgery. They were erected by the beneficence of men to whom both Canada and the Empire owe much, and in their equipment the minutiae of the best schools in America and Europe were studied. Oxford has long been sighing for the opportunity to equip herself with such an instrument of scientific teaching, but we have no such generous patrons in the older countries, and our Government does not take their place. It will take £150,000 or so to repair the loss, and though Montreal is rapidly becoming a city of millionaires, their utmost beneficence will hardly re-create the sentiment belonging to the physics, mining, engineering and chemistry schools lately given by eminent citizens. In this respect the fire—which it is thought was the work of an incendiary—is irreparable."



# The Physician's Library.

## BOOK REVIEWS.

*Diseases of the Nervous System Resulting from Accident and Injury.* By P. BAILEY, A.M., M.D. New York: D. Appleton & Co.

This book is a revised edition of "Accident and Injury in their Relation to the Nervous System," which was published several years ago. In this edition the scope is much wider, and it is an adequate, if not an exhaustive, text-book upon these special diseases. The subject is broadly treated in all its various phases, the chapters upon brain injuries and general physical and mental results of head injuries being especially exhaustive and helpful.

The author has collected a large number of instructive cases bearing upon the different phases of the subject which add considerably to the value of the book.

We can insure the reader of this book a clear understanding of the subject, and it should prove of value to every physician.

D. C. M.

*The Disease of the Nose, Throat and Ear.* By CHARLES PREVOST GRAYSON, A.M., M.D., Clinical Professor of Laryngology in the Medical Department of the University of Pennsylvania; Physician-in-Charge of the Department for Diseases of the Nose and Throat in the Hospital of the University of Pennsylvania, Laryngologist and Otologist to the Philadelphia Hospital. Second Edition, revised and enlarged, illustrated with 152 engravings and 15 plates in colors and monochrome. Philadelphia and New York: Lea Brothers & Co.

The appearance of a second edition in the short time that has elapsed since the first appeared should be gratifying to the author. Grayson endeavors to give lines of treatment which he himself has found best. One sometimes gets a book in which the author has ransacked all literature to gather every and all measures that may be used. This is particularly confusing to the general practitioner and students. Anyone can write a book in which other people's opinions and methods are given, but few are able to write of their own experience. In the former edition but eight pages were given to diseases of accessory cavities of

the nose, and the reviewer remarked adversely on it at the time. Now, however, we find twenty-two pages. The illustrations of the maxillary and frontal sinus operation, taken from Laurens are very plain. The one on page 212, showing both frontal and maxillary trans-illumination in the one cut, with the light in the mouth, might be misleading. The cuts from Laurens showing the mastoid operation are poor. We think further consideration might have been given to lateral sinus thrombosis, and in connection with the diagnosis of a clot too much reliance is given to the aspirating needle. In this connection Whiting alone is quoted, while the views of the English and German aurists are not mentioned. The subject of sinus thrombosis is a very grave topic, and we hope in future editions to see this section much more fully discussed. The book is one in which one cannot help deriving both pleasure and profit in reading, and the publishers, by the excellence of the type and paper, have made this much easier to secure.

P. G. G.

*The International Medical Annual. A Year-Book of Treatment and Practitioner's Index.* Contributors and original contributions to Medical Annual, 1907: Jos. Blumfield, M.D. (Cantab.), "Anæsthesia"; Victor Bonney, M.S., M.D., F.R.C.S., B.Sc., "Gynecology and Obstetrics"; Prof. J. Rose Bradford, D.Sc., M.D., "Renal and Urinary Diseases"; Prof. Alfred H. Carter, M.Sc. (Birm.), M.D., F.R.C.P., "Heart and Blood Vessels"; Frank J. Charteris, M.B., B.C.H., "Materia Medica and Therapeutics"; Chas. C. Easterbrook, M.A., M.D., F.R.C.P. (Edin.), "Insanity"; J. G. Emanuel, B.Sc., M.D., M.R.C.P. (Lond.), "Hematology—Opsonins"; E. Harry Fenwick, F.R.C.S., "Urinary Surgery"; Frederick Gardiner, B.Sc., M.D., F.R.C.S., "Skin Diseases"; Arthur E. Giles, B.Sc., M.D., F.R.C.S., "Gynecology and Obstetrics"; Edw. W. Goodall, M.D., B.S., "Acute Infectious Diseases"; Wilfrid Jas. Hadley, M.D., F.R.C.P., F.R.C.S., "Pulmonary Diseases"; W. Sampson Handly, M.S. (Lond.), F.R.C.S., "Cancer"; Robt. Hutchison, M.D., F.R.C.P., "General Medicine"; Robert Jones, F.R.C.S., "Nerve Anastomosis and Nerve Grafting"; A. Brown Kelly, M.D., B.Sc., "Multiple Telangiectases"; Priestly Leech, M.D., F.R.C.S., "General Surgery"; Jas. Kerr Love, M.D., "Diseases of the Liver"; E. Reginald Morton, M.D., C.M., F.R.C.S., "Radio Activity and Electro-Therapeutics"; George Lane Mullins, M.A., M.D., Sydney, "Australian Diseases"; P. Lockart Mummery, B.C., F.R.C.S., "Rectal Surgery"; Wm. Murrell, M.D., "Colored Urines with Spectra"; Jos. Priestly, B.A., M.D., D.P.H., "Sanitation and Law"; A. W. Mayo Robson, D.Sc.,

F.R.C.S., "Abdominal Surgery"; H. Batty Shaw, M.D., F.R.C.P., "Diseases of the Ductless Glands"; J. Morris Slemons, M.D., Baltimore, "Toxemias of Pregnancy"; J. W. W. Stephens, M.D. (Cantab.), "Tropical Diseases"; Purvis Stewart, M.A. (Edin.), M.D., F.R.C.P., "Nervous Diseases"; Prof. George Fred Still, M.A., M.D., F.R.C.P., "Medical Diseases of Children"; A. Hugh Thompson, M.A., M.D., M.R.C.S., "Eye Diseases"; A. H. Tubby, M.S., M.B., F.R.C.S., "Nerve Transplantation"; J. W. Thompson Walker, M.B. (Edin.), F.R.C.S., "Venereal Diseases"; Norman Walker, M.D., "Skin Diseases"; P. Watson Williams, M.D., M.R.C.S., "Diseases of Nose and Throat"; Prof. J. Whitridge Williams, M.D., Baltimore, "Toxemias of Pregnancy."

In the article on "Deflections of the Septum," written by P. Watson Williams, M.D., no reference is made to an original operation for deflected septum, done at St. Michael's Hospital, Toronto, by Dr. Price Brown. It was noticed in *THE CANADIAN JOURNAL OF MEDICINE AND SURGERY*, March, 1906, p. 179, and reported at length in *The Journal of Laryngology, Rhinology and Otolaryngology*, July, 1906, pp. 309-314.

A slight verbal inaccuracy, showing careless proofreading, changes the name of Dr. W. P. Caven, Toronto, into Dr. W. H. Craven, top of p. 578.

The International Annual of 1907 is a fine collection of papers, showing the advances made during 1906 in the different branches of medical science.

J. J. C.

*Malarial Prophylaxis in Small Isolated Communities in Central Africa.* By R. HOWARD, M.D., B Ch. (Oxon.), Medical Officer to Universities' Mission, Central Africa.

This little pamphlet contains, perhaps, more reliable and original information on the subject of Malarial Prophylaxis than any other yet published. It is divided into three parts, as follows: Part I.—Preamble; General Historical Survey—The Mosquito Malaria Theory, Observations on Mosquitoes, Methods of Malarial Prophylaxis. Part II.—Nyasaland—Geographical and Historical Data, Report of the Malaria Commission; Malarial Prophylaxis in Outlying Districts—Likoma, Kota Kota, Malindi, Steamers, Results Tested by the Health Record, General Conclusions. Part III.—Relapses—Their Mechanism and Prevention. Quinine Administration; Blackwater Fever.

The following are extracts from the work:

"Since 1899 it has been my privilege to act as Medical Officer to the Universities' Mission to Central Africa. In that capacity I have had charge of a number of Europeans living in typical

outlying stations in the neighborhood of Lake Nyasa, and during this period I have personally made observations and directed anti-malarial measures at all stations, so that my conclusions are based on prolonged study and practical knowledge of the difficulties which have to be encountered."

"One point which is often neglected merits discussion, viz., which salt of quinine it is best to use. Sulphate of quinine was the earliest preparation, and there is a tendency to continue to use it blindly. Its insolubility is a great disadvantage, and so many people have employed the bisulphate instead. The latter, however, has nothing to recommend it except its solubility; on account of the high molecular weight of the two sulphate radicles, it has a very low percentage of quinine, while the amount of dilute sulphuric acid which is introduced into the stomach probably accounts for a good deal of the indigestion attributed to quinine.

"There are other salts that are far more suitable, especially the hydrobromate and the hydrochlorate. They are fairly readily soluble, contain a higher percentage of quinine, and are much less likely to disturb the digestion. The bihydrochlorate is the best salt of all; it has a fairly high percentage of quinine and is soluble in its own weight of water, so that there is probably no risk of even a tablet passing through the body undissolved. Its only disadvantage is, that owing to its solubility, the taste is more noticeable than with other salts.

"All these three salts have been found very satisfactory in the experience of the writer."

*The Treatment of Disease.* A Manual of Practical Medicine.

By REYNOLD WEBB WILCOX, M.A., LL.D., M.D., Professor of Medicine, New York Post-Graduate School and Hospital; Consulting Physician to St. Mark's Hospital; Fellow of the American Academy of Medicine; Member of the American Therapeutic Hospital and of the American Medical Association; Permanent Member of the Medical Society of the State of New York; Honorary Member of the Connecticut State Medical Society; Vice-Chairman of the Revision Committee of the U. S. Pharmacopeia. Philadelphia: P. Blakiston's, Son & Co., 1012 Walnut St. 1907. Canadian Agents, Chandler, Ingram & Bell, Limited, Toronto.

No one will doubt the fact that there is available quite enough medical literature dealing with the practice of surgery, of medicine, and of gynecology and obstetrics. There is, however, somewhat of a dearth of practical books on diagnosis and treatment. That the best medical teaching body on earth does not pay one quarter the attention they should to practical clinical

work and diagnosis is a statement that cannot be contraverted, and it is for that reason that a work similar to the one under review is doubly welcome. Dr. Wilcox's book is withal practical, being the outcome of over a quarter of a century's experience teaching in post-graduate and other institutions. New methods of making correct diagnoses are being suggested every day, so that it is only advisable that works treating of diagnosis should be rewritten and brought up to the mark almost annually. The author has certainly tried to make his book, in every respect, modern. He believes firmly, and wisely, that pathology must form the foundation of the correct diagnosis, and that such being the case, a keen understanding along that line, combined with a "broad knowledge of therapeutics in its larger sense," will almost ensure to the practitioner a successful issue. Dr. Wilcox has written a book that will meet with a ready sale to, especially, those whose one desire is to leave nothing undone that will ensure success.

*War With Disease.* By FREDERICK F. McCABE, M.B. (Univ. Dublin), Medical Officer, South of Ireland Imperial Yeomanry; late Civil Surgeon, H. M. Field Force, South Africa. "The great thing in all military service is health, and you will agree with me that it is easier for an officer to keep men healthy than for a physician to cure them."—Lord Nelson, March 11th, 1804. Second Edition. London: Baillière, Tindall & Cox, 8 Henrietta Street, Covent Garden. 1907. (All rights reserved.) Canadian agents: J. A. Carveth & Co., Ltd., 434 Yonge Street, Toronto. Price, 50c.

The object of this very practical little work is to show officers and men on active service or in foreign countries how to maintain the best possible health and fitness. How to avoid the various diseases is told in very simple language. It is interesting to note that the writer refers to military orders given by Moses, and shows how these ancient orders are absolutely necessary for the armies of to-day. This book should be in the hands not only of our army surgeons, but of every officer and private in the service, and we feel sure, if the rules here advocated were followed, the death rate from disease would be reduced to a minimum. w. j. w.

*Plaster of Paris and How to Use It.* By MARTIN W. WARE, M.D., Adjunct Attending Surgeon, Mount Sinai Hospital; Surgeon to the Good Samaritan Dispensary; Instructor in Surgery, New York Post Graduate Medical School. 12 mo; 72 illustrations; about 100 pages. New York: Surgery Publishing Company, 92 William Street. Cloth, \$1.00.

This is one of the most useful books ever presented, not only on account of the general demand for the information and instruc-

tions upon the subject which this book so explicitly, practically and comprehensively covers, but because this knowledge was not previously available, except from such a vast experience as enjoyed by Dr. Ware, or, in part, by reference to many books on allied subjects.

It is a vivid narrative, profusely illustrated, of the many uses to which plaster of Paris is adaptable in surgery. The whole subject, from the making of the bandage to its use as a support in every form of splint, corset or dressing, is graphically described and illustrated. The use of plaster of Paris in dental surgery is also covered. The book is presented in the artistic manner characteristic of the productions of the Surgery Publishing Company. It is printed upon coated book paper and attractively bound in heavy red buckram, stamped in white leaf and gold.

*Paraffin in Surgery.* A critical and clinical study by WM. H. LUCKETT, M.D., Attending Surgeon, Harlem Hospital, Surgeon to the Mount Sinai Hospital Dispensary of New York, and FRANK I. HORNE, M.D., formerly Assistant Surgeon, Mount Sinai Hospital Dispensary. 12 mo.; 38 illustrations; 118 pages. New York: Surgery Publishing Company, 92 William Street. Cloth, \$2.00.

This book covers a special field in surgery of absorbing interest both to the surgeon and general practitioner. The research and original investigations made by these authors in the use of Paraffin have exploded many fallacies previously maintained. It presents the Chemistry of Paraffin, the Early Disposition of Paraffin in the Tissues, Physical State of the Paraffin Bearing on its Disposition, the Ultimate Disposition of Paraffin, Technic and Armamentarium. It thoroughly covers the use of Paraffine in cosmetic work such as Saddle Nose Deformity, Depressed Scars, Hemiatrophia Facialis, with a large number of photographs showing cases before and after operation, with illustrations of micro-photographs of the Disposition of the Paraffin in the Tissues. It also presents other conditions of a functional character, where Paraffin can be used with service, such as Inconsistency of Urine, Umbilical Hernia, Umbilical and Ventrals Hernia, Epigastric Hernia, Inguinal Hernia, etc. The subject is presented in a scientific, yet comprehensive manner.

Full details are given as to the method of preparing the Paraffin, as well as the method and manner in which it should be injected. This book presents a wide field for the use of Paraffin and a copy should be in every physician's library. It is printed upon heavy coated book paper and attractively bound in the best quality of heavy red cloth, stamped in gold.

*A Manual of Obstetrics.* By A. F. A. KING, M.D., Professor of Obstetrics and Diseases of Women in the Medical Department of the George Washington University, Washington, D.C., and in the Medical Department of the University of Vermont, etc. Tenth edition, enlarged and thoroughly revised. 12 mo; 688 pages, with 30 illustrations and three colored plates. Cloth, \$2.75, net. Philadelphia and New York: Lea Brothers & Co. 1907.

King is one of the perennial books. It is now beginning its second quarter-century with its tenth edition and has thus spanned with vigor the most active and exacting period in medical history. No other obstetrical book extant has such a record. Every fact has a reason, and the ever-growing favor bestowed on King can have but one basis, namely merit. The author combines the faculties of a teacher and practitioner, and accordingly has been able to select what is important and to present it clearly. The student thus easily acquires a grasp of everything essential, and the accoucheur can turn to these pages for reference on any point of practice. Suiting both classes of readers this single handy volume receives their combined demand and hence goes through successive editions, enabling the author always to keep it revised to date, as he has just done again, with considerable enlargement both in text and engravings, and with the addition of colored plates.

## *Publishers' Department*

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### AN IDEAL SPOT FOR CONVALESCING PATIENTS.

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How frequently does it occur, especially at this season of the year, that physicians are in a position to refer patients, who are perhaps recovering from illness and are in need of the tonic effect of fresh air, to just such a place as Niagara-on-the-Lake. There is little doubt that whatever the family physician recommends along this line is almost always acted upon, and his advice almost invariably taken as to where the patient will go in order to thoroughly recuperate from his or her illness.

The most important consideration that should attach to any health resort is lofty situation, with pure, dry air, where, if so desired, the patient can sleep under canvas, by that means receiving the tonic and bracing effect of the ozone in the atmosphere both day and night. The busy business man is very frequently unable to get away any great distance from home even to recover his health, he being naturally anxious during his stage of recovery to be within touch of his office and be able to at least give some directions regarding the details as to the conduct of his firm. Toronto is blest peculiarly by having within convenient reach more than one beauty spot whither the patient recovering can be sent for a few weeks time. One of the most picturesque and at the same time convenient spots within easy reach of our city is Niagara-on-the-Lake, the home of the famous Queen's Royal Hotel.

Niagara-on-the-Lake has for many years now been noted as a health resort, being situated at the mouth of the famous Niagara River, less than two hours' sail by steamer from our city. This resort is an exceedingly healthful and at the same time restful place, and any patient referred there can be guaranteed not only quiet by night but by day also. The management are very anxious to bring their hotel under the immediate notice of the medical profession all over Canada, as they feel that physicians are in a position to benefit their patients and themselves and be able almost to guarantee their complete recovery. The rooms of the Queen's Royal are bright and airy. The cuisine has earned for itself quite a notable reputation, all that can be procured from both the Canadian and American markets being served on the table, as the season permits.

In order to convince medical practitioners that the management are anxious to receive their endorsement, they have recently



built, for those desiring more quietude than is usually obtainable in hotel life, several beautiful little cottages in the grounds of the hotel, each fitted with a bath room, hot and cold water, and electric light. These cottages can be rented at very reasonable figures and arrangements made for meals at the hotel at special rates. Physicians may rest assured that any patients referred to the Queen's Royal will not of necessity be confined during their stay to the house, as the management have paid particular attention to providing out-door recreation of almost every kind. The tennis courts are too well known to require more than a mention, they having been used for some years for both the Canadian and International championships.

Golf links have also recently been arranged, so that lovers of this sport will find ready for them a nine hole course immediately adjoining the hotel property. The bowling green in connection with the hotel is known all over the Dominion, having been the scene of many famous matches, not only between Canadian clubs, but those also from across the Atlantic.

The Queen's Royal has been for years the favorite rendezvous of the Royal Canadian Yacht Club of Toronto and any Saturday during the season it is a beautiful sight to see at anchor the different yachts whose owners come over to spend the Sunday at the Queen's Royal, returning in time for business on Monday morning.

A glance at the cuts illustrating this article will at once persuade the reader that no more attractive spot than the Queen's Royal, Niagara-on-the-Lake, is anywhere within as easy reach of our city, and it may be mentioned that special provision is made by the hotel management for the storing of automobiles for those who prefer motoring to Niagara-on-the-Lake in preference to taking the steamer.

That the Queen's Royal has been patronized for many years by not only society but royalty itself. It may be mentioned that this hotel was honored during the visit a few years ago of their Royal Highnesses the Prince and Princess of Wales, being specially selected by the Canadian Government for the entertainment of the illustrious visitors. No one who has had the pleasure of a visit to this beauty spot will feel that the compliment was not well deserved, Niagara-on-the-Lake having been frequently justly called the "Newport of Canada." "How like the sea," exclaimed the Prince of Wales, as he looked over the broad expanse of Lake Ontario from the deck line piazza of the Queen's Royal, and His Royal Highness was right. Far and away the sun-lit billows tumbled and rolled; the breeze came over the fresh waters of the inland sea, pure and invigorating; sails dotted the horizon, the music of the waves rose on the clear, cool air, and to Great Britain's Sailor Prince there was a charm that nothing else could give.

The Queen's Royal is within a few miles of access by rail, boat or trolley car to Niagara Falls, that nature wonder, situated in the garden of Canada with its wealth of vineyards, orchards and maple clad hills, on the most historic ground in America, where Britisher and Frenchman met again and again in that half-century of conflict "When the world was a battlefield and the prize a continent." Guests of the Queen's Royal can leave every half-hour by trolley and reach Niagara Falls within sixty minutes, viewing all the way what is undoubtedly the most wonderful scenery in the world. The trolley cars run for the entire distance along the Niagara River and the edge of the cliff, so that the traveller is able to view the whirlpool and eddies of that famous body of water. Reaching Niagara Falls, carriages can be procured, so that the guest can drive across Suspension Bridge and visit the American side, or, if so desired, go to the different power houses recently built for the distribution of electric energy all over the province.

The management of the hotel arrange impromptu dances, amateur theatricals, etc., one or two evenings each week during the season, so that the evenings can be spent just as enjoyably as the daytime. The annual military camp takes place for two weeks within walking distance of the hotel, when the scene is enlivened by the presence under canvas in the immediate vicinity of several thousand of our regular militia.

It will, therefore, be seen that medical men cannot make any mistake in referring patients to this beautiful resort on Lake Ontario during the months of June, July and August, as the seeker of rest and quietude cannot but be perfectly pleased with Niagara-on-the-Lake, and return to his work, not only feeling recovered in health and strength, but ready and anxious to make up for what he might erroneously call "lost time."