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Original Articles

CASE OF ENTERO-UTERINE ANUS.*

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Report of a case (with specimen) of an entero-uterine anus following an abortion, treated successfully by hysterectomy and resection of bowel.

Mrs. H., multipara, aged 41 years, was referred to me by Dr. Gowan, under whose care she had recently come, after having suffered for many weeks. I saw her on August 10th, 1909, in consultation with the doctor, at St. Michael's Hospital.

Late in May, or early in June, within the first or second month of pregnancy, she had an abortion, following which there developed an entero-uterine anus. Presumably the uterus was punctured during the induction of abortion or during later manipulations, and then the intestine was either dragged in through the opening or it herniated through. At any rate a few days later the fecal matter discharged from the uterus into the vagina, in its entirety, there being none whatever passed per rectum.

Meanwhile the patient presented signs of pelvic peritonitis and was very ill. Later the peritonitis subsided, but she gradually became emaciated. The discharge was of fluid consistence and so irritating that excoriation existed all over the perineum and half way down the inner sides of the thighs, making her distress nothing short of terrible.

*Read at a meeting of the Surgical Section of the Academy of Medicine, Toronto, November 16th, 1909.

To say the least, her condition was not encouraging when one contemplated the radical procedures necessary to restore her to health.

On examination with the speculum one could see the fluid fecal matter escaping from the eroded cervix. Bimanual examination revealed a matting together, in mass formation, of the uterus and all the structures in the right half of the pelvis. The body of the uterus was somewhat enlarged, though fairly firm and apparently empty. The fundus seemed free, but the lower segment was quite fixed. By rectum the mass could be felt immediately above the right utero-sacral ligament. There was no apparent involvement of the rectal wall.

The conclusion arrived at was that the opening was between the small intestine, probably low down, as the emaciation was not extreme considering the time elapsed, and the lower segment of the uterine body.

This probable situation, together with a consideration of various factors, such as the patient's age, the history of peritonitis following the accident, the probable density of the adhesions, the time elapsed, the infected condition of the uterus, and the difficulty of dealing effectively with the tear in the uterus, which, besides being infected, was not recent, led one to decide upon the operation of which the various steps, as performed on August 11th, were as follows:

1. Preparation of the abdomen.
2. Cleansing the vagina with green soap and water and solution of bichloride of mercury (1 in 2000).
3. Closing the cervix with silk sutures to prevent the escape of any fecal matter.
4. Re-cleansing the vagina and cervix thoroughly.
5. Vaginal section into Douglas' pouch and division of vaginal vault all around the cervix and partial separation of the bladder from the uterus.
6. Change from perineal to abdominal position, opening abdomen in middle line and change to Trendelenburg position.
7. Examination of pelvic contents, revealing a conglomerated mass of omentum, intestines, uterus, tube and ovary in the right half of the cavity, the left half being fairly normal.
8. Packing away free coils of intestine with sterile gauze strips so as to expose the uterus and left adnexa.
9. Ligation of the left ovarian and uterine arteries with section of the left round and broad ligaments from above downward into the vagina.
10. Tilting the uterus and mass to the right and pulling it up, and ligation of the right uterine and ovarian arteries with section of the right round and broad ligaments from the vagina upward.
11. Lifting the uterus, tubes, ovaries and the conglomerated mass up through the abdominal incision.
12. Packing the pelvis with strip gauze,

the first end being pushed into the vagina for removal later by that route. 13. Relief of adhesions and the isolation of the intestinal loop entering the uterus and protection of the general peritoneal cavity by more gauze strips. (The loop was not far removed from the ileo-caecal valve, being a part of the ileum.) 14. Resection of the affected loop and anastomosis by silk suturing. As the proximal end was much larger than the collapsed, unused, distal end, the latter was closed and a lateral opening made into it to fit the proximal end. The loop removed was about ten inches in length. 15. Removal of gauze strips and change to flat abdominal position. 16. Closure of abdominal wound after a small wick of gauze was carried through a stab wound in the right iliac region to the region of the anastomosis, but not in contact with the sutures. 17. Dry dressings.

The operation was well borne, the pulse being about eighty on completion. I was assisted by Dr. Gowan and the house surgeon, Dr. Parker, and was indebted to Dr. R. J. MacMillan for most excellent, though long and tedious anesthesia.

So far as the surgical after-condition was concerned, there was little to be noted except a mild local infection, as evidenced by the escape of some foul-smelling pus from the small stab drain and also from the vagina two or three days after the packing was removed. This occurred about the end of the first week, but at no time was there any sign of a fecal leak.

There was no trouble from vomiting nor abdominal distress, and feeding was commenced by mouth after twenty-four hours. No purgative was found to be necessary. The bowels moved of their own accord on the fifth day, and after that daily without more assistance than an occasional enema, the tongue meanwhile remaining quite clean and the appetite good.

The physical condition improved so rapidly that she was able to go to her home in the country on September 10th, just one month after operation.

In spite of all this an unfortunate termination was barely escaped. On August 27th, that is, sixteen days after operation, after three or four sleepless nights owing to intense heat and somewhat noisy surroundings, she became despondent and suddenly leaped out of bed and into the open window. The screams of another patient who saw her brought the nurse hastily in and just in time to catch her by the ankle and hold her until assistance arrived. Following this she was removed to a small private hospital, where she improved rapidly, though at the time of her discharge she was still somewhat despondent. Later reports, however, showed that complete recovery had ensued.

The specimen showed the intestinal wall firmly embedded in the wall of the uterus on the right posterior aspect, about three-eighths of an inch above the junction of the body and the cervix. When fresh the anus had a diameter of about half an inch. The proximal end of the loop was moderately dilated and the distal end quite collapsed. The outer end of the right Fallopian tube was enlarged and firmly adherent to the loop at the junction of the two ends. The right ovary was also adherent to the loop.

On careful inspection it was found that there was a complete solution of continuity between the proximal and distal ends, that the part embedded in the uterine wall was altogether proximal, and that the distal end was completely closed by adhesion to the side of the proximal end and the line of junction was protected by the adherent tube and ovary.

Under the circumstances attending the case any attempt to repair the intestine without removing the uterus would have been attended by extreme difficulty and danger. The operation performed afforded one the power of absolutely preventing any escape of fecal matter and reducing the risk of infection to a minimum. Had the case come under observation immediately after the accident the repair of the intestine might have been more easily accomplished and the tear in the uterus successfully treated by suturing or by drainage.

417 Bloor Street West, Toronto.

A CASE OF INFECTION OF AN INDEFINITE NATURE IN WHICH THE ADMINISTRATION OF SODIUM SALICYLATE APPEARED TO HAVE A BENEFICIAL ACTION.

BY GRAHAM CHAMBERS, B.A., M.B.,

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The object of this paper is to call attention to the possible value of salicylates in the treatment of acute infectious fevers other than rheumatism. At the outset I may state that I recently have used sodium salicylate in the treatment of several kinds of infectious fevers, with apparent benefit in some. This seems to me to be not an unnatural result, believing, as I do, that the curative action of salicylates in acute rheumatism, a disease which is no doubt caused by bacterium, is due to the action of the drug as an internal antiseptic. I might call attention to the fact that in disease caused by the protozoa arsenical preparations are of therapeutic value in, at least, three, namely, sleeping sickness, syphilis, and malaria. This suggested to me that in the therapy of diseases caused by bacteria, salicylates may be of value in more than one, and the observations which I have made on the subject appear to support this view. I am aware that it is usually difficult to estimate the value of any remedial agent in the treatment of an infectious fever. Nevertheless, if the treatment be rational, and the results apparently favorable, one is justified in calling attention to the observation. The following is a case in point:

J. D., age 24, civil engineer, was admitted to the Presbyterian Hospital, New York, Jan. 5th, 1911, under the care of Dr. Gilman Thompson.

The patient complained of weakness, drowsiness, headache, loss of appetite and feverishness. These symptoms developed on Jan. 2nd, but the patient had been ailing since Dec. 1st, 1910.

During the last six years the patient has worked hard and led a strenuous life. Since January, 1910, he has been a clerk in an office. His habits have been fairly regular. He uses tobacco, but no alcohol.

The patient has had no illness of importance until the autumn of 1909, when he had a fever, lasting five weeks, which was diag-

nosed typhoid, although he was only confined to bed for two weeks. During 1910 his health was only fair, suffering, from time to time, from headache.

Present Condition.—The temperature is 103° F., pulse 120, patient apathetic, spleen palpable and firm, and there is no evidence of cardiac or respiratory disease.

Blood culture, Widal reaction, feces for typhoid, von Pirquet test, sputum for tubercle bacillus, and skiagram of chest are negative, and the analysis of urine gives no abnormal signs.

Blood shows: R. B. C.	4036000
Hb.	78%
W. B. C.	7200
Dif. Count—Poly.	55%
Small L.	28%
Large L.	13%
Trans.	3%

Jan. 14th.—Since Jan. 5th the patient has gradually improved. During this period several Widal tests and blood cultures have been made with negative results, and the blood picture has shown very little change.

Jan. 16th.—The patient complains of precordial pain, frontal headache and photophobia. The temp. has arisen to 103° F. and pulse to 100. Widal test and blood cultures negative, spleen palpable, no abnormal findings in the urine.

Jan. 20th.—Patient had a chill this afternoon, lasting about twenty minutes. The temperature ranges from 101 to 102° F. a.m., and 103 to 104° F., p.m. Pulse averages 110. The feces are negative for typhoid, and Widal reaction is negative. The W. B. C. count has risen to 17,800, only 31% of which are polymorphonuclears.

Jan. 22nd.—Patient is more apathetic; the cheeks are flushed, lips dry, and tongue dry, with red edges and brownish coating on the dorsum. Thirst is increased. A number of petechiae are present on the chest. A rough systolic murmur is present at the mitral and aortic areas, and has its P. M. I. at the third interspace in the left parasternal line. The cardiac sounds are strong and the pulse regular, with good volume and tension.

Jan. 25th.—The patient is more apathetic and delirious. There is severe precordial pain, made worse by swallowing cold fluids or jolting the bed, and especially by coughing. The petechiae are disappearing. The spleen is not palpable. There is a cough and a slight amount of tenacious, blood-streaked sputum, which, on examination is shown to contain no tubercle bacilli. The temperature ranges 102 to 104° F., and pulse 116 to 120. The urine shows a

trace of albumin, but no casts. The Wassermann reaction is negative. The W. B. C. is 6100, of which 55.5% are polymorphonuclears.

Jan. 27th.—Patient to-day is drowsy, but somewhat irritable and easily excited. Temperature ranges from 101 to 103.4° F. and pulse from 120 to 128. Patient brought to Toronto General Hospital.

Jan. 28th.—Patient lies on his back or right side, complaining of severe præcordial pain with sharp exacerbations brought on by the patient coughing, swallowing cold fluids, attempting to move, or even by anyone walking across the floor. The cheeks are flushed, lips dry, thirst increased, and the abdomen moderately distended. There is a feeling of fulness and dull pain in the epigastrium and left hypochondrium, increased by attempt to palpate the spleen, which cannot be felt. The anterior limit of splenic dulness is in the left mid-axillary line. There is superficial tenderness over the præcordia, so that the weight of the bedclothes cannot be borne. The temperature is 100.4° F., pulse 112. Ears normal. Eyes normal, except for a slight degree of myopia. The urine contains acetone and a trace of albumin. The Russo test is negative. Systolic blood pressure, 122; diastolic, 95; R.B.C., 5,300,000. No plasmodium.

Hb.	87%
W.B.C.	9930.
Dif. Count—Poly.	64.7%
Small L.	32%
Large L.	2.5%
Eosin.	6%
Trans.	2%

Blood cultures negative. There is a diffuse pulsation in the 3rd, 4th and 5th intercostal spaces of the left side, near the sternum. H. A. B. is inside the nipple line, and left limit of deep cardiac dulness extends to 4 $\frac{3}{4}$ in. from the mid-sternal line in the fifth interspace. The heart sounds are loud. At the mitral area the first sound is loud, short and rough, and followed by a murmur which is not heard all through systole, and is not propagated into the axilla or neck. The second sound is loud, short and sharp at the apex, and exaggerated at the pulmonary area.

Jan. 29th.—80 gr. of sodium salicylate to be given in 24 hours. Pain somewhat relieved.

Jan. 30.—Salicylate increased to 120 gr. in 24 hours. Patient free from pain except on movement. Sleeps well, but perspires freely at night. Temperature, a.m., 100; p.m., 98.4° F.; pulse, 90.

Jan. 31st—Feb. 7th.—120—160 gr. of sodium salicylate given

every 24 hours without evidence of toxic action. Patient is improving. Temperature normal, except a slight rise on Feb. 1st.

Feb. 8th—12th.—70 to 100 gr. of drug in 24 hours. Temperature normal. Salicylate discontinued on the 12th.

Feb. 13th—14th.—Patient does not feel so well. Maximum temperature 99.4.

Feb. 15th—25th.—80 to 120 gr. of sodium salicylate in 24 hours. General improvement. Temperature normal. Drug discontinued on the 25th.

March 10th.—Patient complains of sharp pain at the level of the 7th rib in the right parasternal line, only present at the end of inspiration, and more severe in diaphragmatic breathing than thoracic. A friction rub can be heard at the end of inspiration. There is also stiffness and an aching pain in the muscles of the right side of the face and neck. Maximum temperature 99.3. Sodium salicylate, gr. 80 per day, given.

March 12th.—Patient free from pain. Temperature normal. Given soft diet.

March 18th.—Salicylate discontinued.

April 3rd.—The temperature has been normal for three weeks. Pulse, 80 to 90. Patient has gained in weight and walks about apparently well. The cardiac dullness extends four inches from mid-sternal line. The first sound is somewhat rough, with an ending not well defined.

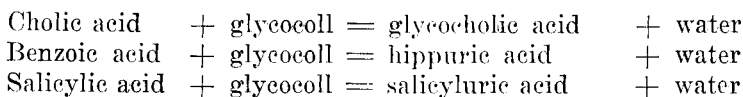
The most interesting feature of this case is the apparently curative action of sodium salicylate. This seemed more evident to us than the inference one draws from reading the clinical history. The history indicates that the patient suffered from an infection of somewhat indefinite nature. During the early part of his illness the character of the fever, the enlargement of the spleen, etc., suggested the presence of typhoid, although the examination of the blood and feces gave no support to this diagnosis. With the elevation of the temperature on Jan. 16th—24th, accompanied by leucocytosis, roughening of the first cardiac sound, apical systolic murmur, and petechiae, the tentative diagnosis should be, I think, ulcerative endocarditis, and such was the opinion of Dr. Gilman Thompson, under whose care the patient was at the time. Again the blood and other laboratory tests failed to clear up the nature of the disease. The appearance on Jan. 28th of praecordial distress, made worse by coughing or swallowing, was additional evidence of cardiac disease.

At the time of the return of the patient to Toronto, examinations were made by several of my colleagues and myself, and we were of the opinion that the morbid condition was sepsis, with endocardial

and myocardial manifestations. The pain on swallowing suggested the presence of pericarditis, but we were unable to find any physical sign of it. I may add that we were agreed that the patient was not suffering from typhoid fever. At no time during the course of the disease was there evidence of bone or joint infection.

I shall conclude this report with a few remarks on the pharmacology of salicylic acid. I shall also mention some observations on the subject which I made four years ago (*Canadian Practitioner*, October, 1907).

When salicylic is given internally it combines in part with glycocholic acid, forming salicyluric acid, a compound analogous in composition to glycocholic acid and hippuric acid. This may be illustrated as follows:



In my experiments I showed that glycocholic was much less toxic than cholic acid. This observation, as well as the fact that hippuric acid is non-toxic or of very slight toxicity, suggests to one that salicyluric is less toxic than salicylic acid. This was shown by Stockman to be the case, and my experiments confirmed his views. We found that salicyluric acid had very little antiseptic action and had very little effect on the fever of acute rheumatism. In my experiments I also showed that the proportion of the salicylic acid which appeared in the urine as salicyluric acid (combined salicylic acid) varied with the dose. With a dosage of 60 grains a day, nearly all the salicylic acid was excreted as salicyluric acid; and with larger dosages the proportion of "combined" salicylic acid diminished. In other words, the larger the dose the more uncombined salicylic acid appears in the urine. This appears to me to have an important bearing on the pharmacology of salicylic acid, because, if salicyluric acid is not wholly formed in the kidney, which is probable, then the larger the dose of the drug the more uncombined salicylic acid is present in the blood and tissues and the greater the antiseptic action. If, for instance, it were shown that the combination of salicylic acid and glycocholic takes place in the liver, which is not improbable, then the exhibition of 60 grains of sodium salicylate a day would exercise very little antiseptic action, because, as I have already mentioned, with this dosage almost all the drug becomes converted to salicyluric acid. This is, I believe, in accordance with clinical experience, because salicylic acid appears only to be of special value in acute rheumatism when exhibited in large doses, say 100 to 300 grains a day.

The mode of administration of salicylic acid deserves attention. In the exhibition of the drug I am accustomed to use sodium salicylate dissolved in water containing a bitter, such as tincture of orange peel. I rarely add bicarbonate of sodium, which is advocated by many, for the following reasons: (1) Salicylic acid, in vitro, is an active antiseptic, whereas sodium salicylate is not. (2) Sodium salicylate in large doses appears to act as an internal antiseptic in acute rheumatism, and it is possible that the exhibition of bicarbonate of sodium along with the salicylate may lessen the antiseptic action of the latter, for, according to the theory of Binz, the internal antiseptic action of sodium salicylate is due to the neutralization of the base of the drug by the carbon dioxide of the blood, thus setting free salicylic acid. (3) The drug, dissolved in water, with a bitter as a corrective, is generally well borne.

It is for these reasons that I do not generally use baking soda as a corrective for sodium salicylate. I may state that the only cases in which I have used it are patients in whom the administration of the drug produces gastric distress, which, I believe, is usually due to the rapid separation of salicylic acid from the salicylate. In these cases the giving of baking soda tends to neutralize the acid of the gastric juice and to a certain extent check the irritative action of the drug. Whether it actually interferes with the action of sodium salicylate as an internal antiseptic I am unable to state. If it is true, as is stated by some physiologists, that it is impossible in a person with healthy kidneys to render the blood alkaline or increase its alkalinity, by the administration of alkalies then the exhibition of bicarbonate of sodium would do no harm.

ECLAMPSIA.

Heinze (*Archiv. für Gyn.*) gives the following method of treatment: 1. Rapid artificial delivery without the co-operation of uterine contractions; vaginal hysterectomy or abdominal Cesarean section if cervix and os are not dilated; forceps and version if sufficiently dilated. 2. Curetting the uterus if eclampsia persists after delivery, even if the placenta has apparently been removed. 3. Decapsulation of the kidneys if the eclampsia still persists and there are signs of serious injury to the kidney. 4. General measures, including venesection, proctolysis, the Jacquet pack, diuretics, heart stimulants, artificial respiration and inhalation of oxygen.

INSANITY.

BY R. H. ROBINSON, M.D., TORONTO.

Physiology is the knowledge of the body; psychology is the knowledge of the spirit; psuchology is the knowledge of the soul.

Medical science and the Bible, when properly understood, are in perfect accord one with the other: "Faith and works going together." "Without me ye can do nothing," and "with God all things are possible to him that believeth." So that in proportion to faith and works going together is God's blessing bestowed. "Faith without works is dead"; and therefore God expects of us that we shall intelligently be able to diagnose and prescribe the most judicious remedies for the diseased condition we meet, and then ask and expect God's blessing to follow according to His will. Physiology implies that much knowledge of the body, whether it be exemplified or not, and in order to obtain the best results the body must be kept free from habits; such habits as tobacco, morphine, cocaine, chloral, liquor, and many others. No matter what binds and controls the human will must be given up. "Purge out therefore the old leaven that ye may be a new lump." "For ye are the temple of the living God." "If any man defile the temple of God, him shall God destroy," *i.e.*, God will let him destroy himself if he chooses that course. The physician's duty is to help him not to do so and assist him to regain his health again, if he has. Medical science must be true to both body and soul to keep the mind right. "No idolator shall enter the kingdom of heaven," makes it obligatory on the part of the physician to sound a note of warning, and if it were not done by him it would often not be done at all, as sometimes there is not much time afforded to call a halt and seek forgiveness.

Psychology includes the knowledge of the mind. When Daniel had the prescience given him as the result of refusing to be defiled by the king's meat and drink, and showed that abstemiousness necessary to develop a clear intellect by living on pulse and water, he exemplified that rational self-denial, while a student at college, and that under the most affluent surroundings provided by the King for all his college students, "in whom was no blemish, but well favored, and skilful in all wisdom, and cunning in knowledge, and understanding science," materialists: but, in addition, he prayed

three times a day for divine wisdom, while the other students, with the exception of Daniel's three friends, sought to develop intellect by the very doubtful methods of self-gratification with a modicum of study thrown in, as some do even now. Liquor and gluttony are never calculated to develop good health and intellect, and what materialistic knowledge they did derive was not honored of God as the most intelligent, and the most intelligent is often required to save some soul and body.

In Daniel was an excellent spirit, and knowledge and understanding, interpreting of dreams, and showing of hard sentences, and dissolving of doubts. Now let Daniel be called, and he showed himself under God equal to the occasion. He had faith in God because he had not defiled himself with the king's meat and drink, and God, to whom all power belongs, honored his fidelity, and he is the same merciful God now. Is insanity due to physical changes in the system? was asked at a clinic recently at one of our hospitals for the insane, and the lecturer (Dr. J.) stated that in four-fifths of all the cases of insanity *no* medical evidence of insanity more than in four-fifths outside the asylum could be determined, and that even in the other fifth there might be a tumor on the brain and yet be quite rational, only suffer pain. The next question was: Wherein does insanity lie? Is it a disease of the soul? The same lecturer's reply was, "Don't know anything about it." The question, no doubt, before the clinic was not looked upon as being strictly according to medical science by some present, while by others it was highly commended. The burden of proof went to show that insanity in most cases is a disease of the soul, that the science of psychology is absolutely borne out by the 107th Psalm, 17-20, and how to deal with it when diseased. No pharmacologist can heal the soul with drugs. "Fools because of their transgressions and because of their iniquities are afflicted: their soul abhorreth all manner of meat; (good advice from father or mother, husband or wife), and they draw near unto the gates of death. Then they cry unto the Lord in their trouble, and He saveth them out of their distresses. He *sent His word* and healed them, and delivered them from their destructions." Because the sickness was in their souls. Matt. 8, 16, says: "And He cast out the spirits with His word." "Lo, bound these many years," yet capable of being delivered by the truth, and there are no end of illustrations not infrequently coming before the Medical Superintendent. Someone has given them the truth—the entrance of which gave light, and once more the mind is free to discern right from wrong. That there are predisposing causes in the physical, such as exhausted nerve energy, harmful habits, alcoholism, syphilis and many other

causes, but we also see hundreds of men and women suffering in the same way outside who are regarded as perfectly sane, and therefore too much stress should not be placed on these accessories or contributing causes, when the tension string snaps and the mind is gone. Insanity *per se* is a disease of the soul, and both soul and body must be treated by their respective remedies, faith and works going together to complete the cure. It would be manifestly unscientific to kneel down and pray God to heal pneumonia or spinal meningitis without using the means to remove the congested conditions. So, too, in insanity, where there are physical complications, water packs, judicious medication, rest in bed and all other helps should go hand in hand with the declaration of God's word and prayer. Faith and works going together every time. There is perhaps no greater power, apart from God's word and prayer, than sanctified music, and if one might be permitted to suggest, no matter how often the piano comes in for some demented patient's revenge, for the sake of the other less violent patients it should next day be put in order as the clocks are by the civic watchmaker in the City Hall. On Christmas eve the writer and his wife were invited to the Christmas eve concert at the Hospital for Insane, Queen Street West, given by the Medical Superintendent, Dr. Clarke, and his gifted orchestra. To see the Medical Superintendent over a thousand patients wielding the baton to their supreme delight was to us a real pleasure and an assurance of success. And next morning about 5 a.m. the writer was awakened out of a three hours' sleep—as, after reaching home about midnight, Santa Claus had to be investigated before retiring—and right before us was "Memory gone how sad the fact," the recollection of the sad condition of some of those in the wards led us to get up and, while not given to poetry, this is what by the favor of kind Providence, came:

YULE-TIDE.

At Queen Street Asylum, 1910.

Memory, how sweet thou art,
When gone how sad the heart;
That vacant look, that vacant stare,
That demonstrates no "image" there.
The body, mind and soul, thy laws transgressed,
And in asylum walls they are obsessed.
Then suddenly that light doth shine,
That makes them once again divine,
And homeward rushes every thought,
To Father, Mother, Sister, "Tot";

And only that the Christmas cheer
 Brings hope to them for the coming year,
 Fond memory would again be blank
 And they once more a hopeless crank,
 But Dr. Clarke and his orchestra try
 To carry them back to the days gone by,
 Of fireside lays
 And golden days,
 When at Yule-tide they used to sing,
 Glory be to the New-born King;
 And thus once more they take a stand
 To trust in God, at His command,
 And never falter, till they are free
 And at home once more for a Christmas tree.

163 Wilton Ave., Toronto.

WHOOPING COUGH.

Ecroyd (*Med. Rec.*) writes that one of his patients has accidentally alighted on a cure for whooping cough. While carrying on experiments in his laboratory, at the time suffering for three weeks from the disease, hydrogen was generated. At once his trouble was ameliorated, the mucus disappeared, and when the inhalation was repeated a like result followed. A younger sister with a more severe attack also experienced immediate relief.

PERSISTING HICCOUGH.

Kaungiesser (*Med. Klin. Berlin.*) reports a case following an attack of influenza. He first tried hypodermic of atropine sulphate, recently strongly recommended for this condition, but with no effect. After an hour and a quarter the patient was given 5 gms. citric acid and 5 gms. sod. bicarb., both in separate solutions, with resulting distension of stomach and pressure on the diaphragm from below. The procedure was a complete success, the hiccough ceasing at once.

Medicine

GRAHAM CHAMBERS, R. J. DWYER, GOLDWIN HOWLAND,
GEO. W. ROSS, WM. D. YOUNG.

The Interpretation of Pain and the Dysesthesias. CHARLES L. DANA. *J. A. M. A.*

This is a magnificent piece of work and invaluable to any interested reader. Let me briefly epitomize the article:

Psychology has shown that all mental activities are accompanied by neural activities. There is no imaginary pain, for there will be a corresponding morbid neural condition. There are no functional psychoses or neuroses. Consider the subject of pain in relation to the seat of disease.

Paresthesias and burning are symptomatic of nerve terminal affections; cramping pains point to the muscular and visceral nerve endings; aching and throbbing sensations are typical of nerve trunk disease; sharp, shooting pains occur in ganglion affections; tract and cord disease present numbness and paresthesias; thalamic lesions have smarting sensations; while, lastly, cortical affections are painless. But psychic pains are least understood and must be described in detail:

Dana divides the psychoneuroses into four groups, namely: Neurasthenics, psychasthenics, manic depressives, constitutional inferiors with hypersensitiveness.

Psychasthenics describe their pain with enthusiasm, in a tumultuous flow of words. The pains are fairly definite, such as arm neuralgias, head pains, fixed pains over ovary, etc., and, while usually due at the beginning to some definite sensory irritation, are emphasized and glorified by the psychasthenic condition. As time passes they become what is termed attention pains, and the local process may have long disappeared.

Neurasthenics have pains usually due to some auto-toxemia, to tired and exhausted muscles and nerves, but in time they may become attention pains.

Among the depressives the sensations, which usually affect the protopathic rather than the epicritic types, are real to the patient. "Pains in knees for 15 years," "Boiling in stomach," "Cold or

stinging sensations on back," "Disagreeable and indefinite sensations about the hands and feet." They are conditions which usually do not affect consciousness, but, owing to his depression, he both becomes hypersensitive to these stimuli and his threshold of consciousness is lowered.

The pains are bizarre and characteristic and form for each patient a symptom complex.

Dana has opened out a splendid field for the observant physician; begin and take an interest in the multitudinous pains of your psychoneurotic patients.

G. W. H.

The Scientific Evidence of the Possibility of Intestinal Antisepsis.

By HORTIO C. WOOD, JR., M.D. *Therapeutic Gazette.*

Can the bowel be rendered aseptic? This is a most important question, to which Dr. Wood replies negatively, but claims it is possible to greatly reduce bacterial growth, especially by beta naphthol and creosote. Two factors are of importance, namely: (1) Can an intestinal antiseptic in non-toxic dose influence bacteria in a volume of fluid equal to that of the bowel? and (2) Will such a drug remain sufficiently long in the intestines to perform this effect?

If one admits the bowel content at 4,000 cc., it would require an ounce of phenol or salicylic acid; so that asepsis is impossible, but mild antisepsis possible. Similarly, no drug remains for a long period in the bowel. Yet some delay sufficiently to allow their antibacterial influence to occur. Gross, however has a special duodenal tube which enters the duodenum and removes the contents from that viscus. Blood droplets may be found on examining the material, and yet more interesting is the fact that on blowing down the tube the patient may be conscious of a slight sensibility. (This fact is of interest to those who deny intestinal sensation.)

Chemical examination for blood was negative in the cases examined by Gross, but the Benzidin test succeeded once where the aloin and guaiac failed. The micro-chemical tests (Teichmann's crystals) were always successful.

G. W. H.

The Diagnosis of Gastric Carcinoma by the Cleavage of Polypeptides. By I. WALKER HALL, M.D. (VICT.), and G. SCOTT WILLIAMSON, L.R.C.P., L.R.C.S. (EDIN.). *The Lancet.*

This new test for cancer originated by Neuland has already been described in this paper. Hall and Williamson advise its use,

and note the following fallacies: Vomits cannot be used as duodenal enzymes are frequently present. Bile points similarly to duodenal regurgitation. Blood vitiates the test, and while this would appear to render the test useless, yet this requires future consideration. The acidity of the gastric contents must be definitely below .18 HCl.

The test, which depends on the breaking up of glycyl-tryptophane by supposedly cancer ferments into tryptophane is hardly on a sound basis yet. The fallacies appear very powerful objections to its use in practice, yet the results in cases require its consideration.

G. W. H.

A Contribution to the Diagnosis of Duodenal Ulcer. By
M. Gross, M.D., New York. *N. Y. M. J.*

Duodenal Ulcer is gradually being recognized as a common disease, and the characteristic symptoms may be wisely recalled.

Alternating gastric health and disease, with shorter or longer intermissions; hunger pain, relief by food; rigidity of rectus; painful area on hammer percussion; pylorospasm, mild icterus; and varying acidity to HCl tests,—are all the common signs.

Absence of blood from the stools is more common than the oft-vaunted presence, which is considered diagnostic. Einhorn lets his patients swallow a miniature bucket, and expects a blood-stained rope to diagnose ulcer and its site; the value of the test lies in its interest rather than the result. (It is a wonder that no gastrologist has advised the patient swallowing a leech in a non-soluble gastric capsule, with a bridle around its head, which, being set free in the duodenum, will forthwith attach itself to the sore area and produce the characteristic pains; and when well filled may be forthwith removed by its reins and its suckers examined for traces of the submucous or muscular fibres of the ulcerated area.)

G. W. H.

Surgery

WALTER McKEOWN, HERBERT A. BRUCE, W. J. O. MALLOCH,
WALLACE A. SCOTT, GEORGE EWART WILSON.

Injury as a Causative Factor in Cancer. WILLIAM B. COLEY.
Annals of Surgery.

In the April number of the *Annals of Surgery* appears a lengthy and most exhaustive paper on this subject.

After pointing out that trauma has been recognized as a causative factor since remote times, and criticizing Phelps' paper in the May issue of last year (wherein the idea was questioned by Phelps, or, in fact, denied), he goes on to give the results of his own extensive experience bearing on this point, and gives the histories in brief of no less than 970 cases, extending over more than twenty years, and the histories of which were taken by himself.

Up to November, 1897, he had had under his care 170 cases of sarcoma, and at that time he wrote in an article for the *Annals of Surgery*: "No clinical feature of the disease had impressed me more strongly than the frequent association of trauma with its early manifestations." Of the 170 cases reported then 46 gave a history of antecedent trauma, and in 9 of the 46 the tumor developed within one week following the injury at the exact site of injury.

Since writing that paper (1897) he has observed 800 additional cases of sarcoma, of which 179 gave a definite history of antecedent trauma.

Of the whole series of 970 cases, antecedent trauma occurred in 225—*i.e.*, in 23 per cent. The tumor developed within the first month after the injury in 117 of the 225 cases (52 per cent.) of typical acute traumatic malignancy, "the reality of which Phelps and others deny."

In using the word cancer he refers to all varieties of neoplasms, not simply to carcinoma. He tabulates his cases in three groups:

- (a) Synopsis of cases published up to 1898.
- (b) Cases of sarcoma with antecedent trauma, personally observed since 1898.
- (c) Cases of carcinoma of the breast associated with antecedent trauma.

Of all cases in the first two classes (225 cases) 105, or 46.66 per cent., originated in the bone, and 120, or 53.33 per cent., occurred in the soft parts.

After giving in detail the various locations of these lesions, both in bone and soft tissues, he gives a most interesting table, showing the interval elapsing between the time of injury and the appearance of the tumor, as follows:

Less than 1 week	50
1 to 2 weeks	13
2 to 4 weeks	54
1 to 2 months	23
2 to 6 months	31
6 to 12 months	15
1 to 2 years	17
2 to 3 years	5
Over 3 years	17

Thus, of 225 cases, 117 (or over 50 per cent.) occurred within one month after injury.

The interval elapsing between the injury and the appearance of the breast tumor (in group c) was as follows:

Less than 1 week	5
2 to 4 weeks	14
1 to 2 months	3
2 to 6 months	8
6 to 12 months	7
1 to 2 years	5
2 to 3 years	3
Over 3 years	7

Or a total of nearly 60 per cent. within six months after the antecedent trauma. Of a series of 250 cases of carcinoma there was a history of antecedent trauma in 82, or 32.8 per cent. In a similar list of cases of carcinoma, observed by Clarence A. McWilliams in the Medical and Surgical Report of the Presbyterian Hospital, on "Statistics of 100 Cases of Cancer of the Breast," it is stated, with reference to trauma as a causative factor: "In our list there is a record on this point in 65 of the patients, of which number 29, or 44.6 per cent., gave the history of a distinct antecedent trauma."

Dr. Coley cites a number of his cases in detail, and assuredly makes out a strong case for trauma as a factor in the causation of neoplastic growth. He says: "Personally I believe

(and more strongly with increasing experience) that all types of malignant tumors are of extrinsic origin. It is not improbable that what we have hitherto included under the vague term of hereditary influence may some day be proven contagion or virus, as has already been done in tuberculosis. . . . Whether we accept the parasitic theory of cancer, or still believe in its intrinsic origin, we must admit that trauma plays a direct and important part in the development of cancer. The argument advanced by some writers that if such were true, all cases of trauma or a larger proportion of cases ought to be followed by cancer, is not logical.

"If fifty people were plunged into an icy pond and only two developed pneumonia, by this same reasoning we might say that, because 48 remained well, the shock and exposure were not causative factors in the development of the pneumonia in the two who contracted it.

"The great argument advanced by Segond against the admissibility of trauma as a causative factor in malignant disease is the absence of any definite knowledge of the condition of the parts prior to the accident.

"In order to have such knowledge scientifically acceptable, he believes that there should be evidence of a medical examination of the locality prior to the injury, and such evidence, he states, is entirely lacking, there being no such cases. My own series of cases supplies this deficiency in at least four instances." He then cites the cases:

1. A case of sarcoma of the humerus; injury producing a fracture of the upper and middle third; X-ray showing absolutely normal structure of bone. Six weeks later X-ray, showing a well-developed sarcoma at the exact site of the fracture.

2. Sarcoma in the groin, starting at the exact site of a hernia incision made four weeks before.

3. Sarcoma starting in the fascia about the external malleolus three weeks after the trauma incident to the stretching and tearing of the fascia and ligaments due to the forcible correction of a flat foot.

4. Sarcoma of femur, in a girl nine years of age, the daughter of a surgeon.

Dr. Coley's paper is to be continued, presumably in the May number of the *Annals*, and should prove of great interest, both by virtue of what we have already read, and also because of the authority which his vast experience in the treatment of malignant disease with the mixed toxins has given him.

Obstetrics

CHAS. J. C. O. HASTINGS, ARTHUR C. HENDRICK.

On Death and Disability Resulting from Childbirth. By H. M. LITTLE, B.A., M.D., Montreal. *Journal of Can. Med. Association.*

The author has availed himself of the clinical material of the Montreal Maternity and also the Gynecological Department (Outdoor) of the Montreal General Hospital.

In the new Montreal Maternity from 1905 to 1909 there were treated some 2,634 patients, and of these 35 died—*i.e.*, 1.33 per cent. mortality. The causes of death were as follows:

Eclampsia	8
Nephritis and Anasarca	3
Vomiting	3
Toxemia	14
Infection	13
Hemorrhage	1
Placenta Praevia	2
Cardiac Diseases	4
Rupture of Uterus	1
Pyelitis	1
Bronchitis	1
<i>i.e.</i> , Deaths from toxemias	40 per cent.
Deaths from infections	37 per cent.
Deaths from other causes	23 per cent.

As regards the three deaths from bronchitis, pyelitis and rupture of the uterus, the patients were past recall before coming under the hospital's care. Of course a ruptured uterus should never occur in these days.

Of the two cases of placenta praevia, one died of thrombosis on the tenth day of an apparently normal puerperium, and the other from concealed hemorrhage. Now, thrombosis always means infection—and it is notorious that all placenta praevias suffer from infection unless the very greatest care be exercised. Hence my advice is to be most rigid in asepsis here.

There is hardly any excuse for a death from hemorrhage.

The author advises, I think wisely, not too rapid an emptying of the uterus, keeping the bladder and rectum empty, and seeing that the uterus itself is completely emptied of the placenta and membranes. Half an hour is long enough to wait for the expulsion of the placenta. The writer states an interesting point when he declares that a previous curettement may influence the mode of attachment of the placenta—and so where that operation has been done manual removal is more likely to be required. The writer doesn't state his reasons for such a statement, and I can hardly agree with him.

Infection—Thirteen cases died. The method advised to avoid sepsis is thorough cleansing of the vulva. Never give an antepartum douche, even when gonorrhoeal vaginitis is present, and as few vaginal examinations as possible, substituting the rectal examination and external palpation.

Toxemia.—This includes nephritis, pernicious vomiting, and eclampsia. No case of eclampsia that was delivered immediately after the *first* convulsion died. Hence early interference is advised for eclampsia, and also for nephritis.

For vomiting, plenty of fluids and purgatives are advised, but a milk diet is contra-indicated on account of the high calcium content.

When in doubt in these cases induce labor by Krause's method or some modification, after having held a consultation.

Of the disabilities following labor, two rules need to be followed:

1. Forceps must not be applied till the cervix is fully dilated.
2. Extensive laceration of the cervix or perineum should be at once repaired.

As regards tight bandaging of the patient and keeping her on her back: these two factors prevent the spontaneous involution of the round ligaments, keep the uterus tilted backwards, and so keeps a laceration of the cervix gaping, and, lastly, prevent the bladder spontaneously emptying itself, and so compels catheterization. Hence the abdominal binder serves no useful purpose.

Reviews

Text-Book of Operative Surgery. By DR. THEODORE KOCHER, Professor of Surgery and Director of the Surgical Clinic in the University of Berne. Third English edition. Authorized translation from the fifth German edition. By HAROLD J. STILES, M.B., F.R.C.S. (Edin.), Surgeon to the Royal Edinburgh Hospital for Sick Children, and Chalmers' Hospital, Edinburgh; and C. BALFOUR PAUL, M.B., F.R.C.S. (Edin.), Assistant Surgeon, Royal Edinburgh Hospital for Sick Children. With 415 illustrations. In two volumes. Price, \$16.00. Publishers: The Macmillan Company of Canada, Limited, 70 Bond St., Toronto.

The present edition of this exhaustive work may well be described as the "last word" on the subject of operative surgery. Few, if any, European surgeons have had such an extensive experience alike in the teaching and practice of surgery as Professor Kocher, and he has condensed his vast knowledge in the present work, which embraces 450 pages more than the former edition. The whole work has been thoroughly revised and re-arranged. Many of the sections have been re-written, while the additions which have been made, both to the text and illustrations, are such as to make the work now cover the whole field of operative surgery.

The two volumes are divided into five parts, viz.: Section 1, which deals with the following subjects: Preparation for operation, beginning of the operation, operative technique, after treatment, detailed consideration of anesthesia, and details in regard to wound treatment; Section 2, surgery of the vascular system; Section 3, surgery of the nervous system; Section 4, surgery of the extremities; Section 5, surgery of the head and trunk. As already stated, the work is truly exhaustive in its scope, masterly in its style, and lucid, both by virtue of the directness of the text and the wealth of illustration. As all the surgical world knows, Professor Kocher has devised a tremendous number of operations, or modifications of other methods, and, while he gives ample credit for the work of those who have gone before (generally giving their operations in detail), one cannot help being impressed with the many improvements he has introduced into operative technique, especially when the details of his methods are placed alongside those of former operators. To take an example at random: His description of his own method of excising the elbow joint. How clear in its description! And to those who have performed the operation—more especially for tubercular disease of the joint—how much more simple

and satisfactory it is than by the older methods. And so one might go on giving example after example of his keen and logical methods, did space permit. We cannot close this brief and all too inadequate review without a reference to Professor Kocher's preface to this last edition. Seldom has the case for the surgeon been put so strongly and fairly as he has stated it in his preface. After dwelling on the absolute necessity for thorough preliminary training of the surgeon in the matter of making exact diagnoses, and in establishing precise indications for treatment, he goes on to say: "The possession of these requisites would destroy the favorite arguments of those physicians who are inclined to disparage surgery and belittle its successes. They maintain that the cases are innumerable in which unnecessary and even injurious operations are performed, and they are apt to hold the whole profession responsible for such unwarranted operations undertaken by men of little experience. Just as the physician is not permitted to write prescriptions without a knowledge of the action and effects of drugs, so the surgeon should not be allowed to perform operations unless he is capable of first making an exact diagnosis and prognosis.

"Even if we admit that the surgeon is responsible for the results of his operations, it must never be forgotten that omissions and blunders in the previous treatment on the part of the public and the physician respectively account for an infinitely larger number of victims than do the errors of the surgeon."

In answer to the question, "What particular considerations are due to the surgeon from physicians and the public?" he lays down the following: "1. In every case where there is any question of operation the surgeon ought to be summoned in the first instance for the purpose of examination and consultation. 2. The choice of where the operation is to be done, as well as the manner of its performance, should be left entirely to the surgeon. 3. It is absurd to wait till the patient has become moribund before calling in the surgeon."

Truly this is a great work, and one which would well repay the careful study any general surgeon or general practitioner might spend on it. From the standpoint of craftsmanship, these handsome volumes reflect great credit on the publishers. T. B. R.

Cesare Lombroso. A Modern Man of Science. By HANS KURELLA, M.D., author of "Natural History of the Criminal," etc. Translated from the German by M. Eden Paul, M.D. Price, \$1.50. New York: Rebman Company.

This book deals with Lombroso's activity as a reformer. Some of it is taken from the author's earlier publications upon the de-

velopment of criminal anthropology. It attempts to establish the position Lombroso occupied in the positive study of the world, but does not deal with his great activity as a reformer of criminology and criminal sociology. It will, no doubt, be of more interest to the student of medical jurisprudence and psychiatry.

Makers of Man. A study of human initiative. By CHARLES J. WHITBY, M.D. (Cantab.), author of "The Logic of Human Character," "the Wisdom of Plotinus," etc., etc. With forty-seven half-tone and other plates. Price, \$3.00. New York: Rebman Company.

This is a very interesting and instructing book. It treats of the lives of forty world-famous individuals, treats of them from the physical as well as the psychological aspect. Their natural vocation is studied, as also family history, parentage and constitution. The book closes with a striking chapter on individuality, its nature and power. It is well worthy a place in every library.

The Principles and Practice of Modern Otology. By JOHN F. BARNHILL, M.D., Professor of Otology, Laryngology and Rhinology, Indiana University School of Medicine, and ERNEST DE W. WALES, B.S., M.D., Clinical Professor of Otology, Laryngology and Rhinology, Indiana University School of Medicine. Second edition revised. Octavo of 598 pages, with 305 original illustrations, many in colors. Philadelphia and London: W. B. Saunders Company, 1911. Cloth, \$5.50; half morocco, \$7.00 net. Canadian agents, J. F. Hartz Co., Toronto.

The second edition of this useful work comes to hand. Like its predecessor, the first edition, it is a compact, beautifully printed, beautifully bound book. The illustrations are excellent, some of the plates being colored. The descriptive matter is tersely and simply written. Among the most important additions to the former work are a chapter on the examination of the functions of the ear, which includes the description and formula of a uniform system of tests accepted by the Eighth Otological Congress at Buda-Pesth in 1909; a more extended statement regarding operative injury to the facial nerve; a description of the modified radical mastoid operation for chronic suppurating ears; several paragraphs commenting upon the symptoms, pathology and surgical treatment of labyrinth suppuration. In the chapter upon the influence of nasal and nasopharyngeal conditions upon affections of the ear, we think that special mention should be directed to the part played by the swollen posterior ends of the inferior turbinates and to adenoid masses behind the tubes.

As the authors state, this work is intended for the use of students and general practitioners in medicine, and we think that it will form a very useful addition to their working library. G. R.

Plaster of Paris and How to Use It. By MARTIN W. WARE, M.D., New York, Adjunct Attending Surgeon, Mount Sinai Hospital; Surgeon to the Good Samaritan Dispensary; Instructor of Surgery in the New York Post-Graduate School. Second edition, revised and enlarged. Price, cloth, square form, \$1.25. De luxe leather, \$2.50. Surgery Publishing Co., New York.

The exhaustion of the first edition and the persistent demand for this helpful book were the incentives for this second edition, which has been completely rewritten and enlarged, and thus its scope of usefulness has been greatly extended. Complete new drawings and marginal side notes in red embellish the book, and ninety illustrations are used to more clearly put up to the eye of the reader the intent of its subject matter.

Such information as history, materials, manufacture of bandages, storage, bandages of commerce, calot plaster bandages, the immediate preparation of bandages, application and precaution, removal of bandages, etc., are all given under the contents of the Plaster of Paris Bandages. Then follow such chapters as Application of the Plaster of Paris Bandage to Individual Fracture, Fractures of the Upper Extremity, Fractures of the Lower Extremity, Moulded Plaster of Paris Splints, Plaster of Paris in Orthopedic Surgery, etc., and all presented in such a comprehensive manner as to make this book of particular service to every doctor. The mechanical features of the book are decidedly striking.

Accidental Injuries to Workmen. With reference to Workmen's Compensation Act, 1906. By H. NORMAN BARNETT, F.R.C.S. With article on Injuries to the Organs of Special Sense. By CECIL E. SHAW, M.A., M.Ch., M.D., and Legal Introduction by THOMAS J. CAMPBELL, M.A., LL.B. Price, \$2.50. New York: Rebman Company.

As there is no work on the market dealing with accidents and their results relative to the Workmen's Compensation Act, 1906, this book will be welcome to the medical profession. The legal introduction embraces the first fifty pages; the Act itself is analyzed, and what constitutes an accident is explained. There is an important chapter on making reports and giving evidence, and injuries are taken up under injuries to bones, joints, muscles, blood-vessels, nerves, internal organs, etc. Altogether this will be found a very important book for all medical men to possess.

State Board Questions and Answers. By R. MAX GOEPP, M.D., Professor of Clinical Medicine at the Philadelphia Polyclinic. Second edition, revised. Octavo volume of 715 pages. Philadelphia and London: W. B. Saunders Company, 1911. Cloth, \$4.00 net; half morocco, \$5.50 net. W. B. Saunders Company, Philadelphia and London; Canadian agents, The J. F. Hartz Company, Toronto.

It is now three years since the first edition of this valuable book for medical students was published. The advances made in medicine in that time have necessitated revision in order to bring it up to date. We consider this a very valuable book for students, as it is not merely a list of papers, but the answers as well succinctly set forth. Indeed, it will well repay medical men to review such a work of this character, putting them in possession of many recent advances in medicine.

International Clinics. Volume I. Twenty-first series, 1911. Price, per volume, \$2.00. Philadelphia and London: J. B. Lippincott Company.

The present volume treats of Diagnosis and Treatment, five papers; Medicine, six papers; Pediatrics, one paper; Surgery, four; Ophthalmology, one; Physiology, one; Anatomy, one; Biology, one; Tropical Medicine, one. Nearly one hundred pages are devoted to the progress of medicine in 1910. These deal with treatment, medicine and surgery, and set forth ably what has been accomplished in these departments of medicine during the year. There are several colored plates, figures and other plates in this volume. Altogether it appears to us one of the best recently issued.

A Treatise on Diseases of the Skin. For the use of Advanced Students and Practitioners. By HENRY W. STELWAGON, M.D., Ph.D., Professor of Dermatology, Jefferson Medical College, Philadelphia. Sixth edition, revised. Handsome octavo of 1,195 pages, with 289 text illustrations and 34 full-page colored and half-tone plates. Philadelphia and London: W. B. Saunders Company, 1910. Cloth, \$6.00 net; half morocco, \$7.50 net. Canadian agents, The J. F. Hartz Co., Ltd., Toronto.

Stelwagon's work on dermatology is so well and favorably known, both to general practitioners and specialists in skin disease, that it is unnecessary for one to call attention to its many excellent characters. It might be described as a comprehensive,

scientific, yet practical book on skin diseases. The author has taken special care to present the subject matter in a plain, elementary manner, which is always appreciated by a student of the subject.

In the present edition much new material has been added and unnecessary and obsolete matter dropped, bringing the book up-to-date.

The work is well illustrated, a character which is to be commended in a treatise on any organ of the body, and especially on dermatology.

Hydrotherapy: A Treatise on Hydrotherapy in General; Its Application to Special Affections; the Technic or Processes Employed; and Use of Waters Internally. By GUY HINSDALE, A.M., M.D., Lecturer on Climatology, Medico-Chirurgical College of Philadelphia. Octavo of 466 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1910. Cloth, \$3.50 net. Canadian agents, The J. F. Hartz Co., Ltd., Toronto.

In the treatment of disease hydrotherapy is an important measure; indeed, there are few general affections in which it is of no value. The medical profession recognize its importance and are making use of it more and more as the science is better understood.

The volume before us is a scientific exposition of the science of hydrotherapy. The text is divided into four parts, namely, general hydrotherapy, special hydrotherapy, technic of hydrotherapy, and the use of mineral waters. Under general hydrotherapy are described the effects of baths on metabolism, blood pressure, rate of heart, blood and respiration. The second division of the work is devoted to hydrotherapy in the various diseases in which it is useful. This is followed by chapters on technic, in which are described the various kinds of baths, rubs, douches, packs, etc. The remaining parts are given to the internal use of water in disease and the special value of mineral water.

The book is well written and gotten up, and we can recommend it to anyone wishing to obtain information on the subject of hydrotherapy.

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COMMENT FROM MONTH TO MONTH.

The Appointment of Dr. Charles J. Clarke to the superintendency of the Toronto General Hospital is the best possible which could be made.

An experienced and capable administrator, occupying a leading position in the Canadian medical profession, an acknowledged expert in psychiatry, the head of the Medical Department of the Provincial University, Dr. Clarke will bring into closer relationship the Medical Department of the University and the Hospital.

The Board of Governors of the Toronto General Hospital have chosen wisely and well and are to be congratulated upon securing the services of a man of Dr. Clarke's ability, experience, and connection.

This journal wishes him every success in his new sphere.

Dominion Registration is a good step nearer. In our next issue we will publish in full the Amendment to the Canada Medical Act which has passed both Houses of Parliament.

Dr. Roddick, as well as Dr. Black, M.P. for Hants, N.S., are to be congratulated upon the successful passage of the bill, Dr. Black being the chief inside promoter, as Dr. Roddick has for so many years been the active outside promoter.

It remains now for the different provincial legislatures at their very next sessions to pass the ratification legislation necessary to make the Act universal and as well make it law.

Those legislatures which did not before pass the ratification legislation should now get actively busy and be the very first to acquiesce. These, it is understood, are Quebec, Ontario and British Columbia. The others will probably have to do so likewise, but as they were agreeable with the Act of 1902, it is quite proper to assume there will be no hesitation with them as regards the amendment.

That this long and much-desired end may now be brought about in a year's time it is safe to predict.

Medical Advertising every now and again engages our attention. That no medical journal could long survive the loss of its advertising patronage is a fact which must be apparent to all. Medical journalism owes a great debt to its advertising patrons. This is equally true of newspapers and magazines.

Medical advertising makes medical journalism possible. Medical journalism, the best or mediocre, has brought to the profession of medicine untold good. Even association journals need and profit by its support.

If this is true, then the profession of medicine owes something to those commercial establishments which consistently or intermittently patronize the advertising pages of the medical press.

To those who consistently patronize the medical press the profession owes the most; to those who intermittently use it the profession owes a great deal; but to those who care nothing at all for the medical press, who even go so far as to sneer at its value, there is nothing left to be said other than that they are purely "out for the coin."

It seems plain then that the profession should patronize those who patronize the medical press. The profession cannot do without the medical press and the medical press cannot do without the medical advertisers.

Those who do not use the medical press at all are mere interlopers.

The cult of the open window, it is said by someone, would in a generation rid Canada of tuberculosis. For long years those active campaigners against tuberculosis have preached the open-air life for the tuberculous, and subsidiary to this the open window.

Indeed, the pendulum has been swung to the extreme limit, and the open window, especially of the sleeping room, has been advocated for all.

With so much publicity with regard to open-air life and the open window and the great advantages to health accruing therefrom, it is interesting to enquire how far the people have gone towards following out the advocacy of the open window.

In city life it would appear that in the late fall, winter and early spring seasons this is not followed out to any very great extent, as one can easily prove by observing just how many windows are open while walking along any street at daybreak.

On a recent morning visit when day was just breaking the writer sauntered homewards along several streets, and although it was a beautifully mild April morning, he was surprised to see only here and there an open window, and even then most of the few which were open were only open to a very slight degree.

This would naturally lead one to the conclusion that the open window is taken very little thought of by the mass of the people and that the publicity campaign so far has produced no particularly striking results.

"Early to bed and early to rise" is an old adage, but most people find the two hardest things in life are to go to bed early and to arise early.

The freshness and quiet of the early morning, especially in spring and summer, as well as the health-giving properties of the purer morning air, should be taken more cognizance of by those fighting tuberculosis; and all would certainly benefit by adopting the rule of arising in spring and summer at daybreak.

The cult of the open window, with the practice of daybreak rising, might well be more actively pushed, but one must not forget that the open window in summer time must be screened from flies and that at all times it renders access decidedly easy for burglars.

Garbage collection and disposal is no doubt a considerable problem in large cities. It is a sanitary matter, and as such should be under the control of the Health Department.

In winter-time snow by-laws are enforced, and every householder is required to shovel the snow from the sidewalks. In summer-time street cleaners are abroad, but the sidewalks and boulevards are totally neglected, except where private enterprise keeps a well-trimmed lawn and a clean sidewalk.

In Toronto this spring the sidewalks and boulevards have

seemed unusually dirty. The present system of collection of garbage, which requires householders to place these conspicuously on the edges of the boulevards, in front or at the sides of houses, is a system which ought to be done away with rapidly. Everyone should take a just pride in seeing a clean city, and clean sidewalks and boulevards are required just as much as clean streets.

There should be a sidewalk and boulevard by-law, requiring all householders or owners to keep these clean and in good condition. But this could not be done where garbage is collected as at present.

All garbage and ashes, where there are no lanes to put receptacles in, should be gone in after by the collectors, and the unsightly barrels, boxes, tubs, etc., kept indoors. Newspapers on boulevards, sticks and stones, as well as dirt on sidewalks and boxes and all sorts of things displayed at shop fronts should be abolished. Surely it is time for our city fathers to look alive to the beauties of a clean, tidy city.

A by-law as indicated above seems urgently needed.

Flies should be put to flight, or, better still, kept from flying. Our Health Officer is to be commended for the way he gets after what may be thought little things.

Attacking at breeding-time and screening all windows and outside doors will go a long way, but until a better system of garbage collection is established these flies will still be flying around.

Dr. Hastings is giving battle to a formidable host, but he will have our best prayers that his prowess will prevail.

News Items

DR. ST. JACQUES, Montreal, has sailed for England.

DR. H. A. BRUCE, Toronto, has returned from Atlantic City.

WINNIPEG is building a hospital for sick children at a cost of \$100,000.

DR. W. T. SHIRIFF, of Hazeldean, has been appointed Medical Health Officer of Ottawa.

CHILLIWACK, B.C., is to have a new hospital. Hon. Dr. Young subscribed \$1,000 for the purpose.

REMEMBER the dates of the Ontario medical meeting at Niagara Falls—May 30th and 31st, June 1st.

DR. LLEWELLYS F. BARKER was operated on at the Johns Hopkins Hospital for appendicitis and is now convalescing.

DR. JAMES A. McCAMMON, Gananoque, has been appointed Sheriff of the United Counties of Leeds and Grenville.

DR. THOMAS DAWSON, M.H.O., Calgary, has been appointed Superintendent of the Hospital for the Insane at Pokona, Alta.

DR. H. G. PICKARD, Minto, Man. (Trinity, '95), formerly of Glamis, Ontario, has been appointed Medical Health Officer of Brandon.

DR. GEO. E. ARMSTRONG, Montreal, President-elect of the Canadian Medical Association, has received the Degree of Doctor of Laws from Queen's University.

DR. CHARLES K. CLARKE, Superintendent of the Toronto Provincial Hospital for the Insane, has been appointed Superintendent of the Toronto General Hospital.

NEW Medical Council, Alberta:—Dr. C. J. Stewart, Calgary; Dr. Brett, Banff; Dr. Mewburn, Lethbridge; Dr. Park, Edmonton; Dr. Crang, Stratheona; Dr. Malcolmson, Frank.

DR. D. W. CATHELL is giving his book on "The Physician Himself" a twelfth and final revision, and will attempt to make it a book without a parallel in usefulness, and also a book without a blemish.

THE Manitoba Medical Association will hold its annual meeting in Portage la Prairie on the 22nd and 23rd of June. Dr. Ingersoll Olmsted, Hamilton, and Drs. Fisher, Reese and Cubbins, of Chicago, will be present.

THE 42nd annual meeting of the American Medical Editors' Association will be held in Los Angeles, Cal., June 26th and 27th, 1911. The President is Dr. J. MacDonald, Jr., New York, who was for many years the Secretary of this Association.

THE Emperor of Germany has conferred upon Dr. William H. Welch of Baltimore the Order of the Crown, second class, in appreciation of his services in propagating German medical science in the United States and in spreading the use of the German language in the medical schools of America.

ALTHOUGH invitations were only sent out for the Reunion of Graduates in Medicine at McGill on June 5 and 6, when the New Medical Building will also be formally opened, already about two-thirds of those invited have signified their intention of being present. Dr. Casey Wood, of Chicago, is organizing a party of men from the Western States, and Dr. Wilfrid Nelson, of New York, is also organizing a party in New York. These parties will be brought to Montreal in special cars.

THE fourth annual meeting of the Academy of Medicine, and the first in their new premises, 13 Queen's Park, was largely attended. Arrangements are now being made for a formal opening of the new building, to be held the latter part of May. The following Fellows were elected as officers for the ensuing year: President, Dr. N. A. Powell; Vice-President, Dr. R. A. Reeve; Past President, Dr. Albert A. Macdonald; Hon. Secretary, Dr. Harley Smith; Hon. Treasurer, Dr. W. A. Young. Chairmen of Sections—Medicine, Dr. Graham Chambers; Surgery, Dr. H. A. Bruce; Pediatrics, Dr. J. T. Fotheringham; Pathology, Dr. J. J. McKenzie; Ophthalmology, Dr. C. Trow; State Medicine, Dr. J. W. S. McCullough. Elective members—Drs. John Ferguson, John Malloch, H. J. Hamilton, J. F. W. Ross, W. P. McKeown, A. McPhedran, F. N. G. Starr, and E. E. King.

GRADUATES who intend coming to Montreal for the McGill Reunion or the meeting of the Canadian Medical Association, should give particular attention to the following conditions laid down by railway companies in connection with their offer of reduced rates: 1. Each person must purchase, not earlier than June 3rd, a first-class ticket to Montreal, paying regular tariff fare, and at the same time must obtain from the ticket agent a Standard Certificate of such purchase, properly filled in and signed by the agent. 2. If through ticket cannot be purchased at starting point, purchase to nearest point where through ticket can be obtained, there purchase through to Montreal, obtaining at the same time Certificate properly filled in and signed by Agent where each purchase is made. 3. On arrival at Montreal this Certificate will be viséd by a Special Agent of the railway lines at the Registration Office, McGill Union, and *must be attended to on June 6th, in order to obtain benefit of reduced rates on the return trip*; for this a fee of 25 cents will be charged. This Certificate must also be countersigned by the Secretary of the Meeting. The following are the reduced rates offered: From points in Canada east of and including Port Arthur, Sault Ste. Marie, Fort William, and the St. Clair and Detroit Rivers, if 49 or less in attendance, return from Montreal to point of departure, at two-thirds of the lowest regular first-class fare; if 50 to 299 in attendance, at one-third of the lowest regular first-class fare; if 300 or more in attendance, the return trip will be free. These reduced fares apply also to ladies accompanying graduates. It is expected that the number of graduates in attendance will exceed 300. Special rates will also be arranged for graduates living West of Port Arthur and directions as to how to obtain these rates will be sent later.

PROGRAMME.

Monday, June 5th.—Informal luncheon at the McGill Union by members of Teaching Staff of the Medical Department to the Graduates in Medicine. Afternoon—Convocation in Royal Victoria College. Evening—Opening of new building. Conversazione given by the Governors of the University.

Tuesday, June 6th.—Morning and Afternoon—Clinics and Demonstrations in Hospitals and Laboratories. Private entertainments. Evening—Banquet tendered by the members of Teaching Staff of the Medical Department to the Graduates in Medicine.

Class Reunions.—At times to be arranged.

Headquarters for information, registration, letters, invitations, etc., at McGill Union. Open Monday, 9 a.m.

Publishers' Department

SURGICAL DISEASES OF THE UMBILICUS.—T. S. Cullen, Baltimore (*Journal A. M. A.*, February 11), after noticing the principal literature of the subject, enumerates and discusses the surgical disorders affecting the umbilicus. Among the non-malignant abnormalities he mentions so-called adenoma, funnel-shaped umbilicus, cystic cavities in the abdominal wall, attachment of Meckel's diverticulum to the navel, patent omphalomesenteric duct, and prolapsus of the bowel through such duct. The term adenoma is a misnomer, but has been so long in use that he employs it. It simply consists in the funnel of mucosa being forced outward and turned inside out. Adenoma may be ligated and cut off or allowed to drop. The parents should be cautioned to watch the child for any obstruction occurring. A funnel-shaped umbilicus can be removed by an elliptical incision removing the entire area and exploring for Meckel's diverticulum, which, if found, should be removed. Where very small fecal fistula exists, one may wait a while for its closure, but, if open after six months, it should be dissected out down to the ileum and removed. A lookout should be made for obstruction in any case. When large it should be removed at once, which is not very dangerous in a healthy child. When prolapsus with inversion has occurred, signs of shock have usually appeared and the chances of saving the child are slight. Of the malignant growths of the umbilicus, four varieties are recognized: (1) primary squamous-celled carcinoma; (2) primary adenocarcinoma; (3) sarcoma; (4) secondary carcinoma. The first of these is very rare and its gross appearance is that of skin cancer ulcer. Primary adenocarcinoma seems to be more frequent, but there is some confusion about it because of the possibility of its being secondary to disease elsewhere. Pernice has collected six cases of sarcoma, but Cullen seems to think that the evidence is not very convincing regarding most of them, which may have been fibromata. Secondary carcinoma is the most interesting of the four and is treated of at some length. If an umbilical nodule is detected in a middle-aged person, Cullen says the condition of the abdominal organs must be thoroughly investigated for signs of cancer of the stomach, gall bladder, intestines, or genital organs. The futility of removing the umbilicus when the primary growth is in the abdomen is especially emphasized. The article is illustrated.