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MARITIME MEDICAL NEWS

A MONTHLY JOURNAL DEVOTED TO
MEDICINE & SURGERY

VOL. XIX. HALIFAX, NOVA SCOTIA, OCTOBER, 1907. No. 10

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THE MARITIME MEDICAL NEWS

VOL. XIX, OCTOBER, 1907, No. 10.

Open Air Treat- In the course of a paper ment of **Pneu-** entitled "Clinical Re- monia. marks on the Open Air Treatment of Acute Pneumonia, in the *British Medical Journal* of August 31, G. E. Rennie reminds us that pneumonia is an acute infection rather than a true respiratory disease. The pulmonary signs are to be regarded as a manifestation of the local reaction of the body tissues to the invading organism. We know of no specific remedy, so treatment must be directed to strengthen the defensive mechanisms. The two chief indications in the treatment of acute pneumonia are to sustain the heart in the conflict with the toxins of the pneumococcus, and to assist in the aeration of the blood. Following the suggestion of Northup, the author has been using the open air method, and this best meets these two indications. He has treated twenty cases in this way, of which but one resulted fatally, and that was in the person of an old man, who was practically moribund when he came under treatment. The patient is placed on a veranda or balcony, with a screen so placed as to prevent cold winds from blowing directly on him. Under this treatment the disease runs a comparatively mild course, and little else is needed. Frequently the crisis occurs within two or three days.

*

Pelvic Intec- W. W. Taylor, in an tions in article contributed to Women. the *Memphis Medical Monthly* for February, finds the first essential in the treatment of an acute

infection of the Fallopian tube and ovaries or pelvic peritoneum to be absolute rest in bed. Mild purgatives should be given. Ice should be applied externally more or less constantly; opium to relieve severe pain. By these means most cases will be cured. In the chronic cases we must rely largely on general treatment, it being of more value than local. Cases requiring operation are those in which there are well-defined abscesses, those which get worse in spite of palliative measures, all cases that have repeated attacks of pelvic peritonitis, cases with a persistent tumour in the pelvis, with repeated acute symptoms, more or less continuous pelvic distress, and which affect the general health, cases that have resulted in fixed displacement of the uterus and ovaries.

*

Glycosuria and In a paper which ap- Surgery. peared in the *Journal of the American Medical Association*, September 7, A. E. Halstead discussed the relation between traumatism and certain surgical diseases and sugar in the urine. After noticing the work of Redard, Hadke and Kausch in this line, he reports his own observations. He has examined in this regard 50 cases of fracture, six of them fractures of the vertebræ. In three of the latter sugar was found; in two directly after the injury, one patient dying on the second day and the other on the third day. The third glycosuric patient died on the twelfth day; all the non-glycosuric patients lived over two

weeks. Of the remaining 44 patients, all of whom had simple fractures—6 had sugar in the urine for periods of twelve or fourteen days; in none were there other signs of disturbed sugar metabolism or was the healing of the fracture influenced. The chief significance of these observations, in his opinion, is in their pointing to shock or cerebrospinal concussion as the principal cause of the condition. Such ephemeral glycosuria does not seem to have any influence on the healing of the injury. Nevertheless, he would postpone operations that are not imperative until the disappearance of the sugar. A more permanent glycosuria might possibly result from the shock of operation or the anaesthesia, and the chances of non-union be greatly increased. The secondary transitory glycosuria due to drugs or infection does not seem to affect the prognosis of surgical infections greatly, but, according to Halstead, it should cause the postponement of major surgery, while the needed measures for its relief are being carried out. It is not a contraindication, however, to necessary minor surgical procedures, but rather the reverse. In long-continued suppuration, the possibility of a secondary glycosuria becoming permanent must be kept in mind. In erysipelas, sugar in the urine is of serious prognostic moment, as an index of the severity of the infection. In diabetes, imperative operations have to be risked, and, from his review of the evidence, Halstead does not think that we can always take the quantity of sugar excreted as a guide to the safety of an operation. Other substances, acetone, diacetic acid, etc., indicate a greater danger of coma than any quantity of sugar alone. He would try a thorough course of treatment in case a high percentage of sugar is

present, before performing any operation that can be postponed. Under aseptic conditions, except in the lower extremities where the circulation is likely to be impaired, wounds heal readily in diabetes. The dangers incident to infection, however, are increased and operations that are avoidable should not be considered. Too much stress can not be laid on the importance of a rigid course of preliminary medical treatment. Inhalation anaesthesia, even by nitrous oxide should be avoided so far as possible. In case operation is unavoidable ether is the least, and chloroform the most harmful. Local or regional anaesthesia should be the form employed whenever possible. Halstead insists on the importance of prophylaxis as regards gangrene in diabetes. The danger of infection of even insignificant abrasions should be impressed on the patient, and corns, warts and calluses of the lower extremities should receive careful attention and should be treated only under the most rigid antiseptic precautions. When gangrene has occurred, the question when and where to operate is of importance, and the condition of the arteries will have to be considered. When the gangrene has reached the dorsum of the foot, obstruction of the popliteal at its bifurcation has possibly occurred, and amputation above the knee is always to be advised. A general anaesthetic is unnecessary in most cases as spinal cocainization will generally suffice.

Exophthalmic Goitre

E. S. McKee contributes to the *Lancet-Clinic*, the following resume of the symposium on exophthalmic goitre, at the last meeting of the American Medical Association: Physiology of the thyroid gland in

its relation to exophthalmic goitre was the subject dealt of by Dr. S. B. Beebe, of New York. He said that recent work had shown that the thyroid belonged to the so-called vital organs. It had been shown that heavy feeding of meat would cause convulsions earlier after parathyroidectomy than before. Pathology of exophthalmic goitre was the subject of Dr. W. G. McCallum, of Baltimore. Thyroid, lymphoid and thymous changes were the only ones constantly observed. Thymus was usually considerably enlarged. Dilatation of the veins was usual and very characteristic. Color an opaque gray. The acini were usually lined with characteristic high cylindrical epithelium instead of the flat form of the normal cell. Diagnosis of exophthalmic goitre, by Dr. L. F. Barker, of Baltimore. Tachycardia was the most constant symptom, the heart always running above 90 and sometimes approaching 100. The exophthalmos is the most striking symptom, though absent in about one-third of the cases. A differential diagnosis was arrived at by the use of the ophthalmometer as to the character of the exophthalmos. The tremor, if present, was bilateral and continuous. Tremors are so invariably present that some had considered them as the fourth sign. The medical treatment was discussed by Dr. R. B. Prebel, of Chicago. He directed treatment to the correction of neuroses and of individual symptoms, and to the improvement of thyroid metabolism. Rest, physical, mental, general and complete. Electrical and hydropathic treatment undoubtedly act only by suggestion, and these patients are specially liable to suggestion. Dr. Albert Kocher, of Bern, Switzerland, discussed the surgical treatment and spoke of the experience of his father and himself in 3,640

operative cases. In the last 91 operations there had not been a single death, and before this the mortality was only 3½ per cent. A careful study of the heart and the blood pressure was of the greatest importance. The degree of intoxication was important, and also the examination of the blood. He found lymphocytosis present, but nothing was known as to its cause. Eighty-three had been cured, some of these as long as seventeen years without recurrence.

*

Diagnosis of Appendicitis. E. S. Bailey, writing in the *Clinique*, thinks that the following from the pen of J. B. Murphy, concerning the diagnosis of appendicitis, is too valuable to be allowed to rest where the practicing physician cannot see it; it deserves to be printed over and over again.

Following up an experience of operating in more than two thousand cases, Dr. Murphy says: "The symptoms of acute appendicitis are, in my experience, in the order of their occurrence: (1) Pain in the abdomen, sudden and severe; (2) Followed by nausea or vomiting; (3) General abdominal sensitiveness; (4) Elevation of temperature, beginning from two to twenty-four hours after the onset of pain. These symptoms occur almost without exception in the above order, and when *that order varies I always question the diagnosis.*" (Italics by Dr. Murphy.) Others items in his paper are concerning temperature; in acute appendicitis it must always be present. It never precedes the pain. In two thousand cases it was always present in the early stage of acute appendicitis.

Radical Cure of Hernia.

W. T. Bull and W. B. Coley, in the *Journal of The American Medical Association* for September 29, give an account of the experience at the Hospital for Ruptured and Crippled, in New York, since the introduction of the Bassini and Halstead methods of the radical cure for hernia. They call attention to the fact that the modification of the Bassini operation in the male, often called the Ferguson operation, was used by them as early as 1892, and also discuss the charge that most of their patients were children; it is true that a majority (1,034) were children, but they have operated on 900 adult patients and have found very little difference in the results. In the 900 adults there have been 13 relapses, 1.4 per cent. Most of the Bassini relapses occurred in direct hernia cases in which the only way of closing the opening above the pubic bone is by transplanting the cord cases very difficult to cure by any method. Hence we have a larger proportion of relapses credited to the Bassini operation than would be the case were the direct hernia operated on by the non-transplanting method. They emphasize the necessity of absorbable suture material and say that dividing their cases into two periods, those before the use of rubber gloves and those after, they find a distinct improvement has followed the use of the gloves. They are also inclined to accept Hamilton Russell's view that all inguinal hernias, except the direct, are due to a preformed sac or unobliterated portion of the processus vaginalis. They would, therefore abandon the terms "congenital" and "acquired" and use instead the classification of total or partial funicular sacs. The authors are inclined to believe that many children under four

years old with hernia, can be cured by a properly applied truss, and that there is little risk of strangulation in these cases, while the risk of operation is decidedly greater than in older children. If a child has reached the age of three or four years and still has hernia, they advise operation. In children over four, they do not advise preliminary truss treatment, as the chances of cure are less and those of relapse greater. Truss treatment is never advocated for femoral hernia. Umbilical hernia can nearly always be cured by mechanical means: the authors use a pad kept in place by adhesive plaster and changed every week or ten days. This treatment may have to be kept up for one or two years. Trusses are seldom of much use as they are very hard to keep in position. An analysis of the 2,032 operations for the radical cure of hernia performed at the hospital between May, 1890, and July, 1907, is given: 1,902 were for inguinal hernia, 76 for femoral hernia, and the others for umbilical, ventral, epigastric and lumbar hernia. In femoral hernia the usual operation was simple closing of the femoral ring with a purse-string suture, after high ligation of the sac and removal of overlying extra-peritoneal fat. The results of this method are entirely satisfactory in the author's experience. They have operated on 114 cases of undescended testis, 25 of which were of the inguino-superficial variety, which they believe to be much more common than has been supposed. The mortality in the 1,978 cases of inguinal and femoral hernia was only 5, or 0.25 per cent. Details of the fatal and relapsed cases are given.

Smallpox and Vaccination. The *Canada Lancet* states that Dr. C. A. Hodgetts, Secretary of the Provincial Board of Health for Ontario, says that 95 per cent. of the cases of smallpox reported to the Board occurred in unvaccinated persons, and of the remaining 5 per cent. very few cases developed in persons who had been vaccinated within five years. The same journal is responsible for the statement that "there are as many cases in Toronto at present as in the German Empire for the whole year, with nearly sixty millions of people. The one is an evidence of the folly of not insisting on vaccination, and the other of the wisdom of that course."

Splenectomy and Immunity. N. Biagi (*Lo Sperimenale*, Florence, 1907, p. 295) discusses at some length the literature dealing with the power of increasing the body's resistance to disease, which is attributed to the spleen. He has removed the spleen from 9 dogs, in each case examining its blood reactions before the operation, and afterwards on several occasions. He finds that the hæmoglobin content, the leucocytic formula, and the resistance of the red cells are not altered by splenectomy; the operation does not affect the formation of hæmolytic, bacteriolytic, or agglutinating substances by the blood. Spleenless dogs are rather more readily killed than normal dogs by the rapid anæmia produced by the injection of hæmolytic immune serum. Biagi believes that the hæmolytic complement for the destruction of the red cells is derived from the large mononuclear leucocytes. He adds that the operation of splenectomy is not nearly so dangerous as it is commonly believed to be, nor

so liable to dangerous sequelæ.—(Epitome, *British Medical Journal*, September 28, 1907.)

Tuberculin Treatment. Karl Von Ruck, in the *Medical Record* of September 7, summarizes the results of sixteen years' treatment of tuberculosis with tuberculin. He has for many years observed no bad effects from the treatment, but rather great benefit. The products of the tubercle bacillus act in a truly specific way by inducing antibacterial or anti-toxine immunity. The limitations of the treatment arise from degeneration of tubercular tissues. The specific treatment will arrest the action of the bacilli and prevent further degenerative changes, but it will not restore advanced changes or remove necrotic tissue or inflammatory products. It cannot remove the bacterial bodies from caseous tissue, or prevent softening and exfoliation. The author tabulates his cases, of which he has treated 1,893 in the past sixteen years, and compares them with a series of cases treated by private physicians. As to the permanency of his results in the first stage, 91.4 have not relapsed. Of the second stage cases, 80.1 per cent. have had lasting results. Of the third stage cases, 37.4 per cent. are still living in good health.

Prevention of E. Marvel, (*Journal of the American Medical Association*, September 21), recommends the use of adrenalin chlorid after separating peritoneal surfaces to prevent readhesions. He allows the solution to flow from an irrigating nozzle over the oozing surface. The natural method of preventing adhesions is removing the exudation by absorption and the peri-

toneum can take care of it, but subsequent exudation should also be prevented. By its vasoconstrictor action, adrenalin shuts off further leakage, and the normal salt solution in which it is dissolved also serves to keep apart the separated surfaces. He uses a dram of the adrenalin chlorid solution to one quart of normal salt solution, making approximately a strength of 1 to 50,000; the temperature ranges 100 to 110 F. and the amount used varies from 500 to 1,500 c.c., according to the size of the cavity and the extent of the adhesions.

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International Congress on Tuberculosis. It is announced that the International Congress on Tuberculosis will hold its next meeting in Washington, September 21st to October 12th, 1908. The American Committee, upon which the responsibilities for the arrangements rest, is composed of eminent men who will unquestionably effect a thorough and successful organization. Those who desire to participate are invited to correspond with the Secretary-General, Dr. John S. Fulton, 810 Colorado Building, Washington.

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Halifax Medical College. The session recently commenced promises to be a particularly successful one. The attendance is larger than it has been for several years, the freshman class being a notably large one. There are thirteen in the senior class.

*

Number of Medical Students. The total number of medical students in the United States for the year ending June 30, 1907, was 24,276, a decrease of 928 below 1906, and a decrease of 1,871 below 1905. Of the total number of students, 22,303

were in attendance at the regular schools, 1,039 at the homeopathic, 545 at the eclectic, 97 in the physio-medical and 292 in nondescript (unclassifiable) schools.—*Journal of the American Medical Association.*

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Hospitals and Diffusion of Professional Knowledge.

Not so very long ago, in this country, at least, hospitals were confined to large centres of population and drew their patients from very extensive surrounding areas. Quite a different state of affairs obtains at present. The growth of the "hospital idea," not only in the profession, but among the laity, has been one of the most notable and significant changes in social sentiment during the past half-century. Now, no town of any considerable size thinks itself at all properly equipped in a municipal way without its hospital. We have no exact figures on the subject, but have little doubt the number of these institutions has multiplied two or three times in the past two decades.

These reflections are induced by some remarks made in the Presidential Address at the recent resumption of the sessions of the St. John Medical Society. Dr. Lunney deplored the fact, that, as at present constituted, so little of real value in the way of scientific information, to the profession at large, emanates from the centres of medical and surgical activity. Of course, he referred more especially, perhaps exclusively, to the hospital in his own city. While this is the fact, it is probably sufficiently true of all to make a reference to it not unworthy of general interest. Nearly every one in the profession knows he is generally welcome at such institutions to witness operations in progress, and to glean what know-

ledge he can from such observations. This, for ages, has been the "stock" reliance of hospitals in the way of a display of their work to those "outside." It is, of course, easy to understand why this should be the case. "Operations" have always been and are probably always destined to be, more or less spectacular in their character, while, almost invariably, they are clearly defined as regards time consumed in performing or observing, and generally, if not always, capable of being brought on at a definite and precise hour. All this is well understood, and doubtless the world of medicine has universally benefitted from such observance.

But, as in the case with every human activity, the obvious and spectacular are by no means all, or even the major part of the work of a hospital, and it was, if we do not mistake, to the routine and every-day work that Dr. Lunney more particularly referred. For example—scarcely a week passes without some new drug, or combination of drugs being introduced to "the market." How many, during, say a year, of the new professional weapons, or processes, or ideas of disease management, or improvements of therapeutic exhibition—or, what not—prove valuable, as worked out by hospital experience? What is the influence of the local climate, or perhaps, weather, upon the frequency or virulence of various classes of disease? What is the measure of success obtained, in the way of prophylaxis, by the effort and financial expenditure of the local Health Boards, as evidenced by the number and type of infective and preventable diseases admitted to the wards? These are a few, and, very likely among the

least important of very many invaluable facts that might be elucidated, from time to time, by every hospital in the country, no matter how small.

But, it will doubtless be urged, such work would turn such institutions into "experimental laboratories," while their almost exclusive function is the care and cure of the sick. This objection, though plausible and almost sure to be made, is superficial, and, in reality, of no weight. All such information as exemplified in the foregoing, and a thousand things besides, is, at all times ready and waiting, lying at the very hands of the officials, and only needing to be garnered, sifted, sorted and properly tabulated to be of inestimable value to the community, especially, if called to the attention and placed in the hands of the profession generally.

In connection with the address referred to, it was more especially suggested that such material would be most useful and interesting in the hands of the society. Not one dollar, or one hour of time, need be given for the express purpose of *producing* or *creating* such knowledge. The ordinary work of each institution does this from day to day, and from week to week. At present, it is largely lost, simply because it is not gathered up (perhaps not always observed) and made use of.

It will also be objected, that hospitals already publish and tabulate records of their work; but these remarks have lamentably failed in the way of clearness and perspicuity if such reports, taken in the average, be held to fulfil the conditions here touched upon.

PRESIDENTIAL ADDRESS.

By ALEXANDER McPHERDAN, M. B.,

Professor of Medicine, University of Toronto.

Delivered at the Fortieth Annual Meeting of the Canadian Medical Association,
Montreal, September, 1907.

IT is my first duty, as well as pleasure, to acknowledge my deep sense of gratitude for the honour you have done me in electing me to the chief office in this Association. I have experienced the unusual courtesy of an election for a second term. This, however, may not imply a compliment but rather a reprimand and an injunction—a reprimand for duty left undone, and an injunction to be more diligent in the discharge of duties of this high office, not to neglect the opportunities nor evade the responsibilities pertaining thereto. If so, I freely acknowledge the justice of the censure. The Presidency has been held by several of the ablest physicians this country has produced, and to succeed such men would be an honour to any one. It would, however, have been in the interests of the Association and much more in accord with my own feelings, had the by-law been observed, which requires that the president be elected from the city in which the meeting is to be held. In justice to Montreal this should have been done, as then some of our difficulties would have been avoided, and such honour as pertains to the position would have been bestowed where it belongs.

However, under the circumstances it is my pleasing duty to gratefully acknowledge the cordial sympathy shown by our Montreal friends, a generous cordiality in keeping with their well-known character. I can only most sincerely thank them for their cordial good-will and co-operation. I hope it will be my privilege

to welcome one of their number as President at the next meeting held in Toronto, when I hope to be able to show evidence of my appreciation of the uniform kindness that has been extended to me here. I wish further to express my great appreciation of the work of the Executive and various committees; the results are evident in the excellence of this meeting.

I may be permitted here to give expression to the deep sorrow with which every member of this Association heard of the calamity that overtook McGill University and Medical Faculty in the loss of their building last April. It is not necessary to assure them of our sympathy. The loss was not McGill's only, but was one also to medical education in this country and on this continent.

We are glad to know that the cloud had its silver lining and that now they are to be congratulated on the near prospect of a magnificent new building than consoled with on the loss of the old one, good as it was. We knew that "Phoenix-like," the institution would rise from its ashes and be greater than ever. As we sorrowed with them so will we all now rejoice with them. We wish them "God-speed."

During the past year several members of this Association have gone to "the bourne whence no traveller returns." Among these were three of the most eminent in the Canadian profession, men of world wide reputation, to whose memory a brief reference is permissible. In this bereavement

this city has to deplore the loss of Sir William Hingston and James Stewart, and Toronto, that of George A. Peters. All three had the common experience of being reared in a hard school, so that success could be attained only by living laborious days and practising the most rigid economy, conditions which often develop as nothing else can, the best that is in a man. Each was a master in his own sphere, each possessed in an eminent degree "the genius for taking pains." Of each it may with truth be said that he was "the noblest work of God, an honest man."

Sir William Hingston was a distinguished type of the surgeon of the old school, a school in which it was essential to possess courage, decision and dexterity. Those of us who were not in close touch with his surgical work were attracted to him chiefly as the man. He was the embodiment of refined courtesy and of frank kindness. He was intolerant only of what was unworthy. We miss the tall, erect, courtly man whom we all loved, and among whose graces there was always such a charm. Canada, in these her yet salad and hoydenish days, can ill spare men of such culture.

James Stewart stood for all that is best in medicine. He was of such singularly quiet and unobtrusive nature that it was only those with whom he was closely associated who knew the riches of both mind and heart that lay hidden behind the simple and unassuming manner. His knowledge of medicine was deep and clear, such knowledge as comes only by living laborious days of self-sacrificing devotion to our Art.

George A. Peters was a type of the best in the modern school of surgery. Among Canadian surgeons, at least, he had no superior, and few

peers. Who could desire higher praise? He was a man of sterling character and rugged honesty, and fearless in his condemnation of what ever was unworthy of the highest traditions of his profession. His was a spirit that no difficulties or dangers could make quail or deviate from the path of rectitude. How vividly in recalling his career we are impressed with the truth of the aphorism of the Father of Medicine: "Art is long and time is fleeting."

I have great pleasure in drawing attention to the fact that Dr. William Bayard, of St. John, N. B., a past president of this Association, completed seventy years in the practice of medicine on the 1st day of August last, and that he is still able, at the age of 93 years, to meet the wishes of many patients by ministering to their wants. His Alma Mater, the University of Edinburgh, on this 71st anniversary of his graduation, showed her appreciation of his character as a man and his work as a physician, by conferring on him the degree of LL.D. This circumstance is, perhaps, unprecedented in modern times; it is, at least, so I believe, in the annals of Canadian Medicine. I have already, in the name and behalf of the Association, extended to Dr. Bayard the greetings and best wishes of the Association. I would suggest that now in Annual Session you authorize me to telegraph the renewal of our high esteem for him and sincere hope that the "eventide" may be calm and without a cloud.

I. RE-ORGANIZATION.

It is just forty years since this Association was organized. The first meeting was held in Quebec under the Presidency of Sir Charles Tupper, one who has since attained such eminence as a statesman. It is

interesting to note that this first meeting was among the largest ones held by this Association—109 being present. At the second meeting, held in this city, there were 135, after that for several years the attendance never reached 100. Even of late years, compared with this first meeting, the Association has not shown the advance either in attendance or work that its founders were entitled to anticipate. However, history has but repeated itself, the higher life, intellectual and scientific, of young countries as of individuals, is always the latest to develop. It is quite possible that to the clear vision of the Fathers of the Association it was evident that its growth would be slow and subject to many vicissitudes, that it would only be after many years of painful struggling that much advance could be hoped for. They doubtless foresaw such advance could come only after the growth of culture, that is, after the conditions of the people became stable and sufficient wealth accumulated at least to give ease, if not luxury to many. For various reasons such a state has been slow in maturing in this country, but it may be said to have now come, at least in the older provinces. Such has been the history of the United States, where only recently science and art have made material advance, and even yet "it is the day of small things" with them in comparison with the development of the natural resources and growth of wealth of that country. Our history will doubtless be similar to theirs, although the indications are that our material growth will be even more rapid in proportion to the population. It is said that, although our population is only six millions, our immigration equals now that of the United States when her population was 40,000,000.

Such great accessions we have good reason to fear, are beyond our country's powers of assimilation.

As a national association we have to bear our part of the great responsibilities imposed upon the country by these great accessions of foreign people and the rapid growth of its material interests. It devolves upon us, as far as possible, to promote the medical and scientific interests of this country so that they may be kept abreast with its material development. This responsibility rests on the older provinces chiefly, as in those there is more leisure and culture. United action on our part will be necessary to cope successfully with these responsibilities and to enable us as a profession to attain and maintain the status in the country to which we are entitled. This country's conditions are unusual. Its geographical extent is very great, and its population as yet only occupies its southern border, extending from ocean to ocean. Community of action as well as of interest will, consequent'y, be difficult to develop and maintain. It seems therefore urgent that all available means should be taken to harmonize the interests of the various parts of the country in order the more efficiently to apply our energies for the advance of general scientific and professional interests. The closer we are in touch with one another the greater should be the stimulus to do higher works; the increased zeal and enthusiasm should yield results which will enhance our reputation as a profession, and also redound to the credit of the country. Every scientific advance, however small, is an asset to the country, both in the intrinsic value of the work itself and in the impetus it gives to further advance. It is difficult to impress laymen, even the best educated, with the

importance of this truth; but that is not a matter of surprise, seeing that we ourselves are lacking not a little in appreciation of scientific achievements. This indifference to scientific and intellectual affairs is due to many causes, chiefly among which is the struggle for existence incident to a young country. This struggle has absorbed so much of our energy that little attention has hitherto been paid to purely scientific matters. Then our training is almost wholly confined to the preparation for purely professional work, and so little research work has been done that our attention has not been seriously directed into scientific channels. The result is that thus far, with a few notable exceptions, we have been content with the discharge of the daily routine of professional duty. That such is the present status of the Canadian profession, few, I think, will deny. The question arises—What is the duty of this Association in relation to such a state of affairs? As the national organization representing the profession of medicine, no one can take exception to the view that it should be the leader in all movements having for their objects the elevation of the status of the profession and the advance of the scientific interests of the country.

In the past the Association has been satisfied with a quiet existence, content to take by the way, anything that was offered, obeying both in letter and spirit the injunction, "take no thought for the morrow." To many, especially of the younger men, living even at our doors it is scarcely known. During the year I have asked not a few to present papers at this meeting who had almost forgotten the Association's existence, if they ever knew of it. It is surely time to awake out of this Rip Van Winkle state, and develop the power of the

Association so that its existence shall be known to the remotest corner of this land. How can this be done? That the present constitution of the Association is inadequate to making any serious effort in this direction, all will agree, and if anything is to be accomplished there must first be such a re-organization as will enable the Association to take effective action on the many important questions that must come before it from time to time. It is only by doing so that we can fulfil the objects which forty years ago its founders had in view. The very existence of this Association imposes on it the duty to consider all questions of national importance. It cannot make good its claim to a national character if it evades the responsibility. While the constitution of the Association at its organization was the best that could be devised to suit the needs of the time, it is but ill-adapted to the greatly altered conditions of the present day. The time seems ripe and the need urgent for a complete re-organization in order to fit the Association to meet the growing demands incident to a growing country, and enable it to occupy its place in the medical world. Even for the continued existence of the Association, it seems necessary to make radical changes in its constitution.

These are some of the motives which, at Halifax two years ago, led the Association to take preliminary steps looking towards re-organization. A committee was appointed to consider the whole matter. Its report is ready for your consideration. The committee in its recommendations has followed closely the constitution of the British Medical Association, the oldest of all similar organizations, and of the American Medical Association, which was modelled

after it, and which has, during the last few years, made such rapid progress in perfecting its organization and increasing its usefulness. Our members are too small and we are too widely scattered across the continent to permit of our following the plan of either organization in its entirety; we must adapt our organization to our own needs. I will leave the report of the committee to speak for itself. The general scheme has been highly approved by the provincial associations of Ontario, Nova Scotia and British Columbia, the only associations before which the question has been presented. It is to be regretted that the scheme could not have been presented before every association and society in the country by some member of the committee.

One of the most important objects aimed at in seeking proper organization, would be the effect that the existence of a vigorous association would have on general medical education. It would enable the profession to bring its opinion to bear on whatever might call for encouragement or amendment. The natural consequences would, not only be an improvement in medical education, but in time a unification of the requirements for qualification in the several provinces. This should furnish a good working basis for general registration for the whole country, a movement that has been so ardently and ably promoted by our distinguished colleague, Dr. Roddick. In view of the fact that medical education in Canada is wholly in the care of the universities, such a basis for registration should be acceptable to all the provinces. There is not a medical school in the country, and therefore no private interests to be considered. I am sure all will regard this as a cause for congratulation. This is the only country in the Anglo-Saxon

world in which such a desirable state of things exists. The Medical Faculties of Dalhousie University in the east, Laval and McGill in Montreal, Queens in Kingston, the University of Toronto in Toronto, the Western in London, and Manitoba in Winnipeg, are all under the control of university courts. This should be a guarantee both of the excellence of the work done and of the certainty of steady advance.

With such conditions it should be possible for the undergraduate in any of these universities to pass from one university to another at the end of any session as seemed to best suit his needs. The requirements in the universities being similar, it would be sufficient for him to present the evidence showing that he had fulfilled these requirements, for him to obtain registration in the institution which he desired to enter. Such an arrangement would lead the several institutions in their own interests to improve as far as possible the character of their work.

If this Association were well organized, embracing in its membership the great majority of the practitioners of the country, and actuated by high ideals, it is not too much to say that, in a few years, it could bring the necessary influence to bear on these universities, and on new ones that may be established, to secure such a general minimum standard of qualification that their degrees would be a passport to legal qualification to practise medicine in any part of the country. If this plan is feasible, and it should be, it is within the "sphere of usefulness" of this Association; this is, in fact, the only organization which can successfully promote such a scheme. Such an opportunity to promote the interests of the country as well as of our pro-

profession, should be sufficient, if there were no other reason, to lead to a proper organization of our forces. This course would not be in the interests of the universities as much as in that of the country, and of this Association as representing the profession. It is much easier to regulate and guide whatever pertains to the welfare of the country in this its early stage of growth, than it will be to gain control after it has developed into a populous country with fixed local interests. In the new western provinces there are some signs of a feeling of antagonism to the older parts becoming evident. There seems to be a fear that they may wish to dominate too greatly the policy of these newer parts. It will take wise management and judicious action to arrest the growth of that feeling, and forestall any attempt that might be made to estrange the sympathy and coöperation of these new provinces. Most of the western profession have been recently graduated from our universities, and should understand us so well that with ordinary judgment it should not be a matter of much difficulty to secure and retain their hearty coöperation in any scheme having for its object the highest interests of the whole country as well as of the whole profession. I say *country*, because we should see to it that the public recognize the fact that this and similar organizations exist for the promotion of what is for the general good as well as for the benefit of those more immediately concerned. The whole is but the sum of its constituent parts, and can be affected for good or ill only through the parts. Therefore, what we, as a constituent part, do to promote our own true interests is of benefit to the country at large. It is highly desirable that the public should realize that the objects of this

Association are not only to benefit the profession, but also, and chiefly, for the promotion of what is for the general good. It is not a "trades union," but a national organization which should have, and has, the nation's welfare for its chief object. It is apparent to all that the country stands in need of all the assistance which this and other agencies within its bounds can bring to its aid, in its enormous responsibility of assimilating the vast numbers of peoples from all nations annually entering its domain, and of developing and maintaining a proper national spirit marked alike by vigour and honour. That she is not coping quite successfully with the difficulties imposed upon her is a subject of common observation. Probably no country developing in population and resources with such phenomenal rapidity has ever been able to prevent, at least temporarily, some deterioration in public morals. It is almost a daily experience to hear some one remark on the decadence of the public conscience. With the large immigration from all parts of the world, and the intense striving after wealth incident to the development of a young country of such large resources, it is doubtless inevitable that there will be some relaxing of the rugged honesty, private and public, of the pioneers of this country, but that there should be even a semblance of ground for the very general charge of moral decadence, is much to be deplored. As loyal Canadians we have a profound interest in this matter. Public morals cannot be degraded without affecting unfavorably all classes, so that in our own interest as well as that of this land which we love, to which we return from our pilgrimages year by year with an ever-increasing affection and pride, and for which, if need be, we would yield our heart's blood, we

should be constrained by duty as well as by loyalty to use our utmost efforts to stem the downward tendency. In such an effort the Association has a part to perform; in order to perform that part effectively it will require to be furnished with every facility with which we can provide it.

Hitherto the Association has been content to minister to the wants of the general practitioner in its two sections of medicine and surgery, but we have reached a stage when it should afford facilities also for the encouragement of all classes of special work. The field of medicine is so broad as to render specializing necessary. While all should possess sound, general knowledge, none can be masters in more than a few branches at most. This year a first step has been taken in extending the work of the meeting by the formation of a Section for Laboratory Work. With a more vigorous association other sections will be necessary in order to bring out the best work in the various departments. An omnibus meeting never accomplishes much that is of the highest value. Men will not do their best work unless there is an opportunity of presenting it to such as are specially qualified to appreciate its value. While there are many questions in all specialties that the general meeting are quite able to discuss, and which should, as far as possible, be there presented, there are others that only those specially trained are able effectively to criticise and judge of their merits. The announcement is just made of the Eighth Medical Congress in Australasia to meet next year. It is to consist of eleven sections. With more than double their population we should be quite as capable of maintaining meetings with as many sections, in which the work presented would be of the highest order. I need not specify what addi-

tional sections should be formed. The widespread prevalence of contagious diseases indicates the necessity of directing even increasing attention to sanitation. Regarding tuberculosis there is a great awakening on the part of the public, but as to typhoid fever there is amazing apathy both in city and country. The formation of a section of state medicine seems therefore very desirable. Many other sections might be formed with great advantage to the Association's usefulness.

Another matter demanding the prompt and earnest consideration of this Association is the nostrum evil. Our friends to the south have been waging an increasingly active crusade against this evil during the last few years, and duty to the public no less than to our own interests demands that our action be prompt and energetic. The public do not understand the matter, and have no conception of the enormous injury done to their best interests. Those among them who give serious thought to the matter hold us responsible for their education in this question. I scarcely see how we can ignore the responsibility without detriment to our own interests as well as to theirs. They will be ready once they understand the matter to aid in suppressing it or mitigating it when it cannot be wholly eradicated.

There are many other questions that might fairly claim attention, such as intemperance and the cure of the inebriate, the physical training of the young, the medical inspection of schools, etc.

The educational authorities of the United States have just reported that 12,000,000 school children—one-third of their whole school population—are suffering from physical defects. Many of these are easily remedied, e.g., malnutrition, defective breath-

ing and vision, and enlarged glands. The nation has a vital interest in the condition, physical and mental, of its children, and it is for this Association to point out the way that these matters should be dealt with.

A JOURNAL.

The second need of the Association is an official journal. It is essential for several reasons. In the first place, the Association's constituency is a very large and sparsely settled one, and it appears necessary therefore that there should be a regular means of communication established in order to maintain a community of interest and an avenue through which the needs of all may be made known. Without such a means of communication it will be difficult to develop a truly national spirit, and unify the interests of the medical profession in Canada.

In determining on such a venture we would not be entering on untried grounds, as we have the example of the two great Anglo-Saxon associations to guide us—the British, and the American Medical Associations. Neither of these associations could possibly have attained a tithe of its present usefulness without its own journal. In fact it is doubtful if they could have continued to exist, at all events they would not have been able to wield the power and influence they now possess. I do not forget that our numbers are relatively small. Still there are over 6,000 physicians in Canada, a constituency surely large enough to maintain a monthly journal of first class character, second to none published either on this continent or in Europe. It should be elastic enough to admit all good contributions offered. Such a journal would, in a short time, attract the bulk of the best work done in Canada, and would thus become a med-

ium to which other countries could turn to learn of the scientific medical work of this country. Hitherto all the work done here has been published through British or United States channels, and has gone to the credit of these countries. We are loyal Greater Britons. We must at the same time be loyal local Britons,—that is, Canadians. We cannot be truly loyal to the greater without being supremely loyal to the less, and it is by our loyalty to our own country that we can best show our devotion to that Nation of which we are rightly proud of being a part.

It requires no argument to prove that with a first-class journal a great impetus would be given to scientific work, and that the position of Canadian medicine would be greatly improved in the estimation of the scientific world. The other sciences would also indirectly share in the benefit, because no class of scientific work can be improved without having the influence reflected upon others.

Such a journal should also be made to meet the needs of the general practitioner, the "bone and sinew" of the profession. A section could be devoted specially to their interests.

The expense has been regarded by some as an insurmountable obstacle. Australia, with less than half our population, has published for years a creditable monthly journal. Can we not do as well? If every member here invested a small amount in such a venture, to be paid back, without interest, when the funds became available, say five, or even ten years hence, it would be one of the best investments they ever made. Such an investment would bring an assured annual return, first, in enhancing the *esprit de corps* and improving the tone of the Canadian profession; second, in creating in us a greater appreciation of our own work and

capacity, teaching us that the home product is equal to that of any other country, a lesson we sadly need to learn; and, thirdly, in stimulating all, especially the young men, to do work of ever-increasing merit, and so add to their own and the country's reputation.

In advocating the establishment of an official journal, I wish it to be clearly understood that no disparagement of existing Canadian journals is intended. However excellent these journals may be, each can only serve its own locality and special *clientele*. It is not possible for any private journal to reach all the Canadian profession, and even if it did, its influence would be much less than that of the Association's own journal. The interests of the private journal, being local and special, should not be infringed upon by an Association journal whose work would be identified with the general interests of the profession of the whole of Canada as well as the promotion of medical science. Anything like a monopoly of the journalistic field is not desired. The aim is not only to stimulate all to do better work and to promote the interests of medical science, but also to bring all the members of the profession into closer touch with one another, so as to further the national spirit and greatly increase their influence in the country, and to enable them to bring their united influence to bear on all matters of national importance. These interests are quite apart from, and should not in any way conflict with, those of the private journals.

I am convinced that a journal is a necessity, if not to our existence, at least to our success. I have full confidence in the ultimate success of our efforts, if steps are taken to establish such a journal, and that within a few years at most, we will have a journal

equal in merit to the best, and in which our ablest men will be more than willing to publish their best work.

Some fear we cannot cope with the difficulties of developing and maintaining such an active organization as I have outlined, or of publishing a journal worthy of our Association and of the Canadian profession. That the difficulties will be considerable no one doubts; still these difficulties can be successfully met by the Canadian profession—a profession whose members are, it is no boast to say, physically and mentally the peers of the best in the world. A survey of this audience should be sufficient to convince any doubter, and this audience is but a fair representation of the great body of physicians scattered across this country from the Atlantic to the Pacific. Great as the difficulties will be I have full faith in our own powers to overcome them. We need but united loyal action to attain a success that will gratify ourselves as well as our friends.

Some will say that these views are chimerical, but to me they but feebly outline the possibilities which lie before us. A few years ago had any one said that this country would now be developing materially with the present phenomenal rapidity, that it possessed such extensive acreage for the growth of wheat and other grains, that it is so rich in mineral wealth, and that it could afford homes for the many millions of population which we now know it is capable of providing, his views would have been scouted as too visionary to merit serious consideration. The venerable Lord Strathcona, whose sagacity excels even his buoyant hope, and who knows this country as perhaps no one else knows it, has just been credibly reported as saying that he believed

this country by the end of the current century will have a population of 80,000,000.

A recent writer, whose book has been most favorably received, who came from England as an immigrant, and remained six or eight months traversing the country from coast to coast, mingling with the masses, and working in forest and field, so as to make a thorough study of the country, says it is quite capable of sustaining a population of 140,000,000. May we not personally look forward to something like a corresponding development on the literary and scientific side?

One of the most potent causes which have retarded the development of Canada in all its aspects—in population, industries, literature, science, national sentiment—has been its proximity to the Motherland and to the strong nation to the south of us. We have been overshadowed by both, perhaps a little overawed, so that we have feared to assert our manhood. But it is to inertia rather than fear that the slow growth of national spirit is due. We have had facilities of all kinds desired close at hand in those two great countries, so that we have been saved the trouble of developing our own resources. But the dawn of a new development has come, and Canada is known the world over as the "land of promise." Are we to be laggards in this national awakening? No one who knows the Canadian profession will doubt the answer.

It is for us to consider whether the profession is to be provincial or national in its character and aspirations; whether it is to consider questions from a provincial, even parochial, point of view, or occupy a higher plane and regard matters in a broad, national spirit, and so take its place and assume its responsibilities as one of the forces moulding the des-

times of the nation, feeling that it has especially committed to its care the development of medical science in its highest character. It may be said that this is too high an ideal. We must not forget that the higher the ideals, if we try to attain them, the greater the success. However, I cannot regard the ideal as too high, but rather that it but faintly indicates all the future holds for us if we are but equal to the demands of the present and grow with the increasing needs of rapidly growing conditions. With a united and courageous association, embracing the whole profession of this country and actuated by high ideals of our duty and of the needs of the country, I have every confidence that the results would far exceed our highest anticipations. Such success, however, can be attained only by earnest united effort. "In Union there is Strength." To the multitude, whether the Nation or Association, as to the individual, true greatness comes only by unremitting toil, energy, and intelligence directed by the highest motives and ideals. To all who so pursue their vocation whether crowned with apparent success or not, true greatness comes in proportion to their deserts. Ours will be no exception to the universal rule.

We are citizens of a giant young country of inexhaustible resources, entering on the threshold of its greatness and power, blessed with an invigorating climate which should produce a virile race such as no country ever excelled. Such is our heritage. You know that "to whom much is given, of him also shall much be required." That we *can* meet these our responsibilities, so as to fulfil the requirements, I have the fullest faith; that we *will* meet them successfully, remains for all, especially the younger members of the profession, by their effort and work, to prove.

PRESIDENTIAL ADDRESS.

By R. H. BURRELL, M. D.,

Lunenburg, N. S.

Delivered before Lunenburg-Queens Medical Society, Riverport, N. S., August 31, 1907.

THIS is preëminently the age of preventive medicine, and while numerous bacterial diseases have fallen or have materially decreased beneath its magic sway, there remains one microörganism which has not altogether succumbed to the advances of preventive medicine, and that is the microörganism which is responsible for the ravages of that malady known as the presidential address.

In the first place I wish most heartily to express my gratitude to the members of this society for having reposed sufficient confidence in me to place me in the proud position which I occupy to-day, and from which eminence I propose to inflict these few remarks. I am not unmindful that in occupying this position, I follow a long line of illustrious presidential ancestry. I shall endeavour to uphold the dignity and traditions of the office to the best of my ability.

There are several matters, some of which appertain to technical subjects, and others of a more or less general nature, which may well engage the attention of the perpetrator of a presidential address. According to the programme, we are to have some such matters touched upon by those who are to follow me. In view of these circumstances, it has occurred to me that a retrospect of the year's happenings, and a pseudo-prophetic utterance regarding the future, might well form the subject matter of my remarks on this occasion.

It is the first time in the history of the society that we have met with our

brethren at Riverport, and I am sure that in this respect our society starts the year's work under most favourable auspices. It affords me, as I am sure it affords us all, great pleasure to meet in this thriving village, and to view from this standpoint the gleaming waters of the beautiful LaHave, the "Rhine of Nova Scotia." I shall never forget my impressions when on one bright sunshiny morning in May, 1900, I first viewed the river in all its grandeur and sublimity. I was driving along what is known as the River Road, when from the top of the hill overlooking Corkum's Ferry, I beheld a vista which has become indelibly impressed upon my mind. To describe it adequately would require the brush of an artist and the pen of a laureate.

Since the last presidential address was delivered, several events have occurred which are of particular interest to the members of this Society. One of our number who was with us on that occasion, has during the interval spent some months in the metropolitan centres of English and American Medicine, and returns to us to-day to give us his impressions of the work seen and done at these great centres.

Another, who has been absent from us somewhat longer than the first mentioned, returns to us to-day fuller of honours than of years, and on behalf of this society I welcome him to his native land, to the county in a certain section of which he so successfully laboured, and to the society in whose deliberations he took

an active part. Furthermore, I congratulate him on behalf of the society, on having attained a Fellowship in the Royal College of Surgeons, a distinction attained by few on this side of the water, and which we know he will carry with equal pleasure to himself and honour to the fraternity. To both these gentlemen we extend a hearty welcome, and we shall be pleased to listen to them at the close of these rambling remarks.

The Lunenburg-Queens Medical Society has during the past year been instrumental in bringing about, and in fact, largely responsible for the amicable arrangement of life insurance fees which prevails in this province to-day. While in the minds of some of us the ideal has not altogether been reached, there has been at least a working basis established upon which the profession may confidently rest. Unfortunately there remain a few of our profession who place pocket above principle, and, as long as these remain, the glorious millenium of a five dollar life insurance examination fee will be more or less indefinitely postponed. This might well form the nucleus of an address on medical ethics, but on this occasion I shall forbear.

I am sorry at this time that I have to say that prophetic utterances of former presidents of this society regarding the treatment of tuberculosis and the establishment of a county hospital, have not yet been fulfilled. In this county, possibly more than in any other county in Nova Scotia, there exists the need for a vigorous anti-tuberculosis campaign. If 600 deaths from tuberculosis per annum is a conservative estimate for the province as a whole, I think 40 or 50 deaths per annum is not too large an estimate for this county. In the absence of reliable vital statistics, it is impossible to make any definite state-

ment regarding the matter. It is, I think, a safe estimate that in the practice of every active practitioner in this county, there are two deaths per annum from some form of tuberculosis, but mostly pulmonary. The great need is a haven where advanced cases may be placed at the public charge, or at least in an institution sufficiently well endowed to permit of free admission and treatment of this class of patients, which after all is the most dangerous source of infection. The difficulty might be met by having a special wing or pavilion attached to the County Poor's Asylum, and practically regulated in the same way with regard to medical attendance and nursing.

Then again, for incipient cases there should be a separate institution to which patients (free or pay) may be sent, and in addition to being treated, be taught to look after their own and their neighbors' physical welfare, and thus to spread the gospel of cleanliness, fresh air and sunshine, broadcast over this fair land. To this end I would suggest and strongly urge the formation of a Lunenburg-Queens Anti-Tuberculosis League at the earliest possible moment.

There is also the matter of a County Hospital, or what is really more to the purpose, a small Cottage Hospital in each town in the county. Apart from making work less irksome for the medical men, it would act as a sort of educator to the people. The old-fashioned idea that a hospital was a sort of respectable slaughter-house or a pest-house, over the door of which was written "All hope abandon, ye who enter here," is becoming more or less eradicated, and people are beginning to realize that we medical men are not such monsters after all, and if they do even half they are directed to do they may lead a fairly comfortable existence.

Public sentiment regarding matters medical and sanitary is largely like public sentiment regarding other matters. It is based purely on public knowledge of the matter in hand. Educate the people; keep hammering the tenets of preventive medicine into them on every possible occasion. If we aim at the stars we shall surely strike the tree tops, and finally we shall reach that golden age when disease shall be the exception, and our efforts be largely spent in regulating the living conditions of the healthy and vigorous. These matters I realize have been treated in a more or less idealistic manner, but we must keep our standards high. Upon the general practitioner in the country falls the greatest burden. He must make early diagnosis in cancer of the stomach, he must advise early operation in acute appendicitis, and if inconvenient to get a surgeon, must attempt it himself. He must be capable of performing Cæsarean section at a moment's notice. In any case the blame of a fatal issue is laid at his door. He must advise the young mother how to rear her infant to best advantage; he must give sage advice to the young man or woman about to embark on the sea of life; he must endeavour to guide the youth of his section in the proper political path; and in many instances he must guide the moral, social and physical forces of a community, and to the best possible advantage. That he has in days that are gone proven equal to these things, and as well found some spare time for a little original research, witness the great Jenner, the discoverer of vaccine. He fought his way through obloquy and ridicule on the part of his professional brethren as well as the public, until to-day and in fact for many years, his is and has been one of the brightest stars in the

medical firmament. We are constrained at this time to refer to and to quote Robert Louis Stevenson's famous appreciation of his favorite physician, Thomas Bodly Scott, of Bourne-mouth. "There are men and classes of men that stand above the common herd; the soldier, the sailor and the shepherd not infrequently, the artist rare'y, rarer still the clergyman; the physician almost as a rule. He is the flower, (such as it is) of our civilization; and when that stage of man is done with and only remembered to be marvelled at in history, he will be thought to have shared as little as any in the defects of the period, and most notably exhibited the virtues of the race. Generosity he has such as is possible to those who practice an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments, and what are more important, Herculean cheerfulness and courage. So it is he brings air and cheer into the sickroom and often enough, though not so often as he wishes, brings healing."

Ours is after all a great heritage. We are the heirs of the ages, and despite the tendency to specialize, we general practitioners are after all the backbone of the profession, and upon us shall fall the responsibility for the physical welfare of the city, town, village or country district in which we live and work. We shall find it more pleasurable to practice in an intelligent community, rather than among an illiterate and superstitious people, which is the bane of any medical man's existence. Thus shall we have inaugurated upon earth that delectable condition of life where no pain or sorrow, tears or sighing shall exist, but all shall realize, in deed and in truth what to John on the Isle of Patmos was merely a vision.

THE PROTECTION AND PERPETUATION OF THE FOREST.

AN IMPORTANT FACTOR IN PREVENTIVE MEDICINE.

By *GEO. E. DeWITT, M. D.,*
Wolfville, N. S.

(Read at meeting of Maritime Medical Association, St. John, N. B., July, 1907.)

THE subject of forest protection and perpetuation may, at first sight, seem foreign to a medical society, but when we spend a little time considering some of the mighty and far-reaching influences the forest exerts upon a country and its people, we may be excused if we occupy a few minutes of the Maritime Medical Association.

The three provinces represented here, New Brunswick, Nova Scotia and Prince Edward Island, once abounded in magnificent forests. The axe, fire and indiscriminate cutting, without any effort having been made to restore the denuded areas, have materially deteriorated and destroyed this magnificent heritage.

The protection and perpetuation of the forest is a subject that should interest the medical profession, because when judicially and prudently conserved, it is a factor in preventive medicine. Forest influences affect temperature and climate, seas, lakes and rivers. The forest contributes for man's purposes, gushing fountains and perennial streams. It contributes to the wood-worker's craft, to the trades, and commerce of the world. It provides a retreat for the holiday seeker, for the sportsman, where he can ply his crafts, a retreat and harborage for the worn-out physical system, where he can recuperate his bodily energies.

My object in suggesting the consideration of the prevention and perpetuation of the forest at this convention is to elicit the attention and interest of the medical profession in the Maritime Provinces; that the medical men of these provinces may with others interested in forestry, teach the necessity of adopting such measures as will be conducive to the betterment of forestry conditions.

The day has gone by when the physician's duty is looked upon only as an agency to cure disease after it has come. If solicitous for the welfare of the people, he must teach and practice preventive medicine. Nova Scotia has six millions of acres of denuded or burnt over, and useless land at the present time. Prince Edward Island is practically bereft of its timber and wood-lands. New Brunswick, having a larger forest area than either of the other two provinces, has also felt the loss of forest devastation, and consequently has taken the lead in the Maritime Provinces in the protection of her forests. These denuded areas cause loss of shelter from winds and storms, the loss of water-sheds, the loss of the forest floor which conserves moisture, and the water supply, storing it into springs for its purity, for man's needs; it causes erosion of soil, carrying it into streams and

depositing it where it is not wanted. It means converting brooks and rivers into rushing torrents in the time of melting snow and heavy rains; it means a diminished supply of water in the dry season, leaving the brooks but trickling streams. It changes the physiographic and climatic conditions of the country.

My object in discussing the subject is to do so from a sanitary standpoint, because of our interest in whatever agencies are conducive to the public welfare, especially to the health of the people. In consequence of deforestation, evaporation from the soil is augmented and accelerated, resulting in unfavourable conditions of soil humidity and interfering with the continuity and volume of water in springs. The forest cover influences the springs, because of the reduced evaporation which the forest shelter gives. Snow also is held longer in the forest, taking a longer time to melt and filter through the ground, and as the forest shelter prevents freezing to a less depth than in the open field, it causes subterranean rather than surface drainage.

Surface drainage into springs, brooks and rivers, where the supply is used for domestic purposes, is objectionable and unsanitary, because of soil particles contaminating the water, which is the result of erosion.

The domestic water supply gotten directly from the forest is, to a great extent, a guarantee of immunity from pathogenic germs. The theory of Pettenkoffer that various pathogenic bacteria exist in the forest, has of late years been discarded. It is claimed by those who know, that in the dense forest, where the atmosphere is rendered acid by the decaying humus, disease germs are not found. Is it any wonder that the holiday seeker

or lover of the woods longs to get away to the forest shelter, where he can breathe the pure forest air without the danger of coming into contact with the germs of disease? Even malaria which was supposed to have had its habitat in the woods or forest, is now known not to be there, but its lurking place is in swamps and stagnant pools, from which the infection is carried by the mosquito.

The water supply taken directly from rivers, as is often of necessity the case in cities, is not as pure as water conducted directly from the forest. Owing to the domestic water supply coming from the St. Lawrence which receives sewage from towns along the Ottawa River, as well as on its own shores and the shores of the Great Lakes, an epidemic of typhoid within the last year has been widespread. If it were in the power of the authorities of the city of Montreal to bring the water supply from the Laurentian Hills, it would not only be free from sewage, but of soil contamination also, and typhoid and other water-borne diseases would doubtless be reduced.

At Three Rivers, Quebec, the water system supplying the city is taken from the St. Maurice, which at times gathers sewage, and in consequence 300 deaths from typhoid occurred in 6 months during the past year. The history of cities in the United States, which take their water from rivers into which sewage drains, is similar in respect to typhoid to the two Canadian cities just named. It is found that the disease, typhoid, is more prevalent in the United States than any other country in the world, except Italy.

During the years 1900 to 1904 inclusive, the rate per 100,000 from typhoid fever in the United States

was 33.7. While England and Wales stood 12.9, Scotland 12.7, Ireland 14.2, Germany 8.5, Norway 6.2, Sweden 12.2, Hungary 28.3, Belgium 20.2, Switzerland 6.5, and Italy 37.8. Commenting upon the prevalence of typhoid fever, the United States census department says: "The water supplies of American cities are probably not wholly to blame for the excess of typhoid cases, as is demonstrated by the fact that the city rate was 25.7, and the rural rate 27.8 per hundred thousand; but when we are cognizant of the fact that the rural population largely receives its water supply from wells which are more or less polluted with surface drainage, we are led to conclude that the excessive rate of typhoid cases in the rural districts is from contaminated water; and knowing also that many of the cities receive their water supply polluted with sewage or soil contamination directly from the river, we conclude also that the cities of the United States which show an average rate of 25.7 of typhoid cases, must look to their water supply as the chief cause."

The district of Columbia takes the unenviable lead with an average rate of 62.8 for the years 1900 to 1904. At Niagara Falls, a still worse condition of affairs exists in regard to typhoid, the rate being from 126.9 to 186.1 during the past five years, thus giving this place the highest death rate from this disease of any city in the United States. The water supply at Niagara Falls is procured from the Niagara River, without filtration or any purification whatsoever, or without reservoirs in which sedimentation can take place.

In the United States we have a people of the highest civilization, with a death rate of one hundred

thousand per year from typhoid fever, a preventable disease. The cause is not far to seek. We admit that insanitary conditions have a small share in the mortality, yet we are compelled to believe that the water supply has the most to do with it.

Bringing the question nearer home, and in touch with our own experience, we have found that the domestic water supply when coming directly from the forest, and freed from soil particles or soil contamination, has had much to do with lessening infectious diseases. Within the last twenty-six years in the province of Nova Scotia, in that section of country from Windsor to Yarmouth, a water supply for domestic purposes has been brought into a dozen towns and villages in the rural districts, and since then typhoid fever has been reduced in these towns and villages at least 90 per cent. These towns procure their water from springs and lakes which are preserved by the forest. This water supply is free from soil, and other contaminations. Not only has typhoid become almost nil in these water supplied districts and towns, but other infectious diseases, as diphtheria and scarlet fever, are much rarer. A similar history of the decrease of infectious diseases, especially typhoid fever, is shown in other parts of the province, where a pure water supply has been obtained.

The act of bringing water into towns, villages and hamlets, from the source of the least contamination is the practice of preventive medicine. This being so it is as much the duty of the medical profession to abet, and encourage such a procedure as it is his prerogative to enforce any other sanitary condition which has to do with the people. The time was when the people believed that an epidemic of disease was the will of God,

and that they were powerless to prevent it. Unsanitary conditions and polluted water supply were allowed to exist, but thanks to the discovery of the germs of contagious diseases, their habitat and the means of preventing them, ideas are changing. Scientific students place disease today where it belongs—to the failure to observe the laws of health; and one of the most important agencies governing the laws of health is pure water supply, and an unadulterated water supply can only come from a storage caused by the influences of the forest.

The forest, which is the natural heritage of a country, is not only conducive to its industries, to the trades and commerce of the world, to agriculture, to its climatic and physio-

graphic conditions, and to the water supply of the people, but amid its leafy shades it is a God given retreat for the tired nerves of the professional man. Let him make friends with the friendly forest, study it intelligently, know its members by name, and learn of their secret mysteries. Watch the unfolding of the leaves in the spring, the golden sunlight piercing its leafy bower, and bask in the cooling shade; watch the falling leaves, the withering fern and the crumbling tree trunk, adding a fragrant and sanitary humus to the forest floor, a treasury for the melting snow and heavy rains, storing them into springs in their purity for man's purposes and needs, and it will recreate and better fit him to battle with daily problems and discharge life's duties.



DIAGNOSIS OF PRESENTATION OF THE FOETUS AND OF POSITION OF THE PRESENTING PART BY EXTERNAL EXAMINATION ALONE.

By DR. STEPHEN E. WEBBER,

Calais, Maine.

(Read before Maritime Medical Association, St. John, July, 1907.)

I WANT first to express to the president and executive of this association my pleasure because of the opportunity you have given me, of presenting here a subject which I consider of vital importance to every general practitioner.

I shall also ask the indulgence of my hearers, in that I have nothing new and original to tell you. These ideas are familiar to any one who has studied modern authors on obstetrics, from whom I have quoted freely. I have studied the subject a good deal. I have practised it for several years. I have had a measure of success. My own personal feeling about external examinations is entirely encouraging. There are some few cases of which I can learn practically nothing by the method; there are certain others of which I am in doubt; there are still others (and these are a majority) which seem to be very plain. The diagnosis of these last is usually confirmed by subsequent events. The main object of this subject is the better protection of childbed.

This is an age of preventive medicine, in all branches of the profession. In the treatment of puerperal fever, prophylaxis is the most important step. Of this prophylaxis, external examination is one of the chief elements. As has been repeatedly insisted, puerperal infection is wound infection, and is due to the introduction of pathogenic micro-

ganisms by the hands or instruments of the doctor or nurse. Hence it naturally follows, that the most scrupulous asepsis immediately before and during labor, is of the utmost importance. Every physician who conducts a labor case cannot feel too strongly his personal responsibility, and he does not perform his whole duty to his patient unless he regards the rules of asepsis as carefully as when performing a capital surgical operation.

"As long as vaginal examinations are made, no matter how carefully we may attempt to sterilize our hands, infection will occasionally occur. For this reason, vaginal examinations should be dispensed with as far as possible, and with this end in view, the accoucheur should never lose an opportunity of perfecting himself in the methods of external examinations."

Another reason for early diagnosis externally, is to afford opportunity to rectify faulty positions of the fœtus. This can best be done before or at the early beginning of labor, before the membranes are ruptured, and before the uterus has shut down to any considerable extent.

The diagnosis of presentation before labor or before sufficient dilatation of the os uteri usually can only be made by external methods, while the actual position of the presenting

part is made out after labor begins or after the part is engaged.

I consider a pre-requisite to the conduct of labor is the diagnosis of the presentation and of the position of the fœtus. Considerable confusion has arisen in regard to the terms *presentation*, *presenting part*, and *position*. By presentation is understood the relation which the long axis of the fœtus bears to that of the mother, and accordingly we distinguish between longitudinal and transverse.

Presenting part is that portion which engages or endeavors to engage at the superior strait, while position has reference to the relation which certain portions of the fœtus bear to certain fixed points of the mother. Therefore, each presenting part may occupy one of several positions.

Our knowledge of the fœtus in utero is obtained, by 1st, Inspection. 2nd, Abdominal palpation. 3rd, Vaginal touch. 4th, Combined examination. 5th, Auscultation.

I shall consider the second and fifth with barely mentioning the first. Obviously abdominal palpation is the most important. Indeed, I consider that under ordinary circumstances, external or abdominal palpation is the most reliable and valuable of all the means at our disposal, and if I were restricted to a single method of examinations, I should unhesitatingly choose it.

In trained hands it enables one to make satisfactory diagnosis without danger of infection, and with the least possible discomfort to the patient; and I think it is not going too far to say that its popularization forms one of the greatest advances in modern obstetrics.

Under these circumstances, it behooves the student to become thor-

oughly familiar with the proper technique and to avail himself of every opportunity to become thoroughly familiar with the various manipulations. Although forms of abdominal palpation were undoubtedly practised from very early times, just as they are still employed by many of the savage peoples, its advantages were first pointed out as late as the latter part of the seventeenth and the early part of the eighteenth century. Its practical importance, however, was not generally recognized until 1878, when Pinard published his work on the subject, after which the method became popularized in France, but was not employed systematically in Germany and in America until Crede and Leopold had repeatedly urged its value.

To properly perform abdominal palpation, the woman should be on a bed or couch, the legs flexed on the abdomen, and the abdominal walls covered by a thin sheet or by nothing. The bladder should be empty. There need be no exposure of the woman, and if the reason for examination be explained, it will be exceptional that she will offer any objection, even though the examination be made before labor begins.

In order to obtain satisfactory results, the examination should be made systematically. This I want to repeat most emphatically. Without system a beginner will fail in diagnosis, become discouraged and give it up, sit down and wait for the presenting part to appear at the vulva or perhaps make a vaginal examination, only to find that he has a breech, or to learn that there is another baby only after the first one is born.

The following are the four manoeuvres suggested by Leopold. Dur-

ing the first three manœuvres the examiner stands at the side of the bed which is most convenient to him, and faces the patient, but reverses his position and faces her feet for the last manœuvre.

FIRST MANŒUVRE.

After ascertaining the outlines of the uterus by inspection, the fundus is gently palpated by the tips of the fingers of the two hands, and the fetal pole occupying it differentiated, the breech giving the sensation of a large irregularly shaped, nodular body, and the head that of a hard, round object, which is freely movable and ballotable.

SECOND MANŒUVRE.

Having determined which pole of the fœtus lies at the fundus, the examiner places the palmar surface of his hands on either side of the abdomen and makes gentle but deep pressure. On one side he feels a hard resistant plane—the back—and on the other numerous nodulations—the small parts. In women with thin abdominal walls the legs and arms can readily be differentiated. In fat persons, however, only nodulations can be felt. In the case of fat persons, or when considerable amniotic fluid is present, the appreciation of the back can be facilitated by making deep pressure with one hand while palpating with the other. After determining upon which side the back is situated, we next note whether it is directly anteriorly, transversely or posteriorly, and thus arrive at the position and variety of presentation.

THIRD MANŒUVRE.

The examiner grasps the lower portion of the abdomen just above the symphysis pubis, between the thumb and fingers of one hand, and tries to decide what is between them.

If the presenting part be not engaged, a movable body will be felt. The differentiation between the head and the breech is made the same as at the fundus, the former being a hard, round, ballotable body. If the presenting part be not engaged, this practically completes the examination, as we now know the situation of the head, breech, back and extremities, and all that remains to determine is the attitude of the head if that presents.

If careful palpation shows that the greatest cephalic prominence is on the same side as the small parts, we know that the head is flexed, and that the vertex is the presenting part. But when the greatest cephalic prominence is on the same side as the back, we know that the head is extended, and we have a face presentation. On the other hand, if the presenting part is engaged, this manœuvre shows that the lower pole of the fœtus is fixed in the pelvis and the details concerning it are ascertained as follows:

FOURTH MANŒUVRE.

The examiner faces the patient's feet, and with the tips of the fingers of each hand, makes deep pressure in the direction of the superior strait. If the head presents, he finds one hand is arrested sooner than the other by a round, hard body—the cephalic prominence; while the other hand descends deeper into the pelvis. In vertex presentations the prominence is on the same side as the small parts, and in face presentations it is on the same side as the back. The degree of descent of the head is indicated by the ease with which the prominence is felt.

When the head has descended into the pelvis, the anterior shoulder can be differentiated by the third step in many instances.

AUSCULTATION.

By itself, auscultation does not give very definite information as to the presentation and position of the child, but it often reinforces the information already obtained. The foetal heart is situated nearer the cephalic extremity than the pelvis. The posture of the foetus in the uterus in most cases is that of anterior flexion, and therefore the sounds of the foetal heart are best transmitted through the back of the foetus. When the foetus is presenting by the cephalic extremity, the foetal heart sounds must necessarily be heard with greatest intensity below a line which divides the uterus about its middle portion. In case the pelvic extremity in presenting, the heart sounds will be heard above this line. In occipito-anterior presentations the heart sounds are heard nearer the median line; in the transverse varieties it is heard more latterly, and in the occipito-posterior it is heard well back in the patient's flanks. In practice, in the foetal heart is heard below the umbilicus, the inference is that the foetus presents by its cephalic pole, while it is above in breech presentations.

The accuracy of abdominal palpation is impaired by very fat abdominal walls, or by excessive amount of amniotic fluid, or by tumors which may be mistaken for portions of the child. Laying aside these possibilities, then, we are ready to apply the rules laid down to the diagnosis of some cases.

If by abdominal palpation we find (1) an irregular breech at the fundus; (2) the resistant plane of the back in the left and anterior portion of the abdomen with the small parts on the right side somewhat posteriorly, we make a provisional diagnosis of cephalic pole presenting in the

left occipito-iliac position. If the head is not engaged it is found freely movable above the superior strait; but if the head is engaged and we find the cephalic prominence on the patient's right, the diagnosis is more certain. If the head has descended into the pelvis we may feel the anterior shoulder. Now if the foetal heart sounds are distinguished below and to the left of the umbilicus, we are sure of our diagnosis. In right occipito-anterior positions, the back of the foetus is to the right and anterior; the small parts are to the left and posterior, while the cephalic prominence is on the *left*, and the heart sounds are below the navel to the right.

In right occipito-iliac posterior positions of the head, the data by external examinations are as follows: The breech is at the fundus, the resistant plane of the back is well back in the patient's right flank, the small parts are to the left and more easily felt than in anterior positions; the cephalic prominence is on the patient's left side. The foetal heart is heard in the right flank, but occasionally it is transmitted through the child's thorax, and is best heard in the middle line or slightly to the left.

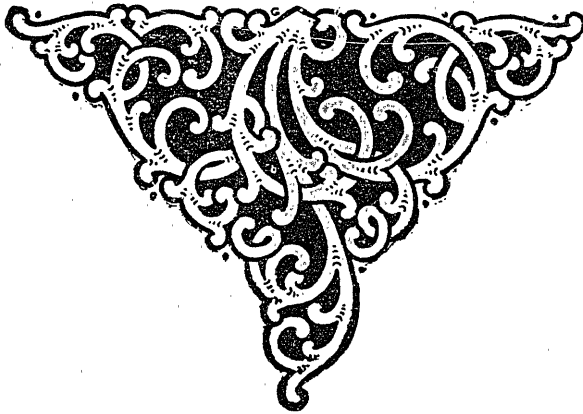
Whenever the child's back is felt on the patient's right side, we must remember the possibilities of a right posterior position, since it occurs nearly as often as the anterior variety. In left posterior occipito-iliac positions the data above are reversed.

FACE PRESENTATIONS.

In left mento-iliac anterior variety we have breech at the fundus, back to the right posterior portion of the abdomen, and distinctly felt only in the upper portion; small parts are in the left anterior portion. The cephalic

prominence is marked and on the right side as the back of the fœtus. The reverse holds true in right mento-iliac. The heart sounds are heard below the umbilicus and on the same side as the abdomen of the child, since other sounds are transmitted through the thorax.

I shall not weary you further by detailing more of the positions of the presenting part, but urge you when you are waiting for some of your cases to make a systematic study of these suggestions as made by Leopold. I assure you that it will be a matter of great satisfaction to yourself and less dangerous to the patient.



ON SOME PHASES OF A FAILING CIRCULATION.

By A. D. BLACKADER, B.A., M.D.

Professor of Pharmacology and Therapeutics, and of Diseases of Children,

McGill University, Montreal.

Read before meeting of Maritime Medical Association, St. John, N. B., July 18th, 1907.

YEAR by year the array of new facts, which modern research is constantly bringing to light, affords us new vantage points from which to study disease, and from which we are able to look back and see clearly the mistakes that have been made in the past. Owing to this enlarging view, the physician finds that from time to time his concepts of disease have to be altered, and with each alteration his therapeutics become more correct and more successful. Illustrations of this are to be found in every domain of medicine. This morning I desire to call your attention to one in the domain of the pathological physiology of the circulation, viz;—so-called heart failure—a misconception, as Janeway said in a recent address, hallowed by long usage and the alleged cause of more deaths than any other medical term. As popularly employed heart failure is merely a synonym of sudden death. It is a term made use of by many writers and teachers, and yet it is a term often at variance with the facts as we now know them, and, therefore, misleading to us as therapeutists.

Sudden death at the height of an attack of lobar pneumonia was the illustration taken by Janeway, and it is certainly a pertinent one. Permit me, however, to quote two of several cases occurring in the wards of the Alexandra Hospital for Infectious Diseases of which the details have been kindly given to me by Dr. Fyshe, the Medical Superintendent under whose charge they were.

CASE I.—M. N., female, aged five years, admitted on the second day of a well-marked case of pharyngeal diphtheria. On admission, a slight amount of laryngeal stenosis was present, but not enough to justify operative interference.

Her highest emperature was 101° F.; her pulse varied from 128 to 148; the cardiac dullness was normal. There were no adventitious sounds within heart or lungs. The patient reacted fairly well to antitoxin, the laryngeal stridor disappearing within twelve hours. On the afternoon of the third day of the disease, however, the patient suddenly collapsed, the pupils became widely dilated, the heart action very rapid, the sounds indistinct. The breathing remained regular until death took place about twenty minutes after the beginning of the collapse. Microscopic examination of the heart showed absolutely nothing pathological in that organ. The liver, the lungs, and the spleen were normal beyond a certain amount of injection.

CASE II.—George W., male, aged nineteen years, was admitted to the hospital on the third day of a very severe attack of scarlet fever. His temperature while in the hospital varied from 103° to 105° F. His pulse, from 140 to a rate uncountable. The notes on admission stated that he was a well nourished, muscular adult with anxious facial expression; his pupils were equal and active; his conjunctivæ much injected; the lips abnormally pale. A most intense dusky red rash covered the body. The breath

sounds throughout both lungs were normal, but the respiration was of a sighing character. The pulse was rapid, of small volume and low tension, and very shabby. Cardiac dullness was normal in extent, but the heart sounds were feeble. No adventitious sounds were present. He responded feebly to a normal saline injection and collapsed a few hours afterwards, during the administration of a second. The autopsy findings as to the cause of death were most unsatisfactory. Nothing definite could be found either macroscopically or microscopically leading to a fatal result.

If questioned as to the exact pathology of these suddenly fatal cases, the general answer would be that the heart muscle, as the result of the action of certain toxins, had undergone degenerative or inflammatory changes which so impaired its functional ability that it was unable to meet the demand made upon its ventricles by some slight extra strain. Such an explanation is plausible, but what does the post mortem show? A striking contrast between the empty heart chambers of such a death, and the engorged auricles and right ventricle of true heart failure. Microscopically, we find only a slight change in the muscle cells; rarely any significant inflammatory lesions. Looking back on the clinical history of such a case, we note also the absence of all ordinary signs of a failing heart. No œdema, no venous stasis, no cyanosis, but extreme prostration, a blanched cool skin, and a rapid ineffectual heart beat. The stage of collapse thus resembles the condition present after a severe hæmorrhage, or in surgical shock.

This striking absence of all ordinary signs of heart muscle failure has made investigators question whether,

after all, the heart is really involved in the circulatory failure. Romburg and several of his pupils in the Leipzig clinic, notably Pässler, have recently investigated this problem very carefully, and published their results in a series of papers. At the outset they studied the mode of death in animals inoculated with one of the following infections: the pneumococcus, the bacillus pyocyaneus and the bacillus diphtheriæ, and found that death occurred after rapidly developing symptoms of collapse similar in every way to the so-called heart failure in man.

They then repeated the inoculations in a large number of fresh animals, and observed the blood pressure at short intervals. They found that it remained normal during the major part of the illness, only beginning to fall when collapse was impending.

Blood pressure, as we know, is dependent upon four separate factors, which may vary independently of one another:

- 1st.—The energy of the heart.
- 2nd.—The peripheral resistance.
- 3rd.—The elasticity of the arterial walls.
- 4th.—The volume of the circulating blood.

The last two have little interest for us at the moment. The tone of the vessels regulating to a great extent the peripheral resistance depends upon impulses from the vaso-motor centres. Experiments show conclusively that this vaso-motor tone is an absolute necessity for the maintenance of the circulation, not only in the arteries, but also in the veins. Any grave injury to the vaso-motor center is followed by stagnation of the blood in the veins, and eventual heart failure because no blood is returned to it. To determine what factor was the

cause of the great fall in blood pressure, Romburg and Pässler tried the effect of four procedures on their infected animals.

1st. Abdominal massage, which increases the work of the heart by emptying the abdominal veins into the right ventricle.

2nd. Temporary compression of the descending aorta above the diaphragm, calling for a maximum effort of the heart by greatly increasing the peripheral resistance.

3rd. Faradic stimulation of the nasal and anal mucosa producing extreme reflex vaso-restriction, if the medullary vaso-motor centre is intact.

4th. Transitory compression of the trachea producing asphyxia, which stimulates strongly both medullary and spinal centres.

They found with the first signs of impending collapse the heart action became more rapid, but the blood pressure began to fall. The chief change noted at this time was a distinct diminution of the reflex sensibility of the vaso-motor centre. The heart maintained its full vigor, and even in some cases by increased action, counterbalanced the tendency to fall in blood pressure.

When complete collapse set in, blood pressure sank rapidly, an entire absence of any vaso-motor reaction to sensory stimulation, and even to the effect of asphyxia was now observed, but abdominal massage or temporary depression of the aorta still caused prompt elevation, showing only a slight impairment of the reserve force of the heart. In the pneumococcus and pyocyanus infection, this impairment was very slight, and could be explained by defective nutrition; but in the case of infection by the bacillus diphtheriæ, the vigor of the heart beat was

distinctly lessened, and on autopsy the heart muscle showed evidence of parenchymatous degeneration. Even this, however, was of minor importance; the real cause of death being, in all cases, complete loss of vaso-motor tone. It seemed to be quite unessential what variety of organism was the infecting agent.

The question still remained as to which part of the vascular system was paralyzed. To determine this, barium chloride, which raises blood pressure by direct action on the peripheral nerves, and the muscles of the small arteries, was injected. Under its action, the peripheral vessels responded almost as promptly as in the normal animal, indicating that they were not at fault. Paralysis of the vaso-motor center was evidently the chief cause of the collapse. As a consequence of its paralytic condition the vessels lost their tone, the blood accumulated in the large veins of the splanchnic area, and was not returned to the heart, and a profound anæmia of the brain, muscles and skin quickly developed, leading to rapid death.

In other words, the animals, under the influence of the poison on the vaso-motor center, were bled into their own veins and the heart failed for want of blood. That the heart muscle was not at fault, was clearly demonstrated in one of their experiments in which, during a severe infection by the bacillus pyocyanus, an endocarditis involving the aortic valve was developed. In the course of a few days cardiac hypertrophy set in; the animal died later on of vaso-motor paralysis, but the heart was found to have increased about one third in weight.

Failure of the circulation taking place at the height of the infection, and due to vaso-motor paresis, is thus

to be sharply differentiated from failure of the circulation taking place during the later stages of the disease, or actually after the febrile reaction has subsided, and due to a myocarditis. The former is characterized clinically by softness and emptiness of the pulse, and by a rapidly failing blood pressure. The latter is characterized by smallness, irregularity and inequality of the pulse, with indications of some dilatation of the chambers of the heart, and developing signs of mitral insufficiency. The former tends to terminate rapidly in death; the latter develops more slowly, and eventually all the indications of a failing compensation can be noted. At the autopsy we find no change of any moment in the heart muscle in the cases of vaso-motor paresis, while in the other class there are the signs of an interstitial myocarditis. In the past there has been much confusion of these two conditions, and drugs have been unnecessarily and unjustly blamed. For successful treatment it is essential that we recognize what the condition is that we are dealing with, before we decide on the therapeutic measures to be employed. In the early stages of vaso-motor collapse, pure cardiac stimulants cannot be expected to have much, if any, value. Digitalis is the only exception, and it may do good, not as a cardiac stimulant, but owing to its action on the vaso-motor center and peripheral vessels.

Atropine in small doses has also a definite action on the medullary centres and small arteries, and, I think I have seen some benefit from its administration hypodermically, 1-100 gr. twice a day. Strychnine also may be employed, but only for its general effect, and as a stimulant to the respiratory apparatus. Caffein has some value and is superior to

camphor. The introduction of normal saline solution is capable of raising blood pressure for a limited period, and it may be associated with small doses of adrenalin. The action of both, however, is very fleeting. It seems almost unnecessary to say that nitro-glycerine and its allies are distinctly contraindicated. As a mechanical measure, raising the foot of the bed twelve or eighteen inches, may be of distinct benefit favoring the return of the blood to the heart.

With our present knowledge, undoubtedly, one of our most potent vaso-motor stimulants is cold, acting as a peripheral stimulant. It may be employed either in the form of a cold bath, or ice-pack or locally. From the experiments of Romburg and Pässler, we note that all stimulants have a rapidly lessening value as the stage of collapse approaches. Its action is, therefore, chiefly by way of prevention, and its value is to be reckoned, not by the fall in temperature, so eagerly looked for by nurses, and which we know is always followed by more or less reaction, but by a rise in blood pressure, and fall in the frequency of the pulse. Much of the benefit derived from tubbing in typhoid, is, I think, to be attributed to a stimulating action on the vaso-motor center.

Failure of the circulation in the later stages of the disease, with developing signs of cardiac weakness, is to be treated on similar lines to that of a degenerative myocarditis.

Closely allied to the collapse met with in acute infectious disease is the condition known as shock in surgery, due to exhaustion of all the important medullary centers, but in which vaso-motor depression plays the chief part. Crile's experiments show that in shock the heart muscle and its nervous mechanism is unimpaired, as is

also that of the vaso-muscular system, but the vaso-motor center fails to respond to any stimulus, irritative, electrical, physiological or pharmacological. Vaso-motor stimulants, while the center is so exhausted, have little action. Strong coffee or a hypodermic of caffeine citrate is one of the most effective. Normal saline solution raises, but cannot sustain, blood pressure. Its aid is purely mechanical. Its value is, however, more definite when shock is associated with profuse hæmorrhage. Crile recommends the addition of adrenalin to the saline in the strength of 1, 50,000 to 1, 100,000, and directs it to be given intravenously very slowly and continuously.

In addition to these measures, absolute rest must be secured. The flow of blood to the heart may be assisted mechanically by raising the foot of the bed, and in some cases by gentle massage of limbs and abdomen. The extremities must be kept warm.

There is another form of circulatory failure in which I have recently been much interested; the failing heart of chronic arterial hypertension. During the last few years, much study has been devoted to the condition of increased blood pressure and perhaps a few remarks on this subject may not be amiss.

When physicians first obtained an instrument to measure blood pressure and found that in a certain number of their patients the blood pressure registered considerably above normal, anxious endeavours were at once made to reduce this excess by the administration of all kinds of vaso-dilators, and again therapeutics were sneered at, because they failed, in these cases, to effect a permanent reduction in the blood pressure. Only slowly did physicians realize the fact that permanent high blood pressure

in certain individuals is a necessity of life, and is, in a great measure, a compensatory manifestation. A recent writer says, "It is to be regarded as one of the great advances of modern medicine, that we are now able to read between the lines, so to speak, and to obtain a new and clearer insight into pathological processes."

Inflammatory lesions themselves are but the wall the tissues build against foreign invaders. The hypertrophied left ventricle fits itself for the extra burden laid upon it. What rash therapist would wish to prevent or hinder such changes? So with increased blood pressure! It certainly is not a condition to be desired; but it is, in many cases, to be regarded as nature's effort to prevent a greater evil; an effort to keep the circulation active through peripheral areas, which through the action of toxic products, metabolic or otherwise, or from a more mechanical interference, such as rigid arteries and the like, have their vascular area abnormally limited.

Let me illustrate my meaning. Persistent high arterial pressure is, as we all recognize, one of the cardinal symptoms in chronic Bright's disease. Pässler's researches on this point are noteworthy. By excision of one kidney, and the removal of successive portions of the remaining one, he was able to bring about the various grades of renal insufficiency, uncomplicated by inflammatory or toxic influences. Animals thus operated upon, developed, first, high blood pressure; this was followed by cardiac hypertrophy and finally by toxæmic symptoms. Very interesting also is the effect that cerebral compression has in raising blood pressure, described in such an interesting way by Leonard Hill.

Sudden cerebral effusion of any nature, owing to the fact that the cranio-vertebral cavity is closed, produces by compression an acute cerebral anæmia, which would inevitably lead to loss of function and death if the medulla did not make a counterbalancing effort. Automatically, the vaso-motor center raises blood pressure above the intracranial tension, and blood is kept circulating through the centers. If the compression increases, the vaso-motor center follows with another rise, and so on, and thus an effort is made to keep just ahead of the advancing brain pressure. Each rise, however, is not steadily maintained. Over-compensation is succeeded by a fall, then a rebound again, giving rise to the Traube-Hering waves in sphygmomanometric readings. Clinically, we have all noted a similar rhythmical variation in the action of the respiratory center, in the well-known Cheyne-Stokes breathing, deep breathing coinciding with the period of high blood pressure, and established circulation; and apnoea with its interruption.

In this effort of the vaso-motor center, blood pressure often reaches a great height; nevertheless, even these high figures may be regarded for the time as salutary. In practice, however, the question arises frequently—is hypertension in all cases necessary and desirable? May not some part of it represent an over-effort on the part of the organism, a functional hypertension added to an essential one, or in the case of the cerebral effusion is not this extreme high blood pressure but part of a vicious circle which the physician must certainly attempt to break?

Careful and repeated examinations only, will enable us to answer these questions. One point may be born in mind. Temporary rises occur more

readily and more frequently in patients with permanently increased blood pressure, compared with those in whom blood pressure is normal.

The treatment of chronic hypertension must be chiefly dietetic and hygienic. The diet must be made simple and very moderate in amount so as to avoid all excess of food. In this matter, Chittenden's experiments on the amount of food necessary to maintain nutrition, are extremely valuable. Except in extreme cases, moderate exercise is beneficial. When it cannot be taken, general massage may take its place with benefit. I have much faith myself in the daily use of a saline laxative, especially if combined with the occasional use of a mild mercurial, grey powder or blue pill. A course of one of the nitrites is of distinct value in all exacerbations whenever blood pressure rises above what may be regarded as normal for the special individual. I have not seen any appreciable value from their continuous use in essential hypertension; indeed, such is not to be expected. I have some faith, however, in the continuous administration of one of the iodides in small doses. I do not think they directly lower blood pressure as some have stated, but they do appear to lessen the viscosity of the blood, a distinct advantage in cases of hypertension.

In all these cases, however, the time comes when the heart begins to weaken, and as a result the blood pressure falls, and gradually all the signs of an uncompensated cardiac lesion develop.

A few years ago, under the delusion that the high blood pressure, in these cases, was the important condition, I feared to employ digitalis, except in small doses, and only when combined with full doses of the nitrites. I was surprised, however, to

find that in many of my cases I had no results until I had gradually raised the amount of my digitalis until I had reached full doses, and the blood pressure had gained its former level. Only then did the œdema disappear and the signs of stasis subside. Many trials have convinced me that such patients demand digitalis in fairly full doses sufficient to maintain blood pressure at its high level, else their capillary circulation fails, and venous stasis develops.

We cannot, however, be forgetful of the fact that all those suffering from permanent high blood pressure are especially liable to sudden and

dangerous complications; anginal seizures, hæmorrhages, uræmic convulsions and the like. In the presence of such acute exacerbations threatening life, nitrites must be employed freely in large doses, and one need not hesitate to increase still further the dosage if the symptoms continue or become aggravated. Venesection in such cases may sometimes prove an effective agent if the nitrites fail us, or the case is very threatening. It seems almost unnecessary to add that at this stage of the disease, rest in bed and the simplest diet are imperative.



EXCESSIVE MENORRHAGIA DUE TO FOLLICULAR OVARIAN CYSTS.

By G. C. VANWART, M. D., (Univ. of Penn.)

Frederickton, N. B.

(Read at meeting of Maritime Medical Association, St. John, N. B., 1907.)

MISS C., aged 21, occupation student, consulted me in May, 1903, because of too much bleeding during her monthly periods.

Previous History.—She was born in New Brunswick and never had had a serious illness.

Family History.—Her father died at 73 years of age from tuberculosis. Her mother died from the same cause at the age of 52 years. Full brothers—four—all living; three are in good health. One is obliged to reside outside the province on account of his lungs. One full sister is living and in good health.

The following letter was received from the patient regarding her half-brothers and half-sisters. "Had six half-brothers and four half-sisters. Two half-brothers and one half-sister are still living and enjoying good health. One girl died in infancy. Two others died at the ages of 17 and 22 years, respectively, from tuberculosis. Four half-brothers died at the ages of 52, 29, 25 and 22 years. All had tuberculosis of the lungs.

History of Illness.—Her menses began in August, 1899, two months before her seventeenth birthday. She was not sick again for four or five months. Menses were always irregular. There was no pain at the monthly periods unless the flow kept up for several days, then there was severe pain in the back. This irregular and profuse bleeding would confine her to bed.

On examination, I found temperature 100° F., pulse 100, regular and compressible, lungs and heart normal, hæmic murmur over pulmonic area and continuous hum in the veins of the neck. No splenic enlargement. Urine, (specimen taken by catheter) specific gravity, 1021; reaction, acid; no sugar, albumen, tube casts, nor pus; phosphates present.

I administered chloroform for pelvic examination. The menstrual flow was dark and very offensive. The uterus and addenda seemed normal. She had been flowing for five weeks though resting in bed the greater part of that time. I advised her to allow me to curette the uterus. She was admitted to the Victoria Public hospital on May 8, 1903. With chloroform as an anæsthetic I did a curettage uteri. She remained in bed two weeks and left the hospital during the third week. The bleeding ceased shortly after the operation. I ordered her a chalybeate and advised her to go to the country. She went to the seaside. Menses did not return till the September following, and then continued for three weeks. She menstruated again the last of November and was obliged to remain in bed six weeks under medical care. From February, 1904 till October 1904, she seemed to be in good health; her menses came on regularly and lasted three days in each month. She suffered no pain, but felt weak during the periods. From October, 1904 till the last of December, 1904, she had

amenorrhœa. Then she was ill for six weeks. This was followed by amenorrhœa till July, 1905. In July the menses returned and she spent four weeks in a hospital under medical care. In November of the same year, she went to Hotel Dieu hospital in Montreal, and on November 4th had the uterus curetted. She returned home the last of the month. From this time until the old trouble returned in January, 1906, she felt very well.

On the 26th of January I examined her again without an anæsthetic, as she would not consent to be anæsthetized for diagnosis only. She was very anæmic from the loss of blood. The uterus was somewhat enlarged, soft, with a fulness and tenderness about the right ovarian region. I advised an exploratory cœliotomy. On February 8th she was admitted to the Victoria Public hospital. With ether as an anæsthetic, I removed the right Fallopian tube and a cystic ovary. The cyst contained about 8 ounces of straw colored fluid. There were no adhesions. The left ovary and tube were normal. I also did a curettage uteri. The menorrhagia stopped at once. The abdominal incision healed kindly, and the patient left the hospital in three weeks. She had amenorrhœa till June, 1906. I was called to see her on July 4th. She had been bleeding for three weeks, at times very freely. She had been in bed during this time, but not under medical treatment. Her appetite was poor, she was nervous and could not sleep well, she had nausea and vomiting, her bowels moved by enema only, she was physically weak and had vertigo.

To control the bleeding I packed the vagina, about the os uteri, with gauze. The patient was discouraged and had made up her mind that she

would never get better. Under rest, diet, hot douches, vaginal tampons and *calcii phosphas præcipitatus gr. x, t. i. d.*, bleeding intermittently ceased.

The uterus was soft and rather enlarged. There was pain over the left ovarian region, but I could not detect any enlargement. The lungs and heart were normal. The urine contained a trace of albumen but no casts.

On the 16th of July, 1906, she went to the hospital for another cœliotomy. The temperature ran from normal to 100° F., the pulse from 100 to 112. Her weight was about 90 lbs. On the 17th July, Dr. Murray MacLaren saw her in consultation. We examined her under chloroform. The uterus was slightly enlarged, soft and movable; on the left side we could feel a small soft movable tumour, which we concluded was a cystic ovary.

On July 20th, assisted by Dr. Murray MacLaren, ether given by Dr. W. H. Weaver, I did a salpingo-oöphorectomy, curetted the uterus and packed the vagina with iodoform gauze. The ovarian cyst contained about two ounces of straw colored fluid.

The abdominal incision healed rapidly, but the bleeding per vaginam continued irregularly in small quantity for ten days. While in the hospital she had considerable nausea and frequent vomiting, headache in frontal and vertical regions with pain in the right eyeball. For nearly a month the temperature varied from 99° to 101° F, the pulse rate also increased. The persistence of this train of symptoms and the strong tubercular history suggested the onset of tubercular meningitis.

When she left the hospital on September 10th she was very anæmic, her

appetite was fair, and she had no menorrhagia.

On July 6th, 1907, the patient reports an increase in her weight and that she has had no further bleeding. The pain in the right eyeball persists and occasionally after over-exertion, she has frontal headache. Ophthalmological examination showed the fundi pale, vessels small, but no organic change; vision in both eyes was equal and normal. An artificial menopause is produced.

She is able to do housework and is now much encouraged regarding herself.

Remarks on the Diagnosis and Treatment. Hæmorrhages not connected with Pregnancy. The probable cause may be:

- (a.) Malignant disease of the uterus.
 - (b.) Fibroid tumours of the uterus and fibroid polypi.
 - (c.) Mucous polypi of the uterus.
 - (d.) Puberty.
 - (e.) Ovarian tumours.
 - (f.) Endometritis of the body of the uterus.
 - (g.) Hæmorrhagic diathesis.
 - (h.) Disease of the heart and liver causing venous congestion.
 - (i.) Pelvic inflammation.
 - (j.) Vascular caruncle.
 - (k.) Foreign bodies in the vagina.
- Ovarian Tumours.*—Lewers says :

“More commonly the disturbance of menstruation caused by the development of ovarian tumours is in the direction of amenorrhœa, the intervals between the periods being lengthened and the loss on each occasion less than formerly. Exceptionally, the growth of an ovarian tumour is attended with menorrhagia or metrorrhagia.”

Endometritis of the body of the uterus.—Lewers also says: “This is another cause of excessive loss of blood. The condition, however, is not well understood, and it is not easy to be certain of its presence in actual practice.” On bimanual examination there is slight increase of the size of the body of the uterus, tenderness of the body and great tenderness on passing the sound.

Penrose says: “Symptoms caused by follicular cysts are those of pressure and ovarian pain. The cyst may become impacted and adherent in the pelvis, and may cause pressure. * * * * In some cases follicular cystic disease of the ovaries is accompanied by menorrhagia, which is only relieved by oöphorectomy. This symptom, however, is not usual.” “If the operator is anxious to arrest menstruation, he must be certain to remove all ovarian tissue and the Fallopian tubes at the uterine cornua.”



OBITUARY.

DR. Edward P. Doherty, surgeon of the Maritime Penitentiary, Dorchester, N. B., died on the third of October. He had been in ill-health for several years, so the end which came gradually was not unexpected.

Dr. Doherty was born in Memramcook in 1861, and was educated at St. Joseph's College. He graduated at the University of Buffalo in 1884 and began the practice of medicine at

Moncton. Thence he moved to Meteghan, N. S. Later he practiced in Fairville, N. B. for several years.

In 1898 he resumed practice in Memramcook, and was appointed surgeon to the penitentiary at Dorchester in 1901.

He had excellent professional qualifications and a kindly disposition, and his death will be heard of with regret by very many friends.

PERSONALS.

Dr. W. R. Morse, formerly of Ohio, Yarmouth Co., has located in Providence, R. I.

Dr. Kenneth A. McKenzie, of this city, was married at Sydney, on the 19th ult., to Christina, daughter of Dr. D. N. Morrison. The NEWS extends its congratulations.

Major G. L. Foster, P. A. M. C., has returned from his course at Aldershot, England, and has been appointed Principal Medical Officer

Maritime Provinces, in place of Major Drum.

Capt. C. D. Murray, P. A. M. C., is now taking a course of instruction in Montreal.

Dr. W. D. Finn is visiting Boston and New York hospitals for a few weeks.

Dr. W. H. Hattie has left for Montreal and Toronto, to visit institutions in those cities.

Captain J. T. Clarke, of Toronto, is attached to No. 8 Detachment, P. A. M. C., Halifax.



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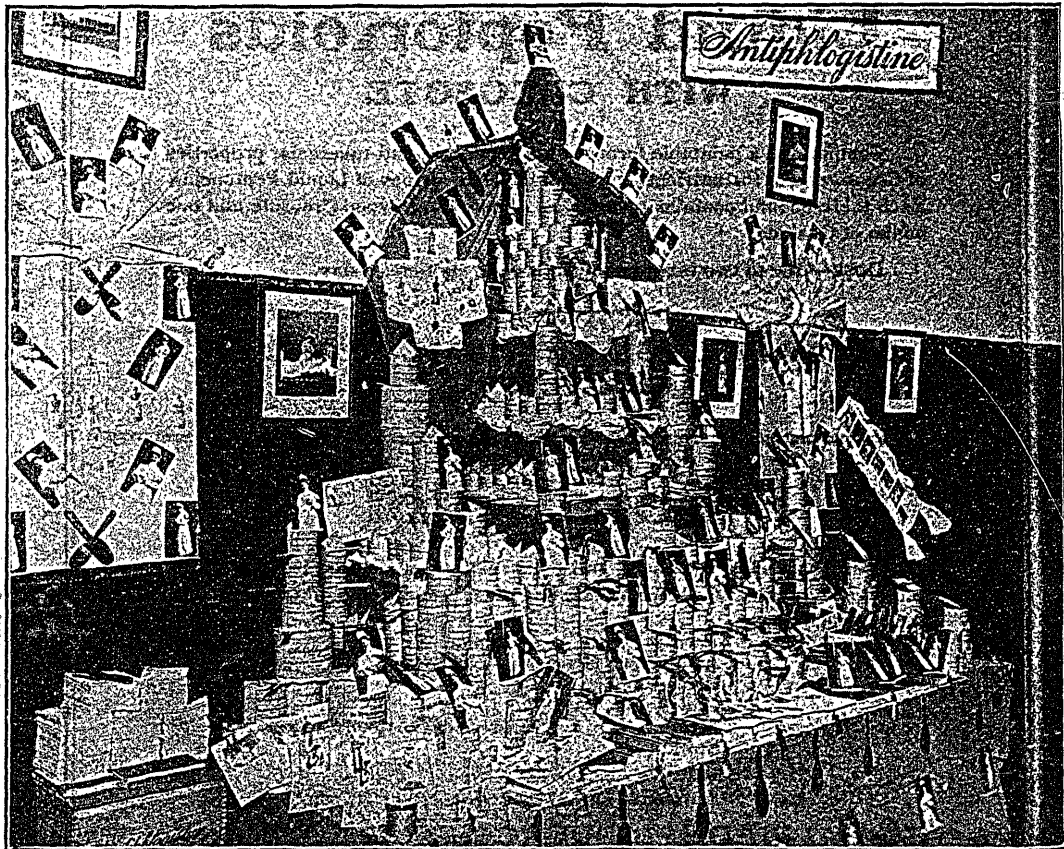
THERAPEUTIC NOTES.

The Care of Growing Girls.

One of the most responsible tasks of the family physician is to advise parents of girls entering upon their teens, as to the diet, mode of life, and hygienic measures best calculated to preserve the health of budding womanhood. In dealing with these cases the practitioner is often called upon to treat the anæmia which in such a large proportion of instances characterizes the unfolding of the growing girl. Full well does the family doctor grasp the meaning of this anæmia, and the vast importance of combating it before it is too late,—

before the impoverished condition of the blood of puberty has left its imprint upon the powers of resistance of the adult organism; has done permanent damage to the future woman and the future mother.

Unsuitable diet, an overindulgence in sweets or spices, over-study, lack of fresh air and physical exercise, indulgence in late hours and abandonment to novel reading, to tight lacing, and other abominations of dress, contribute their quota to the causes of anæmia in the growing girl. Each of these factors is, of course, removable by good common-sense advice



THE ANTIPHLOGISTINE EXHIBIT, CANADIAN MEDICAL ASSOCIATION, MONTREAL, SEPT. 11-13, 1907



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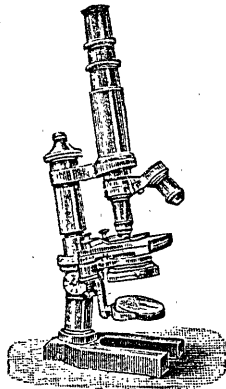
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to parents and by proper exercise of discipline. Still, when the damage has been done, we must assist nature in its generous work of restoration, and here it is that we are obliged to give that sovereign cure of impoverished blood, iron, in such form as may best be suited to these cases.

The question as to what form of iron we should give to produce the best possible effects has been solved by both experimental and clinical researches conducted during the past twenty-five years—ever since Bunge and Hamburger experimentally demonstrated the inferiority of inorganic preparations (Morat and Doyen, *Traité de Physiologie*, Paris, Masson 1904, I, 467). Iron, in the anæmia of puberty, produces the best effects when given in a form that will stimulate digestion and increase assimilation, i. e., in the form of the peptonate. With it should always be combined that second hematinic which has been shown to enhance the value of iron,—manganese,—and the two are best given in the form of the well-known solution, styled "Pepto-Mangan (Gude.)"

With this may be given, in the anæmia of growing girls, minute doses of Fowler's Solution, or else equally small doses of strychnia which may be incorporated with Pepto-Mangan as indicated in individual cases.

Pepto-Mangan has a great advantage over other forms of iron medication in that it does not constipate. Girls at puberty, however, are notoriously prone to constipation. Therefore, this should receive proper attention, chiefly in the regulation of diet, including a sufficient amount of fruit, raw and cooked, and of cereals giving a large residue of cellulose.

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*

Drugs to Assist Labor.

In *Merck's Archives* for August, James E. Davis classifies the drugs used to assist labor under three heads: those producing tetanic contraction of the uterine muscle, as ergot, hydrastis, cotton-wool, etc., those producing normal contraction, as kola, quinin, cimicifuga, glycerin, sugar, etc.; and those which act as general systemic tonics, stimulants, eliminatives, narcotics and anæsthetics. Ergot and other drugs of the

same physiologic type exhibit power, in full doses, to influence tetanic uterine contractions. All unstripped muscular fibres are stimulated. When ergot is administered in small doses, 10 minims or less, the effect is that of a stimulant to the normal intermittent contractions. The drugs of the nontetanic group produce a varying effect upon well established contractions; quinin in doses of 10 grains, fluid extract of kola in 30 minim doses, sugar in one ounce doses, fluid extract of cimicifuga in one dram doses, have resulted in a strengthening of the pains. The use of drugs to assist labor requires a good knowledge of the approximate time required for the desired physiologic effect, and this will, under certain circumstances, determine the particular drug or drugs selected. If given by mouth, ergot, quinin and most other drugs of their class manifest beginning

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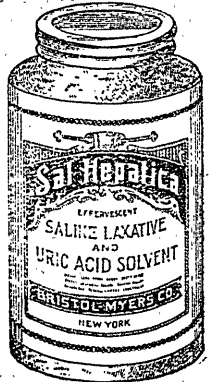
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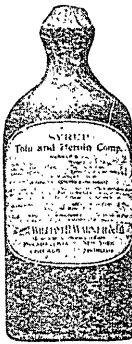
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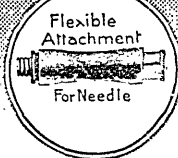
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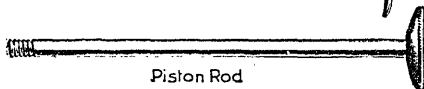
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