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WESTERN CANADA MEDICAL JOURNAL

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*PRAIRIE DIETETICS IN RELATION TO HEALTH AND DISEASE

BY

H. M. SPEECHLY, M.R.C.S., L.R.C.P. (London)

PILOT MOUND, MAN.

As the health of the dwellers on our Western prairies must depend largely on the dietary and methods of diet by which they feed themselves and their children, the problem what to eat and what to avoid should bulk largely not only in the preservation of health but also in the treatment of disease. It is not too much to claim, then, that medical men should pay close attention to this matter even when handling surgical cases. In fact it may be laid down that there are few cases either surgical or medical in which dietary management should be neglected. It is true that the general public dislike interference with the ordinary diet, but I believe that the unpopularity of such a proposition as diet control arises out of a want of appreciation of its importance by large numbers of our profession and therefore of our patients. Professor Wm. Osler rightly contended the other day that the medical profession is not the servant of public opinion but the leader thereof. But how many students in our Colleges are put through a course of instruction in Dietetics? Hence it comes to pass that the question of diet is so often slurred by the profession and too much dependence is placed upon drugging and even surgical methods. Do not, however, imagine that I am advocating the other extreme, of neglecting the medical and surgical arms of

*Read before the Canadian Medical Association, Winnipeg, 1909

precision with which modern science is equipping us, because I am in the habit of using perhaps thirty different drugs as aids to treatment and methodical dieting in my own practice on the prairie. The need is considerable owing to the general average ignorance of good and bad articles of diet among the public and owing to the neglect of certain specialists from the cities to remember that their own special line is governed materially by the all-pervading influence of digestion on disease. Hence it is that sometimes patients who come to the West with "tubercular disease of the throat" recover rapidly under appropriate dietetic management. It might be well also here to state that there are no diseases found on the Western prairies differing from those which affect the Anglo-Saxon race in other parts of Europe and North America.

Let us first consider briefly what is the average Prairie dietary, dividing it into two classes, (1) the Infantile, (2) the Adult.

(1) What do we mean by the Infantile dietary? It should, of course, extend over a period of two years from birth at least; but as a matter of practice on the prairies the first year from birth amply covers this period. It might be supposed that this epoch could be lightly dismissed by saying that of course prairie mothers suckle their infants during that time. Most of them would do so gladly; some do so reluctantly; other few, not many, are too lazy, or selfish, to bother with it; while all too many are unable to fulfil this function as completely as desirable. Defective nipples sometimes compel a mother to stop nursing; but most often the necessity for a nursing mother to do her own work, including the harder tasks of scrubbing, washing, and ironing, prevents her from nursing her child for even six months either because her supply of milk declines to vanishing point or because its quality is spoiled. Too often, then, the babe is fed from the bottle or by the spoon more rarely. Gastro-intestinal troubles follow especially as those wise persons whose name is legion invariably recommend the milk "from one cow" diluted in too strong proportion and mingled with some biscuit preparation such as cream crackers or arrow-root biscuits. Hereditary ignorance permitted largely by the neglect of the profession to

rise above the level of "old women" is responsible for this. The usual train of vomiting, diarrhœa, and constipation is the common effect of this dietary as well as chronic intestinal conditions which predispose to tubercular and other lung complaints. But occasionally true rickets follows and puzzles the uninitiated It is worth noting, however, that the mingling of arrow-root biscuit with the bottle contents does occasionally improve the infant's capacity to digest its milk. Finally while well within this epoch many infants easily slide from this biscuit dietary aided and abetted, it is true, by the male parent into "taking everything that we do" from pork to raw carrots.

(2) From the foregoing period the Adult dietary commences and continues until the end of life, often prematurely closed by dietary mistakes, or until disease or some medical man compels the individual to halt and make a change. Let me urge that no medical man is fully equipped against disease until he grasps the common-sense principles of diet. Faddiness is sheer nonsense and as La Rochefoucauld says (Maxim 285) "Preserving health by too strict a regimen is a wearisome malady." In dietetics we require common-sense and the use not of cast-iron methods but an elastic adaptation of principles to each individual case. Moreover moderation in the use of most articles of diet is the governing principle not prohibition, though in some cases temporary or permanent prohibition cannot be avoided.

Let us, however, consider in detail the average prairie foods. The principal nitrogenous substances are pork, beef, poultry, fish, game and mutton; the carbo-hydrates are represented by porridge, bread, scones, biscuits, cream crackers, dry cereals, prepared wheat products, pies, fruit cakes, all sweet preserves, syrups especially plain and maple syrups, corn sauce, milk puddings, potatoes, butter, beans, beet, turnips, carrots, cuions, tomatoes, cucumbers, cabbage, and pickles; and the hydro-carbons are contained in butter, cream, pork, and eggs. In their seasons quite considerable quantities of oysters are consumed, and fresh fruits, such as apples, small fruits, pears, peaches, cherries, tomatoes, apricots, and strawberries, while the whole year round lemons, oranges, and bananas are eaten in large quantities. It is, then, no exaggeration to state that as the

Western farmer grows more and more prosperous his board may be said to *groan* with an abundance of good things; and so, too, quite often do those who partake too well thereof and not wisely. Yet if guided by a judicious choice one may eat there and exclaim with Dean Swift: "Lord, Madame, I have fed like a farmer; I shall grow as fat as a porpoise!"

It is worth noting, moreover, that the influence of tradition is well marked, so well marked sometimes as to make fetishes of certain articles of diet. For instance the Scotch use of porridge has conferred upon the eating of this product a sanctity almost equivalent to that of a sacred rite. The old English custom of eating a big largely hydro-carbon breakfast of pork foods and eggs washed down with tea or coffee is as the law of the Medes and Persians which cannot be broken. And again the "down-East" influence, touched perhaps with a Yankee blend, is evidenced by the use of apples and maple syrups as being "healthy" at all times and places, or by the use of dry cereals and fruit at breakfast, and of corn sauce, pumpkin pie and Johnny-cake at other meals—all to be taken with the rapidity of a threshing machine in action! Further, in dealing with this subject it is necessary to emphasize the important influence of the Water supply of our Western prairies on the health of our population. In view of the fact that in taking a farm or a homestead the water supply is often the last thing of which account is taken it cannot be pointed out too strongly that many wells are so strongly impregnated with the alkaline earth as to coat heavily the interior of kettles and to cause severe diarrhœa to new-comers. It stands to reason therefore that this same water must be a source of chronic irritation to certain digestions and will complicate the dietetic management of disease. Then again our people should be carefully warned against the impropriety of using any well for human beings that is liable to the surface soakage from stables or privies, a matter quite too often over-looked.

Here it might be asked, "Are there no errors in preparing food and in habits of eating?" Without dwelling too long on these matters it is easy to point out that, while the general average of cooking is excellent in the matter of bread-making and the

cooking of vegetables, puddings, and sweets, the practice of frying meats, especially pork, until the meat fibre is hard and tough practically destroys the nutritive value of meat, and often causes indigestion or constipation. The making of tea is often defective also. The importance of this error in making so excellent a fluid lies in the fact that enormous quantities of tea are consumed in the West. The error lies both in making it too strong and allowing it to stand a long time on a very hot stove. But far more serious perhaps is the great error in habit of bolting food without any pretence at mastication which is all too common amongst the men if less frequent amongst women-kind. Added to this bad habit is the equally prevalent habit of drinking and eating simultaneously. A farmer allows two hours for his horses in which to have food and rest, but allows himself not much more than two minutes to bolt his food and bolt out again to work. What a waste of internal force there will be, largely spent in tackling the food-lumps! Is not a man of more value than a horse?

Briefly now let us touch on the relation of dietetics to the three large classes of disease covered by such terms as Goitre: the Uric Acid diathesis: and Gastro-intestinal disease. It is too much to claim that Auto-intoxication is really at the bottom of all three? Incontestably it is as regards the last two; but I believe that chronic Auto-intoxication is essential to the production of Goitre and that without it Goitre is impossible. Whatever influence water of a tainted sort may have in these cases are they not all the subjects of chronic Auto-intoxication? Are not all the early cases of enlarged Thyroid gland curable by the prevention of Auto-intoxicatioin? I may say this that Goitre is common amongst young and old women but only occasional amongst men in Manitoba and that some dozens of cases occur in my own district. The early cases as a rule improve permanently when the intestinal canal is swept and garnished and dietary precautions are taken.

Finally as bearing more particularly on the Uric acid diathesis and Gastro-intestinal disorders let me urge that our patients should be warned in detail against certain articles of diet. For instance after the growing age porridge, even of the best Scotch or Canadian oatmeal may be positively poisonous and often is especially in hot weather. Or again, the notion that it is neces-

sary to eat large quantities of meat, especially if cooked hard and bolted, during harvest or other strenuous times is quite wrong, and needs to be combatted. The use of sugars especially of Maple Syrup is far too frequent amongst adults who imagine they can do what they used to do in the days of their youth in "sugar time" down in old Ontario. Maple Syrup is one of the most common causes of what is called "*muscular rheumatism.*" Uncooked apples, too, produce more auto-intoxication in winter time in patients of all ages than any other article of diet, because people think they are "healthy" as the phrase is. Are these fruits who are picked on the unripe side of the same value as fruits eaten when really ripe? I think not. The same thing may be said of the pulps of oranges which should always be rejected for being as indigestible as their juice is excellent for human beings. Take again the small fruits so abundantly consumed in the West. Over and over again the seeds, skins, or stones of such fruits as saskatoons, cranberries, raspberries and currants of all sorts are responsible for creating fermenting masses in the bowels which produce severe auto-intoxication.

Thus often the correcting of quite small mistakes in the eyes of the patient makes all the difference between successful and non-successful treatment. It is often "the little foxes that spoil the grapes." I am aware that to many people these doctrines seems crazy but that is simply because they are ignorant of the effects of dietary mistakes. To the sceptical amongst the brethren I would say, "Experto crede."

*THE DUTY OF THE PHYSICIAN IN RESPECT TO TUBERCULOSIS

BY

W. CHESTNUT, M.D., C.M.

WINNIPEG, MAN.

During the last decade there has been a remarkable awakening to our responsibility in dealing with this, the worst scourge of the human race. The remarkable thing however about this awakening is, not that is has taken place, but that it has been so long in taking place. Tuberculosis has been levying annually a greater tribute in human life and suffering than all other infectious diseases combined; but while the public health has been safe-guarded in every possible way against an outbreak for example of small-pox or typhoid fever, tuberculosis has been allowed to work its havoc without any well organized effort to protect the people against this disease.

Tuberculosis it is true, on account of its chronicity, its prevalence and the manner in which it has woven itself into the woof of society, presents a problem much more difficult than that of any other communicable disease; but the appalling loss of life, the human misery entailed and the economic loss can no longer be ignored.

It is high time therefore that the Federal Government, the Provincial and the Municipal Governments and those men under them upon whom rests the chief responsibility of protecting the people against infectious diseases—it is high time that these men, the medical profession as a whole and the people at large set themselves in dead earnest to solve this problem of preventive medicine.

Manitoba has been slow in feeling the pulsation of this movement throbbing elsewhere in the civilized world, but there are

*Read before the Manitoba Medical Association, Brandon, 1909.

now signs of an awakening. The movement broached first at the Winnipeg Medical Chirurgical Society; later taken up by the Provincial Board of Health for a sanitarium for incipient cases, has at last crystallized into form and a building is now in the course of construction at Ninette, which when completed will accomodate 60 patients.

An Anti-tuberculosis Society has been formed in Winnipeg with Dr. Chown at its head, and an active and energetic body of lay and medical men at its back. This Society has already commenced to get its work in line with what is being done elsewhere. Under its auspices a dispensary for tubercular patients has been opened at the Winnipeg General Hospital, where charity cases can have medical advice free of charge by men who are interested in this work.

A visiting nurse has been secured in connection with this work, whose duty it is to visit those patients in their homes, report on the hygienic condition of those homes, the number and health of inmates, air space, lighting, sleeping accommodation, facilities for open air treatment, etc. She also distributes suitable literature, and instructs the patient in the care of his sputum, his habits of life, etc., and she is certain to exercise a potent influence in the education and protection of the people. Her reports will also furnish us with valuable information as to the social and other conditions under which tuberculosis prevails in our city.

An educational campaign has also been undertaken under the same auspices, and every known method of value will be put into use for instructing all classes.

The school teachers have already been addressed on this matter and through them literature has been placed in the hands of the school children for distribution in their homes. As this educational campaign becomes better organized, we hope to see it extend geographically until it has included the whole Province. Needless to say, this can never be accomplished without the hearty co-operation of all the medical men of the Province.

Permit me now to address myself more definitely to the question at issue. Consumption is a communicable, preventable and curable disease—but this dictum has its limitations. It is

curable, but the results of the most approved methods of treatment clearly indicate that diagnosis in the early stages cannot be too earnestly emphasified, as upon this depends our hope of successful treatment. There is considerable misunderstanding as to the meaning of the term "incipient phthisis." It certainly does not mean the presence of all the classical symptoms and physical signs which we are in the habit of associating with the disease. These classical symptoms and physical signs indicate rather that the disease is already beyond the stage where we can hope much from treatment. It does often mean both few physical signs and very indefinite symptoms. The difficulty of diagnosis is therefore very great, but where the probability of phthisis presents itself, we must in the interests of our patients set to work to solve the difficulty by all known methods of value. This we owe to those who consult us, and whose future well-being is in our hands. A great deal often hangs in the balance—not only the hope of the individual for health, but also the support of families and dependants. I cannot emphasize this point too strongly as I am persuaded that here most of us fall down with disastrous results to our patients.

Carelessness in diagnosis, temporizing in treatment, means a loss of valuable time—time which no subsequent diligence or activity on the part of the physician can ever redeem. An early diagnosis is quite as important here as an early diagnosis in cancer. Both are equally curable when diagnosed in a very early stage, and both are equally incurable when allowed to progress.

The diagnosis having been settled, we must next have a definite understanding with both patients and friends. The problem of treatment calls for firmess on the part of the physician, and sacrifice often on the part of the patients and friends. The way back to health is a long and up-hill road, and too many through lack of firmness on the part of the physician or carelessness on their own part fall by the wayside.

It is depressing to note how many of these early cases return to us later in an advanced stage, simply because they have ignored our warnings.

The vast bulk of the cases however are not incipient, but are either advanced or moderately advanced. They are not eligible

for sanitarium treatment. We must, I think, understand that we are here brought face to face with the real problem of tuberculosis. We have here to deal with a vast army—a dangerous army. These are the patients that mingle with the community and that expectorate their millions of germs in the home, in the workshop, in the boarding-house and in public places.

Unless we adopt some radical methods of limiting the infection that this army is spreading broadcast, we can never hope to lessen the mortality to any appreciable degree. Unless we can deal with this infected mass of humanity we can go on building sanitariums for incipient cases and enlarging them to the end of time, and the necessity for them shall never cease to exist. What can we do for these patients? How can we minimize the danger to the community? The problem must be worked out on different lines in the country and in the city. The hopelessly incurable, who owing to circumstances cannot be cared for at home, must be provided for in hospitals located more or less convenient to the larger centres of population; and where these patients are living in boarding-houses and homes where they are a particular menace to the other inmates, every effort must be made to induce them to segregate themselves.

When we have weeded out the advanced cases, we have still left a great mass of chronics, men who will not and cannot desert the post of duty; men who have families and relatives dependant upon them; women who have homes to look after. These women must toil on in their homes, these men must work side by side with their fellow-men while their strength lasts. What can we do to help these and to render them less dangerous to those with whom they associate? We must teach them how to live, and above all how to live so as to protect others. We must exercise some kind of supervision over them, as we cannot trust to their intelligence in this matter.

In the city I know of no single agent likely to accomplish so much as an intelligent visiting nurse. In rural districts where a visiting nurse cannot be employed, unless the physician is willing to give a little attention to these cases, they must go uncared for, and be allowed to spread the infection at will. At one time or another a physician comes into contact with all these

cases, and surely he would be doing a meritorious act in instructing them as far as possible. He should at least see to it that they are instructed in the care of their sputum, and how to avoid the risk of giving the disease to others.

Underlying all work for the prevention of this disease there must be a clear understanding of the fact that knowledge of the nature of the disease and the method by which it is spread are essential to true progress. Ignorance is a great factor in spreading the disease. For centuries people accepted the onset of this scourge as a kind of visitation of Providence not to be interfered with, but the time has come to teach that in this matter we suffer as the result of our own carelessness and indifference. The education of the people must be an important factor in this work, and in this campaign of education we must look for assistance to the physician, and I bespeak for this work now begun in Winnipeg the hearty co-operation of the profession at large. Our education, the stamp of authority set on our words in reference to disease, have made us natural leaders in this campaign. The intelligent laymen are willing to help, but we must direct the work. We must aim to educate all classes of society. The committee in Winnipeg has started right in commencing with our school teachers. How easy it would be for physicians elsewhere if interested, to follow their example. Through the teachers we must reach the children, for this is not the work of a day, but a generation—perhaps of more than one generation, unless science furnishes us with some better remedy than we yet possess.

There is another problem intimately associated with this disease that is worthy of our attention—a problem that fortunately has a much wider influence than that it bears to consumption—I refer to the social improvement of the condition of the poor. In large cities long hours for the working man, bad hygiene in the factories and workshops, food—poor in quality and poorly cooked, vicious habits, and above all unsanitary homes and surroundings tend to further the development of tuberculosis. One has but to look at the bearing of this question in such cities as New York where certain tenement districts are veritable plague spots, to see a warning to our city builders in the West. We must encouruage better sanitary and social conditions for

the working man. And now, lest the country physician may think there is nothing for him to do in this respect let me remind him of the many fine barns to be seen on the prairies, and the many poor human habitations. We do not need to go to the slums of the city to find small, badly lighted and worse ventilated living and sleeping rooms.

The subject of bovine tuberculosis is also worthy of our attention. There can be little doubt that many of the infections of childhood, especially those of glands, bones, joints, meninges and tabes mesenterica are of bovine origin. The securing, therefore, of a safer milk supply is a matter that should receive the earnest attention of the medical profession.

You may consider that in all this I have placed too great responsibilities on the shoulders of the profession, but with our present organization I can see no way of shifting the responsibility or of otherwise accomplishing the end aimed at. Preventive medicine is as much our duty as that of prescribing physic, and often indeed of much greater value. As good citizens we are interested in the wellbeing of the race. We belong to a profession that fittingly lends itself to such work, and lending itself exalts and commends itself to humanity.

*HEADACHE

BY

RAYMOND BROWN, M.D.

WINNIPEG, MAN.

Headache, the most common of all pains to which man is heir, touching as it does all branches of medicine and surgery, to be dealt with in a paper limited to a few minutes' time, must be taken up according to points which we consider most important.

When one attempts to classify headaches according to any of the ordinary forms of classification one's diagram becomes so complex and so interwoven that it becomes useless in a paper of this kind.

If I may be allowed to pass over all those acute headaches which are only one of a long train of symptoms, which accompany the acute and sub-acute infectious diseases, I think the subject is best taken up under three headings:—

1. Mechanical Headaches.
2. Chemical or Toxic Headaches.
3. Reflex Headaches.

Schmidt of Vienna in his little book on "Pain" has suggested this grouping or classification.

It will be seen however that no hard or fast lines can be drawn as some headaches may be classed under two or even all three of these headings. It must be kept in mind that we are dealing with the trigeminal nerve, that great sensory nerve of the head and face, the meningeal distribution of which we especially must not forget.

Mechanical headaches are dependent upon a rise in the intracranial pressure, in which catagory would come all local new growths and the chronic Infectious Granulamata, Hydrocephalus, and certain vasomotor disturbances, interference with

*Read before the Manitoba Medical Association, Brandon, 1909.

venous return from the head as in mediastinal new growths and cordiac insufficiency. The so called "Hydraemic Hydrocepholus" of the anemias and nephritic headaches that occur with the high tension pulse, associated with arterio scleroses, might also be placed in the mechanical class.

Under Chemical or Toxic headaches perhaps would come first "Migraine" the well known sick headache and the Uric Acid Deatheses. I am here assuming Trousseau's dictum that Migraine and Gout are sisters. Here is also perhaps best placed Anaemia, Uraemia, and the metalic poisons together with Post-alcoholic and Post-anesthetic headaches. Inflammations also should be placed in this class.

Under our last heading, reflex headaches, will come the majority of all chronic cases. First, and most frequent of all reflex causes of headache is the eye. It may be hypermetropia, astigmatism, presbyopia or even myopia, a weakened convergence or an over convergence or vertical deviation or a combination of these. Glaucoma as a cause, should, of course, never be forgotten.

In placing the eye most frequent or all causes of reflex headaches, I do not wish to be understood that I contend that every case of headache in which we find mechanically defective eyes that this defect is the cause or whole cause of the headache.

Neither do I wish to be classed among the over zealous specialists who attribute eye-strain as the cause of palpitation of the heart, neuresthenia, anorexia, nausia, and vomiting, epilepsy, etc. True the eye-strain may be a contributing factor in many or all of these troubles but seldom the whole cause.

In an editorial in the journal of the American Medical Association of April 24th, 1909, on headaches, the author states that "of all causes of headache, far and away the most frequent is eye-strain."

In preparation of the paper I have written or consulted a dozen or more prominent aphthalmologists and neurologists, asking each one's opinion as to what percentage of chronic headaches are "asthenopic" that is due to eye strain either entirely or in which the eyes are a contributing factor. The answers were very varied; one gave 60 per cent. to 80 per cent. one gave less

than 50 per cent. several gave 50 per cent. to 65 per cent. One medical man gave a percentage as low as 10 per cent. My own opinion is that one half of all chronic headaches are due to eye-strain either alone or in conjunction with other causes.

So much for the ocular causes. Next in importance but far less frequent as causes of headache are local pathological processes in the nose and accessory sinuses. Irritative catarrhal conditions, adenoids and tonsils, enlarged or cystic middle turbinates, frontal or sphenoidal sinus diseases, an infected antrum or even a bad tooth. I might here report a case of a man, age 20, university student, whose headache was very annoying and principally frontal or temporal. Occasionally the pain would localize in front of the right ear. His examination was entirely negative except for a deflection of the nasal septum to the right so marked as to be making constant pressure upon both middle and inferior turbinates. I did a submucous resection of that septum which entirely relieved him of his headache.

The ear and mastoid should never be forgotten in the routine examination for causes of headaches.

Other reflex causes one might mention are gastro intestinal diorders, parisites, constipation, gall stone diseases and uterine disorders. Yawger of Pennsylvania reports three cases of what he terms "Indurative Headaches," the result of infiltrations or thickenings at various points, chiefly in the muscles of the neck and head, one of the rare causes which we should not however overlook.

Special points in diagnosis would be:—

(a) Careful history taking, eliciting all accompanying manifestations, habits, heredity, time of onset, etc.

(b) Temperature and pulse rate.

(c) Careful urinary examination, not only for albumin and casts but for Indican Dracitic Acid and Acetone.

(d) Careful examination of the eyes.

(e) Taking of blood pressure.

(f) Careful manual examination of head and neck for nodules that might be irritating some nerve.

(g) Special attention to the ears, nose, teeth and sinuses

(h) The topography of a headache may or may not assist one in diagnosis. A headache that is frontal temporal or in the eye ball would suggest an ocular cause, a toxic cause or a sinus. A unilateral headache would suggest the ear, local new growths, a sinus or a toxic cause. Occipital or sub-occipital headache would suggest Hyperteusion or a Uterine headache.

(i) With reference to time of onset. Nocturnal onset or exacerbation would suggest middle ear disease, syphilis, brain tumor or uremia. Headaches in the morning before rising would suggest a toxic origin. Headaches recurring at intervals of a few days to a few weeks, severe and prostrating are suggestive of Migraine.

Treatment.

The treatment of headaches is b st taken up under these headings, Prophylactic, Symptomatic and Curative. Uuder Prophylatic would come

First:—

Correct habits of living, pure food, fresh air, exercise, etc.

Second:—

Education of the public as to evils of allowing children with defective eyes, partly deaf and discharging ears, adenoids, and hypertrophied tonsils to go untreated. This campaign of education can be best carried on by systematic medical inspection of our public school children. Thus would be discovered early and while easily amenable to treatment over 50 per cent. of the causes of all headache.

The Symptomatic treatment of headaches consists in giving antineuralgic drugs and is so well known to all that I shall not take it up except to sound a note of warning.

Many physicians, especially the busy ones, will indiscriminately prescribe caffeine, acetanilid, phenacetine, antipyrin, bromides, chloral, codeine, etc., to their patients with headaches, sending their patients off into what I call the "Headache Powder Habit," which is as bad or worse than the whiskey habit or the morphine habit.

Our country is flooded with proprietery headache remedies which the public can buy at the drug store or the grocery store. Mr. Patient soon finds that this proprietery remedy relieves his

headache just as well as the prescription given him by Dr. X and costs him far less money. Thus the habit is established. It is true there have been a few deaths reported as directly due to the use of these depressing antineuralgic drugs which practically all headache remedies contain but the great evils that come from their use are

First:—

The alleviation of symptoms of serious maladies until too late for treatment.

Second:—

The increasing number of cases being discovered by the internal medical men of weakened general circulation and weak hearts in people who have taken much of these antineuralgic drugs.

The physician had better not treat symptomatically cases that are labelled "Habitual Headache" or "Nervous Headache."

The Curative treatment should always be directed toward the cause

*OBSERVATIONS ON THE MODERN TREATMEFT OF CERTAIN PARALYTIC DEFORMITIES—SPECIAL REFERENCE TO ARTHODESIS

BY

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During recent years revolutionay advances have been made in some departments of orthopedic practice. Wider and wider applications of operative surgery to the treatment of certain orthopedic conditions are being made, with the result that many patients who a few years ago would have been condemned to a lifetime of treatment by mechanical appliances are now largely or wholly freed from this troublesome and expensive thraldom. Especially are the modern operations of arthrodesis and tendon transplantation proving of incalculable benefit to multitudes of patients handicapped by the weakened and deranged mechanical condition of certain parts of the body which results from muscular paralysis, particularly poliomyelitis. It is the chief purpose of this paper to discuss briefly a few points in connection with the operation of arthrodesis.

In performing arthrodesis we deliberately attempt to ankylose a joint in such a position as to secure the largest possible measure of usefulness in the part operated upon. It is applied to joints which are healthy, but which, because of partial or complete paralysis of the muscles controlling them are deformed, weak, or so far out of muscular balance that their normal function is impossible. In rare instances the operation is applicable to the shoulder, hip, wrist, knee and sacro-iliac joints; but it is in connection with the ankle and mid-tarsal joints that it finds it widest and most useful application.

*Read before the Manitoba Medical Association, Brandon, 1909.

At the shoulder joint the operation is useless if all the luxation. Kofman, in 1906, reported six cases. When we recollect that in severe poliomyelitis affecting the lower extremity the growth of the paralyzed limb is often so retarded that it becomes two or three inches shorter than its fellow it is not difficult to understand how the additional disparity in length due to dislocation of the hip is in itself very disabling. But in paralytic luxation, added to the disability caused by the shortening is that due to want of muscular control and to the insecurity of the joint brought about by the substitution of ligamentous for bony support; and under such a combination of disabling conditions there can be no question regarding the advantage of placing and retaining the head of the femur in the acetabulum at the expense of the movement of the joint. In the lower extremity security of support is often a vastly more important practical necessity than freedom of motion; and on account of the free compensatory mobility which can be developed in the lumbar spine there are few important joints the movement of which can be abolished with less disadvantage than the hip.

At the knee arthrodesis should be advised only exceptionally, because by means of muscle-grafting or comparatively simple apparatus most of the disabilities resulting from paralysis of the muscles which control this joint can be satisfactorily controlled. When, as frequently happens, the patient is rendered insecure by paralysis of the quadriceps, being unable to keep the knee from giving way in flexion when weight is placed upon it, immense benefit often results from grafting the sartorius, or slips from the outer or inner hamstrings or one of the adductors, into the top of the patella, and this muscle-grafting operatioin should always be pre-

At the hip the operation is chiefly useful in cases of paralytic muscles controlling the humerus and scapula are paralyzed. But where scapular movement is retained, and some power remains in the hand and elbow, but the muscles which connect the upper arm with the scapula have lost their power, the patient's condition may sometimes be distinctly improved by ankylosing the shoulder, so as to control the humerus to some extent through scapular motion.

ferred to arthrodesis. But muscle-grafting is not always practicable; the knee may be completely flail and without any active muscles available for grafting. Under these circumstances it may be so weak and insecure that the patient must choose between the permanent use of a brace and an operation to stiffen the joint. The age of the patient is an important factor in finally determining the best course to pursue under these conditions. In the case of a child treatment by apparatus should nearly always be choosen in preference to stiffening the joint by operation; but after the patient has reached adult age, if he decides for himself that permanent immobility is preferable to the constant use of a brace the operation should be performed. It will be found that in private practice among those who can afford good apparatus a continuance of mechanical treatment will usually be preferred; but among the poor many will elect operation so as to be relieved of the inconvenience and expense of appliances.

In the treatment of various paralytic deformities and disabilities of the foot and ankle arthrodesis is one of the most useful operations in the whole domain of operative orthopedic surgery. When performed with care and skill in properly selected cases the operation can hardly fail of benefiting the patient. Disappointment and failure are met with chiefly in the practice of those who have not acquired skill in technique or who have failed to grasp the conditions necessary for success.

For the maintenance of its proper form and function and its normal relation to the leg the foot is largely dependent upon a nicely adjusted balance between the various groups of muscles which control it. If any group or any individual muscle is paralyzed this muscular balance is disturbed and deformity inevitably follows. Paralysis of the peronei results in inversion and adduction of the foot, producing the varus type of deformity; if the antagonists of the peronei, the tibialis anticus and tibialis posticus lose their power the foot goes into eversion and abduction and the opposite type of deformity, the valgus foot, results. In the same manner paralysis of the dorsal flexors and of the plantar flexors results respectively in talipes equinus and talipes calcaneus. When muscles in functionally different

groups are simultaneously affected the varying distribution of remaining functional activity gives rise to compound deformities, made up of a combination of two or more of the four primary types just named; thus we get such varieties as equino-varus, equino-valgus, calcaneo-valgus, etc. If all the muscles controlling the foot are paralyzed we get a flail foot, the relation of which to the leg becomes largely dependent upon a variety of accidental or habitual mechanical influences.

Under certain circumstances arthrodesis may be advantageously employed in almost all of the varieties of foot deformity which result from paralysis, but it is in the management of the *valgus, calcaneus and varus types of deformity, simple or combined*, that it is of paramount service. In many of the paralytic deformities of the feet tendon transplantation may be resorted to with great benefit to the patient; but in severe examples of the various distortions it is often impossible to restore the form of the foot and to permanently re-establish its normal relation to the leg by any re-arrangement of the attachment of the active muscles, because the superincumbent weight of the body is a deforming mechanical force too powerful for the transplanted muscles to successfully contend against. But by arthrodesis of the ankle, alone or combined with arthrodesis of the mid-tarsal and occasionally of the subastragaloid joint, the foot can be placed permanently in such relation to the leg that the superincumbent weight is powerless to force it into eversion or inversion, extension or flexion; if properly performed the foot is permanently fixed in such relation to the leg that the line of weight transmission henceforth passes approximately through the centre of the astragalus instead of toward or even altogether outside the boundaries of that bone, and the balance of the foot is easily maintained. In children too young for arthrodesis I often performed tendon transplantation as a temporary expedient to diminish disability and to protect the foot as far as possible against increasing deformity until the child has arrived at the age when arthrodesis may be expected to succeed. In a certain proportion of such cases the transplantation operation accomplishes more than was expected of it so that the contemplated future arthrodesis proves to be unnecessary.

The limits of this paper forbid a discussion of the details of operating on the various types of deformity. A few brief comments on some important points, and an attempt to lay down some general guiding principles will represent the scope of the writer's effort.

Arthrodesis should never be attempted in a patient under eight years of age; if he is past ten years it is still better. In young children, the bones of the foot are so largely cartilaginous that if the operation is attempted at this period a very large amount of tissue must be removed in order to expose sufficient true bony structure, and even then instead of securing bony ankylosis, a yielding fibrous union is very apt to result. On this account the operation in children under eight years of age frequently fails to yield satisfactory stability.

The removal of cartilage from the bony surfaces to be brought into contact should be clean and thorough; if this part of the operation be imperfectly done fibrous instead of bony union must result. The aim should be to get broad, well-fitting, raw bony surfaces into intimate contact with one another. A very sharp chisel is usually the best instrument for denuding the bones; curettes are much less efficient.

In operating at the ankle the cartilage should be evenly removed from the tibia, but in denuding the astragalus its upper surface should be so fashioned that when brought into contact with the tibia any previous tendency to inversion or eversion of the foot will be corrected, the foot being placed in such relation to the line of weight transmission as to be most securely balanced. This can be accomplished by making the slice of cartilage and bone removed from the astragalus more or less wedge-shaped, the base of the wedge being external to correct inversion or internal to correct eversion. In order to overcome a tendency to calcaneus or equinus it may further be necessary to make the section of the astragalus somewhat wedge-shaped in the antero-posterior direction.

Great care should be taken that the relative position of the denuded bones is not disarranged during the application of the dressings. It is decidedly awkward, after having carefully shaped the bony surfaces to fit one another to have the patient recover

with the bones ankylosed in a vicious position. Pegs and wires are unnecessary, however; with proper care the desired relation of the parts can be maintained as long as may be desired by a plaster-of-Paris dressing.

I usually keep the parts immobilized for from 10 to 12 weeks; after removal of dressing a protecting appliances may be advantageously used for a few weeks longer.

When marked abduction or adduction of the front part of the foot exists it may be necessary to perform arthrodesis at the mid tarsal joint as well as at the ankle. Both operations may be done at one time or they may be separated by an interval of two to four weeks. By correctly shaping the bone section the abduction or adduction may be easily overcome.

When a hollow foot (pes cavus) exists in connection with calcaneus a most gratifying result may be secured by the method of Robert Jones. A wedge is removed from the mid-tarsal joint, the base of the wedge being superior; then by bringing up the front part of the foot the abnormal hollowness of the sole is overcome, but for the time being the calcaneus deformity seems enormously increased. A month later arthrodesis of the ankle is performed, the section of the astragalus being made wedge-shaped with the base of the wedge posterior; this overcomes the calcaneus deformity and the net result of the two operations is to produce an incredible improvement. In practice it will sometimes be found more convenient and satisfactory to reverse the two steps of the Jones operation, first operating at the ankle and secondly at the mid-tarsal joint.

ANNUAL MEETING AMERICAN PROCTOLOGIC SOCIETY

(Continued from page 379 of the August Number)

"TREATMENT OF PRURITUS ANI, WITH A CONSIDERATION OF ITS PATHOLOGY AND ETIOLOGY."

By William M. Beach, A.M., M.D., of Pittsburgh, Penna.

The following conclusions were drawn by the writer:—

1. That pruritus ani occurs in mild and severe forms, mostly in middle life; the mild type with simple pruritus, the severe type with marked eczema and skin changes.
as complications.

2. Certain aberration in general metabolism, or in adjacent structures are simply incidental and should be considered

3. Intra-rectal growths, as hemorrhoids, adenomas, etc., or the presence of parasites are contributory.

4. The distinct pathogenesis of pruritus ani consists of single or multiple burrowings from the anal pockets, emitting a serous or sero-purulent substance, which sinus may be complete or blind and is always accompanied by proctitis, and frequently by cryptitis, and small ulcers at the ano-rectal line.

5. These sinuses when complete are the sequelæ to an abscess history, but the origin of the blind recesses is in doubt, and yet it is not unlikely due to an infection by the colon bacillus.

6. The treatment is surgical for the purpose of obliterating the sinuses, correcting a rigid sphincter when necessary, and curing the proctitis and ulceration.

7. Gastro-intestinal and general metabolic disturbances must be met by rational measures.

PERIRECTAL ABSCESS.

Dr. J. A. MacMillan, Detroit, Mich., called attention to the fact that in a large proportion of cases of perirectal abscesses the bacillus tuberculosis is present, and that next in importance as an etiologic factor is the gonococcus. A diagnosis is most difficult when the abscess is located above the levator ani. In this location it is frequently found to be complicated with some disease of one or more of the pelvic organs. In this condition it is sometimes necessary to make an abdominal incision both for exploratory purposes and to rectify the condition. In the treatment of the perirectal abscess, however, the drainage should always be from below.

THE TEST DIET

Dr. Jerome M. Lynch, New York City: The subject of test-diet, as suggested by Professor Schmidt, is one well worthy of study. If, after a proctoscopic examination of the rectum and signoid, and an examination of the stomach contents, a case is still obscure, the test-diet should be given, and an examination of the feces and a thorough examination of the urine, with nitrogen and sulphate partitions, be made. Otherwise, one cannot conscientiously say he has exhausted all the resources at his command.

These tests, he admitted, are not always conclusive, but in most cases they are of great help, often a positive solution of doubtful problems.

Of twenty-five cases under observation during the last six months, he found three of special interest. Case I was referred for treatment on account of moderate diarrhea, with prolapsing and bleeding internal hemorrhoids. The stomach had been previously examined with negative results. Proctoscopic examination, except for hemorrhoidal conditon, was negative. Put on test-diet. The specimen of feces examined had a somewhat pasty consistency, a light yellow color, normal odor, and showed no macroscopic admixture. Microscopic examination showed the usual amount of striped muscle fiber, carbohydrate food remnants and granular detritus, with an excess of free fat and fatty

acids. The starch was properly digested; bacterial flora not excessive; reaction neutral. Sublimate test negative; fermentation test negative. The specimen showed evidence of deficient bile admixture.

The analysis of a twenty-four-hour specimen of urine showed the specimen to contain no albumin and no renal elements, with a normal daily amount of urine, a normal specific gravity and a normal daily excretion of urea. The sulphate ratio, as well as the ratio of the urea and uric acid, was somewhat depressed, with the presence of a marked excess of indican.

Analysis of this report disclosed at once the cause of the diarrhea, namely, deficiency of bile with excess of fatty fluids and depressing of sulphate ratio, causing auto-intoxication.

The other two cases were equally interesting.

Relative to the determination of the clinical significance of the faulty sulphate and nitrogen partition, the writer stated that the relative increase in ethereal sulphate may be due to one of several causes, among which were mentioned stasis in the bowel, ingestion of decomposing nitrogenous food, improper digestion of food in the stomach and upper intestine, by diminution or absence of hydrochloric acid and bile, the result of excessive or faulty bacterial fermentation in the lower portion of the small intestine and the upper portio of the large intestine. This process may exist without an actual toxemia and an actual toxemia may exist without this particular putrefactive process; but they are usually associated.

Excess of ethereal sulphate is usually associated with an excess of endoxyl sulphate, though not always. Without means of estimating the amount of the actual products of toxemia, the relative excess of ethereal sulphates is used as a guide, although subjects to errors, as are other guides.

Fault in the nitrogen partition would seem to justify the inference that the hepatic function is disturbed. The decrease in the relative amount of urea nitrogen probably indicated the degree of the fault. With this decrease there is a relative increase in the amount of one or more of the other forms of nitrogen in the urine. In the severe toxemias of pregnancy, pneumonia, etc., this is chiefly in ammonia nitrogen and creatinin nitro-

gen; in digestive disturbances the increase in the so-called extractive nitrogen, and in lithemic cases and in those of cyclic vomiting, headache or albuminuria, in the purin nitrogen as well, particularly during the acute attack. In cases of enteritis or colitis, owing to the destruction of cells, the purin nitrogen is often increased.

Faulty nitrogen partition may exist without a toxemia, but a hepatotoxemia without a faulty nitrogen partition is practically unknown. Acidosis frequently accompanies a faulty nitrogen partition; but it would seem an evidence of the toxemia rather than of the fault in hepatic function, though this is disputed by some.

SURGICAL TREATMENT OF DIARRHEA

Dr. Samuel Goodwin Gant, New York: Attention is called to the frequency of occurrence of chronic diarrhea, and the simplest and most reliable methods were briefly outlined of diagnosing ulcerative lesions of the colon inducing diarrhea, and also the relative frequency was mentioned between gastric and hepatic diarrhea and those caused by local disease of the large intestine. Here are some points:

1. That acute attacks of diarrhea could sometimes be controlled by diet, rest and internal medication, and, further, that the frequency of the evacuations could occasionally be diminished by these therapeutic measures in chronic diarrhea, but that a cure of the latter could be accomplished only in rare instances in this way.

2. That the treatment of chronic ulcerative colitis by internal medication should be abandoned, because it is harmful in many ways and utterly unreliable in so far as a cure of the diarrhea is concerned.

3. That *direct bowel treatment* by lavage or medicated irrigation, introduced through the anus or from above through the appendix or cecum, is the only rational treatment for diarrhea due to ulcerative lesions of the colon.

4. That operative procedure are contraindicated except in cases where, for any reason, the colon tube cannot be introduced sufficiently high, to insure thorough washing out of the entire

large bowel and when operative procedure are declined.

5. That the surgical treatment of chronic diarrhea gives universal satisfaction, and that he recommended appendicostomy and cecostomy for the relief of this ailment with the same confidence that he did appendectomy for appendicitis.

6. The relative values of *resection, intestinal exclusion,* colostomy, *appendicostomy, simple cecostomy,* and *cecostomy* with an arrangement for irrigating the small intestine (Gant's operation), in the treatment of chronic diarrhea, were fully discussed. The results of his experience show that appendicostomy and cecostomy could be performed most quickly, were the least dangerous, give the best results and were less often followed by unpleasant sequelæ than other procedures.

7. He stated that formerly he was prejudiced in favor of appendicostomy but that a more recent and larger experience had caused him to look with greater favor upon cecostomy, especially when combined with irrigation of the small intestine. He maintained that his cecostomy was suitable in all cases of chronic diarrhea because it could be employed when the frequent stools were due to both an enteritis and an ulcerative colitis and when the lesions were confined to the colon alone, and, further, that his operation should supersede appendicostomy, in many instances, because the appendix was frequently unfit for irrigating purposes because it was too short, too narrow, strictured or bound down by adhesions and often had a tendency to become necrotic, slip back into the abdomen, become closed when not kept open by the introduction of a catheter, and that appendicostomy was not suitable when the small bowel was diseased.

8. He then briefly described the technique of his cecostomy with provision for small intestine irrigation, the main idea of which consisted in making an opening in the cecum and inserting two tubes, one into the cecum and the other into the small intestine through the ileo-cecal valve by the aid of a catheter-carrier. He claimed that the advantage of this procedure over other operations was that either the small or large bowel could be irrigated at will and that there was no fecal leakage about the catheters.

9. In concluding his remarks, he summarized the results

obtained by him in the surgical treatment of chronic diarrhea by the through and through method, and reported thirty-eight cases treated by appendicostomy and fourteen by cecostomy, eight of the latter being operated upon by Gibson, and the remainder by his new procedure, and said the universally successful results obtained by surgery in this class of cases is far better than those obtained by the use of the time-worn way, where they depend upon dieting, rest and medication, as practiced by many physicians to-day.

A REPORT OF TWO CASES OF ANOMALOUS SIGMOID.

Dr. Arthur Hebb, Baltimore, Md.: One case was an extremely long sigmoid, reaching from the mammary line to a point midway of the thighs, when withdrawn from the abdomen; the second case was a short sigmoid, with a mesentery three-fourths of an inch in length, situated above the crest of the ilium, on a line with the lower border of the last rib, coming off from the descending colon. It was only four inches in length. The descending loop, with no mesentery, ran down over the bifurcation of the left iliac artery and ureter; then forward, hugging the left side of the pelvis and down over the anterior and posterior branches of the internal iliac artery where it joined the rectum.

APPENDICOSTOMY AS AN AID TO THE TREATMENT

Dr. John L. Jelks, Memphis, Tenn.: When amebic infection had become very chronic or had extended into all the parts of the colon beyond the use of local measures, and, in some instances, of acute malignant cases, appendicostomy should be performed and irrigation practiced through the appendicial stump. The water is allowed to pass out through the rectum into a catch-basin and is not an unpleasant method of treatment. Dr. Jelks prefers the method suggested by Dr. James P. Tuttle, of New York City, who conceived the plan of allowing the appendix to remain undisturbed after anchorage, for a sufficient time (three or four days), to establish adhesions about the proximal end, before cutting away the distal portion and using the appendical stump-lumen through which to irrigate with the desired solutions.

Dr. Jelks practiced this method and irrigated the colon with formalin-boric, copper-phenol-sulphonate, quinine and normal salt solutions with gratifying results. It was observed, however, that irrigations thus given did not effect a cure. Topical applications (per sigmoidoscope or rectoscope) were in all cases used in conjunction.

The method as used by Weir, and as advised by Tuttle, is practically free from danger, and the author believes is not more hazardous than appendicostomy, and the after-effects are not at all unpleasant to the patient in the ways and degrees that a colostomy must be. He sees no great danger of hernia or wound infection if proper precautions are taken in dressing the same. By this method one may practice almost continuous irrigation of an inflamed colon and rectum with no special degree of pain or discomfort to the patient, the appendix being used as a nozzle, directing the solution into the colon.

He does not advise appendicostomy except in a small percentage of cases, mostly chronic ones, but in these, he insists, that it is a most valuable aid to treatment and that the operation itself is practically free from danger, as is appendectomy when the appendix is not the seat of infection.

The author concludes his article by stating that in all cases requiring appendicostomy we should not permit the stump to close before the expiration of one year. He has been forced to reopen an appendical stump three months after closure and resume irrigations. This was accomplished in his office, but it may become a difficult matter to find the lumen of a closed appendix.

PRIMARY GONORRHEA OF THE RECTUM IN THE MALE

Dr. Alfred J. Zobel, San Francisco, Cal.: A review of the literature for the past five years showed very little to have been written on the subject of rectal gonorrhea, and the cases reported have been rectal gonorrhea in the female and for the most part secondary to an infection of the genital tract.

It was also stated that gonorrhea of the rectum in the male is almost always the result of sodomistic practices, and when so, can be considered of the primary type. The condition has been rather rare in this country, but since the influx of foreigners

from those countries where unnatural practices are common, more cases are now seen.

The cases reported by the writer were seen in the rectal clinic of the San Francisco Polyclinic, and were American boys of sixteen, eighteen and twenty years, respectively. They belonged to the tramp class and were of a rather low order of intelligence. They were ignorant of their true condition and came to the clinic with a self-made diagnosis of "piles." When made aware of the true nature of their trouble it had a markedly depressing effect, upon them, which in one case, after a few weeks, developed into a condition resembling the neurasthenia which often accompanies a chronic posterior urethritis.

The symptoms complained of, briefly summarized were: All complained of such soreness about anus and rectum that they did not care to stand, while walking was an effort and caused great pain. At the time of bowel movement they suffered such excruciating pain that they hesitated to pass their feces, and had become quite constipated. Two were annoyed by discharge from the anus, while one was unaware of its presence, although it was found on examination. In one, the discharge was streaked with blood, and bleeding was noticed at the time of defecation. One complained of an itching sensation about an inch up from the anal aperture, and had severe pain on the drawing in of the anal sphincters. Their appearance was feverish, worried and haggard, and they felt weak, ill and distressed.

It was impossible to make a digital or instrumental examination at the first visit on account of the severely acute pain caused thereby. Therefore, whenever there is the least suspicion of the posibility of a specific inflammation of the anus and rectum, the case should be treated as if it actually exists, and the ultimate diagnosis left to the future. When the acute symptoms have subsided under treatment, there can be seen excoriations and fissures about the anal orifice and in the canal, with marked redness and infiltration of the mucous membrane of the anus and rectum, together with the presence of a purulent secretion. Examination of this secretion shows the presence of the gonococcus.

The author believes that gonorrhea of the rectum in the male is a much more common condition than is suspected by the gene-

ral profession. Many of the latter even do not know that such a condition could exist.

The treatment is directed towards keeping the parts clean; relieving the severe rectal symptoms; reducing the inflammatory exudates; keeping the fecal movements soft; healing the ulcerations and destroying the infective agent.

The author further brings out the important point, which he deems worthy of consideration, that there seem to be no reasons why complications, such as gonorrheal arthritis or an endocarditis could not arise. While so far as he is aware, no cases of an endocarditis or an arthritis resulting from rectal gonorrhea have been reported, yet it would be well for the intermist to bear in mind that an examination of the rectum might furnish the clue in a baffling case where the etiological factor is missing.

OPERATION FOR ANAL PRURITUS

Dr. Thos. Chas. Martin, Washington, D.C.: The use of a solution of cocaine and adrenalin secures local anesthesia and a dry visible field. Radiating incisions do not endanger the nutrition of the parts. Corrugation of the flaps may be effaced by traction of their margins. A skin-tag may be removed with an elliptic incision, which by suture may be given a linear form. Radiating wounds require no suture, coaptate automatically when the patient is in extension, and heal by first intention.

CHLOROFORM IN PHTHISIS

J. Walsh, Philadelphia (*Journal A. M. A.*, August 28) objects to the use of ether in tuberculous cases, especially active tuberculosis of the lungs. During the past six years he has never allowed his patients thus affected to be operated on under ether if he could possibly prevent it, and he has never seen any bad results that could possibly be attributed to chloroform in these cases. During the same period he has seen a number of patients manifesting active tuberculosis of the lungs, which activity appeared from the history to be due either to the operation or to the ether. He reports several cases in which chlorofrom not only did no harm, but seems rather to have a beneficial effect, and one of nitrous-oxide gas anesthesia which had a similar outcome. Two

cases of damaging from ether anesthesia are also reported. While a mere statement of the cases makes it appear that chloroform might be even somewhat curative as asserted by Holmes and Woodcock, of London, he is not ready to advocate it as such. He does, however, believe that in case of necessary operation with anesthesia in all cases of tuberculosis of the lungs, or where it may be suspected to exist, chloroform and not ether should be the anesthetic.

EDITORIAL

Canadian Meeting

At the Canadian Medical meeting many vital matters seemed settled by chance, unless the ordinary members consider it is the best policy to allow a few to decide questions which affect seriously every individual. When the election of officers came on apparently there were no applications. It is often better that secretaries and treasurers should be in office several years, —but new blood is healthy on executives. Why this apathy? Commerce says, "Competition is good for trade." Competition is good for everything, and is expected to be found where there is any good thing. How much more interest would a hot competition for the various official positions on the Association show. If no applications came in for professorships, in the Universities, what would the average man think? Either there was no honor in holding the appointment, or no one capable. Is it *real* lack of interest, or, is it that men coming from different Provinces (all with different requirements of registration, and standards) feel unable to consider questions from the same standpoint. Dr. Thorntnon pointed out that, correctly, we cannot have a Canadian Medical Association so called, till we have CANADIAN REGISTRATION. This may be the root of the matter. When a united purpose animates the Medical men of the Dominion, then we may have well attended meetings and great interest in the proceedings. At present the one common feeling is that there is room for improvement and the sooner that improvement comes the better. But we shall have to get this unity by going from the part to the whole. Dominion re-

gistration, owing to technical reasons is a matter of some years, and discussion of the Roddick Act proves it to be full of weak points, as it gives an individual province much latitude for withdrawal, leaving it at the mercy of a change of council every three years or so. The first part—Western Registration—is a matter *now*, if we choose, there are no technical difficulties in the way; only a few petty provincial obstacles..

Regarding Ontario's Proposals

Ontario's proposal of Reciprocity was ludicrous. The west was offered a great favor—"Any man registered in your province having passed your exam and holding a B.A. or B.Sc. may register in your province; or any man registered five years can on passing the *final exam* of the Ontario Council, register." Thus is shown the attitude of Ontario and the need of a strong Western Association to look after Western interests. Surely we have had proof enough that little account is taken of Provincial representatives to the Dominion. The man representing may have influence, but the force behind him counts as nothing. How different would the attitude be to *Western* representatives. The time is rapidly approaching when we shall have Western Federation. Dr. Thomson (Regina) in his speech stated that now there is a council in Saskatchewan it will be proved that all the members desire is the public welfare and profession's good, so it is expected Saskatchewan will co-operate with the federated Board of examiners. Dr. Fagan also supported the movement, and B.C. at the annual meeting voted in favor of such a Board, and a resolution to that effect has been sent to the Council,—all of which goes to prove that if the men of the various Western Provinces seem to have little time to take a personal interest in the proceedings of the Dominion Association, they find time for a very active interest in Western matters. There is little doubt regarding the success of the meetings of the Western Association when it is formed. In this, at least, they are doing as advised by the Scriptures "looking after the affairs of their own house first."

Benefits of Medical Associations

The test as to whether an association is of any use is the amount of strength the individual members and the profession as a whole derive from the knowledge of the force behind, for personal protection and for the keeping up of a high standard which enables their calling to be one honored and respected by the public. The impetus given to scientific research by members meeting for discussion is another great benefit. One finds that to such as do not join from their *own* sense of the need for strength politically, scientifically and socially, the more material benefits must be proved. To these instances could be quoted where the knowledge at some crisis, that a society of strong and true fellow workers were willing to support and help a member has been of the greatest benefit.

Drs. Hutchison, Gray and Thornton have been appointed representatives of the Manitoba College of Physicians and Surgeons to attend the meeting to be held at Banff, to arrange a Western Federation.

EXTRACT

"No official worker, certainly no Medical Officer of Health would be said to be doing everything he should for the sanitary and social improvement of his district, unless he took stock of all collateral and now official efforts, having the same end in view, and unless he strained every nerve to secure complete co-ordination to avoid over lapping and hiatus, of every effort, and to obtain the regular exchange of information so as to secure the greatest possible return for the given expenditure of energy."—Dr. Newsholme, at the Health Congress, Leeds, August, 1909.

"There are Medical men who not only dispense mixtures but derive a profit from the sale of syrups, trusses, etc., *hoc genus omne*,—may not the dispensing Chemist ask, "Why not sell tooth-brushes as I do—why object to your surgery being called a shop, any more than my place of business"—"The whole system is indefensible. It is derogatory to the medical men who are compelled to adopt it, and the pharmaceutical chemists with whom we ought to be in a position to work hand in hand consider that it is commercially injurious to them. The remedy is to be found only in combination and assertion of their professional status by the members of the medical profession as a whole and in the education of the masses who have already been taught by the legal profession that expert advice without any material symbol is worth paying for."—B. M. J., August 21, 1909.

Dr. E. Gard Edwards, of La Qunta, Col., in a paper, claims that from the practice of many leading surgeons the custom of fee splitting had spread to almost every specialty even in minor referred cases until apparently it was a general practice even among men of high reputation, especially surgeons, and said to be more common in the West than in the East. The existence of the custom, he said, was rarely mentioned in the medical literature, almost never in medical societies, and discussed among the profession with bated breath. To the horde of embryo special-

ists abroad in the land, increasing the already sharp competition, he attributed the condition. He declared fee splitting to be justifiable when a general practitioner had charge of the case before and after operation, and then only when the patient, physician and consultant have a full understanding as to the gross amount of the fee to be paid from beginning to end. No amount of regulating by societies, he felt, would control the evil."—Med. Record, Aug. 3, 1909.

It is said that the first meeting of the famous Dr. Schweninger for many years the medical adviser and personal friend of Bismarck was peculiar. Dr. Schweninger had been called professionally and in the course of his investigations quite naturally asked a number of questions. This so irritated the Iron Chancellor that he said: "I send for you to cure me; I am not here to answer your silly questions." But the doctor quite unimpressed by his patient's political status and dictatorial manner said quietly, "Well, in that case I fear I can do nothing for you. What you need is a Veterinary Surgeon; they are accustomed to treat patients who cannot talk—cows, horses and asses. Doctors have to ask questions." At this Bismarck descended from his high horse and behaved like a sensible patient.

Champion vs Keith, Supreme Court, of Oklahama. The physician called in attendance on an injured person diagnosed dislocation of the hip. Apprehensive, however, that there might be a fracture he put the injured part up in a plaster-of-Paris bandage, which he said was the proper treatment for either condition. The case turned out to be one of fracture of the surgical neck of the femur. The treatment was unsuccessful and the patient brought suit for damages claiming that the physician had not used the ordinary care in making a diagnosis. The court held that the physician had not acted in such a manner as to render himself liable for damages. A physician, or surgeon, is never considered as warranting a cure unless under special contract for that purpose. Where no express agreement is made his implied contract is that he possesses ordinary skill, learning and experience, possessed by those of his profession; that he will use

the ordinary skill and diligence in the treatment of the case and that he will use his best judgment in all cases of doubt as to the proper course of treatment. He is not responsible for damages for want of success unless it is shown to be want of ordinary skill and learning or want of care and attention. He is not presumed to engage for extraordinary skill or attention or diligence nor can he be held responsible for errors of judgment or mere mistakes in matters of doubt and uncertainty.

The true aim of education as now generally recognized is something more than the mere training of the intelligence. in the revised syllabus of physical exercises for public elementary schools, which the London Board of Education have issued, and which has been compiled by the best authorities, the object and effects of physical training are pointed out and the teachers are enjoined to make such training as enjoyable and interesting as possible. The following games are suggested:

Running—1 Running the circle; 2 Cat and mouse; 3 Fox and geese; 4 Borrow a ligth (played with a broomstick); 5 Hawk and doves.

Jumping—1 Stepping stones; 2 Leap frog; 3 Jumping the swinging rope.

Ball—1 Out and in, chase ball; 2 Chase ball in a ring and in two lines; 3 Rolling chase ball, Tower ball.

Miscellaneous—1 French blind man's bluff; 2 Ninepins, tug-of-war.; 3 Singing games.

The value of dancing, especially for girls, and even in some cases for boys, is recognized—ordinary ballroom dancing is not considered advisable.

"Morris dances are easily learned and very enjoyable and there are numerous forms of the reel, the lilt, the jig; there are national and peasant dances such as the Welsh dance; the country dances such as Sir Roger deCoverley or the Swedish dance which have the control and graceful movements which all educational dances should furnish."

MUSIC is at times made use of in the physical training lesson and is of great value if properly employed:

"It must, however, be clearly recognized that it should not

be used in formal lesson with the regular exercises, because exercises performed to music are carried out rythmically more or less mechanically and without much thought or concentration of mind. For this reason the educational and developmental effects are greatly diminished, though fatigue is lessened, and the recreative effect is markedly increased. Music should, therefore, be used in infant classes where it is especially important to avoid fatigue and to make the lessons bright and cheerful. It may also be used to accompany marching or dancing steps when teaching older children."

A letter in the B.M.J. calls attention to the fact that the want of union between medical men is shown in its worst light by the way some medical men send patients to instrument makers, chemists and others, to have X-Ray photos made while they avoid sending them to the medical men who are engaged every day at that work. The sending to outsiders is, of course, quite a business transaction, and commission is required by the wholesale chemist or instrument maker, who does this so that no qualified X-Ray worker gets any such cases. These unqualified workers advertise and the others do not. This is not safeguarding the interests of the patient. Even men on the staff of a hospital have been known to take work away from their hospital.

GENERAL MEDICAL NEWS

SOCIETIES

Canadian Medical Association Annual Meeting

At the annual meeting of the Canadian Medical Association, held in Winnipeg, the following officers were elected:—*President,* Dr. Adam Wright, Toronto; *General Secretary,* Dr. Geo. Eliot; *Treasurer,* Dr. H. B. Small, Ottawa; *Financial and Publishing Committee,* Drs. J. P. Fotheringham, S. F. Tunstall, Murray MacLaren, F. W. G. Starr, and James Bell. Next year's meeting will be at Toronto. Some excellent papers were read and discussed, and the social part of the programme was greatly enjoyed. Among the visitors, were Dr. John Stewart, of Halifax; Dr. Montizambert, of Ottawa; Dr. Powell, of Ottawa; Dr. Wishart, of Toronto; Dr. Waller, F.R.S., of London, Eng.; Prof. Alcock, London, Eng.; Dr. McWeeney, Dublin; Dr. McKee, Cincinnati; Dr. L. Wilson, Rochester, and Dr. Benson, of Douglas.

Alberta Medical Association

The fourth annual meeting of the Alberta Medical Association met August 18th, at Calgary. Dr. Fotheringham, of Toronto; Dr. George Adami, of Montreal, and Dr. Bryce, of Ottawa, were made honorary members of the Association. The following committee were appointed: *Credentials,* Drs. Park, Egbert and Cobbett; *Public Health,* Drs. Arthur Wilson, Evans and Revell; *Legislation,* Drs. Park, Lafferty and Whitelaw; *Publication,* Drs. Lincoln, Madden and Nasmyth; *Bylaws,* Drs. Pirie, Graham and Gunn; *Ethics,* Drs. Egbert, Brandon and Stewart; *Interprovincial Registration,* Drs. Lafferty, Brett, Smith and Kennedy. A number of good papers were read, which will appear shortly, and the social gatherings were enjoyed, including a theatre party. The following officers were appointed, *President,* Dr. Smith, Edmonton; 1*st Vice President,* Dr. Egbert, Calgary;

2nd Vice President, Dr. Newburn, Lethbridge; *3rd Vice President,* Dr. Archibald, Strathcona; *4th Vice President,* Dr. Rush, Leduc; *Secretary Treasurer,* Dr. Cobbett, Edmonton.

Central Alberta Medical Association

At the second semi-annual meeting of the Central Alberta Medical Association the following officers were elected for the ensuing six months: Hon. president, Dr. W. A. Wilson; president, Dr. Duncan Smith; 1st vice-president, Dr. J. G. Sloane; 2nd vice-president, Dr. W. A. Farquharson; secretary-treasurer, Dr. Revell; executive committee, Dr. Shearer, Dr. J. P. McDonald, Dr. Whitelaw.

British Columbia Medical Association

The British Columbia Medical Association met at Seattle for their annual meeting, July 21st. The spirit of affiliation and federation was strong,—a number of societies meeting together, —Washington, Oregon, Idaho and British Columbia. The chairman's address touched on the great need for the medical profession having legislative strength and he urged that a campaign of education be inaugurated by the physicians to impress on the public that what they are asking from the Legislature is for the public good and for the individual welfare of the doctors. The following officers were elected: Dr. R. W. Irving, Tranquille, *President;* Dr. Eden Walkers, New Westminster, *Secretary;* Dr. Helmcken, *Treasurer.*

MEDICAL NEWS

Those of the ethical profession interested in X-Ray work in Cincinnati have organized the Cincinnati Roentgen Ray Society. The following are the charter members: Drs. Otto Juettwer, Kennon Duaham, Dudley Webb, Sidney Lang, Marion Whitaker, Charles M. Paul, Joseph W. Ricker. Dr. Webb was chosen Secretary. The president will be chosen at each meeting, for that meeting. The club is to be social as well as scientific.

An interchange of university students between Great Britain, Canada and America is being supported by a committee headed by Mr. Asquith and Lord Strathcona and the heads of the chief universities. 28 scholarships are proposed,—14 for Great Britain; 10 for the United States and four for Canada. The Americans and Canadians are to have a ten weeks trip in Britain and the British a similar tour in America and Canada.

On August 5th, the Hon. G. R. Coldwell laid the corner stone of the Manitoba Sanitarium for Consumptives.

The entire $10,000, which the committee in charge of financing the building of the new University at Point Grey, Vancouver, B.C., promised to obtain, has all been subscribed, and now only $20,000 is needed to complete the amount necessary.

There was an article in the *London Observer* on the "Rise of Winnipeg."

Professor Karl Pearson, in his paper on "The Problem of Practical Hygenics," says it would have been better for the British Government to endow parentage rather than senility.

A proposal has been placed before the divisions of the B.M.A. for their consideration, to the effect that the B.M.A. should be represented on the management committee of their hospitals and that King Edwards' fund for London should be requested to permit local practitioners to act on the committee for administration of outpatients department.

The University of Alberta makes a beginning with 50 students.

At the annual meeting of the Maritime Medical Association, the questions before the meeting were Affiliation with the C.M.A., Reciprocity with Great Britain and Dominion Registration.

The Secretary of State for War issued, on August 16th, to the Secretaries of Territorial County Associations in England and Wales, a scheme for the organization of voluntary aid for sick and wounded in the event of war in the home territory. The scheme makes use of the existing organization of the British Red

Cross Society and to develop it on a large scale, so that it comprehends every district in England and Wales. The help of the St. John's Ambulance has also been secured for training detachments.

VITAL STATISTICS

Vancouver—Marriages 93; deaths 86; births 125.

It is said that many births in the West go unregistered owing either to forgetfulness or ignorance of the parents. This is an offence punishable by a fine of $20.

Winnipeg—Births 340; deaths 176.

Disease.	Death.
Typhoid 63 (31 outside city)	4
Scarlet fever 11	1
Diptheria 8	0
Measles 8	0
Tuberculosis 17	5
Erysipelas 3	0
Whooping cough 1	0
Chickenpox 5	0
116	10

PERSONALS

Dr. Wilson, of Port Essington, will practise in future in Vancouver.

Dr. Gordon, of Greenwood, B.C., has returned after two years post graduate work in Europe and is settling in Vancouver.

Dr. C. T. Sharpe, of Winnipeg, is at New York, taking a post graduate course.

Dr. A. E. Clendennan, of Edmonton, has been appointed Medical Health Officer in Dominion Public Works for the four Western Provinces. One of his duties will be to see that all rail-

way contractors provide proper medical and hospital equipment for their men.

Dr. W. H. Lang, who has been a resident of Taber, Alta., has removed to Vancouver, where he will practise.

Dr. Brandson, Winnipeg, has returned from his visit to the States.

Miss Georgina Urquhart, M.D., of Vancouver, was married last month to Mr. Gustavus Crawford, Lecturer in Physics, New York City College.

Dr. Wishart, of Toronto, was in Winnipeg attending the Canadian Medical Conference.

Dr. McKee, of Cincinnati, attended the Medical Convention and British Society Meeting at Winnipeg.

Dr. Halpenny, of Winnipeg, has been elected a member of the University Council.

Dr. Johnson, who for some time past has been in Banff associated with Dr. Brett, has removed to Calgary, where he will practice in the future.

We regret to report that Dr. C. A. Elliott, resident physician at the Harrison Springs, has been most severely injured in an accident which occurred while driving from Agassiz to the hotel.

Dr. Leonard Houghton has been appointed resident physician at Salt Springs Island, in place of Dr. G. R. Baker, resigned, and Dr. H. Gross Kemp, at Van Auda, in place of J. H. McDermot, M.D.

Dr. R. Nasmyth, of Toronto, has been visiting the cities of the West and has decided to practise in Moose Jaw.

Dr. G.Folimbee, of Toronto, is now settled near Edmonton.

Dr. D. C. McKenzie, of Belleview, has returned after his three months vacation.

David Brownlee Lazier, M.D., C.M. has been appointed resident physician at Princetown and Medical Officer for the Similkameen district in place of Dr. Schon, who has resigned.

The following have been appointed Health Officers:—Dr. Benjamin Marr, for Corbin, B.C.; Dr. Harvey Christie, for Lillooet; Dr. James Taylor, for Golden, B.C

Dr. H. G. Hamill, of Creelmon, has sold his practice.

Dr. H. C. Wilson, Edmonton, attended the Medical Conference, at Winnipeg.

Dr. Patterson, of Winnipeg, has returned after three months vacation.

Dr. McKenty and family have returned from three months visit to Europe.

We are glad to say that Dr. Robert McKenzie and Dr. McLean are both convalescent.

Dr. W. A. Young, editor of "The Canadian Physician and Surgeon," Toronto, has returned from his visit to Europe. While away he was appointed president of the American Editors Association.

Dr. Hobbs,Homewood Sanatarium, has returned from Europe, where has been studying the Systems of the Nerve Sanatariums.

Dr. and Mrs. Bell, of Regina, are visiting the Coast.

Dr. Drysdale, of Nanaimo, is convalescent.

BORN

HISLOP—The wife of Dr. Hislop, Edmonton, of a daughter.

MARRIED

TERNAN-FARRELL—August 2nd, at the cathedral, St. Albert, W. A. P. Ternan, M.D., son of the late John Ternan, Fleet Surgeon, Royal Navy, at Halifax, N.S., to Theresa, eldest daughter of the late John Farrell, St. Albert.

Attention!

THE Management would be obliged if all who have not yet sent in their Subcriptions would do so as early as possible, at the Third Year of THE WESTERN CANADA MEDICAL JOURNAL ends in December.

Please note that all Communications should be addressed to 8 Commonwealth Block, Winnipeg.

NOTICE

ODD-NUMBERED SECTIONS

As already publicly announced, odd numbered sections remaining vacant and undisposed of will become available for homestead entry on the coming into force of the Dominion Lands Act on Sept. 1, next.

As the records of only the even numbered sections have hitherto been kept in the books of the various land agencies in the western provinces and the time having been very limited since the passing of the act within which to transfer the records of all odd numbered sections from the head office at Ottawa to the local offices, it is possible that the transfer of records in some cases may not have been absolutely completed by the 1st September. In any case where the record of any quarter section has not been transferred, application will be accepted but will have to be forwarded to head office to be dealt with.

As it has been found impossible as yet to furnish sub agencies with copies of the records of the odd numbered sections and in view of the large probable demand for entries, all applicants for entry upon odd numbered sections are strongly advised to make their applications in person at the office of the Dominion Lands Agent and not through a Sub Land Agent. Applications for even numbered sections may be dealt with through the Sub Land Agent as before if desired.

J. W. GREENWAY,

Commissioner of Dominion Lands,
Winnipeg, August 22, 1908.

Synopsis of Canadian North-West Homestead Regulations

Any even numbered section of Dominion lands in Manitoba, Saskatchewan and Alberta, excepting 8 and 26, not reserved, may be homesteaded by any person who is the sole head of a family, or any male over 18 years of age, to the extent of one quarter section of 160 acres more or less.

Application for entry must be made in person by the applicant at a Dominion Lands Agency or Sub-Agency for the district in which the land is situate. Entry by proxy, may, however, be made at an Agency on certain conditions by the father, mother, son, daughter, brother or sister of an intending homesteader.

DUTIES.

(1) At least six months' residence upon and cultivation of the land in each year for three years.

(2) A homesteader may, if he so desires, perform the required residence duties by living on farming land owned solely by him, not less than eighty (80) acres in extent, in the vicinity of his homestead. Joint ownership in land will not meet this requirement.

(3) A homesteader intending to perform his residence duties in accordance with the above while living with parents or on farming land owned by himself must notify the Agent for the district of such intention.

Six months' notice in writing must be given to the Commissioner of Dominion Lands at Ottawa, of intention to apply for patent.

W. W. CORY,

Deputy of the Minister of the Interior.

N.B.—Unauthorized publication of this advertisement will not be paid for.

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is used more to-day than during the last twenty years. Physicians have compared Kasagra with competing products and

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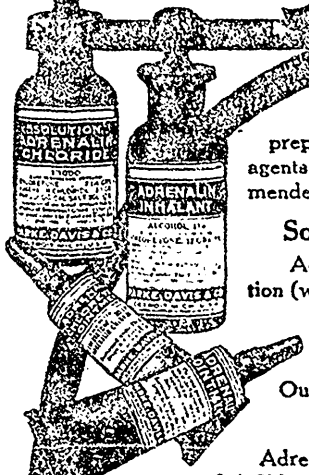
Hay Fever



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Solution Adrenalin Chloride (1:1000).

Adrenalin Chloride, 1 part; Physiological Salt Solution (with 0.5% Chloretone), 1000 parts. Powerful astringent. Dilute with four to five times its volume of physiological salt solution and spray into the nares and pharynx (see Glaseptic Nebulizer adv. below). Ounce bottles.

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Adrenalin Chloride, 1 part; an aromatized neutral oil base (with 3% Chloretone), 1000 parts. Administer with our Glaseptic Nebulizer or other atomizer suited to oily liquids. Ounce bottles.

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Effective either alone or as an adjuvant to Solution Adrenalin Chloride. Collapsible tubes with elongated nozzles.

Adrenalin and Chloretone Ointment.

Each ounce contains: Chloretone, 20 grains (5%); Adrenalin Chloride, 2-5 grain (1:1000). Astringent, antiseptic and mild anesthetic. Collapsible tubes with elongated nozzles.

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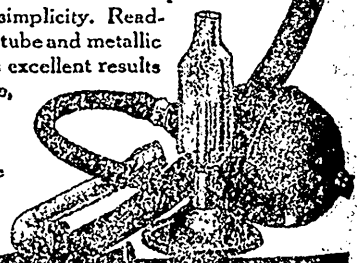
The most practical atomizer ever offered to the medical profession. Combines asepsis, convenience, efficiency, simplicity. Readily sterilizable. All glass except the bulb, tube and metallic base. Produces a fine spray. Affords excellent results with but a few drops of liquid. Price, complete, $1.50.



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