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No. 3

Original Communications.

THE INEBRIATE POPULATION.*

BY DR. E. RYAN, KINGSTON.

What shall be done with the inebriate class of our population? is a question that is daily becoming one of anxiety and importance, to the physician, the economist, and the humanitarian.

The loss to society and the State of the productive activity of this large and ever-increasing class is enormously great. It might not be a difficult matter to arrive at a correct estimate, on this point, but this is not necessary for our present purpose. The question cannot be measured from an economic standpoint solely, nor should it be approached in a purely materialistic manner. It is so inseparably associated with all that makes life valuable, with human ideals and advancement, with the ethical well-being of humanity, that it cannot possibly be regarded in the light of economic science. The mental, moral, and physical development of mankind is entwined in these considerations. I might go further and say, that the continuation of the race itself, in its higher and more valuable attributes, is closely connected with this vital question. For, it must be admitted, that inebriety, in its many forms, is confined to no age, no nation, no race. Down through all the pages of history its course may be traced; at periods, like other endemic diseases, its virulence would seem to abate, only to break out all the more fiercely at another place, or another time.

Alcoholic inebriety stands possibly in the first rank, in the number of its victims. The more general use of alcohol has led,

* Read at meeting of Ontario Medical Association.

as might naturally be supposed, to a wide range of experimental research. Nieloux and Barbier, after patient and brilliant work, rich in pathological results, declare that alcohol, when administered to a woman in labor, will appear in a short time in the blood of the umbilical cord and in the placental circulation. From his study, Nieloux holds, that in the case of inebriates, sufficient alcohol would appear in the foetal circulation to set up a chronic intoxication, or congenital alcoholism. Children conceived in drunkenness and suckled by inebriates, fully develop the alcoholic cell, alcoholic tissues, and an alcoholic tendency. From such strong proofs he suggests the absolute necessity for legislation to prevent this form of racial degeneration.

In the *Prague Medical Journal*, Holitscher elaborates his studies on the action of alcohol. He declares it to be a protoplasmic poison that it reduces the vital activity of the cell, with special selection for the more highly organized tissues, the brain, nerve tissues, and blood vessels. Hardening of these highly-organized tissues follows, with physical and mental degeneration.

Drew states that of those committed to the State Asylum of Massachusetts, 93 per cent. were drinkers, or were the victims of alcoholic heredity.

These are the views of all who have given the subject any pathological or clinical study. The alcoholic cell lays the foundation, on the protoplasmic poison the cell is nourished, the tissues formed by these cells must naturally be aberrant in their functions, whether these be mental or physical in their character.

It would appear, as our modern life became more complex and varied, the nerve strain greater, other drugs and poisons began to play a more important part in the causation of inebriety. The nerve strain due to the struggle for existence, the mad race to meet the demands of modern sensuous and luxurious methods of living, lead to physical and mental instability. The soothing influence of drugs is earnestly canvassed, to stave off the inevitable collapse; physicians frequently recommend this temporary and artificial respite, and often indeed become themselves the victims of this fatal malady. Chloral, morphine, cocaine, chloroform, all have their votaries, and their victims—unfortunately a daily-increasing number. In their debasing mental effect, in their action on the ethical and moral life, the course of these drugs is steadily progressive. It is with the utmost difficulty, on many occasions, the disease is discovered, even the trusted family physician is frequently deceived. The most subtle and cunning methods are resorted to, that detection may be avoided, and when

at last the disease manifests itself, as it inevitably must, nothing is left but a mental and physical wreck. Little personal effort is made by these inebriates to secure escape. Through some unknown method, these poisons select the higher centres of life, the moral characteristic is the first to disappear, the mental follows; the physical life, the least valuable, offers the greatest resistance. The clinical characteristics vary greatly with the individual, his hereditary tendency, his social acquirements, and from many other causes. As a rule, however, the different phases of inebriety run along definite and well-defined lines. The incipient stages of the disease are, therefore, easily discernible, and are early manifest to the family and to the family physician. Of course, sooner or later the whole class of inebriates require medical assistance and supervision. The acute cases, and the periodic drug storms, are frequently, and often very successfully, managed by home treatment. The General Hospitals likewise offer accommodation and methods for the therapeutic management of this particular class.

There is, however, another picture quite familiar to every physician. There is the class in which the disease manifests itself early in life, and goes on progressively from day to day, and from year to year; there may be periods of intermission, there may be none. There is the successful business man, who, after a life of toil, with marked success, becomes a confirmed inebriate. He may, and possibly has been, a moderate alcoholic for years. There is the successful physician, the dentist, the man eminent in law, the woman of social distinction, upon whom inebriety, of some form, has fastened, and who are daily drifting farther away from escape and recovery.

Every medical man knows the line of treatment that should be followed, but, under existing circumstances, he is powerless to act. Home treatment in these cases has proved a failure, though followed with care, patience, and skill. The periodic trips to the General Hospitals have lost their value, indeed they have become a nuisance to all concerned. And this leads us to the "desirability of establishing an institute to which inebriates may be committed by legal process."

In a careful and rather extensive review of the literature on this subject there appears to be but one view, and that is, that success in the treatment of inebriates cannot be obtained without restraint. Kraepelin gives his views in the following words: "We must, therefore, try to induce all our alcoholic patients to abstain completely, if we would obtain permanent results; even then there will be many disappointments; still, it is possible in

half, or even two-thirds, of the cases, which are taken in time, to obtain the permanent recovery of drunkards. In all the more severe cases treatment in an asylum is indispensable, as, in ordinary life, the enfeebled will of a drunkard is exposed to many temptations, which he cannot resist by his own strength. Unfortunately, it is only now that a few asylums are being provided for drunkards, so that they can hardly be dealt with except in lunatic asylums, a circumstance which makes the prompt treatment, on which everything depends, very difficult. Too often the drunkard only comes under correct treatment when he has become a public danger, and so exhibits the most severe forms of alcoholism." On the other forms of inebriety his views are quite familiar.

Defendorf writes: "The successful treatment of chronic alcoholism demands complete abstinence from alcohol in every form. A few patients are capable of carrying out this injunction successfully by themselves, but the vast majority require the treatment afforded by a special institution for alcoholics. * * * The only successful treatment for morphinism is complete abstinence. For this purpose, the first requisite is isolation in a reputable institution. * * * An essential element in the successful treatment of cocaine inebriety is confinement in a reputable institution, where it can be determined, with certainty, that the patient does not have access to the drug."

Crothers, of Hartford, who has given many years of study to the treatment of inebriates, holds similar views. "The first thing in the treatment of inebriates must be to secure the control of the patient. His own volition must be subservient to that of the physician. He cannot reason or direct as to the plan of treatment. Failure always follows self-treatment.

Removal from home is most essential to secure this control. As in other neuroses, particularly insanity, hysteria, and forms of neurasthenia, only control by and contact with strangers are effectual. This helps to break up the morbid trend of reasoning and associations, which cannot be done at home with relatives.

Private and special asylums, if properly managed, have superior advantages, which cannot be obtained elsewhere. In such places the stimulating firmness of a stranger, if coming with tact, does much to rouse up a weakened will. The surroundings, with the central purpose of removing the morphine, will encourage personal effort on the part of the patient. This idea should be made dominant at the beginning."

Oppenheim's views are similar: "Withdrawal of the poison

—which is the principal procedure in the treatment—can be successfully carried out only by enforced hospital treatment.”

It would be quite unnecessary to further multiply the views of eminent observers. All unite in the opinion that there is but one method to be adopted, and that is to secure control of the inebriate, to place him under restraint; in other words, treatment in a properly regulated institution.

He must be taken away from his old environments, from his associations, from his temptations. A new sphere of life must be opened to him. A scientific method of treatment, firmly, systematically, and continuously carried out, appeals to the patient, and secures his co-operation and his active sympathy. The mental effect on the patient, of such, is of the greatest help in his treatment and recovery.

Now, how are we situated in Ontario, on a question of such far-reaching importance? There is not in the Province a single State institution, where these manifold diseases may receive proper treatment. With folded arms we stand idly by while the disease is doing its deadly work. Children are begotten in inebriety, suckled by inebriates, raised in an alcoholic atmosphere, and then sent out to join the grand army of inebriates staggering on to its doom. I need not dwell on the character of its victims; there is no class exempt. When they become a nuisance to society, a danger to the public, the State may step in and send the victim to the asylum; even then it is remarkable how many recover, and are not again affected; which would go to show the necessity of early and timely treatment, in suitable institutions, maintained by the State, and where the inebriate, in the incipient stage of his disease, could be committed by legal process.

The character of the institution, its location, its equipment, its medical supervision, must be carefully considered. It is scarcely necessary to remark, the institution should be conducted under modern hospital methods. The location should, by all means, be cheerful and enticing, and with the best sanitary surroundings. The prospect should be attractive and varied. The grounds must be ample and secluded, as far as possible, for open-air exercise and occupation thereby are valuable factors and cannot be overlooked. The equipment for such an institution should consist of modern therapeutic agencies. The continuous baths are an absolute necessity. From personal observation at Rockwood Hospital, where these baths are now in operation, I can speak of their valuable therapeutic action. Turkish baths, the various forms of douche baths, etc., are necessary comple-

ments. Hot air cabinet, and proper electric apparatus, are valuable and useful aids to treatment.

The institution must be under medical supervision of the highest skill, tact, and experience. There is no class of disease so varied, presenting so many individual characteristics. Each case is a study in itself, and ought to receive special attention and direction.

Need it be added, that a staff of nurses, especially trained, is an elementary consideration.

What legal process should govern the institution? Manifestly, if the State assumes the responsibility, it carries with it the power of inspection, the privilege to admit and dismiss. Clearly, the person of the subject has the inalienable right of protection.

Proper legal forms of admission, for the various classes of inebriates, may be drawn up. When, in the judgment of two properly qualified physicians, attested on these forms, the individual can be classed as an inebriate, this should be deemed sufficient for his admission.

I am well aware this departure necessitates no small public outlay, but I am just as well aware, and every physician of experience will bear me out, that the expenditure will be amply repaid. Inebriety is amenable to treatment, and, if the disease be taken in its early stages, the results are most gratifying. It is worth something to save from final wreckage this large class of our population. It is worth something to secure their return to industrial and economic pursuits. It is worth something to protect the violation of homes, to prevent the commission of crime. Above all, is it the duty of the State to prevent the degeneracy of its population, the hereditary transmission of a vice, a disease that carries with it such endless shame and sorrow, that robs the nation of its brightest intellects, that sears and withers all within its lethal grasp.

GYNECOLOGICAL TREATMENT IN THE INSANE.

BY ERNEST A. HALL, VANCOUVER, B.C.

“The saddest chapter in the history of disease—Insanity—probably the greatest curse of civilized life.”—OSLER.

Herewith I submit a brief history of the cases of mental disease that have come under my observation during 1907. Some could be classed as ‘borderland’ cases, yet all give definite indications of loss of mental control.

No. 136.—Mrs. H., aged 30. Heredity good, married seven years, never pregnant. As a child had been treated for tubercular peritonitis. After marriage she complained of severe pain over left ovary, with constipation and anemia. At times became melancholic, alternating with hysteria. As described by a friend she would sit and cry and mope, and then get cranky with everybody until there was no living with her. She gave a history of a period of severe pelvic pain followed by a bloody discharge from the rectum, after which she improved mentally for a short time. When I saw her, she complained of very little pain. The mental condition was sluggish and characterized by decided delusions, out of which she could not be reasoned, with a most irritable temper. She was incapable of managing her home, and required continual watching.

Pelvic examination. Small hard cervix and fluctuating mass in pelvis. Dilatation of cervix, curettage and removal of ovarian cyst gave a normal convalescence, both mental and physical. At the present time, after an interval of one year, she is enjoying excellent health and happy in her well-ordered home.

No. 137.—Mrs. A., aged 27. Referred by Dr. Henderson. One brother somewhat deficient mentally, two miscarriages, one living child four months old. A few weeks after delivery she developed typical puerperal mania.

Examination showed laceration of cervix with eversion of mucous membrane and subinvolution. Amputation of cervix, curettage, posterior vaginal section, removal of tubes and puncture of ovarian follicles was done under morphine-hyoscine anesthesia with a few drops of chloroform added.

Six weeks after her father wrote:—“She is not quite so noisy, much less troublesome, knows her baby and at times talks reasonably.” Her physician reports her completely recovered several months since.

No. 138.—Mrs. F., aged 57. Good heredity, one miscarriage, no living children. Mental instability with erotomania was present for a brief period at age of 23. One year ago she had influenza,

followed by the same condition. At period of examination she complained of a feeling of impending dread, and manifested suicidal impulses.

Pelvic examination showed retroversion with adhesions.

Treatment recommended.

No. 139.—Mrs. H., aged 36. One brother slightly deranged. Has had three children, followed by several miscarriages. After the last miscarriage she had "fever," which, according to her husband, left her insane, necessitating her confinement to an asylum for three months, afterwards returning to her home, but unfit to properly manage it. Became suspicious of friends, abusive to the children and wholly unreliable.

Examination showed enlarged uterus and deep cervical tear. Amputation of cervix, removal of uterine fungosities, resection of the tubes resulted in but slight mental improvement. Patient has passed from observation.

No. 140.—Mrs. P., aged 49. Heredity good. Dementia of seven years' standing with periods of deep melancholia.

Examination showed right floating kidney and retroversion. Fixation of kidney and suspension of uterus done, no appreciable result until some three months afterwards when her husband wrote:—"Mrs. P. is recovering fast, both in body and mind, she is around and doing the most of her work. I feel so thankful that she is getting all right again."

No. 141.—Mrs. W., aged 65. Good heredity. Religious mania with melancholy lasting several months. Several years previously she had an ovarian cyst removed. She complained of pain in left inguinal region. Pelvic examination was negative. Upon opening the abdomen the omentum was found adherent to the abdominal wall, and the rectum adherent to the side of the uterus and to the stump of the tube. These adhesions were carefully freed.

Death followed from obstruction of the bowels. A post-mortem examination showed a knuckle of ilium had become adherent within the pelvis.

No. 142.—Mrs. D., aged 44. Referred to by Dr. Jeffs. Good heredity. No miscarriages. Youngest child 7 years old. Mild religious delusions for several years. For two weeks were so decided that removal to an asylum was contemplated.

Deep laceration of cervix, small cyst of left ovary, myometritis with fungosities. The appropriate treatment was given. Gradual return to mental health, after two months Dr. Jeffs reports her as recovered.

No. 143.—Mrs. W., aged 36, three children, youngest 10 years,

of excellent heredity and pleasant disposition. Since birth of last child her disposition has slowly changed, until she became irritable, subject to violent outbursts of temper, illtreats the children, and latterly has had periods of delusional insanity lasting several days.

Examination showed lacerated cervix, enlarged and retroverted uterus. Amputation of cervix, curettage, removal of tubes and overlapping of round ligaments. Convalescence normal, mental and physical.

No. 144.—Mrs. H., aged 32. Referred by Dr. King, who gave me the following history: "Had one brother who committed suicide. Since puberty she suffered with severe premenstrual pain. Married seven years ago, no living children, aborted four years ago and again three months ago, no specific history. Her husband sent her to me for examination, stating that she had been a great trial to him, that when he left the house he had to lock her in until his return. During the few days previous to menstruation she will make approaches to all the toughs around town, and even make a raid upon China-town." Dr. King found left pelvic disease and referred the case to me for treatment. I removed left pyosalpinx with dense adhesions and right hydrosalpinx, also dilated and curetted.

Too recent to report.

COMMENTS.

The first matter of interest in the review of these cases is the gradual passing from irritability of temper and the milder stages of mental instability into deeper conditions of irresponsible action which was noticed in the majority of them. With the exception of puerperal cases this gradual development of mental conditions is the more frequent course of development of the insanities due to pelvic lesions. This is the stage which asylum superintendents have not the privilege of observing as the private practitioner has, and it is also the period *par excellence* of the most hopeful treatment, before vicious habits of thought and action have formed, and before secondary cortical degeneration has taken place.

The next point to consider is that all of these patients had well-marked pathological conditions of the pelvis, and with the exception of the one death from bowel strangulation, and one too recent to report, mental improvement followed treatment. This does not by any means prove that the mental conditions were a result of the pelvic disease, but it is at least suggestive that, with a predisposition towards mental instability, hereditary or

acquired, which we must in these cases always predicate, pelvic disease may be an important factor in the causation of the mental unbalance.

My practice is in the treatment of these cases to remove as far as possible hopelessly diseased structure, to correct displacements, repair lacerations, free adhesions especially of the clitoris, to remove no normal parts, except in cases where there is a decided hereditary history and in puerperal cases, in which I feel that I am justified, after consultation with the friends, in removing the tubes. Up to the present writing I have examined 149 women, all with mental trouble; 124 were married and 20 single. Of the married, 116 or 93 per cent., and of the single, 17 or 85 per cent., showed decided pelvic disease. Superficial lacerations of cervix or perineum, minor grades of version without adhesions I don't class as pathological, only such conditions as my honored teachers, Price, Kelly and Martin of Berlin, would consider sufficiently pathological to necessitate treatment in the ordinary course of gynecological practice.

In dealing with these cases we must remember the paradoxical statement of McGuigan of Kalamazoo Asylum, that mental cases require little mental treatment. The recovery is usually blocked to a serious extent by physical conditions only. He states that of the female inmates examined, less than 10 per cent. have normal pelvic organs. He lays down the rule that surgical relief is indicated when we have an abnormal condition present that causes any distress whatever, not especially during the period of mental disturbance, for sometimes it is not noticed then, but particularly in the period of normal mental action.

Horman, Physician to Pittsburg Insane Hospital, speaking of the proven work done along this line by Rohe, Manton and Price, says: "I feel that they have opened up a new field for the gynecologist and established the beginning of a new era for the alienist." He goes on further to state that we should be more concerned about our patients, especially of the neurotic type, who are suffering from uterine disease. Many times, if the uterine disturbances were relieved, the insanity would be removed. I cannot do better than to give a paragraph from one of his articles.

"No fact has been more clearly established by psychologic investigation and neurologic anatomy than that the human anatomy is wholly dominated by the sympathetic nervous system. The whole physical structure is subservient to its influence. It is a despotic force with compulsory requirements. There is no stasis, either active or passive, no modification of the activities,

no irritation, however slight, but will manifest itself through the sympathetic nervous system. I have seen, as already stated, in the treatment of insanities the result of uterine disease, the local or surgical treatment of the trouble not only cure the uterine disease, but effectually cure the concomitant disease occurring in the brain, thus showing the mysterious (?) and unaccountable (?) connection between them. A woman becomes the victim of nymphomania, amenorrhœa, dysmenorrhœa, or some one or more of the many forms of uterine disturbances; it may take on one of the amatory phenomena, especially of nymphomania, a religious turn, devotional enthusiasm of so violent a character as to necessitate removal to a lunatic asylum—and these are not fictitious cases—and all this because of local irritation. Finally, we may have a uterine trouble, an irritation, transmitted through the hypogastric, spermatic and other ganglia and plexuses, from cell to ganglion, passing onward to the sacral, to the cord, the medulla oblongata and the cerebellar and cerebral ganglia, finally by coronata radiate fibres to the cortex of the brain, that most valuable distribution of nervous matter, the seat of mentality and intellectuality, ending in a complete overthrow of the noblest propensity of woman, driving her to a madhouse, there to drag out her existence within the walls of her life prison. Thus, we have the beginning and end of a very sad picture."

DIFFICULT CASE OF LABOR IN SMELLIE'S TIME.

The following report of an interesting case of labor, taken from Smellie's Text-book of Midwifery, was presented to the fourth year students of the Medical Faculty of the University of Toronto, and clinical Class A was asked to consider it and send in a report on the same to Dr. A. H. Wright:

"Head expelled: os contracted round neck: delivery and death of mother.

"I was sent for to see a woman, aged 40, who had borne several children before in 1749. When I came I found the head expelled. I slipped up my fingers and found the os tinea contracted about the neck of the child (which was dead) and endeavored to pull it away, but in vain. I then sent for Dr. L., and I desired him to see what he could do, as my fingers were numbed. He first got one hand into the uterus, and then slipped up the fingers of the other, and brought away the child. The woman's pulse before delivery was strong, and she had little flooding; but we had not

been gone a quarter of an hour when we were sent for again. They told us that immediately after we went away, which was five minutes after delivery, she was seized with a shivering and a vomiting, and had fainted. We found her in a swoon, and held spirits to her nose; but she could not swallow, and died in about half an hour after delivery.'—“Smellie's Midwifery,” Vol II, page 272.

Criticize the treatment. What treatment would you suggest? What was the cause of death?

Answer not to contain more than three hundred words.

STUDENT'S REPORT.

Criticism of Treatment.

1. The doctor should have been there sooner. This error may be attributed to *nurse* or *doctor* or *both*.
2. The child being dead, and woman not suffering, time should have been taken to give an anesthetic before dilating the contracted os with such force.
3. After os was dilated, it wasn't necessary to introduce the hand into uterus.
4. Placenta was removed too soon after delivery of child, and should have been examined to see that membranes and placenta were all present. Uterus was not controlled.
5. Doctor should have remained an hour with patient instead of five minutes, after labor.
6. After returning, the treatment was not suitable for such a grave condition.

Treatment Suggested.

1. On arrival, give anesthetic, dilate the os, and then remove the child.
2. After waiting for 15, 20 or 25 minutes begin expressing the placenta very slowly.
3. Examine the placenta carefully, and if not all present introduce hand and remove the rest. Control uterus with hand.
4. Remain in house for one hour watching patient and treating any complication arising.
5. For serious symptoms give hypodermically, morphia, grs. 1-4, and repeat in ten or fifteen minutes if necessary.
6. Raise the foot of bed and have one doctor give saline by bowel, interstitially or intravenously, as deemed best. Then bandage extremities.
7. The other doctor should give anesthetic immediately and enter uterus to ascertain the cause and remove it if possible. Palpate abdomen to find condition of uterus.

8. After cause was removed, stimulants, as strychnia hypodermically, whiskey internally, should be given.

9. Remain with patient till danger is apparently over and treating as case demands.

Cause of Death.

1. Shock caused by concealed hemorrhage, owing probably to retained placenta, or contraction of lower segment.

2. Tetanic contractions of uterus causing rupture of lower segment, thus producing peritonitis and shock.

REMARKS BY LECTURER (PROF. ADAM WRIGHT).

This case was reported to Dr. Smellie by Mr. A. in 1749, who wished to know the cause of death. Smellie in his reply said: "I have been concerned in several cases, where, though the os internum was torn, the patient has recovered without vomiting or any other bad symptoms; and have known other women die, as it were instantaneously, after delivery, though I always imputed such sudden death to their being exhausted by long labor, the sudden emptying of their vessels, and a greater loss of blood than their constitution could bear."

In considering the answers of the students it should be understood that when this case was submitted they had gone through only a small portion of the course in pathological obstetrics.

Criticism of Treatment.

Although not specifically stated by Smellie, it is probable the patient had been under the care of either a doctor or midwife for some time before the arrival of Mr. A. P. We may agree that "the doctor should have been there sooner." "The child being dead" there was no necessity for undue haste. It is probably not correct to say "the woman was not suffering," because in most, if not all, cases of tetanic spasm of the uterus the patient suffers intensely. While the administration of an anesthetic would have been very desirable, this case occurred in 1749.

There appears to be some confusion of ideas as to treatment of the rigid os. In section 3 of "Criticism of Treatment" we find: "After os was dilated it wasn't necessary to introduce the hand into the uterus;" while in section 1 of "Treatment Suggested," we find: "On arrival, give anesthetic, dilate the os, and then remove the child." It may be stated in this connection that forcible dilatation of a rigid os, especially when there is tetanic

spasm of whole uterus, is the most dangerous procedure which can be adopted. Under such circumstances this form of accouchement forc e nearly, if not quite, always causes death.

The remarks as to the placenta, while in a sense correct, may be deleted, as there is no evidence that the treatment of the third step was any factor in the fatal issue.

It is quite correct to say: "The doctor should have remained an hour with the patient, instead of five minutes, after labor." The distinguished McClintock, of Dublin, the editor of "Smellie's Midwifery," thus comments: "The conduct of these gentlemen in one particular, not noticed by Smellie, was open to severe reprehension, viz., their leaving the patient 'about five minutes after delivery.' It has been for many years an invariable rule with me never to leave a patient within an hour after delivery, even when every step of the labor has proceeded most naturally, even I have often had cause to be thankful for so doing." Such conduct is all the more extraordinary when we consider the fact that the patient must have been in a very serious condition when they left.

The directions for the treatment of the shock and collapse may be accepted in a general way without going into details.

Cause of Death.—It is true that concealed accidental hemorrhage causes, in many cases, tetanic spasm of the uterus with extreme rigidity of the os producing great pain and profound shock. The students will find, however, before the end of the session that there are other more frequent causes of such shock of which a common one is prolonged labor. We believe the students are correct in thinking that there was tetanic contraction or spasm producing the shock; but we wish to add that the cause of death was probably rupture of the uterus, caused by the violent manipulations of the surgeons in the endeavors to stretch the os and deliver the child. There was probably not time for the development of peritonitis. Possibly the morphine and chloroform, at an earlier step, or even when Mr. A. arrived, might have relieved the spasm. If, however, such treatment failed, it is thought that some form of the so-called vaginal Caesarian section would have been the proper procedure.

HEADACHE AND EYE-STRAIN.*

BY DR. WM. CRAWFORD, HAMILTON, ONT.

In considering this subject I do not intend to go into the causes and treatment of all forms of headache, but only that which can be attributed to the eyes as a primary cause, and due largely or entirely to ocular anomalies, and propose to consider some phases of eye-strain where headache is not the only or the most prominent symptom. These two, headache and eye-strain, are so closely connected, the one the effect, the other the cause, that in any discussion of the one, the other will be necessarily considered.

First, as to the special form of headache caused by eye-strain: the most frequent form is that of brow-ache or supra-orbital headache, over one or both eyes, particularly marked after prolonged use of the eyes for close work.

Next, that of deep orbital, where the pain seems more deeply concentrated in the eyeball, and is more frequent where the defect is that of astigmatism, with the pain coming on after prolonged concentration of vision for either distance or near.

Then there is the fronto-occipital, which may be more manifest in the mornings, and following pretty constantly after a previous day's eye-strain, or an evening spent at concert, theatre, or cards. This form may precede a true migraine, and not disappear for a day or two. I wish to distinguish this form from a pure occipital headache, which is often found in connection with a neurasthenic condition.

Then temporal headache, which may follow eye-strain due to any form of eye defect, but is particularly frequent in cases of astigmatism with axes deviating from the vertical.

In distinguishing headache due to some ocular defect from that due to some other cause, the one great factor to consider is that in ocular defects the headache is produced or aggravated by use of the eyes, and is lessened or relieved by their rest. There are exceptions to this, but as a general working rule it will be found to be a practical guide. And the headache due to eye-strain may or may not be accompanied by asthenopia or painful vision. It is an error to suppose that if the vision is normal, or practically so, the headache is not due to eye-strain, as it is in the smaller ocular defects such as hyperopic astigmatism of one-half to three-quarters of a dioptré, or mixed astigmatism of a like amount, that give rise to the most troublesome headache, particularly if the axis be at an angle or against the rule, and in

* Read before the Hamilton Medical Society on April 3rd, 1907.

these cases the vision may be normal. In accommodative asthenopia also the vision for distance may be normal.

According to Hazen, "asthenopia is due to disordered innervation," caused by (1) errors of refraction, and (2) anomalies of the extra-ocular muscles, in about equal proportions.

It may also be due to reflex causes such as nasal obstruction, dental caries, other nose and throat affections, and also from the chest and abdomen, or to any general depression of the constitution.

Hansel says: "The eyes are not exclusive factors in the production of headache, but no diagnosis is complete which ignores them."

The larger refractive defects which are too great to be overcome by any degree of strain, result in suppression of the visual image in the most defective eye, or in squint, if there is considerable difference of defect between the two eyes, but if both eyes are about equally defective the result will be much reduced vision, and probably no headache, but this condition of lowered acuity of vision may, and likely will, have a large share in determining what the life of that person will be, if uncorrected, resulting in subnormal capacity and stunting endeavor; but if corrected early in life will produce a larger and brighter outlook and a development that may result in a distinguished career.

Then, eye defects may be unsuspected, especially in children, and if small in amount may give rise to no symptoms until close application at school, or later at business, may produce headache and asthenopia. Many people who have congenital eye defect go to adult life, and even to old age, with vision much below normal, not knowing anything amiss because they have no headache or pain that they think comes from the eyes, but when the defect is corrected vision is much better and life made more enjoyable. Many people also have poor general health; children are puny and sickly, and do not thrive well, until attention is drawn to the eyes by some soreness or other trouble, when the defective sight is detected, and corrected, when they are at once changed into happy, bright, and healthy people. Every oculist can testify to many such cases from his own experience, and I am no exception to the rule.

Many congenital cases of astigmatism have no headache or asthenopia until they reach adult age, when unusual close application or reduced general health will make manifest the eye-strain and cause headache or asthenopia.

Uncorrected errors of refraction, or muscular anomalies, are a prolific cause of diseased conditions in the eyeball itself. The

unequal strain caused by that condition on the growing eyeball will produce nutritional disturbances in the retina, choroid ciliary body, iris, and even the lens itself, which will retard and modify development and produce defects that no after-correction can remove.

Asthenopia, weak and sensitive eyes, recurring conjunctivitis, chronic conjunctivitis, sick headache, blepharitis, styes, strabismus, choroiditis, retinitis, chronic iritis and cyclitis may be and are often produced or made worse by uncorrected optical or muscular defects.

Again, there is the effects that uncorrected ocular anomalies may produce on the general health to be considered. I have referred to this before, but do so again to impress it on your mind. We all have had occasion to see the change that removal of a bunch of adenoids has had on the general health of a sickly child, and that change is not so great as the correction of an optical defect has on many a puny, sickly youngster.

How many adults have come to midlife with a pronounced ocular defect which has not been corrected, and have been stunted in growth both physical and mental, hindered in their career or utterly repressed, who with early correction might have been distinguished in life, we cannot say. We can see the improvement in like cases when the correction is made both in children and adults, but we cannot estimate what might have been in the others. We know what improvement takes place in many cases of chronic ill-health by the removal of an eye-strain that has been using up a great deal of nerve force, these being clearly reflex in causation, just as a polypus in the nose will cause recurrent attacks of asthma, which will cease to return when the polypus has been removed.

I might mention a few cases from the literature on the subject. Cases of epilepsy have been reported cured by Ranney, Stevens, Colburn and others, which had been treated by other means before without benefit, and which had ocular defects or muscular anomalies corrected, and had remained cured. This is not surprising when we consider that in many cases epilepsy is not a disease, but a symptom, and the cause remote. This is not hard to believe when we think of cases of epilepsy that have been reported cured by treatment directed to the stomach, or to other distant organs. Again, vertigo is a condition that is often produced by ocular defects, particularly muscular imbalance in the vertical plane, and is cured by their correction.

Cases of gastric disturbances are numerous, cited by Thompson, Gould, Parker, and others, which had been treated by other

means before, without result, but which have been relieved by correction of an ocular defect. These and other neuroses, being often reflex in causation, are the result of using up of nerve force by eye-strain in the patient trying to overcome some ocular defect, and diverting to the eyes nerve energy that should have been used in stimulating the different organs of the body to perform their own proper functions.

If an optical error can so influence the general bodily conditions that a chronic state of ill-health can be remedied by optical correction, and this cannot be denied, then it is not too much to say that the general weakness that was the predisposing cause of a fatal disease could have been arrested in many cases by attention to the eyes. Many times all that can be said was that the previous poor health was the predisposing cause, permitting the infection to find a lodgment. Then, might we not with truth go a little farther and say that the primary cause of the condition was eye-strain, which lowered the bodily resistance and nerve tone, and so permitted the infective germ to gain a foothold?

I would like to illustrate this and allied conditions by a brief report of a case or two from my case-book.

Case 1—Miss M. S., aged 25. Factory hand. First seen Sept. 12, 1906. History of ill-health, not strong, cannot stand much work, irritable, mother says very nervous, and has to be humored. No particular benefit has been derived from general medical treatment. About three weeks ago thought she got some foreign body in the eye (left), which made it irritable for a couple of weeks. Four days ago got a slight blow on the same eye, and since cannot see well out of it. Exam., Rt. P. M. and F. N.; L. P. N. Media very hazy, under homatropine found the vitreous very milky, with dark opacities floating about, principally in the lower outer field. Vision, fingers at 1 ft., Rt. V. equal 6/9, and with plus .75 D. Cyl. Ax. 90, V. equal 6/6. Gave Rt. correction, ordered rest of the eyes, gave a nerve tonic. Sept. 29, reported can see much better out of each eye, feeling happier, not so irritable, L. V. equal 6/44. Oct. 16, L. V. equal 6/24. Nov. 2, L. V. equal 6/20. Disk can now be seen. Nov. 12, L. V. equal 6/20, and with minus 1, V. equal 6/16. Left vitreous was cleared up enough to allow fundus to be seen, and showed hyperemia and choroidal changes. Improvement in general health and happiness continued, and she could do her work with much less trouble, and eyes do not now tire. The vitreous and choroidal changes could not be due to the foreign body, or the slight blow, which, no doubt, simply served to bring the condition of

the eye to her notice, and the pathological changes were the result of long-continued eye-strain interfering with the nutrition of the eye.

Case 2—Rev. T. J. H., Clergyman, in active work. Much headache, poor sight, very nervous, so much so that he often had the greatest difficulty in getting through his preaching service, and had often to lie down after, completely prostrated. After correcting a considerable amount of myopic astigmatism, he reported four months after that he had had no headaches for a long time, and was able to conduct his service and do his work with little trouble, and the nervousness was disappearing.

Case 3—Miss B. S., aged 30. Dressmaker. Had been troubled with much headache, and would be laid up for days at a time and utterly unable to work, with attacks that were typical migraine. After correction of .75 D. of hyperopic astigmatism, headaches have disappeared, patient is in better health than for years and gaining flesh. This patient had exophthalmic goitre, and was treated medically with indifferent success for some time before. Since the eye-strain has been removed the progress has been rapid, and is to all appearance cured, with slight protrusion of eyeballs left.

Case 4—A. M., male, aged 24. Poor sight all his life. No pain, no headaches, no inflammatory condition present. R. V. 6/20, with minus 3.5 S. V. equals 6/12. L. V. equals 6/36, with minus 4 is 6/12, with both V. 6/9. This case illustrates another condition where the refractive error was so great that no amount of strain could give good sight, and the attempt was abandoned, and there was no symptom but poor sight. These cases are only examples from my case-book, and could be duplicated by any oculist.

We as oculists have been taunted with the accusation that all eye patients coming to us have been found to need glasses, and the people who do not want to wear glasses stay away. I should just like to reply in few words to this effect, that patients do not consult us unless something is wrong with their eyes, and every oculist will tell you that, in comparison with the whole number of eye patients, the proportion who have some refractive error are in the large majority, in contradistinction to the number who have some diseased condition calling for medical or surgical treatment.

The number of patients who suffer from headaches is very great, and in ophthalmic practice it is a very prominent symptom. Anywhere from 50 per cent. to 80 per cent. of our patients suffer from headaches. Formerly every other method of treat-

ment was exhausted before the eyes were thought of as a cause, but so many patients have of late years been relieved of headaches by correction of some refractive error that patients do not now wait very long before consulting an oculist, or, in many cases, an optician.

Most eyes are a trifle ametropic, that is, have some refractive error, but in regard to the small errors it is only in cases where the eyes are overworked or the patient is in a subnormal condition of general health that it need be corrected.

Many persons from 20 to 30 years of age, with a small amount of refractive error, say, from one-half to one dioptré of hyperopia, will only need correction temporarily when they have a large amount of close work to do, or are in a reduced condition of general health, just as you would give a tonic to tide a patient over a period of general weakness.

Some years ago an interesting study was undertaken by Dr. S. D. Risley, assisted by a corps of competent associates, in examining the eyes of the school children of Philadelphia, when 2,422 eyes in 1,212 pupils were examined. Out of this number only 272 eyes were found to be emmetropic, or normal; 332 were myopic, and every one of these had lowered visual acuity; 1,792 were hyperopic, and 35 per cent. of these had painful vision; 1,330 suffered from astigmatism, and from 50 to 74 per cent. of these, according to the type of astigmatism—whether hyperopic astigmatism 50 per cent., myopic astigmatism 60 per cent., simple astigmatism, or mixed astigmatism, 74 per cent.—suffered from painful vision. Similar results were obtained in Europe, with particular reference as to the prevalence of myopia, and when it is remembered that all myopic eyes have lowered vision and are unhealthy, the significance is apparent. Dr. Risley says in reference to the European statistics: "It was shown that eyes with hyperopic refraction greatly outnumbered the emmetropic and myopic eyes, particularly during childhood, that the emmetropic eye was comparatively rare, but that the state of refraction most nearly approaching this ideal condition retained an almost uniform percentage throughout school life; that myopia, extremely rare or entirely absent before the beginning of the educational process, was found to advance steadily in percentage with the progress of the pupils in the schools, while the percentage of hyperopia diminished in about the same degree."

This points to the fact which is not properly respected yet, that the eyes of the young are in an unstable or changing condition, and that every child before starting to school should have the vision tested, and, if found abnormal, should have the refraction

tion examined under a mydriatic, then, if found much abnormal, have the proper correction given. Many people who have only small defects of hyperopia or astigmatism, which has given them little or no trouble during the early years of life, will, when they have started in business which requires from them more continuous close work, complain greatly of the headache or painful sight, or mistiness of the print after a long or hard day's work.

Then, again, another class of patients who have had good and easy sight all their life, will begin to complain of eye ache after reading; at about 30 or 35 years of age, they are apt to consider that there is some other cause to lay it to than the eyes, when the fact is that they are early presbyopes, and the remedy lies in the use of a weak lens for close work.

Where the defect is great and cannot be overcome by any reasonable amount of endeavor, the patient gives up the effort and resigns himself to defective vision and its consequences, and is comparatively free from pain or headache, and if one eye is good and the other very defective, the poor eye gives up the unequal contest and deviates out of the line of light, and remains so, or suppresses the image formed on the retina, but if the defect is small enough to be overcome by effort it is tried, and the result is eye-strain, headache, and allied symptoms.

It is a fact which is daily observed that when the eye-strain results in reflex symptoms, such as headache, or nervous disorders, the eyes will be free from all local manifestations of disease, such as blepharitis, conjunctivitis, etc., and when the strain results in disease there will be no headache or pain.

I do not wish to leave the impression that because of the almost universal presence of some refractive error most people should wear glasses, nor do I wish to imply that glasses are the only treatment of the effects of eye-strain. I do not need to say to you that there are a large number of people who have a small amount of refractive error, who never suffer from any of the symptoms of eye-strain, and who are in good bodily health, but should they become reduced in health, they will then feel the eye-strain.

Anomalies of the external ocular muscles are also a fruitful cause of eye-strain, and when accompanied by a refractive error are often relieved by the correction of the refractive error alone, or if of larger amount must be treated by graduated exercise or by tenotomy of the offending muscle. Tenotomies and partial tenotomies have been much in vogue in the past, but have now been largely given up, even by those who were the strongest advocates in former days.

I would like to mention some of the limitations of opticians in

regard to the correction of optical and ocular anomalies. I will mention a couple of instances from my own experience. In one case a prominent optician supplied a patient with glasses, who came to me a few days after, and I found that he had well-advanced cataract, and the glasses were absolutely of no use to him. Another was given glasses and "Murine," and when he came to me shortly after had well-marked iritis, due to a constitutional taint. Then, again, no child should have a correction given unless under exceptional circumstances, or for a high-grade myopia, without full mydriasis. Then, again, a functional or subjective examination alone is often deceptive, and needs the controlling influence of the objective examination.

Then in diseased conditions of the retina or choroid, sometimes a convex lens might give some relief for a time and then the disease would be overlooked and would go on unchecked. Again, where an optical error was present and also a pathological condition, and the symptoms were only headache, then if the optical error were only corrected the headache might be relieved and the disease not suspected until much damage had been done. Oculists make mistakes as well as other people, but are less liable to than one who has no knowledge of the ocular apparatus, or only a very limited one. Family physicians should take pains to see that their child patients especially should be taken to an oculist and not to an optician.

In concluding, I would like to mention briefly that the practice of ophthalmology is taking a larger field in the practice of medicine as the years go by, so much so that Dr. H. F. Hansel, in a treatise on "Neuroses Occasioned by Eye-Strain," says: "Any theory of the origin of disordered function which does not embrace a consideration of the ocular apparatus is unscientific and open to criticism," and the same author says: "It is a noteworthy fact that in our strenuous American life the eyes suffer first and most in the general breakdown of the system."

The demands of modern business, the struggle for existence, make demands on no other organ of the body to so great an extent as on the organs of vision, and they in turn demand from the general system a large amount of nerve force.

In the evolution of mankind that is going on, the increased use of the eyes necessitated by changing conditions of life, calling on the eyes for more work than the past has done, demand more attention on the part of the profession and the parents to watch symptoms and to so assist the eyes of children to overcome adverse conditions that the eye may come out of the ordeal a much improved and more highly developed sense organ in the generations to come.

REPAIR OF SADDLE-NOSE BY REPLACEMENT OF BONES WITHOUT SKIN INCISION.

BY D. J. GIBB WISHART.

The photographs "before and after taking" are those of Miss Gertie B., referred by Dr. Herbert Bruce, November, 1907, suffering from marked depression of ridge of the nose, amounting to serious deformity.

The history of this case is briefly as follows: At the age of eleven years, while running, she came into violent collision with a party running in the opposite direction and was knocked unconscious. The deformity has existed ever since. There is no history of syphilis and no impediment to breathing. The patient desires relief merely for cosmetic purposes.

On examination, the nasal processes of the superior maxilla



are found to be spread apart so as to allow the nasal bones to lie side by side and present unitedly a flat surface externally. In addition, the attachment of the upper lateral cartilages to the nasal bone in the middle line has been separated, and a new attachment formed at a lower point. Internally the conditions in both nares are practically normal. The condition therefore presented is a typical saddle-nose, combined with a flattening of the root of the nose, but otherwise a normal relative condition of the shape and position of the parts.

The line of procedure was as follows: As the patient was desirous of the best cosmetic effects, it was decided to make no external incision. Under general anesthetic, a narrow chisel used by Freer in septal resections was introduced through a small slit in the mucous membrane of the outer wall of the nose

on the right side, just over the lower bony margin of the anterior nares, where, through the skin, the suture between the nasal and maxillary bones was marked by a notch. With a hammer the chisel was driven along the suture to its upper end, the finger on the outside of the nose keeping control of its position. This procedure was repeated on the left side. A large pair of Adam's septal forceps was then placed one blade inside of the nose, and the other outside, the skin being protected by a pad of gauze, and the nasal bone of each side in succession seized and loosened from its attachment to the frontal bone and to its fellow.

The nasal bones being now freely movable and ready to be placed in a new position, a specially constructed saw was introduced on each side in succession through a small opening made in the mucous membrane of the outer wall of the nose directly opposite to the root of each maxillary nasal process, and, guided with the finger on the skin, the groove between the cheek and the nose was sawed from top to bottom. The incision with the saw was made just deep enough to allow of the production of a greenstick fracture of the nasal processes, the forceps named above being used in the same way as before.

It was now possible to tilt the maxillary nasal processes towards each other by the pressure of the finger, and this action at the same time produced the elevation of the suture between the nasal bones, and produced sufficient support to the nasal bones on either side to retain them at whatever angle was desired.

Several devices were tried to arrange a suitable external splint, but unsuccessfully, and it was necessary to have the nurse keep the parts in position by regular and frequent manual pressure upon the nasal processes during the first thirty-six hours after operation. This, though somewhat painful, proved quite sufficient for the purpose. The discoloration and swelling due to the bruising by the forceps were considerable, and yet not unduly marked, and speedily passed off.

This procedure secured the replacement of the bony framework, but a slight pitting was still present below the nasal bones in the centre line, and this was overcome by the injection of a small amount of paraffin. The result has been practically a perfect one, as will be seen by the appended photographs.

Selected Article.

TREATMENT OF ANGINA PECTORIS.

BY SIR CLIFFORD ALLBUTT, K.C.B., F.R.S., M.A., LL.D., D.Sc.,
F.R.C.P. (Lond.),

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The remarks which I can make at present on this subject must be scanty. I am engaged upon a representation of the whole matter, to appear hereafter in association with chapters on arterio-sclerosis and other kinds of cardio-arterial disease.

Too often, nay almost universally, angina pectoris is regarded as inevitably fatal. On the contrary, of all perilous maladies it is, perhaps, the most curable. My list of permanent cures is a long one. But, as Sir William Broadbent once sharply retorted, "the *post-mortem* room is not the place to look for cures."

By angina pectoris I mean this disease and not something else, as by appendicitis I should mean this disease and not colic. To say that angina pectoris is not a disease but a "symptom-group" seems to me to be otiose; by a disease we can mean only a series of symptoms recurring with a reasonable degree of uniformity within certain limits, no other acceptation of the word is conceivable. Of course, all nosological classifications are arbitrary, and the names of "diseases" labels of mental concepts, not of things; the thing is the state of a certain person, a state in many particulars peculiar to himself; the disease or ideal concept is no "entity," but a blend of our impressions of many such-like persons—a phantom, or a "composite photograph."

That, in ninety-eight cases out of a hundred, angina pectoris consists in a painful lesion of the first part of the aorta is an inference of my own, long suspected, but first published at a meeting of the Eastern Counties Branch of the British Association at Yarmouth on June 23, 1894. I think, however, that sometimes it is produced by stretching of the pericardium, as in aneurysm of the left ventricle, or by inflammation of that part of the tunic which invests the root of the aorta; very rarely it may depend on some extraordinary kind of disturbance in the mitral area. The innervation of all these parts is approximately the same, and the disease, even in these rare points, scarcely deviates therefore from the common formula. In this article I shall neglect these exceptional cases and regard angina pectoris

as due to tension of a sore aorta. This tenderness may be due to aortitis of any kind, *e.g.*, rheumatic or influenzal aortitis, or atheroma. In the former case the tensile stresses may be about or even below normal, in the latter they may be normal or excessive.

Primarily angina pectoris is not a fatal disease; secondarily, by reflex inhibition of a frail heart, it frequently proves fatal. Even in the case of an infirm heart complete recovery often comes about. In young subjects recovery is the rule to which the exceptions are very few.

I have said that, as a series of symptoms, angina pectoris occurs with notable uniformity within limits, but these limits are wide. In this respect it may be compared with epilepsy, also uniform within limits still wider. Epilepsy varies about a mean, having as extremes *petit mal*, *grand mal*, and the *status epilepticus*. So in angina pectoris we note a *petit mal*—the so-called “stenocardia”—the great attacks, and the *status anginosus*. But yet these limits are of degree only. In angina pectoris there are not, or we have not recognized, such masked and eccentric varieties as pertain to epilepsy.

In treatment, then, we have to regard three purposes: First, to mitigate, if possible, the lesion of the aorta; secondly, to reduce the stresses; thirdly, to block the inhibitory influence on the heart. In many cases to reduce the stresses may be our only means of compassing the restoration or quiescence of the vessel; if so, the means are in their nature similar; and this is the usual condition.

To combat the local affection directly we may use antidotes, as in acute rheumatism for instance, salicylates, and perhaps the iodides. The iodides, with or without mercury, would be required in syphilis. In aortitis arising from other toxins, such as influenza, antidotal means may be lacking, and we have to trust in the recuperative methods of “Nature.” There are, however, intermediate cases, such as gout, in which we may not have antidotes so direct as the salicylates, but tolerably efficacious empirical methods nevertheless, on which we may place no little reliance.

Indirectly we may do much, and for immediate alleviation great things, by reducing the tension, whether this be relatively or positively overbearing. In many, perhaps in most cases the tension depends on pressures exceeding the normal, perhaps very excessive. In elderly persons, to speak generally, angina pectoris is commonly attended with atheroma and often with morbidly enhanced arterial pressures; but I have seen not a few

cases, even in the elderly, in which the angina pectoris seemed to be of infective origin, especially of influenzal origin. In these the arterial pressures were not persistently enhanced, and they ended favorably, I think without exception. Recovery, however, is not invariable in influenzal angina, as there is a decisive number of necropsies on record.

It may be difficult to distinguish between means used simply to reduce pressures and similar means for the elimination of gout or goutinesses; but in practice the distinction is unimportant. The use of gentle and frequent mercurials, such especially as calomel, in persons who tolerate it easily, laxative waters, at a spa or otherwise, colchicum, salicylates, iodides, strict diet, are some such means. We hear more about "intestinal toxins" than we probably comprehend; whatsoever they may be, such medicinal means would contribute to their dissipation also. Flatulent or catarrhal states of the stomach must be detected and relieved. Again, as Dr. Sydney Phillips well says, as in obscure cases of heart disease we ought to remember that the morbid element may be syphilis, so in angina pectoris likewise we shall give the patient the benefit of this doubt, as we do in obscure cerebral cases.

To promote normal metabolism exercise is of much importance; but as exertion raises arterial pressures, at any rate at the beginning of exercise, we shall have to balance tentatively in the individual the one indication against the other. Dr. Francis Hare has used the familiar experience that angina pectoris is prone to come on at the initiation of exertion, but, as the exercise is continued, to diminish and pass off, to suggest that such a patient should be encouraged to enter upon gentle exercise in this cautious fashion; if possible so delicately as not even to foreshadow the pain, and, as he perceives the immunity, to proceed quietly forwards. Thus, Dr. Hare thinks wholesome exercise may be pursued without prejudice to the local disease, which, in his opinion, lies in the heart itself. Such advice loses something of its propriety, as we shall see presently, if my opinions on the seat of angina pectoris are adopted. Still, as there comes a time when a sprained ankle must be gently inured again to activity, so must the recovering anginous patient, whatever his lesion, sooner or later be led back to bodily exertion. Yet any premature stress upon an affected part, and notably on a part so vital, is to be deprecated.

Diet likewise presents two faces to us; that which may reduce high pressures, or prevent them, and that which may counteract a particular morbid habit. Broadly speaking, we have all been

accustomed to consider in cases of arterial plethora, even in cases in which the bodily habit is not gross, that animal meats should be reduced, and that the nitrogenous food should consist for the most part of simpler materials, such as caseins and the like. Here, however, Dr. Hare has laid siege to our prejudices and declared that such patients should eat two meat meals a day; furthermore, that our face should be set not against animal foods but against the carbohydrates—against bread, against potatoes, against farinaceous puddings, against sugars, and so on. Such rules for the present can rest only upon empirical grounds; and, for my part, I think that the chief rule is strict moderation in whatsoever kind. As Prof. Chittenden has shown us, the ordinary man eats far too-much, and has yet to realize that in so doing he throws a lifelong strain upon his excretory functions, a strain which in later life, when exercise is less and the respective organs are worse endowed with margins of safety, tells cumulatively. And till Dr. Hare's doctrines are verified by independent observers, I am sure he will be the first to acquiesce in our observing our old rules in the main, though with open minds to their probable fallacies. We shall all agree that no full meal should be eaten under fatigue nor under vexation; and, indeed, that in angina pectoris all meals should be restricted in quantity. Or if, on the other hand, appetite be defective, it may be solicited by a previous draught composed of hydrochloric acid, pepsine, and perhaps a little strychnine or other bitter stomachic of a more carminative kind, not so much to aid in the digestion of the meal as to arouse the languid viscera by its customary excitants. Moreover, in respect of the carbohydrates this is true, that they are the kind of ingestum most concerned in the disengagement of flatulence, and in this respect must be ordered sparingly and with discretion of form and cooking. Alcohol, strong tea or coffee, and other excitants of the heart must be forbidden.

One means, which in my opinion is essential, although not indiscriminately applicable, is bed; not indiscriminately applicable, yet now unfortunately sadly neglected! I admit that, to realize its importance, my doctrine concerning the seat of the malady has to be adopted; this doctrine will be adopted, it is now finding adoption, but meanwhile *plectuntur anginosi*. To realize that angina is an aortic lesion is to realize the solution that the treatment, in this respect of rest, ranges itself with that of aneurysm. From the date of the first attack of angina the patient should be sent to bed as definitely as if he had revealed an aneurysm. The heart, it is true, cannot be put in dock,

though every stroke of it may tear open the tender part; but we must reduce its labor as much as possible, making the pressure for a while as low as may be consistent with the balance of health. This purpose we can attain by bed and vaso-dilators, in co-operation with the constitutional measures previously described. On the other hand, I know but too well how cautious the physician must be in ordering an elderly patient to bed, or bed and couch, even for three months. To send an old man to bed for some weeks may be to consign him to a living grave; his lungs may become edematous, his energies may flag, and he may never get about again. Or a perishing heart may be kept agoing only by a certain activity of oxidation, and in muscular idleness it may dwindle more and more. In young subjects with sound cardiac muscles and arteries this deterioration is less menacing, yet among them there are the fretting people, the melancholy people, and the indolent and gluttonous. Nevertheless some years ago I constrained a man of over 80 years of age, a wiry, cheerful, atheromatous person (of the decrescent form of atheroma, not the hyperpætic) to keep bed and couch for many weeks, and thus we cured an angina pectoris which had lasted a considerable time, and enabled him to lead a painless life for not a few subsequent years. This gentleman was in a position to be waited upon, amused, carried to a Bath chair, and so forth, diversions which are not within the reach of many sick persons. Dr. Johnson, of Cambridge, will testify to effect of bed in bringing about permanent relief in a grievous case of recurrent angina pectoris in a comparatively young man, which, when we met, had culminated in the *status anginosus* assaulting him again and again with terrible violence.

Of medicinal means of abating the aortic pressure we happily have not a few. Our fathers used antimony for this purpose, and no doubt with some halting advantage. The value of the nitrites in this direction is too well known for me to enlarge upon them; still we are always learning, even in well-worn subjects. If it be said that an effect so transient as theirs cannot be of more than passing service I may inform the reader that in our laboratories Dr. Harvey, of Toronto, has proved on rabbits that to compress the abdominal aorta for half an hour daily for two or three weeks suffices to rend and destroy the arch of the vessel: and we have learned that chloride of barium and digitalis have, by virtue of their pressor effects, an unmistakably evil influence in angina pectoris. To reduce tensions at intervals, even for short periods, seems to give the parts a chance to recover, as the normal heart recovers during the pauses which

seem too brief for such profits. Moreover, Professor Osler assures us that we are too chary in the use of the nitrites; and we drop them too soon. In case of necessity he is not afraid to push the 1 per cent. solution of nitroglycerine as far as 30 minims thrice daily. I am bound to add, however, that in not a few cases I have noted a disposition to a nitrite habit; so that, whatsoever the doses decided upon by the physician, care should be taken not to let the patient drift into an indefinite practice of such medication; indeed, it is desirable that, if possible, the physician should hold the prescription in his own hands. Sir William Gowers advises us that in many conditions, at any rate, the nitrites have more than this virtue of temporary reduction; that by prolonged use they have a "steadying effect on the vasomotor centre"; to this end he is wont to administer them for months together, sometimes with the addition of a little strychnine. We are in need of continuous curves of the arterial pressures of persons under vaso-dilators, that we may know how far they have such effects, or lose their power, or are followed by reactions. I may add that, if the primary condition be hyperpiesis, an unknown measure of vaso-constriction secondary to pain, or to nervous apprehension of pain, continually supervenes.

It is a remarkable contrast between science and empiricism that while the value of the iodides in arterial diseases—in arterio-sclerosis, in aneurysm, in angina pectoris—is universally admitted, and indeed asseverated by clinical practitioners, experiment can find no explanation of this maxim. Meanwhile, explanation or no explanation, we are bound to give the patient the probable benefit of these salts. Unless in the suspicion of syphilis, the ordinary doses of 3 to 5 grains thrice daily are sufficient; this prescription is to be continued for six months, with, of course, such temporary suspension as any intolerance of the patient may indicate. Many persons who resist iodism in its specific form are, on awaking of a morning, disgusted by the coppery taste of it. No pretermissions serve to avert this disgust, but I am disposed to infer, from a slight experience of it, that iodipin, even by the mouth, has less of this disadvantage. It is an iodised oil, and is therefore an organic iodine compound.

Venesection commends itself to us as a reasonable remedy in those cases of angina pectoris in which hyperpiesis is primary and persistent. I have not used it, but Dr. Graham Steell warns us that to abate a catamenial flow which, even if excessive, may be beneficent in reducing arterial pressures in such cases, or likewise to arrest a hemorrhoidal discharge, may be followed by an aggravation of the conditions precedent to the attacks.

Issues, such as moxas and setons, are not without their advocates; such agents are not at present in favor, and they have obvious inconveniences. Nevertheless, I am prepossessed in their favor by the testimony of our ancestors, and would gladly agree to a trial of them. Dr. Knott reminds us that Dr. McBride, of Dublin, in A. D. 1776, and Dr. Darwin recommended issues of one or two peas on the inside of the thigh. Even in the later eighteenth century wine was forbidden to sufferers from this angina, then newly described.

Baths may come into vogue even for angina pectoris, but at present I regard them as too risky, in high pressure cases at any rate, for general use. If used at all it would be with such various hedging about as to make their application too precarious for practical purposes. I know that at certain spas, even in angina pectoris, baths are prescribed, but spa reports require for their assimilation more salt than is always at hand. Concerning the principles of artificial exercises I have said already as much as can be said in this brief article. As to massage also, and especially as to abdominal massage which is recommended for angina, we have to bear in mind Dr. Harvey's experiments on compression of the abdominal aorta. If massage—not of the region of this great vessel and of the splanchnic area, but of the muscular system—can be gently employed, without pressure effects on the arterial system with which it is so closely allied, so as to counteract any ill-effects of rest in bed, so much the better. The practice on each sitting must, however, as we have seen, be stealthily initiated; and till both operator and patient have been intimately watched, and pressures estimated with the help of the sphygmometer, the physician must closely supervise every performance of it.

The "high frequency" electric current has been prescribed against that prevalence of high arterial pressures upon which angina pectoris so frequently—though by no means always—depends. Imposing performances often succeed for a time by virtue of the emotional interest excited in the patient by a new remedy and such may be the only worth of high frequency currents; nevertheless, in hyperpiesis, and even in some cases of ominous stenocardia, I have witnessed good results which suggest further research into their efficacy.

Eccentric physical causes, such as irritation in any sympathetic part of the body, as, for example, by a loaded colon, an eczema, and so forth, must be sought with vigilance and promptly removed. Dr. F. Hare has suggested that, as in asthma, so in angina pectoris, a nasal lesion might determine the attacks.

In the palliation of the attacks themselves we are not without remedies, of which the nitrites, discovered in this connection by Sir Lauder Brunton, are the chief. On their use and application I need not dwell. For my part, I would urge as importunately the need of blocking the reflex by which the heart is inhibited, and, it may be, fatally. This, so far as I know, is best done with atropine, and I beg all my anginous patients to observe the continuous use of this prophylactic until the liability to an attack seems to have vanished. As the tolerance of this agent is established, the daily doses must be increased accordingly. Besides, on the access of an attack I order a dose to be promptly injected under the skin. Morphia, in the vogue of the nitrites, is not to be forgotten; it likewise probably blocks the dangerous reflex path, besides its great efficiency as a palliative. In a series of attacks, and in their imminence, it is invaluable. It is, of course, to be injected subcutaneously. It is of little use to inject less than 1-4 grain at once, or, in case of any particular hesitation, 1-6 grain, followed in ten minutes by another sixth. In cases of this class the boggy of morphinism need not dismay us. Chloroform appears to me likely to prove a very treacherous ally, though its aid is accepted by practitioners no less eminent than Balfour and Professor Osler. The fatal events which have ensued upon the use of this drug for anesthesia are of the same inhibitory nature as the peril of angina, and I cannot counsel any interference which might act in the same sense.

As regards incidental dangers, in Cheyne-Stokes breathing the inhalations of oxygen and carbon dioxide alternately, or of one of them in its appropriate interval, might be helpful. In impending death I recommended some time ago artificial respiration; independently, no doubt, Dr. A. Morison tried it on a patient who was slowly dying, but without success; perhaps in this case the death did not result simply from inhibition but from irremediable static conditions in more than one organ of the long-tormented body, wherein death was the only issue and the only consolation. I still think, nevertheless, that, in a simple case of inhibitory syncope by the violence of anginal pain, artificial respiration may yet score a success.—*Folia Therapeutica*.

Progress of Medical Science.

MEDICINE.

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

Pleural Effusion and its Treatment. Bradshaw lecture delivered by Sir James Barr, November 5th, 1907.

Sir James Barr's work on the Pleura is too well known to need mention. In the paper under discussion he has just endeavored to elucidate certain points in its physics. Among these he draws attention to the fact that effusions due to high venous pressure in the right auricle are aggravated by the imperfect values of the azygos veins, they being unable to withstand the backward pressure of the blood, and in consequence a passive congestion of the pleural membranes ensues, and this is especially likely to occur if there be present at the same time a fall in arterial tension.

Barr believes that the effusion, even in tuberculous cases, may, under the method described below, be removed at a much earlier period than has up to the present been considered safe; after the removal of several pints of fluid in a given case a cavity would be formed in the thorax, which cannot exist under an atmospheric pressure of 15 lbs. to the square inch. It is filled in part by (1) carbonic acid gas from the serum; (2) more or less expansion of the collapsed lung; (3) return of displaced organs and mediastinal contents, and further expansion of the opposite lung; (4) increased quantity of blood; (5) elevation of diaphragm; (6) and falling in of the chest wall. If the amount of fluid removed be excessive or the lung be collapsed and bound down, even all the above factors may fail to completely fill the cavity, and it is to aid in filling this space and to reduce the negative pressure that Sir James Barr injects sterile air into the pleural sac after tapping. Thus the danger of hyperemia and edema is partially overcome. His technique is somewhat as follows: A siphon is used to withdraw the fluid, care being taken to desist before dyspnea occurs; a quantity of sterile air equal in volume to the fluid removed is now introduced; he then re-establishes the syphon and completely withdraws the remaining serum, in its place injecting 4 c. cm. adrenalin solution (1-1000) diluted with 10 c. cm. of sterile normal saline solution, and, if

considered advisable, more air to make a total amount equal to 1-2 to 3-4 of bulk of effusion removed.

The adrenalin contracts the vessels and lessens secretion. Dr. Ewart, of London, has recently been injecting it into the pleural fluid preparatory to withdrawal, and has achieved success in thus stimulating its absorption.

Barr also recommends elimination of common salt from the diet, especially in sero-fibrinous cases; when there is a large amount of effused fibrin the use of citrates is advantageous, and the introduction of trypsin to limit or absorb adhesions. At present he is investigating the injection of liquid paraffin as a lubricating fluid as a protection against adherent pleura.

In empyemata he recommends drainage from the most dependent part, with a valve of gauze and oiled silk to prevent entrance of air and permit exit of pus. The side is to be firmly strapped, the patient using respiratory gymnastics to promote expansion of the lung; and, finally, appropriate vaccines as described by Wright may prove of the greatest benefit.

Estimation of Fat in Feces.

The following is an abstract of a paper read at the seventy-fifth annual meeting of the British Medical Association on the above subject by I. Walker Hall, of Bristol, and refers to the estimation of the total quantity of fat evacuated. 1. Before and after administering a known quantity of fat, prescribe fluid extract of hematoxylin. 2. Transfer entire stools to mortar, add normal KOH solution, stir till all lumps are dissolved, add distilled water to make up 500 c. cm., and shake. 3. Heat 50 c. cm. for 20 minutes. 4. To this add 50 c. cm. of 95 per cent. alcohol; heat for 20 minutes. 5. Add strong HCl until strongly acid. 6. Heat 20 minutes, filter, evaporate to 50 c. cm. 7. Take 5 c. cm. and determine percentage in a "milk" centrifugal tube, and multiply result by 5, or take 20 c. cm. in a Schmidt-Werner tube and estimate; after calculation from the dried residue of the aliquot portion of the ethereal extract, multiply result by 25. If the process be interrupted at (3), then the amount of fat extracted approximates that of the fatty acids; this result deducted from the total amount equals that of the neutral fats present.

Subcutaneous Injections of Air to Relieve Pain.

Gubb, of Algiers and Aix-les-Bains, in the *British Medical Journal* of November 9th, 1907, describes the above method, originated by Dr. Cardier, of relieving pain in obstinate cases

of neuralgia. The results probably are due to mechanical action producing stretching of the finer nerve filaments. A hollow needle, attached to which is a rubber bulb, beyond which again is a glass tube filled with gauze, the whole apparatus being sterile, is all that is necessary. After plunging the needle through the skin over the seat of pain, and making sure a vein has not been injured, insufflation is gently undertaken. The skin, at first blanched, later becomes hyperemic; the air travels widely, accompanied by subcutaneous crepitation; cutaneous sensibility is at once diminished; next, the puncture having been sealed with collodion, the air must be alternately dispersed and brought together again by careful massage. Several days elapse before the air is absorbed.

Over regions such as the genital 200-300 c. cm. may be injected, whereas over the thorax 10-30 c. cm. will suffice. In sciatica inject over the lumbar region, outer side of thigh and supero-external part of the leg, followed by systematic massage.

Gubb has also treated cases of neuritis with success, providing absolute rest is enforced.

A Case of Interlobular Serous Pleurisy.

Cases of interlobular purulent pleurisy are frequent enough, but those of interlobular serous pleurisy are almost unknown.

The classical picture of interlobular empyema reveals its course as divided into three stages—latent, apparent and crisis. Nothing can be said of the first. In the second we have a collection in the pleura, which develops especially towards the axillary region; percussion gives often a metallic sound; expectoration is scanty, and slightly mucous. The febrile process is established and lasts 30, 40 or 70 days until a providential crisis, emptying the contents into a bronchus, eliminates purulent and even fetid material. Such symptoms are almost entirely wanting in cases of interlobular serous pleurisy—hence it is rarely diagnosed. In the case reported by Senfferheld, the first symptoms noticed were slight fever and sharp costal pain. It was impossible to make a diagnosis until there was noticed a dullness of the upper convexity, with a tympanic sound; slight fever in the evening; copious indicanuria. One had to choose, apparently, among pneumothorax, pulmonic inflammation, diaphragmatic hernia. The Roentgen rays revealed an interlobular exudate, perfectly walled off from the diaphragm. The serous character was decided upon from the expectoration and from the nature of a free exudate in the pleura of the other side.—Translated from *Giornale Internazionale delle Scienze Mediche*, by HARLEY SMITH.

Pseudo-Diabetes.

Lebeaupir (*Journ. de Med. et de Chir. Prat.*, July, 1907) discusses that form of glycosuria in which the general health is unimpaired. Polyuria and polydipsia are absent; the urine in these non-diabetic cases shows unaltered specific gravity and quantity, and the "night sample" is free from sugar, which is only present during the day in small percentages; an excess of urea and chlorides is found, as are also leucin and tyrosin. These cases are midway between the temporary glycosuria found, on the one hand, in asphyxia, after anesthesia, in strangulated hernia, etc., and true diabetes on the other.

Thus it is not uncommon to find sugar in the urine of young arthritic subjects, in children whose parents are subjects of gout, diabetes or calculi, in digestive disturbances, lesions of the central or peripheral nervous system, exophthalmic goitre, acromegalia, etc., and, lastly, in the puerperal state.

The treatment adopted is one directed to relieve the cause, as antiseptics in intestinal fermentation; Fowler's solution in azoturie forms; bromides, belladonna, etc., in nervous cases, and the results, providing true diabetes can be excluded, are most satisfactory.

The Significance of the Disappearance of Murmurs in the Course of Valvular Lesions of the Heart.

Although there have been reported some cases of mitral stenosis in which the disappearance of the murmur coincided with an improvement in the disease, and its reappearance took place only when compensation was more or less reduced; although there have been published cases of aortic insufficiency, in which the disappearance of the diastolic murmur happened coincidentally with the cure of the disease, such disappearance, asserts Thomayer, in the *Gazzetta Medica Naliana*, is far from always being a favorable omen. There have, indeed, been known some cases of mitral stenosis in which the disappearance of the murmur was the expression of a weakening of the heart, and was due to the fact that the contraction of the left auricle was no longer energetic enough to produce a presystolic murmur. Thomayer had under his care a woman suffering from aortic insufficiency, in whom the disappearance of the diastolic murmur was followed by an accentuation of the second sound. Symptoms of asystole developed, and shortly afterwards the patient died. The post-mortem revealed the existence, in one of the semilunar valves, of a perforation, the result of the ulceration of a valvular aneurysm—two millimetres in diameter, and

having its edges formed of cicatricial tissue. It is thus easy to account for the disappearance of the murmur. Before the diameter of the perforation was lessened by the cicatricial tissue the blood could flow back during diastole, so as to cause a distinct murmur. As the cicatrization progressed, the perforation becoming gradually smaller, the reflux of blood was not sufficient to cause the murmur.

Thomayer refers to two other cases of aortic insufficiency, in which the diastolic murmur was heard only when the patients were standing; when they were recumbent there was perceptible only an accentuation of the second sound in the aortic area. This peculiarity was due to the great mobility with which the heart was endowed. When the patients were lying down the heart could withdraw itself from the anterior part of the thorax so that the diastolic murmur could no longer be heard.

Thomayer had already referred to the unreliable character of pericarditis with effusion; he had also shown that it was possible, through the existence of pulmonary emphysema, adhesions between pericardium and heart, and other circumstances, that the precordial dullness might be concealed or prevented from increasing. He also called attention to the abnormal mobility of the heart, as a cause of perplexity in the diagnosis of pericardial effusion; inasmuch as, having the power of falling back farther than usual, from the thoracic wall, when the patient is recumbent, any increase in the area of precordial dullness is thus rendered impossible.—Translated from *Giornale Internazionale delle Scienze Mediche*, by HARLEY SMITH.

OBSTETRICS AND GYNECOLOGY.

IN CHARGE OF ADAM H. WRIGHT, K. C. M'ILWRAITH, FRED. FENTON AND HELEN MACMURCHY.

Early Recognition of Uterine Cancer.

In an address, delivered to the Canadian Nurses' Association in Montreal, and published in *The Canadian Nurse*, W. W. Chipman spoke as follows:

“What I wish specially to mention to you to-night is the question of uterine cancer, making special reference to its early recognition. By what signs does it first make itself evident? It is these signs that I wish to impress upon you, for it is in your hands often that the responsibility rests. The woman confides in you more readily oftentimes, and naturally so, than in her physi-

cian. First, let me make a general statement, which I wish you always to keep in mind, and it is this: Any woman who has passed the change of life—by that I mean where her normal menstruation has for some months or years ceased, and who informs you that the menstruation has returned (she often laughingly, or almost boastingly, informs you of this fact, claiming that she has renewed her youth, that she is becoming young again)—I say, anyone who informs you of a blood-loss from the vagina after a period of amenorrhea, at the time of the menopause, treat it as a very serious matter. Question her closely, and if a recurrence of hemorrhage should take place, simply insist that she seek the advice of her physician. By doing this only will you be doing your duty. By doing this you will save lives.

“I wish then, to draw your attention to three chief signs of early uterine cancer. I am speaking now of women who are at or past the climacteric. For it is at that time that cancer is most likely to manifest itself. The most suspicious sign is, as I have intimated, hemorrhage—irregular hemorrhage, often small in amount, often bright red and occurring irregularly. Let this sign make you always very suspicious. Let this sign make you always insist that a careful vaginal examination be made by the woman’s physician.

“The next most important early sign is a leucorrhœa. By that I mean any discharge other than blood. Frequently it is thin, watery, meat-watery, as it is called, being slightly blood-stained. Sometimes it is brownish, and sometimes yellow. Any persistence of such discharges in a woman, especially after the menopause, should make you again suspicious of the presence of early cancer.

“The third sign, and the least important, is pain. Unfortunately, when the woman begins to complain of pain the condition is usually past surgical help.

“So I do not ask you to rely at all upon the symptom of pain. Do not wait for it. Hold in your minds the two signs that I have spoken of: hemorrhages, irregular hemorrhages, and persistent leucorrhœal discharges. Whenever in your practice you meet women who speak to you of these things, treat the condition as being possibly very serious, and insist that they seek medical advice.”

The Treatment of the Vomiting of Pregnancy.

Dr. V. E. Watkins, United States Army, remarks:

There are two forms of the vomiting of pregnancy presented to the clinician for consideration; first, the simple “morning

sickness," and, second, pernicious vomiting, or hyperemesis. The simple vomiting, fortunately, is the form most frequently encountered, and after a varying degree of annoyance to the patient will cease about the end of the third month of gestation. The treatment is largely expectant, as evidenced by the vast number of drugs which have been recommended for the condition. Modifications of diet to suit individual cases, regulation of the bowels, and the use of cerium oxylate in 2 to 5 grain doses will suffice.

Hyperemesis is always associated with an autointoxication, and this autointoxication as the causative factor must be recognized in order that the proper therapeutical measures may be instituted. In simple vomiting the urine is free from albumin, but in the pernicious form albumin is always present. But there is always a marked diminution in the amount of urea excreted. A pregnant woman, therefore, with vomiting, albumin in the urine, and a decrease in the quantity of urea excreted, is in a serious condition, and the treatment must be prompt and energetic. There is no drug known which will control this condition. The three principles involved in the treatment are nourishment, rest in bed, and stimulation. These patients lose their strength with remarkable rapidity, and should be put to bed as soon as evidences of physical weakness are manifested.

The nourishment of the patient is the most difficult problem. In some cases the withdrawal of all food for twelve or fifteen hours, with the patient in bed, will so quiet the stomach that small quantities of fluid will be retained. Milk, either plain or predigested, is to be preferred, and is to be given a teaspoonful at a time and gradually increased in amount until at least two quarts in the twenty-four hours are taken. The intake of fluids must be large, and the patient should be given water freely, preferably carbonated. In other cases the stomach will require more time before retaining the liquid nourishment, and it will be necessary to resort to rectal alimentation for a few days. For the depression of the heart, which is invariably associated with cases of any severity, strychnine is to be used. Improvement in the condition will be manifested by an increase in the quantity of urine, decrease in the amount of albumin, increased excretion of urea, and a gradual return of the patient's strength. If this line of treatment does not succeed, the only recourse remaining is to empty the uterus. Production of abortion will result in a cure if the operation is resorted to soon enough, but unfortunately it is in many cases postponed until the condition of the patient has become so serious that death is inevitable, whether abortion is induced or not.—*N. Y. Med. Jour.*

NOTE.—We desire to refer to a line of treatment whose merits are not properly appreciated. Give the stomach absolute rest for six to ten days. Administer enemata of salt solution, as follows: Inject as high as possible 10 to 12 ounces of salt solution, and repeat often enough to use 4 pints in 24 hours. When the rectum is intolerant a few drops of laudanum should be added to each enema. The salt solution thus injected is generally well borne, dilutes the toxins, and furnishes the needed liquids for the body.

Pure milk is not generally well borne. Milk diluted with soda water, and buttermilk are preferable. In many cases scraped beef is much more easily digested.

We quite agree with Dr. Watkins that the induction of abortion is sometimes indicated; but we have learned that this operation, even when "resorted to soon enough" (which may be considered as soon as a jury of obstetrical experts would decide), does not always result in a cure.

We have referred to the great interest which is now being manifested in "The Ammonia Co-efficient of Urine" in two former issues; and we are pleased to publish in this issue a review of Longridge's paper on the same subject by Dr. McIlwraith.—A. H. W.

The Ammonia Co-efficient of Urine.

Great interest was excited in the ammonia co-efficient of the urine and its relation to the toxemias of pregnancy by Whitridge Williams' article, which appeared in the *Johns Hopkins Hospital Bulletin* for March, 1906, and which was reviewed in the December number of this journal for 1906. In the *Journal of Obstetrics and Gynecology* for July, 1907, there appears an article, on the subject, by Nepean Longridge, Pathologist to Queen Charlotte's Hospital. In his preliminary classification we note that Longridge puts pernicious vomiting and eclampsia together. He refers to the fact that in the liver lobule degeneration in eclampsia is peripheral, and in pernicious vomiting central, but apparently attaches little importance to this fact. Williams, on the other hand, puts pernicious vomiting and acute yellow atrophy together. In both the degeneration starts from the centre of the lobule, and Williams shows that clinically they resemble one another in many points. In eclampsia the degeneration starts from the periphery, and clinically also it is separated from the other two. We think that Williams' grouping is the better one.

Anatomical Researches.—Under this heading Flexner's work

is quoted. He was able to produce lesions identical with those found in the toxemias of pregnancy by the injection of various kinds of toxins; but as to the origin of the toxin in pregnancy, we were left as much in the dark as ever.

Physiological Researches.—One of the main functions of the liver is the transformation of nitrogenous derivatives into urea. In the toxemias of pregnancy the liver is badly damaged. What changes result in nitrogenous metabolism? Folin's doctrine of proteid metabolism is then explained at some length, and as a further complication the question of acidosis or undue formation or retention of acids in the body arises. The conclusion of the argument is that there are two ways in which a high ammonia co-efficient may be produced:—

(1) Failure on the part of the liver to synthesize the ammonia into urea.

(2) Kidnapping of the ammonia by acids before it can reach the liver.

Longridge then goes into the evidence with regard to the variations of the ammonia co-efficient during health. Folin's law is quoted, that the percentage distribution of the nitrogen in urine among urea and other nitrogenous constituents depends upon the absolute amount of total nitrogen present. So that with a small amount of proteid in the diet, the ammonia co-efficient may be high, and vice versa. It is instanced also that in the urine of professional fasters, when the nitrogenous intake is low, the ammonia co-efficient may reach 10 per cent.—Williams' danger point—in perfect health. Ewing's work is quoted to show that a patient who is taking but little food may have a high ammonia co-efficient because she is oxidizing her own fat, and not necessarily because she is suffering from any form of intoxication.

Therapeutic Evidence.—There is no doubt that good is accomplished in certain cases of eclampsia by thyroid extract. Oxidation is increased by thyroid extract. These facts seem to support the sub-oxidation theory of eclampsia. (We might also add that Stroganoff's work is of importance in this connection. He strongly advocated the administration of oxygen in the treatment of eclamptic convulsions, and his results were good.) The question of autolysis of the liver is also taken up. This article forms a valuable contribution to the discussion of the ammonia co-efficient question.

K. C. M.

Editorials.

ASYLUM SERVICE IN ONTARIO.

It is well known that the Ontario Provincial Secretary is taking deep interest in the Asylum service of the Province. Since the visit of Drs. Willoughby, Clarke and Ryan we have heard much about the establishment of a Psychiatry clinic. We are told by Dr. Clarke that Germany, which up to a recent date was far behind England and France in the care and treatment of Insanity, suddenly devoted her energies to the problem, and to-day has left all other countries behind in psychiatric studies. Her psychiatric hospitals have placed within the reach of the medical student and practitioner the possibility of acquiring some knowledge of Insanity, and have shown the general public that mental disease is to be dealt with in the same manner as other diseases.

Dr. Clarke (*University Monthly*) also tells us something as to modern methods in the study of the insane patient; ordinarily such a patient when admitted to an institution is at once put to bed, and kept there for sometimes perhaps a week or more, until his condition physically and mentally is inquired into. His complete examination may take many hours, the physiological analysis alone occupying much time. His history from childhood is inquired into, and no sphere that is likely to afford information is left untouched. A cerebro-spinal fluid examination when necessary is made, and the result is discussed by a conference of the staff, and the line of treatment mapped out. The amount of detail required would surprise one not conversant with the exactions of modern science.

It is expected that a new Psychiatric clinic will be built in Toronto in connection with the new hospital. We are told there will be a building with accommodation for about 100 beds, and a large staff of attendants will be provided for the care of these acute cases. This will probably be in some respects similar to what they call in Glasgow a receiving hospital, where persons suffering from mental disorder are sent. The patients in such

hospital are treated and discharged when cured, or sent on to a lunatic asylum if incurable. It is said that in Glasgow more than half of the patients thus treated are cured.

SCIENTIFIC AND PRACTICAL.

It would seem in these modern days that we have reached a stage when we should consider that science and practice are not antagonistic. We know that in the past, for two or three thousand years at least, there have been conflicts in opinion as to the scientific and practical. It is scarcely necessary to go back to the time of Hippocrates, but we might well consider the discussions that have taken place during the last 30 or 40 years. The following very apt words on this subject are quoted from Dr. J. F. W. Ross' admirable address on "Ideals in Medicine," delivered before the Toronto Academy of Medicine: "A training is useless unless adapted to the real needs of the person trained. The Germans have laid this truth to heart, for their regulations expressly provide that the examinations in physics and chemistry 'hav. to keep particularly in view the *requirements of the future physicians.*' While the Germans have been making a march in advance we have been retrograding owing to our acquiescence with the demands of the teachers of purely scientific subjects. Teachers of physiology and chemistry are intent on turning out physiologists and chemists, and not on turning out well-trained physicians to heal the sick." The last sentence may not be strictly correct as to all such teachers, but certainly the general tendency is in the direction indicated.

As we wish to make no reference to any present teachers, we shall go back to the days of a certain teacher of chemistry, who was possessed of great ability and a profound knowledge of his subject. His lectures, while most admirable for advanced students in chemistry, were practically useless for the average medical student. This fact illustrates the truth of Dr. Ross' contention that in some cases professors aim at the production of pure scientists—not practical physicians.

We want in Canada a happy medium between pure science and narrow empiricism. We want practice founded on science.

We cannot improve much on the words of Sir Thomas Watson, of London, England, to his students 40 years ago, although even then he was only paraphrasing a quotation from Lord Bacon:

“Be not like the empiric ant who clutches from every side indiscriminately for present wants, nor speculative like the spider, who, seeking no materials abroad, spins his web of sophistry from the recess of his inner being; but imitate rather the praiseworthy bee, who, gathering crude honey from various flowers, stores it up within, and by his own operation matures and perfects it for future use.”

A LITTLE BROWN DOG.

An English dog has got very much into history. In 1904 the International Anti-vivisection Society erected a monument to a brown spaniel that had died in a series of vivisection experiments. The statue took the form of a fountain imbedded in a circular mass of granite, on which was the image of a dog with an inscription saying that it had been “done to death” by vivisection in a medical school.

The memorial, after it was finished at a cost of \$750, was offered as a gift to several public bodies, who refused to accept it through fear of becoming embroiled in the quarrel between the vivisectionists and the memorialists.

Finally, the Battersea Borough Council accepted the statue after a stormy debate. The Anti-vivisection Society agreed to defray the costs of any proceedings, such as libel cases which were threatened, and deposited \$1,500 as earnest money. The monument was placed near Battersea Park and dedicated to the public in 1906. From that time the statue had to be protected, especially from medical students. Considerable expense has been incurred by the Council in their endeavors to preserve the image of the brown dog; of late there have been two special policemen on duty day and night to keep the statue from destruction.

To add fuel to the flames of debate the Commissioner of Police

when making up his estimate for 1908, wrote to the Battersea Council and asked if it was prepared to pay \$3,500 for protecting the statue. In answer, some members of the Board, as we are told by the *Toronto Mail and Empire*, fired back a hot demand, "If Battersea organizes a gang sometime of the medical hooligans to raid laboratories in order to destroy instruments or animal torture, would these laboratories be required to pay for protection from the police?"

The anti-vivisectionists expressed their determination that the famous statue was to remain in the Park, even if they have to pay \$5,000 a year to guard it from disfigurement.

THE MOSETIG BATISTE.

No rubber tissue for surgical or obstetrical purposes has ever proved in all respects satisfactory. Dr. Chas. P. Noble, of Philadelphia, published a short article in the *New York Medical Journal*, October 12th, 1907, in which he recommended the medicated batiste as a useful addition to the armamentarium of the hospital. The lighter kinds of rubber tissue are friable, while the heavier rubber cloth, in the shape of draw sheets, aprons, etc., is difficult to sterilize without destroying it.

Dr. Noble says that in Europe batiste has been used for a long time, to take the place of rubber dam and heavy rubber cloth, and also for many purposes for which the rubber tissues are not adapted.

The ordinary batiste, which is said to be named after the alleged first maker, Batiste, of Cambria, France, is a light cambric, or lawn of fine linen, or cloth of similar texture made of cotton. For a time the so-called Billroth batiste was extensively employed as a protective covering for the purpose of keeping patients dry during operations. The Mosevig batiste is used very largely in Europe to-day. It is said that it will stand sterilization in the pressure sterilizer for at least ten sterilizations.

Dr. Noble thought highly of it when he first saw it used in Europe, and had a quantity sent into the United States to be

used in the operating room instead of the rubber apron. It is also useful to put round the necks of patients who are vomiting, to protect the pillows and bedding. As it lacks odor and is quite flexible, it is very satisfactory for such purposes. It is much used in Europe for abdominal surgery, more especially for anastomosis, to assist in shutting off the peritoneal cavity from the incised bowels.

UNIVERSITY OF TORONTO.

The following rules as to salaries have recently been made by the Board of Governors:

In the Faculty of Arts, demonstrators will receive a minimum salary of \$800; lecturers a minimum salary of \$1,200, increasing at the rate of \$100 per annum until \$2,000 is reached; associate professors a minimum salary of \$2,100, increasing at the rate of \$100 per annum to \$3,000; professors, a minimum salary of \$3,100, increasing at the rate of \$100 per annum to \$3,600. It shall be in the discretion of the Board from time to time to advance the salary of a professor to \$4,000.

Regulations have also been made for deductions from the salaries of 5 per cent. to 15 per cent. for the Retiring Fund.

In the Faculty of Medicine it is recognized that there are two classes in the Staff, namely, those who give their entire time to their duties, and those who are in active practice and devote only a part of their time to academic work. In the former class are at present professors of pathology and anatomy, and lecturers in pharmacy and pharmacology. For this the salary basis will be the same as in the Faculty of Arts. In the other class the salaries will stand as at present with some unimportant additions. The salaries in this class are considered rather in the nature of honorariums, than as representing the value of the services rendered.

The 77th Annual Meeting of the British Association for the Advancement of Science was held at Leicester, July 31st to August 7th. The association will hold its meeting in Dublin next summer, and will come to Winnipeg in 1909.

ONTARIO MEDICAL ASSOCIATION.

PROVISIONAL PROGRAMME.

The Committees on Papers and on Arrangements have pleasure in submitting the following programme for the twenty-eighth annual meeting, to be held in Hamilton, in the College of Music Building, James Street South, May the 26th, 27th, and 28th. The present arrangement of papers will not necessarily be adhered to, as a new grouping of subjects may be deemed advisable before the issuing of the final programme. We believe that no programme has been sent out in the history of the Association more replete with interest from the first item to the last than this promises to be. Every practitioner in the Province can well afford to set aside these days for attendance at Hamilton.

The sectional plan of meetings has been adopted, and will be enlarged if the papers will permit of doing so. Sections will meet in the mornings, the afternoons for the addresses and subjects of general interest, while the evenings will be devoted to entertainment.

TUESDAY, MAY 26TH.

Surgical Section—

L. W. Cockburn, Hamilton—"The Treatment of Acromio-Clavicular Dislocation."

H. A. Bruce, Toronto—(Title to be sent.)

N. A. Powell, Toronto—(Title to be sent.)

H. P. Lyle, Surgeon to St. Luke's Hospital, New York—"The Hyperemic Treatment."

Clinic and Luncheon at the General Hospital.

Medical Section—

W. L. Silcox, Hamilton—"Opsonins." Discussion to be led by W. Gibson, Kingston.

W. Goldie, Toronto—(Title to be sent.)

Adam H. Wright, Toronto—"Puerperal Septicemia."

J. Sheahan, St. Catharines—(Title to be sent.)

Benson Cohoe, Assistant Physician to the Roosevelt Hospital, New York.

Clinic and Luncheon at the General Hospital.

General Session—Afternoon.

President's Address.

Symposium: Arteriosclerosis—

Pathology of—J. J. Mackenzie, Toronto.

Cerebral Manifestations—Colin K. Russell, Assistant in Medicine, McGill University.

Aortic Arch Manifestations—Thos. McCrae, Associate Professor in Medicine, Johns Hopkins, Baltimore.

Muscle Manifestations—Harry C. Buswell, Associate Professor in Medicine, University of Buffalo.

Visceral Manifestations—J. H. Bauer, Hamilton.

Treatment—H. A. McCallum, London.

Evening—Smoking concert at the Yacht Club, Burlington Beach.

WEDNESDAY, MAY 27TH.

Surgical Section—

J. P. Morton, Hamilton—(Title to be sent.)

F. N. G. Starr, Toronto—(Title to be sent.)

Edwin Seaborn, London—(Title to be sent.)

G. T. McKeough, Chatham—"Mechanical Ileus, Operation, Recovery, Remarks on the Treatment."

W. E. Olmsted, Niagara Falls—"Ulcer of the Stomach."

E. E. King, Toronto—(Title to be sent.)

Medical Section—

G. S. Glasco, Hamilton—(Title to be sent.)

J. R. Stanley, St. Mary's—(Title to be sent.)

R. J. Dwyer, Toronto—(Title to be sent.)

D. Dunton, Paris—(Title to be sent.)

F. Fenton, Toronto—(Title to be sent.)

George Hodge, London—"The Treatment of Pneumonia."

K. C. McIlwraith, Toronto—(Title to be sent.)

R. Ferguson, London—(Title to be sent.)

General Session—Afternoon.

Address in Surgery—Charles L. Scudder, Surgeon to the Massachusetts General Hospital, Boston.

G. E. Armstrong, Professor of Surgery, McGill University.

V. P. Gibney, Professor of Orthopedic Surgery, College of Physicians and Surgeons, New York.

Evening Session—Dinner at the Royal Hotel.

THURSDAY, MAY 28TH.

Surgical Section—

H. Sinclair, Walkerton—(Title to be sent.)

S. M. McCoy, St. Catharines—(Title to be sent.)

A. E. Garrow, Associate Professor of Surgery, McGill University—"Duodenal Ulcer."

H. Sanderson, Detroit—(Title to be sent.)

D. E. Mundell, Kingston—"Pancreatic Cyst."

Medical Section—

D. King Smith, Toronto—(Title to be sent.)

J. T. Fotheringham, Toronto—"Malignant Endocarditis."

A. R. Gordon, Toronto—(Title to be sent.)

Campbell Howard, Assistant in Medicine, McGill University.

G. R. Cruickshank, Windsor—"The Treatment of Appendicitis."

J. C. Meakins, Pathologist to the Presbyterian Hospital, New York—"Rheumatism."

General Session—Afternoon.

Address in Medicine—Charles G. Stockton, Professor of Medicine, University of Buffalo.

L. G. Cole, Radiographer to the Roosevelt Hospital, New York—Illustrated Lecture.

C. K. Clarke, Toronto—"Psychiatry in Relation to General Medicine."

MEDICAL STAFF REORGANIZATION AT TORONTO GENERAL HOSPITAL.

The Re-organization of the Visiting Staff of the Toronto General Hospital is now said to be complete. The whole scheme exhibits one very bad and rather nasty feature. Several men have had their heads pole-axed for simply attending faithfully to their duties, and leaving altogether out of sight politics, pull, etc. Now, this unsavory action on the part of either the Board or the medical advisers to the Board is abominable; and occurring as it does amongst medical men, who are sticklers for ethics, smacks of quackery. If this sort of slaughtering is to be a feature of hospital work every few years—and many of the young men recently appointed will bear in mind that their tenure of office is for a year only—then it is high time reform, thorough and lasting, should be inaugurated in all hospitals which receive governmental and municipal grants. Taxpayers, lay as well as professional, should have something to say as to the manner their money is spent. To deny the right of a practitioner, who is a taxpayer, or whose patient may be a taxpayer, to follow that patient into the wards of any hospital, irrespective of his being or not being on the visiting staff, does not seem just as just to that practitioner and that patient as it may be advantageous to the hospital and the visiting staff. In

other words, Boards care more for their hospitals and visiting staffs more for their appointments than either care for the patients. It is only the patient and the patient's doctor who is concerned in the case in hand. Every man who is licensed to practice is entitled to practice upon his patient in his own home. The conscientious doctor when he needs the aid of a confrere or specialist, he so advises. Why are there men in the medical profession who for a little questionable fame attached to a hospital appointment will deny the right of other of their regularly licensed confreres to practice in hospitals as well as outside? Why should a poor man, because he has not enough money to pay for his hospital maintenance, have taken from him the right, which he is entitled to as well as any one else, to choose his own medical attendant in any hospital? There are a great many medical men who do not care for hospital appointments. There are others who will pull out tooth and evulse nail to get them. Is their success in life so dependent upon this disgusting wire-pulling? We trow not. It would be just as great, just as distinguished, just as transcendent, if every physician and every surgeon had the privilege, as it is his right, to follow his patient and treat him in any hospital he liked.—*Dominion Medical Monthly.*

Canadian Hospital Association.

The next meeting of the Canadian Hospital Association will be held in the Parliament Buildings, Toronto, April 20th and 21st. Among the papers promised are: "How to Deal with Tuberculosis as a Social Problem," by Dr. W. J. Dobbie, Superintendent of the Consumptive Sanitarium, Weston; "The Unfinished Business of General Hospitals," by Dr. S. S. Goldwater, Superintendent Mt. Sinai Hospital, New York, and President of the American Hospital Association (which Association meets in Toronto in September next); "The Milk Supply," by Dr. Helen MacMurchy, editor *Canadian Nurse*; "Fumigation," by Dr. A. D. McIntyre, Superintendent of the General Hospital, Kingston; "Some Observations on European Psychiatric Hospitals," by Dr. C. K. Clarke, Superintendent Toronto Hospital for Insane; "The Hospital and the Public," by Del Sutton, editor of the *National Hospital Record*; "The Proper Length of the Period of Study for Nurses," by Dr. Henry Hurd, Superintendent of Johns Hopkins Hospital, Baltimore. The presidential address will be delivered by Miss Louise C. Brent, Superintendent of the Hospital for Sick Children, who will hold a reception to the delegates at the new Nurses' Residence on Easter Monday evening.

Personals.

Dr. Colin Campbell has removed from College Street to 93 Bloor Street West.

Dr. J. Milton Cotton, of Toronto, has removed from Simcoe Street to 210 Bloor West.

Dr. Jno. A. Lawson, of Brampton, has been made an associate coroner for the County of Peel.

Dr. James Algie, formerly of Alton, has removed to 75 Dewson Street, corner of Dovecourt Road.

Dr. Samuel Johnson, of Toronto, sailed from New York by the *Campania* on Feb. 1st, for England and the Continent.

Dr. Geo. McDonagh, of Toronto, left for Florida February 1st, expecting to remain either in that State or go over to Nassau for a few weeks.

Dr. W. P. Caven, of Toronto, after an attack of influenza in the early part of January, went to Atlantic City, February 6th, and remained there about two weeks.

Dr. George Elliott, General Secretary of the Canadian Medical Association, has been appointed Provincial Medical Examiner for the Royal Arcanum in Ontario.

Dr. Jno. Caven, of Toronto, had a severe attack of colitis in the early part of February. He left, February 14th, for Jamaica, where he expects to remain until about the 1st of April.

Dr. J. Orlando Orr sailed from New York by the *Cedric* for Naples. After travelling through Italy, Switzerland and France he will visit England, and return to Toronto about May 1st.

Dr. Emory, of this city, who was formerly registered with the College of Physicians and Surgeons of Ontario as a homeopath, had his registration changed in 1902 to that of a regular practitioner.

Hon. Dr. J. O. Reaume, Minister of Public Works and Fisheries for Ontario, was elected President of the North American Fish and Game Protective Association at the recent meeting held in Albany, N.Y., February 12th and 13th.

Dr. D. J. Gibb Wishart, Associate Professor of Laryngology and Rhinology in the University of Toronto, leaves early in March for Italy, where he intends to follow the clinics of Professor Massei and others in Naples, Rome, and Turin. Subsequently he will attend the International Laryngo-Rhinological Congress in Vienna in Easter week, which is being held to commemorate the fiftieth anniversary of the establishment in Vienna of clinical laryngology and rhinology by Turek and Czermak. Later Dr. Wishart will spend some weeks at the clinics of Professor Killian in Freiburg and Hammel in Heidelberg, before going to England.

Obituary.

HENRY GOING, M.D., M.R.C.S.I.

Dr. Going, of London, Ont., died January 27th, 1908, aged 91. He received his medical qualifications in Ireland 66 years ago, and shortly after graduating came to Canada and settled in London, where he continued in active practice for over 60 years.

HARRY PATTERSON LOOMIS, M.D.

Dr. Loomis, of New York, died December 22, 1907, aged 49. He was a son of the distinguished Professor Alfred Loomis, whose text-books on medicine were for many years so popular in Canada. Dr. Patterson Loomis was an admirable physician and a good clinical teacher, and was very highly esteemed by his professional brethren and the public in general.

JOHN HENRY C. F. FISHER, M.D.

Dr. J. H. Fisher, of Toronto, died at his home, 18 St. Patrick Street, February 15th, aged 59. After a supposed slight attack of influenza, he resumed work on Thursday, February 13th. On the following day he was much worse, and died on Saturday afternoon. He graduated M.D. from Trinity University in 1888, and at once settled in Toronto, where he practised up to the time of his last brief illness.

FREDERICK J. BRADD, M.D.

Dr. Bradd, of Peterboro', died December 23rd, 1907, aged 46. He was educated in the Toronto School of Medicine, and received his degree of M.D. from Victoria University in 1888.

W. E. SPRAGUE, B.A., M.D., F.R.C.S. (Edin.).

Dr. Sprague, of Belleville, died suddenly, January 25th, 1908, aged 58. Being a member of one of the oldest families—the Spragues of the Bay of Quinte District—noted for longevity, the Doctor's death was a shock to his family and his many friends. He was a cousin of our friend, Dr. Sprague, of Stirling, who is so well known throughout the Province of Ontario.

FRANK HEYDEN MOSS, M.B.

Dr. Moss, formerly of Toronto, was instantly killed in a railroad wreck in California, Feb. 5th, 1908. He was a son of the late Chief Justice Thomas Moss, and a nephew of Sir Charles Moss, of Toronto. Shortly after graduating from the University of Toronto in 1892 he settled in San Jose, Cal., and practised in that town up to the time of his death.

SIR THOMAS McCOLL ANDERSON, M.D.

Sir Thomas McColl Anderson, Regius Professor of Medicine in the University of Glasgow, died suddenly January 25th, aged 72. He attended the annual dinner of the Glasgow Ayrshire Society and proposed the last toast on the list. On leaving the banquet hall he was suddenly seized with an attack of cardiac failure and died in a few minutes.

Dr. Knight died at Toronto Junction, January 11, 1908.

Dr. Milne, formerly of Port Arthur, died at Denver, Colorado, Jan. 3rd, 1908.

Mr. Wm. Rudolf, eldest brother of Dr. R. D. Rudolf, of Toronto, died at Biloxi, Miss., Jan. 5th, 1908, aged 43.

Correspondence.

REORGANIZATION OF THE MEDICAL STAFF AT THE GENERAL HOSPITAL, TORONTO.

To the Editor of THE CANADIAN PRACTITIONER AND REVIEW:

Dear Sir,—I have read with great interest letters and editorials which have appeared in the medical press upon the Hospital situation, and, on making careful inquiries, I find that the recently appointed Trustees of the Toronto General Hospital announced to the Medical Staff with much ostentation, and after, no doubt, grave consideration, that there was soon to be a re-organization of the Hospital, which would place that institution in the forefront of all similar institutions in the world. The Medical Staff waited patiently for the proposed changes, meantime performing their duties quietly and well. And now the appointments have been made. The expressed intention of the Board, to make merit the basis of all appointments, was departed from. The announcement that the staff would be numerically curtailed was not adhered to. A number of junior men associated with the teaching staff of the University of Toronto, and some others, have received appointments, and many non-school and some school men, also young, with great qualifications, tried accomplishments, and tested capacity, have been ejected from the staff without even a kindly acknowledgment of the great services which they have rendered to the institution. Now there is a disunited staff, a discredited Board of Trustees, a feeling of distrust in the institution, and an unpleasant professional atmosphere surrounding the whole matter.

Yours, etc.,

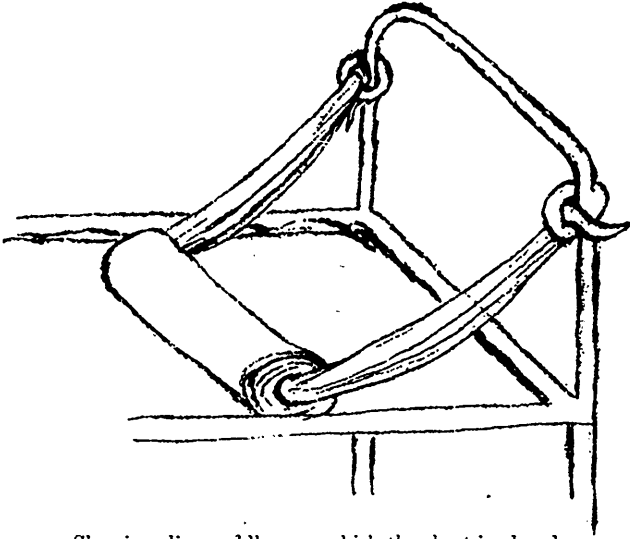
OLD PRACTITIONER.

Toronto, Feb. 20th, 1908.

ILLUSTRATING SLING SADDLE.

The difficulty in maintaining a patient in the semi-recumbent or more erect position in bed has been the experience of us all.

A simple device which I first saw applied at St. Mary's Hospital has given me excellent satisfaction, and while probably familiar to those who have visited the St. Mary's, might not be without interest to your readers. It consists of two sheets, one of which is attached to either side of the head of the bed and passes beneath the draw sheet about three feet from the head. Around this sheet is rolled another, thus making a saddle sling upon



Showing sling saddle over which the sheet is placed.

which, or better within which, the patient sits, being supported behind by the triangle or pillows. This sling effectually prevents slipping forward, or "sinking down in the bed" that patients experience in their attempts to sit up after stomach, peritoneal pus operations, or during convalescence.

I have modified this by the use of a pillow with the sheet, instead of the second sheet rolled round the sling sheet, finding that it is just as effectual in support and more comfortable.

ERNEST A. HALL,

Vancouver, B.C.

Book Reviews.

TEXT-BOOK OF PRACTICAL GYNECOLOGY FOR PRACTITIONERS AND STUDENTS. By D. Tod Gilliam, M.D., Emeritus Professor of Gynecology in Stirling (Ohio) Medical College; Fellow of the American Association of Obstetricians and Gynecologists. Second Revised Edition. Price, \$4.50.

The general practitioner, as well as the student, will find in this work a practical and systematic treatise that will give the foundation for diagnosis and treatment of all the known diseases of women.

There is probably no special subject which is of so much interest to the general practitioner as gynecology, and the doctor who has a clear, practical knowledge of this subject is always well thought and spoken of by his patients.

This work is full of ideas, is very well illustrated, and should be read by every family physician.

HALL'S PHYSIOLOGY. A Text-Book of Physiology, Normal and Pathological. For Students and Practitioners of Medicine. By Winfield S. Hall, Ph.D., M.D. (Leipzig), Professor of Physiology, Northwestern University Medical School, Chicago; Member of the American Physiological Society; Member of American Association for the Advancement of Science, etc., etc. New (2nd) edition, revised and enlarged. In one octavo volume of 795 pages, with 339 engravings and three full-page colored plates. Cloth, \$4.00, net. Lea Brothers & Co., Publishers, Philadelphia and New York. 1905.

Although the field in physiology is well covered with textbooks, this volume has so many good points that it deserves the wide reception which it had in its first edition. We have seen no other short work on physiology that is written in such a clear way for the student, and, best of all, at the end of each chapter practical application is made of the facts stated. Too many medical students learn the subject in their primary years, only to forget it when they come to the bedside, but here is a work which will be of the greatest use. We have noticed some omissions. For instance, no mention is made of erepsin in the intestinal juice, and Chittenden's experiments are not referred to. But, on the whole, it is the best student's book we know of.

Selections.

Diseases of the Heart.

Huchard (*Journ. des Prat.*, Aug. 24, 1907) points out many mistakes made during the clinical investigation of and the treatment of patients suffering from diseases of the heart. He points out that far too much importance is attributed to physical signs and too little to functional troubles; valvular diseases are studied according to their anatomical situation, instead of according to their endocardial or arterial origin; the "central" heart is studied and the "peripheral" heart, as represented by the vascular system, is almost entirely neglected. Other errors are the non-recognition of the factor of alimentary intoxication as an important cause of the dyspnoea of heart disease: the failure to distinguish the various forms of angina and an ignorance of the clinical characters of aneurysmal neuralgia. Dyspnoea occurring in patients with heart disease is frequently considered to be uraemic in nature, whilst really being due to an alimentary intoxication, as is proved by the fact that suppression of meat and the institution of a milk diet will cause a disappearance of the dyspnoea, whilst a return to a meat diet will cause this symptom to return. The author has never known a systole to result directly from emphysema or asthma, as is generally stated in text-books. He states that a systole only occurs in emphysematous asthmatical patients when they have developed arterio-sclerosis. Patients from 45 to 60 years of age sometimes become "asthmatical" (?). Most of these "late asthmas" are really the result of arterio-sclerosis or are due to alimentary intoxication. The author points out that as true asthma can be modified very considerably by alimentary régime, it is necessary in treating a patient with this disease not only to prescribe iodide of potassium, but also to enforce a carefully-regulated dietetic régime. He denies that affections of the digestive tube can ever of themselves give rise to dilatation of the right side of the heart and to asystole, as has been stated by Potain. The so-called "cardiac" epilepsy does not exist: the association of heart disease and epilepsy in the same patient is accidental only. Reduplication of the second sound of the heart, which is said to occur physiologically in connection with the respiratory movements, is, according to the author, always pathological. Functional insufficiency of the aortic or mitral valves may really occur, although doubted by some, but only when there exists some defect in the myocardium. The most important

factor which separates coronary angina from other forms is that in the former there is an ischemia of the myocardium; this is proved by the fact that patients suffering from true angina pectoris die generally from syncope. The so-called gouty, diabetic and tabetic anginas do not depend directly on the several constitutional states, and do not yield to the treatment adopted for those conditions; the terms are, therefore, misleading. With regard to the disputed point as to the danger attached to women suffering from mitral stenosis who marry, the author considers that these patients may be allowed to marry, to become pregnant, and to suckle their children. An exaggerated tortuosity and increased tension of the walls of the temporal artery does not by any means indicate commencing or existing arterio-sclerosis, as is commonly supposed. Death from aneurysm is by many considered to be usually from rupture of the sac; in his researches on the cause of death in aortic aneurysm, however, the author finds this mode of termination far from common. Death may occur slowly, from asystole with compression of the auricles; from inanition due to pressure on the oesophagus; from pulmonary tuberculosis, favored by pressure on the pulmonary artery and vagus nerves, and from a form of arterial cachexia; suddenly, from hemorrhage and syncope; from angina pectoris, from laryngeal spasm; from compression of the air passages; from rupture of the sac into the lungs, bronchi, or trachea, pericardium, pleura, or spinal canal, or by embolism, etc. Another cause of sudden death in aortic aneurysm is a subacute anaemia. In heart disease pleural effusion occurs specially on the right side, due chiefly to the fact that pulmonary embolism is most frequent on the right side, and to the fact that a perihepatitis may extend upwards into the corresponding pleura; this effusion is latent, without inflammatory reaction, and almost always without dyspnoea, and, unless carefully watched for, may be entirely missed.—*British Medical Journal*.

Syphilitic Hepatitis.

G. Breccia (*Riv. Crit. di Clin. Med.*, Florence, 1907, pp. 665, 692) has collected from the pathological literature nine forms of hepatic syphilis, which he briefly discusses. Some of these are associated with fever, and he adds five cases of his own in which he diagnosed febrile syphilitic hepatitis. He notes that the fever may be either continuous, intermittent, remittent or irregular, and is generally of short duration only. He concludes that syphilis should be thought of in patients presenting several of the following signs and symptoms: Enlarged liver, with or with-

out splenomegaly; gastro-intestinal disturbances, anaemia with leucaemia or leucocytosis, jaundice, enlarged lymphatic glands, osteocopic pains, general and progressive debility, intermittent or remittent fever. Of course a history of syphilitic infection or congenital syphilis is very suggestive in such cases. In one of his cases that died the spleen was enlarged and very fibrous; while the liver was much enlarged, smooth, hard, and showed marked parenchymatous degeneration with but little increase in the fibrous tissue. Numerous references to the literature are given.—*British Medical Journal*.

Therapeutic Control of Malignant New Growths.

Bier, the ingenious creator of treatment by hyperemia, has been studying the influence upon malignant tumors of injections of the blood of other animal species, and reports upon the same in the *Deutsche Medicinische Wochenschrift*. He injected subcutaneously in the neighborhood of the tumor 10 to 20 c.c. of defibrinated pig's blood; and in one of his cases observed a well-marked dissolution of the tumor mass, and in another, compression of the carcinomatous tissue by a smart inflammatory infiltration, resulting in the formation of connective tissue. In three cases of benign prostatic-hypertrophy, Bier also believes to have observed good effects, shown by the re-establishment of micturition. He does not consider, however, that the time has yet arrived for a general recommendation of his method. Some experiments upon animals recently reported by Bergell and Sticker from the Berlin Institute of Cancer Research, in the *Deutsche Medicinische Wochenschrift*, are also interesting and worthy of attention. Von Leyden and Bergell had already shown that by means of the injection of substances isolated from the normal liver of animals, they were able to bring about extensive destruction of human carcinomata, though the treatment was not devoid of toxic manifestations. Now, Bergell, in collaboration with Sticker, reports retrogressive metamorphosis in a sarcoma experimentally produced in a dog, by injection of this specific liver ferment at a period when the question of spontaneous cure could no longer be entertained, and which finally resulted in the complete disappearance of the tumor. Although the authors themselves do not seem inclined to overestimate the importance of these experiments for human therapy, they appear to me to be interesting enough to find mention in this brief report of the meagre fruits of the summer's work.—Prof. Strauss, of Berlin, in *Folia Therapeutica*.

Acute Rheumatic Fever.

S. SOLIS-COHEN, Philadelphia (*Journal A. M. A.*, December 21), recognizes acute rheumatism as an infectious disease, due it is probable, to any one of a group of organisms, possibly cocci, allied to the organisms of scarlatina and erysipelas. He also admits a certain constitutional susceptibility or diathesis, intimately related to nervous function, and especially with the vasomotor apparatus and perhaps also with the tissues of the organs of circulation. He reviews the medicinal treatment, largely empirical, that has been found useful—the precordial blisters, the use of alkalies, which has a sort of clinico-pathologic indication in the abnormally acid condition of the body fluids, the use of the tincture of the chlorid of iron and the salicylates. The use of the latter, together with the alkalies, is not contraindicated, and he generally uses them in combination. Ferric medication can also be associated in the “mistura ferro-salicylata,” introduced by him twenty-two years ago, the revised formula of which is given in a footnote. Special care should be given to the condition of the mouth, nose and throat and avoidance of exposure to drafts for susceptible individuals. The resistance of the vasomotor system can be increased by such measures as massage, electric light baths and hydrotherapy. Regular and sufficient elimination is a necessary prophylactic measure and a regulated nutritious diet yielding a minimum of nitrogenous waste. The carbohydrates should be reduced and oils and fats substituted so far as possible. The diet, however, should be individualized to suit the case. The management of the attack is described in detail; the diet should be milk exclusively for at least two weeks and longer if necessary, the bowels should be kept open and the urine alkaline, but the most important measure is complete rest, and it depends on the case whether this be enforced for six weeks, which is Solis-Cohen’s minimum, or whether it be continued to nine or ten weeks more. The great majority of subsequent chronic cardiac lesions are, he says, beyond question due to the neglect of the rest. Local treatment must be guided by the general condition and the patient’s special needs; there are many applications and most of them are useful unless the patient has some idiosyncrasy. If the heart becomes involved during the attack the blisters and alkaline treatment can be kept up, but unless the articular symptoms are still severe, it is usually best to discontinue the salicylates. He speaks highly of the value of rectal, and, in severe cases, of intravenous injections of colloidal silver in cardiac complications, although he can not say they are always.

curative. Bromid of strontium or ammonium may be useful in quieting restlessness; a precordial ice coil or ice bag is useful. The two principal things he insists on in the treatment of acute rheumatism and its complications are individualization and rest, and the latter in all cases is the measure of supreme importance.

The Diagnosis of Appendicitis.

R. T. Morris, New York (*Journal A. M. A.*, January 25), calls attention to the value of tenderness over the right sympathetic lumbar ganglion (one and a half inches from the navel on a line with McBurney's point) as a diagnostic sign in appendicitis in addition to the well-known McBurney's point. He gives the following general statement: 1. "In the early stages of an acute infective process of the appendix the right lumbar ganglia are tender and the left lumbar ganglia are not tender. (The left lumbar ganglia may be described for diagnostic purposes as lying an inch and a half to the left of the navel.) Under these circumstances the point here described is of secondary importance, while McBurney's point is of prime consequence. 2. (A) When an acute inflammatory process of the appendix has subsided, leaving a mucous inclusion or scar tissue, there may be no tenderness on pressure at McBurney's point, but there is tenderness at the point here described and no tenderness at the point of the left lumbar ganglia. (B) When the appendix is undergoing a normal involution process, with replacement of its lymphoid coats by connective tissue, digestive disturbances and various local neuralgias may be due to nerve filaments entrapped in the new connective tissue. There may be no tenderness at McBurney's point, but there is persistent tenderness at the point here described. There is no tenderness at the point of the left lumbar ganglion. (C) When the appendix is congested without the presence of infection, as in many cases of loose kidney, there may be little or no tenderness at McBurney's point, but there is persistent tenderness at the point here described. There is no tenderness at the point of the left lumbar ganglia." Under these conditions (A, B, C) the point here described is of primary importance, while McBurney's point is of secondary or no significance. It will be found useful in differentiating between appendiceal and pelvic irritations. If it is alone tender, it means appendix trouble. If both right and left lumbar ganglia points are tender it signifies pelvic disorder. If neither of these points are tender, the abdominal irritation must be looked for somewhere higher up than the pelvis or the appendix.

Miscellaneous.

RADIUM AND ITS DISCOVERER, MADAME CURIE.

The following, taken from *Harper's Bazar*, written by W. G. Fitzgerald, may be agreeable reading to many of our subscribers, who have shown such deep interest in the valuable contributions recently published from the pen of Dr. Louis Wickham, of the Curie Laboratory for Radium, in Paris:

"One day last spring I halted in astonishment outside the stately Sorbonne University in Paris. 'Surely,' thought I, 'this hoary centre of learning must have been turned into a show-place for the rank and fashion of all Europe?' Great titled ladies in sables and silk were alighting from superb motors, escorted by men whose names are known the world over—gray-haired savants, too, of the rank of Lord Kelvin, Sir William Ramsay, and Sir Oliver Lodge. Russian and American girl-students were pouring in, with the miscellaneous crowd of cosmopolis that represented the beauty, wealth, wit, and intellect of half a dozen nations. And last of all came King Carlos and Queen Amélie of Portugal, with the President of France, escorting Madame Fallieres.

"What could it be? The secret was soon out, for I caught a whisper—'Madame Curie is lecturing!' That marvellous woman, to whom is due the discovery of radium, which has revolutionized all previously held ideas of physical science—Madame Curie, the only woman ever appointed to a professor's chair in the great Sorbonne; a woman now courted by princes and governments. Did not the Shah of Persia himself take jewelled orders from his breast and attempt to pin them on this shyest of women?

"I went to the lecture. It was to be on 'polonium,' the first element discovered by Madame, and thus named for her native country.

"Believing that only the few cared to hear her, she had arranged to speak in a small class-room, seating barely thirty. But now the gay *monde* flocked from far and near, and there was nothing for it but the huge amphitheatre of the University of Paris.

"Even that was packed to the doors, and hundreds shut out, clamoring in vain to see and hear the world's greatest woman of science, whom the foremost thinkers of to-day have been proud to honor and accept as an intellectual equal. On the platform were arrayed a strange jumble of instruments and tubes, bottles

and jars, retorts and crucibles—a modern alchemist's workshop in which nature's secrets are laid bare.

“On the stroke of three an insignificant little black-robed woman stepped in, and the vast and brilliant throng rose with a thrill of homage and respect. Next moment a roar of applause burst forth. The timid little figure was visibly distressed, and raised a trembling hand in mute appeal. Then you could have heard a pin drop, and she began to speak.

“Of her lecture I will say no more. But as I had heard the greatest personages from Sweden to Vienna speak in tones of reverence of this woman, I determined to secure her strange story. This was most difficult on account of Madame's horror of publicity. Not long after the birth of her eldest child Irene, Madame Curie took a tiny cottage on the Boulevard Kellermann, near the Parc Montsouris, a district so remote that hardly any *cocher* knows where it is. To the ordinary Parisian the Boulevard Kellermann is only something little less remote than Timbuctu!

“Here ‘the cleverest woman in the world’ has a little ivy-covered house, lying back from the road, and spends her days carrying on her own and her late husband's work—not forgetting her little girls, Irene, who is nearly seven, and Eve, who is two and a half. A Polish cousin of hers helps her with the children; and there is also old Dr. Curie, her husband's father, to be taken care of—a patriarch well over eighty.

“No one appears to know anything of this illustrious woman except her next-door neighbor, Madame Perrin, who is almost in the relation of sister to Madame Curie. It will be seen that world-fame has absolutely no charm for this woman, nor had it for Pierre Curie. Once or twice he received a newspaper reporter through sheer kindness of heart and unwillingness to appear discourteous. But his wife always declared she loathed reporters and publicity, and that no newspaper had a right to pry into her life.

“Now let me tell the tragic story of her life, love, and marriage. Marie Sklodowska Curie is just forty this year. Her father, Professor Sklodowski, taught science and chemistry at the University of Warsaw. It seems the salary was so paltry that Sklodowski could not even afford to hire a small boy to help in his laboratory, and so at an early age little motherless Marie, instead of playing with dolls and toys, was bustling about in a chemist's laboratory, surrounded by all the paraphernalia that were to become so familiar ere her name resounded the world over. Still, the girl must have had a vague longing to see

the world, for we next find her as governess in a Russian family travelling a good deal in Eastern Europe. She grew tired of this, though, and returned to Warsaw more passionately patriotic than ever.

“Indeed, the young woman was quite a political agitator. Her love for science, however, drew her to Paris, where she arrived almost destitute. Here she established herself in a cheerless garret so intensely cold that when in winter the little bottle of milk was left at her door it speedily turned to ice. Marie Sklodowska was at this time living on less than ten cents a day. She saved all the money she could for her precious books. Then came the fateful encounter with Pierre Curie. The Frenchman was seven years older than the girl, but he soon found in her a kindred soul, and, to her amazement, proposed marriage, so that among other things they might devote their lives to science. But at that time Polish patriotism and politics were uppermost in the girl’s mind; and, without giving her lover a decisive answer, she returned to Warsaw.

“A fortnight later she received a pathetic letter from Curie, in which appears this passage: ‘What a grand thing it would be to unite our lives and work together for the good of science and humanity!’ Forthwith she returned to Paris and married the man of her choice. That marriage was, indeed, ideal. For eleven years they lived and worked in complete unity of thought and ideals. They were never parted even for a single day! Their first home was at Scéaux, about nine miles from Paris. So much time was lost, however, in journeying to and fro that they took a tiny apartment in the Rue de la Glaciere, in order to be near the laboratory of the Ecole de Physique.

“Already Madame Curie’s reputation as a scientist in her own right was so well known that she was permitted to work with her husband in the laboratory—a privilege which had never before been granted to a woman. Oddly enough, France herself was slowest of all among the nations to recognize the genius of the gifted pair. Honors and tributes to their great researches came to them in embarrassing profusion, but not from their own country.

“It was Lord Kelvin, the venerable British savant, that first drew the world’s attention to the Curies; and in May, 1903, the Royal Institution of Great Britain invited them to London to lecture. As everyone knows, this visit was a veritable triumph for the young couple; and Lord Kelvin himself, affectionately leaning on Curie’s shoulder, proclaimed the marvellous discoveries of his French colleagues. Forthwith the Royal Society bestowed the coveted Davy gold medal on Pierre Curie.

"After Great Britain's recognition, Sweden bestowed the famous Nobel prize on both husband and wife. Then came laggard France with the Legion of Honor. But Pierre Curie replied to the government, simply declining the decoration, for it had 'no bearing upon my work.'

"But next day the Curies and Perrins went out to the quaint aerial village of Robinson two or three miles away, to have dinner in the tree-tops, where restaurants are established, and Irene climbed on her father's knee and put a red geranium in his coat. 'You are now decorated with the Legion of Honor,' the little one told him, gravely. And Pierre Curie replied, 'In this case I make no objection.'

"There came a time when the inveterate dislike of the Curies for public functions—dinners, receptions, lectures, and the like—had to be conquered; especially after the award of the Nobel prize by Sweden. Poor Marie Curie was, to put it mildly, not much given to dress. But now, protesting strongly, she had a *décolleté* black silk made; for President and Madame Loubet were giving a dinner at the Elysée Palace in honor of this marvellous husband and wife.

"This reminds me that both M. and Madame Curie have more than once flatly refused to lecture on their discoveries before royalty, alleging as an excuse that their subject would have no earthly interest for anyone who had not made a special study of it. They made an exception in the case of the Shah of Persia; but only because pressure was brought to bear upon them by the French Government.

"It was a very comic *séance*. The room was darkened, and the marvellous mineral they had discovered glowed uncannily. The Shah, greatly startled, leaped up and upset the case of radium. Then the Curies, in turn, were mightily alarmed for their precious atom, and refused to be comforted, even by diamond rings impulsively drawn from imperial fingers.

"The Shah was deeply offended at the cold rejection of all his gifts. The radium shown him was worth \$30,000 a gram. It had been specially extracted from pitchblende, a black oxide of uranium found only in one mine, at Joachimthal, in Bohemia. Whether or not this wondrous 'living' substance will cure cancer is a question for the scientist. But its most wonderful property is that it gives off light of itself, and that without any apparent diminution of its force. In Paris they called radium '*le métal conjugal*,' because it was the joint discovery of husband and wife. It was Madame Curie, however, who first noticed the strange properties of uranium, and drew her husband's atten-

tion to the researches she had been carrying on alone for many months.

“Curie at once recognized the far-seeing pioneer genius of his wife, and abandoned all else that they might work together and solve a problem so sensational.

“But just when world-fame came to them, tragedy came, too. One day last spring Pierre Curie, after lunching with some friends, was crossing the crowded streets of Paris, an absent-minded dreamer with high thoughts fixed on the mysteries of nature. And with the awful suddenness of such things he was struck down by a heavy truck. One of the wheels passed over his head and crushed out a great and noble life.

“So in her little ivy-covered cottage, lost in an out-of-the-way part of the city, you will find Marie Sklodowska Curie to-day—more retired and silent than ever, living only for her children and such benefit as she hopes to do the world by the exercise of her marvellous genius.”

The Craze for Thinness.

Generally speaking, most of us eat too much, many members of the rich and learned classes “digging their graves with their teeth”; nevertheless there is a certain danger of going to the other extreme, as we were reminded by the excellent address of the President of the Sanitary Inspectors' Association at Llandudno, last week. Sir James Crichton-Browne, M.D., declared that all the fashionable food fads and follies of the hour are in the nature of deprivation; aldermen are beginning to look like laths, the tiniest portions are served at dinners, and even light wines are looked at askance. Leaving men out of the question, it is undeniable that a large number of women, both middle and working class, as well as the rich and fashionable, do habitually under-eat, and endeavor by one means or another to reduce not only stoutness, but the reasonable plumpness which is a sign of good condition, and, as often as not, of a good temper. Now, this is a bad state of things, both in itself, and too frequently in the means adopted to secure the desired thinness.

Fashion makers and novelists are, we believe, mainly responsible for establishing the long, thin, willowy figure as the ideal for women. Artists, whatever their sex, have certainly done little or nothing to support this svelte ideal; rather must we look to the fashion plates or the pages of novelists (chiefly, we fear, women novelists) for the idea that women to look “ladylike” must be tall, slim and fragile. The highest hu-

man ideal and expression of female beauty that the world has ever known—the Venus de Milo—is not thin or lanky, neither has she a small waist; she is simply perfectly proportioned, and that is the secret of her beauty. Rubens, we admit, erred on the side of stoutness, and one can hardly imagine his women being in the least intellectual; nevertheless his ideals are better than the thin, scraggy type at the other extreme of the picture. Also, as we freely admit, the fleshy women of the Georgian painters' ideals were too fat and decidedly vulgar; but the pendulum has swung too far the other way, and now even Mr. Gilbert's "plump and pleasing person" would be generally voted ungraceful and verging on the vulgar. Stout persons must, of course, dress with more care than those of medium figures, but thin persons it is impossible to dress with any pretense of affording pleasure to the beholder.

Thinness, moreover, is not only ungraceful; it is a possible source of danger. The majority of healthy children are fat. Animals in "good condition" are generally plump. Fat itself is nature's provision either against cold or famine. When from scarcity of food, lack of appetite, or sickness the individual is deprived of food, the body is nourished by the hitherto superfluous tissue. Fat is a protective to the muscles and organs lying underneath—one never knew a fat consumptive person. Of course, we know that rich or well-to-do people in England need never fear the cold or famine. Nevertheless the principle is the same, and a proper fatness is not only beautiful, but a natural protection against various dangers. Fat is an aid to beauty, for without it the human body would lose much of its grace. Without it there would be no fulness, no flowing lines, no pleasing contour, no soft undulations, no beauty, but only utility. To prove this one has but to look at the anatomical model. In this the skeleton is symmetrical, the muscles anatomically perfect, but without the fat and skin the figure is unpleasing, crude, harsh, and, artistically speaking, hideous. Let but the framework of bone and muscle be clothed with a natural proportion of fat, and perfect beauty is the result. It was through ignoring this fact, by studying and reproducing the muscular frame alone, that another set of artists produced the most unpleasing, though anatomically correct, school of drawing that reproduced the human figure as though intended mainly for medical students or the devotees of the modern mania for muscular development.

But if thinness be bad, the means employed to procure it are generally worse; in some cases they are positively harm-

ful. Many patent medicines and potions are distinctly deleterious, while most "systems" indulged in without proper medical advice do far more harm than good, quite apart from their attaining the undesirable end of slimness. Thus we read of factory girls in a northern town eating six lemons a day, rind and all, in order to appear emaciated and look "interesting." Worse than lemons, vinegar is sometimes drunk by persons who wish to reduce their figures, while gin was long supposed to have the power, and was used, to make people thin. We have even heard of pounded egg-shells being eaten with the food for the same pernicious reason. But, bad as these things are in themselves, they often lead to more dangerous habits. For the body weakened and vitiated by such agents demands and receives stimulation—too generally satisfied with alcoholic beverages or narcotics. In this connection it is of interest to note what a taste for "liquor sweets" is being developed. These contain, in a sugar or cocoa casing, a drop or two of rum, gin, or liqueur, and that they are eaten largely is shown by the case quoted of a poor factory girl who confessed to spending eighteen pence a week on them. Higher in the social scale lozenges containing drugs, either of a stimulating or sedative nature, are eaten. Sir James Crichton-Browne believes that such sweets are largely consumed for their intoxicating properties by women, shop girls and errand boys, and even school-children. The drug habit once acquired is most difficult to give up, and no words are needed to emphasize the fact that it is a most subtle one, and most pernicious in its effects. One of the least of these is that when seriously ill, the drugs prescribed by the physician fail of their intended effect because the system is so used to them they do not cause the desired reaction, and the doctor has to increase the dose or substitute a more powerful re-agent.

Sooner or later—and sometimes even "unto the third and fourth generation"—man has to pay the penalty of transgression, whether in food and drink or clothing. But fortunately for those who properly desire to look their best—even as do the birds and flowers—it is not necessary to suffer to be beautiful. On the contrary, true beauty is the concomitant and result of health, of perfect harmony of function and surroundings, of perfect balance of body and mind. And it is undeniably woman's function and duty to be beautiful, for, conversely, true beauty is a sign of health, and health is the greatest gift of the gods, and the grandest heirloom to hand on to one's children. Even from the mental and moral point of view, health is greatly

to be prized, for no one can habitually think evil thoughts or lead an evil life and yet be healthy. And after all, the highest beauty is that which comes from a beautiful spirit irradiating and expressing itself through a beautiful body.

—*The Queen.*

Smithsonian Institution—Hodgkins Fund Prize.

The Hodgkins Fund Prize of \$1,500 is offered by the Smithsonian Institution, Washington, D.C., in accordance with the following announcement: In October, 1891, Thomas George Hodgkins, Esq., of Setauket, New York, made a donation to the Smithsonian Institution, the income from a part of which was to be devoted to "the increase and diffusion of more exact knowledge in regard to the nature and properties of atmospheric air in connection with the welfare of man."

In the furtherance of the donor's wishes, the Smithsonian Institution has from time to time offered prizes, awarded medals, made grants for investigations, and issued publications.

In connection with the approaching International Congress on Tuberculosis, which will be held in Washington, September 21 to October 12, 1908, a prize of \$1,500.00 is offered for the best treatise that may be submitted to that Congress "On the Relation of Atmospheric Air to Tuberculosis."

The treatise may be written in English, French, German, Spanish or Italian. They will be examined and the prize awarded by a committee appointed by the Secretary of the Smithsonian Institution in conjunction with the officers of the International Congress on Tuberculosis.

The right is reserved to award no prize if in the judgment of the committee no contribution is offered of sufficient merit to warrant such action.

The Smithsonian Institution reserves the right to publish the treatise to which the prize is awarded.

Further information, if desired by persons intending to become competitors, will be furnished on application.

CHARLES D. WALCOTT,

Secretary, Smithsonian Institution.

Washington, February 3, 1908.

Dr. Leander Starr Jameson, Premier of Cape Colony from 1904-1908, has resigned. He was born in Edinburgh in 1854, and is a graduate of the University of London. He organized the famous Jameson raid against the Boers in the Transvaal. For this he was tried in London and sentenced to ten months' imprisonment, of which he served one.

The Oldest Drama.

“It fell on a day, that he went out to his father to the reapers. And he said to his father, My head, my head. And he said to a lad, Carry him to his mother. And . . . he sat on her knees till noon, and then died. And she went up, and laid him on the bed . . . and shut the door upon him, and went out.”

Immortal story that no mother's heart
 Ev'n yet can read, nor feel the biting pain
 That rent her soul! Immortal not by art
 Which makes a long-past sorrow sting again

Like grief of yesterday; but since it said
 In simplest word the truth which all may see,
 Where any mother sobs above her dead,
 And plays anew the silent tragedy.

JOHN McCRAE, in *The University Magazine*.

Varicose Ulcers.

The following has been used with great success in cases of varicose ulcers: The patient is put to bed for two or three days, then the leg is shaved and scrubbed and zinc oxide powder applied; if ulcer is large, put an extra layer of the powder and gauze over it; then paint leg with the following: White gelatine, 150 parts; zinc oxide, pulv., 150 parts; glycerine, 250 parts; distilled water, 450 parts; and apply bandage, then the paint again until there are three layers of paint and two of bandage. Take temperature, and if it is normal do not disturb for two or three weeks. This splint is found to be most comfortable (and to far surpass any elastic stocking), and the patient may go around his ordinary work without its being injurious, as long as there is no temperature.—*The Canadian Nurse*.

The Borderland of Disease.

There is a growing tendency on the part of medical men to recognize the pathological importance of certain, at present, little understood conditions of the blood. Some of these indeterminate deviations from the normal present none of the aspects of the anemias, but nevertheless bear a direct relation to increased susceptibility to bacterial infection. The studies of Wright on the opsonins, so called, are of special interest in this direction, inasmuch as they have in a measure converted many of our abstract theories into concrete facts. That certain constituents of the blood may be diminished without apparent decrease of the corpuscular elements or of the hemoglobin, is at last fairly well established, and while the specific properties of these constituents are not as yet definitely known, there is abundant reason for attributing certain phases of malnutrition, as