

The Canada Lancet

*A Monthly Journal of Medical and
Surgical Science, Criticism and News*

Volume XXXVI.

September, 1902—August, 1903

JOHN FERGUSON, M.A., M.D., Tor.; L R C.P., Edin.,
Editor

PUBLISHED BY THE ONTARIO PUBLISHING COMPANY, LIMITED
63 Yonge Street, TORONTO

LIST OF CONTRIBUTORS TO VOLUME XXXVI.

- A. PRIMROSE, M.B., C.M., Ed., M.R.C.S., Eng., Professor of Anatomy and Clinical Surgery, University of Toronto.
- N. E. MACKAY, M.D., M.R.C.S., Eng., Senior Surgeon to the Victoria General Hospital, Halifax.
- E. R. SECORD, M.D., Brantford.
- D. CLOWES VAN WART, M.D. Fredericton, N.B.
- SIR THOMAS BARLOW, M.D., F.R.C.S., London.
- FRANCIS J. SHEPHERD, M.D., Professor of Anatomy, McGill Medical Faculty.
- JOHN STEWART, M.D., C.M., Edin., Examiner in Surgery, Dalhousie University.
- WILLIAM OSLER, M.D., F.R.C.P., F.R.S., Professor of Medicine, Johns Hopkins University.
- DUDLEY P. ALLEN, A.M., M.D., Professor of Surgery, Western Reserve University, Cleveland.
- J. J. MACKENZIE, B.A., M.B., Professor of Pathology and Bacteriology, University of Toronto.
- S. M. HAY, M.D., Surgeon to Toronto Western Hospital.
- STEWART PATON, M.D., Associate in Psychiatry, Johns Hopkins University.
- A. LAFTHORN SMITH, M.D., Surgeon-in-Chief, Samaritan Hospital, Montreal.
- JAMES STEWART, M.D., Professor of Medicine, McGill Medical Faculty.
- A. MCPHEDRAN, Professor of Medicine and Clinical Medicine, University of Toronto.
- A. D. BLACKADER, B.A., M.D., Professor of Therapeutics and Diseases of Children, McGill Medical Faculty.
- A. B. OSBORNE, M.D., C.M., Oculist and Aurist, Hamilton City Hospital.
- J. F. W. ROSS, M.D., C.M., Professor of Gynecology, University of Toronto.
- JAMES BELL, M.D., Professor of Clinical Surgery, McGill Medical Faculty.
- H. H. MACKAY, M.D., New Glasgow, N.S.
- J. T. FOTHERINGTON, M.D., C.M., Physician Out-Patient Department, Toronto General Hospital.
- GEORGE S. RENNIE, M.D., L.R.C.P., Lond., Hamilton.
- THOMAS J. F. MURPHY, M.D., Surgeon Victoria General Hospital, Halifax, N.S.
- PERRY G. GOLDSMITH, M.D., Oculist and Aurist, Institute for Deaf and Dumb, Belleville.
- HON. JOS. E. McDOUGALL, Senior County Judge, County of York.
- J. H. ELLIOTT, M.D., Physician in Charge, Muskoka Sanitarium.
- JOHN HUNTER, M.D., Physician to Toronto Western Hospital.
- A. GROVES, M.D., Medical Superintendent, Royal Alexandria Hospital, Fergus.
- F. E. LAWLOR, M.D., Physician, Nova Scotia Hospital.
- J. A. MACKENZIE, M.D., Assistant Medical Superintendent, Nova Scotia Hospital.
- BYROM BRAMWELL, M.D., F.R.C.P., F.R.S., Edin., Physician to the Royal Infirmary, Edinburgh.

- ERNEST A. HALL, M.D., Victoria, B.C.
F. N. G. STARR, M.D., Demonstrator of Anatomy, Medical Faculty, University of Toronto.
ANGUS MACKINNON, M.D., Los Angeles, California.
WILLIAM LANE LOWDER, M.D., McKinney, Kentucky.
C. D. MURRAY, M.D., Physician to Victoria General Hospital, Halifax, N.S.
E. KENNEDY, M.D., New Glasgow, N.S.
J. PRICE BROWN, M.D., Toronto.
SIR JAMES GRANT, M.D., K.C.M.G., Ottawa.
JAMES H. RICHARDSON, M.D., M.R.C.S., Eng., Professor Emeritus of Anatomy, University of Toronto.
K. C. McILWRATH, M.B., Tor., F.O.S., Edin., Demonstrator of Obstetrics, Med. Fac. University of Toronto.
W. G. M. BYERS, M.D., Assistant Surgeon, Eye and Ear Clinic, Royal Victoria Hospital, Montreal.
JOHN McMASTER, M.D., Toronto.
T. SHAW WEBSTER, M.D., Gynaecologist to Toronto Western Hospital.
J. C. MITCHELL, M.D., Physician to the Asylum for the Insane, Toronto.
THOMAS S. CULLEN, M.B., Associate Professor of Gynaecology, Johns Hopkins, Baltimore.
J. H. MUSSER, M.D., Professor of Clinical Medicine, University of Pennsylvania.
GEO. A. BINGHAM, M.B., Associate Professor of Surgery and Clinical Surgery, Trinity Medical College.
W. D. FORREST, M.D., C.M., M.R.C.S., Eng., Halifax.
MALCOLM MacKAY, B.A., M.D., Montreal.
R. H. RICHARDS, M.D., C.M., Winnipeg.
A. J. MACKENZIE, B.A., M.D., Toronto.
W. R. RIDDELL, K.C., B.A., B.Sc., Legal Lecturer on Medical Jurisprudence, University of Toronto.
P. H. BRYCE, M.A., M.D., Secretary Provincial Board of Health.
J. W. S. McCULLOUGH, M.D., Alliston.
J. O. TODD, M.D., Gynaecologist, Winnipeg General Hospital.
-

INDEX TO VOLUME XXXVI.

- A**PPENDICITIS, surgical treatment, D. C. VanWart, 15; J. W. S. McCullough, 905
- Dr. Addison on, 671
- Anæsthesia, local, 22
- administration of, 61
- during sleep, 23
- in South African War, 328
- of the drum membrane, 441
- in nose, throat and ear operations, 441
- Alcohol in fevers, 60
- Ascitis, Morrison's operation, 63
- Address, presidential, F. J. Shepherd, 75
- Adrenalin, experiments with, 143
- Allen, Dudley P., early operations on the gall bladder, 147
- Alcohol, toxicity of methyl, 183
- Arm, carrying function of, 186
- Asylum, the hospital for the insane, 219
- Acetonæmia, fatal, 254
- Appendix clamp, 258
- Ammonium compounds, toxicity of, 275
- Arteriosclerosis, 276
- Antiphlogistine, uses of, 361
- Aspirin in diabetes mellitus, 369
- Aneurism of aorta, 398
- Abdominal section, ice following, 399
- Are you in pain? 520
- Arsenic and sodium benzoate, by E. Kennedy, 624
- Anæmia from uncinariasis, 637
- Albuminous expectoration following thorcentesis, 642
- Adenoids in children, prompt removal, 644
- Acetanilid poisoning, 720
- of Abdominal Hernias, 71; Stelwagon's Diseases of the Skin, 132; Vaughan and Novy's Cellular Toxines, 136; Tyson's Practical Examination of the Urine, 209; Progressive Medicine, 209, 430, 597; Gleason's Essentials of Diseases of the Ear, 210; Leroy's Essentials of Histology, 211; Luke's Guide to Anæsthetics, 211; Nothnagel's Diphtheria, Measles, Scarlet Fever and German Measles, 214; New Jersey Board of Health, 217; Bruhl's Atlas of Otolaryngology, 279; The Public and the Doctor, 279; Colbeck and Chaplin's Science and Art of Prescribing, 280; Blakiston's Visiting List, 280; Lea's Visiting List, 280; Reynolds' Practical Obstetrics, 281; Szymonowicz' Histology and Anatomy, 282; Hutchison's Clinical Methods, 283; Le Fevre's Physical Diagnosis, 284; Scudder's Treatment of Fractures, 284; Lewis and Balfour's Public Health and Preventive Medicine, 285; A Beautiful Calendar, 359; Merck's Index, 359; Electro-Therapeutic Practice, 359; Syphilis, a Symposium, 359; Gould's Biographic Clinics, 360; Wood's Reference Hand-Book, 274, 360, 429, 596, 763, 859; Photomicrography, 429; Dudley's Gynæcology, 430; Grayson on the Nose, Throat and Ear, 433; Atlas of Fractures and Dislocations, 436; Grant's Diseases of Face, Mouth and Jaws, 437; Hewlett's Manual of Bacteriology, 437; Senn's Nurse's Guide, 438; Warren and Gould's International Surgery, 507; Woolsey's Applied Surgical Anatomy, 508; Deaver's Surgical Anatomy, 509, 762, 860; Huntington's Anatomy of the Peritoneum, 570; Nothnagel's Diseases of the Bronchi and Pleura, and Pneumonia, 511; Turner's Accessory Sinuses of the Nose, 512; Brubaker's Human Physiology, 513; Gant's Diseases of the Rectum, 514; Cathell's Book on the Physician, 515; Reese's Medical Jurisprudence and Toxicology, 515; Schmidt's

BARLOW, Sir T., natural history of disease, 19

Bartholinitis, 25

Book Reviews—

- American Climatological Association, 66;
- Human and Bovine Tuberculosis, 66;
- Hare's Practical Therapeutics, 67;
- Gradle's Diseases of the Nose, Ear and Pharynx, 68; Coley's Atlas and Epitome

- Genito-Urinary and Venereal Diseases, 516; Saunders' American Year Book, 596; Butler's *Materia Medica, Therapeutics, and Pharmacology*, 597; Eckley's *Dissections and Practical Anatomy*, 598; Posey and Wright's *Diseases of the Eye, Throat, Nose and Ear*, 598; Proust's *Treatment of Neurasthenia*, 599; Gould's *Biographic Clinics*, 599; American Dermatological Association, 600; Roberts' *Outlines of Gynecology*, 600; Haig's *Diet and Food in Relation to Strength*, 602; Grindon's *Diseases of the Skin*, 675; Schmaus' *Pathology*, 676; Norris' *American Text-Book of Obstetrics*, 677; Schalek's *Diseases of the Skin*, 678; Mathison's *Morphinism*, 679; Frenkel's *Tabetic Ataxia*, 679; Eyre's *Bacteriological Technique*, 680; *The Practitioner's Guide*, by Carr, Doran, Pick and Duncan, 681; Williams *Text-Book of Obstetrics*, 681; *Diseases of the Stomach, Nothnagel's System*, 682; *Regional Minor Surgery*, by G. G. Van Shaick, 763; Bartholow's *Materia Medica and Therapeutics*, 764; Sobotta's *Atlas of Histology and Microscopy*, 850; *Diseases of the Pancreas, Suprarenals, and Liver, Nothnagel's System*, 851; De Schweinitz' *Diseases of the Eye*, 852; Cohen's *Physiologic Therapeutics*, 853; Sajous' *Internal Secretions and Principles of Medicine*, 853; Thompson's *Practice of Medicine*, 854; Harrington's *Manual of Hygiene*, 855; Politzer's *Diseases of the Ear*, 855; Cushney's *Text-Book of Pharmacology and Therapeutics*, 856; Peterson and Haines' *Legal Medicine and Toxicology* 857; *Atlas of Diseases of the Mouth, Pharynx and Nose*, 858; Bridge's *Tuberculosis*, 859; Allingham's *Operative Surgery*, 860; *Disorders of Metabolism*, by Van Noorden, 860; Stone's *Practical Points in Nursing*, 861; Griffith's *Care of the Baby*, 861; Chapman's *Medical Jurisprudence*, 862
- Pryor's *Gynecology*, 950; Crocker's *Diseases of the Skin*, 951; *Materia Medica for Nurses*, 952; *Psychology of Sex*, 952; *Surgical Asepsis*, 953; *Expectant Mother*, 953; *Röntgen Rays*, 953; *Materia Medica and Therapeutics*, 954; *Bacteriology*, 955; *Progressive Medicine*, 955; *Uric Acid in Disease*, 956; *Surgical Anatomy and Operative Surgery*, 957; *Anatomy*, 957; *Text Book of Surgery*, 958; *Medical Chemistry*, 959; *Organic Nervous Diseases*, 959; *New Jersey Board of Health*, 960; *American Dermatological Association*, 960; *American Clinatological Association*, 960.
- Burnham, G. H., hypopyon, 171
- Blood-letting in gynecological cases, 184
- Blindness, measures for reducing, 192
- Bladder, removal of for cancer, 204
- Biliary Passages and Gall Bladder, treatment of diseases of, by A. D. Blackader, 241
- Blackader, A. D., treatment of diseases of the biliary passages, 241
- Burns' last illness, 250
- Bacteriology of inflammation of throat, 262
- Bovine, surgical uses of, 288
- Beaumont, William, a pioneer physiologist, by W. Osler, 291
- Bell, James, surgical cases, 309
- Abdomen, contusion of, by Geo. S. Rennie, 370
- Borden, Sir Frederick, honored, 393
College of Physicians' address, 499
- Backache in women, 394
- Bacteriology of the blood, 395
- Bloodless operations, 473
- Bacteria in the intestines, 473
- Bramwell, Byron, phthisis, 523
- Bishop's Medical Faculty, 581
graduates, 572
- Bills on vaccination and inebriates, 588
- Blood pressure in later life, 590
- Brown, Price, sarcoma of nose, 63
- Brain power, how to preserve it, by Sir James Grant, 685
- Eyers, W. G. M., albuminuric retinitis of pregnancy, 703
- Birth, death and marriage rates in Ontario, 756
- Bingham, G. A., operative treatment of goitre, 812
- Bryce, P. H., contagious diseases, 910
- CÆSARIAN section, N.E. McKay, 5
Clark and Hopkins, suit, 13
- Current Medical Literature 22, 181, 254, 325, 394, 473, 557, 636, 720

- Chlorosis, treatment of, 22
 Cancer and tuberculosis, 24
 Campbell, Francis W., 35
 Canaliculi, ligation of, 42
 Canadian Medical Association, 47, 111, 125,
 501, 573, 745, 837, 923
 Cancer in India, 62,
 research, 479
 of the breast, 641
 Correspondence, 72, 140
 College, opening of, 128
 Carotids, extirpation of external, 182
 Chondrodystrophy foetalis, 185
 Christian Science, so-called, 205
 Sir Dyce Duckworth on, 206
 Catgut, sterilization of, 228
 Canadian Medical Protective Association,
 269, 500
 Cirrhosis of the liver in the young, by J. T.
 Fotheringham, 318
 Cholesteatoma of middle ear, 402
 Corneal lesions, acetone in, 483
 Coughs and their treatment, 516
 Cases in Practice, Ernest Hall, 542
 Consumption, open air treatment of, 551
 Convocation Hall Fund, 584
 Chloroform, deaths and fright, 536
 poisoning, 721
 Cataraet, absorption treatment, 646
 Colpoceliotomy, by T. Shaw Webster, 712
 Cullen, T. S., uterine myomata, 778
 Countess of Minto on Victorian order of
 Nurses, 664
 funds for cottage hospitals, 949
 Canada Lancet for July, 849
 Contagious diseases, P. H. Bryce, 910
 College of Physicians and Surgeons, Que-
 bec, 934
 Governors of, 936
- D**OVER'S powder, original, 22
 Dysmenorrhœa, nasal, 46
 Dominion Registration Bill, 199, 748, 755,
 848.
 Davison, J. L., life assurance examinations,
 387
 Deaf-mutes, examination of in Denmark, 402
 Documents in the case, 439
 Dalhousie Medical College, 490
 gift to, 661
 appointments, 735
- Ductless glands, 507
 Diarrhœa in children, 57
 Deafness, Catarrhal, 563
 Dominion Minister of Health, 588
 Disorders of Metabolism, 860
 Dengue fever and mosquitoes, 886
- E**YE, ear, nose and throat, 41, 188, 259,
 330, 402, 480, 562, 643, 725, 917
 Eye defects and mental dulness in children,
 42
 Editorial, 53, 125 196, 269, 353, 419, 493,
 585, 663, 753, 845, 943
 Epilepsy, treatment of, 59
 etiology and prophylaxis of, 183
 Ear Diseases in hysterical subjects, 261
 Eczema of ear, 334
 Endometritis, bovine in, 218
 Ear in relation to general medicine, 259
 Eye, congestion of, 261
 hydrotherapy in, 480
 Ergoapiol, 361
 Epiglottis, removal of, 402
 Electrolysis of eustachian tube, 403
 Expert medical testimony, by his honor J.
 E. McDougall, 443
 Elliott, J. H., treatment of pulmonary
 tuberculosis, 453
 Exercise in chronic disease, A. McPhedran,
 806
- F**OODS, patent, 26
 Fowler, Fife, 37
 Ferroleum, London offices, 741, 288
 Forrest, W. D., Maritime topics and news,
 196, 339, 409, 732, 922
 Fotheringham, J. T., cirrhosis of the liver in
 the young, 318
 Fœtus, death of, chlorate of potash in, 326
 Ferguson, A. H., surgical treatment of
 nephritis, 865
 Federation of Trinity and Toronto Univer-
 sities, 935, 943
- G**EIKIE, Walter B. 33; address to, 937;
 retirement of, 945
 Glaucoma, acute or inflammatory, 452

- Gall bladder, early operations on, Dudley P. Allen, 147
- Goldsmith, Perry G., eye, ear, nose and throat, 41, 188, 259, 330, 402, 480, 562, 643, 725
 tonsillar hypertrophy, 379 ;
 appointment, 422
- Gynecological cases, notes on, by A. Laphorn Smith, 224
- Gall bladder and bile ducts, diagnosis of diseases of, by A. McPhedran, 232
- Glioma of the retina, 259
- Genito-urinary irritation and sanmetto, 287
- Gallstones, surgical treatment, by J. F. W. Ross, 297
- Gasserian ganglion in middle ear suppuration, 405
- Gastric trouble in spinal disease, 422
- Glyco-Heroin, 442
- Groves, A., X-rays in diseased structures, 463
- Grant, Sir James, Jubilee, 499 ; banquetted, 671 ; brain power, 685 ; banquet and presentation, 741
- German doctor's strike, 758
- Goitre, operative treatment, G. A. Bingham, 812
- H**ERNIA of the bladder, E. R. Secord, 11
 History of Medicine, W. Osler, 23
- Human and bovine tuberculosis, 66
- Hypopyon Kerato-iritis, 171
- Hay, S. M., the surgeon on horseback, 172
- Heart, suture of wound, 187
- Halifax Medical College, 197, 735, 922
- Halifax branch, B.M.A., 198, 732
- Hay fever, prevention and treatment, 287
 etiology and treatment of, 659
- Hernia, four cases of, by T. J. F. Murphy, 377
- Heart in pneumonia, 394
- Hunter, John, vomiting of pregnancy, 459
 Ontario Medical Association, 620
- Hall, Ernest, cases in practice, 542
- Headaches, 563
 of nasal origin, 728
- Hospitals in Ontario, 587, 847
 "Hopogan" and "Ektogan," 640
- Hospital patient successfully sued, 671
- Halliday, condolence to Mrs, 736
- Home for incurables, 849
- Haig, A., the washing out plan, 883
- Hæmorrhage from excision of tonsils, 917
- I**NTESTINAL obstruction, A. Primrose, 1
 - Infection in utero, malaria and small-pox, 22
- Infections, mixed and coincident, 60
- International Medical Congress, 146
- Insomnia, by H. H. Mackay, 313
- Immunity, recent studies in, 326, 532
- Inebriates, care of, 423
- Insanity, pathology of, by F. E. Lawlor, 478⁶⁵
 causation of, 845
- Iliac Artery, ligature of common, 474
- J**OINTS, painful, stiff, and rheumatism, 74
 Journal of advanced therapeutics, 146
- Journal of tuberculosis, 507
- Jurisprudence, medical, and toxicology, 515 ;
 insanity and toxicology, 862
- Johnson's, Dr. A. J., appointment, 947
- K**EEPING well, 24
 King Edward's case, 43
- Kidney, prolapsed, 323
- Kennedy, E., arsenic and sodium Benzoate, 624
- L**YMBURNER v. Clark and Hopkins, 13
- Lachnanthes tinctoria, 24
- Labium, melanosis of the, 30
- Laparotomy during pregnancy, 62
- Life insurance and ear diseases, 188
- Larynx in aneurism of the aorta, 189
- Lateral sinus thrombosis, 191
- Lecture, clinical, on nerve cases, by James Stewart, 229
- Laryngology, pineapple in, 260
- Labyrinthitis from salicylates, 260
- Life assurance examinations, by J. L. Davison, 387
- Lord Lister, 423
- Lorenz' sensation, 423
- Laxative antikamma and quinine, 442
- Lithia tablets, 442
- Lawlor, F. E., pathology of insanity, 465
- London Medical College, 492
- Laval Medical Faculty, 576, 844

- Lowder, Ephraim McDowell, 605
 London School of Tropical Medicine, 630
 London's medical women, 848
- M**CKAY, N. E., Caesarian section, 5
- Massage of Breasts, 26
 Moorehouse, W. H., 34
 Middle ear suppuration, 43
 facial palsy from, 44
 non-suppurating disease, 481
 acute suppuration, 728
- Menstruation, thyroid extract in, 59
 Mania, methylene blue in, 62
 Medical literature, L. S. Oille, 72
 Miscellaneous, 73, 141, 217, 287, 361, 439, 516
 Medical exchange, 73
 Medicine, chauvinism in, Wm. Osler, 95
 Mackenzie, J. J., address on Virchow, 155
 immunity, 532
 Pawlow's laboratory, 628
 Mackenzie, A. J., current medical literature, 22, 181, 254, 325, 394, 473, 557, 636, 720
 Milk commission, New York, 186
 Myopia, treatment of, 192
 MacKay, M., Province of Quebec news, 194, 263, 335, 404, 484, 565, 647, 729, 918
 Maritime topics and news, 196, 339, 409, 732, 922
 McPhedran, A., diagnosis of diseases of gall bladder and bile ducts, 232
 exercise in chronic diseases, 806
 Mastoid operations, A. B. Osborne, 251
 Mammary cancer, ovariectomy for, 256
 Medical societies, 47, 111, 266, 350, 411, 569, 653, 737, 745, 817, 922, 928
 Medical students v. policemen, 271
 Medical Council of Ontario 205, 272, 944
 elections to, 275
 matriculation, 353, 419
 members of, 424
 meeting, 753, 931
 licentiates of, 934
 MacKay, H. H., insomnia, 313
 Medical dinners, annual, 355
 Merck's index, 359
 Malt extracts, relative value, 362
 Murphy, T. J. F., four cases of hernia, 377
 Mimicry of pregnancy by tumors, 397
 McDougall, J. E., expert medical testimony, 443
- Menstruation in a male, 464
 Mentally diseased, treatment of, by J. A. Mackenzie, 468
 Mackenzie, J. A., treatment of mentally diseased, 468
 Maxillary antrum, foreign bodies in, 480
 Mastoiditis, symptoms and treatment of, 483
 Manitoba Medical College, 488, 844
 Medical teaching, aid for scientific, 495
 McKinnon, Angus, open air treatment of consumption, 551
 McGill Medical Faculty, 578, 843
 McDowell, Ephraim, by W. L. Lowder, 605
 Murray, C. D., duty of the State regarding tuberculosis, 616
 Medical universities and colleges, 661
 Medicine as a profession, 669
 Medical reminiscences of Toronto, by James H. Richardson, 694
 Medical witness, the, W. R. Riddell, 896
 McCullough, J. W. S., appendicitis, 905
 McIlwraith, K. C., placenta praevia, 702
 McMaster, John, X-rays in the treatment of disease, 708
 Metabolism albuminuria, 723
 Mitchell, J. C., address, 767
 Musser, J. H., treatment of pneumonia, 796
- N**ATURAL history of disease, Sir T. Barlow, 19
 Nitrous oxide anesthesia, 25
 Nevitt, R. Barrington, 40
 Nova Scotia sanitarium, 196
 Nasal operations, hæmorrhage, 262
 Natural Carlsbad salts, 361
 New religio medici, 477
 Nasal catarrh, 478
 asthma, 645
 sarcoma of, 631
 Nephrectomy and absorption, 722
 Nova Scotia council, 736
 Nephritis, surgical treatment of, A. H. Ferguson, 865
 Nasal treatment of ear diseases, 917
- O**ILLE, LUCIUS S., medical literature, 73
 Osler, William, Chauvinism in medicine, 95
 William Beaumont, 291

- Optic, neuritis, 188
- Ophthalmia, purulent, permanganate of potash in, 190
- Obituaries—
- Bertram Spencer, 206; J. Moore Hart, 277; Duncan McLarty, 278; K. McKenzie, 426; Mrs. Dr. C. K. Clarke, 426; A. C. McDonnell, 426; C. W. Hopkins, 427; W. S. Harding, 427; W. B. Lindsay, 427; C. A. McPhail, 427; Dennis Nunnan, 427; A. S. Fraser, 427; A. G. Scott, 428; Arthur Vallee, 504; E. J. Hodgkinson, 504; Alex. Scott, 504; George Bates Mott, 504; George D. Fitzgerald, 504; W. S. McKay, 504; W. H. D. Young, 505; D. Munroe, 505; George Stewart, 505; Henry W. Day, 505; Lt. Col. C. R. Maclean, 506; Frank Turnbull, 594; John G. Giles, 595; H. V. White, 595; W. A. Howell, 672; Richard Johnson, 673; W. Baldwin, 673; Andrew Halliday, 673; D. Gilbert Gordon, 674; R. B. Cotton, 759; Allan Jack, 759; Robert Addington, 759; James G. Atkinson, 759; Samuel Bidgland, 759; Emily H. Stowe, 760; Erastus Gillen, 850; E. H. Hurlburt, 850; S. R. Morse, 850; J. A. E. Ouimet, 850; Charles S. Haultain, 850
- Osborne, A. B., notes on mastoid operations, 251
- Oza *na*. present state of, 330
- Ontario Hospital Association, 356
- Ortinoform in gastric ulcer, 399
- Ontario Board of Health, 403, 538, 835
- Optical College, refused charter, 481
- Ocular defects and wry neck, 482
- Ontario Medical Association, 575, 620, 670, 744, 817
- Obstruction from ingested hair, 637
- Otorrhœa, prognosis in chronic, 646
- Osteopsathyrosis, 722
- P**PRIMROSE, A., intestinal obstruction, 1
Pneumonia, 56
treatment of, 467
- Post-graduate course, 57
- Paralysis, functional and organic, 58
- Pleurisy with effusion, 61
- Personal, 63, 131, 207, 277, 353, 424, 502, 592, 672, 923, 947
- Pruritus Ani, 73
- Pain, treatment of, 74
- Parke, Davis & Co., 74
- Pregnancy, after removal of ovaries, 130
- Province of Quebec news, 194, 263, 335, 404, 484, 565, 647, 729, 918
- Pepto-mangan for girls, 217
in anæmia, 361
value of, 521
- Pharyngitis, treatment of granular. 218
treatment of chronic, 562
- Ptomaine poisoning, glycozone in, 218
- Prostatitis, sanmetto in, 218
- Paton, Stewart, the asylum, 219
- Pregnancy, ovarian, 276
- Prize, four hundred dollar, 288.
- Paraplegia, primary spastic, 325
- Pennyroyal, poisoning from, 325
- Puerperal eclampsia, thyroid extract in, 327
- Paralysis, post-diphtheritic, 329
- Peritoneal tuberculosis, 400.
- Pneumonia in children, 413
- Pneumonia, pericarditis, and tubercular pleurisy, treatment of, 439
- Pulmonary tuberculosis, by J. H. Elliott, 453
- Phthisis, causation and prevention, 523
- Patella, fracture of, open method of treatment, 548
- Pott's disease, 557
- Percentage solutions, 557
- Prescriptions for earache, atrophic rhinitis, and acute conjunctivitis, 564
for laryngeal phthisis, 645
for rheumatism, 724
- Pawlow's laboratory, visit to, 628
- Puerperal psoriasis, 632
- Purgative, a hypodermic, 650
- Placenta Prævia, K. C. McIlwraith, 702
- Presidential address, Ontario Medical Association, J. C. Mitchell, 767
- Pneumonia, treatment of, J. H. Musser, 796
- Protargol in gonorrhœa, 916
- Q**UEEN'S University Medical College, 416
graduates, 660
faculty, 752
Quality in medicine, 522

- R**ODDICK, THOMAS G., 36
 Reeve, R. A., 39
 Ross, J. F. W., surgical treatment of gall-stones, 297
 Red noses, cure for, 312
 Renal cases, diagnosis, 329
 Rennie, Geo. S., contusion of the abdomen, 370
 Renal lithiasis, treatment of, 396
 Rubber tissue in tic douloureux, 476
 Respiratory organs, electric light in, 479
 Richardson, J. H., testimonial, 501
 honored by old pupils, 662
 medical reminiscences of Toronto, 694
 Rectal alimentation, value of, 559
 Phonological terminology, 562
 Retinal hæmorrhage, 563
 in fracture of skull, 728
 Retinoscopy, 643
 Richards, R. H., *Winnipeg Medical News*, 651, 924
 Retinitis, albuminuric in pregnancy, by W. G. M. Byers, 703
 Rhinitis, toxic, 726
 Rational v. empirical therapeutics, J. O. Todd, 887
 Riddell, W. R., the medical witness, 896
- S**ECORD, E. R., hernia of the bladder, 11
 medical literature, 140
 acute thyroiditis, 365
 Spinal cord, traumatic affections of, 29
 Sinclair, George L., 33
 Stimulants and narcotics in proprietary medicines, 55
 Septicæmia, puerperal, 59
 Sanmetto, Enuresis in, 74
 Skin grafting, Bovine in, 74
 Shepherd, J. F., Presidential address, 75
 Surgery, address in, John Stewart, 86
 Stewart, John, address in surgery, 86
 Stomach, acute dilatation of, 130
 skin diseases of, 132, 400, 675, 678
 Saloquinine, experiments with, 141
 Sera, how they are made, 144
 Surgeon on horseback, by S. M. Hay, 172
 School children, nose, throat and ear disease in, 189
 Syphilis and venereal diseases, prevention of, 201
 Summer diarrhoea in infants, 203
 Smith, A. Lapthorn, removal of bladder for cancer, 204
 gynaecological cases, 224
 Sir Walter Scott's sickness, 206
 Stewart, James, clinical lecture, 229
 Schools, practical disinfection of, 256
 Serum, antidiphtheritic, 257
 Squint, early treatment of, 260
 Septum nasi, operation for, 261
 Scarlet fever and antistreptococcic serum, 273
 regulations concerning, and diphtheria, 665
 Syphilis, justus test for, 275
 a cause of insanity, 561
 prevention, 591
 Surgical cases, by James Bell, 309
 Strabismus, non-operative treatment, 330
 non-paralytic, 726
 Stricture of the œsophagus, 332
 Sub-conjunctival injections, 334
 Supra-renal glands, sugar function of, 475
 Saunders' New York office, 522
 Starr, F. N. G., open method of treating fracture of patella, 548
 Smoke nuisance, 539
 Salicylate of quinine, 659
 Strychnine, fixation in tissues, 720
- T**RAUMATIC ptosis, 29
 Tumors, transplantation of, 30
 Treves, Sir Frederick, 32
 Tonsil, the lingual, 41
 hæmorrhage in operations, 483
 the degenerate, 643
 Tuberculosis, prevention of, 49
 etiology of, 479
 etiology of, 556
 congress on, 574
 duty of the State in, 616
 in Cleveland, 639
 Temperature of the body, 181
 Temporo-sphenoidal abscess, 190
 Toronto, West, representative, 205
 Trephining, primitive, 255
 Typhoid, acetone in, 297
 Toronto Medical Society, 266, 330, 411, 569, 653, 737, 833
 Typhoid bacillus, a year after, 328
 Tinnitus, aurium, 233

Trinity Medical College, 341, 583, 746, 838, 839
 Thyroiditis, acute primary, by E. R. Se-
 cord, 365
 Tonsillar hypertrophy and treatment of, by
 P. G. Goldsmith, 379
 Typhoid fever and drinking water, 399
 Toronto Western Hospital Nurses, 418
 Tubes, symptoms in, 482
 Toronto's grand old medical men, 585
 Toronto medical headquarters, 663
 Tobacco nerve deafness, 725
 Tonsillitis, recurring, 727
 Trinity University amalgamation, 937, 943
 Todd, J. O., rational; v. empirical thera-
 peutics, 887

UNIVERSITIES and Colleges, 33, 341,
 414, 488, 576, 660, 746, 838, 931

Uterus, lactation atrophy of, 187
 rupture of, 637

Urine, practical examination of, 209

University Medical Faculty, 344
 finances, 660
 distinguished graduates, 747
 grants, 752, 840, 841, 842
 opening new buildings, 935
 federation of, 935, 943

Urological Association, 575

Uterine myomata and their treatment, T. S.
 Cullen, 778

VAN Wart, D.C., appendicitis, 15
 Virchow, an address on, by J. J. Mac-
 Kenzie, 155

Victorian Order of Nurses, 196

Virchow's cell doctrine, 287

Vomiting of pregnancy, by John Hunter,
 459

Vaccination, compulsory, 493
 anti-vaccination efforts, 666
 Layman's opinion, 758

Victoria General Hospital, Halifax, 735

WOMAN'S Medical College, 348, 842
 Western University Medical College,
 414, 747

Winnipeg Medical News, 651, 924

Watson, Sir Thomas, on influenza, 670

Webster, T. Shaw, colpoculotomy, 712

Washing out place, the, A. Haig, 883

X-RAYS in diseased structures, A.
 Groves, 463
 rules for the use of, 636
 in the treatment of disease, by J. M.-
 Master, 708

ZINC, Oleate of, 256

THE CANADA LANCET

Vol. XXXVI.

AUGUST, 1902.

No. 1

CHRONIC INTESTINAL OBSTRUCTION BY BANDS AS A SEQUEL OF APPENDICITIS. OPERATION. RECOVERY,

By A. PRIMROSE, M.B., C.M., Edin. M.R.C.S., Eng.

Professor of Anatomy and Associate Professor of Clinical Surgery in the University of Toronto. Surgeon to the Hospital for Sick Children, Etc.

APPENDICITIS is frequently accompanied by the formation of peritoneal adhesions which mat together the coils of Intestine in the neighbourhood. In cases where recovery takes place without operation it is remarkable how these adhesions disappear and, if the abdomen be opened at a subsequent period, all trace of them may have been removed. On the other hand firm adhesions may remain and the appendix may be found, after all acute symptoms have subsided and possibly months after the attack, firmly fixed in position by adhesions either to the parieties or to neighboring viscera. Under these circumstances it is somewhat remarkable that obstruction of the bowels is not a more common sequel of appendicitis than it is. The possible method of its production is illustrated in the case which I now record. A child 10 years of age was admitted under my care with symptoms of general peritonitis and acute obstruction the origin of which was obscure. Appendix trouble was suspected but no certain diagnosis was made. She recovered from the attack without operation but subsequently developed symptoms of chronic intestinal obstruction which occasionally gave rise to alarming conditions during which the obstruction threatened to become complete. During these occasional seizures she suffered intense pain, the abdomen became distended and she only obtained relief after a free action of the bowels. These occasional attacks were considered sufficiently serious to warrant operation, in fact the patient was apparently thrown into a critical condition on each attack and it was feared that operation would become imperative during one of these seizures and that under such circumstances laparotomy would be necessary under unfavourable conditions. The abdomen was opened a few days after recovery from one of these attacks and the condition investigated. It was found that there were two kinds in the small intestine and that the appendix was adherent to the point of attachment of the peritoneal adhesions which were the cause of the kinking. The intestine was freed and the appendix removed after which the patient made a good recovery and subsequently the symptoms of obstruc-

tion no longer manifested themselves. The details of the case are as follows:—

E. S. aet. 10 years was admitted under my care in the Hospital for Sick Children on February 6th, 1902, the patient was referred to me by Dr. Charles Wagner, who gave me the following history of her condition previous to her admission into Hospital. The child had been healthy and quite well until Tuesday, February 3rd, when she was suddenly seized with severe abdominal pain and in spite of her efforts to produce a movement of the bowels she was unable to accomplish it although she had taken purgatives freely. Dr. Wagner saw her the following morning and attempted to get the bowels to act but she vomitted magnesium sulphate which had been administered by the mouth and the enemata, which had been given were ineffective. The following day the symptoms of obstruction were still more marked, there was frequent vomiting of greenish fluid and she was unable to retain anything on her stomach, towards evening she was sent to the Hospital as the symptoms were considered urgent. I saw her there on admission about fifty hours after the onset of symptoms. The bowels had not moved for three days. There had been very severe abdominal pain and marked distension. The pain was confined chiefly to the region immediately below the umbilicus, nothing could be detected of abnormal character in the right iliac fossa and neither was anything revealed on rectal examination

On admission to the hospital she had a temperature of 100.3 F. pulse 144, respirations 44, she had the characteristic facies of abdominal distress, the tongue was furred and patchy, the breath was sweet. The abdomen was much distended, very tense and rigid and exquisitely tender. The tenderness however was most extreme immediately below the navel over an area about three inches in diameter and situated in the middle line. The Tympanites was general: there was no area of dulness and no tumour palpable. As the case seemed urgent and one of complete obstruction I ordered immediate preparation for operation. I however thought it wise to try a turpentine enema first and contrary to one's anticipations this proved slightly effectual. The pulse dropped a little in frequency and we thought it safe to postpone operation until the next morning. A second enema was administered at 6 a.m. the following day, and a large very offensive movement resulted. The pulse had come down to 128 and the respirations to 24, whilst the temperature was 99.3. The vomiting, which was a marked feature at the time of admission, became less frequent, and the abdomen less tender and gradually all alarming symptoms disappeared. The bowels moved very freely during the next few days and she seemed to be on the road to complete recovery, when on Feb 11th, five days after

entering Hospital, she developed a rash of a diffuse character, appearing first over the front of the neck and chest. At first this was thought to be of a septic character, but subsequently it proved to be scarlet fever, and she was transferred to the infectious wards where she ran a course of scarlet fever of moderate severity without complications. She was discharged from hospital on April 4th. The nurse in the infectious ward has since informed me that occasionally the child complained of cramp in the abdomen which was relieved after a free passage of the bowels. After the child went home, the mother noticed that the abdomen was unduly prominent, and she applied a binder to support the abdominal walls. The child was somewhat anxious lest an operation would be necessary if further trouble manifested itself and she, of her own initiative, took pains to keep the bowels regular. Purgatives were employed and the bowels were moved twice daily with marked regularity. She remained well until Sunday, April 20th, when suddenly, in the afternoon of that day she was seized with severe cramp in the lower part of the abdomen, she took a dose of l. quorice powder at four p.m., and at eight in the evening there was an enormous movement of the bowels, this was described as brownish, semi solid stuff, with the vilest possible stench. During the night, several other large movements of similar character followed, and in the morning she had complete relief of troublesome symptoms. I saw her the day after with Dr. Wagner in consultation, and we concluded that we had to deal with a case of chronic intestinal obstruction, the cause of which was obscure, and advised operation for relief. The child was readmitted at the Hospital for sick children, for this purpose, on April 23rd, 1902. Two days subsequently, she was suddenly seized with severe abdominal pain, which came on after her dinner, the bowels had moved that morning. The pain only lasted a few hours, however, and disappeared after the application of turpentine stupes to the abdomen. It was evident that operation was imperative, as there was a possibility of the child developing serious and urgent symptoms at any moment. I therefore operated with the assistance of Dr. Wagner on April 30th.

The usual preparations for abdominal section were made and, under chloroform, I made an incision in the middle line below the umbilicus about three inches in length and explored the abdominal cavity. Small intestine, apparently normal, first appeared but below this one found the bowel distended, and the lower part of jejunum firmly tied down to the base of the sacrum by a dense band as thick as an ordinary lead pencil; the gut was fixed here so as to form a V, the left limb was continuous with the distended bowel above whilst the right limb of the V was collapsed. I secured this band by a silk ligature and divided it, thus freeing the gut.

I then overhauled the gut below the band and found, beyond the collapsed segment, that the bowel again became somewhat distended and a second V shaped piece of gut, about 10 inches from the ileo-cæcal valve was found tied down in a similar fashion near the point of attachment of the first. This was divided in the same manner as the first band and the Intestine was thus freed. I now began to suspect the Appendix as the probable source of the trouble; and, on investigation, I found the tip of the appendix was also firmly adherent to the posterior wall of the abdomen, near the point of attachment of the two bands. I freed this and found that the appendix which was short, about two inches in length, was considerably thickened. I removed the appendix in the usual manner and closed the abdominal wound. The patient made an uninterrupted recovery and has subsequently presented none of the symptoms of abdominal trouble which previously distressed her.

The manner in which Obstruction is treated in this case is obvious and the primary cause was no doubt an attack of appendicitis. It was fortunate that we were able to tide the patient successfully over the first attack when she was critically ill and when complete obstruction threatened. Had we been compelled to operate then her chances of recovery would have been very much reduced.

When one is operating for strangulated hernia one observes what I believe is or ought to be the universal custom, in making certain after the division of one constricting ring tissue say at the external ring, that no other constricting agent exists. The good old rule should, in my opinion, always be observed of pulling down the gut into the wound after dividing the construction to make sure that the gut above is normal in appearance and shows no sign of further constriction. The value of this observation was early impressed upon me when, as house surgeon, some sixteen years ago, I assisted a well known London surgeon in an operation for strangulated inguinal hernia. A man 22 years of age was admitted to hospital with a right strangulated inguinal hernia. During the operation two distinct constricting bands were divided one at the external ring and the other higher up the inguinal canal near the internal ring. The hernia contained both bowel and omentum, the latter was removed after ligating with silk, the bowel was returned into the abdominal cavity.

Symptoms of obstruction persisted to some extent subsequent to operation and the man died 46 hours after.

In my notes which I made of the case at the time, and from which I am now quoting, I find that post mortem we discovered a piece of gut was still strangulated. This was about four inches long and was constricted by a ring membrane which was derived from the stump of the

omentum. Thus there had been three constrictions. The case impressed upon me the importance of observing the rule to which I allude in operating for strangulated hernia and illustrates the possibility of more than one constricting agent in cases of strangulation. The same principle of treatment should be observed in operating for strangulation within the abdomen and the case which I now record is a good example to impress the importance of the observation. One might have been tempted to close the abdomen after the first V portion of gut was relieved from constriction, particularly as no immediate evidence of further trouble was observable; but on making search I discovered the second constriction and relieved it; had I not done so I would have failed in my efforts to obtain a cure.

The case which I now record is therefore instructive as an illustration of a form of chronic intestinal obstruction which may follow an attack of appendicitis and it is further interesting from the fact that kinking, with obstruction occurred at two distinct portions of the small intestine.

CAESAREAN SECTION, COELIHYSTEROTOMY, GASTROHYSTEROTOMY.*

N. E. MACKAY, M.D., M.R.C.S., Eng., Senior Surgeon to the Victoria General, Halifax.

This operation antedates the Christian era. For years it was confined to post mortem cases. It consists in the extraction of a child from its mother's womb through an incision made in the abdominal and uterine walls. Some claim that it had its origin in the birth of Julius Caesar. Others again say that it received its title in the phrase *caeso matris utero* in the description of the operation (Pliny). However, be this as it may, one thing is certain the name Caesarean Section was very early given to the operation.

The first to perform the operation was Jacob Nufer a butcher, or sow-gelder, of Switzerland. He performed it successfully on his wife in 1498. The first one recorded by a regular practitioner was by Troutmann of Germany in 1610. During the first 250 years of the history of the operation, no attempt was made to close the urine wound by sutures. For the healing of the wound and the prevention of bleeding, surgeons relied solely on the contractions of the uterine muscular fibres. The first record we have of stitches being used was by a French surgeon, named Le Bras, in 1769. Fully one hundred years elapsed before the general introduction of sutures in closing the wound. In view of these facts is it any wonder should the mortality be high in the early history of the operation ?

In Vienna the operation was done for one hundred years without a successful case (Godson). In the Maternité in Paris similar results were recorded. Chaira of Milan collected 62 operations with only two recoveries. In England during the eighteenth and part of the nineteenth century an almost equally dismal record was obtained. Here and there a successful case was reported but not by leading surgeons who were as a rule opposed to it. Instances of women performing the operation on themselves are recorded. One of the most remarkable of these was a patient who, two hours after operating on herself, walked a kilomètre, breakfasted with her sister, walked about for some time and recovered (by medical aid)* More remarkable still are the recoveries after laceration of the pregnant uterus with the horns of oxen. Harris collected 14 such cases and only four died and two of the four dead women left living children, and and in four cases both mother and child lived.

Porro, of Pavia, not satisfied with the results he had obtained with the operation, devised in 1876 a substitute, familiarly known as Porro's operation. His operation was a partial hysterectomy. He treated the pedicle in the lower angle of the wound. The advantages Porro claimed for his operation were that it lessened the danger of hæmorrhage and sepsis and removed the possibility of a future pregnancy. Since then the operation has been improved upon in various ways by Veit, Bair and Freund.

Very soon after the introduction of Porro's operation, Sanger of Leipzig, in 1882 proposed the closure of the uterine wound by a double row of interrupted sutures, but Leopold was the first to carry out the suggestion. This, the greatest of all advances, so improved Caesarean Section, as to greatly limit the application of Porro's method, and ought almost to banish craniotomy on the living child from the recognized list of legitimate obstetric operations.

It is interesting to compare the mortality of the old Caesarean Section with that of the improved. A fair estimate of all cases operated upon by the old method gives a mortality of 80 or 90 per cent. Meyers collected 1605 cases operated upon in Germany, France, Italy, Britain and America with only 54 recoveries. Bedford's tables of operations in Great Britain gives 131 cases with 23 recoveries. In America, Harris gives 134 operations with 53 recoveries.

On the other hand, with the improved method (Sanger-Leopold), the average death rate may now be put at 15 per cent. Up to 1890, 153 Sanger-Leopold operations have been performed in eleven countries with a mortality of 29 per cent. Between 1880-91 Sanger himself had 35 operations with only 2 maternal and 2 foetal deaths. Prof. Leopold in his

*Recorded by Von Guzenberg.

latest report records 95 recoveries out of 100, but other German operators have not been so successful. The general average mortality of German surgeons is 10 per cent. They have paid greater attention to the technique of the operation than surgeons of other countries, hence they have the highest percentage of recoveries. The French tables show almost equally good results. In America, the record is not so good. The reason of this is that the operation is as a rule too long delayed. It is not resorted to until every other method has failed, and the parts are bruised and often torn, and the patient's strength is exhausted.

The indications for operation are absolute or relative; absolute, when the pelvis is so contracted that delivery of a living child per vias naturales cannot be effected. It is relative, when there is a choice between it and other methods, but where caesarean section may be considered to give the best chances to the mother and child. The indications are furnished by a generally contracted pelvis, by tumors and growths obstructing the passage, and by cancer of the cervix. Placenta praevia and eclampsia may call for the operation. The alternatives are induction of premature labor, symphysiotomy, craniotomy forceps, and version.

The indication is absolute when the child is viable and the conjugate diameter measures 6.5 or 7 centimeters or less, or when the child is dead, 4.5 centimeters or less (Kelly).

The relative indications must be determined by the circumstances of each individual case, and partly by the wishes of patient and friends.

On the best time to operate authorities differ. Some prefer to operate at full term and before labor begins. Others again would rather wait till the patient is in labor and the os dilated. For my own part I am in favour of deferring the operation till the os is dilated as then better drainage and uterine contraction can be secured.

The following case I had in my hospital practice in April last. I believe it is the first of the kind we ever have had in that institution:—

Mrs. C. coloured, age 43, a primipara at full term, was sent to the V. G. H. on April 13th, 1900, by Dr. M. A. B. Smith, of Dartmouth, for operation. She had been in labor over three days. The patient was a resident of Preston, and had to drive 12 miles in an open cart, in a down-pour of rain to get to the hospital. She arrived at three p.m., and a consultation was held at once at which it was decided to perform a conservative caesarean section, or gastrohysterotomy. She was examined aseptically. The os uteri was dilated the size of a fifty cent piece and the head was presenting—occiput anterior—but it had not engaged in the brim of the pelvis. The promontory of the sacrum was well marked, and the true conjugate diameter measured about 7.5 centimeters (3 in.).

There was a cone-shaped contraction of the pelvis and the distance between the tuber ischii was about 8.5 centimeters ($3\frac{1}{2}$ in.). No foetal heart nor uterine souffle could be detected, and palpation failed to detect any movements of the child. The patient, however, assured us she felt the child moving on her way to the hospital. Uterine contractions were feeble. The waters broke two days prior.

The patient was prepared for operation, as quickly as possible, by scrubbing the parts with soap and water, and then washing them with ether and lastly with mercuric chloride solution, 1 in 500, and the vagina was thoroughly douched with a similar solution.

Chloroform was the anaesthetic used. Opened the abdomen by the median incision. The incision extended from two inches above the umbilicus to within two and a half inches of the pubes. It was about six inches in length. To prevent any liquor amnii or blood getting into the abdominal cavity, an assistant with a hand in each flank pressed the uterus well forward against the anterior abdominal wall and held it firmly there. No effort was made to locate the placental attachment; its situation being unimportant, I first made a clean cut $2\frac{1}{2}$ inches in length vertically downward, in the middle of the anterior surface of the uterus, beginning two inches below the fundus. This incision came right down on the placenta. The bleeding was quite free and to control it I instantly inserted two fingers in the wound and gently but rapidly separated the attachment of the placenta on one side of the incision and enlarged the wound downward with scissors, using my finger as a guide, and in a similar way extended it upwards to the fundus. I made the uterine incision 5 inches long. During all this time I kept my hand constantly in the wound to control the hemorrhage which I succeeded in doing fairly well. To ensure strong uterine contractions, and so lessen the danger of hemorrhage after emptying the uterus, and at the same time promote spontaneous separation of the placenta, I ordered at this stage, an assistant to inject half a drachm of antiseptic ergotine in her arm. This had the desired effect. I now inserted my hand into the cavity of the uterus, took hold of the child by the legs and extracted it easily. The cord was divided between two pressure forceps and the child which showed no signs of life, was handed to Dr. Smith to look after. The placenta was peeled off easily and it, together with the secundines, was removed and the cavity of the uterus cleared of clots. There was considerable oozing from the uterine sinuses, so much so, that I was obliged to pack the cavity of the uterus with iodoform gauze. The organ was now eventrated and surrounded with warm sterilized towels and pads, and constant pressure was kept on the edges of the wound by an assistant till

all bleeding had ceased which occurred in three or four minutes. Hardly a drop of amniotic fluid or blood got into the peritoneal cavity. The gauze packing was then removed and the uterus carefully cleared of all clots and the wound closed after the Sanger-Leopold method by a double row of interrupted sutures as follows:—The peritoneum along the margin of the incision was detached from the muscular fibres for a short distance ($\frac{1}{4}$ in.). This made it possible to turn in a greater amount of serous membrane. The deep sutures were then inserted. They were placed three-fourths of an inch apart, and were made to enter at about half an inch from the edge of the wound, pass obliquely through the muscular tissue and emerge near the bottom of the cut surface. The superficial sutures were then placed, two between each deep suture. The needle was made first to pierce the peritoneum and muscle, come out a little below the lip of the wound; then to pick up the free edge of the peritoneum on the same side. A similar course was pursued, in opposite direction, on the other side. They were after the fashion of a Lambert suture. The superficial sutures were first tied and they brought into accurate opposition two strips of serous membrane. Then the deep sutures were tied, causing still further incurvation of peritoneal surfaces and closing up and strengthening the whole. The toilet of the peritoneum was now attended to and the uterus on being thoroughly douched with sterilized saline solution and dried, was returned into the abdominal cavity, and the abdominal wound closed as after an ordinary laparotomy:—The peritoneum by a continuous suture of catgut, the aponeurosis by interrupted sutures of catgut, and the skin by interrupted sutures of silk-worm gut. The operation occupied forty minutes in its performance. Drs. Chisholm and Farrell assisted.

The patient stood her operation well. At 9 p. m. her pulse was 120 and temp. 99. She had a good deal of pain in the night in right arm and leg; was given $\frac{1}{4}$ gr. morphine at three in the morning, after which she rested well.

14th. 8 a. m. still complaining of pain in left arm and leg. The next 24 hours pulse ranged between 108 and 110, and temp. 98.4 to 99.4; respiration from 28 to 36; stomach good till early evening when she felt a little nauseated, and was troubled with flatulency.

15th. Report for next 24 hours; was at times very distressed from tympanites; gave an enema of soap suds and turpentine; some flatus was expelled and the bowels moved slightly; this gave her some relief. Ordered grs. 2 of calomel every two hours; till 8 grs. were taken. The enema was repeated at 7.10 p. m.; no effect; Pulse ranged from 88 to 100 and temp. 98.4 to 99.

At 9 ordered an ounce of castor oil and a high enema of turpentine four hours after. No effect. Patient very distressed with flatulence. Slept a little through the day and night. Temp. at night 97 to 98 and pulse 74 to 88.

16th. Enema of ox-gall. No effect. Stomach greatly distended with gas and patient very distressed. Stomach very irritable. At noon gave her again an enema of turpentine with no relief; put her in knee-pectoral position; no relief. Washed out her stomach and removed 2 quarts of a dark brown liquid therefrom, having a distinct fecal odour. Pulse 104 but it had no volume; temp. normal. Ordered gr. $\frac{1}{2}$ strychnine every two hours. 4 p. m. patient very restless; Pulse more rapid and feeble. Stomach keeping very irritable and abdomen greatly distended. Patient rapidly sinking.

At 10 she vomited quantities of stercoraceous material. Died at 11 o'clock at night.

Post Mortem:—Uterus about normal size for third day after labor. Nothing to indicate septic peritonitis found. Bowels were somewhat congested, also the peritoneum. Uterus pressing on sigmoid flexure, at brim of pelvis. No impacted faeces in intestines. A small quantity of serous fluid in the abdominal cavity. Wound in uterus closed except at one point through which fluid escaped, on manipulation.

This patient evidently died from intestinal obstruction. What was the cause of the obstruction? It was not peritonitis. Her pulse did not indicate peritonitis. In cases of peritonitis I do not attach so much importance to the temperature as I do to the pulse. The volume of the pulse was good till 12 hours before her death. Then again the post mortem proved she did not die of peritonitis. There was no evidence of inflammation present. The obstruction here must have been caused by over-distention with gas. This condition is known as pseudo-ileus. Dr. Greig Smith says he has demonstrated that intestinal over-distention by kinking of the bowels and paralysis of the intestinal muscle, was a cause of true obstruction. The treatment for such cases is free purgation. I strenuously endeavoured to get free operation of the bowels but failed. Could I have done any thing else to save my patient? I think I could. Observe the condition present; A pseudo-ileus and a heavy uterus jammed in the brim of a contracted pelvis and pressing on a loop of the large bowels. The pressure of itself on a semi-paralyzed loop of bowel might have caused all the mischief. I was tempted to reopen the abdomen and remove if possible the cause of the obstruction. If ever again I have a similar case I will do so.

A CASE OF HERNIA OF THE BLADDER.

By E. R. SECORD, M.D., Brantford.

HERNIA of the Urinary Bladder, whether alone, or complicated by coincident hernia of other organs, is a sufficiently rare condition to merit that each case should, in at least a brief form, be put on record. And in this class I would not include those somewhat rare conditions of "Ectopia Vesicae," caused by defective development of the anterior abdominal and visceral walls, but only those cases where the bladder forms the part or the whole of a hernia descending through the ordinary canals for other forms of that condition.

The condition as already mentioned is somewhat rare, the more common cases being those in which the bladder forms only part of the herniated mass, and it appears that, in these cases at least, the hernia of the intestine has usually preceded that of the bladder, the latter only becoming involved when the hernial sac has become large enough to exercise direct traction on the peritoneum covering the posterior wall and fundus of the bladder. Added to this cause there would also seem to be exerted the influence of old age in producing relaxation of the tissues, and again possibly in some cases obstructive causes may be active, such as an enlarged prostate producing dilatation of the bladder, with secondary thinning of its walls, and, in many cases, definite sacculation.

The symptoms which the condition produces are rarely definite enough to allow of a pre-operative diagnosis. Occasionally there is pain and a dragging sensation in the hernia during micturition, and again, in some cases a truss causes such pain as to almost prevent its being worn. This is probably due to the adhesion between the bladder and the sac wall, which prevents the complete reduction of the former, and hence causes the truss to exert undue pressure on part of this sensitive organ.

If for any of these reasons the condition be suspected, a radical cure by one of the many accepted methods, should be immediately done, both to relieve the present symptoms of the patient, and to prevent that increase in the size of the hernia, with increasing probability of strangulation, which is so likely to occur from the failure of the truss to perfectly retain the mass.

The prognosis, in cases which have not been operated upon, is distinctly worse than in uncomplicated cases, owing to the increased probability of strangulation. In unstrangulated cases which are subjected to operation, the prognosis should not be any worse than in ordinary radical cure, if the condition be suspected. Where it is not suspected the danger of opening the bladder in removing redundant sac, or indeed of tying off the whole herniated portion of the bladder, if the unmodified

Bassini operation is done, followed by urinary fistula, or even death from peritonitis due to leakage, renders the operative prognosis more unfavorable. Of strangulated cases the same may be said, the danger, aside from that due to the intestinal lesion, is in proportion to the lateness of the discovery of the condition of the bladder.

I may now give a brief account of a hitherto unreported case of this condition.

In April, 1902, I was asked by Dr. Gamble, of this city, to see a patient of his, who had apparently an ordinary strangulated hernia.

The patient was a well preserved, vigorous old man of seventy-three years, who had had the hernia for forty years. It had been only fairly well retained by the truss, but when it had come down was hitherto easily returnable. According to the history it had been down now for about four hours, but the condition of the bowel as afterwards revealed, would lead one to suppose that it had in reality been down somewhat longer.

The herniated mass, on right side, was large, very tense, exceedingly painful, and presented all the ordinary symptoms of a strangulated scrotal hernia. It was quite irreducible, even after chloroform anaesthesia had been produced.

Operation was advised, decided on, and carried out in quite the ordinary manner. On opening the sac several ounces of blood stained serum escaped. The hernia was now seen to consist of about eight inches of the small intestine, closely and firmly adherent coil to coil, but not at all adherent to the sac wall. The intestine was distended and tense, its wall was in part black, but everywhere retained its lustre. The ring was slightly nicked above and to the outer side, and the intestine drawn down somewhat for closer examination. The distal portion was quite healthy and almost collapsed, while the proximal portion was so distended that it could not be drawn down to any extent. A finger inserted alongside of it felt, as far as it could reach, distended coils of intestine, with almost solid contents. Evidently there was a condition of chronic obstruction from the flexions produced by the bands, as well as the acute obstruction produced by the strangulation. As, however, the patient's condition hardly encouraged the performance of a resection, the whole mass was returned, with the idea of making an artificial anus should the symptoms of obstruction still persist.

An effort was then made to isolate the sac from surrounding parts, and after much difficulty, owing to the closeness and firmness of the adhesions, this was effected. On examining the sac I now found that its inner wall was apparently composed of two layers, which, with the thumb

inside the sac and the fingers outside, could be moved the one over the other. I at once became suspicious of hernia of the bladder, and tried to define the extent to which these two layers were carried, but this I was quite unable to do, owing to the thickness of the sac wall at this point, so that the light showed no dividing line between the double and single layer, nor could I, by any gentle handling, separate the bladder, if such it was, from the sac wall.

I, therefore, placed a temporary catgut ligature around the neck of the sac, and slowly cut across the neck from without inwards towards these two layers, which when slightly nicked, separated and exposed a cavity lined by a pinkish mucous membrane. This cavity was continued downwards on the inner side of the sac for about four inches. Feeling confident now that this was in reality bladder, I closed the opening with Lembert sutures, a difficult proceeding owing to thinness of the bladder walls at this point, returned the bladder within the ring, removed the external portion of the sac and closed the peritoneal opening with catgut. Iodoform gauze was packed down to this point, to afford drainage for leakage should it occur, and the usual operation completed, with the exception that the external ring was not closed so tightly as usual owing to the presence of the gauze.

No leakage having occurred, the gauze was removed on the fourth day, and the old gentleman made a quite uneventful recovery.

In conclusion I may say that the chief difficulty in the case occurred in closing the peritoneal opening of the neck of the sac, without including the bladder at the inner side, but it was done as completely as possible by the use of catgut sutures passed across the neck of the sac, and through its walls, on a fine needle.

I must apologize for the incompleteness of this report, and offer as my excuse the fact that ill-health compelled me to leave the city shortly after the case occurred, and before I had been able to commit all the details to my case books. They have, therefore, been filled in partly from memory. However, I trust that the most interesting features have been mentioned.

LYMBURNER V. CLARK AND HOPKINS.

Before Hon. Justice Ferguson, without a jury.

Cayuga Spring Assizes, A. D. 1902.

Mr. C. W. Colter, K.C., and Mr. A. K. Goodman for Plaintiffs.

Mr. F. V. Teetzel, K.C., and Mr. W. D. Swazie for Defendant Hopkins.

Mr. G. L. Staunton, K.C., and Mr. J. C. Eccles for Defendant Clark.

JUDGMENT.

I think that in the circumstances I am not called upon to consider over again the evidence and elaborate a judgment.

The proper conclusion on the evidence seems to me perfectly plain.

These defendants are sued for negligence or want of skill in their profession.

Many gentlemen of their own profession are called and give their evidence in the witness-box saying that the course pursued by these defendants would have been pursued by the majority of practitioners in the Province; and some of these gentlemen say that they have pursued it themselves. Even the doctor called by the plaintiffs, Dr. McCallum, says, "I have heard the description of the injury and of the treatment of the injury by the defendants. I say the treatment was such as many practitioners adopt at the present time."

As a rule, when a doctor is sued for negligence, and other doctors come forward and say that they would have adopted the treatment that he pursued, the court says that he cannot be convicted of negligence. All he is called upon to do is to bring into the treatment of the case reasonable skill and reasonable diligence.

Some doctors make a suggestion that something else ought to have been done. They do not go on and say that that not being done was the cause of the disaster. But when so many men high up in their profession come forward and give the evidence they give in regard to the treatment of this case how can I convict those two men as being guilty of negligence or want of skill? It seems beyond question that I cannot do that. Remarks were made in regard to those gentlemen that I am far from adopting the meaning of. I cannot bring myself to believe that so many medical gentlemen would be willing to come here and prop up a case by swearing what is untrue or by giving a false opinion, as counsel has contended I should do. I saw nothing in the evidence of those gentlemen to indicate that there was any bias. I cannot say so much in regard to witnesses called for the plaintiffs. On the question of veracity, there is the plain fact here that husband and wife—the father and mother of the child—practically contradict each other. The husband's attention was called to the circumstance, and all he can do is to say that his wife is wrong.

However, the ground upon which I put my conclusion is that these men are charged with want of skill or negligence in the treatment that they adopted in dealing with this injury; they call gentlemen of the same profession—men of the highest respectability, as I think, and some

of them, I think, at least of the highest reputation—men possessing talents which they discovered to me in the witness-box—men of good health, high education, manifestly understanding the subject they are speaking of;—and they say this treatment would have been adopted by the majority of practitioners in the country. It is possible this evidence is all untrue; but I cannot arrive at that conclusion at all. I think the plaintiff, even upon his own evidence has not made a case; but when I take the evidence of this long line of highly qualified and respectable practitioners—take the evidence of their opinion in regard to what was done—there is no conclusion that I can arrive at but that the case fails. I have no hesitation whatever in giving judgment dismissing the action with costs as against both defendants. I order and direct that after thirty days judgment be entered dismissing the action with costs.

A PLEA FOR THE SURGICAL TREATMENT OF APPENDICITIS.*

By D. CLOWES VANWART, M. D.

(University of Pennsylvania), Frederickton, N. B.

MUCH has been written and said on the subject of Appendicitis. I shall make no attempt to treat the subject *in extenso*, but rather base my remarks on personal experience with no references to text books, etc.

We may classify diseases of the vermiform appendix in point of time, as primary and recurrent. Clear cut symptoms are not present in every case, this being particularly true in the first twenty four hours of the disease. The tripod of symptoms which prevent an error in diagnosis are:—

1. Pain: at first, sudden and acute, referred to the epigastric or umbilical regions; later becomes localized over the site of the appendix.
2. Rigidity: this follows the localization of pain and is most marked in the right lower quadrant of the abdomen.
3. Tenderness in the right lower quadrant of the abdomen: this being a constant symptom from the beginning of the attack.

Pain at first colicky is most marked in acute cases and may last only a few hours: as in those cases where the pus forms rapidly. Tenderness is the most constant of these symptoms as would be expected from the fact that inflammation is present. The point of maximum tenderness is always between the attachment of the appendix to the caecum and its apex. In recurrent attacks the only positive symptom is tenderness; and

*Read at a meeting of the Maritime Medical Association, Charlottetown, P. E. I., July 9th, 1902.

when these attacks are mild diagnosis is often difficult, particularly so in the female sex. In cases that are seen early the position of the appendix can be determined, but if the organ contains pus and the sac has ruptured its location becomes a more difficult matter.

It is not my intention to enter into the minutiae of differential diagnosis. Obscure cases of enteric fever may sometimes be confounded with an attack of appendicitis since pain in the ileo-caecal region is present in the early stages of both diseases; but the pain is less acute in the former and there is not the muscular rigidity. Influenza of the digestive type is often at first confounded with a mild attack of appendicitis. Many cases of indigestion are the reflex symptoms of an inflamed appendix.

To illustrate: H. G. L., male, age 24, consulted me in April 1901 for indigestion, I learned from him that "just two years ago he had suffered from a severe attack of cramps that left him sore." He had been taking remedies with more or less regularity up to the time of consulting me. During an acute exacerbation he would have nausea, vomiting and abdominal pain, and was improving from such an attack when I first saw him. On examination I found marked tenderness about the so called "McBurney's Point" with temperature and pulse normal. The patient consented to an operation and was at once removed to the Victoria Public Hospital. The appendix was found post caecal, pointing toward the liver and adhering to the caecum. Two faecal concretions were present, walled off at the distal end of the appendix the latter showing chronic inflammation. An uninterrupted recovery followed the removal the appendix and there has been no recurrence of his former trouble.

The thermometer should not be relied upon for much assistance in diagnosis, since in the presence of pus there may be little or no rise of temperature. To illustrate: R. B., male, aged 12, after considerable physical exertion suddenly developed intense pain in the abdomen. He had tenderness at first about the umbilicus. At the beginning of the third day the maximum point of tenderness was two inches below the edge of the liver in the right hypochondriac region. Third day temperature normal, pulse 90. I advised immediate operation, and found the appendix posterior and to the inner side of the ascending colon with a length of about four and a half inches. The distal end contained a sac of pus and was on the verge of breaking; but no adhesions were found. The appendix was removed and the patient made a rapid recovery.

To further illustrate: Mrs. F. C. H., aged 26. In this case the temperature never rose above 100° F., and the pulse was never below 110. The patient was operated on at the beginning of the third day, the

appendix being found ruptured and gangrenous with deposits of septic lymph on the neighboring parts. Prompt operation, removal of the appendix, and thorough irrigation of the affected area saved this patient's life.

As a cause, I have noticed that attacks have followed undue physical exertion as illustrated in case number 2 of this paper. The anatomical position of the vermiform appendix on the psoas muscle and the caecum filled with faeces is to my mind a sufficient cause to produce an irritated condition of this organ. Constipation was present in a majority of cases. In none of my cases have I found sufficient evidence to warrant the conclusion that an attack may be precipitated by over eating. There is in my opinion a close relationship between Appendicitis and Tuberculosis ; fully twenty-five per cent. of my cases occurring in families of tubercular tendencies.

After opening the abdominal cavity I have always been able to find the appendix, except in those cases where it has sloughed off. Behind and to the inner side of the caecum is the most common position. In but one case have I found it to the outer side of the caecum. I have never found the appendix pointing toward the pelvic cavity except in the female sex.

Three cases that had been allowed to go on to pus formation, and the abscess cavities drained but the appendices not removed, subsequently came under my care for operation. In two of these cases the appendices were found small, contracted and curled on themselves and adhering posteriorly to the caecum. In the third case the appendix was large, inflamed and contained pus, being bound down by adhesions to the outer side of the caecum. A rapid recovery followed the removal of the appendix in each case.

Should the appendix be removed in every case when the abscess is drained? It is not always possible to do so and even when possible is not always safe. In cases where the cavity is imperfectly walled off I should hesitate to disturb the parts; but should temporarily treat the abscess by irrigation and drainage. On the other hand, where the cavity is well walled off my treatment is to remove the appendix. Cases that are seen early and under constant observation and allowed to go on to pus formation with rupture are, in my opinion, improperly treated. It is needless to say that it is no uncommon thing to find an abscess at the first examination. I have seen cases in consultation where the attending physician, knowing that an abscess was present, hesitated about operating, but preferred to wait, hoping that the patient would improve under rest and medical treatment, thus totally ignoring the surgical principle that pus must have vent. An abscess should be suspected when tenderness

and pain continue, vomiting persists or distinct tumor felt. A rapid pulse is a reliable sign of suppuration. I have never seen a chill to denote that pus was forming. The case in which the symptoms do not subside in thirty-six hours from the on-set of the disease is an operative one.

The idea of this paper is to suggest early operation in inflammation of the vermiform appendix whether catarrhal or suppurative. If early operation is insisted on the pus cases with faecal fistula and other annoying complications would not exist. I shall not consider the pathology of the disease or the treatment of its complications. The question is asked: "Should we operate in every case?" When the peritoneum is affected and distended, skin leaky, temperature subnormal, pulse rapid, feeble and compressible my answer is negative. In cases of this nature the system is overrun with sepsis and a *general* anaesthetic produces too great a shock. In such a condition I would prefer to use a *local* anaesthetic, opening the abdominal wall and irrigating as much as possible by means of a normal saline solution.

The arterial supply of the appendix is from the mesenteric artery which may be compared to the trunk of a tree with its branches. By ligating the trunk all supply to the appendix is cut off, and this makes practically a bloodless operation. I prefer ligating the artery and tying off the appendix with chromicized cat-gut, covering the stump with serous membrane if possible, and closing the abdominal incision with silkworm gut.

I am not an advocate of gauze drainage in appendicitis operations. This frequently causes excessive exudation of lymph which may result in annoying peritoneal adhesions and lifelong discomfort to the patient. Its use leaves a weak spot in the abdominal wall inviting the development of hernia. It also acts as a foreign body; and I have known it to depress a patient as well as prolong the condition of shock. Iodoform gauze does not drain well and is very apt to cause iodoform poisoning. If the greater part of the toxic material be removed by careful irrigation the lymphatics and leucocytes will attend to the rest much better than the surgeon with any complicated device.

When I see a case in its early stages I try to avoid the use of opium and its alkaloids, since it locks up all the secretions, except that of the skin, and masks the progress of the case. Morphia may be used in small doses if the pain be very great. Fractional doses of Hydrargyri Chloridi Mitis and Sodii bicarbonatis may be given to arrest the nausea and clear out the digestive tract, while enemas of soap suds with turpentine are found effective. The advantage of having the intestinal tract empty during an operation is plain to any surgeon.

AFTER TREATMENT.

I do not give morphia for the reason already stated. Although the patient complains of pain it does not last longer than fifteen or eighteen hours. Cases do best on a liquid diet from ten to fourteen days. I have noticed that the tongue is much coated, and the breath offensive in some cases even in the presence of normal pulse and temperature and the patient on the road of rapid convalescence.

The following is copied from my case book: F.M., male, age 17, labourer. Previously in good health with no former serious illness. Week before consulting me had cramps for two days. Said he got some better. Constipation from that attack until I saw him, Nov. 15th, 1901. Night of Nov. 14th, 1901, attack of cramps, suffered all night. Nov. 15th 11 a.m. temp. 100°, pulse 100. Cramps and rigidity of abdominal muscles. Ordered tu. pensive stupes, enemas and fractional doses of calomel. Pain so great forced to give $\frac{1}{2}$ grain morphia hypodermically. 5 p.m. patient still in pain. enemas effective. Had to give another $\frac{1}{2}$ grain of morphia hypoderm. ally. Advised immediate operation. Patient consented. Operated on at Victoria Public Hospital at midnight. Abdomen scaphoid. Tenderness greatest above McBurney's point. Incision two inches long. Appendix found post caecal, pointing upwards with abscess in distal end ready to break. Appendix removed with ease. Wound closed. Temperature normal on third day after operation and continued so all through convalescent period. All of superficial and part of deep sutures removed on fifth day. Remaining deep ones on seventh day. Wound not dressed again until the twenty-first day. On the twenty-first day, patient fitted with abdominal pad, left hospital cured.

In conclusion I may say that my only cause for regret has been not that I operated upon a case of appendicitis, but that I did not operate earlier.

 THE NATURAL HISTORY OF DISEASE.*

SIR THOMAS BARLOW, one of those who attended His Majesty in his recent illness, delivered the Address in Medicine before the British Medical Association in August. He chose for his subject "The study of the natural history of disease, the basis of all advance in its treatment." Twenty-five years ago, when the association met in Manchester, the Address in Medicine was delivered by the late William Roberts, on the acute specific fevers in their relation to contagium vivum.

Sir Thomas Barlow passed under review some of the advances that have been made during these twenty-five years. He drew a strong bow

* An abstract of the Address in Medicine before the British Medical Association.

and shot his arrow far. In passing he struck a severe blow at those who do all in their power to hinder the employment of experiment, one of the methods which contribute to make medicine an exact science. The progress of medicine has been along the lines of empiricism, and the survival of the fittest. There is good and bad empiricism. The former strives to follow nature's lead, and preserve that which is useful.

The study of diphtheria is profoundly interesting along this line. There was a time when all was chaos and confusion. Many were the disputes on the difference between croup and diphtheria. It began to be noted that sporadic cases occurred, and there were frequently a number of instances of mild sore throats before an epidemic of diphtheria occurred. The mind began to grasp the thought that contagion must be often concealed, and carried by unknown agencies from place to place. The germ was discovered, and a new era opened up. It was found that during the growth of these germs in the system, either they produced a deadly poison, or acted on the tissues in such a manner that the latter gave out the poisonous ferment. Further study proved that the germs are often found in the throats of those waiting upon the disease, who show no symptoms of it, the throats being healthy & the germs do no harm. Further study led Behring, Roux, Aaronson, Yersin and others to discover that the patient makes an effort to defend himself against these poisons, and that an anti-poison, an anti-body, an antitoxin is produced. The manifest alteration after the use antitoxin, even in unfavorable cases, is convincing enough that we have here a fundamental remedy of great potency. It has now been shown to be a remedy of value in the prophylaxis of the disease.

In rabies, though we know nothing of the micro-organism, it has been fully proven that the poison is lodged in the cerebro-spinal tissues. Pasteur and his pupils have given us the most brilliant results from their studies on this disease. It has been concluded that in the dried spinal cord, the germs are dead but that the immunizing substances remain active. The prophylactic value of the Pasteur treatment is beyond all doubt, though it is of much less value in the developed disease.

The discovery of vaccination was the outcome of long years of painstaking study, on the part of Jenner. But as time went on much knowledge was gained in addition to what Jenner gave us. The necessity for revaccination became apparent, by a study of smallpox epidemics and the protective value of vaccination. Then as experience grew, it became known that many of the bad effects of vaccination could be avoided by a pure lymph and a clean arm. The whole question of mixed infection came before the attention of the profession. The study of the natural

history of vaccination and pus germs has already yielded an abundant harvest.

While the antitoxic serum has not yet been of much service in the acute cases, it has proven useful in the more chronic form. There is much to be hoped for here.

The study of the natural history of tuberculous diseases has brought forth much important information. It is now well known that many suffer from the disease at some time or other and recover. The human body must have a great deal of power to resist the tubercle bacillus, as is shown the large numbers of old tubercles found in persons after death. The discovery of tuberculin is of the utmost value as an aid to diagnosis of the disease, especially in cattle. The study of the disease has led to sounder views on treatment, and the open air method has done much. But the great advance is along the lines of prevention. We know the germ of the disease and its habits of life and growth. From these studies, we now know what must be done to prevent the spread of the disease: Sunshine, water, air, destruction of sputum, and safe-guarding those who are ill, are the foundation principles.

With regard to malaria, experimental research has established the connection between the mosquito and the disease. If care be taken to avoid being bitten by the mosquito, malarial districts have no terrors. This gives a new direction to prophylactic measures. But this has shown that under the name malaria a variety of conditions have been named that are not malaria at all. We now know also from scientific observation how quinine acts, and when it ought to be given to be most effective, by saturating the system when sporulation of the *Amoeba* takes place in the blood.

It is now proved that the epidemic form of Cerebro-spinal meningitis is due to the diplococcus intra-cellularis. Some sporadic cases of great acuteness, where the pneumococcus is the germ found, go to show that meningitis may be caused by several forms of organisms. All this is due to the study of the natural history of disease.

The study of the thyroid gland has led to great advances in myxoedema and exophthalmic goitre. Much of what we know of "organotherapy" is due to these investigations. It has been shown that myxoedema can be produced in monkeys by the removal of the thyroid gland. Once more the natural study of the disease has laid the foundation for treatment.

So the study of acute rheumatism has led to the belief, almost proof, that it is due to a specific diplococcus.

CURRENT MEDICAL LITERATURE.

Conducted by A. J. MacKENZIE, B.A., M.B.

TREATMENT OF CHLOROSIS.

BURNET in the *Medical Press and Circular* says:—Rest, sunlight, and fresh air go hand in hand to promote a cure which is being brought about by careful and suitable dieting and a course of Iron. And in estimating our patient's progress we must examine the blood carefully from week to week—more especially the hæmoglobin. This is a very simple process, and readily acquired. A word of warning! Do not stop the treatment too soon. If you do, relapse and disappointment will result. Go on steadily for some months even after you have satisfied yourself that the blood has been restored to its normal state.

OPERATION UNDER LOCAL ANAESTHESIA.

MMARTIN—*Cleveland Medical Journal*—operates with the aid of $\frac{1}{10}$ of 1 per cent. eucaïne, for removal of hæmorrhoids. He passes his sutures before making the incision, and thus avoids the pain that so frequently accompanies the last stage of such operations.

THE ORIGINAL DOVER'S POWDER.

IN an article on Thos. Dover in the *Dietetic and Hygienic Gazette*, the original formula of the famous "Pulv. Doveri" by which he is known to posterity is given—the case is one of gout:—

"Take opium 1 ounce, saltpetre and tartar vitriolated each 4 ounces, liquorish 1 ounce, ipecacuanha 1 ounce. Put the saltpetre and tartar into a red-hot mortar, stirring till they have done flaming. Then powder them very fine; after that slice in your opium; grind these to a powder, and then mix the other powders with these. Dose: From 40 to 60 or 70 grains in a glass of white wine posset going to bed, covering up warm, and drinking a quart to three pints of the posset-drink while sweating."

"In two or three hours at the furthest the patient will be free from pain; and, though before not able to put his foot to the ground, 'tis very much if he cannot walk next day. The remedy may be taken once a week or once a month."

INFECTION IN UTERO WITH MALARIA, AND SMALLPOX.

THE July number of the *Kingston Medical Quarterly* has an article by Dr. D. E. Mundell, on this subject, with report of a case. The

views of many of the best known students of malaria are given which are to the effect that no truly demonstrative case of congenital infection has been published since the discovery of the malarial parasite. It is also claimed that the fetus enjoys immunity against the anæmia and other secondary effects of the infection. In the case quoted by the writer, the mother suffered from repeated malarial attacks during the early months of her pregnancy, but had good health for some time previous to her confinement. The infant was healthy and continued to thrive for about two months when it began to lose flesh and show signs of pain. The blood was examined, the plasmodium was found, and the administration of quinine was before long followed by restoration to health.

The mother had removed in June to Kingston, a non-malarial district, the child was born in August, after which time mosquitoes (the *Culex*) are rare here; from the evidence, Dr. Mundell believes it was a case of intra-uterine infection. The blood of the mother showed nothing of import at the time the disease was discovered in the child.

In the same number, Dr. J. P. Boyle, of Casselman, Ont., reports a case of foetal small-pox. The child was born prematurely, but alive, fifty well-marked pustules were counted on the limbs, hands and feet. The parents claimed that neither of them had had small-pox, though three weeks previous to the birth of the child they had moved into their present abode—a house in which small-pox had existed for some time previously. The child lived twenty-four hours.

THE PRODUCTION OF ANAESTHESIA DURING SLEEP.

IN *The Medical Age*, July 25th, J. H. Adams discusses the possibility of producing anaesthesia by the administration of chloroform to a person asleep without awaking them. The importance of the point in cases of the criminal administration of chloroform is apparent. The writer refers to the experience of Dr. Ouimsky who, in order to decide the question in a medico-legal case, made several experiments and found that with care a person could be successfully chloroformed without being awakened by the drug.

THE TEACHING OF THE HISTORY OF MEDICINE.

IN the *British Medical Journal* for July 12th, Osler describes the method followed at Johns Hopkins in the teaching of History of Medicine. The course of lectures is not compulsory and is given by Dr. Billings. There is an Historical Club, meeting monthly, which discusses various

epochs in the advance of the science, while in clinical teaching, where occasion offers, reference is made to the names of famous workers and leading questions asked.

LACHNANTHES TINCTORIA.

THE LANCET for July 12th has the reports of Drs. Spitta and Latham on the chemical and therapeutic properties of the herb 'Lachnanthes Tinctoria' which has been vaunted as a prophylactic and cure for tuberculosis. They conclude that lachnanthes consists largely of a resinous substance or substances and some body which is precipitated by lead subacetate and is soluble in water. Five c.c.m. of an aqueous solution of the alcoholic extract is powerful enough to kill guinea pigs, while doses varying from one to three c.c.m. do not exert any inhibitory action on the progress of tuberculosis, but rather seem to hasten it.

KEEPING WELL.

MEDICINE July 1902 has a thoughtful editorial on the importance of individual preventive medicine. It is pointed out that we wrong the profession when we let the idea become fixed that our care is only intended to cure or palliate serious affections, or relieve distressing symptoms. A thorough physical examination with all the aid that physiology can give, repeated say at six month intervals, particularly in those over forty, would reveal those insignificant prodromes that herald the approach of serious affections, and the correction at this time of errors in habit and diet might mean the addition of years to useful lives.

THE OCCURRENCE OF CANCER AND TUBERCULOSIS IN THE SAME ORGAN OR TISSUE.

IN the *Journal of Medical Research* for June, Moak examines the evidence with regard to the supposed antagonism of Cancer and Tuberculosis and reports five cases of their occurring coincidentally in the same organ or tissue. He believes that there is no antagonism but that the reason they are so infrequently found associated is that 82.1-5 per cent. of tuberculosis is fatal before 50 while 73.2-5 per cent. of deaths from cancer occur after that age. But we must consider, too, the cases of latent or healed tuberculosis, and Nægel's statistics show that 92 per cent. of adults over 18 have either active, latent or healed tuberculosis, it follows that many of the cancer cases must occur among these. It is to

be noted, too, that the organs most frequently attacked by tuberculosis are not those most frequently affected by Carcinoma.

AN APPARATUS FOR USE IN PROLONGED NITROUS OXIDE ANÆSTHESIA.

IN the *Lancet* for June 28th, Hilliard describes an apparatus for the prolonged administration of Nitrous Oxide. Operations which require a period of anæsthesia, extending beyond one to two minutes, especially those in the region of the mouth make the use of the ordinary face-piece inconvenient or impossible; the writer obviates this difficulty by using in addition a tube in the form of a No. 7 to 9 gum elastic catheter, 6 inches in length, ending *à boucle*. As soon as anæsthesia is completed by the ordinary method this is passed through the nostril, till it impinges on the posterior pharyngeal wall, and the gas is turned on in it. By this means anæsthesia may be prolonged as long as seven minutes, giving time for any ordinary dental operation, and interfering in no way with the operator. In 300 cases the writer has found no difficulty from bleeding or nasal obstruction, even the presence of adenoids being no contra-indication, and only in one case was difficulty experienced in keeping the patient under. The best position for the patient is sitting up, and if the operation is to be extensive, abstention from food for some hours before is advised.

BARTHOLINITIS.

UNDER this title, M Julien discusses inflammation of Bartholin's glands in the *Gazette des Hôpitaux*, June 26th. The infection is most frequently gonococcus and is associated with the other most common pus-producing organisms. The infection may be direct when it is derived from the male organ, the possibility of this is proven by the existence of this inflammation, without affection of neighboring parts; or indirect where it is derived from the vaginal or urethral secretions. It may be acute or chronic. The acute form differs in no way from an ordinary abscess, surgical interference is advisable to prevent an unsuitable opening.

The chronic form is more troublesome, it may not be noticed or diagnosed without examination of the gland, when it will be found enlarged and somewhat firm, pressure may cause the expression of a drop of a discharge purulent or muco purulent in which—rarely—the gonococcus may be found. The opening in the chronic form is found through the duct of the gland and catheterization and injection of antiseptic

solution—the author uses a concentrated solution of resorcin—may effect a cure. Total ablation of the gland is reserved for special cases, and requires a general anæsthetic.

MESSAGE OF THE BREASTS DURING LACTATION.

IN the *American Journal of Obstetrics* for June this subject is discussed by C. S. Bacon, and the statement is made that, both in theory as described and illustrated in the best known text books, and in practice by masseurs and physicians, the ordinary method is wrong and is handled on a wrong principle. The "caking," or hardening, of the breast is not due to the curdling of the milk. This never takes place within the milk-tubes, nor yet to the presence of milk, for as a rule no milk is formed, according to the writer, until nursing begins, or if any but a very small amount. The hardness of the gland is due to the congestion of the blood and lymph, and therefore massage should be directed to the removal of these, and therefore should be centrifugal in direction, and not aim to the removal of the milk by centripetal stroking. The blood supply of the gland is mainly derived from the subclavian and axillary arteries, the venous outflow and the lymph discharge is by corresponding channels and this is the anatomical basis for action. The massage should begin gently below the clavicle and in the axilla and gradually encroach more and more on the mammary region. By this method a hard and painful breast is rendered lax and comfortable without the discharge of any milk. The writer does not recommend the treatment where there is infection or true inflammation as in mastitis, in such conditions rest is indicated and nothing should be done which will tend to spread the infection.

PATENT FOODS.

THE LANCET, July 5th, 1902, has an article on this subject by Robt. Hutchison, Assistant Physician to the London Hospital and to the Hospital for Sick Children, Great Ormond St. The experience and the position of the writer should give weight to his opinions, especially as we find them founded on common sense and careful investigation, but his conclusions can in no sense be comforting to the manufacturers of such articles, who in the lay press emphasize the wonderful nutritive properties of their preparations, until the practitioner who does not recommend them is considered guilty of almost criminal neglect. The cases in which such a food might be required are: (1) As a stimulant to appetite, (2) To obviate difficulty in chewing or swallowing, (3) When digestion is

impaired, (4) To increase the amount of any ingredient of food, (5) To replace a natural food. The last reason that might justify the existence of such foods would be cheapness, so the ideal artificial food would be the one which in a small bulk contained the maximum of nutritious qualities, which was pleasant and stimulating to the appetite, which was easily digested and cheap—but unfortunately none of these articles combine these qualities.

(1) As a stimulant to the appetite, meat extractives are successful but are the only substances that will replace skilful cooking in this respect.

(2) As to difficulty of swallowing, no food can be more easily swallowed than a liquid, *e.g.*, milk—and if the patient cannot swallow fluid he certainly cannot swallow an artificial food. Then as to compactness, there is no food giving a large amount of nutriment in a very small bulk; meat, which contains 20 per cent. proteid and 80 per cent. water, may be reduced to almost pure proteid by driving off the water; while sugar and butter are each the very high concentrations of carbohydrates and fat respectively—and as one cannot swallow a preparation from which all water has been drawn off without adding more water or other fluid, the advantage of such a preparation is not very apparent.

As for digestibility, the writer believes that the cases are rare in which pre-digestion of food is necessary: for, even where the stomach has lost its power, other parts of the intestinal system are able and ready to take up the duty.

Our knowledge of the fourth head, that of the advantage of increasing any particular constituent of diet is so limited, except in a few instances, *e.g.*, diabetes, that even if the patent foods offered us a means of doing so they would not be of great value.

To replace natural foods the most conspicuous example is that of infant foods, and this is the form in which artificial foods are most frequently prescribed. The writer divides these into three groups: (a) Those intended to be complete substitutes for human milk, *e.g.*, Allenbury's, Horlick's Malted Milk, Carnrick's Soluble Food and Nestlé's Food. These are all desiccated milks with some addition, infants can be reared upon them but they are generally lacking in fat, and after the first few months the addition of some fruit juice is necessary to prevent scurvy. But the chief objection is the great cost.

The second class are the malted and starchy foods. An infant under six months cannot make use of starch, so in these it is supposed to be altered to dextrine. Mellin's food contains no starch and may be a useful addition to milk. Other kinds—those in which the starch is con-

verted during mixing are untrustworthy as careless preparation may render them valueless or harmful.

The third class, starchy foods, cannot be used for children under six months, but after that time flour, oatmeal and other cereals can just as well be used.

The use of patent foods can never be justified on the score of cheapness—the writer pointing out that, by spending one shilling on Valentine's Meat Juice, you get 6 units of energy: in somatose 16½, in meat 511, eggs 1065, in milk 3440, and in sugar 5000. Of course there are people who believe they must have these extraordinary foods, and they may have them.

As to particular classes of foods the writer has some interesting remarks. The proteid foods derived from meat may be useful in forcing nutrition. Those derived from milk by the separation and rendering soluble of the casein are valuable as containing no nuclein products, and so being available in cases with uric acid diathesis. Among these are Nutrose, Eucasin, Protene, Plasmon and Casumen. They offer a means of increasing the nutritive value of ordinary foods and as they are derived from skim-milk are not very expensive. Tropon is derived from mixed vegetable and animal sources, is cheap as derived from waste materials, but is not really soluble and has a sandy taste.

The group of foods intended to supply carbohydrates include the malt extracts. The real value of a malt extract is in the diastase it should contain which would assist in the transformation of further starch into sugar, but such a malt extract is very expensive as it has to be produced so carefully. Ordinary malt extracts have no value except for the converted sugar they contain, and honey at one-fourth the price contains much more.

Cod Liver Oil emulsion contains no more fat than cream nor is it more palatable or easily digested. Petroleum emulsion can have no value except as a lubricant—it is a hydro-carbon, not a fat, and cannot be absorbed but can all be regained from the excreta. "Pancreatic emulsion" is emulsified lard flavored with clove oil.

The beef extracts require some attention. The extracts as such are only useful for increasing appetite; they contain no proteid—merely extractives and mineral matters and their place is in the kitchen.

Another class contains in addition, meat fibre, and of these the best known is Bovril. A teaspoon of Bovril contains about as much food as 8 grammes of lean meat, but one cannot take a great quantity of Bovril without producing thirst and diarrhoea owing to the disproportionate quantity of extractives and mineral matters it contains. The prepara-

tions called beef juices contain the uncoagulated proteid of meat and most of them give the spectrum of haemoglobin, but 'Puro,' for example, is made up by the addition of egg albumen, while 'Boviuine' proves to be blood preserved in glycerine.

Among peptonized foods, or those containing albumose, a good one is somatose, containing 80 per cent. of soluble proteids. But none of these preparations can be given in amounts sufficient to be beneficial without the danger of causing diarrhœa.

Of course all these articles have a psychological value due to the faith the patient places in them that may be a reason for their choice in given cases.

TRAUMATIC PTOSIS.

TRAUMATIC Ptoſis, unassociated with other lesions, is a rare condition. Terrien discusses a case in "Le Progrès Médical," with an examination of possible causes of Traumatic Ptoſis.

1. Where it exists alone :

- (a) From frontal contusion with sub-muscular hæmorrhage.
- (b) Direct contusion of the lid, without wounding, causing severance, or destruction of the motor nerve-endings.
- (c) Wounding, with destruction of the muscular fibres.

2. Where associated with other paralyses :

- (a) Intra-orbital hæmorrhage, with ex-ophthalmia, sub-conjunctival hæmorrhage, and acute-motor paralysis.
- (b) Fractures of the orbit. The symptoms are not definite:—ex-ophthalmia, hæmorrhage—sub-conjunctival and from the nose, acute-motor paralyses, etc.
- (c) Injuries in the region of the cavernous sinus. Clotid injury with artero-venous aneurism, etc.

TRAUMATIC AFFECTION OF THE TERMINAL CONE OF THE SPINAL CORD.

THE rarity of cases, in which an injury, limited to the terminal cone of the spinal cord, can be studied makes the report in the "Gazette des Hôpitaux," July 17th, by Raymond and Cestan, of the 'Salpêtrière,' of more than ordinary interest.

A man of 46 years, in 1895, fell about 30 feet, sustaining an injury to the lower part of the back, resulting in unconsciousness for a short time. There was found pain in the sacro-lumbar region, a superficial bruise, slight paresis of the legs, anaesthesia of the sphincters and

urethra, retention of urine and faeces, with involuntary passages. The motor incapacity gradually became less, and the muscular and tendinous reflexes became normal, but the symptoms of anaesthesia of the mucous membranes, and loss of control of the sphincters remained, also an area of hyperaesthesia, embracing the perineal and scrotal regions.

The autopsy revealed only an atrophy of the sacral roots, and of the terminal cone, which looked as if it had been the site of an old myelitis. The extent of the injury was downwards from the attachment of the roots of the third sacral.

MELANOSIS OF THE LABIUM.

PIOULET, Gazette des Hopitaux, reports a case, in the Hospital at Lyons, of a very rare condition, viz:—a melanotic tumor of the labium minus. It had been removed two years before, after a growth of five years, and had again reached the size of the end of the little finger. It was not painful, but caused some annoyance. Histological examination revealed a melanotic tumor, apparently developed from the endothelium of the blood vessels. The appearance was not entirely distinctive of either sarcoma or carcinoma. Eleven cases are mentioned from the literature on the subject.

THE TRANSPLANTATION OF TUMORS.

IN the June number of the *Journal of Medical Research*, Prof. Leo Loeb of Chicago, gives the results of investigations pursued in the transplantation of tumors into rats. Two series of cases are described, the most important being a series of transplantations of the sarcomatous part of a mixed adenocarcinoma—sarcoma of the thyroid. The reasons for concluding that the growth was a sarcoma and not a granuloma are as follows—the structure was that of a spindle-celled sarcoma with a tendency to form cuboidal or polygonal cells—a polymorphism frequently found in sarcoma. Two of these sarcomata showed a characteristic cyst formation with gelatinous contents. The growth was indefinite, and showed a large number of mitoses, multiple recurrences were observed and various metastases occurred. Small round cells were quite frequently present especially at the progressing margin of the tumor as is common in true tumors.

The sarcomata formed in different rats showed some structural differences based on differences in the cells in the formation of the fibres, and in the degeneration processes which took place. These differences

were constant although the sarcomata originated in the connective tissue of the same part of the body, they were reproduced throughout both series of transplantations, which were carried through forty and eight generations respectively. Certain factors in the constitution of these tumors were constant and others variable, but nutritive and functional as well as genetic influences may have brought this about. Investigation shows that many peripheral sarcoma cells remain alive in the first few days after transplantation and that they mix with the growing connective tissue of the neighborhood. It is very probable that these peripheral sarcoma cells give rise to the tumors after transplantation. Generally the central part of the transplanted piece becomes necrotic and liquified, but the sarcoma cells have power to grow into this part and replace it. All attempts to produce tumors either by transplantation or injection of tumor-fluid in other animals *e. g.* mice, guinea-pigs, and rabbits were unsuccessful. Pieces of tumor frequently gave rise to growth notwithstanding infection which would seem to show that the actively growing tumor cells seemed to possess considerable power of resistance to bacterial toxins. Negative results were obtained from injection of the cystic fluid and from fluid obtained by mincing the tumor with normal saline solution, so that further experiments made with the juice filtered in various ways, indicate nothing as to the character of the tumor-producing agency by their failure. The presence of various complicating factors prevent the experiments throwing light on the question of individual immunity.

Local metastases and contact metastases were formed in the second series of transplantations and secondary nodules were frequently found; the growth of the original tumor was slower than that of the transplanted pieces. By experiment it was found that the tumor-producing agency was not destroyed or even markedly attenuated by keeping the pieces on ice for as long as five days, nor were they markedly affected by exposure to Röntgen rays.

In experiments in the transplantation of an adenoma of the mammary gland, it was found that when pieces were transplanted into the same animal they remained alive *in toto*, and underwent the same series of changes, as the part of the tumor left in its original site, while parts transplanted into other rats became almost entirely necrotic. In the first class pregnancy caused a large increase in the size of the tumor.

On the whole these interesting experiments show the possibility of the transplantation of sarcomata in the rat: they furnish an argument against the theory that the tumor-producing agency in such malignant

growths is a micro-organism, and they add to the knowledge of the physical qualities of this agency without isolating it.

Following Prof. Loeb's article is a preliminary report on Tumor Inoculation by Prof. Herzog. The same tumors were used as in Prof. Loeb's experiments. Pieces of non-infected tumors were maserated with normal saline solution, under aseptic precautions. This was filtered through a pasteur filter, cultures were grown to show that the filtrate was free from known micro-organisms and injections made into the abdominal cavities of rats but without result. As there is a possibility that the pasteur filter may exclude a micro-organism that occupies a casual relation, a further series of experiments was made in which collodion sacs filled with clear fluid from tumors were implanted intra peritoneally either in contact with a transplanted tumor or in one already growing. After remaining for a variable time in this position the sacs were removed and the contents removed under aseptic precautions. Part was used for inoculation of cultures, part injected into animals, but the results in both cases were negative. Attempts were also made to use living yeast cells as a culture medium for a possible micro-organism in case that it would grow only in a parasitic method, but these too were negative in result.

On the whole the experiments seem to point to the conclusion that the tumor producing agency is not a micro-organism.

SIR FREDERICK TREVES.

WE quote the following from the *London Practitioner* of August: "The whole Empire owes a debt of gratitude to Sir Frederick Treves, whose soundness of judgment, strength of character, and pre-eminent skill were the means of saving an almost hopeless situation. We do not pretend, like so many irresponsible scribblers of the general press, to have been behind the scenes, or rather the doors of Buckingham Palace. But it is no secret that Sir Frederick Treves had many difficulties to meet besides those naturally arising from the surgical problem with which he was called upon to deal. A strong man was needed, and fortunately for the King and for the Nation, a strong man was at hand. We venture to offer to Sir Frederick Treves the humble tribute of our admiration of the great qualities which he has displayed in circumstances that might have disabled the judgment and paralysed the nerve of most men, however confident in themselves. We are sure that in saying this we are expressing the feeling of the profession which is proud to have such a man among its members."

UNIVERSITIES AND COLLEGES.

DR. WALTER B. GEIKIE, was born in Edinburgh, Scotland. He came to Canada when quite young. His father was Rev. Archibald Geikie, for some years a minister in Toronto. His brothers are Rev. Cunningham Geikie of Bournemouth, England, and the late Rev. Archibald Geikie of Bathurst, Australia. Dr. Geikie began the study of medicine, while a very young man, in the late Hon. Dr. John Rolph's School—thence going to

Jefferson Medical College, Philadelphia, from which Institution he took a Degree. Returning to Canada he began general practice and was for many years associated with Dr. Rolph, as a teacher, in the old Victoria Medical School. After being for some years engaged in active practice, Dr. Geikie visited the Old Land, taking the Degrees of F.R.C.S. Edinburgh, and L.R.C.P. London. The Degree of D.C.L. was conferred on him in 1889 by Trinity University. In the spring of 1871, when Trinity Medical Col-



W. B. GEIKIE, M.D., C.M., D.C.L., F.R.C.S. ED., L.R.C.P. LON.
DEAN OF THE FACULTY, TRINITY MEDICAL COLLEGE, TORONTO.

lege was re-established, with the late Dr. Hodder as Dean, Dr. Geikie was appointed to the Chair of Practice of Medicine, which he has held ever since. On the death of Dr. Hodder—more than twenty years ago—he was appointed Dean of the Medical Faculty. For many years he was actively engaged on the staff of the Toronto General Hospital as clinical lecturer. He has also represented Trinity Medical College on the Ontario Medical Council for many years.

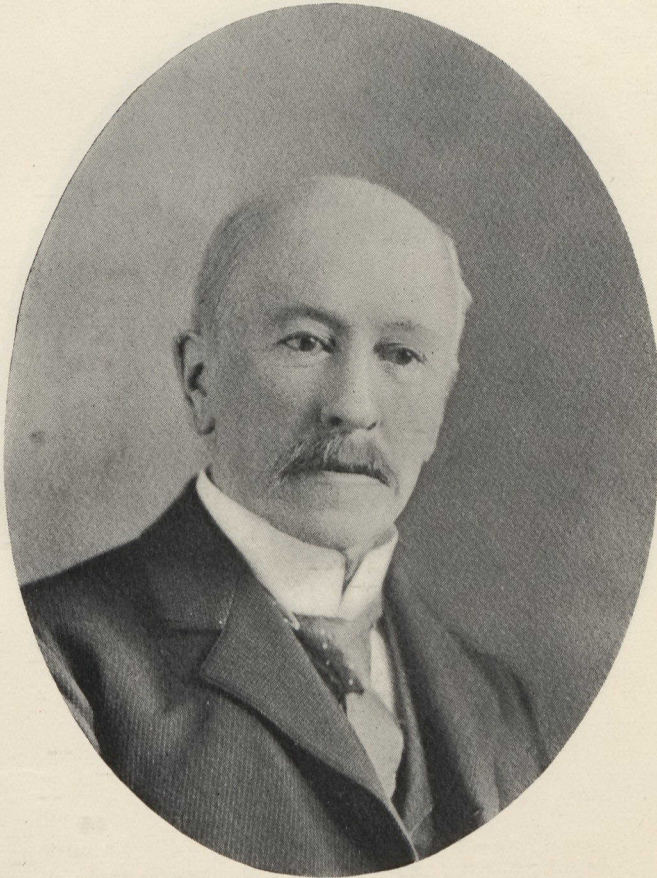
W. H. MOOREHOUSE, M.D., graduated in medicine at Trinity University in the year 1874, taking honors in all the branches. He spent the following year in London and Edinburgh, taking the diplomas L.R.C.S. and L.R.C.P. Edin. He obtained the degree of B.A., Western University, London, by examination in 1901. He was elected President of the Ontario Medical Association in the year 1890. He takes an active part



W H MOOREHOUSE, B.A., WESTERN, M.D., TRINITY, L.R.C.P. AND S , EDIN.,
DEAN OF THE MEDICAL FACULTY, WESTERN UNIVERSITY, LONDON.

in the London Medical Association, of which he was President in 1892. He was elected Dean of the Medical Faculty, Western University, in May, 1891, which position he still holds. He was appointed in the year 1894 by the Senate of the Western University, as its representative on the Ontario Medical Council. He was elected by the Senate of the Western University as Vice-Chancellor in the year 1900.

FRANCIS WAYLAND CAMPBELL, M.D. was born in Montreal. He graduated at McGill University in 1860. In 1872 he assisted in forming the Medical Faculty of Bishops College, acting as its first registrar for ten years, when he became the Professor of Physiology, and, subsequently Dean of the faculty, which he still holds, with the professorship of Clinical Medicine. For ten years, he was secretary of the College of Physicians and Surgeons of Quebec ; and is now physician to the Montreal General Hospital, and the Western Hospital. In 1860, he was gazetted assistant

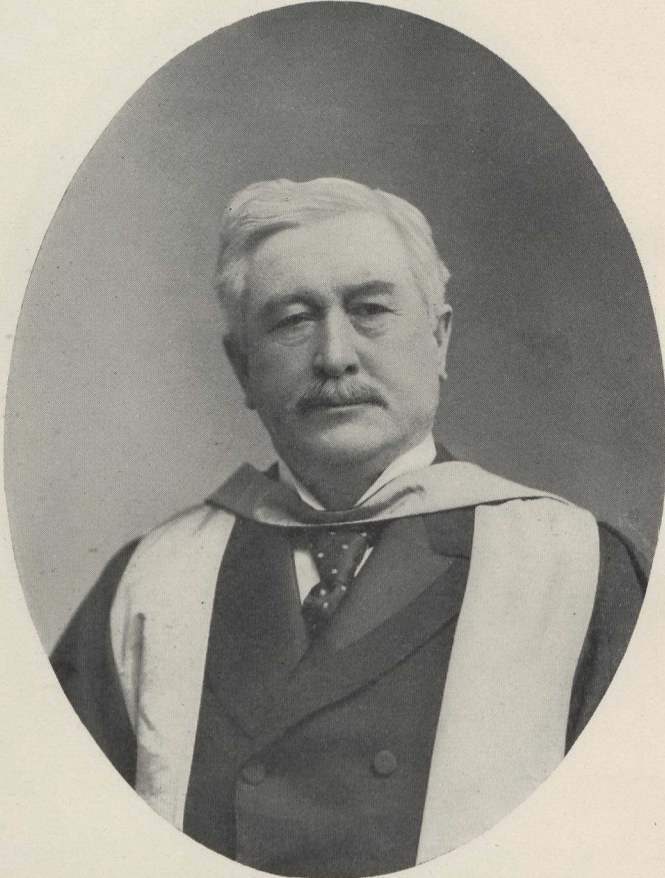


F. W. CAMPBELL, M.D., D.C.L.,

DEAN OF THE MEDICAL FACULTY IN MONTREAL OF BISHOP'S COLLEGE. LENNOXVILLE.

surgeon to the first Battalion, Prince of Wales Rifles, surgeon in 1866, and, in 1883, Surgeon Major to the Canadian Infantry, stationed at St. Johns, Q. He was in active service, with the Prince of Wales Rifles, during the Fenian Raids of 1866 and 1870. From 1864 to 1872, he was one of the editors of the Canadian Medical Journal, when he established the Canadian Medical Record, of which he remained editor for seventeen years. In 1895 he received the honorary degree of D. C. L. from Bishops College, Lennoxville.

THOMAS GEORGE RODDICK, M.D., was born at Harbour Grace, Nfld. He was educated at the Model and Normal Schools, N.S., and graduated at McGill University in 1868, taking the Holmes gold medal. After graduating he was assistant house surgeon at the Montreal General Hospital for six years. In 1872 he became lecturer in Hygiene in the McGill Medical Faculty, and subsequently demonstrator in Anatomy, Professor of Clinical Surgery, and Professor of Surgery, which latter chair he still holds. He has been connected with various medical corps



T. G. RODDICK, M.D., M.P.,
DEAN OF THE MEDICAL FACULTY MCGILL UNIVERSITY, MONTREAL.

in the city of Montreal, and wears the general service medal for the Fenian raid of 1870, and he also received the medal for the Northwest rebellion of 1885. In 1896 he was elected President of the British Medical Society, being the first colonial to hold this office. He was elected to the Dominion Parliament in 1896, and re-elected in 1901. On the retirement of Dr. Craik (1901) he was appointed Dean of the Medical Faculty of McGill University. He was mainly instrumental in carrying through the Houses of Parliament the Dominion Registration Bill.

DR. FIFE FOWLER was born in 1823 at Elgin, Morayshire, Scotland. He attended lectures at King's College, Aberdeen. He was apprenticed to the late Prof. Pirie, and graduated from Mareschal College in 1843 as M.B., and three years later as M.D. He took his L.R.C.P. Edin. in the same year. In 1854 he came to Canada, locating in Kingston. He was invited to take the Chair of Materia Medica and Therapeutics in the Medical Faculty, then being formed, of Queen's. On the resignation of



FIFE FOWLER, M.D., ABERDEEN, L.R.C.S., EDIN.,
DEAN OF THE MEDICAL FACULTY, QUEEN'S UNIVERSITY, KINGSTON.

Dr. Yates he became Dean and Professor of Medicine in 1878. On his retirement from active teaching and hospital work the Faculty and graduates of Queen's endowed a scholarship, to be known as "The Dean Fowler Scholarship." Dr. Fowler now enjoys his well-merited leisure, and as Dean is held in the highest esteem by all his colleagues and present and past students. He lives in the full consciousness that his efforts have been fully appreciated.

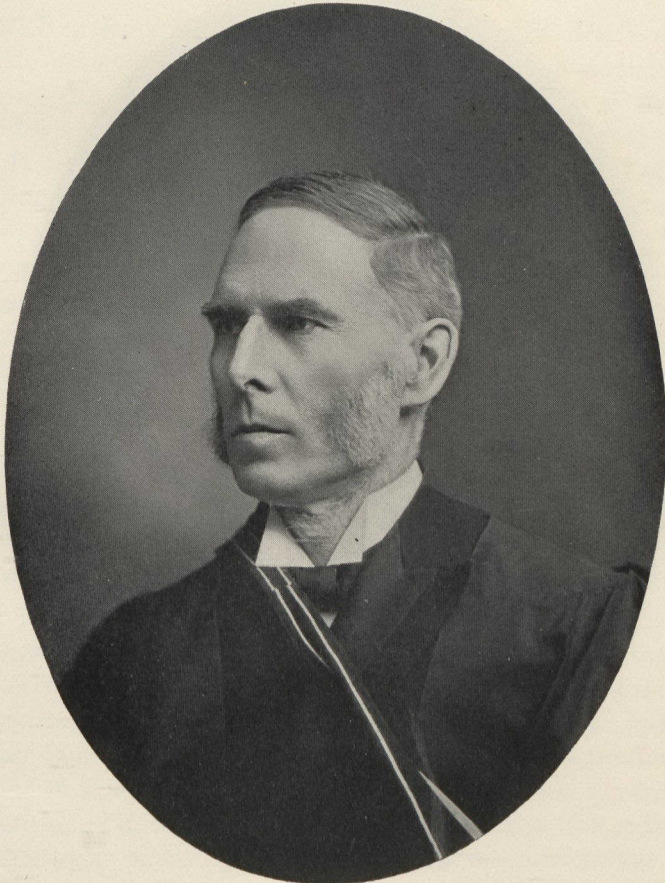
GEORGE L. SINCLAIR, M.D., was born in Norfolk, Virginia, in 1850. He received his education at Dalhousie College and the College of Physicians and Surgeons, of New York, graduating in 1872. In 1876, he accepted the position of assistant medical superintendent of the Nova Scotia Hospital for the Insane, becoming superintendent in 1890. He took the deepest interest in the patients, and did much to bring that



GEORGE L. SINCLAIR, M.D.,
DEAN OF THE MEDICAL FACULTY, DALHOUSIE UNIVERSITY, HALIFAX, N.S.

institution up to its present efficient state. In 1898 he resigned to become Inspector of Hospitals, Asylums, etc., and is devoting himself to the improvement of jails and poorhouses throughout the province. He has been connected with the teaching staff of the Medical College for nearly twenty-five years. Formerly, he was Professor of Anatomy, but, more recently, he has been lecturing on mental and nervous disorders. In 1901, owing to the death of Dr. Edward Farrell, he was appointed Dean of the Medical Faculty of Dalhousie.

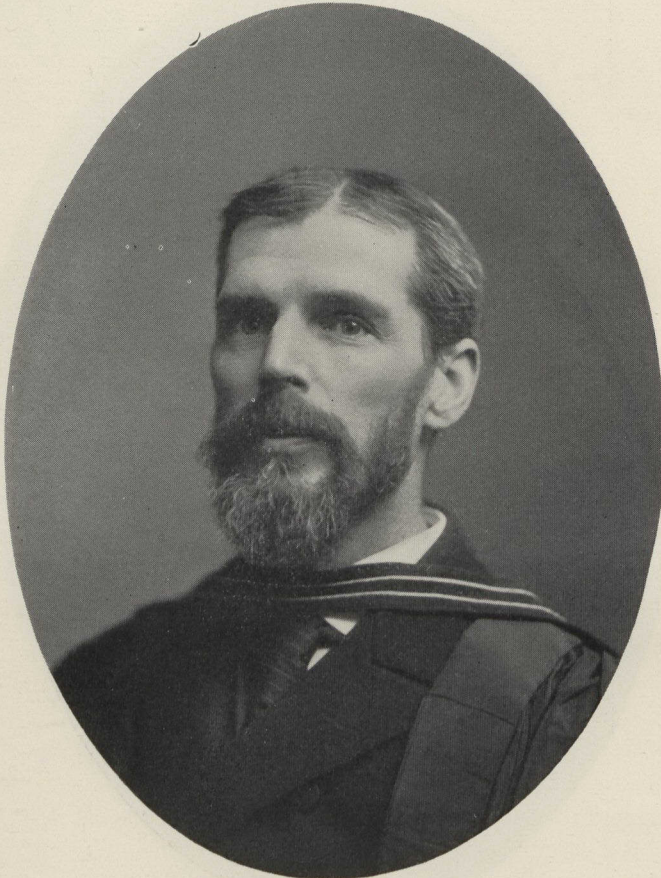
R. A. REEVE, M.D., is well known to the medical profession of Canada. For over thirty years he has been connected with the Toronto General Hospital in the departments of ophthalmology and otology. He was lecturer on these subjects in the Toronto School of Medicine for many years, and has been professor of the same subjects in the Medical Faculty of the University of Toronto since 1887. He has taken an active interest in various medical societies; and has filled the offices of President of the



R. A. REEVE, B. A., M. D., LL. D.,
DEAN OF THE MEDICAL FACULTY, UNIVERSITY OF TORONTO.

Toronto Medical Society, the Toronto Pathological Society, and the Ontario Medical Association. A few years ago he was made Dean of the Medical Faculty of the University of Toronto, a position which he still holds. This year the University of Toronto conferred on him the degree of LL.D., *honoris causa*, on account of his valuable services to the cause of medical education.

R. BARRINGTON NEVITT, M.D., has been in practice in Toronto for some twenty-eight years. He has been actively identified with a number of medical societies ; and is a past president of Toronto Medical Society. He graduated from Trinity University in 1872, taking the degrees of M.D., CM. He is one of the surgeons on the staffs of the Toronto General Hospital, St. Michael's Hospital, and the Victoria Hospital for Sick



R. B. NEVITT, M.D., C.M.,
DEAN OF THE ONTARIO MEDICAL COLLEGE FOR WOMEN.

Children. He took an active part in the organization of the Ontario Medical College for Women, acting at first as secretary. In 1888, on the death of Dr. Barrett, he was chosen as Dean of the Medical Staff, and lecturer on surgery, both of which positions he still holds. Under his guidance the Women's Medical College has made excellent progress, and is now one of the most useful of the many colleges in Ontario.

DISEASES OF THE EYE, EAR, NOSE, AND THROAT.

Conducted by PERRY G. GOLDSMITH, M.D., Belleville,
Fellow of the British Laryngological Rhinological, and Otolological Society.

THE LINGUAL TONSIL.

LEMERE in June *Medicine* has a very instructive article on the lymphoid tissue situated at the base of the tongue immediately in front of the epiglottis. This tissue is in reality situated in the glosso-epiglottic fossa and when projecting well out has been given the name of lingual tonsil. It is the lower segment of the tonsillar ring formed above by the pharyngeal and at the sides by the faucial tonsils. Hypertrophy of this tissue probably begins about puberty, but the symptoms due to its presence do not as a rule show themselves until adolescence. It is essentially a trouble of neurasthenics and women. The symptoms are usually vague and very difficult for the patient to locate. The most common complaint is a weariness of the throat and a feeling as if there was a lump in the throat. The voice becomes easily fatigued and frequently gives out; various degrees of laryngitis with or without pain are not infrequent. In fact the symptoms may, as in refractive errors, be entirely out of all proportion to the magnitude of the organic lesion. Lemere thinks the term Globus Hystericus, which in reality is merely a psychic phenomenon, is in the majority of cases used through ignorance of what is the real trouble.

The galvano cautery, or, if the mass project sufficiently, the guillotine is used to remove the hypertrophy. Occasionally the hot or cold snare may be of service. If suppuration be present, incision gives speedy relief. The writer cannot agree with the remarks made on the treatment of mycosis found in this region and also thinks that the lingual varix, which is very often found in these cases, may be an indication for systemic treatment either alone or associated with operative measures on the same principal as haemorrhoids are treated. Regarding mycosis it must not be forgotten that two germs occur, one in which there is simply a catarrhal state of the crypts, while the other consists of a horny hypertrophy of the lining epithelium—keratosis. The former may, according to Sir Felix Semon be ignored, while Wingraves investigations leads one to treat the latter as he would an ordinary corn with Salicylic acid and Alcohol. The galvano cautery so generally recommended is very rarely successful in curing the disease.

LIGATION OF THE CANALICULI IN ACUTE SUPPURATION OF THE CORNEA.

THE March number of the *Montreal Medical Journal* contains an article by Dr. Bullar who deals with Corneal infections and cataract extractions in cases where there is a purulent condition of the tear sac. All ophthalmologists are agreed as to their inability to satisfactorily cope with corneal suppuration in the presence of dacryocystitis, and none would dare perform any operation involving an opening of the eye ball in such cases. It is a very difficult matter in most cases to get a chronic dacryocystitis cured and the danger of such cases is the almost certainty of purulent Keratitis following even slight corneal abrasions. Bullar in one case passed an iron dyed silk ligature around the canaliculi, thereby shutting off the supply of infection, and rapidly controlled the suppuration process on the cornea. He was induced to do this by losing a case of cataract extraction from suppuration following an operation in a case where the puncta lacrymalia appeared somewhat unhealthy. The other eye was in a similar condition but the operation was successfully performed after ligating the canaliculi. There appears to be no difficulty in opening the canaliculi when they have been ligated two weeks nor does their temporary closure lead to disturbances from increased accumulation in the tear sac.

EYE DEFECTS WHICH MAY CAUSE MENTAL DULNESS IN CHILDREN.

C. S. BULL, in *Pediatrics*, remarks that *Hypermetropia* gives rise to ocular pain, headache and a sense of fatigue in the brain, symptoms incident to weakness of the power of convergence. In many cases the correction of the refractive error will give very good results. It is absolutely useless to attempt to do this without a mydriatic. *Astigmatism* is productive of indistinct vision for both distant and near objects, and may be an etiological factor in the production of various neuroses, and even of epileptiform attacks in susceptible individuals. Gould, of Philadelphia, has recently cited some very remarkable cases in which the correction of even a very small degree of hypermetropia or H. astigmatism, resulted in a complete cessation of epileptiform seizures. The patients were all adults and had been considered epileptics for many years.

Myopia is very frequently responsible for a child's supposed mental dulness. The constant, though ineffectual, effort to see, as his playmates do, causes an apparent backwardness in the child's intellectual development. He frequently shuns his companions, preferring to be by himself.

Correction of his myopic error allows him to see the world as his play-mates do, and the mental dulness vanishes. Myopia, however, is a disease, and does not simply require concave glasses to complete the treatment. The general health should be carefully watched. The size of the school desk, and the direction from which the light falls on the student's book, are important elements to be considered. Moreover, it has been found that the more educated a country becomes, the more myopic its people are.

THE DANGERS OF MIDDLE EAR SUPPURATION.

THE risk a person runs when he goes about with an untreated discharge from the ear is probably not sufficiently recognized by the family physician. Wilde very aptly says: "*When a discharge from the ear exists, we can never tell how, when, or where it will end, or to what it may lead.*" E. E. Clark, in the *Medical Standard*, makes some very pointed remarks. He says:—"The tympanic cavity is a death trap which catches far more people than many of us suppose. In the entire human economy, there is not a single cavity which is of such vital, relative importance to its neighboring structures, as that of the middle ear. It bears such important relationship to all which lie about, hidden away, as it is, deep down in the firmest and hardest bone in the body that, when diseased, it may be as a slumbering volcano, or a quick and violent active earthquake. Next to trauma, ear disease is most often responsible for brain infection and abscess. Every case of suppuration of the middle ear should be regarded as a serious disease." McEwen's well known remark may be quoted, that he would sooner have a charge of dynamite in his ear, than a drop of pus in his mastoid antrum. MacLeod Yearsley, in the July issues of the *Medical Times* and *Hospital Gazette*, has two very instructive papers on chronic suppuration of the middle ear, and the lessons to be learned from them. The relationship between adenoids and suppuration in the tympanum is very forcibly shown, and the importance of removing adenoid masses, either in adults or children, in order to cure a suppurating ear is insisted upon very strongly. The papers showed how much could be done for those suffering from chronic discharge from the middle ear, and to what serious consequences neglect may lead. Taken in time, simple means may do a good deal, but treatment must not be used haphazard without careful and thorough examination. Half an hour, spent in making one's self acquainted with the actual conditions of things, will save much valuable time later.

Aurists frequently see patients with chronic suppurative middle ear catarrh, who have been given a glass syringe and some watery lotion to

syringe into the ear, and some boracic acid powder to blow in afterwards. Should there happen to be a cholesteatomatous mass in the tympanum, a few drops of water will probably be all that is necessary to bring on acute mastoiditis, sinus thrombosis, or brain abscess. The boracic acid which is insoluble in pus, simply cakes up and obstructs the outflow, besides it has very little antiseptic action. As a matter of fact, patients are not even able to properly syringe their own ears. A large aural polypus is a very inviting thing to one who happens to have a snare close at hand; yet one should not imagine it a trivial operation. That polypus may be the barrier between the pus and the meninges. The reviewer once saw a famous London Aurist remove a large aural polypus, and learned of the patient's death four days later from meningitis. The propriety of removing aural polypi from the external auditory canal is a debatable point, many preferring to attack the polypus from behind, and, at the same time, cleaning out the accompanying disease in the antrum auditus and attic.

CATARRHAL INFLAMMATION OF MIDDLE EAR CAUSING FACIAL PALSY.

REIK, of Johns Hopkins, quoted by the Journal A.M.A., suggests that in a considerable number of cases of facial paralysis there exists an acute, or sub-acute, inflammation of the middle ear, as an intermediary condition between the exposure to cold and the appearance of the paresis. He reasons that, inasmuch as the sheath of the nerve is not uncommonly in direct contact with the mucous membrane of the middle ear, or separated from it by a very thin lamella of bone, the nerve may suffer in consequence of a catarrhal condition of the ear resulting from exposure to cold, and he suggests that, in some cases of facial palsy, symptoms of coryza and pharyngitis, followed by a pricking or stinging in the ear, with a sense of fullness, tinnitus, or deafness, will, if looked for, be observed in advance of the muscular weakness. It is advised, in addition to leeching, counter-irritation, purgatives, salicylates, and iodides, that, if there be any indication of exudation in the tympanum, paracentesis should be preformed.

The reviewer has, at present, a patient whose facial paralysis followed a cold two days previously, and with which was associated considerable aural mischief. The urine contained 2 per cent. (bulk) of albumen, and granular casts. There was a dull earache of twenty-four hours' duration, when there was noticed a peculiar feeling on the same side of the face. At this time, there was no noticeable paresis, but next morning complete facial paralysis was present. The aural trouble was soon well, but the facial paralysis has persisted now for over eight weeks. Paracentesis

was not preformed, as there was no exudate present, and the Eustachian tube was patent. Medicinal treatment, together with galvanism, has been persistently tried, but so far with no effect. In this case there was also loss of taste on the anterior half of the tongue which localized the facial lesion, as being situated between the geniculate ganglion and the chorda tympani nerve.

ACUTE CONGESTIVE OR INFLAMMATORY GLANCOMA.

CHAS. KIPPS, in the June journal of the A.M.A., has a very excellent article on acute glaucoma. Kipp was recently asked to see a lady who was nearly blind. The loss of vision had followed an apparent attack of biliousness a few days previously. The eye ball was prominent, eye lids swollen, V=flame of candle at a few feet, cornea cloudy and somewhat less sensitive than normal, anterior chamber shallow, iris swollen, pupil dilated, and tension plus. There had been, for two days, almost incessant vomiting, and great pain in the left side of the head, teeth, and eye. An iridectomy was immediately advised, and, while preparing for the operation, $\frac{1}{2}\%$ sol. of eserine was instilled. The operation was preformed under ether, and was not followed by further pain or vomiting, the patient ultimately regaining her former visual acuity. The above notes from an accurate picture of a *severe attack* of acute glaucoma, which is usually first seen by the family physician. The attack not infrequently comes on about midnight, and is associated with marked gastric disturbance, masking very effectually the real seat of the disease, and when the case is seen by the ophthalmic surgeon, very little information may be gained. In fact, there may be only a slight redness of the eye, which is too often ascribed to cold. When this is associated with a semi-dilated pupil, in a person who has been using nothing in his eyes, the case demands careful examination. Dilation and immobility of pupil are found in no other acute inflammatory eye disease. Even here it is not developed until other symptoms of inflammation have been present for some time.

The causes leading up to an attack, in people predisposed to glaucoma, are various:—such as an attack of indigestion, gastric symptoms being most prominent and are very misleading, over use of the eyes, emotional disturbances, and, what is of greatest importance, the indiscriminate use of atropia in eye water.

The diagnosis is usually not difficult, the main symptoms being (1) gradual failure of eye sight, necessitating frequent increase of presbyopic lenses, (2) colored ring around the lamp or gas flame, (3) diminished sensitiveness of the cornea, (4) increased intra-ocular tension, (5) shallow

anterior chamber, (6) semi-dilated pupil, (7) cupping of the optic disk. These symptoms are usually present, in part at any rate, previous to the acute attack. In fact, Kipp thinks cloudiness of vision and a halo around the light, sufficient grounds on which to perform an iridectomy, as they constitute the first stage of acute glaucoma. Age exerts considerable influence, the disease being rare under 35, and most common over 50: women being more liable than men.

A very full account of the pathology and views of various writers on the pathological condition, causing the increase of tension, is given. He says: "A typical acute glaucoma is an inflammatory disease in the same sense that a strangulated hernia is so, but not otherwise, it exhibits an acute obstruction of the circulation, which can be cut short by the removal of the pressure, but in no other way.

Treatment. A good rule is given, viz.:—Not to use atropine, or other mydriatic, for an inflammation of the eye, especially in elderly people, till you have assured yourself that the pupil is smaller than normal, and that the tension of the eye is not increased. The ophthalmoscope may give very valuable information, as the presence of cupping, not the physiological excavation, will put one on his guard. When acute glaucoma has been diagnosed, eserine salicylate, $\frac{1}{4}$ or $\frac{1}{2}$ % sol., should be instilled in the eye, and repeated at short intervals, until an iridectomy can be performed. If eserine causes increased pain, a 4% sol. of pilocarpine may be tried. Cocaine, 3 or 4%, may also be of use to control the patient's suffering, as well as morphia. Soda salicylate, in 20 grs. doses, with massage of the cornea may give great relief. While myotics may overcome the temporary and present attack, one should not persist in their use at the expense of operative measures. An iridectomy gives better results when it is performed. It is a well known fact that, soon after an iridectomy in acute glaucoma, the other eye frequently has a similar attack. Hence Kipp instils eserine in the sound eye, before operating. Although months and even years may elapse before the second eye is attacked, it very seldom escapes entirely. This has led Germans, and especially Czermack, to advocate a prophylatic iridectomy.

NASAL DYSMENORRŒA.

DR. F. LINDER (*Münchener medicinische Wochenschrift*, June 3, 1902) says that theoretically there is still much to be explained before one can understand the action of cocaineization of the genital tubercles in the nose in reducing or eliminating the pain of dysmenorrhœa as recommended by Fliess. Practically, however, the method is satisfactory in the vast majority of cases, and it is striking how rapid the remedy sometimes acts and for how many hours it persists.

MEDICAL SOCIETIES.

CANADA MEDICAL ASSOCIATION.

Montreal meeting, September 16th, 17th and 18th, 1902.

PROVISIONAL PROGRAMME.

The general meetings and evening addresses will be held in No. 111 Lecture Room, Medical Faculty, McGill University. The sections will meet in other lecture rooms of the same building.

FIRST DAY.

9.30 a.m.—General Meeting, Proposal of Members, Notices of Motions, etc, Striking of Committees; 10.30 a.m., Meetings of Sections.

Surgical Section.—Paper by A. Primrose, Toronto—Filariasis Cured by Operation.

Paper by Dr. Perry Goldsmith, Belleville—Hæmorrhage in Removal of Adenoids and Tonsils.

Paper by H. D. Hamilton, Montreal—Complete Occlusion of Posterior Naris.

Paper by Dr. Casey A. Wood, Chicago—Empyema of Frontal Sinus.

Medical Section.—Paper by John Hunter, Toronto—Pleurisy as Associated with Tuberculosis.

Paper by A. E. Orr, Montreal, on Blood Pressure.

Paper by G. A. Charlton, Montreal—Anæmia Due to Toxines.

Paper by Dr. J. R. Clouston, Huntingdon—The Country Doctor of To-day.

2 p.m.—General meeting—Proposal of members, etc., followed at 3 p.m. by address in Surgery by John Stewart, of Halifax, N.S.; 5 p.m., garden party at the residence of Mr. James Ross, Peel Street; 8.15 p.m., President's address, followed by lantern demonstration on the Exanthemata by Dr. Corlett, of Cleveland, Ohio.

SECOND DAY.

8 a.m.—Exhibition of cases at the different hospitals: Montreal General Hospital, surgical cases; Royal Victoria Hospital, medical cases; Hotel Dieu, medical cases; Notre Dame Hospital, surgical cases; 9.30 a.m., general meeting, followed by a discussion on "Diseases of the Gall, Bladder and Bile Ducts." (a) Medical diagnosis, introduced by Dr. A. McPhedran, Toronto; (b) Medical treatment, introduced by Dr. A. D. Blackader, Montreal; (c) Surgical diagnosis, introduced by Dr. James

Bell, Montreal; (*d*) Surgical treatment, introduced by Dr. J. F. W. Ross, Toronto, followed by Dr. G. E. Armstrong, Montreal.

Medical Section.—2 p.m.—Paper by Dr. J. F. Macdonald, Hopewell, N.S., on Tuberculosis.

Paper by Drs. Starr and McKenzie, Toronto—Multiple Sarcoma.

Paper by Dr. Maude E. Abbott, Montreal—Methods of Classification in Medical Museums.

Paper by A. D. Shirres, Montreal—Degeneration of Spinal Cord in Anæmias, etc.

Surgical Section.—Paper by G. A. Peters, Toronto—A New Symptom of Intestinal Paralysis in Peritonitis.

Paper by Dr. Ferguson, Chicago—Removal of Prostate by Perineal Incision.

Paper by G. E. Armstrong, Montreal—Treatment of Prostatic Hypertrophy by Suprapubic Incision.

Paper by Dr. J. O. Orr, Toronto—Artificial Astigmatism.

Paper by Dr. Burnham, Toronto—Sympathetic Ophthalmia.

Papers by Dr. Monod, and Dr. A. E. Garrow, Montreal.

Obstetric and Gynecologic Section.—Paper by Dr. Robinson, Ottawa—Normal Labor.

Papers by Dr. Laphorn Smith, Dr. Lockhart, and Dr. Chipman, Montreal.

8.15 p.m.—Address in Medicine by Dr. Wm. Osler, Baltimore, followed by reception in Engineering Building at 9 o'clock.

THIRD DAY.

8 a.m.—Exhibition of cases at the different hospitals: Montreal General Hospital, medical cases; Royal Victoria Hospital, surgical cases; Hotel Dieu, surgical cases; Notre Dame Hospital, medical cases. 9.30 a.m.—General meeting—Reception of reports from committees, general business. 10.30 a.m.—Paper by Dr. Robinson, New York—X-ray Treatment of Cancer.

Paper by Dr. Girdwood, Montreal—X-ray as Diagnostic and Curative.

Paper by W. F. Hamilton, Montreal—X-ray as Diagnostic Agent in Thoracic Diseases.

Paper by S. F. Wilson, Montreal, on the Use of High Potentials in X-ray Work.

The afternoon will be given over to an excursion by rail over Victoria Bridge and thence to Lachine (through the courtesy of the Grand Trunk Railway). From here the steamer "Duchess of York" will make

the trip up Lake St. Louis and run the Lachine rapids, arriving in the city about 5.30 p.m. (Lunch on board steamer.) At 8.30 a "smoker" will be given in the Victoria Rifles' Armoury, Cathcart Street.

THE CANADIAN ASSOCIATION FOR THE PREVENTION OF TUBERCULOSIS.

THIS association held its annual convention on 17th and 18th April last. His Excellency the Governor-General of Canada said:—"It was little more than a year since the first conference was held for the prevention of tuberculosis. It was attempted to create public interest in the question, and create an organization in Canada to cope with this great calamity. But proofs are coming to hand that its ravages are, at last, giving way before the knowledge of treatment and prevention which we owe to scientific research. The object of the association is to arouse public interest in the prevention of tuberculosis by collecting expert opinion and disseminating the same, in simple form, throughout the public. We do not desire to cause alarm, but rather to spread useful information on the subject of prevention. The nature of the work is not such as to make an appeal to the eye. It was rather work that required to be quietly done. It would be a mistake, at the present, to embark on the building of expensive sanatoria, and making appeals for a large subscription list for them. The day may come when the association will be able to intrust itself in sanatoria and health resorts. For the present, health matters rest largely with the Provinces. The labors of the association will be, therefore, in the circulation of literature dealing with tuberculosis, its cause, prevention, and cure."

Dr. Knapp, in reply to a vote of thanks, said:—"It is no trifling thing to work in the anti-tuberculosis crusade. It is not easy to convince people that they are doing wrong. They do not like to hear it. There is some indifference on the part of the rich to the tuberculosis movement. I often wish I could take some of our Rockfellers or Carnegies to the tenement districts of New York to show them a poor consumptive father slowly dying the lingering death of a consumptive, deprived not only of the comforts but the necessities of life, and then tell them that if he had gone into a sanatorium twelve months ago it would have cost about \$500, and how easily either of them could have spared the sum. To your Excellency I desire to extend my thanks I have been treated most hospitably,—indeed, I have been treated royally."

The Committee on the Relations of Governments and municipalities towards tuberculosis reported as follows:—

In view of the facts that tuberculosis is a preventible and curable disease, that free from check its tendency is to increase in geometrical ratio, that at a moderate computation it has 30,000 to 40,000 subjects in the Dominion at the present time and is levying a yearly death toll of about 9,000 human lives or one in every 650 of our population, there is presented a situation that demands united, organized, and disciplined effort to arrest this terrible disease and to provide, as far as possible, for the care and cure of its victims.

Therefore consistently with the recognized duties, obligations, and responsibilities of governments and municipal bodies in relation to matters of public health, it is greatly to be desired that they should by legislation, regulation, and necessary financial aid endeavor, with the co-operation of charitable and philanthropic organizations and individuals, to promote efficient effort in dealing with the tuberculosis problem in all parts of the Dominion, and the Committee recommends:

1. That the Dominion Government may be solicited to make to this Association a grant of money to assist in the education of the public on the subject of tuberculosis through such means and agencies as the Council of the Association may from time to time determine.

2. That inasmuch as experience appears to show certain localities to possess favorable climatic and other advantages for the treatment of the disease, that as a consequence such localities become resorts for tuberculous patients coming from less favored and distant parts of the Dominion, and that to such extent an undue burthen is laid upon the local governments or municipal bodies which may be called upon to provide for the care and support of such unfortunates, a claim is established for the co-operation of the Federal Government by vote of public money or otherwise for the establishment and support of sanatoria, hospitals, or other institutions for the care of the tubercularized.

3. That Provincial aid should be sought to enable the Association to promote necessary and uniform legislation in all Provinces of the Dominion for dealing with the subject, and to encourage municipalities, philanthropic associations and individuals by grants, contributions, subscriptions, donations, bequests, etc., to establish, equip and maintain sanatoria for their own people suffering from the disease.

4. That municipalities may most effectually and practically aid in the work by the erection of suitable buildings and by the provision of a per diem allowance for maintaining in the institution such persons as their medical health officers may recommend.

5. Regarding the subject of legislation your Committee beg to observe that it falls under the heads of Federal, Provincial and Municipal.

Federal. Federal Legislation should provide for (1) financial assistance ; (2) prevention and care of cases of tuberculosis ; and (3) provide against the introduction of tuberculous immigrants.

Provincial. Provincial Legislation should provide for (1) notification to the health authorities of all cases of tuberculosis by physicians and householders ; (2) adequate inspection of workshops, factories and schools to secure sanitary conditions favorable to the prevention of tuberculosis ; (3) enabling and encouraging municipal action in establishing sanatoria with the support and under the general provision of Provincial Governments, and (4) controlling the production, inspection and sale of meat, milk and the products of milk.

Municipal. Municipal regulation through powers conferred by Provincial Governments should provide for (1) establishing municipal sanatoria ; (2) systematic inspection of milk and meat and of cows and public dairies ; (3) maintaining the cleanliness of public buildings and conveyances by the prevention of spitting and other nuisances ; (4) giving assistance to advanced cases of disease by removal of patients to hospital or by dispensary aid in their homes ; (5) immediate attention by medical health officers to the confidential reports of physicians attending cases of tuberculosis and filing all such reports for statistical purposes.

Your committee is further of opinion that as regards the work of medical inspection of schools it should include the examination of teachers respecting their freedom from tubercular disease and of the children as to evidences of chronic ill health, particularly as regards enlarged glands, cough and diseased bones and joints. After any prolonged illness a child should be required to bring on returning to school a certificate from the attending physician. Power to restrict attendance at school should be based upon positive evidence of contagion being obtained by the Medical Health Officer.

On the question of guarding against the spread of tuberculosis through food supplies your committee beg to recommend that the Dominion Government be asked to continue and increase the dissemination of information on the danger of the spread of tuberculosis by means of infected meat and milk, and that such information should especially refer to the need for keeping the cattle and byres supplying milk in a healthy and cleanly state. Municipal authorities should further extend their inspection to milk foods and their sources, and provide for periodical inspection of cattle and stables. All slaughter houses should be licensed only when constructed, drained and managed to the satisfaction of the Health Officer, and all meat sold within any municipality or prepared therein should be subject to inspection.

The committee on hospitals, sanatoria and public conveyances reported:—

1. That with the exercise of reasonable care pulmonary tuberculosis is non-contagious, and that consumptives may be treated in a general hospital without in any way being a source of danger to other patients;
2. That many are unable to be cared for outside a general hospital;
3. That the function of a general hospital is to care for all classes not afflicted with dangerously contagious disease;

This Association urges:—

That all general hospitals receiving public aid should make provision for a due proportion of tuberculosis cases. By refusing such cases the general hospitals increase the fear already too prevalent amongst the the people and which tends to make the consumptive an outcast.

That the provision of sanatoria is an indispensable part of measures for the diminution of tuberculosis.

Seaside charitable establishments, holiday colonies for the poor, anti-tuberculous dispensaries and kitchens are also recommended.

That railways and steamship companies should provide for tuberculous invalids specially constructed compartments, which will admit of ready disinfection.

Spitting in railway carriages, street cars and in public places being such a menace to the health of the public, this Association urges that each municipality penalize this offence, and appoint a special officer to see that the anti-spitting regulations are strictly enforced.

The committee on the publication of information recommended that the Dominion government be asked for an annual grant for educational purposes; that a central office be organized at Ottawa; that a library on tuberculosis be established; that an effort be made to collect statistics from all over the Dominion; that suitable reading matter be prepared for distribution, and that, as soon as possible, a quarterly bulletin be issued.

THE CANADA LANCET

VOL. XXXV.

SEPTEMBER, 1902.

No. 13.

EDITORIAL.

KING EDWARD'S CASE.

SO much has been said upon this subject already, that it would seem quite superfluous to return to it again. Restored in health to the love and rejoicing of his people, the King returned to London on the 6th of August, and was crowned on the 9th. The welcome which he received, on his return showed that popular as he was, he had grown very much in the people's affection by his recent severe illness. That his health was good, was abundantly manifested by the ease with which he passed through the Coronation Ceremonies. He walked without assistance, and there was an elasticity in his step that astonished all. Whatever he lost at first, by way of disappointment, has been more than made good by his restoration to health, and the increased love of his world wide empire. While we recognise this great and felicitous result, let us not forget those to whom we owe it. Now that the danger is over, and the King is restored to health and crowned, due tribute of praise and admiration must be paid to the eminent men who waited upon him.

No case could reveal the great progress of modern medical science better. Had the King been taken ill a generation ago, it is fairly safe to say that His Majesty would only have had a few hours to live; and any five experts at his bed side twenty-five years ago, would have been impotent to avert the terrible calamity. When a case, such as that of the King's, is brought under our notice, we see how far the healing art has marched forward. What has taken place in His Majesty's case, is taking place in thousands of obscure homes, and lives are daily saved, that a few years ago would have been inevitably doomed.

With all the resources that the modern transformation of the healing art placed at their disposal, it remains true that, upon the surgeons and physicians summoned to Buckingham Palace in the first hour of crisis, the emergency imposed a responsibility as grave and critical as has ever devolved upon any practitioners in the annals of medicine. Upon their firmness and fineness of judgment, upon their supreme strength of nerve, upon their unflinching and unerring certainty of executive touch, delicate

yet steel-like, depended the fate of a reign and the hope of an Empire. However they may have been influenced by the emotions which have shaken a vast people throughout the extent of that dominion which encompasses this planet, yet, as medical experts, it was theirs to act with minds as serene and composed as though they were above the agitated sphere of human feeling and vicissitude. In spite of all the shouting done by many members of the profession, who knew so much about the King's illness, though not within thousands of miles of his bedside, we see that those who had his case in charge made no mistake. They were not ignorant of the nature of the ailment that threatened His Majesty, nor was there any hesitation, or error in meeting it when it came. Great courage and fortitude were required, and promptness of action demanded and all were found in the persons of those called upon to attend the King, and to them is due the highest praise that a grateful Empire can bestow.

The name of Lord Lister has been before the medical profession for many a year, and none living have done so much for the advancement of surgery. In addition to his scientific knowledge, he has had a vast clinical experience in surgical cases. Sir Frederick Treves is known to the physicians and surgeons of every country and language, as one of the most brilliant of authors, teachers, and operators. In the domain of abdominal surgery and appendicitis especially, he is facile princeps. Sir Thomas Smith's long years of surgical connection with St. Bartholomew's Hospital would bring his way the material to train his mind on the best course to pursue in such a case as that of King Edward's, and Sir Thomas Smith is not the sort of person on whom such opportunities are thrown away. Not a few Canadians have seen Sir Thomas Barlow at his work in London. Those who have had this privilege will at once recall his thorough and painstaking methods. As an evidence of his sound learning, we commend his address on "the study of the natural history of disease the basis of all advance in its treatment," delivered before the recent meeting of the British Medical Association. Sir Francis Laking, in addition to his extensive private practice, has enjoyed extensive opportunities in the wards of St. George's Hospital; and is considered, by those who know him, as the embodiment of sound judgment and of common sense in medicine.

Surrounded by such advisers, the most august personage in the world on the eve of the most august event in his life, would not, so far as human judgment can go, be wrongly advised, or improperly treated. It therefore looks rather out of place, and is certainly in very bad taste, for some surgeons, here and there, to indulge in pyrotechnical displays of their

skill, and what ought to have been done. Verily, if the eminent surgeons and physicians, who waited upon King Edward, had adopted such methods as have been suggested by not a few of those loud shouters in surgery, the chances for His Majesty's recovery would have been annihilated, and the postponed coronation would have been an event of a far different and sadder character. To these self-created wise ones we commend the words of Horace: *Sapientia prima stultitia caruisse.*

STIMULANTS AND NARCOTICS IN PROPRIETARY MEDICINES.

DRUGGISTS are restricted by law from selling stimulants, except under a doctor's order, and from selling certain drugs that are on the list as interdicted. Notwithstanding this they can sell any amount of stimulants and interdicted drugs, provided they are put up as proprietary mixtures.

Alcohol, bromides, chloral, opium, arsenic, strychnia, ergot, and others, can be purchased any day, in any quantity, in many of the proprietary compounds on the shelves of our drug stores.

There should be passed, and vigorously enforced, a law to the effect that no proprietary compound, or preparation, could be offered for sale that contained any of the drugs on the list as noxious, or dangerous.

One of the most remarkable things, in connection with the sale of drugs, is that no one but a legally qualified practitioner of medicine is permitted to write prescriptions containing the proscribed drugs, nor can any one but a legally qualified pharmacist open and conduct a drug store, and yet any one, a carpenter, a stableman, a farmer, a blacksmith, or a scrubwoman, for example, may put up compounds for coughs, pains, teething, rheumatism, skin diseases, women's troubles and so on, for either internal or external use.

The usual history of these mixtures is that some one gets hold of a prescription, which had been ordered for some complaint, and puts it up in quantity, and sells it as a cure-all. Frequently, this is done by some one who does not know any thing about medicine, or pharmacy. Fraud is written all over the wrappers, claims being made that are arrant nonsense.

There ought to be a law compelling manufacturers, and those who put up proprietary compounds, to publish on the wrappers the complete formula of the article, or mixture. It could then be seen how far the monstrous pretensions, so often put forth, would be borne out by the use of the concoction. Many years ago a favorite seller contained black oak bark and cheap whiskey, while another was made up principally from

aloes, molasses and whiskey. A certain ointment was made of wax and lard, colored with carrot.

The government should take this matter up, indeed, we believe that the government will have to deal with the frauds and abuses, now practised under the sale of proprietary compounds. It is nothing short of downright fraud to offer an article for sale as a cure for what is known to be an incurable disease. It is the duty of governments to prevent fraud. It is also the duty of the government to prevent the adulteration of foods, or drinks, or the open sale of a noxious article. Many of these manufacturers should be made to feel "turpe est aliud loqui, aliud sentire. quanto turpius aliud scribere, aliud sentire."

PNEUMONIA.

ACCORDING to the best accepted opinions, the pneumococcus, or diplococcus lanceolatus of Fraenkel, is never absent in true lobar or croupous pneumonia. In association with the pneumococcus, there are numerous other bacteria, such as the staphylococcus, the streptococcus, and Fredlaender's pneumo-bacillus. The bacillus coli communis has been found in some cases along with the pneumococcus. The micrococcus septicaemiae is occasionally found. If an animal be inoculated subcutaneously with the rusty sputum, its blood, as a rule, will contain a pure culture of the pneumococcus.

The pneumococcus does not readily produce pus. When an abscess forms, there is generally mixed infection. Grey hepatization is not a purulent condition. Even though the lung breaks down there may be no pus. When the pleural, or peritoneal cavities of rabbits are inoculated with pneumococci, in addition to the local lesions, the lungs show consolidation and congestion. Pericarditis is also a frequent complication.

If the albumose, and organic acid, obtained by extraction from lung tissue infected with pneumococci, be injected into the thorax of a rabbit, there result both fever and consolidation of the lung. The organic acid does not possess the active qualities of the albumose. Cultures have been made in several media, and the albumose and organic acid obtained in this way acts similarly to the albumose and organic acid extracted from tissue containing pneumococci. It may be inferred from such experiments that the albumose produced by the pneumococci is the principal agent in the production of the fever and the local consolidation in the lung.

A most important fact, in the experimental study of these organisms, is that animals inoculated with the toxins of the pneumococcus become more sensitive to the germs and their toxins. It would appear that the

immunity is of short duration, while the injury to the tissues is very persistent; and, consequently, an attack of pneumonia predisposes to another. It would seem that an antitoxine is not formed. It is a bactericidal power that is developed in the serum.

When animals are inoculated with living cultures of increasing virulency, a certain amount of immunity is obtained. These animals could resist doses that proved speedily fatal to those not having been so treated. The animals that are inoculated with increasingly virulent living cultures do not possess in their blood any antitoxine against the toxins, obtained by various methods from the growth of the pneumococcus. Any resistance that may be produced in any animal must be due to something in the bacteria themselves that is inimical to their growth.

It is in this way that the explanation must be sought for that the serum treatment of pneumonia has not been successful. It does not appear possible to develop an antitoxine in the serum. Any immunising that may be produced must be obtained directly by employing the organisms, either living or dead.

A POST-GRADUATE COURSE.

THE time has come when some effort should be put forth to organize a Post-Graduate Course of medical instruction. There are many physicians in Ontario who would be glad to avail themselves of the opportunity of attending such a course of instruction, if it were only placed within their reach. In order to take advantage of hospital work and clinical teaching, they must go to New York, Baltimore, Chicago, or Philadelphia. These centres are excellent, but they are not so easily reached as Toronto to the practitioners of Ontario. Our practitioners could come into Toronto at comparatively slight cost, as compared with the above named places; and could, on short notice, return home if their presence became urgently required.

There is now in Toronto ample hospital facilities for teaching, and clinical work. There are numerous suitable lecture rooms and wards where lectures and clinics could be given. It does not require to be argued that there are many in Toronto who are thoroughly competent to deliver lectures, or give clinics and demonstrations on medical, surgical, pathological, or bacteriological subjects. What is lacking is the union of these persons into a group with a common object in view; and that object, the Post-Graduate Course.

The whole field of medicine should be treated as a science. There should be no jealousies in its pursuit. Toronto is now in a position to do much for the advancement of this science in the Province of Ontario.

There are the men, the materials and the facilities. Let there also be the willingness to co-operate, one with another, in the establishment of a Post-Graduate Course, as the most effective means known of raising the standard of scientific medicine in this Province. It may be safely said that the medical educational standard for Ontario is one of the highest in the world; but it has not yet reached its resting place. An important step towards this would be a Post-Graduate Course.

We commend to our readers' attention the following words of Dr. Powell in his presidential address at the Ontario Medical Association: "We have so far failed to make adequate provision for post-graduate institutions. We have the men, the hospitals and the material to meet all needs, but they are not utilized as they might be. In the past, professional jealousy was so keen and controversy so bitter that success would have been hardly a possibility. Now, *laus Deo*, we know each other better; and out of mutual respect can come united and successful action."

The CANADA LANCET hopes to be able, in the near future, to chronicle the fact that an organization has been effected looking towards this end.

FUNCTIONAL AND ORGANIC PARALYSIS.

DR. THOMAS BUZZARD, at the recent meeting of the British Medical Association, B.M.J., August 9, opened the discussion on this subject. He stated that he meant by "functional paralysis," cases that simulated, more or less closely, those arising from structural change, affecting the nervous system, without being dependent upon any discoverable changes in it; and of such a character that they could be simulated by a healthy person. Functional paralysis could sometimes be removed rapidly or suddenly by persuasion or physical or moral shock. There was probably no symptom which, alone and unsupported, could be relied upon to establish a diagnosis of functional paralysis.

Functional hemiplegia was rarely preceded by an apoplectic seizure, but was gradual in onset, and did not pass from flaccidity to contracture as in the organic form. There was likely to be much more anæsthesia than in the organic form. The functional form rarely, if ever, attacked the face. The Babinski sign was absent in functional hemiplegia; and an effort to sit up in bed, without the aid of the arms, did not raise the affected heel from the bed, which was the case in the organic form. Though gradual contracture was not likely in the functional form, a strong contracture, without previous flaccidity, might take place; but in organic contracture the whole arm could not be extended at one time,

whereas in the functional form, the arm, hand and fingers could be brought into one line at the same time. The deep reflexes, and ankle clonus could not be relied upon, as ankle clonus might be found in functional hemiplegia. The absence of the plantar reflex was strongly corroborative of the functional type. The presence of the toe phenomenon was positive of organic change.

Paraplegia rarely presented difficulty, as the Babinski toe phenomenon and the plantar reflex were wanting in the functional cases. In insular sclerosis, there was sometimes a temporary paralysis of one or more limbs, which should be held to be organic, although there frequently were hysterical symptoms in such cases. These, however, like the paralysis, arose from the central disease.

EDITORIAL NOTES.

Thyroid Extract in Painful Menstruation.

Dr. J. Coplin Stinson, writing in the American Journal of Obstetrics and Diseases of children for July, remarks that he has had some excellent results from the administration of thyroid gland extract in painful menstruation. He contends that it influences metabolism in such a way as to have a specific action upon uterine and ovarian tissue. The vascular and nerve supply to those organs become more normal. The nerves are much less sensitive, and in this way it is really an anodyne to these organs. There is improved pulse, and better assimilation. He gives one grain of thyroidin three times a day for two days before the period, and two or three grains three times a day during the period. The treatment is kept up for some time in the intervals as well.

Puerperal Septicæmia.

There has been much confusion created by the various terms employed in speaking of the fever that occurs shortly after labor. Peritonitis, phlebitis, metritis, pelvic cellulitis and many other names have been given to this febrile state. It is quite erroneous also to speak of puerperal fever as a distinct disease, due to one cause only, as it is proper to speak of typhoid fever as due always to the same germ. In puerperal fever the condition is one of a true surgical septicæmia or pyæmia, and there are a variety of germs capable of causing the disease. The severity and symptoms thus vary somewhat according to the nature of the infection.

Treatment of Epilepsy.

Sir W. R. Gowers, on the treatment of epilepsy, remarks that whether this be with bromides, or any other agent, the endeavor must be to find

a dose of the drug, or a combination of drugs, which is capable of arresting the attacks, slight or severe, and which the patient can bear. This must be continued persistently until it is reasonable to suppose that stability has been established, and then should be discontinued by gradual diminution. It is therefore, important that the dose should not be larger than can be continuously borne. The doses should be no larger than suffice to arrest the attacks and provide a margin against exciting causes. If the treatment was more persistent than is usually the case, there would be more cures.

Mixed or Coincident Infections.

E. W. Goodall, in writing on the above topic, states that 41,483 cases of infectious diseases admitted into the fever hospitals of London 1,191 were at the time suffering from more than one infection. Scarlet fever and diphtheria occurred together 589 times, scarlet fever and whooping cough 186 times, scarlet fever and varicella 163 times, diphtheria and morbilli 66 times, scarlet fever and morbilli 65 times, diphtheria and whooping cough 34 times, diphtheria and varicella 27 times, and combinations of scarlet fever or diphtheria with rebulla, or enteric fever, a few times. In addition to the above there were many instances of patients contracting a second fever while convalescing. Among 30,417 cases of scarlet fever there were 1,501 cases of diphtheria, contracted in the wards during the illness, or convalescence of the scarlatina, 1,018 cases of chicken-pox, 302 of measles, 197 of whooping cough, and 168 of rubella. Among 9,789 cases of diphtheria admitted there afterwards occurred 768 of scarlet fever, 100 of chicken-pox, 70 of measles, and 38 of whooping cough. Among 1,277 cases of enteric fever there were 9 cases each of scarlet fever and diphtheria.

The use of Alcohol in Fevers.

The following remarks occur in the work on Diet by the late Thomas King Chambers: "The use of alcohol in fevers is regulated partly by the temperature and partly by the condition of the nervous system. If the heat of the blood is above 103° generally, and if above 105° always, there is a necessity for wine. And it should be continued till such time as the temperature is below 101° for 24 hours together. If there is great prostration of strength or tremulousness of the hands or quivering in the voice and respiration, if there is delirium of a low muttering character when the patient is left quiet, then also it is required. Or if the patient is habituated to a full allowance, it is well to continue to give a little. A sharp, weak, unequal beat of the heart is a warning that

some of these symptoms are likely soon to come on. All these indicate that the nervous system is feeling very sensitively the destructive metamorphosis going on, and has its power lowered by its sensitiveness. Then is the opportunity for the strong anæsthetic we are speaking of, which I order without scruple, regulating the quantity and the frequency of the dose solely by its physiological effects, the diminution of temperature and the steadiness of nerve force. But I do not hold it as a specific, or a necessary cure of fever."

Administration of Anaesthetics

Dr. W. Foster Cross, Anæsthetist to St. Bartholomew's Hospital, in the *Medical Times and Gazette*, makes some very pertinent remarks on certain classes of patients in which the administration of anæsthetics is accompanied by special dangers: Alcoholic require a large amount of chloroform, they struggle a great deal, the preliminary stage is unusually prolonged, and there is generally some rigidity throughout the operation. In shock cases and those reduced by long suppuration, very small quantities of chloroform, or any anæsthetic takes rapid effect. The pulse is liable to be very weak in these cases. Even if the pulse is fairly good, it does not remain so long. An equal part mixture chloroform and ether given on lint, is useful in these cases. In cases of intestinal obstruction, the patient is often under the influence of morphia, there is usually distention of the abdomen, frequent vomiting, weak, rapid pulse, and a dusky color of face. The head should be kept well on the side, as the vomiting is often very sudden. The best anæsthetic is a mixture of ether and chloroform. Cases of empyæma require great caution. In these cases it is not safe to use ether by itself, as it excites coughing, and throws strain on the heart, which may be hampered as it is by pressure and displacement. In such cases, it is best to give chloroform. It should be administered carefully, and not pushed deeply. The anæsthetic should not be given till the patient is on the table, as those patients do not stand being transported. When the pleural cavity is opened, the anæsthetic should be greatly reduced, or stopped.

Acute Pleurisy with Effusion.

Much discussion has taken place on whether the above conditions can be caused by cold alone; or, if there must be some other factor in the case, usually microbial infection of the pleura. Dr. George R. Murray, of Durham, in *THE LANCET*, of May 24, places himself on record to the effect that acute pleurisy with effusion is almost always due to infection by

germs ; but that it is sometimes caused by simple exposure and cold, or the pneumococcus, typhoid bacillus the strepto- and stephylococcus pyogenes.

The best method of determining the presence of tubercular bacilli is to inject a guinea pig with the fluid obtained by aspiration. It is necessary to use a large quantity of the fluid. Tested in this way, 85 per cent. yielded positive results, in the guinea pigs. In the German Government's report, on the efficiency of tuberculin, it is stated that 87 per cent. of persons with pleuritic effusion gave the reaction. Tested by clinical method, the subsequent study of cases of pleurisy with effusions shows that a very large percentage become tubercular, ranging from 40 per cent. to 90 per cent. according to the time over which the observations extended. Tested by the post-mortem finding the same conclusions are arrived at. In nearly all cases of death, in acute pleurisy with effusion, tubercles are found in the plura and lung. From 85 to 90 per cent. of cases of acute pleurisy with effusion are therefore tubercular.

Cancer In India.

From the May number of the Indian Medical Gazette we learn some interesting things about cancer. In the first place it is very common among the natives. One-third of the cases occurs in the cheek. This is attributed to the custom of chewing the betel nut. There were not many cases on the lips, as the natives do not smoke pipes. The penis among the Hindoos is a very common situation for cancer. On the other hand, it is extremely rare among the Mohammedans, as they are circumcised. Many cases occurred on the thigh and abdomen, due to the custom of carrying there a fire basket for warmth in Northern India. Malaria had no preventive influence.

Laparotomy During Early Pregnancy.

In the post graduate for July, Dr. Reuben Cronson describes the case of a woman who came under his care in the third month of her pregnancy. On examination he discovered tumors, which he thought were most likely cystic. On their removal it was found that there was a dermoid cyst in each ovary. The patient made a good recovery and went on to full term. The appendix was also removed.

Methylene Blue In Mania.

It has been noted that when methylene blue was administered to patients, it had a calmative and depressant effect. This property has been made use of in Mania. It is given in grain doses hypodermically ; or in

two grain doses by capsule, twice daily or oftener. There were no ill effects, nor digestive derangements. The patients slept well, they were relieved of excitement, without dullness, or depression.

Morrison's Operation for Ascites.

F. Telden Brown, M.D., in the *Annals of Surgery* for August describes a case which was operated upon for the relief of ascites, due to Laennec's cirrhosis of the liver. A five-inch incision was made between the ensiform and the umbilicus, and a two-inch incision above the symphysis. The surfaces of the liver and spleen, and the peritoneal surfaces opposed to them were vigorously rubbed with dry gauze sponges, held in long forceps. The parietal peritoneum, in front of the omentum, was treated in the same way before they were sutured by a transverse line of 8 or 10 chromicized catgut sutures. The upper wound was closed. The lower wound was drained by a glass tube, one and one-quarter inches in diameter, through which was led gauze for capillary drainage. The abdomen was well supported by adhesive strapping. Compression of the upper portion of the abdomen was kept up for three months. On the twenty-third day the large tube was changed for a smaller one. On thirty-eighth day the drainage tube was removed. The patient was greatly benefited.

Our Book Reviews.

We take this opportunity of calling attention to our reviews. These reviews are prepared with the object of giving the readers of THE CANADA LANCET some of the salient features of these very important works. It is hoped the perusal of these reviews will amply repay the reader for his trouble.

PERSONAL.

Dr. J. A. Stoddard of Pueblo, Colorado, formerly practising in Halifax, Nova Scotia, recently paid a visit to the Maritime Provinces. He read a paper at each of the medical association meetings.

The assistant city medical officer of Halifax, Dr. J. M. Purcell, has been in the small-pox hospital ever since last October. Dr. Purcell was rather unfortunate. He would no sooner have one batch ready to leave than another would be forwarded to his care. He is however at length out and we are glad to say the city is once more free from the disease.

Dr. M. A. Curry, surgeon to the coronation contingent, has returned to Halifax looking none the worse for his trip to the old country.

Drs. O. R. Salter, of Oxford, Dr. Beckwith, of Halifax, and Dr. L. M. Crosley, of Yarmouth, were married during the month of July.

Dr. J. A. Mackenzie, assistant medical superintendent of the Nova Scotia hospital, intends leaving for New York shortly on an extended visit.

The death occurred at Yarmouth, N.S., on June 15th of Dr. J. H. Harris. He had been ill for some time and his end was not unexpected. He had at one time a very large practice, but of late years owing to bad health had given up a good part of it.

The death of Dr. Nelson Price, of St. John, occurred recently in South Africa. Dr. Price went out with the hospital corps and was doing good work with them when he unfortunately contracted enteric fever from which he never recovered. The death of this promising young man at the early age of 28 is particularly sad.

At St. Andrew's church, Vancouver, Dr. Robert Telford and Miss Ella Maud Munro were married by Rev. E. D. McLaren.

A. McGill, graduate in the person of Dr. A. J. Lomas, has been appointed surgeon on the steamship Botanga. The vessel left England on July 17 for South Africa.

Dr. A. S. Langrill and Miss Margaret Langrill left for the Mackinac islands on August 5th.

Dr. Greene and Dr. Kingsley Gibson, of Ottawa left 5th August for Metis where they intend joining a yachting party and go on a two-weeks' cruise on the lower St. Lawrence.

Dr. F. C. Hood and Mrs. Hood returned to Toronto in the early part of August after an absence in England of several months.

Dr. George Waters, a veteran practitioner of Cobourg died 3rd August at the age of 65. Deceased practised in the town from 1868 till a couple of years ago, when his health failed and the lingering illness, which followed, caused his death.

It is reported that Dr. A. Donaldson of Brockville, who accompanied the Hospital corps to South Africa with the Canadian Mounted Rifles, will not return to Canada, having accepted a commission in the British army.

Dr. Percy E. Butler, Milltown, and Miss Harriet Eleanor Stickney of Calais, were married at the home of the bride in the latter part of July.

Dr. John C. McKinnon, of Antigonish, N.S., who died recently was 54 years old. Death was due to pneumonia. Deceased took his course of professional study in Harvard University, in 1870, receiving his degree from that institution.

Dr. Pearson James, of Galt, who secured his degree of M.B. at Trinity Medical College last spring, leaves Wednesday morning for Glasgow, where he will take a course in one of the large hospitals.

Dr. William Minaker, who died at Chicago, after a lingering illness, was born at Milford, Prince Edward county, in 1847. He graduated from Trinity Medical College, with high honors, practised in Meaford, Thorold and Winnipeg, ere locating in Chicago in 1884.

Dr. William H. Klock, one of the leading physicians of Ottawa, died at the age of 41. Dr. Klock was a graduate of McGill University of the class of '85. He also held degrees from the Universities of Glasgow and Edinburgh.

Dr. and Mrs. Murray McFarlane spent some time in Newfoundland salmon fishing. They proceeded thence for Maine, and returned to Toronto about the end of August.

Dr. W. H. Groves was appointed surgeon of the *Tarquah*, the vessel selected for the use of Hon. Joseph Chamberlain and the colonial party at the naval review at Spithead.

Dr. McCort, of Thessalon, returned home from a lengthy visit with friends at Toronto and other points east. His many friends will be pleased to learn that the doctor was greatly recuperated in health while east.

Dr. C. S. Hamilton, of Smithville, who has been seriously ill, is now improving.

Dr. Edmund E. King and family, of Toronto, were holidaying at Hastings for a couple of weeks.

Dr. A. Cranston, of Galt, who has been enjoying a holiday in Alma for three weeks, returned home.

Dr. Goldwin Howland, of Toronto University, has been appointed registrar of the National Hospital for Nervous Diseases, London, England.

Dr. F. Montizambert, director-general of public health for the Dominion, is out West for the purpose of inspecting the quarantine station at William Head and also to investigate general health conditions. He will spend a day at Vancouver on his way to Victoria.

Dr. Alex. Roberts, of Lanark, left a short time ago for Dawson, Yukon, whence he goes to practice his profession.

Dr. Dowling, formerly of Eganville, has been appointed medical adviser for the St. Charles' Home, Water street, Ottawa.

We regret to record the death of Dr. Christie, M.P. for Argenteuil County. He was a firm believer in total abstinence. He was honest always in the expression of his views. He was a man of kindly nature and good abilities. The record which he leaves behind him is creditable to himself and to his country. He died at his home in Lachute 5th August.

Dr. R. Ernest McConnell, son of Dr. J. B. McConnell, of Montreal has been appointed senior physician in charge of the burgher camp at Volksrust, in the Transvaal.

Dr. and Mrs. Hooper, who have been guests of Mrs. J. P. Mackay, Westmount, have returned to St. Catharines.

Dr. Hutchison has taken up his residence in the house lately occupied by Dr. Chown, corner of Donald and Ellice Sts., Winnipeg.

Dr. G. Sterling Ryerson, of Toronto, returned in the early part of August from his trip to England. He was attached to the Colonial Contingent by Order of the Imperial War Office; and was detailed to the medical charge of the New Zealand Contingent. He reports having had some very interesting experiences with the New Zealanders.

Dr. Herbert Roaf, who graduated at the University of Toronto last spring, has been appointed to the Colonial Fellowship in the Department of Pathology of the University of Liverpool.

BOOK REVIEWS.

TRANSACTIONS OF THE AMERICAN CLIMATOLOGICAL ASSOCIATION, FOR THE YEAR 1901.

THIS volume contains a number of excellent papers on Climatology, Respiratory and Circulatory diseases. A large portion of the book is devoted to the home and sanatorium treatment of tuberculosis. The book merits reading.

HUMAN AND BOVINE TUBERCULOSIS.

Prof. Adami's Report.

EVERY word upon this subject from a reliable source is of value. The Report of Prof. J. George Adami on Bovine Tuberculosis, addressed to the Minister of Agriculture for Canada, is to hand. It has been well known that he has been working upon this important subject for a number of years; and naturally one turns to his report for the results of these years of labor. His conclusions are:

Tuberculosis is readily communicated from cattle to cattle, either by the inhalation of dust, through milk, by contamination of stalls and drinking water, through saliva and nasal discharges, or rarely by intra-uterine infection.

Human tuberculosis is transmissible to cattle, either by pure cultures, or more readily by mixed infections.

Certain breeds of swine appear to be readily infected with both human and bovine tuberculosis.

Human tuberculosis in the great majority of cases, is conveyed from one person to another, either by inhalation, by the alimentary tract by the genital tract, through wounds, or in utero. All evidence goes to show

that the bacilli infecting a human being comes from a previous case in man, in the great majority of instances.

By their sojourn in the human body, and passing from man to man, the bacilli have acquired properties differing from the bacilli of cattle, in shape and rate of growth.

These differences appear to be only such as living in different animals is capable of producing, and that these different bacilli are only varieties of one species. The bacilli take on the characteristics of those of that animal, regardless of the source from which they originally came.

Bovine tuberculosis can be conveyed to man either through the digestive canal, or by wounds, in the latter way oftenest.

The passage of the bacilli through cattle renders them less virulent for man; but more so to cattle, guinea-pigs or rabbits.

In the case of children, the frequency of intestinal and abdominal tuberculosis must be accepted as conclusive evidence upon the frequency of infection through milk. In order that such infection may take place, it would seem that the milk must come from cattle extensively diseased, especially with udder disease.

All measures for the reduction of the disease among cattle are necessary, as it will avert much loss to the farmer, and considerable risk to the community.

Dr. Adami is to be congratulated upon his able report, and the skill with which he has avoided extreme views.

HARE'S PRACTICAL THERAPEUTICS.

A Text-Book of Practical Therapeutics, with special reference to the application of remedial measures to disease and their employment upon a rational basis. By Hobart Amory Hare, M.D., B.Sc., Professor of Therapeutics and Materia Medica in Jefferson Medical College of Philadelphia, Physician to the Jefferson College Hospital, etc., etc. Ninth edition, enlarged, and largely re-written. Illustrated with 105 engravings and 4 colored plates. Lea Brothers & Co., Philadelphia and New York. 1902.

IN 1890, the first edition of this work appeared. In the twelve years that have elapsed since that date, no less than nine editions have appeared. This alone is comment enough in praise of the work. The work is divided into four sections: General therapeutical considerations; drugs; remedial measures other than drugs and feeding the sick; diseases; table of doses, and index of diseases and remedies. Under each of the above headings, excellent advice and information can be found, in a readily available form.

The first part of the work deals with general therapeutics, and, as might be expected, discusses the methods of administering drugs, their dosage, idiosyncrasy, incompatibility, weights and measures, classification

of drugs, absorption, etc. In every one of these topics useful information is furnished.

The second part of the work takes up the study of drugs under an alphabetical arrangement, instead of under some fanciful system of grouping them either chemically, botanically or therapeutically. The common names of the drugs are used, though technical names are also given. Thus we meet with charcoal, carbolic acid, chromic acid, iron, etc., as the titles to the descriptions of these drugs. The comments under each drug are brief, pointed, accurate and up-to-date. There are many excellent formulæ and suggestions on the best methods of prescribing the drugs, either alone or in combination.

The third part of the work is specially interesting. It deals with "remedial measures other than drugs and foods for the sick." In this section acupuncture, antiseptics, antitoxin, cold, counter irritation, disinfection, heat, inhalations, lavage, rest, climate, transfusion, venesection, etc., etc., receive due attention. This section will repay careful study. There are very many valuable suggestions contained in it.

The fourth part is devoted to the treatment of diseases, which are taken up in alphabetical order. This portion of the work consists of 255 pages. It leaves nothing to be desired, as the suggestions are timely and reliable. At a glance, the busy man can find what is considered the best thing to do in almost every disease.

The book contains 857 pages and is printed and bound in most attractive style. In matter and form, it would be hard to imagine anything better than Hare's Practical Therapeutics.

DISEASES OF THE NOSE, PHARYNX, AND EAR.

Diseases of the Nose, Pharynx, and Ear. By Henry Gradle, M.D., Professor of Ophthalmology and Otology, Northwestern University Medical School, Chicago. Handsome octavo of 547 pages, profusely illustrated, including two full-page plates in colors. Philadelphia and London: W. B. Saunders & Co., 1902. Cloth, \$3.50 net. Toronto, J. A. Carveth & Co., Agents.

DURING the last few years there have appeared a considerable number of excellent books dealing with diseases of the nose, throat, and ear, but we think this one quite the most readable. It deals with the anatomy and physiology in brief, yet sufficient space, while symptomology and treatment are not burdened with a long list of matter, clipped from other works. It has been the author's aim to give in detail only those procedures that have stood the test of clinical experience.

There are few omissions of things that are new and of *tried utility*. He depreciates too much reliance being paid to the various antiseptic

tablets and fluids in nasal irrigation, since they have no therapeutic influence beyond their mechanical effect: He prefers the hydrocarbon oils made up with oil of cloves, menthol, or oil of wintergreen. Regarding the toxic effect of cocaine in nose and throat surgery, he states that in thousands of cases he has used a 20% solution and has not had any toxic effects. In the next sentence (page 72) the author speaks of occurrences that are not uncommon in which patients so anaesthetised feel faint and very nervous, necessitating their lying down for a few minutes. We do not think this can be entirely explained by the shock of the operation, as the occurrence is fairly common before operative measures have taken place and we think is usually ascribed to cocaine poisoning. Nirvanin is highly spoken of as a substitute for cocaine. There are no toxic effects, but this is offset by the necessity of using the drug by injecting it into the tissues as it will not act on the free surface of the mucous membrane. The chapters on accessory sinus disease are concise and thorough. The illustrations from Zuckerkandl are very clearly outlined. In connection with nasal synechia no mention is made of the difficulty of preventing re-union or the use of rubber splints, which are so useful in these troublesome cases. In connection with adenoids, a point, too frequently omitted by writers now-a-days, is strongly insisted upon, viz:—"If the adenoids are not removed a hypertrophic condition of the turbinals, especially the posterior ends, as well as septal overgrowth, are very often found in older children." The author's experience has led him to condemn narcosis for adenoid operations. If he can operate thoroughly without narcosis he is singularly fortunate. We think the operation brutal without anaesthesia and unjustifiable when such safe agents as nitrous oxide gas and, if *skillfully* given, hydrobromic ether are available. The shock following these operations is sometimes severe and cases of death have occurred due to it when the operation is performed without an anaesthetic. Under hay fever, the author says a person who is poor and uneducated is practically proof against this disease. In connection with diphtheria, 300 to 600 units of antitoxine are given as sufficient for immunizing purposes. The CANADA LANCET, July, 1896, has an article proving the fallacy of this view. Diseases of the ear take up 189 pages out of a total of 534, and there is, therefore, considerable curtailment. The various tuning fork tests and their significance, and the diseases of the labyrinth might be considerably enlarged upon. Under the treatment of Eustachian catarrh the author says it can be permanently *cured* by a single inflation in those cases in which the inflammatory process in the naso-pharynx has subsided without leaving permanent lesions. One does not often get such happy results in this country. Under adhesive

or proliferative inflammation of the middle ear, the author recommends a Politizer bag or Eustachian catheter for the patient's use at home. No mention is made of Dundas Grant's self inflator, which is often of more use in the patient's hands than the Politizer bag in the surgeon's. It is also advised that if pneumo-massage shows no decided benefit after a few sittings, the patient may be permitted to use it at home for a few months. At the end of this period the patient might have a very flaccid membrane and a considerable increase of deafness. Regarding the prognosis of deafness the author says: "The history of steady progressive deafness with tinnitus not controlled by inflation, the demonstration of Eustachian obstruction and the absence of gross lesions in the nose, give the therapist little chance of successful intervention. The so-called sclerosis of the middle ear cannot be influenced by any known means." Dr. St. John Roosa once remarked in speaking of these cases, "Yes, gentlemen, they will all hear, but it will be when Gabriel blows his horn." The suppurative diseases of the ear are carefully considered. In cases where a carious spot is found on the external surface of the mastoid leading to some cells below the antrum, the author depreciates opening the mastoid antrum unless it is distinctly indicated by the clinical signs. In operating for the relief of mastoiditis, the author advises following any sinus that may be found on the external surface of the bone. This we cannot agree to, as the sinus does not always lead to the antrum, and if it should it usually does so in a very roundabout way, besides in following a sinus one does not know where his instruments are in relation to the lateral sinus or facial nerve as he does if he goes direct to the antrum immediately behind the spine of Henlé. The technique of Ballance's skin grafting is omitted entirely. Diseases of the auditory nerve occupy but one and a half pages. More can be done for these cases if they are carefully investigated, particularly in the anaemic and congested forms, than is usually mentioned in text books.

The preface says the book does not pretend to be an encyclopedia, and hence lacks literary and historical completeness. It is this that makes the book of most value to the general practitioner who wants an up-to-date work that he can easily read and comprehend. In this the author has admirably succeeded.

SAUNDERS' MEDICAL HAND-ATLASES.

Atlas and Epitome of Abdominal Hernias. By Privatdocent Dr. George Sultan, of Cottingen. Edited, with additions, by William B. Coley, M.D., Clinical Lecturer on Surgery, Columbia University (College of Physicians and Surgeons). With 119 illustrations, 36 of them in colors, and 277 pages of text. Philadelphia and London: W. B. Saunders & Co., 1902. Cloth, \$3.00 net. Canadian Agents, J. A. Carveth & Co., Toronto, Ont.

THIS new edition to Saunders' series of Medical Hand-Atlases covers one of the most important subjects in the entire domain of medical teaching, since these hernias are not only exceedingly common, but the frequent occurrence of strangulation demands extraordinarily quick and energetic surgical intervention. While the well-known work of Macready will always remain a classic, it has never made any claims to deal with the operative side of the subject, and this is a side that, during the last decade, has been steadily growing in importance, until now it is absolutely essential to have a book treating of the surgical aspect of the subject. This present atlas does this to an admirable degree, and without question, will prove of very great value to the general surgeon and practitioner.

The illustrations are not only very numerous, but they excel, in the accuracy of the portrayal of the conditions represented, those of any other work upon abdominal hernias with which we are familiar. Indeed, like all the other numbers of this excellent series, the work is a worthy exponent of our present knowledge of the subject, and in its field is unrivalled.

The work deals with hernia in general, and special hernias. Under the first portion the questions of frequency, origin, general diagnosis, general treatment, accidents of hernia, strangulation, and the treatment of strangulation.

The second portion treats of the special varieties, as inguinal, femoral, umbilical, obturator, sciatic, perineal, diaphragmatic, ventral, lumbar, internal hernias.

The combination of short, clear description, and such superb illustrations, make the book practically perfect.

CORRESPONDENCE.

The editor does not endorse nor hold himself responsible for the opinions expressed by correspondents.

Editor of CANADA LANCET:

ST. CATHARINES, 1902.

BOTH the ruling authorities and the professors generally of the Medical Colleges in Canada have hitherto displayed chronic indifference with regard to the creation of a permanent medical literature for this country. At present they show no intention to change their minds.

The medical institutions of this country, about ten in number, are either faculties of Universities, or like Trinity Medical College at Toronto, in direct affiliation with Universities. Nevertheless, neither their University Associations, nor the time honored standing of medicine as a learned profession, nor yet personal ambition, has incited the professors to become authors of medical books. The college authorities on their part have been content to forego literary standing for their institutions to the extent even of depending entirely on foreign authors for the text books and books of reference needed in the courses of medical study. This admission of inferiority deserves animadversion. *Sera nunquam est ad bonos mores via.* Hopes of reformation are to be entertained.

I make no comparisons with the older countries of Europe, but cross the International boundary into the United States which, it will be observed is a new country like Canada, where a striking contrast is exhibited between the vigor and progress of our neighbor in the creation of a national medical literature, and the inertia and backwardness under comment. Actuated by a praiseworthy ambition, numerous professors of American medical colleges, likewise many physicians on the staff of large hospitals although not professors in colleges, have written books in great numbers on all the various branches of medicine, which have extensively displaced European text books for college use, as well as in the libraries of physicians in the United States. They have done the same in Canada.

American medical authors have attained a position of equality with those of Europe in the medical world of letters. The first move yet remains to be taken by Canadian professors of medicine to acquire similar standing. The general catalogues of medical books are in evidence. According to custom the annual announcements of the Canadian Medical Colleges contain lists of the text books and books of reference recommended to the students for study and adopted by the professors as authorities. Not a work is mentioned in those lists that I can discover written by a professor in any of those colleges. The majority of the books are of American production. The balance are European. Such abject dependence on foreign authors for college text books is indefensible

An excuse for the condition of affairs just outlined has been heard to the following effect. The demand for medical books written by Canadian authors would probably be confined to this country, and on account of the small population, would be published at a loss. This excuse implies that Canadian professors of medicine have no love of authorship of medical works for its own sake. For its rejection one reason is supplied by the familiar aphorism,—“there is always room at the top,” for medical men. Let the professors of Canadian Medical Colleges write books of as high a grade of excellence as that which they boast is maintained by their institutions in the education of students to become successful physicians both abroad and at home, and their works will be read on their merits outside Canada. With regard to the home demand, there are 6,000 physicians in Canada, a number constantly increasing, who are available to purchase Canadian medical works and are doubtless willing to do so if they are really meritorious. The authorities and professors together, of the Canadian medical institutions, can easily arrange their college curriculums in order to secure the use of approved Canadian text books by their many hundreds of students.

A well defined aspiration should be entertained to give Canada high standing for its medical literature. Following precedents set in other important activities, as an expeditious move towards the desired production of superior Canadian medical text books I suggest that a conference be held of representatives from the medical colleges of Canada to procure united and harmonious action. I trust there are professors of high scholarly and professional attainments available to write such books.

Yours truly, LUCIUS S. OILLE.

MISCELLANEOUS.

MEDICAL EXCHANGE.

OUR readers who contemplate changing their location would from month to month secure a short cut to their needs by watching the offers of Dr. Hamill on our advertisement page under The Canadian Medical Exchange heading. Some of the best practices for sale sometimes do not appear among his list as they are sold during the interval of the issues of this journal, but if you make your wants known to him you will receive all offers which present by private letter.

FOR PRURITUS ANI.

R Betul-ol (Methyl-Oleo-Salicylate Co	ʒi
Salol	gr. xx
Ol. Olivae	ʒii
Misce ft. M.	

Sig. For external use by painting over the surface.

FOR PAINFUL STIFF JOINTS, SPRAINS AND MUSCULAR RHEUMATISM.

R	Olei Terobinth	ʒiii
	Botul-ol	ʒii
	Acid. Oleici	ʒii
	Menthol.....	ʒi
	Sp. Vini Rect.....	ʒiii
	Misce ft. lin.	

Sig. For external use by friction, or if too tender, applied to any muscular part of the body, as this liniment will be easily absorbed by the skin and carried by the circulation to the seat of the lesion.

SANMETTO IN ENURESIS AND ATONIC OF THE GENITO-URINARY ORGANS.

WESLEY H. Watson, M.D., Cincinnati, O., has used Sanmetto for the past eight years, and can truthfully say that it has been an aid in practice, in such cases as enuresis, catarrhal trouble and atonic conditions of the genito-urinary organs. In every case where it was used faithfully it proved to be a potential remedy.

BOVININE IN SKIN GRAFTING.

DR. T. J. BIGGS, of Stamford, Conn., speaks highly of Bovinine in skin grafting. The part to be grafted is prepared by means of a skin curette, and a Thiersch pack for 24 hours. A bovine pack was applied for 24 hours, and kept wet with it. The grafts were then placed and fastened with strips of perforated rubber tissue. Over this was placed sterilized gauze saturated in bovine and a bandage applied. The dressings were kept wet with bovine for a number of days, until the grafts became united.

THE TREATMENT OF PAIN.

CONSTANT demands are being made upon the members of the medical profession for something to relieve pain. Dr. Hugo Eugel, in the Boston Medical and Surgical Reporter, speaks highly of Antikamnia, for all kinds of pain. He gives gr. V. and in ten minutes, a second dose of a similar amount, followed in ten minutes by a third dose if required. He has found this method very valuable in all forms of pain.

PARKE, DAVIS & COMPANY'S PRICE LIST.

THIS firm recently issued a very complete list of their Preparations and their Prices. A copy was sent to every physician in Canada; but if any one did not receive one, a duplicate will be gladly forwarded on receipt of request.

FERROLEUM, LONDON OFFICES.

MR. F. M. TUCKETT, representing Ferroleum, has opened offices at 86 Clerkenwell Road, E. C. He extends a cordial invitation to physicians, visiting London, to call at these offices, when he shall be glad to do what lies in his power to entertain such visitors.