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THE  
**Maritime Medical News**

A MONTHLY JOURNAL OF

**MEDICINE AND SURGERY.**

Vol. XV.

HALIFAX, NOVA SCOTIA, JANUARY, 1903.

No. 1.

## Emergency Food

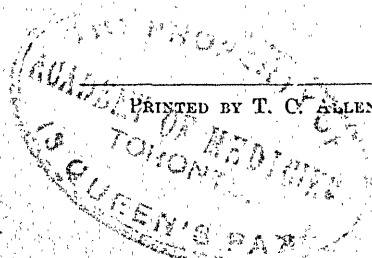
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**MATRICULATION.**—The matriculation examinations for entrance to Arts and Medicine are held in June and September of each year.

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**ADVANCED COURSES** are given to graduates and others desiring to pursue special or research work in the Laboratories of the University, and in the Clinical and Pathological Laboratories of the Royal Victoria and Montreal General Hospitals.

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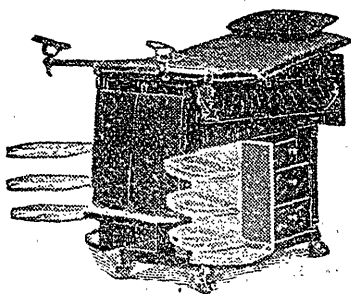
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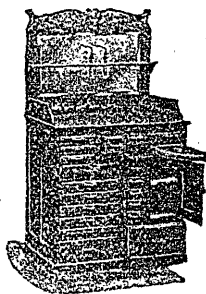
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 E. H. LOWRISSON, M. D., Lecturer on Ophthalmology, Otolary, Etc  
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The Thirty-Fourth Session will open on Tuesday, September 2nd, 1902, and continue for the eight months following.

The College building is admirably suited for the purpose of medical teaching, and is in close proximity to the Victoria General Hospital, the City Alms House and Dalhousie College.

The recent enlargement and improvements at the Victoria General Hospital, have increased the clinical facilities, which are now unsurpassed, every student has ample opportunities for practical work.

The course has been carefully graded, so that the student's time is not wasted.

The following will be the curriculum for M. D., C. M. degrees:

**1ST YEAR.**—Inorganic Chemistry, Anatomy, Practical Anatomy, Biology, Histology, Medical Physics (Pass in Inorganic Chemistry, Biology, Histology and Junior Anatomy.)

**2ND YEAR.**—Organic Chemistry, Anatomy, Practical Anatomy, Materia Medica, Physiology, Embryology, Pathological Histology, Practical Chemistry, Dispensary, Practical Materia Medica (Pass Primary M. D., C. M. examination).

**3RD YEAR.**—Surgery, Medicine, Obstetrics, Medical Jurisprudence, Clinical Surgery, Clinical Medicine, Pathology, Bacteriology, Hospital, Practical Obstetrics, Therapeutics. (Pass in Medical Jurisprudence, Pathology, Therapeutics.)

**4TH YEAR.**—Surgery, Medicine, Gynecology and Diseases of Children, Ophthalmology, Clinical Medicine, Clinical Surgery, Practical Obstetrics, Hospital, Vaccination, Applied Anatomy. (Pass Final M. D., C. M. Exam.)

Fees may now be paid as follows;

One payment of . . . . .	\$300 00
Two of . . . . .	155 00
Three of . . . . .	110 00

Instead of by class fees. Students may, however, still pay by class fees  
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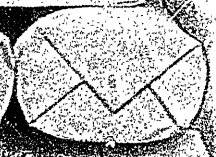
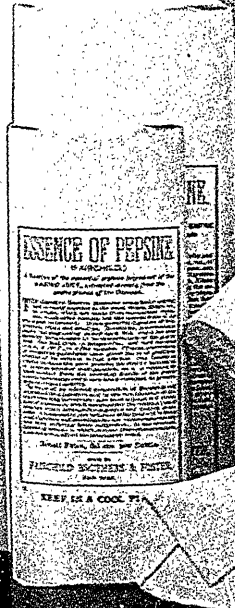
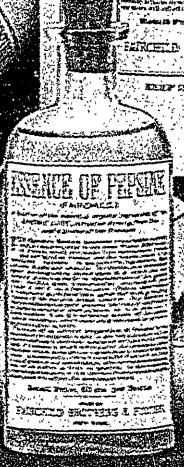
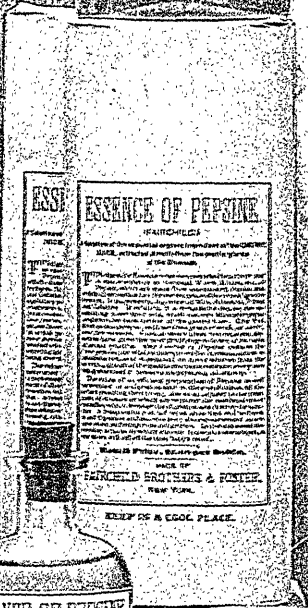
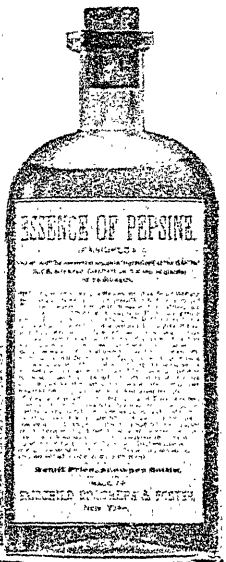
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# Fairchild's Essence of Pepsine

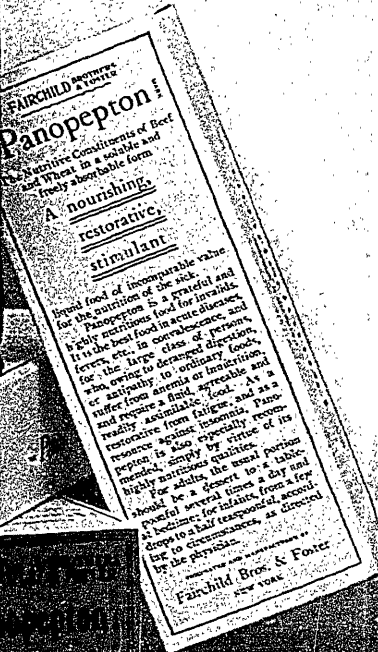
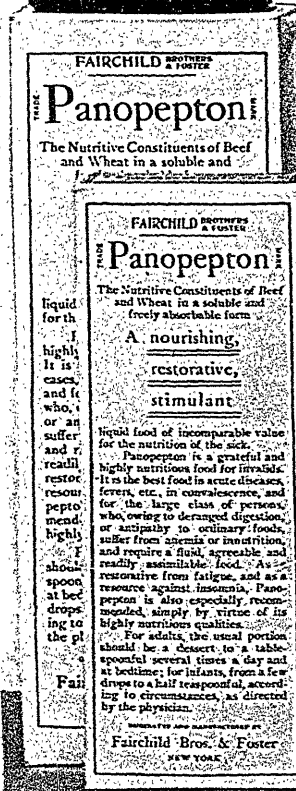
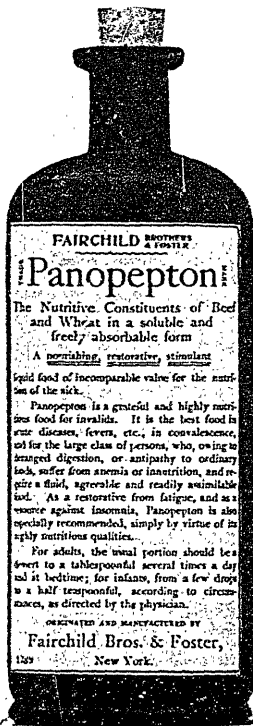
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# Panopepton

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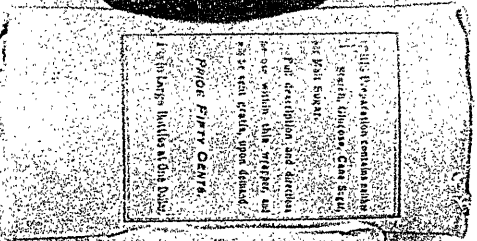
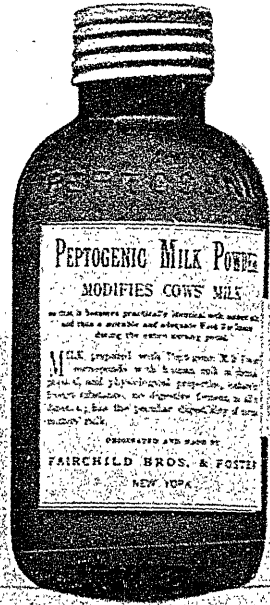
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This preparation contains either Sterilized, Creamed, or Fat Free milk. It is highly digestible and adapted for use within the infant's digestive system. It is the best milk upon which to raise the young child.

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Which is Prepared  
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perfectly  
digestible  
form, and pro-  
motes the  
development of  
the  
child.

This is the most practically identical with mothers' milk, and thus adapts it to the digestive functions and organism of the nursing infant. There is no other method of infant feeding which gets so close to Nature as that afforded by the PEPTOGENIC MILK POWDER and process.

MILK prepared with this process is the most perfect and physiological preparation, adapted for infant nutrition, and digests rapidly in the stomach; has the peculiar digestibility of pure mothers' milk.

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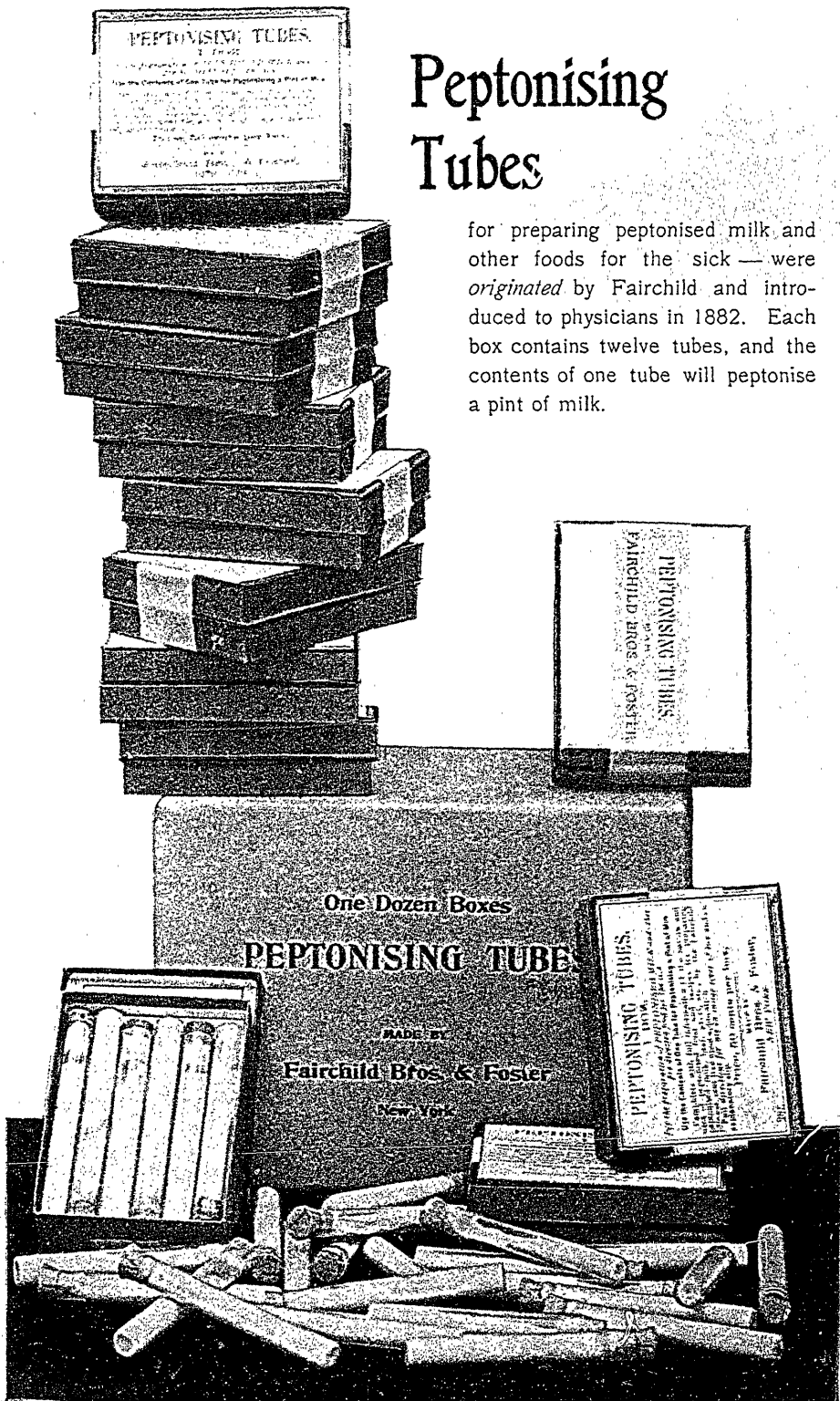
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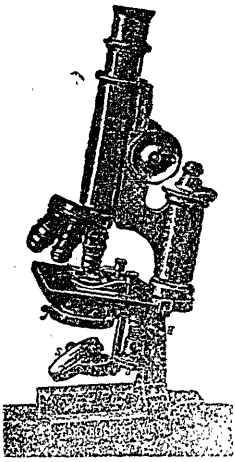


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THE  
MARITIME MEDICAL NEWS.

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

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VOL. XV.

HALIFAX, N. S., JANUARY, 1903.

No. 1.

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## Original Communications.

### GALL-STONE DISEASE.\*

By M. A. B. SMITH, M. D., Professor of Applied Therapeutics and Class Instructor in Practical Medicine, Halifax Medical College.

My chief object in preparing a paper on this subject was to report three or four cases of my own. I find on looking up the recent literature of the disease that it is one which has been a good deal discussed lately, both as to its etiology, pathology and especially as to its treatment. So we find there are surgeons who write that "the presence of gall-stones in the gall-bladder is always an indication for their removal," while internists say that "scarcely one out of twenty or thirty of those who suffer from gall-stones will ever need to undergo an operation."

A good deal of confusion seems to exist as to what is implied by gall-stone disease. I think I am correct in saying it used to be understood to mean primarily the obstruction of the biliary passages by gall-stones. It is now made to include inflammation of the gall-bladder, or common duct or both, with the implication by some that gall-stones may have little or nothing to do with the symptoms formerly included in this term.

The gall-bladder is a small pyriform sac, lying in its own fissure on the under surface of the liver, which receives through its duct—the cystic duct, the bile from the hepatic duct and discharges it through the same into the common duct. It is not a necessary organ. Cases

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\* Read before meeting of Medical Society of Nova Scotia, New Glasgow, July, 1902



are on record where it was congenitally absent, and it is not found in some of the lower animals, as the camel, goat and deer. The common duct is, according to Gray, three or four inches long and a quarter of an inch in diameter. At an autopsy lately I found the papillary opening into the duodenum would admit only a very small bougie, but the length of the duct was more than four inches.

Prof. W. H. Thomson of New York, in his recent article on cholelithiasis says: "The bile itself is a secretion about equal in daily amount to the urine, that is, from two to three pints, but of such low specific gravity that it contains only from one to two per cent of solids. It is secreted by the liver cells under such low pressure that it almost resembles simple leakage, so that the slight obstruction caused by a catarrhal swelling of the mucous membrane of the biliary passages may suffice to cause jaundice. During active digestion it flows uninterruptedly along the hepatic ducts directly into the intestine and not into the gall bladder, this flow being much aided by the contraction of the diaphragm in active respiration. In the intervals of digestion, and particularly during the repose of sleep, the biliary outlet is closed by the sphincter-like contraction of the muscular wall of the duodenum, and the bile then flows into the gall-bladder instead." Kehr verifies this in cases where fistula of the gall-bladder was established.

It is agreed, I believe, that infection by micro-organisms is the primary cause of the formation of gall-stones, of which the commonest is the bacillus coli communis, and a less common the typhoid bacillus. Kehr says that staphylo and streptococci are also present where a purulent inflammation is set up. The avenues mentioned by which these reach the gall-bladder are the bile-duct, the blood and the liver. A. A. Berg, of Mount Sinai Hospital, N. Y., is my authority for the latter statement. He says: "The diminished virulency of the invading bacteria is due to the fact that the usual channel of infection of the biliary tract is by the bile, the organisms being excreted by the liver, where their virulency has, as a rule, been much lessened." The presence of bacteria in the gall-bladder sets up an inflammation of a greater or less degree according to the character of the invading organisms. The catarrh set up causes degeneration and desquamation of the epithelial cells of the lining membrane of the gall-bladder. This catarrh has been called a "stone-building catarrh." It causes precipitation of the bilirubin and calcium of the bile. This forms a

small, hard, dark concretion, about which cholesterin, which forms the greater part of most gall-stones, is deposited. Cholesterin has been called "bile-fat." And so the so-called bile-stone is not a stone at all.

But the infection itself may do more than cause the formation of gall-stones, according to Kehr. He holds that "upon the degree of infection depends the kind, duration and intensity of the inflammation, which appears as a serous, seropurulent, pure purulent and gangrenous cholecystitis," and further that "if a lodgement of the stone occurs it is almost always the consequence, not the cause of the inflammation." This statement, according to Thomson, and in my judgment also, is not in accordance with the character of the pain in gall-stone disease, which is too sudden and torturing to be due to anything else but the contraction of the tube around the stone. Prof. Sailer, of Philadelphia, quotes Janowski as suggesting that "the continual mechanical irritation of the mucous surface predisposes it to infection, but the mucous membrane acquires great toleration for mechanical irritation, and the fact that stones are not infrequently found at autopsy that have never produced any symptoms during life renders it probable that unless they act mechanically to produce stagnation of the bile by occlusion of the duct, and thus favour infection, it is more than likely that inflammation of the gall-bladder will not occur." It is only when the stone leaves the gall-bladder and arrests the flow of bile that trouble begins. Thus the existence of the stone is, after all, the responsible factor.

This brings us to another etiological factor which is universally acknowledged to be an important one in the production of calculi, namely stagnation of the bile or anything which interferes with its flow. Age, sex, mode of dress and sedentary habits are indirect causes interesting to consider but which are not of much value in considering treatment. As has been said the bile flows with so low a pressure that it is a simple leakage and so its flow is easily obstructed.

But are there any etiological factors which we can point to, which alter the bile itself so as to cause gall-stones to be formed, which otherwise would not occur? I must refer to the new work of I. H. Keay, M. D. on "The Medical Treatment of Gall-Stones" He says: "If then, the products of indigestion lead to a deteriorated quality of bile, and to the consequent excretion of cholesterin, lime and other materials that constitute gall-stones, a new light is thrown on the treatment of this disease." He tells us that cholesterin, one of the

necessary constituents of a gall-stone, is derived, not from the liver, but from the lining membrane of the gall-bladder and ducts, and if the causes which lead to this irritation are removed we may escape the formation of gall-stones. Thomson makes a similar statement.

The irritating properties are: (1) Stagnation which has been referred to. (2) Substances conveyed from the intestine to the liver and excreted from the liver with the bile. Irritation of the gall-bladder and bile-ducts does not always extend from the duodenum, but from the liver. This has been proved by the fact that certain irritant drugs excreted by the liver have the same effect of causing a large excretion of lime, cholesterin and other materials of which gall-stones are composed. So badly digested food resulting in abnormal products of digestion is, when mixed with the bile, irritating to the bile-passages. If this be true it furnishes a new hope of success in treatment. (3) Bacteria which have been also referred to. These coming from a healthy intestine and so deprived of some of their virulence, and meeting with a non-irritated lining of the bile passages and gall-bladder may be harmless to produce gall-stones. But if the bile be stagnant or the lining membrane of the gall-bladder be diseased they doubtless become a cause of gall-stones.

When we come to the treatment of cholelithiasis, we find, as I have indicated at the beginning of this paper, opposite views held by medical men and surgeons. Keay says, his early opinion of the treatment of this disease may be summed up in a few words—relieve pain, olive oil—but expect nothing from it, and, if symptoms are urgent, advise operation. He continues: "So far, however, from regarding medical treatment as useless, I am firmly convinced that if a correct diagnosis be made in the earlier stages and suitable treatment adopted, the question of operation will almost never arise." Thomson is of a somewhat similar opinion, but makes it clear that when such danger signals as continued fever, a typhoid condition including dryness of the tongue and occasional sweats, perhaps hyperleucocytosis found from an examination of the blood, and if tenderness and rigidity are also to be found, there is no excuse for postponing laparotomy.

My own views of the medical treatment of cholelithiasis are as follows: Examine carefully the gastric and intestinal digestion. An analysis of the gastric contents should, as Kehr suggests, always be made. Give such a diet as is indicated by the character of the gastric juice. Treat the intestinal catarrh if it is present. Give enough food

because it promotes the flow of bile, but give it judiciously. Encourage an active out-door life if case permits, and an avoidance of sedentary habits. Then imitate the Carlsbad treatment as far as possible. Hare says "mineral waters antagonize the development of acid tendencies and aid in the solution of mucus." They relieve intestinal indigestion, and by regulating the bowels disinfect them. Fothergill was a strong advocate of sulphate of soda to promote the flow of bile.

As to medicinal treatment my small experience has led me to adopt the long famous Durande's mixture—three parts of ether and two of turpentine given in capsule. I believe it is much more likely to be freely absorbed and carried to the liver if given in capsule. Does it act by promoting a flow of bile or by dissolving the gall-stones or both? In a recent letter from Prof. Thomson, whose article I have before quoted, he says: "I fully believe in the solution of gall-stones in the biliary passage where a free supply of normal bile can get at the concretions. I have not used Durande's mixture as such but I used to employ spts. ether sulph. for years, with excellent results, but as I mention in my article I prefer olive oil in milk at night as less disturbing to digestion. It may be that the turpentine is a good addition but the mode of operation would be the same, i. e., it would promote the secretion of normal bile. I wrote at length on the etiology of gall-stones to show that they are neither by origin nor by composition a bit stony." Prof. Thomson had however written previously on the action of ether on gall-stones as follows: "The solubility of sulphuric ether has led to the use of the ether in biliary calculi, both to break up or reduce the size of the concretion, and to relieve the pain and spasm." In the American Text Book of Surgery it is said: "Walker has succeeded in dissolving a stone impacted in the common duct by means of ether injected through a sinus left after cholecystotomy." Turpentine will also dissolve gall-stones as has been long recognized. This then is the treatment I suggest for continued use in ordinary gall-stone cases, and I believe it acts in causing their solution. I follow Thomson's indications which I have mentioned as to where surgery should step in, but at best it cannot prevent the reformation of gall stones. I append an account of three cases treated by Durande's mixture.

CASE I.—Mrs. E. W., 59 years, wife of merchant. Was called to see her August 14th, 1889.

Patient has always been a delicate woman. She has had ten

children of whom only three are living, the rest having died young. Seven years before present attack she had an attack of gall-stones and passed a stone by the bowel as large as a beechnut.

*Status præsens.* Patient is a very thin woman, somewhat jaundiced, confined to bed. She is suffering from violent pains of a paroxysmal character in the region of the gall-bladder. The stools are light in color and the urine dark. I gave her a mixture containing opium for the pain, and a saline mixture.

I did not see her again till Sept. 22nd following, when she was still suffering from the effects of gall-stones. It occurred to me to put her upon the following mixture :

R	Æth. sulph.....	ʒiii
	Ol. terebinth....	ʒ ii
M.	Sig. Ten drops to be taken in capsules as directed, 3 times a day after meals.	

From this time all her symptoms improved, and she continued to take the capsules for about five weeks. Never after that, though she lived for eleven years, and though her death occurred only two years ago, had she any symptoms of gall-stones.

CASE II.—D. W., druggist, about 22 years of age. Unmarried.

He had suffered several attacks of pain from gall-stones. I was called in haste to see him in the night of Dec. 9th, 1893. He had pain just under the ribs in a line from the right nipple to the umbilicus. Pain is paroxysmal and lancinating. I administered morphine hypodermically. This is followed in a short time by jaundice, but pains recur at intervals.

On Jan. 8th, 1894, I placed the patient upon Durande's mixture. From that time he ceased to be troubled with the symptoms of gall-stones. He continued to take the capsules for some weeks. I saw this patient not long ago and he expressed himself as never having had a return of the symptoms mentioned, and as believing that the capsules had cured him.

CASE III.—Mrs. W., 48 years old. Married over 30 years. She has always been in delicate health. She "took cold" after her second child was born, 29 years ago. This occurred two weeks after the confinement. She became unconscious, and remained so all night. No reason was known. She came to herself gradually the next day. She does not remember having any fever at the time, but a pain and soreness, chiefly at a point three inches below the border of the ribs, in

the right mamillary line. This was the first time she ever had a pain there. Always since she has been subject to a dragging, tired feeling in that side after exertion.

The patient thinks the present trouble began two years after what has just been narrated, or about 27 years ago. She was then seized with a very severe pain in the pit of the stomach, which extended around the waist to the back. She had no doctor. After a day vomiting began, and the pain left her. She vomited during a whole week, and then got better. She did not at that time notice any yellowness of the skin.

After that she had similar attacks at times, sometimes being free from them as long as a year. In eight years she had to have a doctor only twice. But she dieted herself by the doctor's orders, and also took podophyllin pills by his orders. Eight years ago she was very yellow during one of these attacks, and again four years ago.

A year ago patient took what she described as a "dreadful" pain across the pit of the stomach, which extended around the waist, and especially on the left side in the mamillary line, just below the ribs. She called in a doctor, who attended her for a week, during which she had violent attacks of pain every two days. Morphine was required for each attack. After this week the doctor ordered her to hospital.

Patient was admitted to the hospital on May 20th, 1901, and was discharged on June 12th following. She was operated on by Drs. MacKay and Chisholm. These surgeons state that they found three gall-stones in the hepatic ducts behind or above the cystic duct, and they thought it better not to open these tubes. They therefore did not anticipate any particular improvement from the operation. Patient on coming to vomited, as she states, "a quantity of green material, and which continued all night." For a few days after this she was better of pain, and had only two attacks, and they were light, before leaving the hospital.

She had only been home three days before the pain came again very severely. She had a doctor to give her hypodermics of morphine every day or two till the 1st of July, when three doctors came. They all agreed that the trouble was gall-stones. Then her regular doctor administered olive oil, a wine-glass three times a day. She took this for a month during which she had no pain. Then the pain returned and she gave up the oil. She then sent for a fourth doctor. He also

gave her morphine. The pain came every day and she had hypodermics every day.

The patient stated that one evening about October 1st after a hypodermic of morphine, she became comatose for more than twenty-four hours. Her physician, who was with her most of that time, did not think the quantity of morphine he used could have produced this prolonged unconsciousness. At another time she was so ill that her physicians, in consultation, did not think she could live till her daughter who was sent for, could come from Truro to Halifax.

Condition Nov. 17th, 1901. Hardly middle-sized, very thin woman. Pale and sallow. Bedridden. Gall-bladder not to be palpated, some pain on pressure over the epigastrium and region of the gall-bladder. Urine does not contain albumin. Analysis of gastric contents after test meal shows free HCl absent, peptones diminished, no lactic acid and total acidity normal. She states that pain comes about once a week starting at pit of stomach and going around to right shoulder blade. Pain comes at first gradually but before an hour would be dreadful. It may come either before or after food. After pain, cold shivers and fever, which has gone, the doctor said, as high as 104°. Fever lasts three days and then goes down till pain begins again. A "beating" sensation very distressing in epigastrium. She has a slight mitral murmur. Vomiting occurs only if there is great pain. Flatulence always after food. Constipation severe.

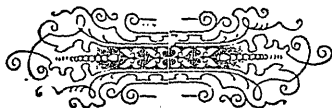
I treated her tentatively giving her an occasional calomel and soda purge for the next ten days, during which she complained of a dragging feeling and tenderness over the gall-bladder and of gastric uneasiness. On November 30th, after a powder of calomel and soda she began to complain of more distress and on the following day there was frequent vomiting of a green coloured fluid. That night as I could not attend, another physician saw her who administered morphine hypodermically on account of the pain, and remained with her two hours. The next day I found her distinctly jaundiced, and the urine contained bile.

I then placed her upon the treatment, which she has been taking ever since. I gave her Durande's mixture—three parts of sulphuric ether and two parts of turpentine. This I prescribed in a tightly corked bottle, with a box of empty gelatine capsules and a dropper. Patient was directed to have ten drops put into each of two capsules

and to take these three times a day after food. She had been subject to constipation, and was directed to take also from half to one tumbler full of Hunyadi water very early every morning. She was also given some digitalis in Fairchild's essence of pepsin for the "beating" sensation and mitral disease. As to her diet she had been advised that she could eat anything she cared for. It was now limited to the following: Breakfast—roast apple, one egg, toast, peptonized milk. Dinner—rice, one or two oysters, two soda biscuits, a glass of peptonized milk. One cup of curd during the afternoon. Tea—toast and a little stewed fruit, such as rhubarb. She was then very weak, and not even able to sit up in bed.

From that time till the present month of June she has continued to improve. She has never had the least return of pain or required the smallest dose of morphine, to which she had become so habituated. In seven weeks from the commencement of this treatment she was allowed to sit up in a chair for a few minutes. Gude's pepto-mangan was also substituted for the mixture of digitalis and essence of pepsin. She has gradually regained strength, and increased in flesh. She spends as much time as possible out of doors and drives a great deal. She is now, in fact, in very fair health. Her diet has lately been increased by the addition of white fish and chicken at dinner time.

NOTE. Mrs. K. has remained free from symptoms of gall-stones to this date (January, 1903). Since the above paper was written I have treated a less severe case, diagnosed by another physician as well as by myself as gall-stones, using the treatment mentioned, with a like successful result.





## SOME OF THE MISTAKES OF SURGICAL GYNECOLOGY.\*

By T. A. STODDARD, M. D., Gynecologist to St. Mary's Hospital, Pueblo, Colo.

We are met here in the interests of suffering humanity, and not, as generally supposed by the laity, for our own personal aggrandizement or the furtherance of our own selfish aims.

The subject I have chosen is one both broad and deep, and if you will excuse me, I will try to avoid the deep, keeping myself confined to the broad, so that I may have sufficient latitude to say what I wish, without getting beyond my depth.

You will pardon me if I appear somewhat dogmatic in what I have to say on this subject, but personal experience and observation in this line of work has a tendency to either dogmatize or disgust one. We have seen men risk and ruin their reputations and bring discredit upon our noble profession; we have seen valuable lives lost or rendered miserable or valueless by egotistical attempts at operative interference in unsuitable cases, or by men whose operative skill was in an embryonic state, if it was not entirely absent. Such are the sins of commission. Again, we have seen many cases urgently demanding operative interference, which have been temporized with, treated with opiates, and on "the expectant plan." Such are the sins of omission. We see and hear every day of operations which only serve to laud the skill of the operator, without benefiting the patient. Egotism, ignorance and jealousy are the factors which contribute more than all others to these mistakes to which I will call your attention for a few minutes.

1. It is a mistake to promise too much in the way of results

Very many of the cases which demand operative interference are so complicated that only the charlatan would dare promise anything but a possible benefit. Take, for instance, some intra-abdominal pathological condition, and, before the abdomen is opened, we cannot be positive of the exact condition existing. I have in mind a case to which I was called by a brother practitioner, who informed me that

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\* Read at meeting of Maritime Medical Association, Charlottetown, July, 1902.

it was a case of acute obstruction of the bowels, due to the patient having swallowed a number of plum-stones. The obstruction had been complete for twenty-three days. I opened the abdomen and found cancer of the sigmoid flexure, involving at least six inches of the bowel. I performed colotomy at once, thus saving the patient for a time, but she eventually succumbed to the malignant growth. Here was a case that, according to the family physician, gave no history of any previous trouble, and yet there was incurable disease. I would have made a sad mistake if I had promised a cure. And yet many good men are making this mistake constantly, to their own personal and professional injury, and to the discredit of the profession at large.

2. It is a mistake to ask a patient to allow you to operate in preference to some one else.

This is an evidence of want of self-respect, and even if the results are satisfactory, we are likely to receive contumely. Again, the case may be worse than we anticipated, and we are not able to give the results we promised—for the first two mistakes go together—and then I can conceive of a no more ridiculous and painful position than that occupied by the operator. If our patient need an operation, let us tell her so, and, if need be, urge her to have it done, but don't let us ask her to give us the preference.

3. It is a mistake to do a major operation when a minor one will serve the purpose as well, or better.

Plastic work in the vagina has, of late, been much neglected by the rank and file of the profession, as well as by those who are considered leaders. This is, no doubt, due in a large measure to the desire on the part of operators to have a large list of major operations. Much can be done by judicious plastic work to correct displacements of uterus, bladder and urethra, and to overcome many of the painful pelvic symptoms which are erroneously thought to be due to diseased viscera. The modified barbarous Alexander's operation has fortunately, to a great extent, been relegated to "the things that were," except by a few immortals who have gone wild over the "vaginal route." Hysterrhaphy will doubtless soon occupy a still more obscure position after it has done much to damage surgical work in this field. Hysterectomy is done when operations of much less magnitude

would serve the purpose as well so far as the patient is concerned. The abdomen is being opened for simple displacements, which, under proper treatment, would require no operation. We seem to have become madly insane in this matter of major operations, and the sooner a halt is called the better for humanity.

4. It is a mistake to think that any particular method of operating is the only correct one in all cases.

Take, for example, the different operations for repair of a lacerated perineum. We have Werth's, Hegar's and Hildebrandt's, Goodell's, Stude's and Voos', Simon's, Bichoff's and Tait's, and a host of others too numerous to mention. Now, the operator who will blindly follow any of these methods without a conception of the eternal fitness of things, has no right to be allowed to attempt such work. In all the field of surgery there is no department which demands greater originality than this. There are scarcely two cases alike, and, therefore, few cases can be successfully operated upon by following any set rule of stitch and suture. Have we not all been more or less disgusted with some of our teachers of and writers in surgery? One will say that the Tait operation is the proper one, and will explain fully how it is done, scarcely mention any other method, and thus leave the student under the impression that he has received the "sumum bonum" of the method of repair of all cases of lacerated perineum. Some of these so-called methods are absolutely pernicious and misleading, and show only a desire on the part of the originator to get his name before the public, and to narrow the opening into the vagina, both of which are accomplished with great eclat.

The choice of methods for removal of the uterus or its appendages must be left to the operator in each particular case, and the dictum of the advocates of this, that, or the other method must be ignored entirely, except in an elective way, and the manner of operating, as well as the line of after treatment of the stump or of the patient, must be decided by the operator in relation to the existing pathologic condition and the peculiarities of the case.

Every case demands careful study and intelligent use of anatomical and surgical knowledge and principles, without regard to Prof. A.'s or Dr. B.'s method. The man who has no mechanical ability, but must do everything by rule of "thumb," has no more right to attempt

operations of this character than the quack who has no knowledge of anatomy.

5. It is a mistake to sacrifice blood and tissue for the sake of rapidity.

Prolonged anæsthesia is certainly to be deprecated, and shock to be guarded against, but to my mind shock is not produced by loss of blood, or by reason of lengthy operations. Shock, I firmly believe, is a purely reflex condition, or rather a result of reflex action, and may be produced by injury to the solar plexus or not. If the anæsthetic is carefully administered until reflexes are completely quiescent, and no work done while these are active, and care exercised in handling the abdominal viscera, I believe that this bugbear of the surgeon will cause him less concern in the future than in the past. Get the patient in the best possible condition, and take time to do the operation well. If an operation is not done as well as it can be done, it is not done well enough, and nothing will excuse a man in doing an operation half way right, not even a want of time or fear of shock. Be sure and secure all bleeding vessels, for there is no doubt that many deaths attributed to shock have really been due to loss of blood. Some years ago, among my first operations, was one where I removed a large ovarian cyst which had many adhesions. I secured all bleeding points, and left the patient in charge of the house surgeon, whom I asked to notify me if any unfavorable symptoms arose. About two hours later I was telephoned that shock was profound. I went in all haste, opened up the wound and found severe hemorrhage, due to slipping of a ligature. I secured the vessel, which was in the omentum, again closed up the abdomen, and the patient made slow but uneventful recovery. This taught me a lesson which I never forgot.

6. It is a mistake for any physician to attempt major operations unless he has thoroughly prepared himself, by work of a similar character on the dead.

At the present time it seems to be a fad for everyone, general practitioners and all, to attempt any or all the work which has come to be considered special. This is brought about by two causes:—  
(a) many place themselves before the public as specialists, without the necessary qualifications, and are therefore no more fitted for

the work than the general practitioner. This is not as it should be, and there is as much need of protecting the public against such men as against the veriest quack, who goes from town to town. Some begin the practice of a specialty as soon as they have graduated, without ever having done any general practice whatever. The men who do this are dishonest with their patrons and discourteous to their medical brethren.

(b) The second cause is that men who have prepared themselves for special work still do general practice, and thus insult their confreres in general practice by tacitly saying, "I am as good a general practitioner as you, and I can do special work better." Now, while there may be some show of truth in this, still it is insulting, and I contend that the man who places himself before the public as a specialist in certain lines, should give up general practice for his patients' sake and for his brother practitioners' sake. It is hardly reasonable to expect the general practitioner to send his special cases to the specialist who does general practice as well. For this cause operations are attempted by incompetent men, or operations are delayed until too late, and thus an injury is done to all.

October last I was called in consultation by a general practitioner to see a lady who was supposed to have had a miscarriage a few days before. The doctor had been in attendance four or five days, and the day on which I was called he had curetted the uterus for supposed retained placenta. Shortly after the curettment the patient began sinking, and eight hours afterwards I was called, found the patient in extremis, and every evidence of collapse from hemorrhage. There was dullness over the lower part of the abdomen. I diagnosed ruptured tubal pregnancy, and refused to operate, first, because the patient was too far gone, and second, because the family physician did not agree with me in the diagnosis. The patient lived only a few hours, and I was fortunate enough to secure an autopsy, which proved the correctness of my diagnosis. The placenta was located toward the outer end of the tube, and here the tube had ruptured, allowing the blood to escape into the abdominal cavity. The foetus was apparently well formed, and about the fourth month. The history of this case should have led any one to

suspect the true state of affairs, and had I been called in before the curetage, this life might have been saved. There seems to exist in the mind of the general practitioner an antipathy for all specialists. There is no doubt that if the general practitioner were endowed with the skill of a Michael Angelo, he would carve the gynecologist knee deep in the almond-shaped ovulating glands of the human female, a scalpel in one hand and a ligature carrier in the other, surrounded by bleary-eyed assistants, whose desire for gore and gland is only exceeded in intensity by that of their principal. Possessing this spirit I have seen men go to operations whose nerve consisted of corn-juice and ignorance, and dared to lift over the bared abdomen that instrument so potent for good, but equally potent for harm, and I have trembled for the profession. We cannot get by reading alone what is necessary to render us capable of doing with success, and in the best possible manner, any operation, however simple.

7. It is a mistake to attribute to electricity the virtues many claim for it.

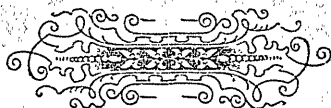
The weight of opinion the world over is that the use of electricity in the treatment of fibromata and myomata has done little good and much harm, and that, too, when used by men who thoroughly understand its therapeutic application; but when we consider the many who use this agency without any knowledge of its use or abuse, then, and only then, will it appear before us in its proper light. True, there are some men of ability who claim for this agency some excellent if not wonderful results; but against these are arrayed a long list of the most eminent men who ever graced the profession of medicine, men of honor, men of science, and men of research, who, after giving this a fair trial, have discarded it as useless if not positively harmful. When a fibroid has reached such a size as to cause symptoms, the only proper course to pursue is to remove it by surgical means, and not subject the patient to the dangers of sepsis and delay. They tell us, certainly, of numerous cases of cure by electricity, but so have we heard of cancers cured by Christian Science, and "falling sickness" by faith cure.

It rests with us as specialists to set the example of being careful and conservative. Many misconstrue the word conservative. It is not conservative to perform a hysterectomy when a plastic vaginal

operation will do better; neither is it conservatism to treat a pus tube or an abscess of the ovary by local application alone. It is not conservative to do Alexander's operation, when a curettment, in nine cases out of ten, will serve the same purpose; neither is it conservatism to apply for months the electric current to a bleeding fibroid. It is not conservative to curette the uterus for every case of painful menstruation; neither is it conservative to give tonic, and advise change of air for a case of deep-seated purulent endometritis.

Let us be conservative, but let us also be honest with our patients, honest with ourselves, and honest with those who learn from us or are taught by us. Let teachers in our colleges be chosen because of their fitness, and not because of any political pull.

Let them be men, sober, painstaking and broad-minded, slow to follow fads, and deeply grounded in the humanitarian principles of the great profession of medicine, and then we may expect from the rising generation of physicians more men of mentality, and fewer of those who grasp at every fad which is foisted upon the profession, and who act as barnacles to impede our progress.



## INSOMNIA.\*

By H. H. MacKAY, M. D., New Glasgow, N. S.

Probably the best way to define insomnia would be to define what sleep is, and as there are different degrees of sleep there would have to be the corresponding degrees of inability to sleep or "Insomnia."

Sleep might be described as that condition of physiological repose in which the functioning of the brain and nervous system is no longer projected on the field of consciousness. Sleep does not usually fall with equal force upon all the organs at once. Its invasion is progressive—some parts of the body may be fast asleep, while others are partly awake, and while still other portions may be more active than when ordinarily awake. Upon this fact depend the phenomena of dreams and various forms of somnambulism.

General sleep of the whole body is made up of the particular sleeps of its various parts. The cerebrum, sensorium, spinal cord, and the various muscles and organs must jointly and severally repose for sleep to be sound and complete.

Excitability of one or more of these systems disturbs the repose of the whole body, and insomnia results. In this way we can readily see the necessity of using all of the parts of the body nearly equally if we are to have sound and complete sleep. Sleep is preceded by a feeling best described as sleepiness, and usually comes on gradually, one set of centres in the brain being obscured after another, generally in definite order until all are involved.

The centres in the motor areas are the first involved, one group of muscles after another becoming relaxed, until the whole body resumes the horizontal position. Even the tension of the firmly contracted muscles of a hemiplegic limb is lessened during sleep. The only exception to this rule is where the sphincters remain contracted, but these in children sometimes relax during profound sleep, giving rise to enuresis. The motor centres in the brain fall asleep before those in the spinal cord, so that the normal inhibitory influence of the

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\*Read before Medical Society of Nova Scotia, New Glasgow, July, 1902.



former is, for the time being, lost; and the activity of the centres in the cord is manifested, often by spasms and muscular contractions, when persons are falling asleep, more especially if tired by muscular exertions. The action of the freed spinal centre is so strong at times that the spasm awakens the sleeper.

Sleep next extends to the psychical centres in the hemispheres of the brain. The will ceases to control the working of the intellectual faculties and the power of perception grows less. The mind, no longer inhibited from within, nor corrected from without, revels in absurdities, fantasies, and dreams until, at length, all intellection terminates, or, at least, no knowledge of it is retained.

The special senses are next invaded. The eye ceases to see clearly, the eyelids drop, and the eyeballs are rotated upwards, the pupils being contracted, as if to shut out the light, the extent of contraction of the pupil indicating the depth of sleep. Any external excitation through the skin, or other sensory organs, causes dilatation of the pupils, even if it does not awaken the sleeper. This feature can be studied easily during chloroform narco-sis. The senses of touch and taste fall next, as illustrated by the infant going to sleep with its mouth full of food. The sense of smell is more persistent and often prevents sleep. This is often illustrated by certain plants in bed rooms preventing sleep, but if sleep is once produced the sense of smell is weakened, because for the keen preception of odours it is necessary that the fragrant particles be di-solved in the mucus of the schneiderian membrane and during sleep this mucus is very scantily secreted—hence odours that would prevent sleeping will not awaken. The sense of hearing (superior temporo-sphenoidal convolution) seems to be the most persistent of all the special senses. This sense has been used to estimate the depth of sleep by comparing the loudness of noise necessary to awaken the sleeper. Noises frequently, though not necessarily, prevent sleep, and loud noises often fail to awaken the sleeper, such as thunder, while an accustomed or expected noise readily arouses.

Lastly, the centres in the medulla are affected to a certain degree, the respiration is slowed, and the heart beats are reduced correspondingly. Sleep, having progressively invaded these parts of the nervous system, is said to be profound, and no act of volition can modify or terminate it.

If the inception of sleep be considered, it will be apparent that the

centres situated highest in the cerebrum are the first invaded, while those at a lower level are successively included. This may depend upon the centres growing inactive consecutively, according to their position, and ceasing to attract a working supply of blood, or it may arise from the va-cular supply of the centres becoming lessened relatively to their distance from the heart.

Probably the best way to study the cause of Insomnia would be to study the cause of sleep. Among the causes of natural healthy sleep we might mention the alternation of day and night. It would appear that sunlight is a stimulant to organic activity, more especially in its higher forms and with its disappearances this activity is replaced by a period of repose.

"The night brings sleep  
To the green woods deep,  
To the birds of the woods its nest,  
To care soft hours,  
To life new powers,  
To the sick and weary, rest."

In this tendency to repose at night, man shares with all other living creatures. It would be very interesting in this connection, if we had the time, to look into the causes that have induced part of the animal kingdom to reverse this order of nightly repose and replace it by a period of activity. Prominent among the causes which predispose to sleep at night is the cessation of a majority of sensations which are constantly pouring in upon the brain during the period of daylight, Physiologists are now agreed that during normal sleep there is vascular dilatation of the skin, as a result of which there is a fall of blood pressure in the arteries at the base of the brain which lessens the blood supply to the cortex.

Professor Mosso, of Turin, conducted, upon three persons, in each of whom a portion of the skull was wanting, permitting movements of the brain to be felt through the scalp, a series of experiments connected with the cerebral circulation, particularly during sleep. By means of special instruments, he took tracings of the movements of the brain and thoracic walls, and of the pulsations of the heart and of the radial artery at the wrist. He further devised the plethysmograph by means of which he estimated and registered the quantity of blood in the forearm. He showed :

(1) That in the act of going to sleep, a dilatation and relaxation of the vessels of the forearm occurred with a corresponding contraction

in the vessels of the brain, this change becoming more pronounced during deep sleep.

(2) That all external stimulation, however slight, such as a ray of light falling upon the eye, a noise, etc., is attended by a contraction of the vessels of the forearm, a greater blood pressure, and an increased flow of blood to the brain.

(3) That these changes are accompanied by a modification of respiratory rhythm and an acceleration of the heart beats.

(4) And during sleep the quantity of blood in the brain is subject to fluctuations without any apparent cause; these fluctuations may account for dreams and the different degrees of sleep.

Fatigue of any sort is one of the most energetic causes of sleep. Every muscle rests after contraction; even the heart gives a momentary pause after contraction. We often see women going to sleep between pains of a severe labour. Based upon these experiences, physiologists have suggested that sleep was caused by a supposed loading of the cerebral tissues with the acid products of their own disassimilation during the period of wakeful activity. The acid reaction of the brain and nerves after exertion, corresponding to the acid reaction of muscle after contraction, suggested the probability that an excessive presence of lactic acid and its sodic compounds might be the real cause of cerebral torpor and sleep. If this were so, the lactate of sodium would be the best medicine for insomnia which it is not. This theory does not explain the great stupefaction produced by cold, nor the unbroken sleep of the unborn.

Pfluger advanced the hypothesis that the state of wakefulness is maintained by a certain degree of activity in the cortical substance of the brain. Like all other bodily organs, this substance is renovated by the assimilation of nutrient material derived from the blood. By this process, oxygen is stored up in chemical combination, forming explosive compounds, of which the precise composition is not understood. When for any reason the supply of oxygen is insufficient, as in hæmorrhage producing cerebral anæmia, or when the red blood cells are impregnated with C. O., chloroform, or any substance capable of excluding oxygen from the hæmoglobin of the blood, the cerebral tissues are imperfectly renovated, the explosive constituents of the cortical substances are thus inadequately renovated after mental activity, and the sensitive portions of the brain are no longer fitted to manifest the highest forms of intelligent activity. But, when nothing

interferes with the healthy nutrition, the requisite degree of instability, in the protoplasm of the brain, is effected by the taking up of oxygen. Under the influence of the various nervous impressions reaching the brain, the unstable protoplasmic compounds break up into simpler forms. The energy thus liberated, in some way we cannot understand at present, and projected upon the field of consciousness, bring us into conscious relation with the external world.

By the "neuron theory" sleep is explained in a simple way. The cortical cells of the motor areas have processes, extending towards the surface, called dendrites; and a protoplasmic process, extending downwards through the white matter of the brain, the internal capsule, the crus, the pons, the medulla, and into the spinal cord, where it terminates in a brush like extremity, the end tuft. Here it has a certain relation with the motor cells in the anterior horn of the cord, probably one of contact, though this is not definitely known. If the nerve cells retract, this contact is broken; if the abnormal contraction of the nerve process is relieved, for the time being, the contact once more takes place. Evidently, if the neurons are functionally active their dendritic processes must be in contact, without which consciousness is impossible. When the nerve cells are exhausted by fatigue, there is every reason to believe that their volume shrinks, and it is therefore more and more difficult for them to remain in contact. When relaxation comes, the processes retreat and unconsciousness, that is sleep, supervenes.

From this it would seem reasonable to suppose that unconsciousness, or sleep, is produced by something acting on the nerve cells in the brain which causes their dendrites, or processes, to retract so that the contact between each cell is broken. Whether this be due to something introduced into the blood by the metabolism of the tissues, or by chemical changes in the nerve cell itself, it is hard to say. Whatever the exact cause is, it seems to be proved beyond doubt that, during normal sleep, there is cerebral anæmia, with corresponding vascular dilatation of the skin. In the treatment of insomnia we should bear this in mind. The bulk of evidence goes to show that there are no vasomotor nerves to the cerebral vessels, and that the volume of circulation through the brain is regulated by variations of arterial pressure in other parts of the body.

It is not my intention to go into the classification of insomnia, nor to diagnose its special causes. What we require more than anything

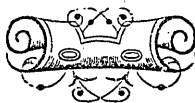
else, in order to treat any abnormal condition, is to first understand the physiology of the normal condition, and thence to trace out the various causes which led to the abnormal.

In persons of a sanguine temperament, the heart is, as a rule, large and powerful, and the bodily functions easily and quickly performed, so that, in health, such persons usually sleep well and soundly. In middle life, they frequently become subject to circulatory derangements which not infrequently leads to disturbed sleep. Many in this class are gouty, and, consequently, have a predisposition to insomnia, depending on an altered state of the blood from imperfect metabolism. Such persons bear loss of sleep badly. If the cause of insomnia is recognized, intelligent treatment can be given.

The neurotic temperament includes a class whose brain and nervous system dominate greatly over the other systems of the body. In health, sleep is of short duration; they are great workers, and apt to fatigue their nervous systems, which, combined with a tendency to nervous disease, is apt to bring about insomnia. In middle age, when defective innervation brings about faulty digestion, resulting in impaired nutrition of the brain and nervous system, sleeplessness is seldom absent.

Persons of lymphatic temperament usually sleep well. Their functions, being languidly performed, have no tendency to circulatory or neurotic diseases, which are great sources of insomnia.

It is well, therefore, to study the temperament of the individual, as it often gives a clue to the cause of the insomnia, and the regulation of the cause is necessary for rational treatment.



## CASE OF CANCER OF THE PYLORUS.\*

By A. B. ATHERTON, M. D., Fredericton, N. B.

J. F., aet 51, male. His mother died at about fifty from supposed cancer of the stomach. He began to have dyspeptic symptoms three years ago. These have grown more and more severe. During the last eighteen months attacks of pain and vomiting have been frequent, sometimes occurring after almost every meal for a week at a time. Gas on the stomach seemed to be largely the cause of these, and they came usually an hour or two after eating. He had been under the treatment of several medical men during that period, Dr. McNeill of McKeen's Corner, York Co., being the last. After using various drugs and employing lavage, the relief obtained was so slight that the Doctor thought some more radical measures were advisable and referred him to me. After examining him, although nothing in the way of a tumor could be felt, I agreed with Dr. McNeill that it was proper to make an exploratory incision at least.

I should have stated that whereas his usual weight had been from 145 to 150 pounds, it had fallen to 127 pounds.

OPERATION. On January 24th, 1902, Dr. McNeill giving the anæsthetic and Dr. B. E. Wiley assisting, I made an incision four and one-half inches in length extending from near the ensiform cartilage down toward the umbilicus. At first I felt nothing abnormal, but when I took the pylorus between my thumb and finger I found a hard lump about the size of a marble lying in the posterior wall. There were also some enlarged glands felt in the omentum along the larger curvature of the stomach near by the pyloric tumor. The pylorus was now separated from the adjoining parts, and after clamping the the stomach and duodenum, about two inches of it were resected, and the portion of omentum containing the enlarged glands also cut away. A double row of silk sutures was then put in a portion of the wound in stomach so as to reduce the opening in it to the size of the duodenal one, and the two were united by a row of uninterrupted silk sutures, passed through all the coats and tied within. These were

\* Read before New Brunswick Medical Society, St. John, July 1902.

fortified by a continuous silk suture all the way around except at the posterior side where it was impossible to use them without separating these parts more fully than had been done for resection. I therefore trusted entirely to the single line of interrupted sutures at this point.

The parts were now returned within the abdomen, and the peritoneal cavity sponged clean. Then through and through fish-gut sutures put in, and iodoform gauze and a sterilized pad applied. The usual adhesive straps and bandage over all.

The operation lasted one and one-half hours; one-twentieth grain of strychnine was given during it. The pulse was 108 and of fair strength at its conclusion.

The tumor was yellowish white on section, and it and the half dozen lymphatic glands removed were found on microscopical examination by Dr. Wiley to be carcinomatous. The mucous membrane was nowhere ulcerated, and the lumen of the pylorus would just admit a lead pencil.

Jan 25th. Patient had one hypodermic of one-sixth grain morphine in night, and slept three and one-half hours. No vomiting. One nutrient enema of peptonized milk. Temperature rose to 100.2° during first of night. It is 99.6° this morning and the pulse 84. Takes a teaspoonful of water every half hour by mouth. The nutrient enemata to be given every eight hours.

Jan. 26th. Had twenty minims of tincture of opium in enema last evening for pain. Slept six hours. Has had a few teaspoonfuls of peptonized milk by mouth this morning. During the day he awoke from sleep feeling chilly and did not obtain extra covering for a little time. His temperature ran up to 102.6°, and pulse to 112. The room was rather cold and this was probably the cause of the cold feeling. He complained only of a little headache; no abdominal pain of consequence.

Jan. 27th. Slept seven hours without any opiate. Temperature has dropped to 99.5°, pulse 104, irregular in force. Took two ounces of peptonized milk in the night. May have one ounce of peptonized milk or beef tea, as he likes, every hour. Gas is passing freely.

Jan. 29th. On giving his usual daily wash-out, preparatory to administering the nutrient enema this morning, the bowels were well moved. Temperature this morning 98.6°, pulse 84, most of the time more or less intermittent. May have two soda crackers in beef tea

during the day. Only two nutrient enemata to be given in the twenty-four hours.

Jan. 31st. Doing well. Slept nine hours in night. Taking more food by mouth, consisting of corn-starch, soda crackers, beef tea and chicken broth.

Feb. 2nd. Nutrient enemata omitted. Bowels moved every second day by soap and water enema. Temperature about normal. Pulse still intermits more or less. Has had one-twentieth grain strychnine occasionally. Wound has been dressed twice since operation and one or two sutures removed at its upper part. Says he "never felt better in his life." Is very hungry.

Feb. 10th. There has been a little suppuration along the course of the uppermost sutures, but otherwise he has done well. Is now eating some meat well chewed and other plain food. Pulse has ceased to intermit.

Feb. 25th. Wound soundly healed. Left hospital to-day. When weighed found he had gained five and one-half pounds since admission.

April 1st. Weighs twenty pounds more than before operation. Is now of about normal weight. Feels in first rate condition every way.

REMARKS. One of the most important lessons, it seems to me, to be learned from this case is the desirability of making an early exploratory operation in many of these cases of stomach trouble which have resisted all kinds of known medication. If one waits until there are more positive signs of cancer such as the presence of a tumor or the occurrence of hæmatemesis, he shall often find that the disease has made such progress as to preclude its safe removal by the surgeon's knife. And what is true in cases of malignant disease of the stomach holds good in regard to cases of cancer of the bowel. Only recently I operated on one in the lower end of the sigmoid flexure, which for three weeks had produced almost complete obstruction, and where the distension had caused a localized gangrene of the cæcum with a perforation in its centre and extravasation of some of its contents. The patient had only consulted a physician a few weeks before, thinking she was suffering from some form of simple indigestion. In her case there was no marked emaciation, and no great pain had been felt until obstructive symptoms had set in.

In the case reported, much credit I think is therefore due to the physician for having recognized that the medical treatment was no



longer of any permanent use, and that resort should be had to the knife. It would be well if all obscure and acute abdominal cases were brought to the surgeon sooner than is the ordinary custom. The abdomen has in recent years been the field in which surgery has gained its greatest triumphs, and these triumphs will become more and more numerous when the family physician who is first called becomes aware of the importance of more prompt action, and sees that the best surgical advice available is early applied to the case in hand. Even in strangulated hernia it has more than once been my experience to be called in consultation after several days of attendance by the physician in charge, and where on operating I have found that gangrene had already occurred.

In conclusion let me call attention to the intermission of the pulse for a number of days after the operation, and the subsequent return to regularity. Whether this is of common occurrence in extensive operations on the stomach, I do not remember to have seen recorded, but such was the case in the only two pylorectomies I myself have done. One might very well suppose such effect may be due to a reflex action produced on the heart through the gastric fibres of the pneumogastric nerve.



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VOL. XV.

HALIFAX, N. S., JANUARY, 1903.

No. 1.

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## Editorial.

### THE TREATMENT OF PLEURISY WITH EFFUSION.

The December issue of *The American Journal of the Medical Sciences* contains an article on "The Treatment of Pleurisy with Effusion," by Francis Delafield of New York. The paper is of some interest as its object is to advocate early resort to aspiration as the best method of procedure in managing this affection; and a claim is also made that other modes of treatment are not specially called for, when removal of the fluid is done without delay.

The conclusions arrived at by Dr. Delafield are based upon two hundred cases of pleurisy with effusion treated by aspiration at the Roosevelt Hospital, and the results obtained in private practice.

The tabulated statement of the hospital cases affords information as to age, the amount of fluid in the chest on admission, as indicated by the physical signs; the day of the disease when tapping was done, the amount and character of the fluid, subsequent tapplings, other treatment; and the period from the first tapping to the end of the pleurisy.

"None of the patients died, none of them were injured by the operation and in none of them was the chest infected."

Complete cure followed in one hundred and eighty-two of the cases; in six cases the result was unknown owing to the patients having left hospital; in six cases the result was doubtful; and six cases were not benefited at all by treatment. In all of the cases there

was considerable fluid, the physical signs indicating that the chest at least was one-third full of fluid. It is of interest to note that the fluid removed in twenty-five cases was bloody but this appeared to make no difference as these cases did as well as the others.

The prognosis in the hemorrhagic variety of pleurisy with effusion is distinctly favorable, unless it appears as a complication of some other serious disease, is a fact now very generally recognized.

In one hundred and twenty-one of the cases the pleurisy was on the left side, in seventy-nine on the right side.

The chief point of interest is that in one hundred and eighteen of the two hundred cases aspiration was the only treatment; in the others, measures designed to promote absorption of the fluid were also carried out without any distinct advantage. Dr. Delafield's paper certainly conveys the impression that early and repeated aspiration is the only treatment necessary in pleurisy with effusion.

A close examination of the tabulated statement of cases convinces us that the benefit of early resort to aspiration is at least doubtful, and the rejection of other measures of treatment unwise.

Early aspiration, irrespective of the quantity of fluid and prior to abatement of general symptoms, although occasionally followed by prompt recovery, is not judicious practice. In the majority of cases the fluid returns necessitating subsequent tapplings and the risk of infection is certainly increased.

A comparison of the cases treated by aspiration only, with those where measures intended to promote absorption of the fluid were employed in addition, distinctly favors the latter procedure.

In fifteen cases tapped prior to the tenth day of the disease and no other treatment resorted to, the result was unsatisfactory in two cases, twelve subsequent tapplings were required, and the average period from the first tapping to the end of the disease was about fourteen days; whereas in sixteen cases aspirated not later than the tenth day and medical treatment was taken advantage of, all made a good recovery, subsequent tapplings were only necessary twice and the average period from the first tapping to the end of the disease was about ten days.

## THE LATE DR. HARDING.

The following article taken from the *St. John Globe* will be found of considerable historic interest:—

“In referring to Dr. W. S. Harding a few days ago mention was made of the fact that he had a great deal of hard work at the time ship fever came here with the immigrant vessels. The late Mr. W. Reynolds, in an article in the *New Brunswick Magazine* in 1898, told in detail the sad tale of the sufferings of the people coming to this country over fifty years ago. The main points in Mr. Reynolds' article are as follows:

The first of the immigrant ships to arrive in St. John was the brig *Midas*, on the 5th of May, 1847. It was from Galway and had made the passage in thirty-eight days. During the voyage two adults and eight children had died and many of the passengers were sick when landed on Partridge Island. Following this came other vessels, and on the 16th the barque *Aldebaran* arrived. It had left Sligo with 418 passengers and of these thirty-four, chiefly children, had died during the forty-eight days' voyage. Over one hundred were sick when they reached here, eighty of whom subsequently died, being buried on the island. Many of the vessels were overcrowded, and food and water were scarce on almost every ship.

During the month of May twelve vessels arrived and were placed in quarantine, the passengers being removed to the Island Hospital. Among these craft were some veritable death ships, one of them the *Mary Dunbar* from Cork, having smallpox on board.

Dr. George J. Harding was the quarantine physician and was assisted by Dr. George L. Murphy, but the cases multiplied so rapidly that further medical aid was necessary. In the latter part of May two doctors from the city were sent to the hospital on the Island. One of these was Dr. W. S. Harding; the other Dr. J. Patrick Collins, who was destined to give his life in the effort to lessen the sufferings of the people of his race. Dr. Collins was then only twenty-three years of age and there was every promise of a most brilliant career for him. He had been married in the previous autumn to a sister of the Revs. Pas. and Edmond Quinn, who is still living.

Drs. Harding and Collins were well aware of the terribly infectious character of the fever, but they went to the Island to do their duty whatever might be the result. During the month of June thirty-five vessels arrived, having on board 5,800 souls. Two hundred died in quarantine, and over 880 of them were sick in the hospital at the close of the month. Drs. Harding and Collins both contracted the fever and on July 2nd Dr. Collins died, a martyr to his duty and a hero in the truest sense of the word. The funeral took place on the following Sunday, and was the largest ever seen in St. John.

In the meantime the infection was extending to the city and by the last of July 660 had been admitted to the Immigrant Hospital at the old poor house, at the corner of Great George's (now King) and Wentworth streets. Of these, sixty-two had died and the death rate was increasing. When this refuge became too crowded, sheds along the back shore, near the Marine Hospital, were brought into requisition.

It transpired that Dr. Geo. Harding had by this time also contracted the fever, but recovered. Dr. Wetmore was sent to the Island with Dr. W. S. Harding at this time. In the city Drs. W. Bayard, Wetmore and Paddock were ill, one after the other, in their attendance at the poor house, but all recovered. Andrew Barnes, steward of the Marine Hospital, died from it.

In July 4,058 more immigrants arrived, making a total of 9,900 up to that time.

During the six months the fever raged on Partridge Island the scenes were beyond description. Oftentimes five hundred people had to be carried ashore, helpless from the terrible disease. Those were gruesome processions. In many instances a whole day was consumed in debarking. Many of those, not sick, camped about the various places over the Island, securing what shelter they could. A supply of tents was sent down from the city, but in the blustery days these were swept away by the score. Others used the rude boards sent down to convert into coffins, and erected huts.

As to the coffins, it soon grew so hard a task keeping up to the demand that even the board receptacles were finally abandoned and the dead were interred in their clothing only. There being little earth on the rocky isle many graves showed evidences of the clothing of those

buried, and the stench was something awful. Quicklime was generously used, and the thinly-earthed spots deepened. At one time, through the prostration of the hospital staff, forty-five bodies accumulated. These were placed in one large pit.

Long after the fever ceased St. John had many poor on its streets. Beggars from door to door were common, and some of them were pitiable sights, truly! Many who recovered went to the United States, their originally-intended destination. Fever ships arrived at other New Brunswick ports and in some cases the disease made great havoc.

By November the epidemic on the Island was under control, and the patients were removed to the city poor house. The number of Irish immigrants landed on the Island that year was 15,000. About 800 died on the voyage, 601 died in the hospital and on the Island, 595 died in the poor house hospital, making the total mortality in excess of two thousand."





## Society Meetings.

### NOVA SCOTIA BRANCH BRITISH MEDICAL ASSOCIATION.

Nov. 12th 1902. Dr. G. M. Campbell, President in the chair.

On motion the President was elected to represent the Branch on the Advisory Board of the Victorian Order of Nurses.

Dr. G. C. Jones then read his paper on "Reminiscences of Field Hospital Work in South Africa." The enlistment, equipment and transport arrangements of the Canadian Field Hospital were discussed. He also gave a brief and entertaining account of the work done and related a number of most interesting cases.

Dr. H. M. Hare referred to some of his experiences in China. One case, a coolie, lay for three hours in a ditch after being slashed with a knife across the abdomen, with bowels protruding and yet recovered.

The discussion was continued by Drs. Goodwin, Kirkpatrick, Murphy, Lowerison, Hawkins and C. D. Murray.

A vote of thanks was then tendered Dr. Jones for his interesting and instructive paper.

Nov. 26th, 1902. Dr. Goodwin presented an obstetrical case which was first attended by a midwife and subsequently he was called. He found it necessary to turn and bring down an arm. Child did not breathe for some time and artificial respiration by several methods was tried. The right arm was found to be paralyzed. Drs. MacKay and Chisholm had seen the case and thought some nerve was injured. Faradism was used with no benefit so far. The deltoid muscle seemed all right. Possibly nerves of brachial plexus had been pressed upon as child was very difficult to deliver. The patient was then shown.

Dr. Mathers then exhibited a woman who had had extensive ulceration of the lower lid and face which healed under potassium iodide and mercurial ointment. There was left considerable deformity of lower lid with inability to close the eye. He (Dr. M.) would like some advice as to a plastic operation being performed.

Dr. Curry then showed a case of supposed pernicious anæmia. The

man, aged 54, was a shoemaker by trade, and had been a hard drinker. Had been in the hospital for some months. Red corpuscles were three millions, hæmoglobin forty per cent. All ordinary iron preparations and arsenic had been given with no benefit.

Dr. M. A. B. Smith said there was much difficulty in staining the red cells in this case—they were easily broken and the white cells also stained badly. The red cells did increase, for on the patient's entrance to the hospital on July 14th hæmoglobin was ten per cent. and red cells 2,800,000.

The President, on discussing Dr. Goodwin's case, mentioned a case where the shoulders were larger than the head and consequently extreme difficulty in withdrawing. On examination there was found to be paralysis of right arm. Massage and passive movements were carried out, and now—two years afterwards, the child has fairly good movement of the arm.

Dr. Curry said he had had a somewhat similar case but the paralysis was not so pronounced. It recovered in five to seven months.

Dr. Murphy also referred to a case of his and he had seen several others. All of them got well—his own case in about seven months.

Dr. D. A. Campbell thought Dr. Goodwin's case to be traumatic paralysis, particularly involving the musculo-spiral nerve. The outlook in these cases was not satisfactory. Had only one in his own practice; shoulders were large and quick delivery was necessary.

Dr. Mader had no experience in such cases. Possibly in Dr. Goodwin's case the nerve had been partially severed and the question was whether to make an incision and suture the nerve if required.

Dr. Goodwin in replying, said after turning, the child was very hard to extract. Dr. Mader's suggestion, which he had also thought of, he considered good. The question was how long to wait before operation.

Dr. Murphy then discussed Dr. Mathers' case. He thought it well to have an operation done on the lid. At least it was worth trying.

Dr. Ross referred to the great necessity of putting all such doubtful cases on iodides; no matter whether you can get a history of syphilis or not.

Dr. Lowerison did not consider the case favorable for operation. If upper lid does not cover the eye, ulceration of the cornea is apt to occur.

Dr Mader thought Dr. Murphy's suggestion a good one and if not satisfactory another plastic operation might be done. In syphilitic cases, he thinks wounds nearly always heal by first intention.

Dr. Hattie in discussing Dr Curry's case, said the blood examination was against the diagnosis of pernicious anæmia. The case seemed more like simple anæmia.

Dr. D. A. Campbell also thought the evidence did not bear out the diagnosis. Probably the anæmia was secondary. Had seen the patient on his admission to hospital and made a careful examination of the man and found marked diminution in size of the liver. Patient had used alcohol freely and there may be degenerative changes in liver, stomach and bowels—possibly an atrophic condition of liver.

Dr. M. A. B. Smith said from the evidence of the last two speakers the case was not pernicious anæmia. Dr. Halliday had also thought so from the blood examination. He (Dr. S.) had examined the man and did not think liver altered in size. He had two theories—either atrophic condition of stomach or malignant growth somewhere.

Dr. Curry, in reply, said he suspected the case to be pernicious anæmia. He felt sure there was no cancer of the stomach. Here was a progressive anæmia, and patient gets a nourishing diet with iron and arsenic and gets apparently no better. Did not make a positive diagnosis but suspected it pernicious anæmia. The liver he had thought about normal.

Dr. Chisholm then showed a man who had met with a very severe injury producing fracture of upper condyle which united in a false position. He performed transverse osteotomy and straightened leg, like for genu valgum. Dr. C. also showed a case of mixed infection—hard and soft chancres and a papular eruption on the body.

Dr. Murphy congratulated Dr. Chisholm on result of his first case.

Dr. Ross referred to the treatment of the second case. In soft chancres cauterization followed by a wet antiseptic lotion till the slough is removed.

The President then showed specimens from a post-mortem. The case was one Dr. Chisholm reported at the recent meeting at the Victoria General Hospital. An artificial anus had been made at the junction of the jejunum and the ileum. The appendix was found attached to the bowel and considerable adhesions were present. The point of obstruction was in the ileum near cæcum. The portion of bowel between artificial anus and obstruction was gangrenous.

Dr. Chisholm said he had reported the case before as successful but unfortunately not so. Probably better to have operated again a week after the first operation, though condition present was not satisfactory. The cause of death was the want of function in part of the bowel below obstruction, the distension alone producing gangrene.

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### Obituary.

DR. G. D. FITZGERALD.—The people of Amherst on Saturday night, Jan. 10th, were startled to hear of the sudden death of Dr. Gerald D. Fitzgerald, which occurred about 8 o'clock in the evening from apoplexy, with which the deceased was seized about 6.30 o'clock. The doctor had not been well that day and had remained in the house all day. About 3.30 o'clock he was down stairs attending to some business matters over the telephone, and some one noticed that upon going upstairs again he appeared rather weak. About six o'clock those who were down stairs heard him breathing very heavily, and on going to his room to ascertain the cause, the doctor was found unconscious. Dr. McQueen was called in, and finding the case a very desperate one, sent for Drs. McDougall and Bliss, and all three endeavoured in every way possible to restore consciousness, but their efforts proved fruitless. Dr. Fitzgerald expired about eight o'clock.

Dr. Fitzgerald was a graduate of Queens University of the class of 1893 and was in the thirty-second year of his age. He came here last May and was working up a lucrative practice. He was a fine looking man, of splendid physique and athletic bearing. A younger brother died under similar circumstances some two years ago. Both parents are dead and the brother who is coming to look after the remains is, as far as we can learn, the only surviving member of the family. It is understood that he was to receive about \$17,500 the last of this month, the result of a suit in a will case that had been pending for some time.

## Matters Personal and Impersonal.

The annual sleigh-drive of the Halifax Dispensary staff was held on the 15th inst. and was voted a most pronounced success. The dinner was held at Hotel Bellevue, Bedford, and the toast list brought out several stars in oratorical ability.

Dr. Andrew Halliday returned from Gravenhurst last month, fortunately somewhat improved in health. He is now continuing the open air treatment near Shubenacadie.

Dr. A. C. Hawkins has been appointed medical examiner of immigrants at this port and not Dr. C. D. Murray as stated in last issue.

Dr. J. G. McDougall, of Amherst, has presented Dr. C. A. McQueen with a magnificent solitaire diamond ring in acknowledgement of Dr. McQueen's services during Dr. McDougall's severe illness in the early part of last year.

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### Notes.

#### THE VALUE OF GUDE'S PEPTO-MANGAN IN ANÆMIA.

BY DR. ENRIQUE DIAGO, HAVANA, SUPERINTENDENT OF HOSPITAL NO. 1, HAVANA, CUBA, AND DR. JOSE F. BENITEZ, HAVANA, CHIEF OF THE LABORATORY, HOSPITAL NO. 1, HAVANA, CUBA.

*Translated from the "Progreso Medico," Havana, April, 1902.*

Anæmia is a very common disease in this country (Cuba), and consequently one against which the physician is often obliged to contend in the practice of his art. While the use of the ordinary iron preparations often give all the effects that could be desired, yet it usually produces a condition which may be regarded as a secondary disease—constipation. In looking about for a preparation which would not present this very serious disadvantage, which cannot always be counteracted by the coincident administration of laxatives, we came across Gude's Pepto-Mangan, which, according to the published statements of many clinicians, seemed to us a remedy worth trial in a large series of cases. Accordingly, we obtained a sufficient supply of this preparation for our hospital, and began to treat all our cases of anæmia, in which iron was indicated, with Gude's Pepto-Mangan.

In presenting now the results of our observations with this pharmaceutical compound, we may say at once that our expectations were more than realized, when we noted its efficiency in combating the disease, and its perfect palatability and freedom from constipating after effects.

One of us, Dr. Benitez, chief of the laboratory of the hospital, undertook the task of keeping minute records of all the cases observed, including a record of the amount of hæmoglobin and of the number of the red blood cells, both before and after the treatment. For the purpose of illustration, we relate briefly six cases, which show conclusively the effects of Gude's Pepto-Mangan on persons with anæmia, and prove without doubt that the administration of this remedy is connected with none of the disadvantages and discomforts attending the use of the ordinary preparations of iron.

Case I.—N. G., aged twenty-six years, was admitted to the hospital, suffering from loss of nutrition, emaciation, pallor of the skin and mucous membranes, loss of memory,

anorexia, mental depression,—in a word, from all the typical symptoms of anæmia. This condition was traced in his case to a chronic malaria, from which the patient had been suffering for a long time. The patient weighed only 102 pounds at the time of admission.

Pepto-Mangan (Gude) was given in doses of two tablespoonfuls twice daily, at breakfast and at dinner respectively, with some cinchona wine. The first blood examination showed 2,400,000 red blood corpuscles c. m., by the Thoma-Zeiss method. Ten days after the beginning of the treatment, this patient, who had been so extremely pale when he entered, began to improve as regards the color of his cheeks and general appearance. His general well-being was so marked that he spoke with pleasure of the marked improvement in his condition which had taken place since he had been taking the new remedy at our hospital. In these ten days he had gained five pounds in weight and was able to walk around the ward without the lassitude which he had felt when he was admitted. The blood was examined a second time, showing an increase of 300,000 red blood cells. The patient was discharged cured after fifty days' treatment, weighing 130 pounds and with a blood-count indicating 2,800,000 red blood cells c. m.

Case II.—Mrs. C. D., aged 34 years, who gave a history of miscarriage, was admitted with the symptoms of anæmia, secondary to the loss of blood occasioned by the accident mentioned. The chief symptoms were emaciation, loss of strength, and gastrointestinal disturbances. She weighed only ninety pounds when she entered the hospital, and her blood showed a marked diminution in the amount of hæmoglobin, and only 2,300,000 red blood cells to the cubic millimeter.

Gude's Pepto-Mangan was prescribed in the same doses as in the preceding case, and all went well until the tenth day, when the patient of her own accord, in order to facilitate the cure, and to accelerate the recovery, took five tablespoonfuls of the preparation during the day, causing a slight disorder of the stomach. The administration of Pepto-Mangan was thereupon discontinued, and tablets of bismuth and salol, together with a purgative were given. Five days later, the Pepto-Mangan was resumed, at first in doses of two teaspoonfuls, and two days later in doses of two tablespoonfuls. The further course of the treatment went on without any mishap, and the patient recovered completely. On leaving the hospital the hæmoglobin was found normal, and the number of red blood cells was found to have increased to 3,500,000 c. m., while the patient's weight had increased twenty-one pounds within fifty days.

Case III.—Mr. M. D., aged 26 years, who had suffered during the preceding month from an attack of acute articular rheumatism involving a number of joints, entered the hospital complaining of the symptoms of anæmia. He had the appearance of a convalescent, with pale skin and mucous membranes, fatigue in walking, emaciation, etc. There was œdema about the ankles, but no valvular lesion in the heart, and there were in addition, absence of appetite, insomnia, functional depression of the genital apparatus, and dyspepsia. The patient weighed only 92 pounds, and his blood when examined showed a decrease in the amount of hæmoglobin and only 2,500,000 red blood cells c. m. At the end of fifteen days' treatment, which consisted of the administration of two tablespoonfuls of Pepto-Mangan (Gude) at breakfast, of the same amount at dinner and of an additional tablespoonful at noon, the patient had gained a great deal of strength, his pallor had almost disappeared, the hæmoglobin had increased and reached its normal quantity, and the red blood cells had increased to 3,200,000 c. m. The patient was therefore discharged completely cured at the end of forty days after admission.

Case IV.—Mr. R. G., aged 42 years, who did not show any signs of organic disease, and who presented no characteristics of a gouty or lithæmic diathesis, was admitted to the hospital in a greatly disturbed state of mind on account of attacks of vertigo, palpitation of the heart, extreme weakness, and various erratic pains in the muscles. He gave a history of a recent attack of influenza, during which his nervous symptoms had become intensified. He had not had a very marked rise of temperature, and the respiratory passages were scarcely affected during this attack, but there were severe pains in the back and joints, and an intense headache. The examination of the blood showed the presence of 3,000,000 red blood cells c. m., and the patient was found to weigh only 110 pounds.

He was placed exclusively on Pepto-Mangan (Gude) treatment. Twenty days later, the pains had ceased; he ate well; his weight had increased to the extent of four pounds, and the red blood corpuscles had increased in number by 200,000. Thirty days after admission he was discharged cured.

Case V.—Miss C. P., aged 16 years, was admitted to the hospital with a very pale skin and a deficient muscular and adipose development. Her menstruation had become irregular, and she had suffered from various nervous disturbances. Her growth had not kept in harmony with her nutrition, and she presented the characteristics of chloroanæmia, as frequently seen in Cuban girls,—namely, accompanied by a series of neurasthenic symptoms. She weighed only 87 pounds, and the blood count showed only 1,800,000 red blood corpuscles c. m. After ten days' treatment, the number of red blood corpuscles increased by 500,000, and the weight of the patient by three pounds. Twenty six days after admission, she was removed from the hospital by her relatives, and on discharge her weight was 94 pounds.

Case VI.—Mr. G. F., aged 38, whose previous history was negative, and who had not suffered from any severe illness shortly before admission, entered complaining of loss of flesh and strength, decrease of normal weight and extraordinary fatigue after his usual work. He attributed these symptoms to transgressions of hygienic rules. The first blood examination showed 2,600,000 red blood cells c. m. The patient weighed 106 pounds on admission. Thirty-six days later, after having been under treatment with Pepto-Mangan (Gude) during the entire period, he was discharged at his own request. He had increased eleven pounds in weight and his red corpuscles numbered 2,850,000 c. m. (an increase of 250,000). He went back to his usual work without experiencing any unusual fatigue.

To sum up the results obtained with the employment of Pepto-Mangan (Gude) in the treatment of anæmias, we may say conscientiously, that it is the best remedy we know of for this purpose, and that we do not hesitate to commend it to the medical profession at large, and especially to our confreres in Cuba, as an iron preparation that possesses all the advantages that can be demanded of such a remedy and none of the disadvantages that are characteristic of other iron preparations. We would especially emphasize also that Pepto-Mangan (Gude) is very pleasant to the taste, and is most easily taken by patients of all ages and with the most delicate digestions.

HAVANA, March, 1902.

A MOST SEASONABLE SUGGESTION.—As the time is fast approaching when there is a demand for cough remedies, it will not be amiss to present a suggestion and a good remedy. In place of opiates which always dry up expectoration, disturb digestion, cause constipation, and render the patient uncomfortable and drowsy, it is desirable to employ the most efficient and popular cough sedative of the present day, namely: Antikamnia and Heroin Tablets. This remedy relieves cough by its soothing effect upon the air-passages, but does not interfere with expectoration, and, in fact, renders it easier by stimulating the respiratory muscles. Only a very small dose, one tablet, every one, two or three hours, for adults, is required to produce a satisfactory result.

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L. G. ARMSTRONG, M. D.

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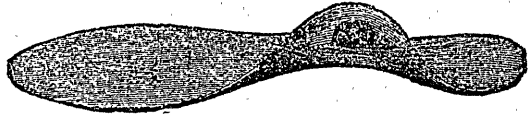
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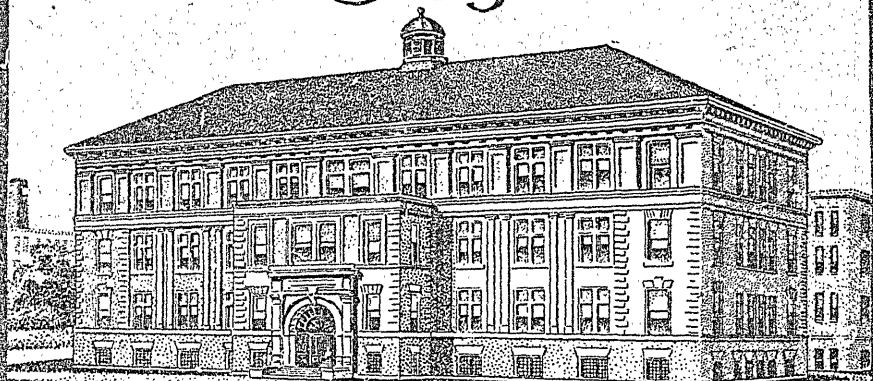
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