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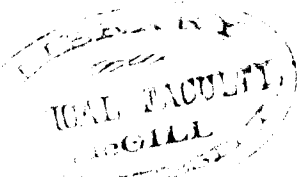
PRESIDENTIAL ADDRESS, ONTARIO MEDICAL ASSOCIATION

BY C. J. MCGILLIVRAY, M.D., WHITBY, ONT.

LADIES AND GENTLEMEN:—

My first duty is to thank you for the honor you have conferred upon me in electing me to preside over this meeting. I do not flatter myself that this honor came to me personally because of individual merit, or for services rendered this Association; I take it that the honor was conferred upon a representative of that great majority of our profession in this Province—the General Practitioners, and more particularly the country practitioners, in whose ranks I labor.

The voice of the country practitioner is not often heard in this assembly, if we make one notable exception in the person of our esteemed friend, Dr. T. S. Harrison, for here are met the lecturers and professors of our schools, the clinicians and teachers of our hospitals; the specialists in every branch and department of medicine and surgery; the rotund, well-groomed, prosperous-looking general practitioner of the city; the consultant of Provincial reputation, and “members of the Academy of Medicine”; so that naturally the country practitioner, overawed by this array of talent, is not very aggressive nor assertive in meetings such as this. But come out with him into his own little bailiwick, and learn if his voice is always silent there. There we still find occasionally the old-fashioned family physician, looked upon by half the countryside as the wisest of counsellors, the truest and most unselfish of friends, and who is oftentimes the social and intellectual beacon of his community. Whilst he is no expert in skiagraphy or the making of the Wassermann tests, in bacteriology or the microscopical



EDITOR,

examination of the blood, yet he must have a good working knowledge of obstetrics, of gynecology, of internal medicine, of minor surgery, of therapeutics, of affections of the eye, nose and throat, of hygiene and the public health, and a special knowledge of pediatrics, a subject too often overlooked in the schools. But what of his other duties? He must know how to draw a will. I have known him to act as judge of the prize babies at the fall fairs. He will be coroner, medical officer of health, examiner for a half-dozen life insurance companies, member of the Library Board, or more probably of the School Board. This is a very common duty. He will be a member of the Town or Township Council—This is another very common duty—or a member of the County Council or even of the Legislative Assembly. He is probably well known in social circles; and, odd though it may seem to some of you, well known in religious circles. He must be prepared at any time to take the platform and make a speech. Such are some of the activities—medical, social and municipal—of the country practitioner, who is so unobtrusive and non-aggressive in assemblies such as this. In the name of these men scattered all over the Province, I thank you for the honor conferred upon one of us by electing me to preside over this meeting.

I wish further to thank those who have labored so faithfully and given so much of their time and thought in preparation for this annual meeting. The programme is extensive and varied. It is the menu card of the annual feast prepared for you. I trust you have come here with appetites keen-edged for the discussion of things professional, old and new. For at this feast, as at all others, "*Fames est optimum condimentum.*"

For a portion of this programme we are indebted to our medical brethren of the great neighboring Republic. To them I extend a warm welcome from this Association. We are indeed pleased to have them with us. Reciprocity in medical thought is, and always has been, the world over, one of the outstanding landmarks of the profession. This is one kind of reciprocity that we have no objection to in this country.

Without encroaching upon the field of the Committee on Necrology, I would like to recall the names of many of our brethren who have gone down "through the valley of the shadow" since our last meeting; but will content myself by mentioning only three—Dr. Daniel Clark, who for thirty years was Superintendent of the Queen Street Asylum, and was in my day the Lecturer in Mental Diseases—Dr. Fred. Fenton, the genial,

kindly, companionable friend, whose sad, untimely death cast such a gloom over us all. He was with us last year in London, and at that time promised a long and successful career in his chosen work—and John Caven—what shall I say of him? I knew him best as I knew him first, as the young and boyish-looking Lecturer in Pathology in the University of Toronto, twenty-five years ago. At that time I thought I myself knew something of teaching, as I had been engaged in that work for many years, but I was glad to sit at the feet of John Caven and learn afresh the art of making obscure things plain and difficult things easy for the student. I have heard it said, and I can quite believe it true, that he was the best teacher of pathology that the University has ever had. His intellect was ever keen and alert. His witty remarks, quick repartee, sharp criticisms and boundless enthusiasm endeared him to his students and made his subject—dry and tiresome as it is apt to be—the best-liked on the curriculum. He was a great teacher. I like to remember him as such.

I do not propose to enter into a detailed survey or review of the many advances made in medical or surgical treatment during the last two years. I could not, if I would. Many of you are more competent to do that than I. I am rather going to content myself with a few remarks on matters which have interested the profession during my term of office; to act the bystander, as it were, watching the trend of events, rather than as one "*in medias res.*"

The annual meeting of the Medical Officers of Health and the annual meeting of this Association have this year both been held in the month of May. For the first-mentioned of these meetings, practitioners are brought to Toronto from every part of the Province, even from the remotest parts. Would it not be wise for the officers of the two societies to get together and arrange that, on any future occasion when both meetings are due to meet in Toronto, a united meeting be held; or, if that be found unwise, that at least the meetings be held in the same week. Such an arrangement would be of mutual advantage. We might then have at our annual meetings some whom we rarely see here.

Sir James Whitney, in his short address at the opening ceremonies of the new General Hospital, announced that "the Provincial Legislature had decided to appoint a Commission to investigate the whole subject of medical education and the practice of medicine in the Province." Two most important ques-

tions over which so many wordy battles have been fought, viz., medical education and what constitutes the practice of medicine. "The term medicine," said Sir James in his announcement, "will include all plans or means of alleviating or curing human defects, disorders, diseases, or wounds. The powers of the Commission will include the rights and by-laws of the College of Physicians and Surgeons, of all universities, colleges and schools, and the teaching therein; also, of the osteopaths, dentists, opticians, Christian scientist, and members of any other class or creed engaged in the practice of any branch of Medicine." This announcement of the Premier was a most satisfying one. Whether or not such a Commission would be helpful in solving the vexed problem of what is absolutely essential in the way of medical education of the future practitioner, is very doubtful; for the views of those physicians graduated by the College of Physicians and Surgeons and the view of the irregular practitioner are as far apart as the poles. Let me illustrate the difference by a concrete example of two boys from my own town. In small communities it is easy to follow the career of our boys. One, A. B., passed up through the High School, matriculated into Queen's University, took two years in Arts, then took the double course of Arts and Medicine, and graduated this year B.A. and M.D. At the end of his six years' university course, standing on the threshold of the practice of medicine, knowing his own limitations, and disagreeably conscious of how little he knows of the great field of medical knowledge which lies before him, much of which is still a veritable "*terra incognita*," he has resolved on another year of study, and has become an interne of one of the Montreal hospitals. The other young man, C. D., barely reached the fourth reader in the Public School, never got within hailing distance of the High School, went out into life, got married, married a nurse, is said to have taken a six months' course in chiropractic by correspondence, then hung out his shingle in one of our flourishing Western towns as a full-fledged, duly qualified chiropractor; not, as in the case of the former young man, conscious of his own limitations, but bold, aggressive, cocksure. The poet's maxim:

"A little learning is a dangerous thing:
Drink deep, or taste not the Pierian spring,"

does not appeal to him; and, worst of all, he is recognized by the public as a regularly qualified practitioner. How long will

this deplorable difference in the medical education, or lack of medical education, of the regular and the irregular practitioner be allowed to continue? Down through the centuries the medical profession has claimed to be, and has prided itself in being, one of the learned professions, and this claim, down to the present time, has been universally recognized as a just claim. How long will the world continue to recognize us as one of the learned professions, if the door to our profession is wide open to all who have little or no primary education before the study of medicine is begun, and whose technical studies are practically negative? Let us keep our ideals high; let us strive to live up to the reputations that the centuries have given up. I believe that the Medical Council and the universities are and have been alert on the question of medical education, of what is required for the Entrance or Matriculation Examination, and of what is required of students after their special study of medicine begins. Year by year the matriculation examination has been getting harder and harder. Many advocate that it should be still further raised so as to correspond with the examination at the end of the second year "Arts" course of the University. And, year by year, the time for the technical study of medicine required of students is being prolonged, until the three-year course has been discontinued for the four-year course, and the four-year course for the five-year course. I repeat that I do not think that the Medical Council and the universities have been remiss in the matter of the education, primary and technical, of those whom they can control. What about those over whom they have no control—the Christian scientists, the osteopaths, the chiropractors, *et hoc omne genus*. There are those of us who, in our innocence, confidently thought that the Medical Council could control throughout the Province every form and variety that the practice of medicine could assume. But such confidence has long since vanished into thin air. Welcome the suggestion of Sir James Whitney. Let us have a Commission. Let us have it clearly declared:

1st.—What is meant by the practice of medicine.

2nd.—What primary education is required before entering upon the study of medicine.

3rd.—What technical education is required after the study of medicine has been begun.

The following quotation from one of the medical journals embodies my view of this question: "If Sir James Whitney establishes a Commission made up of men of the highest type,

who know the situation, and who are likely to back up the Medical Council and the universities in their endeavors to make medical education in Ontario worthy of this great Province, good will result. We would humbly suggest that there is but one way to bring about the desired result. That is, establish a high standard, and make all 'pathies' and faddists conform to this standard. It is a simple matter to answer the query: how many of the 'pathies' would remain if this rule were adopted? The eclectics have disappeared; the homeopaths are almost extinct, and the osteopaths, chiropractors, faith healers and other peculiar sects will cease to exist just as soon as they are forced to spend five years in study and pass examinations of the stringent kind. Under these conditions, very few will be anxious to remain under the shelter of the charlatan banners. Scientific medicine has no apologies to offer for its existence, and any government failing in its duty to uphold it will be guilty of interfering with the best interests of the public it serves."

It is very pleasant to comment upon the fact that, since the last meeting of this Association, the Dominion Medical Council, in accordance with the conditions of the Canada Medical Act, has been organized, and the first examination held. Dr. Roddick, whose courage, diplomacy and untiring perseverance brought this result about, must be more than gratified. It was in 1902 that the "Roddick Bill," or Canada Medical Act, was introduced into and passed by the Dominion House. The first and apparently insuperable difficulty that met this bill in its progress came from the Provinces. They, and not the Dominion House, had complete control of all matters pertaining to education, and they were unwilling to give up their prerogative. It took nine long years of continuous effort on the part of Dr. Roddick and those associated with him to persuade the Provinces that it was to their advantage to accept the Act. In 1911 the Act was amended and became operative when a so-called "enabling clause" had been passed by each of the Provinces. This was done in 1912, and the Canada Medical Act was in operation. The next step was to form the Dominion Medical Council in accordance with the terms of the bill. On November 7th, 1912, the members of the Council, representing every Province and every University and College in the Dominion, met in Ottawa for the purpose of organization. They very properly elected Dr. Roddick as their first President; formed Committees; laid their plans, and adjourned to meet

again in the same place in June, 1913. At the adjourned meeting they completed their organization; selected July 1st, 1913, as the first day of registration for practitioners holding Provincial diplomas for ten years or more, and appointed October 10 to 17, 1913, at Montreal, as the time and place for the first examination under the Act. It must have been particularly pleasing to Dr. Roddick to have been present at and to have witnessed, in his own well-loved University of McGill, and in his own city of Montreal, the holding of the first examination under the new Act.

Now that the Dominion Medical Council is an accomplished fact, it is merely a mild expression of the truth to say that only a big man would have tackled the job, and that only a big man could have brought it to a successful issue. If ever a man deserved the gratitude of the medical men of Canada, that man surely is Dr. T. G. Roddick. I trust that a resolution expressive of the appreciation of this Association for service done will be presented to Dr. Roddick before the sessions close.

In the official programme which you have in your hands, you will see that notice of motion has been given for the separation of this Association from the Canadian Medical Association. The Provincial Association of Ontario was the first to affiliate with the National Association, and all the other Provinces, with the exception of Quebec, have followed her good example. Is Ontario to be the first to separate? And will the other Provinces follow her bad example? President after President of yours, in his annual address, has urged the formation of city and county Associations all over the Province; (you are to have a report on that very question to-day); and that such Associations become affiliated with the Provincial Association, just as the Provincial Associations are affiliated with the National; and further, that membership in the city and county associations would entitle to membership in the Provincial Association, just as membership in the Provincial Association would entitle to membership in the National. Thus the various Medical Associations of the whole Dominion would be cemented together by bonds of common interest. Was the whole scheme, as laid before you by your former Presidents, a possibility, or was it merely a beautiful dream? The whole scheme will be guillotined, its head cut off, as it were, if this Association approves of the motion of separation of which notice has been given. We do not disagree with the advocates of separation who say that affiliation has worked in some respects to the disadvantage of the Association;

but surely there have been some compensating advantages. If our agreement with the National Association, made at the time of affiliation, has worked to our disadvantage; if we have grievances, as I believe we have; if we have suffered in the loss of our annual meetings of 1910 and 1913, and also in our financial arrangements, as claimed, surely these grievances can be remedied without recourse to such drastic measures as separation. The whole question will be before you this afternoon for discussion. Let wise and sane counsels prevail. If permitted to make a suggestion, I would suggest that prudent representatives from both Associations be appointed, that they meet, adjust their differences, make a new agreement if deemed wise, and report to their several associations for approval at the first possible opportunity. But whatever you do, don't to-day approve of a motion of separation. Ever remember that the friends of the one Association are the friends of the other.

By again referring to your programme, you will see that a resolution will be submitted to you re "Workman's Compensation Bill." At the recent session of the Provincial Legislature an Act was passed entitled "Laws relating to the liability of employers to make compensation to their employees." You are all familiar with the agitation which this proposed legislation caused among medical men. The members of the Medical Council and of the Academy of Medicine of Toronto were especially energetic in their opposition to the passing of the bill. We take this opportunity of thanking the members of these two societies for the opposition they put up, for the campaign of instruction as to the nature of the bill which they carried on, for the pressure they brought to bear upon the Government by argument and by appeal, in order to secure a proper recognition of the rights of the medical man and a proper guarantee of remuneration for services performed.

No one has any fault to find that such an Act should be on the statute books. There was an Act somewhat similar on the statute books before, viz, "The Employers' Compensation Act"; but in it the medical or surgical expenses became an important part of the claimant's account for his injuries; whereas, in the new Act no provision is made for the medical or surgical expenses. The basic principle of the whole Act is that neither the injured, nor his friends, nor the municipality shall bear the expenses due to the injury, and yet, *mirabile dictu*, the first thing the injured is called upon to do is to contract an expense for medical or surgical aid. To the one that has been injured

some things can be dispensed with; some things are luxuries; but the prompt and skilful attention of one or more members of the medical profession is a necessity—a first and absolute necessity. And yet no provision is made for these who, by their presence, may save life or limb. They are, however, left liable, as before, for suits for malpractice. This omission to provide medical help for the injured is the weak spot of the Act, and if the weak spot be not strengthened, the whole Act may prove unworkable.

The members of the Medical Council and of the Academy of Medicine in particular, and the profession in general, pointed out to the Legislature this weakness in the Act, suggested amendments which would strengthen it, directed their attention to similar Acts in various States to the south of us; but to no purpose. The Act went through as originally drafted. Amendments must surely come. Sir William Meredith, who drafted it, has said, "He does not claim that the Act is perfect, or that the last word has been said." That the last word has not been said is the view of many. Let us therefore persist in our endeavor to secure what we deem our due. I bespeak a cordial reception and support for the resolution about to be submitted.

I must not close without making some reference to the "Hospital for Insane," which is in the course of erection at Whitby.

Perhaps some of you will remember a very interesting article on "The Ontario Hospitals for Mental Diseases," read before the Canadian Medical Association in 1912 by Dr. Ryan, Superintendent of Rockwood Hospital, Kingston. I am taking the liberty of repeating some of the information contained in that article.

Prior to 1905, therapeutic measures, laboratory work, research work, and pathological work were almost unknown in the hospitals for the insane of the Province. Few records of patients, if any, were kept. The disturbed patients were restrained by drugs, locked doors and iron bars. The Government, through the Department of the Provincial Secretary, the Hon. W. J. Hanna, took advantage, in 1905, of the retirement of a number of the superintendents to bring about a radical change of method in connection with these hospitals. A commission was sent to Europe to examine the system used in Germany and other countries. Three times Commissions were sent to visit the most advanced state hospitals in the neighboring Republic. Fortified with information thus obtained, a conference of the superintendents, assembled for the purpose, adopted

a new system of classification and of treatment, which was at once put into operation in all the hospitals of the Province. Now, patients are carefully examined both as to their mental and physical condition; laboratories have been established; pathological experts appointed, dieticians engaged, complete records kept, and training schools for nurses established. Therapeutic measures are employed; hydrotherapy, electrotherapy, massage are in constant use. In a word, the inmates who require treatment are treated as patients in any other hospital are treated.

What are the results? Restraint disappeared, straight-jackets burned, drugs used for therapeutics only, bars gone from the windows and locks from the doors, the noise and turmoil changed to the calm quietness of the sick-room, the percentage of recoveries substantially increased, the people losing their dread of these hospitals, physicians sending in patients for treatment, voluntary patients received and treated—the “open door” to these hospitals established.

Dr. Ryan, in closing his address, paid a graceful tribute to the Provincial Secretary, as the man, above all others, who had made this change possible for us in Ontario.

Mr. Hanna must have been gratified at this open recognition and public acknowledgment of the good work done in and through his Department for the patients of the Hospitals of the Insane, and might have rested on his laurels and been content; but just about the time Dr. Ryan's address was delivered, new and still greater opportunities for service presented themselves, and the Provincial Secretary rose to the occasion. The Queen Street Asylum in Toronto had been sold; the old system of housing so many and such varied cases under the one roof had long been condemned. New quarters must be secured. This was Mr. Hanna's opportunity. If good results had been accomplished under the old conditions, still better results might be expected under the new. The Government can now pick out their own site, can erect a hospital in accordance with the very latest view as to best methods of classifying and housing the patients. A block of land of six hundred and forty acres, including several farms, was secured at Whitby. The site selected is an ideal spot on the lake front, just such a place as is chosen for a summer resort, with beautiful Lake Ontario to the south, the sheltered waters of Whitby Bay to the east, the Town of Whitby to the north. If environment means anything in the

treatment of the sick, what site could be more desirable than the one selected?

On this site the Government proposes to erect a Hospital Village. A good deal of the work has already been done: farm lands underdrained, roads made, walks laid, a railway spur from the Grand Trunk Railway put in, sewerage system installed, light and water system installed, seven cottages erected and almost ready to be occupied. A good start has been made. I cannot enlarge fully upon the plan of the Government as to what buildings are to be built, and how arranged, as their plans as yet are merely tentative and subject to many changes; but in general terms I might say that they propose erecting close to the lake front several hospitals for all acute cases, for all newly admitted cases, and for cases sent in by physicians for treatment, in which hospitals all patients requiring treatment will receive the care and attention that the most modern hospitals afford.

At some considerable distance away from the lake front a whole series of cottages are to be erected for patients not requiring medical treatment, but merely supervision of personal hygiene, the most easily managed patients, and those who will work. Off in another direction a number of cottages for private patients are to be built.

In all the buildings used as hospitals not only will liberal provision be made for the treatment of patients, but liberal provision will also be made for medical research work, for pathological research work, for laboratory work, and for general neurological study or investigation. In a word, the Government is resolved to make the "Whitby Hospital for the Insane" the most complete of its kind, so that when finished it will be a credit to the Province, the pride of her people, the best on the continent.

Many visitors, especially visitors interested in psychiatry, have already visited Whitby to see the site, and to learn something of what is proposed to be done. Let me, in his own words, give you the impression of one of these visitors—Dr. H. I. Kloff, Superintendent of the Hospital for the Insane at Allentown, Pa.—who, before leaving for home, being interviewed, said: "I came to Toronto for the purpose of inspecting the plans and site for the Hospital for Insane at Whitby. I regard the site as ideal, in many respects superior to any other similar institution in America. The plans, which have been prepared with great care, and after studying the latest improvements in build-

ing both in Europe and America, embrace all the best facilities for hospital treatment and custodial care of the insane. The arrangement of the different buildings and the site selected will certainly make the new institution a model which will be most creditable to Ontario. The great work being done in Ontario in your reformatory, industrial farms and hospitals is often commented on in the United States, but it requires a personal visit such as I have made to demonstrate what is being done in the Province."

Perhaps I have dwelt at too great length on this subject; but I have no apology to offer, for I have felt that whilst the work that Mr. Hanna and his department have done in prison reform and matters pertaining to the public health, in rescue work and in the establishment of shelters for neglected children is pretty well known, his work in connection with hospitals for the insane is not generally recognized.

En passant I should perhaps mention that much of the work at Whitby is being done by prison labor—a camp of one hundred and twenty to one hundred and fifty men from the Central Prison being always present. The whole question of the prison farm and prison labor is an intensely interesting one, one that has come much under my notice during the last two years; but I shall add nothing further on the subject, as we hope, before the sessions are over, to hear from Mr. Hanna himself on that question.

In conclusion, I thank you for your attentive hearing, and trust that you will find all the sessions of this annual meeting both enjoyable and profitable.

SURGICAL LIMITATIONS IN DIABETES *

By HERBERT A. BRUCE, M.D., F.R.C.S.

Associate Professor of Clinical Surgery, University of Toronto; Surgeon to the Toronto General Hospital.

Until comparatively recently it was the general rule to avoid surgical operations altogether in cases of diabetes, owing to the belief that diabetic patients were especially liable to suppuration in operation wounds, and they were therefore not infrequently allowed to die from acute abdominal emergencies without any attempt being made to relieve the condition by surgical interference. The significance of surgery in connection with diabetes has been so little recognized that Naunyn, in his most recent work on Diabetes,¹ devotes only a few paragraphs to the consideration of that branch of the subject.

Owing to the recent advances in the knowledge of the disturbances of metabolism which characterize diabetes, and the great improvements in surgical technique and asepsis, the prognosis of operation in this condition has very materially improved, and many writers, including Israel,² König,³ Kausch,⁴ Mayo Robson,⁵ Bland Sutton,⁶ Umber,⁷ and Manges,⁸ have reported good results from operation, sometimes even major operations, and in very severe cases of diabetes.

Umber thinks that under the present conditions the reluctance of many surgeons to operate in diabetes is no longer justifiable, and he even goes so far as to express the opinion that the indications for surgical interference are practically identical in diabetic and non-diabetic subjects. Most of the other authorities, however, including Mayo Robson and Kausch, with whose opinion I am in accord, recommend operation in diabetes only for conditions which threaten the safety of life or impairment of function, and state that it should then be performed with the most careful and special precautions, both in the preliminary preparation of the patient and in the endeavor to secure thorough asepsis at the operation. Under such conditions they believe that in a large proportion of cases in which the urine contains sugar, even in considerable quantity, surgical operation may be safely and successfully performed, and that

*Read before the Academy of Medicine, Toronto, April 7, 1914.

in a certain number of cases it may even result in temporary or permanent improvement in the diabetes.

Narcosis in Diabetic Patients.—It cannot be denied that the presence of diabetes increases the danger of a surgical operation to a certain extent, but this danger may largely be minimized by special precautions in regard to anesthesia, and by rendering the urine of the patient free from sugar by a course of antidiabetic treatment previous to operation if the nature of the case allows of sufficient delay for this.

The chief immediate risk in operation is the supervention of diabetic coma on narcosis, and in some cases it is impossible to prevent this. It is generally recognized that true diabetic coma is due to an intoxication of the organism by oxybutyric acid. Kausch therefore recommends that alkali should be administered before anesthetization, and that the diabetic organism should be saturated with it, with the object of neutralizing the acid intoxication. If signs of coma appear energetic sodium treatment should be undertaken, per os, per anum, subcutaneously and intravenously. Even in cases in which the diabetes is in an early stage the coma cannot be ignored, as is shown by three cases reported by Futh.⁹ In all these three cases diabetes was in a very early stage, or was not suspected before the performance of operation, and fatal diabetic coma appeared after an extensive laparotomy.

Most of the writers on the subject are agreed that local anesthesia is preferable to general anesthesia, and that if local anesthesia is not sufficient ether should be employed in preference to chloroform, which has much more frequently been assumed to be responsible for diabetic coma. Kausch states that, judging from his experience at the Breslau Clinic, increase of acetonuria and glycosuria is much more common after chloroform than after ether, and Becker¹⁰ found that severe acetonuria was constant after chloroform narcosis in diabetes. Lépine¹¹ thinks that the remote results of chloroform intoxication are more to be dreaded than its immediate results, and that it is likely to render existing acetonuria much more severe.

Kausch, who has had considerable experience in these cases, recommends that if it is necessary to give a general anesthetic it should invariably be given in the early morning, in order not to prolong unnecessarily the period of physiological hunger, as it is a well known fact that this leads to acetonuria, or tends to increase it if already present. If possible the urine should

be rendered free from sugar before the narcosis is undertaken, and sodium bicarbonate should be administered. The quantity of the anesthetic and the duration of narcosis should be reduced as much as possible. Several consecutive narcoses at short intervals should be avoided, owing to the fact that in diabetes the organs are less capable of resisting narcotics, and should therefore be allowed time to recover from the shock of the previous narcosis.

Umber recommends intravenous injections of sodium bicarbonate in incipient coma, but does not think they are advisable as a prophylactic before operation, owing to the risk of producing thrombosis of the veins of the arm. Körte¹² states that if coma has already appeared sodium bicarbonate is the only means of saving the patient, but is successful in only a very small proportion of cases. He thinks this may be partially due to the fact that the treatment is usually deferred until a late stage of the coma, and that the alkali is given in insufficient doses. He gives doses of 50, 100, or even 150 g. in the course of twenty-four hours.

Schwarz of Prague¹³ has recently reported good results from a combination of the acid derivatives of carbohydrates and sodium bicarbonate. It is given in a dose of about 70 g. in a half litre of water, which has been previously neutralized by the addition of sodium bicarbonate, and in two of the cases in which he has used it incipient coma has disappeared. The rationale of the method consists in the fact that the carbohydrate is used and burnt up by the diabetic organism, and we thus get the same effect as from the administration of carbohydrates in a healthy individual.

Emergency Operations in Diabetes.—Umber is of the opinion that at the present day the dread of surgery in diabetes, which is still felt by many physicians and surgeons, is no longer justifiable, and that while the presence of diabetes is still a serious drawback from a surgical point of view, it should not by any means be regarded as by any means an absolute contraindication to surgery. Operations for conditions which do not represent a danger to life, or the impairment of important functions, such as those for deformities or benign growths, should as a rule not be undertaken, but there should on the other hand be no hesitation in proceeding with urgent or emergency operations, such as those for acute appendicitis, acute intestinal obstruction, strangulated hernia, or injuries. Umber reports two cases in which he operated for acute appendicitis

with good results, the progress of convalescence being practically the same as in non-diabetic cases.

If the condition for which operation is indicated allows of a few days' delay it is advisable to carry out anti-diabetic treatment with the object of inducing aglycosuria, and thus increasing the tendency to healing. If the acute nature of the condition, such as acute intestinal obstruction or appendicitis, does not permit of such a delay, the operation should be carried out immediately, and subsequent dietetic treatment relied upon for the production of aglycosuria as rapidly as possible.

The most difficult cases to deal with are those with acidosis, as slight trauma under such circumstances not infrequently leads to fatal results. In cases with increasing acidosis the oatmeal cure before operation is especially indicated, and Umber recommends that at the same time the patient should be given doses of 0.1 extract of opium, which tends to relieve both glycosuria and acidosis. In cases of severe acidosis, if operation cannot be delayed, he recommends the administration of alkali per os and per rectum, together with the intravenous injection of opium. He believes that while the importance of acidosis cannot be denied, it has to a certain extent been exaggerated, and that, if the diacetic and oxybutyric tests have a negative result, operation should be proceeded with, even if the acetone reactions are very intense. If the proportion of ammonium nitrogen to the total amount of nitrogen excreted in the urine remains within normal limits the danger from severe acidosis or the supervention of diabetic coma after operation is not sufficiently great to prevent the performance of a necessary operation.

Furunculosis and Carbuncle in Diabetes.—In the setting up of these conditions, as well as of diabetic gangrene, the condition of the vessels in the region affected is of the utmost importance, and Umber states that in every case of diabetic gangrene which he has examined by the X-rays there has been a typical sclerosis of the arteries supplying the diseased area. Arteriosclerosis is therefore a serious complication which has to be considered in these cases.

In furunculosis associated with slight diabetes Pilcher¹⁴ recommends that incision should if possible be avoided. Endeavors should be made to produce aglycosuria, moist dressings applied to the lesion, and finally Bier's hyperemic treatment.

Pilcher considers the prognosis exceedingly grave in cases of carbuncle, associated with arteriosclerosis and diabetes, and

in his experience the condition has invariably terminated in death after a short illness. In his opinion the fatal result in these cases is due to a combination of diabetic toxemia and general septicemia.

Diabetic Gangrene.—Umber is of opinion that the primary cause of diabetic gangrene is sclerotic endarteritis, resulting in a deficient vascular supply, and his experience indicates that in some cases the presence of diabetes may be entirely overlooked, owing to the absence of glycosuria. Such cases should not be described as diabetic gangrene, but as arteriosclerotic gangrene in diabetic patients. The onset of gangrene, even in cases of slight diabetes, may be accompanied by disturbance of metabolism and signs of acidosis, these symptoms sometimes retrogressing on removal of the gangrenous focus. König¹⁵ reports two instances of this sequence of events. These cases were not cases of severe diabetes which, by the operation, were transformed into slight diabetes, but cases of slight diabetes which reverted to their original character after removal of the gangrenous focus, which was disturbing internal metabolism.

Until comparatively recently operation for diabetic gangrene was expected to result in diabetic coma and death within a short period, but the perfecting of the technique during the last two or three decades, and above all the careful preparation of the patient for operation, have greatly improved the results, and Ochsner¹⁶ believes that in diabetic amputations the wounds as a rule heal by first intention.

Most of the authorities on the subject, including Bouchardat,¹⁷ Umber, Pilcher and Lépine, recommend that whenever possible operation should be delayed, in order to allow time for the improvement of the general condition of the patient and for the production of aglycosuria by general antidiabetic treatment. This is of special importance in the presence of arteriosclerosis, in view of the possibility that with improvement of the general constitutional condition the case may be placed in a more favorable position as regards the prognosis of operation. But whilst it is no doubt advisable, in the presence of severe diabetes, to postpone operation as long as possible, it should at the same time not be forgotten that in not a few cases constitutional conditions, which have previously been uninfluenced by treatment, quickly respond to it after removal of the gangrenous lesion.

Lépine recommends that during this waiting period air douches, at a temperature of 300 degrees, should be used daily,

and states that under the influence of this treatment in favorable cases the ichorous fluid drains away, the tissue gradually mummifies, and that if the line of demarcation becomes well marked and septicemia is disappearing one may then operate under comparatively favorable conditions.

In subacute gangrenous phlegmon such conservative treatment is not suitable, and operation should be performed without delay, amputation being performed at a very high level. Operation should also not be delayed if there is no improvement in the general and local condition under general anti-diabetic treatment and local antisepsis, and if the extension of gangrene and sepsis and pain indicate the urgency of surgical intervention.

As regards the technique of operation care should be taken to avoid any interference with circulation. With this object no preliminary Esmarch bandages should be used, the flaps should be made from within outwards, and sufficiently thick and long to fall back without tension. Pilcher is of opinion that with scrupulous precautions one may expect about 50 per cent. of successful results in diabetic gangrene of the extremities.

Amputation should of course be done in healthy tissues, and it is advisable that it should be done sufficiently high up, in order to avoid the necessity of a subsequent operation for recurrent gangrene above the wound. Heidenhain¹⁸ reports the results of operation in eleven cases of senile diabetic gangrene in Küster's Clinic. In all these cases Küster, who commenced with a comparatively low amputation, was afterwards obliged to operate higher up for recurrent gangrene, and finally, in some cases in which the gangrene involved the dorsum or sole of the foot, he had to amputate above the knee-joint. Recovery followed in six of the eleven cases.

Umber reports cases in which acidosis disappeared after operation for gangrene. In one of these the diabetes had been present for twenty years. In another case, in which the diabetes was very severe, coma was averted by anti-diabetic treatment, and for two years after an operation for gangrene the patient was able to perform his ordinary duties as a military officer. Death from diabetes did not occur until six years later.

Operation for Trauma in Diabetes.—It has not yet been definitely established that the theory, which was first advanced by Verneuil,¹⁹ that bones do not unite well after fractures in diabetes, is correct, but it seems only natural to assume that the

regenerative capacity of the tissues of the body is lessened to a certain degree.

Kausch has made a special study of fractures in diabetes, and has collected eleven cases of traumatic glycosuria, nine of which were fractures. Of these nine cases three were fractures of the lower leg, one a fracture of the patella, three compound fractures of the toe, and two fractures of the pelvis. In one there was contusion of the lower leg, and in one of the neck of the femur. It has been frequently stated that traumatic diabetes is very often associated with severe polyuria and slight glycosuria, but in all these cases the first urine evacuated after the trauma contained sugar up to one per cent., and in no single one of them was there any further symptom of diabetes.

In 1886 Rédard²⁰ reported seven cases of fracture, which developed what he describes as ephemeral glycosuria after the trauma. Hädke²¹ found alimentary glycosuria in fifteen of twenty-five cases of recent fracture at the Dantzig Clinic.

Kausch does not believe that the inference that this ephemeral glycosuria is of no significance to the surgeon is correct, and thinks that, in spite of the few reports in literature, cases of the kind are by no means rare, and that there is a possibility that in them we are dealing with slight or so-called latent diabetes, which as the result of the trauma or operation becomes for the time being more severe. These results indicate that individuals who, as regards sugar metabolism, we must assume to be perfectly normal, may excrete sugar as a consequence of trauma or operation, and thus favor the assumption that there is a definite connection between trauma and glycosuria. There are as far as we know no positive signs by which we can determine whether true diabetes or merely ephemeral glycosuria is present, and he therefore recommends that in doubtful cases if possible the surgeon should wait for further developments. If the urgency of a particular case renders this conservative course impracticable he should proceed as if diabetes was present, and take all the special precautions, more especially in relation to narcosis, which are considered advisable when performing operations on diabetic subjects.

Operations on the Pancreas in Diabetes.—A definite connection of the pancreatis secretion with carbohydrate metabolism was first established by Mering and Minkowski²² in 1889, and Mayo Robson believes that from 70 to 80 per cent. of cases of diabetes are of pancreatic origin.

Whilst Mayo Robson is of opinion that a very considerable proportion of cases of glycosuria are due to disease of the pancreas, cancer of the pancreas is very rarely associated with diabetes, and in more than a hundred cases of pancreatic cancer he has observed it in only three per cent. He reports cases in which glycosuria disappeared after operations, including the removal of cancer of the head of the pancreas, secondary carcinoma of the biliary ducts, biliary calculi associated with enlargement of the pancreas, duodenal ulcer associated with cholangitis and interstitial pancreatitis, and catarrhal pancreatitis associated with gall-stones.

Körte reports a case in which the urine contained sugar to the amount of 6.9 per cent. After the removal of a large necrotic sequestrum from the pancreas it remained free from sugar for nearly two years, when there was a recurrence, which again subsided under anti-diabetic treatment. The patient ultimately died of diabetic coma six years later.

Mayo Robson points out that many cases of pancreatic origin may be benefited or even cured by operation, and he believes that in some instances surgical treatment at an early stage may prevent the onset of diabetes. He therefore emphasizes the importance of considering individual cases of diabetes from the point of view of their etiology.

On the other hand Ochsner does not consider that it has been by any means proved that a large proportion of cases of diabetes are due to disease of the pancreas. He has had the opportunity of operating on a large number of cases of pancreatitis, but only very few of the patients had also suffered from diabetes. Whilst he acknowledges that it is undoubtedly true that there is danger from pressure on the islands of Langerhans in pancreatitis, he does not think that the autopsies which have been made in cases of this nature are yet sufficient to prove that this pressure causes diabetes.

Operations for Tumor in Diabetes.—Neoplasma are very rare in diabetes, but they do occur in exceptional cases. In 1888 Tuffier²³ collected 54 cases from the literature, 36 being malignant tumors, 13 benign growths, and 5 indefinite. Boas²⁴ found diabetes in only 12 of 366 cases of intestinal carcinoma, and Naunyn, in 777 cases of diabetes, found 1 case of carcinoma of the cheek, 2 of carcinoma of the stomach, and in addition 7 cases in which carcinoma of the stomach or liver was diagnosed, but in which the diagnosis was not confirmed by section.

Landau²⁵ and Hoffa²⁶ report two cases of operation for removal of pelvic carcinoma. The patients, who had previously suffered from diabetes, had been free from symptoms for some years, but glycosuria developed immediately after the operation, resulting in death from diabetic coma.

More recent observations, however, appear to indicate that the removal of tumors, more especially of those involving the genito-urinary tract, sometimes lead to the disappearance of glycosuria, even in cases of severe diabetes. Henkel²⁷ concludes, as the result of his own experience, that it is practically certain that the formation of tumors in the female genital organs may induce glycosuria, which is cured on the removal of the cause.

Bland Sutton thinks that as a rule it is advisable to abstain from hysterectomy in diabetic subjects, as he has gathered from the statistics that such operations are attended by a high mortality, but that in exceptional instances the operation is indicated. He reports two cases, in women of 43 and 69 years of age respectively, in which the urine contained sugar in considerable amount. Subtotal hysterectomy was performed, in one case for a large fibroid, and in the other for fibroid and suspected cancer of the uterus. At the time when the cases were reported both patients were alive and well, one three years and the other eight years after the operation. Joslin²⁸ reports a case of severe diabetes and fibro-myoma of the uterus, in which the sugar disappeared from the urine on removal of the growth. Miller²⁹ reports a similar case of severe diabetes and cancer of the uterus. When the case was reported, several months after removal of the cancer, the urine still remained absolutely free from sugar.

Manges³⁰ has recently reported two cases of severe diabetes and prostatic disease. In one of these cases, in which there was a family history of diabetes, removal of the prostate resulted in great improvement in the diabetes and disappearance of acidosis, the diabetes recurring with a fatal result one and a half years later. In the other case, in which the diabetes was of long standing, there was complete recovery and rapid disappearance of sugar, which did not return in spite of a liberal diet. The patient subsequently died from pus kidney.

In all of these four cases the disappearance of sugar was sudden and complete after the removal of the tumors, although in one of them there was a bad family history of diabetes.

The cases of this nature which have been reported up to the present are too few in number to allow of any conclusion as to the cause of the disappearance of sugar after operation. Manges suggests, as the most probable explanation, that removal of the tumor may remove some nervous or toxic irritating agent, which in some way which is at present unknown to us interferes with carbohydrate metabolism.

In conclusion I should like to refer to a few cases which have come under my own observation, in which I have considered it desirable to give the patients the benefit of surgical treatment in spite of the complicating diabetes.

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Prostatectomy.— J. L. Thomas (*The Lancet*) describes his new combined method of prostatectomy. Under spinal anesthesia, an incision is made into the bladder after it is emptied of fetid urine. Then Thomas pours about one ounce of pure tincture of iodine into the bladder, and injects tincture of iodine through the meatus along the urethra into the prostatic bed. After this he drains perineally. During the whole of the performance the patient lies on his back. The perineal opening is made on the point of the forceps passed transvesically from above, the legs being simply spread apart. Enucleation is then done by the forefinger in the bladder, but frequently Thomas passes the other forefinger into the perineal opening to assist the enucleation from below. He claims it is of great importance to pour the tincture of iodine into the bladder, as this flows into every hole and corner of every fresh raw surface. A cleaner urethra is also obtained by the injection of the iodine, as well as flooding the freshly-made prostatic bed.

INSOLATION—ITS PROPHYLAXIS AND TREATMENT

BY PAUL G. WOOLLEY, M.D., CINCINNATI.

The treatment of insolation (*N. Y. M. J.*), has been based upon the fact that in this condition too much heat has been produced in the body, and too little heat given off—the disease being due entirely to heat retention. Thus the whole treatment has been to reduce the temperature of the body by the application of cold, and by encouraging superficial evaporation. Little account has been taken of the abnormal substances being continuously produced because of the increased temperature, and that these are not being eliminated with sufficient rapidity.

The cases of heat exhaustion and sunstroke call for little classification other than mild, severe and hyperacute, as the causes are all obviously the same.

Victims falling where there are no therapeutic remedies at hand must be conveyed to some place where ice can be obtained and baths given.

The two main objects in view in treating any form of insolation are to reduce the heat content of the body and bring about elimination of its toxic contents. When these are done time will attend to the hemorrhages, the destruction of tissue, the fatty degeneration and the rest. But there may remain residual symptoms, such as tendency to relapses, headaches, partial loss of memory, loss of sustained attention, polyuria, even to glycosuria.

Treatment of insolation, therefore, should combine refrigeration with elimination, active enough to produce good results without embarrassing organs, such as the heart, which are already damaged. To accomplish the former the practice is to give ice-cold packs or baths. To compass the latter, recourse is commonly had to stimulants. This latter seems not the best, except as a last resort. Ice-packs or baths should not be continued for more than a few minutes at a time and should be discontinued when the rectal temperature has reached 104°F.

To replace the water lost to the body before the attack, and to increase the elimination, there is no better method than the infusion of saline solutions. Such solutions should be alkaline if it is true that the oxygen content of the body is low and the acid

content high. For rectal use the solution should be prepared as follows: Sodium chloride, thirty grams; sodium carbonate (crystallized) twenty grams; water, one thousand c.c. For intravenous use the alkaline solution should be very carefully prepared. The carbonate cannot be boiled. The salt solution should therefore be made and sterilized, after which the crystals of carbonate may be added. If the crystallized sodium carbonate cannot be obtained and use must be made of the ordinary dried form the amount indicated above must be divided by three.

PLACENTA PREVIA

BY SIR J. HALLIDAY CROOM, M.D., F.R.C.P., Edin.,
Professor of Midwifery, University of Edinburgh.

In a clinical lecture (*Medical Press and Circular*), delivered at the Royal Maternity Hospital, Edinburgh, Professor Croom discussed the practical management of placenta previa. It is a complication involving a maternal mortality of eight per cent., and a fetal mortality of over seventy per cent. Each case must be treated on its merits.

Special attention is drawn to the lower uterine segment which develops only during pregnancy, being completely formed in the process of labor. It is difficult to determine whether it is uterine or cervical, or both. Whatever its origin, it is a phenomenon of labor, and therefore a knowledge of it is requisite to the successful treatment of placenta previa. Its upper limit is Bandl's ring; posteriorly it is in relation to the rectum; anteriorly to the bladder and urethra; latterly to the broad ligaments, with the ovaries and tubes. On its anterior surface the broad ligament is reflected, loosely attached. It is looser posteriorly, the muscular tissue, imperfectly and loosely arranged, mostly longitudinal, running from the cervix up in a slightly curved manner. It is the entire absence of circular fibres which prevents the closure of vessels. The muscular layer thin, it gradually gets thinner with retraction and contraction of the upper part of the uterus, still further thinning out as the head descends. When the placenta is situated in this region it interferes very materially with pregnancy and labor;

also with the accommodation of the child; also with contraction of the uterus, causing inertia and bleeding.

As the os dilates, the placental area gets too large for the placenta, the vessels are ruptured, and exposure of the sinuses takes place. Thus bleeding goes on, as there are no circular muscular fibres to contract the vessels.

The two outstanding risks are hemorrhage and sepsis. If they could be eliminated placenta previa would be a simple complication.

As to the method of dealing with a placenta previa, there is nothing in its nature absolutely fatal, but these two essentials must be kept in mind.

Three principles are laid down: 1. The saving of blood, no matter how little, at every possible juncture; 2. Careful anti-septic manipulations; 3. The careful selection of a method of delivery suitable to each individual case.

With few exceptions, once a placenta previa is diagnosed, the sooner the uterus is emptied the better. Temporizing is only advisable where the hemorrhage is very slight; or in a hospital perhaps. There is a great advantage in treating these cases in a well-appointed hospital.

Where the placenta is marginal and can be treated by rupture of the membranes and subsequent delivery by forceps is not the class of cases dealt with, but rather those cases where there has been very profuse hemorrhage, where the cervix is either closed or admits, perhaps, two fingers, and where the placenta is flush with or overlaps the os internum. The best thing to do here is to pack the vagina. For this, four distinct advances can be claimed: 1. It stops hemorrhage; 2. It gains time—to; 3. Stimulate and nourish patient; 4. If need be, to send her to hospital.

Everything depends on the way the packing is managed. This is best and most satisfactorily done under an anesthetic—packing with wet sterilized cotton wool, with speculum and dressing forceps, until the canal has been completely filled. The other essentials are an abdominal binder and a firm, tight perineal bandage. No packing is possible without an opiate. The pain is unendurable without it, and furthers the dilatation.

When this has been done the blood has been conserved. Croom finds in many instances with the plug in situ, and the woman comparatively out of danger, external version can be done with advantage and comparative ease.

Now when this version has been performed and the patient's general condition improved, the packing is withdrawn and the

condition of the cervix ascertained with the gloved hand. As cervical tears are responsible for a great many deaths, and as it is better to avoid artificial dilatation and accouchement forcé, with the gloved hand a foot can be pulled down slowly. As the leg descends it has three effects: 1. It stops hemorrhage; 2. Dilates the cervix; 3. Stimulates the uterus. When the breech has entered the cervix it is well to let it stop there; only maintaining such traction as will prevent hemorrhage. How long has the breech to remain there? Until it is delivered spontaneously, which, of course, involves usually the death of the child. If, for any reason the child requires to be delivered quickly, then it should be accomplished partly by traction and partly by suprapubic pressure.

Now if, when the packing is removed, the cervix is not dilated, then a reapplication of the pack should be made. When this has been removed for the second time there may be sufficient dilatation of cervix to allow of the manipulations above described. If artificial dilation be required, the safest method is Harris' method, by means of the fingers. If a living child is specially desired recourse can be had to the Champetier de Ribes bag. It has these disadvantages: It is not always at hand, except in the hospital; from want of constant use in private practice, it gets hard and brittle, and is then easily ruptured; it has an obvious means of infection. The method of delivery in the half-breech is both safer and easier than the bag.

A very large number of cases of low attachment of the placenta can be dealt with simply by rupture of the membranes, and either spontaneous delivery or delivery by means of forceps.

Even after the child has been successfully delivered, the placenta requires to be artificially delivered. This involves a very considerable post-partum hemorrhage, and it is probably the case that more women succumb to post-partum hemorrhage than the hemorrhage associated with placenta previa.

THERAPEUTIC NOTES

Endocarditis in Children.—Floyd M. Crandall says the management of the acute stage has been a comparatively simple matter—rest in bed for six weeks to two months. This quietness should be continued if the heart becomes irregular or too rapid. Difficult problems may arise, after the child is out of bed, with a murmur. It is a mistake to maintain restrictive treatment too long. As to exercise to be permitted, the action of the heart is the best guide under exercise. Arbitrary rules do more harm than good. Each case should be studied and the patient, rather than the disease, treated.

High Blood Pressure.—F. de H. Hall (*Clinical Journal*, London), places less value on drugs in arteriosclerosis the longer he watches these cases. Drugs with an aperient action are serviceable. First place is given to calomel and blue pill. In addition to their aperient action they have a remarkable effect in lowering blood pressure. Aperient mineral waters, or a teaspoonful of Epsom or Glauber's salts, may be taken in half a tumblerful of warm water before breakfast. Iodides come next to the aperients. Hall usually employs potassium iodide, but some tolerate the sodium iodide best. The Wassermann test should be made in syphilitic patients, and if positive, mercury should be given, preferably by inunction. He does not advise salvarsan in these cases. After a mercurial course, potassium iodide. Small doses of thyroid extract may be given to the obese or at the menopause, with a combination of bromide and iodide of potassium. This will be found useful in diminishing weight. It relieves the patient of flushes and feeling of fullness in the head. Chocolate tablets of potassium or sodium nitrite, one to two grain doses, may be tried, up to five grain doses, if the iodides are badly borne. Hall has got beneficial results from hippurates of ammonia and lithia in a few cases, usually using the latter, three or four grains daily. For emergencies he reserves the more powerful amyl nitrite, nitroglycerine and erythrol teranitate, as they act more quickly as vasodilators—such emergencies, anginal or dyspneal attacks. For very acute attacks the inhalation of three minims of amyl nitrite on a pocket handkerchief gives immediate relief. The action of this may be continued by 1-100 grain of nitroglycerine. This dose

may be increased up to 1-10 grain. In patients who get anginal symptoms on starting to walk he has found 1-4 grain doses of erethrol tetranitrate most useful. This should be given a quarter of an hour previously. As a remedy, blood-letting has been found of the greatest service. Where the patient is unconscious and cerebral hemorrhage is feared, venesection is indicated; also in convulsive cases with high tension. From ten to twenty ounces of blood, according to the severity of the attack and the sex of the patient, withdrawn, brings about good results.

Placenta Previa.—A. Brindeau (*Revue Mens. de Gyn d'obs. et de Péd.*) relies on the rupture of the membranes, the inflatable bag, bipolar version, manual or instrumental dilatation, etc. He claims surgical treatment is only exceptionally required. Rupture of the membranes suffices to arrest the hemorrhages in about one-half the cases, but if labor does not follow, this may lead to complications. It is not always easy to introduce the metreuryuter in placenta previa, and it might push up the placenta and separate it completely. With instrumental or bimanual dilatation there is still a mortality of seven or eight per cent.

When hemorrhage continues the uterine artery can be clamped through the posterior roof of the vagina; or the aorta can be compressed by the hand or rubber-tube around the waist. A chair may be slipped under the mattress, thus raising the patient's pelvis. Hemorrhage, in this way, stops of itself, when the venous pressure is less than the intra-uterine pressure.

Intestinal Stasis.—Norman Porritt (*B.M.J.*) has found pituitrine of value in promoting movements of the intestine in three cases of obstinate intestinal stasis, after abdominal operations.

Chronic Joint Disease.—S. Gara (*Med. Klinik*) refers to the chronic joint affections developing from a basis of metabolic disturbance, for instance, gout, gastro-intestinal derangement, etc. Close study of these cases reveals more or less enlargement of the thyroid, suggesting abnormal functioning of the gland. Practising at a spa he has seen a considerable number of these cases, and urges physicians to be on the lookout for them and to give them systematic thyroid treatment.

Reviews

The Myth of the Birth of the Hero. By OTTO RANK, of Vienna.
New York: Nervous and Mental Disease Publishing Co.

This book is a psychological interpretation of Mythology. There are chapters on Moses, Oedipus, Paris, Perseus, Romulus, Hercules, Jesus, Siegfried, Lohengrin, besides others not so well known to the majority of mortals. There is an introduction explaining the scope of the book.

X-Rays. An Introduction to the Study of Röntgen Rays. By G. W. C. KAYE, B.A., D.Sc., Head of the Radium Department at the National Physical Laboratory, etc. Price 5 shillings net. London: Longmans, Green & Co.

To one who wishes to begin the study of present-day methods and apparatus, this book will be found admirably suitable. It does not profess to be a hand-book but rather an introductory treatise upon the subject. It will give a fair and accurate insight to the man of general scientific bent.

Dial - Ciba. — W. Zuelachaur (*Deut. Med. Wochen.*) has used this new hypnotic in a wide variety of conditions in mental cases, and finds it has several advantages over older hypnotics. It can be given in smaller doses—from one-tenth to two-tenths grain usually being sufficient to produce many hours of normal sleep. More than this dose was only required in one or two cases of insomnia, and only once was four-tenths used. It can be used in still smaller doses to quiet patients during the day. The disadvantage is that it quickly establishes a tolerance so that the dose has to be raised. Chemically the substance is diallyl barbituric acid. There have not been observed any harmful or undesirable side actions.

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COMMENT FROM MONTH TO MONTH

To Sir Thomas G. Roddick are extended our warmest congratulations. The announcement of His Majesty's birthday honours came with gratifying pride to the medical profession in Canada. Being looked and hoped for it was therefore, no surprise. No other medical man in Canada had worked so long, faithfully, and at last successfully, as did Dr. Roddick, for the completion of Dominion Registration. Successively Sir Thomas has occupied distinguished positions at the hands of his medical confreres all over the Dominion. There is no medical man more beloved throughout Canada than the new Knight. May he long be spared to that profession in which he has been a shining light and now an illustrious Knight!

The Next Step in Life Conservation is to be the reporting of all diseases, or, at best, the major part of them. Life-saving campaigns have been inaugurated in every civilized country during the last two decades, with the result, that there has been a very noticeable diminution in the deaths from certain diseases, such as tuberculosis, typhoid fever, smallpox, and the infectious dis-

eases of childhood. But whilst the death rate has been cut down, the amount of sickness, on the other hand, has not been controlled to the appreciable degree expected. Some even claim sickness has increased.

In a well-reasoned article upon this subject, Mr. Louis I. Dublin, Ph.D., Statistician, Metropolitan Life Insurance Company, New York, claims that "the basis of any campaign against sickness must be an accurate knowledge of its prevalence." Delivered, as this address was, before the Association of Life Insurance Presidents, and bearing in mind the vital interest insurance and fraternal companies and societies have in the conservation of human health and human life, the education of the people by the medical profession, and particularly officers of health, is seemingly bearing abundance of fruit.

Heretofore it has been considered only necessary to know only the number who have died from any particular cause, but, hereafter, emphasis must be placed upon the number of cases of sickness themselves. This will necessitate on the part of the State the recording of all preventable diseases in order that a proper foundation is laid for an efficient sanitary administration.

Gradually departments of health have added reportable diseases to their lists; and it is within the near future that, in addition to communicable diseases, others, such as the occupational diseases and injuries, the venereal diseases, and certain diseases of unknown origin, such as cancer, will be added. The proper control of morbidity will the more effectually curtail the mortality.

Acne.—Sibley (*Clinical Journal*) says sulphur, internally, is often a good remedy. A teaspoonful of the following powder may be taken in milk the first thing in the morning: Flowers of sulphur, neutral tartrate of potash, sulphate of magnesia.

Where it is necessary to bring about a local reaction plaster mulls may be applied. These should contain salicylic acid or resorcine, the former often combined with creosote. The strength of these plasters varies from five to forty per cent. Vaccine treatment is often useful as an adjunct to local treatment; but severe cases often do better under vaccine treatment than mild ones. It must be continued for six months at least, and long after all spots have ceased to disappear. In the majority of cases repeated small doses of x-rays will bring about a satisfactory cure.

Editorial Notes

DOMINION MEDICAL COUNCIL

OTTAWA, June 19.—Officers were elected by the Medical Council of Canada, which has just concluded its annual session here, as follows:—

Honorary President, Dr. T. G. Roddick, Montreal; President, Dr. R. S. Thornton, Deloraine, Man.; Vice-President, Dr. R. J. Gibson, Sault Ste. Marie, Ont.; Registrar, Dr. R. W. Powell, Ottawa; General Counsel, F. H. Chrysler, Ottawa.

The examinations of the Council for admission to the register were ordered to take place at Montreal in October, 1914, and the spring examination in Winnipeg in June, 1915.

At the close of the session Dr. T. G. Roddick, the retiring president, who was elected honorary president for life, with a seat on the executive, entertained the Council at luncheon. The next session will be held in Ottawa, June, 1915.

All the provinces were represented at the sessions, as well as all the universities, the Government appointees being Dr. T. G. Roddick and Dr. Braithwaite, of Edmonton. Dr. Bapty, of Victoria, was unable to be present. The diploma of L.M.C.C. was granted to Hon. Dr. Roche, Minister of the Interior.

VACANCIES ON MCGILL TEACHING STAFF FILLED

Several changes in the teaching staff of McGill University were announced yesterday afternoon at the meeting of the Governors in the Royal Victoria College. Three resignations were accepted, those of Dr. Walton, Dr. Howard T. Barnes and Dr. R. B. Miller.

Keen regret at the loss of Dr. A. E. Barlow and H. H. Lyman, who perished on the Empress of Ireland, was expressed by the Board. Dr. Barlow was a member of the teaching staff and Mr. Lyman a graduate of McGill.

Dean Walton has accepted a position with the Egyptian Government at Cairo; Dr. Barnes will take up the duties of Professor of Physics in the new University of British Columbia, and Dr. Miller will go to the Western University in London, Ont.

The appointments in the different faculties were as follows: G. R. Mines, M.A., to the Joseph Morley Drake Chair of Physiology.

Dr. Douglas McIntosh to be Professor of Physical Chemistry.

Dr. J. W. Tait, Assistant Professor of Psychology.

Dr. A. B. Gordon, given titular title of Professor in the Department of Oriental Languages.

Dr. F. M. G. Johnston, Associate Professor of Chemistry.

Dr. R. V. Kriebel, Assistant Professor.

A. R. Maclean, J. B. Robertson and L. A. Brown were re-appointed demonstrators in chemistry, and T. West, of Victoria University, Manchester, and H. S. Reid and M. J. Marshall, graduates of McGill were appointed demonstrators in the same subject.

Appointments were made in the Faculty of Medicine as follows:

Dr. L. J. Rhea, Associate Professor of Pathology; Dr. C. K. Russell, Lecturer in Neurology; Dr. A. Freedman, Assistant in Anatomy; Dr. Maude E. Abbott, Lecturer in Pathology; Dr. H. B. Cushing and Dr. C. A. Peters, Lecturers in Medicine and Clinical Medicine; Dr. E. M. von Eberts, Lecturer in Surgery and Clinical Surgery; Dr. H. C. Burgess, Lecturer in Gynecology.

Dr. J. J. Ower was appointed to the fellowship in Pathology maintained by Dr. James Douglas, of New York, one of the Governors of the University, and Dr. R. H. Malone to the studentship in the same subject maintained by the same benefactor.

In the Department of Dentistry Dr. A. Clifford Jack was appointed Lecturer in Dental Anatomy; Dr. L. H. Thornton, Superintendent of Dental Clinic, and W. L. Bond, K.C., Lecturer in Dental Jurisprudence.

DR. H. S. BIRKETT, MCGILL DEAN OF MEDICINE

The honor of Dean of the Faculty of Medicine has been bestowed on Dr. H. S. Birkett by the Board of Governors of McGill University. Dr. Birkett will assume his duties at the end of June, when Dr. F. J. Shepherd vacates the office.

The new Dean of the Medical Faculty is considered the foremost authority in Canada on throat and nose diseases, and in his specially chosen field has a reputation in Europe and in the States for sound and brilliant work.

Although an effort had been made to fill the place, the Governors had to report no success in selecting a Deanship for the Faculty of Law. The choice will not be made until the return of Principal Peterson, who is about to take his annual trip to Europe.

The hope of the Governors that they would have a definite announcement regarding their plans for a combined armory and gymnasium was not realized. The expected word had not yet arrived from the Department of Militia. With the \$100,000 donated by J. K. L. Ross, the Board is in a position to go ahead with a thoroughly modern gymnasium in any event, however.

INTERNATIONAL REPUTATION.

Dr. Herbert Stanley Birkett is one of the most eminent physicians in Canada, with an international reputation as a specialist in diseases and troubles of the throat and nose. The son of the late William Birkett, merchant, of Hamilton, Ont., he was born there on July 17th, 1864. He received his education at Forest House School, Chester, England, and at McGill University, where he graduated in medicine in 1886, carrying off the Holmes Gold Medal in that year. In 1886 and 1887 he was senior house surgeon at the Montreal General Hospital, and from 1886 to 1889 he was assistant physician at the Montreal Dispensary. Devoting himself more and more to his special subject, he was appointed laryngologist to the Montreal Dispensary in 1889, and acted in that capacity until 1891. From 1891 to 1899 he was laryngologist to the Montreal General Hospital.

In the years 1889 and 1890, Dr. Birkett was Junior Demonstrator of Anatomy at McGill University. He was promoted to be Demonstrator of Anatomy in 1890, and held that post until 1896. In 1895 he was appointed Professor of Laryngology and Ontology at McGill, and in 1898 he was appointed specialist in the same subjects at the Royal Victoria Hospital. These posts Dr. Birkett has held ever since.

MANY HONORS CONFERRED.

Dr. Birkett is connected with all the chief medical bodies in the Dominion, the United States and Great Britain. For some years he was general secretary of the Dominion Medical Association, and also of the Montreal Medical-Chirurgical Society. In 1898 he was elected Vice-President of the American Laryngologi-

cal Association. In 1902 he became Vice-President of the Montreal Medical-Chirurgical Society. In 1897 he was Secretary of the Laryngological Section of the British Medical Association. From 1890 to 1896 he took an active part in the affairs of the American Association of Anatomists. Later honors included the Presidency of the Montreal Medical-Chirurgical Society; the Vice-Presidency of the Section of Laryngology and Ontology of the British Medical Association, in 1906; and the Presidency of the American Laryngological Association in 1907-08.

HIS MILITARY ACTIVITIES.

Dr. Birkett was connected with the Canadian volunteer militia for many years, and for ten years has held the rank of a Lieutenant-Colonel. He organized the first bearer corps in Montreal. In 1893 he was attached to the Army Medical Staff at Aldershot, England, and took a first-class certificate at the training school there. He was appointed P.M.O., M.D., No. 5, in 1906 and retired, retaining rank, in 1910. In 1909 he was elected President of the Association of Medical Officers of the Canadian Militia.

Fracture of Upper End of Humerus.—Harold B. Thompson (*Northwest Medicine*) describes a figure four splint which he has used with great success in several cases of fracture of the humerus near the shoulder. The splint is illustrated and described by Scudder, and is accredited to the clinic of V. Hacker. Dr. Thompson claims he had not known of this until he had made and used the splint several times. It fits the inside of the upper arm, side of chest and upper surface of forearm laid horizontally across the body. It is held in position by adhesive strips half way round the body at the level of the nipple and umbilicus, and also around the arm and forearm. The whole is then immobilized by a bandage through the figure-four splint and around the arm and forearm, and then around the entire body.

News Items

Dr. Walter Wilkins, Montreal, is in Germany.

Dr. John Hunter, Toronto, has gone to England.

Dr. George McDonagh, Toronto, has sailed for Europe.

Dr. Tannenbaum, Montreal, is summering in the Catskills.

Dr. J. T. Finnie, Montreal, is spending some months abroad.

Dr. Walter Walker Wright, Toronto, has gone to England for some time.

Dr. C. J. Patton, Montreal, is spending two months in Pennsylvania.

Dr. Kennedy C. McIlwraith, Toronto, has returned and resumed practice after several months abroad.

Dr. Edward Seaborn, London, Ontario, has been made a Fellow of the American College of Surgeons.

The announcement is made of the death of Dr. M. J. Glass, of Poplar Hill, Ontario, at the age of 65 years.

Dr. L. deL. Harwood, Montreal, has returned from Paris feeling much improved after a serious operation.

Dr. W. A. Thomson, Regina, has been east attending the meetings of the Dominion Medical Council, American Medical Association, and the Canadian Medical Association.

The Moose Jaw Medical Society has elected the following officers: President, Dr. Geo. P. Bawden; Vice-President, Dr. C. H. Freeman; Secretary-Treasurer, Dr. C. G. Sutherland.

Dr. Rowland Webb, Grand Rapids, Mich., paid a flying visit to Toronto on his way home from Philadelphia, where he received a fellowship in the American College of Surgeons.

Dr. Chester Brown, Toronto, recently attached to the Ontario Board of Health, has been appointed assistant medical officer and bacteriologist at the William Head Quarantine Station, British Columbia.

Dr. H. W. Hill of the Hygienic Institute at London, Ontario, has been granted a year's leave of absence and will do special work for the Minnesota Board of Health. It is stated Dr. Hill will not return to London.

Dr. Lowery, port physician of Montreal, under the Department of Agriculture, states that so far no instructions have been issued to guard against the introduction of bubonic plague reported to have appeared in several American southern ports.

The Saskatchewan Medical Association is holding its annual meeting this year in Saskatoon, on the 18th, 19th and 20th of August. Dr. George R. Peterson, Saskatoon, is the President, and Dr. J. T. McKay has been appointed Secretary in place of Dr. A. Wilson, recently resigned.

The Ontario Board of Health reports 1,503 cases of infectious diseases in the province for the month of June, with 89 deaths, as against 1,566 cases and 154 deaths for the corresponding month in 1913. Only 95 cases of tuberculosis were reported in June, as against 143 in June, 1913. The claim is made that physicians are not regularly and promptly reporting these cases.

The late H. H. Lyman, Montreal, drowned in the Empress of Ireland disaster, left \$20,000 to McGill University and his entire entomological collection and library. To the Children's Memorial Hospital, he also left \$25,000; to the Montreal General Hospital, \$3,000; Royal Victoria, \$3,000; Protestant Hospital for the Insane, \$3,000; Anti-Tuberculosis League, \$1,000.

Orchitis. — The anti-meningococcic serum of Dopter, prepared at the Pasteur Institute, Paris, is said to be very effectual in epididymitis and orchitis. It is injected into the gluteal muscle in the centre of a line from the superior iliac spine and the summit of the fold of the nates. The dose is 20 c.c., or five drachms, repeated, if necessary, in five or six days. Rarely a third injection is required. The effects of the injection are felt in a few hours, pains disappear, sleep supervenes and the following day the part is less sensitive to pressure. The swelling is absorbed gradually and progressively.