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Original Articles

PRESIDENT'S ADDRESS—ONTARIO MEDICAL ASSOCIATION.

BY N. A. POWELL, M.D., TORONTO.

GENTLEMEN,—To utter words of kindly greeting is always a grateful task, and to-day it becomes my pleasant duty to welcome you to the twenty-second annual meeting of the Ontario Medical Association. To all of you—to our guests, to old friends, and to those who are with us for the first time—I offer a greeting which is none the less sincere because it happens to be official. The Ontario Medical Association may be fairly taken as representative of what is best and most progressive in the profession of this Province. This being so, I would be an ingrate, indeed, if I did not, first before all else, thank you for the evidence of good-will shown in your having bestowed upon me for this year the office of president. Being deeply sensible of this kindness, the selection of a topic to which I might with advantage invite your attention, has weighed heavily upon me. If one could have been found the intrinsic interest of which would more than have atoned for my own imperfect presentation of it, then, indeed, I should have felt a measure of contentment. I can claim no marked success in the quest for a subject such as this, but a number of topics seem to have sufficient interest to justify their discussion in your presence. The first of these has to do with

bearing of recent and of pending legislation, Dominion or Provincial, upon the welfare, the rights, and prospects of Ontario physicians. Before entering upon any consideration of these matters, it is just as well that we should put aside the modesty with which we have for a long time been tongue-tied and claim boldly that in regard to the regulating of the study and practice of medicine by legislation, this Province has been and still is in advance of any other Province or State on this continent. More than this, our methods of conducting examinations by a board representing all the interests concerned, and having the sole power to confer license for practice, while it has served as a model for the organization of many State boards, is still better than any other. Our examinations have been and are more exacting and searching and our standards are higher than those of any other State or Province. The influence for good which has thus been exerted cannot easily be computed. It is quite true that *upon paper* examinations have been set which would appear to present greater difficulties for students, but the percentages required for a pass and the proportion of candidates rejected have uniformly been lower than has obtained with us. Numberless students who, after being graduated here, have passed some one or more of the better class of State examinations in the United States, or have taken degrees in our Mother Country, testify to this fact. Their uniform report is that our examinations present greater difficulties than any other. The net result of the operation of the Ontario Medical Act of 1869 and of amendments thereto has been that there is to-day in this Province a profession of which we can justly feel proud, and that scattered over the world are countless progressive and successful physicians who, having been trained here, owe no small measure of their success to the fact that for more than thirty years the medical colleges of this Province have had to teach up to the requirements of a rigid State examination. We are proud of this record as a record, but what has been done is of importance mainly as indicating what better results may still be attained. Where we stand on any question or what we have done, is of less importance than the direction in which we are moving. In medicine we are facing a wonderful to-morrow! The measureless growth of its sciences within recent years, imposes upon us grave responsibility, and we cannot afford to "mark time" while other and even less favored States or Provinces are progressing.

Claiming all that I have for the Ontario Medical Act and

its influence upon the profession here, I am far from claiming that it is incapable of improvement, or that its provisions have always been wisely and judiciously administered. A long series of indictments could be laid against successive Medical Councils. If I were to undertake even an enumeration of the mistakes, the shortcomings, and the follies of these bodies, I should have no time to discuss them. It is the part of wisdom to learn from the mistakes of others, and, recognizing such mistakes, let us try for the future rather to avoid and correct them than to waste time in harping upon them.

During the past winter a bill to amend the Ontario Medical Act was introduced into our Provincial Legislature by Dr. Jessop. In brief, this bill asked that the Medical Council should be composed entirely of the territorial representatives, and that the universities, the medical colleges, and the homeopathic faction should no longer have direct representation. Although without mandate from you upon the matter, I felt called upon to oppose this bill, for reasons with most of which I need not trouble you just now.

Admitting for the sake of argument that the homeopathics are over-represented, we still must remember that when our Act was passed, a direct bargain was made with these gentlemen, and that it should be carried out in good faith till changed by mutual agreement. Those who trade on the name of Hahnemann, or who, at a greater or less distance, follow his vagaries, are diminishing in numbers and in influence, and for us to drive them into making application for separate incorporation and into the position of an oppressed minority, would be foolish in the extreme. As to the right of representation of the universities actually engaged in the educational work of the country, and of the medical colleges, there can be no question. It does seem to me, however, that the members of the Medical Council who represent charters in abeyance, or universities having no direct interest in medical education, should no longer have the right to appear at the Council meetings, and that our Act should be amended so as to reduce the membership and expense to this extent.

Dr. Jessop's bill was thrown out with, I believe, a strong feeling on the part of the House Committee which dealt with it, that some such provision as this should become operative in the near future.

A measure of much greater importance to us is the one promoted in the Dominion House by Dr. Roddick, and providing for inter-provincial registration. This measure has passed

the House, been amended in the Senate, and received Vice-regal sanction. Members of this association will recall the fact that Dr. Roddick strongly advocated his bill from this platform two years ago. They may not as easily recall the fact that I objected to the measure as being manifestly and disastrously unfair to Ontario. As then put forward, the bill gave as large a representation to Prince Edward Island, to Alberta, and to other provinces with a few score of practitioners as to this Province with over 3,000 registered practitioners.

I am glad to say that the protest we raised was effectual, and that the bill was re-drawn with the representation arranged upon a more equitable basis.

An examination of the bill as it finally passed the Senate leads me to fear that it has been emasculated, and is now potent neither for good nor harm. I may be wrong in this estimate, and since the main object of the bill is a desirable one, I should be glad to find myself mistaken. What we in Ontario must guard with jealous care is the standard which we now have. There must be no leveling down to meet the needs of schools in any part of the Dominion. Pledges will not suffice; we must have power to prevent it being done; and if we have such power and use it, I am exceedingly doubtful if we shall ever see the Act in operation.

During the session of the House of Commons just closed the Canada Evidence Act of 1893 was amended so as to limit to five the number of expert witnesses who may be called on either side, in civil or in criminal cases when the consent of the judge for the calling of a larger number has not been asked for and obtained, before beginning the examination of the first witness to give opinion evidence. This, in my judgment, is a sensible enactment, tending to lessen, but not competent to remove certain abuses which His Honor Judge McDougall may touch upon in his address before you to-night. It will have some tendency to lessen the advantage which always goes with a long purse in litigation, but it appears to run counter to the statement, which we have from the very highest of authorities, that "in the multitude of counsellors there is safety."

The development and extension of cottage hospitals in very many of the cities and larger towns of Ontario, is a movement in the right direction, and a natural outcome of the more complete and practical training which our students are now receiving. It has greatly increased the number of positions as house surgeons, now available, and these positions become year by year a more important factor in medical education. The status of

the hospital interne in Ontario is a live subject, and in order that it may be studied from a view point new to most of us, I have asked a gentleman, who is still a hospital resident and who is filling his position with advantage to his hospital and credit to himself, to read a paper on the subject at this meeting. I hope he will take up the appointment of graduates in medicine, who, on account of our fifth or so-called clinical year, are still without the license to practise, that he will discuss the relation of these gentlemen to the administration of anesthetics, and, most important of all, that he will consider the advisability of the appointment of a certain proportion of the house surgeons of our larger institutions every six months, with a graded service of eighteen months, instead of our present unsatisfactory plan of appointing all together once a year, and for one year only. In a recent visit to some of the surgical centres of the neighboring Republic, I was impressed by the fact that no surgeon whom I saw at work was doing better operative surgery than is being done here from day to day, but that the assistance given and the "team" work, if I may borrow a term from the campus, was far and away better than anything we see here. We have as good or better men to select from, but the present plans of appointment and terms of service do not give them half the chance they should have. Besides that, every operator is handicapped by having as his chief assistants men who have just been appointed, and by losing them when they are becoming trustworthy and helpful. A graded course, with responsibility increased as experience is gained and with men who are lazy or inefficient weeded out at the end of the first six months, would be better for the residents themselves, infinitely safer for the patients, and would help the surgeons who are operating to obtain the results they individually strive for. The first six months of such service would naturally be spent in performing the less responsible duties of the position, and during this time, in my opinion, the administration of anesthetics should be placed in other hands.

In another respect we appear to be falling behind the procession. While here in Toronto, as I know, and in Kingston and in London, as I fully believe, excellent teaching is given to undergraduates in medicine, we have so far failed to make adequate provision for post-graduate instruction. As a consequence, gentlemen desiring to review courses have been going in large numbers to Manhattan Island and to certain large towns in Pennsylvania, Maryland, and Illinois.

We have the men, the hospitals, and the material to meet

all needs, but they are not utilized as they might be. In the past professional jealousy was so keen and controversy so bitter that success would have been hardly a possibility. Now, *Laus Deo,* we know each other better and out of mutual respect can come united and successful action. True, we are given to criticizing each other a good deal, but with rare exception, this is in the spirit of rivals rather than antagonists. Old animosities are dying out and are not being replaced.

"The teeming future,
Glorious with visions of a full success,"

Holds for us a grand, united, and splendidly equipped school of medicine, doing for the students of a coming time what in an imperfect and patchy way we are striving to accomplish now.

I have faith in that future and in the men who shall sway its destinies, and believe that with absolute fairness to all real interests the wisest course can be found and followed.

The reaper whose name is Death, has not been idle in the year that has passed since we last met. Your Committee on Necrology will present the names of certain of our members who rest from their labors and whose memories we honor. Permit me to refer to two only of the number: Dr. John Coventry was president of this association in 1899, and well and worthily did he perform the duties of his office. He died from the disease which cuts off, in the midst of their greatest usefulness, so large a number of physicians—from an acute pneumonia. Leslie M. Sweetnam, in the full tide of professional success and with an ever-widening circle of patients and of friends, who appreciated his sterling worth and who loved him for what he *was* as well as for what he *did,* fell a victim to blood-poisoning received in operation—I had almost said to a wound received in action.

In one of the songs which Homer chanted when the world was young we hear Idomeneus crying to Nestor:

"Worth many a life is his
The skilful leech, who knows with practised hand
To extract the shaft and healing drugs apply."

If this were true when men were wild and when human resources were few, how shall we estimate the value to the communities in which they practise, of wise and prudent physicians, honest to their own consciences and armed with all the aids which advancing science has placed in their hands?

Looking further afield we have to regret the death of a man

who, with the possible exception of the elder Gross, did more for the development of surgical pathology than any other surgeon in the New World. Christian Fenger was your guest three years ago, and those who met him only at that time will join with all who knew him more intimately in the belief that he has made a lasting impression upon surgical science. Recalling the fact that surgical pathology has progressed more rapidly than any other department of medicine; that, as has been truthfully stated, it has made more progress in the last thirty years than in the previous thirty centuries, we can appreciate the splendid work which this great investigator and teacher was able to crowd into thirty-five years of professional life. His work and the work of others like him will live. Their best knowledge will continue to be utilized for the benefit of mankind.

" Were a star quenched on high,
For ages would its light,
Still travelling downward from the sky,
Shine on our mortal sight.

" So when a good man dies,
For years beyond our ken
The light he leaves behind him lies
Upon the paths of men."

The interest you have always shown in the Ontario Medical Library and the financial aid you have from year to year given towards the upbuilding of a working library for all the physicians of this Province, leads me to mention that after the death of Dr. L. M. Sweetnam, his friend and our friend, Dr. Howard A. Kelly, of Baltimore, authorized me to select from Dr. Sweetnam's extensive library every book not already in the Ontario Medical Library, and these, to the number of about three hundred, he purchased and presented to us. He did this in order that the collection should be kept together, and should form in some degree a Memorial Library. Dr. Kelly's action was a pleasant surprise to many who did not know him; all who have the pleasure of knowing him intimately recognized it as just another large-hearted, generous act, such as he is continually doing. Dr. Osler's establishment of the Bovell Memorial Library in honor of an old teacher of his, was along the same line, and may have prompted this latter gift. I am glad to be able to tell you that through the generosity of the president of the Library Association, Dr. J. F. W. Ross, a catalogue of the principal works now on our shelves is being printed, and copies will shortly be sent to members of this association. They will

then be enabled to see what an extensive library has been accumulated, and should remember that these books are at all times available to them without expense.

The continued presence of smallpox in Ontario, the large number of cases reported, and their wide distribution, are causes of regret, of alarm, and of humiliation. Of regret, on account of the loss of life, the direct expense, and the indirect interruption of bread-winning involved; of alarm, because the end of the outbreak does not seem to be as yet in sight; and of humiliation, because we appear to have taught the public less faithfully than our fathers did the demonstrated fact that this disease can be controlled, and in times of epidemic can only be controlled, by vaccination and re-vaccination. Two of the factors which increase the difficulty of stamping out smallpox undoubtedly are humbug vaccination and a failure to make the differential diagnosis between this disease and chicken-pox. In regard to the first, let me cite the case of a girl exposed to so-called chicken-pox occurring in a man who had come here from Cleveland. This man lied to his physician about his symptoms. I cannot use Browning's euphonism and say, "He fell from truth in climbing toward it"; he knew that he had been exposed to smallpox and that he had the symptoms of that disease, but to avoid being placed in quarantine, he lied, and as a result his physician took smallpox and died from it. The girl referred to and one other member of a large family had certificates of vaccination, but no scars, and both took the disease. Both had been "vaccinated" by a physician who did not believe in Jenner's discovery and who had used the uncharged ends of ivory points in performing the operation. Justice fails when a man who spreads smallpox is not made to atone so far as he can for his offence by serving a long term in the penitentiary. May I here raise the question of the necessity for a standard certificate of vaccination stating the result obtained in each case, and may I in this connection also ask if the time has not arrived for placing chicken-pox on the list of diseases which must be reported to our medical health officers?

It is a matter for mutual congratulation that we have now available in our gloriously health-giving Muskoka region a hospital for the free treatment of fifty patients with incipient phthisis. If my own connection with this and with its sister institution, the Muskoka Cottage Sanatorium, had been less intimate, I might have been tempted to say more regarding them. Old men are said to talk of what they have done, children of what they are doing, and fools of what they are going to do.

As I am no longer a child, have not as yet begun to grow old, and cannot bel /e you would have placed one of the third class in the chief office of this association, I am precluded from entering into any detailed statements at present. Instead, let me be content with extending, on behalf of the Board of Trustees of the National Sanatorium Association and of my associates of its medical staff, a cordial invitation to each one of you to visit Gravenhurst at your earliest convenience, and to see for yourselves just what is being done. Let me assure you that the "latch-strings" there always hang outside for the members of this association.

Perhaps from a professional standpoint the most regrettable incident of the year was the simultaneous publication in all of the Toronto daily papers of advertisements of the so-called "Ramage process" for the cure of phthisis as "demonstrated" at a private hospital here. The hospital in question is conducted by two of the members of this association, and the advertisements to which I refer appear to set at defiance the code of ethics which we have adopted and by which we profess to be governed. I would willingly have passed over, in silence and sorrow, these publications if it were not for the conviction that by so doing I would have shown a cowardly dereliction of duty. The medical men to whom I have referred are engaged in active practice and are reputed to be wealthy. By their direct connection with flagrant advertisements of this character, they appear to have established a *prima facie* case against themselves. If they are right in what they have done and are doing, they should be given an opportunity of proving it and of removing the stigma that now rests upon them. The matter is one for consideration by our Committee of Ethics, and to this body I now officially transfer it, in the full belief that it will be dealt with fairly, courageously, and in a spirit of professional self-respect.

Before closing it is only right that I should express my deep sense of obligation to the gentlemen who have labored so earnestly to make this meeting a success. In times of political excitement like this I may refer to them as my Cabinet, Dr. Parsons being Secretary of State; Dr. Fotheringham, Minister of Education; Dr. J. M. Cotton, Minister of Public Works; and Dr. A. R. Gordon, Chancellor of the Exchequer. How efficiently they have labored will never be known, because they are far too modest to speak of it themselves and I am much too prudent to let the real facts escape, lest I should lose all credit for the result attained.

I am sure, gentlemen, that we have all watched with keenest interest the movements of the armies of our Empire, which in South Africa have been making history. We have felt an honest pride in the bravery and fighting skill of the thousands who have gone from Canada to aid the Mother Land. Only a few days ago we were thrilled with the story of how Canadian surgeons at Hart's River for a whole day long and under a withering fire of shot and shell went on with the work of caring for the wounded. While we unite in profoundest thankfulness to Almighty God that the end of this bitter struggle has come, we exult in the part taken by our own country in a conquering peace. We have fought a good fight! we have kept the faith! What has been gained?—

"Do you not see your Greater Britain's soul
Has come to birth?
Do you not hear above the sighs, the song
From all those outland hearts which peace kept dumb?—
'There is no fight too fierce, no trail too long,
When love cries 'Come!'"

TUBERCULOSIS AND THE HOME.

BY ALEXANDER MCPHEDRAN, M.B., TORONTO,
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It is in the home that the great majority become infected with tuberculosis and it is in the home that they have to be cared for; therefore, the relation of the home to tuberculosis becomes the most important of all the practical aspects of the question of the prevention and cure of tuberculosis. Careful examination shows that the death rate from this disease is steadily decreasing, so that the risk of dying from it is probably not more than half as great as it was in the time of our grandparents. This improvement is due chiefly to the better sanitary state of the home and its surroundings; but partly also, without doubt, to the improved conditions of living, especially in regard to food. In the prevention and treatment of all diseases it is as essential to have an intelligent public as an educated profession. This its true, for example, of diphtheria, smallpox, scarlet fever, and typhoid fever, for without an intelligent observance of the requirements discovered by the science of medicine as necessary to prevent and treat these diseases, physicians can do little towards gaining the object aimed at. This is well illustrated

in regard to smallpox, which cannot be controlled unless the public submit to vaccination, which, if properly observed, has been so amply proved an efficient preventive of the disease. Of tuberculosis it is no less true that unless the public duly appreciate and put into practice the means that have been evolved and proved efficient by the profession in the prevention and cure of the disease, physicians will be able to accomplish little, notwithstanding the marvellous advance made in our knowledge of the disease. The public is slow to learn, and it is only by patient and constant repetition of the dangers and the means to be adopted to prevent them, that we can hope for success.

Tuberculosis stands by itself in many of its characteristics: its insidious beginning, its slow progress, its protracted duration, and its apparent want of contagiousness. All these characteristics render it difficult to prevent, no less than to cure.

Tuberculosis is not contagious in the sense that smallpox, scarlet fever, etc., are contagious. There are no emanations from the sufferer carrying the poison of the disease to those about him. All the germs of tuberculosis are practically contained in the sputum, and that is easily collected and destroyed. Like typhoid fever, it is easily managed so as to be without menace to the other occupants of the house. Typhoid fever never spreads to those about the patient if the excreta are scrupulously destroyed and due cleanliness observed. So it is with tuberculosis : if the excreta are carefully destroyed and due cleanliness of patient and surroundings observed, those living in the same house are quite safe; they will never contract the disease from such exposure. Cleanliness of the house, however, means purity of air, as well as of floor, walls, clothing, etc. The abundant furnishings too often seen in the homes of all classes are detrimental to the inmates, because they collect dust which is being constantly thrown into the air of the room. The less the hangings and furniture the more easily is the air of the room kept pure and free from germs of all kinds, especially those of tuberculosis. It is quite impossible to have the air pure and have the walls covered with draperies, etc. With thoroughly clean floors, walls, and furnishings, and an abundant supply of pure air, the presence of one or more tuberculous persons is no menace to anyone in the house; the disease never spreads from the sick to the well under such circumstances. If we get the general public to fully understand this truth, we will have done much toward checking the spread of tuberculosis in every home in which there is one or more affected persons. Such knowledge will also prevent the fear of contagion that is be-

coming so unreasoning. The disease is without danger if proper care is observed.

The absolute control of the contagion is well shown in sanatoria. No one has become infected in these institutions, or in their neighborhood, from them. This is well illustrated by the fact that in localities in which sanatoria have existed for some years the occurrence of tuberculosis among the local population has markedly diminished. This is due to the education of the people by the example set by the sanatoria. The people are gradually educated in the care of their homes and in the necessity of outdoor life, and their health is improved as a consequence. If our homes were made as sanitary as the sanatoria, tuberculosis would soon cease to be found in them, except the occasional cases coming home after being infected abroad.

Tuberculosis may be classed with typhoid fever as a "filth disease"—a disease propagated by want of cleanliness in its widest sense—a cleanliness that means purity of air, of house, of food and drink, as well as of person. With improvement in water supply and in drainage, typhoid fever has been lessened in Toronto, so that there is not now one case for every twenty that occurred fifteen years ago. Last year there were relatively few cases, yet all these were unnecessary; they were the tribute paid to want of cleanliness. Of this both the public and the profession should have no doubt.

In regard to tuberculosis, neither the public nor the profession yet fully realize that it, too, is a disease acquired through want of cleanliness, which leads to infection of the air breathed; and that it can, therefore, although with great difficulty, be prevented with as much certainty as typhoid fever. When this is once realized it will be comparatively easy to adopt the means to arrest the spread of infection. The well-kept house needs but the "open window" to render the spread of the infection in it impossible, even although one or more of its inmates are affected by the disease.

The prevention of typhoid fever rests chiefly on the proper performance of duty by the authorities that have to do with water supply and drainage. In tuberculosis, on the other hand, prevention depends chiefly on the individual. If he sees to it that the air of his home is pure, he fulfils the first great requirement in preventing the occurrence of tuberculosis in his household.

It is important that every facility possible be provided to encourage a life in the open air. All houses should, therefore, as far as possible, have ample verandahs and balconies at-

tached to them. Such conditions not only encourage an out-of-door life, but also create a greater desire for fresh air, with the result that the windows and doors will be oftener open. It will naturally follow that greater care will be taken in the beauty and cleanliness of the surroundings, and thus improvement follow in the sanitary condition of the neighborhood, whether it be city, village, or country. Such improved conditions in the home, as well as in the surroundings, would benefit the sick and the well, and result in the production of more vigorous health in people generally. A healthful life in fresh air, with sanitary surroundings, is necessary not only for making the sick from any cause well, but also no less for making the well more vigorous and preventing their becoming sick. Unless care is taken the public may soon come to think that fresh air is of importance in the treatment of tuberculosis only, and that it is of no consequence in connection with other conditions.

Briefly stated, the prevention of tuberculosis can be effected without any doubt by having the air in the homes, workshops, stores, halls, etc., pure: that is, that the air, wherever breathed, by men or animals, shall be pure. This is a difficult condition to fulfil, but it should be aimed at, for the higher our aim the nearer will we come to attaining our object.

151 Bloor Street West.

A CASE OF APPENDICITIS.*

By J. O. Todd, M.D.,
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The genial secretary of this association, in answer to my query as to what subject would be most acceptable on his programme, said: "Anything you like, so long as it will provoke a discussion." I, therefore, had not to climb very high on the ladder of alphabetical indices to reach such a desired topic, for "A" stands for appendicitis; and on looking over my list of cases for such as would seem to be of most interest, it occurred to me that it was not the most complicated or uncommon cases that would be provocative of the greatest discussion, but rather the simpler ones; for, it seems to me, the point in the discussion of appendicitis to-day lies not in the question of method

* Read before the Southern Medical Society of Manitoba.

in operating, but in the determination of whether we shall operate at all or not; and this question lies before us, not in the difficult and well-established cases of appendicitis, where operative measures are imperative, but in those simpler ones of much more favorable prognosis. Hence, Mr. President, I have to give you only a "first attack" for the assembled gentlemen to "chew the rag on." I use the phrase advisedly, sir, for I have the authority of Brauder Matthews for it in a recent defence of Americanisms.

Miss S., of Manitoba.—Treated in private ward of Winnipeg General Hospital. Her family physician stated in a letter that she had an attack of appendicitis three months ago; that she had been laid up in bed three weeks with pain, abdominal rigidity and marked tenderness in the right iliac region. These symptoms had been intense for one week, and then gradually subsided. Temperature had been taken irregularly, but had registered 101 3-5 F. There was some vomiting at the commencement; but this soon subsided. Bowels had always moved regularly up to the onset of the attack, but then became constipated, and have so remained since. The treatment was enemata to relieve the bowels and local applications of heat. Neither opium nor salines were used. From the patient herself I find that she had never had other severe illness. This attack came on with severe abdominal pain, which became gradually more intense, eventually settling and remaining for a week in her right side. She cannot attribute any cause, never having been troubled with indigestion, constipation or diarrhea. Physical examination reveals some tenderness and slight resistance over McBurney's point, but no tremor. Per rectum nothing definite could be found except that uterus and appendages were normal.

Here we have a case about as simple as possible, with symptoms just clear enough to establish a diagnosis. Its clinical course indicates only the simplest measures, and yet, with the knowledge of a second case to-night in my mind and its fatal outcome, I freely admit the great concern I felt in advising this patient to postpone operative interference.

The two questions I am going to raise in this case are: (1) Was an operation at any time in its course demanded, or is it demanded now? (2) Is operation now justifiable? Of course, if the first question is answered fully in the affirmative, the second falls; but if the first is negatived, then the second is in order; and I submit that it is upon the true answering of these questions that our consciences are cleared in our dealings with this dreaded and treacherous enemy of mankind. My answer to the first

question, "Was operation demanded in its course, or is it demanded now?" is: No. I am well aware that in so doing I cannot be classed as a follower of so well-known an authority as Dr. John B. Deaver, of Philadelphia, whose pronounced opinions are given to us in his own book, for, I contend, his cases therein noted are, with few exceptions, of so decided a character that, truly, they admit of no discussion as to the appropriateness of surgical interference. The dictum of Dr. Deaver, "operate upon diagnosis," put into general practice, would, I fear, subject that clever operator to the danger of being made the practical demonstration of the burden of Kipling's well-known ballad—for many good men and true would be for "a hangin' Donny Deaver in the mornin'," and, Mr. President, a quotation from a paper given by a prominent United States operator would, I fancy, justify them in "a hangin'" of somebody else, for this eminent person lays down the teaching (I give the words as published), "An appendix is better in a bottle than in a belly."

There is a noticeable predominating feature in Dr. Deaver's cases. They "recovered uneventfully." This, in spite of the fact of counter-advice causing delay, in spite of all sorts of odds and ends being found in the appendix, such as pins, pus-sacs, perforations, and of doubles and twists in the shape of the appendix, enough to puzzle, one would think, a Philadelphia doctor as well as a lawyer.

The fact that these cases so uniformly recover after such vicissitudes of delay would seem to be an argument rather favoring delay than haste in operative procedures.

A calm writer in the "Encyclopedia Medica" says: "Surgeons who see only the most severe cases are very apt to have false ideas of the great mortality in cases of appendicitis which are not operated on." I think this is very true, for impressions derived, as Dr. Deaver's are derived, from hospital experience alone, are apt to be dyed in the deepest red, since it is notorious that hospitals get the worst class of cases. We need, then, the reports of the physicians in general practice amongst whom there is the highest percentage of recoveries. We want the physician practitioner to assert himself and tell us his numbers of recoveries and deaths in cases given medical treatment alone. It is, happily, quite true that in skilful hands and under careful technique that the mortality of simple opening of the abdomen with excision of the appendix is extremely low—1.8 per cent.—but let a hand be imperfectly cleansed, a ligature touch an unclean spot, a wipe escape the arithmetical powers of the nurse,

let any one of the many links that make up the chain of aseptic technique be broken and we know what are the results—not always a death; hence the evils that attend operative interference are not reckoned with under such a statistical showing as a 1.8 per cent. mortality; but in those troublesome suppurations from stump or abdominal wall, in rupture through the scar, in mucous sinuses. I am afraid, Mr. President, if I go on in this strain that I shall lay myself open to a charge of treachery to my college chair. My motives, however, are far from such a taint, for it is my supreme confidence in moderate, discriminative surgery of the appendix that fortifies me to proceed. I hold, sir, that surgical excision of the appendix is unsatisfactory on too many counts to make it a specific for appendicitis. Medical treatment is still more unsatisfactory. Hence await we the coming of a line of treatment that will be certain, radical, and rational, and with the haziness surrounding the microbic factor in the etiology of appendicitis cleared away by more accurate knowledge, is it too much to hope for an antitoxin that will combat the destructive microbe's products? The second question, is an operation justifiable? I ask because the surgeon is frequently placed as I was placed in this case, in the position of being asked to operate, and I have to answer to it—yes; for while, to my mind, the evidence before us is too biased on the surgical side to justify our insisting on excision, I am yet free to admit that our knowledge of the course of appendicitis is sufficiently clear to support us in taking the stand, that the probable future of the patient, as horoscoped through her appendix, will be darkened by a recurrence of the attack in a simpler or severer form. With these uncertainties before us I therefore think we are justified in favoring rather than opposing excision; and when after a few days' consideration this patient returned, asking for immediate operation, I felt clear in acceding to her request.

The patient on the operating table, the method of opening the abdomen comes up for selection. I adopt the McBurney layer method, by which a two-inch curved incision, the upper third intersecting McBurney's point, opens skin and fascia to external oblique; this is cut by nicking its fibres, pushing a grooved director beneath and cutting parallel to its course; the internal oblique and transversalis are separated by the knife handle in the direction of their fibres, which in this region are so nearly alike that distinction is needless; the transversalis, fascia, and the peritoneum are cut by separate intersecting incisions. There are objections to this method. It is not, I think, adapted to drain-

age cases. It renders manipulation more difficult in thick abdomens, or where adhesions are extensive, but it seems to me the two latter objections are counterbalanced by the lessened risk of subsequent hernia. I have to operate in a day or two upon a very large ventral hernia through the ordinary oblique incision that healed kindly under the careful hands of a former member of our staff. The base of the appendix was easily located by following the cecal longitudinal band, while the balance of the organ had to be liberated from a bed of recent adhesions. Choice of method of amputation now comes up. My early impressions were in favor of the cuff method, by which a peritoneal flap is stitched over an absorbable ligature, constricting muscular, submucous, and mucous layers. I now feel that this method is unnecessarily complex for many cases. I use it only in those cases of thick cecal ends, for it undoubtedly lessens the danger of infection from everted mucous surfaces by retaining the infective products within the peritoneal cuff, while plastic peritonitis is going on without. But given a smaller organ, as in this case, I feel safe in ligating over the peritoneum, cauterizing with pure carbolic and drawing together, by a few sutures, adjacent peritoneum. The abdomen was closed by tier sutures of catgut and a subcuticular silk.

PREVENTION OF THE SPREAD OF THE ZYMOTIC DISEASES.

By D. Gilbert Gordon, M.D., Toronto.

A very large part of the sickness from which we suffer, especially in our cities, is no doubt due to one or other of the diseases commonly spoken of as zymotic. Among these, I think, should be placed pulmonary tuberculosis. When we consider that these diseases are conveyed only from the sick, directly or indirectly, we realize how much could be done if proper care were exercised to prevent the spread of these, ordinarily called "dirt diseases."

The importance of such prevention is very great, not only because of the danger to life to which the affected one is exposed, the suffering and expense entailed upon them and their friends, but also because of the unfortunate sequellæ often following such. The domestic means which may be used to pre-

vent the spread of these diseases is the subject of these few pages. So much is being said just now with regard to pulmonary tuberculosis that I will not refer to it. Smallpox, too, is outside of our field, being completely taken charge of by health officers.

Typhoid Fever.—The bacteria in this disease most authorities agree is the bacillus described by Eberth and Gaffky. While there are some who would support Murchison's theory that the disease may be produced *de novo,* still there are many who believe with Prof. Vaughan that it may be produced by one or many bacilli resembling Eberth's bacillus; and really the evidence given in favor of this theory is quite fascinating. One thing, however, all are agreed upon, and that is, that the contagion reaches the body by the stomach, through the medium of infected food or water. The report of the commission appointed by the United States to investigate the cause of the severe epidemic of typhoid among the troops in the late Cuban war is instructive in this respect.

The source of infection is what concerns us in our attempts to prevent its spread; while the theory of Pettenkofer is now no longer tenable, that the contagion does not come from the patient in a form which can produce the disease, yet there is ground for the theory, for recent investigation makes clear that the bacillus becomes more virulent after exposure to the air, especially so if the air is foul, as for example, soil air or sewer air. The virulency is markedly increased by its deposition in the soil, especially when the nitrification process is active. It is easy to understand how the severity of an epidemic, as well in the number of cases attacked as in the acuteness of each case, will depend on the surroundings. For instance, a well is polluted by absorption from soil in the neighborhood of a barnyard, cess-pool, or privy-pit. The bacillus being conveyed through such media would be much more virulent and produce a more violent attack than if produced under more sanitary conditions. The place to do the most effective preventive work is undoubtedly the bedroom. If all feces and every article which might possibly come in contact with the feces were thoroughly disinfected, the disease would be stamped out.

As the bacilli are also found in the urine, it should also be disinfected. With regard to the treatment of the feces, much care should be exercised. Such solutions as chlorinated lime, six ounces to the gallon; bi-chlor. of mercury, 1-500 acidulated. Pure carbolic and glycerine, equal parts, are useful. This solution is declared by some to be valueless for this purpose, as the germ is found to thrive in carbolic.

The solution used should always bear a relationship in quantity to the amount of the stool to be treated, all solid material should be broken up. The discharge and the stool should be kept in contact for about four hours. A rubber sheet should be worn next the mattress, and all linen should be soaked in carbolic solution before being sent to the laundry. The patient's food refuse should be destroyed; the dishes used by the patient washed in the room. The nurse should be careful to disinfect her hands after handling the patient or the linen before touching any of the food used by others.

Diphtheria.—The etiology of this disease is still considered by some uncertain; for often it will appear independently of any pre-existing case. Such appearance is generally associated with dampness of soil and decaying organic matter, and no doubt is to be accounted for by the fact that the diphtheria bacillus is present, and can wait its opportunity, on account of its capability of retaining life for a long period when the surroundings are favorable. The most fruitful source of infection in this disease is no doubt the inhaling of particles of infected membrane direct from the patient during coughing, sneezing, singing, or speaking, or from dried membrane flying about. There is evidence that it can be conveyed by milk, but none that it ever comes from the cow, neither is there any evidence that it is carried through the medium of water; neither has it been shown that it is ever carried by domestic animals. Although cats and dogs are afflicted with a disease resembling diphtheria, yet it is found to be an entirely different disease.

Some have claimed that a true diphtheria throat may be found in a patient sick with scarlet fever, apart from infection from a pre-existing diphtheria patient. That there is such a thing as post-scarlatinal diphtheria is certain, but it is probable that the prevalence of this disease after scarlet fever is accounted for by the fact that the fauces and nasal passages are in a suitable condition to lodge the bacillus diphtheria. It is certainly suggestive that it occurs thus almost entirely in hospitals where both diseases are treated. The prophylaxis in this disease should be directed towards the complete disinfection of any exudation from nose or throat and the quarantine of the patient during the infected period.

Dr. Herman Biggs (New York Health Department) after a careful bacteriological examination of the passages of 405 cases, found that in 245 cases the bacilli disappeared after three days, in 103 after 7 days, in 34 after 12 days, in 16 after 15 days, in 4 after 21 days, and in 3 after 35 days.

In the laboratory of the Board of Health of Philadelphia the average persistence of the bacilli is 29 days. In one case the persistence was 112 days.

In 2,150 cases examined in New York a few years ago, the bacilli were found to exist in 9 of these cases for from between 56 to 90 days. At the same time in the examination of 350 cases not known to be exposed to the disease, 8 revealed the bacilli, two of whom afterwards developed the disease, while in six of these bacilli existed exactly resembling the Klebs-Lœffler, but were not virulent in animals.

The bacilli are found to live as follows: on gelatine, five months (Hoffman); on blood serum, seven months (Lœffler); on dried membrane, sixteen weeks (Lœffler); on dried membrane, seventeen weeks (William Park); on silk and clothing, one hundred and seventy-two days (Abel). The necessity, therefore, of keeping the patient in quarantine until a careful culture examination shows the throat and nose clear, and of a careful disinfection of all articles coming into contact with the disease is important. This is being more fully recognized here, as in other places. For example, in Minneapolis a school building has been erected in order that children in quarantine should not lose their time. During this time the frequent treatment of the throat and nasal passages by a suitable disinfecting solution should be practised; and during the time at least that the patient is kept in complete isolation it is wise to keep the air of the room saturated with medicated steam.

Scarlet Fever.—The infectious material in this disease is, unfortunately, not known. That it is due to some one of the streptococci is not generally believed. One thing, however, is certain, and that is, that it is very tenacious of life and easily transmitted.

The main medium of its transmission is the desquamated skin. Our attention, therefore, should be directed to this source of infection. The quarantine should last while there is any desquamation, or while there is any congestion of the fauces. The most important prophylactic measure should be a thorough daily antiseptic bath, followed by a complete anointing with antiseptic oil. This should be begun after the acute stage is over.

Measles.—We are accustomed to consider measles a trivial and inevitable disease. In very young children it is certainly often far from trivial on account of the bronchial and lung complications so frequently accompanying it.

Infection is given off from the throat, nose, lung, and skin

during the whole period of the illness. The catarrhal stage, however, at the beginning of the disease is the time when infection is particularly active. Isolation of the patient should be complete and any other children in the family should be forbidden to attend school. Antiseptic bathing and anointing when the rash has faded should be carried out.

Whooping Cough.—There is a good deal of uncertainty as to the infective material in this disease. The bacillus of Koplik is considered by most authorities as the certain cause. He found it present in 13 out of 16 cases. In many of the cases no other organism was present. It was readily isolated in pure culture, but inoculation into animals produced no symptoms resembling those in man. The fatal character of the complaint (the most fatal of any of the infectious diseases of children), and the serious after consequences, make it imperative that the greatest care should be taken to prevent its spread. The affected child should be isolated, and if the child is allowed outside, measures should be adopted to prevent other children being exposed.

With regard to mumps and chicken-pox ordinary isolation and care should be used.

In all these infectious diseases where disinfection of the room and its contents is done, there seems to be no disinfectant equal to formaldehyde. This gas, dissolved in water to the point of saturation, represents our formalin of commerce. This as a disinfectant is fairly penetrating, non-poisonous, not injurious to the skin or fabrics, and is easily applied. Formalin, with water 1 to 5, sprinkled on a sheet, hung up in the room, will be sufficient. The room should be kept well closed for twelve hours, and a quart of formalin will be sufficient for an ordinary room, say 15 ft. by 18 ft.

Reports of Societies

ONTARIO MEDICAL ASSOCIATION.

On the 4th and 5th days of June the Ontario Medical Association held their twenty-second annual meeting in the city of Toronto. Dr. Newton Albert Powell, Toronto, the President of the Association, occupied the chair, while Dr. Harold C. Parsons, of the same city, performed the duties of Secretary.

The meeting was one of the largest ever held by the Ontario Medical Association, nearly two hundred physicians being in attendance from different sections of the Province.

At the morning session of June 4th the following papers were read and discussed: "Deformities Consequent upon Injury, Either Traumatic or Pathological, to the Epiphyseal Cartilages in Long Bones," by B. E. McKenzie, Toronto; "Some Points in Life Insurance," by John L. Davison, Toronto; "Transplantation of the Omentum into the Abdominal Wall for the Relief of Ascites due to Cirrhosis of the Liver," by George A. Peters, Toronto; "The Cure of Chronic Bright's Disease by Operation," by Alexander Primrose, Toronto; "Tonsillar Hypertrophy, Its Operative Treatment, and the Comparative Value of the Different Methods," by Perry G. Goldsmith, Belleville; "Some Comparative Results of the Medical and Surgical Treatment of Appendicitis," by J. P. Armour, St. Catharines.

One of the most interesting discussions of the whole meeting arose over the paper of Dr. Davison with regard to examinations for life insurance. The medical men seemed to be of the unanimous opinion that the life companies did not pay enough for the examinations. Dr. Davison, as medical director of a large old line company, deprecated the careless examinations often sent in to be passed upon, and emphasized the importance of examiners sending a private letter to the medical director, which would always be held strictly confidential. After a long experience the companies had found it would be better for the examiner to give the examination paper to the agent and not send it direct to the head office. Dr. Davison gave some interesting statistics, culled from United States and Canadian reports, showing the large amounts medical men were drawing from the companies for life assurance examinations.

Dr. Peters' case of transplantation of the omentum was one which excited a good deal of attention. The patient, a man of

from forty-five to fifty years of age, was present in apparently excellent health. To illustrate the great reduction in his girth, which had taken place after the aforesaid operation, Dr. Peters had him draw on a pair of pantaloons he had worn when his abdomen was full of ascitic fluid. The waist-band of these trousers measured sixty-four inches.

On the afternoon session convening Dr. Powell delivered the annual presidential address. It dealt chiefly with recent medical legislation in the Province of Ontario, and the Dominion measure for a Medical Council, which has been so successfully promoted by Dr. Roddick, M.P. Dr. Powell stated that he had felt called upon as President of the Association to oppose the Jessop bill before the last Legislature, which sought to reform the Ontario Medical Council and do away with the homeopathic representation to that body. As the homeopaths had given up certain rights, and a mutual agreement arranged with them years ago, he did not consider it fair dealing to wipe out their representation unless with their own consent. The parliamentary success of the Dominion Medical Council bill was assured, but he thought that the measure had been so emasculated that it would not be of great weight either for good or evil. Dr. Powell also touched upon some matters of medical ethics, and upon the close of his interesting and able address was voted a hearty vote of thanks, moved by Dr. McPhedran and seconded by Dr. Harrison, of Selkirk.

Dr. J. Algernon Temple contributed a paper on "Ventro-Fixation: Its Value and Results," in which he expressed himself as being flatly opposed to any such operation.

The meeting then divided into sections. In the Obstetrical Section the following papers were read and discussed: "Placenta Prævia," H. D. Livingston, Rockwood; "How Best to Treat Obstetric Emergencies," C. J. C. O. Hastings, Toronto; "Notes on Five Cases of Ectopic Gestation," R. E. Webster, Ottawa; "The Treatment of Septic Abortion," Kennedy McIlwraith, Toronto. In the Medical Section these papers were contributed: "Pneumonia," David Hoig, Oshawa; "The Treatment of Pneumonia," J. C. Mitchell, Enniskillen; "A Recent Epidemic of Cerebro-Spinal Meningitis," Alexander McPhedran, Toronto; "Primary Tracheal Diphtheria," R. D. Rudolf, Toronto; "Where Can Our Consumptives Best Be Treated?" J. H. Elliott, Gravenhurst Sanitorium; "Pleurisy with Effusion," D. Gibb-Gordon, Toronto.

At the evening session of the first day, His Honor Judge McDougall, of the County Court, contributed a timely paper on

"Medical Testimony in Courts of Law." He went into the causes as to why expert testimony in the courts was at such a low ebb, which he considered arose chiefly out of the method of securing and employing such witnesses. In his opinion the medical expert ought to be an assistant or adviser of the court. He referred to the amendment to the Canada Evidence Act, passed at the recent session of the Dominion Parliament, which limits experts to three, or five, if asked for before the commencement of the trial. This he considered a move in the right direction. Mr. I. H. Cameron, of Toronto, and Dr. Harrison, of Selkirk, discussed the judge's paper. Mr. Cameron considered that the popular criticism of the medical expert was a harsh one, because the public did not understand the difficulties under which the expert worked. The expert was not testifying as to facts, but giving his opinion on facts; and, therefore, unanimity was not to be expected in the present state of medical science, which rendered two views possible and likely in every case.

"Dry Labors" was the title of a paper next contributed by Dr. Adam H. Wright, of Toronto, Professor of Obstetrics in the Medical Department of Toronto University. This proved to be a very able, interesting, and practical paper. Dr. Wright recorded observations in twenty-two cases.

The balance of the evening was taken up with lantern demonstrations, both being particularly good. The first by Dr. H. A. McCallum, of London, was "On Certain Functional and Organic Diseases of the Nervous System"; the second, "On Anomalous Forms of Smallpox," was conducted by C. A. Hodgetts, Inspector for the Ontario Board of Health; there was also a paper by S. H. Hutchinson, of the house staff of Toronto General Hospital, on "The Status of the Hospital Interne in Ontario."

The morning session of the second day was largely devoted to the presentation of clinical cases, which proved to be a valuable change from the old stereotyped addresses in medicine and surgery. The list embraced a case of situs inversus in a child, leontiasis ossea, scleroderma, Charcot's disease of the hip in a young man of about twenty-eight years, which proved a very interesting case, and was presented by Graham Chambers, Toronto; pseudo-hypertrophic muscular paralysis, muscular dystrophy, lateral sclerosis, adenoma sebaceum, in a young girl of twenty-three or twenty-four, which showed the little tumors well around the nose and on the cheeks; an unusual case of varicose veins, extensive necrosis of the skull, chronic hereditary tropho-edema of lower extremities, fracture of pelvis in a child,

with complete laceration of the perineum, by the ramus of the pubic bone, subsequent repair of perineum and bowel, recovery; removal of stones from common bile duct; notes of patient whose abdomen had been opened eight times; three cases of transplantation of the ureters into the rectum for exstrophy of the bladder, one in a baby girl, one in a boy of six years, and another in a lad of twelve, these being presented by Dr. George A. Peters; an unusual case of multiple peripheral neuritis, case of urtical pigmentosa; a case of marked disability, arising from fracture of coccyx, recovery by amputation of coccyx; chronic intestinal obstruction cured by operation, three cases of pyothorax, and a case of splenic leukemia.

Then followed papers on the X-ray: "The Use of the X-ray Other than Diagnostic," C. R. Dickson, Toronto; "The Use of the X-ray in Cancer, Lupus, and Hodgkin's Disease," with exhibition of patients, J. E. Hett, Berlin; "Results that Are Being Obtained by the Use of the X-ray," with exhibition of patients, John McMaster, Toronto. These papers were listened to with a good deal of interest, and the patients examined carefully. "Stricture of the Esophagus" was the title of a paper contributed by Beverley Welford, Woodstock, while D. J. Gibb-Wishart, Toronto, read notes upon the use of hydrobromic ether as an anesthetic in adenoids and tonsil operations. J. Price-Brown, Toronto, dealt with the use of India-rubber splints in the treatment of deflected nasal septa. Personal experience of the climate and health resorts of the South-Western States was recorded by Dr. C. D. Parfitt, Superintendent of the Free Hospital for Consumptives at Gravenhurst. Graham Chambers, Toronto, gave some interesting notes on cases of syphilis of the lungs and of the brain. Cerebral embolism was dealt with by Dr. John Gillies, of Teeswater. J. T. Duncan, Toronto, told how much ophthalmology the general practitioner should know, and also dealt with the discovery of the cause of headaches. H. B. Anderson presented a patient, the subject of tabes dorsalis, with involvement of the cranial nerves. W. B. Thistle, Toronto, reported a case of brain tumor, with interesting localizing symptoms, and also the specimen. John Hunter, Toronto, read notes of a case of acute nephritis.

Between the forenoon and afternoon sessions of the second day a luncheon was provided by the Entertainment Committee, under the able management of Dr. J. M. Cotton, Toronto. This proved a bright and joyful relief spell from the work of the literary and scientific sessions. Dr. Powell presided. Dr. Roswell Park sat on his right as the guest of the Association. Bright

and witty speeches were delivered in response to the different toasts, Dr. Harrison, at seventy-four, always being called upon and proving a general favorite with the members. Dean Geikie and Dean Reeve made happy replies to the toast to Medical Education. Dr. A. A. Macdonald, of Toronto, contributed his famous song, and all joined in the bag-pipe chorus.

On adjourning to business again, Dr. Roswell Park read a paper on "Gall Bladder Surgery," which was discussed by Dr. Ingersoll Olmsted, Hamilton, who has performed three of Finney's operations. Hadley Williams, London, then read a paper on "Fractures of the Shaft of the Femur."

H. A. Bruce, Toronto, showed a patient from whom he had lately removed successfully the gasserian ganglion for trigeminal neuralgia. Cancer of the breast occupied the attention of T. K. Holmes, of Chatham. L. W. Cockburn, Hamilton, described the technique of the removal of the cervical glands. Abdominal neuroses, by D. Campbell Meyers; while George H. Burnham concluded the meeting with remarks upon some eye cases.

The following were the officers elected for the ensuing year: President, J. C. Mitchell, Enniskillen; Vice-President, George A. Bingham, Toronto; Secretary, Harold C. Parsons, Toronto; Treasurer, Andrew R. Gordon, Toronto.

A. R. Robinson and S. A. Knopf looked in on the meeting during its progress.

TORONTO CLINICAL SOCIETY.

Stated Meeting, May 7th, 1902.

Dr. J. F. W. Ross, President, in the chair.

The following Fellows were present: Drs., Small, Orr, Ross, Baines, Pepler, Cotton, Rudolf, Goldie, McCollum, Harrington, McIlwraith, Fenton, Hastings, Silverthorn, Bingham, Nevitt, Lehman, Fotheringham, Stark, Garrett and Elliott.

The minutes of the preceding meeting were read and confirmed.

MEMBRANOUS GLOSSITIS.

Dr. A. J. Harrington reported this case, which occurred in a child of eleven months. The child had had measles in March, 1902. There was a history of injury, and five days later Dr. Harrington was called to see the child. The temperature was

103 and the respiration 36. On April 8th the whole cast of the tongue exfoliated. The whole system was thoroughly saturated with sepsis. Death resulted. Specimens and cultures were exhibited.

Dr. Baines discussed this interesting case, stating that the condition was a new one to him. He reported a case of metrorrhagia, which occurred in a young girl aged sixteen, following an attack of mumps.

Dr. Rudolf referred to a case of mumps in the submaxilliary glands, expressing his belief that mumps had always been confined to the parotid glands.

Dr. Pepler spoke of having observed mumps in the different salivary glands.

NOTES ON UROTROPIN.

Three cases were reported by Dr. Fenton, to which he had administered this drug. Most marked results had been obtained from the employment of it in an old man with enlarged prostate and residual urine. Drs. King and Baines spoke favorably of the drug.

MYXOMATOUS DEGENERATION OF THE VILLI OF THE CHORION.

Dr. C. J. C. O. Hastings reported three cases of this condition which he had observed in his own practice, all of which recovered. Drs. Silverthorn, McIlwraith, and Ross discussed this paper.

Dr. Fotheringham referred to a case which was reported to the society by himself and Dr. Bingham, some months previously, a case of exophthalmic goitre, in which loss of voice occurred after operation. The loss of voice had extended over eight months, when the patient awoke one morning with her voice restored, proving that the condition had been due to hysteria.

The following officers were elected for the ensuing year: President, Dr. E. E. King; Vice-President, Dr. G. R. McDonagh; Corresponding Secretary, Dr. W. J. McCollum; Recording Secretary, Dr. George Elliott; Treasurer, Dr. Geoffrey Boyd; Executive Committee, Drs. J. F. W. Ross, J. Orlando Orr, J. T. Fotheringham, H. C. Parsons, and H. A. Bruce.

GEORGE ELLIOTT,
Recording Secretary.

Physicians' Library

NEW BOOKS RECEIVED.

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

Diphtheria. By WILLIAM P. NORTHRUP, M.D., of New York. Measles, Scarlet Fever, and German Measles. By PROFESSOR DR. TH. VON JURGENSEN, Professor of Medicine in the University of Tubingen. Edited, with editions, by WILLIAM P. NORTHRUP, M.D., Professor of Pediatrics in the University and Bellevue Medical College, New York. Handsome octavo, 672 pages, illustrated, including 24 full-page plates, three of them in colors. Philadelphia and London: W. B. Saunders & Co., 1902. Cloth, $5.00 net; half morocco, $6.00 net. J. A. Carveth & Co., Toronto, Canadian agents.

ADRENALIN CHLORIDE IN OPHTHALMIC, NASAL AND AURAL SURGERY.

Green (*British Medical Journal*) records thirteen cases illustrating the use of adrenalin chloride in ophthalmic, nasal, and aural surgery. Adrenalin chloride in a solution of 1-1000 obviates the difficulties which were formerly encountered in using solution of the gland substance. The solution requires dilution to the extent of 1-5000 for nose and for ear work, and 1-10,000 for instillation into the eye. The diluent should be either boiled water or salt solution, and the dilution should be kept in colored bottles, as light changes it to a brick red color. In ophthalmic work its chief use is in inflammatory conditions of the conjunctiva, pannus, iritis, keratitis, sclerotitis, and dacryocystitis. In aural work it is indicated in middle ear inflammations and polypi. In nasal work it may be employed for swellings of a vascular nature and hyperemias and in operations in which a bloodless field is desired. The nostril should always be plugged after operation, as bleeding may commence after thirty or forty minutes and become very troublesome.—(F. T. S.)—*Philadelphia Medical Journal.*

Desiring to make a practical, useful journal for the General Practitioner, the Editors respectfully solicit Clinical Reports from subscribers and others.

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MEDICAL EXPERT WITNESSES.

One of the most valuable contributions during the recent session of the Ontario Medical Association was the address by Judge McDougall upon expert evidence in courts of law. The subject was particularly timely, as, unfortunately, there can be no doubt that there has developed lately in our midst a few gentlemen who might fairly be termed professional witnesses. We have been at some trouble to inquire, and we are safe in saying, that some at least of the men who appear regularly in court have never been known to refuse to give evidence in any given case, nor have their views ever been known not to harmonize with the views of the counsel who engage them. As was pointed out by Mr. Cameron in the discussion which followed Judge McDougall's address, medical men are frequently called upon not to give evidence as to the facts, but to express opinions upon certain given conditions. This undoubtedly allows wide latitude, yet the fact that the impression has gained ground that medical evidence is influenced largely by

the chance that they are retained to give evidence for or against a certain cause, does not tend to elevate the standing of the profession nor to increase the value of medical testimony. Judge McDougall suggests that in place of the present admittedly defective system, medical witnesses should be appointed and paid by the State to act in an advisory capacity to the judge, and not to appear, as at present is the case, as contestants on one or the other side. Even with the advice of such a board, we believe that ofttimes the court would have great difficulty in coming to an intelligent conclusion, because, we frankly say that, in our opinion, in certain cases of fracture of the skull the evidence has been so contradictory and mystifying that even the witnesses themselves have, upon cross-examination, been apparently doubtful as to what exactly they had set out to prove.

Judge McDougall might, perhaps, have gone further and have suggested that in cases where the verdict would likely turn upon the medical evidence, that medical men who believed themselves capable of expressing opinions upon the probable lines of fracture in a skull, or the probable course of a bullet under certain conditions, should not be eligible for such appointments. Such men possess a wisdom so astonishing that it seems unfair to compel them to waste their time in court for the small remuneration likely to be offered.

FEES FROM HOSPITAL PATIENTS.

The question of fees from hospital patients has been again brought prominently forward by reason of a suit entered against a man treated in one of the city hospitals, for the surgical services rendered him. Regarding the merits or demerits of this particular case we are not in a position to speak. The facts brought out were, however, sufficient to warrant the judge before whom the case was tried to award the surgeon the full amount of his claim. For some reason or other this case has been rather widely discussed, editorially, in the lay press, and comments most unfair to the medical profession passed upon it.

The Toronto *Star* in particular is moved to heroically stand up in defence of hospital patients against the rapacity of their medical attendants. Unmindful of the fact that one swallow does not make a summer, and perhaps the editor only thought he saw a swallow, the *Star* feels the necessity of some action being taken to limit the charges of hospital doctors, and to protect the patient from grinding and oppression. The grounds upon which some radical change in the existing conditions is urged by the Star are: first, that at present no tariff exists and, secondly, that the medical men of the Province, being in possession, according to the view of the *Star,* of a franchise, the public have a perfect right to step in and protect the unfortunate victims of the doctors' greed!

It is only when one reads such articles that we appreciate the true estimation in which the medical profession is held by the laity and fully realize the fact that, while gratitude may exist in the individual, it is exceedingly rare in the community. This one isolated case, and we believe that even in this case the comments have been most unfair, has been seized upon as a weapon of attack upon the whole medical body. We are regarded, apparently, as vultures, taking into our care suffering and helpless mortals, with the ultimate object of depriving them of an amount, if not in excess of the value of our services, at least in excess of the patient's ability to pay.

We can assure the editor of the *Star* that, far from opposing the framing of a legal tariff of charges, the whole medical body will welcome it. No one will object, and it is not necessary to offer as an excuse for such action that the medical body enjoy a franchise. We fail to see upon what ground such a statement is based. The term implies the conferring of some right upon certain individuals from which others are debarred. Such is not the case. Anyone may enjoy the privileges at present enjoyed by the medical profession upon fulfilling the same conditions as have already been fulfilled by its members. Even the editor of the *Star* is eligible. Furthermore, the so-called franchise is adopted in every civilized country, certainly not more in the interest of the physician than in the interest of the public, who, it must be evident, de-

serves protection from fraudulent healers as much as protection from excessive charges by competent men.

We have said, and truly said, that gratitude collectively is rare. When one considers the hundreds of hospital patients treated yearly, and the fact that not twice in a year is suit brought to enforce payment of fees against them, it may reasonably be concluded that hospital patients are either a very honest class, or that in few cases only is a fee demanded. So common has the custom of not asking fees from hospital patients become that the mere mention of money comes as a rude shock to them. Why should a doctor want money? Why should one particular patient be picked upon for a fee, even though he may have more of this world's goods than the doctor will ever have, when the man in the next bed, and every bed down to the end of the ward, received his treatment for nothing? Why should a profession which gave to the world, without money and without price, vaccination, chloroform, antisepsis—the three greatest gifts ever conferred by man upon the human race—ask money for services which in comparison are trivial? Why should a body of men who have abolished human pain, without asking any copyright on the process, expect monetary rewards? Why should the only class in the community which not only gives, but is expected to give, its services for nothing, ask pay? The lawyer may quite properly say to the accused murderer, in danger of suffering the death penalty if left undefended, "Where is your money?" and if it is not forthcoming send him adrift; but if that same individual were in danger of death from sickness, and a physician demanded money before offering succor, he would be denounced, properly so, as a brute. Why is this? The reason is, as we have stated before in discussing a similar subject, "He that humbleth himself shall be walked upon."

Editorial Notes

CANADIAN MEDICAL ASSOCIATION.

Below will be found a list of papers already promised for the annual meeting at Montreal, on Sept. 16, 17, and 18. Members and others contemplating contributing to the success of this meeting should notify the General Secretary at an early date of their intention. Arrangements as to railroad and steamship rates, entertainments, clinics, etc., will be announced in due time.

"Address in Medicine," by Professor William Osler, Baltimore; address in surgery, by Dr. John Stewart, Halifax, N.S.; lantern demonstration on the exanthemata," by Dr. Corlett, Cleveland, Ohio; paper by Dr. D. Campbell Meyers, Toronto; paper by George S. Ryerson, Toronto, subject not yet decided on; paper by A. Lapthorn Smith, Montreal, also card specimen; paper by F. A. L. Lockhart, Montreal; "On Some Points in Cerebral Localization," illustrated by a series of morbid specimens and some living cases, by James Stewart, Montreal; paper and specimens, by Dr. Geo. A. Peters, Toronto; "The Country Practitioner of To-day," by J. R. Couston, Huntingdon, Que.; paper by Dr. P. Coote, Quebec, Que.; "The Pathologic Prostate and Its Removal Through the Perineum," by A. H. Ferguson, Chicago; paper by George E. Armstrong, Montreal; paper by Ingersoll Olmsted, Hamilton; "Empyema of the Frontal Sinus," by Dr. Casey A. Wood, Chicago; "on Tuberculosis," by J. F. Macdonald, Hopewell, N.S.; "X-ray in Cancer," by A. R. Robinson, New York; "On Degeneration of the Spinal Cord, Anemia, Mal-nutrition, with Microscopic Specimens," by David A. Shirres, Montreal.

GEORGE ELLIOTT,
129 John Street, Toronto. *General Secretary.*

CIGARETTE SMOKING.

The question of the harmfulness of cigarette-smoking, according to the *Medical Record,* is continually coming to the front. Dr. H. F. Fiske, Principal of the Northwestern Academy in Evanston, Ill., has recently stated that only 2 per cent. of those addicted to cigarette-smoking in the school had been able to reach the first grade, while in the lowest grade there was a percentage of such smokers of 57.

A mass of evidence has been brought against the cigarette as

a most injurious factor in undermining the health, and especially of seriously affecting the nervous systems of persons accustomed to smoking them to a large extent.

There can be no doubt that cigarette-smoking is exceedingly harmful to the young, and probably smoking of any description in adolescence or adult age is calculated to be opposed to sustained mental effort.

That, however, cigarette-smoking in itself is more harmful than are the other modes of using tobacco has never been proved; indeed, the experience of those who have made a study of the matter points to an opposite conclusion. The experiments made by the Health Department of Chicago, some five years ago, failed to reveal any of the peculiar insidious and noxious properties in several brands of cigarettes examined which it is often stated they possess, and the analysis undertaken in the laboratory of the *London Lancet,* three years ago, of many brands, both American and English, reached similar results.

Smoking when young is harmful in many ways, and undoubtedly, as Dr. Fiske says, tends to weaken and deaden the mental faculties.

For this reason, therefore, cigarette-smoking is to be condemned in the young, and not because the cigarette *per se* is especially injurious.—*Dietetic and Hygienic Gazette.*

TOBACCO AS A DISINFECTANT.

The subject of tobacco possesses a peculiar and engrossing interest for all sorts and conditions of men. Despite the fact that the general public are continually being warned of the evil effects which will assuredly follow indulgence in the soothing weed, smoking continues in much the same manner as usual. There can be no doubt—as has been pointed out on several occasions in the *Medical Record*—that smoking to excess, or following the habit when young, is hurtful to the health, and to some people a positive danger. The wisest way is to steer a middle course.

There are, too, enthusiasts with regard to tobacco, and who attribute to the South American weed all the virtues under the sun. These eulogists, of course, are as much in error as those who deny it any saving grace.

A discussion was raised in an English lay paper of a recent date as to the merits of tobacco as a disinfectant, and much interesting matter was brought forward.

The *Lancet* was called to give, so to speak, expert opinion, and further information on the matter was forthcoming.

The belief that tobacco possesses extraordinary properties in warding off certain diseases of a contagious nature is almost as old as the introduction of smoking into Europe. During the great plague tobacco was largely used for this purpose, and children were encouraged to smoke as a precautionary measure. "In 1888," says the *Lancet*, "Dr. Paul Tassinari, of Pisa, subjected the germs of various deadly diseases—such as anthrax, cholera, and typhus fever—to the action of dense clouds of imprisoned tobacco-smoke, during periods of 100 and 150 hours, and he came to the conclusion that in most cases, and especially when large cigars had been employed as generators, the development of pathogenic bacteria was either partially or wholly arrested." This experiment, however, by no means proves the case, for, as the *Lancet* says, no one keeps a cigar in his mouth for one hundred hours at a time.

Workmen in tobacco factories are often pointed to as examples of the disinfecting properties of tobacco. It is declared that they are immune from epidemics. On the authority of some experiments conducted in France, it would appear that there are some fairly good grounds for this belief, but the investigations have not been carried out to a sufficiently wide extent to justify the passing of any authoritative opinion. The matter is as yet *sub judice*, and will, probably, remain so for an indefinite period. Strong tobacco will keep away insects, and certain mild species of mosquito, but that it will render a person immune to contagion is a theory that will not commend itself to the common sense of a sane man.—*Medical Record.*

THE BANANA AS A FOOD.

A writer in the current number of *Longman's Magazine* waxes enthusiastic over the possibilities of the banana as a food, and suggests that those living in temperate climes should avail themselves of its nutritive properties.

The banana is to the dwellers in tropical lands, and especially to the South Sea Islanders, what oatmeal is to the Scotch peasant. The contributor to *Longman's* states that the banana as a form of nourishment can claim first place among vegetable products that are food for mankind, for it is twenty-five times as nutritive as the ordinary white bread eaten in this country, and forty-five times as nutritive as the potato.

Moreover, it satisfies that other essential condition of a breadstuff, namely, the possibility of an easy and abundant production.

The suggestion of its advocate is that the banana, like wheat, should be dried and ground down into flour. Mills might be erected where it is grown, or within easy reach, and then, at the suitable time, the fruit could be gathered and dried, and transformed into flour. Banana bread has been voted excellent, is now made in Chicago, and might just as well be made in any other place, could the flour be obtained reasonably.

There would seem every reason in favor of the banana fruit being widely utilized as a food. In these days, when pessimists and even scientific men are warning us that the world's supply of wheat may in not the far distant future become insufficient, the act would be a wise one to cultivate and to procure the nutritive breadstuff which the banana so bountifully provides.—*Dietetic and Hygienic Gazette.*

THE EFFECT OF INOCULATION AGAINST TYPHOID FEVER.

A vivid interest is being shown everywhere at the present time with regard to the etiology and means of prevention of disease, and of none can this fact be more truly stated than of typhoid fever.

The opportunities for studying this affection have been exceptionally favorable during the long protracted campaign in South Africa, and it may be said that our knowledge of the disease has been proportionately increased.

The theory advanced by Dr. Victor Vaughan and others, while the Spanish-American campaign was in progress, that probably flies played a somewhat important part in spreading the infection of interic fever, would seem to have received a certain amount of confirmation from the recorded observations of British surgeons in South Africa within the past few years.

With respect to inoculation against typhoid fever, although some undoubtedly valuable information has been gained, no convincing proofs that the method is of any striking and definite value as a means of prevention have been forthcoming.

Brigade-Surgeon Lieut.-Colonel Crombie, late of the Bengal Department of the British Indian Army, gives in the *Lancet* of May 3 some statistics on the subject, from evidence afforded by the war in South Africa.

Of 250 officers who recently came before the Medical Board, London, invalided from South Africa on account of wounds and disease, it was found that 112, or 44.8 per cent., had been inoculated against enteric fever; that 29, or 11.6 per cent., had had previous attacks of typhoid, and that 109, or 43.6 per cent.,

had not been inoculated or had a previous attack. Of the total number (250) 59, or 23.6 per cent., suffered from enteric fever in South Africa, but of these a considerable number were actually invalided on account of debility following enteric fever, so that this latter percentage cannot be put forward as representing the real proportion of officers so infected. It is, of course, considerably higher than the actual ratio. Of the 112 who were inoculated, 32, or 28.5 per cent., suffered from typhoid. Of the 29 who had had a previous attack only 3, or 10.3 per cent., had a second attack in South Africa, and of the 109 not inoculated, 24, or 22 per cent., had attacks in South Africa. Of the 112 who were inoculated, 102 had been inoculated once, with thirty cases, or 29.4 per cent., and 10 with two cases, or 20.0 per cent., had been inoculated twice.

It is stated that there would seem to be a very general consensus of opinion among medical officers in South Africa that inoculated cases run a milder and more favorable course than those not inoculated. According to the statistics of Dr. H. H. Tooth this leads to a higher percentage—2·5 per cent.—of recoveries among men, and, for obvious reasons, it would, probably, be higher among officers.

Thus inoculation would seem to afford a certain amount of protection against typhoid fever.—*Medical Record.*

THE DEATH OF DOWIE'S DAUGHTER.

A few days ago the daughter of Dowie, the fanatical agitator of Chicago, perished by fire. As a father this man is entitled to sympathy—which we would be the last to withhold from him—but as a promulgator of false and mischievous doctrines he has met with a terrible awakening. It is reported that the father in the last moments, seeing his daughter dying in his arms, summoned a physician. He has thus recanted in the face of death.

Dowie has for a long time been holding a carnival of ignorance and superstition in Chicago. There is no remedy for such an abuse except an enlightened public opinion, and public opinion in this country is evidently not as yet sufficiently enlightened to put an end to the fantasies of Dowie and of the Christian Scientists. We are by no means sure that this shocking tragedy will have any permanent effect upon these people. Their passion is to declaim against an enlightened and scientific practice of medicine; and the tendency of some of them to fly to this practice as a last resort when hard pressed by disease or accident, seems to have no effect upon their fellows.—*Philadelphia Medical Journal.*

News Items

THE Medical Society of Nova Scotia meets at New Glasgow on the 2nd and 3rd of July.

DR. R. A. REEVE has been re-elected President of the Alumni Association of Toronto University.

DR. REYNOLDS, Assistant Superintendent of the Hamilton Asylum for the Insane, died recently at Baltimore, Md.

THE medical profession in Halifax are agitating for a medical library for the profession and the Province of Nova Scotia.

IN the new civic hospital which Montreal will some day erect the patients are to be segregated according to religious belief.

DR. R. F. RUTTAN, of McGill University, was in Toronto recently, the guest of Dr. D. J. Gibb-Wishart, of Grosvenor Street.

DR. P. H. BRYCE, Secretary of the Ontario Board of Health, states that Ontario will be clear of smallpox in a month or two.

DR. BEEMER, of the London Asylum, has been transferred to Hamilton, and Dr. Bell, of the Toronto Asylum, takes Dr. Beemer's place at London.

DR. J. C. MITCHELL, President of the Ontario Medical Association, Enniskillen, Ont., is moving to Toronto, where he will enter the Asylum service.

DR. P. G. WOOLLEY, Fellow in Pathology at McGill University, has been appointed bacteriologist in the United States Bacteriologic Laboratories at Manilla.

DR. E. M. VON EBERTS, who for the past number of years has been Superintendent of the Montreal General Hospital, will leave that institution on the 1st of September.

THE Kingston Medical and Surgical Society has elected the following officers for next year: President, Dr. W. T. Connell; Vice-President, Dr. Forster; Secretary, Dr. Mylks.

THE Maritime Medical Association will meet this year at Charlottetown, on the 9th and 10th of July. Dean Geikie, of Trinity Medical College, will deliver a talk on Therapeutics.

DR. W. M. FORD, who was appointed Rockefeller Fellow in Bacteriology at McGill University a year ago, has recently

been appointed one of the investigators at the Rockefeller Institute at New York.

THE Medical Faculty of McGill University graduated a class of eighty-two last week. This year the coveted Holmes Gold Medal goes to the Province of New Brunswick, that honor having been won by Mr. R. McL. Van Wart, of Fredericton.

DR. R. F. RUTTAN, who has been Registrar of the Medical Faculty of McGill University for the past eleven years, has resigned that office to accept the Chair of Chemistry to which he has been appointed in succession to Dr. Girdwood, who recently resigned.

AT the June Convocation of Toronto University, amongst others who received the honorary degree of Doctor of Laws were: President Ira Remsen, of Johns Hopkins University; Dr. W. H. Drummond, Montreal, and Dr. R. A. Reeve, Dean of the Medical Department of the University.

DR. W. G. TURNER has been appointed Superintendent of the Montreal General Hospital in succession to Dr. von Eberts. Dr. Turner was graduated from McGill University two years ago, and since that time he has been connected with the Royal Victoria. He is at present senior house surgeon.

A MILITIA medical course is being conducted at Ottawa, with Surgeon-Major Gorrell, of that city, in charge. The following have registered for the course: Drs. Moorhouse and Watts, Winnipeg; Dr. Sands, Kingston; Dr. Hill, Montreal; Drs. Gardiner, McCarthy, Birkett, Williams, and Shillington, Ottawa.

DR. PRICE BROWN left on May 23rd for a ten-days' trip to the East. He purposed attending the annual meeting of the American Laryngological Association, which was to take place this year in Boston.

THE Royal Victoria Hospital, Montreal, has appointed the following fifteen gentlemen on the house staff: Admitting Officer, Dr. A. G. McAuley; Medicine, Drs. Colin K. Russell, W. W. Francis, J. R. Byers, J. C. Colby; Surgery, Drs. E. Penner, E. J. Mullalley, J D. Dixon, J. L. D. Mason; Ophthalmology and Laryngology, Dr. Newbold C. Jones; Gynecology, Dr. James R. Goodall; Anesthetist, Dr. L. C. Harris; Locum Tenens, Drs. Herman K. Stockwell and J. A. Macnaughton; Externe in Medicine, Dr. F. C. L. Cantlie.

Selected Abstracts

STOMACH VERTIGO.

Dr. Charles Sumner Fischer (New York Academy of Medicine) read this paper. He said that stomach vertigo was of that character in which everything whirls around the patient like a revolving wheel. Nausea usually followed the attack, and was associated with pain in the stomach radiating to the back, and usually with constipation. There was no loss of consciousness and no misconception of the hallucinations. The attack usually occurred on an empty stomach, but might take place after an ordinary meal. At times the gastric symptoms were very definite. Attempts had been made to associate gastric vertigo with well-defined pathological conditions in the stomach. A review of the literature showed a wide difference of opinion regarding the state of the stomach in these cases of vertigo, and also as to its frequency. There was reason for believing that gastric vertigo might result reflexly from either cerebral congestion or anemia. Since the work of Bouchard in 1884, on intoxications, gastric vertigo had been included in the long list of affections supposed to be due to autointoxications. It had never been proved that there was any direct relation between gastric vertigo and abnormalities of the stomach secretions. In the early stages of chronic gastritis it was quite possible that hyperchlorhydria might exist, but in the later stages it was not present and the vertigo then would be associated with diminished acidity. In all cases of chronic gastric disease in which the nervous system was diseased, one should be slow to make the diagnosis of gastric vertigo. The most common form of chronic gastric disease met with in this country was the nervous atonic variety, and it was with this form that stomach vertigo was most often associated. It was possible that in this variety the general nervous system had suffered in nutrition to such an extent as to make it particularly vulnerable to stimuli from distant organs. Vomiting was a common accompaniment of vertigo, whatever its origin, and hence the mere presence of nausea and vomiting was not sufficient to establish the diagnosis of gastric vertigo. To attempt to make such a diagnosis from the character of the vertigo was futile. The cases of gastric vertigo could be conveniently studied in three groups, viz.: (1) Those cases of vertigo accompanied by nausea, palpitation and intense fear, following indiscretions in diet; (2) severe attacks occurring in the course of chronic disease of

the stomach without any indiscretion in diet; and (3) mild and fleeting attacks occurring in the course of chronic gastric diseases and general neurotic conditions. He was inclined to think that true gastric vertigo was rare and belonged only to the second of these groups.—*Medical Record.*

THE NEUROLOGICAL DIAGNOSIS OF VERTIGO.

Dr. Pearce said that iodide of potassium was often given in largo doses by neurologists, and that it sometimes was responsible for attacks of intense vertigo. In migraine vertigo was often one of the symptoms of the fully-fledged attack. In neurasthenia and hysteria vertigo was usually subjective. It was less frequently complained of in the latter, and did not appear to be so constantly present. The more important cases of vertigo coming under the notice of the neurologist were those due to organic disease of the brain. In these the centres in the medullar and cerebellum were involved, directly, as by sclerosis, tumors, hemorrhage, thrombosis, abscess and trauma, and, indirectly, by changes in blood pressure. In the pons and medulla tumor was the most common course. Vertigo was due to changes in blood pressure was observed chiefly in connection with that form of epilepsy known as petit mal, and in general paresis. Cerebral endarteritis was also a fertile cause of vertigo due to brain disease; indeed, vertigo was often one of the prominent symptoms of advanced arteriosclerosis. As a symptom of apoplexy, vertigo was important, and often occurred for weeks before the apoplectic attack. In the cerebral manifestations of syphilis vertigo was a symptom of the highest importance.—*Medical Record.*

THE ABORTIVE TREATMENT OF FURUNCLE BY THE MEANS OF SUBCUTANEOUS DISINFECTION.

A. Bidder (*Deutsche medicinische Wochenschrif*) says that beginning furuncles and carbuncles may be aborted by the subcutaneous injection of a 2 per cent. aqueous solution of carbolic acid, and also that advanced lesions may be rapidly cured in the same manner. Weaker solutions may give equally good results, but they have never been employed by the author. On the other hand, stronger solutions (3 and 4 per cent.) have frequently been advantageously used. In beginning furuncles or carbuncles the needle of an ordinary hypodermic syringe, filled with the carbolic acid solution, is introduced close to the border of the zone of inflammation and inserted in a diagonal direction until the centre of the lesion is reached. A few drops of the solu-

tion are then injected and the needle withdrawn. The canal thus made serves for the exit of the main portion of the solution, which is then to be injected in the following manner: Beginning at a point on the border of the zone of inflammation, directly opposite to the place where the needle was first introduced, the needle is inserted to the centre of the lesion in a manner entirely similar to that above described. The entire contents of the syringe (about thirty drops) is then injected. The major part of the solution thus injected soon flows out through the canal first made. In large lesions it is often advantageous to use larger needles than those which usually accompany the ordinary hypodermic syringe as the outflow of the carbolic acid solution is much accelerated thereby. In advanced lesions which are discharging pus the primary insertion of the needle is unnecessary, as the carbolic acid solution exudes freely from the fistulæ which already exist. The after-treatment consists of the usual antiseptic dressing. Immediately after the injection the pain in the lesion is increased and there is usually some fever. These symptoms, however, subside in twenty-four hours and rapid recovery takes place. In the case of beginning lesions scarcely any scar remains. Nine cases are reported in illustration of this method of treatment.—*Medical Record.*

LINEN SEWING-MACHINE THREAD FOR LIGATURES AND SUTURES.

Arthur E. J. Barker (the *Lancet*) says that this material can be obtained everywhere, and that it is relatively very cheap. It can be easily sterilized by boiling in plain water, and then stored in methylated spirits. It is enormously strong, and ties a most uncompromising knot. It is easy to work with, and runs through the eye of any suitable needle easily, having been spun with special care in order to travel evenly through the sewing-machine needle. He has used several sizes, and now limit these to three, viz.: No. 40, which is as thick as need be desired for the abdominal wall or ligature of the larger arteries; No. 60, which is thinner, but still very strong; and No. 90, which is as fine as can be desired, say, for a suture of the intestine. He finds it convenient to procure No. 40 as a white thread, No. 60 in red, and No. 90 in black. He has prepared it by simply boiling it for an hour in ordinary water, and then keeping it in spirit. A little of the dye comes out of the finer sizes in boiling, but does not appear otherwise to alter the thread which can be boiled over and over again without rotting it. It is well borne by the tissues, and altogether seems to be an ideal article for the purposes named.—*Medical Record.*

Special Selections

EFFECT OF ATHLETICS UPON GROWING BOYS.*

By Watson L. Savage, M.D., Columbia University.

In offering this subject for your consideration I present a problem suggested by the examination of boys entering the freshman class of Columbia University, and one that must come before secondary schools for solution. That we may understand clearly its scope, it is necessary first to define and classify athletics. The word is here used to include all forms of competitive games, sports and contests requiring exertion, in which the boys in our secondary schools participate, be it a game of golf on the one hand or an eight-oared boat race on the other. But as it will be impossible in the limited time allowed for this paper to take up each game and analyze it, I have classified them and shall use one as a type of its class. These may be classified under three heads: 1. Individual Antagonistic. 2. Team Contests. 3. Racing.

The first division includes such games as are participated in by two or more men, each one depending upon his own individual effort and of short duration, as golf, boxing, fencing, wrestling, handball, tennis, jumping, vaulting, shot-putting, hammer-throwing, discus-throwing, gymnastics, etc. This first group may be subdivided, according to the character of the sport as follows: (*a*) golf, tennis, handball, squash, racquets, all of them light action movements attacking alternately a ball; (*b*) fencing, boxing, wrestling, sports of direct personal contact; (*c*) shot-putting, hammer-throwing, high and broad jumping, discus-throwing, pole-vaulting, heavy gymnastics, etc., all requiring extreme effort of short duration.

In the second group, team contests, a given number of men contend against an equal number, each playing or having a distinct part to perform. The sub-divisions are two: (*a*) cricket and baseball, where one team rests and the other performs the bulk of the work, while the plays require skill rather than strain, and the duration of effort is short; (*b*) basketball, lacrosse, the various polos, hockey, football, etc., where both teams play at the same time for a given period.

* Republished from the *Am. Phys. Ed. Review.*

The third and last large group, racing, comprises: (*a*) rowing, running, swimming, bicycling, etc., where the single individual is competing against one or more, doing the same act continuously for a given distance or length of time; (*b*) contests in which all the players on each side are performing the same thing at the same time, such as tug-of-war and crew rowing, the strain being continuous for the full period of the contest.

Division (*a*) of the first group—golf, squash, tennis, handball, etc.—is classified according to the strain upon the heart. Golf would hardly be considered a game of sufficient activity for healthy boys bubbling over with youthful vigor; yet it has excellent qualities, recommending it to all ages, both sexes, and all degrees of physical condition, and better for approaching second childhood than in leaving the first. Squash ball is a cross between tennis and handball, quite new in this country and little known. Tennis develops quickness of action and thought and a high degree of co-ordination. Its strain upon the heart is limited, owing to the nature of the game, for it has frequent intervals of rest, but it has also the disadvantage of being a one-handed sport. I shall therefore take handball as the best type of this group, and the most severe, requiring as it does the use of both hands, right or left, as the occasion arises. The ball is in play continuously, but must be reached and played with the hands, requiring bending forward, back, and to the sides, and thereby bringing into play the waist, trunk, back, and legs. It therefore cultivates quickness of action, mental acumen to the highest degree, judgment of distance, direction, angle, use of force instantly, while the ground must be covered at the same time; decision must be made as to where the ball shall be returned out of reach of the opponent, and a more or less severe strain put upon the heart, regulated largely by the skill of the player and his opponent. It should therefore be classed as a vigorous, valuable game for boys, developing quickness of mind and body, judgment of force, angles, distance, reaction, etc., perfect co-ordination without an undue amount of danger from overstrain, since it is always within the power of the player to limit his action; an excellent game to train for most any other form of contest, especially ball games.

As a type of subdivision (*b*) of this same first group—contests in which two men oppose each other—I should select the sport of boxing. This is a light, active exercise which may be taken in moderation and brings the entire body into activity, the legs being quite as useful as the arms and hands. There is

necessity to keep the body on a firm foundation and at the same time to move quickly and in varying directions. During the bout, which is usually limited to periods of short duration, according to the strength of the individual, the muscles of the legs are kept at high tension. The arms are in constant motion and also at high tension in readiness to act in an instant. The muscles of the neck, as well as the back and dorsal muscles, are brought into constant action. The entire muscular system is under tension at all times. The brain is kept very sharply awake studying the opponent, anticipating his movements, and endeavoring to find an opening for attack or repulsion. The brain becomes very active and there is a nervous strain as well. The activity, excitement, and continuous tension make a demand upon the heart and lungs which easily becomes very severe. But this is at times within the power of the individual to fall back upon the defensive, and thus relieve the pressure if it become too great, and gives time to adjust and not to force to a limit, or even to withdraw for a few moments at any stage of the game. The strain upon the organs, however, is so severe that the contest should always be under the control of a master who can observe the condition of the boys and limit the duration of the bouts.

Some have objected to boxing on the ground that it makes the lad pugnacious and quarrelsome, and inclined to seek fight and arouse trouble. Yet the fact of the case is quite the contrary. A thorough knowledge and the practice necessary to obtain this knowledge will develop the very elements to keep out of trouble with dignity and self-possession, the exercise requiring chiefly quick thought and action. Whatever else he will learn, the boxer will find that to lose his head is to lose everything, and this lesson has accordingly a most beneficial effect on the hot-headed. It is practically thumping into the lad's head the necessity of the control of his temper. Again, the slow, heavy, sluggish boy will learn one of the best of lessons from this exercise, for it will awaken him and arouse in him an interest for his work. Most other forms of exercise may be taken in a listless way, but here is one that gives the teacher opportunity to overcome listlessness without incurring criticism for corporal punishment. Further, as your hands are always with you, you have a ready weapon, if made effective with training, for self-preservation and protection in time of need. To sum up, we see that boxing develops quickness of eye, thought and action, self-possession, confidence and courage, a high degree of co-ordination, balance; is a delightful exercise.

full of interest and skill, requiring the use of both hands freely; develops the heart, expands the lungs; improves the carriage; opens the pores of the skin; and in short, is a most valuable exercise. Under proper regulation it may be considered one of the best general exercises in physical training for schools. It is excellent to prepare men for teams, and might well be made a part of the early training preparatory to such teams. It should not be made merely a small part of the day's order, but, in that event, should always be limited and kept well in control by the master in charge.

Fencing has many of the elements of boxing. It develops quickness of eye, co-ordination of the entire body, and is not quite as severe upon the heart. It does not develop courage, as the element of danger is eliminated by protection, is one-sided, and, in this country, has no practical value. The sport is more suited for girls than boys, and there is some danger of inducing curvature of the spine during the growing period, unless sufficient forms of other exercise are given to offset the results of this one-sided work.

Wrestling should be postponed in a boy's training until the growth has been attained, the bones have become well ossified, and the muscular development well advanced. The danger of injury to the body in this sport is greater than the gain in compensation, and the continued strain put upon the whole system at one time, where the chest wall is contracted, muscles set, breath held, and every force exerted, brings a strain upon the heart that seems to me dangerous.

The sports of division (*c*) of the first group—shot-putting, discus-throwing, hammer-throwing, high and broad jumping, and heavy gymnastics—require extreme effort for their successful performance, a long and thorough course of preparation and training, which from the nature of the case must be progressive. There is no special effort of the brain, the strain upon the heart is limited to a single effort of short duration, followed by a long period of rest and relaxation. While fully aware that the breath is held during an extreme effort, I see no reason why these sports should not become a part of the athletic training of our growing boys. Gymnastics would be considered the best type of these for school boys, as they can be perfectly regulated and require a small amount of mental application, at the same time keeping the organs of the body in a healthier state. I do not care to open up the old question of gymnastics *versus* athletics at this time, so passing to section (*a*) of the second large group—cricket and baseball—I should

place preference, on the basis of physical strain upon the boy, to the former. Cricket, unfortunately, is little played in this country, baseball being the American game. Both sports require much practice, great skill, judgment of distance, speed, force, calculation, study of position, direction, movement, quickness of action and perfection of co-ordination, in short, games of a very high educational value, requiring sudden physical exertion of short duration, yet not too highly educational, as sometimes argued, for the boy does not know how to use his brain in the game except as he develops and strengthens mentally, while at the same time the danger of over-exertion physically is small.

In the class of sports (*2b*) comprising lacrosse, the various polos, hockey, basket-ball, football, etc., both teams are in equal activity during the entire period of play, which is regulated by a length of time rather than by the exertion required in a number of skilful acts. They require for successful operation continued activity of all participants in the game, broken only by periods of suspension due to conditions and rules of the game. There are, however, in these sports, other intervals for the various members of the teams to get moments of rest and relaxation. Short periods of rest for the player to recover his "wind," as the expression is, allow opportunity for the heart to adjust itself and the lungs to get rid of the waste products of exertion. In these games, above all others, the necessity of harmony and co-operation among the players is absolute; the boy must lose his identity and must become a part of one great whole. He must obey implicitly the orders of his captain, and at the same time be alert to carry out his part of the game successfully and vigorously. He needs to be ready to change, on the instant, from attack to defence; he must keep the field of operation constantly in mind, taking advantage of every opening, fill every gap, putting his whole heart and soul into the game. He must be aggressive, fearless and energetic in attacking his adversary, and ready to sacrifice himself at the altar of duty by springing into such a position as to receive the attack and thereby protect his comrades. Such sports bring out every ounce of latent energy there is in a lad. The greater the element of danger in a game the more forcibly does it operate to develop these characteristics, so that we would place football highest in the category of these sports, and I believe that the occasional injury to the individual is a necessary sacrifice for the good of the many. Notwithstanding the fact that in every season a number of boys are more or less severely injured, seeming

in the aggregate very large, yet from consideration of the number playing football during the season, this is comparatively small. To offset this damage, we have, I believe, the best game to bring out the strong and vigorous qualities that make men of boys. The strain upon the heart is relieved and lessened by the intervals and breaks in the game caused by the various rulings and regulations governing the same. The benefits to be gained by these forms of sports, therefore, must be self-confidence, obedience to commands, courage, aggressiveness, determination, alertness, quickened co-ordination, speed in decision and action, strength of body and generalship. What qualities would be more desirable or valuable to a young man in fighting the battles of life?

We now arrive at the third and last group, which includes (*a*) racing in general, such as foot races, skating, swimming, and bicycling; (*b*) tug-of-war, rowing, etc. In all these events the strain is continuous from the beginning of the race to the end. The large muscles of the body which make the greatest demand upon the heart are under severe strain from the firing of the pistol to the finish, and the plucky lad, full of courage and spirit, will not stop until the goal is reached, no matter how great is nature's outcry. One of the most unfortunate conditions of these contests is that skill which requires much preliminary practice plays very little part; the boy, therefore, does not prepare for the worst before he must tax himself to the limit. In other words, he does not give his heart a chance to become strong enough to fulfil the demands made so severely upon it. One such race is liable to cripple the heart of the rapidly-growing boy, and to such an extent as to injure him for life. And what is there to offset this condition? What compensation has he for the risk he takes?

This last and most injurious group (3*b*) covers contests that require a number of boys to perform the same act for a continuous period, such as tug-of-war, crew rowing, etc. This adds another element of danger over those in the previous group from the fact that every one on the team is controlled by the strongest of them all, and is compelled to continue to the very end of the race. While it may be entirely safe for a well-trained, vigorous lot of young men who have completed their growth to compete in such events, it is wholly wrong for growing boys to be allowed to put such a tremendous strain upon the heart as is involved in such a contest. There is no room for question that extreme physical labor is accountable for many heart lesions, and many a lad is handicapped for life by severe

physical strain put upon him during the period of development. How many this number is we do not know at present. It is a well-known physical fact, however, that heart lesions are far more common among men than among women, and the explanation is made that man's occupation calls forth greater physical exertion than that of women, and continuing the point of comparison, boys' sports are of a severer physical nature than those of girls. In our examination of young men on entering college, we find cases where the heart's action has been uncertain, irritable, irregular, rapid and excitable, with faint lesions and murmurs of the mitral valve, for which we could find no cause, reason or history except early-followed and excessive athletics, and those of the group last mentioned. I believe the danger to be principally during the period of life from twelve to sixteen, or the period of rapid growth.

The argument may be offered that it is inconsistent to permit boys to play football when the injury resulting is sometimes serious and apparently more frequent of occurrence than in racing. To this I shall reply that the benefits gained in the one game more or less justify the risks taken, while in racing there is little to say that is favorable. What can be the educational value in a distance foot-race to the boy, say, of fourteen years, since it is merely a case of physical training without due compensation.

The argument of the greater damage in the one sport is not verified by facts. Consider that the number who participate in football is far greater than of those who engage in this class of racing. In addition, the injury received in football is evident on the surface, for it is external and readily diagnosed, and may be directly charged to the sport. Such injuries are usually of a temporary character and are not detrimental to the boy's usefulness in after life, while the exact reverse is true in the case of an overstrained heart. I claim that the real and permanent danger is more frequent and more serious, and the compensation at least questionable in the latter sport.

That early racing makes a more competent athlete later in life I am convinced is false from the records of intercollegiate champions. It is an exceptional case where a boy who was a champion junior in his school becomes both a scholastic champion and an intercollegiate champion in middle and long distance events. The occasional instance of this kind has usually been a boy older than the average school lad, whose utmost effort had accomplished this feat after the period of growth and when he had become mature and settled. Rather how many

cases do we observe from our scholastic records of young men who gave great promise when put into college contests, yet failed to fulfil expectations! And why does this happen so often? The usual explanation offered is that the boy is in superior company and thereby outclassed. My own belief is that he is outclassed, not always because he did not originally possess the qualities of a champion, but that he was allowed to exert himself beyond his capacity during his younger days, thereby aborting his capabilities.

During the years of rapid growth, the system under natural conditions has much more labor put upon it than at any other time in life, and, unfortunately, it is also the period when the mental strain due to our present educational arrangements is far too great. Let us, then, whose duty it is to safeguard the health of the student, refrain from permitting a third baleful influence by allowing over-exertion in physical effort. From this standpoint, I deem that the physical director of the secondary school has the greatest responsibility and the most delicate duty to perform, and should correspondingly be the best qualified.

I would particularly recommend and cannot too strongly urge the careful examination of the heart both before and after exertion, and the recording in each case of the branch of sport in which the youth participates. In following out this plan it would be most interesting to note the length of time the heart takes in every case of athletic effort to recover its normal rate. To be sure, this would be one guide, but *that one* not requiring a foreknowledge of medicine. Under these precautions, I would recommend the games of group 1, *a, b,* and *c,* with the exception of wrestling and classes *a* and *b* of the second group, since these create (1) a healthy spirit of rivalry in schools; (2) are valuable factors in education; (3) they tend to improve the health with the minimum danger of serious injury. Lastly, I would recommend that all games requiring a continuous severe strain upon the heart of more than thirty seconds, such as running, swimming, rowing, skating, cycling, tug-of-war, be eliminated from the sports in our secondary schools, because:

1. They are entirely unnecessary to the school.
2. Because they have little or no educational value to the student.
3. Because they may abort the future capabilities of the lad in athletics.
4. Because they endanger the health and future of the boy.

—*Dietetic and Hygienic Gazette.*

HOW TO CONDUCT A NORMAL LABOR.*

BY JAMES MORAN, M.D., NEW YORK,
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We, as physicians, ought to give more care to the pregnant and puerperal woman than we usually do.

As soon as I am engaged to attend a woman and have made a diagnosis of pregnancy, I examine the urine, and have her bring once a month a sample of the night's and morning's water. After the eighth month I examine it every week, particularly if it contains albumin, sugar, or tube casts. I examine the heart and lungs, also, and give my patient instructions in regard to diet, exercise, hygiene, and clothing.

The diet should be of a nature easily digested, and nourishing in character. A moderate share of exercise daily in the open air is very necessary to the health of the pregnant woman. Violent exercise and long journeys over bad roads should be avoided if possible. Frequent or daily baths of moderately warm water help to keep the skin active and the patient in good condition. The bowels should be kept regular, if necessary, by a mild cathartic.

The clothing should be worn loosely and hung from the shoulders, so that there may be no constriction around the waist. The circular garters should be replaced by the long side supporters. Corsets, if worn at all, should be worn loosely, and after the fifth or sixth month, discarded and a corset-waist used instead. Wearing of tight corsets predisposes the mal-development and mal-position of the fetus, and also impedes the functions of the kidneys. The breasts if pendulous should be supported by a suitable bandage or underwaist. The nipples should be kept free from pressure. Any mild ointment may be used to keep them soft and in a healthy condition. If depressed they should be massaged and manipulated to bring them into proper shape.

On the first or second visit of the patient to my office I get her history as far as possible. If she has had children, and difficulty in previous labors, I try to ascertain the cause and nature of the difficulty, whether it was due to kidney disease, tumors, deformed pelvis, or very large children. With a primipara I

* Read at the meeting of the New York Celtic Medical Society at the Academy of Medicine, in February, 1902.

examine to ascertain if there is any deformity or mal-formation, or any diseased condition. If the trouble in the multipara is due to a small pelvis or a very large child, I can do much to lessen the difficulty in the next confinement, by limiting the amount of food and drink of the mother during the last two months.

I allow her very little liquid during the last month, provided there is no trouble with the kidneys. By this method the child will not accumulate a lot of unnecessary fat.

The Room and Bed.—I give each patient, when she comes to engage me, a printed card with instructions as to the proper kind of room and how to prepare the bed, and a list of the things that are necessary for herself and the child.

The patient should be confined in a large and well ventilated room, and a sunny one if possible. If the weather is cold the room should be kept warm by steam, gas, or a stove. The room should be well aired and cleaned before admitting the patient, and if there has been any infectious disease in the room a thorough fumigation is necessary.

The bed should have a firm mattress, covered with rubber or oilcloth, a clean sheet or blanket should next be put on over the rubber, and both fastened to each side of the mattress and at the corners with safety-pins. Then, on top of these where the patient lies, should be placed a second piece of oilcloth, four feet square, and over this a pad or clean sheet, folded three or four times. The bed is now ready for the patient. A rug or oilcloth is placed at the bedside to protect the carpet.

Preparation of the Patient for Labor.—She should have much the same care and treatment as if she were undergoing an operation. When the pains of labor are felt, some medicine should be taken to move the bowels. Either of the following will suit: (1) Epsom salts, one tablespoonful in a cup of hot water; or, (2) a seidlitz powder in a cup of water; or a bottle of magnesia.

Then, two or three hours later, an enema should be administered, of a quart of hot water and soapsuds, with one drachm of spirit of turpentine; the injection should be repeated every half hour until the bowels move freely. The patient should then take a warm bath, using plenty of soap and washing the genitals with great care, after wiping dry. She then puts on a clean chemise or night-dress, and a clean sheet is now folded once across and put around her waist and fastened in front with a large safety pin. The night-dress can then be folded up above the sheet and fastened so as to remain there until after delivery. The patient should not use the water-closet after this, but the chamber or bed-pan.

Vaginal douches I do not give unless there is some infection of the genital tract. I make sure that the bladder is emptied during the first, and the early part of the second stage, of labor.

Little or no solid food should be given after labor begins. Solid food in the stomach might be very injurious should surgical anesthesia be required. Chicken broth, mutton broth, or other nourishing soups, and plenty of water may be given during the first stage of labor.

Outfit for Patient and Child.—One rubber sheet or oilcloth large enough to cover the entire width of the bed and the greater part of its length. A second piece of oilcloth about four feet square. Six abdominal binders one yard and a quarter long and half a yard wide, made of the cheapest grade of unbleached muslin. Four bed pads, each four feet square and two or three inches thick, made of cheese-cloth and stuffed with non-absorbent cotton. They should be stitched or tufted enough to prevent the cotton slipping. One pound of absorbent cotton. Twenty-four vulvar pads or napkins, sterilized. Twenty-four baby napkins. One small blanket to wrap the baby in. Three-quart or four-quart fountain syringe and a douche-pan. Two or three wash-basins and from half a dozen to a dozen clean towels. From six to twelve clean sheets. Rug or oilcloth to protect the carpet at the bedside. Eight ounces of olive oil and a cake of ivory or castile soap. One new nailbrush. Two dozen large and two dozen small safety-pins. Three clean aprons. One pot or kettle of boiling water and a pot of cold water, boiled and covered with a towel.

Examination of the Patient.—Before making the examination I scrub my hands and arms for several minutes with soap and water, changing the water two or three times, then soak them for a few minutes in a solution of bichloride of mercury, and then rinse them off in a two-per-cent. solution of lysol. A similar solution of lysol is used to wash off the patient's genitals just before the examination is made.

I never make an examination under cover of the bed-clothes or the patient's clothing, as contact with any of these may infect *the* examining fingers. I use sterilized rubber gloves if I have attended any infectious cases a short time previously.

In my first examination of the patient I try to ascertain the condition of the vagina and cervix, the position and presentation, and the probable duration of labor, and whether or not it will be necessary for me to remain. I do not make frequent examinations.

All this care and preparation of the patient and washing and

scrubbing with the use of antiseptics may seem unnecessary and impossible to carry out, particularly with a poor patient in a tenement house. But I find that almost all of it can be done with very little difficulty if the physician takes the trouble to impress on his patient the necessity of thorough cleanliness and the great danger of sepsis or childbed fever, and most women feel their importance more when there is some fuss made over them, and will take extra efforts to have something that their neighbor never had for a confinement.

I must confess that I did not take these precautions until the last few years. During my first years of practice I had several cases of puerperal fever—some running a mild course, others with a high fever for two or three weeks, and three patients died of sepsis, contracted no doubt in labor. My experience in this misfortune is no exception to the general rule, as I have seen many such cases in consultation in the practice of other physicians.

When I take all these precautions I find I have no trouble with my confinements. They run through with a normal temperature, and I am saved a lot of worry and all the trouble I formerly had in washing and curetting of the uterus. Now, I have no trouble with the so-called milk-fever and "a touch of malaria," that formerly served as a cloak to cover my mistakes.

In addition to the usual things in my obstetrical bag, I also have a double tenaculum, a uterine dressing forceps, and a square yard of iodoform gauze in a sealed glass bottle, so that, in case of post-partum hemorrhage, I can pull down the cervix and pack the uterus. I also carry a needle-holder and perineum and cervix needles with sterilized sutures, so that I can repair all lacerations at once.

When the pains are severe and the os is rigid, I usually give 20 grains of chloral every half hour, till three or four doses are taken. This may be given by either the mouth or rectum. Quinine and sulphate of strychnine I find act better than ergot in producing uterine contractions and keeping up the tone of that organ, and there is not the danger in using these that there is in the use of ergot. Morphine, in one-eighth grain doses, I use now in almost all my cases; where the woman is suffering severely and labor progresses slowly, I give it every hour and sometimes every half hour. It does not prolong labor, but allows the woman to bear down with more force and very much less suffering, and it calms her fears. It gives me often a chance to go and make two or three calls before she requires my assistance, and it acts much as does chloral in relaxing the cervix and perineal muscles.

I find most patients do better by being on their feet until labor is well advanced. When the patient goes to bed, I place under her hips the Kelly pad, covered with a clean napkin. This saves the bed from the discharges.

When the child's head is well down and pressing on the perineum I give a little chloroform during the pain. I find that this enables her to bear down with more force and less suffering. It also causes relaxation of the cervix and perineum. When the occiput is well down under the pubic arch and the vulva wide open, the patient's limbs should then be kept extended, in order to relax the perineum as much as possible. When the knees are flexed upon the abdomen, the skin of the perineum is put on the stretch, and there is more danger of it tearing than when the legs are extended. Sufficient chloroform may now be given to stop pain and muscular action. I can now usually, by upward pressure on the child's forehead, deliver it in from fifteen to twenty minutes. This method will save the perineum from tearing, in the great majority of cases, and spare the mother much keen suffering. As soon as the head is born I stop the chloroform and wipe off the child's eyes with a saturated solution of boric acid.

In cases where labor is progressing very slowly and the pains are nagging in character and of very little force, if the cervix is well dilated, I find by experience that it is better to use the forceps, and, by slow and easy traction, deliver the child. In such cases, waiting too long wears out the strength of the mother; the uterus loses its tone and power of contraction, and there is great danger of post-partum hemorrhage.

Following the delivery of the child I make firm pressure on the fundus, and this pressure is kept up by myself or the nurse for at least half an hour after expulsion of the placenta, or until all danger of hemorrhage is passed. After the placenta is delivered it should be examined carefully to see that no part of it remains in the uterus.

All blood clots should be removed, and a careful examination of the vagina and cervix made, and any lacerations found should be repaired at once if the patient's condition will permit it. A sterilized gauze pad is then placed over the vulva and the abdominal binder is put on as soon as the uterus is firmly contracted. The binder should be fastened from above downward and the uterus should be pressed firmly against the pelvic brim. Putting on the binder from below upward, may push the uterus into the abdominal cavity, causing it to relax and produce hemorrhage. The patient should now be put in bed and have absolute rest, and friends and relatives be kept out of her room.

After an hour or two, if the mother is in good condition, the child can be put to nurse; this is done to stimulate uterine contraction and to increase or hasten the flow of milk. Before the child is put to nurse, its mouth should be washed with a solution of boric acid; the mother's nipples should be washed at the same time with a similar solution, and this should be repeated after each nursing. The patient should remain quietly on her back until all danger of hemorrhage has passed. After the second day I advise my patient to lie on the abdomen for a short period of from five to twenty minutes, several times each day and night, while she remains in bed. This is done for two reasons: First, to prevent or correct a retroversion or retroflexion, which may have previously existed; secondly, to afford better drainage from the vagina.

The diet of the mother, after labor, should be liquid: milk, cocoa, soups, and plenty of water, may be given to stimulate the kidneys and bowels. After the second or third day a little solid food may be given. So long as there is a free reddish discharge the patient should be kept in bed, except when she has to get up to attend to the calls of nature.

When I make my last call, which is usually about the tenth or twelfth day, I make a careful examination of the vagina and uterus, to ascertain the condition, and I give instructions as to douches or any other treatment that I may see indicated.

Before leaving my patient I impress on her the necessity of nursing the child, no matter how difficult it may be, and warn her of the great mortality of infants artificially fed, and I instruct the mother as to the proper kind of diet to use, in order that she may have sufficient good milk to nourish her child. Water should be drunk freely between the meals, and, by so doing, constipation of both mother and child is prevented.

FRACTURES OF THE UPPER THIRD OF THE FEMUR.

By W. Burt, M.D., Paris, Ont.

As it does not yet seem to be generally established that all, or nearly all, fractures of the femur may be treated by the straight position with Buck's extension apparatus, I will add to the record one of my latest experiences, with the permission of Dr. Sinclair, who asked me on the day following the accident to see the case with him and others. The doctor has handed me a short history of the accident, which is as follows:

Y. L., aged sixteen years, always enjoyed good health. He met with the present accident in the Y.M.C.A. gymnasium on November 16th, 1901, while trying to jump over a horizontal bar three feet from the floor. He caught the left foot, which tripped him, and he fell with great violence to the floor.

He was seen shortly afterward by Dr. Dunton and myself. Under an anesthetic, we found the femur dislocated upward on the ilium, which was reduced, the head of the bone going in with a thud. After the reduction of the dislocation we discovered that we had a fracture of the upper third of the femur to deal with and shortening to the extent of two inches and a half, the proximal fragment projecting markedly forward and outward. On an assistant making extreme flexion and extension upward, I could push the upper fragment into place, but the moment I let go it would tilt forward. The greatest flexion on the part of the assistant would not reduce the fracture. We put him up with a flexion apparatus, but the displacement remained.

I have been induced to publish this case on account of the articles by Dr. Hibbs and Dr. Shaffer in your issues of February 1st and 8th, and for the reason that there are to-day teachers of surgery who would think it a criminal procedure to treat a fracture of the upper or lower third of the femur in the straight position. I feel that if ever I had a bad case and was proceeded against for malpractice, there are many surgeons who would testify that a better result might have been obtained by the flexed position.

In my early days, when I was an interne in the Brooklyn City Hospital, and fractures of the thigh were somewhat numerous for a time, I gleaned from Hamilton's classical work and discarded double-inclined planes and flexed positions altogether, and I have never had reason to repent, fractured thighs coming under my care now and again ever since.

In the present case Dr. Sinclair, with the assistance of Dr. Dunton and Dr. Scott, put up the fracture in the flexed position, and with all that they could do the upper fragment was plainly visible, projecting forward and outward. Their faith was in the flexed position. I felt that the straight position could not make matters worse and possibly a good deal better. The flexed apparatus was removed and Buck's extension applied. The projecting forward of the upper fragment disappeared in a great measure almost immediately, and I felt that the condition of affairs would still improve and that in a few days at least the fragments would be in the best possible condition, which took place.

I examined our patient about three weeks ago, at the request of Dr. Sinclair. I found him in the garden, using a wheelbarrow, and scarcely favoring the injured limb at all. The contour of the limb was normal. A better result could not be desired. Any unevenness on the outer side could not be detected, nor was there shortening to the extent of five millimetres.

I may state here, what is self-evident to everyone, that the tendency of the upper fragment to tilt outward is completely overcome by Buck's extension apparatus, which brings both fragments into a straight line, and the pelvis does the tilting, which often makes the fractured limb to appear the longer. This is why I take exception to the necessity of abducting the limb when applying the apparatus. There are other points which the advocates of the extension splint allege for their method, which those in favor of Buck's apparatus will not concede to them, *e.g.*, immobility of the pelvis, continuous extension, and mobility of the lumbar spine.

Not long after the above-mentioned case occurred, Dr. Sinclair had a compound fracture of the lower third of the femur in a boy, aged twelve. Although the lower part of the thigh was much swollen, the same procedure was adopted, and the result is most promising. The doctor tells me that there is not a quarter of an inch shortening, and the patient is walking without a cane, favoring the limb very little. Coaptation and the long side splints were used in both cases.

While I should not say that there are not many surgeons who can obtain good results with inclined planes and extension splints, neither should I like to say that a better result might have been obtained in some cases by the straight position with Buck's appliance. In the present status of affairs I do not think that those who pin their faith to the flexed position should malign those who have greater confidence in the straight position or give testimony against them in case of suit for malpractice. It is next to impossible for the surgeon to visit a case several miles in the country and make daily changes of the dressings, as is required with the extension splint, whereas almost any onlooker can attend to the treatment by Buck's plan, and then, again, it is so simple, no special apparatus being required. The use of anesthetic is seldom required unless it is thought desirable to use plaster-of-Paris, both as a coaptation splint and to prevent shortening after reducing the fracture, a plan to which, if I remember right, the late Dr. Henry B. Sands was very partial.—*N. Y. Med. Jour.*

NOTE ON THE OCCURRENCE OF ASCITES IN SOLID ABDOMINAL TUMORS.

BY WILLIAM OSLER, M.D., BALTIMORE, MD.
Professor of Medicine, Johns Hopkins University.

The interesting lecture by Dr. Eden in the *Lancet* of February 8th, on two cases of solid abdominal tumor with ascites, calls attention to a not sufficiently recognized cause of abdominal dropsy. In 1885, I saw with Dr. Walker, of Dundas, Ont., a woman with recurring ascites, of doubtful origin, for which she had been tapped many times. Fortunately I saw her a day or two after the removal of the fluid, and was able to feel a tumor in the lower part of the abdomen. A week later, Dr. Thomas, of New York, removed a solid ovarian growth, and the patient has been well ever since.

My interest in the subject has been renewed recently by a very remarkable case referred to me by Dr. Koehler and Dr. Fackler, in a woman, aged fifty-three, who had had at intervals for three years attacks of ascites. Within the past four months she had been tapped four times. Ten years ago it was stated that a tumor had been detected in the abdomen. There was a good deal of discussion as to the nature of the case, and she was referred to me for a decision as to the advisability of an operation. There was a solid tumor in the lower abdomen, which could be moved from side to side. I suggested the possibility of dropsy dependent upon a solid ovarian tumor, and asked my colleague, Dr. Kelly, to operate. He found a large fibroma of the right ovary with twisted pedicle and adhesions to the omentum. The tumor was removed, and the patient has recovered.

Dr. Hunner, Professor Kelly's first assistant, has very kindly collected for me the cases bearing upon this point from the gynecological clinic of the Johns Hopkins Hospital. Among 9,400 cases there have been ten patients with solid ovarian tumors, the ages ranging from thirty-two to sixty-three. In six of these cases ascites was present on admission. Three of the cases had required repeated tapping. All of the cases recovered after operation.

As Dr. Eden remarks, ascites is the rule with solid tumors of the ovary, and so rare with fibroids of the uterus that its presence almost serves to exclude them. Other forms of tumor may be associated with ascites. In Montreal I saw a case of leukemia with recurring ascites. On the occasion of my first visit the distension was so great that the spleen could not be

felt; in fact, the diagnosis was not made until after the patient had been tapped. In a case of solid tumor of the mesentery there was an ascites of moderate degree.

The association is one to which the attention of the profession has not been called sufficiently. I was so impressed with it in the case upon which Dr. Thomas operated, that I made a reference to solid tumors as a cause of recurring ascites in the first edition of my text-book (1892). The question of operation is a very important one; the solid ovarian tumor is usually benign, and, as mentioned, the cases in Dr. Kelly's clinic have uniformly recovered.—*Phil. Med. Jour.*

TYMPANIC VERTIGO.

Dr. William P. Brandegee defined tympanic vertigo as that form characterized by changes or pathological conditions in the middle ear. These conditions of the middle ear comprised all those tubal changes caused by difference in atmospheric pressure; those changes in the tympanum due to inflammatory products, either fluid or solid; those changes due to connective tissue products, and those changes the result of residual products. The vertigo arising from venous engorgement of the walls of the Eustachian tube or from hypersecretion of the lining membrane, was usually mild in type, but where there were hypertrophic changes the vertigo was often exceedingly severe. Frequent inflation, preferably by the catheter, was indicated in the congestive cases. The use of the nasal douche in congestive conditions should be prohibited as a prophylactic measure. In the acute catarrhal and purulent cases early incision of the drum membrane might be indicated. After the subsidence of the acute symptoms there should be given a course of middle-ear inflation in order to restore the hearing and break up any adhesions that may exist. In the more severe inflammatory cases it might be necessary to remove the ossicles or even do a Stacke operation. The patency of the Eustachian tube should be restored, and, in the speaker's opinion, this was best accomplished by electrolysis.—*Medical Record.*